

Measuring Client Modes of Engagement in Humanistic Experiential Psychotherapy

by

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for the degree of Doctor of Philosophy

School of Psychological Science and Health
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Abstract

The role of clients' emotional engagement has progressively played a central role in psychotherapy. This project inserts itself in this debate by seeking to validate the Client Modes of Engagement (CME) theoretical model (Elliott 2006; 2013a). While Elliott's CME framework—a process-diagnostic map based on clients' experiential content—was grounded on decades of research and clinical practice, it had yet to be made amenable to empirical investigation. This project responds to this absence by offering the Client Modes of Engagement Observational Coding System (CME-OCS) and the Client Modes of Engagement Questionnaire (CMEQ-R₂). These instruments measure the construct from both the perspective of external observers (CME-OCS) and therapists (CMEQ-R₂).

This dissertation explores the application and validation process for both the CME-OCS and the CMEQ-R₂. The results confirmed that the CME-OCS is a reliable coding system for identifying CMEs during EFT psychotherapy. Additionally, the findings suggest that there are interactions between CMEs, phases of therapy, and outcome groups. Moreover, I established that there are differences in the ways outcome groups' transition between CMEs at particular stages of therapy.

I applied both classical psychometric properties methods and Rasch modelling with the purpose of examining the CMEQ-R₂'s psychometrics, refining the instrument, and later applying it in a process outcome study. The results suggest that levels of CME early in therapy and changes in levels of CME over therapy—as measured by the CMEQ-R₂—are significantly associated with client pre-post therapeutic improvement. I also found firm ground for arguing that therapists can distinguish between levels of CMEs and that their perspective can be systematically analysed. Together, both instruments pose important implications for research and clinical practice. Overall, this study validates the contention that researchers and therapists should be particularly attentive to clients' manner of engagement and focus of attention on specific levels of their emotion scheme.

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Chapter 1

The Client Modes of Engagement Model

1.1 Introduction

Six decades of clinical research clearly support the contention that psychotherapy is an effective treatment for a variety of psychological difficulties (Castonguay & Beutler, 2006; Cuijpers, 2017). In the last few decades, researchers have become increasingly interested in studying the particular in-session processes that account for therapeutic transformation (Goldfried, 2010; Greenberg & Newman, 1996). So far, research findings suggest that it is the combination of clients' emotional arousal, along with their ability to express, label, reflect, elaborate, and create meaning out of their emotional experience, that is key for a successful therapeutic process (Greenberg, 2010). Diverse theoretical perspectives recognize the underlying importance of how clients process emotions. Recently, there has been an increased appreciation of the importance of emotional processing for therapeutic transformation in such diverse psychological modalities as the Psychodynamic (Diener, Hilsenroth, & Weinberger, 2007; Fosha, 2002) and Behavioural/Cognitive (Clark & Beck, 2010; Foa & Kozak, 1986) approaches, as well as recent Neuropsychological studies (Davidson, 2015; Siegel & Solomon, 2013). Moreover, processing of emotional experiences serves as the fundamental concept upon which the Humanistic/Experiential perspective is grounded (Elliott, Watson, Goldman & Greenberg, 2004).

Emotion-Focused Therapy (EFT) emerged within the field of Humanistic/Experiential psychotherapy (HEP). It is grounded on the understanding that emotions shape our behaviour and are deeply intertwined with our most

fundamental needs. The assumption is that re-processing difficult experiences during psychotherapy is fundamental for clients' emotional growth. Therefore, the aim of the therapeutic process is that of facilitating clients' contact with their emotional experiences and cultivating their ability to fully process these. For this reason, EFT research has focused much of its attention on understanding in-session emotional processes that account for therapeutic transformation. The overall argument is that optimal human functioning is the result of deep awareness, emotional flexibility, the ability to symbolize and organise inner experiences, the capability of accessing new emotional states and creating new meanings, and the facility to share these with others in an appropriate manner (Auszra, Greenberg & Herrmann, 2013; Watson, 2011). In contrast, psychological difficulties arise from overwhelmed emotional states, a lack of emotional awareness, emotional avoidance, or a tendency to rigidly symbolize experience (Watson, 2011). In this way, emotionally overwhelmed or disengaged modes of processing, as well as stances during which clients rigidly narrow their attention to specific aspects of their experience, interfere with their ability to access, express, elaborate, symbolize, and transform their emotions (Elliott et al., 2004).

With emotions as a central focus of EFT, researchers have sought to explain how these organise the process of experiencing. In order to refine and study the different active ingredients involved in the process of experiencing, Greenberg, Rice & Elliott (1993) proposed the concept of "Emotion Schemes"—by which individuals internally integrate emotional memories and personal experiences (Elliott et al., 2004; Greenberg & Paivio, 1997). An Emotion Scheme is conceived as an ever-changing network of interconnected elements that together produces an implicit or

experienced emotion (Elliott et al., 2004). Emotion Schemes are not immediately available to awareness; rather, focusing on different elements of the scheme activates them. It is only by bringing particular elements into awareness that these spread to the other elements of the network and thus produce an emotional experience. Clients may have difficulties processing their experience fully when they either rigidly attend to one specific element as a way of avoiding emotions, or when they attend to these elements in a chaotic and disorganised manner, thus, impeding the integration of different aspects of emotional experience. It is expected that for optimal emotional processing to occur, all elements need to be activated in a coherent and organised manner. However, according to this theory, there are different styles in which clients may engage with their experience depending on how they contact and activate the different elements of their emotion scheme. Indeed, Greenberg and colleagues (1993) pointed out that clients process their experience differently, and that there are modes of engaging that are more productive or less productive. The authors referred to these as “Modes of Engagement”: “the content of what clients say and the manner in which they say it... provides an indication of their stance toward their experience” (Elliott et al., 2004, p. 65).

While the last couple of decades have indeed seen the development of various insightful models for explaining emotional processing (Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007), there is still a need to develop a model that examines, differentiates, and elaborates upon the different active ingredients of the client’s emotional process. Indeed, developing a framework capable of examining and understanding the different dimensions underlying emotional processing during psychotherapy has become important.

Most of the research studying clients' styles of processing has given emphasis to emotional activation or distancing (i.e., Auszra et al., 2013; Greenberg, Auszra, & Herrmann, 2007; Missirlian, Toukmanian, Warwar, & Greenberg, 2005) while less attention has been given to "the focus of clients' attention and the activity in which she or he is engaged during session" (Elliott et al., 2004, p. 65). Indeed, while the original formulation of Client Modes of Engagement (Greenberg et al., 1993) provided a useful means of paying attention to and exploring the manners in which clients are engaging with their experience, Elliott (2006) pointed out that it did not sufficiently differentiate between the manner in which clients process their experience and the client's focus of attention on particular elements while experiencing. Elliott (2006) argued that clients' focus of attention is inextricably related to the Emotion Scheme model and should be investigated in order to gain a more refined understanding of the inner workings of the experiential process. Thus, in response to this gap in research, Elliott (2006; 2013a) proposed a model that clearly specified and combined both the ways in which clients process their experience and their focus of attention toward its specific elements.

1.2 Rationale for This Project

Elliott's (2006; 2013a) Client Modes of Engagement model was the product of many years of research, clinical work and observation. However, it still needs to be elaborated on, expanded upon and empirically validated in at least the following ways:

1. The model still needs further conceptual clarification and refinement in order to articulate how Client Modes of Engagement encompass the complexity of the Emotion Scheme model. That is, the model still needs to specify how the various

manners in which clients' process their experience intertwines with each element of the Emotion Scheme network.

2. As is fundamental to any theoretical framework, this model needs to be amenable to empirical investigation. Particularly, it must be operationalized and then accompanied by measurable systems that permit the observation of the construct under study. This would provide empirical grounds for the proposed model. To date, there are no psychometrically sound measures that take into account each element of the Emotion Scheme model and the different styles of processing these elements. In order to study how client experiential modes may present during psychotherapy, it is necessary to develop measures that capture clients' momentary and habitual manner and focus of attention.

3. In order to determine its clinical relevance, the Client Modes of Engagement model needed to be empirically validated by showing how it relates to therapeutic change both within sessions and across therapy. This kind of validation may provide grounds for the model to serve as a useful empirical tool for measuring the kinds of processes that lead to in-session resolution and overall client improvement.

4. The coding systems that have been developed so far in order to study aspects of client emotional processing are not user-friendly for practitioners in routine practice. They require extensive training, are time-consuming, and are focused on research endeavours (Machado, Beutler, & Greenberg, 1999). Moreover, their complexity makes them difficult to implement in studies by other research groups. In order to reduce the practice-research gap and show its clinical

applications, the Modes of Engagement model still needs to be converted into an understandable and user-friendly evaluation system that can be used by practitioners.

These four points are the principal research tasks that will be addressed in this project. The aim of this investigation is to elaborate, expand, validate, and develop useful clinical applications for Elliott's Modes of Engagement model. These research tasks are expected to contribute in relevant and substantial ways to our scientific and practical understanding of psychotherapy.

This project proposes a process diagnostic model based on different kinds of client experiential content as they are accessed through the schematic structures of emotional processing. The model is an orientation specific measure of client styles of engagement that serves as a tool for putting EFT theory into practice. The project develops two measurements: a non-participant observational tool for empirically validating the Client Modes of Engagement Model, and a participant observational measurement that assesses therapists' views of how their clients process their experience.

Most of the research that has been conducted on client emotional processing within psychotherapy sessions has been from a non-participant observational methodology (Greenberg & Pinsof, 1986; Machado et al., 1999). While this type of tools has been fundamental to current understandings of emotional processing, there is a need for complementary research conducted through participant observational measurement as a means of accessing a larger picture of the phenomena involved in research. Thus, in order to provide a more exhaustive understanding of emotional processing, the Modes of Engagement model will be first analysed through a moment-to-moment non-participant observational method, and then used to develop

a therapist participant observational measurement. This will provide a more comprehensive validation for the expanded Client Modes of Engagement model.

One of the aims of my proposed framework is to provide a useful and user-friendly tool for therapists to direct client emotional processing during therapy. Indeed, if we assume that emotions are crucial to therapy, practitioners should be able to recognize how clients process their experience (Elliott et al., 2004). It is thus important to develop a model that can evaluate if practitioners are in fact capable of distinguishing and differentiating between different styles of processing. Indeed, as Orlinsky and Howard (1986) point out, therapists' experience can and should "be made the subject of psychological science" (p. 479). The participant observational method is particularly well suited to measure experiential phenomena and may represent an authentic display in naturalistic settings and psychotherapy practice more aptly than non-participant observational systems (Machado et al., 1999). This line of research can also provide evidence on how accurate therapist ratings of clients' emotional processing are in predicting psychological improvement. This in turn, can shed light and give further information to develop strategies for the enhancement of practitioner training and supervision. Indeed, there is evidence suggesting that participant observational instruments are particularly successful in predicting therapeutic improvement (Orlinsky & Howard, 1986). These tools are close to practice and presumably provide opportunity for therapists to echo client's internal process by resonating empathically with them — therapists' subjective experience is, in this sense, more proximate to the client's experience. By developing a participant observational instrument, the project provides a user-friendly means for therapists to facilitate client emotional processing during therapy.

1.3 Epistemological Framework

Every research endeavour is built on underlying ontological beliefs about the nature of reality and epistemological beliefs about how to access this reality. The views researchers hold about the phenomenological world influence their inquiries in fundamental ways. These stances determine what knowledge is believed to be and how best to access it. In turn, these standpoints prescribe our role as researchers along with the relationship between those we are studying and ourselves.

Various seminal philosophical belief systems have historically guided research in the field of psychotherapy — including positivism and post-positivism. These have served as determinant factor in research decisions ranging from the selection of field of interest, to methodological choices, analytic approaches and the eventual dissemination of results. This section contextualizes the position taken by this research project in the wider context of other epistemological beliefs.

Positivist epistemology was the product of Enlightenment philosophy and the ontological realism upon which it was grounded — the belief that reality is the singular and a priori make-up of the world (Lindlof & Taylor, 2011). Crucial to this philosophy was the claim that true access to knowledge can only be achieved through the empirical observation of objective reality. As such, it served as the foundational belief system for the modern natural sciences buttressed by the belief that it is through the scientific method alone that observers may access true knowledge of the phenomenological world. The belief that essential reality can be objectively apprehended was grounded on the ontological assumption that reality exists independently from the observer.

It was Comte (1865/2009), a French sociologist and philosopher, who coined the term positivism. He argued that true knowledge about the social world could only be accessed through the scientific method; as such, he pioneered the use of logical positivism in the social sciences. In turn, social scientists began rigorously implementing the premises and methodology of the natural sciences as a means to gain credibility. As such, researchers began adopting quantitative approaches to social phenomena. From a positivist standpoint, the objective of research in the social sciences was assumed to be the search for the objectively observable mechanisms of cause and effect that determine human behaviour. Positivists believed that the deductive method of inquiry was the sole legitimate approach to knowledge.

The influence of positivism in psychology has been widespread. However, during the late 20th century, various advances in both the natural and social sciences provided grounds for questioning many of this paradigm's central postulations. Stimulating debate arose during the 1970s and 1980s among thinkers who sought to challenge the premises of ontological realism (Lindlof & Taylor, 2011). Thinkers (i.e. Bhaskar, 1975) for example, questioned the notion that scientific facts exist independently from the observer. Likewise, some scholars (Bogdan & Taylor, 1975) began endorsing the legitimacy and importance of employing qualitative methods in the social sciences. From a post-positivism standpoint, not all social realities — including some that appear in counselling — can be fully understood through the quantitative methods used in the natural sciences (Corman, 2005; Zoller & Klein, 2008). They argued that research conducted in natural settings rather than controlled studies were important means of investigating human behaviour. In this context, a post-positivist paradigm emerged.

Where positivism embraced realism and posited that scientists were capable of accessing an objective truth, post-positivism recognized that science should be concerned with accuracy but also that this can never be fully achieved. Indeed, while post-positivists do believe in the value of the scientific method for studying social phenomena, they challenge the central ontological tenet about objective reality upon which positivists grounded their knowledge paradigms (Lindlof & Taylor, 2011). From the standpoint of the social sciences, individuals and social realities interact through symbolic expression, collaboration and interpretation, and that these realities are therefore emergent in nature. Thus, relationships of cause and effect cannot be reduced to generalizable laws that fully explain phenomena. While post-positivists do believe in the value of the scientific method, they do not consider that an absolute, value-free truth is attainable — this standpoint is known as critical realism (i.e. Bhaskar, 1975). Therefore, reducing research biases through a rigorous methodology is important for post-positivists.

Moreover, this philosophical standpoint contends that social phenomena cannot be reduced to first principle laws (i.e. limiting human behaviour to neurophysiological explanations (Lindlof & Taylor, 2011). Rather, researchers propose that social and individual phenomena are a complex of a diversity of factors that can more fully be accessed through various lenses. Indeed, both quantitative and qualitative methods are considered legitimate means of inquiry. These approaches also advocated for the use of both deductive and inductive methods. Legitimizing various approaches provided social sciences with a more comprehensive set of tools for examining complex phenomena. Moreover, researchers began giving equal value

to the conceptualization of phenomena, and the verification of concepts (Lindlof & Taylor, 2011).

The epistemological paradigm that best describes my philosophical standpoint in this project is post-positivism. In keeping with this position, this study has been conducted both through a deductive and inductive process. While I use quantitative methods extensively, these are grounded on an extensive discovery-orientated process. As such, the project began with a rigorous inductive method which objective was to further refine and clarify the categories (rationale #1) of the Client Modes of Engagement Model in order to construct measurements that could then serve to empirically study this construct (rationale #2). My method for developing the tools constructed in this project followed a rational-empirical approach substantiated by the theory and by the premise that it is necessary to remain close to the data. This was fundamental in order to investigate how the construct relates to change processes in psychotherapy (rationale #3). In agreement with a post-positivist perspective, I acknowledge that there is always an element of fallibility to any research endeavour. Likewise, in keeping with a post-positivist approach, the project was designed under the premise that studying the Client Modes of Engagement construct through different methods would provide a more comprehensive understanding of how clients engage with their experience (rationale #4). This research project is built on the implicit acknowledgement that there is always an element of fallibility to any research method; however, employing multiple tools provides a more comprehensive approach to the phenomena under study and thus seeks to address this inherent fallibility. Indeed, this research project employs both a multi-perspective set of measurements — participant and non-

participant observational tools — and diverse statistical approaches — multi-level statistics, Classical Statistics and the Rasch Model.

The belief in the value and significance of the experience of social actors in generating knowledge is a fundamental contribution of post-positivist philosophy (Ryan, 2006). In fact, my decision to develop a participant observational tool that would reflect the experience of practitioners was founded on the assumption that this would provide access to important information about the therapeutic process and should be included in studies about human behaviour. Indeed, the presumption was that the inclusion of research in natural settings is valuable and that these are more authentically displayed through participant observational systems.

Additionally, while post-positivists agree that the search for causal explanations is important, they argue that these causes are numerous, interactive, and evolving. Indeed, this project assumes that change is an emergent process rather than a linear one. Thus, the aim is not the establishment of a causal links, but the systematic investigation of the inner-workings of the process of change in psychotherapy — that is, how and why change occurs.

1.4 Expectations for the Studies

This research is mainly exploratory in nature. The construction and validation processes were not grounded on any particular hypothesis or prediction about the Modes of Engagement model. However, before embarking in the discovery-oriented process through which I built my instruments, I did have certain expectations that served as a preliminary foundation for the subsequent research. Indeed, my thorough revision of the literature in the field suggested that moments of experiential or Change Mode within the Modes of Engagement construct would probably be related

to better therapeutic outcomes. Moreover, the decision to embark on the process of building tools was founded on the expectation that it is in fact possible to construct an instrument for empirically measuring and validating it.

When I began this project I had at my disposal two methods for gauging the construct under study. One instrument was a non-participant observational outline and the second was a participant rating scale (Elliott 2013a, 2013b). Given that both instruments had over two decades of face value I expected that the construct was indeed amenable for systematic observation and that it was indeed possible to create a psychometrically sound participant observational measurement. This, in itself, provided sufficient rationale for testing the validity of the Client Modes of Engagement model (Elliott, 2006, 2013a).

1.4.1 Overview of the Study: Two Instruments for Gauging Client Modes of Engagement.

This research project is divided into two complementary studies. I have organised the chapters to reflect this process. Following the present Introduction (Chapter One), Chapter Two provides a review of the literature on emotional processing with the aim of developing a strong theoretical framework for this research project. The first section provides a historical account of the central role that emotional processing has played in different theoretical orientations. The chapter goes on to focus on the EFT approach to the subject. The following section offers a systematic examination of the Client Modes of Engagement framework and the different elements within this construct. Then, it provides an overview of pre-existing non-participant observational systems that assess some aspect of emotional

processing. Lastly, the chapter explain the rationale for developing two new tools to measure the Client Modes of Engagement model.

Two Instruments for Studying Client Modes of Engagement

The subsequent chapters are divided into two parts. Part I explores the construction of a Non-Participant Observational System (CME-OCS) (Chapter 3) and the application and validation process for this tool (Chapter 4). Part II provides an overview of the construction process for a Participant Observational Scale (Chapter 5) and the application, refinement and validation process for the CMEQ-R₂ (Chapter 6).

Part One: Non-Participant Observational Tool for the Client Modes of Engagement Model

Chapter Three explains the rigorous discovery-oriented process through which the Client Modes of Engagement Observational Coding System (CME-OCS) was constructed. The aim was to refine, clarify and articulate different categories and styles of client engagement according to this model. Further, with these categories in hand, the goal was to build a non-participant observational method for systematically identifying client in-session moment-to-moment modes of engagement and empirically investigating the construct. Finally, the chapter provides a detailed overview of the CME-OCS manual accompanied with appropriate examples.

Chapter Four presents the application and validation process for the CME-OCS. The aim was to apply the CME-OCS to a sample of socially anxious EFT clients (five most improved and five least improved clients) and examine the relationship between the Client Modes of Engagement construct (Elliott 2006, 2013a) and therapeutic outcome. Further, the study was interested in determining

how this construct works over the course of early, middle and late stages of psychotherapy. Also, the research sought to determine how client transitions between different modes of engagement during therapy relate to therapeutic outcome and stages of therapy.

Part Two: Participant observational Instrument for the Client Modes of Engagement Model

Chapter Five provides a recount of the discovery-oriented process through which a new version of the Client Modes of Engagement questionnaire within the EFT Therapist Session Form (EFT-TSF; Elliott, 2013b) was constructed. The aim of this process was to first adapt the questionnaire in order to develop an easy to use and practical measure that helps therapists reflect upon clients' Modes of Engagement during psychotherapy sessions. Then, I examine the psychometric properties of the adapted scale (CMEQ-R) using a pilot sample collected through an internet-based survey of client accounts. This includes an exploration of the CMEQ-R's reliability, factor structure and construct validity. This process provided valuable information in order to considerably modify the adapted CME measure into a more refined, accessibly worded and psychometrically sound questionnaire. The objective was to adapt it so that it could be employed in a validity study.

Chapter Six documents the application of the adapted version of the CMEQ-R in order to determine the relationship between Client Modes of Engagement and therapeutic outcome across EFT and Person-Centred psychotherapy. The participants for this study were recruited from the Strathclyde Social Anxiety and Practice-Based Protocols and from EFT therapists in routine practice (from Scotland, Ecuador, Spain and USA). The aim was to test the predictive validity of the CMEQ-R₂ Scale.

Chapter Seven brings together the studies conducted for this research project and provides a collective examination of the findings. I evaluate how the discovery and validation processes for my CME instruments provide important information about the Modes of Engagement framework. I first provide a summary of the findings and then discuss the importance of these results. Then, I analyse the psychotherapeutic implications and limitations of these findings. I conclude with a discussion of the overall contribution of this project to the body of knowledge in the field and offer possible routes for further research.

Chapter 2

Literature Review

2.1 Introduction

This chapter develops the research project's theoretical framework. While there is an overwhelming amount of research related to emotional and cognitive processes in general, my research concentrates specifically on psychotherapy and, in particular, on the humanistic experiential approach. The first section focuses on the central role of emotional processing in psychotherapy and examines the interconnectedness between cognition and emotion; these include bodily experience, perception and action tendencies. Then, I offer an historical account of how different psychotherapeutic orientations have viewed and worked with what they commonly refer to as cognitive-emotional processing. This provides a background for exploring how humanistic-experiential approaches to emotional processing fit within the broader tradition. This chapter follows with an exploration of humanistic experiential/EFT theory emphasizing particular clients' styles of processing their experience. As mentioned in the Chapter 1, the current research project focuses fundamentally on exploring the modes of engagement construct. The following section goes on to discuss relevant humanistic-experiential process analysis systems that have been developed to study client processes during psychotherapy. Exploring these non-participant observational systems puts the Client Modes of Engagement (CME) measure into context with similar but somewhat different pre-existing instruments.

2.2 Situating the Modes of Engagement Framework: The Role of Emotional Processing in Different Theoretical Perspectives

This section reviews relevant literature studying the role that emotional processes play in psychotherapy. I begin by defining cognition and emotion, and exploring evidence that suggests that these processes are deeply intertwined. I then provide an historical account of how the main psychotherapeutic orientations have understood emotions and cognitions. Each of these perspectives has given different value to the expression, activation and elaboration of different aspects of client experiences.

I highlight the notion that even though psychotherapeutic orientations differ on how they approach affective-cognitive processes, there is a general agreement that the client emotional experience needs to be considered, explored, understood, and positioned as a key aspect of psychotherapy. The purpose of this section is to explore the centrality of emotional processing within the main therapeutic modalities, and to situate the humanistic-experiential view within these psychotherapeutic movements.

2.2.1 The Intertwined Concepts of Emotion and Cognition

Recent neuropsychological evidence suggests that emotions and cognitions are interlinked and inseparable (Damasio, 1994; Damasio & Carvalho, 2013; Davidson, 2000; Davidson & McEwen, 2012; Nesse & Ellsworth, 2009). LeDoux's (1996) seminal research during the mid-nineteen nineties proved that the neural bases of affective-cognitive processing were inseparably interconnected. He discovered two sensory pathways by which an emotional-producing-stimulus triggers behavioural, physiological, and higher order cognitive processes. One pathway he

called the “low road” — a quick sub-cortical pathway that rapidly connects present with past response associations and prepares the individual for immediate intuitive reactions. The other pathway he referred to as the “high road” — a slower higher cortical connection that triggers higher-order reflective processes and creates contextual meaning. In every situation, both pathways are activated and are at the basis of emotional processing.

Panksepp (2009) expands on this integrative view of emotions and cognitions. He employs the term “primary-process” to refer to evolutionary informed, unconditioned, pre-propositional emotions that have a “mind of their own”. These are linked to cognitive information processes that generate affective states, which are associated with bodily reactions and generate tendencies towards action. Accordingly, emotions are “action programs” — instinctual reactions that do not require deliberation. For Panksepp, emotions are elicited by the detection of exteroceptive (visual, auditory, olfactory) and interoceptive (visceral, hormonal) stimuli. Thus, emotions include visceral and muscular reactions, and cognitions (i.e., attention focus and modes of thinking) that can be consciously “felt” (feelings). Feelings are “mental experiences of body states” and have a valence: pleasant or unpleasant. As such, emotions and feelings are primarily instinctual — they direct the organism to actions that satisfy survival needs and return the body to homeostasis. In a similar vein, Frijda (1988) argues that emotions are cognitive processes that are aroused by real or imaginary events have a regulatory function, signal what is important for the person, and are fundamental for developing a readiness and tendency to act.

So far, research provides solid evidence of the interconnectedness of affective-cognitive processes. While there is a general consensus that emotions and cognitions are indeed inseparable, different theoretical orientations have tended to emphasize one over the other for clinical or research purposes. However, most approaches seem to be moving away from a sole focus on cognitive narratives towards an emphasis on the integration of affective-cognitive-bodily interventions as a means of accessing emotions and processing experiences (i.e. Baker, Gale, Abbey & Thomas, 2013; Diener et al., 2007; Elliott, et al., 2004; Foa, Hembree & Rothbaum, 2007; Leahy, 2016; Linehan, 2015; Siegel, 2013). While there is general agreement among the pre-eminent psychotherapeutic orientations that exploring unpleasant feelings is indeed beneficial during therapy (Pascual-Leone & Greenberg, 2007), the importance of emotional activation, expression, elaboration, and transformation, is rarely overtly acknowledged as a focal point of the psychotherapeutic process. A review of how the various psychotherapeutic orientations have viewed and worked with affective-cognitive processes will contextualize the impact that the humanistic experiential tradition has had by emphasizing clients' experiencing; particularly the contribution that the EFT theory offers to the field with its Modes of Engagement model.

2.2.2 Psychodynamic Approaches to Emotional Processing

The concept of "catharsis", developed by Breuer (Freud & Breuer, 1974) at the end of the nineteenth century, first highlighted the importance of emotional activation as a significant psychotherapeutic process. Breuer's "cathartic" technique involves asking clients to express emotions associated with traumatic experiences during hypnotic states. In contrast, although Freud introduced free association as a

method for remember and exploring past emotional experiences, he did not pay much attention to arousing emotions during sessions. In the 1940s, Ferenczi argued that psychotherapists should explore clients' subjective past experience by activating the emotions produced by these experiences through empathic reciprocity (Rachman, 2007). Alexander and French (1946) developed the concept of "corrective emotional experiences" to refer to moments in which clients have the opportunity to face formerly unbearable emotional situations under more favourable circumstances. These authors maintained that intellectual insight by itself is not sufficient, and that clients need to "revive" corrective emotional experiences during psychotherapeutic encounters or during parallel daily life experiences. Similarly, Horowitz, Rosenberg, Baer, Ureno and Villaseñor (1988) suggested that emotional arousal together with the expression of interpersonal unmet wishes and wants transformed self-other interpersonal problems. More recently, Fosha (2002) developed Accelerated Experiential-Dynamic Psychotherapy (AEDP), which stresses the importance of a safe therapeutic environment for optimal emotional processing.

A recent meta-analysis examining the effectiveness of emotional activation and expression during psychodynamic therapy supported the idea that exploring clients' affective experience is indeed beneficial for therapeutic outcome. The meta-analysis examined thirteen psychodynamic research studies. Interestingly, although only two of the studies included considered experiencing and expression as a factor related to outcome, the results of the meta-analysis suggested that emotional experiencing and expression did indeed relate to therapeutic improvement (Diener et al., 2007).

2.2.3 Behavioural and Cognitive Approaches to Emotional Processing

Within the cognitive behavioural tradition, it was Wolpe (1969) who first suggested the need to activate emotions in psychotherapy. He argued for applying Pavlovian conditioning principles by using Reciprocal Inhibition and Systematic Desensitization techniques while activating emotions. Both of these methods involved exposing clients to real or imaginatively induced affective stimuli, along with behavioural response prevention and relaxation techniques. The goals of these interventions were to eliminate previous negative emotions through extinction and habituation, or by associating the original negative emotions with less intense emotions via relaxation techniques. Lang (1977) developed his Bio-Informational Theory to explain how imagery works during Systematic Desensitization. He proposed that emotional images are encoded in memory associative networks. Remembering images that prompt physiological responses can reactivate these. Lang distinguished between narrative descriptions of images and the actual constructive processes of experiencing images. From this perspective, psychotherapy can modify affective response elements by evoking memory networks through vivid imagery processing.

Rachman (1980; 1981) enriched the field of behaviour therapy by proposing the need to process emotions in order to overcome problematic behaviours. Rachman defined emotional processing as “a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behaviour can proceed without disruption” (Rachman, 2001, p. 165). He suggested three criteria for emotional processing: indication of emotional disturbance; a waning of emotional disturbance; and reoccurrence of an undisturbed routine behaviour. His work

influenced many cognitively-oriented psychotherapy researchers, including Teasdale (1999), who extended Rachman's work and proposes a framework to define helpful and unhelpful ways of emotional processing. Further, he proposed that "mindful experience/being" is the sole means of facilitating this type of processing.

The cognitive-behaviour perspective assumes that people impose cognitive representations on emotions (Clark & Beck, 2010; Izard, Kagan, & Zajonc, 1984; Lazarus, 1966, 1991; Lazarus & Folkman, 1984). Thus, emotions are the consequence of core beliefs, automatic thoughts, and appraisals. This perspective is based on the two-factor Schachter-Singer theory of emotions (Schacher & Singer, 1962) that suggests that people name their emotions using cognitive interpretations of internal and external events. When no available explanation is found for the bodily reaction, the person interprets the physiological response based on their available cognitions. The argument is that people interpret their physiological responses by looking at environmental cues in order to label their arousal.

Emotional processing within CBT has been considered an important aspect for therapeutic improvement. Various researchers (Baker, et al., 2013; Baker, et al., 2012) have found that the effectiveness of exposure techniques is enhanced when therapists explore clients' emotional processing styles (i.e., avoidance, suppression, distraction), work on expanding their emotional landscape, and facilitate a more open emotional processing stance. Likewise, Leahy (2002; 2007; 2015; 2016) has examined the role that beliefs and expectations about emotions play in psychological difficulties. Based on his research findings, Leahy developed the Emotion Schema Therapy model that considers emotion to be an "object of cognition". This approach assumes that interpretation, appraisal, and regulation of emotions, are key elements

of how individuals process their emotions. He advanced a variety of cognitive-behavioural techniques to focus clients' attention on their affective experiences and to prompt the acceptance, tolerance, identification, labelling, and linkage of emotions to events and thoughts.

In a similar vein, Foa and colleagues developed their Emotion Processing Theory to examine how emotions are processed during psychotherapy interventions (Foa et al., 2007; Foa & Kozak, 1986; Foa, Rothbaum, & Furr, 2003; Rauch & Foa, 2006). From this perspective, memory networks contain associations between specific stimuli, emotional reactions, and meaning elements. These networks are naturally programmed to produce physiological responses that organise fight-or-flight survival behaviours. However, they can become pathological when the structure contains rigid non-realistic associations. To modify the pathological elements of the memory network, the emotional element (i.e., fear) needs to first be activated. The emotional experience must be fully felt in the presence of realistic information, along with disconfirming evidence. The therapeutic strategy proposed by this approach suggests that the fear emotion reaction needs to be regulated. They propose achieving regulation by exposing the client to real or imaginary traumatic stimuli for extensive periods of time. The expectation is that dysfunctional emotions decrease through association with disconfirming, non-threatening evidence, which results in cognitive re-structuring.

The Dialectical Behaviour Therapeutic model (Linehan, 1993, 2015; Lynch, Trost, Salsman, & Linehan, 2007) has also focused on emotions with the objective of regulating and tolerating them. Clients practice mindfulness techniques as the basic method to learn to accept, tolerate and regulate painful emotions. From this

perspective, affect regulation is used to deal with painful feelings by reducing the intensity of clients' emotions in order to attain a working distance.

2.2.4 Neuropsychological Perspectives on Emotional Processing

Research findings in neuroplasticity and cognitive neuroscience provide strong evidence of the importance of eliciting emotional activation to induce new emotional reactions to previous fear eliciting stimuli (Armony, 2013; Phelps & LeDoux, 2005). The amygdala plays an important role in consolidating long-lasting emotional memory networks. To modify previously learned emotional memory structures, the person needs to activate the amygdala while arousing new, real or imagined experiences that facilitate cognitive reappraisals of the event.

Davidson's (2014, 2015) neuro-scientific research suggests that emotional responses can become patterns in the brain, and eventually result in enduring emotional personal styles that, although somewhat stable, can also be changed through specific psychotherapeutic interventions. According to Davidson, there is a first unit of emotion, called an "emotional state" that is triggered by an experience, real or imagined, and that lasts for a few seconds and then fades, giving way to the next emotional unit. The second emotional unit can endure for minutes to days and is called "mood". If a particular mood is maintained for years, it becomes a personal style. Emotional styles tend to facilitate similar first emotional states and thus become self-sustaining. From Davidson's neuroscientific perspective, interventions should concentrate on regulating emotions through mindfulness meditation and compassion training techniques. Research conducted with a variety of clinical and non-clinical populations support Davidson's contention (Hölzel et al., 2010; Pickut et

al., 2013; Weng et al., 2013). These studies suggest that such interventions are not only helpful in regulating emotions but can transform brain functions.

Likewise, Daniel Siegel's Interpersonal Neurobiology model of psychotherapy (Siegel & Solomon, 2013) understands the mind, body, and brain as a whole, as animated by emotions. From this perspective emotions are the way people connect with each other. They are at the heart of interpersonal relationships and thus serve as the basis for healing processes. This model proposes that mental dysfunctions are produced by a lack of brain integration that results in neural chaos and rigidity. Siegel (2009, 2013) observes that, in the same way that abusive and neglectful relationships generate neural disintegration, compassionate and kind interpersonal relationships repair the neural integration and harmony of the brain. This model has fostered a variety of research to support the argument that interventions that facilitate emotion regulation and left-right brain connections (i.e., mindfulness, body awareness, non-verbal communication) have significant therapeutic benefits (Fosha, 2009; McGilchrist, 2013; Ogden, 2013; Panksepp, 2009, 2013; Siegel, 2013; Solomon, 2013).

2.2.5 Humanistic/Experiential Approaches to Emotional Processing

There are a variety of models of Humanistic-Experiential psychotherapies (i.e. Gendlin, 1962; Greenberg et al., 1993; Perls, Hefferline, & Goodman, 1951; Rogers, 1959). While these perspectives have different theoretical foci, they are all founded on a shared belief that the psychotherapeutic process must help the client become aware of their emotional experience. These models posit that emotions are a fundamental source of adaptive information rather than something that needs to be regulated and dealt with. Emotional processing has been approached through an

emphasis on attending to clients' experiences during therapy, and through the cultivation of tolerance to emotions in order to allow them to emerge naturally (Pos, Greenberg, Goldman, & Korman, 2003). Within the Humanistic-Experiential perspectives, it is the Emotion Focused Therapy model that has given particular emphasis to the advancement of a theoretical framework to understand clients' emotional processing in depth. From this perspective approaching, attending and allowing emotions is certainly necessary, but it is not sufficient for optimal emotional transformation. For this to occur, EFT emphasizes the need for reflecting on and making meaning of emotion. Therapeutic change is contingent on strategies that encourage emotional activation along with the need for exploring the beliefs and situations related to the present affective experience. For complete emotional processing, EFT encourages clients to symbolize, differentiate, and identify the underlying needs of these emergent experiences. These processes provide the basis for contacting growth-orientated motivational action-tendencies. Given its centrality to this research project, an expanded review of EFT research and theoretical framework is developed in a separate section below.

2.2.6 Emotion and Cognition: Conclusions

Working with emotional processing has been an important goal for psychotherapeutic work regardless of theoretical orientations (Whelton & Greenberg, 2004). There is general agreement that the ability to contain and modulate emotions allows clients to activate and process them productively. In spite of these agreements between psychotherapeutic orientations, there are differences in the way affective-cognitive processes are understood and worked through during psychotherapy. In the psychodynamic orientations, the approach to emotions has moved gradually from an

emphasis on catharsis, to an increased interest in emotional arousal and expression, towards a greater focus on secure interpersonal attachments as a means of facilitating emotional processing. Cognitive-behavioural approaches have gradually come to recognize the importance of emotional processing; however, work on emotions is generally not treated as the central focus of therapy (Whelton & Greenberg, 2004). When emotions impede psychological functioning, Cognitive-behavioural models emphasize the need to develop strategies for emotion regulation. This approach deals with emotions through cognitive-restructuring rather than making use of emotions for their intrinsic therapeutic value. Similarly, mindfulness-based psychotherapies have cultivated self-regulatory, body-based methods, to learn how to develop self-compassionate attitudes, in order to step-back from, tolerate, and accept emotions. In the Interpersonal Neurobiology model (Siegel, 2013), there is an emphasis on the beneficial role that emotional interpersonal connections and mindfulness-based techniques have on brain integration. The humanistic-experiential perspectives differ from the previously discussed models in that they have considered emotions to have an intrinsic value for human functioning, and have, accordingly, focused on emotions as central to psychological functioning. Within this tradition, EFT has given particular emphasis to examining emotional processing in a refined and empirically grounded manner.

2.3 Emotion Focused Therapy and the Central Concept of “Emotion Schemes”

2.3.1 Introduction

This section explores the main elements of the humanistic-experiential Emotion Focused perspective. In particular, it elaborates on the theoretical

framework upon which emotion theory and emotion schemes are constructed. It begins with an introduction to the humanistic underpinnings of this theory and then explores the concept of emotion as a key organizing principle of experience. The section then examines EFT emotion scheme theory that is conceived as a higher order process that yields and organises experience. This process includes perceptual-situational, symbolic-conceptual, bodily-expressive, and motivational-behavioural elements. The purpose of this section is to offer a solid foundation for exploring the concept of Modes of Engagement in-depth in subsequent sections.

2.3.2 Theoretical Underpinnings of EFT

Emotion-Focused Therapy is an evidence-based approach (APA, 2012) focused on the study of clients' affective-cognitive processes in psychotherapy. It incorporates current cognitive, neuroscience and emotion theory with person-centred, experiential, and gestalt approaches (Greenberg, 2011; Elliott et al., 2004). EFT's fundamental objective is to facilitate clients' contact with their emotional experience. Over thirty years of research has provided evidence of EFT's effectiveness as an integrative treatment approach for a range of psychological difficulties, including depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson 2006), complex trauma (Paivio & Pascual-Leone, 2010), couples distress (Greenberg & Goldman, 2008), borderline personality disorder (Pos & Greenberg, 2012), social anxiety (Elliott, 2013c), among others. All of these efforts have served to establish EFT as a neo-humanistic, emotion focused, process-oriented approach (Greenberg, 2011; Watson, 2011).

Carl Rogers' client-centred humanistic, relational-based understanding of human functioning (Rogers, 1959) provided the theoretical foundation upon which

EFT was conceived. Indeed, EFT views individuals' growth and self-actualization tendency as rooted in the accessibility that individuals have to adaptive and flexible emotional systems (Greenberg et al., 1993). Emotions, from an EFT perspective, are seen as systems that embrace all aspects of life. They serve as signals that help ensure our survival and contain important information about what is most important for the individual (Greenberg, 2011; Watson, 2011). Thus, emotions are deeply intertwined with our most fundamental needs. From this viewpoint, emotions have the capacity to shape our behaviour such that we maintain interest, stay connected, and continue being motivated. The manner in which individuals internally integrate emotional memories and organise and encounter personal experiences, is referred to as an "emotion scheme" (Greenberg et al., 1993; Greenberg & Paivio, 1997). EFT gives particular emphasis towards the activation and restructuring of emotion schematic memories, performed in the context of a caring, empathic, safe and facilitative therapeutic environment (Greenberg et al., 1993).

2.3.3 Emotion Schemes

The use of the concept of "Emotion Scheme" can be tracked back to Bartlett (1932) that conceived a schema as an active organization of past reactions or experiences operating in a well-adapted organismic response. Schemas were seen as activated outside awareness and not immediately available for introspection (Neiser, 1979). Piaget (1958) added and emphasized the action-oriented aspect of schemes rather than the pattern recognition aspect of Bartlett definition. Piaget defined "schemes" as common structures of all the interchangeable actions that a person uses to obtain the same goal (Pascual-Leone and Johnson, 1991). Greenberg and Safran (1987) initially introduced the idea of emotional schemata memory to explain the

importance of arousing affect in psychotherapy. The authors posit that the activation of emotional memory produces intense present affective experiences that are evoked by activating emotion schemata structures. Greenberg and Safran (1989) expanded the concept by conceiving emotional schemes as analogue structures that cannot easily be activated by direct recall or conscious association; rather, in order to surface, they require being expressed, elaborated, and reflected upon. Pascual-Leone and Johnson (1991) conceptualized emotion schemes as purpose-directed schematic units that ultimately negotiate the meeting of some need. Greenberg (2002b) posited that “emotion schemes” are non-conscious mental structures that interact with incoming information to determine both, what is perceived and experienced, and to provide the framework for our responses to the world. Emotion schemes, the author points out, work as our core means of organising both our experience and our self-responses. These structures are seen as ever-changing organizations that accommodate to new incoming experience. Emotion schemes are not simply conceptual and classificatory in nature, but rather they are seen as embodied set of expectations and reactions. What is crucial is that although they involve cognition, they go beyond purely representation of cognition to include emotion, motivation, and relational action as well. Emotion schemes yield and organise experience. These schemes contain and accrue emotional reactions along with salient features of the situations that elicit emotions (Greenberg, 2002b). Emotion schemes that affect individuals’ psychological functioning are those that represent the “self-in-the-world” emotional experience. It is this “self-in-the-world” integrative, cognitive, affective, motivational, and relational action structures that organise our manners of experiencing. Greenberg and Watson (2006) described “Emotion Scheme” as a

“response-producing, internal organization that synthesizes a variety of levels and types of information, including sensorimotor stimuli, emotion memory, and conceptual-level information” (pg. 30).

Elliott and colleagues (2004) expanded on the concept of emotion schemes indicating that these structures are activated by relevant cues that are not immediately conscious until clients are able and willing to bring them into awareness. This means that emotion schemes are accessed through the implicit emotional experience they produce. These schemes are believed to be internal self-organizations that are flexible, dynamic and naturally adaptive. They are seen as being moulded by moment-to-moment interactions with internal and external experiences. The authors point out that individuals have a variety of schematic emotional memories that varies in their intensity, energy and salience (Elliott et al., 2004). According to Elliott and colleagues (2004), emotion schemes contain four main elements: perceptual-situational (awareness of current situations and memories), symbolic-conceptual (self-reflective verbal or visual representations), bodily expressive (expressions of body and proprioceptive sensory feelings), and motivational-behavioural (desires, wants, wishes and intentions). These elements conjointly form a network that yields a “felt sense” of the world and its surroundings. Together, these elements have been referred to as an emotion scheme nuclear process — an organization of all elements into a particular affective mode. The activation of any one element can set off a chain reaction, activating the other elements. When individuals have difficulty processing their emotions, it can be due to a disregard or failure to fully process one or more of these emotion scheme elements. The following section delves into a detailed account of each of the elements of the

scheme being proposed along with the different ways in which they manifest themselves and are processed.

2.4 Client Modes of Engagement: Different Dimensions of Emotional Processing

2.4.1 Introduction

The purpose of this section is to present a contemporary framework for clients' modes of engagement, which is the central concept developed throughout this research project. This section provides an exhaustive account of how the concept of Client's Modes of Engagement fits within the theoretical framework of EFT, and how it has developed as a fundamental theoretical tool within EFT. The section begins with a historical overview of how the Client Modes of Engagement concept came into being.

After providing this context, I will focus on examining relevant research in order to explore the ways in which clients manifest their emotional experiences from different stances while they attend to their emotion scheme elements. This will provide valuable information that helps elucidate a more in-depth understanding of each Mode of Engagement. The objective is to fully differentiate between the different manners in which clients process their experience, and the particular content of the experience upon which clients choose to focus. This will serve to better systematize and deploy the conceptual framework within this research project. The following section is constructed in such a way that it mirrors this research project's proposed model. Each element of the emotion scheme is analysed

thoroughly making a distinction between experiential and non-experiential theoretical stances.

2.4.2 Historical Underpinnings

Rice and Greenberg (1990) became interested in understanding how psychological change comes about. They posited that affective-cognitive information processing is a fundamental aspect of change. This has given way to studies focusing on manners of processing experience that facilitate transformation. The concept of Modes of Engagement was developed through this approach. It was initially formulated during the First International Conference on Client-Centred and Experiential Psychotherapy in Leuven, in 1988. The term was used to refer to clients' stances that facilitated the successful resolution of EFT tasks. The development of this concept was influenced by the earlier work of Laura Rice, David Wexler, and Fred Zimring, which explored, through a humanistic lens, how clients process information and construct meaning from their experiences (Lebow, 2008). These authors argued that when clients indulge in selective attention, they limit their awareness of the wholeness of their experiences. Thus, they pointed out that broadening clients' attention and facilitating the elaboration of the different components of their experience, helps to deepen and complete missing aspects.

For EFT, the way and the focus in which clients express their experiences has been referred to variously as “modes of engagement”, “expressive stances”, and “emotional processing modes” (Greenberg et al., 1993; Elliott et al., 2004). Historically, EFT had given emphasis to the manner in which experience is processed—which refers to how the content is articulated—it gave particular attention to the vividness of the account, vocal quality, fluency of speech, and the

emotional state in which the person is involved while describing the content (Elliott, 1993b). Elliott (2006) proposed an elaborated Modes of Engagement model that built upon this approach but also includes a focus on the content of the narrative itself. Further, this proposed model argued that the content of the narrative could be conceptually tied to the emotion scheme model. According to this model, during psychotherapy, clients access their emotion schemes through different modes of engagement. Each mode can facilitate or interfere with clients' ability to come into contact with their emotional experiences, as well as with their capacity to elaborate, express, symbolize, and transform them.

The original Modes of Engagement framework distinguished between four experiential stances through which clients access their experiences (Greenberg et al., 1993). "Attending/Awareness" referred to moments when clients focus their attention on sensory information from internal and external stimuli. Moments in which clients' consciously and deliberately attempt to access emotion scheme elements such as perceptual experiences, bodily sensations, conceptual meanings, feelings, behaviours and motivations, was termed "Experiential Search". "Active expression" referred to moments when clients express emotions and enact associated wishes or action tendencies. Finally, "Interpersonal Contact" stance referenced instances during which new ways of interpersonal experiencing emerge when clients encounter themselves and others in the present. Elliott and colleagues (2004) added two modes "Self-Reflection" and "Action Planning" experiential modes to the original framework. These stances referred to instances in which clients were able to step back and become disembedded from their experience in order to consolidate and integrate experiential work. Clients acknowledge, consolidate, integrate and act upon

these novel emotional experiences. For this reason, in this dissertation I refer to these manners of engagement as the Change Mode.

Additionally, Elliott and colleagues (2004) also added a set of non-experiential modes of engagement to the previous model. They argued that there was a need to broaden these non-experiential modes in order to fully describe clients' problematic processes. They proposed incorporating into the model instances during which clients engage rigidly with one element of their emotion scheme without being able to access and integrate information from other elements (Elliott et al., 2004). These modes refer to moments in which clients are dominated by one emotion scheme element without integrating others. The "purely external" mode describes instances during which clients attend solely to situational-perceptual aspects of the experience, and thus may become rigidly focused on external events or people with minimal emotional access. The "purely conceptual" mode refers to moments when clients engage in abstract intellectualizations without attending to their concrete experience, or they may somatise ("purely somatic" stance) by focusing mostly on their physical sensations and symptoms. Elliott (2013a) labelled these modes as "Restricted" modes in order to differentiate them from a second non-experiential stance that he termed the "Dysregulated" mode. This later mode was added in order to incorporate problematic instances during which clients become unable to fully contact their experience because they are either over regulating or under regulating their emotions. The Dysregulated Mode of engagement includes instances during which clients are accessing their scheme elements from either an emotionally distant stance, or in a chaotic and disorganised manner. This impairs their ability to symbolize and articulate their experience in a coherent way.

Additionally, Elliott (2013a) identified the need to further refine, organise and clarify the dimensions of the original model in order to clearly distinguish between clients' manner of engagement and their focus of attention. This distinction, Elliott argues, provides an important means of reassessing and systematizing clients' modes of engagement. Luborsky (1984) had previously defined "focus of attention" as the content of the clients' narrative, the implicit or explicit ideas and propositions articulated, or the semantic aspects of the clients' speech (Elliott, 1993b). Elliott (2006) points out that during therapy, clients may either focus their attention selectively on a single emotion scheme element—situation-perceptual, bodily-expression, conceptual-symbolic, and motivational-behavioural—or may attend to these elements in an integrative manner. Elliott (1993a) had previously suggested that the manner of processing and the focus of attention are both fundamental aspects of the communication process that support and occur in parallel with each other. However, in order to observe and measure them, it is necessary to clearly distinguish between both components, and to differentiate the sub-processes within each of them, while maintaining a view of the wholeness of the experience (Elliott, 2006). The proposed model assumes a continuum of processes, with clients moving back and forth in the manner (non-experiential and experiential modes), and continuously shifting their focus of attention among the different elements of their emotion scheme. According to this model, progression towards therapeutic resolution occurs when clients, from an experiential stance, are able to integrate the full range of elements within the emotion scheme in a coherent manner. The fundamental contribution of this research project to Elliott's proposed model is to systematize, study and provide evidence to support his conceptual framework. For a historical

overview see Table 2.1. The following sections introduce a systematic examination of each of the different modes of engagement.

Table 2. 1. Historical Overview of the Modes of Engagement Concept

Stages	Client Modes of Engagement Construct: Historical Overview	Source
Stage I: 1988- 1990	<p><u>Original Formulation</u></p> <p>First International Conference on Client-Centred and Experiential Psychotherapy, Leuven, in 1988</p>	<p>Rice, L. N., & Greenberg, L. S. (1990). <i>Fundamental Dimensions in Experiential Therapy: New Directions in Research</i>. In G. Lietaer, J. Rombauts, & R. Van Balen (Eds.), <i>Client-Centered And Experiential Psychotherapy In The Nineties</i> (Pp. 397–414). Leuven, Belgium: Leuven University Press.</p>
Stage II: 1993	<p><u>Conceptual Processing Dysfunctional Reliance (first approximation of non-experiential modes “Purely Conceptual”)</u></p> <p><u>Experiential Modes:</u></p> <ul style="list-style-type: none"> • Attending/Awareness • Experiential Search • Active Expression • Interpersonal Contact <p><u>Session Experienced Impacts ≈ Change Modes</u></p> <ul style="list-style-type: none"> • Perceptual Change • Problem Solution • Interpersonal Impacts 	<p>Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). <i>Emotion in psychotherapy</i>. New York, NY: Guilford Press.</p>
Stage III: 2004	<p><u>Non-Experiential Modes:</u></p> <ul style="list-style-type: none"> • Purely External [Added] • Purely Conceptual [Added] ≈ Conceptual Processing Dysfunctional reliance [Stage II] • Purely Somatic [Added] <p><u>Experiential Modes:</u></p>	<p>Elliott, R., Watson, J. C, Goldman, R. N., & Greenberg, L. S. (2004). <i>Learning emotion-focused therapy: The process-experiential approach to change</i>. Washington, DC: American Psychological Association.</p>

	<ul style="list-style-type: none"> • Internal Attending • Experiential Search • Active Expression • Interpersonal Contact • Self-Reflection [Added] ≈ Session Experienced Impacts. • Action-Planning [Added] ≈ Session Experienced Impacts. 	
Stage IV: 2006-2012	<p><u>Non-Experiential Modes:</u></p> <p>Dysregulated Mode:</p> <ul style="list-style-type: none"> • Flooded [Added] • Distancing/Dissociated [Added] <p>Restricted Mode:</p> <ul style="list-style-type: none"> • Externalized = Purely External [Stage III] • Somaticizing = Purely Somatic [Stage III] • Abstract/Purely Conceptual = Purely Conceptual [Stage III] • Impulsive [Added] <p><u>Experiential Modes:</u></p> <p>Working Modes:</p> <ul style="list-style-type: none"> • Externally attending • Body-Focused • Emotion-focused [Added] • Reflexive/Symbolizing • Active Expression <p>Change Modes:</p> <ul style="list-style-type: none"> • Self-Reflection 	Elliott, R. (2006, November 19). Modes of Engagement and Emotion Schemes [Blog Post]. Retrieved from http://pe-ef.blogspot.com/2006/11/modes-of-engagement-and-emotion.html
Stage V: 2013-2018	<p><u>Non-Experiential Modes:</u></p> <p>Dysregulated Mode:</p> <ul style="list-style-type: none"> • Flooded • Distancing/Dissociated <p>Restricted Mode:</p> <ul style="list-style-type: none"> • Externalized • Somaticizing • Abstract/Purely Conceptual • Impulsive <p><u>Experiential Modes:</u></p>	Elliott, R. (2013a). <i>Client Modes of Engagement</i> . Unpublished Manuscript, Strathclyde University, United Kingdom.

	<p>Working Modes:</p> <ul style="list-style-type: none"> • Externally attending • Body-Focused • Emotion-focused [Omitted] • Reflexive/Symbolizing • Active Expression <p>Change Modes:</p> <ul style="list-style-type: none"> • Re-perceiving/altered perception [Added] • Body shift/relief [Added] • Self-reflection/meaning perspective [Added] • Action-planning/carrying forward [Added] 	
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2.5 Non-Experiential Modes of Engagement

2.5.1 Dysregulated Modes of Engagement

Non-experiential Dysregulated Modes of engagement refer to moments in which clients have difficulty processing their emotions because they either are: a) overwhelmed or flooded by the intensity of their emotional reaction or, b) distanced from their emotional experience and are thus interrupting or avoiding entering it. During these moments, clients present difficulties in making full contact with their experience, and are unable to access the adaptive information that emotions provide.

Flooded/Overwhelmed Dysregulated Modes of Engagement

Flooded modes of engagement refer to instances during which clients are confronted with highly intense emotional experiences. This experience is so overwhelming that clients are unable to think clearly, to process information at emotional and cognitive levels, to organise or communicate their thought, and remain unable to symbolize and understand others' perspectives (Kennedy-More & Watson 1999). When emotions are activated beyond the clients' ability to comprehend them, they become overwhelming and paralyzing. In this context,

psychological difficulties emerge (Barrett & Satpute, 2013; Gross, 2015; Kring & Elis, 2013; Kring & Mote, 2016; Panksepp, 2009). The theoretical model for the flooded mode of engagement can be tracked back to Gendlin's (1996) work on the importance of finding the appropriate experiential distance for the client to process emotions. Gendlin argued that if the distance between the client's self and their experience remains too close, they would have no working distance to be able to process their emotions. According to Fosha (2001), emotion dysregulation occurs during stress reactions in which individuals are unable to access the adaptive information that emotions naturally provide. During these moments, emotion dysregulation itself becomes a source of stress, and has a spiralling, disorganizing, and traumatic effect on the individual.

Research findings suggest that although there is an inherited component to individual differences in the ability to regulate emotion, affect modulation skills also develop across the lifespan (Gross, 2015). From a developmental perspective, emotion dysregulation occurs early in life before infants begin to develop the ability to modulate their emotions without the support of their caregiver (Bowlby, 1969). Fosha (2001) argues that people learn this skill from their early attachment figures. Children, the author points out, learn to "conquer" positive states and regulate their emotions through the dyadic process between child and caregiver. The child's ability to modulate affect is thus facilitated by their caregiver's attuned responses. Similarly, Bradley (2000) considers that secure attachment provides the child with a sense of certainty, interpersonal reliance, and self-confidence, which is at the basis of emotion regulation. When the caregiver is not responsive and attends mostly to negative and intense attention seeking behaviours, the infant learns to display increasingly

intensifying strategies to seek the caregiver's attention. This eventually becomes overwhelming, chaotic and disorganizing for the child. Initially, the infant's affect modulation is wholly dependent on its caregiver. In time, as cognitive and language abilities develop, these afford the child the capability of internalizing emotion regulation strategies learned during the dyadic process, whether these are adaptive or maladaptive.

Individuals who developed overwhelming maladaptive responses during early childhood do not acquire the physiological, cognitive (i.e., situation selection, attention deployment), and behavioural (i.e., situation modification, physiological modulation) strategies necessary to modulate affective responses during stressful situations (Bradley, 1990; Gross, 2015; Gross & Levenson 1993). It is the interaction between cognitive, emotional, and interpersonal processes which together help modulate affect. Those who experience emotion dysregulation are unable to integrate these processes successfully (Kennedy-Moore & Watson, 1999). Indeed, research findings suggest that during emotion dysregulation outbreaks there are neurological disconnections within the brain's neural systems that support these various processes (Barret & Satpute, 2013; Kring & Elis, 2013; Kring & Mote, 2016; Sauer & Baer, 2009).

A variety of psychotherapeutic interventions have developed effective strategies that foster the ability to self-regulate overwhelming emotions in spite of biological predispositions (Davidson, 2015). Research indicates that flooded emotional dysregulation can be reduced by body-focused voluntary actions (i.e., breathing) or by higher processes such as meaning-making and language (Costafreda, Brammer, David, & Fu, 2008). Mindfulness-based cognitive

psychotherapy interventions have given particular emphasis on developing emotion regulation strategies (Hofmann, Sawyer, Fang, 2010; Linehan, 1993, 2015; Lynch et al., 2007; Segal, Williams & Teasdale, 2002). These techniques have proven to be effective means of decreasing the intensity of clients' emotions, and help clients learn to attain a working distance with which to deal with, accept, and tolerate painful experiences.

Pascual-Leone, Gillespie, Orr and Harrington (2016) conducted research on the effectiveness of specific strategies for emotion-regulation. The study, which was conducted with clinical and subclinical populations, compared various types of interventions. Their findings indicated that affect modulation during dysregulated states, including emotionally overwhelmed ones, could be reached by simple (i.e., self-directed caring re-appraisals, positive self-talk, self-nurturing) or more complex strategies (i.e., specific meaning-making, meaning transformation, combined regulation strategies). However, even though the clinical and non-clinical groups did not differ in the frequency of behavioural strategies for emotion regulation, they did show differences in the type of methods employed. The non-clinical participants used broader and more complex emotion regulation techniques than the clinical group. The results suggested that the employment of meaning-making interventions promoted higher levels of emotional awareness than behavioural strategies (i.e., distraction, suppression, or behaviours to calm themselves such as sitting or walking). These findings suggest that when clients present overwhelming emotions, behavioural emotion regulation strategies and less evocative forms of intervention, are initially preferable until some level of regulation is achieved. Once clients are able to bear intensely painful emotions, articulating the meaning of these emotional

experiences and expressing underlying unmet needs, is necessary for therapeutic transformation.

