University of Alberta

Client Perceptions of Emotional Experience in Counselling

by

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A Thesis Submitted to the Faculty of Graduate Studies and Research

in partial fulfilment of the requirements for the Degree of Doctor of Philosophy

in

Counselling Psychology

Department of Educational Psychology

Edmonton, Alberta

Fall 2002

Abstract

With growing evidence for the utility of the client's emotional experience as an active change agent in the therapeutic change process, this study investigated clients' perceptions of their emotional experience in counselling. In-depth interviews were combined with a concept mapping analysis to gather data about clients' perceptions of their emotional experience in counselling. Two questions were addressed: 1) What were the client's emotional experience in counselling? and 2) What was helpful about these experience? Two data collection sessions were conducted with two separate groups of participants. In the initial data collection session 9 adult client participants, aged 18 or older (3 male, 6 female) with a mean of 21 sessions were interviewed using an open-interview format. The data-gathering interview was designed to gather information on participants' experience of emotion in the therapeutic process. Summaries of participant interviews are presented that provide qualitative information and a contextual framework against which to view the concept map. Common themes across interviews were examined in conjunction with the concept map results. In the second data collection session 22 adult participants, age 18 or older (7 male, 15 female) with experience exploring emotional material in therapy were asked to participate in a sorting and rating task utilizing statements extracted from the interviews. Results of the sorting and rating task were analyzed using the concept mapping method. This method combines multidimensional scaling and hierarchical cluster analysis to generate a thematic

representation of the underlying structure of the phenomenon of emotional experiencing. The analysis resulted in 8 thematic clusters: (1) Understanding My Emotions, (2) Volatility, (3) Avoidance, (4) Negative Influence of Emotions, (5), Dealing with Emotions, (6) Resolving Emotions, (7) Integration, and (8) Connecting to Self. Further analysis of the data identified three main components of participants' emotional experience consisting of Breakdown of Coping Strategies, Increased Emotional Awareness, and Reorganization. While researchers have investigated various components of this process, the process itself has not previously been identified.

Acknowledgements

Completing this dissertation and my Ph.D. degree would not have been possible without the support of many people. I am blessed to have had such support.

Thank you to my supervisor, Dr. Barbara Paulson, for your never ending belief in what I am capable of, your continued encouragement and "pep talks", and for letting me vent in your office, on the phone, over coffee, over wine and anywhere else I could get away with it.

To Drs. Robin Everall and Derek Truscott, your always timely and valuable feedback is greatly appreciated. Never was I kept waiting when I asked you for feedback. Thank you.

Thank you to my family, who were always there with whatever encouragement and support was needed - offering it before I even asked. Great geographical distances may divide us, but I never doubted how close you really were.

To my cousin Marni for asking the pivotal question - "In five years will you regret not doing this?" - this question was a turning point that kept me going. Thank you.

To Joan, for you invaluable thesis template that made formatting simple and for your incredible patience and generosity, my unending gratitude.

And to all my friends, particularly Carmen, Kelly, Sarah and Jane, thank you for listening, for buying me coffee, wine, dinner etc. when I was too broke, for packing boxes when I had to move and for always, always being there.

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Chapter 1

Introduction

The purpose of this study is to investigate client perceptions of their emotional experience in counselling. Given that a predominant reason clients seek therapy is emotional distress, therapists have concerned themselves with working with clients' emotional experience (Lane & Schwartz, 1987). Peake and Egli (1982) indicate that clients come to therapy in a state of "diffuse discomfort which they are unable to differentiate or articulate further" (p. 163). For therapeutic progress to occur this state must be explored while anchored within the context of a human relationship. Lane and Schwartz note, "Much of psychotherapy consists of helping patients to clarify what they are feeling, understand the origins of their feelings, and tolerate their intense emotional states better while minimizing the tendency to exclude these states from conscious awareness" (p. 133).

Support for the contention that facilitating in-session emotional experience is related to positive outcome has emerged over the last decade from the psychodynamic-interpersonal, cognitive-behavioural and humanistic-experiential theoretical and empirical literatures (Arnkoff & Glass, 1992; Carek, 1990; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Clark, 1995; Klein, Mathieu-Coughlan, & Kiesler, 1986; Mahoney, 1991; Newman, 1991; Safran & Greenberg, 1991; Saunders, 1999) thereby beginning to establish the client's emotional experience as an active agent of therapeutic change. Despite this

growing support the majority of information available on the subject derives from the clinician's perspective. Empirical research has predominantly come from the experiential-humanistic paradigm highlighting techniques associated with deep experiencing (Greenberg, Rice, & Elliott, 1993). Further, additional research in the area of emotional experience outside of this paradigm indicates that the theoretical orientation of the therapist is unrelated to level of the emotional experience of the client, but that a strong relationship exists between in-session emotional experience and positive outcome (Lawhead, 1994; Saunders, 1999; Wiser & Goldfried, 1998). According to Lawhead high moments of client emotional experience were related predominantly to clients' internal processing, and clients were surprised to learn that therapists had specific intentions to guide their behavior, thus highlighting the need for continued research on the client's perspective.

Elliott and James (1989) propose that researchers, theoreticians and practitioners are better able to understand the therapeutic process if they are acquainted with the types of experiences clients have in therapy. The client's perspective is particularly important as clients' and counsellors' perspectives frequently differ (Bachelor, 1992; Elliott & James, 1989; Gershefski, Arnkoff, Glass, & Elkin, 1996; Lawhead, 1994; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988). As a result researchers have begun examining clients' perspectives of their therapeutic experience as one way to identify active agents in the counselling change process (Caskey, Barker, & Elliott, 1984; Elliot,

1985; Elliott & James, 1989; Heppner, Rosenberg, & Hedgespeth, 1992; Lietaer, 1992; Llewelyn et al., 1988; Paulson, Truscott, & Stuart, 1999; Saunders, 1999).

