EMOTIONAL CHANGE PROCESSES IN RESOLVING SELF-CRITICAL SUBTYPES OF DEPRESSION DURING EXPERIENTIAL TREATMENT

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Abstract

This mixed-methods study explored emotional processing that predicts long-term outcomes within subtypes of self-critical depression during experiential psychotherapy. First, I validated Kagan's (2003) qualitative analysis which identified four subtypes of self-criticism among depressed clients: (1) compare and despair; (2) too sensitive/needy; (3) internalized 'shoulds'/unacceptable feelings; and (4) unworthy/not good enough. I did this by performing a confirmatory reflexive thematic analysis (Braun & Clarke, 2006) on the same original sample (*n* = 42) Kagan used to establish her self-critical subtypes. Kagan's classification system was reliably applied by new coders. I then used Emotion-focused therapy (EFT) theory to hypothesize and extend Kagan's self-critical subtypes into higher-order self-critical subtypes. As hypothesized, two higher-order self-critical categories emerged: (1) 'Socially Inadequate' (SI) self-criticism which combined Kagan's first three self-critical subtypes, and (2) 'Core Worthlessness' (CW) self-criticism that retained Kagan's fourth subtype. Higher-order self-critical subgroups were then examined for differences in working phase emotional processing (WP-EP) occurring within clients' in-session emotion episodes. This was performed using proportion analyses and THEME 6.0 sequential pattern analyses (Magnusson, 2000). Measures used were: (1) discrete emotion states and higher-order emotion scheme categories operationalized by the Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). I also measured (2) the apparent "target" of emotion episodes measured by the Object Valence Scheme (OVS; Choi, 2013). WP-EP differences were found. SI clients expressed more other-positive, and CW clients expressed more fear, shame, and negative self-evaluations. I also examined differences between higher-order self-critical subgroups on 18-month follow up outcomes for clients who provided this data (*n* = 29). Higher-order self-critical subgroups did not

differ on any 18-month post-treatment outcome measure. Finally, depressed versus nondepressed clients at 18-month follow up within each higher-order self-critical subtype were compared for WP-EP differences. Supporting theorized EFT emotional change processes, nondepressed clients in both subgroups expressed greater proportions of, or more sequences involving, primary adaptive emotions and fewer sequences of being "stuck" in secondary and CAMS-uncodable emotions. Further, nondepressed SI clients expressed specifically more hurt/grief and self-soothing. Nondepressed CW clients also expressed more primary maladaptive emotions and needs. Clinical applications, limitations, and future directions are discussed.

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Chapter 1: Introduction

Self-criticism is a widely implicated depressogenic cognitive-affective structure and important treatment target in virtually all treatments of depression (Arieti & Bemporad, 1980; Beck, 1983; Blatt, 1974; 2004; Greenberg, 1992; Greenberg, Rice, & Elliott, 1993). Also, because depressed individuals represent a heterogenous population, subtypes of depressions (here, subtypes of self-critical depression) have become of interest to clinical researchers (de Vos, Wardenaar, Bos, Wit, & de Jonge, 2015; Goldberg, 2011; Lieblich et al., 2015). Furthermore, a general concern in the treatment of depression for clinical researchers is the identified importance of preventing depressive relapse (Westen, Novotny, & Thompson-Brenner, 2004). This study addresses all three lines of research. First, validation of an extant qualitative model of depressive self-critical themes/subtypes originally articulated qualitatively by Kagan (2003) was successfully undertaken by testing whether re-application of her self-critical themes (Kagan's self-critical classification system) could be reliably re-applied (that is, re-emerge reliably) in a confirmatory reflexive thematic analysis (Braun & Clarke, 2006). Following this, the study furthered Kagan's qualitative self-critical theme/subtype analysis by deductively hypothesizing that emergent higher-order self-critical themes/subtypes based on emotion-focused therapy (EFT) theory (Greenberg et al., 1993; Greenberg & Watson, 2006) would emerge. These higher-order self-critical themes were then conceptualized as the basis for two higher-order self-critical subtypes that represented a higher-order EFT-theory based 'subtype solution'. Emotional processing during the working phase (WP-EP) of therapy (WP-EP is already identified in previous research as the most predictive of outcome during experiential therapy for depression; Pos, Greenberg, & Warwar, 2009) was then investigated for differences that might differentiate these depressive self-critical themes/subgroups. Since there is general agreement that

transforming emotion schemes or schemas is an essential treatment target across all treatments in order for resilient resolution of depression to occur (Greenberg & Watson, 2006; Teasdale, 1999), the occurrence of specific types of emotional processing was examined as a predictor of resilient *long-term* follow-up, that is, at a time after which any impact of the therapy relationship could be agued to be long-past (Teasdale, 1999). To predict long-term outcomes, working phase emotional change processes that could predict successful versus unsuccessful long-term resolution of depressive symptoms within each self-critical higher-order theme/subgroup was explored. Outcome was defined as having a non-depressed Beck Depression Inventory score at 18-month follow up (BDI < 10; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961).

In this introduction, I will first discuss the diagnosis of depression, then outcome research for experiential treatment for depression, and then briefly describe the current practices in subtyping depression including self-critical depression. Following this, I will describe how EFT theory in particular views self-critical depression. Then, I will describe extant emotional processing literature for experiential treatment of depression. I complete this introduction by reviewing Kagan's (2003) self-critical subtypes that emerged from her qualitative analysis. Finally, I will then more clearly define my study aims.

Depression: Definition, Problem, and Treatment

The term 'depression' has become a common word in our everyday lexicon. It is well-known among people to describe a low emotional state often described as "feeling sad" or "feeling blue" that is accompanied by diminished interest or participation in work, relationships, and other activities. Clinically-speaking, the DSM 5 (APA, 2013) defines an episode of Major Depressive Disorder (MDD) as a mood disturbance lasting for at least two weeks characterized by the presence of five (at minimum) of nine specific symptom criteria across four domains. To

meet diagnostic criteria for a MDD episode, one of the two following base symptoms must be first met: (i) either feeling chronic sadness or (ii) feeling loss of interest in previously enjoyable activities. The four symptom domains are: (1) emotional (e.g., down/depressed mood, feelings of worthlessness, excessive guilt, or hopelessness), (2) cognitive (e.g., concentration difficulties, indecision, suicidal ideation), (3) physiological (e.g., fatigue, sleep problems, appetite/weight changes, psychomotor retardation or agitation), and (4) behavioural (e.g., anhedonia, suicidal behaviour). Given the diverse possible presenting symptom combinations that an individual may have to meet clinical criteria for a diagnosis of MDD, MDD clearly has a heterogenic presentation (Goldberg, 2011).

Depression statistics and relapse. MDD is one of the most prevalent mental disorders in the world, affecting 4.4% of the world's population (World Health Organization, 2017). This is estimated to be over 300 million people worldwide. In Canada, one in ten Canadians are expected to develop MDD in their lifetime (Patten & Juby, 2008). Between both physical and mental diseases, MDD is currently the disease with the greatest social/economic burden in the world (World Health Organization, 2017). In Canada alone, lost productivity due to depression is estimated to be 32 billion dollars annually (Conference Board of Canada, 2016).

The devasting impact of MDD on both individuals and the societies within which they live is largely maintained by the disorder's high propensity for relapse. These rates are estimated to fall between 50% to 80% (Andrews, 2001; APA, 2010; Judd, 1997; Westen & Morrison, 2001). In fact, the average depressed person experiences four major depressive episodes in their lifetime. Therefore, although clients may experience symptom relief in a number of treatments at therapy termination, many will experience future depressive relapses (Beshai, Dobson, Bockting, & Quigley,

2011; Ellison, Greenberg, Goldman, & Angus, 2009; Hollon, Stewart, & Strunk, 2006). Therefore, understanding resolution of depression long term is quite important.

Experiential treatments and depressive relapse. Emotion-focused therapy (EFT) is an effective short- and long-term treatment for depression (Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Goldman et al., 2004; Greenberg & Watson, 1998; Watson & Pos, 2017; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). In fact, a growing body of quantitative and qualitative research supports the efficacy of humanistic experiential psychotherapies (HEPs), including EFT, for the treatment of depression (see meta-analysis by Elliott et al., 2013). For example, in a study by Watson et al. (2003), EFT was found to be equivalent to cognitive-behavioural therapy (CBT) for reducing depressive symptoms at treatment termination, yet was, as well, found to be superior to CBT in reducing interpersonal problems. EFT has also been found to be superior to other HEPS such as client-centered therapy (CCT) in terms of preventing depressive relapse at long-term follow up (Ellison et al., 2009; Goldman et al., 2006), likely because EFT is a more structured treatment (Elliott et al., 2013; Watson & Pos, 2017). As such, EFT has been identified as possibly efficacious in the acute treatment and subsequent prevention of depression (Hollon & Ponniah, 2010). Resolving important tasks in EFT has been also associated with improved long-term follow up (e.g., Greenberg & Pedersen, 2001). Furthermore, EFT chair work intervention for self-criticism, in particular, has been shown to have medium to large effect sizes at 6-months post treatment in a small sample (Shahar et al., 2012).

Subtyping depression. Given the recurring nature of depression, the importance of identifying effective *long-term* treatments to support resilient recovery and prevent depressive relapse is paramount (Westen et al., 2004). We know that Division 12 of the American Psychological Association has identified many equally effective short-term treatments for MDD

(APA, 2016). However, many would argue that one of the best ways for improving *long-term* outcomes would be to identify depressive client subgroups who may be well-suited to a particular therapeutic intervention (Beutler, Clarkin, & Bongar, 2000). This strategy is supported in the literature, given that multiple routes to depression are described by multiple theories (Street, Sheeran, & Orbell, 1999). Identifying MDD subtypes is therefore one important new area of research that might accomplish this empirical goal.

Some attempts to subtype depression have already been made. Depression has been subtyped based on symptomatic presentation. For example, Goldberg (2011) identified depressive subgroups based on whether the depression was accompanied by somatic symptoms, panic attacks, obsessional traits, physical illness, or pseudo-dementing cognitive impairments. Depression has also been subtyped into four subgroups based on neurological markers linked to specific symptom presentations (Drysdale et al., 2016). In the HEP intervention domain, depression has also been categorically subtyped based on therapy processes found to relate to depression such as depth of emotional processing (Wong, 2016) or more generally, depression has been subtyped based on the content of depressive themes such as self-critical versus dependent depressions (Blatt, 1974; 2004). Supporting the value of parsing depressive subtypes to establish which subtypes fit which treatment, Sotsky et al. (1991) found that when a client was particularly prepared to engage in a specific process targeted by a particular treatment for depression, they fared better in that treatment. Therefore, the task for clinical researchers and my goal in the present research is to parse or elucidate self-critical depressed client subgroups and then match these with their optimal emotional paths and interventions for experiential therapies in particular in order to examine if self-critical subtypes of depressed clients differ in their

response to experiential treatments. Here, because of my focus, I will review self-critical depression particularly.

Self-critical Depression: One well-known depressive subtype

Self-criticism is identified as an important source of client difficulties, particularly depression (Whelton & Greenberg, 2005). Shahar (2015) defines self-criticism as an intense and persistent relationship with unrealistically high-performance self-standards that lead to self-hostility, self-derogation, and depression when these excessive standards are not met. Emotion-focused therapy, psychodynamic, and cognitive approaches all converge on a 'content' differentiation between two common personality based subtypes of depression first introduced by dynamic writers, one of which is self-critical depression (the other is dependent depression; Beck, 1983; Blatt, 1974; 2004; Greenberg, Elliott, & Foerster, 1990; Greenberg et al., 1993; Greenberg & Watson, 2006; Whelton & Greenberg, 2005). Therefore, all approaches to treatment identify self-criticism as a core depressogenic vulnerability. The link between self-criticism and depression is well-supported in the literature (Abela, Sakellaropoulo, & Taxel, 2007; Abu-Kaf & Priel, 2008; Besser & Priel, 2003; 2005; Brewin & Firth-Cozens, 1997; Cox, McWilliams, Enns, & Clara, 2004; Derosa, 2000; Enns, 1999; Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006; Luyten et al.; 2007; McGillivray & McCabe, 2007; Mongrain & Leather, 2006; Öngen, 2006). Several studies have identified preponderant self-critical processes among depressed samples (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Blatt, Zuroff, Hawley, & Auerbach, 2010; Choi, 2011; Kagan, 2003; Segal, Shaw, & Vella, 1989; Vanheule, Desmet, & Meganck, 2008). Using the Depressive Experiences Questionnaire (DEQ-S; Blatt, D'Afflitti, & Quinlan, 1976), I have also demonstrated that self-critical depression is a preponderant type of depression in the York University experiential treatment sample (Choi, 2011).

Self-criticism is particularly dangerous to mental health for several reasons. First, clients can fail to even experience self-criticism as problematic because they rationalize that being self-critical is a helpful self-enhancement tendency (Costandius, 2009). For example, because some clients confuse positive aspects of perfectionism with the negative consequences of self-criticism, they can subsequently experience low self-esteem and depression as a result of failing to be perfect (Hewitt & Flett, 1991). In fact, self-critical perfectionism has been typically viewed as a pervasive neurotic style and does positively correlate with depression (Grzegorek, Slaney, Franze, & Rice, 2004; Hewitt & Flett, 1991) and diminished goal progress (Powers, Koestner, Zuroff, Milyavskaya, & Gorin, 2011). Second, self-critical depression is also insidious because it has been linked to the onset and severity of depression (Abela, Webb, Wagner, Ho, & Adams, 2006; Hawley, Zuroff, Brozina, Ho, & Dobson, 2014; Luyten et al., 2007; Sherry, Richards, Sherry, & Stewart, 2014; Straccamore et al., 2017; Zuroff, Igreja, & Mongrain, 1990; Zuroff, Santor, & Mongrain, 2005). Third, and most relevant here, self-criticism has also been found to negatively impact both the therapeutic alliance (Whelton, Paulson, & Marusiak, 2007) and treatment outcomes as well. This has been true for outcomes in cognitive-behavioural group therapy (Enns, Cox, & Pidlubny, 2002; Marshall, Zuroff, McBride, & Bagby, 2008) and supportive-expressive therapy (Blatt, 2004). Therefore, targeting and resolving self-criticism is likely an important means for lasting change among the depressed population. Self-criticism has also been linked to other psychological difficulties such as social anxiety disorder (Cox et al., 2000; Iancu, Bodner, & Ben-Zion, 2015) and eating disorders (Brennan, Emmerling, & Whelton, 2015).

Emotional processes in self-critical depression. Across major psychological approaches, self-critical depression is characterized by problematic emotional processes concerning having

typically excessive, perfectionistic, and unachievable standards (Beck, 1983; Blatt, 1974; 2004, Greenberg et al., 1993; Greenberg & Watson, 2006). The self-critical individual is often intensely afraid of failing to reach their goals and may pursue these goals relentlessly. However, the belief is that inevitable failure and then perceived shortcomings prompt the individual to blame and censure themselves, leaving the individual often feeling fundamentally weak, unworthy, and unlovable because of their perceived failures. It is therefore assumed that this type of individual overvalues mastery strivings and will work excessively (i.e. 'are workaholics,') in order to feel competent and worthy of love (Blatt, 1974; 2004). This may lead to these individuals avoiding relationships until they have obtained a sense of 'worthiness' from their work. This often leads an individual to experiencing problems, because this type of person suffers from an unhealthy personality structure emerging from an unbalanced dialectic between striving for self-definition versus being related (Blatt, 1974, 2004). A healthy personality develops both personal competence *and* mature relationships. So, the 'introjective' or self-critical personality structure overinvests in the self-definition dimension and neglects the relatedness dimension. This 'introjective' individual is sensitive to disruptions of personal agency and competence and subsequently becomes 'introjectively' depressed when self-perceived 'failure' occurs.

The emotional underpinning of self-critical depression suggests a specific role for shame as a key to understanding self-criticism (Greenberg & Paivio, 1997; Whelton & Greenberg, 2005). In fact, Gilbert and Proctor (2006) have demonstrated a mutually reciprocal relationship between shame and self-criticism. Shame can be conceptualized as a social emotion coming from negative views of self originating from others and/or from self-directed negative views of self. Both are thought to increase one's vulnerability to and perpetuate self-criticism. Conversely, it

has been found that individuals higher in self-criticism are also more prone to experiencing shame (Gilbert & Miles, 2000).

Dependent depression versus self-critical depression: A comparison. Alternatively, dependent depression is assumed to be marked by undervalued mastery motivations and overvalued relationship pursuits (Blatt, 1974; 2004, Greenberg et al., 1993; Greenberg & Watson, 2006). The dependent individual relies heavily on others to meet their needs and the quality of their relationships determines their level of self-esteem. It is difficulty in close relationships that leaves this type of individual feeling alone, inadequate, and yearning for the 'other' to care for them. Compared to self-critical depression, dependent depression is viewed as a more 'child-like' depression. According to Blatt (1974, 2004), an 'anaclitic' or dependent personality structure develops when one overinvests in the relatedness dimension and neglects the self-definition dimension. The anaclitic individual is sensitive to disrupted relationships and becomes 'anaclitically' depressed when relationship disturbances occur.

Resolving self-critical depression. My focus here is on self-critical depression and my core interest is how one transforms or 'solves' this difficulty. According to Blatt (1974, 2004), therapeutic change in self-critical depression occurs when treatment shifts a self-critical client's initial focus from self-blame and low self-worth towards building more nurturant, resilient positive views of self. Whelton and Greenberg (2005) have also argued for this, and for supporting a client's resilient emotional self-resources that they can use to do battle with their self-criticism. Whelton and Greenberg suggest that in this way, one's pathological introjective 'personality structure' can become rebalanced, providing self-critical clients with emotional resources that facilitate their living more balanced adaptive lives in the service of all their needs.

Blatt et al. (2010) have found, in fact, that self-critical depressed clients resolved their depression when they developed more positive representations of self.

From a cognitive therapy approach, self-critical, or what they call 'autonomous', depression is again viewed as arising from the activation of dysfunctional cognitive schemas in which self-worth again primarily hinges on beliefs about the importance of autonomy and accomplishments (Beck, 1983; Clark, Beck, & Alford, 1979). In a CBT stress-diathesis model (Monroe & Simons, 1991), disruptions in personal mastery activate one's vulnerability to feeling inadequate leading to a depressive episode (Robins, 1990). Convergent with Blatt (2004), autonomous depression is thought to be resolved by means of cognitive schematic change in therapy that supports healthier core beliefs and thinking patterns about the self (Beck, Rush, Shaw, & Emery, 1979)

Emotion-focused therapy view of change in self-criticism. I will now discuss the manner in which EFT views emotional functioning within client problems, including the process of resolving self-criticism.

EFT (Greenberg, 2017; Greenberg et al., 1993; Greenberg & Watson, 2006) is an empirically-validated humanistic experiential psychotherapy (HEP; Elliott et al., 2013) treatment for depression that asserts that all human behaviour springs from the integrative and dynamic functioning of internal cognitive-affective structures which the EFT approach calls emotion schemes (ESs). In any given situation, ESs are assumed to rapidly and automatically synthesize a wide variety of information (e.g., sensations, perceptions, cognitive appraisals, memories, motivations) to organize one's moment-to-moment experience and response in situations. EFT also has articulated a now-globally accepted emotion scheme typology (Greenberg & Safran, 1987); one that suggests that there are different types of emotion schemes: primary or secondary,

adaptive or maladaptive. Primary adaptive emotion schemes (PAEs) are conceptualized as providing "good information" in a situation, organizing the individual for helpful emotional responses to get needs met in the situation they are in (e.g., anger for boundary-setting at violation, sadness/grief for reaching out to others after a loss). Primary maladaptive emotion schemes (PMEs) are conceptualized as typically overlearned emotional responses from past situations. They are thought to provide "poor information" in a present situation and most often organize an individual to engage in unhelpful emotional overreactions (e.g., experiencing deep-seated shame after receiving constructive criticism, abandonment fears when one's partner goes to work). These emotional overreactions are often sequelae of painful experiences from developmental contexts within which needs were not met (e.g., maladaptive shame from an overly critical parent, maladaptive fear from a neglectful parent or adulterous partner). Perhaps once an adaptive reaction for coping with a childhood situation (e.g., shame for what an overly critical parent considered 'bad' or misbehavior), maladaptive emotions no longer support adaptive coping in present situations. Finally, secondary emotion schemes (SEs) are conceptualized as emotional responses that follow (often covering, interrupting, or avoiding) primary emotional reactions, adaptive or maladaptive (e.g., fear of expressing primary anger, anger at someone who hurt you). Secondary emotion schemes (SEs) also provide "inappropriate information" about the environment in any situation and often unhelpfully obscure one's access to primary emotions and/or derail the process of getting one's important and deepest needs (connected to primary emotions) met in a situation.

From an EFT perspective, all client difficulties are also thought to emerge from problematic emotional processing problems within which problematic emotion schemes (too many secondary or maladaptive and not enough adaptive emotion schemes) are assumed to occur

(Pos, Greenberg, & Elliott, 2008). EFT theory has identified several global emotional processing difficulties that can be targeted to predict change in experiential therapy for depression. These can be resolving unfinished business or better accessing one's internal world (Greenberg & Pedersen, 2001; Pos, Greenberg, Goldman & Korman, 2004; Watson & Pos, 2017). In EFT, self-criticism is a marker of one such particular global depressogenic emotional processing problem; one that suggests to the therapist to engage the client in a self-critical split chair task (Greenberg et al., 1993). In this task, the client's internal self-critical voice as well as the client's criticized self are located and voiced from different chairs. This allows both parts of the self to make contact (Perls, Hefferline, & Goodman, 1951) with each other, differentiate from one another, and to enter into a therapeutic (emotionally-based) dialogue with each other. Within this emotion-based dialogue, one process goal is the self 'receiving' the criticisms from their angry critical self, and then the non-critical self articulating the felt emotional impact of being criticized to their self-critic. This process typically starts with expressions of 'secondary' hopelessness or resignation but then hopefully progresses to the criticized self feeling and expressing 'primary maladaptive' emotions (such as shame and fear). Resolution is then facilitated by helping the self chair access an experience of its valid unmet needs, often marked by a stage in which the client's 'criticized' self articulates these unmet needs. Following this, 'primary adaptive' emotions hopefully emerge in the 'criticized self' that facilitate that self chair to experience and express more empowerment in the face of their critic. This can lead the critical side of the client to 'soften'. At this stage, there can be a notable emotionally- positive shift of seeing the self as worthy, in both the critical and criticized sides of the self. Resolving self-critical depression can be aided by helping the client access early 'learning' of how their self-criticism first took hold (e.g., learning to be self-critical from a harsh critical parent). Higher

degrees of resolution on EFT chair tasks have been associated with positive outcomes among depressed clients at 18-month follow up who received experiential psychotherapy (Greenberg & Pedersen, 2001).

From an EFT perspective (Greenberg, 2017; Greenberg and Watson, 2006), therefore, self-critical depression is conceptualized as the experienced activation of a 'bad self' self-organization brought on by self-critical processes within the client (Greenberg et al., 1990). During this depressogenic 'bad self' experience, there is chronic activation of secondary emotions in the critical self (e.g., self-blame and self-anger) as well as shame-based maladaptive emotions in the criticized self of feeling inherently worthless, helpless, and/or unlovable. Negative thoughts and judgments about the self (e.g., "I can't do anything right" or "I am a loser") may also accompany these secondary and primary maladaptive emotion activations.

EFT, therefore, seeks to help the client restructure depressogenic self-criticism by working with emotion schemes connected to the client's self-critical self-organizations. A safe and supportive client-centered therapeutic relationship is thought to facilitate this (Greenberg & Watson, 2006). 'Generic' self-critical depression is assumed to resolve through emotion schematic change in which the client reduces their secondary emotions, and begins to process their maladaptive emotions (e.g., deep-seated shame and fears), often initially inaccessible due to the interruptive or 'protective' nature of secondary emotions (Weston, 2018). Following this, a client is helped to access and express their core, often historically unmet, needs linked to their maladaptive emotion schemes (e.g., need for parental approval that was never received). Once articulated, accessed needs are believed to facilitate the access of primary adaptive emotions that can reorganize and mobilize the individual in ways to get needs finally met. For example, a need for self-preservation against a harsh self-critic can lead to adaptive anger that sets new limits and

boundaries with the self-critic. Alternatively, a need for acceptance can lead to cultivating a newfound sense of pride, confidence, and compassion for oneself. As such, adaptive emotion schemes are conceptualized as important agents of transformation and resolution of maladaptive emotional vulnerability to self-critical depression. Specific emotions such as assertive anger, core pain, grief, self-soothing, self-compassion, self-acceptance, and pride are all identified as potentially transformative primary adaptive emotions for self-critical depression (Choi, Pos, & Magnusson, 2016; Rinaldi, 2017). None of these primary emotions have yet been identified as particularly important to resolving certain types of self-criticism. The process of moving from secondary to maladaptive to adaptive emotion has been modelled through task analytic research on resolving the self-critical split two-chair task (Greenberg, 1984). Several volumes (e.g., Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Watson, 2006) comprehensively detail this intervention and the self-critical resolution model that emerged from the task analytic research of this intervention.

In my master's research (Choi et al., 2016), I rigorously investigated the EFT model of emotional change in a sample of nine highly self-critical clients who either had or had not resolved their self-critical depressions by termination after receiving experiential treatment for their depressions using the Classification of Affective Meaning States (CAMS; Pascual-Leone & Greenberg, 2005) measure. I explored specific emotion schemes alone and in sequences in order to investigate the validity of EFT emotion theory in these cases of high self-criticism. I found that during experiential treatment, self-critical depression was marked by chronic activation of primary maladaptive emotions such as deep-seated shame and fear, and secondary emotions including self-anger and self-blame. Compared to poor resolvers of self-critical depression, good resolvers were marked by an empowered self-stance towards one's internal self-critic and more

positive views of self, as well as accessed needs and primary adaptive emotions of core pain, grief, and assertive anger. This validated EFT change theory (Greenberg & Watson, 2006; Whelton & Greenberg, 2001). I did not examine specific themes of self-criticism in relation to these specific emotions in my master's research. Other research also highlights the importance of accessing self-assuring and positive aspects of the self in resolving self-criticism (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Shahar et al., 2012). When I examined higher order emotion schemes or types in my master's thesis, good resolvers of self-criticism also expressed more emotion schematic sequences indicating transformation of 'secondary to primary adaptive emotions', as well as 'secondary to primary maladaptive to primary adaptive emotions', again supporting the emotional change process theorized in EFT (Elliott et al., 2004). In contrast, poor resolvers of self-criticism expressed more emotion schematic sequences of primary maladaptive emotions and secondary emotions, suggestive of emotional 'stuckness,' even after accessing core emotional needs that are thought to support primary adaptive emotional access in EFT theory.

Increasing clients' access to primary adaptive emotional resources as measured by the CAMS instrument has also been found to predict good outcome in depressed, emotionally injured, traumatized, and socially anxious clients during EFT treatment (Haberman, Shahar, Bar-Kalifa, Zilcha-Mano, & Diamond, 2018; McNally, Timulak, & Greenberg, 2014; Nussbaum, 2014; Pascual-Leone, 2009; Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007); in individuals with adjustment disorders undergoing psychodynamic therapy (Kramer, Pascual-Leone, Despland, & de Roten, 2015); and in clients with borderline personality disorder engaged with motive-oriented therapeutic relationships (Berthoud et al., 2017). This suggests that

interventions that facilitate adaptive emotion access can reduce client difficulties across many different disorders and treatment approaches.

We know then that emotional processing is important, particularly within experiential treatments. We also know that EFT, an empirically-supported experiential treatment for depression (Watson & Pos, 2017), assumes that change in emotion schemes is important for deep *lasting* change in depression (Greenberg, 1992; Greenberg & Pedersen, 2001; Greenberg & Watson, 2006). This desired emotion scheme change is reducing and transforming 'secondary and primary maladaptive emotions' and increasing access to core needs, primary adaptive emotions and positive views of self. While in my master's research I demonstrated these EFT emotion-schematic theory-expected change processes that predicted *termination* outcome for nine *highly* self-critical depressed clients (Choi et al., 2016), in the current study I furthered my masters research by more rigorously examining emotional change processes that predicted *long-term* outcome among *themes/subgroups* of self-critical clients first qualitatively identified by Kagan (2003). Specifically, I explored emotional processing within these self-critical themes/subtypes by exploring emotional processing occurring in all clients' emotion episodes (EEs; Korman, 1998) sampled from clients' two working phase sessions of therapy that clients had already identified as being most helpful to them (Pos et al., 2009). All client EEs were rated using two different emotion process coding measures. First, I used the Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005), which captures 10 different specific categories of emotions as well as permitted me to examine higher ordered emotion scheme typology (e.g., secondary, primary maladaptive, and primary adaptive emotions) constructed from the specific emotion categories (see 'Method' section). Second, I used the

Object-Valence Scheme (OVS; Choi, 2013) to capture clients' relational valence (positive or negative) to personal objects (self or other) present in each emotion episode.

Previous empirically explored HEP emotionally-based subtypes of depression. In humanistic experiential psychotherapies (HEPs) including EFT, one emotional process distinction has been researched as potentially informing subgroups among depressed clients receiving experiential treatments—this is low versus high experiencers (Pos et al., 2009; Wong, 2016). This subgrouping emerged from research showing that levels of experiencing at the beginning of therapy could define groups of clients whose outcomes varied (Pos, 2006). Increased emotional experiencing resulted in better outcomes for the clients initially less in touch with their internal worlds. One explanation of this result was that the measure used to tap emotional processing may have impacted these results. Experiencing during emotion episodes (EE-EXP; Klein, Mattieu, Gendlin, & Kiesler, 1969; Pos et al., 2003) was the measure used and described the degree to which clients referred to their internal emotions and use this internal experiential information to resolve their difficulties. From an experiential therapy research perspective, low experiencers (Wong, 2016) were marked by low early therapy modal experiencing. These clients entered therapy with a tendency to be externally focused, with limited verbal access to their internal emotion world. They were assumed to be depressed because they were 'cut off' from their internal emotions. In contrast, high experiencers had higher modal experiencing, had emotion language, and were assumed to enter therapy with some capacity to have better initial contact with their internal worlds. These high experiencers were assumed to be depressed because of their inability to transform specific emotional difficulties. In that study, it appeared that low EXPers made the most emotional processing gains because of the way experiencing was measured, i.e., low EXPers entered treatment with lower experiencing

levels and therefore had more room for experiential growth that could be captured by the EE-EXP scale compared to high EXPers. Rather than view the high EXP group as 'non-responders', Pos (2006) assumed that high EXPers were still making treatment gains, but doing so in another emotional processing domain—emotion scheme change. Since the EE-EXP scale does not capture emotion scheme typology changes, it was assumed these would be better captured by another emotional processing measure: The Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). For this reason, Wong (2016) compared both the EE-EXP and the EE-CAMS measures' capacity to predict long-term outcome for depression for high and low early experiencers. Surprisingly, Wong found that more expression of primary adaptive emotions and less expression of secondary emotions (both measured by the CAMS) predicted long-term client improvement in both low and high experiencing subgroups. However, and again surprising, the proportion of emotion episodes with peak ratings of EXP Level 6 did uniquely predict good outcome in high experiencers. Wong (2016) suggested that Level 6 EXP might be considered a potential emotion scheme change marker and that, conversely, frequent expressions of secondary global distress and rejecting anger (secondary emotions) that predicted poor outcome in low experiencers, suggested those CAMS categories could be implicit measures of emotional avoidance in low experiencers.

In the current study, rather than examine emotional process differences for 'experiencing subtypes' of depressed clients, I chose to examine differences in emotion scheme proportions and sequences as well as examine other specific emotional processes captured by the OVS measure that predict long-term clinical outcomes in *self-critical subtypes* of depression. This is because, as reviewed above, self-critical depression has been a long-considered important subgroup of clients suffering from MDD. As such, my goal in the current study was to more

precisely identify emotional processing differences that occur between and within subtypes relating to the important emotional processing problem of self-criticism. I again argue that the importance of examining emotional processing within subtypes of this particular emotional processing difficulty rests on the possibility that self-critical subgroups may struggle in emotionally-meaningful and distinctly different ways while resolving their self-criticism. That there is more than one way to resolve self-criticism depending on the type of self-critical process that one struggles with. Distinguishing emotional change process differences between self-critical subtypes as well as between good and poor resolvers within self-critical subtypes may have important implications for understanding the change process in self-critical depression, preventing depressive relapse, and informing clinical practice. Knowing which emotional 'road' a specific subtype of self-critical clients takes while resolving depression may be very important for more precise and productive outcomes with this disorder (Pos, Wong, & Rinaldi, 2018).

Expanding Self-critical Depression: Kagan's Self-critical Subtypes

To our knowledge, only two studies have explored subtypes of self-criticism within experiential therapy. First, self-critical subtypes have been explored by Whelton and Henkelman (2002) who identified eight different categories of self-criticism based on the researchers' perceived themes of clients' self-criticism: (1) demands and orders; (2) exhorting and preaching; (3) explanations and excuses; (4) inducing fear and anxiety; (5) concern, protection, and support; (6) description; (7) explore / puzzle / existential; and (8) self-attack and condemnation. No relationships to outcome or emotional processing were undertaken as these clients were a subsample of Whelton (2001) who had engaged in an analogue therapy study in a laboratory setting.

A second study focused on the narrative content of self-criticism in real experiential therapies. Kagan (2003) explored self-critical themes/subtypes qualitatively by conducting a grounded theory qualitative analysis. She identified four primary content or narrative self-critical themes/subtypes expressed by 40 depressed clients who had undergone experiential treatment in the York II clinical trial (Goldman et al., 2004). I will list and briefly describe these self-critical themes/subtypes that Kagan (2003) found. These were: (1) compare and despair, (2) too sensitive/needy, (3), internalized 'shoulds'/unacceptable feelings, and (4) unworthy/not good enough.

In Kagan's 'compare and despair' category, self-criticism focuses on comparing oneself to others and subsequently feeling that one is behind and inferior to others. One is not where one ought to be in life as a result of failing to live up to expectations or one's potential. One also suffers from lacking direction when expectations are unclear. As a result, these clients often collapse into helpless despair about their undesired place in life.

In Kagan's 'too sensitive/needy' category, self-criticism centers on judging oneself for one's need for others. One views one's need for others as undesirable and/or a sign of being too sensitive and weak as a person as a result of having these needs.

In Kagan's 'internalized 'shoulds'/unacceptable feelings' category, self-criticism concerns judging oneself for falling short of moral or perfectionistic standards (e.g., "I should never fail" or "If I can't take care of myself, I am bad" or "I need to always put others' needs before my own"). Alternatively, one may judge oneself for experiencing feelings that are deemed unacceptable to the self (e.g., "feeling sad is bad" or "being mad is bad"). These represent internalized rules and values according to the way individuals live their lives. They are entrenched in moral self-criticism that is quite resistant to challenge and change.

Finally, in Kagan's 'unworthy/not good enough' category, self-criticism focuses on an experience of self as being negative at the core (e.g., "I am worthless" or "I am unlovable"). Oftentimes, one can feel unworthy in response to having already failed to live up to perfectionistic goals and standards (e.g., "I am worthless if I cannot take care of my family"). This was a category within which the self really has 'bought into' the critic's view of self as worthless. The criticized self seems 'defeated'.

Goals of Current Study

The current study tested the validity of Kagan's (2003) current qualitatively-derived self-critical themes/subtypes of depressed clients and explored potential differences among these self-critical subgroups in terms of their emotional processing and outcomes. While my master's thesis investigated global self-criticism identified by the Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976) and identified emotional change processes that demarcated more versus less successful resolution of global self-criticism at treatment termination, the current study sought to more closely examine self-critical depression based on the aforementioned self-critical themes/subtypes identified by Kagan (2003) while also examining emotional processes predicting resolution of self-critical depression in the *long-term*. I accomplished this using a hierarchy of goals.