Failure to regulate overwhelming emotions interferes with affective-cognitive information processes necessary for self-control and pre-meditation, resulting in difficulty reflecting, distinguishing and making use of adaptive natural emotions (DeYoung & Reuter, 2016; Panksepp, 2009). Indeed, Horowitz and Znoj's (1999) research findings suggest that emotion dysregulation alters client's focus of attention, their perception of self and others, and their thought processes. This results in a difficulty understanding and expressing what they are experiencing. The specific maladaptive responses in each of these three areas, as observed in Horowitz and Znoj's study, are particularly useful to illustrate how overwhelming emotional stances disorganise the focus and the manner in which clients experience their emotion scheme elements. Kennedy-Moore and Watson (1999) argue that overwhelming experiencing lead to interpersonal difficulties, because they experience these moments as beyond their control, and they interpret this as a sign that there is something wrong with them. Elliott's (2013a) model is founded on the assumption that when clients are in an unregulated state, the way that they appraise past and present situations and self and others in relation to these events becomes compromised. Similarly, their ability to articulate and comprehend their experiences is impaired when in an overwhelmed state. In support of this postulation, Horowitz and Znoj (1999) observed that clients' failure to regulate emotions results in incoherent and disorganised narratives due to the amplification of irrelevant details, a chaotic sense of time, and fragmented recalls of episodic memories. The study also found that clients in an emotionally overwhelmed state of mind display disjointed

thought processes, intrusive and excessively vivid images, and prolonged inability to emerge from fantasy. Indeed, Horowitz and Znoj (1999) observed that emotionally under-regulated clients describe dazed sensations, a sense of emptiness, excessive bodily-sensed excitement, and exaggerated hyperactive movements. Finally, when clients attempt to access motivations for action, emotion under-regulation impairs their ability to control their behaviours. This failure to regulate emotions results in chaotic, excessive and pressured speech, while ignoring self and others' boundaries.

Distanced/Dissociated Dysregulated Modes of Engagement

Emotional avoidance is a form of dysregulation in which the individual employs conscious or unconscious strategies to distance or dissociate themselves from events that elicit negative internal emotional experiences (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). Although emotional avoidance provides short-term relief, eventually this may result in physical (Stanton et al., 2000) and psychological difficulties (Hayes et al., 2004). The theoretical framework for the Distanced Mode of Engagement can be traced back to Gendlin's (1996) work on the appropriate working distance for processing emotion. Gendlin argued that when the distance between the self and the experience is too large, the client remains unable to properly experience or relate to the emotion. Indeed, research in this area indicates that experiential avoidance and actively abstaining from outwardly expressing emotions are both related to higher levels of physiological arousal, aggressive behaviours, and distress when encountering emotional triggers (Tull, Jakupcak, Paulson, & Graz, 2007). Further, Choi, Vickers and Tassone (2014) found that emotional avoidance is associated with low mood, which intensifies avoidant responses, and results in a spiralling maladaptive cycle difficult to break.

From an attachment perspective, emotional avoidance results from childhood experiences of abandonment and recurring unresponsiveness on the part of the caregiver (Fosha, 2001). The child learns that their emotional reactions will not provoke a response or result in attention. Thus, as an attempt to preserve the connection with the caregiver, the child avoids expressing their emotional experience through strategies such as numbing, distancing, and silencing. Continuous emotional avoidance results in a sense of loneliness, difficulty communicating, extreme distress, and an inability to access personal inner experiences (Bowlby, 1988). These disruptions in communication with the self and self/other are at the core of psychopathology (Fosha, 2000).

Kennedy-Moore and Watson (1999) proposed a five-stage model to examine emotional experiences and understand their underlying processes. The authors associate affect dysregulation with disruptions in the communication of emotions. They conclude that communication disturbances produce avoidance or blocking of, and distancing from, affective expressions. For example, individuals may block or minimize the expression of their physiological reactions to an event. When this happens, the person may later consciously perceive these physiological reactions, yet still avoid communicating the emotional impact caused by the event. Moreover, the individual may refrain from expressing their difficulty in labelling and interpreting this experience. If the person considers that their emotion contradicts their beliefs and values, they may avoid expressing it. Likewise, the individual may attenuate the expression of their affects when they expect a negative reaction from others. Therefore, Kennedy-Moore & Watson (1999) conclude that interrupting the expression of experiences can result in emotional processing impairments. Indeed,

various studies indicate that emotional distancing requires an excessive amount of energy from the individual; this may hinder their ability to adaptively cope with situations thus becoming a risk factor for multiple psychological difficulties (Pennebaker & Beal, 1986; Spinhoven, 2014; Taylor & Bagby, 2000; Taylor, Parker, Bagby & Acklin, 1992). Further, from a behavioural perspective, emotional avoidance prevents the individual from being exposed to dreaded situations (Meier, 2014). By doing so, individuals become unable to participate in desensitization and habituation processes, thus increasing the likelihood of maintaining problematic emotions, cognitions and behaviours. Indeed, Foa and colleagues (1983) found that phobia clients who lack opportunities for habituation to feared stimuli are likely to experience treatment failure.

From an EFT perspective, avoidance of painful emotions deprives individuals of the adaptive information that emotions carry (cf. Perls et al., 1951). As such, the EFT model suggests that people who overregulate their emotions may have difficulty contacting the emotion scheme elements that provide the guidance needed for adaptive actions (Carryer & Greenberg, 2010; Elliott et al., 2004). Blocking emotional experience prevents awareness and symbolization of internal experiences (Greenberg, et al., 1993; Greenberg, 2002a). The reluctance to articulate life stories interrupts the process of self-awareness, self-reflection, and meaning creation (Angus & Greenberg, 2011, Paivio & Pascual-Leone, 2010).

Emotional avoidance may prove particularly disruptive to the psychotherapeutic process (Elliott et al., 2004; Foa & Meadows, 1997; Fosha, 2004; Timulak, 2015; McNally, Timulak & Greenberg, 2014). When clients disengage, they miss therapeutic opportunities to access, elaborate, express and make meaning

from their experiences. Indeed, research findings suggest that moments of silence can be counterproductive to the therapeutic process when these are the result of clients' emotional disengagement or of their unwillingness to express their emotions (Brown, 2008; Frankel & Levitt, 2009; Frankel, Levitt, Murray, Greenberg, & Angus, 2006; Ronningstam, 2006; Stringer, Levitt, Berman & Mathews, 2010). Avoiding the expression of painful experiences can also result in narratives that come across as incoherent, fragmented and disorganised (Dimaggio, 2011). Indeed, there is evidence suggesting that clients with personality and psychiatric difficulties have impoverished narratives (Dimaggio, 2011; Dimaggio, Catania, Salvatore, Carcione, & Nicolò, 2006). These are characterized by a reluctance to make references to emotional states, and a lack of connection between emotional or felt sense experiences and the meaning-making processes associated with them.

The behavioural outcomes described by Horowitz and Znoj's (1999) study illustrate Elliott's (2013a) argument that emotional avoidance alters the focus and the manner in which clients experience their emotion scheme elements. Horowitz and Znoj's (1999) research findings exemplify how emotional avoidance may result in specific maladaptive responses. The study observed that emotional avoidance results in clients focusing solely on peripheral elements of the situation at hand. Indeed, the authors found that when recounting said situation, clients terminated the contemplation of events prematurely and interrupted examinations of episodic memories. Clients also perceived and appraised others irrationally. Accordingly, the Modes of Engagement model argues that when clients suppress emotionally laden memories and events, this prevents them from attending to key aspects of their experience. Horowitz and Znoj (1999) also observed that emotional over-regulation

results in impaired articulation of concepts during problem solving, refusal to use imagery, and reluctance to symbolize images into words. These observations support Elliott's (2013a) contention that when clients avoid symbolizing and conceptualizing their experience they aren't able to express and reflect upon it. Further, the Modes of Engagement model suggests that emotional avoidance prevents clients from accessing the information that their body carries, and from perceiving their underlying motivations and experiencing their needs. This may result in a lack of motivation to carry forward adaptive actions. Horowitz and Znoj's (1999) study supports this contention as well. They observed that emotional avoidance results in clients experiencing numbness, prolonged body rigidity and immobility. They also found that emotional over-regulation was associated with clients deflecting actions, displaying restless behaviours and employing escapist humour.

In short, emotional over or under-regulation prevents clients from fully accessing, differentiating, elaborating, symbolizing and articulating what they are experiencing. As such, emotion dysregulation can be conceived as a mode of engagement that impairs clients' ability to integrate their emotion scheme elements in a balanced and organised fashion (Elliott, 2013a).

2.5.2 Restricted Modes of Engagement

Restricted modes of engagement refer to non-experiential stances in which clients are dominated by a single emotion scheme element (Elliott et al., 2004). These isolated manners of processing prevent clients from accessing, integrating and elaborating the wholeness of their experience. Elliott (2013a) differentiates various ways in which Restricted Modes can manifest themselves. Clients may process their experience by remaining abstract and conceptual, by externalizing, by somatising, or

by action focused (i.e., impulsive) modes of engagement ungrounded in their emotions to the exclusion of all other emotion scheme elements. The subsequent sections elaborate further on each of these modes.

Externalized: “Perceptual/Situational” Restricted Mode of Engagement

Externalized story telling refers to moments in which clients maintain a sole focus on recalling episodic memories and appraising events and people, without integrating emotions or other emotion scheme elements into their experience (Elliott et al., 2004). According to Rennie (1994; 2007), this type of narrative is a “rich, dynamic manifestation(s) of clients’ struggles with disturbing feelings... there is usually more going on than is being told” (Rennie, 1994, p. 242). Rennie’s qualitative research findings suggest that clients may use externalized storytelling as a way to skip over experiencing. His findings indicate that this type of narrative enables clients to stay with a general sense of themselves as a way of dealing with disturbing thoughts, thus delaying entry into their internal experiences (Rennie, 2007). Interestingly, the study found that, in some instances, while clients are engaged in externalized storytelling, they begin realizing that parts of their stories are not completely accurate. These moments of experienced inaccuracy promote self-reflective processes that stimulate the development of clients’ insights. Thus, what enriches clients’ externalized story is the inclusion of an inward focus that reveals these inaccuracies, along with the self-reflective process this encourages.

Angus and colleagues have given special attention to investigating different varieties of storytelling (Angus & Greenberg, 2011). These authors suggest that narratives provide opportunities to co-develop accounts of clients’ problematic experiences during psychotherapy. The manner in which the narrative is discursively

designed gives the teller and the recipient access to the unique personal significance of the event (Muntigl, Knight, & Angus, 2014). Angus and Greenberg (2011) label moments in which clients, in a disengaged bystander stance, provide details of the circumstances of a significant personal event without elaborating on its subjective meaning or emotional impact as “empty stories”. This supports the idea that the Externalized Modes of Engagement is based on a lack of emotional grounding. Indeed, Boritz, Barnhart, Angus and Constantino (2017) conducted a study that found that therapeutic recovery is compromised when clients engage solely in empty storytelling without integrating other types of narrative.

Likewise, Ribeiro, Bento, Gonçalves and Salgado (2010)—another research team also interested in studying narrative—found that narrative reconstructions during psychotherapy are hampered when clients focus their attention on rigid and recurrent themes about events, without integrating more complex and diverse meaning-making processes. This results in a difficulty developing new or different meanings and narrative possibilities. According to Toukmanian (1992; 1996), difficulties in processing information appear when clients use an automatized perceptual activity. Clients who hold rigid and inflexible perceptions find it difficult to create alternative ways of seeing and adapting to the world. In these studies, the implication is that a sole focus on perceptual situational elements leaves other emotion scheme elements undealt with, especially implicit or experienced emotion.

Muntigl and colleagues' (2014) study found that when clients do not make explicit the emotional impact and the meaning of their experience, therapists might not be able to engage with the clients' affective stance. This may deny therapists a full understanding of the significance of the problematic event which, in turn, can

compromise the therapist' empathic responses. If this happens, the therapist may fail to focus the client's attention on the feelings that arise. Greenberg and Angus (2004) suggest that externalized storytelling can be overcome when therapists invite clients to access and label the emotions associated with their experience. They also emphasize the importance of encouraging clients to attend to the emotional impact of the event, and to the integration of affective-cognitive meaning-making processes in therapy.

Somaticizing: "Bodily-Expressive" Restricted Mode of Engagement

Somatizing refers to moments in which clients' main focus of attention is on their body felt-senses. In this stance clients are absorbed by their sensory experiences that serve as manifestations of their psychological distress. Clients concentrate on communicating predominantly through descriptions of sensory experiences or physical symptoms as well as physical manifestations of illness, without attending to other emotion scheme elements, especially implicit or experienced emotion (Elliott et al., 2004).

Various studies, from a developmental perspective, have associated somatization with a history of insecure attachments (Taylor, Mann, White & Goldberg, 2000; Schmidt, Strauss & Braehler, 2002); particularly, instances during which the infant attempts to satisfy their attachment needs by seeking their caregivers' attention. In these moments, the child expresses emotional distress through physical somatization. Stuart and Noyes (2006) developed a model of somatization as the result of a combination of insecure anxious attachment, experiences of rejection, unavailability from significant others, and a lack of reassurance from medical professionals. These authors found that clients

experiencing somatising processes tend to manifest physical complaints as a means of pushing away their experience. For this reason, they have difficulties achieving insight regarding the responses that they elicit in others, understanding what they want and what they need, and linking and connecting past and present experiences. Interestingly, these authors also suggest that therapeutic interventions, such as co-constructing metaphors, expanding communication, and being empathic and attuned, facilitate somatising clients' interpersonal functioning and symptom relief. van Dijke and colleagues (2013) observed that clients who present with somatoform disorders (SoD) report a reduced ability to foster operational thinking, and present difficulties fantasizing, stepping back from and contacting their affective experiences. As such, the authors argue that during somatising processes it is recommendable to employ therapeutic approaches that use experiential and mentalization processes (i.e. ability to understand the needs, desires, beliefs, feelings of oneself and others) in order to enhance clients' ability to effectively process their emotional experience.

Various studies researching trauma support the contention that broadening clients' restricted focus on their bodily sensations or symptoms is important to the therapeutic process. O'Kearney and Perrott's (2006) research, which focuses on trauma narratives from clients suffering from post-traumatic stress disorder (PTSD), found that those who rely mostly on sensory-dominant trauma memories have difficulty connecting to their conceptual, causal, logical and temporal associations. As such, they display fragmented narratives and thus remain unable to fully process their experience. Also, a study with genocide trauma survivors reported that clients who rely mostly on bodily descriptions of their experiences displayed more PTSD symptoms than those who incorporated more emotional words in their narrative (Ng,

Ahishakiye, Miller, & Meyerowitz, 2015). From the modes of engagement perspective, the above research findings suggest that clients, who rely mostly on somatization to communicate their traumatic experiences, lack the ability to integrate other emotion scheme elements into their narrative. Traumatic memories may manifest themselves as encoded solely in sensory-motor responses that remain unattached from their symbolic forms and their situational context (Mollon, 2002). This, in turn, results in incoherent, fragmented narratives, and difficulties in drawing meaning from these experiences. Thus, a restricted focus on physical sensations hinders clients' capacity to process all aspects of emotionally painful experiences.

Abstract/Purely Conceptual: "Symbolic-Conceptual" Restricted Mode of Engagement

Moments in which clients attempt to maintain a logical conceptual stance without accessing other emotion scheme elements are referred to as Abstract or Purely Conceptual modes (Elliott, 2013a). Baker and colleagues (2013) argue that when psychological therapies that rely predominantly on conceptual or propositional systems to process information, clients show difficulty accessing emotional material through verbal means. Indeed, Bohart (1993) suggested that emotional difficulties cannot be solved merely through abstract and intellectualized processes since there is no such affect-free reasoning. When clients engage in primarily abstract non-experiential modes, they may encounter obstacles to access emotional information that is vital for therapeutic change (Baker et al., 2013; Elliott et al., 2004). Moreover, conceptual, over-generalized, and intellectualized autobiographical narratives are related to a reduced ability to access emotions and meaning-making processes in clients dealing with depression (Boritz, Bryntwick, Angus, Greenberg &

Constantino, 2014; Park, Goodyer, & Teasdale, 2004), and in clients with personality and psychiatric disorders (Dimaggio, Salvatore, Popolo & Lysaker, 2012). Similarly, Clarke (1996) has found that when clients rely solely on cognitive symbolization without accessing emotional components, they encounter difficulties in creating meaning from their experiences. Likewise, there is evidence suggesting that clients who interpret their difficult life stories in an abstract-cognitive manner, without an accompanying emotional language, present low narrative integration and coherence (Adler, Wagner, & McAdams, 2007).

Impulsive/Acting-Out: “Motivational-Behavioural” Restricted Mode of Engagement

The motivational behavioural stance, in the Restricted Mode, refers to instances during which clients concentrate solely on their desires, wishes, wants and needs, without attending to other emotion scheme elements. As a result, clients tend to display impulsive tendencies towards acting-out (Elliott et al., 2004). Studies that have observed clients with eating disorders are helpful to illustrate this manner of processing. Ivanova and Watson’s (2014) study, for example, demonstrates how eating disorder populations show deficits in their ability to process and regulate emotions. The authors have observed that this population presents impulsive action tendencies. People who display these tendencies tend to regulate or push away their emotional experience by bingeing, purging, or by extreme exercising or dietary restriction during anorexia periods. Thus, the authors suggest that in order to break this restricted impulsive manner of processing, treatments need to focus on working through emotional processing deficits. Indeed, there is evidence suggesting that people with eating disorders have an impaired ability to distinguish their emotions

from their bodily reactions, as well as to identify, make sense, express, and label their affective states (Bydlowski et al., 2005).

Likewise, there is evidence suggesting that self-harm behaviour (e.g., cutting) is an attempt to avoid distressing emotions that are appraised as unacceptable or dangerous, and to keep these away from the self and from the outside world (Morris, Simpson, Sampson, & Beesley, 2015). According to Morris and colleagues, self-harm behaviours are the result of volatile and abusive early life experiences in which the child feels afraid of conveying their affective responses. Under these circumstances, emotional pain is expressed as self-induced physical pain. Thus, impulsive self-harm behaviours could be understood as helping to hide emotional pain or pleasure from others, or as attempts to express or symbolize emotional pain.

As the various studies referenced above suggest, from the Modes of Engagement perspective, self-damaging activities may also be impulsive expressions emerging from a sole focus on desires, wants and needs, without integrating other emotion scheme elements, especially experienced emotion. Both research on eating disorders and those focusing on self-harm demonstrated that the lack of narrative integration of the full extent of the emotional experience is a core aspect of their maladaptive tendencies. Thus, broadening the focus beyond the impulsive aspects of the clients' emotional processing, by accessing other emotion scheme elements, may be a key component of psychotherapeutic treatment.

2.6 Experiential Modes of Engagement

2.6.1 Working Modes of Engagement

The Working Mode refers to moments in which clients are in full contact with their emotional experiencing. When this happens, clients are able to attend to,

be aware of, articulate and make meaning of the full range of their emotional reactions in a regulated, organised and balanced manner. They are able to distinguish, integrate, organise, and communicate the different elements of what they are experiencing in the present moment (Elliott, 2013a). In this sense, the Working Mode refers to instances during which clients are able to bring a particular element into the experience while incorporating and productively using the information that is available from all other elements of the experience, especially experienced or implicit emotion.

The Experiential Modes of Engagement builds upon Gendlin's (1962) and Rogers' (1959) concept of "experiencing". These authors define this as a whole organismic process in which the individual uses and is fully aware of the direct available experiential data from their phenomenological field. When this happens, all experiences can be assimilated in the self's structure. Bohart (1993; 1995) refines Rogers' and Gendlin's conceptualization of experiencing by arguing that the concept should be expanded to not only include a whole-bodied experience, but also what he refers to as a meaning-apprehension process of the complexity of human relationships with others, with themselves, and with the environment.

More recently, the EFT perspective defines experiencing as,

...an on-going dynamic synthesis that is created and recreated by active engagement with the internal and external environments. Emotional experience is "produced" by a progressive construction that emerges out of sensorial and cognitive/affective experiences that are interpreted through self-reflection and narrative (Paivio & Pascual-Leone, 2010, p.79).

Within this context, the broad category of Working Client Modes of Engagement proposes that in addition to a whole-bodied meaning apprehension of the experience, the productive client engagement in therapy involves their being able to focus their attention on one element while remaining in contact with the emotional core of the experience in such a way that other emotion scheme elements become integrated and can then be successfully communicated. Moreover, the Working Mode of Engagement provides clients with useful information that enhances their ability to become fully aware and to differentiate the components of their experience. Indeed, from this perspective, this project uses Elliott and colleagues' (2004) emotion scheme structure that divides these elements into: perceptual-situational, symbolic-conceptual, bodily-expressive, motivational-behavioural. The argument is that these elements together generate an overall sense of a particular emotion — an emotion process. This can only be fully recognized once the client integrates into the experience all elements of the emotion scheme.

The following section will explore studies that help to elucidate how the different elements of the Emotion Scheme can be processed and manifested while clients are engaged in an experiential stance. The objective of the following section is to distinguish and distil the different emotion scheme elements that are processed during the wholeness of the experience.

Externally Attending: “Perceptual-Situational” Working Mode of Engagement

When clients are trying to make sense of their life experiences, their focus of attention is on remembering specific autobiographical memories and appraising events and people in order to generate a coherent story (Elliott et al., 2004). During

these instances, clients attend to the perceptual-situational aspects of their experiences in an emotionally engaged manner, while remaining in contact with the other elements of their emotion scheme. The client is able to intertwine all of these elements and thus contact the wholeness of the experience. In this way, their manner of experiencing is profoundly enriched.

In 1969, Klein and colleagues formed a research group that focused on measuring experiencing during clients' narration of life stories (Klein, Mathieu, Gendlin & Kiesler, 1969). The group's research was key to early understandings of these narrations. The Experiencing Scale was used to assess the quality of experiential involvement. This research instrument consists of a seven-level process scale which, on one end, describes instances during which the speaker narrates accounts of external events with minimal personal involvement (i.e., no references to personal feelings or private experiences in relation to the story) and, on the other end, describes accounts of external events that incorporate personal feelings or private experiences. Research using the Experiencing Scale has consistently shown that while clients are narrating their life stories, therapeutic progress is related to an increase in personal and emotional involvement (Klein, Mathieu-Coughlan, & Kiesler, 1986). Thus, these findings support the contention that in order to achieve psychotherapeutic improvement, it is fundamental that clients focus on external events while accruing attention to the emotional meaning of these life experiences.

Toukmanian (1992) developed the perceptual-processing model to focus on studying the ways in which people perceive and represent reality. She contended that therapy should concentrate on helping clients develop more flexible ways of appraising events. Guidano (1991) had previously argued that this flexibility helps

clients develop alternative ways of differentiating and organizing their self-schemata. This provides clients with tools for more adaptive life choices and with novel avenues for the creation of meanings about themselves and others. Supporting this contention, Toukmanian (1986) points out that progress in therapy occurs when clients move from more simple ways of appraising events, to more complex and differentiated means of doing so. Clients achieve this level of complexity by integrating more information into their schemes; this serves to deepen their understanding of situations, of themselves and of others. Based on this approach, Toukmanian (1986) developed the Client Perceptual Processing (LCPP) measure — a psychotherapy tool dedicated to assessing clients' perceptual functioning. Missirlian and colleagues (2005) used the LCPP measure in a study assessing levels of perceptual processing during experiential therapy in clients suffering from depression. The study found that higher levels of perceptual processing were linked to improvement in psychotherapy.

More recently, several studies have researched the therapeutic advantages of helping clients to incorporate autobiographical details and meaning-making processes into the account of their life stories. Studies particularly interested in understanding how people construct narratives to represent their experiences of themselves, others and the world, suggest that when clients are engaged in an experiential stance, guiding them to focus on “what happened” and “how it felt”, facilitates the articulation of coherent narratives and prompts the emergence of new meanings (Boritz, Angus, Monette, Hollis-Walker & Warwar, 2011; Boritz et al., 2014). In a similar vein, Pennebaker (1997) developed a study with trauma survivors researching the psychological benefits of writing and talking about external traumatic

events. The study found that the writing process stimulates the clients to incorporate into the experience organised symbolic and conceptual means of explaining it. What this is suggesting is that the integration of linguistic and symbolic features facilitates the processing of external events.

O’Kearney and Perrott’s (2006) review of trauma narratives found that there is less story fragmentation when thoughts and feelings are introduced into the account to organise and enrich it. Additionally, a study conducted by van Minnen, Wessel, Dijkstra and Roelofs (2002) studying changes in trauma narratives from pre-treatment to post-treatment, during prolonged exposure therapy, found that clients with good outcomes were increasingly able to integrate emotional language and organise their accounts of traumatic events. From an Working Modes of Engagement perspective, the results of these different studies seem to support the contention being made in this project that when clients are attending to external events vividly, while integrating other emotion scheme elements, they are able to organise and connect their life stories in a coherent and emotionally meaningful manner.

Body-Focused: “Bodily-Expressive” Working Mode of Engagement

The bodily focused stance refers to instances during which clients give careful attention to their bodily sensations and the meaning of these bodily felt senses, while remaining in contact with other elements of the experience in an emotionally engaged manner. During these moments, clients’ attention on bodily sensations allows mental images, memories and concepts that are basic to thinking and meaning creation to surface (Rennie & Fergus, 2006). Eugene Gendlin’s (1962) pioneer work on the concept of the “felt sense” emphasized the importance of focusing on the body in order to understand human experience. Gendlin used this

term to refer to bodily sensations that communicate important inner experiences that need to be worked through. Accordingly, he argued that people draw on their intricate, subjective, implicit and sensed bodily experience to symbolize it, and then return to it again and again before they can move forwards towards a full creation of meaning. Gendlin's seminal work proved that positive therapeutic outcomes were contingent on clients' ability to access their issues through the implicit bodily felt senses associated with them (Hendricks, 2007; Pascual-Leone & Yeryomenko, 2017). Based on Gendlin's work, EFT considers an inward and directed focus on the body as a means of accessing emotion scheme elements in order to create meaning out of experiences (Elliott et al., 2004). Nicolaou and Elliott (2016) argue that important information about emotions, meanings, memories, and actions can be accessed through forms of non-verbal communication such as physical symptoms. That is, bodily sensations not only carry significant information but also constitute experiences that have personal meanings and functions. Thus, the implication is that when clients focus their attention and fully explore their physical symptoms while also integrating other aspects of the experience, they are able to broaden their understanding of self, others and events.

Body-oriented psychotherapeutic approaches understand the body and the mind as intertwined and inseparable. According to this view, cognitions, emotions, perceptions and sensations are all part of the embodied process of experiencing. The fundamental premise of this approach is that our core beliefs are embedded in the body. Studies, in this area, suggest that carefully and mindfully focusing on bodily felt senses enhances clients' self-awareness which is, in turn, associated with a decrease in psychological difficulties (Röhrich, 2009; Röhrich, 2015; Röhrich &

Priebe, 2006). For example, bodily-oriented psychological interventions have been found to be more effective in reducing negative symptoms in clients with schizophrenia than supportive counselling (Röhrich & Priebe, 2006).

In a similar vein, Mindfulness-based psychotherapeutic interventions strive for an inward focus on bodily sensations as a means for psychological health. This technique requires clients to fully attend to their present internal and external stimuli by focusing on bodily sensations, breathing modulation and muscle relaxation (Bishop et al., 2004). Davis & Hayes (2011) have found that mindfulness techniques facilitate self-reflection, a full sense of experiencing, an acceptance of mental states, and a sense of deep connection with others. Moreover, research in this area has also demonstrated that mindfulness-based interventions increase body awareness that, in turn, promotes psychological and physical self-regulation (Boyle, 2011). Further, studies on the effectiveness of mindfulness-based psychotherapy suggest that body awareness, which facilitates connections with emotions, reduces symptoms in clients with chronic pain and depression (de Jong et al., 2016).

Interestingly, studies from a neuroscience perspective also provide strong support for the functional integration of bodily and emotional awareness, along with cognitive processing. There is evidence of a gut-brain and brain-gut axis that transmits information sensed in the gut to the brain. It is through bodily felt senses that the brain can identify the incoming information and activate adaptive response mechanisms (Mayer, 2011). Likewise, Damasio's (2005) research establishes a link between bodily sensations and thinking and decision-making processes in the brain. Indeed, he writes that "the soul breathes through the body, and suffering, whether it starts in the skin or in a mental image, happens in the flesh" (1994, p. xvii).

Recent psychotherapeutic and neuroscience studies consistently support the contention that the body carries important and meaningful information. It is thus essential to access and elaborate upon inward bodily sensations in order to achieve full experiencing. Indeed, since the body is part of the wholeness of the experience and inseparable from the individuals' full emotional scheme nuclear process. It should thus be explored in-depth in connection with all the elements that together make-up the process of experiencing.

Reflexive/Symbolizing: “Symbolic-Conceptual” Working Mode of Engagement

While clients are in an experiencing stance, their energy and attention is focused inwards. During these moments clients are engaged in accessing their inner-experience through symbolizing. This facilitates the unfolding of this experience through language in order to evaluate and articulate it in a more nuanced and crystalized manner. Symbolization is not relegated to abstract and intellectualized approaches alone; rather, it refers to a process of naming and expressing the experience in order to achieve awareness and to regulate affect. During these instances, clients are able to approach the presentness of the experiencing process in a nuanced and specific manner while remaining in contact with all elements of the emotion scheme. From an EFT perspective (Greenberg & Watson, 2006), symbolization is a fundamental process that has to take place in order to create meaning.

This symbolization process includes a conceptual understanding of the personal value of the experience. In order to reflect and symbolize, individuals need to approach the experience in an active, curious and vivid manner (Greenberg &

Watson, 2006). During this stance clients are bringing into the symbolization process other emotion scheme elements, and learn to be precise, refined, be mindful and track their emotional experience.

Several authors have claimed that in order to enhance emotional awareness, symbolization and reflection, individuals need to delve into affective-cognitive processing in an integrated manner (Auszra et al., 2013; Elliott et al., 2004; Greenberg et al.; 2007; Kennedy-Moore & Watson, 1999; Missirilian et al., 2005). Indeed, some studies have found that episodes of high emotional arousal along with conceptual symbolization of these episodes predict good therapeutic outcomes (Greenberg et al., 2007; Missirilian et al., 2005). Further, a study conducted by Auszra and colleagues (2013) suggests that mid-therapy emotional activation in combination with symbolization and differentiation was especially predictive of good outcomes. Similarly, from a narrative informed perspective, the symbolization of experience serves as a fundamental means of constructing a sense of self. Indeed, Angus and Greenberg (2011) point out that identity is built through an on-going process of symbolizing our experience and organizing our actions and emotions, in order to give coherence to a narrative of the self. In this sense, it is precisely through symbolization that individuals come to understand themselves. Likewise, Lewin (2010) found that shifts between descriptions of inner experiences and the interpretive analysis of these experiences during emotion-focused and client-centred psychotherapy was conducive of higher levels of experiencing. These studies support the contention that emotional engagement must go hand in hand with symbolic-conceptual elements.

Interestingly, there is some research indicating that when clients are emotionally activated, some self-distancing (observer stance in the construction of experiences) may emerge naturally to facilitate self-reflection processes (symbolization and self-understanding processes) (Kross & Ayduk, 2008; Park, Ayduk & Kross, 2016). In this sense, dynamic and balanced shifts between self-distancing and self-immersion (first person stance in the construction of experiences) processes may be useful as long as they are continuously connected with the emotional experience. These studies found that a third person self-position facilitates self-reflection and meaning-making processes. In response to this evidence, Barbosa and colleagues (2018) studied how emotional self-immersion and self-distancing relates to therapeutic improvement during experiential work. Their results indicate that self-immersion and self-distancing processes appear at different stages during psychotherapy. Self-immersion stances appeared more frequently during moments of awareness and problem clarification, whereas self-distancing stances were more predominant during moments of understanding, insight, resourcefulness and problem solution. These observations led the authors to conclude that self-distancing helps clients to maintain a functional distance from strong emotions, while self-immersion helps clients to access and be aware of their emotional experience. Thus, it seems that the interplay between moments of distancing and moments of immersion are important for the process of emotional symbolization, as well as for the creation of meaning, and emotional transformation of the self.

In general, an emotionally engaged conceptual symbolization of the experience provides clients with important cues about the sources of their distress, their needs and possible solutions. Symbolization requires a dialectic synthesis

between the immediate experience and its elaboration. This synthesis serves to provide the client with multiple ways of narrating the experience. Once symbolization has occurred, clients are in a position to step back from the experience and reflect upon it. This process of symbolization can serve as a foundation for a subsequent creation of new self-meaning (Greenberg & Watson, 2006).

Active Expression: “Motivational-Behavioural” Working Mode of Engagement

Motivational-behavioural stances refer to moments when clients, while emotionally engaged, focus their attention outwards towards their motivations and actions. When this happens, clients become aware and actively express their needs, wants, wishes, and action-tendencies to themselves and to others (Elliott, 2013a). This stance refers to instances during which the client is motivated towards expressing their immediate emotional experiences in an active manner — it is through this tendency towards doing that the clients’ energy is invested in discovering these needs, wants, and wishes (Rice & Greenberg, 1990). During this stance, it is by doing that clients process the experience and discover their needs. Differently than during the Restricted Mode, clients give careful and mindful attention to these motivations while remaining in contact with the full range of elements of their emotion schemes instead of limiting their attention to their motivations alone.

The Transtheoretical Model (Norcross, Krebs & Prochaska, 2011) and the Motivational Interviewing approach (Miller & Rolnick, 2013) were both developed as means of understanding the processes that underlie clients’ motivations towards taking action. Both theoretical approaches can be seen as giving importance to what

EFT refers to as motivational-behavioural elements. The Transtheoretical Model suggests that individuals need to go through a process of bringing into awareness the fullness of the experience, the costs of unhealthy behaviour and the benefits of behavioural changes to resolve their difficulties. According to this model, the first step begins when clients attend to and become aware of the benefits of healthy actions. This, in turn, promotes a sense of self-efficacy that motivates clients to express intentions and to eventually display actions and become committed to behavioural changes. Likewise, the Motivational Interviewing approach, posits that clients' ambivalence towards behavioural changes can be resolved through an accrued awareness of the need to take action. This process arouses individuals' internal motivation, which in turn heightens their sense of self-agency. These models suggest that when clients come into contact with what they need and what they want, the motivation towards adaptive action tendencies emerges along with the development of self-agency and efficacy.

Contacting clients' motivations and action tendencies in an emotionally grounded manner has been emphasized in EFT as a key step towards the resolution of psychological difficulties (Elliott et al., 2004). In order to do so, clients must undergo a process that helps them move towards full contact, awareness, exploration and elaboration of core emotional pain. This is necessary in order for clients to be able to identify their underlying wants and needs (Timulak, 2015). Indeed, the EFT approach has developed specific tasks (i.e., empty-chair, two-chair dialogues) to encourage clients to actively and verbally express their needs, wants and action tendencies to themselves and to imagined significant others (Elliott et al., 2004). Studies directed towards understanding how clients resolve interpersonal conflicts

during empty-chair dialogues—a technique that encourages clients to actively and verbally express their experience to an imagined significant other—find that accessing and articulating underlying unmet organismic needs is fundamental (Elliott et al., 2004). There is also evidence suggesting that the active verbal expression encouraged in this type of intervention is important for therapeutic success and is superior to other techniques that do not involve emotional activation or verbal expression such as psycho-educational interventions (Paivio & Greenberg, 1995). In a similar vein, Pascual-Leone's (2009) research findings provide further evidence suggesting that two-chair dialogue techniques promote clients' full awareness of personal losses. This mobilizes the self to actively express underlying needs. Active expression of needs is a pivotal step in developing self-acceptance and a sense of personal agency that serves as a means of preparing and guiding clients to take action. In short, interventions that facilitate emotional engagement through vivid enactments encourage clients to access underlying needs, strengthen, motivate, and empower the self for action. A focus on motivational-behavioural elements, while the client is emotionally engaged, is vital for action-tendencies to emerge.

2.6.2 Change Modes of Engagement

Change modes refer to instances during which clients are in full contact with their emotions and are experiencing some kind of internal change, shift or transformation, such as a sense of newness or discovery. These moments of novelty emerge during experiencing from previously integrated emotional processing. As a consequence, clients experience and express various kinds of therapeutic change. When new emotions, bodily-felt senses, action tendencies, needs and perceptions of

self and others emerge, this results in a transformational process of the emotional scheme network (Elliott, 2013a).

The theoretical underpinnings of the concept of Change Mode are supported by over three decades of research by Elliott and colleagues. These studies have observed different aspects of the process of change, including research on significant events in psychotherapy (Elliott, 1984), on aspects of therapy that are seen as helpful or unhelpful by both clients and therapists (Elliott, 1985), on the concept of insight in psychotherapy (Elliott et al., 1994), and on accounts of personal change during therapy (Klein & Elliott, 2006), among others. The overall import of these studies is to indicate that clients consider integration, newness and discovery as insightful, helpful and significant in the process of therapeutic change. Transformational processes are the result of clients' mindful attention to previously overlooked or silenced emotion scheme elements — a process that naturally leads to meaning construction, integration and synthesis (Elliott et al., 2004; Greenberg, 2011). Indeed, research findings suggest that mindful emotional engagement, expression and symbolization, in conjunction with meaning creation and self-reflection, lead to positive change (Bohart, 1977; Clarke, 1991; Elliott, Greenberg, & Lietaer, 2003; Elliott et al., 2004; Kennedy-Moore & Watson, 1999; Missirilian et al., 2005). Overall, as will be explained in further detail below, the Change Modes refer to instances that occur through experiencing, during which clients focus their attention on transformational processes such as new perceptions of self, others or events, new bodily sensations, new meanings, and new motivations or action tendencies.

Re-perceiving: “Perceptual/Situational” Change Mode of Engagement

While attending to their perceptual-situational element during experiential work, clients may begin to experience changes in the way they perceive others, events, or situations. When this happens, new understandings, insights and awareness emerge, which consequently leads to alternative, more adaptive or more positive ways of re-perceiving external events.

Change emerges when new aspects of the experience are attended to and seen through a different lens. Re-perception of life events requires clients to re-experience and elaborate on specific episodic memories. According to Bohart (1995), in order to re-perceive life events, people need to go through a “reconfiguration” process, in which they broaden their perceptual reality by including in their experience something that they sense as new. The process of reconfiguration involves active participation by engaging in perceptual quests that “lead to the detection and apprehension of new or more finely ordered meaning patterns” (Bohart, 1995, p. 320), during which clients make sense of their experience. In this way, Bohart argues that perceptual change is the process by which clients re-perceive their subjective reality in a refined manner by bringing novelty into their experiential patterns. Indeed, in a study examining immediate therapeutic impacts, clients reported that acquiring new perspectives was a significantly helpful therapy event (Elliott, 1985). Clients stated that re-perceiving resulted in expanded awareness, moments of insight and cognitive restructuring. Likewise, Elliott and colleagues’ (1990) study on depression, which tracked changes after experiential psychotherapy, found that the acquisition of new perspectives about others was key in developing a more realistic sense of acceptance, patience and tolerance towards them (Elliott et al., 1990).

Toukmanian's Perceptual Processing Model contends that how people interact with their surroundings depends on their perception of reality. Research using this perspective has shown that perceptual processing changes over the course of therapy. Toukmanian (1986) observed that clients who benefit from therapy tend towards higher and more complex forms of perceptual processing as therapy progresses. These clients are more inclined to differentiate and integrate experience in a progressively refined manner in later therapeutic sessions. The trend is towards the integration of more meaning-making instances in order for newly emerged perspectives to arise. Further, in a study employing two-chair dialogues, Toukmanian (1992) found that clients who achieve resolution display higher levels of perceptual processing — these include the re-evaluation, differentiation, and integration of clients' interpersonal issues.

Angus and colleagues corroborate the contention that re-perceiving brings about novelty and newness. They have carried out various studies analysing clients' narratives across therapy. For example, their research tracking changes in clients' perspectives of others and events during psychotherapy indicates that re-perceiving emerges when clients engage in narratives that involve vivid, specific, and detailed autobiographical accounts (Angus & Greenberg, 2011; Angus & Hardtke, 1994). They suggest that this process helps bring coherence and newness to life stories by filling in memory gaps. Additionally, these studies find that during moments of re-perception clients shift among instances during which they are externally attending (what happens), emotionally engaged (how it felt), or reflecting (what it means).

In short, re-perception of life events happens when clients are prompted to re-experience their life stories and are invited to reconstruct their immediate perceptions

or appraisals of others and events in light of new emotional awareness (Elliott, 2013a). Newness emerges when clients recall their life stories in a vivid and detailed manner while bearing in mind other emotional scheme elements. In particular, studies support the argument that the integration of meaning-making processes, while recalling life stories, helps to construct coherent narratives and re-appraise others and events.

Body-shift: “Bodily Expressive” Change Mode of Engagement

The successful processing of problems carried as tensions in the body provides clients with a foundation for focusing on new positive bodily sensations (Elliott, 2013a). These moments of change, which naturally result in a sense of relief and expanded awareness of the body, are referred to as “bodily shifts”. Individuals perceive the world in and through the body; as such, it serves as a source and a receptor for this form of therapeutic change (Berg, Sandahl, & Bullington, 2010).

Gendlin (1962; Hendricks, 2007; Sharma, 2011) referred to changes in bodily sensations that occur through experiential therapeutic work as “felt shifts”. He understood these shifts as means through which the body acknowledges the appropriateness of the symbols (words, phrases or images) that are being brought into awareness. This implies an expanded contact with the whole quality of the sensation. Gendlin (1996) considers these felt shifts as ways in which the body “talks back” to the experience.

Hendricks’ (2001) review of research regarding the effectiveness of Gendlin’s focusing method supports the contention that attending to bodily sensations, along with the ability to pause and allow for a fresh bodily experience, are key for lasting change. Similarly, Cornell’s (2013) review of “focusing”

techniques finds that becoming aware of, heightening this awareness, and experiencing felt shifts, results in clients expressing excitement, feeling energetic, peaceful, clear-minded, grounded, and open to carrying forward new actions and experiences.

From a neuroscientific lens, body signals are believed to shape and modulate cognitive-reflective processes required for the creation of meaning, linguistic understanding, and reflective processes (Onnis, 2016). Staunton (2002) suggests that attention to body sensations provides insight and symptom relief. The author suggests that becoming aware of nuanced changes in bodily sensations allows clients to reach their highest potential for reason and creativity. This, in turn, gives a foundation to develop new adaptive actions (Damasio, 1994).

Mindfulness-based and body-oriented theoretical frameworks also provide evidence of the importance of attending to the body as a means of fostering clients' growth-oriented tendencies. According to Ottoboni (2013) and Segal and colleagues (2002), attending to bodily sensations facilitates a clearer understanding of psychological states and fosters thinking and decision-making processes. This focus on felt senses also increases the intentionality necessary to carry out novel and appropriate actions and to find ways to resolve difficulties. Boyle (2011) reported that applying mindfulness-based interventions increased body awareness and thus helped clients to respond to the environment in new more functional and conscious manners. Additionally, studies on the effectiveness of mindfulness-based psychotherapies that promote attention to bodily sensations suggest that working with the body increases levels of consciousness. This results in new affective-cognitive wirings in the brain (Davis & Hayes, 2011; Kabat-Zinn, 2003).

In recent years, there has been a renewed interest in what the body conveys, along with its implications for psychotherapeutic work and for affective-cognitive processes in brain networks. This line of research has emphasized the importance of client awareness of bodily changes as a means of fostering the integration of body-affective-cognitive-behavioural processes. In short, these body-oriented interventions promote decision-making, and facilitate the emergence of novel associations between affective-cognitive processes and help clients to carry forward adaptive action tendencies. Embodied cognitions, actions and emotions are essential for therapeutic change.

Self-Meaning Creation: “Symbolic-Conceptual” Change Mode of Engagement

Achieving new emotionally-grounded, positive and adaptive views and understandings of the self requires that clients symbolize and conceptualize. It is precisely through this on-going process that individuals make meaning through experiencing. Meaning creation is a type of processing that results from the integration of beliefs, behaviours, motivations, and emotions (Guidano, 1991). Greenberg and Pascual-Leone (2001) suggest that for the emergence of new meaning to occur, all the elements of the emotion scheme must be worked on in an integrative and simultaneous manner. The construction of new understandings of the self is a process that entails attending to a feeling, then consciously symbolizing it, and finally making meaning from the symbolized experience. Symbolization helps clients develop more adaptive and novel responses for functioning. Watson and Greenberg (1996) point out that symbolizing results in increased self-awareness, the acquisition of new insight, the development of a more profound understanding of the self, a

greater ability to regulate emotions, and a newfound contact with novel feelings and needs. Further, Clarke's research (1991; 1996) has worked specifically on meaning creation processes in clients who hold "cherished beliefs" — emotionally charged cognitions about the self and the self in the world that are appraised as either positive or negative. According to Clarke's model, successful creation of new meanings requires the integration of affective and cognitive processes that involve accessing the emotional experience, symbolizing it through language, exploring the origins of cherished beliefs, and appraising their tenability. So far, several research findings support the contention that emotional activation, in conjunction with symbolic conceptual expressions, result in the development of new meanings and new narratives about oneself (Greenberg & Watson, 2006; Greenberg & Pascual-Leone, 1995; Watson & Rennie, 1994).

Within the dialectical-constructivist framework, new explanations about the self-require a dyadic process during which clients attend to, elaborate, and symbolize their internal voices until they become reconciled into a new more integrated self-view (Brinegar, Salvi, Stiles & Greenberg, 2006; Elliott et al., 2004). In EFT the activation of these dialogues can occur during two-chair tasks. Studies using this type of intervention suggest that accessing, elaborating and integrating these voices gives rise to new, more positive, adaptive or assertive self-views (Elliott et al., 2004; Greenberg & Malcolm, 2002; Paivio & Greenberg 1995). Further, self-reflection processes during experiencing result in a self-transformational process. When asked about their experience of personal change during therapy, some of the changes reported by clients are expanded self-awareness, increased self-understandings

(Klein & Elliott, 2006), more positive feelings towards oneself, and reduced self-criticism (Elliott et al., 1990).

The ability to narrate and reflect upon the self through personal stories is fundamental to achieving an adaptive, coherent, and differentiated view of the self. Angus and Greenberg's (2011) research on narratives suggests that the elaboration of autobiographical memories that contain self-defining themes provides clients with a sense of who they were and who they are. This facilitates a sense of purpose, an integration of the self and a new sense of identity, which results in increased awareness, self-power and a sense of new possibilities. The authors call this form of narrative "self-identity change stories" because they contain reconstructions of personal identity and new views of the self. In a more recent study, Carpenter, Angus, Paivio and Bryntwick (2016) report that clients who recover include significantly higher proportions of "discovery stories" in their narratives. These types of stories refer to a more general sense of novelty than re-perceptions of the self-alone; however, new views of the Self seem to be an important aspect of these narratives. During these moments of discovery, clients develop new ways of viewing themselves, others, and situations (i.e., "I realize I'm an individual and I have the right to vent my feelings and what I think is right or good for me"; Angus & Greenberg, 2011, p. 90). Similarly, Gonçalves and Ribeiro (2012) use the term "reconceptualization" to reference narrative processes in which the client makes a contrast between previous self-narratives and emergent ones (i.e., "before I was ... and now I see myself as... and now I understand how I changed"). The authors again find that reconceptualization is more common in good outcome cases and are almost absent in poor outcome cases (Mendes et al., 2010).

In short, in order for clients to broaden the meaning of their experiences and achieve new understandings of themselves and their feelings, they need to appreciate new possibilities. For this to happen, clients must become dis-embedded from previous assumptions about themselves, while selectively amplifying, consciously processing and symbolizing their experience. This facilitates the emergence of new ways of understanding the self through self-reflective processes.

Carrying Forward Action: “Motivation-Behavioural” Change Mode of Engagement

After experiencing, clients may attend to the motivational-behavioural elements of their emotion scheme. The new sense of personal agency that is cultivated through experiencing inspires the development of motivations, intentions, and tendencies towards action. During these instances, clients’ attention is on discovering and expressing new needs, wants and wishes. They begin to develop new plans for action, to display new behaviours and to elucidate new solutions. “Carrying forward” is a fundamental principle of humanistic therapy. The assumption is that people are inherently inclined towards growth; for this reason, clients are always actively searching for and discovering novel ways to approach their difficulties (McLeod, 2003).

A sense of self-agency needs to be experienced in order for new actions to develop (Levitt, Lu, Pomerville & Surace, 2015). When clients feel that they are “the source and controller of [their] own actions” (Campbell, Carrick & Elliott, 2014, p. 594), this experience may promote novel action tendencies. Campbell and colleagues observed that during humanistic counselling clients with life-limiting illnesses are able to develop a sense of an agentic self. Based on these observations, the authors

developed a hierarchical model of self-agency that ranges from a passive non-agentic stance towards a more autonomous, active, and fully agentic one. Once clients approach the later stance, they start to experience hope, wants, desires, and a need to initiate action in a more proactive and purposeful manner. This experience results in a joyful acceptance of self and an active engagement with life that includes new plans and goals.

There are other models that also explain how clients progress throughout therapy from a non-involved stance, towards a full commitment for behavioural change. Stiles' Assimilation Model (2002) suggests that therapeutic change follows a sequence that starts when clients become aware of and acknowledge their problems. Once this happens, clients can go on to state, clarify, understand, and make meaning of their difficulties. Finally, this process of assimilation brings about an agentic stance in which clients become resourceful and actively motivated towards problem resolution and mastery. Norcross et al., (2011) developed the Transtheoretical model to explain clients' readiness to act in more functional and healthy ways. Their approach suggests that individuals go from a lack of awareness and motivation to change ("pre-contemplation") towards greater awareness and commitment to behavioural changes. According to this model, for transformation to happen, individuals must first become aware of the benefits of behavioural change ("contemplation"). This awareness motivates clients' intent to act ("preparation"), which then leads towards taking actions and sustaining these changes through time. In the same vein, from a client-centred perspective, Miller and Rolnick (2013) developed the Motivational-Interviewing model in order to explain how clients can bolster their engagement, increase their intrinsic motivation, and strengthen their

commitment to behavioural change. These authors suggest that in order to elicit an internal motivation towards taking actions, clients must develop a belief in their own capabilities of self-transformation along with a full awareness of the reasons and the needs for these changes. The model also suggests that when clients express an intention to act, this bolsters a sense of readiness to change. A commitment towards taking steps for action emerges when clients actively engage in “mobilizing change talk” — the term refers to narratives that show commitment to new behaviours. What these models are implying is that a commitment towards behavioural change naturally emerges from an accrued awareness of new motivations and new needs. Novel behaviours place clients in different situations and contexts. Once this happens, their sense of agency over their environment affects their desire, readiness and commitment for change.

Rotter’s (1966) concept of Internal Locus of Control refers to an individual’s sense of control over their environment, which can be understood as an aspect of self-agency. Rotter’s term provides further nuance to the processes underlying clients’ motivational-behavioural changes. For example, in a study that investigated the relationship between locus of control and behavioural change, Chen and Wang (2007) found that a commitment to change appears more often in individuals with higher levels of internal locus of control. It seems that an internal locus of control makes individuals feel more obligated to sustain and commit to behavioural changes. Clients with a higher internal locus of control are more prone to believe that they are in control over their environment and thus over their ability to change. Therefore, they are more likely to commit to change motivated by their own desires. However, it should be noted, that if these clients sense that they will not be able to sustain

changes over time, they are more likely to become inhibited and thus less likely to change. Still, Chen and Wang's study on clients' internal locus of control supported the idea that an increased sense of self-agency underlies motivational-behavioural change processes.

The relationship between clients' action-oriented agentic expressions towards behavioural change and therapeutic improvement can be observed in several studies. This has been evidenced in Bento, Ribeiro, Salgado, Mendes, and Gonçalves's (2014) research tracking innovative moments — narratives that express new thoughts, feelings and actions that are different from the dominant problem saturated narrative. The authors observed "performing change" episodes (i.e., "I want to do things that I thought were impossible for me") appears more frequently in good outcome cases whereas they were sometimes absent in poor outcome cases. These moments are instances during which clients are engaging in action-oriented agentic expressions. Likewise, Angus and colleagues (i.e., Angus and Greenberg, 2011; Carpenter et al., 2016) found that moments in which clients expressed a motivation towards action occurred more frequently in successful cases. An example of these moments is when clients offer "unexpected outcome stories" (i.e., "I was nervous to do it, but I finally got the courage to do it, and it felt right!"). Indeed, instances during which clients engage in action planning and problem-resolution have been reported as helpful and significant therapeutic transformational events (Elliott, 1985). In all likelihood, this occurs because during these moments clients experience their fully agentic-self. Further, Shearer (2015) found that clients reports of feeling internally motivated, being persistent, maintaining awareness of what they want and need, and believing in their ability to achieve goals through actions were all helpful

for their therapeutic process. In short, when clients become aware of their difficulties, and fully experience and elaborate upon them, their sense of agency is activated. This motivates them towards a focus on new action planning and problem-solving (Elliott, 2013a).

2.7 Process Analysis Systems Measuring Aspects of Emotional Processing

This section serves as an overview of valid and reliable Process Analysis Systems developed within the humanistic-experiential field to assess different domains of clients' emotional processing during psychotherapy. The purpose of this brief section is to offer a background and to provide evidence that affective-cognitive processes occurring during psychotherapy can be observed and measured for research purposes. Although these measures came out of different theoretical approaches, they share a common interest in measuring some aspect of clients' affective-cognitive processes during psychotherapy. Each of these measures emphasizes different aspects of emotional processing — this includes measuring different narrative styles, types of emotions, levels of arousal or vocal quality; or concentrating on perceptual processing. While there are various non-participant observational tools that described some aspects of emotional processing none of these tools capture or encapsulate the full spectrum of the emotional scheme as proposed in this project.

2.7.1 The Experiencing Scale

Klein and colleagues developed The Experiencing Scale (EXP) as a seven-point instrument designed to measure clients' involvement in psychotherapy, as proposed by Eugene Gendlin and Carl Rogers (Klein et al., 1986). The EXP scale has been applied expansively in a variety of studies with diverse theoretical

underpinnings. The EXP scale is based on a one-dimensional process, which measures the gradual increase of clients' references to inner experiences. The scale measures the progression of clients' involvement in inner-references that clients verbally express during psychotherapy. The EXP assesses the quality of clients' verbal communications on a scale that ranges from lower levels of involvement (progressive ownership of feelings), to intermediate levels (a shift from external accounts to internal accounts), and finally to higher levels of involvement (the integration and expansion of internal accounts). Among other findings, research conducted with the EXP (Klein et al., 1986) suggests that: a) levels of experiencing can be learned, b) higher levels of experiencing correlate positively with "helpful" therapist interventions, c) higher levels of experiencing are positively associated with therapeutic improvement at different stages of therapy, d) there is an increment in levels of experiencing across therapy and, e) the EXP scale measures modes of productive functioning instead of personality traits. Finally, studies indicate that the EXP scale has high reliability coefficients ranging from 0.80 to 0.94.

2.7.2 The Client Vocal Quality System.

The Client Vocal Quality System (CVQ) is a measure developed by Rice and colleagues (Rice & Kerr, 1986). The instrument was formulated through a Client-Centred framework, as an attempt to capture clients' inward focus by observing vocal quality patterns. The scale is based on observations of the pitch, fluency, pace, terminal contours, and energy of speech quality. CVQ takes into account a variety of vocal quality patterns: a) focused, b) externalizing, c) limited, and d) emotional. Several research studies using this measure indicate that a higher incidence of focused voice is related to good therapeutic outcomes (i.e., Horvath & Greenberg,

1989; Rice & Kerr, 1986). There have been two approaches used to measure CVQ reliability. One analysis is based on aggregate inter-judges rank order correlations (ranged from 0.70 to 0.79) and the other uses categorical data analysis (Cohen's Kappa = 0.49).

2.7.3 The Client Expressed Emotional Arousal Scale

The Client Expressed Emotional Arousal Scale (CEAS) was developed by Warwar and Greenberg (1999) to measure emotional intensity and quality by observing voice quality and body expressions. The CEAS is a seven-point scale that ranges from no emotional arousal to restricted emotional arousal. It is based on voice quality such as pitch, pace, terminal contours, speech fluency, and bodily expressions. Research using CEAS with clients with depression suggests that emotional arousal is predictive of therapeutic outcomes that are significantly above the therapeutic alliance (Carryer & Greenberg, 2010; Greenberg et al., 2007; Missirlian et al., 2005). The inter-rated reliability of this scale ranges from 0.75 to 0.85.

2.7.4 The Client Emotional Productivity Scale-Revised

The Client Emotional Productivity Scale-Revised CEPS-R was developed by Auszra and colleagues (2013), from an Emotion Focused Therapy perspective, as a tool for measuring clients' emotional productivity during therapy. The CEPS-R proposes three domains through which emotional processing occurs: emotional activation, emotion type and manner of processing. In order for emotional processing to be considered optimal it must meet criteria for all three of these dimensions. This means that emotion has to be present, the emotion type must be primary, and all stipulated aspects of the manner of processing must be present. These 7 emotionally

related components are: attending, symbolization, congruence, acceptance, regulation, agency and differentiation. Research findings using CEPS-R suggest that, for depressed clients, emotional productivity is related to therapeutic outcome. The inter-rater reliability of the CEPS-R using Cohen's Kappa was 0.85.

2.7.5 The Emotion Category Coding System

The Emotion Category Coding System ECCS is an observer-rated tool, based on EFT Theory, developed by Herrmann, Greenberg and Auszra (2016). The instrument was designed in order to reliably assess different types of emotions (primary emotions, primary adaptive emotions, primary maladaptive emotions, secondary emotions, instrumental emotions). The coding system was specifically created to assess Emotion Focused sessions. It was built so that a given segment of therapy could be observed and rated. The coding system is divided into four main categories: secondary/instrumental, primary maladaptive, primary adaptive, or uncodable. The procedure for rating begins with observers rating whether or not an emotion has been activated. If so, the emotion is categorized depending on its type. Finally, these categories are grouped depending on whether they are considered pleasant or unpleasant. Research findings using ECCS find that a) fewer secondary emotions and more primary adaptive emotions during the middle stages of therapy is predictive of therapeutic improvement, b) when primary maladaptive emotions (i.e. shame) appear more frequently in the middle stages of therapy, these are associated with good outcomes and, c) clients who shift from primary maladaptive emotions (sadness) to adaptive emotions (adaptive anger) over the course of therapy are more likely to have good outcomes independently of the level of emotional activation. The inter-rater reliability for emotional activation using Cohen's Kappa was 0.88; it was

0.82 for categories referring to emotions, and it was 0.84 for names referring to particular emotions.