Emotional Restructuring and Meaning Making

The role of restructuring the emotional experience and its role in the creation of new meaning in the therapy process is receiving increasing support (Clarke, 1989, 1996; Greenberg & Pascual-Leone, 1997; Watson & Greenberg, 1996; Young & Bemak, 1996). It is regarded as an essential component in the process of meaning construction (Clarke, 1989; Greenberg & Pascual-Leone; Stein, 1995). Clarke (1989) posits that creation of meaning involves the client's need "to construct the meaning of emotionally charged experience by putting it into words" (p. 139). Stein states, "Episodes of intense emotional 'disorder' are often natural expressions of the attempts of the self to restructure itself" (p. 180). Maroda (1999) notes

> In response to a moment of emotional dissonance, the patient necessarily creates a new experience to resolve the dissonance. Intellectual insight is the naming of this experience. Although a vitally important part of the process, intellectual awareness follows, rather than precedes, the emotional experience. (p. 15)

According to Greenberg & Pascual-Leone (1997)

> . . . the creation of personal meaning involves an ongoing dialectic between two streams of consciousness; consciously mediated conceptualization on the one hand, and automatic, immediate emotional experiencing on the other - a dialectic between reason and emotion, explanation and direct experience. . . Therapy thus needs to help clients attend to their emotional experience in order to create new meaning. (p. 157)

Thus the creation of meaning is held to involve the coupling of emotional and cognitive processes (Greenberg & Pascual-Leone, 1997; Littrell, 1998; Watson & Greenberg, 1996; Young & Bemak, 1996).

The Research Question

From an examination of the literature it is apparent the emotional experience plays a pivotal role in creating new meaning for clients, and it is important to attend to both the emotional experience and cognition in therapy. A review of the literature on emotion and emotional experience establishes the usefulness of attending to the emotional experience in therapy. Emotion provides an orienting and adaptive function in the lives of individuals Izard, 1992, 1993; Plutchik, 1994). Attending to the emotional experience is important in therapy because: (a), both therapist and client gain information about the meaning events hold for clients and also about the client's beliefs and values; (b), access to this information influences decision-making on the part of the client; (c) access to information that tells clients something is wrong motivates clients to change; and (d), expression of unexpressed emotion may help change the client's relationship with a problematic event (Greenberg & Pascual-Leone, 1997). Thus, information is gleaned about the self in interaction with the environment. Since emotions provide information and are relational and motivational in nature the client's affective response acts as an important resource and focus in therapy.

In our previous research (Paulson et al., 1999) clients clearly identified experiencing emotion as a key factor in the helping process. Given the growing support for the emotional experience as an active change agent (Maroda, 1999; Saunders, 1999; Stein, 1995) and the need for continued research on the client's perspective this dissertation addressed the questions what was the client's emotional experience in counselling, and what was helpful about this experience? Addressing these questions has the potential to provide a greater understanding with respect to whether and how experiencing emotion is beneficial to clients. Further it will provide information that can only be hypothesized about unless clients are directly asked about their experience. The addition of this information to the existing body of literature provides clinicians with additional information regarding the therapeutic process thereby informing clinical conceptualization and treatment decisions.

Definitions

Kennedy-Moore & Watson (1999) break emotion down into three primary components and one secondary component. Primary components consist of emotional arousal, emotional experience, and emotional expression, and are defined as follows:

> Emotional arousal: The physiological aspect of emotional responses. One of the three primary components of emotion . . .
>
> Emotional experience: The subjective, felt sense of emotional responses. One of the three primary components of emotion. Inclusive term for the phenomenological aspect of affect, emotions and feelings.

> Emotional expression: Observable verbal and nonverbal behaviours that communicate and/or symbolize emotional experience. Expression can occur with or without self-awareness, it is at least somewhat controllable, and it can involve varying degrees of deliberate intent. One of the three primary components of emotion. (p. xv)

The secondary component of emotion outlined by Kennedy-Moore and Watson, emotional reflection, is defined as "Thoughts about emotional expression, experience or arousal" (p. xv). Related to self-reflection is the concept of emotional insight, defined as "the ability, through self-reflection, to recognize, label and understand one's own emotional experience" (p. 63). Kennedy-Moore and Watson's definition of emotional experience is adopted for use in this dissertation.

To further elucidate the concept of emotional experience the reader is referred to Lewis (1993) who posits that the

> Emotional experience is the interpretation and evaluation by individuals of their perceived emotional state and expression. Emotional experience requires the individual to attend to their emotional states . . . Without attention, emotional experience may not occur, even though an emotional state may exist. (p. 226)

Answering the Question

Before answering the research questions, literature with respect to theories of emotion, the role of emotion in therapy and emotional experience is reviewed. This review, contained in Chapter 2, provides a context for this study. Chapter 3 outlines the rationale for conducting an exploratory study using qualitative interviews, the presentation of case summaries, a thematic analysis and the use of a concept mapping

analysis to answer the questions. Results of the study are presented in Chapter 4. They are presented in two forms: firstly, case summaries provide qualitative information with respect to participants' emotional experience in counselling; secondly, concept map results provide a graphic representation of the constituent elements and underlying structure of participants' experience. Study results are further discussed in Chapter 5 with respect to new findings and how findings fit with and add to the existing literature.

Chapter 2

Literature Review

The investigation of emotion can be dated back to the inception of psychology as a formal discipline. The following review sets out categorizations of psychological theories and how each views the role of cognition versus emotion. In addition, it provides an overview of the various ways emotion has been conceptualized and its role in psychotherapy. Finally, this chapter outlines the various ways emotion has been studied within a therapeutic context.