Qualitative Goal 1: Validating Kagan's four self-critical themes/subtypes. My first goal was to validate Kagan's (2003) self-critical categories/subtypes that had emerged from her qualitative analysis by examining whether her self-critical category/subtype codes could be reliably applied in a confirmatory reflexive thematic analysis (Braun & Clarke, 2006). What I mean by this analysis is that I deductively used Kagan's extant codes to re-code her original data. I also allowed for inductive grounded codes to emerge during this process. Further, while I know

that reliability is generally less important than validity in qualitative research, I assumed that recoding the data reliably would additionally support the validity and credibility of Kagan's (2003) qualitative findings (Guest, MacQueen, & Namey, 2012). I will discuss the issue of qualitative validity more fully in the 'Method' section. I first hypothesized that Kagan's (2003) four self-critical categories/subtypes would be validated during qualitative thematic re-coding of her data.

Qualitative Goal 2: Extending Kagan's qualitative analysis using EFT-based higher-order themes/subtypes. I also wanted to further Kagan's qualitative analysis. I did so by hypothesizing (deductively proposing) two higher-order self-critical depression categories/subtypes that were based on EFT theory. These were informed by other quasi-qualitative research findings (Greenberg et al., 1990).

Given that Kagan's first three subtypes concern self-standards and that her fourth subtype concerns negative core self-evaluations, it was hypothesized that two higher-order self-critical themes/subtypes based on EFT theory (as opposed to four subtypes based on Kagan's four themes) would emerge: (i) a higher order "persecutory" self-critical subtype that collapses Kagan's subtypes one to three (compare and despair, too sensitive/needy, internalized 'shoulds'/unacceptable feelings) and (ii) a higher order "Core Worthlessness" self-critical subtype that retains Kagan's fourth subtype of unworthy/not good enough. In hypothesizing these two higher-order categories/subgroups, I hypothesized that self-criticism can be viewed as emerging from two shame processes that are consistent with Gilbert and Proctor's (2006) distinctions between externally- or internally-driven shame. One is persecutory or 'externally-based' shame-based self-criticism characterized as experientially distant or avoidant self-criticism in which individuals are harshly self-blaming and self-punitive. In the EFT self-critical

split chair task, persecutory self-criticism aligns with the stance of the internal critic's chair (Greenberg & Watson, 2006). This persecutory self-criticism is often expressed from the vantage point of a punitive judge.

In contrast, I assumed another higher-order self-criticism would be coherent with Kagan's (2003) original 'unworthy/not good enough' category and which I wish to rename as 'Core Worthlessness'. This self-criticism is hypothesized to characterize someone who is more experientially aware and connected with their feeling "small" due to experiences of their core unworthiness. I assumed that in this core unworthy subtype, self-criticalness would be expressed from the vantage point of the persecuted self, converging with the concept of internal shame described by Gilbert and Proctor (2006). In the EFT self-critical split chair task, this self-criticism will more frequently be voiced from the client's chair (also known as the chair of the 'experiencing self') who feels shamed and 'flattened by' their self-critic (Greenberg & Watson, 2006). In other words, 'Core Worthlessness' self-criticism is expressed from the vantage point of a defeated recipient of criticism.

These two proposed higher-order self-critical categories/subtypes also converge with two types of self-criticism identified by Gilbert et al. (2004): one type wants to hurt the self and feels self-disgust and self-hate (converges with 'persecutory' self-criticism) and one type who dwells on mistakes and feels inadequate (converges with 'Core Worthlessness' self-criticism). Gilbert et al. also highlighted the importance of future research on self-critical subtypes.

My second goal was therefore to expand on Kagan's (2003) qualitative data from which her four self-critical categories had emerged. I wanted to take her analysis further and to explore higher-order self-critical categories based on EFT theory. This could allow me the adequate sample sizes to examine and compare emotional processes between subgroups at this higher

level of distinction. Kagan never examined emotional processes within her sample, nor did she examine outcomes in relationship to her self-critical categories/subtypes. As such, my study was a mixed-methods study employing a combination of qualitative and quantitative analyses to examine self-critical subtype differences in emotional processing and outcome. Please see the 'Method' section for more information on these procedures.

Goal 3: Examining emotional process differences between higher-order self-critical subgroup categories. Once the higher-order EFT-theory based themes/subtypes of self-criticism emerged, I examined emotion schematic processing differences *between* the two higher-order self-critical categories/subgroups during the working phase of experiential treatment that might distinguish the two higher order subgroups. This was explored in terms of proportions of higher order CAMS-coded emotion schemes identified in EFT theory (secondary, primary maladaptive, and primary adaptive) and emotion episode (EE) proportional differences in specific emotion processing states measured by the CAMS measure. I also employed THEME (Magnusson, 1993; 2000) analyses of CAMS emotion code sequences to explore any potential consistent emotion sequence differences between self-critical categories/subtypes. EE proportional differences in Object-Valance Scheme (OVS; Choi, 2013) categories were also explored between self-critical subgroups.

Consistent with their higher-ordered EFT-theory based thematic descriptions, it was predicted that depressed clients with higher-order 'persecutory' self-criticism would express greater proportions and sequences of self-punishing secondary emotions, particularly rejecting anger towards the self during the working phase of experiential treatment. Conversely, it was predicted that depressed clients with higher-order 'Core Worthlessness' self-criticism would express greater proportions and sequences of primary maladaptive emotions, particularly fear

and shame, and negative self-evaluations during the working phase of experiential treatment. It was assumed that 'Core Worthlessness' self-critical clients would be in greater contact with their deeper emotions (i.e., their primary emotions) in general.

Goal 4: Examining long-term outcome differences between higher-order self-critical subgroup categories. My fourth goal was to explore whether any differences were present in *long-term* outcome between the two EFT theory-based higher-order self-critical categories/subgroups. In terms of examining outcome differences among self-critical categories/subgroups, I hypothesized that higher-order 'Core Worthlessness' self-critical clients would have better long-term outcomes than higher-order 'persecutory' self-critical clients. This was because it is assumed by EFT theory that worthless feelings underlie persecutory self-criticism and are also closer to a client's core pain (Greenberg & Goldman, 2015). As such, these self-critical categories I thought could be viewed as different stages in the process of resolving self-criticism. In line with EFT theory, I assumed that 'Core Worthlessness' self-critical clients would be better positioned to resolve their depressive self-criticism than 'persecutory' self-critical clients given their greater access to primary maladaptive emotions, which would situate them closer to being able to access core needs and primary adaptive emotions needed for resolving their self-critical depressions.

Goal 5: Examining emotional processing differences predicting long-term outcome within each higher-order self-critical subgroup category. My fifth goal was to explore emotion schematic processing during the working phase of experiential treatment *within* each self-critical category/subtype that might distinguish good and poor long-term resolvers of that particular higher order self-critical depression theme/subtype. This was accomplished in two ways. First, I explored proportional differences in CAMS and OVS codes between good and poor long-term

resolvers of a particular self-critical subtype. Secondly, I employed THEME (Magnusson, 1993; 2000) analyses of CAMS codes within each self-critical subtype to explore patterns of emotion that occurred more frequently in good versus poor long-term outcomes within each self-critical subgroup.

Based on previous findings, it was hypothesized that better resolvers of higher-order 'persecutory' self-criticism would express reduced proportions of secondary emotions and increased proportions of primary adaptive emotions, as well as sequences that demonstrate this transformative process. On the other hand, better resolvers of higher-order 'Core Worthlessness' self-critical clients were expected to express reduced proportions of primary maladaptive emotions and increased proportions of primary adaptive emotions that are accompanied by sequences that show this transformative process. I had no additional specific hypothesized expectations relating to additional emotion processes that might demarcate good versus poor long-term resolvers within each higher-order self-critical subgroup.

Importance of Study

HEPs, particularly EFT, have been shown to resiliently resolve depression (Elliott et al., 2013; Goldman et al., 2006; Watson & Pos, 2017). Identifying whether some higher-order self-critical subtypes reliably resolve their self-criticism better than others and elucidating the optimal emotion schematic change pathways they take while resolving their particular self-criticism would have beneficial implications for case conceptualization and treatment planning. Long-term clinical outcomes for these subgroups in experiential therapies would then be improved. Moreover, empirically linking emotional change processes to client recovery is essential for all psychotherapy research, not only for ongoing validation of EFT tenets and practices (Wampold,

2001). Such research is essential for effectively combating the disease burden depression presents today and in the future.

Chapter 2: Method

Participants

The study participants were 42 clients from the York II OMH-funded randomized clinical trial for experiential therapy for depression that occurred at York University (Goldman et al., 2006). All participants were randomized to receive either short-term (16-20 sessions) emotion-focused therapy (EFT) or client-centered therapy (CCT). To be included in the study, all clients met criteria for a major depressive disorder based on the Structured Clinical Interview for DSM-IV (SCID-IV; Spitzer, Williams, Gibbons, & First, 1995) and had a Global Assessment of Functioning (GAF) score of at least 50. Exclusion criteria included current treatment for or currently receiving medication for depression, having made a recent suicide attempt, having a current bipolar or psychotic disorder, being engaged in current substance or alcohol abuse, having antisocial or borderline personality disorder diagnoses, being currently suicidal or being in a currently abusive relationship. For full information on the York II Depression Project's inclusion and exclusion criteria, please see Goldman et al. (2006).

Self-critical process in the study sample. Unlike my master's research that quantitatively examined emotional processing in highly self-critical depressed clients (based on their pre-treatment score on the Depressive Experiences Questionnaire or DEQ; Blatt et al., 1976), this study qualitatively explored general self-critical themes in a sample of depressed clients who received experiential therapy, without consideration of the degree of self-critical depression clients reported at treatment onset. The current sample included forty clients who were originally analyzed in Kagan's (2003) study and two additional clients who had available emotion process

data. All 42 clients in the present study expressed self-critical themes based on the current qualitative re-analysis of Kagan's data. Thirty-one clients (74%) scored in the high average range or above on self-criticalness defined as scoring greater than 0.67 standard deviations above the normative sample on the Self-criticism subscale of the DEQ (Blatt et al., 1976). Considering that the DEQ is a self-report measure, some clients may have underreported their self-criticism as underreporting is not uncommon on self-report measures including those querying depressive symptoms (Hunt, Auriemma, & Cashaw, 2003).

Subgroups and outcome in the study sample. Within each higher-order self-critical subgroup, good and poor outcomes were determined based on 18-month follow up scores on the Beck Depression Inventory (BDI; Beck et al., 1961). Good outcome was defined by a client having an 18-month BDI score of 9 or less and poor outcome was defined by a client having an 18-month BDI score of 10 or more. Not all clients in the current sample provided follow-up data; but twenty-nine out of 42 clients (69% of the total sample) provided 18-month follow up data. These were the clients categorized as good and poor long-term outcome cases based on the BDI criterion. Thirteen clients did not provide 18-month data and were not involved in any analyses of long-term outcome. However, these 13 clients were retained in the sample for auditing and validating Kagan's (2003) self-critical categories, subgrouping, and examination of working phase emotional process differences between higher-order self-critical subgroups because these analyses were not based on long-term outcome.

Client Demographics

In the total sample of 42 clients, 27 were women and 15 were men. The mean age of the sample was 40.0 years old (*SD* = 9.74). In terms of marital status, 13 clients were single (never married), 17 clients were married, and 12 clients were divorced at treatment outset. In terms of

education level, 6 clients had a high school education, 16 clients had completed college or university, and 20 clients had post-college/university training. Additional demographics results by self-critical client subgroups are provided in the 'Results' section.

Therapists

There were 16 therapists for this sample of 42 clients. Female therapists totalled 14 and there were 2 male therapists. All therapists were Caucasian. In terms of level of training, 12 therapists were advanced Ph.D. level clinical psychology graduate students and 4 therapists were clinical psychologists. It was noted in the original outcome write up for the study (Goldman et al., 2006) that therapists received a minimum of 40 hours of training in EFT and CCT, and provided treatment in both therapy conditions in the trial. Therapists served as their own controls by seeing an equal number of clients in each of the two modalities. Therapist effects could not be examined in the present study due to insufficient numbers of clients per therapist that would permit analysis at the therapist-level.

Treatments

In the original study (Goldman et al., 2006), clients were randomly assigned to receive one of two experiential treatments: either EFT or CCT. In the present sample, 23 clients received EFT and 19 clients received CCT. In the original York II trial, clients were no longer assigned to the CCT condition after the trial was completed. Thirty-eight clients (19 EFT and 19 CCT clients) were included in the York II trial. Any remaining clients in the York II trial received EFT, and for this reason there were more EFT therapies included in this study. Treatment adherence was achieved in the original study (see Goldman et al., 2006).

Experiential psychotherapies include client-centered, existential, and Gestalt approaches to psychotherapy (Greenberg, Watson, & Lietaer, 1998). Humanistic experiential

psychotherapies or 'HEPs' (Elliott et al., 2013) have recently become the umbrella term that encompasses a range of experiential psychotherapies, including EFT and CCT. These treatments' central focus is on deepening the client's awareness of their subjective experience and supporting their reflexivity and sense of agency within the context of a safe and supportive therapeutic environment. These important foundational relationship conditions are described in CCT (Rogers, 1942; 1951).

Client-centered therapy (CCT). CCT is a well-known psychotherapy modality first developed by Carl Rogers (Rogers, 1951; 1957). The CCT therapist removes the client's experience of conditions of worth, often placed by society and others, by providing the Rogerian relational conditions of empathy, unconditional positive regard, and congruence. Within this relationship, the therapist is empathically attuned to the client, views the client with unconditional positive regard, and strives to be congruent in the relationship with the client. These facilitative conditions increase the client's sense of safety to freely approach, observe, and symbolize salient and poignant parts of their internal emotional experience. In doing so, the client is supported in using information from their inner world to permit intrinsic organismic growth and engagement in adaptive behaviours.

Emotion-focused therapy (EFT). EFT is an integration of CCT, existential therapy, and Gestalt therapy, as well as integrates emotion theory and constructionist meaning-making principles (Greenberg et al., 1993; Greenberg & Watson, 2006). As in CCT, the EFT therapist provides the client-centered facilitative relationship throughout treatment and for the initial three sessions, provides this relationship exclusively. Thereafter, the therapist continues to provide this CCT style of relationship while also looking for client markers of underlying problematic emotional processes, which are theorized to underlie and maintain client's presenting mental

health complaints. When markers arise, the therapist facilitates process-directive interventions designed to activate, explore, and resolve these problematic underlying processes. The main process-directive interventions include: (1) two chair work for addressing the markers of internal splits or conflicts (including self-critical splits for self-criticism); (2) empty chair work for the marker of unfinished business (lingering bad feelings) with previous others; (3) empathic affirmation to address the marker of client vulnerability; (4) self-soothing for client marker of emotional distress; (5) systematic evocative unfolding for the client marker of a problematic reaction; and (6) focusing for client marker of an unclear felt sense. Once the underlying emotional problem is resolved and transformed, it is expected that the mental health concern (e.g., depression) will also be resiliently ameliorated. As such, EFT aims to work not only with depressive symptoms but with the underlying emotional processing difficulties assumed to underlie the depression (Greenberg & Watson, 2006; Watson & Pos, 2017).

Pre- and 18-month Post-Treatment Measures

Self-critical subgroups were examined for differences on a range of pre-treatment (all the following measures) and 18-month post-treatment measures (all following measures except the DEQ, which was not administered at 18 months post-treatment in the original outcome study).

Beck Depression Inventory (BDI; Beck et al., 1961). The BDI is a widely-used 21-item self-report inventory measuring depressive symptomology severity. Each item has four response alternatives scored on a 4-point Likert scale. A sample item is: “A) I do not feel sad; B) I feel sad or unhappy; C) I am unhappy or sad all of the time and I can’t snap out of it; and D) I am so unhappy or sad that I can’t stand it.” The BDI has demonstrated good internal consistency as well as good discriminant and concurrent validity (Beck, Steer, & Garbin, 1988).

Symptom 90 Checklist-Revised (SCL-90-R; Derogatis, 1983). The SCL-90-R is a widely-used instrument that measures global psychiatric symptomology (e.g., depression, anxiety, etc.). The present study only used scores on the Global Severity Index (GSI), which measures overall psychological distress. The SCL-90-R has demonstrated high internal consistency coefficients (.79 to .90), test-retest reliability (.80 to .90), and convergent validity (Derogatis, 1983; Groth-Marnat, 2009).

Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES is a 10-item self-report inventory that measures global self-esteem. Items are scored on a 4-point Likert scale ranging from "strongly disagree" to "strongly agree." An example item is: "I take a positive attitude toward myself." The RSES has shown high internal consistency, test-retest reliability, and construct validity (Bagley, Bolitho, & Bertrand, 1997; Rosenberg, 1965).

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasernor, 1988). The IIP is a 127-item self-report inventory that assesses an individual on eight different interpersonally dysfunctional problems. The present study used only the global score of interpersonal dysfunction. The IIP has shown high test-retest reliability and demonstrated good construct validity (Gurtman, 1996; Horowitz et al., 1988).

Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976). The DEQ is a 66-item self-report inventory measuring the depressive vulnerable personality dimension of self-criticism. Items are scored on a 7-point Likert scale that ranges from "strongly disagree" to "strongly agree." A sample item measuring self-criticism is: "I set my personal goals and standards as high as possible." The DEQ has shown good internal consistency, substantial test-retest reliability, and the self-criticism subscale has demonstrated good construct validity (Atger et al., 2003).

Emotional Process Measures

Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). The CAMS instrument measures the occurrence of 10 discrete and specific emotional processing states empirically found to be linked to the resolution of client global distress in psychotherapy (Pascual-Leone, 2009; Pascual-Leone & Greenberg, 2007). The measure is applicable to coding an individual's engaged and aroused emotional content. The 10 specific emotion categories are (from less to more productive emotional processing): (1) global distress (GD), which refers to overwhelming and/or undifferentiated affect that is difficult to feel; (2) rejecting anger (RA), which captures instances of distancing or destructive anger; (3) fear/shame (FS), which captures core feelings of inferiority, worthlessness, and existential fears (e.g., fears of abandonment); (4) negative self-evaluation (NSE), which captures explicit self-name-calling; (5) need (ND), which refers to expressions of core existential needs, typically chronically unmet needs; (6) relief (RE), which captures instances where one feels 'better,' 'on the right track,' or more hopeful; (7) hurt/grief (HG), which captures experiences of core sadness, loss, and pain; (8) assertive anger (AA), which captures expressions of adaptive anger that lead to healthy limit setting; (9) self-soothing (SS), which refers to nurturance and compassion directed towards the self and; (10) acceptance and agency (ACAG), which captures instances where one accepts and/or finds a way to proactively cope with a difficult reality. Categories are differentiated by distinctions in emotional tone, involvement, arousal, and meaning-making. The full CAMS manual can be found in Appendix A.

Emotion scheme typology: Transforming CAMS categories into emotion scheme types. To examine emotion scheme (ES) types postulated in EFT change theory, ratings of CAMS categories were also assigned to a higher order ES type based on EFT theory and in consultation

with Dr. Pascual-Leone (CAMS measure author). The proportion of secondary emotion (SE) schemes were calculated by summing the proportion of EEs coded with CAMS categories of global distress (GD) and rejecting anger (RA). The proportion of primary maladaptive emotion (PME) schemes were calculated by summing the proportion of EEs coded with CAMS categories of fear/shame (FS) and negative self-evaluation (NSE). Finally, the proportion of primary adaptive emotion (PAE) schemes were calculated by summing the proportion of EEs coded with the CAMS categories of relief (RE), hurt/grief (HG), assertive anger (AA), self-soothing (SS), and acceptance/agency (ACAG). The CAMS category of need (ND) was retained as its own category in analyses involving ES types because needs represent an important self-contained category in the emotion schematic change process articulated by EFT theory (Greenberg & Watson, 2006). All analyses in the current study examined emotional process on both the level of individual CAMS codes and on the level of ES type categories. This method follows Choi et al. (2016).

Object-Valence Scheme (OVS; Choi, 2013). The OVS measure is a nominal coding scheme that was created by the author from simple grounded thematic analysis of client emotion episode narratives to capture aspects of the objects or targets of emotion events present in clients' emotion episode narratives, not captured by CAMS codes. The OVS measures the valence (positive or negative) of a client's view of 'personal objects' (self or other) within emotional responses. The full OVS manual can be found in Appendix B.

The OVS measure consists of five codes. (1) The self-positive (SP) code is given when the client expresses a positive view of self. This can be expressed through positive self-evaluation (e.g., "I am capable.") and self-supportive action tendencies (e.g., self-compassion or self-acceptance). (2) The self-negative (SN) code is given when the client expresses a negative

view of self. This can be expressed through negative self-evaluation (e.g., “I am a loser.”) and self-rejecting action tendencies (e.g., self-criticism or self-loathing). (3) The other-negative (ON) code is given when the client expresses a negative view of the other. This can be expressed through negative other-evaluation (e.g., “He’s such an idiot!”) and distancing or rejecting action tendencies towards the other (e.g., blame or anger at the other). (4) The other-positive (OP) code is given when the client expresses a positive view of the other. This can manifest as a positive other-evaluation (e.g., “He is so nice to me.”) and supportive or approaching action tendencies towards the other (e.g., love or protection of the other). An (5) uncodable (UC) code is used when there are no positive or negative views of the self or other expressed by the client within an emotion episode narrative.

Qualitative Analysis Procedure

Here I will discuss my qualitative methodology more clearly.

Self-critical category audit and validation. The first goal of the current study was to audit and validate Kagan’s (2003) qualitative (inductive) conceptualization of four self-critical depression categories. To do this, I engaged in a rigorous qualitative thematic analysis (Braun & Clarke, 2006) of Kagan’s original data set. I re-coded her original data using her extant qualitatively obtained self-critical categories. Thus, this thematic analysis used an extant theoretical classification system to deductively re-code Kagan’s data set. Moreover, since Kagan’s self-critical categories originally had emerged from her qualitative analysis of the same data, the current analysis was also considered a *confirmatory* thematic analysis. Further, however, while the self-critical codes used in the present analysis were deductive in nature, it was held possible for new inductive codes to emerge both from the data and from fluid revisions of extant deductively-based codes. This method converges with Stiles’ (1993) concept of

'reflexive validity', which posits that theory should be constantly extended by and assimilate new observations, including observations by new observers. This, Lather (1986) would also describe as supporting 'construct validity' of a theory. As such, given that I used both a deductive and inductive thematic analysis, the current analysis could be articulated as a confirmatory *reflexive* thematic analysis (with a twist). The 'twist' I would argue is that this current qualitative analysis does not fit into any current descriptions of qualitative research. As such, I may have been pushing the boundaries of qualitative research. All qualitative coding was carried out using ATLAS.ti statistical software (Friese, 2014). Having said all of the above, I will now describe the processes of re-coding and validation of Kagan's (2003) data that unfolded across several stages.

Thematic analysis steps. In the first stage, as part of a holistic approach, two independent coders (a university professor and a Ph.D. level clinical psychology graduate student), read and re-read the data corpus until familiarity with the data was achieved. The corpus was the same treatment session summaries Kagan (2003) used to establish her self-critical categories.

Kagan's original data. The data which Kagan (2003) had used for her original qualitative analysis were overall therapy session summaries that contained for each client, all of their session verbatim written responses obtained from three post-session therapy measures. The post-session therapy measures filled in by the client were the Client General Session Evaluation Questionnaire (GESQ) that included the Helpful Aspects of Therapy Form (HAT), and the Client Task Specific Measure (CTSM). The GESQ consisted of five items the client rated the therapy session on (e.g., the degree to which something shifted for them as a result of or within the session) and the HAT consisted of seven items in which the client rated their perceptions of significant events in the therapy session. I did not include analysis of any quantitative rating

within these summaries. I only coded client written responses; for example, client descriptions of concerns about oneself and others discussed within the session. The CTSM consisted of 12 Likert-scored items that asked clients to rate their progress on diverse tasks of treatment (e.g., self-criticism, unfinished business with a significant other). Each client's global therapy summary could contain 16-20 individual session summaries depending on how many sessions that client had received. See an example of an individual session summary in Figure 1. In addition to the client reports, a post-session therapy measure was also completed by the therapist for each session. This measure was called the Therapist Session Questionnaire (TSQ). The TSQ asked therapists to rate their perception of significant client themes and shifts in the therapy session relating to the client's core themes developing in therapy. Again, I only coded written responses; for example, the therapists' descriptions of their clients' core issues (such as self-criticism).

After each rater became familiar with each client's global session summary, the two coders, in a second stage, consensually and qualitatively applied Kagan's (2003) four self-critical category codes to each client's session summary (see Figure 1 for an example of a coded individual session summary). The consensual coding of the two raters was accomplished first for 10 randomly sampled clients of Kagan's original sample of 40 clients. The goal of consensual recoding of these 10 clients using Kagan's self-critical categories in this stage was to provide a form of audited (agreed upon) recoding by the two new raters of Kagan's self-critical categories. Consistent with the reflexive approach to thematic analysis (Braun & Clarke, 2006) and to improve construct validity (Lather, 1986; Stiles, 1993), the coders applied Kagan's (2003) code categories in the session summaries. Simultaneously, I allowed myself to qualitatively modify, or add to, Kagan's categories if I found another category was emerging from the data. If I found

something that did not fit into one of Kagan's self-critical categories, I created a new self-critical category outside of Kagan's classification system. Therefore, my qualitative process entailed both inductive and deductive coding, that allowed both new as well as honing of Kagan's self-critical categories. I have attempted to be as transparent as possible in this explication of my approach and methodology here. This is also viewed as best practice for establishing the 'face validity' of findings in qualitative research (Guest et al., 2012; Miles & Huberman, 1994; Creswell & Plano Clark, 2011).

Once the two coders consensually re-coded the session summaries of an initial randomly chosen 10 clients, the coders were deemed reliable coders of Kagan's (2003) self-critical categories. The two coders then proceeded to independently code 10 additional clients' session summaries at random in a third stage. These codes were used to provide a quantitative reliability analysis. Therefore, while Rennie (2012) has suggested that reliability or validity of a qualitative data analysis depends solely on how convinced the reader is by the rhetoric relating to descriptions found, in the current study, valid reliability was also provided by inter-rater reliability obtained at the conclusion of this third stage. Establishing reliability of categories becomes more important in more structured datasets, as is the case here (Guest et al., 2012).

In the fourth stage, once the two coders were quantitatively established as reliable coders of Kagan's (2003) self-critical categories, the two coders split the remainder clients for independent coding (10 clients per coder). However, in addition to this independent coding and in order to maintain valid reliable coding, each client's codes were again audited by a second coder. Disagreements were discussed until consensus was achieved to improve validity of ratings. Two additional clients were added during this stage, as emotional process data was

available from Wong (2016), and session summary data could also be constructed using the identical method used with other clients from their post-session therapy measures.

Saturation issue in the current study. I will now discuss the issue of saturation in the current study. Theoretically saturation (Glaser & Strauss, 1967) occurs when no new categories or themes emerge and using new data does not result in new categories emerging. In the current study, since I was limited to the available data, it is unclear if saturation, in the classic sense, was obtained. Still, since the coders could apply Kagan's codes reliably and did so with 42 cases, I am satisfied that saturation of her codes did in fact occur. This is because saturation typically occurs within 12 qualitative interviews (Guest, Bunce, & Johnson, 2006) and I had codes on 42 client overall session summaries during which no new codes emerged.

Qualitative Goal 2: Subgrouping clients to higher order EFT-theory based subtypes. Once coding was completed for all clients, consensual review of their complete self-critical category codes resulted in each client being qualitatively assigned to one of Kagan's (2003) four self-critical themes/subgroups based on their preponderant self-critical theme code. This constituted the fifth stage of my qualitative analysis. Each client's subgroup was determined by considering their most frequently occurring or most salient self-critical category code that had been consensually assigned to that client across their session summaries.

In a final stage of subgrouping clients into self-critical categories, the coders considered the EFT deductive self-critical higher-order categories of clients whose self-criticism most frequently reflected the 'criticizer' and clients whose process more often reflected the felt consequence of being criticized or reflected 'the criticized self' as articulated in EFT theory. Kagan's (2003) categories were collated to reflect this distinction. The coders, therefore, organized Kagan's four self-critical themes/categories into the two higher order EFT-theory

based self-critical themes/ categories. So, this resulted in two emergent higher-order EFT categories of self-criticism, which I named 'Socially Inadequate' (SI; changed from 'persecutory') and 'Core Worthlessness' (CW) self-criticism. If the client's preponderant self-critical code was one of Kagan's (2003) first three codes, they were deemed a SI client. If the client's preponderant code was Kagan's fourth category, they were deemed a CW client. This higher-order theory-driven classification was consistent with what Taylor-Powell and Renner (2003) describe as condensing categories into internally-consistent higher-order categories. A bias in this higher-order qualitative analysis is hereby declared. It was informed by the researchers' knowledge of EFT theory and chair work.

Emotional Process Coding Procedure

All emotional processes were exhaustively coded within all of a client's working phase emotion episodes (EEs) using two emotional process measures: CAMS and OVS. The current study used both newly-rated process codes and secondary archival process data (Choi et al., 2016; Wong, 2016).

Emotion episode sampling. Emotional processing was examined within client emotion narratives called emotion episodes (EEs; Greenberg & Korman, 1993; Korman, 1998). EEs are segments of a psychotherapy session within which the client expresses past or present emotional experiences in response to a real or imagined event. A complete EE has five different components: (1) an antecedent situation, (2) an emotional response, (3) an action tendency associated with the emotional response, (4) appraisals of self or situation, and (5) a relevant concern or need. To be identified, an EE only requires two components: an antecedent situation and an emotional reaction expressed in words or action tendency. The length of an EE can range from a few lines to several pages of a therapy transcript.

Every EE from two of each client's working phase sessions were archivally sampled from Pos (2006). The two working phase sessions were those between the fourth session and the fourth last session identified by each client as their two most productive sessions based on post-session evaluation questionnaires (see Pos, 2006, for a complete description). When clients had identified more than two sessions as equally helpful, the sessions most distal from termination were chosen to represent the client's working phase session (Pos, 2006). On average, working phase sessions occurred between sessions 8 and 12.

CAMS and OVS coding. In the current study, three coders (one university professor and two Ph.D. level clinical psychology graduate students) coded all EEs from the two working phase sessions on both the CAMS and OVS measures. All coders received reliability training on the CAMS measure by the measure's developer Dr. Antonio Pascual-Leone during three trainings, culminating in 25 total hours of training. The current author trained all coders on the OVS measure.

CAMS coding. Eighty-two sessions from 42 clients were emotion coded in the current study. One client's sessions were not available for coding. Of these 82 sessions, 62 sessions were CAMS coded by two raters independently permitting reliability calculations; 12 sessions were CAMS coded by two raters consensually (no independent codes for reliability analysis); and 8 sessions were CAMS coded by one rater after reliability was established (4 sessions each). Raters A and B coded 37 sessions independently (786 CAMS ratings in total). Raters B and C coded 25 sessions independently (498 CAMS ratings in total). CAMS codes were calculated as the proportion of total EEs having a particular code. So, if a client had a global distress proportion of .25 it would mean that 25% of that client's working phase EEs had been coded as 'global distress'.

OVS coding. In terms of EE-OVS codes, 60 sessions were OVS coded by two raters independently allowing for reliability calculations; 12 sessions were OVS coded by two raters consensually (no independent codes for reliability analysis); and 10 sessions were OVS coded by one rater after reliability was established (primarily by the author). Raters A and B coded 37 sessions independently (731 OVS ratings in total). Raters B and C coded 23 sessions independently (432 OVS ratings in total). OVS codes were calculated as the proportion of total EEs having a particular OVS code.

General coding procedure. During emotion coding, all raters were blind to client outcome. Rating disagreements were consensually resolved among raters. If consensus could not be reached on a particular CAMS or OVS rating, the impasse was resolved by deferring to expert opinion (Dr. Pascual-Leone in the case of CAMS coding, and the author in the case of OVS ratings). All ratings used in the analyses were consensually agreed upon. Reliability analysis used only original ratings for sessions for which two raters coded independently.

Examining emotional processes in self-critical subtypes. Emotional processing was examined between higher-order self-critical themes/subtypes, and within higher-order self-critical themes/subtypes between the within subtype outcome groups. Outcome within each self-critical theme/subgroup was examined at 18-month follow up. As previously mentioned, 'good outcome' was defined as a client having an 18-month follow up BDI score of 9 or less. This is because a BDI of 9 or less identifies a non-depressed client (Beck et al., 1961). 'Poor outcome' was defined as a client having an 18-month follow up BDI score of 10 or more.

Emotional processing between and within higher-order self-critical themes/subtypes were examined in a number of ways. I first examined descriptive analytic data, visual representations, and Mann-Whitney *U*-tests of proportions of individual EEs coded as CAMS codes, CAMS

higher ordered derived ES codes, and OVS codes among working phase emotion episodes. In a second analysis, I used THEME 6.0 statistical software (Magnusson, 1993; 2000) to examine emotional processing differences in sequences of EE codes between self-critical subgroups as well as between 18-month outcome groups within self-critical subtypes on CAMS code and CAMS-derived higher order ES code emotional sequences. In other words, THEME detected emotional processing sequences that differentiated higher-order self-critical subgroups, as well as sequences that differentiated good versus poor resolvers of self-critical depression within each higher-order self-critical subgroup. THEME has been previously used on this type of data (Choi et al., 2016).

Explaining THEME analysis. How does THEME accomplish this? THEME essentially detects complex patterns in longitudinal data occurring over time. These patterns are often difficult to overtly see because they are embedded in "noisy" complex behavioural data, including, in this case, psychotherapy dialogue. THEME employs binomial analysis to detect behavioural patterns called *T*-patterns found to be temporally linked significantly more often than expected by chance alone. Related T-patterns are further agglomerated by THEME into more complex sequential behavioural patterns that can be viewed according to a range of possible organizing principles. For example, THEME can provide the user with the longest, most frequent, or most hierarchically complex behavioural patterns in a dataset. The organizing principle chosen would be based on the researcher's rationale. In this case, I chose the organizing principle of longest emotional patterns that predicted outcome groups within a self-critical subgroup. This would indicate complex emotional processing sequences that demarcate higher-order self-critical subtypes. Or, within a higher-order self-critical subtype, this identified

complex emotional processing sequences that potentially help good outcome clients as well as sequences that potentially hinder poor outcome clients from resolving their depression.

Also, I should inform the reader that in all THEME analyses, patterns are detected if a code sequence has a 0.5% or less probability of occurring by chance in any given subgroup. As well, groups can be compared for sequences if individual CAMS code EE patterns as well as and CAMS coded ES patterns occur significantly more often in sessions of a particular self-critical category/subgroup than another. This is tested using binomial tests (*p* level = .05). Also, THEME generates copious output. For this reason, I often summarized obtained patterns by condensing them into global pattern types based on pattern similarity for parsimony of presentation.

Making sure THEME results are non-random. THEME also does due diligence by comparing obtained patterns to patterns obtained from randomized data to ensure that obtained patterns are reliably non-random. THEME accomplishes this through two randomization procedures: shuffling and rotation. In the current THEME analyses, all obtained patterns were compared to patterns extracted from 200 bootstrapped procedures (100 from shuffling procedures and 100 from rotation procedures) that randomized the real data. In randomized shuffling, the event timestamps from the real data are randomly redistributed among the event series. In rotation, event timestamps from the real data are all shifted a random number of degrees in relation to other event series. All obtained patterns in the current study were found to be non-random with obtained patterns from the real data significantly differing from the number of patterns resulting from randomizations of the real data. In other words, obtained patterns were significantly non-random and therefore reliable.

THEME is free for academic use and has been used in a growing number of innovative research areas including monitoring hormonal changes and organizational team performance (Borrie, Jonsson, & Magnusson, 2002; Zijlstra, Waller, & Phillips, 2012).

Chapter 3: Results

Data Preparation

All variables were evaluated for normality using Shapiro-Wilk tests (Shapiro & Wilk, 1965). Most variables were normally distributed with no assumptions of normality violated. Non-normal variables were analyzed using non-parametric test alternatives. For example, proportional data of EE-CAMS, CAMS-derived EE-ES, and EE-OVS codes were tested using Mann-Whitney *U*-tests (Mann & Whitney, 1947) because most code category proportions were non-normally distributed. Mann-Whitney *U*-tests are applicable to small samples with non-normal data.