2.7.6 The Narrative Process Coding System

The Narrative Process Coding System NPCCS was developed by Angus and colleagues (Angus, Levitt, & Hardtke, 1999) to empirically study narrative processes. The tool is designed to identify three distinct modes of narrative: external, internal and reflexive. The external mode refers to narratives that are descriptive, and concentrate on what is happening during a given situation. The internal mode refers to narratives in which feelings, reactions and emotions are associated with life events. Finally, the reflexive mode refers to a reflective process during which the client makes connections between the internal and external mode. The NPCCS inter-rater reliability using Cohen Kappa is 0.78.

2.7.7 The Narrative-Emotion Process Coding System

The Narrative-Emotion Process Coding System (NEPCS) was developed by Boritz and colleagues (Boritz et al., 2014) to assess narrative and emotion processes. The NEPCS consists of two broad categories. The first one refers to narratives that serve as problem markers and include those which exhibit under-regulated, over-regulated or unintegrated accounts (same old stories, empty stories, un-storied emotions, abstract stories, competing plotline stories). The second category refers to narratives that serve as change markers and include accounts that integrate both emotions and reflective processes (unexpected outcome stories, discovery stories, and inchoate stories). Research findings suggest that least improved clients construct narratives that display problem markers more frequently than those with good outcomes, whereas the most improved group construct narratives that include change

markers more frequently than bad outcome clients. The NEPCS inter-rater reliability using Cohen Kappa is 0.84.

2.7.8 The Levels of Clients Perceptual Processing

The Levels of Clients Perceptual Processing (LCPP) scale was developed by Toukmanian (1986) as an attempt to measure perceptual-cognitive modes that clients apply to attribute meanings to situations and events. The LCPP scale is a qualitative instrument that contains eight ordered, mutually exclusive categories ranging from low levels of perceptual-cognitive processing to higher levels (a. undifferentiated statements, b. elaborations, c. differentiation with external focus, d. differentiation with analytic focus, e. differentiation with internal focus, f. re-evaluation, g. integration). Research findings suggest that therapeutic effectiveness is related to higher perceptual processing skills. Internal consistency as measured by the coefficient alpha ranges from 0.81 for clients' dependency to 0.96 for clients' and therapists' exploration. Reliability can either be calculated separately for each category or can be ordered by category level so that inter-rater reliability is then calculated for the whole scale. The two-judge inter-rater reliabilities for all 8 categories range from 0.79 to 0.94.

2.7.9 The Innovative Moment Coding System

The Innovative Moment Coding System (IMCS) (Gonçalves, Ribeiro, Mendes, Matos & Santos, 2011) is the only non-humanistic scale included in this review. I take into account because it measures concepts akin to the Change Mode. The IMCS is an observer-based coding system built upon five mutually exclusive categories (action, reflection, protest, reconceptualization, performing change). The coding system is built on a narrative framework of therapy that provides a structure

through which to identify moments of novelty that emerge during psychotherapy. It is important to note that innovative moments are conceived as alternative narratives that appear in contrast to the client's dominant problematic narrative — a self-repeating pattern that affects the way the client constructs various aspects of their life and result in suffering and dysfunctional behaviour. The observer extrapolates these problematic patterns by analysing the communication between client and therapist during therapy. The IMCS relies exclusively on client verbal narrative discourse and only employs transcripts in order to analyse these moments. This coding system has been found to have a strong reliability of over 0.8 Cohen's Kappa.

2.8 Rationale for the Development of New Instruments

The above-discussed coding systems describe some aspects of emotional processing. However, none of these non-participant observational methods capture or encapsulate the full spectrum of Elliott's (2006; 2013a) model. Among the coding systems that most closely relate — both theoretically and practically — to different aspects of Elliott's Client Modes of Engagement model (2006; 2013a) are Auszra and colleagues' CEPS-R (2013) and Boritz and colleagues' NEPCS (2014). Additionally, Gonçalves and colleagues' IMC (2011), which focuses on moments of novelty, is also worth mentioning. The CEPS-R is founded on the theoretical assumption that, in order to achieve optimal emotional processing, clients must display all seven basic features of the authors' proposed construct. The objective of the tool is to capture moments of optimal emotional processing as described by the construct. For this reason, the model is not designed to consider different levels or styles of emotional processing. Moreover, Auszra and colleagues' (2013) construct does not define optimal emotional processing as instances during which clients are in

full contact of all the elements of the emotion scheme in a balanced and integrated manner — according to Elliott’s (2006; 2013a) model: situational/perceptual, bodily/expressive, symbolic conceptual and motivational/behavioural. Rather, Auszra and colleagues’ model gives considerable weight to the type of emotion that the client is focusing on (primary, secondary or instrumental), along with the symbolization and meaning-making processes in which the client is involved (symbolization, congruence, differentiation), but there is only partial recognition of other components of their experience such as bodily/expressive, or situational/perceptual elements. For instance, the model does give particular importance to a client’s agentic stance, but does not include clients’ expressions of needs, wants and wishes; thus, it only includes a limited recognition of the motivational/behavioural element of the experience. In this sense, while Auszra and colleagues’ construct certainly could relate to the experiential or Change Mode as proposed in this project, it does not encapsulate the clients’ momentary and habitual manner and focus of attention. Moreover, the model does not make any practical or theoretical differentiation between client’s experiential processing (experiential mode) and their expression of transformation and novelty (Change Mode).

Furthermore, the CEPS-R poses a single overall question — it asks the coder to decide whether the client’s emotional expression during therapy is or is not productive. Thus, since all seven features of the model must be displayed, the question under study is not what the level or style of client emotional processing is, but whether or not there is evidence of the authors’ construct. An important goal of the current project is developing a coding system that gives the same weight to these different client expressions. Since the CEPS-R relies on video recordings, it is more

difficult to recognize and pick out the emotion scheme component present in client narratives with the same specificity that a transcript of the therapy session would permit. This method gives considerable weight to non-verbal paralinguistic expressions (e.g., emotional regulation), while giving less detailed attention to the clients' specific narrative content. According to an EFT perspective, both the manner of processing and the focus of attention occur in parallel and support each other — they are fundamental aspects of client communication (Elliott, 1993a). In this sense, in order to capture the full spectrum of the client's emotion scheme elements as they interact during therapy, it is recommendable to work with both video recordings and transcripts. In developing a coding system for the Client Modes of Engagement model, this project aims to capture precisely the different levels and styles through which the components of the experience may present in particular ways. It is this specificity that is important in order to capture the fullness of how clients process their experience.

The primary motivation of Boritz and colleagues' NEPCS (2014) is refining the three modes of narrative processing described in Angus and colleagues' Narrative Process Model (NPCS) (1999)—external, internal and reflexive—and the interaction between them. This model considers narrative processing to be the result of autobiographical memory, reflexive meaning-making, and emotion, but does not fully consider other elements of the emotion scheme such as bodily/expressive and motivational/behavioural components. Indeed, the aim of the NEPCS is to capture a scope of narrative processing that ranges from unsymbolized narratives to those that entail the creation of meaning. Since Angus and colleagues' original Narrative Process formulation stipulated the 3 categories mentioned above, it did not provide

the full spectrum of the Emotion Scheme Model (Elliott, 2006; 2013a). While the NPCS's external mode has some overlap with the situational/perceptual mode as proposed by the CME, the internal mode has some similarities to bodily/expressive elements, and the reflexive mode is closely related to symbolic/conceptual elements of the experience, Angus and colleagues' model does not provide any exact equivalent to motivational/behavioural elements of the experience. Thus, from a Modes of Engagement perspective, the NPCS does not provide complete coverage of the emotion scheme model. In this sense, the NPCS is not designed to identify levels or styles of emotional processing. Moreover, while the original NPCS did not establish discrete narrative markers, when adapting the original model, the NEPCS categorized the narrative process into discrete markers rather than a continuous series of narrative emotional processes. Thus, the NEPCS does not lend itself to sequential analysis.

Particularly, Angus and colleagues' measure focuses on the degree of specificity of client narratives, along with the narrative and/or emotional coherence and reflexivity of these accounts, and centres around studying discrete narrative markers that derive from the interplay between narrative emotion and meaning-making processes. Moreover, the NEPCS, similarly to the CEPS-R, also relies exclusively on video recordings — this makes it difficult to identify the specific emotion scheme components that are present in the text of the narrative. On the other hand, while the NEPCS provides a means of coding a wider scope of different discrete narrative emotion markers, it is not built to capture movement from one mode of processing to the next or of identifying different levels of emotional processing — this is central to the Modes of Engagement model.

Lastly, while Gonçalves and colleagues' IMCS (2011) is not focused on measuring emotional processing per se, it is concerned with the study of moments of novelty. However, there is an important theoretical difference between the way in which the IMCS determines what a moment of novelty entails, and how the Modes of Engagement model defines instances of client change. In the IMCS, rather than concentrating on the transformational process that emerges directly from a working experiential stance, novelty is described in contrast with a previously consensually prescribed problematic self-narrative. Indeed, the manual requires that the researcher first establish the dimensions of the client's problematic self-narrative (personal, interpersonal, professional, etc.), and then make a list of these self-repeating problems. Innovative moments are then defined as all those alternative narratives that digress from the client's dominant problematic patterns — as pre-established by the researchers. Conversely, in the Modes of Engagement model, change emerges from a process of experiencing that requires the entire host of elements to be felt in the present. Thus, the IMCS is founded on a cognitive reframing of the narrative, while the Modes of Engagement model is based on an experiential reframing of the experience. Moreover, since the IMCS relies solely on transcripts, it does not consider client manifestations that are outside verbal articulations — these include paralinguistic and nonverbal indicators. Thus, there is no focus on emotional activation during therapy or on the bodily expressive qualities of client communication.

Overall, while many of these above-mentioned coding systems may relate to some components of the Client Modes of Engagement model (Elliott, 2006; 2013a), they do not build upon a framework that encompasses both the complexity of the

emotion scheme model and the various styles through which these elements intertwine with each other as clients are processing their experience.

Furthermore, these instruments have been developed based purely on non-participant observational methodologies — by means of observing audio, video, or transcripts of psychotherapy sessions. While these have certainly provided important tools for understanding how clients process their experience during psychotherapy sessions, non-participant observational methodologies can only access certain aspects of this process. Moreover, since non-participant observation measurements are directed towards research purposes they tend not to be user-friendly. Not only do they require extensive training but they are extremely complex, difficult to implement, and are designed with research purposes rather than general practice in mind. Indeed, the coding systems discussed above are not only difficult for practitioners to apply in routine practice but are not designed by a complementary participant observational instrument that mirrors the same framework. Understanding the same construct through two different measurement lenses can provide a fuller picture of emotional processing. Indeed, while non-participant methodologies are fitting for measuring specific behavioural markers (Greenberg & Pinsof, 1986), participant observational instruments would be more appropriate for measuring experiential phenomena. This line of research can also provide evidence on the accuracy of therapists' ratings of clients' emotional processing to predict psychological improvement. This, in turn, can shed light and give further information for developing strategies to enhance practitioners' training and supervision. A complementary participant observational tool, for practical purposes, offers additional means of closing the gap between research and practice. Thus, a multi-

perspective set of tools, is a particularly valuable contribution to knowledge in the field. It is thus important to note that there is a stark lack of participant observational instruments that seek to measure emotional processing. For this reason, there is an urgent need for the development of reliable and valid measurements for gauging therapists' experiences (Orlinsky & Howard, 1986). One of the crucial goals of this research project is to develop a complementary set of tools consisting of a non-participant observational measure and a participant observational instrument that would provide a means of accessing a fuller picture of the Client Modes of Engagement construct.

Particularly, what is lacking is a process diagnostic model built upon the content of client's flow of experiences. I consider that Elliott's perspective (2006; 2013a), built through the schematic structures of emotional processing and grounded on the existing literature, provides a sound foundation for building upon the already existing instruments. This may result in a more comprehensive understanding of the complexities of emotional processing.

2.9 Concluding Remarks

This thesis is derived from an EFT Humanistic/Experiential perspective on emotional processing. The project is intended to support a meaningful dialogue with current research on this concept stemming from within EFT and from different theoretical approaches. This chapter has introduced the historical underpinnings of emotional processing, the role emotional processing plays in therapeutic outcomes. Then, the chapter has explored the different dimensions of emotional processing within the Client Modes of Engagement conceptual framework through a systematic examination of each of the different modes proposed by Elliott's (2006; 2013a)

framework. Finally, the chapter provided a revision of different existing non-participant observational tools that measure some aspect of emotional processing, in order to provide a rationale for the development of the two complementary measurements constructed for the present study.

Elliott (2006; 2013a) has proposed a thought-provoking framework for studying emotional processing that considers that both the client's manner of processing and their focus of attention are integral aspects of this construct. However, the model still needs to be refined and empirically validated. In particular, as discussed previously, there still a need to develop a set of complementary non-participant and participant observational instruments that are designed to match up in an integrative way and to fully capture the EFT Modes of Engagement Model (Elliott 2006, 2013a). This will provide a more detailed and nuanced picture of the wholeness of the process. Thus, the objective is to develop a non-participant observational tool that can mirror and work in combination with a participant observational measurement that assesses therapists' perspectives of their client's style of processing experiences. Indeed, constructing instruments that, (a) thoroughly assess Client Modes of Engagement; (b) build on these foregoing valuable non-participant observational measures and (c) are easy-to-use, is essential in order to construct a more comprehensive and practical approach to assessing client emotional process.

The University of Strathclyde Ethics Committee (UEC) has approved the following studies included in this dissertation and sponsorship has also been confirmed.

Chapter 3

Client Modes of Engagement Manual Development

3.1 Introduction

This chapter outlines The Client Modes of Engagement Coding System (CME-OCS) — a nonparticipant observer-based method developed in order to identify and differentiate client in-session modes of engagement. This instrument provides a systematic means for identifying the level of client access to the different emotion scheme components of their experience. The CME manual was developed with two fundamental objectives in mind: a. to construct an instrument that would clearly differentiate the four levels of client engagement: Dysregulated, Restricted, Working, and Change modes, and b. to provide researchers with a much-needed reliable instrument to code video or audio segments of Humanistic/Experiential psychotherapy.

The aim of this chapter is to describe the process through which the CME Observational Coding System was developed. The following sections provide detailed description of the construction phase for the manual. The development of the coding system required a rigorous discovery-oriented process in order to establish well-defined categories and definitions. This involved the systematic observation of Client Modes of Engagement in EFT psychotherapy sessions. This chapter goes on to explain the procedure and rationale for selecting the unit of observation used in the CME, explores how each coding category was established, and outlines the training procedure I used in order to establish interrater reliability. Finally, I explore and explain the CME-OCS and its coding procedures in detail; I

also provide transcript examples of each of the Client Modes of Engagement categories.

3.2 Rationale for Developing an Observational Coding System

My approach to psychotherapy has been predominantly informed by the humanistic/experiential tradition and influenced by different emotional processing theories (Elliott et al., 2004; Greenberg, 2002a; Pascual-Leone & Greenberg, 2007). The construction of this manual was grounded on the EFT theoretical perspective regarding what may or may not be considered optimal levels of clients' engagement during psychotherapy. The coding system is based on the Client Modes of Engagement model as described and refined by Elliott (2006; 2013a). Elliott's proposal resulted from several decades of extensive clinical observation and through his experience training and supervising EFT and Person-Centred psychotherapists. The Client Modes of Engagement model is a process diagnostic system that is based on different kinds of client experiential content. The manual serves as an instrument to systematically outline the ways in which clients engage with their experience during the therapeutic process. The tool was developed specifically for audio and/or videotapes in combination with transcripts of therapeutic sessions.

The initial construction phase for the CME-OCS followed a theoretically-driven deductive process, based on the available literature as outlined in Chapter 2. The manual was constructed through the research-based understanding that, during sessions, clients are involved in different modes of engagement. That is to say that clients focus their attention on specific components of their emotion schemes (situational-perceptual, symbolic-conceptual, bodily-expressive, and motivational-behavioural) in a particular manner (Dysregulated, Restricted, Working, Change).

The purpose for developing the manual was to provide a CME conceptual framework through which to identify these modes of processing experience.

The method for developing the coding system followed a rational-empirical approach derived from my epistemological position (Chapter 1) and based on a continuous feedback loop between the theoretical framework guiding this investigation and the premise that it is necessary to remain close to the data. As such, the data was used as a discovery-oriented opportunity that followed a natural and grounded reflective process. This was founded on constant and systematic feedback between careful observation of the data and expert clinical judgement.

Initially, I had at my disposal two pre-existing tools for observing Client Modes of Engagement during psychotherapy. The first instrument at my disposal was a detailed outline used for EFT training that provides a framework and qualitative descriptions for each client mode of engagement category. The outline was a particularly useful tool for learning to recognize and distinguish between different styles of client engagement during therapy — it was designed for use with video or audio recordings and transcripts of EFT psychotherapy sessions. The second tool at my disposal was a 14-item CME Rating Scale (subsection III) from the EFT Therapist Session Form (v4.4, Elliott, 2013b). This tool had been successfully employed in the counselling centres of the University of Toledo and the University of Strathclyde as an instrument for self-monitoring and supervising in-training person-centred/experiential psychotherapists as they learned to distinguish between different modes of emotional engagement. The successful application of both tools for over two decades suggested that the phenomenon under investigation was amenable to systematic observation and that it was indeed feasible to empirically

observe the different dimensions of Client Modes of Engagement proposed in this framework.

Observational systems are valuable methods for the systematic analysis of complex human processes (Floyd, Baucom, Godfrey, & Palmer, 1998). These systems establish categories and criteria that can be useful for organizing complex processes so that these can then be converted into a set of statistically useful data. As discussed in Chapter 2, various observational tools for EFT existed that described some aspects of emotional processing — for example, The Client Emotional Productivity Scale-Revised (Auszra et al., 2013) and The Narrative-Emotion Process Coding System (Boritz et al., 2014). These non-participant observational measures have provided particularly valuable insight about client actions and expressions during psychotherapy (i.e. speech frequency, content of narrative, vocal tones, outerbodily expressions, among others). However, none of these tools captured or encapsulated the full spectrum of the emotional scheme as proposed in this project. Thus, it was essential that I first endeavour to develop an observational tool that was grounded on the same conceptual framework as the self-report instrument at my disposal. Indeed, I proposed that having both participant and non-participant instruments to systematically analyse my proposed framework could, among other things, help to bring research and routine practice into conversation with each other.

The self-report tool had a face-validity of over two decades of use. However, as Greenberg and Pinsof (1986) well point out, the renewed importance given to self-report instruments (discussed in Chapter 2) should not underestimate the importance of observational measures. After all, each of these instruments provides different access strategies to examine psychotherapeutic processes. As such, they are able to

measure different aspects of the construct under study. The strength of having various instruments for gathering data is that the phenomenon can be examined through different strategies and provide answers to different questions. For this reason, the self-report tool would prove particularly useful when used in conjunction with a more direct approach such as an observational instrument. Both measurements should be thought of as complementary.

Additionally, there are certain advantages to developing an observational tool, even when a similar tool is already available. Floyd and colleagues (1998), for example, point out that developing a new instrument can produce fresh and novel understandings of the general matter under investigation — in this case, it can provide new insight into client emotional processing. Moreover, they suggest, when well-established coding systems become standardized, there is always the possibility that the phenomena under study become dependent on these systems. When this happens, there is the risk that the replication of research is the product of the instrument being used.

The primary question a researcher must ask themselves before choosing a coding system is whether the tool fully addresses the fundamental matter of interest for the research project (Floyd et al., 1998). My objective was to have at my disposal a multi-perspective set of tools that would combine the inner-looking macro and subjective perspective of self-report systems with an outward-looking micro-observational perspective. While adopting an existing coding system had the significant benefit of saving time and providing linkage between different research teams and findings, in this case, doing so would have required changing the framework under study. Given these considerations, I undertook the project of

developing a moment-to-moment observational manual. What follows is a detailed description of each step of the CME instrument construction process.

3.3 Deriving the Categories for the Client Modes of Engagement Model

With the large body of literature on the subject in mind and these two instruments in hand, I began to observe video and audio recording of EFT sessions conducted by my supervisor Robert Elliott. The intent was to find the best examples of EFT clinical work, in order to refine and understand each category of the modes of engagement model in EFT practice terms. The tools at my disposals provided a guideline for focusing my attention on a limited set of traits for each mode of engagement. During this process I was fortunate to have access to psychotherapists practicing in the Counselling Unit of the University of Strathclyde. Their experience and the discussion that ensued provided a deeply productive and constructive environment during this process. These conversations, along with the guidance and advice of my supervisor, Robert Elliott proved essential when identifying objectively discernible elements for each observed mode. As Floyd and colleagues (1998) point out, access to experts provides a valuable means of validating the code classification process as it occurs. These authors suggest that observing recorded sessions in tandem with expert advice is a particularly useful initial strategy for refining the categories at work, broadening and tightening the classification system in order to make finer distinctions between categories, and/or adjusting categories in ways that had not been suggested by previous research.

My initial intent in developing the manual was to determine the kinds of Client Modes of Engagement that appear moment-to-moment during psychotherapy sessions. To do this, I needed to find a way of analysing, classifying and recognizing

the various modes of processing experience as they appeared during psychotherapy sessions. The aim was to distil the categories in such a way that the manual itself would require as little clinical judgement as possible when applied by external observers. Indeed, this experience proved an invaluable source of clarity about the processes and categories I was dealing with.

When I began this process, I had at my disposal the ratings from the Experiential Psychotherapy for Social Anxiety Comparative Study. All of the therapists from both studies had filled out the 14-item CME Rating Scale (subsection III) from the EFT Therapist Session Form (v4.4, Elliott, 2013b). This meant that, while observing the video and audio recordings and creating the CME categories, I could also review previous ratings by other therapists. This information proved useful and suggested that there were parallels between my moment-to-moment observations and the therapists' session-by-session self-reports. This experience verified, for me, the usefulness of constructing an observational instrument grounded on the same theoretical framework as the self-report instrument. Indeed, eventually, I would use the 14-item CME Rating Scale (subsection III) (v4.4, Elliott, 2013b) as the basis for constructing a more refined version of this self-report tool (see Chapter 5).

After having observed a range of videotaped EFT therapy sessions I began the formal observational process by working with the whole set of therapeutic sessions from one of the most improved case of the Experiential Psychotherapy for Social Anxiety Comparative Study (EFT protocol). The objective was to guide my observations by the best accessible example of a good outcome case. Further, this method of watching an EFT therapy case from beginning to end gave me a sense of

temporal progress. I expected that these sessions would contain examples of different modes of engagement that occur moment-to-moment. The overall objective was to identify and then refine the description of these various modes in order to make them amenable for coding transcript, video or audio recordings. Eventually, I also engaged with video and audio sessions conducted by a variety of other EFT therapists.

During this process, I used an open coding method with the goal of describing, labelling and categorizing the different features of the modes of engagement under scrutiny. This procedure consisted of a refinement of the categories by means of systematic feedback between my supervisor and my own clinical judgement. The aim was to establish categories that were not only theoretically sound, but applicable to clinical experience. All in all, this method was fundamental to the eventual construction of a coding system that was not only theoretically grounded but also guided by clinical intuition and systematic observations. The CME model is thus supported by both theory and clinical knowledge.

During the process of observing the recorded sessions, it became clear that it was indeed possible to observe, distinguish and categorize the different modes of engagement through video and audio recordings and transcripts of psychotherapy sessions. The categories under analysis started to evolve and become more sophisticated. However, I also realized that discerning each of the emotion scheme elements moment-to-moment, in a mutually exclusive manner, was extremely complex and time consuming. While I was able to find examples of each of the elements, clearly differentiating among them became increasingly complicated and thus potentially unproductive. Even when I tested a variety of different possible units

of analysis, some client responses contained overlapping elements in a single unit. I had doubts that it would be possible to determine a predominant element that could be reliably rated by other observers. Further, I realized that some elements occurred so infrequently that statistical analysis would prove unreliable. All in all, I realized that if the manual were to include each separate element, along with the manner of processing the experience, there would be 16 overall categories with which to work. Coming up with statistically reliable results would have been extremely complicated given the amount of data that I had to work with in the first pilot study. I thus decided that I would have to reduce the number of components to be coded. The challenge then became coming up with a system that would maintain the proposed framework but reduce its complexity.

3.4 Creating Code Categories

The conceptual framework for the modes of engagement model is a level/process-diagnostic system based on different kinds of client experiential content. Taking this into account, I made an initial strategic decision regarding the CME observational system. In order to reduce the amount and complexity of the elements to be coded, I would cluster the categories into four levels of client engagement. As proposed by Elliott (2006, 2013a), these four categories would be divided into different levels of client processes from the most chaotic and disorganised client mode of engagement to the most organised and productive way of engaging with experience.

In order to establish clear, discrete and reliable domains for analysis, it was fundamental to develop mutually exclusive and exhaustive categories. The point was to construct a tool that observers could use to clearly and easily distinguish between

the different styles of engagement. Moreover, this would provide a framework for classifying each style into independent categories (Floyd et al., 1998). While my observations at that point in the study did not follow the orderly pattern proposed by Floyd and colleagues (1998), in retrospect, their suggestions reflect my process of discovery well.

The decision took into account one of the foundational theoretical arguments of EFT: it is the style in which clients engage with their experience, rather than the content of what clients are talking about, which brings about change (Elliott et al., 2004). Indeed, the premise of this project is that in order to more robustly describe a style of engagement it is important to take into account three different aspects of the experience: the way that clients use their emotion scheme elements (element scheme presentation), the way in which clients engage with their experience (manner of engagement) and the kind of information that clients express (content/ the verbal component of the experience). Together, these encompass the process of experiencing. It is through the conjunction of these three aspects of the experience that a level of client engagement can be established. The manual is grounded on the assumption that it is through the interaction of these different criteria that the different modes of client experiencing can be described in a more nuanced manner. As Elliott (1983) argues, a comprehensive process analysis must attend to different levels of experiencing and the interaction among these levels.

The resulting classification system employs a multi-level four-domain framework for modelling the CME. The manual includes four reliable and mutually exclusive levels (Dysregulated, Restricted, Working, Change mode) and is constructed to be sensitive to moment-to-moment in-session shifts. In order for the

CME coding system to be more reliable, I developed an exhaustive system that would encompass all manifestations of the construct under study.

3.5 Selecting a Unit of Observation

In order to systematically observe the data and objectively code the criteria, it was important to first establish an appropriate unit of observation. The chosen unit will have a direct effect on sampling protocols (Floyd et al., 1998). In clinical psychology, the most common procedures are either event or time sampling. Event sampling entails coding the occurrence of events during an established observational period, while time sampling entails selecting time intervals during which occurrences can be coded. Given the purpose and aim of this project, it was necessary to establish a unit of observation that would consider moment-to-moment transitions. On the other hand, I wanted to establish a unit of observation in which the rating unit and the contextual unit were the same. The idea was to use a unit of analysis that would provide the possibility of establishing the Client Modes of Engagement without depending on access to the preceding or subsequent segment. Thus, I decided that segmenting the video and audio recordings into one-minute “time bins” was a good way to capture Client Modes of Engagement as single units. In order to determine the ideal unit length, I embarked in a careful analysis of the data. No formal comparison between units of length was conducted for the purpose of this project. However, as Floyd and colleagues (1998) recommend, I tested the different time samples of my data and adjusted the length of the sample in order to find the smallest possible unit of analysis that could fully capture a mode of engagement. In my experience, the one-minute time bin (approximately between 30 and 100 words of the transcript) is the smallest possible unit through which a segment of therapy can

be meaningfully coded and then placed into one of the four modes of engagement categories. I found that responses divided into shorter segments are difficult to rate reliably. Indeed, the one-minute unit has been used repeatedly in other comparable coding systems (i.e. Boritz et al., 2014).

According to the CME observational coding system, the one-minute time bin includes all the verbal interactions between client and counsellor within the unit of analysis. However, the unit is centred on the client's narrative within the context of the counsellor-client interaction during therapy. Thus, for the purpose of coding, observers should only consider the identifiable *client* mode of engagement. The unit is considered rateable when clients have intervened with statements that contain at least five words. Minimal expressions of agreement or disagreement should not be considered (“mmm”, “yes”, “no”, “right”, “ay”). Moments that do not clearly fit into the established modes of engagement categories (i.e., units which include less than five words uttered by the client, when the unit of analysis only includes non-verbal forms of communication, or when the unit does not contain the sufficient information for coding) should be labelled under the category “Other”.

The coding system is designed for analysis within a whole therapy and across therapy sessions. For the first pilot study, I decided to code each minute of a whole therapy hour, while discounting the first five minutes (which usually involve greetings and preparation to begin therapy) and the final five minutes (which tend to be a reflective summary of the therapeutic process). This strategic decision was made in order to maintain reliability and avoid including irrelevant data when identifying the client mode of engagement. Including the first five minutes of therapy, for example, would have skewed the results because observers could easily confuse the

niceties of first greetings and chitchat with the Restricted Mode of engagement.

Likewise, during the last five minutes of therapy it is common that clients and therapists close the session with a reflection on the work done. This can easily be confused with the Change Mode.

The manual has been developed so that it can be applied to any point of the therapeutic hour. However, I was particularly interested in examining the transitions between modes for an entire hourly session in order to obtain a more natural feel of the therapeutic process. Given the manageable amount of data, it was feasible and valuable to code the entire therapy hour for each session studied. Moreover, Klein and colleagues (1986) point out, that it is important to include samples from at least two different time periods, especially if the research is interested in considering the data in relation to outcome — including samples from the midpoint or the working phase of therapy is particularly beneficial. When sampling only the initial or final sessions, the research risks missing the actual progress.

In this first pilot study, I employed early, middle and late stage sessions from 10 different clients — in total I used 30 recorded therapy sessions. As stated above, the CME-OCS does not require that observers code therapy in this way; theoretically, they could choose to select different segments and stages. Indeed, if future researchers are interested in coding a larger amount of sessions, it is recommendable to choose a certain number of segments from each hourly session. While my pilot study does not do this, studying different phases of therapy would indeed be an interesting approach for further investigation.

3.6 Training

Once the coding manual had been developed, the next step in order to establish interrater reliability was to train a coder. I decided to work with a willing PCT and EFT post-graduate student. While the student had been trained in the same overall humanistic/experiential field as this study, she was uninvolved observer. This meant that she neither had information about the hypothesis nor expectations for this research project. This lack of involvement is essential in order to control for biases (Floyd et al., 1998). For example, experts have greater difficulty and can show more resistance to following coding criteria and protocol. While expert judgement was valuable for developing the coding categories during the first phase, using an unbiased observer at this point provided important advantages. This served to avoid introducing idiosyncratic criteria and ensured intraobserver consistency and interobserver agreement (Floyd et al., 1998).

The training process for the external observer began with approximately 30 hours during which we discussed each mode of engagement category in detail along with numerous corresponding examples of video and audio recordings. The recordings were drawn from a variety of different therapists who participated in the Experiential Psychotherapy for Social Anxiety Comparative Study but had not been, and were not going to be used as cases for this project. As recommended by Floyd and colleagues (1998), these sessions involved both didactic and experiential training. We met for hourly sessions during which the trainee would first be asked to rate one-minute bins according to the CME; we would then compare her ratings with my own and discuss any discrepancies. After our hourly meetings, the trainee would then use the CME-OCS to rate sessions independently. I considered the inter-rater

agreement to be achieved once adequate reliability with my own ratings had been reached. For this purpose, I established an inter-rater agreement at a kappa of 0.80.

3.7 Client Modes of Engagement Coding System

3.7.1 Coding Procedure

I established various rating principles that coders should follow. Firstly, in order to ensure that raters began the process with a sense of familiarity with the session being observed, I recommended that they watch the entire therapy session before beginning the minute-to-minute coding procedure. After having done so, coders would then segment the session into one-minute time bins and listen to each segment with the transcript in hand. This was particularly important because the transcript provided additional assurance that the subtleties of the session would be taken into account. In order for a mode of engagement to be coded it had to include at least 5 words uttered by the client (minimal expressions of agreement or disagreement should not be included). Finally, the coder would identify the predominant mode of engagement expressed in each one-minute bin. In the case that coders considered that there were two dominant modes overlapping in a single time bin, they would have to decide which mode they considered to be predominant. As a general rule, I suggested that a mode that occurred more than 50% of the one-minute time bin would be considered to be more salient. Finally, coders would identify one or more indicators of the content component of the mode of engagement that had been identified for each segment. Once both the manner and the content of the emotion scheme element had been established, coders would be able to identify the client mode of engagement (see Appendix A).

3.7.2 Dysregulated Modes of Engagement

In this mode the emotion scheme elements present themselves as disorganised or/and incoherent. During these instances clients lack a sense of direction and have difficulty processing the components of their emotional experience and/or making full contact with them. Clients remain unable to access the adaptive information that the emotional experience provides. The client's ability to articulate and understand their experiences is impaired; they either avoid or are unable to work through their emotion scheme elements.

Presentation of the Emotion Scheme Element: *Disorganised/chaotic.*

Manner of Engagement: The level of client emotion is either too high (flooded) or too low (distanced) for the person to be able to use the information carried in the experience. Flooded emotions are made evident in the client's voice quality — expression is disrupted by the intensity of the experience; it is unrestricted, may seem uncontrollable, and may present itself as periods of intense verbalization and/or by moments of silence during which the client seems to be distancing themselves from the experience (rather than processing it).

Indicators

The client interrupts or avoids entering their emotional experience.

The client appears to be falling apart.

The client seems unable to control their emotional arousal.

The client may report a sense of confusion or of feeling lost.

The client expresses a sense of being stuck in their emotional experience.

The client uses overwhelmed language (i.e. “this is too much”; “I can't stand it anymore”; “this is killing me”)

Contents of the Emotion Scheme for the Dysregulated Mode of

Engagement: The Dysregulated mode describes the style of engagement rather than the client's focus or the specific content of their dialogue per se. However, in order to gain a complete picture of the emotion scheme process it is important to observe how clients express this Dysregulated mode through the distinct elements of their experience. There are four prototypical types of content that the client may engage with within this mode. The following are descriptions of these different contents as framed by the emotion scheme model.

- a. *Perceptual/Situational:* The client has difficulties engaging fully with the different aspects of their episodic memories or events because their level of emotion remains too flooded or too distanced. The client cannot use this information to make sense of, or become aware of how events relate to their core emotional experience.
- b. *Bodily/Expressive:* The client has difficulties engaging fully with the different aspects that the body is expressing and experiencing because their level of emotion remains too flooded or too distanced. The client presents excessive and overwhelmed nonverbal reactions without being able to symbolize the bodily sensations they are experiencing. These non-verbal experiences reflect a state of physical collapse.
- c. *Symbolic/Conceptual:* The client has difficulties engaging fully with the symbolic/conceptual aspects of their experience because their emotions are overwhelmed or distanced. Client are unable to make sense of or symbolize their experience.

d. *Motivational/Behavioural*: The client has difficulties engaging fully with their organismic wants, wishes, needs and action tendencies. These present themselves in a chaotic/disorganised and undifferentiated manner.

3.7.2.1 Transcript Dysregulated Mode Example 1:

C: I'm afraid the person won't be able to either understand me or I'm not going to be able to get my point across ((shaking))

Th: So not only would I cry but also, I would be incoherent.

C: Yeah, I'm incoherent ((crying))

Th: ...and they won't understand, and it's, I guess, important that they understand.

C: ((crying)) I'm overreacting.

Th: Oh, ok-ok ...cause' ...

C: ((crying)) ... like nothing has happened right now and I am crying.

Th: Yeah, and is it because you are anticipating? or, because of the opening up? Ok, let's see.

C: ((crying)) I don't know ((crying))

Th: Ok, can you breathe?

C: ((sobs))

Th: Can you breathe? Maybe put your feet on the ground and just kind of ...

C: I can't, sorry ((sobs)). I just feel like crying.

Comment: This is a transcript of a one-minute time bin. In order to decide that the predominant mode in which the client is engaging is the Dysregulated Mode, coders may take into account that: the client is having difficulty engaging with the experience (i.e. Perceptual/Situational: the client cannot identify a context or

reason for her emotions, and Symbolic/Conceptual: “nothing has happened”, “I don’t know”, Motivational/Behavioural: “I can’t”). The level of emotion is clearly flooded (i.e. Bodily/Expressive: crying, shaking)

3.7.2.2 Transcript Dysregulated Mode Example 2:

Th: Maybe do you want to sit and be XX [two-chair enactment], or is that too much?

C: I don't particularly want to sit there

Th: That's fine, absolutely. We are just trying to get a hold of it, pull it a bit

C: I feel anesthetized

Th: Ok, so what's happening right now? What's going on with you?

C: Nothing concrete

Th: So, there are tears for you right now. Is it ok to express them? Or, is it going to be too much?

C: I don't know; it's too much; I want to stop.

Comment: In this case, the client’s dysregulation is being manifested through a distancing (i.e. Bodily/Expressive: “I feel anesthetized”). The experience seems to overwhelm the client (i.e. Motivational/Behavioural: “it’s too much; I want to stop”) that does not permit an engagement with the experience (i.e. Conceptual/Symbolic: “nothing in concrete”).

3.7.2.3 Transcript Dysregulated Mode Example 3:

Th: And somehow crying...

C: It's embarrassing ((sobs))

Th: It's embarrassing. Ok. It's embarrassing that you are crying, yeah. For you it's embarrassing, right?

C: It's embarrassing ((sobs))

Th: I mean I'm used to people crying here, that's what- that's what the tissues are for, that is why all of this ... I mean, so I am used to that, but for you this is a hard thing, it's a hard thing, it's not easy to cry here or in any place, and ... do you know what that's about?

C: I don't know ((sobs))

Th: Ok-ok, I mean, I guess what I meant was ... umm ...you don't know -I know you told me last week that you often don't know why you cry.

C: Yeah, I don't know ((sobs))

Th: Umm, but I-I think what I meant was, let's see if I can figure this out. Let's see. Sometimes I get too complicated for my own good or anybody else's, umm, what I meant was, do you know why it's embarrassing for you to cry?

C: I just ... No

Th: Where does the embarrassment comes from?

C: Not really... Not sure ((sobs/laughs))

Comment: The client is having difficulty engaging with the experience (i.e. Perceptual/Situational: the client cannot articulate a context or a reason for her bodily/expressive and conceptual reactions, Symbolic/Conceptual: "It's embarrassing", "I don't know"). The level of emotion is clearly flooded (i.e. Bodily/Expressive: sobbing).

3.7.3 Restricted Modes of Engagement

Restricted Modes of Engagement refers to instances during which clients are dominated by a single emotion scheme element (Elliott et al., 2004), and process

their experience through an isolated stance. During these moments, clients focus on one element of their experience to the exclusion of all other emotion scheme elements. These isolated manners of processing prevent clients from accessing, integrating and elaborating the wholeness of their experience. Clients seem uncertain of how the emotion fits into the experience as a whole (i.e. what relation it has to their bodily experience, to their action tendencies, and the overall meaning). Clients are able to attend to one emotion scheme element but have difficulties or remain unable to integrate and make use of other elements of their experience. The client's attention is not grounded on their emotions, and lacks vividness and freshness.

Presentation of the Emotion Scheme Element: Restricted.

Manner of Engagement: The client's verbal expression of their emotions is static; when they do express their emotions, it comes out as objectified, abstract and with minimal elaboration. Clients do not pay careful and mindful attention to what they are experiencing — emotions are articulated in a rehearsed manner or through seemingly pre-planned responses. The emotion is expressed through generalities and is treated as something that has to be reported without further elaboration of the subjective experience. The importance of the emotion is ignored or it is used to make the “story” engaging rather than helping the client feel it in the present.

Indicators

- The client is focused on explaining their experience to the therapist rather than experiencing it in the present.
- The client is focused on producing “evidence” that supports a particular way of thinking and acting.
- The client seems to be a passive observer of their emotional experience.

- The client talks through stereotypes or/and in an evaluative manner.

Contents of the Emotion Scheme for the Restricted Mode of Engagement: Clients may express this Restricted mode of engagement through distinct components of their experience. The following are descriptions of the four-prototypical types of content that may characterize the Restricted mode of engagement within the emotion scheme model.

- a. *Perceptual/Situational:* The client's sole focus is on recalling episodic memories, without integrating other emotion scheme elements; thus, experience is circumstance-oriented. The client expresses repetitive or *cliché* descriptions and appraisals of the situation without experiencing them freshly in the moment. Situational details are either superficial, serve only to connect the narrative, or are overly detailed — these details are mentioned but are not used to intensify or deepen on how the self relates emotionally to the situation. Situational descriptions may include objective details (i.e. time of day) but lack sensory specificities (i.e. details of sensory experience or of emotional reactions).
- b. *Bodily/Expressive:* The client's sole focus is on body sensations, without integrating other emotion scheme elements. While the client provides detailed descriptions of their physiological experiences, there is a scarcity of involvement with the wholeness of the experience. The client dwells on pain or other physical signs of injury or illness but does not experience these as connected to emotional experiences; also, does not give careful and mindful attention to these bodily felt senses. The client concentrates specifically on their somatic experience, excluding all other aspects of the experience.

- c. *Symbolic/Conceptual*: The client's sole focus is on abstract concepts, and maintains a logical conceptual stance, without integrating other emotion scheme elements. The client articulates conceptual, over-generalized, and intellectualized narratives without emotional involvement (i.e. stating of beliefs, values, self-concepts or named general feelings without experiencing them in the present). The client does not convey the idiosyncratic meaning of this experience and seems to be an observer or reporter of their emotional experience.
- d. *Motivational/Behavioural*: The client's sole focus is on wishes, wants, needs, desires, or action tendencies without integrating other emotion scheme elements. Rather than staying with strong or distressing emotions, the client impulsively acts out (or describes acting out) their wishes, wants, needs or action tendencies in an unreflective non-experiential manner. The client describes previous behaviours or future possible behaviours without integrating other emotion scheme components.

3.7.3.1 Transcript of Restricted Mode Example 1:

C: I can't see my father today. Well I could see him maybe after work, but I can't see him before that.

Th: Is he on a level where his GP needs to step in?

C: Well, normally the GP comes to the house. Also, my uncle was able to get into the house twice this week and dad of course is aware of this and gets out of the house before 9am...

Th: ...in the morning ...

C: Yeah, he likes to be out early, especially when he's not well, but he must have gone out really pretty early.

Th: and he stops sleeping?

C: Oh, yeah. I know that from when I stayed with him. He may-well just be up and down, and ... umm ... I suppose his mind is active so he just can't switch off ... umm ... and I've been into his house and it was just dreadful, absolutely ... especially the clothes. I couldn't find any... I couldn't find a thing. It was all ... lots of things rolled up.

Th: So, you could tell by the state of his house ...

C: ... dreadful, mm-hmm, I mean he finds it hard, so umm ... anyway, my uncle had tried to bring the GP, but my father went down to complain
(laughs)

Th: Your father ...

C: ... about his brother ((laughs)) ... to the Riverside, on Dumbarton road, and of course...

Th: and what is the Riverside?

C: it's to do with mental health

Comment: The client is focused on the Perceptual/Situational element of her experience (i.e. "He may-well be up and down"). Her memories seem episodic (i.e. the story remains about her father, never turning the attention inwards) without integrating other emotion scheme elements. The story remains descriptive. The client appraises her father's action but does not engage with her emotions.

3.7.3.2 Transcript of Restricted Mode Example 2:

C: When I was about three years old, my parents had just gotten into a fight and my father was a very sort of big burly guy with a big voice and he has, mm-mh, he has sort of a bombastic style and he is just very domineering and my mother mm-mh ... she's about my size, you know? She's a rather small woman and umm ... they had just gotten into a fight and my mum-they-we were living in my grandparents' house and they had built an upstairs kitchen, you know? So there was a kitchen in the upstairs and my mum was up there cooking and I walked into the room into the upstairs kitchen and she was crying and she yelled at me to get out so I just started walking back out because I always did what I was told ... right ... and umm ... my father came barrelling up the stairs and he was absolutely irate and he started yelling at her and asking what I had done wrong and umm she's-she just kept crying she just said nothing and my father just kept yelling at her and-and pushing her and umm then he started to beat me ...yeah

Th: Oh...mm-mh- mm-mh

C: Yeah ... he just-he started to beat me, he said, well I must have done something, if she was yelling at me I must have done something...

Th: ... and as you're talking about it now, wh-what's happening just now for you when you're talking about it?

C: Mm-mh, I remember as a child ... I don't know how old I was but it was a little bit after that. I was quite young. I was under five because we were still living in that house and we moved when I was five down into the middle of the town, and I remember seeing my father behind a curtain kissing

somebody, and I don't remember who it was but it wasn't my mother. I mean it was a passionate kiss, right? it wasn't just a peck on the cheek, and I remember thinking at the time they're not supposed to be kissing that way.

Comment: The client is focused on the Perceptual/Situational element of her experience (i.e. Her memories seem episodic (i.e. "my parents had just getting into a fight"). Although the story is violent, she never turns the attention inwards towards her own emotions) without integrating other emotion scheme elements. The story remains descriptive. The client appraises her parents' actions but does not engage with her emotions.

3.7.3.3 Transcript of Restricted Mode Example 3:

C: I am having problems working. I do have a lot of noise. I can't concentrate because I constantly have that noise, and I can't focus properly, right? ... because I do have a lot of noise that I'm not always able to shut off and I'm trying-you know? Trying to read things and I'm getting bombarded with ideas about stuff, so I think it's all connected. I can't think of any examples, but it's all connected.

Th: mm-hmm, mm-hmm

C: ... and that is the reason why I'm here, because I am having problems working ...

Th: ... with work, yeah, mm-hmm.

C: ... or even, I think, I think it's all connected

Th: ... so, it feels as it is all connected

C: Yeah, and then there's the noise and an inability to concentrate

Th: ... and they feel quite linked

C: Yeah, they are linked. I think that the noise is bothering me because it-all-
everything that I've been thinking about is all stuff connected with recent
conversations that I've had with people.

Th: So, it's all linked. Ok, ok.

Comment: The client is focusing on Symbolic/Conceptual elements of the
experience. She engages with the experience in a purely conceptual, abstract and
intellectualized level without becoming emotionally involved (i.e. "I think that
it's all connected, I can't think of any examples, but it's all connected").

3.7.4 Working Modes of Engagement

The Experiential Working mode refers to moments during which clients are
able to bring any element of their emotion scheme into awareness while productively
using the information available from all other elements of the experience. These
instances are grounded in the freshness of the emotion. At these moments, the client
is experiencing the various emotion scheme elements in a mindful, fully present,
manner. When this happens, clients are able to attend to, be aware of, articulate and
make meaning of the full range of their emotional reactions in a regulated, organised
and balanced manner. The distinguishing feature of this mode is that clients are able
to use the elements of the experience in a subjective and integrated manner.

Presentation of the Emotion Scheme Element: Integrated.

Manner of Engagement: The client's energy is focused inward while in contact with
the immediate emotional experience in a unique and personal manner. Rather than
dealing with a general emotional state, the client is working with the specificity of
the experience. The client expresses an emotional experience and shows a
willingness to elaborate on it by mindfully attending to it. The experience is fresh

and rather than being something simply talked about, requires a high level of experiencing. The language clients are using to express emotions is poignant, colourful, detailed and their voice quality remains focused — the pace of the language has a irregular, hesitant quality to it rather than seeming rehearsed or pre-planned. The client's attention is turned inward in a concentrated manner that explores and integrates the elements of the experience.

Indicators:

- Clients are in the process of searching for and constructing clear connections between the emotion scheme elements. These connections become apparent or surge forth from the present emotional experience.
- The client's emotions are clearly present as vivid emotional expressions that are being symbolized in words (i.e., the client cries and elaborates on their feelings, needs, or events; the client expresses fear and connects it to their bodily sensations, situations, symbolic-perceptual experiences, or action tendencies).

Contents of the Emotion Scheme for the Working Mode of Engagement: Clients may express the Working mode through distinct components of their experience. The following are descriptions of the four-prototypical types of content that may characterize the Working mode of engagement within the emotion scheme model.

- a. Perceptual/Situational:* The client attends in an emotionally engaged manner to the perceptual/situational elements of their experience, while integrating these with other emotion scheme elements. The client is thus in touch with the wholeness of the experience. The client remains emotionally involved while remembering specific memories and appraising events and people.

They mindfully experience the self within their narrative. The client usually uses the first-person narrative voice and recounts their experience predominantly in the present. Emotional reactions are connected to the specificities of the event being told. The client uses situational details and sensorial specificities that make the account vivid, personal and subjective.

- b. Bodily/Expressive:* The client has an inward and direct focus on their bodily expressions as a means to access other elements of their emotion scheme. Clients attend, in an a mindful and emotionally engaged manner, to their bodily reactions, while integrating into the experience vivid accounts of memories, concepts, meanings, feelings, needs, wishes or images to capture the wholeness of their experience.
- c. Symbolic/Conceptual:* The client attends in an emotionally engaged manner to the symbolic/conceptual aspects of their experience, while integrating these with other emotion scheme elements. The client is thus attempting to put into words the wholeness of the experience. They access their inner-experience through a process of symbolizing it. Clients make a mindful effort to name and express their experience as a means of unfolding it through language. It is through this process that clients develop a more precise and refined manner of expressing their emotional experience. Clients approach the presentness of the experience with active curiosity about its meaning or value while remaining emotionally involved. They elaborate and articulate on fresh emotions that are being experienced in the present moment in a nuanced and specific manner.

d. *Motivational/Behavioural*: The client is mindfully and emotionally engaged with their needs, wants, wishes, and action tendencies, while integrating other aspects of their emotion scheme. The client expresses their desires, needs, and wishes with an active and emotionally engaged stance. Needs, wishes and action tendencies are existential or organismic in nature (i.e., the need of affiliation, nurturance, autonomy, support, acceptance, approval).

3.7.4.1 Transcript of Working Mode Example 1:

[During a two-chair task]

C: What happens now is ... I walk to my desk and I sit down and immediately feel like bummed out ... just like going home ... but now I'm there and I have some work to do, but I can't concentrate on the work because ...

Th: ... because I'm feeling ...

C: ... feeling so sad, frustrated, defeated ... mm-hmm ... you know, come in the door. I can't even do that, umm ...

Th: ... I can't even-I can't even enter a room. I don't even know how to enter a room.

C: Yeah, I can't enter the room.

Th: You don't even know how to enter a room, right? You are rubbish. Yeah. So you, tell him that ...

C: ... you can't even get into ... What's the point in sitting in and doing your work? Your work is pointless next to that. If you can't even walk into a room... you know? What's the point of even sitting and doing your drawings, right?

Th: It doesn't matter, right? You're such a failure as a human being ...

C: yeah-yeah, I'm a failure, that's the feeling. I'm rubbish ... just go home right now

Th: ... deprive ...

C: Yeah, just go on and crawl up ...

Th: ... crawl into a ball. Go home. So, you are basically saying ...

C: Just go home and don't even try. Just give up. Go home and hide. Who knows ... maybe you can think of something for tomorrow. Try to come in tomorrow.

Th: mm-hmm, but you failed for today.

C: Yeah, it's a loss. Yeah, it's all a loss. I feel like a failure deep down... You feel like rubbish right now anyway.

Th: So, you're not going to be able to do any work ...

C: How can you be creative when you feel like rubbish? Because creativity has to come from something, from some kind of inspiration ... you're rubbish ...

Comment: While the client is mainly attending to the Perceptual/Situational aspect of the experience (i.e. telling a story "I walk into my desk and I sit down"), he is also bringing to bare other elements of his emotion scheme (i.e. Bodily/Expressive elements such as "you just go and crawl up", "I feel like a failure deep down". Conceptual-Symbolic elements such as: "because creativity has to come from something". Motivational/Behavioural elements such as "Go home and hide") in an emotionally engaged manner (i.e. "I am feeling sad," "defeated").

3.7.4.2 Transcript of Working Mode Example 2:

Th: What's the quality of that-that gut feeling?

C: It's like a bridge that wasn't built properly. It can be blown over by pigeons.

Th: A bridge that can be blown over by the wind?

C: Not strong. Not made of steel that can stand anything.

Th: Not strong. Not made of steel. Can't stand anything. Is that the quality?

The gut feeling? Ask it, and wait and see what it says.

C: I'm like a person. A bridge. The sea, the wind and the rain can blow me over. I'm not strong enough to stand storms or tempests.

Th: Like a bridge. Not being able to stand a tempest and storm, mm-hmm ...

C: The sadness is with the young man that I was. The lonely young man ...

Th: Sadness for the lonely young man that I was. Sadness ...

C: Maybe also compassion

Th: Compassion. Compassion for the young man I was. So, the gut feeling has compassion also. Do you want to check it out? Ask it and just wait for an answer.

C: There isn't enough compassion.

Th: There isn't enough compassion.

C: Too fond of being self-critical. Also, I feel a pain that my sexuality has been so disrupted.

Th: Pain about my sexuality

C: And anger about my parents never doing their duty ... teaching me about sex, giving me a proper sexual identity.

Th: Anger towards my parents?

C: Anger, yes.

Th: Check if that is the felt sense: Anger at my parents about my sexual difficulties.

C: Yeah, I don't know why they just couldn't talk about sex

Th: I don't understand why they couldn't talk about it?

C: ... sense of having been failed ...

Th: been failed? It went down to failed.

Comment: While the client is mainly attending to the Bodily/Expressive aspect of the experience (i.e. talking about the gut feeling), he is also bringing to bare other elements of his emotion scheme (i.e. Perceptual/Situational elements such as “my parents never doing their duty”. Conceptual/Symbolic elements such as “the sadness is with the young man that I was”. Motivational/Behavioural elements such as “The sea, the wind and the rain can blow me over”, “I am not strong enough to stand storms or tempests”) in an emotionally engaged manner (i.e. “compassion”, “anger”, “pain”).

3.7.4.3 Transcript of Working Mode Example 3:

C: ... getting near to the destination, like a 15-minute journey, and just feeling like my breath was quite (T: mm-hmm) ... and all of that butterfly kind of sick feeling in my stomach, umm, and then you know, it got worse when I was walking to the place, feeling shaky almost, and then getting my beer and, by that point it was ...

Th: ... it's a little bit like ...

C: ... it's like fear, genuine fear. It feels silly but it is strong, yeah, and then walking up and actually feeling a little bit of relief that the anticipation is over. You are there, but you are still left with the ... obviously, the anxiety doesn't go away...so then you have all the dry mouth

Th: Let's try something. Come over here. So, you sit in the bus and then, what do you do to make him anxious?

C: Here you go, you are going to the party, and umm, there is a lot at stake here

Th: There is a lot at stake here. Everything depends on it. That is probably too much.

C: Maybe not everything, but, a lot depends on it.

Th: A lot depends on it, ok. Go ahead. What else do you say? What do you do?

C: You are going against the unknown here. You don't know how it is going to be there, what the place is going to be like, what is going to be happening.

Th: It could be a disaster.

C: Yeah. You may end up sitting there, having had no more than a two-minute conversation with everyone there.

Th: You might go there and just miss everybody.

C: You won't connect, everything will die and then you would be left ... no one would like to speak to you anymore, and you would be left just sitting there waiting for the night to be over.

Th: Change, what happens when you hear that?

C: umm, I don't want it to happen because that hurts.

Th: ... that hurts ...

C: ... and frightens me because I want to keep the friendships, the connections.

Comment: There are various predominant emotion scheme elements the client is bringing to bare into his emotion scheme (i.e. Bodily/Expressive elements such as “those butterfly kind of sick feeling in my stomach”, “feeling almost shaky”. Perceptual/Situational: he is talking about a situation that takes place during a 15-minute bus ride. Conceptual/Symbolic elements such as “there is a lot at stake here”, “it could be a disaster”. Motivational/Behavioural elements such as “just sitting there waiting for the night to be over”) in an emotionally engaged manner (i.e. “I feel frightened”).

3.7.5 Change Modes of Engagement

The Change Mode refers to instances during which clients, while in full contact with their emotions, are experiencing an internal shift, change or transformation, such as a sense of newness or discovery. New emotions, bodily-felt senses, action tendencies, needs and perceptions of self and others emerge from the exploration of previously emotional processing (Elliott, 2013a). During these instances, clients report having experienced therapeutic change in the present moment. This results in a reorganization of the emotional scheme. During these instances previous scheme element organizations are transformed into new and novel ways of experiencing.

Presentation of the emotion scheme element: Integrated/Change.

Manner of Engagement: During the Change Mode, emotions are activated and there are clear signs of regulated emotional arousal. These instances are grounded on the

previously integrated processing of emotion. Clients continue to carry therapeutic work forward. They report or express the emergence of new or deeper/more expansive emotions, including the acceptance of positive emotional change (i.e. protective anger, connecting sadness, self-compassion).

Indicators:

- The client allows new more adaptive emotional experiences to be felt in the present, in a regulated manner such that the person is able to symbolize it in a new and coherent narrative.
- Narratives emerge in which new intentions; purposes, expectations, hopes, needs, and action tendencies are articulated.
- Clients describe novel and positive ways of feeling, thinking, acting or understanding.
- Clients display positive embodied experiences.
- Clients show novel awareness of what was/is important and helpful to them.
- Clients develop adaptive solutions to fulfil their unmet needs.

Contents of the Emotion Scheme for the Change Mode of Engagement

Change mode may be expressed through distinct components of client's experience.

The following are descriptions of the four-prototypical types of content that may characterize the Change Mode of Engagement within the emotion scheme model.

- a. Perceptual/Situational:* During experiential work the client expresses new, alternative, more adaptive, or more positive ways of perceiving others, events, or situations. Through re-experiencing, the client discovers or brings into awareness new aspects or new appraisals of others, events, or situations, that were not noticed before.

- b. *Bodily/Expressive*: The client expresses or appreciates the easing of previous problem-related tension carried in the body. This provides the client with new opportunities to focus on novel positive bodily sensations. This sense of transformation or bodily shift results in a sense of relief and expanded awareness of the body.
- c. *Symbolic/Conceptual*: Through an on-going and conscious process of symbolization and conceptualization the client develops new emotionally grounded, positive and adaptive views and understandings of the self. Clients begin to change previous assumptions about themselves. The client expresses new more adaptive or more differentiated emotions in the present moment. As a result of this present emotional awareness the client expresses new meanings, beliefs and values about the self.
- d. *Motivational/Behavioural*: Through experiencing, the client receives, accepts and discovers new needs, wishes, wants, or action tendencies. This process leads clients towards a novel sense of personal agency that inspires a surge of new motivations, intentions, and action tendencies. The client elaborates new plans for actions and new behaviours emerge. They elaborate on problem-solving strategies that lead to more adaptive solutions to fulfil their unmet needs. The client makes reference to what they deserve after elaborating on what they are lacking for their well-being.

3.7.5.1 Transcript of Change Mode Example 1:

C: It's like this is represented in my head. It's not a real person. I suppose a bit like if you suddenly stood up to your boss...

Th: ok-mm-hmm.

C: ... and you weren't scared to stand up for what you actually felt.

Th: You felt it

C: You are asserting yourself and you feel confident in your assertion. It feels a bit like that.

Th: It feels a bit like that, yeah?

C: Standing up to my horrible boss.