Physiological Theories

William James proposed one of the first theories of emotion. He posited a relationship between bodily experienced sensations and the subjective experience of emotion wherein bodily changes occurred first and the feeling of emotion was based largely on a person's recognition of these changes (Greenberg & Safran, 1987; James 1884/1984; James1890/1950/1998; Plutchik, 1994). In essence James suggested we feel sad because we cry. Similarly Lange, a Danish physiologist and contemporary of James, proposed that changes in the circulatory system, visceral and postural changes, along with expressive action produced felt emotion. Due to the common hypothesis advanced by James and Lange, that subjective feelings are based on feedback from bodily experience, this theory became known as the James-Lange theory (Greenberg & Safran). In The Principles of Psychology (1890/1950/1998) James states,

> Our natural way of thinking about coarse emotions is that the mental perception of some fact excites the mental affection called the emotion, and that this latter state of mind gives rise to the bodily expression. My theory, on the contrary, is that the bodily changes follow directly the perception of the exciting fact, and that our feeling of the same changes as they occur is emotion. Common sense says, we lose our fortune, are sorry and weep; we meet a bear, are frightened and run; we are insulted by a rival, are angry and strike. The hypothesis here to be defended says that this order of sequence is incorrect, that the one mental state is not immediately induced by the other, that the bodily manifestations must first be interposed between, and that the more rational statement is that we feel sorry because we cry, angry because we strike, afraid because we tremble, and not that we cry, strike or tremble, because we are sorry, angry or fearful, as the case may be. (p. 26)

Essentially, James argued that specific patterns of autonomic arousal are experienced as a particular emotion.

Canon (1927/1987) challenged James' theory on the basis that autonomic arousal, associated with emotional states according to James, can be evoked without concomitant emotional arousal through activities such as exercise and drugs. Further research revealed that physiological patterns associated with emotion were not diverse enough or distinctive enough to provide any clear listing of emotion (Canon, 1927/1987; Mandler, 1975; Munn, 1961).

Cognitive-Arousal Theory

Among contemporary emotion theories, cognitive-arousal theory also takes into account how somatic changes play a role in mediating subjective emotional experience. In addition, this theory addresses the relationship between cognition and emotion. Cognitive-arousal theory proposes that when the individual experiences physiological

arousal the person examines the environment for a causal explanation of the arousal (Greenberg & Safran, 1987; Plutchik, 1994; Safran & Greenberg, 1991; Schacter & Singer, 1962). Accordingly, physiological arousal could be experienced either as joy or anger depending on the interpretation of the situation. This theory, therefore, assumes that consciously recognized arousal is necessary for emotional experience. The emotional quality of the experience is determined by the cognitive label of that experience. Problems with this theory stem from overlooking the role the limbic lobe and frontal cortex play in the experience of emotion (Greenberg & Safran). In addition, Plutchik notes that the psychopharmacological literature indicates many drugs can profoundly affect emotional feelings without affecting the autonomic nervous system.

Cognitive-Appraisal Theories

Cognitive appraisal theories are similar to cognitive arousal theories with their emphasis on the importance of cognitive activity in the experience of emotion. They differ, however, in their conceptualization of how evaluation occurs in the production of emotion. Cognitive appraisal theories contend that the evaluation component in the production of emotion has motivational implications (Greenberg & Safran, 1987; Plutchik, 1994; Safran & Greenberg, 1991).

Richard Lazarus, who has been the main proponent of cognitive-appraisal theory, notes that to study emotion one must include the study of cognition, motivation, adaptation, and physiological activity (Lazarus, 1991a). He posits that people are

involved in an ongoing appraisal of every stimulus they encounter in terms of its personal relevance and significance. According to Lazarus, this appraisal is a cognitive activity that results in emotion (Lazarus, 1991b). As cited in Plutchik (1994) Lazarus states, "appraisal is a necessary and sufficient cause of the emotions, and that the emergence of different emotions in infants and young children at different ages reflects the growth of understanding about self and world" (p. 88). He divides the appraisal process into primary and secondary types, describing primary appraisal as a function of the stimulus properties, motives and beliefs of the individual, and sociocultural factors, such as norms, values and role demands (Lazarus, 1991a, 1991b). Essentially the individual appraises the situation with respect to his or her goals and the extent to which the situation is goal congruent. Secondary appraisal involves the evaluation of the types of behavior that will enable the individual to cope with the situation as perceived (Lazarus, 1991a, 1991b).

Evolutionary-Biological Theories

A group of theories that can be categorized as evolutionary-biological in nature hold that the existence of emotion contributes to survival. They include the idea that emotions are forms of communication signals that have adaptive or survival value and that different emotions are associated with different expressive-motor behavior (Greenberg & Safran, 1987; Plutchik, 1994). Differential emotions theory posited by Izard indicates that facial expression plays a role in the emotion process (Izard, 1977). An emotion is experienced when a perceived stimulus produces neural activity in the brain. The

connection between the stimulation and neural activity is partially innate and partially learned. This activity produces expressive behavior in the form of a facial expression specific for the emotional state, and the brain's perception of this facial expression results in a subjective feeling (Izard). It is only after an emotion has been activated and facial feedback provides the differential data for a specific experience that the individual is aware of a subjective experience. Fundamentally emotion is thus defined as having neural, expressive and subjective components. According to Izard, though cognition interacts with the emotion process, emotional processing can operate independently of cognitive processing (Izard, 1992, 1993).