Given the study's exploratory nature, relatively small sample size, as well as to minimize the risk of prematurely losing interesting observations due to commission of Type II errors (Rothman, 1990; Streiner & Norman, 2011), no corrections for family-wise error were made in the current analyses. Therefore, interpretation of the findings should consider this. Where appropriate, post hoc testing was completed using Fisher's Least Significance Difference (LSD) tests for ANOVA. Adjusted standardized residuals (*z*-scores) were examined for chi-square tests.

Inter-rater Reliability of Self-critical Category Codes

During the validation process, all four of Kagan's (2003) self-critical categories were retained, albeit some of their thematic descriptions were slightly revised by the current researcher. Only one new self-critical category was added (self-interruption of feelings). This yielded in total five self-critical category codes. Cohen's (1960) kappa (*k*), the appropriate rater

reliability statistic for nominal-scaled data, was used to calculate inter-rater agreement for self-critical category ratings by the two coders across sessions of 10 clients chosen at random. All self-critical category ratings for the 10 clients (446 self-critical category ratings in total) were included in the reliability sample. Cohen's *k* for self-critical category ratings was .72, which is considered very good agreement beyond chance (Fleiss, 1981).

Inter-rater Reliability of CAMS and OVS ratings

Cohen's *k* for CAMS ratings was .84 between raters A and B (for 786 CAMS ratings) and .80 between raters B and C (for 498 CAMS ratings in total). Cohen's *k* for OVS ratings was .88 between raters A and B (for 731 OVS ratings in total) and .76 between raters B and C (for 431 OVS ratings in total). This is considered excellent inter-rater reliability as *k*-values above .75 are viewed as excellent agreement beyond chance (Fleiss, 1981).

Potential Client Effect Confounds

Twenty-nine out of 42 clients provided 18-month follow up outcome data, including BDI scores, while 13 clients did not. Since my later long-term outcome analyses compared clients who did and did not report being depressed at 18 months, I wanted to improve confidence in my assumption that emotional processes would be the important predictors of these outcome categories. Therefore, I did two preparatory tests. First, I wanted to make sure that clients who did or did not provide follow up measures did not differ on demographic variables, therapy type received, pre-treatment degree of reported problems, termination outcomes, or emotional processing. Second, I wanted to check if clients who were or were not depressed long term differed on pre-treatment measures to increase my confidence that emotional processes measured in this study did in fact predict outcome group differences within higher-order self-critical subtypes.

Were there any differences between clients who did and did not provide follow-up measures? The two groups were tested for differences on demographic variables (e.g., age and gender), therapy type received, pre-treatment measures, pre- to post-treatment difference scores on outcome measures, and emotional processing measures (CAMS and OVS).

No significant differences in depression at treatment termination were found for those who did or did not provide 18-month follow-up data ($p > .05$). Therefore, whether someone did or did not provide follow up data was not related to how depressed they were at termination of treatment. Concerning demographic data, a chi-square test indicated more men (13 out of 15 male participants) gave long-term follow up data than women (15 out of 27 female participants; $\chi^2(1) = 4.20$, $p < .05$, $\Phi = .316$). Clients who provided long term follow-up data were less self-critical ($M = 0.23$, $SD = 1.13$) than clients who did not give long-term data at treatment termination ($M = 1.13$, $SD = .61$; $F(1, 37) = 9.80$, $p < .005$, partial $\eta^2 = .209$). Long-term outcome provided clients also reported fewer global symptom complaints ($M = 0.57$, $SD = .38$) at treatment termination than clients who did not give long-term data ($M = 0.91$, $SD = .56$; $F(1,40) = 1.64$, $p < .05$, partial $\eta^2 = .096$). No other differences in therapy type received, pre-treatment measures, and emotional processing were found. Therefore, the only differences found between long term data providers and those who did not were that long-term data providers were more likely to be male and were less self-critical and distressed on global symptoms at treatment termination. No difference pre-treatment or termination in the BDI were found nor any differences in any emotional process were found.

Were there any differences between depressed versus non-depressed clients at 18 months? The two groups were tested for differences on demographic variables (e.g., age and gender) and pre-treatment measures. Education level had a significant relationship with 18-

month BDI outcome ($\chi^2(2) = 8.00$, $p < .05$, $V = .534$). Compared to high school and post-college/university graduates, college/university graduates tended to be depressed at 18 months post-treatment. All other tests examining pre-treatment differences were non-significant.

Therapy Effects: Does therapy type affect long-term outcome?

Chi-square testing explored whether therapy type had an impact on long-term depressive outcome, independent of self-critical subgroup membership. Results indicate that EFT clients were more likely to be non-depressed than depressed (13 to 2 clients) at long-term follow up compared to clients who had received CCT (6 non-depressed to 8 depressed), $\chi^2(1) = 6.15$, $p < .05$, $\Phi = .461$. The relevance of this result will be discussed later.

Analysis 1: Qualitative Thematic Analysis of Data Using Kagan's Self-critical Categories

Auditing and validating self-critical categories. From the confirmatory reflexive thematic analysis, Kagan's (2003) self-critical themes/subtypes were all retained. Their thematic distinctions were, however, somewhat 'sharpened' to more accurately (in the eyes of the present researcher) capture their thematic essence. In addition, one category/subtype (self-interruption of feelings) was added, yielding a total of five different self-critical categories/subtypes reported here. I will now discuss these five self-critical categories/subtypes, the four original and one new category/subtype, that emerged.

1. Compare and Despair (CD). Kagan's (2003) term and description for this kind of self-criticism was retained. Kagan described that this kind of self-criticism concerns comparing oneself to others and chronically feeling like one does not measure up to the standards or achievements of others. One has fallen short of expectations and squandered one's potential for success. Despair follows comparisons that leave the individual feeling stuck, helpless, and hopeless about their perceived inferiority.

My thematic description of compare and despair (CD) converged highly with Kagan's (2003) category description. I also intuited that in CD, ongoing upward comparisons and a main theme of "not keeping up with the Joneses" prevail. I noticed another distinction that I felt was relevant for this theme/subtype. CD self-criticism appears to be imposed from 'external' sources and to have a 'superficial' quality because it appears to come from expectations based on others', societal, and cultural standards as opposed to self standards. Therefore, self-criticism of the CD type aligns with the voice of one's self-critic. It is the self-critical organization that expresses frustration and appears ineffective in its attempts to motivate the self to accomplish and live up to standards. I also felt that CD had a superficial quality because CD individuals appeared to be despairing about not having met 'external' and not self-valued measures of self-worth (e.g., a good job, being married with children). The despair also had a superficial or child-like quality because, as opposed to the despair demonstrating a deep sense of defectiveness, it was often expressed in the context of whining or jealousy towards others who have what the CD self-critic covets.

For example, *Debb* (pseudonym for client #407) expressed significant CD self-criticism throughout her treatment, describing feeling chronically inadequate for performing poorly at her job and concerned about whether she could ever support herself if she separated from her husband. A key distinction that placed her in this category was that she did not feel fundamentally worthless as a result of her lacking skills at her job, which would be more consistent with the 'unworthy/not good enough' self-critical category discussed later. Rather, she 'apparently despaired' about the negative consequences of her limitations, which was consistent with the CD category/subtype. She also felt her marriage and her relationship with her children did not meet her expectations. She expressed that she felt she was inferior for her lack of

accomplishment and she was jealous of others' achievements. *Kel*, (pseudonym for client #435) also expressed substantial CD concerns. He entered treatment feeling like he had not lived up to his potential with regards to work and relationships. He despaired about his general lack of passion and direction in life. He chronically felt like he did not measure up.

2. Too Needy/Dependent (TND). Kagan's (2003) 'too sensitive/needy' theme/subtype I renamed 'too needy/dependent' and its thematic description was somewhat reworked in my qualitative thematic analysis. This was because I felt Kagan's original description of being too sensitive and needy considerably overlapped with two other categories/subtypes she had identified. This made it difficult to differentiate this category/subtype. It overlapped with her third category/subtype of 'internalized shoulds/unacceptable feelings' (i.e., it is unacceptable to feel dependent on others; one should not be too dependent) as well as her fourth category/subtype 'unworthy/not good enough' (i.e., one is weak or worthless for being too needy). I retained this TND code as a category/subtype, however, because it did capture unique emergent thematic content in some clients. The TND client specifically judges, dislikes, or fears a particular relationship content, that of having any need for attachments. The purpose of this self-critical theme appeared to be specifically in the service of avoiding pain from experiencing needy feelings or to avoid perceived specific negative consequences of attaching to others. Negative self-appraisals (e.g., "I am weak") express critical beliefs concerning perceived excessive need for others (e.g., for support, connection, love, etc.). The reason for self-judgment appeared to be in the service of warding off possible negative consequences of being attached to others (e.g., others taking advantage of oneself).

Needing others was experienced as painful because it triggers past painful experiences where affiliation needs were interrupted or never met (e.g., being disapproved of or neglected by

a parent). However, although the client self-critically fears getting hurt again, no deeper processing of any original sense of worthlessness or interpersonal trauma is articulated. Therefore, I believe one can think of TND as being a superficial self-critical category related to a deeper self-critical process/subtype, likely feeling 'unworthy/not good enough.' However, I maintained the TND category/subtype when the client is minimally aware or minimally processes the painful origin of their TND. Instead, the clients mostly judge themselves for needing others. The term 'sensitive' was also removed from the original category/subtype name because I thought it was 'too vague'. I replaced this term with 'dependent' to more accurately capture the thematic content of TND. Like CD, TND also possesses an external quality that aligns with the voice of one's internal self-critic in which the self-critic criticizes oneself for needing others and being weak as well as pressures oneself to be strong, 'rational,' and independent in the world.

For example, *Mitchell* (pseudonym for client #903) expressed feeling scared to feel and was angry with himself for his need for others. He moved away from these needs and rallied himself to be rational and independent. During treatment, he connected his neediness to abandonment fears rooted in unfinished business with his parents growing up. I considered this a healthy need for attachment that was developmentally interrupted and thus never met. He was aligned with his critical voice that desired to quash and 'protect' the self from attachments and to be more rational. In contrast, *Mike* (pseudonym for client #417) had always been over-protected by others his whole life and now felt unable to stand alone and be self-reliant in the world. He criticized himself and felt weak for now, as an adult, depending on others. I considered his self experienced needs for attachment developmentally-sourced and excessive and that covered unprocessed underlying core feelings of unworthiness. However, because his self-criticalness of

being dependent was preponderant, he was identified as one of the TND self-critical category/subtype clients.

3. Unacceptable Feelings and Shoulds (UFS). Kagan's (2003) term and description for this self-critical category/subtype were retained. Kagan described that her UFS self-critical theme referred to self-criticism surrounding failure to reach moralistic or perfectionistic standards and expectations, as well as expressing self-criticism for having 'unallowed' emotions. My current thematic analysis agreed with Kagan's thematic description of UFS. Clients of this category/subtype had strict internalized rules for how a person should be in the world and how failure to follow rules means being a "bad boy" or "bad girl." As such, there was a moralistic 'taste' to these clients. However, my revised sense of the UFS meant that I applied this code when clients appeared to obey, and be in agreement with, 'introjected' external sources of their self-criticism. The rules and subsequent self-judgments these clients voiced appeared to come from 'internalized external' sources (e.g., others such as critical parents, society, or culture). What distinguished this code from the CD code for me was that in this category/subtype, clients expect to fit in with others and society by being 'good' in other's eyes. In this sense, following the rules meant being deemed good enough to be "in the club" and to receive all the perks that would come with this membership (e.g., perceived approval by others). Like CD and TND, UFS appeared to align with the voice of the self-critic. In this UFS self-critical type, the critic is like a harsh superego, pressuring the self to follow internalized rules and standards to be good enough. The self-critic also berates the self when the self falls short of meeting these expectations. This type of self-critic is a coach-like "should-er," pushing the self to "just do it" like the Nike ad campaign. However, unlike CD, which is more superficial about rules for obtaining self-worth, UFS clients appeared to have sophisticated "if-then" rules for obtaining self-worth, typically

outlining role obligations (e.g., “If I can’t take care of children and control my emotions, then I am out-of-control and a bad parent).

Another distinction that I found useful when coding these UFS individuals was that, while feeling bad if they are not being good enough, they were not in my opinion accessing nor processing any core feelings of worthlessness and inadequacy because they appeared to be more likely to be in the self-criticizing stance of the critic. I hypothesized that many clients expressing UFS could have had experienced painful past events and even have deep-seated feelings of worthlessness as seen in ‘unworthy/not good enough’ clients. However, currently these clients did not approach this pain and instead expressed self-critical admonitions to follow “the rules” as a way to fit in the world.

For example, *Nick* (pseudonym for client #404) criticized himself for not being able to assert himself in his personal relationships (i.e., he did not feel entitled to his anger and needs). He did not feel as successful as his brothers and he felt he did not measure up in his father’s eyes as a firstborn son. This led him to feel like a “weak man” and “bad son”. Maralyn (pseudonym for client #460) also criticized herself for not being a “good daughter” to her mother who was harshly disapproving and critical towards her. She felt guilty about wanting to distance herself from her mother (that was not ‘permissible’ to do according to her self-critic) who would threaten suicide and create significant distress in the client’s life if the client made any effort to separate from her mother.

4. Core Worthlessness (CW). For the current qualitative thematic analysis, ‘unworthy/not good enough’ was reconceptualized as ‘Core Worthlessness’ self-criticism. This captured the deep-seated nature of negative core self-evaluations, which I found to be characteristic of this self-critical category/subtype. Kagan’s (2003) thematic description for this category/subtype was

mostly retained. Central, still, are that clients of this type explicitly state negative core self-evaluations, often triggered in the context of having 'failed to live up to moral or perfectionistic standards for being good enough and worthy'. This self-criticism was marked by having a more internal, explicit global quality that had emerged from a painful developmental origin. Like all aforementioned self-critical categories thus far, CW self-criticism represented internalized criticism 'learned' from external sources. However, this type of self-criticism was explicitly expressed from the client's internal voice, akin to expressions of core pain in the experiencing self chair in an EFT self-critical split (Greenberg & Watson, 2006). As such, the client expresses CW self-criticism, particularly negative self-evaluations, from a defeated versus a 'top dog' persecutory vantage point. The CW self explicitly agrees with the criticism received. Moreover, the negative self-evaluation in these clients appeared to express global enduring and entrenched beliefs about the self triggered across multiple social contexts. Finally, the negative self-belief of this type of self-critical client tended to have developed during a known past painful historical event that left the client sure of their unworthiness. For example, parental abandonment or abuse may have left an individual feeling unworthy, unlovable, and invalid.

For example, *Kimmi* (pseudonym for client #421) described feeling "ugly," "stupid," and like she was "garbage" as a child because of her parents' physical and emotional abuse. These negative core evaluations she expressed were now activated in present situations where others disapproved of her (e.g., her decision to switch careers was disapproved of by her family and friends). She was also afraid of having her "badness" seen by others, and so, distanced herself from others, including romantic interests, making herself lonelier. *Rodger* (pseudonym for client #452) also described a history of feeling like he was not a good enough academic achiever in his

parents' eyes. He was also bullied in school. As a result, he always felt 'invalid' and that he was not worthy of asserting himself in his relationships.

5. Self-interruption of Feelings (SIF). SIF was the only new self-critical theme/subtype that emerged in the current qualitative analysis of thematic self-critical content. SIF self-criticism referred to being self-critical for having any experiences associated with emotions and needs. The self-critic's essential message in these clients was "don't feel, it is too overwhelming to experience." An *implicit* message given by the critic was that one could not tolerate feeling emotions. Specific rules concerning particular disallowed feelings were not articulated. For this reason, I considered that SIF as a 'primitive' pre-class or sub-category of Unacceptable Feelings and Shoulds (UFS) when there is a global rule for not feeling emotion.

For instance, *Keith* (pseudonym for client #405) entered therapy acknowledging his tendency to hold back feelings in general to avoid pain. He also used alcohol as a way to escape feelings which he found painful.

Subgrouping clients. Kagan (2003) never explicitly subgrouped her sample by giving particular clients one of her four obtained self-critical categories/subtypes. In the current study, when self-critical ratings were completed for all 42 clients, each client was assigned to a self-critical subgroup based on the client's preponderant self-critical category/subtype rating across their session summaries of client and therapist post-session reports. All clients (n = 42) were found to express self-critical category codes. As such, they were all considered to be self-critically depressed and assigned to a self-critical subgroup. Table 1 provides a summary of self-critical subtype frequency in the current sample.

Analysis 2: Results regarding EFT-deduced Higher-order Emergent Self-critical Types

In the present study, as well, as a result of additional qualitative reflection on the five self-critical categories, two higher-order self-critical categories emerged that deductively organized (Taylor-Powell & Renner, 2003) my five original self-critical categories into two higher-order self-critical categories/subtypes based on the source or 'vocal' origin of one's self-criticism as described in EFT theory. These higher-order self-critical 'categories/subtypes' (as well as Kagan's (2003) 'categories/subtypes') will be henceforth referred to simply as 'subtypes' and 'subgroups' in this document for parsimony of presentation. It is important to recall these subtypes emerged from qualitative methodological procedures where 'categories' or 'themes' are the appropriate terms.

Higher-order EFT-theory based self-critical subtypes. A higher-order two self-critical subtype 'solution' emerged deductively from the researchers' background knowledge of the two-chair task format within EFT therapy. Reviewing the revised thematic descriptions of Kagan's (2003) subtypes from the current confirmatory reflexive thematic analysis, two higher-order subtypes were formed, coherent with what the researcher intuited was the preponderant initial position of clients in regard to their self-critical process. Clients were assigned to a higher-order subtype based on their first-order assigned Kagan subtype. One subtype of higher-order self-critical clients was aligned with the self-critic's stance. This first higher-order self-critical subtype, coherent with EFT theory, I named the 'Socially Inadequate' higher-order subtype. Secondly, I observed some clients who had an internal self receiving the self-criticism and who appeared defeated by their self-critic. This second higher-order subtype I continued to name 'Core Worthlessness' self-criticism. Since no clients had self-interruption of feelings as their primary subtype, this subtype was dropped as a higher-order subtype and was accepted as a sub-category of the UFS self-critical subtype.

'Socially Inadequate' (SI) higher-order self-critical subtype (n = 20). In this subtype, 20 clients predominantly had expressed across their summaries, codes of one of Kagan's (2003) first three self-critical subtypes, 'compare and despair' (CD), 'too needy/dependent' (TND), or 'unacceptable feelings and shoulds' (UFS). These three Kagan subtypes all converged on a type of self-criticism that is socially-oriented/systemic. These clients' self-critical dialogue also was voiced mainly from within the position or 'voice' of the self-critic that would be played as a critical chair in the EFT task of two chair work. The SI subtype appeared organized around accusing the self of being inferior and inadequate as a result of being unable to meet internalized social goals and standards, whether they concern accomplishments, being independent, role obligations, or feeling particular emotions. These self-critics also strove to follow internalized rules to become 'good enough' to gain perceived membership into and approval from some important group. Their critic perceives the self's inevitable failure and subsequently blames the self for any shortcomings. The self is judged as guilty of any 'crimes' in a 'court belonging to that of others and/or society.'

'Core Worthlessness' (CW) higher-order self-critical subtype (n = 22). In this subtype, 22 clients had predominantly expressed CW codes across their session summaries, indicating self-criticism and a defeated self. These clients poignantly expressed CW themes, articulating core negative self-evaluations tied to past painful interpersonal experiences. Often, these were clients with a history of trauma. Thus, 'arriving' at painful negative core self-evaluations demarcated a CW client. CW clients often presented with predominant core negative beliefs about the self (e.g., "I am incompetent" or "I am invalid"). Their self-criticism was aligned with the voice of the experiencing self in EFT two chair work, who is in touch with painful feelings of

worthlessness. The client finds oneself guilty of actually being worthless (i.e., guilty in one's own court).

Analysis 3: Differences Between Subtypes within the EFT-theory based Higher-order Self-critical Subgroups

The 'Socially Inadequate' (SI) and 'Core Worthlessness' (CW) subgroups were first examined for differences on demographic variables (e.g., age and gender), therapy type received, and pre-treatment measures. I then examined both higher-order subgroups on emotional processing measures (CAMS and OVS) and 18-month outcome measures.

Between higher-order self-critical subgroup demographic, pre-treatment, and therapy differences. In the SI subgroup (n = 20), there were 11 women and 9 men. The mean age was 40.2 years old (SD = 9.44). In the CW subgroup (n = 22), there were 16 women and 6 men. The mean age was 39.6 years old (SD = 10.22). No differences between SI and CW subgroups were found on any demographic variable or pre-treatment measure. Subgroups did differ on type of therapy received ($\chi^2(1) = 6.02$, $p < .05$, $\Phi = .379$). Compared to other subgroups, CW clients tended to receive EFT (n = 16, z = 2.5) versus CCT (n = 6; z = -2.5), while SI clients tended to receive CCT (n = 13, z = 2.5) versus EFT (n = 7; z = -2.5).

Between higher-order self-critical subgroup emotional process differences. Emotional processing differences between higher-order self-critical subgroups were examined using proportional analyses (individual CAMS categories, CAMS coded ES subtypes, and OVS categories during the working treatment phase) and THEME analyses examined subgroup sequence differences of working phase emotional processing codes. For ease of presentation, a table summarizing CAMS and OVS coded emotional process differences between higher-order self-critical subgroups can be found in Table 2.

The mean proportions of CAMS coded EEs during the working phase of treatment for the SI versus CW self-critical subgroups are displayed in Table 3 and visualized in Figure 2. The proportion of CAMS coded-EEs presented as emotion scheme (ES) categories for SI and CW self-critical subgroups are displayed in Table 4 and visualized in Figure 3. The 'objects' or 'targets' of EEs measured by the OVS coded-EEs between SI and CW subgroups are displayed in Table 5 and visualized in Figure 4.

Mann-Whitney *U*-tests indicate in the working phase of therapy, CW clients expressed significantly greater proportions of hurt/grief CAMS-coded EEs ($M = 0.08$, $SD = 0.08$) than SI clients ($M = 0.03$, $SD = 0.04$), $U = 123.50$, $p < .05$, partial $\eta^2 = .127$. CW clients also expressed significantly less uncodable CAMS-coded EEs ($M = 0.17$, $SD = 0.11$) than SI clients ($M = 0.27$, $SD = 0.14$), $U = 118.50$, $p < .05$, partial $\eta^2 = .140$. CW clients expressed more other-negative OVS-coded EEs ($M = 0.37$, $SD = 0.16$) than SI clients ($M = 0.26$, $SD = 0.18$), $U = 126.00$, $p < .05$, partial $\eta^2 = .118$. CW clients also expressed less other-positive ($M = 0.11$, $SD = 0.07$) and uncodable OVS-coded EEs ($M = 0.39$, $SD = 0.15$) than SI clients (respectively, $M = 0.06$, $SD = 0.05$, $U = 134.00$, $p < .05$, partial $\eta^2 = .096$; and $M = 0.29$, $SD = 0.13$, $U = 134.00$, $p < .05$, partial $\eta^2 = .096$). While not significant at the $p = .05$ level, CW clients also expressed more ($p = .12$) CAMS-coded negative self-evaluation ($M = 0.05$, $SD = 0.06$) than SI clients ($M = 0.03$, $SD = 0.04$) and also expressed less ($p = .14$) CAMS-coded self-soothing ($M = 0.01$, $SD = 0.02$) than SI clients ($M = 0.03$, $SD = 0.04$).

THEME-detected emotion patterns coded within EEs were explored that occurred with significantly greater frequency in SI ($n = 19$; one client did not have available emotion process data) compared to CW clients ($n = 22$) independent of having provided 18-month depressive outcome. These are displayed in the Table 6 for CAMS coded EEs and CAMS coded EEs

summarized into ES patterns. To inform the reader concerning THEME analyses, in all THEME analyses, patterns were first detected if a code sequence had a 0.5% or less probability of occurring by chance across all clients across both higher-order self-critical subgroups. Next, individual CAMS code EE patterns as well as and CAMS coded ES patterns were examined for occurring significantly more often in sessions of SI versus CW clients using binomial tests (*p* level = .05). Since THEME generates copious output, obtained patterns were condensed into global pattern types based on pattern similarity for parsimony of presentation.

For SI clients, 19 clients contributed 38 (two working phase sessions each) working phase sessions to the THEME analysis. Only one CAMS and CAMS coded ES pattern occurred with greater frequency in sessions of SI clients versus sessions of CW clients. This pattern contained EEs in which SI clients accessed recurrent CAMS-uncodable emotion.

For CW clients, 22 clients contributed 44 working phase sessions to the THEME analysis. For CAMS codes, CW clients expressed 15 patterns in their working phase EEs more often than SI clients did. I condensed these into three global pattern types: (i) recurrent adaptive anger, (ii) recurrent fear/shame, and (iii) recurrent hurt/grief. For CAMS coded ES subtype codes, CW clients expressed ten patterns in their working phase EEs more often than SI clients did. Aligning with the CAMS code sequence findings, I condensed these into two global pattern types: (i) recurrent primary adaptive emotion and (ii) recurrent primary maladaptive emotion.

Between higher-order self-critical subgroup 18-month outcome differences. Recall that not all clients provided 18-month outcome data. As such, 18-month outcome differences between self-critical subgroups were examined for only clients that provided this long-term data (*n* = 29 or 69% of cases). Higher-order groups did not significantly differ on any long-term outcome measure, when 18-month outcome was measured as the difference between pre- and 18-month

outcome on the BDI, SCL-90R, RSE, and IIP. Difference scores were considered more valid than residual gain scores of outcome because no linear relationship between pre- and 18-month scores existed for any outcome measure. In other words, in spite of emotional processing differences noted above, neither SI nor CW clients were doing better on average at 18 months post treatment termination. As such, both higher-order subgroups of self-critical clients did equally well on their long-term outcomes.

Analysis 4: Emotional Processing Differences within the EFT-based Higher-order Self-critical Subgroups between 18-Month Outcome Groups

Each EFT-theory based higher-order self-critical subgroup had both good and poor depression outcomes based on their 18-month BDI outcome scores indicating whether these clients were depressed or non-depressed clients at long-term follow up. Identifying emotional processing differences that demarcate good versus poor resolvers of self-critical depression at 18-month follow up within each higher-order subgroup was undertaken using the 29 clients who provided 18-month BDI outcome data. Fifteen of these clients were SI clients and 14 of these were CW clients. Emotional processing differences for depressed versus non-depressed clients within subgroups were again examined in two ways. First, I examined proportion differences in working phase CAMS rated EE categories, CAMS coded EEs expressed as ES categories, and OVS coded EE categories. I then examined sequence differences in CAMS individual coded EEs and CAMS coded EEs expressed as ES categories detected by THEME that might differentiate outcome groups within each higher-order subgroup. For ease of presentation, a table summarizing emotional process differences between long-term outcome groups within higher-order self-critical subgroups can be found in Table 7.

In the THEME analyses, THEME first detected patterns of EEs with individual CAMS codes and then patterns in EEs identified as CAMS coded ES codes that had a 0.5% or less probability of occurring randomly across all clients within each higher-order subgroup. Next, individual CAMS code patterns and CAMS coded ES patterns occurring with significantly greater frequency in sessions of good versus poor 18-month outcome clients within each subgroup were identified using binomial tests (p level = .05).

'Socially Inadequate' (SI) EFT-theory derived self-critical subgroup: Good and poor 18-month outcome group differences on emotional processing. Looking specifically at SI clients who provided 18-month follow up data (n = 15), there were eight good outcome clients and seven poor outcome clients based on BDI scores at 18-month follow up.

Mean proportions of CAMS coded EEs by individual CAMS categories between good and poor outcome SI clients are displayed in Table 8 and visualized in Figure 5, by CAMS coded EEs by ES categories are displayed in Table 9 and visualized in Figure 6, and by proportion of EEs with targets measured by OVS code categories are displayed in Table 10 and visualized in Figure 7.

Mann-Whitney U-tests did not detect any emotional processing differences that differentiated SI outcome groups. Due to the small sample of clients (less than 9 per outcome group) within the SI good and poor long-term outcome groups, I report trends (ps < .15) toward significance here for these three emotional processes in Tables 8 to 10. Notably, non-depressed SI clients at 18 months expressed less secondary emotions (M = 0.15 versus 0.31) such as rejecting anger (M = 0.08 versus 0.16). They also expressed more hurt/grief (M = .05 versus .03) and self-soothing (M = .05 versus .01), and less other-negative emotional processing (M = 0.18 versus 0.32; all ps < .15) compared to SI clients who were depressed at 18 months follow up.

THEME-detected emotion sequences that differentiate long term outcome groups within the 'Socially Inadequate' (SI) self-critical subgroup. THEME-detected patterns of CAMS coded specific emotions occurring with significantly greater frequency in depressed versus nondepressed SI clients at 18 months on the BDI are displayed in the top half of Table 14 and THEME-detected patterns of CAMS coded ESs occurring with significantly greater frequency in depressed versus nondepressed SI clients at 18 months on the BDI are displayed in the top half of Table 15. Seven clients depressed at 18 months contributed 14 (two working phase sessions each) working phase sessions to the THEME analysis. Eight clients not depressed at 18 months contributed 16 working phase sessions to the THEME analysis. Only one specific CAMS emotion pattern occurred with greater frequency in sessions of non-depressed versus depressed 18-month outcome SI clients. Five of eight good outcome SI clients accessed hurt/grief. Conversely, depressed 18-month outcome SI clients expressed eight specific emotion patterns more often than non-depressed at 18 months SI clients did. I condensed these into four global pattern types. These were sequences of EEs in which the following four expressed patterns occurred: (i) global distress to uncodable emotion, (ii) recurrent global distress, (iii) recurrent rejecting anger, and (iv) fear/shame coded EEs followed by EEs coded as rejecting anger.

In terms of CAMS coded ES ratings, SI clients not depressed at 18 months did not express any ES pattern significantly more often. However, depressed SI clients at 18 months expressed 20 patterns more frequently than good 18-month outcome SI clients did. I again condensed these into four global pattern types. These were working phase sequences of EEs in which the following four expressed CAMS coded ES patterns occurred: (i) secondary emotion leading to uncodable emotions, (ii) recurrent secondary emotions, (iii) secondary emotion

leading to primary maladaptive emotion leading to secondary emotion, and (iv) primary maladaptive emotion leading to secondary emotion.

'Core Worthlessness' (CW) EFT-theory derived self-critical subgroup: Good and poor 18-month outcome group differences on emotional processing. Fourteen CW clients provided 18-month follow up data, of which there were 11 good outcome clients and 3 poor outcome clients based on 18-month BDI outcome scores. The low number of poor outcome clients within this group calls for careful consideration of results relating to outcome differences.

Mean proportions of EEs coded by specific CAMS categories between good and poor outcome CW clients are displayed in Table 11 and visualized in Figure 8. Mean proportions of EEs coded by CAMS codes coded as ES categories are displayed in Table 12 and visualized in Figure 9. Mean proportions of EEs coded by OVS categories are displayed in Table 13 and visualized in Figure 10.

Mann-Whitney *U*-tests indicated that non-depressed CW clients at 18 months expressed more primary maladaptive emotions in the working phase of therapy ($M = 0.27$, $SD = 0.18$) than depressed CW clients at 18 months ($M = 0.09$, $SD = 0.07$), $U = 4.00$, $p < .05$, partial $\eta^2 = .291$. Not depressed CW clients at 18 months also expressed more needs in their working phase sessions ($M = 0.11$, $SD = 0.06$) than depressed CW clients at 18-months ($M = 0.03$, $SD = 0.03$), $U = 2.00$, $p < .05$, partial $\eta^2 = .392$. Not depressed CW clients at 18 months also expressed more self-negative emotional processing in their working phase EEs ($M = 0.18$, $SD = 0.14$) than depressed CW clients at 18 months ($M = 0.03$, $SD = 0.03$), $U = 2.00$, $p < .05$, partial $\eta^2 = .392$. Non-depressed CW clients at 18 months also expressed less CAMS-uncodable emotional content ($M = 0.15$, $SD = 0.09$) than CW clients who were depressed at 18 months ($M = 0.36$, $SD = 0.09$; $U = 1.00$, $p < .05$, partial $\eta^2 = .448$).

Again because of the small group sizes, I report trends toward significance in these emotion process variables in Tables 11 to 13. Notably, non-depressed versus depressed CW clients at 18 months expressed less secondary emotion (M = 0.20 versus 0.34) such as global distress (M = 0.11 versus 0.24), and more fear/shame (M = 0.25 versus 0.09) and negative self-evaluation (M = 0.02 versus 0.00; all ps < .15).

THEME-detected emotion sequences that differentiate long term outcome groups within the 'Core Worthlessness' (CW) self-critical subgroup. THEME-detected patterns of CAMS coded specific emotions occurring with significantly greater frequency in depressed versus nondepressed CW clients at 18 months on the BDI are displayed in the bottom half of Table 14. THEME-detected patterns of CAMS coded ESs occurring with significantly greater frequency in depressed versus nondepressed CW clients at 18 months on the BDI are displayed in the bottom half of Table 15. The three clients who were depressed at 18 months contributed six working phase sessions to this THEME analysis. Eleven clients who were not depressed at 18 months, contributed 22 working phase sessions to the THEME analysis. Only one more frequently-occurring global pattern for non-depressed CW clients at 18 months was detected, which I condensed from 10 unique patterns detected by THEME: fear/shame leading to accessing recurrent needs. Non-depressed CW clients at 18 months more frequently accessed their core maladaptive emotion in their working phase sessions and expressed experience of their needs. Conversely, CW clients depressed at 18 months expressed 10 unique patterns more frequently. I reduced these to 3 global pattern types; (i) recurrent uncodable emotions, (ii) uncodable emotion leading to global distress, and (iii) recurrent global distress. So, CW clients who were depressed at 18 months expressed working phase emotional processing EE sequences that were either repeatedly off the CAMS track of categories or often expressing global distress.

In terms of CAMS coded ES ratings, CW clients not depressed at 18 months expressed 33 unique patterns more frequently than CW clients who were depressed at 18 months. I condensed these into seven global pattern types. CW clients who were not depressed at 18 months expressed CAMS coded ES sequences in which: (i) expressed needs lead to adaptive emotions and then more expressed need, (ii) expressed needs lead to expressed primary maladaptive emotion, (iii) expressed primary maladaptive emotion leads to expressed adaptive emotion, (iv) expressed secondary emotion leads to expressed primary maladaptive emotion, (v) expressed adaptive emotion leads to need expression and then to further expression of adaptive emotion, (vi) expression of primary maladaptive emotions lead to expressions of need, and (vii) recurrent needs were expressed. CW clients who were depressed at 18 months expressed eight patterns more frequently than non-depressed at 18 months CW clients. I reduced these eight patterns to two global pattern types. CW clients who were depressed at 18 months expressed CAMS coded ES sequences in which: (i) uncodable emotion leads to expression of secondary emotions and (ii) recurrent CAMS-uncodable emotions were expressed.

For an overall tabular summary of these between and within self-critical subtype differences in emotional processes, the reader is referred to two summary tables, Tables 2 and 7, respectively.

Chapter 4: Discussion

We know that self-critical depression is an important depressive subcategory (Beck, 1983; Blatt, 1974; 2004) and that is it a particular target of change during experiential psychotherapy, especially EFT (Greenberg & Watson, 2006; Whelton & Greenberg, 2005). Previous research has identified that emotional change processes can predict *short-term* resolution of self-critical depression (Choi et al., 2016). To examine emotional change processes

that can predict *long-term* resolution of *subtypes* of self-critical depression, the present study followed a mixed-methods approach to explore its primary objectives. Mixed methods in this context can be argued to have occurred in two ways. First, my qualitative analysis was a mixed method qualitative analysis in so far as it used both inductively- and deductively-driven categories/themes or 'subtypes' of self-critical depression. As well, and more globally-speaking, this study employed a mixed methods methodology because it integrated qualitative analyses of the self-critical themes/subtypes and quantitative analysis of the emotion codes related to these self-critical subtypes. Some would argue that this follows an exploratory-sequential mixed methods approach (Creswell & Plano Clark, 2011) in which there is initial qualitative data analysis followed by subsequent quantitative analytic procedures. The resultant findings are bolstered by the strengths of both methodologies.