Th: Your inner bully, yeah? Which is also scared of rejection and failure and all those things, but he bullies you and you try to avoid that.

C: It actually feels good

Th: It feels good actually, yeah? Maybe just breathe into that a bit, yeah? It's a nice feeling, yeah-yeah, maybe you just want to save it for a little bit, yeah?

Mm-hmm

C: Yeah, I'd like to think it could stick. Yeah, it can stick.

Th: ... that you can stand up to the inner bully. That you can feel like you are ok as you are, and then you can dare to be yourself.

C: ... dare to be myself and to believe that is good enough.

Th: That's really exciting actually, to believe in that part of you that is good enough.

C: I almost feel like a little butterfly of good things, the exciting kind, yeah-mm-hmm.

Comment: The client expresses the emergence of new or deeper emotions (i.e.

Bodily/Expressive: "I almost feel like a little butterfly of good things".

Motivational/Behavioural and Perceptual/Situational: "like you suddenly stood

up to your boss". Conceptual/Symbolic: "it actually feels good", "I'd like to think

it could stick. Yeah, it can stick”, “dare to be myself and believe that it is good enough”), grounded on previously integrated processing of emotion.

3.7.5.2 Transcript of Change Mode Example 2:

Th: ... What is this that you are experiencing in this moment?

C: Umm ... a sense of relief, it's a sense of ...

Th: It's not my fault. It's not about me.

C: I've been freed up somehow.

Th: Free

C: Mm-hmm, I have been freed up, because ...

Th: because this has really imprisoned you, this sense of not being loved by your mother, and not being able to let go of that, and then trying to seek everyone's approval, acknowledgment, recognition ...

C: 'cause during all the time I did it ... the first thing I thought about was ... they won't like me so I'll do something for them to like me.

Th: I'll be like my mom, right? (C: Aye) so I'll do something to try to get you ...

C: Aye, I'll do something.

Th: ... to please. But, of course, your experience is that you're never good enough

C: Aye, mm-hmm. I'm not good enough, so it's a wee bit like that balloon I got with the hole in it, do you know what I mean?

Th: Yeah, yeah. Just collapsing, and then there is emptiness.

C: ... it's this ... you keep trying to blow it up, and it is never gonna go up, not with a puff.

Th: That is really amazing, isn't it?

C: Oh, Aye, it's amazing.

Comment: The client expresses the emergence of new or deeper emotions (i.e.

Bodily/Expressive: "I've been freed up somehow", "a sense of relief".

Motivational/Behavioural: "you keep trying to blow it up, and it is never gonna go up, not with a puff"), grounded on previously integrated processing of emotion (i.e. the Conceptual/Symbolic: " 'cause during all the time I did it ... the first thing I thought about was ... they won't like me so I'll do something for them to like me").

3.7.5.3 Transcript of Change Mode Example 3:

[Two chair enactment]

Th: It seems unfortunate. What do you want from him?

C: I want you to ... I want you to be in the world feeling part of the group that you can be part of, and being part of the group, and being part of the group that you can be part of, and that you belong with, and doing your thing and feeling good about it, feeling part of it.

Th: I want you to be with people that want to be with you?

C: Yeah, where people find you lovable. And to do that you need to believe ...

Th: So tell him.

C: You are lovable to the right people who, who ...

Th: The people that can see who you are?

C: Yeah, because when you compare those people to the other group, you can see how those people are. But, if you act the way you are carrying on, you prevent yourself from seeing that.

Th: It's like: I want you to see that, I want you ...

C: Yeah, I want you to see these people as your group, and then you'll feel better and you'll act better.

Th: ... that actually you are at home, you are in your group ...

C: You will feel more comfortable, more relaxed and happy, and you will be better to be with because you see them in that way, and you don't distance yourself.

Th: I want you to open yourself up. Do you see the possibilities that can come with that?

C: Yeah

Th: And do you love him from this part of you? Can you give him that sense of "I do love you, I see that you are lovable," and give yourself that? Can you say it?

C: Yeah, you are lovable. I am lovable!

Comment: The client expresses the emergence of new or deeper emotions (i.e.

Perceptual/Situational: talking about being part of a group.

Motivational/Behavioural: "I want you to see these people as your group, and then you'll feel better and you'll act better". Conceptual/Symbolic: "you are lovable to the right people"), grounded on previously integrated processing of emotion.

3.8 Summary

This Chapter discussed the deductive and inductive process through which I developed the Client Modes of Engagement Observer Coding System (CME-OCS). This coding system provides a means of identifying levels of client engagement with the emotion scheme elements of their experience. The CME-OCS described above is divided into four discrete and identifiable CME levels: Dysregulated, Restricted, Working and Change. The coding system provides a set of indicators and examples in order to help raters identify each CME level. It is important to note that the descriptions of the four modes of engagement categories included in the coding system are not a finished product. It is expected that further use of the manual with different populations will provide opportunity for a greater refinement of the proposed modes. The observational manual described in this chapter is a first approach to constructing an empirical measurement within the theoretical framework of the EFT Modes of Engagement model as proposed by Elliott (2006; 2013a).

Chapter 4

Application of the Client Modes of Engagement Observational Coding System

4.1 Introduction

This chapter discusses the application of the Client Modes of Engagement Observer Coding System (CME-OCS). The aim of this study was to apply the CME-OCS to a sample of ten clients with social anxiety difficulties who were attending Emotion-Focused Therapy (EFT). This research aimed to explore the relationships between Client Modes of Engagement (CME) and overall treatment outcome (as measured by the mean residual gain). Moreover, this study examined how each CME evolves from early, to middle and to late phases of therapy, and how these relate to outcome (a selection of the most improved and least improved clients from the sample under study). Additionally, the study examined how therapeutic outcome is related to the ways clients' transition between Client Modes of Engagement at different phases of therapy.

4.2 Method

4.2.1 Sample

The sample used in this study was drawn from the University of Strathclyde Therapy Research Clinic archival database from The Experiential Psychotherapy for Social Anxiety Comparative Study. This project (Elliott et al., 2017) compared the effectiveness of standard Person-Centred Therapy (PCT) and EFT for clients who presented social anxiety difficulties. Both the University of Strathclyde and the local National Health Service (NHS) approved the ethics statement for this project. The clients for Elliott and colleagues' study (2017) were primarily recruited via websites

(e.g., Strathclyde Counselling Unit, PCT Scotland and other mental service user sites); flyers distributed to medical practitioners and newspaper announcements. From the sixty-one clients who consented to take part in the study, thirty-one received PCT (average number of sessions=14.7, SD=5.7) and thirty received EFT psychotherapy sessions (average number of sessions=17.9, SD=5.5). Clients for this study were from a Scottish community sample and were of European origin (M=2, F=8; Average age= 35.2; SD=10.7). For the present study, only the database of clients that received EFT was used.

4.2.2 Participants in the Experiential Psychotherapy for Social Anxiety

Comparative Study

Clients

All participants in The Experiential Psychotherapy for Social Anxiety Comparative Study met the criteria for social anxiety disorder as established by the Structured Clinical Interview for *DSM-IV* Axis I disorder (SCID-IV; First, Spitzer, Gibbon, & Williams, 2007) and the Social Phobia Inventory (SPIN; Connor et al., 2000). The inclusion criteria were that clients: a) considered themselves as having a problem with social anxiety; b) met the *DSM-IV* social anxiety criteria based on the SCID (First et al., 2007); c) were mentally competent to give consent; d) showed competence in written and spoken English; e) agreed to being recorded and to follow research procedures; and f) were between 18 and 65 years-old. The exclusion criteria were that clients: a) were attending psychotherapy or counselling elsewhere; (2) were in a severe substance abuse condition; (3) were in an active psychotic condition; (4) were in a current domestic violence situation; or (5) were suffering from other clinically predominant disorder/problem (e.g., social anxiety secondary to medical

condition or depression). These criteria were used to exclude clients with severe difficulties that might have been unsuitable for brief EFT or PCT psychotherapeutic intervention. Typically, clients reported having had social anxiety difficulties for between six and ten years before participating in the project. For the present study, I selected the five most improved EFT cases and the five least improved cases from the database. The outcome categorization method is explained in subsequent sections.

Therapists

Fifteen psychotherapists (F=11, M=4) of European descent, with a post-graduate degree, at least two years of PCT training, and a minimum of 6 years of psychotherapy experience, participated in the Experiential Psychotherapy for Social Anxiety Comparative Study. EFT therapists participating in the study had received at least 10 days of EFT training (at least Level I & II) with Robert Elliott — one of the originators of EFT and the principal investigator of the study. All therapists were strong advocates for one or both therapeutic approaches. In the present study, clients received EFT from five of these psychotherapists (F=3, M=2, ranging from late 40s to mid 60s).

Treatment

In the Experiential Psychotherapy for Social Anxiety Comparative Study, clients were assigned to one of two treatments — EFT or PCT. All clients were first informed about the research procedures and signed informed consents agreeing to have all sessions audio or video recorded. Clients were then offered up to twenty free fifty-minute humanistic psychotherapy sessions. Only clients who received EFT were considered for inclusion in the present study.

Emotion Focused Therapy (EFT)

EFT (Greenberg et al., 1993; Elliott et al., 2004) is a short-term (ranging from 8 to 20 sessions) evidence-based marker-guided psychotherapy intervention. This psychotherapeutic approach is based on the premise that primary emotions are adaptive because they guide people's actions towards satisfying fundamental needs. EFT embraces Carl Rogers' Client Centred approach to the therapist-client relationship that is based on the tenets of unconditional positive regard, empathy, and genuineness (Rogers, 1959). This therapeutic modality integrates Gestalt (e.g., chair dialogues) and experiential (e.g., focusing, systematic evocative unfolding) interventions. The aim of EFT is to access, activate, symbolize, and elaborate emotions that are perceived as distressing for the individual, in order to transform maladaptive schematic structures.

EFT for Social Anxiety (EFT-SA)

EFT-SA for Social Anxiety (Elliott, 2013c; Elliott & Shahar, 2017) is founded on the idea that it is beneficial to provide a genuine caring and empathic therapeutic environment for clients with social anxiety, while facilitating their access to a process of emotional deepening. This process encourages clients to explore and symbolize specific experiences of social anxiety. Therapists help clients to access, evoke and symbolize secondary emotions of fear of others during specific social experiences. Tasks involve enactments of unresolved interpersonal conflicts and internal self-critical voices connected with social anxiety. The goal of EFT-SA interventions is to work with clients' primary maladaptive emotions of self-contempt and shame in order to transform them into adaptive emotions such as self-soothing, assertive/protective anger, compassion and connecting sadness. The aim is to

strengthen adaptive emotions and connect clients with their unmet needs in order to activate their action tendencies towards re-establishing authentic, satisfying social relationships and life goals.

4.3 Procedure for The Experiential Psychotherapy for Social Anxiety

Comparative Study

4.3.1 Treatment Adherence

All participant psychotherapists had manual-based training (Elliott et al., 2004) and were supervised every two weeks and monitored through video and/or audio recordings to ensure adherence to treatment. Also, therapists completed the EFT Therapist Post-Session Form (v4.4, Elliott, 2013b) that assess Process-Experiential therapy principles (e.g., presence/genuineness), EFT therapeutic tasks (e.g., chair work), Client Modes of Engagement (CME) (e.g., flooded), and therapist's response modes (e.g., empathic conjectures). In order to control allegiance effects for EFT, the project had an EFT and PCT expert supervise the therapists. Therapists' treatment adherence for The Experiential Psychotherapy for Social Anxiety project was moderate to extensive as measured by the use of process-guiding EFT tasks (Elliott et al., 2017). Clients were asked to complete the Client Post-Session Questionnaire (CPSQ Version 2.0; Elliott, 2008) in order to evaluate how helpful or hindering they had perceived the EFT in-session therapeutic strategies. For the present study, each session selected was checked to assure protocol adherence using both the EFT Therapist and Client Post-Session Forms.

4.3.2 Outcome Categorization

The outcome categorization for the PCT and EFT in the Experiential Psychotherapy for Social Anxiety Comparative Study was based on 53 clients who

received at least three sessions. To categorize clients into most improved and least improved outcome groups several quantitative instruments were applied. The instruments used for classifying clients were: a) the Personal Questionnaire (PQ; Elliott et al., 2016)—a questionnaire to assess problem distress identified by the client, b) the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2002)—an outcome measure developed to assess general problem distress, c) the Social Phobia Inventory (SPIN; Connor et al., 2000)—a measure to assess social phobia in three dimensions: fear, arousal, and avoidance, d) the Inventory of Interpersonal Problems (IIP; Maling, Gurtman & Howard, 1995)—a self-report measure to assess interpersonal problems—and e) the Strathclyde Inventory (SI; Freire, Elliott & Cooper, 2007)—an experimental Person-Centred outcome measure. The aforementioned instruments all have well-established psychometric properties (see cited references). The studies for all of these measures indicate that they have good/excellent psychometric properties, validity and reliability. The measures were administered at the entry level (clients completed all the questionnaires before their first session), at the middle phase of therapy (after the eighth session) and at the end of therapy. The measures were also administered during the six and eighteen-month follow-up session. Additionally, clients filled out the PQ before each session in order to keep a weekly measure of psychological distress. All the outcome measures mentioned above were used to compute the client's degree of therapeutic improvement by regressing each of the post-measures on its pre-measures to obtain standardized residuals and then computing the mean of these residuals to obtain a single measure (Mean Residual Gain). The means of these residuals were used because they hold all the information about the post-outcome

measures that had not been explained by the pre-outcome measures (the client's baseline). For the purpose of the present study, the five clients with the highest mean residual gain scores and the five clients with the lowest mean residual gain scores were selected. These ten clients represent the total sample for the present study.

4.3.3 Session Selection

One session from the early, middle, and late phase of therapy were chosen (N=30) from each of the ten cases included in the study (the five most improved and the five least improved clients from the sample under study). All initial sessions were excluded under the assumption that these are used to assess clients' difficulties, to discuss general therapeutic goals and agreements, and to establish therapeutic alliance (Weerasekera, Linder, Greenberg, & Watson, 2003). For this reason, the second and third sessions were selected to represent the early phase of therapy. To represent the middle phase of therapy, I first divided the total number of sessions by two and chose the three sessions surrounding the resulting number (e.g., $18/2 = 9$, either the 8th, 9th, or 10th session was selected). This decision was made under the assumption that during the middle phase of therapy clients are engaged in a reflective and experiential process (Horvath & Bedi, 2002). In all cases, the last session was excluded under the assumption that, in general, it was used for closure and to discuss the progress made during therapy. For this reason, the penultimate and antepenultimate sessions were selected to represent the late phase of therapy.

As Greenberg, Watson, and Goldman (1998) argue, choosing sessions at random may miss meaningful and relevant information and should not be the preferred method for process-research. Moreover, the client's process across and within sessions is unlikely to occur in a uniform manner (Greenberg & Safran,

1987). For this reason, steps were taken to ensure that the sessions were selected in an equivalent manner for each client. Accordingly, the present study responds to this concern by selecting sessions that were reported as the most helpful by therapists and both most improved and least improved clients alike. In order to do so, once I had divided the cases into three distinct phases and reduced the number of sessions under consideration, one session for each phase was selected. I considered the combined scores from the Client Post-Session Questionnaire (CPSQ-Version 2.0; Elliott, 2008) and the Therapist Overall Session Ratings (TOSR - Section II from v.4.4; Elliott, 2013b). Since, both the CPSQ and the TOSR had been filled out by the client and therapist after every session, I was able to calculate the client's and therapist mean score for each session. Firstly, I calculated the mean score for Section II: Therapist Overall Session Ratings (composed of 4 questions using a Likert scale) of the Therapist Session Form. Lastly, I calculated the mean score for each Client Post-Session Questionnaire (CPSQ-Version 2.0) (the questionnaire is composed of 4 questions using a Likert scale). In order to standardize the mean score for these two measures, I reverse scored question 1 and 4 of the Client Post-Session Questionnaire and the Therapist Overall Session Ratings. Once this had been done, the higher the mean scores for both of the above-mentioned measures, the better the evaluation of the respondents' perception of the session's helpfulness, quality, progress and therapeutic shifts would be. Sessions with the highest combined scores were selected under the assumption that both the therapist and the client perceived the session as beneficial. Helpful sessions were assumed to contain CMEs that would reflect a good example of the therapeutic process. Moreover, this method sought to attain a level of

uniformity across clients and time periods as well as to optimize the possibility of choosing overall helpful sessions.

4.3.4 Unit of Analysis

Within the context of the counsellor-client interaction, the focus of the unit of analysis was on the client's narrative. As discussed in the previous chapter, all the selected sessions were divided into one-minute time bins. The first and the last five minutes of therapy were discounted. The unit was considered for rating if it contained at least five words (for more information, see Chapter 3). All sessions selected were transcribed from beginning to end. Only client verbalizations were rated and analysed. Therapists' responses were not rated. That is, while observers listened to therapist verbalizations, these were not taken into account for the ratings. The rater used both the transcript and the audio during the codification process. For examples of one-minute units and their ratings please refer to Chapter 3.

4.3.5 Consent

Both the University of Strathclyde and the local National Health Service (NHS) approved the ethics statement for the use of archival data (i.e. therapeutic audio/video sessions; outcome measures) from the Experiential Psychotherapy for Social Anxiety Comparative Study (Elliott et al., 2017). In order to maintain confidentiality, the identification of clients was done with numbers and of therapists with initials.

4.4 Measure

4.4.1 The Client Modes of Engagement Observational Coding System (CME-OCS)

As described in the previous chapter, the CME-OCS is a non-participant observer-based method developed to systematically identify in-session Client Modes of Engagement (CME). The CME-OCS coding system is grounded in an EFT framework that integrates the concepts of mode of engagement and emotion schemes. The manual was constructed through the research-based understanding that, during sessions, clients engage in particular modes of engagement while focusing their attention on different components of their emotion scheme. The CME-OCS is a process diagnostic model that is based on different kinds of client experiential contents: situational-perceptual, symbolic-conceptual, bodily-expressive, and motivational-behavioural. The manual was developed specifically for audio and/or videotapes in combination with transcripts of therapeutic sessions. The CME-OCS has four categories that identify the manner in which clients access the different emotion scheme components of their experience — Dysregulated, Restricted, Working, and Change modes (see chapter 3 & Appendix A for in-depth details about the CME-OCS).

4.5 Research Questions

First, the present study sought to examine the tendencies of occurrence of the CMEs within and across psychotherapy. To address this objective the following study analysed the following research questions:

- 1) Can specific CMEs be systematically and reliably identified in recorded video/audio sessions in combination with transcripts of psychotherapy sessions?

- 2) What is the relationship between the probability of the occurrence of particular CMEs and therapeutic outcome?
- 3) How do CMEs evolve (a) during sessions and (b) across phases of therapy?
And, c) How do these changes relate to therapeutic outcome?

Second, the current study sought to examine whether there were differences between both outcome groups' ability to transition amongst different CMEs. To address this objective the present study analysed the following research questions:

- 1) Are there differences between most improved and least improved groups in their ability to transition amongst CMEs?
- 2) Are there differences between most improved and least improved groups in their ability to transition amongst CMEs across distinct phases of therapy (early, middle, and late)?

4.6 Results

4.6.1 Descriptive Statistics

Mean proportions of CMEs by outcome and phases of therapy are presented in Table 4.1. A total of 1465 instances of CMEs were coded using the therapy session audios or videos (not all clients agreed to be video recorded). There were three audio/videos for each client in the study (N=10). A total of 501 CMEs was identified in the early phase of therapy (34% of all modes coded), 508 CMEs were identified in the middle phase of therapy (35% of all modes coded), and 456 CMEs were identified in the late phase of therapy (31% of all modes coded).

Table 4. 1. Cross Tabulation of Client Modes of Engagement by Phase

Phase	Modes of Engagement				Total
	Dysregulated	Restricted	Working	Change	
Early	40	372	78	11	501
	8.0%	74.3%	15.6%	2.2%	100.0%
Middle	11	210	197	90	508
	2.2%	41.3%	38.8%	17.7%	100.0%
Late	49	162	148	97	456
	10.7%	35.5%	32.5%	21.3%	100.0%
Total	100	744	423	198	1465
	6.8%	50.8%	28.9%	13.5%	100.0%

In Table 4.2 the mean proportions of each CME are presented by phase of therapy (Phase) and type of therapy outcome (Outcome). As can be seen in Table 4.2 there were a total of 756 instances of CMEs coded in the most improved group (52% of all CME), and 709 in the least improved group (48% of all CME). It should be noted that the descriptive accounts of patterns and trends in the data that follows refer to Table 4.1 and 4.2 and do not imply statistically significant relationships unless otherwise specified. The following descriptive statistics are presented in order from the most frequent (Restricted) to the least frequent (Dysregulated) mode of engagement present across all therapy sessions, as reported in Table 4.1 and Table 4.2.

Table 4. 2. Cross Tabulation of Client Modes of Engagement by Session and by Outcome

		Modes of Engagement				
	Phase	Dysregulated	Restricted	Working	Change	Total
Least Improved	Early	18	190	36	5	249
		7.20%	76.30%	14.50%	2.00%	100.00%
	Middle	9	166	64	11	250
		3.60%	66.40%	25.60%	4.40%	100.00%
	Late	48	116	38	8	210
		22.90%	55.20%	18.10%	3.80%	100.00%
Total		75	472	138	24	709
		10.60%	66.60%	19.50%	3.40%	100.00%
Most Improved	Early	22	182	42	6	252
		8.70%	72.20%	16.70%	2.40%	100.00%
	Middle	2	44	133	79	258
		0.80%	17.10%	51.60%	30.60%	100.00%
	Late	1	46	110	89	246
		0.40%	18.70%	44.70%	36.20%	100.00%
Total		25	272	285	174	756
		3.30%	36.00%	37.70%	23.00%	100.00%

4.6.1.1 *The Restricted Client Mode of Engagement*

The Restricted CME was the most frequently occurring mode throughout all sessions (N=744, 50.8% of all modes coded). However, this mode of engagement occurred more frequently in the least improved group (N=472, 66.6% of all modes coded) than in the most improved group (N=272, 36% of all modes coded). This difference was most notable in the middle and late phases of therapy. For the middle phase of therapy, the Restricted Mode occurred less frequently in the most improved group (N=44, 17.1% of all modes in the middle phase of therapy) than in the least improved group (N=166, 66.4% of all modes in the middle phase of therapy). Also,

for the late phase of therapy the Restricted Mode occurred less frequently for the most improved group (N=46, 18.7% of all modes coded in the late phase of therapy) than for the least improved group (N=116, 55.2% of all modes coded in the late phase of therapy).

4.6.1.2 The Working Client Mode of Engagement

The Working Mode was identified 28.9% of all modes coded (N=423). This mode appeared almost twice as frequently in the most improved group (N=285, 37.7% of all modes coded) than in the least improved group (N=138, 19.5% of all modes coded). This difference was most notable in the middle and late phases of therapy. During the middle phase the Working Mode occurred more frequently for the most improved group (N=133, 51.6% of all modes coded in the middle phase of therapy) than for the least improved group (N=64, 25.6% of all modes coded in the middle phase of therapy). Also, during the late phase of therapy the Working Mode occurred more often for the most improved group (N=110, 44.7% of all modes coded in the late phase of therapy) than for the least improved clients (N=30, 18.1% of all modes coded in the late phase of therapy).

4.6.1.3 The Change Mode of Engagement

The Change Mode was present in 13.5% all modes coded (N=198). This mode appeared much more frequently in the most improved group (N=174, 23% of all modes coded) than in the least improved group (N=24, 3.4% of all modes coded) where it was almost absent. For the middle phase, the Change Mode also appeared more often in the most improved group (N= 79, 30.6% of all modes coded in the middle phase of therapy) than in the least improved group (N=11, 4.4% of all modes coded in the middle phase of therapy). A similar pattern can be observed for the late

phase. The frequency of the Change Mode is much higher for the most improved group (N=89, 36.2% of all modes coded in the late phase of therapy) than for the least improved group (N=8, 3.8% of all modes coded in the late phase of therapy).

4.6.1.4 The Dysregulated Mode of Engagement

Finally, the least common CME was the Dysregulated Mode (N=100, 6.8% of all modes coded). Its frequency amongst all modes coded was 10.6 % (N=75) for the least improved group and 3.3% (N=25) for the most improved group. The frequency of the Dysregulated Mode for was much higher for the least improved group (N=48, 22.9% of all modes coded for the late stage of therapy) than for the most improved group (N=1, 0.4% of all modes coded for the late stage of therapy) during the late phase. This notable difference between most improved and least improved groups is not present in early and middle phases of therapy.

4.6.2 Question 1: Can Specific CMEs be Systematically and Reliably Identified Through Video/Audio Sessions in Combination with Transcripts of Psychotherapy Sessions?

Interrater Reliabilities. As the principal rater, I coded the entire set of one-minute units for all of the sessions, which resulted in total of 1465 ratings of modes of engagement. To get interrater reliability, I trained a second coder—a student with a post-graduate degree and experience with PCT and EFT psychotherapy, as mentioned earlier. The second rater coded one third of the total sessions while remaining unaware of the hypothesis of the study and client therapeutic outcome. The sessions were randomly selected and divided in such a way that early, middle and late sessions were equally represented. Each of the selected sessions was divided into three parts (beginning, middle, and late phase) that were then randomly assigned

to the second rater for coding. If a difference between the results of ratings between the main coder and the second coder became apparent, the codings made by the second rater were used for data analysis. The interrater reliability as measured by Cohen's Kappa was 0.87. According to Cicchetti (1994) this is considered a high level of interrater reliability.

4.6.3 Question 2: What is the Relationship Between the Probability of the Occurrence of CMEs and Therapeutic Outcome?

The Statistical Approach. To analyse the probability of occurrence of CMEs for both therapeutic outcome groups (most improved and least improved), I cross-tabulated the modes of engagement by outcome. To test if there were differences between therapeutic groups with regards to the probability of being in each CME, I computed a chi-squared test for independence (chi-squared = 243.23, df= 3, $p < 0.001$). I concluded that there was an overall difference in the distribution of probabilities of the occurrence of CMEs for both therapeutic outcome groups. All results are shown in Table 4.3.

Table 4. 3. Client Modes of Engagement by Outcome

Modes of Engagement	Least Improved	Most Improved	Total
	Percentage		
	Standardized Residuals		
Dysregulated	75	25	100
	10.6%	3.3%	6.8%
	(3.8)	(-3.7)	
Restricted	472	272	744
	66.6%	36.0%	50.8%
	(5.9)	(-5.7)	
Working	138	285	423
	19.5%	37.7%	28.9%
	(-4.7)	(4.5)	
Change	24	174	198
	3.4%	23.0%	13.5%
	(-7.3)	(7.1)	
Total	709	756	1465
	48.4%	51.6%	100.00%

Note. The standardized residuals are the difference between the observed frequencies and the expected frequencies. The expected frequencies are computed assuming that there is no difference between the least improved and most improved group in terms of CMEs. A positive residual implies that there were more observed frequencies than expected frequencies and vice-versa. Generally, the cut-off for the residual indicates an important difference between the observed and the expected frequencies is 2 or -2.

To further specify these results, I used the residuals and the effect sizes. As is standard in this type of analysis I used the odds ratio as a measure of effect sizes (Ellis, 2010). There was a difference between the probability of being in the Dysregulated Mode for the least improved group (10.6%) and the most improved group (3.3%) (residual=3.8, effect size=0.33). Thus, it was three times more probable for the least improved group to be in the Dysregulated Mode than for the most improved group to be in this mode. Also, there was a difference of 30.6 % between the probabilities of being in Restricted Mode for the least improved group (66.6%) versus the most improved group (36.0%) (residual=5.9, effect size=0.58).

Conversely, the probability of the most improved group (37.7%) of being in Working Mode was about twice the corresponding probability for the least improved group (19.5%) (residual=-4.7%, effect size=2.1). For the Change Mode, the probability of being in the most improved group (23%) was 20% more than the probability of the least improved group (3.4%) being in the same mode (residual=-7.3%, effect size=8.1). Thus, it is notable that for the least improved group, the probability of being in Change Mode was quite small. Moreover, clients in the least improved group spent about 2/3 of their overall therapy time in the Restricted Mode. Remarkably, clients in the most improved group spent very little of their overall therapy time in the Dysregulated Mode (3.3%). Since the statistical analysis established that there were in fact differences in the overall probability of being in distinct modes of engagement for most improved versus least improved groups, in order to understand the data more profoundly, the next step in this study was to determine how CMEs evolved across phases of therapy related to therapeutic outcome.

4.6.4 Question 3: How do Client Modes of Engagement Evolve During Sessions and Across phases of therapy? How are these Changes Related to Therapeutic Outcome?

The Statistical Approach. The structure of the data for the present study was as follows: There were six variables used in this study. The minute variable (*Minute*) recorded each one-minute time bin within each session. The phase variable (*Phase*) referred to the stage of therapy corresponding to the session being observed and was a three-level categorical variable (Early, Middle, Late). The client variable (*Client*) recorded the specific client from each session being coded. The therapist variable

(*Therapist*) was a categorical variable that specified the therapist to whom each therapy corresponds. In this study, there were a total of five psychotherapists. Some of the therapists had more than one client. The outcome variable (*Outcome*) classified the clients according to their therapeutic outcome (most improved and least improved). Finally, the observation or response variable (*CME*) indicated the mode of engagement coded for each one-minute time bin within each session included in the study for each client.

Since I observed how CMEs appeared for each time-bin during the duration of each session, the study was longitudinal. Moreover, the study had a hierarchical structure. One level was that of the client, with the observation nested within each client. The second level was that of the therapist, with the clients nested within their corresponding therapist. The appropriate statistical model to take into account this hierarchical structure was a multilevel statistical analysis that controls for repeated measures (Snijders & Bosker, 2012). Outcome was not considered as a different level but as a particular characteristic¹ of each client.

The Outcome, Phase and Minute variables were modelled as having fixed effects, whereas the Client and Therapist variables were modelled as having nested levels of random effects (e.g., client #11 had 55 observations corresponding to the early phase session, his/her therapist was Therapist #1 and his/her outcome was Least Improved). A particular outcome could depend on a random effect related to each nested level and on the fixed effects related to each variable. The data were unbalanced because the number of observations varied across and within the levels. In order to best address the complex nature of the data structure, a multilevel logistic

¹ This study considers Outcome (Most Improved or Least Improved) as a particular characteristic of each client (as one could see gender or age as a particular client characteristic).

regression approach was employed. This type of statistical analysis estimates the fixed effects associated with each independent variable plus the variance of the random effects associated with the nested structure of the observations. The multilevel logistic regression approach permitted the simultaneous evaluation of both between- and within- subject analysis.

Given the complex structure of the study, the strategy for the statistical analysis of the data was to begin with the simplest model and increase complexity until I obtained the best statistical fit. Hence, I began by analysing the data with the fixed coefficient model, which assumed that all clients behave similarly at every phase and for any therapist. The model also assumed that CMEs would depend only on Minute, Phase, and Outcome variables and their interactions. Once I fitted the fixed coefficient model I began adding one additional random effect at a time and compared the new model with the previous model in order to assess if the new model provided a significantly better fit.

I fitted a statistical model for each of the four modes of engagement. In order to model the probability that a client was at each mode, I applied a generalized hierarchical linear mixed logit model fitted by maximum likelihood (Agresti, 2007; Snijders & Bosker, 2012). In this way, I was able to determine if there were differences in these probabilities according to Phase, Outcome and Minute. I used a dummy variable for the presence (coded as 1) or absence (coded as 0) of the mode of engagement that I was analysing. The explanatory variables were: Phase, which is a nominal variable with three levels (Early, Middle, and Late), Outcome, which is a nominal variable with two levels (Most Improved and Least Improved), and Minute, which was a continuous variable. I also used the interactions of Outcome by Phase

and Phase by Minute in the model. Because of the nested nature of the data, I used a hierarchical model to fit it. Thus, to answer the research question # 3 I modelled the evolution of each mode of engagement one by one. Statistical analysis for this research was generated using the R statistical language (R Development Core Team, 2011) and the *multilevel* version 2.6 (Bliese, 2016) and *lme4* (Bates, Mächler, Bolker, Walker, 2015) packages.

Steps Followed to Model the Data. What follows is an example of the step-by-step process I used in order to obtain the final model for the probability of being in a specific mode. Specifically, I use the Working Mode as an example of the process employed in order to provide an ampler illustration of how I analysed the data (see Table 4.4). I began by considering a model with only fixed effects and taking into account all possible two-order interactions between Outcome, Phase and Minute. To assess how well this model adjusts the data I used the deviance² statistic (Snijders & Bosker, 2012). For the initial model the deviance was: 1578.5, df=1455. To test if the interaction between Phase: Minute was significant I considered another model (see Table 4.4, Model 2) without that interaction, the deviance for Model 2 was: 1578.8, df=1457. To compare these two models, I calculated the difference of the deviances as 0.3. This statistic has a chi-square distribution with 2 degrees of freedom. Hence, the associated p-value was calculated as 0.9. So, I concluded that

² The deviance is a measure for the statistical quality of fit of a model. It is used in generalized linear models as a means of comparing two models. It works in a similar way as the residual variance in ANOVA linear models. It can be used to test hypothesis related to the two models being compared. To obtain the deviance of a model the difference in natural logarithms of the likelihood of the present model with the likelihood of the saturated model (i.e., the model with all possible parameters) is computed. To compare two different models, one could compute the difference in deviances. The resulting statistic should follow an approximated chi-squared distribution. Hence, one could compute a p-value to test the hypothesis that both models fit the data equally against the alternative hypothesis that they do not. There are other goodness-of-fit statistics (e.g., AIC, BIC) but these do not provide a framework for testing hypothesis about the two models because they calculate a relative measure of the quality of a model to fit the data.

both models have the same information about the data and that from now on I will use Model 2. Next, I introduced random effects. I first considered random intercepts³ (see Table 4.4: Model 3-4). As with the previous models, for Model 3 and 4 I computed the deviances, the degrees of freedom, the differences of the deviances and the p-values associated with them (p-value of the difference between the deviance of Model 3 and the deviance of Model 2 was $p = < 0.001$). Therefore, I concluded that there were random intercepts for Therapists and Clients.

Next, I fitted a model to find out if there were random intercepts just for Clients (p-value of the difference of the deviance of Model 4 and Model 3 was $p = 1$). Hence, I concluded that random intercepts including Therapists do not provide a better statistical fit to the data. However, the relationships within groups could be more complicated and there could be random slopes⁴. So, in Model 5 (see Table 4.4) I included a random slope for Phase and Client (deviance=1456.8; df=1427; $p = 0.008$). Hence, I concluded that there were random slopes for Phase within Clients. Thus, the most adequate model that I found to fit the data was Model 5 because it took into account random slopes. For the other CMEs I followed the same method.

³ To model the effect of a level that is nested within another level (e.g. the effect of having repeated observations for a single client) one could simply add a constant (different for each client) to the model. This constant is assumed to be the random result of the characteristics of the level (e.g. clients) that are not taken into account especially in the model (e.g. gender, age).

⁴ A random slope model assumes that the effect of the groups could be different for each unit within the group in general (the intercept), and also that there is a different interaction of a specific variable (the one that we are modeling with random slopes) for each member of the group. Hence, each member of the group responds differently to that variable (e.g. each client has a different behavior within each phase).

Table 4. 4. Model Comparison & Fitting for Probability of Being in Working Mode

Models		Deviance	Df	P-value
Model#1: Fixed Effects	All two order interactions: Outcome + Phase + Minute + Outcome:Phase + Outcome:Minute + Phase:Minute	1578.5	1455	
Model#2: Fixed Effects	Outcome + Phase + Minute + Outcome:Phase + Outcome:Minute	1578.8	1457	0.9
Model#3: Fixed Effects+Random Effects	Fixed Effects: Outcome + Phase + Minute + Outcome:Phase + Outcome:Minute Random Intercept: Therapists+Clients	1508.3	1442	<0.001
Model#4: Fixed Effects+Random Effects	Fixed Effects: Outcome + Phase + Minute + Outcome:Phase + Outcome:Minute Random Intercept: Clients	1508.3	1447	1
Model#5: Fixed Effects+Random Slopes	Fixed Effects: Outcome + Phase + Minute + Outcome:Phase + Outcome:Minute Random Slopes: Phase slopes and intercepts depend randomly on Clients	1456.8	1427	0.008

4.6.5 Testing for Differences in the Probability of Occurrence of Particular Client Modes of Engagement (CME-OCS) Across Phases of Treatment and Outcome

The following sections document the results found using Model#5: Fixed Effects+Random Slopes (see Table 4.4) for the probability of being in each Client Mode of Engagement according to outcome, phase of therapy (early, middle, late), minute spent in therapy, the interactions between outcome and phase of therapy, and the interactions between outcome and minute spent in therapy.

Dysregulated Mode of Engagement. There was evidence of effect by outcome ($F_{(1,1427)}=7.5, p=0.006$). There was evidence of a phase effect ($F_{(2,1427)}=27.4, p<0.001$). There was evidence of minute effect ($F_{(1,1427)}=6.25, p=0.01$). There was evidence of a significant interaction between outcome and phase of therapy ($F_{(2,1427)}=26.6, p<0.001$). There was a significant interaction between outcome and one-minute time bin ($F_{(2,1427)}=14.4, p<0.001$). There was a significant interaction between phase and minute ($F_{(2,1427)}=4.06, p<0.001$).

The results stated above imply that there was a general minute-by-minute in-session tendency for clients from both outcome groups to engage less frequently in the Dysregulated Mode as time went by. However, the probability of each outcome group of engaging in the Dysregulated Mode was significantly different for each phase of therapy (see Figure 4.1). The most dramatic differences between both outcome groups can be seen by the late phase of therapy. While both outcome groups display a similar tendency to engage in the Dysregulated Mode during the early phase of therapy, they displayed significant differences by the middle and late phase of therapy. For the most improved group, the proportion of time spent in the

Dysregulated Mode became significantly lower by the middle phase of therapy than it had been by the early phase of therapy. This tendency remained similar for the late phase of therapy. For the least improved group, on the other hand, the proportion of time spent in the Dysregulated Mode in the middle phase of therapy remained similar than in the early phase of therapy and increased significantly by the late phase of therapy.

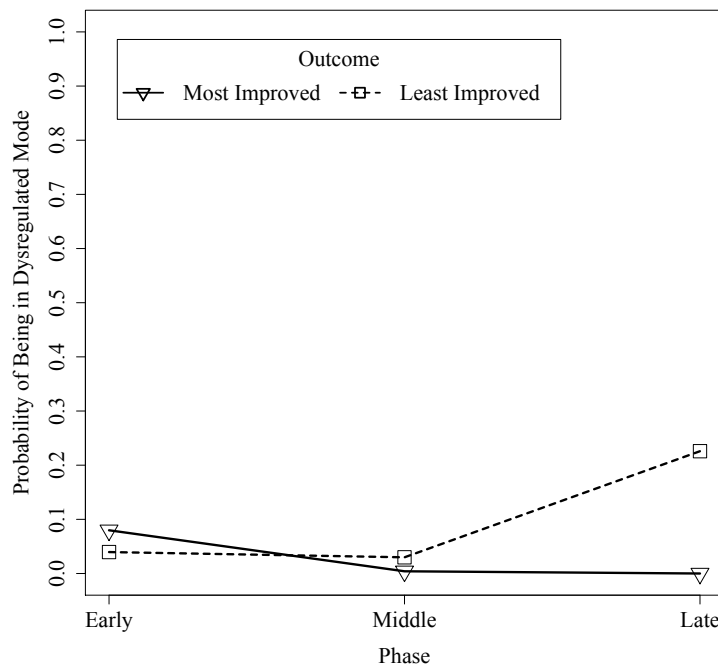


Figure 4. 1. **Probability of Being in Dysregulated Mode of Engagement**

The figure displays the proportion of time spent in the Dysregulated Mode by phase of therapy and therapeutic outcome. Results demonstrate a significant interaction between phase of therapy and outcome. There is a significantly higher proportion of Dysregulated Mode in the least improved group during the late phase of therapy.

Restricted Mode of Engagement. There was evidence of phase effect ($F_{(2,1427)}=6.98, p=0.003$). There was no evidence of minute effect ($F_{(1,1427)}=1.85, p=0.18$). There was evidence of a significant interaction between outcome and phase of therapy ($F_{(2,1427)}=24.2, p<0.001$). There is a significant interaction between

outcome and minute ($F_{(2,1427)}=18.5, p<0.001$). There is a significant interaction between phase and minute ($F_{(2,1427)}=41.0, p<0.001$). There was no evidence of an overall outcome effect ($F_{(1,1427)}=2.89, p=0.087$).

The results stated above imply that for both groups, each minute that elapses in a single session during the early and middle phases of therapy decreases the probability of being in Restricted Mode. However, this decrease per minute spent in therapy was significantly more pronounced for the most improved group than for the least improved group. In terms of phases of therapy, there was a significant difference between the ways both outcome groups engaged in this mode during the middle and late phases of therapy (see Figure 4.2). In fact, the most improved group tended to engage significantly less in the Restricted Mode by the middle phase of therapy than the least improved group. Their tendency to engage in this mode remained stable between the middle and late phases of therapy. For the least improved group, on the other hand, the tendency to engage in the Restricted Mode decreased slightly between the early, middle phase and late phases of therapy. For the most improved cases the proportion of time spent in the Restricted Mode during the middle and late phases of therapy was significantly less than for the least improved group.

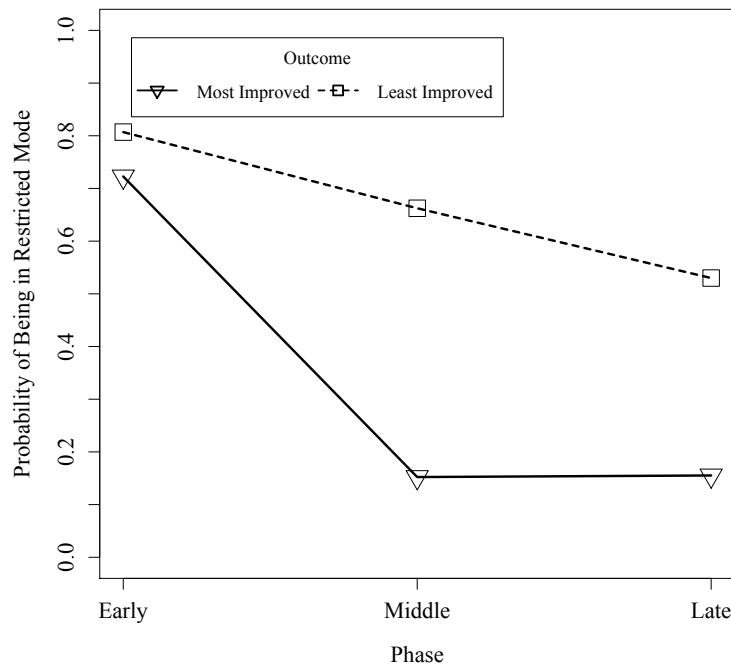


Figure 4. 2. ***Probability of Being in Restricted Mode of Engagement***

The graph displays the proportions of Restricted Mode by phase of therapy and therapeutic outcome. Results demonstrate a significant interaction between phase of therapy and outcome. There is a significantly higher proportion of Restricted Mode in the least improved group across all phases. Although both groups have similar probability of being in Restricted Mode for the early phase, for the most improved group this probability quickly falls to around 10% and stays there for the late phase. For the least improved group the probability of being in Restricted Mode decays much slower and always at the same pace.

Working Mode of Engagement. There was evidence of outcome effect

($F_{(1,1427)}=7.8, p=0.005$). There was no evidence of phase effect ($F_{(2,1427)}=2.4, p=0.3$).

There was evidence of minute effect ($F_{(1,1427)}=25.1, p<0.001$). There was evidence of

a significant interaction between outcome and phase of therapy ($F_{(2,1427)}=14.08,$

$p<0.001$). There was evidence of an interaction between outcome and minute

($F_{(2,1427)}=23.04, p<0.001$). There is no evidence of interaction between phase and

minute ($F_{(2,1427)}=0.285, p=0.87$).

The above-mentioned findings indicate that there is a general minute-by-minute in-session tendency for both outcome groups to engage more frequently in the Working Mode as time goes by. Still, this in-session tendency is markedly higher

for the most improved group. In the early phase of therapy, both outcome groups begin with a similar tendency to engage in this mode, however, for the most improved group, this tendency increases markedly by the middle phase and stays about the same for the late phase (see Figure 4.3).

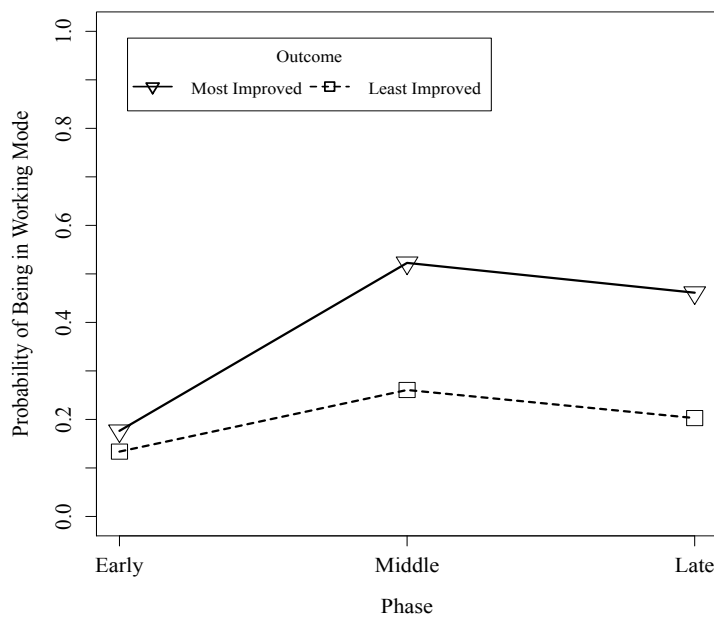


Figure 4. 3. **Probability of Being in Working Mode of Engagement**

The figure displays the proportions of Working Mode by phase of therapy and therapeutic outcome. Results demonstrate a significant interaction between phase of therapy and outcome. There is a significantly higher proportion of Working Mode in the most improved group across middle and late phases of therapy. Although the probability of being in Working Mode increases by the middle phase of therapy for both groups, this increase is more pronounced for the most improved group. There is a slight decrease of the probability of being in Working Mode for both groups during the late phase.

Change Mode of Engagement. The overall outcome effect was not significant ($F_{(1,1427)}=0.04, p=0.83$). There was no significant overall phase effect ($F_{(2,1427)}=2.4, p=0.30$). There was a significant effect for minute on the probability of being in Change Mode ($F_{(1,1427)}=25.5, p<0.001$). There was evidence of a significant interaction between outcome and phase of therapy ($F_{(2,1427)}=23.1, p<0.001$). There is no evidence of interaction between outcome and minute ($F_{(2,1427)}=0.48, p=0.49$).

The findings discussed above imply that there was a general minute-by-minute in-session tendency for clients from both outcome groups to engage more frequently in the Change Mode as time went by. While, during the early phase of therapy, the tendency to engage in Change Mode was practically absent for both outcome groups, by the middle phase of therapy the tendency of both outcome groups to engage in this mode deviate considerably (see Figure 4.4). The most improved group engage considerably more often in the Change Mode by the middle phase of therapy; this tendency continues to increase at a slower pace by the late phase of therapy. On the other hand, the least improved group barely ever engage in this mode at any phase of therapy.

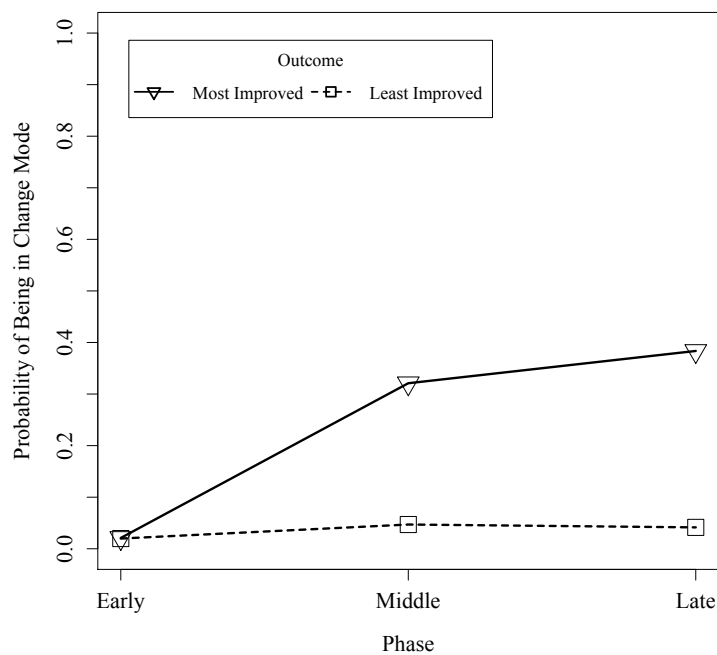


Figure 4. 4. ***Probability of Being in Change Mode of Engagement***

The graph displays the proportions of Change Mode by phase of therapy and outcome. Results demonstrate a significant interaction between phase of therapy and outcome. The least improved group rarely engages in the Change Mode. Conversely, there is a substantial increase of the probability of being in Change Mode for the most improved group by the middle phase of therapy. This trend continues increasing, but at a slower pace, during the late phase of therapy.

Comprehensive Graphical Displays of the Modes of Engagement

Above we have described four highly complex multilevel logit models. In order to better understand and visualize the behaviour of Client Modes of Engagement across therapy sessions, the following section provides a comprehensive graphical display of the evolution of the minute-by-minute behaviour of CMEs during each therapeutic session for each client. Moreover, the graphical displays also include the expected evolution of CMEs across early, middle and late phases for both outcome groups calculated using the weighted mean by applying the predictions of the multilevel logit models. Each figure (Figures 4.5 to 4.7) corresponds to each of the three phases of therapy (early, middle, late). The right panel within each figure corresponds to the least improved group while the left panel corresponds to the most improved group.

The Expected Overall Evolution of CMEs during the Early Phase of Therapy

Each panel of Figure 4.5 displays the expected overall evolution of CMEs during the early phase of therapy. We can observe that in the early phase of therapy, clients from both outcome groups tended to start their session in the Restricted Mode and progress slowly towards the Working Mode. This increase became more pronounced by the end of the early phase (approximately minute 40) for the most improved outcome cases and slightly less pronounced for the least improved outcome cases. However, overall both outcome groups behaved in a similar manner during the early phase of therapy.

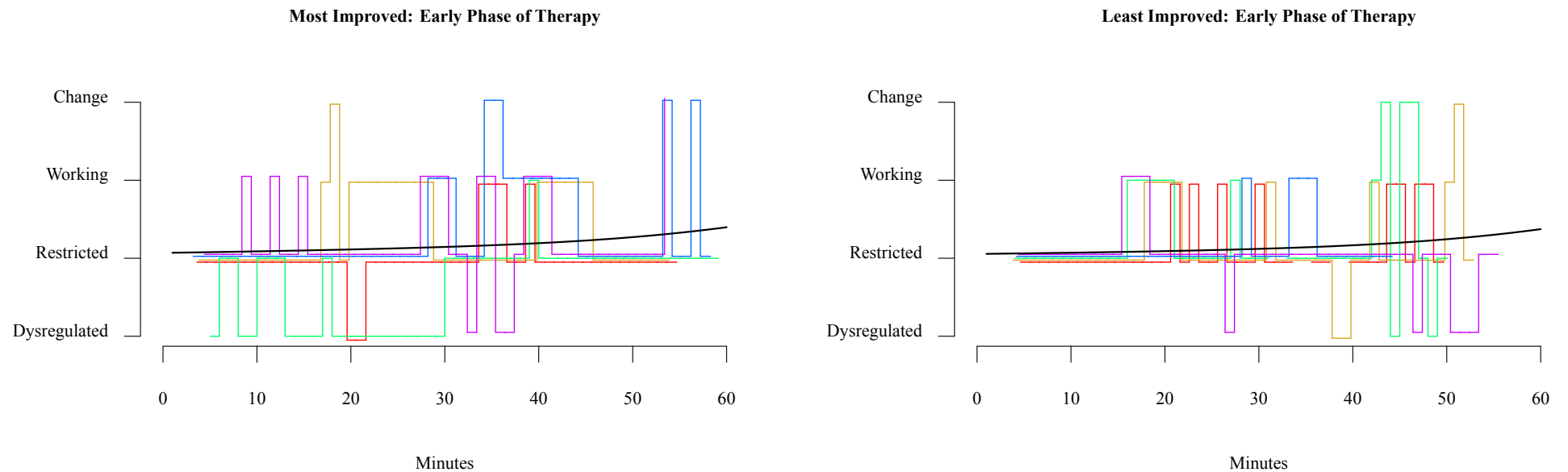


Figure 4.5. The Evolution of CMEs Across the Early Phase of Therapy

Each panel in the figure shows the evolution of CMEs for every client during the early phase of therapy. The left panel corresponds to the most improved group; the right panel corresponds to the least improved group. Each of the 10 clients is represented by a different colour so that one can follow each client's particular evolution with regards to the CME. The solid black line in each panel corresponds to the expected CME calculated using the probabilities obtained by the logit models fitted for each CME. In both panels, it can be seen that clients start at the Restricted Mode and slowly increase during the session. However, the most improved group increases slightly faster towards Working Mode.

The Expected Overall Evolution of CMEs during the Middle Phase of Therapy

Each panel of Figure 4.6 displays the expected overall evolution of CMEs during the middle phase of therapy. As can be observed, according to the expected evolution the most improved group begins sessions somewhere between the Restricted and Working Mode. For the most improved group, the movement towards Working Mode increases until around the middle of the session (approximately minute 25) and then the rate decreases, reaching equilibrium between Working Mode and Change Mode. Remarkably, at this phase, the evolution of CMEs for the least improved group visibly differs from the most improved group. Interestingly, at this phase, the evolution of CMEs for the least improved group remains quite similar to their behaviour in the early phase of therapy [see right panel of Figure 4.6]. In the least improved group, clients tend to stay in the Restricted Mode longer and progress towards Working Mode at a slower pace, rarely reaching Change Mode.

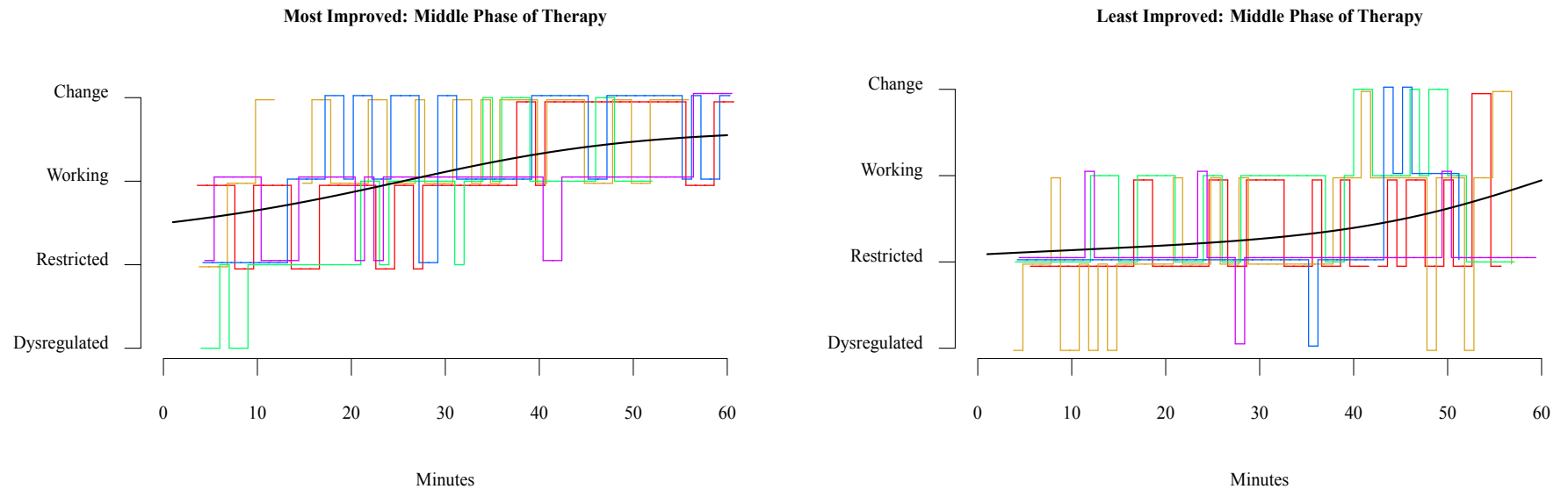


Figure 4. 6. *The Evolution of CMEs Across the Middle Phase of Therapy*

Each panel in the figure shows the evolution of CMEs for every client during the middle phase of therapy. The left panel corresponds to the most improved group and the right panel corresponds to the least improved group. Each of the 10 clients is represented by a different colour so that one can follow each client's particular evolution with regards to CMEs. The solid black line in each panel corresponds to the expected CME calculated using the probabilities obtained by the logit models fitted for each CME. In both panels, it can be seen that clients begin this phase between the Restricted and the Working Mode. For the most improved clients, the rate towards Working Mode increases more rapidly until they reach equilibrium between Working Mode and Change Mode. On the other hand, least improved clients tend to stay in Restricted Mode longer and progress at a much slower pace towards Working Mode.

The Expected Overall Evolution of CMEs during the Late Phase of Therapy

Each panel of Figure 4.7 displays the expected overall within-session evolution of CMEs during the late phase of therapy. It is interesting to observe that during this phase the overall evolution of the most improved group remains similar to their evolution during the middle phase of therapy [see left panels of Figure 4.6 and Figure 4.7]. While the least improved group also tended to maintain similar CME patterns than in the middle phase of therapy, they began the session in a lower level mode of engagement (between Dysregulated and Restricted) than they did in the middle phase of therapy. Remarkably, the least improved group not only rarely reached Change Mode but also did so at a lower rate than they did during the middle phase of therapy, indicating that they had lost ground.