From the perspective of Nico Frijda (1980) emotions are biologically adaptive in that they deal with concerns related to the individual. He proposes that emotional experience consists mainly of an awareness of action readiness. Emotions are defined as changes in readiness for action, such as the impulse to run or attack or changes in readiness for modifying or establishing relationships with the environment (Frijda). They deal with concerns related to individual satisfaction. Frijda posits a hypothetical process in which an individual is confronted with a stimulus event that is then analyzed in terms of known events. The event is judged against its relevance to the individual's interest, and the situation is appraised in terms of what the individual can or cannot do about it. A plan of action is then generated (Frijda). Frijda's theory is functional in nature in that the purpose of emotion is to act to deal with emergency issues related to life's satisfactions.

Plutchik's psychoevolutionary theory also holds emotions to have a vital, biologically adaptive function in that they help the organism deal with key survival issues. He ties together the interplay of emotion and cognition in his assertion that thinking evolved in the service of emotion because it facilitated evaluation of emotional events (Plutchik, 1994). He contends that events are evaluated cognitively as to their significance for an individual's well-being. According to his theory, various emotional as well as physiological changes result including anticipatory reactions associated with various urges such as to explore, attack or retreat.

Theories conceptualizing emotion from an evolutionary-biological perspective are important because they place the role of emotion within the context of biological adaptation. While they vary in their emphasis on the role of cognition in the emotional process, they highlight the point that if emotion did not contribute to our survival it would have been eliminated over the course of evolution.

Cognition and Emotion

It is clear from an overview of the theories of emotion that a relationship exists between emotional experience and cognition, and that each is also related to somatic experience. The theories vary with respect to their attribution of primacy of one over the other. On the one hand, somatic changes are postulated to produce the subjective experience of emotion. On the other, cognitive labelling of diffuse somatic arousal is proposed as producing emotion. Additionally, cognitive appraisals of events are held to

be the necessary and sufficient cause of emotion. In the evolutionary-biological categories the role of cognition is considered as a component of emotional experience. Distinctions are clearly made between emotion and cognition, and Izard (1993) notes that emotion is fundamentally about motivation, positive and negative feelings, readiness or tendency to cope, and cues for cognition and action. In contrast, he posits cognition is about knowledge, learning, memory symbol manipulation, thinking and language. The interaction between emotion and cognition is acknowledged as common because of the motivational and cue producing functions of emotional experience and cognition's role in guiding person-environment interactions (Izard).

Within the context of a Zeitgeist that favoured the primacy of cognition the work of Robert Zajonc (1980) began to challenge the commonly held assumption that emotion was an epiphenomenon resulting from cognition. He argues instead that the emotional experience can and does occur prior to any higher-level cognitive processing. From his review of the experimental literature Zajonc offers evidence for his argument and concludes that cognitive and affective processes operate under separate systems.

Zajonc (1984) further outlines problems with the definition of emotion as provided by those who adhere to cognitive-appraisal theory. He states, "Even if cognitive appraisal of a given emotional excitation cannot be documented, according to the definition it must have nevertheless taken place" (p. 117). He notes that the other aspects of emotion - bodily processes, overt behavioural expression and subjective experience - all

require cognitive appraisal as a necessary precondition if emotion is a post-cognitive event. Instead his review of the literature indicates people respond emotionally prior to reasoning why, and he outlines evidence for the support of affective primacy (Zajonc, 1980). The implication of this position is that it is a mistake to assume that emotion is a post-cognitive event and challenges the prevailing assumption in experimental psychology that cognition is somehow more fundamental than emotion.

Emotion and the Brain

Advances in neuroscience support Zajonc's contention that cognitive appraisal is not a requirement for emotion. Neural pathways have been identified with respect to the experience of fear and indicate a subcortical pathway can activate emotions independent of the neocortex (LeDoux, 1987, 1998a, 1998b; Plutchik, 1994). With respect to fear, LeDoux (1998a, 1998b) discovered a direct pathway from the thalamus to the amygdala bypassing the neocortex. The direct pathway from the thalamus to the amygdala implies that the brain's initial evaluation of an event, at least with respect to fear, takes place without the input of the neocortex, which is involved in higher cognitive functioning such as thinking and reasoning (LeDoux, 1998a, 1998b). In addition, pathways also exist from the thalamus through the cortex to the amygdala providing the individual with more information about the stimulus as a result of cortical processing. LeDoux (1998a) notes that the evolutionary advantage of a direct pathway from the thalamus to the amygdala is time. He hypothesizes that in the presence of dangerous stimuli the individual can begin

to respond more quickly which is advantageous in dangerous situations. With the addition of cortical processing, the individual gains further information about the dangerous stimuli and can thereby alter the initial response if it is inappropriate.

From his work LeDoux (1998a, 1998b) concludes that the amygdala is the key brain structure involved in the immediate evaluation of emotionally significant stimuli and the releasing of emotional responses. It is involved in two information processing pathways; a subcortical pathway involved in emotional processing and a cortico-limbic pathway that brings in cognitive information processing for the same stimuli. The implications of LeDoux's work for emotion theory is that it further challenges the long held view of cognitive primacy. His findings suggest that neural-evaluative processes can lead to emotional experiencing without higher order cognitive processing.

Current research and theories posit that emotions and cognitions are intertwined in a complementary relationship with each altering and reforming the other (Bower, 1981; Greenberg & Pascual-Leone, 1997; Greenberg & Safran, 1984; Jacobsen, 1984; Kennedy-Moore & Watson, 1999; Leventhal, 1984; Plutchik, 1990). Plutchik (1985) outlines the futility of the debate regarding emotional versus cognitive primacy. He argues that the problem is primarily one of definition. Instead he posits that emotion and cognition form a complex feedback-loop system and notes that within such a system " . . . one can intervene at any point to influence the system" (p. 199). He states,

> I believe the current debate on the issues of primacy, like the Jamesian one before it, is not a fruitful one. It is based on a narrow conceptualization of the theoretical terms affect and cognition as subjective experiences. The controversy disappears if emotions are conceptualized as complex chains of inferred events with feedback loops that usually begin with an external stimulus and an evaluation of that stimulus. (p. 199)

The present literature holds that understanding the interplay between affect and cognition is more important than knowing which component is primary (Greenberg & Pascual-Leone; Kennedy-Moore & Watson; Plutchik, 1985; Watson & Greenberg, 1996).