My goals are revisited here. Following this, I will discuss the results related to each goal. Let me first summarize the qualitative portion of my study. I had two qualitative goals. My first goal was to reapply, audit, and validate as reliable, an extant qualitative, that is, inductively-derived typology of self-critical categories of depression that had been proposed by Kagan (2003) from her grounded theory analysis of York II clients (Goldman et al., 2006) who had received experiential treatment of their depressions. This was successful. Reliable reapplication of Kagan's (2003) qualitative self-critical categories occurred within a new confirmatory reflexive thematic analysis (Braun & Clarke, 2006) of her original dataset using ATLAS.ti software. Reliable re-coding of her self-critical categories also permitted refined revisions to her categories as well as new categories to emerge if necessary. In my confirmatory reflexive thematic analysis, reliability of Kagan's initial qualitative codes for self-critical categories was established. Her categories were successfully and reliably re-applied by two new coders who

viewed her codes as validly representing the self-critical types within the sample. The new coders only made minor refinements to her codes. Only one difference on the first level of qualitative coding occurred using Kagan's self-critical categories. I discerned one extra category, which I called 'Self-interruption of Feeling'. However, since this emerging category never was a primary code and would have yielded a 'too small' group if considered alone, I finally considered this small group a subcategory of self-criticism subsumed by the already extant Kagan code of 'Unacceptable Feelings and Shoulds'. It was therefore deemed not relevant for further examination.

My second goal was also qualitative. It was to extend Kagan's qualitative analysis by further examining possible deductively-derived higher-order self-critical subtypes based on EFT theory. I hypothesized that Kagan's inductively-derived qualitative self-critical category framework could be organized by EFT theory into two higher-order self-critical categories. This deductively-driven higher-order set of two self-critical themes or subtypes was based on two higher-level self-critical categories consistent with EFT theory: (i) an experientially-distant 'persecutory' self-critical subtype (which I later called/named 'Socially Inadequate') focused on standards, self-blame, and the critic perspective. It merged three of Kagan's categories: (1) compare and despair, (2) too sensitive/needy, and (3) internalized shoulds/unacceptable feelings. The second higher-order EFT-theory driven self-critical subtype assumed some clients were (ii) experientially-engaged and experienced core feelings of worthlessness. I called this higher-order self-critical subtype 'Core Worthlessness'. Clients who were coded with this higher-order self-critical theme were marked by expressing a criticized self perspective with core feelings of unworthiness. This latter subgroup of self-critical clients became a simple re-naming of Kagan's found self-critical category description of unworthy/not good enough. The hypothesis suggested

above was therefore supported, as an EFT-theory based higher-order two self-critical themes did organize Kagan's inductively-derived qualitative self-critical categories/themes.

My next three goals were examined through more classical statistical procedures. My third goal explored emotional processing differences (on the CAMS and OVS measures) between the higher-order EFT-theory based self-critical subgroups, which did differ. I examined emotional processing differences during the working phase of therapy using all 42 clients, and by using both proportional analyses and THEME pattern detection analyses of their emotion episodes. I had hypothesized that based on EFT theory, the higher-order persecutory ('Socially Inadequate' or SI) self-critical client group would express more secondary (or experientially avoidant) emotions, particularly rejecting anger, during the working phase of treatment. Alternatively, 'Core Worthlessness' (CW) self-critical clients would express more primary maladaptive emotions, particularly fear, shame, and negative self-evaluations compared to SI clients. As expected, CW clients expressed more negative self-evaluation and sequences of recurring fear/shame access. CW clients expressed negative self-evaluations that defined them. Conversely, SI clients did not express more rejecting anger as hypothesized. They expressed more other-positive codes (displaying their definitive alignment with 'other-based rules') on the OVS measure and more uncodable EEs on the CAMS measure, including THEME-detected sequences of recurrent access of CAMS-uncodable emotion.

My fourth study goal was to examine self-critical subgroup differences on 18-month depressive outcome. I compared the long-term outcome for the 29 clients with available long-term data (15 SI clients and 14 CW clients). I had hypothesized that 'Core Worthlessness' (CW) self-critical clients would have better long-term depressive resolution than persecutory 'Socially Inadequate' (SI) self-critical clients given their greater experiential contact for engaging in

therapeutic emotional schematic change. This hypothesis was not supported as no long-term outcome differences were observed. Both self-critical subtypes appeared to do equally well overall in this therapy. While CW clients were more in touch with their experience than SI clients, which might lead one to assume they would do well overall in treatment (Pos, 2006), this was not born out.

Finally, while the higher-order subgroups (SI and CW) of self-critical depression did not differ on their long-term outcomes, it was still of interest to discover whether the 'road taken to outcome' would differ for each group by exploring whether within subgroups, differences in emotional processing occurred that related to long-term outcomes. To do this, I explored emotional change processes that might predict good versus poor long-term resilient resolution at 18 months within each higher-order EFT theory-derived subtype of self-critical depression. Marked differences consistent with EFT theory occurred for clients that resolved versus did not resolve their depressions within each higher-order self-critical subgroup. Again, I used the same two different analytic methods to investigate this: proportion analyses and THEME analyses. Based on previous research supporting the EFT emotion schematic change process (Choi et al., 2016; Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2009; Piccirilli, 2018; Rinaldi, 2017; Wong, 2016), it was hypothesized that good resolvers of persecutory 'Socially Inadequate' (SI) self-criticism would express reductions in secondary emotions and increases in primary adaptive emotions, whereas better resolvers of 'Core Worthlessness' (CW) self-criticism would express reductions in primary maladaptive emotions and increases in primary adaptive emotions during the working phase of experiential treatment. These hypotheses were mostly supported. While not statistically significant at the $p = .05$ level, statistical trends indicated that non-depressed SI clients at 18-month follow up expressed less working phase secondary emotions, particularly

rejecting anger, as well as fewer sequences involving secondary emotions including global distress and rejecting anger. Non-depressed SI clients at 18 months also expressed greater access of primary adaptive emotions of hurt/grief. These results were consistent with EFT theory. It makes sense that decreasing expression of secondary emotions and starting to work through core pain (hurt/grief) is helpful to the client for resolving their self-critical process.

As for the CW subgroup, non-depressed CW clients at 18-month follow up had expressed, as hypothesized, more primary maladaptive emotions and needs during the working phase of therapy, as well as emotion sequences of fear/shame leading to accessing needs and other emotion sequences accessing primary adaptive emotions. This reflected the movement from secondary emotion to maladaptive emotion to need and primary adaptive emotion access. This was also coherent with EFT theory. It makes sense that access of primary maladaptive emotion would precede expressing needs, needs that the therapist hopefully validated. EFT theory does assume (Greenberg & Watson, 2006) that accessing needs helps clients approach and work through maladaptive emotion and access adaptive emotion in resolving core worthlessness, or the client's 'core pain' (Goldman & Greenberg, 2015). Hopefully, reductions in maladaptive emotion would occur later in therapy for these clients as hypothesized.

Therefore, in total, the current study had five core objectives. Findings for each study goal are further elaborated and discussed below. Following this, limitations and future directions are discussed.

Goals 1 and 2: Validating Kagan's Self-critical Categories and Explicating EFT-theory based Higher-Order Self-critical Subgroups

Validity in qualitative research. The issue of validity in qualitative research should be addressed here again. I admit that this qualitative study was unorthodox in that I used extant

theory to organize higher-order categories or themes of self-criticism. As such, this study used both a deductive (i.e., theory-driven organization of Kagan's (2003) grounded deduced themes) and inductive approach (allowed for inductive grounded themes to emerge) to the data. I also admit to the difficulty in doing grounded qualitative thematic parsing of data that was not interview data. As such, the data was partially from client data and also included a 'second therapist eye' in the form of the therapist reports of sessions which were also used.

First, let me say that Rennie (2012) and other qualitative researchers believe that, given the post-modernist view in qualitative research, there are many valid views on reality. Therefore, it is possible that another researcher might find different higher-order categories, other than my 'Socially Inadequate' (SI) and 'Core Worthlessness' (CW) categories, emerging from the data. The current researcher, in fact, admits that while doing the current analysis, other higher-order qualitative self-critical categories might have also been considered. For example, a second higher-order categorization that was toyed with was one in which clients appeared to be sub-dividable into clients whose self-criticism were self-driven versus other-driven. Since this alternate view was very coherent with my SI/CW views presented here, and due to the need to be parsimonious in this document, I stuck with the original plan that I had and did not pursue other theme/subtype 'solutions'. Still, I admit other parsings of the data may be possible.

Now, let me examine the validity of my current study using Levitt, Wertz, Motulsky, Morrow, and Ponterro's (2017) recent APA TASK Force recommendations for designing and reviewing qualitative research. They state that data collection should be faithful to the subject under examination and I believe that it was. Kagan's (2003) data was directly related to qualitative parsing of self-criticism. They also suggest that I contextualize my study, which I think was done here also given my reviews of depression, self-criticism, etc. They feel that the

data that emerges should lead to insights which I believe (hope) has occurred. Specifically, that there are many roads to self-criticism and to its resolution and that knowing these differences can be useful to the clinician and researcher. I also think I made clear that as an emotion-focused researcher, that I am biased by those theories and, in fact, was faithful to them in the higher-order themes or categories of self-criticism that I was examining. In terms of the analysis, Levitt et al. (2017) suggest that researchers declare that their personal perspectives have influenced the data. I again suggest that the design made room for this given the theory-driven higher-order self-critical themes I examined and also given that I admit that other perspectives are possible. My data was, as they suggest, very grounded. My contributions to the field and future research are also given and further discussed later on in the paper. I have noted and will further discuss how coherent the current results are to previous research. As such, I feel the current study satisfies the current ethics of qualitative research.

Stiles (1993) provided an older view of validity in qualitative research which I would also like to address here. Stiles believes that the impact of results and where that impact may go will determine the validity of my study. Will readers, participants, or only investigators feel the impact of this study? Since I cannot be assured that any participants will read this, I cannot be sure they will be impacted. However, other readers and researchers may read this and be impacted. Stiles also suggests that validity concerns whether an interpretation is internally consistent, useful, robust, generalizable, or fruitful. I believe the SI/CW self-criticism distinction is a clinically useful one, which I will elaborate upon later on. One way validity is assured, Stiles states, is through triangulation of data. I believe that the data itself provides a sort of triangulation because it came from both client and therapist. Agreement between these two perspectives on the client sessions successfully allowed for this. The fact that new coders could

reliably see Kagan's (2003) codes itself also attests to their validity. The reliability of current coders fits in here I believe. In addition, I also demonstrated coherence, as Stiles suggests, between raters through the reliability analysis as well as through the connections I made and will discuss further between my findings and other areas of research. Coherence of the current data will also occur in your minds as readers, if you find my study believable and you resonate with the results that I found (Rennie, 2012). My qualitative analysis should also uncover a truth about self-critical clients, in this case that there are recognizable types of self-criticism. I hope I have sowed the seeds for possible future research as a result. As such, I hope that this current study acts as a catalyst for future mixed-methods research. Having said all of the above, I hope I have demonstrated due diligence in the qualitative validity arena.

Validating Kagan's self-critical categorization. Kagan's (2003) original self-critical categories were all retained albeit their thematic descriptions were somewhat 'honed'. Therefore, Kagan's original categories were validated by reapplication of her coding system within her original sample, as well as, applying it to two more/new clients. The method that I used, which was a recoding of Kagan's original data, contrasts from a cross validation procedure using a new sample (e.g., McCarthy, 2014). Coding new data would be important as a next stage of future study that might further validate Kagan's (2003) qualitative typology. The reason I performed the validation of Kagan's analysis in this way was to have the opportunity to further her analysis by exploring higher-order categories informed by EFT theory.

Explicating the two higher-order EFT-theory based self-critical subtypes. I would like to underline that my higher-order thematic elaboration of Kagan's (2003) four self-critical categories, while based on EFT self-split theory, created a higher-order classification system based on the source of one's self-criticism. Kagan's categories of 'compare and despair' (CD),

'too needy/dependent' (TND), and 'unacceptable feelings and shoulds' (UFS) were all marked by a punitive self-judger, perhaps aligned with or representing internalized rules and criticisms of others and of one's culture, society, or system. This 'Socially Inadequate' (SI) higher-order self-criticism is similar to what Thompson and Zuroff (2004) describe as comparative self-criticism, in which one holds negative views of oneself when comparing oneself to others. It has, in fact, been found that negative social comparisons can mediate the relationship between self-criticism and depression (Sturman & Mongrain, 2005), making sense of this self-critical subtype. This 'top dog' self-criticism also converges with the self-critic position that is typically 'separated from the self' in EFT two-chair interventions and which is articulated in a separated chair in order for the criticized self to become aware of this self-critical process (Greenberg, 2010; Greenberg & Watson, 2006).

I believe that the 'Socially Inadequate' (SI) subgroup organized self-critically aligned clients into one group because of this shared process of having introjected external criticism. What is interesting is that the introjected self-critic appears to be a part of the self that the client is strongly aligned with. Another articulation of this fits with Blatt's (2004) psychodynamic conceptualization of self-critical depression in which the self-critic represents a harsh, punitive superego that has been formed from the internalization of a parental figure who criticized one's self-worth and self-strivings (i.e., a negative introject). Jacobson (1953) too has postulated that depression can emerge from a profound loss of self-esteem at the hands of an overactive superego. In each case, a self-critic operates as a problematic 'shoulder' and 'musterbator'. When this self-criticism functions in this way in a person, it leads to dysfunction as described by cognitive theorist Albert Ellis (1962). Furthermore, this external self-criticism converges with the concept of socially-prescribed perfectionism in which individuals perceive that others

'prescribe' excessive standards on them and subsequently exert significant self-pressure to be perfect and meet these standards (Hewitt & Flett, 1991). Individuals are critical of themselves for failing to meet these high standards and feelings of shame and helplessness follow. The relationship between self-criticism and perfectionism has also been empirically demonstrated in the literature (Dunkley, Zuroff, & Blankstein, 2006; Blatt, Quinlan, Pilkonis, & Shea, 1995; Hewitt & Flett, 1991; Trumpeter, Watson, & O'Leary, 2006). It would not be surprising if perfectionism is more likely to occur in clients of this type. Future research might explore this. Given that there is anxiety about being accepted by others in the SI subtype, the relationship between depression and social anxiety difficulties is also suggested by the SI self-critical subtype (Stein et al., 2001).

In contrast, 'Core Worthlessness' (CW) self-critical clients were characterized by a self-criticism with felt consequences internally experienced by a defeated self. The critic has won the day and the self is connected to internally felt pervasive and painful feelings of worthlessness, shame, and inferiority which the self feels are 'true'. This type of self-criticism, accepted as 'true' self-criticism, is voiced from the experiencing self position, which is typically separated from the self-critic in EFT two-chair interventions and is eventually supported and empowered in in EFT therapy (Greenberg, 2010; Greenberg & Watson, 2006). Due to the self-criticism being already implicitly accepted by and voiced by the defeated self, the self is 'held hostage' by the self-critic's core message: "I am fundamentally worthless, incompetent, and/or unlovable."

The painful developmental origin of the 'Core Worthlessness' (CW) subtype also points to the known relationship between trauma and depression (Flory & Yehuda, 2015). Moreover, how attached we are to our introjected self-critical others (Blatt, 2004) may play a role in whether we can express our resilience. Resilience may require the capacity to individuate from

important others and to stand on one's own two feet (Pos & Paolone, in press). Some CW clients may have had this core of individuality that supported their individuation, which might have helped them resolve their feelings of worthlessness. My guess is being able to recognize specific types of resilience will be essential to treating CW clients successfully.

Goal 3: Emotional Processing Differences Between Higher-Order EFT-theory based Self-critical Themes/Subgroups

Considering that both higher-order EFT-theory based themes/subgroups did equally well on long term outcome (discussed below), the fact that there were some differences between these two groups in terms of their emotional processing speaks to the actual validity of these two higher-order subtypes being different groups of clients. The two groups of self-critical clients (SI versus CW) did appear to be expressing different emotional processes in therapy and these differences were independent of outcomes within the groups.

Differences between the two higher-order self-critical subgroups on emotional processes were summarized in Table 2. 'Socially Inadequate' (SI) self-critical clients expressed more proportions and sequences of emotional content not codable on the CAMS measure while CW clients were the opposite. SI clients in general expressed less fear and shame, less other negative emotion, and less assertive anger. 'Core Worthlessness' (CW) self-critical clients, as hypothesized, expressed more negative self-evaluation and fear/shame. As hypothesized, they also appeared to be more 'in tune' with their feelings as they expressed fewer uncodable emotions and more core pain (i.e., hurt and grief). They were also more frequently other-negative. While SI clients did not express more rejecting anger as I expected, consistent with the apparent value they place on fitting in and achieving worthiness in the eyes of others, SI clients expressed less other-negative emotional processing and more other-positive emotion, and

generally refrained from expressing sequences of assertive anger as well. These SI clients perhaps were more reticent to express negative views of and anger towards others. It would make sense that anger towards others might be interrupted in these clients and this could explain why they did not express assertive anger a much as CW clients did. These are the clients who will likely need to work on their self-interruption of anger. Future research should examine whether SI clients experience more anger suppression than CW clients due to their positive valuation of others and whether nondepressed SI clients are able to express anger later in therapy.

Interestingly, SI clients also expressed more self-soothing than CW clients. This is a curious finding considering that SI clients are thematically described as being more aligned with their self-critics and thus more self-punitive and self-loathing. Upon closer inspection, I noted that self-soothing distinguished long-term good resolvers of SI self-criticism from poor resolvers. This suggested that the stronger presence of self-soothing among SI clients compared to CW clients likely pertains only to the good outcome SI clients in particular, which I will discuss further below. Still, this highlights the importance of learning to self-soothe for SI self-critical clients in particular. This is another difference between groups that suggests real differences (Bateson, 1979).

As hypothesized, CW clients expressed more primary maladaptive emotions, including more negative self-evaluation as well as sequences of recurring fear/shame access. Moreover, they appeared to be more experientially engaged based on having more CAMS-codable emotional content, particularly accessing their core pain (i.e., hurt/grief). They also did not express the notable self-soothing SI client did even when they had good outcomes. This again suggests differences between these two self-critical types. Consistent with their thematically-described stronger tendency for feeling their core unworthiness and emotions in general, CW

clients were in touch with their core maladaptive painful self-evaluations and appeared to be more capable of feeling deeper painful emotions. They were also capable of expressing other-negative emotion and adaptive anger. However, in this process they may need the therapist to soothe them if they lack this capacity. SI clients appear to be able to express self-soothing but not their anger and pain. They likely will need to be helped to not interrupt their anger and to feel their pain. As such both the SI and CW client will need to learn to individuate from others, but again in their own way. This individuation is considered a core step required before being able to access adaptive anger and resolve unfinished business in EFT therapy (Greenberg & Watson, 2006; Pos & Paolone, in press).

In summary, while both higher-order subtypes are self-critical and must feel inadequate on some level, emotional differences between an SI and CW client can be seen that suggest these are two distinct types of self-critics. We might consider that on average, the SI client is like an 'obedient coper' who must maintain more positive regard for others while avoiding pain. In contrast, the CW client may be a 'wounded individual' who, due to their greater experiential capacity, is in touch with their core worthlessness and pain, and also more oppositional towards others. This would suggest two different ways of interacting with each type in therapy due to their different needs.

Goal 4: 18-month Outcome Differences Between Higher-Order EFT-theory based Self-Critical Themes/Subgroups

Despite hypothesizing from EFT theory that by being in touch with their pain (i.e., being more experientially engaged with their core painful unworthiness), CW clients would be better positioned to transform and resolve their self-critical depression than SI clients, this was not found. This could mean that within each type there is resilience, which reminds us of distinctions

made by Whelton and Greenberg (2005). Both CW and SI subgroups had good outcome clients who may have therefore shown some resilience. Therefore, in spite of my belief that CW clients would fare better in treatment because they seemed more in touch with their core pain, the SI clients who were capable of feeling their hurt/grief and self-soothing also fared well in experiential treatment.

One way to make sense of this result is to recognize that both subgroups may feel pain in different ways and that all pain is not equal. Further, the CAMS measure may not 'pick up' a client's pain in the same way, with the same code. Making sense of the types of core pain that CW and SI clients experience may be important. One thing that seems certain is that if EFT theory is true and 'arriving at' feeling pain is essential for good outcome, then for CW clients core pain may be expressing the primary maladaptive emotion that they feel, but for SI clients the core pain may be expressing their hurt/grief. This was suggested by the analysis of good and poor outcomes within subtypes which I will discuss more below. Another possibility is that perhaps some core pain is harder to deal with than other pain. Perhaps the CW subtype is defined by early expression of core pain in the self, but that resilient SI clients access their pain later in therapy. Since the current study did not examine emotional processing late in therapy, this possibility could not have been captured. I will now discuss emotional processes predicted good outcomes within particular subgroups.

Goal 5: Emotional Processing Differences Marking 18-month Good and Poor Outcome within Higher-Order EFT-theory based Self-critical Themes/Subgroups

Working phase emotional processing also distinguished non-depressed versus depressed outcome clients at 18-month follow up within each EFT-theory based higher-order self-critical themed subgroup. These analyses again suggested important emotional differences between

these higher-order self-critical subtypes. Each type perhaps is helped by travelling down a particular emotional path. Again, I used two analytic approaches (proportion analyses and THEME pattern analyses) to provide a dual view of these emotional change processes.

The most robust finding across both self-critical subgroups was that greater proportions and more sequences involving primary adaptive emotion (PAE) predicted good long-term 18-month depressive outcome. Emotion sequences suggesting 'stuckness' in secondary and uncodable emotions (perhaps emotional avoidance) predicted poor long-term 18-month depressive outcome. This is a general finding consistent with EFT theory and consistent with Wong (2016) who found also that secondary emotions predict depression at 18 months for any experiential client who was treated in the York I and II studies (Goldman et al, 2006; Greenberg & Watson, 1998). Therefore, poor resolvers of any self-critical type appear to be more 'emotion phobic' (McCullough et al., 2003). Perhaps this is because they are also more cognitively rigid (Fossati, Ergis, & Allilaire, 2001), which may hinder their resolution of self-critical depression. This will be an important area of future research as well. Thus, findings across both subgroups support global EFT theory concerning the role of transforming unproductive emotional schemes by accessing PAE. PAEs are posited in EFT to be core emotion schematic change processes in resiliently solving any self-critical subtype depressions. Furthermore, transforming maladaptive emotion 'spells' with new adaptive emotional experiences is supported by the emotional reconsolidation literature (Dudai, 2004; Lane, Ryan, Nadel, & Greenberg, 2015), which also validates the EFT theory of change.

***Self-critical higher-order themed subgroups and emotional processing*.** Still, the study's core objective was to specify a more nuanced view of emotional change processes for particular self-critical subgroups to support case formulation and treatment planning. Specific emotional

change processes predicting 18-month depressive outcome by higher-order self-critical theme/subgroup were found and summarized in Table 7. Not depressed 'Socially Inadequate' (SI) clients who resolved their self-criticism in the long term accessed hurt/grief and self-soothing during the working phase of therapy and expressed less rejecting anger and other-negative emotional processing. 'Core Worthlessness' (CW) clients who resolved at 18-month follow up accessed primary maladaptive emotion, needs, and self-negative emotional processing during their working phase sessions. Now, I will elaborate these emotional processing differences found by subgroup.

'Socially Inadequate' (SI) subgroup: Emotional change processes distinguishing depressed and nondepressed clients at 18-month follow up. Non-depressed SI clients at 18-month follow up expressed (as trends) less rejecting anger, less other-negative targeted emotions, as well as more hurt/grief and self-soothing (Table 7 will remind you of this). Therefore, SI clients who were not depressed at 18 months expressed some reductions in secondary emotions and increases in primary adaptive emotions as hypothesized. Reducing secondary anger and negativity towards others, appears to be important for resiliently resolving the SI subtype. A decreased negative-other tendency suggests that SI clients find it *unhelpful* to be other-negative and may prefer to be positive towards others instead. As a result, I would suggest that interruption of anger is likely to occur in this type of client. These clients may also have a preferred tendency to be more rational and 'non-blaming' (e.g., an independent need to 'rise above it' or preference for not letting others know they are hurt). The SI capacity to self-soothe, also helped these good outcome SI clients likely after expressing their core vulnerable pain (i.e., hurts and losses). It is important that these SI clients did express core pain in the form of hurt/grief, supporting the EFT principle of following the client's 'pain compass' as suggested by

some EFT case formulation (Goldman & Greenberg, 2015). As such, the SI client appears to resolve their depressive self-criticism by not focusing on their anger towards others but instead accessing their 'true self' and soothing the pain of perhaps having to live up to others' standards. Self-compassion, coded as self-soothing in this study, also acts in opposition to being self-critical and supports psychological well-being (Kelly, Zuroff, & Shapira, 2009; Neff, Kirkpatrick, & Rude, 2007). Reclaiming the true self may be the inner resilience needed to support long-term resolution among these SI clients. Future research might do well to examine how the therapist engages or discovers this capacity in an SI client and uses it to help SI clients further develop this capacity of self-soothing. Markers within SI clients of this capacity to self-soothe would also be important to explicate.

Future research should seek to unpack what kind of hurt/grief events these clients express in therapy. That these clients felt their hurt/grief suggests that these good outcome SI clients were experiencing their losses more, perhaps loss of self. Furthermore, later helping these SI clients to access their anger and strength may be the route these clients eventually take to resolve the SI depression. Since I did not examine later emotional processing, I could not determine this. It makes sense however because only a client who can self-soothe is likely to be able to both tolerate their deep pain and use anger to eventually differentiate from the 'powerful others' (Pos & Paolone, in press) whose 'spells' and 'rules' may have captured and held these clients 'hostage'. Perhaps the good long-term outcome SI client must graduate from obeying another's 'laws' to setting laws for themselves. They can find their true self values instead of marching to someone else's 'tune'. Values work may be important to the SI clients. The fact that good outcome SI clients express more self-soothing appears to suggest that it is helpful to these clients if they can stand alone and take care of themselves.

SI clients who were depressed 18 months post treatment expressed more sequences suggesting 'stuckness', including oscillations between secondary emotions and CAMS-uncodable emotions. They also expressed one particular pattern type where they appeared to escape painful fear/shame emotion by moving to unhelpful rejecting anger. Remember that these clients also expressed significantly less self-soothing, which is coherent with this type of client's inability to tolerate feeling their pain (Pos & Paolone, in press). As such, poor SI resolvers appear unable to tolerate pain and 'escaped' by expressing secondary emotions like rejecting anger and global distress. Since a general tendency towards negative information processing has been found among depressed individuals (Street et al., 1999), future research could examine this potential vulnerability in SI clients in particular.

'Core Worthlessness' (CW) subgroup: Emotional change processes distinguishing depressed and nondepressed clients at 18-month follow up. Non-depressed CW clients at 18 months post treatment had expressed more primary maladaptive fear/shame and negative self-evaluation, needs, as well as more emotion sequences involving 'secondary to maladaptive to need and adaptive emotion access'. These CW clients illustrated the entire EFT theorized movement from 'secondary to maladaptive emotion to need and adaptive emotion access' that is considered important to good outcomes. So, and in contrast to SI clients, CW clients who were non-depressed at 18 months expressed greater contact with their core fear/shame that led to the expression of their needs and subsequent primary adaptive emotion. This may be an important step in building resilience in these clients. Perhaps resilient CW clients might need the therapist more during their resolution and be able to disengage from others who hurt them and then re-attach to the therapist because of some sense of others being loving and their own worth on some level. Perhaps these good outcome CW clients thrive on the client-centered relationship

conditions offered in HEPs and reclaim their sense of 'lovableness' as a result. The alliance may be a more important predictor of good outcome for these clients.

Still, the role of processing core maladaptive fear/shame appears centrally important in CW clients as opposed to accessing vulnerable adaptive hurt/grief/pain and self-soothing in SI clients. This is an interesting difference–that the core pain of each group appears to be slightly different. CW clients express their painful core maladaptive shame and fear while SI clients are served best by expressing and soothing painful hurt and grief. Congruent with the core emotional change process theorized in EFT therapy (Greenberg, 2010; Greenberg & Watson, 2006), accessing primary maladaptive emotion (PME) and needs likely reduced future occurrences of PME for CW good long-term outcome clients. One cannot ignore the core maladaptive vulnerability of the CW client but must, as well, work through it to reliably and resiliently resolve it. This suggests a stronger need for the therapist in valuing the CW client to transform their core maladaptive pain resiliently. An important area of future research would be to qualitatively explore categories of needs and related primary adaptive emotions that mark resolution of CW self-criticism. For example, a specific need for acceptance may lead to later helpful emotional expressions of self-compassion and self-acceptance.

Depressed CW clients at 18 months post treatment, again, expressed more stuckness in emotion sequences of CAMS-uncodable emotion and global distress. This again appears to be indicative of some level of experiential avoidance among poor CW resolvers. Perhaps some painful maladaptive worthlessness and related existential fears are too painful and overwhelming to experience. This suggests that some CW clients will stay stuck in global distressed states. Future research should examine life and client factors that contribute to poor resolution of the CW subtype.

Thus, overall, resolving CW self-criticism in the long-term appeared to be marked by helping the CW client approach, process, and transform painful 'negative self' while accessing existential needs.

Parsing EFT change pathways? In parsing higher-order subtypes of self-criticism, this also appeared to parse two different general emotion schematic change pathways for resolving self-critical depression in EFT theory. Nondepressed CW clients at 18 months post treatment moved from secondary to primary maladaptive to primary adaptive emotions in the working phase of experiential treatment. Conversely, accessing primary maladaptive emotions did not appear to distinguish nondepressed SI clients at 18 months post treatment, and as such, these clients may move directly from secondary to primary adaptive emotions to resolve their self-critical depression. This supports two potentially disparate schematic change pathways for resolving self-criticism in EFT theory. Pascual-Leone and Greenberg (2007) have found that depressed clients can move directly from secondary emotions to primary adaptive emotions. Perhaps nondepressed SI clients do not need to express primary maladaptive emotions because they are more resilient in terms of having self-esteem. However, there were no pre-treatment differences in self-esteem found between higher-order self-critical subgroups in the current study. The potential for different general change pathways in resolving emotional difficulties like self-criticism in EFT theory represents an important area of future research.

Client Effects: Who is more likely to resolve self-critical depression?

Pre-existing client factors can affect outcome and therefore are also important to consider when treating self-critical depression. Client factors are helpful markers to look out for when matching a client to a particular treatment to increase chance of client-treatment fit and success (Beutler et al., 2000).

While not measured in the current study, clients who are low in self-agency are helpful to identify because low self-agency may be linked to a lack of assertiveness that maintains self-critical processes (Gay, Hollandsworth, & Galassi, 1975; Ludwig & Lazarus, 1972; Whelton & Greenberg, 2005). At the very least, low agency would make it difficult to resolve therapy tasks which would ask assertiveness of the client (Pos & Paolone, in press). All HEPs aim to improve a client's agential capacities and the HEP therapist must work harder for clients presenting to treatment with lower levels of self-agency to resolve self-criticism from a particular subtype perspective. Future study should investigate the relationship of client self-agency and resolving self-critical depression, and whether self-agency may differentially relate to resolving particular self-critical subtypes. Aforementioned client factors are also worth investigating in a similar manner: emotion phobic tendencies (McCullough et al., 2003) and cognitive rigidity (Fossati et al., 2001).

Finally, 13 clients did not provide 18-month outcome data. No pre-treatment difference on any pre-treatment measure was found, increasing our confidence that follow-up clients did not differ from non-follow-up clients in any pre-treatment distress. While no differences in depression at termination were present, non-follow-up clients were more self-critical at termination and reported more termination distress on the SCL-90-R global symptom index. This suggests the possibility that these clients did not provide follow-up data because they had not been as successful in treatment. This cannot be demonstrated empirically here, as there is no real long-term data on these non-follow-up clients. The fact that more men provided follow-up data is interesting given that there were more women in the York I and II samples overall (Goldman et al, 2006; Greenberg & Watson, 1998).

Still, it should not be overlooked that some non-follow-up clients did not return for follow up due to having more problematic and complex presentations at the end of treatment. Factors responsible for this could represent important client markers of non-responders to a short-term experiential treatment. Future research should examine marker-driven termination of treatments as some clients may require a longer course of treatment to resolve their self-criticism and depression.

Therapy Effects: EFT versus CCT

Converging with previous lines of research (Elliott et al., 2013; Ellison et al., 2009; Goldman et al., 2006; Watson & Pos, 2017), for the clients who did provide 18-month follow up data, EFT clients did experience better long-term 18-month treatment outcomes than client-centered therapy (CCT) clients. This was independent of higher-order EFT-based theory self-critical subgroup membership. EFT clients also accessed more working phase adaptive emotions, particularly hurt/grief and assertive anger. Both of these emotion states are important emotional processing states identified in EFT treatment of depression and in some other client problems as well. This is important to note because EFT has been identified as the best HEP for long-term resolution of depression (Elliott et al., 2013; Ellison et al., 2009; Goldman et al., 2006; Watson & Pos, 2017). The results here echo this. EFT appears to be more adept at helping clients access deeper and helpful emotional processing states for client improvement than CCT, and if as suggested at present that emotional processing is the key for resolving all self-critical processes, this may explain why clients receiving EFT had better long-term outcomes. Perhaps it is reasonable to assume that the structured nature and focused goal of deepening client's emotional experiencing in EFT helps clients access and transform core maladaptive themes. It is assumed that EFT, through its own balance of acceptance and directiveness, helps support clients' self-

agential capacities. The importance of supporting self-agency in the resolution of depression is supported in the literature across the lifespan (Hobbs & McLaren, 2009; Kim, & Cicchetti, 2006). Moreover, EFT may be more generally more efficient than CCT as a shorter-term protocol (Ellison et al., 2009). This makes sense when we consider that EFT is a more structured and directive treatment (Watson & Pos, 2017) than CCT. Further, EFT is also grounded and continually refined by new and innovative process research (Pos & Choi, in press).

It should also be acknowledged that because these self-critical subtypes have been examined long after the trials for depression occurred that random assignment to treatment did not occur in relationship to the self-critical types found here. This is clear because 'Socially Inadequate' (SI) clients tended to receive CCT in the present study, while 'Core Worthlessness' (CW) clients tended to receive EFT treatment. However, since no difference in long-term outcome was found for these two higher-order self-critical subgroups, receiving CCT or EFT did not seem to matter. What we do not know though is whether the SI group would fare better in EFT and the CW would fare worse in CCT, i.e., if subgroups were assigned opposite treatments. Therefore, a potential confound of self-critical subtypes by treatment type is present in the data. Still, independent of solution, a self-critical subtype that received EFT did appear to fare better long-term. Especially because EFT emotion theory of change has been supported in different ways for both higher-order self-critical subtypes, this suggests that processing emotions is helpful across all self-critical clients (Greenberg & Watson, 2006). Still, more research will be required in order to see if it is the self-critical subtype or EFT therapy that was more causal in the resolution of a particular self-critical type.

Were self-critical subtypes resultant of a therapy effect? It should be acknowledged that since SI clients tended to be CCT clients and that CW clients tended to be EFT clients, one can

ask: Are the higher-order self-critical subtypes of SI and CW real 'trait' subtypes of self-critical depression or are they 'states' elicited by treatment type? In other words, does CCT 'pull' for SI themes in clients and does EFT 'pull' for CW themes in clients? This is difficult to answer without further research. Future research should examine whether good outcomes in either self-critical group is independent of receiving EFT.

It is possible that EFT's proclivity and structured goal for deepening client access of their core painful maladaptive emotions may draw out more CW process themes in clients compared to CCT, which may be more following of the client's experiential track (e.g., a therapist may follow a client's avoidance). The short-term nature of the two treatments in the York I and II studies (Goldman et al., 2006; Greenberg & Watson, 1998) must also be considered. If core painful unworthiness underlies all self-criticism, it is possible that EFT just works faster than CCT at facilitating client access to it. Given more time in treatment, it is possible that CCT clients would get to more CW process themes. Only comparisons of emotional processing between CCT and EFT will begin to answer this question. This investigation is now occurring in the Pos lab at York University.