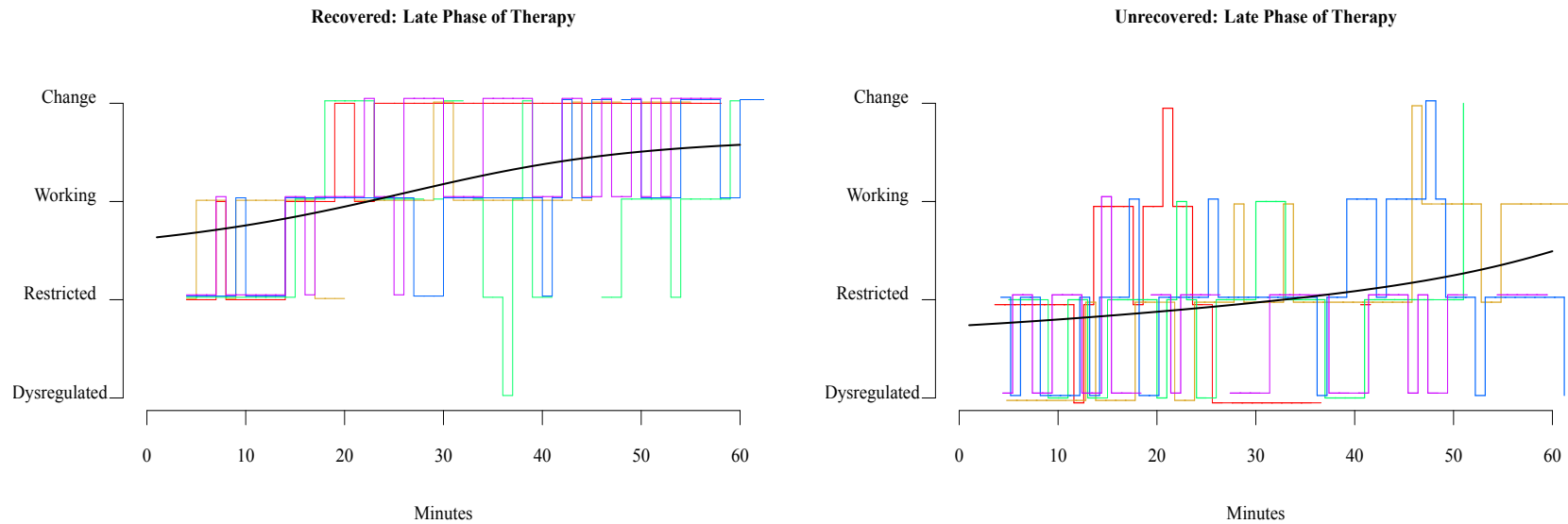


Figure 4. 7. *The Evolution of CMEs Across the Late Phase of Therapy*

Each panel in the figure shows the evolution of CMEs for every client during the late phase of therapy. The left panel corresponds to the most improved group, the right panel corresponds to the least improved group. Each of the 10 clients is represented by a different colour so that one can follow each client's particular evolution with regards to CMEs. The solid black line in each panel corresponds to the expected CME calculated using the probabilities obtained by the logit models fitted for each CME. In the most improved group the overall evolution is similar than in middle sessions. This is also the case for the least improved group, however, this group starts at a lower level mode of engagement (Restricted and Dysregulated)

4.6.6 Question 4: Are There Differences Between Most Improved and Least Improved Groups in Minute-to-Minute Transitions Amongst CMEs?

The Statistical Approach. In order to analyse whether there are differences between both outcome groups' ability to transition amongst different CMEs, I computed minute-to-minute one-step transition matrices. For these matrices, rows correspond to the current CME and columns correspond to the CME found in the subsequent minute. Each entry corresponds to the conditional probability of that transition for each row of the matrix.

Table 4. 5. One-Step Transition Matrix for the Most Improved Clients

CME after one-step (1-minute; t= +1)				
Previous CME	Dysregulated	Restricted	Working/Experiential	Change
Dysregulated	61.9%	28.6%	9.5%	0.0%
Restricted	2.4%	80.1%	15.5%	2.0%
Working	0.4%	11.3%	72.3%	16.1%
Change	0.0%	3.2%	20.1%	76.6%

For example, the transition matrix for the most improved group (see Table 4.5) shows that there is a 15.5% probability that a client who is in a Restricted Mode in the present minute will transition to the Working Mode in the next minute. Also, there is a 72.3% probability that a client that is in Working Mode in the present minute will remain in that mode in the next minute.

The one-step transition matrix implies that these probabilities have been computed from one minute to the next. The data to compute these matrices is obtained by cross-tabulating the variable that corresponds to the current CME/minute with the variable that corresponds to the next CME/minute. This can be done for each outcome group and each phase of therapy.

In order to analyse these transition matrices, I adjusted a log-linear regression model for categorical variables (Agresti, 2007). These models can be complex to interpret. For this reason, I decided to fit models with an increasing level of complexity in order to better interpret the results. For the first model that I fitted, the explanatory variables were the current CME, the subsequent CME and the Outcome. For this first model, I left out the phase variable. The objective was to test whether or not the transition matrices differ according to Outcome. In order to do so, I used models that either included or excluded the outcome variable. I then computed the difference between the deviances that corresponded to these models (difference of deviances=60.6, $df=7$, $p<0.001$, effect size: 1.4). With this information, we can conclude that the transition matrix for the most improved group is different from the transition matrix for the least improved group. In order to further investigate the difference between the two transition matrices, I computed the corresponding standardized Pearson residuals. The results are displayed in Table 4.6.

Table 4. 6. Cross Tabulation of Transitions Between Client Modes of Engagement Across Phases Divided by Outcome

	Most Improved					Least Improved			
	Dysregulated	Restricted	Working	Change		Dysregulated	Restricted	Working	Change
	Percentage					Percentage			
	Standardized Residuals					Standardized Residuals			
Dysregulated	13	6	2	0	Dysregulated	32	28	3	1
	61.9%	28.6%	9.5%	0.0%		50.0%	43.8%	4.7%	1.6%
	(0.5)	(-0.8)	(0.6)	(-0.6)		(-0.5)	(0.8)	(-0.6)	(0.6)
Restricted	6	201	39	5	Restricted	27	358	47	4
	2.4%	80.1%	15.5%	2.0%		6.2%	82.1%	10.8%	0.9%
	(-1.7)	(-0.2)	(1.2)	(0.8)		(1.7)	(0.2)	(-1.2)	(-0.8)
Working	1	31	198	44	Working	4	44	72	12
	0.4%	11.3%	72.3%	16.1%		3.0%	33.3%	54.5%	9.1%
	(-1.5)	(-3.3)	(1.6)	(1.4)		(1.5)	(3.3)	(-1.6)	(-1.4)
Change	0	5	31	118	Change	1	3	10	7
	0.0%	3.2%	20.1%	76.6%		4.8%	14.3%	47.6%	33.3%
	(-1.4)	(-1.7)	(-2.2)	(2.7)		(1.4)	(1.7)	(2.2)	(-2.7)

Note. The standardized residuals are the difference between the observed frequencies and the expected frequencies. The expected frequencies are computed assuming that there is no difference between the least improved group and the most improved group in terms of CMEs. A positive residual implies that there were more observed frequencies and vice-versa. Generally, the cut-off for the residuals indicates an important difference and the expected frequencies is 2 or -2.

For the purpose of analysing the standardized residuals obtained by fitting the model that included the outcome variable, I am going to concentrate on the residuals that have an absolute value greater than two because they correspond to p-values less than 5%⁵. These standardized residuals are used in the present study as effect sizes for the differences between the observed and the expected values (Ellis, 2010). I found that the probability of staying in Change Mode for the most improved group (76.6%) is significantly higher than the corresponding probability for the least improved group (33.3%) (residual=2.7). Also, for the most improved group the probability of making a transition from Change Mode to Working Mode (20.1%) is significantly less (residual=-2.2) than the corresponding probability for the least improved group (47.6%). Finally, I found that, when in Working Mode, the probability of the most improved group of transitioning to Restricted Mode (11.3%) is significantly lower (residual=-3.3) than the probability for the least improved group (33.3%).

4.6.7 Question 5: Are There Differences Between the Most Improved and Least Improved Groups in Minute-to-Minute Transitions Amongst CMEs at Distinct Phases of Therapy (Early, Middle, Late)?

The Statistical Approach. In order to analyse how clients transition amongst CMEs in different phases of therapy and test if there are differences between outcome groups, I computed the transition matrices for all phases and all outcomes — six matrices in total (see Table 4.7 to 4.9). To statistically analyse the transition matrices by phase, I fitted a log-linear model of categorical variables for the

⁵ The standard deviation of standardized residuals is 1. These have an approximately normal distribution. Hence, residuals that have an absolute value greater than 2 are at the 5% tails of the distribution. Thus, the observed differences between the probabilities are unlikely to be due to chance.

frequencies that corresponded to each phase — three-log linear analysis in total (Agresti, 2007).

Early Phase. To test if there is a significant difference between the one-step transition matrices for the most improved and least improved groups during the early phase of therapy (see Table 4.7), I computed the difference between the deviance of the model with all the variables and all their two-way interactions with the deviance of the model excluding the outcome variable. The difference of the deviances of these models was 1.7, $df=7$, $p=0.97$, effect size: 0.23. Given these results, we can conclude that in the early phase of therapy there is no difference in CME transitions between both outcome groups.

Table 4. 7. Cross Tabulation of Transition Between Client Modes of Engagement & Outcome: Early Phase

	Most Improved				Least Improved				
	Dysregulated	Restricted	Working	Change	Dysregulated	Restricted	Working	Change	
	Percentage				Percentage				
	Standardized Residuals				Standardized Residuals				
Dysregulated	13 65.0% (1.0)	6 30.0% (-0.8)	1 5.0% (0.6)	0 0.0% (-1.0)	Dysregulated	2 28.6% (-1.0)	4 57.1% (0.8)	0 0.0% (-0.6)	1 14.3% (1.0)
Restricted	5 3.0% (-0.2)	147 88.6% (0.2)	12 7.2% (-0.6)	2 1.2% (0.4)	Restricted	6 3.7% (0.2)	141 86.0% (-0.2)	16 9.8% (0.6)	1 0.6% (-0.4)
Working	1 2.4% (0.6)	12 28.6% (-1.1)	28 66.7% (1.0)	1 2.4% (-0.7)	Working	0 0.0% (-0.6)	14 51.9% (1.1)	11 40.7% (-1.0)	2 7.4% (0.7)
Change	0 0.0% (-0.8)	3 27.5% (-0.1)	1 12.5% (0.6)	4 50.0% (0.2)	Change	1 20.0% (0.8)	2 40.0% (0.1)	0 0.0% (-0.6)	2 40.0% (-0.2)

Note. The standardized residuals are the difference between the observed frequencies and the expected frequencies. The expected frequencies are computed assuming that there is no difference between the least improved group and the most improved group in terms of CMEs. A positive residual implies that there were more observed frequencies and vice-versa. Generally, the cut-off for the residuals indicates an important difference and the expected frequencies is 2 or -2.

Middle Phase. The second model I fitted corresponded to the middle phase transition matrices (see Table 4.8). As before, to test the difference between the transition matrices I fitted a model that included current CME, subsequent CME, Outcome and all the two-way interactions between these variables. In order to test if the outcome variable significantly improves the fitting of the data, I fitted the same model but excluded the outcome variable (differences of deviances=180.3, $df=7$, $p<.001$, effect size: 2.4). I found that the two transition matrices for the middle phase are different depending on outcome. To analyse these differences further I computed the standardized Pearson residuals for the difference between the observed and expected frequencies.

As seen in Table 4.8, the probability of staying in Restricted Mode is lower for the most improved group (63.8 %) than for the least improved group (83.9%) (residual=-5.6). Also, the probability of staying in Working Mode is significantly higher for the most improved group (73.6%) than for the least improved group (56.7%) (residual=3.8). Moreover, the probability of moving from Working to Change Mode is significantly higher for the most improved group (18.6%) than for the least improved group (10%) (residual=2.3). Finally, the probability of staying in Change Mode is significantly higher for the most improved group (72.1%) than for the least improved group (33.3%) (residual=4.5). Thus, in the middle phase of therapy, the most improved group tended to transition upwards towards more productive modes of engagement (Working and Change) and were less likely to stay in lower level modes (Dysregulated and Restricted) and more likely to stay in higher level modes (Working and Change).

Table 4. 8. Cross Tabulation of Transition Between Client Modes of Engagement & Outcome: Middle Phase

	Most Improved				Least Improved				
	Dysregulated	Restricted	Working	Change	Dysregulated	Restricted	Working	Change	
	Percentage				Percentage				
	Standardized Residuals				Standardized Residuals				
Dysregulated	0	0	0	0	Dysregulated	1	6	2	0
	0.0%	0.0%	0.0%	0.0%		11.1%	66.7%	22.2%	0.0%
	(-0.7)	(-1.7)	(-1.0)	(0)		(0.7)	(1.7)	(1.0)	(0)
Restricted	1	30	14	2	Restricted	4	130	19	2
	2.1%	63.8%	29.8%	4.3%		2.6%	83.9%	12.3%	1.3%
	(-0.9)	(-5.6)	(-0.6)	(0)		(0.9)	(5.6)	(0.6)	(0)
Working	0	10	95	24	Working	2	18	34	6
	0.0%	7.8%	73.6%	18.6%		3.3%	30.0%	56.7%	10.0%
	(-1.0)	(-1.1)	(3.8)	(2.3)		(1.0)	(1.1)	(-3.8)	(-2.3)
Change	0	1	18	49	Change	0	0	6	3
	0.0%	1.5%	26.5%	72.1%		0.0%	0.0%	66.7%	33.3%
	(0)	(-0.1)	(1.7)	(4.5)		(0)	(-0.7)	(-1.7)	(-4.5)

Note. The standardized residuals are the difference between the observed frequencies and the expected frequencies. The expected frequencies are computed assuming that there is no difference between the least improved group and the most improved group in terms of CMEs. A positive residual implies that there were more observed frequencies and vice-versa. Generally, the cut-off for the residuals indicates an important difference and the expected frequencies is 2 or -2.

Late Phase. In order to test differences between late phase transition matrices, I fitted a model that included the following variables: current CME, subsequent CME, Outcome and all two-way interactions between those variables. I compared the deviance of this model with the deviance of the model excluding the outcome variable (difference of deviance=107.5, $df=7$, $p < .001$, effect size: 1.83) and found that the transition matrices are different by outcome. To further analyse those differences, I computed the standardized Pearson residuals. As seen in Table 4.9, the results show that the probability of transitioning from Restricted to Working Mode for the most improved group (34.2%) is significantly higher (residual=2.2) than for the least improved group (10.3%). Also, the probability of transitioning from Change Mode to Working Mode for the most improved group (15.4%) is significantly lower (residual=-2.3) than for the least improved group (57.1%). Finally, the probability that the most improved group remains in Change Mode (83.3%) is significantly higher (residual=2.4) than that of the least improved group (28.6%). Thus, in the late phase of therapy, good outcome clients are less likely to stay in the Restricted Mode. Moreover, the most improved group tended to transition upwards towards more productive CMEs, and when arriving in Change Mode, tended to stay there for longer periods of time than the least improved group.

Table 4. 9. Cross Tabulation of Transition Between Client Modes of Engagement & Outcome: Late Phase

	Most Improved				Least Improved				
	Dysregulated	Restricted	Working	Change	Dysregulated	Restricted	Working	Change	
	Percentage				Percentage				
	Standardized Residuals				Standardized Residuals				
Dysregulated	0	0	1	0	Dysregulated	29	18	1	0
	0.0%	0.0%	100.0%	0.0%		60.4%	37.5%	2.1%	0.0%
	(-2.7)	(-2.1)	(3.4)	(0)		(2.7)	(2.1)	(-3.4)	(0)
Restricted	0	24	13	1	Restricted	17	87	12	1
	0.0%	63.2%	34.2%	2.6%		14.5%	74.4%	10.3%	0.9%
	(-2.4)	(-0.6)	(2.2)	(0.6)		(2.4)	(0.6)	(-2.2)	(-0.6)
Working	0	9	75	19	Working	2	12	27	4
	0.0%	8.7%	72.8%	18.4%		4.4%	26.7%	60.0%	8.9%
	(-1.3)	(-1.8)	(0.7)	(1.1)		(1.3)	(1.8)	(-0.7)	(-1.1)
Change	0	1	12	65	Change	0	1	4	2
	0.0%	1.3%	15.4%	83.3%		0.0%	14.3%	57.1%	28.6%
	(0)	(-1.5)	(-2.3)	(2.4)		(0)	(1.5)	(2.3)	(-2.4)

Note. The standardized residuals are the difference between the observed frequencies and the expected frequencies. The expected frequencies are computed assuming that there is no difference between the least improved group and the most improved group in terms of CMEs. A positive residual implies that there were more observed frequencies and vice-versa. Generally, the cut-off for the residuals indicates an important difference and the expected frequencies is 2 or -2.

4.7 Chapter Summary

Through exploratory statistical analysis, the application of the Client Mode of Engagement Observational Coding System (CME-OCS) sought to investigate whether there was a relationship between the probability of the occurrence of CMEs and therapeutic outcome. Moreover, the study examined how CMEs evolved during sessions and across therapy and how this related to therapeutic improvement. Finally, the study analysed whether there were differences between the most improved and the least improved groups in their ability to transition amongst CMEs. The results of the study indicated that the CME-OCS offers a reliable instrument for identifying CMEs during psychotherapy. The findings also showed that there are differences between both outcome groups in the ways and frequency with which CMEs express themselves during therapy. Also, I found that there are significant interactions between CME, phases of therapy, and outcome groups. Finally, the findings indicate that there are differences in transitions amongst CMEs between phases of therapy and amongst outcome groups. The results of this study are further explored in the discussion section of this dissertation (Chapter 7).

Chapter 5

Developing and Revising the Client Modes of Engagement Questionnaire

5.1 Introduction

This chapter documents the development of a participant observational measurement designed to assess therapists' views of how clients process their experience during therapy. This process involved three stages. When I began, I had at my disposal a 14-item Client Modes of Engagement (CME) rating scale — a subsection of the EFT Therapist Session Form (v4.4, Elliott, 2013b). While this questionnaire had face validity, its psychometric properties had yet to be explored. For this reason, Stage I of this study involved exploring the scale for reliability, factor structure, constructs validity and examining possible correlations between this measurement and two other instruments. The results of Stage I, motivated the construction of a revised version of this rating scale. During Stage II of this study I generated new items for a CME scale to create a more robust measure of Elliott's CME model (2006; 2013a). These items were first subjected to analysis by expert raters and using this feedback, were reworded and refined. Stage III involved examining the resulting 32-item instrument for reliability, factor structure and possible correlations with the Therapist Overall Session Ratings Form (subsection II) from the EFT Therapist Session Form (v4.4, Elliott, 2013b). Additionally, I explored possible factors (i.e., gender, professional experience) that might influence the CME model. In sum, this chapter provides an in-depth account of how the 14-item CME rating scale (v4.4, Elliott, 2013b) became a revised 28-item questionnaire.

The main objectives of this study were:

1. To investigate the psychometric properties (reliability, construct validity and factor structure) of the 14-item CME questionnaire.
2. To use feedback in order to develop a revised version of the CME questionnaire that better reflected the proposed CME theoretical framework.
3. To investigate the psychometric properties (reliability, construct validity and factor structure) of the 32-item CME scale.
4. To explore factors that may influence Client Modes of Engagement ratings.
5. To study whether the Client Modes of Engagement ratings (both the 14-item and 32-item CME) are related to the session outcome ratings.
6. To use these results to develop an easy-to-use and practical 28-item CME questionnaire.

5.2 Stage I

The following section describes how I analysed the 14-item CME questionnaire and how I came to the conclusion that the instrument could be used to reflect the CME theoretical model but needed to be refined in order to attain better reliability and factor structure. Both the University of Strathclyde and the local National Health Service (NHS) approved the ethics statement for the use of archival data from the Experiential Psychotherapy for Social Anxiety Comparative Study.

5.2.1 Procedure

When I began this project, I had at my disposal a considerable amount of archival data from the Experiential Psychotherapy for Social Anxiety Comparative

Study (Elliott et al., 2017). This data consisted of 790 EFT Therapist Session Forms (EFT-TSF) that had been filled out during the duration of the protocol. The EFT-TSF contained a subsection with a 14-item CME rating scale and a Therapist Overall Session Ratings form (v4.4, Elliott, 2013b). I also had at my disposal the Client Post-Session Questionnaire (CPSQ Version 2.0; Elliott, 2008). This questionnaire that was directed towards clients mirrored the EFT-TSF's Overall Session Ratings directed towards therapists—both therapists and clients had answered the corresponding forms for the same session. It should be noted that all statistical analyses performed at Stage I for the 14-Item CME scale and the subsequent examination of possible correlations with the Therapist and Client Overall Post Session Evaluation should be understood as exploratory and very tentative. The data used for this preliminary phase involves extensive nonindependence of observations because of the multilevel nature of the data.

5.2.2 Participants

The Experiential Psychotherapy for Social Anxiety Study participants consisted of 10 therapists. Five were female (50%) and five were male (50%). The participants had all completed the EFT Therapist Session Forms for a total of 34 different clients. Of the 34 clients 10 were males (29%) and 24 were female (71%). Each client had attended approximately 20 sessions with a few exceptions (e.g., two clients had attended over 40 sessions). The therapists had been asked to fill out a post-session form after each session — a total of 790 Forms. Clients came from a Scottish community sample. However, ethnicity and socioeconomic status had not been recorded. For recruitment procedure and more detailed information please refer to Chapter Four.

5.2.3 Measures

Therapist Overall Session Ratings Form from the EFT Therapist Session Form (v4.4, Elliott, 2013b). The Therapist Overall Session Ratings form (subsection II of the EFT-TSF) is a scale designed to evaluate the overall helpfulness, quality, progress and shifts made by the client during a session from the therapist's perspective. The instrument includes four questions: The first question, "Please rate how helpful or hindering to your client you think this session was overall", is named *T.Helpful* throughout the chapter. This item provides a nine-point Likert scale that goes from "extremely hindering" to "extremely helpful". The second question, "How do you feel about the session you had with your client?" is referred to as *T.Quality* throughout this chapter. This item includes a seven-point Likert scale that goes from "perfect" to "very poor". The third question, "How much progress do you feel your client made in dealing with his/her problems in this session?" is called *T.Progress* throughout this chapter. The item provides a seven-point Likert scale that goes from "a great deal of progress" to "in some ways his/her problems have gotten worse this session". Finally, the fourth question, "In this session something shifted for my client. S/he saw something differently or experienced something freshly", is named *T.Shift* throughout this chapter. The question provides a seven-point Likert scale that goes from "not at all" to "very much".

The 14-item CME Rating Scale (subsection III) from the EFT Therapist Session Form (v4.4, Elliott, 2013b). The Client Modes of Engagement questionnaire is a subsection of the EFT Therapists Session Form constructed to assess Client Modes of Engagement during a psychotherapeutic session from the therapist's perspective. The scale serves as a self-monitoring and supervising instrument to

facilitate training for person-centred/ experiential psychotherapies. The items included in the questionnaire were developed after extensive clinical observation and grounded on the CME theoretical framework. This resulted in a 14-item scale designed to assess modes of emotional engagement. The questionnaire has been used in various counselling settings (i.e., University of Toledo and University of Strathclyde). The scale asks participants to rate the perceived extent to which the client was involved in different modes of engagement. Respondents are asked to rate their answers using a five-point scale (1: “absent”, 2: “occasional”, 3: “common”, 4: “frequent”, 5: “extensive”) indicating the perceived extent in which the client engaged in different CMEs during the therapeutic hour. For more information please refer to Table 5.1 and Appendix B.

Table 5. 2. Fourteen-Item Client Modes of Engagement Questionnaire

Items	
1	External: Attending to other people, external events; may be specific or general.
2	Purely conceptual: Formulating things in linguistic or abstract terms without reference to concrete experiencing.
3	Somatic: Attending to chronic pain or illness signs.
4	Flooded: Overwhelmed by unsymbolized emotion
5	Action-focused: Focused purely on wishes or action; driven or impulsive, without reflection
6	Containing/distancing: Avoiding or holding painful or frightening feelings or experiences at bay.
7	Internal attending: Turning attention inward to clear feelings, thoughts, images or bodily sensations.
8	Experiential search: Examining unclear internal experiences with curiosity; staying with vague or ambiguous experiencing.
9	Active expression: Displaying or enacting strong, vivid, specific reactions.
10	Interpersonal contact: Trusting, opening up to therapist.
11	Re-perceiving: Re-construing experiences in light of new emotional awareness; noticing new things or seeing experiences in a different way.
12	Appreciating: Allowing self to enjoy easing of previous problem-related tension carried in body; receiving a felt shift or experiencing relief.

- 13 Self-reflection: Standing back from experience in order to develop meaning perspective.
- 14 Action-planning: Moving toward action on basis of emotional processing; experientially-based problem-solving, movement toward productive action.

Note. Client Modes of Engagement (subsection III from the EFT Therapist Session Form; v4.4, Elliott, 2013b).

The Client Post-Session Questionnaire (CPSQ Version 2.0; Elliott, 2008). The Client Post-Session Questionnaire is a scale designed to evaluate the overall helpfulness, quality, progress and shifts made during a session from the client’s perspective. The instrument includes four questions: The first question, “Please rate how helpful or hindering to you this session was overall”, is named *C.Helpful* throughout the chapter. This item provides a nine-point Likert scale that goes from “extremely hindering” to “extremely helpful”. The second question, “How do you feel about the session you have just completed?” is referred to as *C.Quality* throughout this chapter. This item includes a seven-point Likert scale that goes from “perfect” to “very poor”. The third question, “How much progress do you feel you made in dealing with your problems in this session?” is called *C.Progress* throughout this chapter. The item provides a seven-point Likert scale that goes from “a great deal of progress” to “in some ways my problems have gotten worse this session”. Finally, the fourth question, “In this session something shifted for me. I saw something differently or experienced something freshly”, is named *C.Shift* throughout this chapter. The question provides a seven-point Likert scale that goes from “not at all” to “very much”.

5.3 Results

Preliminary Analysis. The internal consistency of the 14-Item CME Rating Scale was assessed applying Cronbach’s alpha (0.80). According to Streiner (2003)

$\alpha = 0.80$ is an acceptable value for research purpose instruments.

Principal Axis Factoring⁶. Principal Axis Factoring was conducted in order to explore how the items reflected the factors of the CME. The Bartlett's test ($p < .001$) and the Kaiser-Meyer-Olkin (KMO) measure (KMO = .84) showed a suitable correlation matrix and sampling adequacy. Initially, I used a criterion of eigenvalue ≥ 1 in order to decide how many factors to extract. This resulted in a four-factor solution and accounted for 51.16% of the overall variance (see Table 5.2). As can be seen in Table 5.2, even after varimax rotation, this solution was not fully interpretable and some factors needed to be discarded. Various items showed cross-loaded items ($> .4$) within two factors. Hence, it was not possible to discriminate clearly between those factors with regards to construct validity. For example, *Item 12* ("Appreciating"), *Item 13* ("Self-reflection") and *Item 14* ("Action-planning") all show high loadings in Factor 1 and in Factor 2. Also, some items can be considered trivial as they don't have loadings $> .4$ (*Item 5* ["Action-Focused"] and *Item 1* ["External"]). Next, the reliability of each factor was assessed using Cronbach's alpha coefficient. The results show that Factor 3 ($\alpha = 0.48$) and Factor 4 ($\alpha = 0.41$) cannot be considered to be reliable. Finally, as recommended by Gorsuch (1997) Factor 3 and Factor 4 should not be considered as they have less than three salient items (loadings > 0.40).

I then considered other possible factor extractions (i.e. see Table 5.3 for the three-factor extraction). All of the results considered presented low reliability and poor factor discrimination. Also, I observed that some items did not fall into their

⁶ This is a repeated measure study because the same questionnaire was filled out by the same client and therapist but for different sessions. Hence, the usual analyses are not entirely appropriate for this data.

corresponding theoretical construct (i.e. Factor 3 [see Table 5.3] and Factor 4 [see Table 5.2]). Thus, not only was the instrument's construct validity weak, but also some factors were not interpretable. However, while the psychometric properties of these items were not adequate, upon further inspection I found that the different solutions tested did fall broadly into factors that reflected the CME theoretical model I was aiming to properly measure. Given these results I concluded that the instrument could serve as a useful foundation for the construction of a more refined CME questionnaire.

Table 5. 3. Results of Varimax-Rotated Principal Axis Analysis on the 14-Item CME Questionnaire (Four-Factor Extraction)

Item	Factor			
	1	2	3	4
8. Experiential search	0.86	0.04	0.00	0.16
7. Internal attending	0.80	0.04	-0.02	0.16
13. Self-reflection	0.72	0.41	0.13	-0.12
12. Appreciating	0.71	0.44	-0.03	-0.08
11. Re-perceiving	0.63	0.52	-0.08	0.03
14. Action-planning	0.62	0.48	0.16	-0.04
9. Active expression	0.13	0.62	-0.25	0.36
10. Interpersonal contact	0.34	0.60	0.03	0.17
2. Purely conceptual	0.05	0.09	0.71	-0.08
6. Containing/distancing	-0.21	-0.12	0.40	0.32
5. Action-focused	<i>0.18</i>	<i>0.25</i>	<i>0.36</i>	<i>0.21</i>
1. External	<i>0.01</i>	<i>-0.16</i>	<i>0.34</i>	<i>0.08</i>
4. Flooded	-0.02	0.11	0.06	0.60
3. Somatic	<i>0.30</i>	<i>0.13</i>	<i>0.11</i>	<i>0.39</i>
Variance explained (%)	24.85	12.43	7.44	6.45
Eigenvalue	4.92	1.74	1.42	1.04
Reliability ^a	0.90	0.87	0.48	0.41

Note. Boldface indicates items with loadings > .40 (salient factors) as well as ambiguous items; ^aCronbach's alpha calculated using items with a loading > .30; Trivial items are Italicized.

Table 5. 4. Results of Varimax-Rotated Principal Axis Analysis on the 14-Item CME Questionnaire (Three-Factor Extraction)

Item	Factor		
	1	2	3
13. Self-reflection	0.84	0.05	0.06
12. Appreciating	0.83	0.10	-0.10
11. Re-perceiving	0.77	0.24	-0.16
14. Action-planning	0.76	0.17	0.07
8. Experiential search	0.75	0.07	0.06
7. Internal attending	0.70	0.07	0.04
10. Interpersonal contact	0.51	0.44	-0.06
9. Active expression	0.27	0.69	-0.35
4. Flooded	-0.03	0.49	0.15
3. Somatic	<i>0.28</i>	<i>0.34</i>	<i>0.17</i>
2. Purely conceptual	0.12	0.01	0.54
6. Containing/distancing	-0.25	0.22	0.47
1. External	<i>-0.03</i>	<i>-0.04</i>	<i>0.39</i>
5. Action-focused	<i>0.25</i>	<i>0.3</i>	<i>0.34</i>
Variance explained (%)	29.86	8.97	7.16
Eigenvalue	4.92	1.74	1.42
Reliability ^a	0.90	0.60	0.30

Note. Boldface indicates items with loadings > .40 (salient factors) as well as ambiguous items; ^aCronbach's alpha calculated using items with a loading > .30; Trivial items are Italicized.

Although the 14-item CME Ratings Scale did not display proper psychometric properties, I still believed that it would be valuable to explore possible correlations between the Ratings Scale, the Therapist Overall Session Ratings form and the Client Post-Session Questionnaire as a preliminary approach to building a more refined instrument.

Therapist and Client Overall Session Ratings. In order to explore correlations between my available measures, I first sought to determine whether the Therapist and Client Overall Session Ratings had suitable psychometric properties.

For this purpose, I ran Principal Axis Factoring on the Therapist Overall Session Ratings form. The KMO measure showed sampling adequacy ($KMO = 0.83$) and the Bartlett's test, $p < .001$ yield a suitable correlation matrix. The Therapist Overall Session Ratings had a first-factor eigenvalue of 3.2 and accounted for 78.8% of the overall variance, with no other interpretable factors present.

Likewise, the Client Post-Session Questionnaire revealed sampling adequacy when I ran a KMO ($KMO = 0.83$) and yield suitable correlation matrix when I ran a Bartlett's test, $p < .001$. All the items for both measures loaded over .40 and fell under one main factor. The Client Post-Session Questionnaire had an eigenvalue of 3.2 and accounted for 79.9% of the overall variance. Results can be seen in Table 5.4.

Table 5. 5. Results of Varimax-Rotated Principal Axis Analysis on the 4-Items Overall Session Ratings For Clients (Left) for Therapist (Right)

Results of varimax-rotated principal axis analysis on the Client Post-Session Questionnaire		Results of varimax-rotated principal axis analysis on the Therapists Overall Session Ratings	
Item	Factor	Item	Factor
1. Please rate how helpful or hindering to you this session was overall.	0.86	Please rate how helpful or hindering to your client you think this session was overall.	0.77
2. How do you feel about the session you have just completed?	0.79	How do you feel about the session you have just completed with your client?	0.77
3. How much progress do you feel you made in dealing with your problems in this session?	0.91	How much progress do you feel your client made in dealing with his/her problems in this session?	0.91
4. In this session something shifted for me. I saw something differently or experienced something freshly:	0.83	In this session something shifted for my client. S/he saw something differently or experienced something freshly:	0.87
Variance explained (%)	79.9	Variance explained (%)	78.8
Eigenvalue	3.2	Eigenvalue	3.2
Reliability ^a	0.94	Reliability ^a	0.92

Note: ^a Cronbach's alpha.

Descriptive Statistics for each Item of the CME Model and their

Correlations with the Therapist and Client Overall Session Ratings. In order to explore whether the CME Rating Scale is related to therapists' and clients' session outcome evaluations, I calculated the Pearson and Spearman correlations⁷ between the 14 items of the CME Ratings Scale, the 4 items of the Therapist Overall Session Ratings form and the 4 items of the Client Post-session Questionnaire (see Table 5.5). I found that the Pearson and Spearman correlations were practically the same (for this reason I only report Pearson correlations). These correlations (see Table 5.5) can be understood as effect sizes (Cohen, 1992). The results described below correspond to the most noteworthy correlations in Table 5.5.

I first calculated the means and standard deviations (SDs) for each of the 14 items of the CME instrument (see columns 1 and 2 of Table 5.5) to describe the CME Ratings Scale. The mean scores for *Item 1* ("External"), *Item 6* ("Containing/distancing"), *Item 7* ("Internal attending"), *Item 8* ("Experiential search"), *Item 9* ("Active Expression") and *Item 10* ("Interpersonal Contact") of the CME Ratings scale were around 3 with an SD of around 1. This suggests that therapists tended to rate these processes as occurring "commonly" within any given session. Additionally, the mean scores of the respondents for *Item 2* ("Purely conceptual"), *Item 3* ("Somatic"), *Item 4* ("Flooded"), *Item 5* ("Action Focused"), *Item 11* ("Re-Perceiving"), *Item 12* ("Appreciating"), *Item 13* ("Self-Reflection") and *Item 14* ("Action-Planning") of the CME Rating Scale were around 2 with an SD

⁷ The Pearson correlations are the usual manner to compute correlations for continuous data and to assess the degree of linear relationships between two variables. The items of these questionnaires are discrete. Hence, the use of a Pearson correlation could be seen as not entirely appropriate. The Spearman correlations could be used for discrete data. Hence, these correlations could be seen as more appropriate for this kind of data.

of around 1. This suggests that therapists rated these processes as occurring “occasionally” within any given session.

Table 5.5 shows the correlations between each of the four items of the Client Post-Session Questionnaire (*C.Helpful*, *C.Quality*, *C.Progress* and *C.Shift*) and the 14-Item CME Ratings Scale (column 3 to 6 respectively). *Item 11* (“Re-perceiving”) and *Item 12* (“Appreciating”) of the CME Ratings Scale both yield a moderate correlation (Cohen, 1992) with *Item 2* (“*C.Quality*”) and *Item 3* (“*C.Progress*”) of the Client Post-Session Questionnaire (see Table 5.5). Thus, there is a moderate positive correlation between the client’s perception of the quality and progress they are making in a session and *Item 11* and *12* of the CME Ratings Scale. *Item 13* (“Self Reflection”) of the CME Ratings Scale shows a moderate correlation with the client’s perception of the session’s quality (*Item 2*, “*C.Quality*”). Likewise, *Item 8* (“Experiential Search”) of the CME Ratings Scale have a moderate correlation with the client’s perception of quality, progress and shifts made during a given session. The fifth column of Table 5.5 provides an index of the four items of the Client Post-Session Questionnaire (*C.Index*). I calculated the *C.Index* by rescaling each item to a common metric and averaging the scores of the 4 items. The correlation between the *C.Index* and the first factor extracted was close to 1; thus, the *C.Index* corresponds to the main theoretical construct (helpfulness, quality, progress, shift) of this rating scale. *Item 8* (“Experiential Search”), *Item 11* (“Re-Perceiving”), *Item 12* (“Appreciating”) and *Item 13* (“Self-reflection”) of the CME Ratings Scale show a moderate positive correlation with the *C.Index*. This not only suggests that the above-mentioned processes correlate with how clients evaluate a given session, but

also that clients consider these processes beneficial when evaluating a therapy session.

Likewise, Table 5.5 shows the correlations between each of the four items of the Therapist Overall Session Ratings form (*T.Helpful*, *T.Quality*, *T.Progress* and *T.Shift*) and the 14-Item CME Ratings Scale (column 8 to 11 respectively). *Item 7* (“Internal Attending”), *Item 8* (“Experiential Search”), *Item 11* (“Re-perceiving”) and *Item 13* (“Self Reflection) of the CME Ratings Scale show a positive moderate correlation with the therapist’s perception of the client’s progress (“*T.Progress*”) and shifts (“T. Shifts”) during a given session. *Item 12* (“Appreciating”) of the CME Ratings Scale shows a positive moderate correlation with the therapist’s perception of the quality (“*T.Quality*”), progress (“*T.Progress*”) and shifts (“*T.Shift*”) made by clients during therapy.

The last column (*T.Index*) of Table 5.5 provides an index of all items of the Therapist Overall Session Ratings form. The process to compute this index was the same as the *C.Index*. The *T.Index* shows a moderate correlation between *Item 7* (“Internal Attending”), *Item 8* (“Experiential Search”), *Item 11* (“Re-perceiving”), *Item 12* (“Appreciating”) and *Item 13* (“Self-reflection”) of the CME Ratings Scale and the *T.Index*. This suggests that the above-mentioned processes correlate positively with how therapists perceive clients’ improvement in a given session. This also implies that therapists consider the presence of these processes to be beneficial when evaluating a therapy session. For a more detailed account of all correlations, please refer to Table 5.5.

Table 5. 6. Descriptive Statistics and Correlations Between CME-Items and Client, Therapist Overall Session Ratings

Item	N° Columns											
	1	2	3	4	5	6	7	8	9	10	11	12
	Means	SD	r C.Helpful	r C. Quality	r C. Progress	r C. Shift	r C. Index	r T.Helpful	r T.Quality	r T.Progre ss	r T. Shift	r T. Index
1. External	2.79	0.9 1	-0.06	-0.13**	-0.10*	-0.07	-0.13**	-0.03	0.01	-0.05	-0.01	-0.01
2. Purely conceptual	2.26	0.9 2	-0.12**	-0.1*	-0.14**	-0.16	-0.16**	-0.23***	-0.15**	-0.24***	-0.19***	-0.21***
3. Somatic	1.58	0.8 5	-0.05	0.01	0.04	0.02	0.05	-0.03	0.09*	0.06	0.09*	0.12
4. Flooded	1.75	0.8 7	-0.09	-0.03	-0.09*	0.00	0.00	-0.04	-0.06	-0.09*	-0.05	-0.03
5. Action-focused	1.61	0.7 9	-0.05	-0.05	-0.09	-0.08	-0.04	-0.19***	-0.18***	-0.16***	-0.10*	-0.20***
6. Containing/ Distancing	2.64	0.9 3	-0.12*	-0.17***	-0.22***	-0.13	0.21***	-0.19***	-0.15***	-0.26***	-0.22***	-0.23***
7. Internal attending	2.80	0.9 5	0.23***	0.28***	0.29***	0.27**	0.29***	0.19***	0.24***	0.34***	0.42***	0.37***
8. Experiential search	2.55	1.0 3	0.21***	0.32***	0.34***	0.31***	0.34***	0.27***	0.28***	0.38***	0.47***	0.44***

9. Active expression	2.72	0.99	0.07	0.10*	0.16**	0.09***	0.14**	0.15***	0.14**	0.21***	0.18***	0.18***
10. Interpersonal contact	3.33	0.85	-0.02	0.07	0.06	0.03	0.04	0.14**	0.15***	0.17***	0.20***	0.16***
11. Re-perceiving	2.34	0.97	0.25***	0.34***	0.37***	0.29***	0.38***	0.29***	0.27***	0.41***	0.47***	0.44***
12. Appreciating	2.34	1.04	0.21***	0.32***	0.33***	0.22***	0.36***	0.26***	0.32***	0.4***	0.43***	0.47***
13. Self-reflection	2.34	0.99	0.18***	0.30***	0.29***	0.21***	0.30***	0.19***	0.26***	0.32***	0.39***	0.37***
14. Action-planning	1.88	1.11	0.12***	0.24***	0.20***	0.10*	0.24***	0.11**	0.17***	0.25***	0.27***	0.27***

Note. N for clients' correlations = 465 – 474; N for therapist' correlations = 527 – 543. P-Value is shown between parentheses signs. All correlations > .1 are statistically significant at $p < .05$. Boldface indicates Pearson Correlations > 0.30⁸. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

⁸ Due to the large sample size most of the correlations are statistically significant at $p < .05$. However, to interpret these correlations it is appropriate to use the effect sizes corresponding to them. Cohen (1992) suggests using the absolute value correlation as its effect size. This is reasonable as the correlation shows the strength of the relationship. The standard interpretation for the effect size is the correlations between 0.1 and 0.3 correspond to a small effect size, small strength relationship. Correlations between 0.3 and 0.5 correspond to a medium effect size, medium strength of relationship and finally, correlations larger than 0.5 correspond to a large effect size, large strength of relationship. In this table medium and large correlations are shown using boldface.

5.4 Stage II

As observed in the previous section, while the psychometric properties of the 14-item scale showed that it needed to be revised, the instrument did provide a broad and functional framework with which to work. The scale, for example, revealed some promising correlations between therapists and clients' overall session evaluation and the CME Ratings Scale. This section describes how I used the original 14-item CME Ratings Scale as a conceptual framework for the construction of a revised 32-item CME Questionnaire. During this stage, I used expert feedback in order to develop a CME instrument that better reflected my proposed theoretical framework.

5.4.1 Item Selection

I used the four domains (Dysregulated, Restricted, Working and Change) of the Client Modes of Engagement Model as my guiding framework as I formulated items for the revised CME instrument. As a reference, I employed the outline of the four domains of the Modes of Engagement Framework that is used for EFT training; this outline provides qualitative descriptions for the distinct modes of engagement subcategories. Likewise, the 14-items of the original CME questionnaire served as the backbone for this process. Indeed, I first formulated a list of seventy-two possible items based on the definitions offered by the CME questionnaire for each of the 14 items (see Appendix C). Since user-friendliness was of prime importance, I was careful to employ clear and straightforward language. The objective was to ensure face validity, relevance, and readability. I included various items referencing each subcategory of the above-mentioned domains in order to allow experts to be able to choose the item they deemed most suitable amongst various possible options.

5.4.2 Item Refinement

Once the items had been generated, the principal researcher and an expert in the field (my supervisor, Robert Elliott) independently reviewed the list. The objective was to eliminate items that were deemed to be redundant, unclear, difficult to rate, or were found to be wordy or contained unnecessary jargon. After crosschecking the items, I ended up with sixty-two items that we considered successfully reflected the core modes of engagement domains (see Appendix C). Thus, we agreed that this list was ready to be examined by external experts for further refinement.

5.4.3 Scale Refinement/Construct Validity

In order to build construct validity for the above-mentioned sixty-two-item list, I developed a survey using SurveyMonkey (2015). The objective of this survey was to gather feedback from experts regarding the accuracy and clarity with which the proposed items expressed the Client Modes of Engagement categories. Links to this survey were sent to eight experts in humanistic/experiential psychotherapy — four women and four men. All experts held a post-graduate degree in counselling, had been practicing for at least ten years, were familiar with the EFT conceptual framework, and had been under the supervision of Robert Elliott for at least five years. Responses were securely collected by the SurveyMonkey software and then downloaded automatically to an Excel spread sheet for statistical analysis.

The survey asked that potential respondents to give their informed consent by clicking on an “I agree” option in order to begin the questionnaire. If respondents agreed to continue, the online questionnaire provided a brief definition of each mode of engagement. The experts were then asked to perform several tasks rating each of

the sixty-one items. The first task asked respondents to rate the items on a scale: 1 (“very accurate description of this state”), 2 (“somewhat accurate description of this state”), 3 (“slightly accurate description of this state”), 4 (“poor description of this state”), and 5 (“does not describe this state”). The second task was optional and gave the respondents the opportunity to provide comments or suggestions for each of the sixty-one items. The third task first provided a brief definition of each CME category and then asked respondents to rank how suitable they found the items in terms of their category: the scale went from 1 (“the best descriptor”) to 3 (“the worst descriptor”). In order to answer, respondents were asked to take into account whether the item being rated was: (a) “relevant to the definition”, (b) “written in a simple and straightforward way”, and (c) did not contain “jargon”. Finally, respondents were given the opportunity, if they deemed it necessary, to suggest better ways of describing the modes of engagement categories. The process of using the resulting feedback in order to decide whether to eliminate, reword or refine the items is explained in detail below.

5.4.4 Editing the Items

The feedback gathered provided valuable suggestions about how to best edit my list of items with the aim of coming up with a shorter, straightforward and concise set of items that fully reflected every aspect of the Client Modes of Engagement theoretical framework. The use of simple wording and grammar was of primary importance because the intention was that eventually native and non-native English speakers alike would use the questionnaire (see Chapter 6).

Table 5.6 offers the list of items rated by the experts. Row A is organised in terms of their corresponding CME category. Row B provides a summary of the

feedback offered by experts for each item. The list of the resulting 32 items can be found in Row C.

5.4.5 Using Feedback

This section provides a more comprehensive account of how I used the expert feedback to refine the CME questionnaire. The following is an account of how and why items were chosen, added, edited or eliminated. I do not discuss simple rewording and slight editing; rather, I provide an account of the kinds of suggestions and feedback I received and how these helped me shape the questionnaire. Consensus of opinion was a fundamental means of deciding how and what should be rewritten or edited out.

Table 5. 7. Rewording, Deletions, and Additions of the CME Questionnaire

Guiding Categories Definitions		
Row A	Row B	Row C
Old Items	Feedback	New Items
Overwhelmed/flooded client state: "Overwhelmed by symbolised emotion; disorganised & chaotic, with various other elements present in a disorganised fashion"		
1	My client was overwhelmed by emotions whose source could not be identified.	“Clarify the meaning of the concept”
2	My client expressed emotional experiences in a chaotic and disorganised manner.	“Disorganised hard term to rate”; “don't hold a standard of what is organised”; “chaotic: great word”
3	My client was so overwhelmed by emotional experience that could not elaborate upon them.	Add word: “articulate”
4	New Item	Include additional Item
Distance/dissociate client state: "Avoiding or holding painful or frightening feelings or experiences at bay"		
5	My client continuously deviated towards less emotional alternative narratives.	Omit “deviated”; Omit “continuously”
6	My client abruptly distanced themselves from their emotions.	“Abrupt does not fit for me”; “remove abruptly”; “abruptly too strong word”
7	My client seemed to be putting an emotional barrier between self and the experience.	The word “putting” might be too “conscious”; “I don't believe clients are always aware of intentionally raising barriers”

8	My client was in a numb or emotionally blocked state.	“O.K.”; “Good descriptor”	My client was in a numb or emotionally blocked state.
9	My client experienced being in a fuzzy, partially dissociated, or disoriented state in the session.	“Fuzzy is too fuzzy”	My client experienced being in a confused, disoriented, or dissociated state in the session.
10	My client avoided or held off painful or frightening experiences.	Use phrase “emotionally charged”	My client avoided or held off painful or frightening emotionally charged experiences.
Externalized client state: "Attending exclusively to other people, external events; may be specific or general"			
11	My client was preoccupied with external events without referencing emotional reactions to those events.	“Very accurate description”	My client was preoccupied with external events without referencing emotional reactions to those events.
12	My client was expressing repetitive or clichéd descriptions of external events.	Omit “repetitive or clichéd”; “not accurate descriptor”	<i>Deleted</i>
13	My client was evaluating situations without intensifying or deepening how they relate emotionally to the situation.	“Abstract”; “Item 14 more accurate descriptor”	<i>Deleted</i>
14	My client evaluated others’ behaviour/feelings with minimal reference and attention to their emotional experience.	“Redundant with previous”; “more accurate description”	My client evaluated others’ behaviour/feelings with minimal reference and attention to their own emotional experience.
15	My client was telling stories about external events in a long-winded or boring manner.	“Not respectful of client”; “Too judgemental”; Omit: “in a long winded and boring manner”	<i>Deleted</i>
16	Emotions were expressed with a whining or complaining quality with a consistent focus on others.	“Don't like the word 'whining'”; Omit: “whining”	My client focused on complaints about others with minimal reference to self-experience.
17	My client expressed experiences as if they were a passive observer.	“Less to the point”; “ambiguous”	<i>Deleted</i>

Abstract/purely conceptual client state: "Formulating things in linguistic or abstract terms without reference to concrete experiencing"

18	My client expressed ideas, beliefs in abstract and logical terms without specific reference to concrete experiences.	"Clear description of basic category"	My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences.
19	My client expressed their motivations in abstract terms.	"Contains most jargon"; "unclear, seems very abstract"	<i>Deleted</i>
20	My client described him or herself in general or abstract terms.	"Jargon"	<i>Deleted</i>
21	My client spun complicated theories in their head about self or others.	"Don't like use of word spun"; "too figurative"	<i>Deleted</i>
22	My client's descriptions of emotions seem to be pre-planned responses, expressed as if rehearsed.	Add "in rehearsed, clichéd or empty terms"	My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty.
23	My client emotions were "talked about" in an abstract manner rather than "felt".	"Accurate descriptor, need a bit of clarity"	My client talked about emotions in a general, global or theoretical manner.

Somatizing client state: "Attending exclusively to pain or illness signs or symptoms, or dwells on body appearance or functions to the exclusion of other aspects of experience."

24	My client dwells on physical symptoms or signs of illness or physical pain without reference to emotional experience.	"Divide Item in two items"	My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning.
25	New Item		My client was preoccupied with bodily signs of illness or injury.
26	My client appeared physically uncomfortable during the session.	"Not sure about this one"; "not accurate"	<i>Deleted</i>

27	My client was unable to elaborate or symbolize the emotional experience within their body.	“This is hard to rate because its a negative item”	<i>Deleted</i>
28	My client complained about body sensations without reference to emotional experience.	“Reported? I think its better”	My client reported disturbing bodily sensations without exploring them.
29	My client appeared to be quite concerned or self-conscious about their physical appearance or body image without elaborating upon it.	“Make the statement simpler”; delete: “without elaborating upon it”	My client was focused on his/her physical appearance or body image without reference to emotional experiences.
Impulsive client state: "Focused purely on wishes or actions; acting out; driven, without reflection"			
30	My client described their behaviours as driven purely by wishes and desires carried out without reflection.	“Contains a bit of jargon”; omit: “without reflection”	My client described their behaviours as driven purely by wishes and desires.
31	My client rather than exploring strong and distressing emotions acted out in an unreflective, non-experiential manner.	“Contains jargon”	<i>Deleted</i>
32	My client concentrated on superficial or impulsive desires (e.g., escaping from problems), rather than exploring deep emotional wants or needs.	Omit: “superficial”; Delete: “rather, too judgemental”	My client focused on impulsive desires (e.g., escaping from problems) without exploring further deep emotional wants or needs.
33	My client behaved impulsively during session (e.g., got up and left before the end, or acted aggressively).	“Contains jargon”; This is a bit like saying, “my client did something I didn't like”	<i>Deleted</i>
34	My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something	“Important to include”; “very accurate”	My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something.

Externally attending client state: "Mindful receptive focus on perceptual experience/memories; emotionally engaged narrative"

35	My client focused on memories in a fully engaged, receptive and mindful manner.	“Sounds good”; “very accurate”	My client focused on memories in a fully engaged, receptive and mindful manner.
36	My client narrated experiences with others in rich detail and was receptive to the emotional experiences that arose from them	“Jargon”	<i>Deleted</i>
37	My client evaluated events and situations in order to explore and understand the underlying emotional foundation of the experience.	“Seems convoluted”	<i>Deleted</i>

Body-focused client state: "Careful receptive attention to bodily experience and associated felt meaning"

38	My client was self-aware of their own feelings, thoughts, images related to body sensations.	“Jargon”	<i>Deleted</i>
39	My client looked inward and explored the physical bodily reactions related to his/her emotional experience.	Omit: “physical”; “like this one”	My client looked inward and explored the bodily reactions related to his/her emotional experience.
40	My client gave careful attention to bodily experiences and their meaning.	“Doesn’t give enough content”	<i>Deleted</i>
41	My client expressed the emotional experiences arising from their body sensations.	“Redundant”	<i>Deleted</i>
42	My client elaborated their emotional experience by means of relating them to their body sensations.	“Like this one” “seems a bit convoluted”; “accurate”	My client elaborated experiences by associating them with body sensations or reactions.

43	My client patiently attended to their bodily experiences and the meanings of these.	“Don't think use of word patiently adds anything” “jargon”	<i>Deleted</i>
Emotion-focused client state: "Awareness and symbolisation of immediate emotional experience"			
44	My client was fully immersed in the emotional elaboration and exploration of his/her experience.	“I think that is really nice!” “Good item”; “move 'emotional' to precede 'experience'”	My client was fully immersed in the elaboration and exploration of their emotional experience.
45	My client was focused on his/her subjective flow and nuances of their emotional experiences.	“I don't like this item, it seems abstract and too poetic”; “Contains jargon”	<i>Deleted</i>
Reflexive-symbolizing client state: "Active curiosity and reflection on the meaning, value or understanding of experience"			
46	My client was actively curious about the personal meaning, value or sources of experiences.	Maybe add in “was reflective and actively...” “I like this one”	My client was reflective and actively curious about the personal meaning, value or sources of their experiences.
47	My client was able to explore the personal meaning of experiences.	“Bit of jargon”	<i>Deleted</i>
48	My client stood back from their experiences in order to consider their meaning.	“Too general”	<i>Deleted</i>
Active Expression: "Expressing wants/needs; enacting strong emotions in a productive manner"			
49	My client was able to access and clearly express deep underlying wants and needs.	“Ok”; “simplify”	My client put basic, important wants or needs into words.
50	My client was able to actively express strong emotions to and from an imagined other or aspect of self.	“References a task”; “primary emotions”; “drop strong”	My client expressed deep underlying emotions.

Re-perceiving: "Noticing new things in their situation not attended to before or seeing previously-attended-to aspect of their situation in a different light; new understanding, insight or awareness of self or others"			
51	My client attended to new aspects of their situation.	"Not enough detail to capture the essence of the state"; "seems too general"	<i>Deleted</i>
52	My client perceived experiences in a different light or from a different perspective.	"Convolutud"	<i>Deleted</i>
53	Through exploration of experiences my client arrived at new understandings, insights or awareness of their situation.	"I like this one - it is richer than above description"; "try 'about' instead 'of'"	Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation.
Body-shift state: "Allowing oneself to enjoy the easing of previous problem-related tension carried in the body"			
54	My client's body sensations shifted positively after focusing on his/her emotional experiences.	"Don't like 'positively'"	<i>Deleted</i>
55	My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.	"More straightforward than above"	My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.
Receiving emotional change "Allowing oneself to feel and appreciate new, more adaptive emotions"			
56	My client allowed themselves to feel new, more adaptive emotions.	"Good item"	My client allowed themselves to feel new, more adaptive emotions.
57	My client's emotional experiences of self, others or situations became more positive.	"I am not keen on use of positive - could be interpreted as value-judging"	<i>Deleted</i>
Self-reflection/meaning perspective "Standing back from successfully processed experiencing; becoming dis-embedded from previous assumptions so as to appreciate new possibilities, achieving a new explanation of one's situation or feelings"			

58	My client was able to step back or disembed self from previous assumptions in order to achieve a new meaning perspective on experiences.	“Nice but complicated item”; “look for simpler structure”	My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning.
59	My client was able to locate new emerging experiences within the broader frame of their life.	“Seems backwards in emphasis”	<i>Deleted</i>
Action-planning state "Moving toward action on the basis of successfully processed experiencing; problem-solving; oriented toward developing productive solutions"			
60	My client articulated a desire to move toward adaptive actions on the basis of successfully processed experiences.	“Contains a bit of jargon”; “eliminate articulate, better word: “express”	My client expressed a desire to take action based on their newly emerging emotions.
61	The way my client articulated experiences demonstrated new problem-solving abilities.	“Not sure about this; sounds very behavioural”	<i>Deleted</i>
62	My client oriented himself or herself toward developing productive solutions.	“Contains jargon”	<i>Deleted</i>
63	My client expressed a sense of personal agency based on their emotional experiences.	“Maybe too narrow”; “Contains jargon”	<i>Deleted</i>

Dysregulated Mode

Overwhelmed/Flooded

The survey offered respondents the following description of the Overwhelmed/Flooded state: “*Overwhelmed by unsymbolised emotion; disorganised & chaotic, with various other elements present in a disorganised fashion*”. The experts were offered three proposed items (Items 1 to 3) to describe this state. Respondents were then asked to rate how accurately they thought these items reflected the category.

While experts agreed that Item 1 and 3 were useful, feedback suggested the need to reword them slightly for the sake of nuance, clarity and specificity in order to avoid confusion or misunderstandings. For example, the word “articulate” was added to Item 3 in order to express both the difficulty of reflecting emotions and of exploring them. On the other hand, while the general consensus was that Item 2 was also an accurate description of the state and that the word “chaotic” was a “great word” to describe the overwhelmed/flooded mode, experts took issue with the use of the term “disorganised”. In general, respondents felt that, since there is no clear standard for determining what an “organised” or, conversely, a “disorganised” narrative looks like, the term would be difficult to rate.

Moreover, one of the respondents suggested that I include an additional item in order to fully reflect every aspect of the overwhelmed/flooded mode of engagement. Taking into account this feedback, all three items were kept after the necessary editions and the following item was added to the questionnaire: “*My client was flooded with painful emotions that they could not cope with*” (Item 4).

Distanced/Dissociated

The survey respondents were provided the following description of the Distanced/Dissociated state: *“Avoiding or holding painful or frightening feelings or experiences at bay”*. The survey then proposed six items (Items 5 to 10) to describe the Distanced/Dissociated mode of engagement. After reviewing the feedback items 5 through 7 were all eliminated. There was general consensus that none of these items provided an accurate description of the process. Moreover, respondents raised concerns about the use of certain words. For example, respondents felt that “abruptly” did “not fit” the description or was “too strong” a term for the mode being captured. Likewise, the experts raised concerns about suggesting that clients “put” an emotion and raise “barriers”. Both words implied too much consciousness of choice on the part of clients.

Items 8 through 10 were kept. Respondents agreed that the items were accurate descriptions of the state being portrayed. Item 8 was left as is. Item 9 had very high approval ratings, but some experts were not comfortable with the use of the term “fuzzy” and the word was thus removed. Likewise, a respondent suggested adding “emotionally charged experience” to item 10 in order to emphasize additional overtones.

Restricted Mode

Externalized

The survey respondents were provided the following description of the Externalized state: *“Attending exclusively to other people, external events; may be specific or general”*. Respondents were then provided 7 items (Items 11 to 17) that captured the Externalized process. Items 12, 13, 15 and 17 were eliminated given a

general consensus that they were poor descriptions of the mode being portrayed. While the ratings suggested that Item 13 was a slightly accurate description, it was considered “too abstract” and ultimately was eliminated because there was consensus that item 14 was a more accurate portrayal of the same description. Respondents took issue with the wording of Item 15. In particular, they felt that describing client’ narratives as “long-winded” and “boring” felt judgmental in tone and slightly disrespectful. Items 11, 14 and 16 had high approval ratings and were all kept. Item 14 was very slightly edited for clarity purposes. An expert suggested that I remove the word “whining” from Item 17 since it could be construed as judgmental.