Conceptualizations of Emotion

Taking into account the vast amount of information on emotion Plutchik (1994) suggests that it is a concept that includes a variety of aspects including physiological changes, a motivational component reflecting the individual's intention or readiness to act, a cognitive appraisal of events and a subjective feeling state. He proposes the following integrated definition:

> Emotion is a complex set of interactions among subjective and objective factors, mediated by neural/hormonal systems, which can (a) give rise to affective experiences such as feelings of arousal, pleasure/displeasure; (b) generate cognitive processes such as emotionally relevant perceptual effects, appraisals, labelling processes; c) activate widespread physiological adjustments to the arousing conditions; and (d) lead to behavior that is often, but not always, expressive, goal-directed, and adaptive. (p. 5)

Consistent with such an integrative definition Izard (1993) has proposed an organized hierarchical system of emotion activators consisting of four types of emotion-activating systems: neural, sensorimotor, motivational and cognitive. He accounts for the

generation of emotion at each level. He contends that while neural processes are encompassed in all emotion-activating systems that they can also activate emotion independent of cognition. His contention is supported by evidence from psychopharmacological research and research on the effects of direct stimulation of brain structures. Generation of emotions at the sensorimotor level is accounted for by motor messages to and from various muscle groups, muscle spindles or cutaneous receptors. Empirical studies suggest that expressive motor behavior, as studied in facial expression and body posture, can alter ongoing emotional experience and generate positive and negative emotional experiences (Izard). At the motivational level sensory processes involved in a drive state, such as pain, activate an emotion. Emotion at the cognitive level is accounted for through processes such as cognitive appraisal and attribution.

Izard notes the hierarchical structure of the emotion system in a variety of ways suggesting that the neural level is the most primal level of emotion activation and cognitive the highest. In addition he outlines this hierarchy from a developmental perspective indicating that neural and sensorimotor systems are involved in emotional activation prior to motivational and cognitive processes. As well, increasingly complex information can be processed at each higher level. Izard's model is a solid attempt at synthesizing current knowledge on emotion and is an example of an integrative model of emotional processing.

Emotion can then ultimately be conceptualized as a synthesis of a number of different levels and types of processing that emerge into awareness as the holistic

emotional experience. An emotional response includes aspects of subjective experience, physiological change and expressive behavior (Frijda, 1994; Greenberg & Safran, 1990; Izard, 1993; Levenson, 1994). The antecedent conditions arise from an interaction between the individual and his or her internal or external environment and act fundamentally to establish the individual's relationship to and position in the world (Frijda; Greenberg & Safran; Levenson). They are emotionally evaluated by a system that provides meaningful feedback in terms of the individual's well-being, plans and goals (Greenberg & Safran; LeDoux, 1994; Levenson). LeDoux likens the emotional evaluation system to the cognitive appraisal system, however, the emphasis is on the emotional nature of the function and can be located in the amygdala. This evaluation process results in a response by the individual that can be seen as a solution for coping or responding to the antecedent condition. Frijda states,

> The best characterization of what they aim at is the production of relational behavior; that is, they motivate behavior meant to maintain or modify a particular kind of relationship with the environment. They aim to change (or maintain) the relationship, not the environment itself. (p. 114)

Emotion in Psychotherapy

From Freud onward emotion has played a role in psychotherapeutic theory. However, this role has been differentially emphasized by various theoretical perspectives. From a psychoanalytic perspective emotions are viewed as being drive-related and are a mode of drive discharge (Freud, 1910). More recently various psychoanalytic writers

have argued for the central role of emotion in analytic work (Allen, 1980; Fialkow & Muslin, 1987; Goldfried, 1980a). Maroda (1999) states,

> We have known for some time that most of what we do is not interpretation (Compton, 1975) and that the change process probably relies a great deal more on emotion than intellectualization. That is, the acquisition of insight depends on a unique emotional experience antecedent to the insight . . . But the step that we have yet to make is the one where we recognize that without intensive affective experiences within the treatment, there is no deep and permanent change . . . As long as we continue to value what we think more than what we feel, we are in danger of excluding the information that is most important.

In a comprehensive review of "Affect in Psychodynamic Psychotherapy" Carek (1990) states,

> It appears that the most effective psychotherapy involves both an affective, experiential component and a cognitive one. That is, emotionally things fall into place and there evolves a cognitive awareness or understanding that the patient can carry over to future experiences. Yet in this duality so often it appears that a premium is on understanding, insight if you will, the cognitive element, over the affectual experience. Yet it could be argued that the affectual experience takes precedence and that insight is something that comes after the fact. There just are a number of instances in which patients do respond with greater overall functioning without there being an accompanying cognitive element, i.e., an understanding of what brought about the change . . . Rarely, if ever does intellectual insight generate freer emotional experience, despite what, for example, beginning students of psychotherapy with their bent towards intellectualization with patients would like to believe. Meaningful reflection in psychotherapy depends on the scrutiny of concrete, affect-laden material and the inability to deal with the concrete proves to be a very real handicap in psychotherapy. It is the toleration of affect that leads to ever greater flow of the emotionally laden material that lends itself to reflection. (p. 277)

Historically, psychoanalytic theory has favoured the exploration of emotional material. While acknowledging the role of cognition, proponents of this orientation contend that a cognitive exploration of the problem in the absence of an emotional component fails to produce lasting change. The importance of working with affect-laden material is stressed.