On the other hand, the current study replicated (lower-order) categories that were found by Kagan (2003) on which the EFT-theory based higher-order subgroups organized, and it is important to note that there were CCT clients who were identified as CW clients and EFT clients who were identified as SI clients in the present study independent of knowing the therapy that was received. As such, this would support the validity of the higher-order self-critical subtypes as trait phenomena. Perhaps both are true that SI and CW self-criticism are some combination of both client states and traits. Future research should investigate whether these subtypes occur in

self-critical clients during non-experiential based treatments. Their re-emergence and re-occurrence in other samples would support their validity as trait categories.

While I believe that the higher-order self-critical subtypes are somewhat related in terms of how clients of each subtype differentially experience and cope with their core unworthiness (i.e., CW clients are more emotionally engaged than SI clients who appear to be more rational), I believe both the current qualitative and quantitative analyses (i.e., thematic analysis and emotional change process analyses) performed support their validity as self-critical trait subtypes. Clinically-speaking, they represent potentially orienting and useful categories for identifying and treating different types of self-critical clients. I will elaborate on their clinical usefulness in the next session.

Implications for Clinical Practice

The current study identified two higher-order subgroups of self-critical depression based on EFT theory and emotional change processes that accompany successful 18-month resolution within each subgroup. This research is potentially clinically relevant and useful for case formulation and treatment planning because it can help clinicians thematically identify self-critical types of clients and then inform treatment intervention selection. In other words, if a clinician can identify when he/she has a client with self-critical subtype X, he/she can intervene with in a way that helps the client go down optimal change path A and avoid the non-optimal path B, treatment outcomes for depression will be improved.

Take-home message for clinicians. The current qualitative analysis indicated a difference between self-critical clients who are more in touch with their self-critic, 'Socially Inadequate' (SI) clients, versus their criticized self, 'Core Worthlessness' (CW) clients. In reviewing both qualitative and emotional process findings, the prototypical SI client can be

identified by a clinician as being a more rational and emotionally-avoidant client who is initially aligned with their self-critic, overvalues social approval, and judges oneself for failing to live up to standards that are typically internalized from others (e.g., "I am behind others" or "I should never be angry"). In contrast, the clinician can discern a prototypical CW client as being a more experientially-engaged and 'pained' client who is aligned and in touch with their defeated criticized self and painful developmentally-sourced feelings of worthlessness, and who may value connection from the therapist and may be more able to view others negatively.

As such, the emotional paths SI and CW clients take to resolving self-criticism long term appear to be different. The SI client appears well-positioned to overcome their self-criticism by overcoming their emotional avoidance to reclaim their 'true self' and to be able to soothe deep hurt or grief (e.g., perhaps the emotional impact of not living up to others or standards). The therapist tasks are likely to help the client not avoid, to be assertive when needed and to support this client's capacity for agency perhaps through self-compassion. Conversely, the CW client appears apt to resolve their self-criticism by accessing and transforming their painful 'negative self' and accessing existential needs. The therapist's task is to help the client process maladaptive shame and fear, and help them feel entitled to needs that will help engender adaptive emotions that resolve this vulnerability. Thus, accessing deeper pain (albeit likely different types of pain) is vital to access for both subtypes. SI pain appears to be related to the emotional impact of perhaps of having to live up to others' standards or losing the approval that may come from stopping the self from compulsively meeting others' standards, whereas CW pain appears to be more related to the pain of feeling fundamentally worthless. The therapist may help the SI client individuate from others and develop their own values and standards. Conversely, the therapist may provide the CW client with the corrective experience of feeling worthwhile that is intrinsic

in the receiving of a client-centered relationship free from conditions of worth. Therapists can also notice markers of non-recovery. Both client subtypes are hindered by escape and avoidance of their deeper pain. SI clients tend to get more stuck in unhelpful secondary anger and CW clients tend to get more stuck in global distress. It will also be important for the therapist to be savvy about client factors that appear to represent another class of global markers. If the particular client is lacking resiliency or self-agency, the therapist would be wise to focus on formulating a treatment plan that targets this problematic process (e.g., being more of a cheerleader for the client) in addition to targeting self-criticism. Future research is needed to replicate and further refine these current findings.

On another note, process research in general can also inform training opportunities that can inform better treatment of all types of self-criticism. A clinician would be wise to continue to realize that emotion schematic categories represent micromarkers for the therapist to attune to and work with (Pos & Choi, in press). Final outcomes can be optimized by employing specific and targeted treatment of self-critical processes and its subtypes as an effective strategy for resolving depression, preventing relapse and therefore reducing the immense disease burden depression currently presents.

Limitations and Future Directions

All studies have limitations. First, this study was limited by the relatively small sample size. In particular since not all clients provided 18-month outcome data, the current study was only able to examine emotional processes within 15 ‘Socially Inadequate’ (SI) clients and 14 ‘Core Worthlessness’ (CW) clients. Subtypes of self-critical depression represent an important new area of research. Future research should examine a larger sample of each higher-order EFT-theory based self-critical subgroup to see if additional emotional processes distinguishing them

emerge as well as test the replicability of emotional processes found in the current study that distinguish these subgroups.

Second, and also due to sample size as well as the stage of this exploratory research, this study performed a number of quantitative analyses without corrections to family-wise error. Again, this was a tack intentionally taken done due to the small sample size and exploratory nature of the study (Streiner & Norman, 2011) because it minimized non-detection of potentially interesting findings. Findings from this study must be replicated in larger samples for validity testing through using more statistically conservative methods, including corrections to Type I error.

Third, since the study only looked at working phase emotional processing, further validation of emotional change processes found would come from future exploration of late phase emotional processing. This includes examining whether primary maladaptive emotions do indeed decrease by late treatment for CW clients, which would validate the EFT tenet of working through emotion maladaptive emotion to transform and reduce its reoccurrence (Greenberg & Watson, 2006). It would also be of research interest to see if SI clients express more adaptive anger by late treatment. Perhaps they needed to first access hurt/grief and self-soothing (i.e., in the working phase of treatment) before they access adaptive anger towards negative others in their life. This would validate the importance of accessing adaptive anger in EFT.

Fourth, therapist effects could not be examined in the current study due to inadequate client to therapist ratios and should be examined in the future. It is possible that therapists who possess certain qualities such as stronger facilitative interpersonal styles helped clients achieve stronger outcomes in the present study (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). Alternatively, there may have been countertransference type reactions between therapists

and certain types of self-critics. A client-centered therapist with high socially-prescribed perfectionistic tendencies may be more inclined to agree with the social rules around achievement and emotions expressed by an SI client for example, which may have potentially stifled progress towards more productive emotional processing and subsequent better long-term treatment outcome.

Fifth, a question remains, do higher-order self-critical subtypes reflect developmental stages in the process of resolving self-criticism or are they discrete subtypes of self-criticism? This study cannot answer this question. Consistent with EFT theory (Greenberg & Watson, 2006) which posits that core feelings of worthlessness underlie overt self-criticism, it is possible that these two higher-order subtypes are developmentally linked. Support for this comes from the fact that some clients initially expressed Social Inadequate (SI) self-criticism before later expressing preponderant Core Worthlessness (CW) self-criticism across their post-session summaries. However, some SI clients who resolved their depression at 18-month follow up never expressed CW themes, and the opposite was also true. This suggests that both arguments may be true, that CW underlies SI themes for some clients, but not for everyone. This is an important area of future research to further investigate.

Sixth, future qualitative research is needed that parses subtypes of different CAMS categories of emotional processing. This will be helpful in the future as it is still possible that the analyses used here were unable to make more specific distinctions that might have differentiated the emotional processes responsible for change within each higher-order self-critical subgroup due to the global nature of some of the CAMS categories. In light of previous research that has categorized different kinds of needs (Ferreira, 2017), subcategories of needs might be important to parse in order to really know which needs facilitate adaptive emotions and what kinds of

adaptive emotions in CW clients who resolve their self-criticism. Or, subcategories of hurt/grief may be essential to parse to refine our understanding of what SI clients experience to resolve their self-criticism in the long term. Of course, it goes without saying that bigger samples of self-critical depressed clients receiving HEPS are needed in order to accomplish some of these research goals. Although emotional processing differences between subgroups may not have been as specific as hoped at times, affective differences found in the processing of good versus poor long-term outcomes within different higher-order self-critical groups were found. This supports the validity of subtyping research for self-critical depression and the different affective roads for resolving different types of self-criticism.

Finally, if Teasdale (1999) and Greenberg (2002) are correct, which does appear true, and if cognitive-affective schematic transformation of depressogenic schemas or schemes is a transtheoretical process, future research should also examine whether these emotional change processes occur and relate to outcome in other treatment modalities like cognitive-behavioural therapy and psychodynamic therapy. As such, self-critical depression resolution should be explored in different psychological interventions. Such research would further support psychotherapy integration theory and practices among seemingly different psychological approaches to treating depression and self-criticism.

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Appendix A

The Classification of Affective-Meaning States (CAMS)

Classification of Affective-Meaning States

A. Pascual-Leone & L. S. Greenberg

The source of this document can be cited as:

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Purpose of the Coding System

The Classification of Affective-Meaning States (CAMS) is a measure that was developed to rate the presence of emotion states relevant to the model of this research project. The measure is applicable to coding emotion events when participants are engaged, emotionally involved, and aroused. Thus, the following coding system assumes that participants are not explicitly avoiding or interrupting arousal or emotional experiencing. Although clients may be naturally ambivalent about engaging, heightening and essentially allowing upsetting emotions, the events used for coding should follow the initial "allowing" of feeling (Greenberg & Paivio, 1997; Greenberg & Safran 1987). The codes themselves are intended to describe emotional experiences that are being "allowed" by the individual[1].

That having been stated, the coding system is designed to track the changing "flow of emotions": Which emotions are occurring and in what sequence. The measure was created in light of preceding research that has shown some emotional experiences are more productive than others (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997; Sicoli & Greenberg, 2005).

[1] For observable criteria that might identify emotionally resistant and interruptive processes see the work of Davenloo (1990) from a short-term dynamic perspective or of Weston & Greenberg (2005) from an experiential perspective.

Criteria

Each emotion state is evaluated on up to five criteria, which address three distinct facets:

Emotional tone

A. Emotion/ Action tendency

Involvement

B. Expression (i.e. non-verbal behaviours, emotional arousal...)

C. Vocal Quality

Meaning

D. Stance and/or Adaptivity

E. Specificity

These criteria capture key affective-meaning (i.e. "emotion") states. In the first criterion, emotion words and action tendencies serve as a rough guide suggesting the type of self-organization that a client is in. Some categories of coding are based on Greenberg's (2002; Greenberg & Paivio, 1997) categorizations of primary vs. secondary and adaptive vs. maladaptive emotion. Those qualitative distinctions are captured mainly by the two "meaning criteria" listed above in addition to the Vocal Quality Scale (Rice & Kerr, 1986)[2].

Fosha's (2000) distinction between core affects and core states is also quantified in this measure through a combination of criteria. The core affects are captured by higher

[2] Note that although the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) would be a well suited contribution to these criteria, it was not included so that it could be used later as a dependent variable, providing construct validity to the current measure and model.

ratings on "emotional involvement criteria" including the Emotional Arousal Scale (Warwar & Greenberg, 1999) in particular. Core states, on the other hand, are reflected by the meaning criteria as well as certain types of vocal quality, i.e. the focused voice (Rice & Kerr, 1986).

A richer degree of conceptual differentiation and integration in the clients' discourse is characteristic of productive meaning states (Wexler, 1974). Two types of criteria in this measure are intended to reflect, at least in part, this richness and level of formulation. "Specificity" is a criterion for some facet of meaning differentiation while "Stance and/or Adaptivity" is a criterion for the degree to which meaning is integrated and/or formulated to a healthy end.

Because the observational rating of a client's subjective "involvement" is quite limited, involvement is judged in the context of previous arousal and engagement. In this classification system, it is a reasonable assumption that a client's expressed arousal is carried on internally unless there has been a dramatic change in topic. From this perspective, the involvement criteria are met if emotional expression is observable and/or if clients provide a detailed physical description of their emotional experience. In this way, clients who are reticent about outwardly expressing arousal yet disclose that they are, i.e. "on the brink of tears" (without ever actually tearing), have met the criteria for affective involvement (assuming all other verbal and non-verbal indicators are consistent with the verbal report).

Minimum Unit for Coding

For a rater to make any given code the participant must utter a minimum of two consecutive statements that indicate the same emotion class. This requirement is consistent with what has been used in other ratings of comparable clinical material (i.e. see Sicoli & Greenberg, 2005). There are two theory-driven exceptions to this rule. In the case of coding either a "Need" or a "Negative Evaluation" (see classifications to follow) a single clear statement is sufficient to make the code. The justification for this exception is that, by definition, both these classifications are crystallized statements of meaning.

1. Global Distress

Diagnostic definition:

Emotional tone

A. Presence of at least one of the following:

1) An experience clearly labelled by either client or therapist as any of the following:

a) hurt,

b) pain,

c) confusion,

d) hopelessness,

e) helplessness,

f) resignation,

g) unelaborated loneliness,

h) unelaborated emptiness,

i) self-pity,

j) vague self-blame, guilt,

k) irritability,

l) undifferentiated complaint/whining...

2) An experience that is described by the client as:

a) undesired,

b) aversive, and

c) producing suffering.

(i.e. engaged, high emotional arousal that the client describes simply as feeling bad, awful, turmoil, miserable, etc.)

Involvement

B. Presence of at least one (or both) of the following:

1) The experience is of high expressive arousal and is rated to be > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).

2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.

- There is non-verbal behaviour reflecting a state of suffering or collapse, which may include one (or more) of the following:

a) tears,

b) lowered head,

c) slumped body language,

d) sighs,

e) eyes to floor...

C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern

(i.e. the voice may break, tremble, rise to a shriek, become very low),

- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

2) "External voice quality", which has a premonitored quality, suggesting that the content being expressed is not being newly experienced and symbolized. It is characterized by:

- a "talking at" quality,
- moderate to high energy, which is fairly full and directed outward,
- extremely regular accentuation achieved primarily by a rise in pitch,
- there is an even pace with highly expected terminal contours.

Meaning

D. The client is non-agentic, lacks a sense of direction, and there is no adaptive action tendency associated with the distress state.

- I.e. not clearly knowing what to say or do,
- feeling stuck.

E. The object of distress is one or the following[3]:

1) Unknown and elusive.

"Unknown Distress"

[3] Examples of "Unknown Distress" are found in 076#7, 516#2; "Minimally Explored Distress" in 507#3; "Limited and Avoided Distress" in 512#3.

- I.e. the client is uncertain of what the feeling is or why the feeling exists – i.e. "I'm feeling X and I don't know what it is about or why I am feeling it".
- When answering the question, "What is the problem?", the observer is unable to determine what the suffering is about in concrete or specific terms.
- It is as if the client were making the statement:
  - "I don't know what it is but it bothers me".

2) Known but minimally elaborated in terms of its subjective experience.

"Minimally explored Distress"

- There is little elaboration of the client's experience beyond that it is distressing – i.e. "It feels bad when someone does not understand or care". (Note that who is not specified).
- Clients do not convey their idiosyncratic experience:
  - They use global terms, like feeling "bad";
  - They refer to their concern in second or third person, i.e. "one feels bad when people don't care";
- It is as if the client were making the statement:
  - "I know what it is but not how I feel about it".

3) Unaddressed beyond the subjective sense of victimhood.

"Limited & Avoided Distress"

- Any meaning is heavily other/circumstance-oriented.
- The client has a marked lack of agency, (as if being helpless was itself the object of distress, i.e. "I'm so upset that I'm helpless").
- The client makes excuses, rationalizations, justifications with a quality of defensiveness and whininess.
- The client makes pathetic or desperate pleas.
- The client seems avoidant yet is unable to disengage from the distressing material. Sometimes the client refers to "it" indicating the emotional distress in non-elaborative terms.
- The meaning is as if the client were making the statement:
    - "It just happened to me and I feel like a victim".

Conceptual definition:

Global distress could alternatively be referred to as "undifferentiated distress". This category of emotion is best characterized as an emotionally expressive reaction to some deeper underlying concern. Distress is global in the sense of all embracing or undifferentiated, such that the presenting undifferentiated feeling might allude to specific negative emotions but those emotions remain "fused". If deeper core concerns are not being articulated but clients are aroused and distressed about some (general) aspect of their circumstances the rater must code this category.

Expressions of global distress do not capture any meaningful object of emotion or meaningful action tendency. As a result this experience gives the client no meaningful

sense of direction; i.e. "I'm feeling bad", as opposed to a more differentiated statement like, "I resent him for what he did and don't want to overlook it." Thus, in global distress the object of emotion is usually referred to in generalities and the emotional response is also one of generality, -- i.e. "The way I feel now about all that stuff, it freaks me right out".

The experience of global distress can be described as being of high expressive arousal and low meaningfulness in regards to some personally sensitive theme. It indicates to the person that something is happening that is undesired, aversive, and is producing pain. The person wants the experience to be over with yet cannot seem to get over it. This affective-meaning state is characterized by feeling as if one is a victim of emotional suffering.

Examples:

Some case examples of statements that typify this category follow. One must be aware, however, that such statements in isolation do not necessarily merit a code but are given support by the meaning-context in which they are expressed.

- "I could cry for a really long time."(Nt. Cry about "what" is not specified.) (hurt)
- "I feel hopeless, lost, sad, discouraged." (hopeless, no sense of direction)
- "I wish I could get past it or turn it off." (no sense of direction, complaint)
- "I feel alone, it's so hard." (self-pity, unelaborated loneliness)
- "I'll never get there. There's no use." (hopeless, helpless)
- "It's so awful and I don't know what to do." (pain, confusion)

Points of discrimination:

The observer will notice that what many clients describe as "sadness" will be coded here as global distress. In doing so a distinction is drawn between feeling "tearful and troubled" (sad, in more popular parlance) and feeling tearful over a clearly recognized loss (see "specific adaptive hurt/grief" below). An example of this was when a client said, "I felt sad for no apparent reason. I was teary and just had this sadness that came over me. All of a sudden I feel like I want to cry and I don't know where it's coming from. Something's going on deep inside". In this example, the client is using "sadness" to describe the subjective experience of an undifferentiated state -- global distress. Thus, sadness may or may not be global distress depending on the quality with which it is expressed. Greenberg's (2002) emotion-focused approach would describe this type of sadness as secondary sadness, indicating that there is some underlying and more primary emotional concern.

Note that especially in cases of complaint, whining, and the like, global distress tends to be very other/circumstance-oriented, such that there is little elaboration on the client's experience beyond the fact that it is distressful.

Aroused statements such as, "It's just too painful" or "It's so hopeless!" are expressions of emotion in their own right – they are pain or hopelessness, respectively. Nevertheless, these statements suggest some underlying emotion that remains unarticulated, herein that feeling/concern has only been referred to as "it". The underlying feeling may or may not be within the client's scope of awareness. Again, if

deeper core concerns are not articulated but clients are aroused and distressed about some (general) aspect of their circumstances the rater must code this category. Thus, raters should consider:

- What does 'it' refer too? What is the client *actually* upset about?
- Has the concern at hand been sufficiently differentiated?
- Is the client grappling with the concern's specific and personal nature?
- Is the object of emotion grounded in relatively concrete terms?

Answering "No" to all or some of these questions is indicative of global distress.

Some clients have developed a way of interrupting or curtailing their emotion when this emotion-state becomes unbearable for them. Upon such an occasion, either the interruption is successful and the client's level of arousal drops dramatically or it is unsuccessful and the person continues to express aroused global distress.

General description of content:

Although the affective-meaning state describes a quality rather than content per se, some types of content seem to be prototypical expressions of this state. The following, which is not an exhaustive list by any means, are descriptions of content that characterize global distress when deliberated with high emotional arousal. Some of these descriptions use examples of client statements as illustrations.

- Statements of a "poor me" quality are characteristic expressions of this state. Such statements are usually made from the position of victim and are made in a tone of complaint and often self-pity.
- Statements that protest the eternity of the injury or suffering. Since universals are almost always overly simplistic, they are also a sign of limited differentiation. Therefore, words like always, never, forever, etc. may be serve as indicators of Global Distress. These statements also often have a "poor me" quality. For example:
    - "I have been suffering every day of my life".
    - "I've been saddled with this difficulty my entire life and the pain is really, really intense".
- Statements that the client makes about perennial doubt or uncertainty.
    - "I don't know, I don't know"
    - "I'm so doubtful about whether that is the truth or not."
    - "I need to know why you did that" (…in a desperate tone of voice. If it were an angry tone of voice this may indicate another affective-meaning state).
- Statements that are hypersomatic. Very detailed descriptions of physiological experiences of affect can sometimes lack any description of personal or idiosyncratic meaning. Although such physical accounts are very detailed they are

usually only specific on a somatic level and are non-specific on a meaning level, making them characteristic of global distress.

- Statements that clients use to describe themselves as out-of-control, insane, or overwhelmed by emotional intensity are all characteristic of global distress. In this type of statement self-pity is often only implicit and emphasis is put on the client's sense of disorganizing and intense arousal.
    - "It makes me crazy to think…"
    - "It absolutely enrages me that you don't even care"
- Taking an argumentative position or a complaining position regarding one's "stuckness" is a strong indicator of undifferentiated emotional distress.
- Statements of character assassination may border on a different state (i.e. Rejecting Anger) but otherwise should be considered expressions of Global Distress. For example:
    - "You are selfish and self-centred!"
- Statements of vengefulness from a position of distance (rather than anger).
    - "Screw you. If you don't have any consideration for my feelings I won't have any consideration for yours".
- Statements indicating avoidance rather than emotional engagement.
    - "I don't want to have to deal with him".
    - "I don't want to imagine him" (Note that these comments do not comment on what the client would like to do, they are simply negations).

Relating Global Distress to the literature:

This sort of affective-meaning state has been referred to as secondary emotion in Emotion Focused Therapy and therapists are encouraged to go underneath this feeling (Greenberg, 2002). Other instances of global distress are labeled as emotional pain by the experiential tradition, in which case therapists are encouraged to validate and differentiate the emerging emotion (Bolger, 1999; Greenberg & Bolger, 2001). Sicoli and Greenberg (2005) talk about verbal and non-verbal markers of hopelessness, some of which are also in these criteria.

In psychodynamic therapies this state is referred to as defensive emotion or anxiety (in the broad sense) and the intervention is to interpret this state as a defense (Greenberger & Mitchell, 1983). Reik (1948) has referred to a particular affective-meaning he observed in his clients as the “masochistic morass”. His use of that term captures many of the same experiential features of the global distress construct (although not the motivations he attributed to it). Some psychodynamic authors have referred to instances of collapse into global distress as a mini-dissociative defence (Fosha, 2003).

It appears that both the psychodynamic and Emotion Focused approaches agree on the apparent lack of depth of Global Distress. From another perspective, the cognitive behavioural tradition refers to this state simply as negative emotion, something to be regulated and bypassed (Greenberger & Padesky, 1995).

Experimental research on the fundamental dimensions of subjective emotion states has identified "Distress" as a common factor that underlies aspects of cognitive, emotional, and motivational domains of experience (Mathews et al., 2002).

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2. Specific Maladaptive Fear & Shame

Diagnostic definition:

Emotional tone

A. Presence of at least one (or more) of the following:

1) An experience clearly labelled by either client or therapist as any of the following. Note that the client must be "in" the state and suffering by the state – not avoiding it.

Shame-based emotion:

a) Shame

- i.e. feeling inadequacy, humiliation, embarrassment...

b) "Feeling Empty" (elaborated)

- Other forms of a Shame-Sadness blend,
- i.e. "I'm withdrawn, miserable about my defectiveness"

c) Collapsing in the face of self-contempt

- The client makes specific and harsh statements of self-contempt while at the same time collapsing into an obvious state of suffering (i.e. crying, etc.).

Fear-based emotion:

d) Fear

- i.e. feeling threatened, unsafe, defenseless, incompetent...

e) "Feeling Lonely" (elaborated)

- Other forms of a Fear-Sadness blend, i.e. dread.

f) Shame-Anxiety

- i.e. "I'm afraid I will be humiliated"

g) Guilt

- i.e. "It's all my fault", "I deserve to be punished".

2) The action tendency is to withdraw in some way (i.e. escaping, hiding, turning sadly inwards…) from something/someone aversive. Generally the client reacts defensively sometimes even passively by "closing down" under the weight of this "dreaded state".

Involvement

B. The experience may range widely from minimum to high expressive arousal.

- Non-verbal behaviour which may include one (or more) of the following:

a) covering face with hands,

b) lowered head,

c) closed eyes or diverted/downcast gaze,

d) fear brow (eyebrows raised and straitened),

e) fear mouth (open but with lips tense and drawn back tightly),

f) tears...

C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern

  (i.e. the voice may break, tremble, rise to a shriek, become very low),

- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

2) "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The presenting concern is the source of deep and enduring personal pain.

- The emotion is full of suffering but familiar in quality.
- It is clear to the observer that this state moves the client in a destructive/unhealthy direction.
- The core concern is self-referencing, e.g.:
  - "I am defective",
  - "I am insecure, abandoned".

E. The object of emotion is clear and specific – i.e. "I feel ashamed/afraid of X".

Conceptual definition:

This category of emotion is best characterized as the emotional expression of a core underlying concern, which is the source of deep and enduring personal pain. Although emergence of the emotion may involve a significant other, (as in "feeling shame in the eyes of the other"), this type of emotion is clearly self-oriented (as in "I am the one who is shameful").

Idiosyncratic meaning is usually quite important for this type of affective-meaning state. It represents an unhealthy and very painful way of viewing and experiencing oneself that is regrettably familiar to the client, like an age-old emotional wound. For this reason this category can be described as being of high arousal and high meaningfulness. The nature of this category is that it represents a highly personalized pathogenic state, which is imbued with emotion and sets the clients on a trajectory of

destructive self-organization. The client is completely taken over by the emotion and experiences it as insuperable. There are action tendencies associated with this state (i.e. withdrawing, escaping, etc.) but the familiarity of this highly aversive state gives the sense that the client has no real expectancy of getting away, as it were.

The expression of specific maladaptive emotion often requires a good deal of meaning exploration. More often than not there is eventually the elaboration of some implicit need and an evaluation of client's relation to that need. For example the client may come to the painful conclusion that, "I am not loved or understood".

General description of content:

Although clients almost never use such statements, the essence of these core concerns are captured in summary phrases such as, "I am shamefully unlovable, worthless, or incompetent" or "I am afraid I will die/be annihilated". In any of these cases the client's own description and expression of the concern must be done in a manner that is relatively concrete, specific and personal. In short, this affective-meaning state should be coded when clients make clear and emotionally expressive statements about their sense of fearfulness and/or shamefulness.

Points of discrimination:

The expression of these feelings is done in a specific and detailed fashion (otherwise they may be better represented as global distress). Often clients will not actually use the word "shame" since it is not usually found in common parlance and is perhaps too penetrating. Nevertheless, harsh, overt self-criticism and self-disparagement

may accompany statements indicating that clients feel shame about their shortcomings. Deeply seated objects of shame are more often than not either in regards to (1) clients' competence in the world or (2) their ability to have relationships. Also, in this affective-meaning state, the object of fear is usually the danger of utter destruction possibly as a result of abandonment, rejection, or personal incompetence.

Fear and shame are by far the predominant families of emotions subsumed under this category although variations of these may blend with sadness. Some clarification on the common experience of feeling "lonely" or "empty" will be helpful here. The maladaptive state of "sad loneliness" is conceptualized as existing in the transition (i.e. a loop) between global distress and specific maladaptive fear. Although loneliness is often discussed as a form of sadness, what make loneliness such a painful feeling are its ramifications, which are always tinged with an element of fear. Ultimately, what makes loneliness maladaptive is the tacit meaning it entails of, "Somehow if I'm alone I won't be OK/secure/able to cope". Inevitably, when loneliness is elaborated there is a colouring of fear that gives the idea of being alone its bite. This is consistent with the observations of several authors who have pointed out that attachment disorders are all primarily fear based (Freud, 1995/1913; Bowlby, 1997/1969; Sartre, 2001).

Similarly, feeling "empty" is understood as somewhere between global distress and maladaptive shame, depending on the degree of meaning elaboration the client is able to create. In either case, raters will have to make a judgment on the level of meaning

differentiations and personalization that the client makes in order to determine the code that is most fitting: global distress vs. specific maladaptive fear and shame.

The differentiation of meaning and the freshness of the experience are two of the most discriminating characteristics between global distress and specific maladaptive distresses (i.e. fear or shame). In contrast to global distress, which seems to state: "I feel awful but I don't know why or what it is about", maladaptive fear or shame state: "I feel awful and I do know exactly why!" Although some instances of global distress may have a familiar quality to clients especially if distress is part of a maladaptive personality/social style (i.e. self-pitying), the familiar maladaptive emotion is always being felt freshly in the moment. It is not just being talked about, it requires a high level of experiencing.

Sadness is sometimes maladaptive and at other times adaptive. The following comments help demarcate the difference between healthy and unhealthy types of sadness. Sadness (in the sense of grief or loss) has been described as having two distinct action tendencies that are sequentially ordered (Bowlby, 1997/1969). Initially, the action tendency in response to a loss is to cry out and essentially to reach out. A prototypic illustration is when a child gets lost in the supermarket and cannot find mother and cries out. Should crying for help prove unsuccessful the second action tendency of sadness is to withdraw and conserve energy for the hard times that evidently lie ahead.

When this second action tendency of "closing down" in sadness becomes an enduring or chronic emotional pattern, it represents a maladaptive version of sadness. The

more it becomes an enduring source of personal and self-referencing pain the more it acquires a sense of shame and becomes "shame-sadness" (i.e. "I have lost because I am defective/inadequate"). Needless to say, a lost child is also frightened and so it makes intuitive sense that fear, shame and sadness in their maladaptive forms are amalgamated together here as specific core maladaptive states.

Some forms of shame-anxiety, guilt, and self-contempt are more particular variants of this maladaptive rubric and identifying them will assist in coding. Shame-anxiety is a hybrid feeling. It alerts individuals to the imminent danger of being shamed (Mindell, 1994). This maladaptive state highlights once again the intimate relationship between fear and shame based emotions. The clearest instances of shame-anxiety can be commonly found in social phobias.

Guilt is maladaptive when it rallies self-blame and self-punishment. The most easily recognizable instance of this is found in "survivor guilt" (Garwood, 1996). Guilt is related to the family of fear-based emotions through the dread of punishment and inescapable culpability. Once again, withdrawal and "closing down" signals the maladaptive action tendency of this category.

The expression of contempt in self-criticism, especially during two-chair work can be understood as reflecting a maladaptive way of coping with unhealthy shame (Mindell, 1994; Whelton, 2000). For this reason, when a client expresses obvious emotional suffering at the same time as making specific statements of self-contempt the suffering (i.e. tearing, etc.) is considered a reflection of maladaptive shame.

Other discrete maladaptive emotions such as anger or disgust clearly exist but are not distinct parts of this model. This affective-meaning criteria does not apply to those discrete emotions because of their radically different action tendencies. Although they may be experienced as unpleasant, anger and disgust are not "dreaded" emotional states, to use the words of Horowitz (1987). Accordingly, their action tendencies are not of withdrawing and "closing down" as is the case in this model component.

During the elaboration of meaning some clients become very emotionally aroused[4]. Alternatively, clients begin to intellectualize and in a literal sense distance themselves from the specific and emotionally evocative details that facilitate maladaptive emotion. This form of loop can be referred to as a distancing. If this happens before the rater is able to confidently code the maladaptive emotion the occurrence should not be rated. Alternatively, if the maladaptive emotion is sufficiently aroused and activated then the occurrence will be rated and distancing will likely mark the end of that code.

Similarly, some clients have developed a way of self-interrupting or curtailing their emotion when this emotion-state becomes unbearable for them. Upon such an occasion the interruption is often not fully successful and clients will revert to the less specific expression of aroused global distress (in an attempt to distance themselves from the painful specifics). This occurrence would signal a change in code from one affective-meaning state to another. Otherwise, the interruption is successful and the client's level

[4] In this project it could be helpful to raters to know that soothing by the therapist is usually critical around this point to allow the client to tolerate unpleasant feelings and continue with the task at hand – avoiding either distancing or self-interruption. However, unless it is in the form of explicit and adaptive self-soothing, such soothing should not be coded.

of arousal drops dramatically perhaps accompanied by a change in topic. In that case, the occurrence would not be rated or it would signal the end of the code if there had already been sufficient expression to make one.

Relating Fear & Shame to the literature:

Authors writing on Emotion Focused Therapy have referred to this type of emotion as a primary maladaptive emotion. In that tradition, therapists encourage their clients to "own" these maladaptive feelings as their own, to experience them fully and then attempt to help the client transform these feelings. In other words, this type of state must be actively engaged rather than avoided so that it can eventually be changed by the emergence of another subsequent feeling (Greenberg, 2002).

Psychodynamic theorists have referred to this category of experience using various terms. Horowitz (1987) has referred to this as a class of "dreaded states" that must be regulated, while McCullough et al. (2003) has referred to "pathogenic affect", which must be "faced" by the client. This affective-meaning structure is also represents the "response from self" in a core conflictual relationship theme (CCRT) described by Luborsky et al. (1994). Thus, the psychodynamic tradition generally treats this type of emotion as something that must be willfully tolerated and believes it will eventually change through insight. Doing that is considered the most central target of Psychodynamic therapies.

Both experiential and psychodynamic approaches understand the maladaptive state as one that the client is embedded in, such that within its framework the client has

great difficulty finding any viable alternative to hopelessness and despair (Safran & Muran, 2000). Cognitive and behavioural approaches to therapy have not found it useful to differentiate these fear and shame states from a more global state of distress; consequently (like global distress) it is referred to generically as "negative emotion". As with more global distress CBT therapist work toward helping the client regulate these unpleasant feelings (Greenberger & Padesky, 1995)

Ekman and Friesen (1975) described the fear-mouth and fear-brow as well as some of the other expressive criteria for this state.

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3. Generic Rejecting-Anger

Diagnostic definition:

Emotional tone

A. Presence of at least one (or more) of the following:

1) An experience clearly labelled by either client or therapist as any of the following:

a) rage,

b) reactive anger/ feeling mad,

c) hate,

d) resentment,

e) frustration,

f) angry protest (not wining),

g) repulsion,

h) anger-disgust,

i) angry-tears.

2) The action tendency is an attempt to rid oneself of something/someone noxious. Sometimes clients swear and use name-calling. Generally the client reacts with an angry tone to avoid suffering and to defend/protect the Self. This is embodied by one of two sub-categories[5]:

a) "Distancing Anger"

- pushing away and producing distance,

b) "Destructive Anger"

- attacking, lashing out and destroying.

Involvement

B. Presence of at least one (or both) of the following:

1) The experience is of relatively high expressive arousal and is rated as > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Arousal does not render the expression as out of control or incoherent.

2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.

- There is non-verbal behaviour reflecting a state of anger and protest, which may include one (or more) of the following:

[5] "Distancing anger" can be seen in 516#12; "destructive anger" in 076#7.

a) Shaking a fist, chopping, pointing,

b) Dismissive gestures - i.e. waving away,

c) Shaking the head,

d) Emphatic nodding with statements,

e) Angry mouth (i.e. pressing lips together - or - firm lower lip with mouth open in a squarish shape as if shouting),

f) Squinting and angry tears.

C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern (i.e. the voice may break, tremble, rise to a shriek, become very low),
- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

2) "External voice quality", which has a premonitored quality, suggesting that the content being expressed is not being newly experienced and symbolized. It is characterized by:

- A "talking at" quality,
- Moderate to high energy, which is fairly full and directed outward,

- Extremely regular accentuation achieved primarily by a rise in pitch,
- There is an even pace with highly expected terminal contours.

Meaning

D. The client takes the position of plaintiff rather than victim and does not make specific self-affirmations.

   For example, the client:

   - Expresses "angry tears" vis-à-vis some concern.
   - Acts as a plaintiff voicing an injury/concern.
   - The tone is of agentic protest rather than powerless complaint.
   - There is no explicitly declared positive self-evaluation.