Abstract/Purely Conceptual

Respondents were provided the following description of the Abstract/Purely Conceptual state: *“Formulating things in linguistic or abstract terms without reference to concrete experiencing”*. The survey then provided 6 items (Items 18 to 23) to reflect the state. Items 19, 20 and 21 were eliminated. Interestingly, survey respondents felt that these items remained too abstract, figurative and contained jargon. Item 18, 22 and 23 were generally considered to be accurate descriptions of the process and were kept with slight editions for the purpose of clarity. It was suggested that I add the word “empty” to Item 22 because it is a word that therapists understand and frequently employ to describe this type of process.

Somatizing

Respondents were provided the following description of the Somatizing state: *“Attending exclusively to pain or illness signs or symptoms, or dwells on body appearance or functions to the exclusion of other aspects of experience”*. The survey included 5 items (Item 24, and 26 to 29) to reflect this state. Item 26 and 27 was

eliminated because there was general consensus that they were poor descriptors of the state. Item 27, in particular, was considered to be “too hard to rate” because it was written as a negative statement. Item 24, 28 and 29 were considered to reflect the mode of engagement well and were kept with a few editions for clarity purposes. While Item 24 was considered to be a very accurate description an expert pointed out that it contained two separate descriptions. I thus, divided the item into two separate statements (see Item 24 and 25) for the purpose of clarity and rateability.

Impulsive

Respondents were provided the following description of the Impulsive state: “*Focused purely on wishes or actions; acting out; driven, without reflection*”. The survey offered 5 items (Items 30 to 34) that described the state. Item 31 and 33 were discarded because respondents thought they were poor descriptions and contained too much jargon. There was general consensus that Items 30, 32 and 34 were accurate descriptions and were kept with slight editions for the sake of clarity and simplicity. Additionally, an expert thought that the use of the word “rather” lent Item 32 a judgmental tone and thus the Item was reworded in order to refocus its meaning.

Working Modes

Externally Attending

The experts were provided the following description of the Externally Attending state: “*Mindful receptive focus on perceptual experience/memories; emotionally engaged narrative*”. The survey offered 3 items (Items 35 to 37) that described this process.

Ultimately only Item 35 was kept since it was highly rated, and the general consensus was that it was an extremely accurate description that fully reflected the

Externally Attending process. The other two Items were thought to be a bit convoluted and contained jargon. Thus, they were eliminated, as they were unnecessary.

Body-focused

Respondents were provided the following description of the Body-focused state: “*Careful receptive attention to bodily experience and associated felt meaning*”. The survey provided 6 items (Items 38 to 43) that described the Body-Focused mode of engagement. Items 38, 40, 41 and 43 were discarded because there was general consensus that they were either redundant, a lesser fit than the other two items, and/or contained a bit of jargon. Additionally, items 39 and 42 were deemed to be accurate descriptors of the Body-Focused mode. Both of these items were slightly edited to eliminate jargon and redundancy for the sake of clarity and simplicity.

Emotion-focused

The experts were provided the following description of the Emotion-focused state: “*Awareness and symbolization of immediate emotional experience*”. The survey then offered 2 items (Items 44 to 45) that reflected this process. There was clear agreement that Item 44 was not only a highly accurate description but was able to fully reflect the process in its entirety. An expert, however, suggested that I add the descriptor “emotional experience” to the item in order to provide further overtones. Item 45, on the other hand, was deemed to be “too abstract”, “too poetic” and contained jargon. Thus, I decided to only keep Item 44 with edits.

Reflexive-symbolizing

Survey respondents were provided the following description of the Reflexive-Symbolizing state: “*Active curiosity and reflection on the meaning, value or*

understanding of experience". The survey included 3 items (Items 46 to 48) that described this process. There was a general consensus that Item 46 was a highly accurate description of the entire process. However, it was suggested that I add the word "reflexive" to nuance the Item further. The Item was kept, and this suggestion was accordingly inserted. Item 47, on the other hand, was considered to be somewhat slightly accurate, but it was redundant with Item 46 and was a poorer description of the same process. Item 48, was believed to be "too general" and contained jargon. For this reason, both Item 47 and 48 were eliminated.

Active Expression

The experts were provided the following description of the Active Expression state: "*Expressing wants/needs; enacting strong emotions in a productive manner*". The survey provided 2 items (Items 49 to 50) that reflected the process. While there was general consensus that Item 49 was a bit wordy but an accurate description of the mode of engagement, Item 50 was found to be difficult to read and contained jargon. Respondents also found that the use of the word "strong" in Item 50 felt judgmental in tone. However, I did not consider that these items were redundant. In fact, they expressed different facets of the Active Expression state. Thus, while Item 49 was kept with editing in order to clarify the meaning and simplify the wording, Item 50 was rewritten in order to better and more fully reflects the process.

Change Modes

Re-perceiving

The experts were provided the following description of the Re-perceiving mode: "*Noticing new things in their situation not attended to before or seeing previously-attended-to aspect of their situation in a different light; new*

understanding, insight or awareness of self or others". The survey included 3 items (Item 51 to 53) to describe this process. Item 51 and 52 were found to be too general and did not successfully "capture the essence of the state". Both items were discarded. However, there was general consensus that Item 53 was an accurate and rich descriptor of the Re-perceiving mode. This item was thus kept with light editing with the aim of making it more concise.

Body-shift

Respondents were provided the following description of the Body-shift state: "*Allowing oneself to enjoy the easing of previous problem-related tension carried in the body*". The survey offered 2 items (Item 54 to 55) that reflected this process. While Item 54 was deemed to be somewhat accurate, experts felt that it was a bit convoluted and contained jargon. The item was thus discarded in favour of Item 55 that was found to be a more accurate description of the same process. Item 55 underwent some light editing.

Receiving Emotional Change

Experts were given the following description of the Receiving Emotional Change state: "*Allowing oneself to feel and appreciate new, more adaptive emotions*". The survey provided 2 items (Item 56 and 57) that reflected this mode. There was general consensus among respondents that Item 56 was simple, straightforward and, in general, a very accurate description of the process while Item 57 was a redundant and poorer description of this same mode. Moreover, some respondents expressed concerns that the wording of Item 57 could be interpreted as a value judgement of clients' emotions.

Self-Reflection/Meaning Perspective

Experts were provided the following description of the Self-Reflection/Meaning Perspective state: “*Standing back from successfully processed experiencing; becoming dis-embedded from previous assumptions so as to appreciate new possibilities, achieving a new explanation of one’s situation or feelings*”. The survey included 2 items (Item 58 and 59) that described this process. Respondents considered Item 58 to be an accurate description of the process but suggested that it may be too complicated to rate. The experts suggested that I edit the item for clarity and that I get rid of jargon (i.e. “disembedded”) in order to avoid confusion. Item 59, on the other hand, was considered to be a somewhat to slightly accurate description of the process, but respondents argued that it did not correctly emphasize the most salient features of the mode. For this reason, I kept and edited Item 58 and discarded Item 59.

Action-Planning

The experts were provided the following description of the Action-Planning state: “*Moving toward action on the basis of successfully processed experiencing; problem-solving; oriented toward developing productive solutions*”. The survey included 4 items (Items 60 to 63) that described this process. Item 61 was generally considered a slightly to poor description of the state; respondents argued that the wording sounded “behavioural” rather than based on emotional processing. There was also consensus that Item 62 and 63 were not accurate descriptions, contained jargon, and were “too narrow”. Item 60, on the other hand, was generally considered a somewhat to very accurate description of the state that could be perfected by

editing out jargon. For these reasons, all Items except Item 60 were discarded. I then edited Item 60 to make the wording clearer and more straightforward.

5.4.6 Differences Noted in Item Development Amongst the CME Domains

A fundamental aim of the process of developing the questionnaire was to construct a short and user-friendly instrument. For this reason, I aimed to eliminate as many items as possible while also striving to describe all theoretical aspects of the domains. During the entire process of constructing the items described above, it became evident to me that while the Dysregulated and Restricted domains of the CME framework required various descriptors in order to capture these processes in full, the Working and Change domains could be wholly captured with one or two items. Indeed, when I began writing the first set of items, I intuitively came up with more descriptors for the Dysregulated and Restricted domains than for the other two. Likewise, the survey respondents repeatedly suggested that one or two items were enough to capture the Working and Change domains while they tended to recommend keeping or even adding items for the Dysregulated and Restricted domains (none of the respondents suggested reducing the number of items I had originally suggested for these later domains). In fact, these differences also became evident when submitting the 14-item scale to analysis (see Tables 5.2 & 5.3). Indeed, I found that the factor structure for the Restricted and Dysregulated domains was unreliable. The results suggested that for these factors more items would be needed to have adequate reliability.

While both clients and therapists experience the Working and Change domain as more structured and organised emotional processes, the Dysregulated and Restricted domains are more difficult to express and apprehend. This could explain

the disparity in the number of items needed to capture the different domains in full. The process of using expert feedback with the aim of building an easy to employ and concise questionnaire which items were able to fully capture each of the four domains of the CME framework resulted in a 32-item questionnaire designed to assess clients modes of emotional engagement.

5.5 Stage III

This section describes how I explored the psychometric properties (reliability, construct validity and factor structure) of the 32-item CME Ratings Scale. The section goes on to explain how I investigated possible factors that may influence the CME measurement. I explore possible correlations between the 32-item CME Ratings Scale and the Therapist Overall Session Ratings Form. This section concludes by explaining how I used the results of the above-described stages in order to refine my previous instrument into a 28-item CME questionnaire (Revised Version I of this dissertation [CMEQ-R]).

5.5.1 Procedure

After obtaining ethics approval from the University of Strathclyde Ethics Committee and with the 32-item questionnaire in hand (see Appendix D), I constructed an online survey using the SurveyMonkey data collection system (2015). The resulting questionnaire had various sections. Respondents first gave informed consent by clicking on an “I agree” option. The platform then asked participants to identify their gender, their theoretical orientations (Humanistic, Behavioural, Psychoanalysis/Psychodynamic, Cognitive, Interpersonal or Systemic) and their years of professional experience. The survey also required that respondents answer the Therapist Overall Session Ratings Form (subsection II). This instrument included

four questions: The first question, “Please rate how helpful or hindering to your client you think this session was overall”. This item provides a nine-point Likert scale that goes from “extremely hindering” to “extremely helpful”. The second question, “How do you feel about the session you had with your client?”. This item includes a seven-point Likert scale that goes from “perfect” to “very poor”. The third question, “How much progress do you feel your client made in dealing with his/her problems in this session?”. The item provides a seven-point Likert scale that goes from “a great deal of progress” to “in some ways his/her problems have gotten worse this session”. Finally, the fourth question, “In this session something shifted for my client. S/he saw something differently or experienced something freshly”. The question provides a seven-point Likert scale that goes from “not at all” to “very much”. The last section of the survey requested that respondents fill out the 32-item CME questionnaire (see Stage II [Table 5.6]). To fill out the 32-item CME questionnaire the respondents were asked to recall one particular session that had taken place recently and was fresh in their mind. The respondents were asked to report the session number they were thinking about. The 32-Item CME questionnaire asked participants to rate the extent to which their client was engaging in each of the following CME processes during that particular session.

Approximately 950 mass emails were sent to psychotherapists listed on various available databases (i.e. the EFT servers list and the British Association for Counselling and Psychotherapy listing). E-mails were also sent to colleagues at the University of Strathclyde’s Counselling Unit. In order to ensure anonymity, neither email addresses nor Internet Protocol (IP) numbers were recorded. Data was securely

collected by the SurveyMonkey software and downloaded into an Excel spreadsheet for later analysis.

5.5.2 Participants

I had 350 psychotherapists that started responding the online survey. After eliminating those participants who did not complete the CME section of the survey, I had 230 survey participants (n=230) at my disposal. These included 68 males (30%), 155 females (67%) and 7 respondents who did not specify their gender (3%). Neither ethnicity nor socioeconomic status was recorded. A precise estimate of response rates cannot be calculated since the amount of people who viewed the online questionnaire was not recorded.

5.5.3 Measures

32-Item CME Questionnaire. The revised 32-Item CME questionnaire (see Table 5.6 & Appendix D) was constructed as a self-monitoring and supervising instrument to facilitate training for person-centred/experiential psychotherapies. The questionnaire was built to reflect the proposed CME theoretical framework (Elliott, 2006; 2013a) with its 4 domains and 16 guiding categories. The questionnaire asked participants to rate the extent to which their client had engaged in each of the 32 CMEs during a given session using a five-point Likert scale (1: “absent”, 2: “occasional”, 3: “common”, 4: “frequent”, 5: “extensive”).

The Therapist Overall Session Ratings (subsection II) from the EFT Therapist Session Form (v4.4, Elliott, 2013b). The Therapist Overall Session Ratings Form is a 4-item rating scale. The questionnaire is designed to be filled out by therapists after any given session in order to measure the perceived helpfulness,

quality, progress and shifts that occurred during the session (For more information see Section 5.2.3 “Measures”).

5.6 Results

Preliminary analyses. To test for internal consistency on the 32-items of the CME Ratings Scale I applied Cronbach’s alpha (0.91). According to Streiner (2003), an acceptable Cronbach’s alpha value for research purpose instruments, is $\alpha = 0.80$.

Principal Axis Factoring. The 32-items were analysed using Principal Axis Factoring. The KMO measure (KMO=0.81) and Bartlett’s test ($p < .001$) showed sampling adequacy and a suitable correlation matrix. I used the eigenvalue ≥ 1 criterion that resulted in five factors. However, since the scree plot revealed a four-factor extraction that accounted for 50% of the overall variance I decided to use this solution. I also used a varimax rotation in order to explore a simpler structure that resulted in four interpretable factors. These results can be seen in Table 5.7. Each factor was named after its corresponding CME.

Factor 1, was named *Change/Working* because it encompasses all items measuring the Change and Working Modes of Engagement (see Chapter 2, “Literature Review”, Section 2.6.1 and 2.6.2). This factor is the most numerous of the four, containing 12 items. Moreover, the three highest loading items all refer to the Change Mode (*Item 2*, “Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation”; *Item 28*, “My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning”; *Item 23*, “My client allowed themselves to feel new, more adaptive emotions”). Other items included in Factor 1 were those that measured Reflective/Symbolizing elements (i.e. *Item 32*, “My client was reflective and actively

curious about the personal meaning, value or sources of their experiences”), Body-Focused elements (i.e. *Item 6*, “My client looked inward and explored the bodily reactions related to his/her emotional experience”) and Active Expression elements (i.e. *Item 25*, “My client put basic, important wants or needs into words”), among others. The internal reliability of the *Change/Working* factor was very high with a Cronbach alpha of 0.92.

Factor 2, was named *Dysregulated* because it includes all items measuring the Dysregulated Mode of Engagement (see Chapter 2, “Literature Review”, Section 2.5.1). This factor contains 7 items and is the third most numerous of the four factors. The three highest loading items reflect an Overwhelmed/Flooded state in which the client can’t cope, articulate or identify their emotions because their experience is flooded (*Item 24*, “My client was flooded with painful emotions that they could not cope with”; *Item 7*, “My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them”; *Item 18*, “My client was overwhelmed by emotions and unable to identify their source or origin”). The factor also includes items that describe an overwhelmed/bodily experience (i.e. *Item 29*, “My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something”), an overwhelmed/impulsive experience (i.e. *Item 31*, “My client focused on impulsive desires without exploring further deep emotional wants or needs”) an overwhelmed/symbolic experience (i.e. *Item 22*, “My client experienced being in a confused, disoriented, or dissociated state in the session”), among others. The internal reliability of the *Dysregulated* factor was high with a Cronbach alpha of 0.88.

Factor 3, was named *Restricted* because it includes items reflecting a Restricted Mode of Engagement with the exception of the somatising process (see Chapter 2, “Literature Review”, Section 2.5.2). This factor contains 9 items and is the second most numerous of the four factors. The three highest loading items refer to an externalized process (*Item 20*, “My client focused on complaints about others with minimal reference to self-experience”) and an abstract/purely conceptual process (*Item 17*, “My client talked about emotions in a general, global or theoretical manner”; *Item 26*, “My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences”). Factor 3 also includes items that refer to a perceptual/situational process (i.e. *Item 5*, “My client was preoccupied with external events without referencing emotional reactions to those events”) and an impulsive/acting state (*Item 15*, “My client described their behaviours as driven purely by wishes and desires”), among others. The internal reliability of the *Restricted* factor was high with a Cronbach alpha of 0.83.

Factor 4, was called *Somatizing* because it includes all items that measure the somatizing process within the Restricted Mode of Engagement (see Chapter 2, “Literature Review”, Section 2.5.2). With 4 items, this is the least numerous of the four factors. The 4 items included in this factor, in order of loading are: 1. *Item 12*, which expresses a somatizing experience of physical symptoms (“My client dwelt on physical symptoms without elaborating their emotional meaning”), 2. *Item 14*, which reflects a somatising experience of bodily sensations (“My client reported disturbing bodily sensations without exploring them”), 3. *Item 27*, which expresses a somatising experience of bodily signs of illness or injury and, 4. *Item 8*, a narrow focus on physical appearance (“My client was focused on his/her physical appearance or body

image without reference to emotional experiences”). The internal reliability of the *Somatizing* factor was high with a Cronbach alpha of 0.83.

Table 5. 8. Results of Varimax-Rotated Principal Axis Analysis on the 32-Item Client Modes of Engagement Questionnaire

Item	1. Change/Working	2. Dysregulated	3. Restricted	4. Somatizing
2. Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation.	0.83	0.04	0.01	0.08
28. My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning.	0.82	0.19	-0.01	-0.04
23. My client allowed themselves to feel new, more adaptive emotions.	0.79	0.16	0.13	0.08
32. My client was reflective and actively curious about the personal meaning, value or sources of their experiences.	0.72	0.14	0.05	0.07
16. My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.	0.69	0.11	0.12	0.10
21. My client focused on memories in a fully engaged, receptive and mindful manner.	0.68	0.08	0.07	0.16
6. My client looked inward and explored the bodily reactions related to his/her emotional experience.	0.66	0.01	0.21	-0.18

4. My client was fully immersed in the elaboration and exploration of their emotional experience.	0.65	0.10	0.25	0.13
11. My client expressed a desire to take action based on their newly emerging emotions.	0.65	0.07	0.00	0.00
25. My client put basic, important wants or needs into words.	0.64	0.10	-0.01	0.10
13. My client expressed deep underlying emotions.	0.63	-0.16	0.21	0.08
30. My client elaborated experiences by associating them with body sensations or reactions.	0.52	-0.02	0.22	-0.43
<hr/>				
24. My client was flooded with painful emotions that they could not cope with. (R)	0.13	0.77	0.17	0.14
7. My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them. (R)	0.14	0.75	0.04	0.22
18. My client was overwhelmed by emotions and unable to identify their source or origin. (R)	0.17	0.69	0.17	0.19
1. My client expressed themselves in a chaotic manner. (R)	0.02	0.58	0.21	0.06
29. My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something. (R)	-0.02	0.56	0.18	0.26

22. My client experienced being in a confused, disoriented, or dissociated state in the session. (R)	0.07	0.55	0.14	0.11
31. My client focused on impulsive desires (e.g., escaping from problems) without exploring further deep emotional wants or needs. (R)	0.15	0.45	0.34	0.33
<hr/>				
20. My client focused on complaints about others with minimal reference to self-experience. (R)	0.19	0.38	0.64	0.08
17. My client talked about emotions in a general, global or theoretical manner. (R)	0.04	0.04	0.61	0.11
26. My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences. (R)	0.05	0.07	0.61	0.10
19. My client evaluated others' behaviour/feelings with minimal reference and attention to their own emotional experience. (R)	0.18	0.30	0.61	0.15
5. My client was preoccupied with external events without referencing emotional reactions to those events. (R)	0.34	0.22	0.56	0.22
10. My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty. (R)	0.24	0.09	0.49	0.26
9. My client avoided or held off painful or frightening emotionally charged experiences. (R)	0.31	0.24	0.48	0.20

3. My client was in a numb or emotionally blocked state. (R)	0.18	0.34	0.42	0.35
15. My client described their behaviours as driven purely by wishes and desires. (R)	<i>-0.12</i>	<i>0.16</i>	<i>0.32</i>	<i>-0.04</i>
12. My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning. (R)	0.02	0.24	0.26	0.73
14. My client reported disturbing bodily sensations without exploring them. (R)	-0.01	0.26	0.27	0.69
27. My client was preoccupied with bodily signs of illness or injury. (R)	0.10	0.24	0.12	0.57
8. My client was focused on his/her physical appearance or body image without reference to emotional experiences. (R)	0.10	0.35	0.13	0.48
Variance explained (%)	19.65	11.724	10.15	8.05
Eigenvalue	9.38	4.72	2.05	1.64
Reliability ^a	0.92	0.88	0.83	0.83

Note. Boldface indicates items with salient loadings > .40; (R)= reversed-score items; N for therapist' correlations = 219 – 224; Trivial items are Italicized; ^aCronbach's alpha calculated using items with a loading > .40.

5.7 Exploring the Psychometric Properties of the EFT Therapist Session

Form - Subsection II Overall Session Ratings

My approach to exploring the psychometric properties and correlations of the 32-Item CME questionnaire was similar to my previous analysis of the 14-Item Ratings Scale. After exploring the factor structure and reliability of the 32-Item CME questionnaire, I analysed the psychometric properties of the Therapist Overall

Session Ratings Form. The following section presents these results.

Preliminary Analysis. I ran reliability analyses (Cronbach's alpha) on the Therapists Overall Session Ratings Form in order to test for internal consistency of its 4 items (0.89).

Table 5. 9. Correlation Matrix - EFT Therapist Session Form - Subsection II
Therapist Overall Session Ratings

	S. T. Help	S. T. Quality	S. T. Progress	S. T. Shift
1. S. T. Help	1	0.68	0.70	0.69
2. S. T. Quality	0.68	1	0.68	0.65
3. S. T. Progress	0.70	0.68	1	0.77
4. S. T. Shift	0.69	0.65	0.77	1

Principal Axis Factoring. The Therapist Overall Session Ratings Form is conceptualized as measuring a single overall session experience. Indeed, the four items of The Therapist Overall Session Ratings form are highly correlated (see Table 5.8). The sampling adequacy was confirmed (KMO = 0.84) and the structure of the correlation matrix was also appropriate (Bartlett's test, $p < .001$). The one-factor solution was fully interpretable and accounted for 67% of the overall variance (see Table 5.9). Then, using the statistical procedure called a Very Simple Structure (Revelle & Rocklin, 1979) I tested the hypothesis that 1 factor was sufficient (this can be thought as a quasi-confirmatory model). The chi-square for this test was 5.88 with 2 degrees of freedom and its corresponding p-value was 0.05. Hence, I concluded that only a single factor was needed to explain the correlation structure of the instrument.

Table 5. 10. Results of Varimax-Rotated Principal Axis Analysis for the Therapists Overall Session Ratings Form

Item	Factor
1. Please rate how helpful or hindering to your client you think this session was overall (T. Helpful).	0.73
2. How do you feel about the session you have just completed with your client? (T. Quality).	0.76
3. How much progress do you feel your client made in dealing with his/her problems in this session? (T. Progress)	0.89
4. In this session something shifted for my client. S/he saw something differently or experienced something freshly (T. Shift)	0.87
Variance explained (%)	67
Eigenvalue	3.1
Reliability ^a	0.89

Note. ^aCronbach's alpha.

5.8 Exploring Possible Correlations Between the 32-Item CME Ratings Scale and The Therapist Overall Session Ratings Form

Since my analysis of the 14-item CME Ratings Scale (reported in Section 5.3) was very similar to my examination of the 32-item CME Ratings Scale and since Table 5.10 is sufficiently self-explanatory, I only describe the most noteworthy correlations between the *T.Index* (*T.Helpful*, *T.Quality*, *T.Progress* and *T.Shift*) and the 32-Item CME Ratings Scale. To calculate the *T. Index*, I rescaled each item to a common metric and averaged the resulting scores.

Items 2, 4, 23 and 28 of the CME Ratings Scale showed a high positive correlation with the *T.Index*. Interestingly, 3 of these 4 items (*Items 2, 23, 28*) are all expressing a Change Mode of Engagement. Although *Item 4* expresses an element of the Working Mode of Engagement, it is capturing an in-depth exploration of emotional experience. It is noteworthy that this element reflects one of the most

fundamental aspects of the EFT theory of change processes. *Items 6, 11, 13, 16, 21, 25 and 32* of the CME Ratings Scale express a moderate positive correlation with the *T. Index*. *Items 6, 13, 21, 25 and 32* are all describing different elements of the Working Mode of Engagement. *Item 11 and 16* are expressing a Change Mode. This suggests that therapists perceive the presence of the Working and Change Modes as beneficial in terms of the helpfulness and quality of a given therapy session, and the observed progress and shifts experienced by the client during this session. *Items 3, 5, 7, 8, 9, 18, 19, 24 and 31* express a moderate negative correlation with the *T.Index*. These items reflect the Dysregulated and Restricted Modes of Engagement. This suggests that therapists do not consider sessions during which these items are present as being particularly helpful or good quality and that they do not perceive the client as making progress or experiencing shifts during the session. For further details see Table 5.10.

Table 5. 11. Client Modes of Engagement Descriptive Statistics; Correlations Between CME-Items and Therapist Overall Session Ratings

Item	Means	SD	T. Helpful	T. Quality	T. Progress	T. Shift	T. Index
1. My client expressed themselves in a chaotic manner. (R)	1.63	0.92	-0.12	-0.20**	-0.15*	-0.09	-0.16*
2. Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation	3.05	1.20	0.54***	0.51***	0.69***	0.71***	0.73***
3. My client was in a numb or emotionally blocked state. (R)	1.79	1.08	-0.27***	-0.28***	-0.31***	-0.29***	-0.33***
4. My client was fully immersed in the elaboration and exploration of their emotional experience.	3.17	1.20	0.39***	0.35***	0.45***	0.49***	0.50***
5. My client was preoccupied with external events without referencing emotional reactions to those events. (R)	1.90	1.07	-0.24***	-0.24***	-0.34***	-0.36***	-0.36***
6. My client looked inward and explored the bodily reactions related to his/her emotional experience.	2.46	1.20	0.25***	0.30***	0.34***	0.37***	0.37***
7. My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them. (R)	0.87	1.08	-0.45***	-0.35***	-0.32***	-0.21*	-0.35***
8. My client was focused on his/her physical appearance or body image without reference to emotional experiences. (R)	1.30	0.75	-0.18**	-0.21**	-0.29***	-0.34***	-0.31***
9. My client avoided or held off painful or frightening emotionally charged experiences. (R)	2.33	1.12	-0.26***	-0.29***	-0.35***	-0.32***	-0.36***

10. My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty. (R)	1.50	0.86	-0.23***	-0.23***	-0.22**	-0.27***	-0.27***
11. My client expressed a desire to take action based on their newly emerging emotions.	2.69	1.21	0.37***	0.34***	0.45***	0.40***	0.46***
12. My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning. (R)	1.43	0.85	-0.17*	-0.21**	-0.17*	-0.21**	-0.21**
13. My client expressed deep underlying emotions.	3.09	1.15	0.30***	0.25***	0.29***	0.38***	0.36***
14. My client reported disturbing bodily sensations without exploring them. (R)	0.74	0.86	-0.32**	-0.25**	-0.23*	-0.19*	-0.26**
15. My client described their behaviours as driven purely by wishes and desires. (R)	2.13	1.09	-0.00	-0.05	-0.05	-0.02	-0.03
16. My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.	2.53	1.17	0.36***	0.40***	0.46***	0.44***	0.49***
17. My client talked about emotions in a general, global or theoretical manner. (R)	2.32	1.12	-0.20**	-0.10	-0.11	-0.11	-0.14*
18. My client was overwhelmed by emotions and unable to identify their source or origin. (R)	1.83	1.03	-0.28***	-0.28***	-0.32***	-0.27***	-0.33***
19. My client evaluated others' behaviour/feelings with minimal reference and attention to their own emotional experience. (R)	2.08	1.12	-0.27***	-0.23**	-0.29***	-0.28***	-0.31***
20. My client focused on complaints about others with minimal reference to self-experience. (R)	1.89	1.04	-0.18**	-0.21**	-0.23***	-0.25***	-0.26***

21. My client focused on memories in a fully engaged, receptive and mindful manner.	3.30	1.12	0.33***	0.39***	0.42***	0.48***	0.48***
22. My client experienced being in a confused, disoriented, or dissociated state in the session. (R)	1.59	0.85	-0.12	-0.18**	-0.21**	-0.10	-0.18*
23. My client allowed themselves to feel new, more adaptive emotions.	2.74	1.18	0.53***	0.50***	0.65***	0.62***	0.68***
24. My client was flooded with painful emotions that they could not cope with. (R)	1.87	1.06	-0.29***	-0.29***	-0.30***	-0.22**	-0.30***
25. My client put basic, important wants or needs into words.	3.05	1.10	0.22**	0.24***	0.30***	0.31***	0.32***
26. My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences. (R)	2.05	1.09	-0.14*	-0.12	-0.12	-0.16*	-0.15*
27. My client was preoccupied with bodily signs of illness or injury. (R)	0.69	0.81	-0.34***	-0.24*	-0.22*	-0.18	-0.25**
28. My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning.	2.85	1.19	0.46***	0.45***	0.61***	0.60***	0.63***
29. My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something. (R)	1.46	0.82	-0.17**	-0.33***	-0.26***	-0.15*	-0.26***
30. My client elaborated experiences by associating them with body sensations or reactions.	2.26	1.20	0.09	0.17*	0.21**	0.24***	0.22**
31. My client focused on impulsive desires (e.g., escaping from problems) without exploring further deep	1.83	1.03	-0.26***	-0.35***	-0.29***	-0.30***	-0.34***

emotional wants or needs. (R)

32. My client was reflective and actively curious about the personal meaning, value or sources of their experiences. 3.44 1.19 **0.36***** **0.43***** **0.49***** **0.51***** **0.53*****

Note. Boldface indicates Pearson Correlations > 0.30. Using Cohen's standard interpretation these correspond to medium (<0.30) or large (<0.5) effect sizes; (R) = items reverse-scored before correlation with criterion measure; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

5.9 Exploring Factors that may Influence Client Modes of Engagement

Ratings

Informant Gender: Males vs. Females. I performed a t-test on the overall index from the 32-Item Ratings Scale to analyse whether there are differences between male and female respondents. There was no statistical difference between the mean for male and female respondents ($t = 0.5$, $df = 221$, $p = 0.60$). The effect size was very small ($d = 0.06$). The mean of the overall index (sum of items) for male respondents was 111 (SD = 15, N = 68) and for female respondents it was 110 (SD = 18, N = 155).

Theoretical Orientation. I performed a t-test to analyse whether there were differences between therapists of humanistic and non-humanistic orientations. For the purpose of this analysis the data of the respondents were divided into two groups. Group one was composed of respondents that considered their orientation to be humanistic (some of these respondents were not exclusively humanistic in their approach to therapy). Group two included therapists that did not consider their orientation to be humanistic. There was no statistical difference between the means of these two groups ($t = -0.2$, $df = 228$, $p = 0.8$). The effect size was very small ($d = 0.05$). This suggests that there is no differences in the ways therapists answer the

CME questionnaire that is dependent on theoretical orientation. The mean of the overall index for non-humanistic theoretical orientation respondents was 109.8 (SD = 18.3, N = 87) and for humanistic theoretical orientation respondents were 110.2 (SD = 16.5, N = 143).

Professional Experience. I performed a between-subjects one-way ANOVA in order to analyse whether there are differences related to professional experience. The questionnaire provided 6 distinct options for rating a therapist's experience (see Table 5.11). No statistical significance was found between these 6 categories ($F_{5,159} = 0.55, p = 0.74$). The effect size was small ($\eta^2 = 0.02$). This suggests that there are no differences in the ways therapists answer the 32-Item CME Ratings Scale that is dependent on *professional experience*.

Table 5. 12. Descriptive Statistics of Professional Experience

Professional Experience	Frequencies Percentages		CME	
	N	%	Mean	SD
Less than 2 years	19	12	115.4	14.0
2 to 4 years	11	7	115.1	20.3
4 to 8 years	37	22	110.1	22.3
8 to 16 years	36	20	110.9	13.2
16 to 25 years	33	21	115.0	14.9
More than 25 years of experience	29	18	111.1	16.6

Session Number. I tested whether or not there was a significant correlation between session number and the overall score of the 32-Item CME Ratings Scale. No statistical significant correlation was found for therapy duration ($r = -0.05, t = 0.5, df = 228, p = 0.6$). This indicates that the 32-item CME Ratings Scale is not influenced by the duration of therapy (overall length of therapy does not indicate how far into a session the client is, but how many sessions the client has attended so far).

5.10 Developing the 28-Item Client Modes of Engagement Questionnaire

The above-mentioned analysis suggested that some further refinement of the items was necessary. After exploring the factor structure for each item of the 32-Item CME Ratings Scale, I found that 4 of these items should be discarded for the purpose of creating the shortest possible version of the questionnaire. *Item 2* (“Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation”) was omitted because it showed a loading > 0.80 . This suggested that the item was redundant (Gorsuch, 1997). Also, after discussion with an expert, there was consensus that it was too similar to *Item 28* (“My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning”). Likewise, *Item 23* (“My client allowed themselves to feel new, more adaptive emotions”) was also dropped because it showed high loading and thus seemed redundant. Additionally, the item expressed a similar process to *Item 13* (“My client expressed deep underlying emotions”) —both items had been developed in order to reflect the appearance of a primary emotion. After consultation, it was agreed that one item was enough to reflect the process. On the other hand, *Item 30* (“My client elaborated experiences by associating them with body sensations or reactions”) was dropped because it showed loadings above 0.40 in Factor 1 and Factor 4 and it was thus found to be ambiguous (Gorsuch, 1997). Moreover, there was consensus that the process expressed in *Item 30* was already reflected successfully in *Item 6* (“My client looked inward and explored the bodily reactions related to his/her emotional experience”). Also, after inspecting the correlations (see Table 5.10) between *Item 30* and *T. Helpful* (0.09) *T. Quality* (0.17), *T. Progress* (0.21), *T. Shift* (0.24) and *T. Index* (0.22) I found that all the correlations were small.

Hence, I decided that *Item 30* showed poor correlations with the items of the Therapist Overall Session Rating form and thus I decided to remove the item from the questionnaire. Finally, *Item 15* (“My client described their behaviours as driven purely by wishes and desires”) was eliminated because its loadings were less than 0.4. Thus, it was considered to be a “trivial” item (Gorsuch, 1997). Moreover, examining the correlation (see Table 5.10) between *Item 15* and Therapist Overall Session Rating, *T.Index*, (-0.03) I found that this item didn’t have any relationship, also, after consultation, research clinic colleagues considered that the item contained EFT jargon. Taking into account all these shortcomings I decided to omit *Item 15*.

5.11 Chapter Summary

The result of the three stages mentioned-above was a 28-Item CME questionnaire. This instrument was the outcome of an in-depth examination of the original 14-item CME instrument (Stage I). The information yielded from the first stage of this study was then enriched by expert feedback in order to refine and reword the scale, which resulted in a 32-item CME questionnaire (Stage II). The 32-Item CME Rating Scale was then submitted to statistical analysis (factor and reliability analyses); its correlations with the Therapist Overall Session Ratings Form were investigated; and the questionnaire was probed for factors that might influence the respondents. The resulting revised version of the CME Ratings Scale was named the Client Modes of Engagement Questionnaire –Revised (CMEQ-R) and was considered ready to be submitted to a validity and outcome study. The results of this initial study are further explored in the discussion chapter of this dissertation (Chapter 7).

Chapter 6

Application of the Client Modes of Engagement Questionnaire

6.1 Introduction

This chapter describes the final study of this research project. As previously discussed, long-established psychometric properties revealed that the CMEQ-R had good reliability and validity and was thus ready to be used. In order to confirm this, I will report how I first carried out a Rasch analysis to examine the psychometric quality of the CMEQ-R in the specific sample used in the current study. In particular, I explored whether the scale functioned as intended; I also analysed reliability estimates, potential item reduction, and examined whether the item hierarchy made sense theoretically. The findings of these analyses led to item and scale revisions for calibration purposes. Taking into account the results yielded by this study, I reduced the instrument to a 24-item 3-point scale, which will be referred to from now on as the CMEQ-R₂. Once validity and reliability had been confirmed, I went on to apply the instrument to explore the ways in which Client Modes of Engagement—as measured by the CMEQ-R₂—manifest in therapy.

The following sections document the use of Rasch analysis, the subsequent application of the CMEQ-R₂ through a process outcome study that explored the relationship between CME and outcome across phases of therapy using regression analysis.

6.2 Rasch Analysis of the CMEQ-R

6.3 Rationale for Applying the Rasch Model to the CMEQ-R

While long-established psychometric approaches can be useful, they have their own shortcomings. Thus, once I had applied evidence-based classical statistical analysis, in order to continue calibrating and perfecting the CMEQ-R, I decided to use the Rasch Model in order to achieve a broader understanding of how the instrument was functioning. This decision was made by considering Wright and Mok's (2004) suggestion that in order to fully analyse an instrument such as the CMEQ-R—built to measure a single construct through different levels of engagement—an appropriate psychometric approach should be employed. Specifically, the authors propose that appropriate psychometric analyses should: a) produce linear measures; b) work with missing data; c) provide precision estimates; and d) have means of detecting misfitting items or persons.

Likewise, Bond and Fox (2001) suggest that since ordinal raw data is inherently non-linear, it is recommendable to apply Rasch analysis transformation in order to achieve linearity for the different scores. Moreover, they point out that the index scores used, as scores in these analyses are sample and instrument dependent. Additionally, they argue that the Rasch model is generally better suited to compute means, standard deviations and correlations. Calibrating my instrument through Rasch analyses would allow me to construct an additive scale and assess the extent to which the instrument was fitted by the latent dimension implicit in the Rasch analysis (Bond & Fox, 2001).

Furthermore, the Rasch model is a useful means of recognizing gaps in the construct's continuum by identifying items and persons that have not been well

targeted by the instrument. The model can identify items that are so rarely endorsed that they do not accurately reflect the construct under study. Conversely, Rasch analyses can detect persons who have not been well targeted by the items; that is, they can reveal persons who do not find that the instrument provides enough items to represent their latent dimension. Thus, this model is able to identify misfitting items and persons. Also, these types of analyses can examine the degree to which the instrument's items consistently measure a single latent dimension on an increasing monotonic scale from easy to difficult to endorse. For these reasons, while Rasch modelling was not the central focus of this research endeavour, the application of this type of analysis served to strengthen the reliability and validity of the CMEQ-R and provided valuable information for further refinement of the instrument.

Applying a Rasch Model also offered a means of inspecting scale functionality in a way that long-established evidence based methods did not provide. As Low (1988) has demonstrated, respondents can use rating scale levels in inconsistent manners, and are sometimes unable to differentiate between rating scale categories. Thus, it was particularly important to investigate how the CMEQ-R scale was being understood and used by respondents. Moreover, by using this model, I was able to analyse whether the item hierarchy made theoretical sense. Further, I used the Rasch model as an additional way of analysing reliability. Moreover, since one of my main objectives for this project was to construct a user-friendly and practical instrument, the fact that the Rasch model permitted further item reduction, was extremely promising. Finally, applying the Rasch Model provided the necessary information for conducting a subsequent process-outcome study.

6.4 Method

6.4.1 Participants

Twenty-seven Experiential/Humanistic Psychotherapists filled out the questionnaire for a total of 97 clients. The final number of complete questionnaires used for the Rasch analysis were 1198 CMEQ-Rs. Seventeen (63%) of the therapists who participated came from the Strathclyde Research Clinic. Ten (37%) of these participants were recruited from various EFT training groups. Fifty-four (55.7%) of the clinical cases included belonged to the Strathclyde Research Clinic Protocols. Forty-three (44.3%) of these clinical cases came from the EFT training groups.

6.4.2 Measure

6.4.2.1 28-Item CME Questionnaire (CMEQ-R)

The CMEQ-R was constructed as a self-monitoring and self-supervising instrument to facilitate Person-Centred/Experiential psychotherapy (see Appendix E). The questionnaire, which reflected Elliott's CME theoretical construct (2006; 2013a), includes 4 domains and 16 guiding categories. The questionnaire asks therapists to rate the extent to which their client engaged in each of the 28 CME items during a given session using a five-point Likert scale (0: "absent", 1: "occasional", 2: "common", 3: "frequent", 4: "extensive"). (see Chapter 5 for an in-depth review of the development process of the CMEQ-R).

6.4.3 Data Analysis

I began this study using the Rasch model to explore the psychometric properties of the CMEQ-R — as educational and psychological testing standards suggest. In order to fit the Rasch models, I applied the statistical language R with the following libraries: eRm (Mair, Hatzinger & Maier, 2016); car (Fox & Weisberg,

2011); psych (Revelle, 2017); and WrightMap (Torres Irribarra & Freund, 2014).

Given that the CMEQ-R was taken after each session, the data included multiple data points. For this reason, the observations are not completely independent. The statistical significance levels and sample size–based error estimates should be interpreted with caution.

6.5 Results

6.5.1 Rating Scale Analyses

To assess rating scale functionality, I decided to analyse how participants were using the 5-point scale of the CMEQ-R. I began by examining whether I had at least 10 observations for each response category—in line with Linacre’s (2002) recommendation for Rasch analysis. Once I had confirmed that I had enough observations for applying Rasch analysis, I calculated the total count for each of the scale categories of the 5-point scale and their corresponding step thresholds (see Table 6.1). The step threshold is understood as the estimated difficulty of choosing one rating category over the other. Linacre (2002) suggests that step thresholds should increase monotonically. Indeed, my response categories followed a progression from “absent” to “extensive” as becomes apparent when examining the step thresholds. However, as can be seen in Table 6.1, I found that none of my adjacent categories had a suitable distance between each other (1.4 logits apart but not more than 5 logits). This can be confirmed visually inspecting the probability graphs in Figure 6.1.

Table 6. 1. Summary of the CMEQ-R Five-Point Rating Scale Category Functioning

Category	Observed count	Step Threshold	Step Standard Error
0 (Absent)	3603	None	-
1 (Occasional)	4265	-1.18	0.02
2 (Common)	4550	-0.24	0.01
3 (Frequent)	4952	0.41	0.01
4 (Extensive)	16174	1.01	0.01

Note. Observed count refers to the total number of responses for a given category.

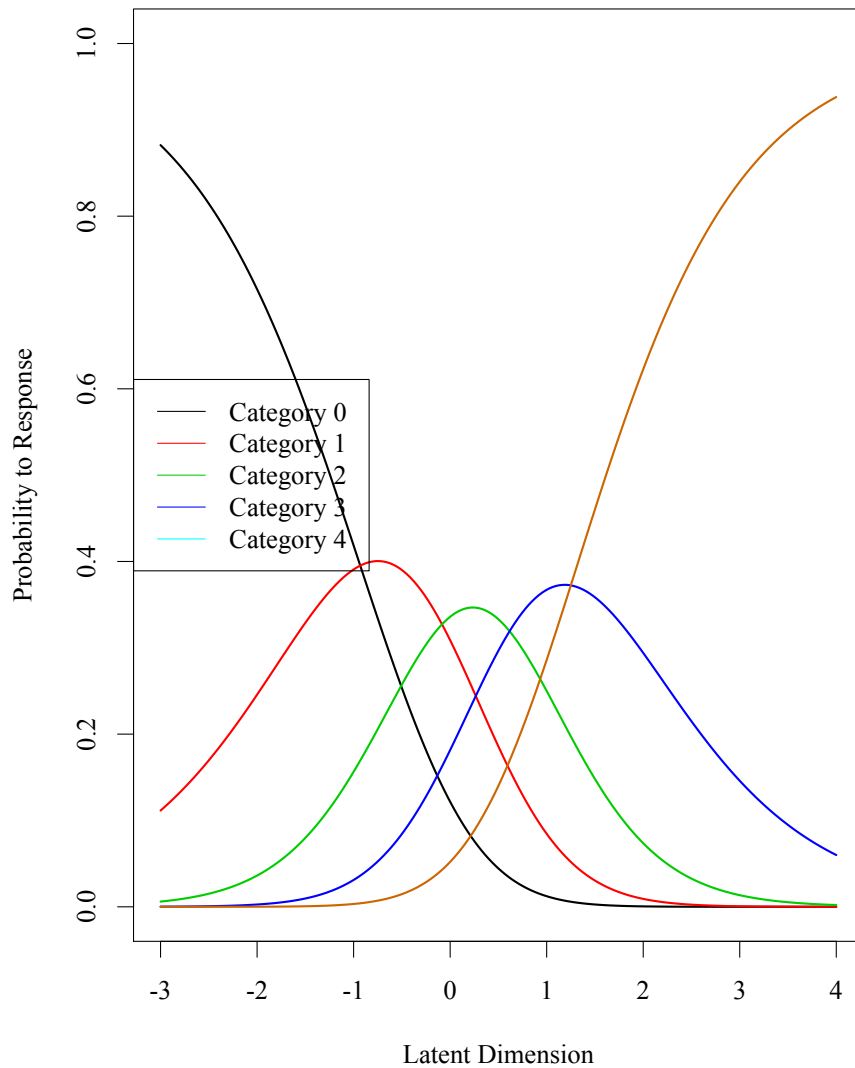


Figure 6. 1. *Item Characteristic Curve of the Five-Point Rating Scale*

The graph displays the probability for each of the five categories as a function of the CMEQ-R score.

Thus, I determined that the participants did not reliably distinguish between the categories. Hence, I concluded that the rating scale could be improved by examining and collapsing categories of my five-point scale.

In order to choose a Rasch model that best fitted my data, I fitted several Andrich Rating Scale Models (RSM; Andrich, 1978) (see Table 6.2). I then compared between these models using several criteria: person and item separation,⁹ infit and outfit mean squares¹⁰, conditional likelihood¹¹, and Akaike Information Criteria (AIC)¹². These models were explored with the aim of collapsing category scales in order to make the questionnaire easier to understand, while maintaining an acceptable person and item separation. Taking these into account, I chose a 3-point category scale which combined Category 1 and 2 and Category 3 and 4, and removed 4 misfitting items (*Item 12*, “My client was overwhelmed by emotions and unable to identify their source or origin”, *Item 3*, “My client was flooded with painful emotions that they could not cope with”, *Item 7*, “My client allowed themselves to enjoy a

⁹ Separation is related to the number of statistically different performance strata that the test can identify in the sample. It is computed using the ratio of the “true” standard deviation to the “error” standard deviation. Additionally, it is related to reliability—defined as the “true” variance to the “observed” variance.

¹⁰ Infit refers to information-weighted or inlier-sensitive fit. This measure is sensitive to the pattern of responses to items targeted on the person, or the pattern of the person targeted on the items. The outfit statistic is related to the outlier within the sample. The mean square statistics provide the size of the variability. The outfit and infit mean square statistics are expected to be close to 1.0. Values greater to 2.0 indicate a distortion of the instrument. Values between 0.5 to 1.5 are acceptable for the instrument. Misfitting items are those that have a mean square outfit greater than 2.

¹¹ The method used for Rasch analysis in order to estimate the parameters of the model (item thresholds and person scores) was to maximize the likelihood criterion. In the case of the Rasch Model it is possible to separate the fitting of the item parameters and the fitting of the person parameters. This procedure of separating the person and item parameters with the purpose of fitting them is known as “conditional likelihood.” Statistically, a higher conditional likelihood makes for a better model.

¹² Taking into account only conditional likelihood could lead to overfitted models. These may be very good for the dataset under study but not for generalizing to other datasets. For this reason, while it is advisable to use criteria that takes into account how well the model fits the data, it is also important to consider how many parameters are used to achieve this fit. It is generally agreed that it is better to use as few parameters as necessary. One of the preferred criteria to achieve this is taking into account AIC—an estimator of the relative quality of statistical models for a given dataset. The lower the AIC the better.

sense of relief or easing of previous problem-related tension carried in their body”, *Item 17*, “My client put basic, important wants or needs into words”) as the best of these models. This model was chosen because it had the highest conditional likelihood and the lowest AIC. The separation measures for persons (3.09) and items (6.89) were adequate and similar to the other models explored. This was also true for person reliability (0.91), item reliability (0.98), and infit (0.95) and outfit values (0.98).

Taking all this into account, the CMEQ-R was collapsed into a 3-point rating scale (0: “absent”, 1: “occasional/common” and 2: “frequent/extensive”), which omitted the four misfitting items and thus enhanced construct validity, improved conditional likelihood and displayed a better-fitted AIC. The decision to use this model was also taken in light of the fact that collapsing the instrument to a 3-point scale, made it more user-friendly while having a minimal cost of person reliability and improving item separation (see Table 6.2 for a summary of the statistics of the 3-point rating scale). All subsequent statistical analyses were performed using this refined model. From now on my instrument will be referred to as CMEQ-R₂.

Table 6. 2. Summary of Changes in Person and Item Separation and Reliability as a Result of Collapsing Rating Scale Categories and Removing Misfitting Items

Rating Scale	Separation (G)		Reliability		Infit MSQ	Outfit MSQ	# Misfitting Items	C.log-Lik	AIC
	Person	Item	Person	Item					
Original 5-point scale	3.16	6.75	0.91	0.98	0.95	0.99	5	-28335	56729
4-point scale (combining 3 & 4)	3.12	6.18	0.91	0.97	0.96	1.00	5	-18833	37723
3-point scale (combining 1 & 2; and 3 & 4)	3.08	6.52	0.90	0.98	0.96	0.98	4	-13863	27783
4-point scale (combining 3 & 4; and removing 5 misfitting items)	3.12	6.80	0.91	0.98	0.93	1.01	0 (12, 3, 28, 7, 17)	-10276	20598
3-point scale (combining 1 & 2; 3 & 4; and misfitting items)	3.09	6.89	0.91	0.98	0.95	0.98	0 (12, 3, 7, 17)	-9763	19574

Note. The alternative solutions that were tried in order to maximize the conditional likelihood (C.log-Lik) and AIC and at the same time maintain acceptable separation and also retain items. The model chosen for this study is the last model of the table in bold face.

6.5.2 Three Point Scale Probability Graph and Thresholds' Table

The probability map (see Figure 6.2) displays the separation between the three categories of the 3-point scale obtained through Rasch analysis. Table 6.3 displays the total count for each of the scale categories of the 3-point scale and their corresponding step thresholds. The black line represents the probability of choosing category 0 according to the latent dimension. As can be seen, as the latent dimension increases the probability of choosing category 0 decreases. The red line represents

the probability of choosing category 1. When the red line crosses with the black line it shows the position of the first threshold (-1.07) relative to the position of the item. The green line represents the probability of choosing category 2 according to the latent dimension. The point where the red line and the green line cross corresponds to the position of the second threshold (1.43). These two thresholds divide the latent dimension in three parts — to the left of the first threshold, the probability of choosing Category 0 is higher than that of choosing the other 2 categories; in the space between the two thresholds, it is more probable to choose Category 1. Finally, to the right of the second threshold, it is more probable to choose Category 2. In order to reasonably discriminate between scale categories, both thresholds should be at least 1.4 logit units apart. Thus, as can be seen in Figure 6.2, the 3 categories discriminated well between each other.

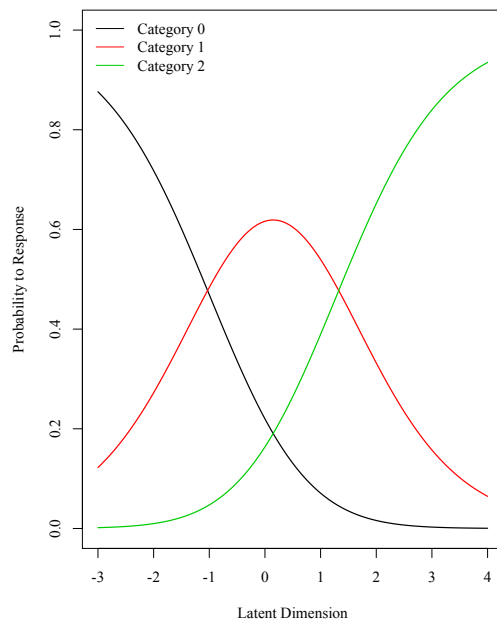


Figure 6. 2. *Item Characteristic Curve of the Three-Point Rating Scale*

The graph displays the probability for each of the three categories as a function of the CMEQ-R₂ score. The Client Modes of Engagement (CMEQ-R₂) three-point rating scale combined category 1 and 2; 3 and 4; and removed 4 misfitting items from the CMEQ-R).

Table 6. 3. Summary of the CMEQ-R Three-Point Rating Scale Category Functioning

Category	Observed count	Step Threshold	Step Standard Error
0 (Absent)	3603	None	-
1 (Occasional + Common)	8815	-1.07	0.02
2 (Frequent + Extensive)	21126	1.43	0.02

Note. Observed count refers to the total number of responses for a given category.

6.5.3 Person and Item Reliability

The Rasch Person Reliability Index was (0.91). Thus, I concluded that the participants in this sample could be considered reliable. In this case, reliability implies that if I were to use a different measure on the same sample of persons in order to assess the same construct, they would be placed in a similar point along the measure.

The Rasch Item Reliability Index was found to be high (0.98). This means that if the same set of items were answered by a different sample with the same levels of CME, the items would be placed in a similar point along the measure.

6.5.4 Person and Item Separation and Strata

In order to explore the tendency of endorsing each CMEQ-R₂ item, I transformed the Rasch separation statistics (G) into a strata index (strata) ($\text{Strata} = [4G + 1]/3$). A separation of 2.0 (corresponding to 3 strata) is the minimum acceptable value (Wright & Masters, 1982). I found that the item separation for my instrument was 6.89. This implies that items have a separation between nine and ten levels of endorsement difficulty. The Rasch Person Separation Index was 3.09. Thus, there were at least between four and five groups of participants that can be differentiated by using the questionnaire.

6.5.5 Person-item map

The person-item map (see Figure 6.3) is composed of two sections. While a full person-item map exploration is outside of the scope of this research project, the discussion below provides a picture of the instrument's item hierarchy. The upper section represents the distribution of the Rasch scores for each questionnaire (CMEQ-R₂). This distribution is somewhat skewed to the left indicating that it is easier to endorse the items from top to bottom of the hierarchy. The lower section shows the item hierarchy. Each item is placed along the logit scale using the corresponding thresholds and the item score (the black dots). These items are largely organised in ascending order from the Dysregulated mode, the Restricted Mode, the Working Mode, and finally the Change Mode. As the figure shows, the item hierarchical is not perfect. Some items are placed in a similar position in the parameter distribution. This implies that these may be redundant—the items may not discriminate well between each other (i.e. see the “Overwhelmed/not articulate”, “Chaotic manner”). Additionally, there are some gaps between the items (i.e. see the “Preoccupied/External”, “Focused/memories/fully”); this may suggest the need for an additional item. However, in total these items do seem to contribute statistic information about the instrument and to capture the overall structure of the CME construct. Still, there is room for improvement in terms of the separation between items.

Person-Item Map

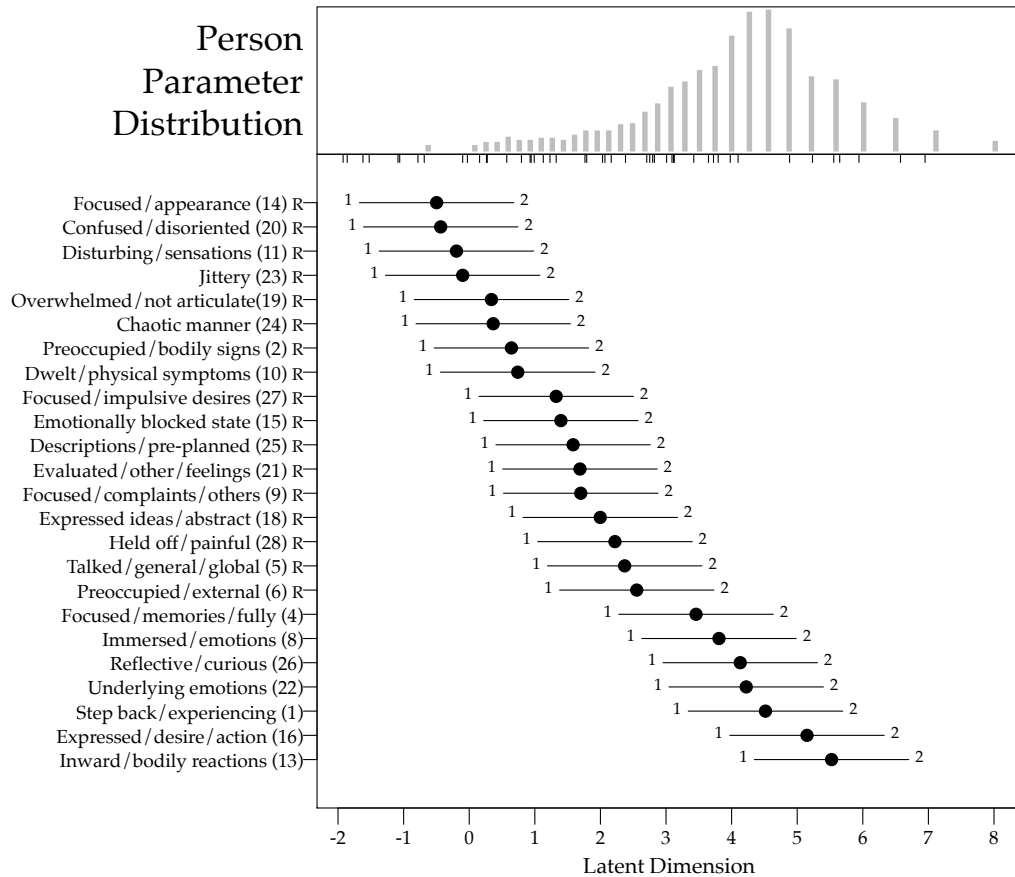


Figure 6. 3. *Person Item Map for the 3-Category CMEQ-R₂*

The figure shows the person score distribution for 3-category, 24 items CMEQ-R₂ together with the items locations (black dot) and the item thresholds for each category. (R) = Items reverse-scored.

6.6 Process-Outcome Study

After ethics approval from the University of Strathclyde Ethics Committee and once sample specific reliability and validity had been established for the CMEQ-R₂, I decided that the next step should be applying a process-outcome study that would analyse possible relationships between the instrument and outcome. The following section documents this process.

6.6.1 Method

The protocol of the Strathclyde Counselling Unit's Research Clinic included the application of the CMEQ-R₂. Thus, all of the completed cases from this Clinic were automatically considered for inclusion in this study.