As opposed to psychoanalytic theory the cognitive-behavioural perspective posits that emotion is a post-cognitive phenomenon. This approach maintains that the cognitive meaning of the event determines the emotional response. The meaning a person attaches to an event is contained within a cognition such as a thought or image. Further, if a person attaches an unrealistic or extravagant meaning to an event the result is likely to be an inappropriate or excessive emotional response. Proponents of this orientation concur that the client's emotional reactions are generally the immediate source of distress. They contend, however, that the route to clients' emotions is through their cognitions. (Beck, 1976). While affect is not ignored, it is viewed as an aspect of behavior to be managed, reduced or explained (Messer, 1986). As a result, change is perceived as being brought about by challenging irrational beliefs and thereby changing the emotional reaction (Beck, 1976; Ellis, 1962).

With emotion emerging as a change agent that cuts across therapeutic orientations researchers in the cognitive-behavioural field started to attend to its role in therapy. Rachman (1980) notes that with respect to the use of systematic desensitization, "The

implication is that the fear must be experienced before it can be reduced or eliminated . . ." (p. 52).

Powell (1988) comments on client insights that accompany emotion associated with target symptoms in behavior therapy.

> In about 15% of the patients we have treated behaviourally for physical and emotional problems, . . . we find evidence of behavior therapy-aroused insight. As these men and women became aware of the conflicts related to the formation of their symptoms, some degree of remission nearly always followed. (p. 188)

The humanistic-experiential tradition has conceptualized emotion as an orienting system that provides the individual with adaptive information and is viewed as an important motivator of change (Greenberg, 1993; Greenberg & Safran, 1989). In keeping with the contemporary integrative views on emotion Greenberg and his colleagues have outlined a theoretical perspective of emotions and their role in therapeutic change. Accordingly, Greenberg acknowledges the adaptive nature of emotions as an orienting and meaning-producing system and suggests emotion is an integration of affect, cognition, motivation and relational action. The importance of emotions in therapy is seen as multifaceted. Emotions are viewed as a guiding structure in the individual's life determining what is of personal significance, providing individuals with information about their needs, goals and concerns and preparing them for action to meet those needs (Greenberg & Korman, 1993; Greenberg & Paivio, 1997; Korman & Greenberg, 1996).

Working with emotions in therapy thus provides the client with access to this material that may otherwise remain as tacit knowledge. Further, since emotion is seen as regulating mental functioning and influencing action processing of emotion leads to behavior change. In addition, bringing into conscious awareness triggers that elicit automatic emotional reactions aids clients in gaining a sense of clarity and control. This tradition, therefore, emphasizes the biological importance of emotion and stresses the importance of the interplay between emotion and cognition in the process of change.

The Therapeutic Relationship

It is important to note that working with emotions in psychotherapy does not take place in a vacuum but within the context of a therapeutic relationship. The therapeutic relationship has long been held as a key factor in therapeutic change (Gaston, 1990; Goldfried, 1980a; Horvath & Symonds, 1991) and several studies have found that the quality of the therapy alliance is an important predictor of outcomes (Gaston, Thompson, Gallagher, Cournoyer & Gagnon, 1998; Horvath & Symonds, 1991; Howard & Orlinsky, 1972; Samstag, Batchelder, Muran, Safran & Winston, 1998). In interviews with prominent theorists Goldfried (1980b) found differences in the definition of the therapeutic relationship but strong agreement on its major contribution to the change process.

Many researchers who investigate psychotherapy outcome suggest that the therapeutic relationship may be the 'quintessential integrative variable' across theoretical

conceptions of psychotherapy because it is so consistently shown to be predictive of good outcome (Safran & Muran, 1995). Greenberg and Safran (1989) contend a strong therapeutic relationship is necessary for creating a sense of client safety that allows for the exploration of uncomfortable emotional material. "Without a relationship bond in which clients feel accepted, safe and supported, they will not enter into exploration of their feelings" (p. 27). According to Raingruber (2000) "Being attentive to feelings during a session enhances the client-therapist bond and facilitates the clients' psychological progress and growth" (p. 41). However, Littrell (1998) contends that the exploration of emotional material within therapy in and of itself provides contentious results unless such an exploration is mediated within a controlled, systematic manner.

Levels of Emotional Experience

A variety of studies have been conducted to explore the role experiencing emotion plays in therapy. As early as 1971, Kiesler conducted a study in which the first 30 interviews for 12 hospitalized schizophrenic and 26 neurotic outpatients were examined using the Experiencing Scales (Klein et al., 1986). Results indicated that while neurotic clients attained higher levels of experiencing than schizophrenics, more successful cases in both groups had higher levels of experiencing at all points in therapy. Due to other methodological considerations it was not possible for Kiesler to relate experiencing to successful outcome since 25 out of the 38 cases continued with therapy beyond the 30th session.

Hill et al., (1988) examined the role therapist responses played in eight cases of brief psychotherapy using experienced therapists and anxious depressed clients. A variety of therapist response modes were associated with various levels of client emotional experience. Results suggest that while therapists and clients diverge in what they perceive as helpful, at low levels of experiencing both therapists and clients rate interventions aimed at exploration of feelings and behaviours as most helpful. Notably, at high levels of experiencing most anything the therapist does is rated as helpful by the client suggesting that affective involvement is related to clients' perceptions of successful therapy.