E. The client stresses the noxiousness of the experience rather than the violation of values and self worth per se.

   For example, the client:

   - Is angry about some wrongdoing or how offending circumstances were injurious.
   - Limits concern to the immediate noxious experience of transgression rather than referring to the violation or injury.
   - The experience of violation is not articulated in specific, concrete, and personalized terms but rather is only addressed in generic and broad statements.

Conceptual definition:

This category of affective-meaning state is represented by the expression of anger. The main thrust of this instinctive and reactive anger, however, is in rejecting some offensive object. Often this anger is expressed from an "underdog" position such that the client seems to speak from the position of plaintiff or even victim. The almost instinctive expression of rejecting-anger might be described as one of hedonistic righteousness, where the client reacts defensively to avoid pain. The arguments used in expression of this anger often contrasts the Self's status against what the offender did wrong or how the offending circumstances were injurious.

This affective-meaning category is described as generic because it relates to a class of angry feelings rather than a specific or specialized one. When clients express this state it usually entails high arousal and moderate meaningfulness (on account of its limited-specificity). It is generally a state of anger that sets the client on a trajectory of productive (albeit limited) self-organization. The meaning carried by this state is conveyed by a sense of self-righteousness against being hurt but is generally limited to the immediate experience of transgression (i.e. "I'm upset because you hurt me"). Thus, it is described as being moderately meaningful and can represent some organization toward recovery from injury although this is a state, which individuals often gets "stuck in".

It is important to understand that although rejecting anger can be somewhat adaptive for the organism experiencing and expressing it, it is fundamentally aggressive.

Under normal circumstances anger and aggression can provide an important and adaptive service in self-preservation and sometimes even the preservation of attachment ties. In this way, sometimes those needs are defended even before they are concretely experienced. This is the adaptive side of rejecting anger. In other instances, instrumental or operant expressions of rejecting anger become so automatized that the expression becomes consolidated developmentally and form maladaptive personality structures of anger. A chronically reactive angry disposition is a structuralized (and pathologized) rendition of rejecting anger.

Examples:

Some prototypical statements that capture the spirit of this affective-meaning class might be:

- "I hate you for injuring me." (hate, outrage)
- "F-you!" (reactive anger, rejection)
- "I'm pissed off!" (protest)
- "I'm just angry that it happened." (protest, frustration)
- "You are sick! Disgusting, pathetic." (repulsion)
- Character assassination, when the client insults and disparages the other, are usually also examples of Rejecting Anger.

Points of discrimination:

Complaint/protest may be either an expression of rejecting-anger or global distress depending on the context and on the proportion of protest vs. pain/helplessness in

which the complaint is expressed. Neither should hostility be taken as synonymous with rejecting-anger. For example, insults directed at the offending object or person are indicative of rejecting-anger if they serve to punctuate a more articulate statement of rejection. Belligerent swearing, on the other hand, especially with either a tone of whining/complaint or with a tone of unbridled and inarticulate rage suggest that the client is more in a state of global distress, depending on the tone and context. The focused intent to harm another and the tendency to escalate out of hand are both characteristics of "malignant" aggression or rage, which is not the same as Rejecting Anger. Consequentially, aggressive rage might be codable as Global Distress but is likely to be better considered uncodable within the current classification system.

The category of "assertive-anger" is described further on (see code #7, below) but it is useful at this time to highlight the features that discriminate rejecting-anger from assertive-anger. There are at least seven discriminating features:

1) Rejecting anger is characterized by hedonistic righteousness. For example, "I'm upset because what you did *hurt me*", is an expression of rejecting-anger and hedonistic righteousness. As contrasted with, "I'm upset because what you did to me *was wrong* and I deserve to be treated with respect", which is an expression of assertive-anger and ethical righteousness. This difference is that rejecting-anger stresses the noxiousness of individuals experience rather than the violation of their values, ethics, and self worth per se.

2) Rejecting-anger is somewhat healthy and adaptive in that it is defensive against some offending object, as seen in the acts of repulsion or anger-disgust. However, the characteristic action tendency of "general rejection" is not explicitly self-affirming of any declared positive self-evaluation. This is one of the reasons that swearing and name-calling is more prominant in rejecting-anger than in assertive-anger. In this sense, rejecting-anger embodies a moderate level of meaningfulness while assertive-anger embodies higher, more developed meaning of self-affirmation.
3) In rejecting-anger an individual characteristically speaks from the position of "underdog" or plaintiff. Thus, the client is less agentic than in assertive anger (albeit not entirely devoid of agency, since no agency would be characteristic of global distress).
4) Rejecting-anger principally produces negative statements aimed at creating distance. In contrast, assertive-anger principally yields positive statements in an effort of affirmation (which, of course, will also imply some sort of distancing). The affirmation effort of assertive-anger puts a person in the position of an "advocate and activist" with equal footing against the offending object. This also suggests that assertive-anger embodies a more differentiated level of meaning.

5) Rejecting-anger tends to make use of more "you" language given its stance of general rejection. This language, however, relates "you" to "my injury", unlike the language used in global distress, which is restricted to one or the other. Conversely, assertive-anger tends to make more use of "I" language by way of self-affirmation. "I" statements in assertive anger often give a sense of genuineness.
6) Rejecting-anger involves more emotional arousal than assertive-anger, (but less arousal than disorganized rage, which is a form of global distress).
7) Rejecting anger is the type of anger that an individual feels he or she needs to "get over" or "get rid of". Harboring such feelings of anger/resentment/hate/etc. is inherently unpleasant. This is not the case, however, for assertive-anger. An individual who is faced with feelings of anger that are well oriented toward the assertion of personal needs and rights often feels positively about his or her anger. In some sense assertive anger can be followed through to "completion" while rejecting anger tends to be more ongoing.

It is not uncommon for the client who expresses anger to eventually feel suddenly overwhelmed or unable to continue. This is best described as a collapse of the Self. In essence, this happens when clients are organized to fight but their initiative precipitously

turns into a flight response. Thus, the client collapses into fear and hopelessness and regresses toward "global distress".

General description of content:

Expression of generic rejecting-anger is frequently elicited by being confronted with or imagining making contact with the offensive object – whether that be self-critical statements or some significant other, etc.

Interrogatory, rhetorical questions and accusations may characterize rejecting-anger if the client refers to a specific injury and directs reasonable accusations toward an (imaginary) offending other. Otherwise, raters should consider global distress as an alternative code. For example, "Why did you do X, Y & Z??" in a protesting tone is best represented as global distress; whereas "Did you ever for one minute take into consideration X??" in an accusing tone may very well be rejecting-anger.

Relating Rejecting Anger to the literature:

EFT theorists have referred to this as secondary anger on account of its reactivity regarding some concern that is not fully articulated (Greenberg, 2002). Many psychodynamic theorists, on the other hand, have referred to rejecting anger as a sense of entitlement or narcissistic rage. Whereas in the language of Short Term Dynamic Psychotherapy, which is focuses explicitly on affective processes (as does EFT), this has been referred to as "murderous rage" (Davenloo, 1990) (although the use of that particular term may suggest more malignant rage than defensive aggression, to use Fromm's, 1973, terminology).

In discussing attachment and separation, Bowlby (1997/1996) similarly identified two types of anger, one stemming from hope the other from despair. He referred to the "anger of despair" as desperate and coercive, a feeling state that becomes destructive both toward the self and the other. By definition, rejecting anger is experienced from the position of underdog or plaintiff, and in this sense it is an expression of desperation and an "anger of despair". However, it is not always self destructive and in other instances Rejecting Anger is best captured by Fromm's (1973) description of "defensive aggression", an aggressive response to a general immediate threat.

. The combination of being both generic and somewhat adaptive is possible because Rejecting Anger is an immediate here-and-now response to an ill-defined threat. Of course, this adaptive role refers to normal circumstances and normal psychological/emotional functioning. The expression of rejecting anger as a structuralized facet of personality is described in several cluster B personality disorder. Authors such as Linehan (1993) and Korman, (2005) have discussed this as being part of personality structures of people with Borderline Personality Disorder and dysfunctionally angry individuals in particular. The emotion theory presented by Greenberg has referred to this type of deeply rooted and destructive emotion as primary maladaptive anger (Greenberg & Paivio, 1997; Greenberg, 2002).

Non-verbal expressions of anger and protest such as those described in this criteria were documented by Ekman and Friesen (1975) and have also been observed by Whelton (2000) in a psychotherapeutic setting.

Introductory note on "Negative Evaluation" and "Existential Need"

The following two codes **(4 & 5)** reflect a well-differentiated level of meaning and clear symbolization, rather than distinct and separate emotion states per se. Occasionally a client may accomplish this by using a complex metaphor but it will always be highly personalized. Since these two codes are more reflective of how meaning is symbolized than some other codes, these events are often coded in the context of other emotion states. Usually this will occur near the climax of a state, when clients are making sense of and putting words to their experienced arousal.

As a heuristic for coding, if emotional arousal appears prior to a statement of negative evaluation or existential need then the appropriate emotion should be coded first (even if only briefly), followed by the statement. Otherwise if the statement occurs in the middle of some emotion state, then the state should be coded before the statement (and again after the statement if it is appropriate).

4. Negative Evaluation

Diagnostic definition:

Emotional tone

A. The client clearly makes a statement (or endorses a therapist statement) of negative self-evaluation reflecting at least one of the following prototypes:

   1) "I am not lovable (i.e. unwanted, unable to love, defective…)"

2) "I am worthless (i.e. useless, incompetent, inadequate…)"

3) "I will be destroyed (i.e. fall apart, go crazy, die, be annihilated…)"

4) "I will be abandoned and unable to survive on my own"

Involvement

B. The meaning state is currently activated.

C. Presence of at least one (or both) of the following vocal qualities:

1) The client has a "focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

2) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern
  (i.e. the voice may break, tremble, rise to a shriek, become very low),
- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

Meaning

D. In a short statement, the negative evaluation crystallizes the meaning behind a client's deep and enduring personal pain.

As a belief, it is:

1) Absolute and unqualified,
2) Internally attributed,
3) Stable in time.

E. The negative evaluation occurs in the context of some congruent emotional arousal (i.e. fear, shame, guilt…).

Conceptual definition:

It is common for the clear articulation of a negative evaluation to emerge as a statement that crystallizes in plain words the essential meaning of a client's emotional experience. Nevertheless, the emphasis of this code is not on the emotion but rather the distillation of meaningfulness. In the clearest examples, negative evaluations are stated as if they were simple "observations" and they reflect some belief about the client or the client's emotional experience.

This is a code that reflects a level of symbolic precision vis-à-vis the Self rather than a change in affective tone, per se. The negative evaluation has also been called a core negative belief and is the kernel of the presenting emotion. A negative evaluation does not denote an emotion per se. However, in using this code the rater should be confident that this is the crystallization of meaning related to the current negative

emotion. In this sense the negative evaluation is often an elaboration of a presenting fear or shame based emotion.

Examples:

Appropriate examples include:

- "If I get angry then I will fall apart". (Emotion will destroy me)
- "I guess I just can't handle it". (I am worthless/I will be destroyed)
- I don't have what it takes". (I am worthless, incompetent)
- "I'm broken, defective". (I am worthless)
- "I must have deserved to be ignored". (I am not lovable)

The spirit of this last statement has appeared often enough to make it a prototypic embodiment of a negative evaluation.

Points of discrimination:

The articulation or even efforts to articulate and symbolize negative evaluations are usually extremely painful to the client. Given the noxiousness of symbolizing these negative evaluations regarding the Self, it is not uncommon for the client to experience negative emotion perhaps even before the code can be made.[6]

A negative evaluation usually is a statement made in first person (i.e. an "I" statement). In some instances, when the criticisms are very specific, a negative evaluation may also be expressed in second person if there is clear contact with the "self", as during

[6] It could be helpful for raters to be aware that soothing is usually very important here in allowing clients to tolerate distress just long enough to spell-out the meaning of their negative emotion. However, unless, it is a specific response to a specific and articulated need, self-soothing would not be coded.

an imaginary dialogue between parts of the self. Relatively benign statements, such as, "I'm too emotional, over reactive, hypersensitive, crying" are ambiguous in the degree to which they express negative judgments and could simply indicate plans or intention, i.e. "I would like to be less reactive." Thus, coding a negative evaluation should be reserved for relatively harsh self-criticisms.

General description of content:

In case examples a negative evaluation is usually identified when the client makes some statements about specific and central self-criticism. Another scenario in which this code could be used is when the client gives concise autobiographical examples, which crystallizing the ultimate self-related "reason" for their negative emotion (i.e. "I was never very good at getting stuff done and that's sad"). This code is not appropriate for other-related evaluations (i.e. "He doesn't love me").

Relating Negative Evaluation to the literature:

Negative evaluations have been referred to by Cognitive Behavioural Theorists as "core dysfunctional beliefs", negative thoughts, or negative assumptions about the Self and one's emotion. That tradition handles negative cognitions by actively engaging them and attempting to modify them through reason (Greenberger & Padesky, 1995). Doing so is considered to be the most central target of Cognitive Behavioural Therapy.

This type of negativity has also been described in psychoanalysis as the "Superego" (Freud, 1961). Similarly, some psychodynamic theorists have referred to this as the "expected response from other" in a core conflictual relationship theme (Luborsky

et al., 1994). In these approaches, therapists encourage the analysand/client to simply acknowledge that they harbor such negative evaluations and expectancies.

The humanist tradition of psychotherapy has also referred to negative evaluations by a number of names. In Client-centred therapy these are the "conditions of worth" that a person has assimilated (Rogers, 1961). In Gestalt therapy (Perls et al., 1951) and approaches influenced by Gestalt (i.e. Process-Experiential Therapy) harsh negative evaluations are referred to as the "self-critic". In these humanist therapies clients are encouraged to expand their awareness of negative evaluations; an aim which is similar to that of the psychodynamic approach, although the methods differ. More process-directive approaches in the humanist tradition attempt to actually arouse and vivify the client's experience of the self-critic (Greenberg, Rice, & Elliott, 1993; Greenberg & Paivio, 1997).

Negative evaluations are essentially consciously verbalized appraisals about one's inability or inadequacy in the arenas of personal agency and/or communion. These two aspects of life are of most central importance to human existence. As such, a negative evaluation is an expression of impotency and/or alienation (Bakan, 1966). The criteria stating that a negative evaluation must be (1) absolute and unqualified, (2) internally attributed, and (3) stable in time, are three features of negative attribution styles that research has found to be characteristic of depression and anxiety (Weiner, 1985; Seligman, Abramson, Semmel, & von Baeyer, 1979).

5. Existential Need

Diagnostic definition:

Emotional tone

A. The client explicitly makes a statement (or endorses a therapist statement) describing the need they have for healthy functioning – i.e. "I need X". The statement may reflect a need for any one (or more) of the following:

1) recognition/affirmation
    - i.e. admiration, praise, respect, have accomplishments recognized
2) approval/acceptance
    - i.e. to be liked, to be believed in
3) affiliation/affection
    - i.e. love, tenderness, warmth, intimacy, friendship, belonging, co-operate, socialize
4) support
    - i.e. help, protection, emotional support
5) nurturance
    - i.e. 'mothering', soothing, validation, sympathy
6) autonomy
    - i.e. independence, freedom, avoid feeling confined or restrained, resist influence or coercion
7) inviolacy

- i.e. to preserve one's self respect, psychological distance, immunity from criticism

8) joy, beauty, or playfulness in life

- i.e. specific positive feelings in relation to the experience of life itself

9) A metaphorical image or autobiographical example that conveys the client's need for one of the above.

Involvement

C. The meaning state is currently activated and in the context of some emotional arousal.

D. The client has a "focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

E. The existential need is something enduringly essential to the client for healthy functioning and development. As a need, it is usually:

- Uncompromisable & straight forward,
- Internally attributed,

- Stable in time.

F. The need is unmet, has not been sufficiently attained.

- It may be stated using past or present tense but should be a currently felt need.
- It is stated as an observation or discovery about the Self rather than with anger or as a demand on others.
- It emerges as an insight and/or as heralding acts of agency.

Conceptual definition:

The symbolization of a primary need often emerges as an "I" statement formulated in plain language. This is sometimes done with a sense of child-like vulnerability or simplicity. It is not uncommon for such a declaration to be embedded in some form of aroused emotion. Nevertheless, the emphasis of this code is not on the affect but rather on the distillation of meaning.

Meaning may be presented in the form of a wish, need, desire, or sense of direction. Examples may also be in the form of metaphorical images or autobiographical examples but will often be disarming and direct statements of the client's needs relating to essentially three overarching categories: attachment (i.e. "I need love -- to feel valued, important, special, supported…"), personal agency (i.e. "I need freedom -- individuality, to feel separate, independent…"), or survival (i.e. "I need to feel safe -- protected…"). On some occasions clients will express a need only after a direct query by the therapist. If

that is the case, raters should be sure that the need is specific and well articulated before they code it as such.

Examples:

Some case examples of client statements regarding needs include:

- "I need to be worth it". (I need love/value)
- "I have been waiting for the eyes for love." (I need love, metaphorical image)
- "I need encouragement". (I need love/support)
- **"**I want protection, support, … " (I need love/parenting relationship)
- "I felt like I was his adopted daughter, It was so nice." (I need support/parenting relationship)

As a helpful hint, observers should look for the words:

I need...

I want...

I wish...

I don't need...

I don't want...

...or equivalent.

Points of discrimination:

Phrases that begin with, "I want you to…." or "I need you to…." are usually not statements of an existential need. To satisfy this code the statement must be more grounded in the client's Self. Thus, the statement of a need will more likely begin with

turns of phrase like, "I want or need to feel….", without reference to any other party on which the demand might be made. Need statements are not demands but rather self-observations, if you will, of what the organism requires to function in a healthy way.

Note that making plans or setting goals is not sufficient to be coded as a "need". Occasionally, clients will make statements such as, "I want to be able to love myself". Without a context that serves to buttress it, this is an ambiguous statement with respect to a "need". In isolation it is unclear if the speaker is making a statement of what is essential and missing from his or her life (i.e. an existential need) or whether the speaker is beginning a list of goals, objectives, or mantras, which would not meet criteria for coding a need (i.e. "I want to be able to love myself, to take better care of myself, I need to work harder, I need to visit my mother more often,...").

The expression of a need should be coded when it appears as a statement of self-discovery or self-observation. Specific and adaptive assertive-anger also will usually have a clear statement of need that is being affirmed. The distinction between the two codes can be found in the fact that assertive-anger is no only an expression of need but also of the client feeling entitled and deserving of having that need met. Thus, a statement of feeling entitled or deserving of the need may be better coded as Assertive-Anger. Generic demanding may be better coded as Rejecting Anger.

<u>Relating Existential Need to the literature:</u>

By their very nature, humanist psychotherapies highly value a client's articulation of personal needs. The statement and significance of certain needs has been discussed at

great length in the theory and practice of Emotion Focused Therapy (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg, Rice & Elliott, 1993). Therapists in that and some other experiential approaches actively encourage and support clients to acknowledge and more importantly experience their needs more fully. Doing this is considered to be main target and catalyst of change in Emotion Focused Therapy.

The "need" is a term that was elaborated by Murray (1938) from a psychoanalytic approach. A need, as referred to by this category of meaning, is what some psychodynamic researchers have called the "wish" in a core conflictual relationship theme (Luborsky et al., 1994). Psychoanalytic and psychodynamic approaches direct their efforts at bringing a client' s need or wish into consciousness.

Both experiential and the psychodynamic approaches agree that clients suffer from some unmet concern. Work by both Murray (1938), and Prager (1995), formed the basis for the classification of client needs in this coding system. Pedersen (1996) synthesized and elaborated their works for coding in this type of therapeutic context. The need for "joy" and "playfulness" has been contributed by the school of Gestalt therapy as part of an individual's need for positive experiences vis-à-vis life (Perls et al., 1951). In essence, statements of existential needs are statements that address the overarching concerns of human agency and communion, described by Bakan (1966) as the core dynamic drives in human existence.

Cognitive Behavioural Therapy does not conceptualize the the expression or experience of an existential need as relevant to its approach. In their manual Greenberger

and Padesky (1995) have referred to the formulation of a more "balanced belief", contrasting it against a presenting core negative belief. In this regard, it is apparent that cognitive and behavioural approaches have a categorically different conception of the healing process. Nonetheless, the nature of an expressed need as internally attributed and stable in time is consistent with cognitive attributional theories of motivation and emotion (Weiner, 1985).

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6. Specific Self-Soothing

Diagnostic definition:

Emotional tone

A. The presence of caring, tenderness, soothing, or nurturing. Perhaps in one (or more) of the following forms:
    1) In an explicitly reflexive manner,
    2) Imagining nurturance/soothing,
    3) Attributed nurturing/soothing,
    4) Acknowledging existing resources and recalling current examples

Involvement

B. The meaning state is currently activated. If arousal is present it is sufficiently regulated and is compatible with the process of self-soothing.
C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:
   - Disruption of vocal pattern
     (i.e. the voice may break, tremble, rise to a shriek, become very low),
   - Uneven pace,
   - Irregular accentuation pattern,
   - Unexpected terminal contours.
2) "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:
   - Uneven pace,
   - Ragged, unexpected terminal contours,
   - Stop-and-go, unexpected pattern,
   - Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. Attending to the unmet need is done with a positive self-evaluation (which could be either explicit or implicit). It is self-evident that this is adaptive and healthy for the client.

E. The object being soothed is clearly the Self.

Conceptual definition:

This affective-meaning state is distinctly reflexive in its nature. Intimately tied to the existential need, in this state clients move to an agentic position and begin to meet their own expressed need. This may be done in a variety of ways but will be characterized by caring, tenderness with oneself, and the act of self-nurturing. If the client attributes the role of soothing to another person, place or thing through role-play or some other imaginative exercise, it is ultimately considered to be an act of the client unto him or herself.

Examples:

Clients might do this by:

- Using an explicitly reflexive manner;
    - Soothing or nurturance of "child self" by current "adult self"
    - Positive self-talk: i.e. "I know that I'm going to be alright".
- Imagining nurturance/soothing;
    - "I can imagine being hugged or going to a safe place"
    - "I can imagine a better situation in the future"
    - "I know God's love is always out there".
- Attributed nurturing/soothing;
    - Offering words of soothing or nurturance toward oneself while role-playing the position of some significant other, (i.e. speaking from the other chair as mother, "I do care for you").

- Imagining the apology/regret of some offending other in a way that is tantamount to imagining the other taking a nurturing stance.

- Acknowledging existing resources and remembering current autobiographical examples,
  - "My existing family/friends care for me and protect me now"
  - **"**My mother in law gives me what I needed. For example…"
  - "…My sister loves me, my husband brought flowers".

Points of discrimination:

A need and a positive self-evaluation are events rather than states per se. However, when there is a confident expression of positive self-evaluation and at the same time an organization toward actively attending to some unmet need, that is the state of self-soothing. Self-soothing should be only coded if there is an explicit effort to grant an explicit need.

Self-soothing can be understood as an implicit expression of self-assertion. Although a state of self-assertion (elaborated below) is much more combative and anger-based both of these affective-meaning states are built upon a clear sense of some existential need and a positive self-evaluation. Note that if self-soothing represents a healthy way of being in the personal domain, self-assertion (or assertive anger, below) represents a similarly healthy way of being in the interpersonal domain (or when problems are couched interpersonally, as in dialogues).

Relating Self-Soothing to the literature:

Self-soothing is a concept that first emerged out of the literature on attachment (see Bowlby, 1997/1969). Kohut explicitly discusses "Self-soothing" as a specific client behaviour that demonstrates healthy maturation. He describes this as the healthy enactment of "mothering" vis-à-vis oneself in a manner adopted from prior caregivers (Kohut, 1977). Despite the contributions of Self Psychology, this reflexive state has been most highly valued and is perhaps most often referred to in humanist psychotherapies. In an experiential treatment manual Bierman (2003) explicitly refers to "Self-nurturing" as an auto-intervention that should be fostered when clients feel vulnerable.

Although it has not been extensively elaborated as a construct, the gist of this affective-meaning state has been referred to in various ways. The "focusing attitude" in many experiential therapies (Gendlin, 1981; Cornell, 1996) is a less explicitly active state but still has the same intentionality as self-soothing. Similarly, "compassion for the Self" (Nhat Hanh, 1976) reflects a certain disposition or preparedness for self-soothing but does not denote the explicit behavioural engagement that is required in this affective-meaning state. Likewise, Fromm's (2000/1956) conception of "self-love" also suggests the self-soothing disposition.

In the cognitive and behavioural traditions to therapy, self-soothing has taken on different forms. The cognitive approach refers to collecting "evidence against" a core negative belief (Beck, J., 1995). And depending on its tone, this can be suitably understood as a rationally driven method by which an individual is lead to acknowledge

his or her existing resources. In that approach, more affectively laden forms of self-soothing occur only incidentally as part of skills training and positive self-talk. In a behavioural vein, Dialectical Behavioural Therapy explicitly treats self-soothing as a skills set that is discussed, taught, and deployed as one of the steps toward emotional regulation (Linehan & Schnidt, 1995). In an integrative fashion, Dialectical Behaviour Therapy has provided a practical operationalization of self-soothing for clients in the form of "self caring behaviours" (Korman & Bolger, 2000; Linehan, 1993b).

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7. Specific & Adaptive Assertive-Anger

Diagnostic definition:

Emotional tone

A. The presence of anger in one (or more) of the following:
    1) Self-affirmation/assertion
        - (i.e. "I am OK"),
    2) Entitlement to an already stated existential need
        - (i.e. "I deserved to be protected, cared for"),
    3) Affirmation/assertion of ethical standards & rights
        - (i.e. "What you did was wrong"),
    4) Boundary setting or separation
        - (i.e. "I won't allow it to happen anymore").

Involvement

B. Presence of at least one (or both) of the following:

1) The experience is of moderate to high expressive arousal and can be rated as > 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Any arousal is sufficiently regulated and useful to the process of assertion.

2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.

- There is non-verbal behaviour that reflects active assertion in a considered and deliberate manner, which may include one (or more) of the following:

    a) Head nodding,

    b) loud voice,

    c) body leaning forward,

    d) assertive gestures (i.e. finger pointing, chopping, stop signal...),

    e) steady gaze directed outward.

C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern

  (i.e. the voice may break, tremble, rise to a shriek, become very low),

- Uneven pace,

- Irregular accentuation pattern,

- Unexpected terminal contours.

2) "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The client is agentic and assumes a position of being both entitled and deserving of the need.

- The client takes the role of advocate or activist for him or herself.
- The client seems to have a sense of equal footing against the offending object.
- The client takes a reflective stance that allows anger to be active yet sufficiently regulated to be useful for self-assertion.

E. The object of anger is clear and specific.

- It is clear to the observer what injustice or unfairness was done and by whom.
- The assertion may be anchored in some specific autobiographical context.

Conceptual definition:

This category of affective-meaning is represented by the expression of anger, which is a clearly an empowered expression of the Self. The main thrust of this anger is

in its self-assertion, whether that be the assertion of personal boundaries or of some stated need. The client is strong, clear, well-grounded, and speaks with a sense of growing confidence. Often this anger is expressed from an "advocate" or "activist" position such that clients seem to speak and confront their objects of anger like opponents of potentially equal force. Ultimately, assertive-anger defends some Positive Evaluation (i.e. "I am lovable") and to the extent that it does this it is self-affirming. This type of anger is often founded upon a new, positive evaluation of the Self. The positive evaluation, however, is usually tacit until some point where the anger becomes sufficiently activated.

On the other hand, a need is usually explicit in this form of anger (the client is battling for something specific) and it is also often anchored in some specific autobiographical context. One might describe the assertion of need and/or Self as driven by a sense of ethical righteousness. When clients express this type of state it entails moderate to high arousal and high meaningfulness. It represents a healthy state rich in specific, personally relevant meaning and organizes the client on a productive and ultimately positive trajectory.

Examples:

Typical expressions using this anger are:

- "I cannot accept this". (Ethical righteousness & separation)
- "You are not a valid judge of me".(Ethical righteousness & separation)
- "I have value!" (Self-assertion)
- "It's not OK, because I need more". (Assertion of need)

- "I'm angry I have been mistreated". (Ethical righteousness)

Some case examples are given below:

- "We are not the same". (Boundary setting/ Self-assertion)
- "I am finished with you". (Boundary setting/ Self-assertion)
- "I can love, I am loveable". (Self-affirmation/need)
- "I have been mistreated and abused". (Ethical righteousness)
- "I was not put here to be mistreated. I have to be whom I am".
- "I resent being stepped on when I'm trying to move forward".
- "How dare you! I feel gritted teeth. Stay away from me an mine".

(Ethical righteousness/assertion of Self)

Points of discrimination:

Some more aggressive statements, for example, "Give me a break! That's stupid. You don't even know me", are bordering on "rejecting-anger". However, given the right context this could be a statement representing, 'you are not a valid judge of me' – which would be "self-assertion". The distinction between these two codes is made based on supporting statements and contextual evidence given that no code should ever be made based on a single statement.

In this project it could be useful for raters to note that EFT therapists often attempt to encourage and facilitate the arousal of this affective-meaning state. Similarly, self-validation is also a common part of this emotional process as clients try to accept support from their therapist and try to buttress their own assertion. Albeit healthy, the

effort to assert oneself against some negative evaluation of the self or offending other/circumstance is usually very difficult and sometimes frightening for the client. One critical difference between the development of anger and fear is individual's appraisal of their ability to cope with the negative stimulus. Given that such appraisals are ongoing, it is not uncommon for the client's self-assertion to collapse into negative emotion (either global distress or specific maladaptive fear/shame). This is literally a client's change of trajectory from an organization for "fight" to some organization for "flight". Validation and/or soothing can play a part in the prevention of such collapses.

Relating Assertive Anger to the literature:

This self-affirming category represents "primary adaptive anger" in the language of Emotion Focused Therapy. Therapists using that approach aim at actively engaging and elaborating this healthy type of anger in the hopes of having it propel the client forward into a healthier, more active, and more resolved state of being. Whelton (2000) referred to this affective-meaning state as self-resilience or assertion when discussing client behaviours within a therapeutic context. Gestalt therapists introduced the notion of "assertiveness" and assertiveness training in psychotherapy as a healthy form of anger to be allowed and made use of (Perls, et al., 1951; Perls, 1969).

Comparably, psychodynamic theorists have referred to this type of client activity as a demonstration of "good ego strength" or a "healthy sense of entitlement". This is contrasted with the more usual sense of entitlement, which by default is considered to have a narcissistic and unhealthy quality (Greenberg & Mitchell, 1983). Even so,

psychodynamic and Cognitive Behavioural theorists and therapists tend to have strong reservations about arousing the expression of anger and consequentially have not developed or used refined distinctions among client's experiences of anger.

Assertive-anger is a construct that has not proved relevant at all to Cognitive Behavioural Therapy. This is probably on account of the fact that, whether adaptive or not, the experience of anger is a generally a negative one for clients. Nonetheless, if collecting rational "evidence against" a core negative belief (Beck, J., 1995) is imbued with a sense of deserving and agency then it might meet criteria for assertive-anger.

Assertive Anger is well described by Bowlby's (1997/1996) "anger of hope", which may be found in the context of attachment. The "anger of hope" is an emotion that aims to rectify an undesirable relationship situation. Anger is the impetus to repair close relationships when the other is inaccessible. In both the contexts of attachment as well as personal agency (i.e. survival and competence) Assertive Anger, like the "anger of hope" in relationships, engages the person in adaptive problem solving and the expression of non-hostile anger. Fromm (1973) aptly described this as "benign aggression" – a beneficial expression of anger that promotes well-being.

The notion that individuals literally fight for the assertion of their rights from a position of anger is consistent with rights theory (Ignatieff, 2000). Social actions and assertions of the self by an individual are built upon an emerging positive self-evaluation, which then takes its momentum from the emotional experience of anger. Thus, specific

and adaptive self-assertion is an anger-based experience whether it be personal or socio-political (Ignatieff, 2000).

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8. Specific Adaptive Grief/Hurt

Diagnostic definition:

Emotional tone

A. The presence of one (or more) of the following:

1) Sadness over a loss

- i.e. loss of person, of innocence, of a thing one never had, loss of a missed opportunity, etc.
- i.e. regret, remorse...

2) Recognizing one's woundedness,

- i.e. reporting and reflecting on past emotional/physical damage.

3) Specific and idiosyncratically elaborated pain,

4) Realistic hopelessness over regaining lost object (but not out of despair).

- The above emotional tones must be without blaming, self-pity, or resignation.

Involvement

B. Presence of at least one (or both) of the following:

1) The experience is of high expressive arousal and is rated as > 4 on the Emotional Arousal Scale (Warwar & Greenberg, 1999). Any arousal is

sufficiently regulated and useful to the process of grief or recognizing one's woundedness.

2) The client verbally reports his or her arousal, indicating that the emotional tone is activated.

C. Presence of at least one (or both) of the following vocal qualities:

1) "Emotional voice quality", which is disrupted or distorted as a result of overflowing feeling. This is characterized by:

- Disruption of vocal pattern

  (i.e. the voice may break, tremble, rise to a shriek, become very low),
- Uneven pace,
- Irregular accentuation pattern,
- Unexpected terminal contours.

2) "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The client takes a reflective stance that allows Grief/hurt to be active yet sufficiently regulated to be useful for the healing process. This means the emotion is self-oriented, personalized and integrative. I.e.:

- Hurt: The client takes the position of one who is recognizing and describing the impact of a deep wound. The client acknowledges that wound as a personal loss.
- Grief: The client takes the position of one who is grieving or saying "good-bye" to bad memories, good memories, hopes and dreams, and finally "good-bye" to either the relationship as a whole or to a part of one's life.

E. The object of grief/hurt is clear and specific:

- It is clear to the observer what object has been lost and/or what is the source of hurt – (i.e. the loss of X relationship, i.e. the hurt from being neglected in the manner of X).
- The grief/hurt may be anchored in some specific autobiographical context – (i.e. "This is what happened..." or "When I was younger, this is what it was like...").

Conceptual definition:

This category of emotion is imbued with very specific and often profound meaning that acknowledges the genuine sadness of a loss or injury. Reporting past emotional/physical damage while being in an aroused state especially if it is done with a

sense of self observation or reflection, can be a very new and insightful experience. Although grief is unpleasant and usually entails some form of withdrawal, this type of sadness is described as adaptive because of its well-grounded, underlying tone of realism and acceptance of things as they are. This allows for one to move on. Note that grief is a healthy way of experiencing loss in the personal domain, while hurt similarly represents an adaptive way of experiencing injury in the interpersonal domain (or when problems are couched interpersonally). Both of these feelings are considered to represent the same broader affective-meaning state. Adaptive grief or hurt often flow from some sort of implied positive evaluation of Self, i.e. "I am lovable... but nevertheless, I have lost".

This affective-meaning state will usually involve a discussion of needs although, at this point, the reference to needs will be in the spirit of, "what I missed and will never have again". In other words, this state of grief or hurt will essentially describe a process of mourning or saying "good-bye" to the bad memories, the good memories, the hopes, and dreams and finally to a part of one's life. Alternatively, the state may entail recognizing and describing the impact of a deep emotional wound, which is acknowledged as a personal loss.

When clients express this state it is with moderate to high arousal and with high meaningfulness. Given its adaptiveness this represents a healthy state rich in personally relevant meaning and organizes the client on a productive trajectory of "letting go".

Examples:

Some case examples of specific and adaptive grief/hurt follow:

- **"**I'll never know who I could have been". (Grief)
- "I would have liked to have had a mother who cared for me". (Grief)
- "You have made life very difficult for me". (Sadness/regret)
- "My Sister and parents have no intention of coming to visit and that's sad". (Sadness/describe loss)
- "Until I moved out I didn't realize how uncared for I was. I hadn't noticed the abuse I had to endure, until much later when things were better". (Recognizing one's hurt)
- **"**I'm sorry you are wasting your life, and father's and sister's lives, but I will not let you waste mine". (Sadness/describe loss)

Note that this last example is bordering on angry self-assertion; therefore this coding might be swayed by the emotional context and depending on the angry vs. sad tone.