In order to recruit practitioners who had EFT training I endeavoured to create a network of EFT training groups in the United Kingdom, Ecuador and Spain. I contacted and met with psychotherapists who had engaged in EFT training in order to invite them to participate in the present study. Practitioners who volunteered were trained in the CMEQ-R₂ and the research protocol. I met with them in person or by videoconference for approximately two hours every one or two weeks during the duration of the data collection phase of this study (about one year and a half). It was important that they understood how to follow the research procedures diligently. These meetings were used to do clinical case peer-supervisions and follow-up on research procedures. Psychotherapists were expected to: a. invite clients to volunteer; b. fill out the corresponding outcome measures before beginning therapy, at mid-therapy, and at the end of therapy (see the following section for a more in-depth explanation of the measurements); and c. fill out the CMEQ-R₂ after each session of an entire therapy case. The filled-out questionnaires were returned to the researcher with no other personal identification other than the code of the therapist and the gender of the client.

6.6.2 Measures

6.6.2.1 28-Item CME Questionnaire (CMEQ-R₂)

The CMEQ-R asked participants to rate the extent to which their client had engaged in each of the 28 CME items during a given session using a five-point Likert

scale (0: “absent”, 1: “occasional” 2: “common”, 3: “frequent” 4: “extensive”. (For the development process, see Chapter 5). As mentioned above, for statistical purposes, this questionnaire was collapsed into a 3-point scale 24-item instrument by removing 4 misfitting items, resulting in the CMEQ-R₂ (see Appendix F).

6.6.2.2 Working Alliance Inventory (WAI-SR)

The WAI-SR (Hatcher & Gillaspay, 2006) is the short version of the WAI (Horvath & Greenberg, 1989), which was developed to measure the strength of the client and therapist relationship. The WAI-SR has 12-item with three subscales: Bond, Task and Goal. Each item uses a 5-point Likert scale (1: “seldom”, 2: “Sometimes”, 3: “Fairly Often”, 4: “Very Often”, 5: “Always”) and has an internal consistency ranging from 0.91 to 0.92.

6.6.2.3 Clinical Outcome Routine Evaluation-Outcome Measure (CORE)

The CORE (Evans et al., 2002) was developed to assess clients’ general psychological distress across psychotherapy. This measure consists of 34 items with four subscales: Well-being, Problems/Symptoms, Life Functioning, and Risk/Harm. Each item uses a 5-point Likert scale (0: “Not at all”, 1: “Only Occasionally”, 2: “Sometimes”, 3: “Often”, and 4: “All or most of the time”). The CORE is a widely used measure with internal consistency of 0.94 and has good test-retest reliabilities.

6.6.2.4 Strathclyde Inventory (SI)

The SI (Freire et al., 2007) is based on Rogers’ (1959) descriptions of the ‘fully functioning person’. This self-report consists of 31 items measuring clients’ psychological well-being. Based on previous research with a non-clinical population, the instrument identifies two factors that measure this concept: congruence/fluidity and incongruence/structure-boundedness. The SI uses a 5-point Likert Scale (0:

“Never”, 1: “Only Occasionally”, 2: “Sometimes”, 3: “Often”, 4: “All or Most of the Time”).

6.6.2.5 *Personal Questionnaire (PQ)*

The PQ (Elliott et al., 2016) is an outcome-measure based on client-generated psychological difficulties. This instrument is constructed conjointly between a trained interviewer and the client. The aim is to construct items that reflect the specific problems that led the client to seek psychotherapy. Clients are asked to identify problematic topics related to symptoms, mood, specific performance, relationships and self-esteem. The result is a list of approximately 10 items that are then ranked in order from the most to the least important. Clients then rate each item with a 7-point anchored scale according to how much the problem has bothered them during the past seven days (1: “Not at all”, 2: “Very Little”, 3: “Little”, 4: “Moderately”, 5: “Considerably”, 6: “Very Considerably”, 7: “Maximum Possible”). The internal consistency of the PQ ranges from 0.70 to 0.80.

6.6.3 *Participants*

Eighteen Experiential/Humanistic psychotherapists participated in this study. They were from the United Kingdom, Ecuador, and Spain. Robert Elliott and/or Les Greenberg had trained all of these psychotherapists — at minimum, they had attended level one and two of the EFT individual training program. The participants gathered the CMEQ-R₂ data from a total of seventy-three completed psychotherapeutic cases. Fifty-two (71.2%) of these clinical cases belonged to the Strathclyde Research Clinic Protocols (Practice-Based Protocol= 38 (73%); Social Anxiety Protocol=14 (27%). Twenty-one (28.8%) of these clinical cases came from the EFT training groups. Forty-one of the clients from these clinical cases were

female (56.2%), twenty-eight were male (38.3%), and four (5.5%) did not specify gender.

The inclusion criteria established for psychotherapists was that they: a) should have received at least level one and two of EFT training and were practicing some form of Humanistic/Experiential psychotherapy; b) were primarily practicing with adults; c) were willing to follow the research procedures (i.e., completing self-report questionnaires, administering outcome measures, and keeping in continued contact with the researchers), and d) had high spoken and written English proficiency. There were no exclusion criteria beyond what is implied by the inclusion criteria.

The inclusion criteria established for the clinical cases were that clients: a) showed interest in receiving counselling or psychotherapy; b) were willing to take part in research procedures (filling self-report questionnaires); and c) were 18 years old or above. The exclusion criteria established for the clinical cases were that clients had any one of the following circumstances: a) they were receiving additional psychotherapy or counselling elsewhere; b) they had severe substance abuse difficulties; c) they were in a current active psychotic condition; d) they were in a severe current domestic violence situation; or f) they had literacy or intellectual functioning difficulties.

6.6.4 Data Preparation

I began my Process Outcome Study by using the previous Rasch analysis to compute the CMEQ-R₂ person score for each questionnaire. Given that I had at my disposal the CMEQ-R₂ for all sessions across therapy, I decided to divide the therapeutic process into three phases (early, middle and late). Since the first, second

and third session of therapy are usually used to establish goals, assess difficulties, and establish an alliance, I decided that these three sessions would represent the early phase of therapy (Horvath & Bedi, 2002). On the other hand, assuming that all sessions between the fourth and the fourth to last session are generally considered a working stage of therapy, I decided that these sessions would represent the middle phase of therapy. Lastly, I decided that the late phase of therapy would be represented by the last three sessions. This was done after taking into account that these sessions generally serve to discuss the progress made during the therapeutic process and are used as closure.

In order to create a variable that would represent the early phase of therapy (*PSS1*), I computed the mean person score of the CMEQ-R₂ for the three first sessions. The variable for the middle phase of therapy (*PSS2*) was computed using the mean person score of the CMEQ-R₂ for all sessions of the middle phase of therapy. I then computed a variable for the late phase of therapy (*PSS3*) using the mean person score of the CMEQ-R₂ for the last three sessions of therapy.

The difference between *PSS2* and *PSS1* was then calculated (*dPSS12*) in order to represent the change between the mean person scores of the middle to early phase of therapy. A variable representing the change between the late and middle phase of therapy (*dPSS23*) was computed using the difference between *PSS3* and *PSS2*. Since, I used mean scores, I didn't have to consider whether there were repeated measures. The *PPS1*, *PSS2*, *PSS3*, *dPSS12*, *dPSS23* are the variables of interest of this study.

The control variables that I considered for the models were: a. *Totsessions* — this variable represents the total number of sessions for a given client; b. *Protocol* —

to create this variable I used three binary variables representing each of the protocols used to collect data for this study: the Social-Anxiety Protocol (*ProtocolSA*), the Practice-Based Protocol (*ProtocolPB*) and the EFT Training groups protocol (*ProtocolEXT*); c. *Therapist* — this is a categorical variable to represent each therapist; d. *WAI-SR* —the short version of the Working Alliance Inventory is a process variable commonly used to control for outcome predictions. Research on the therapeutic working alliance suggests that the nature of the relationship becomes established between the third or fourth session (Horvath & Bedi, 2002). For this reason, I calculated this variable using the mean score for each questionnaire filled out by the client at the beginning of the fourth session.

In order to compute the dependent variables, I used three outcome measures: the CORE, the Personal Questionnaire-PQ, and The Strathclyde Inventory-SI. The questionnaires to compute these outcome measures were filled out by clients before the first session of therapy (I used these to calculate the *pre-CORE*, *pre-PQ* and *pre-SI* variables), and at the end of the therapeutic process (I used these to calculate the *post-CORE*, *post-PQ*, and *post-SI* variables). These outcome measures were used to compute the degree of therapeutic improvement by regressing each of the post-measures on its pre-measure and then obtaining the mean of their standardized residuals (*Mean Residual Gain*). That is, I used the residuals of these regressions because they hold all the information about the post-outcome measure that had not been explained by the client's baseline (pre-outcome measure). The residuals had to be standardized in order to be able to add them into a single measure.

6.6.5 Data Screening & Tests of Normality

In this study, strict normality of the continuous variables was not necessary due to the fact that I had a relatively large sample (73 clients). The inferences were based on the central limit theorem of statistics that implies that regression estimates will have an approximately normal distribution with a large enough sample size. However, I did perform an exploratory analysis of the data using q-q norm plots to assess whether my data was distributed normally. In examining the resultant graphs, I found that while my variables were not strictly normal, they were approximately normal. Also, in order to look for outliers, I performed box-plots for each continuous variable. I found that there were a few outlier points due to input mistakes in my database and thus fixed them appropriately.

6.7 Results

6.7.1 Preliminary Correlation Analyses

I performed preliminary correlation analyses in order to examine the bivariate linear relationships between the following variables: all CMEQ-R₂ process variables (*PSSI*, *PSS2*, *PSS3*, *dPSS12*, *dPSS23*), the *WAI-SR*, the total number of sessions, all pre and post-outcome measures, all residuals between pre and post-outcomes, and the *Mean Residual Gain* (see Table 6.4). The p-values associated with the correlations were adjusted to take into account the multiple tests that were carried out. Only the p-values that are statistically significant are indicated using the asterisk (*) system.

In order to discuss a few interesting patterns revealed by these calculations, it is first important to review the findings shown in Table 6.4. As can be observed, *PSSI* is correlated with the *Mean Residual Gain* and the *post-CORE*. Additionally, *dPSS12* is correlated with the *Mean Residual Gain*. *dPSS23* is correlated with the

post-PQ, *post-SI* and the *Mean Residual Gain*. *Totsessions* is not correlated with anything. The *WAI-SR* is correlated with the *post-PQ*, *post-CORE*, *post-SI* and the *Mean Residual Gain*. The *pre-PQ* is correlated with the *pre-CORE* and *pre-SI*. The *post-PQ* is correlated with the *post-CORE*, *post-SI*, and the *Mean Residual Gain*. The *pre-CORE* is correlated with the *post-CORE* and *pre-SI*. The *post-CORE* is correlated with the *post-SI* and the *Mean Residual Gain*. The *pre-SI* is correlated with the *post-SI*. The *post-SI* is correlated with the *Mean Residual Gain*.

The correlations listed above provide insight regarding patterns in the bivariate relationships between the CMEQ-R₂ variables and the outcome variables. As can be inferred from these correlations, the three CMEQ-R₂ variables employed are not correlated with each other and will thus not present problems of colinearity. Likewise, the control variable *WAI-SR* is not correlated with any of the above-mentioned variables of interest. Moreover, the post-Therapy Outcome variables are all correlated with each other. On the other hand, the pre-Therapy Outcome variables are generally not correlated with the other variables but are correlated with each other.

Table 6. 4. Pearson R Correlations of Process Variables, Outcome Variables and Control Variables

	<i>dPSS</i> <i>12</i>	<i>dPSS</i> <i>23</i>	<i>WAI-SR</i>	<i>TotNSessio</i> <i>ns</i>	<i>pre-PQ</i>	<i>post-PQ</i>	<i>pre-Core</i>	<i>post-Core</i>	<i>pre-SI</i>	<i>post-SI</i>	<i>Mean.Residual.</i> <i>Gain</i>
<i>PSSI1</i>	-0.21	-0.09	0.18	0.04	0.13	-0.13	-0.03	-0.36*	0.15	-0.21	-0.30*
<i>dPSS12</i>		0.18	0.04	-0.16	-0.07	-0.31	0.00	-0.30	0.03	-0.30	-0.33*
<i>dPSS23</i>			0.26	-0.13	0.25	-0.37*	0.28	-0.27	0.15	-0.46*	-0.39*
<i>WAI-SR</i>				0.08	0.11	-0.57*	-0.11	-0.43*	-0.14	-0.53*	-0.39*
<i>TotNSessions</i>					0.00	-0.17	-0.17	0.00	-0.06	-0.01	-0.02
<i>pre-PQ</i>						0.17	0.50*	0.03	0.55*	0.06	-0.16
<i>post-PQ</i>							0.33	0.76***	0.12	0.60*	0.84***
<i>pre-Core</i>								0.37*	0.70***	0.27	-0.02
<i>post-Core</i>									0.20	0.86***	0.88***
<i>pre-SI</i>										0.47*	-0.13
<i>post-SI</i>											0.83***

Note. *PSSI1*= CMEQ-R₂ for the Early Phase; *dPSS12*= Change between the mean person scores of the middle CMEQ-R₂ to early phase of therapy; *dPSS23*= Change between the mean person scores of the late CMEQ-R₂ to middle phase of therapy *WAI-SR*= Working Alliance Inventory short version; *pre-Core* = Pre-Therapy Clinical Outcome Routine Evaluation; *post-Core* = Post Therapy Clinical Outcome Routine Evaluation; *pre-PQ* = Pre-Therapy Personal Questionnaire; *post-PQ* = Post Therapy Personal Questionnaire; *pre-SI* = Pre-Therapy Strathclyde Inventory; *post-SI* = Post Therapy Strathclyde Inventory; *TotNSessions* = Total number of sessions of a given client. *p < .05. **p < .01. ***p < .001. Sample size ranges for N=50 to N=73.

To explore the relationship between *Protocol* (categorical variable) and the *Mean Residual Gain*, I performed a one-way ANOVA of the mean residual gain by type of *Protocol* ($F=5.527$, $p\text{-value}< 0.001$) (see Table 6.5). The results suggest that the different protocols have different *Mean Residual Gains*. Therefore, this variable should be used as a control variable in the regression models.

Table 6. 5. One-way ANOVA of Mean Residual Gain by Type of Protocol

	df	Sum Sq	Mean Sq	F value	p-value
Protocol	2	8.23	4.12	5.53	0.01
Residuals	70	52.12	0.75		

To explore the relationship between *Therapists* (categorical variable) and the *Mean Residual Gain*, I performed a one-way ANOVA ($F=1.073$, $p\text{-value}=0.403$) (see Table 6.6). Since the p-value is not significant and some therapists had only one client, I did not include this variable in the regression model.

Table 6. 6. One-way ANOVA of Mean Residual Gain by Therapists

	df	Sum Sq	Mean Sq	F value	p-value
Therapist	17	14.10	0.83	0.98	0.48
Residuals	55	46.28	0.84		

Taking these patterns into account, I decided that I was going to fit a model for the *Mean Residual Gain* as the dependent variable — the *Mean Residual Gain* variable holds information about the post-outcome variables, once having extracted information from the pre-outcome variables. I used the *WAI-SR* and *Protocol* as control variables. I didn't use *TotNsessions* and *Therapists* because these variables

didn't seem to be related to the *Mean Residual Gain* (as seen in Table 6.5 and 6.6). I used *PSSI*, *dPSSI2* and, *dPSSI3* as the process variables.

6.7.2 Graphical Displays of the CMEQ-R₂ for Each Phase of Therapy

In order to help the reader analyse the relationship between the CMEQ-R₂ and outcome, I decided to create a graphical display of how the CMEQ-R₂ discriminates between improved clients and those who remained in the clinical population¹³. In order to do so, I developed a visual display of the behaviour of the CMEQ-R₂ index score for each phase of therapy. I used the CORE to divide the clients into two groups (see Figure 6.4). One group included all clients who displayed improvement and were no longer in a clinical state and the other group included all clients who remained in a clinical state — a client can be considered to be in a clinical state when they have a mean CORE score of more than 1. I then plotted each group's CMEQ-R₂ score for Early, Middle, and Late phases of therapy. The left panel of Figure 6.4 corresponds to the population that was no longer in a clinical state; each client is represented by a red line. The right panel corresponds to the clinical population; each client is represented by a green line. The thick black line represents the mean CMEQ-R₂ for each phase of therapy. As can be observed, the non-clinical group displays an increase of their CMEQ-R₂ index score. This does not happen for the clinical group; their CMEQ-R₂ index score remains at a similar level for each phase of therapy. Thus, the visual display shows that the CMEQ-R₂ index score seems to discriminate well between these two populations.

¹³ A score reduction of the CORE is considered an indication of improvement. A mean score reduction of 0.5 or higher establishes both reliable change and a significance level of $p < 0.05$. Clinical populations are established for each measure using the mean score as indicator. For the CORE the score should be more than 1.

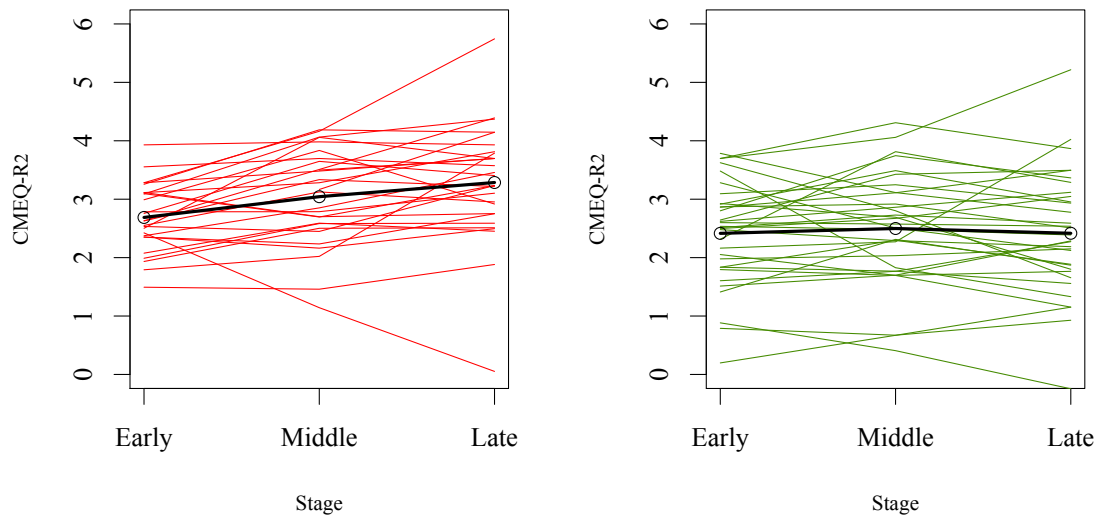


Figure 6. 4. *Visual Display of the Behaviour of the CMEQ-R₂*

The left panel of the figure corresponds to clients that were no longer in a clinical state; a red line represents each client. The right panel corresponds to the clinical population; a green line represents each client. The thick black line represents the mean CMEQ-R₂ for each phase of therapy.

6.7.3 Regression analyses

I used two approaches to analyse the relationship between CMEQ-R₂ and the mean residual gain: a hierarchical regression approach and a full regression model. I used both models to analyse the significance of each variable and the amount of variance these explained within this model.

6.7.3.1 Hierarchical Regression Analysis

I employed hierarchical regression analysis¹⁴ in order to examine the size and significance of incremental contributions to outcomes of the variables of interest. In order to do this, I first controlled for possible effects of variables included in previous steps. It is important to take into account that the results of hierarchical regressions depend on the order in which the variables are entered. There are several

¹⁴ As a variant of the multiple regression procedure, this type of analysis provides the possibility of deciding a specific fixed order in which variables may be entered. As such, hierarchical regression analysis provides a means of taking into account the effects of the control variables and of examining the effects of predictors independently from any possible additional influence (Howitt & Cramer, 2017)

ways of performing hierarchical regressions; none of the models can offer a completely satisfactory solution. I chose to use an ad hoc approach by first entering the control variables and then the variables of interest in order to reflect the psychotherapeutic process (see Table 6.7). I entered the control variables so as to obtain the incremental explained variance of the CMEQ-R₂ over and above the control variables. The first variable entered was the *WAI-SR* because it is a set variable that previous research has established as a moderate but robust predictor of outcome (Horvath and Symonds, 1991). Secondly, since I had used three different therapy protocols I entered *Protocol* (*ProtocolSA*, *ProtocolPB* and *ProtocolExt*). I then entered my three variables of interest: first the *PSSI* (CMEQ-R₂ for the early phase of therapy), then the *dPSSI2* (difference between the CMEQ-R₂ for the middle phase of therapy and the early phase of therapy), and finally, the *dPSSI3* (the difference between the CMEQ-R₂ for the late phase of therapy and the middle phase of therapy). Given the lack of clear established methodology to enter the variables, the results of these hierarchical regressions should be understood as indicative instead of conclusive. However, the full regression models, along with the partial η^2 effect sizes, the differential R², and the test of significance of the beta coefficients, can be used to establish the statistical significance and the relative importance of each variable once the other variables have been taken into account in the regression.

6.7.4 Hierarchical Regression Results for the Mean Residual Gain

In Step 1, the *WAI-SR* accounted for 15% of the variance of the *Mean Residual Gain*. It showed statistical significance with a p-value < 0.001. In Step 2, when *Protocol* was entered, it incremented the explained variance by 4% as measured by the adjusted R². This was not a significant increase (F=2.95, df=2, 69,

p-value= 0.06, effect size $f^2= 0.09$). In Step 3, I entered the early CMEQ-R₂ (*PSSI*) that explained an additional 6% of the variance. This increase was found to be statistically significant with $F= 6.73$ and $df=1, 68$, p-value = 0.01. The effect size $f^2= 0.10$ is considered to be small. In Step 4, I entered *dPSSI2* (the difference between *PSSI* and *PSS2*). The change in adjusted R^2 was found to be 10% of the variance. This increase was statistical significant with $F=11.92$, $df=1, 67$, p-value < 0.001, $f^2= 0.18$ (considered to be medium effect). In Step 5, I entered *dPSS23* (the difference between *PSS2* and *PSS3*). The change in adjusted R^2 was 7%, $F= 9.84$, $df=1, 66$, p-value < 0.01, effect size $f^2=0.15$ (considered to be small/medium effect). This suggests that the three CMEQ-R₂ variables seem to explain the variance of the *Mean Residual Gain* when the variables are entered in the fixed ordered that I chose. These results will be validated with the full regression model.

Table 6. 7. Hierarchical Regression for the Mean Residual Gain

Step	Included Variable	R ² Adjusted	R ² Change	F Change	df	p-value	Beta	Effect Sizes (f ²)
1	<i>WAI-SR</i>	0.15					-0.42 ***	
2	<i>WAI-SR</i>						-0.33 **	
	<i>ProtocolPB</i>						0.41	
	<i>ProtocolSA</i>	0.19	0.04	2.95	2,69	0.06	-0.17	0.09
3	<i>WAI-SR</i>						-0.25 *	
	<i>ProtocolPB</i>						0.35	
	<i>ProtocolSA</i>						-0.45	
	<i>PSSI</i>	0.25	0.06	6.73	1,68	0.01	-0.36 *	0.10
4	<i>WAI-SR</i>						-0.25 *	
	<i>ProtocolPB</i>						0.20	
	<i>ProtocolSA</i>						-0.49 .	
	<i>PSSI</i>						-0.45 **	
	<i>dPSS12</i>	0.36	0.10	11.92	1,67	<0.001	-0.52 ***	0.18
5	<i>WAI-SR</i>						-0.17	
	<i>ProtocolPB</i>						-0.01	
	<i>ProtocolSA</i>						-0.66 *	
	<i>PSSI</i>						-0.52 ***	
	<i>dPSS12</i>						-0.48 **	
	<i>dPSS23</i>	0.43	0.07	9.84	1,66	<0.01	-0.39 **	0.15

Note. *WAI-SR*= Working Alliance Inventory short version; *ProtocolPB*= Practice-Based Protocol; *ProtocolSA*=Social Anxiety Protocol; *PSSI*= CMEQ-R₂ for the Early Phase; *dPSS12*= Change between the mean person scores of the middle CMEQ-R₂ to early phase of therapy; *dPSS23*= Change between the mean person scores of the late CMEQ-R₂ to middle phase of therapy; *p < .05. **p < .01. ***p < .001.

6.7.5 The Full Regression Model for the Mean Residual Gain

The first column of Table 6.8 displays the full regression model using all the control variables and the CMEQ-R₂ variables of interest (*PSSI*, *PSS2*, *dPSS12*, *dPSS23*) for each stage of therapy. The third column of Table 6.8 shows the t-values for the test of significance of the beta coefficients. The last column shows the p-values associated with these tests.

Table 6. 8. Full Regression Model for the Mean Residual Gain

	Beta	Std. Error	t value	p-value	
(Intercept)	2.15	0.47	4.61	0.00	***
<i>WAI-SR</i>	-0.17	0.11	-1.61	0.11	
<i>ProtocolPB</i>	-0.01	0.21	-0.03	0.98	
<i>ProtocolSA</i>	-0.66	0.26	-2.51	0.01	*
<i>PSSI</i>	-0.52	0.13	-4.13	0.00	***
<i>dPSSI2</i>	-0.48	0.14	-3.37	0.00	**
<i>dPSSI23</i>	-0.39	0.13	-3.14	0.00	**

Note. *WAI-SR*= Working Alliance Inventory short version; *ProtocolPB*= Practice-Based Protocol; *ProtocolSA*= Social Anxiety Protocol; *PSSI*= CMEQ-R₂ for the Early Phase; *dPSSI2*= Change between the mean person scores of the middle CMEQ-R₂ to early phase of therapy; *dPSSI23*= Change between the mean person scores of the late CMEQ-R₂ to middle phase of therapy; *p < .05. **p < .01. ***p < .001.

The first column of Table 6.9 displays the percentages of the variance explained by each variable after taking into account all other variables. The third column shows the partial η^2 for each variable. The last column shows the differential R^2 for each variable within the full model. It should be noted that these percentages are similar to the ones obtained by the hierarchical regressions once we take into account the fact that these variances have not been adjusted.

Table 6. 9. Full Regression Model for the Mean Residual Gain

	SSR	df	partial η^2	dR ²
(Intercept)	10.14	1	0.24	
<i>WAI-SR</i>	1.24	1	0.04	0.02
<i>Protocol</i>	3.95	2	0.11	0.07
<i>PSSI</i>	8.12	1	0.21	0.13
<i>dPSSI2</i>	5.40	1	0.15	0.09
<i>dPSSI23</i>	4.69	1	0.13	0.08
(SSE):	31.4			
(SST):	60.4			

Note. *WAI-SR*= Working Alliance Inventory short version; *Protocol*= Type of protocol used; *PSSI*= CMEQ-R₂ for the Early Phase; *dPSSI2*= Change between the mean person scores of the middle CMEQ-R₂ to early phase of therapy; *dPSSI23*= Change between the mean person scores of the late CMEQ-R₂ to middle phase of therapy; SSR= Sum of Squares associated with each variable; partial η^2 = partial eta squared for each variable in the regression; dR²= differential percentage of the variance explained; SSE= Residual sum of squares; SST= Total sum of squares.

As can be observed in Table 6.9, the effect sizes of the CMEQ-R₂ variables correspond to a medium effect. Also, the total variance explained by the CMEQ-R₂ is 30% (adjusted 26.6%). As can be seen in Table 6.9, the Social Anxiety Protocol is significantly better to predict *Mean Residual Gain* than the other two protocols (Practice-Based Protocol and External Protocol) once the other variables are taken into account. Since *Protocol* is a significant variable, I decided to test whether there were significant interactions between *Protocol* and my CMEQ-R₂ variables (*PSSI*, *dPSSI12*, *dPSSI23*). I fitted a new model by including all the terms of interaction plus the *WAI-SR* variable. To compare this model with the previous model without interactions, I computed the F statistic (F= 0.96, df= 4, 61, p-value=0.43). I found that the interactions between *Protocol* and my CMEQ-R₂ variables did not provide additional information.

6.7.6 Question 1: Does the Early Phase CMEQ-R₂ Predict Outcome Over and Above What is Predicted by all the Other Variables in the Equation?

Applying the hierarchical regression for the *Mean Residual Gain* and entering *PSSI* (Step 3) explained an additional 6% of the variability of the *Mean Residual Gain* over and above what was explained by the control variables (Steps 1 and 2). This was a statistically significant increase of the variance explained by the model (p-value = 0.01). For the full model, the beta coefficient of the *PSSI* was -0.52. The effect size as measured by the partial η^2 was 0.21 (this is considered a medium effect). For the full model, the differential R² of *PSSI* was 13%. I tested for the statistical significance of *PSSI* (t = -4.13, p-value <0.001). Given, the above discussed evidence, I can conclude that *PSSI* helped predict outcome with a medium

effect size even after controlling for *WAI*, *Protocol* and CMEQ-R₂ of the other phases of therapy.

6.7.7 Question 2: Does the Middle Phase CMEQ-R₂ Predict Outcome Over and Above what is Predicted by all the Other Variables in the Equation?

To estimate the relationship between the mean CMEQ-R₂ for the middle phase of therapy and outcome, I used the difference between the mean middle phase CMEQ-R₂ and the corresponding value for the early phase (*dPSSI2*). *dPSSI2* was chosen because, as shown in the correlation matrix (see Table 6.4), this difference is not correlated with *PSSI1*. Thus, it could provide different information about the *Mean Residual Gain* not included in *PSSI1*. I expected that the larger the difference between the middle and early phase CMEQ-R₂, the better the *Mean Residual Gain* would be. Conversely, the smaller the difference between both CMEQ-R₂ phases, the poorer the *Mean Residual Gain* would be.

Applying the hierarchical regression for the *Mean Residual Gain* and entering *dPSSI2* (Step 4), explained an additional 10% of the variability of the *Mean Residual Gain* over and above what was explained by the control variables in Steps 1 to 3. This was a statistically significant increase of the variance explained by the model (p-value <0.001). For the full model, the beta coefficient of *dPSSI2* was -0.48. The effect size as measured by the partial η^2 was 0.15. This is considered to be a medium effect. The differential R² of *dPSSI2* for the full model was 9%. I tested for the statistical significance of the *dPSSI2* within the full model (t= -3.37, p-value <0.01). The full regression model showed that the difference between the middle and early CMEQ-R₂ helped predict outcome with a medium effect size over and above all other variables. Not only that, but the sign of the beta coefficient was consistent with

the hypothesis that the larger the difference between middle and early phase CMEQ-R₂, the better the mean residual gain would be.

6.7.8 Question 3: Does the Late Phase CMEQ-R₂ Predict Outcome Over and Above What is Predicted by all the Other Variables in the Equation?

To estimate the relationship between the mean CMEQ-R₂ for the late phase of therapy and outcome, I used the difference between the mean late phase CMEQ-R₂ and the corresponding value for the middle phase (*dPSS23*). *dPSS23* was chosen because, as shown in the correlation matrix (Table 6.4), this difference is not correlated with *PSS1* and *dPSS12*. Applying the hierarchical regression for the *Mean Residual Gain* and entering *dPSS23* (Step 5), explained an additional 7% of the variability of the *Mean Residual Gain*, over and above what was explained by the control variables in Steps 1 to 4. This was a statistically significant increase of the variance explained by the model (p-value <0.001). Moreover, the beta coefficient of the *dPSS23* for the full model was -0.39. The effect size as measured by the partial η^2 was 0.13. This is considered to be a small to medium effect. The differential R² of *dPSS23* for the full model was 8%. I also tested for the statistical significance of *dPSS23* within the full model (t= -3.14, p-value <0.01).

The full regression model showed that the difference between the late and middle CMEQ-R₂ helped predict outcome with a medium effect size over and above all other variables. Not only that, but the sign of the beta coefficient was consistent with the hypothesis that the larger the difference between the late and middle phase CMEQ-R₂, the better the *Mean Residual Gain* would be. Conversely, the smaller the difference between both CMEQ-R₂ phases, the poorer the *Mean Residual Gain* would be.

I concluded that the three CMEQ-R₂ for each phase of therapy could be used to predict therapeutic improvement after having controlled for *WAI* and *Protocol* with a total adjusted variance explained of 26.6%.

6.7.9 Question 4: Do Different Protocols Produce Different Outcome Results?

The results of the full regression model showed that the type of Protocol used is significant. Once I controlled for the other variables, *ProtocolSA* seemed to produce better outcomes ($t = -2.51$, $p\text{-value} = 0.01$). I then explored whether there were interactions between *Protocol* and the CMEQ-R₂ for the early, middle and late phases. In order to do so, I introduced interaction variables in the full regression model. I found no interaction effect.

6.8 Chapter Summary

This study involved the examination of the sample specific psychometric quality of my participant instrument, the subsequent refinement of the questionnaire, and finally an analysis of the instrument's relationship to therapeutic outcome. I first used the Rasch model in order to examine the functionality of the rating scale categories of the questionnaire, I also examined item and person reliability and separation, and explored whether the item hierarchy made sense theoretically. The result was a more refined 24-item, 3-point scale CMEQ-R₂. I then conducted a Process Outcome study using a regression model. The findings showed strong evidence that the early, middle and late phase CMEQ-R₂ is related to overall therapeutic improvement. These results are discussed in greater depth in Chapter 7.

Chapter 7

Insights Offered by this Research Endeavour

7.1 Introduction

The overall objective of this research project was to empirically validate and investigate the Client Modes of Engagement (CME) conceptual framework proposed by Elliott (2006; 2013a). Up to the time of writing, there were no psychometrically sound measures for investigating and validating this construct. In order to fill this knowledge gap, I developed two measures that would permit the empirical and systematic observation and validation of the framework under study. The project resulted in the development and eventual application of a non-participant observational coding system (CME-OCS) and a user-friendlier participant observational questionnaire (CMEQ-R₂). These instruments offered the possibility of empirically validating the CME framework from both a participant and a non-participant perspective as well as examining how CMEs relate to therapeutic change both within sessions and across therapy. As such, this project constitutes an important contribution to knowledge from a Person/Centred-Process/Experiential perspective.

The following discussion offers an in-depth examination of the findings yielded by this research endeavour. Mirroring the structure of the dissertation as a whole, this last chapter is divided into two overall sections. Part I involves a discussion of the main insights generated during the development and implementation of the CME-OCS, and Part II offers an analysis of the findings produced during the development and implementation of the CMEQ-R. The chapter then offers reflections on the possibilities offered by the development of a multi-

perspective set of instruments, and an exploration of the limitations and implications of this project in conversation with the available literature. I also discuss possible research and clinical implications, suggestions for possible future directions, and lastly, a meditation of my own journey as both researcher and practitioner.

7.2 Main Findings: Development and Application of the CME-OCS and CMEQ-R₂

The CME-OCS and the CMEQ-R₂ were developed as psychotherapy process diagnostic systems for researchers and therapists respectively. Both instruments were constructed with the objective of deepening current understanding of how CME manifest during psychotherapy. These instruments provide a means of identifying client experiential content as they are accessed through the schematic structures of emotional processing. The decision to approach this research endeavour through the development and application of a participant and a non-participant measure was based on the premise that these two instruments would yield important complementary data and thus offer a fuller picture of the complex processes under investigation. In the following section, I discuss the main findings that arose from this exploratory process along with the insights yielded by the eventual application of the CME-OCS and the CMEQ-R₂.

7.3 Part I: Main Findings Yielded by the CME-OCS

My exploratory process offered important and fruitful information. To begin with, my results suggested that there are at least four identifiable levels of Client Modes of Engagement that are amenable for research: Dysregulated, Restricted, Working, and Change Mode. Moreover, I determined that the CME-OCS is able to reliably discern amongst these levels (at least in the sample studied). Indeed, as

reported in the result section, all four modes were evidenced across all phases of therapy for both outcome groups. These results opened the door for the application of the CME-OCS as a process measure of the CME construct.

The broad assumption upon which EFT is grounded is that the aim of the therapeutic process is that of facilitating clients' processing of their emotional experiences—it is precisely this which brings upon positive change (Elliott et al., 2004). Thus, the general hypothesis under investigation for this first exploratory process was that there would be clear differences in the ways most and least improved clients engaged with CMEs both in-session and throughout therapy. I expected that there would be a considerably higher proportion of least improved clients engaging in the Dysregulated and Restricted Mode. Conversely, I expected that there would be a significantly higher proportion of most improved clients engaging in Working and Change Mode. After all, the CME model understands these two modes as fundamental and productive processes that lead to emotional growth and recovery (Elliott et al., 2004; Elliott, 2013a).

The results of this first study reflected my initial hypothesis in powerful ways. Firstly, I was indeed able to establish that there are clear differences in the overall probability of both outcomes groups of being in particular CMEs. These differences reflected the CME theoretical construct. I found that the proportion of least improved clients who tended to engage in unregulated, chaotic and disorganised processes of experiencing (Dysregulated Mode) was greater than the proportion of most improved clients engaging in these same modes. Also, least improved clients tended to spend more in-session time overtaken and isolated by a single emotion scheme element (Restricted Mode) than most improved clients. Conversely, the most

improved group tended to spend considerably more time exploring and integrating the different elements of their emotion scheme (Working Mode) than the least improved group. Likewise, there was a critical distinction between the probability of the most improved and least improved group of bringing novelty and discovery into their processes of experiencing (Change Mode). Moreover, for the least improved group, the Change Mode was almost absent.

These findings are also consistent with other research projects investigating forms of emotional engagement that lead to change processes. Indeed, previous studies in the field suggest that it is advantageous for clients to incorporate meaning-making processes into their narratives (i.e. Boritz et al., 2014; Gonçalves et al., 2011; Toukmanian, 1996). Toukmanian (1996), for example, found that clients with rigid and fixed perceptions have difficulty transforming the ways they understand their experiences. Boritz and colleagues (2014), likewise, found that facilitating the articulation of more coherent narratives leads clients to embark on meaning-creation processes. In general, my findings not only corroborate these previous studies, but also suggest that most improved clients engage in qualitatively different emotional experiences than least improved clients and have a more diverse array of emotional elements that they bring to bear into their experience during therapy.

7.3.1 Evolution of CMEs Across Phases of Therapy

Once I had determined that there were overall differences in the ways CMEs manifest in both outcome groups, I focused on investigating the evolution of CMEs across early, middle and late phases of therapy in terms of therapeutic outcome. The results showed significant interactions between CMEs, phases of therapy and outcome.

While both outcome groups displayed a similar behaviour during the early phase of therapy, significant differences in the amount of time spent in particular CMEs became evident by the middle and late phases of therapy. I found that there is a tendency for clients to become less chaotic and disorganised as time goes by during a single therapeutic session. Indeed, there is a generalized minute-by-minute decrease in the time spent in the Dysregulated Mode during any single session in all phases of therapy for both outcome groups. However, I found clear differences amongst both outcome groups in the amount of time spent engaging in the Dysregulated Mode across therapy. Most improved clients spent significantly less of the middle and late phase of therapy engaging in this mode. This suggested to me that clients who are involved in therapy in more productive manners have a tendency to organise their experiences more fully and permanently by the time they arrive at the middle and late phase of therapy.

The probability of being in the Restricted Mode during the early and middle phase of therapy also decreased for each minute spent in a single session for both groups. Thus, the results suggest that during a single therapeutic session there is a general tendency for clients to become less isolated and overtaken by a single emotion scheme element. This decrease, however, was significantly more pronounced across therapy for improved clients. Indeed, during the middle and late phase of therapy, the most improved group spent a significantly lower proportion of time in the Restricted Mode than the least improved group. It would seem that during the middle and late phases of therapy, most improved clients have a greater tendency to bring to bear other elements into their experience and to spend proportionally less

in-session time overtaken by a single element of the emotion scheme than least improved clients.

Interestingly, albeit with different propensities, both outcome groups continued to engage in the Restricted Mode during all phases of therapy. It seems that this mode may not be intrinsically unproductive; to some extent, it is not necessary for clients to stop engaging in the Restricted Mode. One possible explanation for these findings is that sole-focus narratives can help clients contextualize their difficulties by supplying details that offer a way to organise and centre their emotional processes. As long as clients engage in this mode sparingly by the middle and late phases of therapy, these instances could provide a framework for bringing to bear other elements into the experience in a productive manner. Additionally, sharing sole-focus narratives may serve the important role of revealing clients' more salient difficulties to therapists. This, in turn, may help create an empathic bridge between therapists and clients. On the other hand, engaging in the Restricted Mode may also operate as an avoidance strategy, particularly in cases when there is a clear propensity for clients to engage in single-mode-focused processes. It seems that if the client remains unable to experience and integrate the different elements of the emotion scheme, they remain persistently stuck. This may imply that the least improved group become swamped and increasingly wedged into this single-mode of processing. On the other hand, the most improved group seems to be able to find ways of using and integrating more of the elements of the emotion scheme in fruitful ways. This indicates to me that a sole-focused narrative may lessen opportunities for bringing other emotion scheme elements into the experience and may explain why least improved clients continue to be highly dominated by this

stance during the middle and late phases of therapy. These reflections are particularly interesting because this mode was so prominent in the cases studied. One important indication is that the Restricted Mode, in itself, may neither be inherently dysfunctional nor productive. Rather, as I will discuss below, how fruitful it is may depend on the dynamic interplay of this mode in relation to other CMEs.

When examining the Working Mode, I found that, for both outcome groups, time spent in this mode increased by the middle phase of therapy. Interestingly, while during the early phase of therapy both groups started with a similarly low propensity to bring multiple emotion scheme elements to bear on their experience, for the least improved group this propensity only increased slightly by the middle and late phase of therapy. In contrast, the tendency of the most improved group to engage in the Working Mode increased considerably by the middle phase of therapy. Indeed, by this phase of therapy, the most improved clients tended to spend considerably more of their time bringing to bear a greater array of emotion scheme elements into their experience. This tendency remained relatively constant until the end of therapy. Relatedly, Auszra and colleagues (2013) found that mid-therapy emotional activation, when in combination with symbolization and differentiation, is particularly predictive of good outcomes in a sample of clients with depression. In a similar vein, Missirlan and colleagues (2005) reported that the presence of emotional arousal, along with higher levels of perceptual processing during the middle and late stage of therapy, significantly decreased the probability of displaying depressive and general distress symptoms by the end of therapy. Engaging in the Working Mode during the middle phase of therapy may indicate that clients in the

process of recovery are laying the grounds for a deeper level of inquiry, meaning making, and exploration.

During the late phase of therapy, there was a slight decrease in the probability of being in Working Mode for both groups. This tendency should be understood in the context of how clients in both outcome groups engaged with other CMEs during this phase. For the most improved group, for example, the slight decrease in the Working Mode corresponded with an increase in their tendency to engage in the Change Mode. Conversely, for the least improved group, this slight decrease in their tendency to engage in Working Mode corresponded with a considerable increase in their tendency to engage in the Dysregulated Mode. One explanation for this could be that, in order to fully benefit from engaging in the Working Mode, clients should not mainly “pass by” this experience but also “work through” the variety of elements of the emotion scheme. It seems that clients need to first deeply engage in the Working Mode, thus bringing their emotion scheme elements to bear in their experience in an organised manner, in order to foster shifts and bring moments of novelty into their experience.

It would seem that after arriving in Working Mode, least improved clients quickly return to a chaotic and disorganised process without taking advantage of the opportunities presented by these instances. It is possible that least improved clients are still not ready to integrate a greater array of elements into their experience, to stay at that level of integration and depth of their experience, and thus these instances lead back to a sense of chaos. Moreover, it is possible that when in Working Mode, the possibility to move to processes of transformation demands more energy than these clients are ready to expend at that moment.

In this sense, my findings provide valuable insights for critics of the “venting hypothesis” which argues that the greater the experiences of distress during psychotherapy the better. Opponents of this premise have long argued that clients who remain in chaotic and disorganised emotional processes are unable to organise their narratives and consider new perspectives (Angus, Watson, Elliott, Schneider & Timulak, 2015; Boritz et al., 2017; Greenberg & Pascual-Leone, 2001). Indeed, I would posit that the tendency of the least improved group to go back from Working Mode to Dysregulated processes implies that they do not “work through” the Working Mode in a productive way. Kennedy-Moore and Watson (1999), point out that intense emotional expressions during therapy require verbal articulation, elaboration, exploration, and a level of understanding, in order to process experiences productively. The CME theoretical perspective would suggest that engaging in the Dysregulated Mode likely echoes feelings of intense distress that can make it difficult for clients to bring various elements into their experience in an organised and productive manner. Clients’ chaotic or disorganised stances may be inadequate means of using Working Mode processes for moments of change to emerge.

There were substantial differences in the ways both outcome groups engaged in the Change Mode. The least improved group rarely engaged in this mode during any phase of therapy. Conversely, for the most improved group there was a substantial increase in the proportion of time spent in Change Mode by the middle phase of therapy. This tendency continued to increase at a slower pace during the late phase. Comparably, Mendes and colleagues (2010) found that the good outcome group tended to experience significantly more moments of “reconceptualization”

during which they contrasted previous self-narratives with emergent ones. Bento and colleagues (2014) also found that the recovered clients showed a greater tendency to narrate moments in which they “performed change” — engaging in action-oriented agentic expressions. Both of these studies found that these moments were almost absent from least improved clients’ narratives. As discussed above, for the most improved group, the slight decrease in the proportion of time spent in Working Mode during the late phase of therapy mirrored the slight increase of time spent engaging in the Change Mode.

7.3.2 Differences Between the Most Improved and Least Improved Groups in their Ability to Transition between CMEs

Once I had inspected how CMEs evolved within sessions and across therapy, I decided to investigate the relationship between therapeutic outcome and the minute-by-minute probability of a transition from one CME to another. Consistent with my general hypothesis, I found clear differences in the way patterns of transitions manifested amongst both outcome groups; I also found differences between patterns of transitions and phases of therapy. Research exploring emotional processing transitions is quite sparse. Indeed, to my knowledge, there are only a handful of studies that employ this kind of analysis (Boritz et al., 2017; Cunha, Gonçalves, Hill, Mendes, Ribeiro, Sousa et al., 2012).

7.3.2.1 Transitions Between Client Modes of Engagement: Early Phase

I did not find any significant differences between the ways both outcome groups transitioned between CMEs during the early phase of therapy. This suggests that transitions between CMEs during initial phases of therapy were similar between both outcome groups. Clear differences, however, became evident by the middle

phase of therapy. It seems that disparities in the ways most and least improved clients shifted emerged somewhere in the middle of the therapeutic process.

7.3.2.2 Transitions Between Client Modes of Engagement: Middle Phase

By the middle phase of therapy, I found marked dissimilarities in the ways both outcome groups transitioned between CMEs. When in Restricted Mode, the least improved group tended to transition less often than the most improved group. As pointed out earlier, the mere presence of the Restricted Mode during the middle phase of therapy is not necessarily problematic in itself. Indeed, these findings are better understood in the context of my previous results regarding the proportion of time spent in this same mode. Together, both results provide a deeper understanding regarding how the Restricted mode can be used productively or unproductively during therapy. Indeed, while both outcome groups engaged in this mode during all phases of therapy, it was the sustained and persistent sole focus on a single emotion scheme element that was particular to the least improved group. Likewise, Boritz and colleagues' (2017) study researching narrative transitions across therapy found that during a single session, least improved clients tended to remain particularly stuck on a single narrative marker "storytelling" (i.e., externalising) mode and shifted less often than recovered clients. I would posit that when clients are entrenched in this sole focus of attention it may be more difficult for them to transition from a Restricted Mode to other CMEs.

In terms of the Working Mode, during the middle phase of therapy, the most improved group tended to transition between longer periods of Working Mode and shorter periods of Change Mode. Least improved clients, on the other hand, tended to transition between short bouts of Working Mode and extended periods of Restricted

Mode. As discussed earlier, this could imply that least improved clients are not able to make use of the Working Mode and continue sliding back to the Restricted Mode. The most improved clients, on the other hand, seem to make particular use of the Working Mode during the middle phase of therapy, thus preparing the ground for a greater use of the Change Mode later on. In sum, when the most improved group arrived at more productive modes of processing experience they tended to stay in these modes longer.

These findings are consistent with similar research studying change processes. Brinegar and colleagues (2006) have shown that in order to consolidate meaning-making moments, clients need to rehearse, construct and stay with these opportunities until they can fully become integrated. Likewise, Gonçalves and colleagues (2011) found that clients who stay with moments of change, become aware of the shifts that occur between the past and present self, elaborate upon these experiences, and are better able to construct new understandings of the self. In the same vein, Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves (2011) found that recursive articulations of reconceptualization, along with the ability to articulate new aims and projects (“performing change”), were clear markers for good outcome cases.

7.3.2.3 Transitions Between Client Modes of Engagement: Late Phase

In general, the late phase of therapy showed similar results to the middle phase. Some differences amongst outcome groups, however, became more pronounced. For example, I found that the probability of transitioning from Restricted to Working Mode was higher for the most improved group than for the least improved group. In fact, for least improved clients, the probability of

transitioning from Restricted to Working Mode in the late phase of therapy was lower than during the middle phase of therapy. This suggests to me that a sole focus on a particular emotion scheme element had become even more entrenched by this late stage.

When in Change Mode, most improved clients tended to transition to Working Mode less often than during the middle phase of therapy. I would posit that, by this later stage, most improved clients had taken advantage of the processes yielded by the Working Mode and were now ready and committed to processing and experiencing discovery and novelty. As previously noted, least improved clients rarely achieved Change Mode at any stage of therapy; when they did, the probability of maintaining this mode was markedly lower than for the most improved group. It is clear from these findings that arriving and engaging in Change Mode was not a random process that emerged haphazardly. Rather, it is evident that clients who used therapy more productively went through particular patterns for engaging with their experiences.

Interestingly, Boritz and colleagues' (2017) research on differences in the ways both outcome groups shift between problem and change markers concluded that in general it was more difficult to transition out of problem markers (which can be likened to the Restricted and Dysregulated Modes) than change markers (which can be likened to the Change and Working Modes). It is important to note that their study did not take into account phases of therapy when examining these shifts. My research, on the other hand, specifically studied how minute-by-minute transitions may have been particular to different phases of therapy. Once this variable was taken into account, my findings suggest more nuanced and differentiated transition

patterns. In general, when reaching Working Mode, the most improved group tended to maintain this process for longer periods than the least improved group and were more inclined to transition to Change Mode. The least improved group tended to stay in Working Mode for shorter periods of time and were more inclined to transition to Restricted Mode. For this reason, the least improved group tended to display quicker downwards transitions whereas the most improved group tended to transition less quickly and instead tended to maintain more productive processes. In this research I was not only interested in understanding general tendencies to transition between CMEs in relation to outcome, but also in understanding how these transitions evolved across therapy. That is to say, in taking into account phases of therapy, my study provides a more refined examination of how these transition patterns manifest at different moments of the therapeutic process.

7.4 Part II: Main Findings Yielded by the CMEQ-R₂

The second part of my research project involved the development of a participant CME instrument, a subsequent examination of the psychometrics of this rating scale, and finally an exploration of the relationship between the resultant questionnaire and therapeutic outcome. Overall, I was able to determine that the CMEQ-R could be subjected to both long-established evidence based analysis and Rasch Modelling. Indeed, as reported in Chapter 5 and Chapter 6, both statistical methods yielded fruitful information for refining the instrument under study. The final result was the revised 24-item 3-point scale CMEQ-R₂.

In order to develop my participant instrument, I went through an exploratory process of generating items with the aim of constructing a more robust measure of Elliott's CME framework (Elliott, 2006; 2013a; 2013b). These items were first

subjected to analysis by expert raters and were later carefully reworded and refined using their feedback. Once the items had been refined, I explored the psychometric properties of the instrument by submitting the CMEQ-R to evidence-based long established statistical analysis. I was able to determine that the instrument had good reliability. Also, the factor structure provided evidence that the instrument as a whole was indeed measuring the Dysregulated, Restricted, Working and Change Modes of Engagement. This, in turn, served as a first indication that the questionnaire had good construct validity. Additionally, by exploring correlations between the CME Rating Scale and the Therapist and Client Overall Session Ratings Form (v4.4, Elliott, 2013b) (see Chapter 5), I found that some items measuring the Working and Change Mode were positively correlated with clients' and therapists' overall perception of the helpfulness, quality, progress, and therapeutic shifts of a given session. These findings served as an intimation that the instrument could predict overall therapeutic outcome.

Once the psychometric properties analysis had confirmed that the instrument's psychometrics were sound, I decided to examine the CMEQ-R's predictive validity through a process outcome study. In order to do so, I first needed to explore the instrument's sample specific psychometrics —as recommended by educational and psychological testing standards. I decided to submit the rating scale to Rasch analysis with the intention of further refining the instrument and evaluating scale functionality, person and item reliability and separation, item hierarchy, and exploring potential item reduction. As far as I have been able to determine, this is the first study to employ Rasch analysis to explore and refine a participant CME instrument.

The analysis provided several unique contributions to understand the functionality of the CMEQ-R₂. Firstly, the results suggested that the instrument's rating scale advanced monotonically from "absent" to "extensive". However, I found that therapists were not able to discriminate well between categories. Taking into account person and item separation, conditional likelihood, and Akaike Information Criteria (AIC), I removed 4 misfitting items to improve item reliability and optimize infit and outfit statistics. Indeed, when examining these 4 items, I found that they still contained a bit of jargon and seemed redundant or ambiguous; this probably affected reliability in the first place. The results also indicated that adjusting the instrument to a 3-point scale would improve user's ability to discriminate between categories. The resultant 24-item 3-point scale CMEQ-R₂, displayed moderate but adequate person separation —discriminating well between 4 to 5 groups of participants. Also, item separation was adequate with between nine and ten levels of endorsement difficulty.

Moreover, I found that the instrument's item hierarchy reflected the CME theoretical model well. Items that were least highly endorsed were those that assessed Dysregulated and Change processes. That is to say, both processes were perceived by therapists to occur less often and less extensively overall across therapy. These results are consistent with other comparable studies researching processes of change. Gonçalves and Ribeiro's (2012) study, for example, found that while innovative moments, and more specifically, instances of "reconceptualization" appear more often in good outcome cases, they are still relatively rare. Processes that appear less frequently during therapy will evidently be endorsed less often than more frequent processes. It is important to note that these findings can only be understood for the sample used. Indeed, it is probable that items measuring the Dysregulated

mode received low scores because populations with severe dysregulation had been excluded from the sample. Overall, the psychometrics yielded by these analyses were found to be sound and thus opened the door for a subsequent process outcome study. Notwithstanding, additional cross-validation of the functionality of the CMEQ-R₂ is still recommended.

I was particularly interested in exploring the predictive utility of the CMEQ-R₂. In order to do so, I decided to examine the relationship between the CMEQ-R₂ and overall outcome by using a multiple regression approach between outcome (as measured by the mean residual gain) and my variables of interest (the early phase CMEQ-R₂, the difference between the middle and early phase CMEQ-R₂, and the difference between the late and middle phase CMEQ-R₂) after controlling for different protocols and the therapeutic relationship (as measured by the *WAI-SR*).

The results of the regression procedure indicated that the higher the Rasch person CMEQ-R₂ scores for the early phase of therapy, the better the outcome at the end of therapy. In order to obtain a high CMEQ-R₂ score, therapists would have to have rated Working and/or Change items as having emerged often and extensively during a given session of the early phase of therapy. This implied that therapists already perceived the presence of these productive styles of engagement at this early stage for clients who showed better overall improvement at the end of therapy. Conversely, lower CMEQ-R₂ scores in poorer outcome cases indicate that therapists rated the extent to which clients engaged in the Dysregulated and/or Restricted modes of engagement as occurring more often and more extensively than Working and Change modes. This implies that less productive CMEs can likewise be observed in the early phase of therapy for clients who showed less improvement at the end of

therapy. Similarly, Auszra and colleagues' (2013) study using the Client Emotional Productivity (CEP) instrument — an observational coding system — for clients with depression, likewise concluded that early phase emotional processing was an independent predictor of outcome.

While the findings described above suggest that clients enter into the therapeutic process at different levels of engagement, it is important to note that while low or high CMEQ-R₂ scores in the early phase of therapy do provide significant predictive utility they are not guarantee of any particular outcome. Indeed, the results of this study suggested that the change in CMEQ-R₂ score between the middle and early phase of therapy (as measured by *dPSS12*), and between the late and middle phase of therapy (as measure by *dPSS23*), were also strong predictors of outcome. That is to say, if a given client's CMEQ-R₂ score increased by the middle phase of therapy, this would serve as a predictor that the client will eventually display a better outcome by the end of therapy than what had been predicted by the early CMEQ-R₂ score. Likewise, the change in CMEQ-R₂ score between the late and middle phase of therapy served as a distinct predictor of outcome.

There are several studies that provide indication of the relationship between phase of therapy, emotional processing and outcome. For example, Auszra and colleagues (2013) found that middle phase emotional processing (as measured by the CEP) served as a distinct predictor of outcome over and above the Working Alliance Inventory (WAI). Likewise, Carpenter and colleagues' (2016) findings using the NEPCS 1.0, for example, suggest that a high proportion of Unexpected Outcome Story (related to the Change Mode) was present at early and late stages of therapy for

recovered clients. Relatedly, Angus and colleagues' (2017) research investigating narrative emotion processing (as measured by the Narrative-Emotion Process Coding System 2.0, NEPCS) in a trauma population, found that recovered clients displayed productive narratives from the early phase of therapy. The study also found that recovered clients displayed significantly higher proportions of Discovery Story (related to the Change Mode) than unrecovered clients during the early and late phases of therapy. Conversely, the authors found that unrecovered clients displayed significantly more Superficial Storytelling markers (related to the Restricted Mode) than recovered clients during the middle and late phases of therapy. Additionally, Pascual-Leone and Yeryomenko (2017), in a meta-analysis of the Client Experiencing Scale (EXP) examining the predictive relationship between experiencing and self-report outcome measures, concluded that there were no overall differences between the strength of the predictive utility of the early, middle and late phases of therapy. Moreover, the authors found strong evidence suggesting that clients who tended to engage with their emotions in a deeper, more internally focused and reflective way, while displaying meaning-making processes, had better outcomes at the end of therapy. It is important to note that all the above-mentioned studies employed an observational system and thus could not arrive at any conclusion about the ability of therapists to perceive these processes.

In sum, I determined that the CMEQ-R₂ predicted general symptom distress. Thus, the CMEQ-R₂ can be considered an important instrument to predict outcome, at least in the groups studied. Indeed, as I discuss below, I found that the ways the CME appeared in each phase of therapy (early, middle and late) served as autonomous predictors of outcome (as measured by the mean residual gain) over and

above all the other variables used. The results suggest that CME processes that arise during the early, middle and late phases of therapy mediate the predictive utility of the CMEQ-R₂ scores. This implies that Client Modes of Engagement are amenable to change and can be better understood as a process that emerges and shifts across therapy. Given that therapists are able to recognize these modes and that, along with clients, they are fundamental actors of the psychotherapeutic process; this may suggest that these processes can be facilitated by therapist intervention. This, however, remains an avenue for future research.

7.5 The Importance of Approaching the CME Construct through Two Different Lenses

The CMEQ-R₂ and the CME-OCS were developed as means of capturing a fuller spectrum of CME model (Elliott, 2006; 2013a; 2013b). The aim was to analyse clients' manners of engagement both through the valuable subjective perspective of the therapist and the meticulous external observation of audios, videos and transcripts of sessions. Amongst other things, my multi-perspective approach offered a means of complementing therapist inward-looking session-by-session macro-observation (CMEQ-R₂) with an outward-looking micro-observational minute-by-minute (moment-to-moment) analysis (CME-OCS). It was through these two perspectives and the advantages each offered, that this research project has been able to study in-session, phase-by-phase and across therapy evolutions of CME processes.