Along a similar theme, Saunders (1999) investigated clients' affective experience during therapy. The object of the study was to explore how the client's in-session emotional state might be related to client's perceptions of the therapists' emotional state. The affective environment of the session combined both how the client felt in the session and how the client perceived the therapist felt in the session. Exploratory factor analysis was used to uncover the structure of the affective environment. This analysis yielded six stable, interpretable factors. Factor correlations indicate client reports of their own emotional experience were related to their perception of their therapists' emotions: positive client feelings were associated with positive therapist feelings and vice versa. In addition factor correlations suggest that clients can feel distressed while at the same time feeling close to the therapist. However, they rated session quality higher when they felt

less distressed or inhibited, when they perceived the therapist to be confidently involved and not distracted, and when they perceived mutual affection with the therapist. The affective environment of the session was also contrasted to outcome. Clients' emotional experience was correlated with their perception of session quality and was somewhat related to treatment effectiveness. Results suggest that clinicians can use the client's in-session emotional experience as an indicator of the quality of the alliance, which has consistently been shown to be correlated to successful outcome (Horvath & Symonds, 1991).

Wiser and Goldfried (1998) studied the relationship between therapists' interventions and clients' emotional experience in psychodynamic-interpersonal and cognitive-behavioural therapies. When results were examined across orientations three intervention strategies were related to high emotional experiencing on the part of clients: affiliative and noncontrolling interpersonal stances, reflections and acknowledgements, and highlighting using minimal non-specific content (e.g., "Hmm, I see"). Across orientations lengthy verbal interventions and affiliative but moderately controlling interventions were associated with attentional movement away from experiencing. In the cognitive-behavioural group additional interventions were associated with lower experiencing including highly controlling comments, questions, and interventions highlighting minimal affective content.

Raingruber (2000) conducted a phenomenological study exploring how focusing on feelings during therapy sessions relates to shifts in clients' self-understanding. She contends that being with feelings during a therapy session helps clients focus on their experience, feel heard, listen to their therapist's response, and develop greater self-understanding. An interpretative phenomenological investigation was undertaken wherein eight pairs of clients and nurse-therapists viewed tapes of their therapy sessions and described significant interactions and responses. All the clients were being seen for mild depression or situational crises. Results suggest that focusing on emotional issues during therapy sessions helped clients become clearer about what they were saying. In this process clients recognized insights not previously recognized. Tacit knowledge became manifest in that clients could "see" what had previously been ambiguous. Being with feelings during the session allowed clients to experience and feel what had been unclear, pay attention to another's response, and understand something new about themselves in the process.

Emotional Arousal

Support for the positive effect of emotional processing was found by Hunt (1998) as a strategy for coping with dysphoria following a depressing life event. Unfortunately, Hunt does not define emotional processing but does make reference to Rachman's (1980) ideas that pathological distress is often the result of incomplete processing. According to Rachman emotional processing involves the use of strategies that focus the client's

attention on the distress and causes of that distress. Factors that impede emotional processing include avoidance and distraction. Hunt's study addresses the question of whether emotional processing helps people recover after a depressing life event. Specifically, this study attempted to look at whether emotional processing is equal to or more effective than either distraction or unemotional cognitive restructuring and problem solving.

Participants consisted of undergraduate psychology students who participated voluntarily for additional course credit. Subjects were randomly assigned to one of three treatment groups: an emotional processing group, a distraction group or a cognitive restructuring group. Results indicate that emotional processing appears to be a more effective strategy for ameliorating subclinical dysphoric mood than either distraction or positive cognitive restructuring and unemotional problem solving.

This finding raised the question of how emotional processing helped ameliorate depressed mood and three hypotheses were ultimately tested: 1) activation of the emotional structure which underlies the dysphoric mood (indicated by emotional arousal) leads to habituation. Habituation refers to a decline in response strength after repeated exposure to a stimulus; 2) Habituation of emotional arousal leads to more effective, less biased cognitive restructuring later on; 3) Cognitive restructuring, defined as the integration of new information into the underlying emotion structure, is more effective when the emotion structure is activated and the person is emotionally aroused.

Results support the hypothesis that paying attention to distressing material decreases the response strength and that emotional arousal contributes to more effective cognitive restructuring at low to moderate levels of arousal. On the contrary, attempted emotional restructuring without emotional arousal appeared to increase dysphoric mood. The author notes the limitation that participating subjects were not part of a clinical population and that by using a laboratory mood induction the degree to which these results can be generalized to true depression is limited.

Watson (1996) investigated the role of different kinds of therapeutic interventions and affective involvement when she examined the relationship between clients' descriptions of external events, emotional arousal and resolution of problematic reactions. Problem resolution in this study was characterized by high levels of emotional arousal through evoking the problematic situation and differentiating the client's inner subjective experience. Watson suggests that vivid description of an event facilitates emotional arousal and increases awareness of the event in consciousness.

Following along these lines Rosner, Beutler & Daldrup (2000) hold emotional arousal as a key concept in most theories of change. In an effort to understand the role of emotional expression of such arousal two treatments with opposite assumptions about the expression of emotions were compared. This study compared the clinical efficacy of two different group therapy models: 1) focused expressive psychotherapy and cognitive therapy. Focused expressive psychotherapy, consistent with its theoretical

underpinnings, sought to increase the level of emotional intensity and to activate the specific emotion of anger, both of which are seen as means of altering and reducing depression. The cognitive therapy group sought to reduce the general intensity of affect and directly emphasized the reduction of sadness and depression. The authors hypothesized that comparing these two treatments would reveal two distinguishing patterns: 1) anger would be more frequently aroused than positive emotions in focused expressive psychotherapy groups while the opposite would hold in the experience of cognitive therapy patients, 2) the overall level of emotional intensity would be higher in focused expressive psychotherapy than in cognitive therapy.