Points of discrimination:

The difference between "specific adaptive grief/hurt" vs. "global distress" is shown, for example, in mourning the loss of a loved one vs. the helplessness and vague despair of being without that loved one. Similarly, both blaming the other and self-pity are indicative of global distress rather than grief/hurt. Raters must also be careful to discriminate between the acceptance of hurt/loss vs. resignation, the latter is a rendition of hopelessness and therefore should be categorized as "global distress".

When a client talks about how much he or she has suffered the observer must make a judgment call: Is the elaboration a broad, sweeping and generalizing complaint?

Is it in a whining tone? (If so, these suggest global distress). -- Or is the client making a specific observation regarding his or her Self? The latter is grief/hurt in the form of "recognizing one's hurt" and "acknowledging a past wound". Thus, if a statement about how bad life was is specific and from a position of, "oh, I'm understanding it better now … the nature of my suffering is clearer now" – that is indicative of grief/hurt.

The degree to which an individual assesses him or herself as "damaged" is also a discriminating criterion for coding grief/hurt. If an individual essentially states, "I'm so badly damaged, I can't function", the appraisal is that he or she is broadly and permanently damaged. The grave and enduring nature of this statement suggests it is an expression of fear/shame and given its incisiveness would likely be coded as a negative evaluation. In contrast, if an individual states, "Although I've been very badly damaged, I can function", the appraisal is that he or she had been locally rather than totally damaged, as it were. Acknowledging one's wounds or losses while appraising them as at least somewhat repairable is indicative of grief/hurt. Describing oneself as unsalvageable or hopeless is not.

The counterpoints of grief and hurt are self-soothing and self-assertion, such that depending on the presenting concern, grief acts as the complement to self-soothing and hurt often serves as the complement to assertive-anger. In this coding system, the two feelings of grief and hurt have been collapsed together into a single category/ In contrast, self-soothing and assertive-anger have been preserved as independent classifications in the coding. The reason for this is that hurt and grief are believed to be experientially

much closer to one another than self-soothing and assertive anger. Even so, the natures of adaptive grief/hurt vs. assertive-anger/self-soothing is such that both sets of emotions entail highly personalized and complementary meaning constructions and as such are healthy trajectories of development.

In rating affective-meaning states the consequence of this is that the two types of affective-meaning categories (grief/hurt vs. self-soothing and assertive-anger) form an experiential couplet and it is not uncommon for clients to pass back and forth between the two, while remaining on a highly meaningful level. This must be taken into consideration, as it will assist raters who are attending to the variation of emotionally aroused segments of video.

Relating Grief/Hurt to the literature:

Theorists in Emotion Focused Therapy have most often referred to this affective-meaning state as "primary adaptive sadness" (Greenberg, 2002; Greenberg & Paivio, 1997). On some other occasions it has also been referred to as a type of "primary hurt" (Greenberg & Bolger, 2001; Bolger, 1999). Emotion Focused Therapists actively engage and facilitate the experience of these special types of sadness. The aim therein is to have clients recognize and symbolize the most poignant source of their hurt or grief so that they can "complete" it, as it were. In this approach to therapy, feeling specific hurt and grief more "fully" allows clients to "let go" and move forward to a healthier, more active, and more resolved state of being. Other experiential therapists, such as Bierman (2003), have developed the expression of grief into a formal treatment intervention. In this

structured task clients are encouraged to literally, "say good-bye", to the good things and bad things related to some aspect of their lives 'that will never come again', and say good bye to any previously anticipated 'hopes and dreams' that will never happen.

Taking an experiential-dynamic approach, Fosha (2000) has also referred to certain grief experiences as being part of what she calls the "healing affects". In her approach, which is a variant of Short-Term Dynamic Psychotherapy, this state is also to be elaborated and fully experienced for positive therapeutic results.

The notion of a healthy and adaptive grief/hurt state is not entirely new. The unique meaning captured by this type of reflexive sadness is akin to the Buddhist notion of, "seeing oneself with the eyes of compassion" (Naht Hanh, 1976). The specificity and reflexivity of this experience is essential and is what sets this type of state apart from the simplistic experience of global distress and catharsis, in the sense of emotional-purging (as described by, i.e. Janov, 1970, 1991, or Stone, 1995).

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9. Relief

Diagnostic definition:

Emotional tone

A. The presence of one (or more) of the following:

    1) An experience clearly labelled by either client or therapist as any of the following:

        a) Feeling better,

b) Feeling lighter,

c) Hopeful,

d) Positive,

e) A small sense of accomplishment...

2) The client feels a "bodily shift"

- i.e. less tense, can breath more easily, feels less choked up...

Involvement

B. The meaning state is currently activated. If arousal is present it is sufficiently regulated and is compatible with relief.

- There is non-verbal behaviour reflecting a slightly positive state, which <u>may</u> include one (or more) of the following:

a) Crying "tears of self-recognition",

b) Deliberate sighing often with an open mouth or with voice,

c) Smiling,

d) Nodding,

e) Making eye contact..

C. Presence of a "focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,

- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The client has articulated some aspect of personal meaning and now feels oriented toward adaptive self-development. The client's sense of relief is of "finally, being on the right track".

E. The client is finished working on the issue for the moment. There is no requirement for a high degree of specificity in meaning. The state of relief is a "pause" or "resting place" between the difficult thoughts and feelings involved in a change process.

- Note: The issue is usually not fully resolved and it is not being avoided.

Conceptual definition:

The affective-meaning state of relief is one of the few states in this coding system that denotes "feeling good". As they pause to reflect on the process in which they are immersed clients sometimes feel the ramifications of what they have just expressed or realized on a bodily level. This creates a reduction in tension or a sense of relief. In this sense the client (deliberately or not) takes a moment and acknowledges his or her efforts in the process. The client has made some step in emotional processing and is able to recognize the progress on some level. The experience is a sense of relief, hopefulness, or accomplishment in having produced a shift.

Given that positive experiences tend to have an inherently lower degree of specificity in meaning than negative experiences, sometimes it is difficult to determine precisely what is relieving to a client. Nonetheless, based on the task analytic research, there is some reason to believe that there are at least two levels of "Relief" and it may be helpful for raters to be aware of them. The first level of relief (#1) is related to an expressive event, exemplified by the statement, "I feel better now that I've symbolized and captured my distressing experience in words". The second level of relief (#2) is related to a micro-change event. Relief #2 is exemplified by the statement, "I feel better about the whole situation and although it's not resolved I'm relieved that it had actually changed a bit".

Although this is an important affective-meaning state for describing the emotional processing of clients, in some ways it is epiphenomenal to the actual meaning-making, expression, or change it refers to. It is believed that relief may not be explicitly required for emotional processing. However, it may provide a useful function in meaning consolidation, emotional-regulation, and as an opportunity for interpersonal bonding.

Examples:

Some case examples of relief follow:

- "I feel like I can breath again"
- "I feel a bit better, it feels good having said that"
- "I don't know why I'm crying, it's good to get that off my chest"
- "It's like a big burden is lifting off of me"

- "I'm glad to know that I'm finally doing something"

Points of discrimination:

The "Relief" code was developed later in the development of this classification system. Initially, this positive state was not being coded at all and was a source of confusion for raters. By default raters were obliged to note this state as being either "uncodable" or a "mixture" of other available codes. This did not occur with a very high frequency but occurred often enough the relief code was developed from a homogeneous set of states that had hereto been unidentified. Identifying such recurrent states reduces the likelihood of their being confused with other more common affective-meaning states that occur in the session.

The two affective-meaning states that are most similar to relief are self-soothing and the state of acceptance and agency (see code #10). Although self-soothing at times is a suitable code for when an individual feels good, the good feelings must be functionally directed toward meeting some need. That is not the case for relief, which is a "good feeling" with no functional intention. Acceptance and agency (below), otherwise know as resolution, should be coded when content appears to be resolved. Relief should be coded when content is clearly not yet resolved but is still progress. In this way, Relief is a state that refers to "feeling better" in light of any progress that is being made.

Relating Relief to the literature:

As an affective-meaning state relief has not been addressed in much detail by the literature. In part, this is because it is not a "problem state" and as such is not often

targeted by psychotherapy therapists and researchers. Nonetheless, Gendlin (1964, 1981, 1996) has referred extensively to the concept of a "felt shift" as a small moment-by-moment outcome, some of which are positive experiences of relief. He has referred to the "tears of self-recognition" as a form of positive experience that can follow a felt shift. Following in the experiential school, Rennie (1998) has discussed the role of reflection upon an ongoing emotional experience in perpetuating the development of that same experience (also see Greenberg, 2002). Relief as a pause for reflection on one's progress, which is in turn experienced in a positive way, is captured but the work of these experiential theorists.

Fosha (2001) has also made special note of the role of positive affective experiences and good feelings, such as the feeling of relief, in therapeutic change. Like experiential theorists, she has also given attention to "the experience of the experience", indicating that although the transforming power of affect may be painful the meta-experience of that transformation may be a positive one (Fosha, 2000).

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10. Acceptance & Agency

Diagnostic definition:

Emotional tone

A. The presence of one (or more) or the following:

    1) Letting go or moving on,

    2) Feeling, comfort, calm or good,

3) A goal to carrying positive feeling forward into the future or to tell someone,
4) Recognition of positive as well as negative aspects involved in change,
5) Feeling stronger when coping with the original concern,
6) Pride-assertiveness.

Involvement

B. One notes a dissipation of arousal. The experience is of low expressive arousal and can be rated as < 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).

C. "Focused voice quality", which is described as turning attention inward with a concentrated use of energy and the quality of groping toward new meaning. This is characterized by:

- Uneven pace,
- Ragged, unexpected terminal contours,
- Stop-and-go, unexpected pattern,
- Accent is done with loudness or a drawl (rather than a pitch rise).

Meaning

D. The presence of "new meaning". Defined by any one (or more) of the following:

1) Broadening appreciation of oneself and surrounding circumstances,
2) The consideration of somewhat new, alternative perspectives,
3) Sense of greater clarity,
4) Being the owner of self worth.

E. The presence of a "novel feeling". Defined by any one (or more) of the following:

1) Expression in a clearly integrative and affirmative manner,

2) No longer feeling disoriented,

3) Having some plan of action.

Conceptual definition:

This is the complete resolution of distress in all its varieties. In other words, there are little or no lingering feelings of global distress, fear, shame, anger, or grief. This affective-meaning state is characterized by high meaningfulness and low arousal. The affective-meaning state of "acceptance and agency" has three salient features. They are the dissipation of arousal, the emergence of a novel feeling and the creation of new meaning (as detailed in the criteria, above).

By definition, a state of acceptance and agency usually has a broad and global focus. Unlike the other adaptive states listed, which are highly specific in their meaning, a resolution state like acceptance and agency is relatively global. Of course, unlike global distress it can be positive and the new general meanings and feelings it engenders are often projected into the future.

Examples:

Clients may describe an experience of Acceptance & Agency by:

- Using positive feelings,
    - "I feel warm and secure."
    - "I feel at peace with this".

- Carrying the positive forward,
    - "I liked feeling like that it felt good. Somehow I think I'm going to start feeling it a lot more".
    - "I'm going to try to work on positive images of you, mother, and try not focus in on your suicide."
    - "I'm going to tell my wife about this. I don't know if she will understand but…"
- Taking the positive with the negative:
    - "It does hurt but I feel OK about it. I feel stronger about letting it go. I can get on."
    - "This part of my life has a bitter-sweet feeling to it."
- Feeling stronger:
    - "I think I could handle that now".

Points of discrimination:

Although the client often develops a sense of greater clarity as part of the Acceptance & Agency state, it is often not necessarily an easy affective state to negotiate. Current forgiveness and acceptance may also be signs of Acceptance & Agency. Even so, raters must heed discussion of such topics with a grain of skepticism. One must not assume that when a client refers to "forgiveness" or "acceptance" it necessarily involves letting go, per se. As it happens, clients often have their own understanding of what they

mean when they use these words.

Relating Acceptance & Agency to the literature:

Greenberg, Rice, and Elliott (1993) introduced the notion of a resolution state regarding certain therapy tasks and goals. Work by Pedersen (1996) has verified and elaborated a model of the resolution process regarding "unfinished business". Although the construct is a universal one, describing this affective-meaning state is an attempt to capture the "finished", healthy state using criteria taken from systematic observation. In the Buddhist tradition, this affective-meaning state has been described as a mindful and authentic acceptance of the Self and its circumstances (Nhat Hanh, 1976).

Introductory note to "Mixed/Uncodable" and "End"

The following two codes **(11 & 12)** are distinct from all other codes in that they are not intended to code particular affective-meaning states. These two codes are included in the classification system because of their structural function in coding. If there is a change in the type of affect and meaning a client is experiencing that cannot be adequately represented using the other 10 codes one of these two codes will be used. For that reason these final two codes in the classification system do not follow the same set of criteria as the affective-meaning states (i.e. Emotional tone, Involvement, Meanings...).

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11. Mixed/Uncodable

Diagnostic definition:

A. The presence of some change in state that is different from the preceding state but is not accounted for by any other code.

   For example, as in any one of the following:

   1) There is not sufficient information/disclosure in the video to make a code.
   2) There are no two contiguous statements that could coherently represent the client's experience.
   3) There are potential codes for the sequence but they cannot be made with any degree of confidence.

B. It is clear some code must be made for the sake of continuity.

C. Note: When this code is used, any potential codes should be listed in parentheses.

   - When two codes seem emergent but are not sufficiently strong each in their own right one might code:
     - I.e. "Mixed/Uncodable: (Self-Soothing/Relief)".

Conceptual definition:

When categories cannot be separated with confidence by the rater, the code of "Mixed/Uncodable" must be used. This code will be useful for the purposes of taxonomy and reliability. Obviously, specific codes are more useful that the code "Mixed/Uncodable". However, it is preferable to the omission of phenomena (when the

rater is relatively confident that some code is required) and also much more preferable to any code that would otherwise be made with poor confidence.

General description of content:

The two most frequent scenarios for this code are:

- The client's line of process-development gets interrupted or is cut short before the rater has a clear sense of which category coding may have been most appropriate. Even so, the rater is relatively certain that the event in question does merit a code of some sort.
- A client uses therapist-fed statements for several moments but seems to neither endorse nor reject them, thus blending and obscuring the actual affective-meaning process.

Relating Mixed/Uncodable to the literature:

This category is a standard category in continuous comprehensive coding systems used in ethology (Bakeman & Gottman, 1986; Martin & Bateson, 1986). It is used to prevent raters from being obliged to code phenomena with low confidence in their ratings (for whatever reason) or to prevent forced coding of phenomena that do not fit any of the available categories. If a large number of Mixed/Uncodable codes are made in a data set the phenomena they refer to can be examined for patterns.

Patterns may indicate coding confusions. Alternatively, if there is a coherent cluster of phenomena that have hereto been mixed or uncodable, this could yield the identification of another affective-meaning state not yet included in the existing

classification system. The state of Relief (code #9) described above was identified and described through this method. Since this classification is intended for continuous coding, from the perspective of ratings there cannot be any missing data. However, when data is deemed uncodable will likely acts as missing data from the perspective of most analyses. For these reasons, research of all kinds that makes use of observational methods requires such a code in order for continuous rating to be valid. This type of code is also frequently used to insulate rating systems against inflated error in reliability.

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12. End Code

Diagnostic definition:

A. A dramatic drop in emotional arousal. The experience is of low expressive arousal and can be rated as < 3 on the Emotional Arousal Scale (Warwar & Greenberg, 1999).

B. A content change in conversation through one of the following:

   1) A change of topic, (which is not emotionally evocative).

   2) A change to a different, less emotional level of analysis.

      Case examples include:

      a) Psycho-educational discussions initiated by the therapist,

      b) Unfocused intellectualization by the client,

      c) Humour diverts and ends a state of arousal,

      d) The therapist begins to end the session.

3) The client remains silent (and not visibly aroused for two whole minutes).

C. Criteria A and B are sustained for a period of at least two minutes.

Conceptual definition:

The classification system of affective meaning states is designed to code emotionally aroused streams of experience. When the client's experience is no longer regarding emotionally involved material the coding system ceases to be appropriate. The end of a segment is delineated with an End Code.

Points of discrimination:

The segment may include some subsequent moments of discussion if they are immediate commentaries on the current emotional experiences. Note that either therapist or the client may initiate shifts in the content or level of discourse that marks the ends of a segment (assuming the other person in the dyad does not resist the change in content). Note that occasionally (but not necessarily) a change of task entails a shift in topic and/or analysis. An example of this is when the therapist initiates an intervention in order to help the client find a focus or to vivify the client's emotion. Thus, a change in task may also indicate the end of a segment assuming arousal is low.

Naturally, a change in topic marks the end of a segment if it is not emotionally linked. Similarly, two minutes of silence is considered to be enough to suggest the end of an emotion segment or at least that there is no longer direct continuity to the state that follows.

Relating End Code to the literature:

This category is a standard category in continuous comprehensive coding systems used in the observation of behaviour (Bakeman & Gottman, 1986; Martin & Bateson, 1986).

Pascual-Leone & Greenberg, 2005 © 83

Appendix:

Additional resources for coding and reliability

Figure 1:
Coding criteria at a glance

		Global Distress	Fear & Shame	Rejecting Anger
Emotion	A. *Emotion/Action*	Vague, whining, hopeless, pain, self-pity, irritable, confusion	withdraw/ close down: fear, shame, lonely, empty	distance/ destroy: frustration, hate, disgust
Involvement	B. *Arousal*	high, >4	.	high, >4
	C. *Voice*	emotional; focused	emotional; focused	emotional; external
Meaning	D. *Stance*	non-agentic, no direction	deep & enduring pain	protestor
	E. *Specificity*	unknown, avoid, minimal	clear & specific	stress wrongdoing not Self

		Negative Evaluation	Need
Emotion	A. *Emotion/Action*	"I am…unlovable/worthless/ ….abandoned/destroyed	"I need… recognition/support/ approval/affection/autonomy…
Involvement	B. *Arousal*	.	.
	C. *Voice*	emotional; focused	focused
Meaning	D. *Stance*	absolute, internally attrib., stable	simple, internally attrib., stable
	E. *Specificity*	.	need is unmet, obsevation

		Self-Soothing	Assertive Anger	Hurt/Grief
Emotion	A. *Emotion/Action*	caring/tenderness/nurturing reflexive, imaginary, attributed	Anger: self/rights -affirmation entitlement, boundary setting	Hurt: recognizing one's hurt Grief: sadness over loss
Involvement	B. *Arousal*	.	moderate-high, >3	high, >4
	C. *Voice*	emotional; focused	emotional; focused	emotional; focused
Meaning	D. *Stance*	adaptive & healthy	agentic, entitlement position	wound Impact/Say goodbye
	E. *Specificity*	action refers to Self	clear & specific	clear & specific

con't

	Mixed/Uncodable	End Coding
A.	Presence of emotional state • not sufficient info for id • no 2 coherent statements • potential codes, w no certainty	Absence of emotional state • drop in arousal, and evocativeness
B.	A code must be made for continuity	• change in topic, not evocative OR
C.	List potential codes	• change in level of analysis, not evocative

I.e.
- o Process interrupted,
- o Blending states.

I.e.
- o Psycho-educational discussions,
- o Unfocused intellectualization,
- o Humour dissipates a state of high arousal,
- o therapist begins to end the session.

Start: →

Code:	GD								
Note:	Hurt, helpless								

Note: codes will be easiest recorded in a vertical fashion, so that quotations can be given as notes etc.

Reliability

Aligning CAMS Ratings for Reliability

Following is a detailed description of the rules by which independent ratings were aligned for reliability purposes in the absence of inherently fixed anchors. This procedure protocol also identifies the different sources of error or agreement in reliability. Aspects of this alignment process are illustrated in figure 2. The two independent raters are referred to as "A" and "B". There are four rules in this procedure:

1. Rater A and rater B's codes are matched according to sequence, which is measured in 30 second intervals.
    a. A and B are matched in time on the marker code (Global Distress), which they make, confirming the initial event selection for Global Distress.
    b. If they agree on the subsequently ordered codes then those codes are all counted as agreements.
2. There are three types of errors (see figure 2)
    a. If a code is missing by rater A in relation to B it is an error of omission.
    b. If a code is superfluously made by rater A in relation to B it is an error of commission.
        - Note that omissions and commissions are essentially the same error depending on who is the primary rater (i.e. depending on the perspective of A vs. B). For this reason I will simply refer to both of these as error of omission.

c. If A and B each have a commission/omission error in the same sequential order relative to one another this is considered to be a full (pure) error. A full error is when A and B have coded the same sequentially occurring event in different ways. In other words, the raters disagree on the event in question (rather than it having been overlooked or overcoded, which is omission or commission, respectively). This type of pure error is best examined using a confusion matrix (an example follows, see figure 4).

- Note that if there is agreement subsequent to an error of omission then one of the sequential ratings lacks a "placeholder" and the two ratings are misaligned (even though they may demonstrate some accordance). Thus, any codes that match following an omission must be put into question until the ratings can be re-aligned. The tools used to reinitiate the alignment of codes are the matching time rule and the rationalist analysis of continuity (the next two rules).

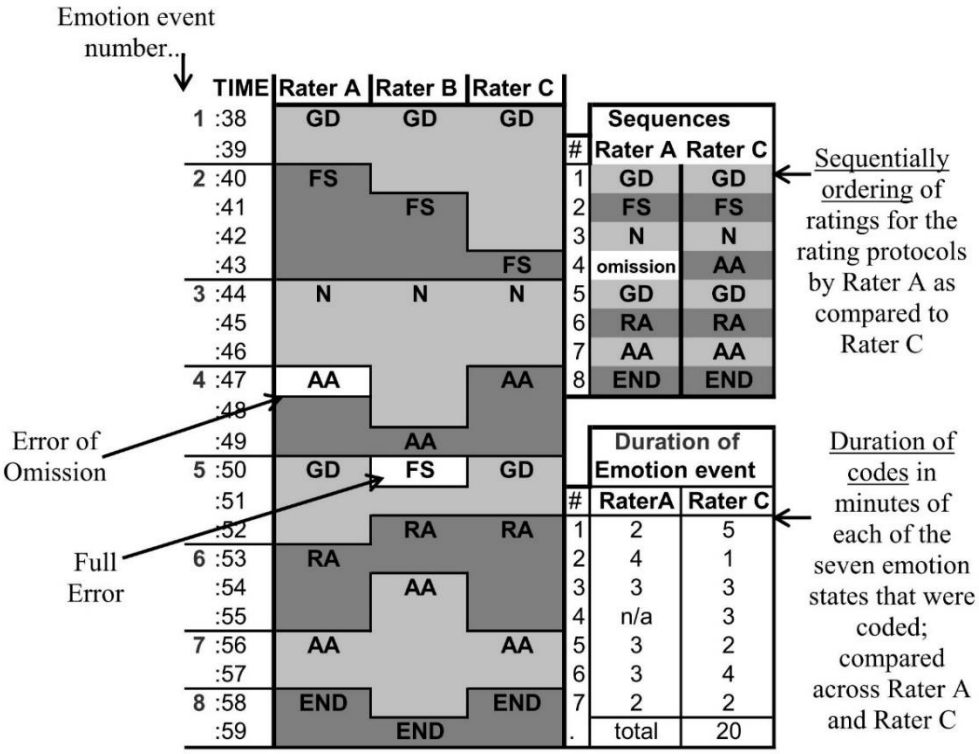
3. Aligning rating of A and B is always done within the constraints of a matching time rule. There must be a minimum of one minute overlap between A and B's codes for one to assume that the two raters are coding the same event. This rule is especially useful following an omission of one rater's codes relative to the other's codes, and when the sequential order of coded events is lost. However, this rule is also used as a guiding principle to all code alignment.

4. Moreover, the continuity of codes is also being checked using a rational analysis of continuity. This is possible because some affective-meaning codes are more likely to be confounded than others. Primary examples of this are (i) Negative Evaluation and Fear/Shame, or (ii) Assertive Anger and Rejecting Anger. For example, if rater A were to code a particular event at a particular time as Assertive Anger and rater B were to code a particular event at around the same time as Rejecting Anger, it would be considered a full error for the purposes of reliability. This is because the two raters have made different ratings at the same point in their sequence of codes and it is fair to assume from a rationalist perspective that they were coding the same event. This continuity analysis, like the matching time rule, allows rating alignment to continue despite interruptions (i.e. errors).

Reliability. Finally, reliability between independent rater was measured by agreement in the ratings of A vs. B.

Figure 2: An example of aligned ratings

of three hypothetical raters



Two of the three aspects of reliability measurement (sequential reliability and duration reliability) were produced using comparative tables similar to those on the right of this figure.

Reliability of the Measure

Of the total sample of 34 cases used in the doctoral research of Pascual-Leone (2005), 27 cases (79.4%) were randomly selected and independently re-rated in their entirety by a second rater for the purposes of establishing reliability. With respect to the number of actual codes made during data collection 352 out of 395 individual codes (89.1%) were re-rated. Ratings produced by continuous cross-classification must be aligned (see preceding section) and then require different forms of reliability depending on how data are being used. First, the continuous nature of ratings required that independent rater agreement on what constitutes a discrete *change in state* be demonstrated; this is referred to as the *unitization of observations* and reached a percent agreement of 85.9% (see figure 3). Second, the classification of eleven different codes in the measure required that the *sequential ordering* of those classes also be reliable in the ratings; which they were, Cohen's $\underline{k}$ = 0.91 (see figure 4). Third, the continuous nature of ratings required that an agreement be demonstrated between independent raters on the *duration of any given unit* of coding and this was also show to be high, $\underline{r}$ = 0.76. According to Fleiss (1981), levels of agreement above .75 can be considered excellent agreement above chance. Thus, the measure demonstrated high overall reliability.

Figure 3: Agreement about unitization of observations

		Rater B	
		Event	**Not**
Rater A	**Event**	265	44
	No	43	

Estimated total events: 308.5; **Agreement: 85.90%**

Total Agreements / [(Total Agreements) + (Omissions of A + omissions of B)/2]
This agreement formula was developed by Dr. F. F. Strayer at the LESC. Note that a Kappa statistic cannot be calculated for unitization because the frequency of events left uncoded by both raters is unknown.

Figure 4: Confusion matrix to examine pure errors

Rater A	Rater B	1 GD	2 FS	3 NE	4 N	5 RA	6 AA	7 SS	8 HG	9 A&L	10 End	11 Relief	12 Mix	13 Omi	sub-totals		Base rates
1	Global Distress	61			1				2				1	8	73		24%
2	Fear/Shame	1	38										1	5	45		15%
3	Negative Evaluation	1	3	21									1	4	30		10%
4	Need				32									10	42		14%
5	Rejecting Anger		1			20	2		1					6	30	Total	10%
6	Assertive Anger				1	1	12							1	15	#	5%
7	Self Soothing	1						8				1		4	14	codes	5%
8	Hurt/Grief		1					1	23					6	31	made	10%
9	Acceptance & let go														0	by	0%
10	End Code										24				24	Rater	8%
11	Relief										1	2			3	A:	1%
12	Mixed/Uncodable	1											1		2	306	1%
13	Omission	12	8	2	7	7	2	3	2						42		
	sub-total:	77	51	23	41	28	16	12	28	0	25	3	4	44	# of observations:		
													Total # of codes by Rater B:		308	Absolute obs.	352
Coding base rates by rater:		25%	17%	7%	13%	8%	5%	4%	9%	0%	8%	1%	1%			Mutual obs..	260

NB: Marginal homogeneity is found by comparing raters' base rates.

Representative Proportion			
Full Study N =		**Reliability sample**	**Proportion**
# Cases	34	27	79.4%
# Codes	395	352	89.1%

Appendix B

The Object-Valence Scheme (OVS)

1. Self-Negative Code (SN)

The subject expresses a negative view of the self in any of the following ways:

- **negative evaluation of the self**
    - e.g., “I’m so worthless”
- **rejection of the negative self**
    - self-criticism
    - self-loathing
    - self-blame
    - self-disgust
- **desire for disconnection with the negative self**
    - e.g. “I need to hide that part of myself, it’s disgraceful”

2. Self-Positive Code (SP)

The subject expresses a positive view of the self in any of the following ways:

- **positive self-evaluation**
    - e.g., “I’m very skilled at what I do, not many people can do what I do”
- **support of the positive self**
    - self-acceptance
    - self-compassion
    - self-soothing

  - self-protection
  - self-coaching
  - self-assertiveness/self-affirmation
- **desire for connection with the positive self**
  - e.g., “I’ve really let myself go over the years, I want to rediscover my real myself now”

3. Other-Negative Code (ON)

The subject expresses a negative view of the other in any of the following ways:

- **negative evaluation of the other**
  - e.g., “He’s such an idiot, I can’t deal with him anymore”
- **rejection of the negative other**
  - criticizing the other
  - blaming the other
  - attacking the other
  - hating/disliking the other
  - anger/resentment/disgust towards the other
- **desire to distance/disconnect from the negative other**
  - e.g., “My boss is so arrogant, I just packed my things and never came back”

4. Other-Positive Code (OP)

The subject expresses a positive view of the other in any of the following ways:

- **positive evaluation of the other**

    - e.g. “He’s simply the best, he’s always looking out for me”

- **support of the positive other**
    - accepting the other
    - soothing the other
    - protecting the other
    - asserting on behalf of the other
    - liking the other
    - care/love for the other
- **desire to approach/connect with the positive other**
    - e.g., “I really miss her and the connection we had, I’m going to call her tonight”

5. Uncodable (UNC)

This code is given when criteria is not met for any other code. Two common scenarios for this are:

- **the object is absent or not clear**
    - e.g. “Everything is just falling apart at the seams, it feels so hopeless”
- **the object is present (self or other), but there is no clear positive or negative view of the object**
    - e.g. “The professor gave us a pop quiz today, I was scared because he gave us no indication that it was coming up”

Table 1

Frequency Table for Client Membership in Revised Lower-Order Kagan (2003) Self-critical Subgroup Categories

	Frequency of Clients Having This Code as Most Frequent or Salient	*Client Numbers*
Compare and Despair	8	405, 407, 409, 413, 414, 415, 420, 435
Too Needy/Dependent	4	401, 411, 417, 903
Unacceptable Feelings and Shoulds	8	406, 410, 419, 425, 426, 427, 429, 978
Core Worthlessness	22	402, 403, 404, 412, 418, 421, 422, 423, 428, 430, 431, 433, 436, 437, 450, 452, 454, 458, 460, 476, 925, 933
Self-interruption of Feelings	0	

Note. $N = 42$; In this revision of Kagan's (2003) self-critical taxonomy, Compare and Despair's name was retained; Too Needy/ Dependent was renamed from Too Needy/ Sensitive; Unacceptable Feelings and Shoulds was renamed from Internalized Shoulds/Unacceptable Feelings; Core Worthlessness was renamed from Unworthy/Not Good Enough; and Self-interruption of Feelings was not in Kagan (2003) originally. Frequency represents the most frequent self-critical code the client was given. No client was given the Self-interruption of the Feelings code most frequently. Clients who were assigned to the Core Worthlessness subgroup were either given the Core Worthlessness code most frequently or had salient expressions of the Core Worthlessness code.

Table 2

Summary of Specific Working Phase Emotional Processes identified from both Proportional and THEME Analyses distinguishing Socially Inadequate and Core Worthlessness Clients

	Socially Inadequate (SI)	*Core Worthlessness (CW)*
Specific Emotional Processes	• More UC*, SS^{*t}, and OP* • Less NSE^{*t}, HG*, and ON* • More UC-UC sequences • Less FS, AA, HG sequences	• Less UC*, SS^{*t}, and OP* • More NSE^{*t}, HG*, and ON* • Less UC-UC sequences • More FS, AA, HG sequences

Note. Full sample (n = 42). ^{*t} = trend (.05 < p < .15); * = p < .05. Outcome = BDI at 18 months post-treatment. UC = uncodable on CAMS measure; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion. GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency. SP = self-positive; SN = self-negative; OP = other-positive; ON = other-negative.

Table 3

Comparing Mean Proportions of Working Phase CAMS emotion category coded EEs between EFT-theory based Higher-Order Self-critical Subgroups

	Socially Inadequate (SI)	*Core Worthlessness (CW)*	*Mann-Whitney Significance Level*
CAMS Uncodable (UC)	.27 (0.14)	.17 (0.11)	.01*
CAMS Global Distress (GD)	.13 (0.11)	.15 (0.10)	*ns*
CAMS Rejecting Anger (RA)	.14 (0.13)	.10 (0.08)	*ns*
CAMS Fear/Shame (FS)	.15 (0.13)	.20 (0.16)	*ns*
CAMS Negative Self-Evaluation (NSE)	.03 (0.04)	.05 (0.06)	$.12^{t}$*
CAMS Need (ND)	.10 (0.07)	.08 (0.05)	*ns*
CAMS Relief (RE)	.09 (0.08)	.08 (0.09)	*ns*
CAMS Hurt/Grief (HG)	.03 (0.04)	.08 (0.08)	.02*
CAMS Assertive Anger (AA)	.03 (0.04)	.06 (0.07)	*ns*
CAMS Self-Soothing (SS)	.03 (0.04)	.01 (0.02)	$.14^{t}$*
CAMS Acceptance & Agency (ACAG)	.00 (0.01)	.01 (0.04)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant; 'Socially Inadequate' self-critical subgroup ($n = 20$), 'Core Worthlessness' self-critical subgroup ($n = 22$). Mean proportions and standard deviations by subgroup are presented in columns two and three. Mann-Whitney *U*-tests examined whether the group means differed per category (indicated in the last column).

Table 4

Comparing Mean Proportions of Working Phase CAMS-coded EEs calculated as ES Categories between EFT-theory based Higher-Order Self-critical Subgroups

	Socially Inadequate (SI)	*Core Worthlessness (CW)*	*Mann-Whitney Significance Level*
ES Uncodable (UC)	.27 (0.14)	.17 (0.11)	.01*
ES Secondary Emotion (SE)	.27 (0.20)	.26 (0.13)	*ns*
ES Primary Maladaptive Emotions (PME)	.17 (0.15)	.25 (0.17)	*ns*
ES Need (ND)	.10 (0.07)	.08 (0.05)	*ns*
ES Primary Adaptive Emotions (PAE)	.18 (0.10)	.25 (0.17)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ˡ* = $p < .15$ (trend); 'Socially Inadequate' self-critical subgroup (n = 20), 'Core Worthlessness' self-critical subgroup (n = 22). Mean proportions and standard deviations by subgroup are presented in columns two and three. Mann-Whitney *U*-tests examined whether the group means differed per category (indicated in the last column).

Table 5

Comparing Mean Proportions of Working Phase OVS coded-EEs between EFT-theory based Higher-Order Self-critical Subgroups

	Socially Inadequate (SI)	*Core Worthlessness (CW)*	*Mann-Whitney Test Significance Level*
OVS Uncodable (UC)	.39 (0.15)	.29 (0.13)	.05*
OVS Other-Negative (ON)	.26 (0.18)	.37 (0.16)	.05*
OVS Other-Positive (OP)	.11 (0.07)	.06 (0.05)	.03*
OVS Self-Negative (SN)	.15 (0.10)	.17 (0.13)	*ns*
OVS Self-Positive (SP)	.10 (0.08)	.11 (0.09)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ‘* = $p < .15$ (trend), *ns* = not significant; ‘Socially Inadequate’ self-critical subgroup ($n = 20$), ‘Core Worthlessness’ self-critical subgroup ($n = 22$). Mean proportions and standard deviations by subgroup are presented in columns two and three. Mann-Whitney *U*-tests examined whether the group means differed per category (indicated in the last column).

Table 6

THEME-detected Sequences of EE-CAMS Emotion and CAMS coded Emotion Schemes occurring with greatest frequency within each Higher-order EFT-theory based Self-critical Subgroup

	CAMS Emotion Patterns	*CAMS-coded ES Patterns*
Socially Inadequate (SI)	UC-UC-UC (15/19 clients)	UC-UC-UC (15/19 clients)
Core Worthlessness (CW)	FS-FS (18/22 clients) AA-AA (10/22 clients) HG-HG (10/22 clients)	PME-PME (21/22 clients) PAE-PAE (19/22 clients)

Note. Full sample used here (n = 41, minus one client who did not have available data). These are the longest CAMS and CAMS-coded ES patterns detected by THEME analyses condensed into global pattern themes based on pattern similarity. These patterns are occurring with greater frequency (binomial test, p = .05) in each self-critical subgroup. In brackets are how many clients in each subgroup who possessed this pattern. UC = uncodable; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion.