There has been a general tendency to use non-participant observation systems to study clients' emotional processing in psychotherapy (Machado et al., 1999). While there is robust literature suggesting that observational instruments are valuable methods for the systematic examination of emotional processes (see Chapter 2), there

have been very few research endeavours that use or develop participant instruments for this same purpose. To my knowledge, aside from the 14-item questionnaire CME rating scale (Elliott, 2013b [v.4.4]) which this project endeavoured to refine and validate, resulting in the CMEQ-R₂, there is only one other research study on emotional processing that uses a participant instrument to measure therapist's perspective on client's emotional processing. Orlinsky and Howard (1986) developed the Therapist Session Report in order to measure the therapist's perception of their own involvement in the therapeutic process along with their view of clients' experience.

The decision to develop a multi-lens set of instruments was made under the premise that there are as many subjective perspectives as there are participants of the therapeutic process (i.e., researcher, client, therapist), and thus, there are advantages to using as many lenses as possible (Orlinsky & Howard, 1986). Certainly, the decision to develop a multi-lens perspective was made under the central premise that therapy is a process that depends on a deep interpersonal dialogue between clients and therapists. Moreover, I posit that giving therapists a voice in the research process may offer means of bridging the gap between practice and research by creating a space in which both are involved in the development of therapeutic strategies to deepen client's emotional engagement. Indeed, the present discussion is informed by these joint voices.

The application of the CMEQ-R₂ provided firm ground for arguing that the CME framework is clinically relevant and that the information yielded from therapists' perspectives can likewise be systematically analysed. These findings are particularly important when taking into account that there has been a tendency to

assume that the development of systematic methods of investigation should avoid the use and/or inclusion of experiential data (Orlinsky & Howard, 1986). As Orlinsky and Howard well point out, eschewing “subjective” data in favour of what is considered to be “objective” data pursues a misleading idea of empiricism at the expense of valuable information. Indeed, this research endeavour was developed under the premise that as researchers we should not underestimate the importance of both perspectives, and that, in conversation with each other, these enrich our understanding of the CME construct.

The use of multi-perspective instruments also took into account that the development of either instrument would necessarily imply making decisions that would constrict and affect the type of data that could be coded. A multi-perspective approach provided a combination of information gathered from externally scrutinized perceptions of clients’ emotional processing and an instrument that offered a means of “penetrating the psychological ‘interior’ of psychotherapy” (Orlinsky & Howard, 1986, pg. 499). Observational measures, for example, can only provide a limited amount of information about behaviour and are not necessarily helpful when attempting to generalize results to other situations. These can also be expensive and labour-intensive, and thus pose significant limitations to the amount of data that can be coded and analysed. On the other hand, since participant measures depend on subjective appraisals, the data they yield can be affected by interpersonal relationships and personal distortions. These measures tend to be more user-friendly and applicable to practice but are less amenable to detailed analysis of the narratives (Orlinsky & Howard, 1986).

The CME-OCS may be used as an observational guiding instrument to measure external observers' perception of the overt behaviours and expressions of clients during therapy. It may also serve as a more nuanced and meticulous means of identifying and scrutinizing CMEs as therapy unfolds. The CMEQ-R₂, on the other hand, provides the possibility of drawing from therapists' perspectives in order to research this data systematically in such a way that therapists' subjectivity becomes researchable (Orlinsky & Howard, 1986).

7.6 Limitations of this Research Project

While this research endeavour has resulted in separate systematic and empirically validated participant and non-participant instruments to measure the Client Modes of Engagement construct and has provided strong data suggesting the validity of the construct itself, both studies and their respective instruments have particular limitations. The section below explores sample issues, treatment modality issues, measure issues and methodological issues that should be taken into account in order to understand the limitations of my findings. The subsequent sections provide a discussion of each of these four factors for both the development and application of the CME-OCS and the CMEQ-R₂.

7.6.1 Sample Issues

Several methodological decisions regarding sampling should be taken into account in order to appreciate the implications and limitations of my findings. For the application of the CME-OCS, I used a selection of the five most improved and five least improved cases from the Experiential Psychotherapy for Social Anxiety study. The rationale for this selection was the hope that these ten cases would best reflect the best and poorest examples of EFT practice. This selection method

provided a means of studying extreme examples of how CMEs manifest in therapy. Since the objective was the conceptual clarification, refinement and articulation of the categories of the CME model, I considered that extreme examples of the spectrum would facilitate the process of clearly differentiating and identifying the nuances and specificities of each category. As such, this study only represents the application of the CME-OCS to these two extremes in the continuum of therapeutic processes.

It is also important to note that the Experiential Psychotherapy for Social Anxiety study had previously screened out clients suffering from severe substance abuse problems, clients with current active psychotic conditions and clients in current domestic violence situations. Accordingly, the findings of the present study cannot be applied to clients who suffer from of the above-mentioned exclusion criteria. With these considerations in mind, I believe that my findings regarding the application of the CME-OCS are pertinent to the majority of clients who do not fall into the aforementioned excluded samples.

As discussed, in order to apply the CME-OCS, I decided to select a sample session from three distinct moments of the therapeutic process (early, middle and late). Thus, the results cannot be considered representative of the performance of CME across every session of therapy. However, it should be noted that the CMEQ-R₂ was applied across every session of therapy. Since the non-participant CME-OCS instrument and the participant CMEQ-R₂ were developed under the same theoretical construct and with the objective of complementing each other, I believe that together both studies provide a fuller understanding of the evolution of CMEs across therapy.

The main limitation for the analysis of the 14-item CME psychometric properties analysis comes from the multilevel nature owing to the complexity of the data. This exploratory and very preliminary examination was only able to be conducted involving extensive co-dependence of observations. It should be mentioned that this first exploratory examination was seen as a very preliminary indication of the instruments psychometric properties and not as conclusive or indicative of a good model for the scale. However, for the first examination of the newly developed CMEQ-R I partly responded to the aforementioned drawback by examining the psychometric properties of the CMEQ-R through an internet-based sample.

The first collection of data for the development of the CMEQ-R₂ depended on web-based participants. When using an online questionnaire there is always the risk of alienating and thus excluding potential participants who feel less comfortable using computers or technology in general (Hewson, 2003). Moreover, spam filters may have prevented certain participants from receiving the recruitment e-mails in the first place. Additionally, web-based questionnaires pose sampling issues related to a general lack of information about the community of online participants (Wright, 2005). Since the questionnaire was anonymous, and the system did not control for Internet Protocol (IP) or participants' emails, it was not possible to control for respondents who completed the questionnaire more than once. Using paper and pen data collection when applying Rasch Analysis to the scale in part mitigated these limitations. It is probable that the employment of both web-based and paper and pen data collection strategies provided an additional degree of reliability and validity.

7.6.2 Treatment Modality Issues

Given that this research endeavour was grounded on an EFT theoretical framework, I used samples of clients who were undergoing a Person-Centred/Experiential psychotherapeutic process for the application of both the CME-OCS and the CMEQ-R₂. Studying how CMEs behave in other therapeutic modalities was beyond the scope of this research endeavour. For this reason, at the moment the results can only be understood for the samples used. However, I do believe that it is likely that my findings do not simply reflect EFT or Person-Centred intervention styles and that the CME model fundamentally encompass different general styles of client emotional engagement. This postulation is based both on my own observations and the large body of research on change processes (see Chapter 2) suggesting that emotional processing is indeed a key ingredient for therapeutic change — the fundamental premise upon which EFT is grounded. However, at this point, the claim that the results observed represent a broader framework of how all clients engage with their emotional experience remains a theoretical speculation that cannot be answered by the present study.

7.6.3 Measure Issues

This research project used the mean residual gain to represent therapeutic outcome; this was calculated using client self-report measures (see Chapter 4 and 6). Indeed, this project only measured outcome in terms of how clients answered the administered questionnaires. Thus, it is important to take into account that self-reports are only one amongst various possibilities for measuring outcome (i.e. observer reports, qualitative analysis). The findings can only be understood in terms of the measure of outcome used. Likewise, since I measured the CME model through

a therapist participant and external observational instrument, the results can only be understood in terms of these measures.

Moreover, during the first phase of the development of the CMEQ-R, I asked the web-participants to recall a specific recent past session in order to fill out the questionnaire. When asking therapists to answer retrospectively, the problem of memory recall is always a factor. For example, it is possible that what was being remembered were the overall characteristics of the therapeutic process rather than a single session itself. Taking this factor into account, I was careful to design the questionnaire in such a way that the questions would elicit episodic memories. The survey, for example, asked therapists to recall very specific and detailed modes of engagement that happened during a single session. This may have facilitated a focus of attention on a particular session. It should be noted that when revising the CMEQ-R₂ by using Rasch analysis, I asked therapists to fill-out the questionnaires at the end of each therapeutic session. Thus, the problem of memory recall was not a limiting factor during this second revision of the psychometric qualities of the instrument.

7.6.4 Methodological Issues

Since the decision to develop the CME-OCS and the CMEQ-R₂ was made under the premise that the perspectives offered by these instruments are constitutive elements of the therapeutic process, it is thus important to point out that clients' perspectives regarding the CME have not been measured in this study (Orlinsky & Howard, 1986). This is particularly important because the decision to develop a multi-perspective set of tools took into account that there are inconsistencies in the ways clients, therapists, and trained observers perceive in-session therapeutic processes (i.e. external observers may perceive the session as low in emotional

intensity while the client may judge the same session as highly emotional; Warwar, Greenberg, & Perepeluk, 2003). In this context, the development of a client participant instrument would provide a new dimension to the field of knowledge on CMEs, which is still lacking from this study.

Moreover, participant and non-participant instruments each pose particular limitations. For example, the application of the CME-OCS reflects external observers' perception of how the CMEs manifest in therapy. Thus, evidently, the results can only represent CMEs as perceived by external observers. The same can be said about the CMEQ-R₂, which as a participant instrument can only reflect therapists' perspectives of the same construct. While the findings of both studies, when examined together, may provide more information, each study should be understood in terms of their respective context and limitations.

Lastly, in order to analyse the relationship between my instruments and therapeutic outcome, this research project employed a process-outcome correlational methodology. For this reason, the results do not offer causal information regarding the direction of the relationship between CME and outcome. Since change processes during therapy are extremely complex and multi-layered, untold variables and approaches would be necessary in order to establish such a causal relationship. Indeed, causality cannot be proved without accounting for all the variables. My process-outcome study is one amongst many different approaches through which this complex set of processes can be examined (Hayes, Castonguay, & Goldfried, 1996). However, as Elliott (2010) points out, process outcome studies offer the important advantage of being generally accepted and widely used. For this reason, it is readily

understandable. Indeed, Stiles (1996) points out that process-outcome studies are particularly apt for analysing the depth of client explorations.

7.7 Future Research Directions

This research endeavour has not only culminated in two reliable CME instruments, while providing validation for the CME construct under study and offering significant insights into how CME patterns are related to outcome, it also poses deep and interesting questions for future study. Indeed, in my view, the new avenues for investigation that arose from this project are the most fruitful and generative contribution to knowledge it offers.

As discussed, this research project was fundamentally based on the premise that offering complementary instruments to examine the CME model would serve as a particularly useful means of gathering information from a greater array of actors involved in the study and practice of psychotherapy. Indeed, as discussed above, this research springs from the joint voices of external observers and therapists. As such, it never escapes my attention that I am still lacking the client's perspective.

The development of a complementary participant instrument centred on the client's perspective on CME processes would serve to grow and carry forward my innovative multi-perspective approach, which in turn would provide a deeper understanding of the CME model. Putting clients' voices in conversation with observers and therapists would provide a further grasp of the complexity of emotional engagement. As Timulak and Keogh (2017) suggest, including clients' views as co-constitutive agents of the therapeutic process may serve to offer a broader understanding of mechanisms of change and may offer a greater array of perspectives when developing intervention strategies.

Also, it is imperative to continue validating my instruments. Convergent validity should be explored for the CME-OCS by comparing it to other similar measures (i.e., Auszra et al., 2013; Boritz et al., 2014). Indeed, examining how the CME-OCS overlaps with other similar observational systems would provide additional validity and elucidate common factors or divergent aspects that may require further refinement. In this sense, exploring commonalities would enrich our understanding of the CME construct and emotional processes in general. This type of comparative study provides valuable information about what aspects of client emotional engagement each of the measures are capturing. To my knowledge, other than Orlinsky and Howard (1986), there are no other Experiential/Person-Centred participant instruments available measuring therapist's perspectives on emotional processing. For this reason, exploring convergent validity for the CMEQ-R₂ may be difficult at present. Still, there was some convergent validity explored in this research through my multi-perspective approach to the CME construct using the CMEQ-R₂ and the CME-OCS. However, studies employing either instrument are not only welcome, but also a particularly important next step in the process of validation and refinement.

Given that the samples employed for this research project were gathered from Person-Centred/Experiential psychotherapies, the findings can only be understood in terms of this theoretical approach. It would thus be interesting to apply the CME-OCS and the CMEQ-R₂ to a sample of clients undergoing different therapeutic modalities in order to explore whether the results observed represent a broader framework of how clients engage with their emotions. Since the Person-Centred/Experiential approach emphasizes the processing of emotion as a principal

tenet, examining how CMEs manifest in modalities that give less emphasis to this process would be interesting. This would permit a deeper exploration of whether emotional engagement is a general factor for therapeutic success or a particular dynamic observed in certain kinds of therapeutic modalities. Additionally, since this research endeavour was developed using a population that had been screened for clients with severe substance abuse problems and clients with current active psychotic conditions, the findings should be understood in the context of the population used. Thus, an interesting avenue for future research would be to expand the study to more extreme populations. On the other hand, the application of the CME-OCS was done using a selection of the five most and five least improved cases from the Experiential Psychotherapy for Social Anxiety study. While this was optimal for the developmental stage of the instrument, there is still room for future research considering more moderate outcome cases. Such a study would provide valuable insight into how CMEs manifest in less clear cut-off situations.

Moreover, in order to continue studying the intricacies of minute-to-minute CME manifestations during therapy, it would be interesting to expand the application of the CME-OCS to all sessions of a given therapy. An examination of every session of a therapeutic process would provide further insight into how CME express themselves within and across sessions. This, in turn, would offer a more comprehensive picture of the dynamic interplay of CMEs over the course of therapy.

The sample size used for the development and application of the CME-OCS should also be taken into consideration. Smaller sample sizes provide less detailed information about how the construct under study relates to other heterogeneous variables that might appear in a larger population (i.e. cultural differences, gender,

age). Since the CME framework (Elliott, 2006; 2013a) has many complex and interacting levels, future studies applying the CME-OCS to larger samples could yield more nuanced and detailed information on individual differences. In fact, it is important to take into account that statistical analyses of larger sample sizes may reveal differences that may not appear in small studies. For this reason, my findings, while a fairly comprehensive examination of the CME construct, should be understood as preliminary.

Additionally, I believe the CMEQ-R₂ could be adapted as a session-level observer instrument. Applying the questionnaire in this way would have the added benefit of being an easy-to-use and practical means of observing a larger number of sessions. The instrument would have the added benefit of having been developed and applied using the experiences of therapists.

The results of the present study indicate clear relationships between minute-to-minute CME transitions and therapeutic outcome. It would thus be particularly fruitful for both research and clinical purposes to investigate the relationship between therapist intervention and these transitions. Future studies could investigate therapeutic techniques looking to enhance or facilitate more productive CME transitions.

Finally, I believe that a particularly interesting avenue for research offered by my project is a close examination of how the uses of the CMEQ-R₂ as a training instrument may affect or change the ways practitioners engage in the therapeutic process. Throughout this endeavour, I have been particularly interested in offering a user-friendly and practical instrument. For this reason, a follow-up study exploring

feedback from therapists who have continued employing and applying the questionnaire would be important in order to continue refining it.

7.8 Implications for Clinical Practice

The CME-OCS and the CMEQ-R₂ can serve as useful training and supervision guides for clinicians as they learn to identify and track CME processes and moment-to-moment emotional engagements during psychotherapy — the first as a meticulous means of examining and understanding the CME model and the latter as a self-monitoring instrument. Significantly, the results yielded by the application of the CMEQ-R₂ suggest that therapists are indeed able to distinguish between different levels of CME processes that are predictive of therapeutic improvement. As such, the importance of the CME-OCS and the CMEQ-R₂ as guiding instruments for therapists to develop a kind of CME process-diagnostic map based on clients' experiential content should not be underestimated. Particularly, the findings of the present study support the contention that therapists should be particularly attentive to: a) the presentation of the emotion scheme elements, b) the client's manner of engagement, and c) the client's focus of attention on specific elements of their emotion scheme.

As Orlinsky and Howard (1986) suggest: “a well-designed questionnaire can provide most literate individuals with a suitable set of words and statements for reporting at least the most salient features of their experiences” (p. 483). Indeed, the CMEQ-R₂ provides therapists with a more refined vocabulary with which to distinguish, identify, and focus on particular CMEs as they arise during therapy. Developing a more sophisticated toolbox with which to articulate the subtleties of emotional engagement can be particularly helpful. The CMEQ-R₂, in serving as a

tool for therapists to develop a more attuned ear for recognizing, naming, tracking and focusing on particular modes of engagement, provides a means of creating a bridge between therapists and clients for communicating these processes. Indeed, the therapeutic process arises through the development of this interpersonal empathic relationship between the therapist and the client. As Elliott and colleagues (2004) argue, for this exchange to occur, it is important that the therapists first recognize and reflect upon client's processes in order to help them access, expand, elaborate, and make sense of their experiences. Clients welcome practitioners' attempts to provide words that fit when they are trying to articulate them (Angus & Greenberg, 2011). As such, using this shared vocabulary as a guide to help untangle clients' emotional experience can deepen the therapeutic relationship. Being able to recognize CME and access a more refined repertoire of evocative language with which to create a shared conceptualization of experience may help create a fruitful reciprocal dialogue between the client and the therapist. This mutual dialogue helps both therapists and clients resonate with the client's emotional engagement, access their core pain and identify how this may be transformed (Timulak, 2014).

Moreover, I posit that the CMEQ-R₂, in providing a more immediate repertoire for identifying client's internal emotional processing, also helps develop an empathic awareness of this process. Indeed, as a training tool, the CMEQ-R₂ helps therapists keep close track of clients' experiencing as it emerges. That is, the CMEQ-R₂ may serve as a means of recognizing, tracking, focusing, resonating with, and responding to clients' moment-to-moment transformational process. When therapists are able to do so, it may be easier for them to match the client's Zone of Proximal Development (ZPD). Ribeiro and colleagues' (2014) findings suggest that when

therapists don't match clients' ZPD, ambivalent problematic self-narrative voices become stable without the emergence of novelty. Similarly, Mendes and colleagues (2016) found that clients' setbacks occurred more frequently when therapists exceeded clients' ZPD by overstepping in their intent to move the client forward. In this sense, learning to resonate with client's emotional engagement may help therapists recognize when to "push where it moves" (Leiman & Stiles, 2001). As such, the CMEQ-R₂ offers an important tool for learning to develop strategies to facilitate productive CME engagements as they appear in therapy.

While there is need for further research exploring how therapists may more productively facilitate CME processes, findings yielded by the CME-OCS do suggest a repertoire of useful guidelines. Indeed, learning to identify CMEs as they arise can be valuable when deciding to implement appropriate interventions or recognise possible tasks to work through. This is particularly important in the context of previous research suggesting that therapists can either facilitate or impede more beneficial ways of client engagement (Sachse, 1993; Gordon & Toukmanian, 2002). Indeed, as Timulak (2014) points out, the role of therapists is the orchestration of "therapeutic tasks in a way that increases the likelihood of the client experiencing those adaptive emotional experiences" (p.747).

Significantly, the results of the current study propose that none of the four levels of the CME-OCS are inherently dysfunctional or productive in themselves. Rather, it is the dynamic interplay between lower level CMEs and higher-level processes that create a more productive way of engaging with experience. As such, every emergent CME can be seen as a window of opportunity for the therapist to facilitate clients' productive emotional engagement.

If practitioners consider that a style of client engagement may be helpful at certain instances, it could be useful for them to have a clearer idea of why they are facilitating this process and what they may expect to achieve when doing so. For example, the findings of this study posit that in general it is important to facilitate clients' CME transitions from chaotic, disorganised or persistently "wedged in" modes of engagement to more integrative or innovative emotional processes. However, the results suggest that the Restricted Mode may serve a useful purpose at certain moments of therapy. In this sense, it would be beneficial for therapists to fine tune their ability to understand when the Restricted Mode is being used in more productive ways and when clients have become persistently stuck in this mode of engagement. Moreover, helping clients sustain more integrative moments through longer periods of time facilitates the exploration of emotional experience. Indeed, the findings of the present study support the contention that moments of discovery, newness and novelty tend to emerge from clients' sustained experiencing of the Working Mode of Engagement. Likewise, the findings suggest that instances during which clients are in Change Mode should be elaborated in order for these to be strengthened. In sum, the results of the present study may complement therapists' repertoire of knowledge in order to implement interventions that can better facilitate these dynamics during therapy.

On the other hand, the CMEQ-R₂ and the CME-OCS can be particularly useful tools for group supervision. Indeed, during the data collection portion of this research project, I offered volunteers the option of engaging on group supervision for training purposes. I generally received favourable feedback on these group settings. I

noticed that during these meetings, reviewing the CMEQ-R₂ prompted fruitful and educational discussions about possible interventions, techniques, and EFT markers.

In closing, although the CME-OCS and the CMEQ-R₂ are grounded on an EFT framework, they make no reference to any particular EFT marker. As such, these instruments have the added benefit of being amenable to being adopted and incorporated into any therapeutic modality. In fact, I would not only welcome the possible adoption of these instruments in other clinical settings, but I see this as a promising avenue for further application and research. It is my belief that this project has culminated by offering useful clinical tools that help close the gap between research and practice.

The following section explores how this research endeavour has served as a discovery process that has invited deep personal reflection. Indeed, this project has been precisely that, a process. As such, while it is important to explore the contributions to knowledge it offers to the field of psychotherapy, I close this dissertation with a final exploration of the contribution it has made to my own journey as both a therapist and a researcher.

7.9 My Journey: The Implications of this Research Project on my Practice

I began this research endeavour aspiring to make intertwined contributions to both practice and research as part of my journey as a PhD student. It has been in the context of the dialogue between my work as a researcher and as a therapist that I have grown in both areas. In fact, I believe that the CME model, at its core, requires this kind of conversation between practice and inquiry to continually take place. I can enumerate at least three crucial ways in which this experience has transformed me. First, the process of developing and applying instruments in order to empirically

validate the CME construct has changed the way I understand clients' manner of engagement. Second, constructing a set of multi-perspective tools strengthened my view of the importance of bridging the gap between research and practice and transformed how I emotionally engage in therapy. Third, I discovered the deep importance and fruitfulness of inserting myself into a network of peers and the continual supervision that this offers.

Engaging in a research endeavour usually involves moving from an interest, a curiosity, or a belief to a more systematic examination of the concern at hand. Indeed, drawing from both experience and personal views, I had embarked on this project with the conviction that Elliott's CME model reflected and was able to articulate the ways clients engage with their experiences during psychotherapy. Yet, it was in the process of constructing my instruments, going back to the categories, and refining the concepts, that I learned to think more slowly, rigorously and systematically, to take a few steps back, and to be more meticulous with my personal theoretical affinities. In sum, I learned to cultivate a more methodical and critical eye. It was precisely for this reason that I deeply believed, and still do, that constructing empirically valid instruments would offer a way to tap into clients' emotional engagement. Still, I had not predicted how deeply the experience of research itself would put me in a personal dialogue at the intersection of research and therapy. Developing complementary participant and non-participant instruments offered me the opportunity to enter into a dialogue between a more micro-external view of the construct and the valuable experience of seasoned therapists. Moreover, doing so, not only provided a means of quantifying the CME model, but also offered

me a set of lenses through which to engage in the therapeutic process with a more focused and systematic eye.

Confirming that therapists can indeed distinguish between different modes of engagement, and that their perspective on the client can provide a valuable source of knowledge to empirically examine the construct, transformed the way I engaged emotionally in therapy. Indeed, the knowledge that therapists are not passive actors of the research process, and that our perspective of how clients are engaging emotionally can predict therapeutic improvement, contributed to an increased sense of agency and response-ability as an actor in the therapeutic process.

Constructing and applying both the CME-OCS and the CMEQ-R₂ served as valuable self-training experience that helped me cultivate a more attuned ear for identifying CMEs. Firstly, observing therapy sessions repeatedly, and with an eye for details, enabled me to think more carefully about the emotional processes I was witnessing. Continuous use of the CMEQ-R₂ as a practitioner, on the other hand, has taught me to keep in mind the different items of the questionnaire during psychotherapy. In my experience, knowing that I would fill out the questionnaire after any given session compelled a more attuned sense of attentiveness and careful consideration to whether the processes were manifesting in-session. The end of each session became an opportunity for retrospection with the added benefit of immediacy as I reflected on these processes. As such, the CMEQ-R₂, provided a structure and guidance through which to undergo this monitoring process. Additionally, filling out the CMEQ-R₂ after every session provided a process diagnostic map of what was happening across therapy. All in all, I have learned that the repertoire of knowledge provided by the dialogue between research and practice offers a means of learning to

attend actively and be more genuinely present during the therapeutic process; to listen wholeheartedly to the client's internal experience with, not only a more attuned eye for CME as they arise, but a more attuned ear for recognizing how these may be more fruitfully facilitated in the context of the client's patterns of engagement.

This process pushed me to become more aware that I had a tendency to pay closer attention to certain modes and sometimes overlook others. Throughout this research endeavour, I came to understand the particular significance that moments of novelty have for therapeutic improvement. Also, I had given less thought to the implications that chaotic or disorganised narratives can have on the therapeutic process. I now pay closer attention to how clients are engaging in particular patterns of transition between CMEs and value these as deeply significant. Indeed, I have come to understand that different levels of engagement and moments of transition are opportunities to facilitate a more in-depth engagement with experience.

Finally, this research project demanded that I look for and build a network of peers. This network has provided inspiring companionship during this discovery process. I found that empowering practitioners as agents in the research project was tremendously valuable. Indeed, the ensuing dialogue became a source of knowledge and self-development, for which I am particularly grateful.

7.10 Final Remarks

The present project has responded to the growing interest in the role that clients' emotional engagement plays in psychotherapy by empirically validating and refining the Client Modes of Engagement (CME) theoretical model (Elliott 2006; 2013a). Indeed, this research endeavour was grounded on the belief in the clinical and research value of the CME framework and thus in the importance of constructing

reliable means of investigating the construct through the external observation of audio/videos and transcripts of EFT sessions (CME-OCS) and the subjective perspective of the therapist (CMEQ-R₂).

The process of application and validation of these instruments provided strong empirical evidence for arguing that Elliott's CME proposed framework indeed reflects the ways in which clients engage with their experience during psychotherapy. It also provided firm ground for arguing that the therapist perspective can be systematically analysed, and that therapists can indeed distinguish between levels of CMEs. This is particularly important because there are remarkably few instruments that take into account therapists' valuable perspective of the psychotherapeutic process. Certainly, the construction of these multi-perspective tools provides important means of bridging the gap between research and clinical practice. The findings of this study validate Elliott's CME framework that is founded on the contention that researchers and therapists should be particularly attentive to the client's manner of engagement and their focus of attention on specific levels of emotion scheme processing. I close this project with the hopes that these valuable contributions to the theory and practice of psychotherapy will provide fruitful avenues for future research on the subject.

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Appendices

Appendix A. Client Modes of Engagement Observational Coding System

Manual

CME-OCS: CLIENT MODES OF ENGAGEMENT OBSERVATIONAL CODING SYSTEM

The Client Modes of Engagement Coding System (CME-OCS) is a nonparticipant observer-based method developed in order to identify and differentiate client in-session Modes of Engagement. The instrument provides a systematic means for identifying the level of client access to the different emotion scheme components of their experience. There are four Modes of Engagement codes: Dysregulated, Restricted, Working and Change Modes.

Coding Procedure.

The coder watches the entire audio/video session accompanied by the transcript for initial familiarity.

The transcript, audio/video is segmented into 1-minute time bins.

The coder watches/hears and reads the 1-minute time bin transcripts and rate the salient/predominant (more than 50% of the time) mode of engagement.

Coding Procedure: Minimum Utterances.

A one-minute time bin that is uttered by the client with less than 5 words will be coded as "Other". (Minimal expressions of agreement or disagreement are not considered for counting transcript words ("mmm", "yes", "no", "right", "ay").

Coding Procedure: Emotion Scheme Element.

The researcher firsts learn to identify each emotion scheme element in an audio/video and transcript of a therapeutic session. The definitional criterion for each element of the Emotion Scheme is stated below:

Perceptual-Situational Element

Episodic Memories.

The client expresses non-evaluative descriptions of specific external events, things, people, situations, circumstances that surround client's problematic issues. Descriptions can be general (i.e., It always rains in Scotland), specific (i.e., so the police came to my house, then they took...); can be descriptions of others (i.e., ...and my mother called my sister and told her that...); descriptions of self in relation to others (i.e., ...and I went to her office...); or descriptions of self in relation to situations (i.e., ...I was making dinner when...). Includes episodic descriptions of childhood memories (i.e., I was five years old when...)

Appraisals.

The client expresses appraisals of external events, things, people, situations, circumstances that surround client's problematic issues. They can be real (i.e., everyone has been very nice to me) or imagined (i.e., If I were by myself in a party nobody will talk to me; everyone would be angry with me...); past (i.e., everyone was horrible; my father was always angry at me; after my father left my mother was very depressed for a while; I had a difficult childhood; my sister was always sad/angry/depressed), present (i.e.,

and now my mother is coming to visit...she is very demanding), or future situations (i.e., He will probably be mean to me). Includes evaluative appraisals of childhood experiences (i.e., I had a very difficult childhood; my family was male-orientated).

Bodily Expressive Element

Bodily Sensations.

Refers to client descriptions of body sensations such as the bodily location/sensation aspect of the felt-sense (i.e., I feel it in my chest; I feel butterflies in my stomach; My heart is broken; I have a knot in my throat; I think I was sweating heavily), or by reference to somatic symptoms (i.e. itching, tingling, numbness, dizziness, headaches, pain, muscle tension).

Nonverbal Expression.

The client refers to specific parts of the body (i.e., crying to express sadness; laughing to express joy), including facial affect expression, emotional expression in the voice or body movements (i.e., shakes feet, rubs hands, nervous laughter, fearful facial expression). Other possible nonverbal expressions are sighs, intense changes in voice shifts, distressed voice quality.

Symbolic/Conceptual Element

Concepts/Identities.

The client expresses reflections about beliefs, thoughts, states and values about self (i.e., I guess I'm intelligent; I should try to be independent; It's important to me to be kind to others; I deserve to be appreciated; I think I am good enough) and self in relation to others (i.e., I guess it would be better for me to leave him; It's important to me to be kind to others). Includes

metaphors to express beliefs, thoughts and values about self and self in relation to others (i.e., I thought I was superman; I'm fishing in troubled waters; Time is a thief) Includes self-reflective explorations about the meaning of beliefs, values, thoughts and feelings, including wondering about personal experiences or raising questions about self (i.e., Why do I behave like this? ...Why do I feel this?); wondering about beliefs or the meaning of others' behaviours (i.e., I think my father was hard with me because... I wonder if my father really loved me; I think I would never get support from them). The client may also explore the meaning of the emotional experience (i.e., Why do I feel this way? How do I make myself feel this way?).

Motivational/Behavioural Element

Needs/Wants.

The client descriptions of needs or wants emanating from the self. Needs/wants are generally about things wanted/needed for self and/or from others (i.e., I need to be protected/cared for/loved/understood/held/supported; I want to be able to stand up for myself/to get my feelings out/to do my own thing/take better care of myself; I need to stop hurting myself/letting other people walk all over me/get better organised/not get overwhelmed by my feelings).

Needs/wants/wishes are physically or psychologically fundamental (i.e., I need to connect to others; I need protection). They can be expressed in the past, present or future (i.e., I needed support; I need love; I will need protection) or more specific (i.e., I need for my father to believe in me). Needs may be related to the self (i.e., I want to be stronger; I need to be more

assertive; I want to be more careful) or to others (i.e., I need him to understand that I care).

Action Tendencies.

The client describes past, present, or future behavioural response tendencies to specific problematic or difficult situations, thoughts or emotions (i.e., I punched him; I ran away; I refused to answer; I left; I told him to stop; I avoided). Includes reports of client nonverbal emotional reaction tendencies to difficult situations (i.e., I probably would cry) or client reports of body or gestural behavioural reaction tendencies to situations (i.e., I chewed my fingernails/pulled back/tried to make myself smaller/froze/tried to control my breathing).

CLIENT MODES OF ENGAGEMENT (CMEs). The descriptions that follow represent each of the four levels of the Clients Modes of Engagement manifestations. The researchers should use the definitional criteria relying on the descriptive manifestations of each “Emotion Scheme Element” to code a Client Mode of Engagement: Dysregulated, Restricted, Working and Change.

DYSREGULATED MODE

Definitional Criteria. Emotion scheme elements are presented in a chaotic, unclear, unspecific manner without the client being able to attend, symbolize or elaborate on them. The client is unable to work through an experience. The level of emotion is either too much or too little for the person to be able to use the information that the emotional experience provides. Verbal expression is either disorganised/incoherent, or minimal/largely absent. The client is thus

either unable to work on experience or directly and clearly avoids working on it. The client appears to mostly or entirely either (a) overwhelmed by experienced emotion, or (b) cut off from it, to the point of dissociation.

Perceptual/Situational. The level of emotion is too little or too much for the individual to be able to pay full attention to the different aspects of the situations and how they interact. The client cannot use the information that the situation provides to make sense or become aware of how the situation relates to the emotional experience.

Symbolic/Conceptual. The client has difficulties engaging with the symbolic/conceptual aspects of their experience because their emotions are flooded or the client is too distant from the emotional experience. The client is unable to make sense of or symbolize their emotional experience.

Bodily/Expressive. The level of emotion is too little or too much for the individual to be able to work with the information that their body carries. The individual may present overwhelmed excessive nonverbal reactions without being able to symbolize the body sensations experienced (i.e., crying, shaking, sweating, trembling, being minimally able to verbally express their emotional experience in a coherent, organized manner). The client may also present extremely contradictory non-verbal emotion expressions. (i.e., expressing sadness while laughing).

Motivational Behavioural. The level of emotion is too little or too much for the individual to be able to work with the information carried by their wants/wishes/needs and action tendencies. The client expresses wishes, wants and action tendencies that put them in an incoherent and disorganized stance

of being. These wishes or wants are verbally expressed in a non-coherent, disorganized manner.

Indicators:

- The client appears to be falling apart.
- The client seems unable to control their emotional arousal.
- The client may report a sense of confusion or of feeling/being lost.
- The client uses expressions such as: this is too much; I can't stand it anymore; this is killing me (refusing to work further during the therapeutic process).
- The client directly avoids or holds painful or frightening experiences at bay.
- The client narrative lacks a sense of direction with a noticeable scarcity of agency.
- The client expresses a sense of collapse.
- The client articulates their experience with a distorted or disruptive narrative.
- The client shows a complete lack of agency and is unable to work further during the therapeutic process.
- The client refuses to elaborate or provide information (i.e., I don't want to talk about this anymore or constantly saying "I don't know, I can't think of anything; I'm not sure; I feel nothing).

- For these refusals to be coded in this category, the client response should be final with no further elaboration after therapist prompt to continue the experiencing.

RESTRICTED MODE

Definitional Criteria. Clients are dominated by a single emotion scheme element and process their experience through an isolated stance. During these moments, clients focus on one element of their experience to the exclusion of all other emotion scheme elements. These isolated manners of processing prevent clients from accessing, integrating and elaborating the wholeness of their experience. Clients seem uncertain of how the emotion fits into the experience as a whole (i.e. what relation it has to their bodily experience, to their action tendencies, and the overall meaning). Clients are able to attend to one emotion scheme element but have difficulties or remain unable to integrate and make use of other elements of their experience. The client's attention is not grounded on their emotions, and lacks vividness and freshness.

Perceptual/Situational (Externalizing). The client's sole focus is on recalling episodic memories, without integrating other emotion scheme elements; thus, experience is circumstance-oriented. The client expresses repetitive or *cliché* descriptions and appraisals of the situation without experiencing them freshly in the moment. Situational details are either superficial, serve only to connect the narrative, or are overly detailed — these details are mentioned but are not used to intensify or deepen on how the

self relates emotionally to the situation. Situational descriptions may include objective details (i.e. time of day) but lack sensory specificities (i.e. details of sensory experience or of emotional reactions).

Conceptual/Symbolic (Abstract). The client's sole focus is on abstract concepts, and maintains a logical conceptual stance, without integrating other emotion scheme elements. The client articulates conceptual, over-generalized, and intellectualized narratives without emotional involvement (i.e. stating of beliefs, values, self-concepts or named general feelings without experiencing them in the present). The client does not convey the idiosyncratic meaning of this experience and seems to be an observer or reporter of their emotional experience.

Bodily/Expressive (Somatising). The client's sole focus is on body sensations, without integrating other emotion scheme elements. While the client provides detailed descriptions of their physiological experiences, there is a scarcity of involvement with the wholeness of the experience. The client dwells on pain or other physical signs of injury or illness but does not experience these as connected to emotional experiences; also, does not give careful and mindful attention to these bodily felt senses. The client concentrates specifically on their somatic experience, excluding all other aspects of the experience.

Motivational/Behavioural (Impulsive). The client's sole focus is on wishes, wants, needs, desires, or action tendencies without integrating other emotion scheme elements. Rather than staying with strong or distressing emotions, the client impulsively acts out (or describes acting out) their wishes, wants, needs

or action tendencies in an unreflective non-experiential manner. The client describes previous behaviours or future possible behaviours without integrating other emotion scheme components.

Indicators:

- The person seems more as an observer of their emotional experience than being able to experience them in the present moment.
- The client may make references to emotional reactions but in an intellectualized and abstract manner without experiencing them freshly in the present.
- The client has a sense of direction but lacks present vividness.
- The client narrative has a pre-monitored property.
- The client is trying to express external events of appraisals of others but with a lack of emotional involvement during the process.

WORKING MODE

Definitional Criteria. The client is productively working by bringing a particular emotion scheme element to bear on the other emotion scheme elements. Clients are able to bring any element into awareness while productively using the information available from all other elements of the experience. These instances are grounded in the freshness of the emotion. At these moments, the client is experiencing the various emotion scheme elements in a mindful, fully present, manner. When this happens, clients are

able to attend to, be aware of, articulate and make meaning of the full range of their emotional reactions in a regulated, organised and balanced manner. The distinguishing feature of this mode is that clients are able to use the elements of the experience in a subjective and integrated manner.

Perceptual/Situational (Externally/Attending). The client attends in an emotionally engaged manner to the perceptual/situational elements of their experience, while integrating these with other emotion scheme elements. The client is thus in touch with the wholeness of the experience. The client remains emotionally involved while remembering specific memories and appraising events and people. They mindfully experience the self within their narrative. The client usually uses the first-person narrative voice and recounts their experience predominantly in the present. Emotional reactions are connected to the specificities of the event being told. The client uses situational details and sensorial specificities that make the account vivid, personal and subjective.

Bodily/Expressive (Body/Focused). The client has an inward and direct focus on their bodily expressions as a means to access other elements of their emotion scheme. Clients attend, in an a mindful and emotionally engaged manner, to their bodily reactions, while integrating into the experience vivid accounts of memories, concepts, meanings, feelings, needs, wishes or images to capture the wholeness of their experience.

Conceptual/Symbolic (Reflexive/Symbolizing). The client attends in an emotionally engaged manner to the symbolic/conceptual aspects of their

experience, while integrating these with other emotion scheme elements. The client is thus attempting to put into words the wholeness of the experience. They access their inner-experience through a process of symbolizing it. Clients make an effort to name and express their experience as a means of unfolding it through language. It is through this process that clients develop a more precise and refined manner of expressing their emotional experience. Clients approach the presentness of the experience with active curiosity about its meaning or value while remaining emotionally involved. The client elaborates on fresh emotions that are being experienced in the present moment in a nuanced and specific manner.

Motivational Behavioural (Active/Expression). The client is mindfully and emotionally engaged with their needs, wants, wishes, and action tendencies, while integrating other aspects of their emotion scheme. The client expresses their desires, needs, and wishes with an active and emotionally engaged stance. Needs, wishes and action tendencies are existential or organismic in nature (i.e., the need of affiliation, nurturance, autonomy, support, acceptance, approval).

Indicators:

- Client may at first struggle to make a coherent, congruent and organized narrative, but eventually clear connections between the emotion scheme elements become apparent or surge forth from the present emotional experience.
- Client emotions are clearly present; they are vivid emotional expressions that are symbolized in words (i.e., client cries and

elaborates on the feelings, or events, or needs behind the tears; the client expresses fear and connects it to body sensations, or situations, or symbolic-perceptual or action tendency; from the emotional experience the client expresses a belief, connects it to situations, or needs, or body sensations or emotional expression, or action tendencies).

- Nonverbal emotional expressions are coded as experiential when they are regulated, symbolized in words, felt with awareness, carefully attended (i.e., I have this knot in my throat, it seems that it is difficult for me to express how I feel, it reminds me of how I felt when I was little, I have felt this same feeling when I am in front of strangers).
- Verbal emotional expressions are coded as experiential when they are clearly felt in the present moment and they are differentiated rather than global.

CHANGE MODE

Definitional Criteria. The client is experiencing an internal shift, change or transformation, such as a sense of newness or discovery. New emotions, bodily-felt senses, action tendencies, needs and perceptions of self and others emerge grounded in previous integrated processing of emotions. During these instances, clients report having experienced therapeutic change in the present moment. This results in a reorganization of the emotional scheme. During these instances previous scheme element organizations are transformed into new and novel ways of experiencing.

Perceptual/Situational (Re-perceiving). The client expresses in the moment new, alternative, more adaptive, or more positive ways of perceiving others, events, or situations. The client discovers or brings into awareness new aspects or new appraisals of others, events, or situations, that were not noticed before. The client sees others, events, or situations in a different light. There is new understanding, insights or awareness of the situation or others.

Bodily/Expressive (Body Shift/Relief). The client expresses or appreciates the easing of previous problem-related tension carried in the body as in receiving a felt shift. This provides the client with new opportunities to focus on novel positive bodily sensations. This sense of transformation or bodily shift results in a sense of relief and expanded awareness of the body.

Conceptual/Symbolic (Meaning Perspective). The client expresses new more adaptive or more differentiated emotions in the moment. The client expresses new meanings, beliefs, and values about self as a result of present emotional awareness. The person reports or expresses changes in the perception of the self, such as the critical other becoming more compassionate or softer.

Motivational/Behavioural (Action Planning/Carrying Forward). The client expresses new needs, wishes, wants, or action tendencies or elaborates in problem solving or strategies towards more adaptive solutions to fulfil the needs. The client make references to what he or she deserves after elaboration of what the client is missing or lacking or is important for the client's well being. This process leads clients towards a novel sense of personal agency that inspires a surge of new more adaptive motivations,

intentions, and action tendencies. The client elaborates new plans for actions and new behaviours emerge. They elaborate on problem-solving strategies that lead to more adaptive solutions to fulfil their unmet needs. The client makes reference to what they deserve after elaborating on what they are lacking.

Indicators:

- Allowing new more adaptive emotions to be felt in the present in a regulated manner such that the person is able to symbolize it in a newly coherent narrative.
- Previous scheme element organizations and elaborations are transformed into new ways of experiencing.
- New narrative organization emerges in which new intentions; purposes, expectations, hopes, needs, action tendencies, or new ways to fulfil them are articulated.
- Client describes new ways of feeling, thinking or understanding.
- Client expresses that he/she is different in some positive way (feelings, thinking, acting).

Appendix B. 14-Item Client Mode of Engagement Scale

III. Client Modes of Engagement:

Please rate the extent to which your client was engaging in each of the following modes of Engagement during the session:

Absent	Occasional (1 - 5% of responses)	Common (10 – 20% of responses)	Frequent (25 - 45% of responses)	Extensive (≥ 50% of responses)
1	2	3	4	5

1 2 3 4 5	1. <u>External</u> : Attending to other people, external events; may be specific or general.
1 2 3 4 5	2. <u>Purely conceptual</u> : Formulating things in linguistic or abstract terms without reference to concrete experiencing.
1 2 3 4 5	3. <u>Somatic</u> : Attending to chronic pain or illness signs.
1 2 3 4 5	4. <u>Flooded</u> : Overwhelmed by unsymbolized emotion
1 2 3 4 5	5. <u>Action-focused</u> : Focused purely on wishes or action; driven or impulsive, without reflection
1 2 3 4 5	6. <u>Containing/distancing</u> : Avoiding or holding painful or frightening feelings or experiences at bay.
1 2 3 4 5	7. <u>Internal attending</u> : Turning attention inward to clear feelings, thoughts, images or bodily sensations.
1 2 3 4 5	8. <u>Experiential search</u> : Examining unclear internal experiences with curiosity; staying with vague or ambiguous experiencing.
1 2 3 4 5	9. <u>Active expression</u> : Displaying or enacting strong, vivid, specific reactions.
1 2 3 4 5	10. <u>Interpersonal contact</u> : Trusting, opening up to therapist.
1 2 3 4 5	11. <u>Re-perceiving</u> : Re-construing experiences in light of new emotional

awareness; noticing new things or seeing experiences in a different way.

1 2 3 4 5 12. Appreciating: Allowing self to enjoy easing of previous problem-related tension carried in body; receiving a felt shift or experiencing relief.

1 2 3 4 5 13. Self-reflection: Standing back from experience in order to develop meaning perspective.

1 2 3 4 5 14. Action-planning: Moving toward action on basis of emotional processing experientially-based problem-solving, movement toward productive action.

Appendix C. Client Modes of Engagement 72 and 62 Items List

Original 72-Item CME	Items List: Client Modes of Engagement	62-Items Retained
<i>Guiding Category 1: Flooded: Overwhelmed by unsymbolised emotion; disorganised & chaotic, with various other elements present in a disorganised fashion</i>		
1	My client was overwhelmed by emotions whose source could not be identified.	1
2	My client was unable to label their emotional experience.	
3	My client described her/his emotional experience in global terms without being able to provide details or specify them.	
4	My client expressed emotional experiences in an incoherent, chaotic and disorganised manner.	2
5	My client was so overwhelmed by emotional experience that they could not elaborate on them.	3
<i>Guiding Category 2: Distanced/Dissociated: Avoiding or holding painful or frightening feelings or experiences at bay</i>		
6	Instead of making full contact and staying with strong emotional experience, my client deviated towards less emotional alternative narratives.	4
7	My client abruptly distanced themselves from their emotions.	5
8	My client actively avoided or refused to engage in emotions.	
9	My client seemed to be putting an emotional barrier between self and the experience.	6
10	My client cut off or blocked painful emotions from awareness.	
11	My client were in a numb or emotionally blocked state.	7
12	My client experienced being in a fuzzy, partially dissociated, or disoriented state in the session.	8
13	My client avoided or held off painful or frightening experiences.	9
<i>Guiding Category 3: Externalized: Attending exclusively to other people, external events; may be specific or general.</i>		
14	My client was preoccupied with external events without referencing emotional reactions to those events.	10
15	My client was attending to external events with low/absent emotional involvement.	
16	My client was expressing repetitive or clichéd descriptions of external events.	11
17	My client was evaluating situations without intensifying or deepening how they relate emotionally to the situation.	12
18	My client evaluated others' behaviour/feelings with minimal reference and attention to their emotional experience.	13

19	My client was telling stories about external events in a long-winded or boring manner.	14
20	Emotions were expressed with a whining or complaining quality with a consistent focus on others.	15
21	My client expressed experiences as if they were a passive observer.	16
<i>Guiding Category 4: Abstract/Purely conceptual: Formulating things in linguistic or abstract terms without reference to concrete experiencing.</i>		
22	My client expressed ideas, beliefs in abstract and logical terms without specific reference to concrete experiences.	17
23	My client expressed their motivations in abstract terms.	18
24	My client described themselves in general or abstract terms.	19
25	My client spun complicated theories in their head about self or others.	20
26	My client remained oblivious to their internal experience.	
27	My client's descriptions of emotions seem to be pre-planned responses, expressed as if rehearsed.	21
28	My client expressed only general or abstract emotions.	
29	My client emotions were "talked about" in an abstract manner rather than "felt".	22
<i>Guiding Category 5: Somatizing: Attending exclusively to pain or illness signs or symptoms, or dwells on body appearance or functions to the exclusion of other aspects of experience.</i>		
30	My client dwells on physical sensations but does not experience them as connected to emotional experiences.	23
31	My client dwells on physical symptoms or signs of illness or physical pain without reference to emotional experience.	24
32	My client appeared physically uncomfortable during the session.	25
33	Although my client made references to body distress, they were unable to elaborate or symbolize the emotional experience within their body.	26
34	My client complained about body sensations without reference to emotional experience.	27
35	My client appeared to be quite concerned or self-conscious about their physical appearance or body image.	28
<i>Guiding Category 6: Impulsive: Focused purely on wishes or actions; acting out; driven, without reflection</i>		
36	My client described their behaviours as driven purely by wishes and desires carried out without reflection.	29
37	My client rather than exploring strong and distressing emotions acted out (or reported acting out) in an unreflective, non-experiential manner.	30
38	My client concentrated on superficial or impulsive desires (e.g., escaping from problems), rather than exploring deep emotional wants or needs.	31
39	My client behaved impulsively during session (eg, got up and left before the end, or acted aggressively).	32
40	My client had difficulty reflecting upon his/her behaviours, wishes, wants or needs.	

41	My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something (eg run out of the room).	33
	<i>Guiding Category 7: Externally attending: Mindful receptive focus on perceptual experience/memories; emotionally engaged narrative</i>	
42	My client focused on past experiences and memories in a fully engaged, receptive and mindful manner.	34
43	My client narrated external experiences in a fully emotionally engaged manner.	
44	My client narrated experiences with others in rich detail and was receptive to the emotional experiences that arose from them.	35
45	My client evaluated events and situations in order to explore and understand the underlying emotional foundation of the experience.	36
	<i>Guiding Category 8: Body-Focused: Careful receptive attention to bodily experience and associated felt meaning</i>	
46	My client was self aware of their own feelings, thoughts, images related to body sensations.	37
47	My client looked inward and explored the physical bodily reactions related to his/her emotional experience.	38
48	My client gave careful attention to bodily experiences and their meaning.	39
49	My client expressed the emotional experiences arising from their body sensations.	40
50	My client elaborated their emotional experience by means of relating them to their body sensations.	41
51	My client patiently attended to their bodily experiences and the meanings of these.	42
	<i>Guiding Category 9: Emotion-Focused: Awareness and symbolisation of immediate emotional experience</i>	
52	My client was fully immersed in the emotional elaboration and exploration of his/her experience.	43
53	My client was focused on his/her subjective flow and nuances of their emotional experiences.	44
	<i>Guiding Category 10: Reflexive-Symbolizing: Active curiosity and reflection on the meaning, value or understanding of experience</i>	
54	My client was actively curious about the personal meaning, value or sources of experiences.	45
55	My client was able to explore the personal meaning of experiences.	46
56	My client stood back from their experiences in order to consider their meaning.	47
	<i>Guiding Category 11: Active Expression: expressing wants/needs; enacting strong emotions in a productive manner</i>	
57	My client was able to access and clearly express deep underlying wants and needs.	48

58	My client was able to actively express strong emotions to and from an imagined other or aspect of self.	49
	<i>Guiding Category 12: Re-perceiving/altered perception: Noticing new things in their situation not attended to before or seeing previously-attended-to aspect of their situation in a different light; new understanding, insight or awareness or self or others</i>	
59	My client attended to new aspects of their situation .	50
60	My client perceived experiences in a different light or from a different perspective.	51
61	Through exploration of experiences my client arrived at new understandings, insights or awareness of their situation.	52
	<i>Guiding Category 13: Body-shift/Relief: Allowing oneself to enjoy the easing of previous problem-related tension carried in the body</i>	
62	My client’s body sensations shifted positively after focusing on his/her emotional experiences.	53
63	My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.	54
	<i>Guiding Category 14: Receiving Emotional Change: Allowing oneself to feel and appreciate new, more adaptive emotions</i>	
64	My client allowed themselves to feel new, more adaptive emotions.	55
65	My client’s emotional experiences of self, others or situations became more positive.	56
	<i>Guiding Category 15: Self-reflection/Meaning Perspective: Standing back from successfully processed experiencing; becoming dis-embedded from previous assumptions so as to appreciate new possibilities, achieving a new explanation of one’s situation or feelings</i>	
66	My client was able to step back or disembed self from previous assumptions in order to achieve a new meaning perspective on experiences..	57
67	My client expressed the sense of discovery related to experiences.	
68	My client was able to locate new emerging experiences within the broader frame or their life.	58
	<i>Guiding Category 16: Action-planning: Moving toward action on the basis of successfully processed experiencing; problem-solving; oriented toward developing productive solutions</i>	
69	My client articulated a desire to move toward adaptive actions on the basis of successfully processed experiences.	59
70	The way my client articulated experiences demonstrated new problem-solving abilities.	60
71	My client oriented themselves toward developing productive solutions.	61
72	My client expressed a sense of personal agency based on their emotional experiences.	62

Appendix D. 32-Item Client Modes of Engagement

<p>32 ITEM: Client Modes of Engagement</p> <p>Please rate the extent to which your client was engaging in each of the following processes during this session:</p>	<p>ABSENT</p>	<p>OCCASIONAL (1-5% of responses)</p>	<p>COMMON (10-20% of responses)</p>	<p>FREQUENT (25-45% of responses)</p>	<p>EXTENSIVE (≥ 50% of responses)</p>
1. My client expressed themselves in a chaotic manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Through exploration of experiences my client arrived at new understandings, insights or awareness about their situation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My client was in a numb or emotionally blocked state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My client was fully immersed in the elaboration and exploration of their emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My client was preoccupied with external events without referencing emotional reactions to those events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My client looked inward and explored the bodily reactions related to his/her emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My client was focused on his/her physical appearance or body image without reference to emotional experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My client avoided or held off painful or frightening emotionally charged experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My client expressed a desire to take action based on their newly emerging emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | | | | |
|-----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 13. | My client expressed deep underlying emotions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | My client reported disturbing bodily sensations without exploring them. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | My client described their behaviours as driven purely by wishes and desires. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | My client talked about emotions in a general, global or theoretical manner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | My client was overwhelmed by emotions and unable to identify their source or origin. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | My client evaluated others' behaviour/feelings with minimal reference and attention to their own emotional experience. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | My client focused on complaints about others with minimal reference to self-experience. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | My client focused on memories in a fully engaged, receptive and mindful manner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | My client experienced being in a confused, disoriented, or dissociated state in the session. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | My client allowed themselves to feel new, more adaptive emotions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | My client was flooded with painful emotions that they could not cope with. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | My client put basic, important wants or needs into words. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. | My client was preoccupied with bodily signs of illness or injury. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. | My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. | My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. | My client elaborated experiences by associating them with body sensations or reactions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

31. My client focused on impulsive desires (e.g., escaping from problems) without exploring further deep emotional wants or needs.
32. My client was reflective and actively curious about the personal meaning, value or sources of their experiences.

Appendix E. 28-Item Client Modes of Engagement Questionnaire (CMEQ-R)

Client Modes of Engagement Questionnaire		ABSENT	OCCASIONAL (1-5% of responses)	COMMON (10-20% of responses)	FREQUENT (25-45% of responses)	EXTENSIVE (≥ 50% of responses)
Please rate the extent to which your client was engaging in each of the following processes during this session:						
1.	My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	My client was preoccupied with bodily signs of illness or injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	My client was flooded with painful emotions that they could not cope with.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	My client focused on memories in a fully engaged, receptive and mindful manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	My client talked about emotions in a general, global or theoretical manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	My client was preoccupied with external events without referencing emotional reactions to those events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	My client allowed themselves to enjoy a sense of relief or easing of previous problem-related tension carried in their body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	My client was fully immersed in the elaboration and exploration of their emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	My client focused on complaints about others with minimal reference to self-experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	My client reported disturbing bodily sensations without exploring them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	My client was overwhelmed by emotions and unable to identify their source or origin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	My client looked inward and explored the bodily reactions related to his/her emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	My client was focused on his/her physical appearance or body image without	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

reference to emotional experiences.						
15.	My client was in a numb or emotionally blocked state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	My client expressed a desire to take action based on their newly emerging emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	My client put basic, important wants or needs into words.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	My client experienced being in a confused, disoriented, or dissociated state in the session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	My client evaluated others' behaviour/feelings with minimal reference and attention to their own emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	My client expressed deep underlying emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	My client expressed themselves in a chaotic manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	My client was reflective and actively curious about the personal meaning, value or sources of their experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	My client focused on impulsive desires without exploring further deep emotional wants or needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	My client avoided or held off painful or frightening emotionally charged experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix F. 24-Item 3-Point Scale Client Modes of Engagement Questionnaire

<p>24 ITEM: CMEQ-R₂</p> <p>Please rate the extent to which your client was engaging in each of the following processes during this session:</p>	<p><i>ABSENT</i></p>	<p><i>OCCASIONAL+</i></p>	<p><i>COMMON</i> <i>FREQUENT</i> <i>+ EXTENSIVE</i></p>
<p>My client expressed themselves in a chaotic manner.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client was in a numb or emotionally blocked state.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client was fully immersed in the elaboration and exploration of their emotional experience.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client was preoccupied with external events without referencing emotional reactions to those events.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client looked inward and explored the bodily reactions related to his/her emotional experience.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client was so overwhelmed by their emotions that they could not articulate or elaborate upon them.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client was focused on his/her physical appearance or body image without reference to emotional experiences.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>My client avoided or held off painful or frightening emotionally charged experiences.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My client's descriptions of experiences seemed to be pre-planned, rehearsed, or empty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client expressed a desire to take action based on their newly emerging emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client dwelt on physical symptoms (e.g., pain) without elaborating their emotional meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client expressed deep underlying emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client reported disturbing bodily sensations without exploring them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client talked about emotions in a general, global or theoretical manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client evaluated others' behaviour/feelings with minimal reference and attention to their own emotional experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client focused on complaints about others with minimal reference to self-experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client focused on memories in a fully engaged, receptive and mindful manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client experienced being in a confused, disoriented, or dissociated state in the session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client expressed ideas or beliefs in abstract or logical terms, without specific reference to concrete experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client was preoccupied with bodily signs of illness or injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client was able to step back from previous ways of experiencing in order to achieve a new sense of meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client was jittery or had trouble sitting still in the session and seemed to want to get up and do something.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client focused on impulsive desires (e.g., escaping from problems) without exploring further deep emotional wants or needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My client was reflective and actively curious about the personal meaning, value or sources of their experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>