Table 7

Summary of Specific Emotional Processes identified from both Proportional and THEME Analyses distinguishing Good Outcome (non-depressed at 18-month follow-up) versus Poor Outcome (depressed at 18-month follow-up) for Higher-order EFT-theory based subgroups

	Good Outcome Client Sessions	*Poor Outcome Client Sessions*
Socially Inadequate (SI)	• More HG^{*t} and SS^{*t} • Less SE^{*t} (RA^{*t}) and ON^{*t} • More HG sequences	• Less HG^{*t} and SS^{*t} • More SE^{*t} (RA^{*t}) and ON^{*t} • More *stuck* sequences of UC-CAMS and SE (GD, RA) • More *escape* sequences of FS→RA
Core Worthlessness (CW)	• More PME* (FS^{*t}, NSE^{*t}), ND*, SN* • Less UC*, SE^{*t} (GD^{*t}) • More *movement* sequences of SE→PME→ND→PAE	• Less PME* (FS^{*t}, NSE^{*t}), ND*, SN* • More UC*, SE^{*t} (GD^{*t}) • More *stuck* sequences of UC and GD

Note. N = 28 (15 SI clients and 14 CW clients who provided 18-month follow up data). ^{*t} = trend ($.05 < p < .15$); * = $p < .05$. Outcome = BDI at 18 months post-treatment. UC = uncodable on CAMS measure; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion. GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency. SP = self-positive; SN = self-negative; OP = other-positive; ON = other-negative.

Table 8

Comparing Mean Proportions of Working Phase CAMS Category coded EEs between Not Depressed and Depressed at 18 months Socially Inadequate (SI) Clients

	Depressed at 18 months SI Clients	*Not Depressed at 18 months SI Clients*	*Mann-Whitney Significance Level*
CAMS Uncodable (UC)	.26 (0.13)	.29 (0.16)	*ns*
CAMS Global Distress (GD)	.16 (0.14)	.07 (0.06)	*ns*
CAMS Rejecting Anger (RA)	.16 (0.07)	.08 (0.10)	.06^{t}*
CAMS Fear/Shame (FS)	.14 (0.10)	.19 (0.15)	*ns*
CAMS Negative Self-Evaluation (NSE)	.04 (0.05)	.03 (0.05)	*ns*
CAMS Need (ND)	.08 (0.07)	.12 (0.08)	*ns*
CAMS Relief (RE)	.11 (0.12)	.09 (0.05)	*ns*
CAMS Hurt/Grief (HG)	.01 (0.02)	.05 (0.05)	.14^{t}*
CAMS Assertive Anger (AA)	.03 (0.04)	.03 (0.04)	*ns*
CAMS Self-Soothing (SS)	.01 (0.03)	.05 (0.05)	.15^{t}*
CAMS Acceptance & Agency (ACAG)	.00 (0.01)	.00 (0.01)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant; 'Socially Inadequate' (SI) self-critical subgroup ($n = 15$ with 8 good outcomes and 7 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 9

Comparing Mean Proportions of Working Phase CAMS-coded EEs calculated as ES Categories between Not Depressed and Depressed at 18 months Socially Inadequate (SI) Clients

	Depressed at 18 months SI Clients	*Not Depressed at 18 months SI Clients*	*Mann-Whitney Significance Level*
ES Uncodable (UC)	.26 (0.13)	.29 (0.16)	*ns*
ES Secondary Emotion (SE)	.31 (0.18)	.15 (0.10)	$.06^{t}$*
ES Primary Maladaptive Emotions (PME)	.18 (0.12)	.21 (0.17)	*ns*
ES Need (ND)	.08 (0.07)	.12 (0.08)	*ns*
ES Primary Adaptive Emotions (PAE)	.17 (0.13)	.22 (0.06)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant 'Socially Inadequate' (SI) self-critical subgroup ($n = 15$ with 8 good outcomes and 7 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 10

Comparing Mean Proportions of Working Phase OVS Category coded EEs between Not Depressed and Depressed at 18 months Socially Inadequate (SI) Clients

	Depressed at 18 months SI Clients	*Not Depressed at 18 months SI Clients*	*Mann-Whitney Significance Level*
OVS Uncodable (UC)	.34 (0.10)	.42 (0.18)	*ns*
OVS Other-Negative (ON)	.32 (0.15)	.18 (0.21)	$.08^{t}$*
OVS Other-Positive (OP)	.09 (0.06)	.14 (0.08)	*ns*
OVS Self-Negative (SN)	.14 (0.11)	.17 (0.11)	*ns*
OVS Self-Positive (SP)	.12 (0.09)	.09 (0.05)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant; 'Socially Inadequate' (SI) self-critical subgroup ($n = 15$ with 8 good outcomes and 7 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 11

Comparing Mean Proportions of Working Phase CAMS Category coded EEs between Not Depressed and Depressed at 18 months Core Worthlessness (CW) Clients

	Depressed at 18 months CW Clients	*Not Depressed at 18 months CW Clients*	*Mann-Whitney Significance Level*
CAMS Uncodable (UC)	.36 (0.09)	.15 (0.09)	.02*
CAMS Global Distress (GD)	.24 (0.11)	.11 (0.07)	.07^{t}*
CAMS Rejecting Anger (RA)	.11 (0.09)	.09 (0.11)	*ns*
CAMS Fear/Shame (FS)	.09 (0.07)	.25 (0.19)	.07^{t}*
CAMS Negative Self-Evaluation (NSE)	.00 (0.00)	.02 (0.03)	.12^{t}*
CAMS Need (ND)	.03 (0.03)	.11 (0.06)	.02*
CAMS Relief (RE)	.09 (0.14)	.10 (0.01)	*ns*
CAMS Hurt/Grief (HG)	.02 (0.02)	.09 (0.09)	*ns*
CAMS Assertive Anger (AA)	.06 (0.07)	.07 (0.08)	*ns*
CAMS Self-Soothing (SS)	.00 (0.00)	.01 (0.01)	*ns*
CAMS Acceptance & Agency (ACAG)	.00 (0.00)	.00 (0.01)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant; 'Core Worthlessness' (CW) self-critical subgroup ($n = 14$ with 11 good outcomes and 3 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 12

Comparing Mean Proportions of Working Phase CAMS-coded EEs calculated as ES Categories between Not Depressed and Depressed at 18 months Core Worthlessness (CW) Clients

	Depressed at 18 months CW Clients	*Not Depressed at 18 months CW Clients*	*Mann-Whitney Significance Level*
ES Uncodable (UC)	.36 (0.09)	.15 (0.09)	.02*
ES Secondary Emotion (SE)	.34 (0.17)	.20 (0.12)	$.10^{t}$*
ES Primary Maladaptive Emotions (PME)	.09 (0.07)	.27 (0.18)	.05*
ES Need (ND)	.03 (0.03)	.11 (0.06)	.02*
ES Primary Adaptive Emotions (PAE)	.18 (0.22)	.26 (0.18)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend), *ns* = not significant; 'Core worthlessness' (CW) self-critical subgroup ($n = 14$ with 11 good outcomes and 3 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 13

Comparing Mean Proportions of Working Phase OVS Category coded EEs between Not Depressed and Depressed at 18 months Core Worthlessness (CW) Clients

	Depressed at 18 months CW Clients	*Not Depressed at 18 months CW Clients*	*Mann-Whitney Significance Level*
OVS Uncodable (UC)	.36 (0.16)	.34 (0.12)	*ns*
OVS Other-Negative (ON)	.44 (0.04)	.32 (0.17)	*ns*
OVS Other-Positive (OP)	.06 (0.06)	.06 (0.05)	*ns*
OVS Self-Negative (SN)	.03 (0.03)	.18 (0.14)	.02*
OVS Self-Positive (SP)	.11 (0.13)	.09 (0.04)	*ns*

Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, [t]* = $p < .15$ (trend), *ns* = not significant; 'Core Worthlessness' (CW) self-critical subgroup ($n = 14$ with 11 good outcomes and 3 poor outcomes). Mean proportions and standard deviations by subgroup are presented.

Table 14

THEME-detected CAMS Emotion State Sequences for Good versus Poor 18-month Outcomes within each Higher-order EFT-theory based Self-critical Subgroup

	Good Outcome Client Sessions	*Poor Outcome Client Sessions*
Socially Inadequate (SI)	HG (5/8 clients)	GD-UC (4/7 clients) GD-GD (3/7 clients) RA-RA (5/7 clients) FS-RA (6/7 clients)
Core Worthlessness (CW)	FS-ND-ND (6/11 clients)	UC-UC-UC (3/3 clients) UC-GD (2/3 clients) GD-GD (3/3 clients)

Note. Outcome = BDI at 18 months post-treatment. These are the longest CAMS patterns detected by THEME analyses condensed into global pattern themes based on pattern similarity. These patterns are occurring with greater frequency (binomial test, $p = .05$) in each outcome group within each self-critical subgroup. In brackets are how many clients in each outcome group who possessed this pattern. UC = uncodable; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency.

Table 15

THEME-detected CAMS-coded ES Emotion Sequences for Good versus Poor 18-month Outcomes within each Higher-order EFT-theory based Self-critical Subgroup

	Good Outcome Client Sessions	*Poor Outcome Client Sessions*
Socially Inadequate (SI)	None	SE-UC-UC (4/7 clients) SE-SE (7/7 clients) SE-PME-SE (4/7 clients) PME-SE (5/7 clients)
Core Worthlessness (CW)	ND-PAE-PAE-ND (4/11 c's) ND-PME (6/11 clients) PME-PAE (6/11 clients) SE-PME (10/11 clients) PAE-ND-PAE (5/11 clients) PME-PME-ND (6/11 clients) ND-ND (5/11 clients)	UC-SE-SE (1/3 clients) UC-UC-UC (3/3 clients)

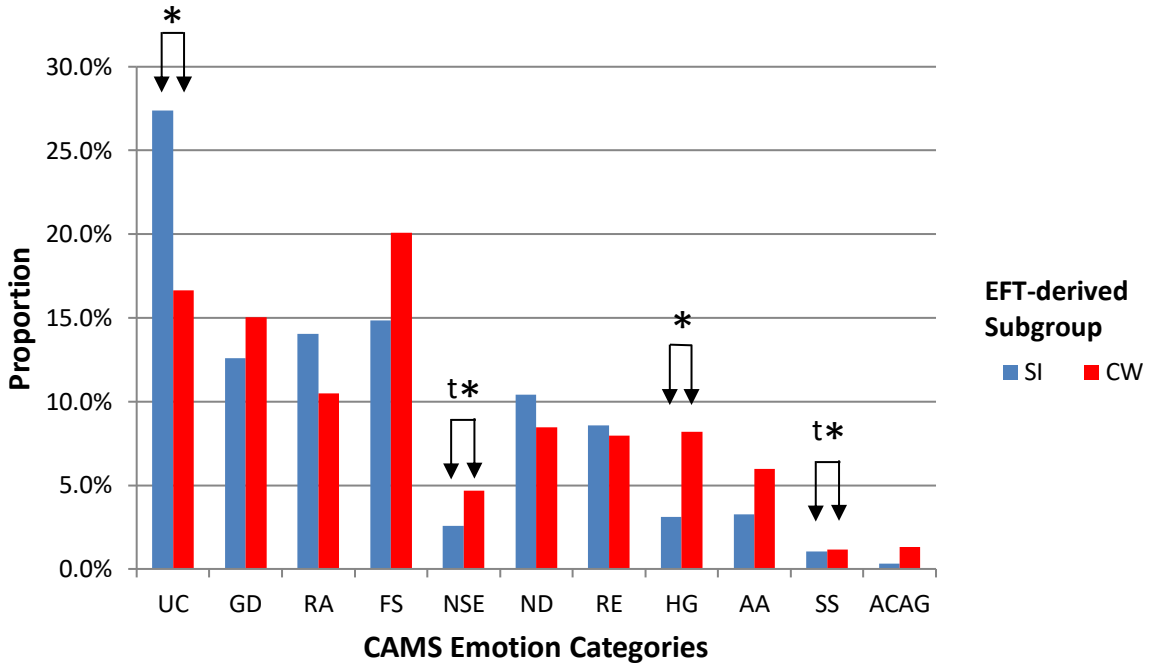
Note. Outcome = BDI at 18 months post-treatment. These are the longest ES patterns detected by THEME analyses condensed into global pattern themes based on pattern similarity. These patterns are occurring with greater frequency (binomial test, $p = .05$) in each outcome group within each self-critical subgroup. In brackets are how many clients in each outcome group who possessed this pattern. UC = uncodable; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion.

Figure 1. Treatment session summary sample: Session six for *Colby* (pseudonym for client #420) coded with Kagan's (2003) self-critical categories

Client Written Responses on Post-session Client Questionnaires[a]	*Therapist Written Responses on Post-session Therapist Questionnaires*[b]	*Kagan (2003) Self-critical Category/Subtype Codes*
Concern about self: self-esteem Concern about others: ex-wife's beliefs Shift? (rated 5 out of 7): I have again realised that much of my down feels come from not feeling busy in society. Not working to my potential. Not having the chance to be useful. Rather wasting away. Wants to behave differently? (rated 4 out of 7): I have a day job lined up that I believe will solve many problems	Primary focus: a) Primary concerns relating to self: "beating himself up" for being a failure b) Concerns in regards to relationships with others: lingering bad feeling about his ex-wife Significant shift?: No Emotional arousal or intense emotion?: No Emotional pain in session?: No Relief from shift?: No Shame?: No Forgiveness?: No Hopelessness?: No	COMPARE AND DESPAIR COMPARE AND DESPAIR

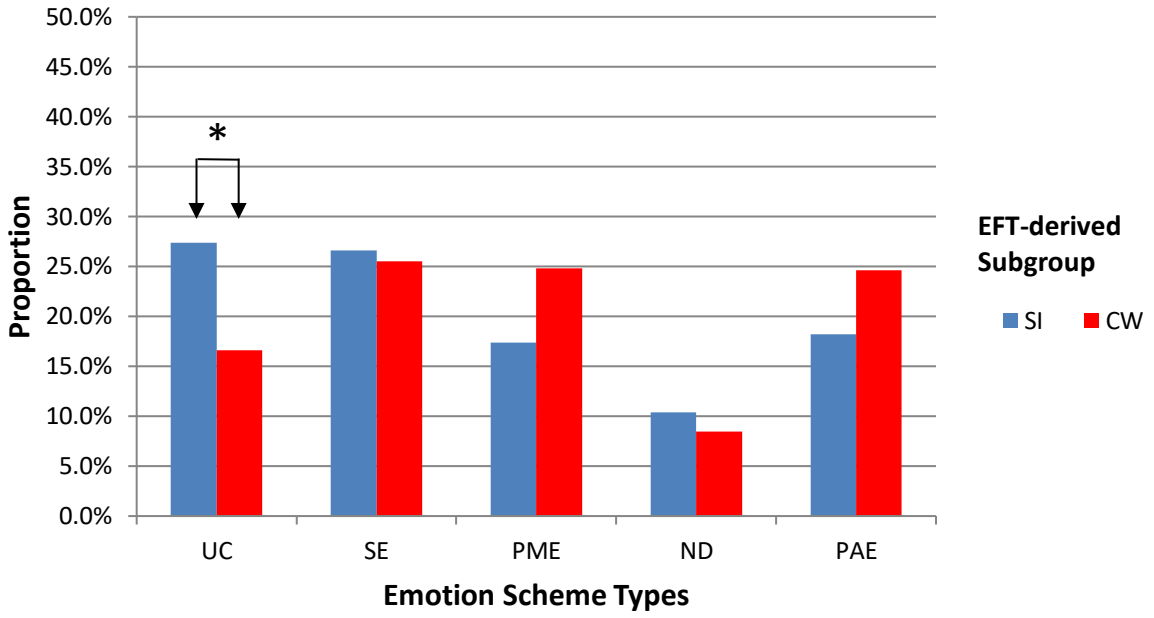
Note. [a] = Post-session client questionnaires included the Client General Session Evaluation Questionnaire (GESQ), which also included the Helpful Aspects of Therapy Form (HAT), and the Client Task Specific Measure (CTSM); [b] = Post-session therapist questionnaire was the Therapist Session Questionnaire (TSQ).

Figure 2. Mean proportions of CAMS-coded WP-EEs for each EFT-theory based higher-order self-critical subgroup: Socially Inadequate (SI) and Core Worthlessness (CW)



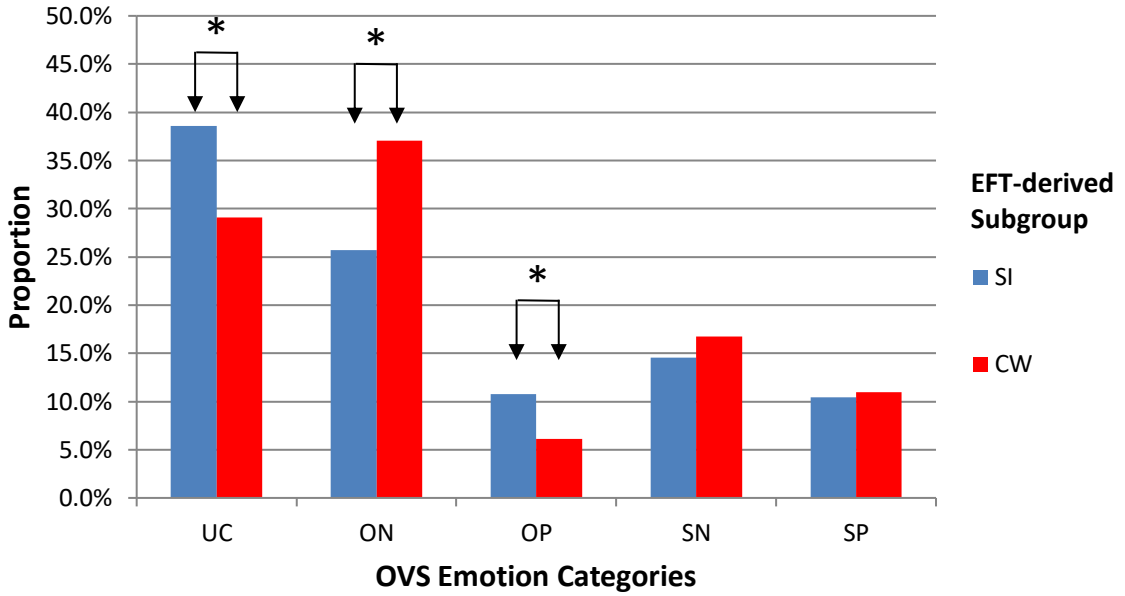
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, t* = $p < .15$ (trend); WP-EE = working phase emotion episodes; SI = Socially Inadequate self-critical subgroup ($n = 20$), CW = Core Worthlessness self-critical subgroup ($n = 22$); UC = uncodable; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency.

Figure 3. Mean WP-EE proportions rated with CAMS-coded ES categories for each EFT-theory based higher-order self-critical subgroup.



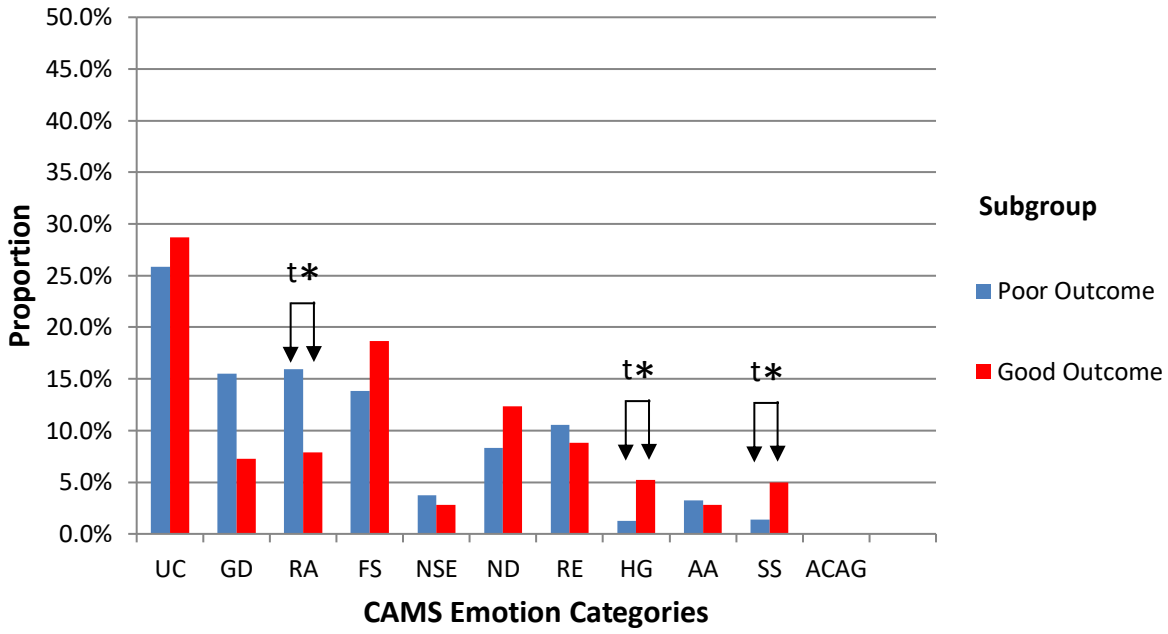
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, [t]* = $p < .15$ (trend); WP-EE = working phase emotion episodes; SI = Socially Inadequate self-critical subgroup ($n = 20$), CW = Core Worthlessness self-critical subgroup ($n = 22$); UC = uncodable; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion.

Figure 4. Mean WP-EE proportions rated with OVS categories for each EFT-theory based higher-order self-critical subgroup.



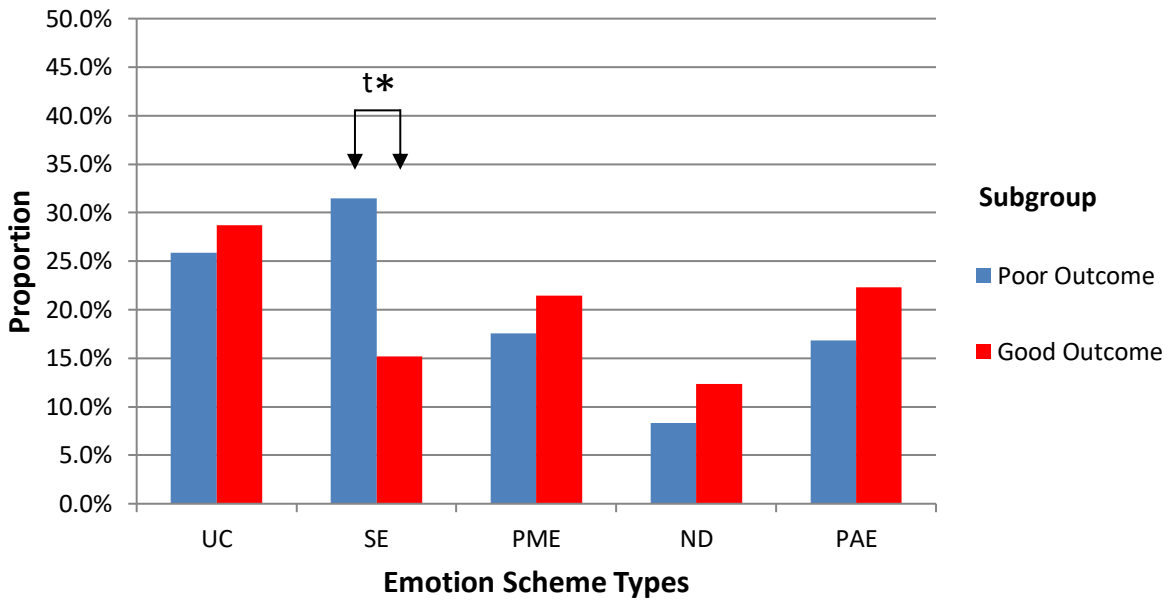
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; SI = Socially Inadequate self-critical subgroup ($n = 20$), CW = Core Worthlessness self-critical subgroup ($n = 22$); UC = uncodable; ON = other-negative; OP = other-positive; SN = self-negative; SP = self-positive.

Figure 5. Mean proportions of CAMS-coded WP-EEs for good versus poor outcome 'Socially Inadequate' (SI) clients (EFT-derived subgroup).



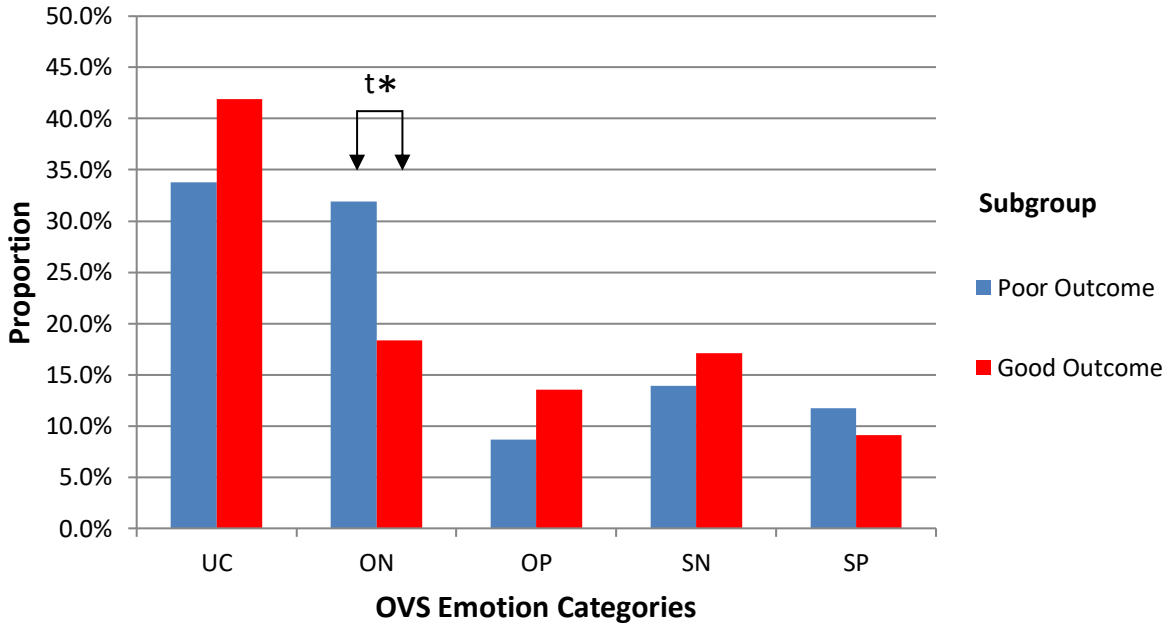
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Socially Inadequate (SI) self-critical subgroup (n = 15 with 8 good outcomes and 7 poor outcomes); UC = uncodable; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency.

Figure 6. Mean WP-EE proportions rated with CAMS-coded ES categories for good versus poor outcome 'Socially Inadequate' (SI) clients (EFT-derived subgroup).



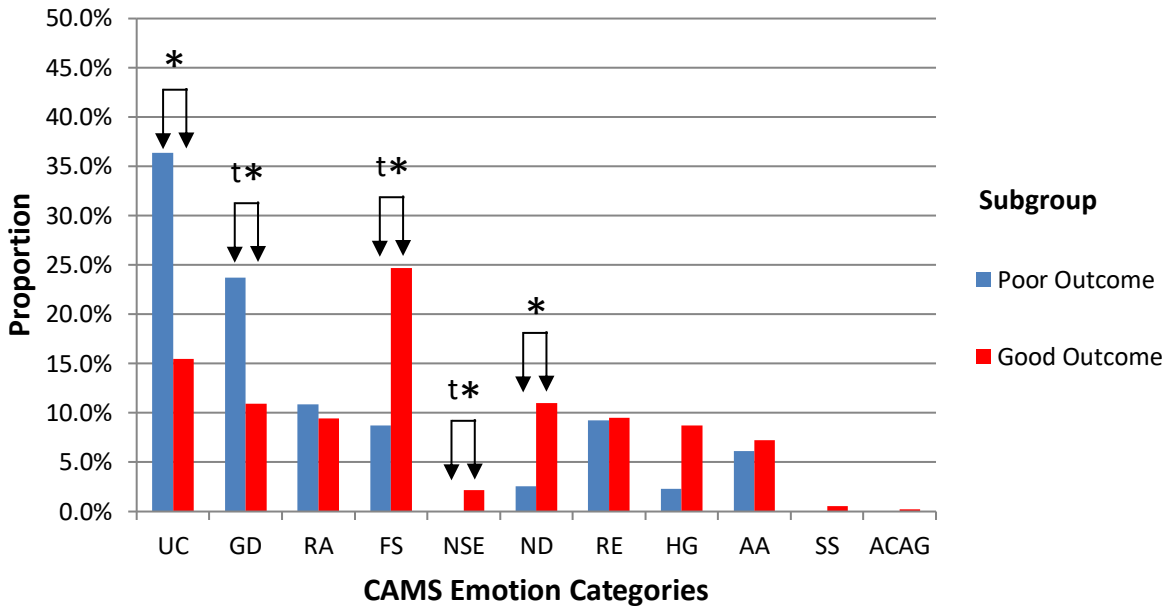
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Socially Inadequate (SI) self-critical subgroup (n = 15 with 8 good outcomes and 7 poor outcomes); UC = uncodable; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion.

Figure 7. Mean WP-EE proportions rated with OVS categories for good versus poor outcome 'Socially Inadequate' (SI) clients (EFT-derived subgroup).



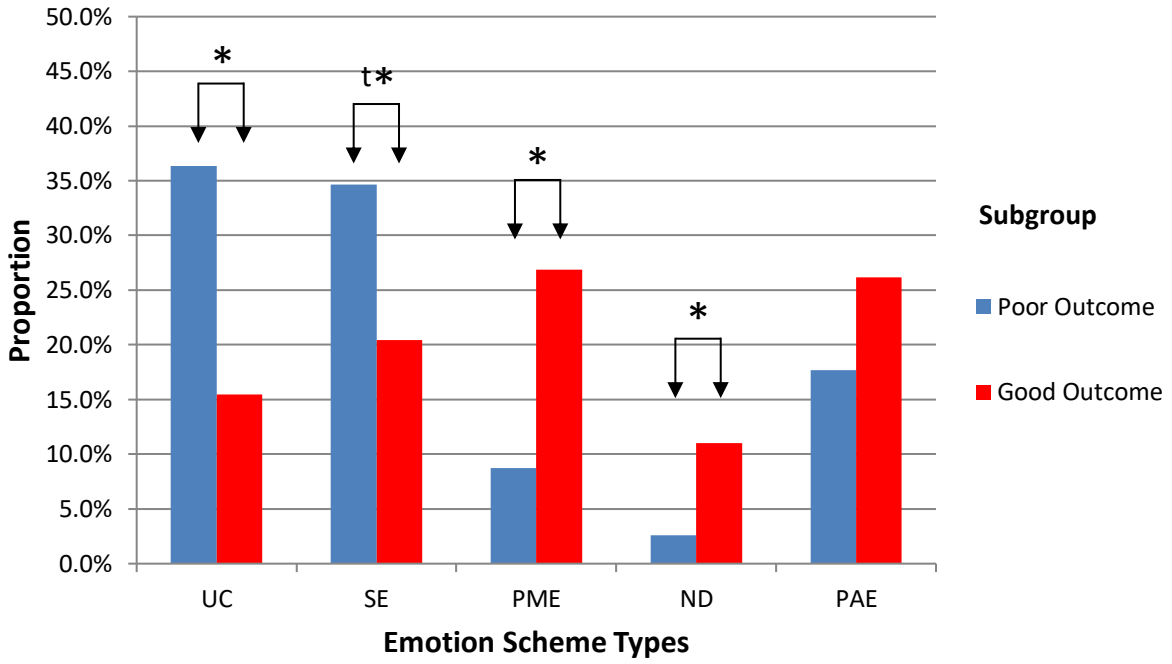
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Socially Inadequate (SI) self-critical subgroup (n = 15 with 8 good outcomes and 7 poor outcomes); UC = uncodable; ON = other-negative; OP = other-positive; SN = self-negative; SP = self-positive.

Figure 8. Mean proportions of CAMS-coded WP-EEs for good versus poor outcome 'Core Worthlessness' (CW) clients (EFT-derived subgroup).



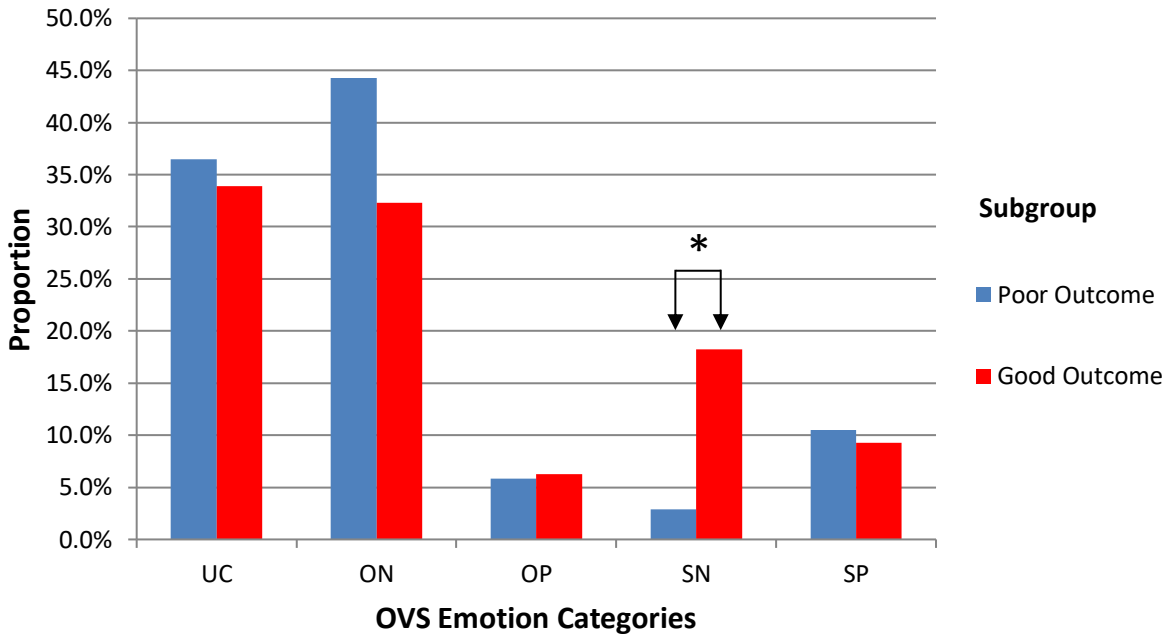
Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Core Worthlessness (CW) self-critical subgroup (n = 14 with 11 good outcomes and 3 poor outcomes); UC = uncodable; GD = global distress; RA = rejecting anger; FS = fear/shame; NSE = negative self-evaluation; ND = need; RE = relief; HG = hurt/grief; AA = assertive anger; SS = self-soothing; ACAG = acceptance and agency.

Figure 9. Mean WP-EE proportions rated with CAMS-coded ES categories for good versus poor outcome 'Core Worthlessness' (CW) clients (EFT-derived subgroup).



Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Core Worthlessness (CW) self-critical subgroup (n = 14 with 11 good outcomes and 3 poor outcomes); UC = uncodable; SE = secondary emotion; PME = primary maladaptive emotion; ND = need; PAE = primary adaptive emotion.

Figure 10. Mean WP-EE proportions rated with OVS categories for good versus poor outcome 'Core Worthlessness' (CW) clients (EFT-derived subgroup).



Note. * = $p < .05$; ** = $p < .01$; *** = $p < .005$, ^{t}* = $p < .15$ (trend); WP-EE = working phase emotion episodes; Core Worthlessness (CW) self-critical subgroup ($n = 14$ with 11 good outcomes and 3 poor outcomes); UC = uncodable; ON = other-negative; OP = other-positive; SN = self-negative; SP = self-positive.