In addition the authors were interested to see whether a connection existed in emotional processing among clients participating in group psychotherapy. Specifically the authors wished to determine if the emotional experience of patients who observed others work in one or the other treatments showed a similar emotional pattern to those who were the direct objects of therapeutic intervention. They hypothesized that when a given patient was the focus of therapeutic attention in either group, others in the group who observed the process would experience similar emotional qualities and emotional intensity proportional to but less than that experienced by the targeted patient.

Participants suffering from major depression were randomly assigned to two treatment groups. Emotional experience was assessed both through its direct expression and indirect expression through vocal patterns. Trained raters rated participants on The

Client's Emotional Arousal Scale and the Non-verbal Arousal Instrument. Results suggest that there was no significant difference in the frequency of expressing either anger or positive emotions in the two therapies. The intensity of emotion did not differ between the two therapies. This is surprising given the different underlying assumptions regarding emotion. However, observing clients differed in the expression of primary emotions between the two therapies with cognitive therapy observing clients expressing more positive emotions and more negative feelings than focused expressive observing clients.

Overall process assumptions between the two groups were not confirmed. In addition, there was no clear indication of the presence of a connection in emotional processing between active and observing group members. While the emotional experience clearly exists in group psychotherapy the results of this study suggest its role remains unclear.

Mackay, Barkham and Stiles (1998) conducted an intensive analysis of one female client's emotional experience in psychodynamic-interpersonal therapy. A helpful session that contained an episode of the client's emotional experience was identified by both the client and the therapist. Using a tape-assisted research interview, brief structured recall, the client was asked to talk about the event in her own words as the session tape was reviewed. In addition the investigators also developed and applied a protocol to assess clients' emotional tone from audiotapes and transcripts of their therapy session. During the emotional episode the client was able to express previously unexpressed anger.

Results indicate that over the course of the event the client's experience of anger changed from one that was characterized by an angry emotional tone but lacking in emotional arousal to one that sustained emotional arousal as anger was expressed. In staying with and expressing her feelings of anger the client's feelings changed as the feeling was re-experienced. The client identified this event as being a significantly helpful moment in therapy and an analysis of the client's course of therapy suggested the session within which this emotional event took place was a turning point. However, the results of this study focus on a single event with a single client limiting the conclusions that can be drawn.

Experiential Paradigm

A variety of studies conducted by Greenberg and his colleagues focus on exploring the role specific interventions from the experiential paradigm play in level of emotional experiencing and their relationship to outcome. Greenberg and Clarke (1979) and Greenberg and Rice (1981) conducted studies to compare the effect of a two-chair intervention with an intervention where counsellors accurately reflected clients' feelings to facilitate resolution of personally meaningful conflicts. Results suggest that the two-chair technique deepened experience and increased client awareness more effectively than empathic reflection. Clients were involved in both types of sessions but reported greater and more numerous shifts in awareness in the two-chair session.

Using a two-chair intervention Greenberg and Webster (1982) explored the difference between resolvers of an intrapsychic conflict related to making a decision versus nonresolvers. Resolvers were characterized by exhibiting an expression of criticism by one part of the personality, followed by a softening of that criticism, and a corresponding expression of a felt want. Depth of emotional experiencing exerted a role in the manifestation of the felt want and the softening of the critic adding further support for the general contention that emotional experiencing plays an important role in therapy.

Similar results were obtained by Greenberg and Foerster (1996) when the intense expression of feeling was identified as one of the components that discriminated between successful and unsuccessful resolution of lingering bad feelings toward a significant other.

Paivio and Greenberg (1995) tested the efficacy of experiential therapy using an empty-chair dialogue for resolving feelings related to a significant other where they compared the results of this intervention with a placebo control group. Results were both clinically and statistically significant supporting improvement for the majority of clients in the empty-chair dialogue group. While this study appears to support the effectiveness of empty-chair dialogue, an important limitation of the study is the use of a placebo control group that fails to control for expectancy and support. Clients in this group likely received less support than those in the therapy treatment group. Further, it is well established in the literature that therapy from a variety of theoretical orientations produces positive results when compared to groups receiving no treatment. The authors

acknowledge that future research needs to compare more equivalent treatments before the efficacy of the empty-chair dialogue intervention can be firmly established.

McQueeney, Stanton & Sigmon (1997) compared a problem-focused intervention with an emotional focused intervention for coping with a stressful life event. They note that emotion-focused coping is directed toward regulating affect surrounding a stressful encounter whereas problem-focused coping involves direct attempts to modify the problem causing the distress. Participants were 29 infertile women who, on average, had been attempting conception for four years. Based on literature findings that emotion-focused coping may be relatively effective for uncontrollable stressors, the emotion-focused intervention was expected to be more effective than the problem-focused treatment with regard to affective outcomes. It was hypothesized that problem-focused treatment would be relatively beneficial in enhancing perceptions of control over infertility.

To evaluate the efficacy of the strategies two treatment programs were compared to a no-treatment control group. A variety of questionnaire inventories were used to assess perceived control over infertility, level of distress regarding infertility, psychological adjustment, global negative affect and use of coping strategies promoted in the treatment. At treatment termination both groups reported significantly less global distress than controls, and the problem-focused group evidenced greater infertility-specific well-being than controls. However, at a 4-week follow-up initial gains made by

the problem-focused group diminished somewhat, whereas initial gains for the emotion-focused group were augmented at follow-up. By 18 months, the advantage of emotion-focused coping decreased. Findings suggest that both forms of coping may be useful, but at different points in the infertility process. Of import, however, are the continued treatment gains of the emotion-focused group even after termination.

Recently Greenberg and Watson (1998) compared a client-centered treatment and process-experiential treatment on a sample of depressed adults. They investigated whether the addition of process-experiential interventions in addition to client-centered empathic responding would produce better outcomes than client-centered empathic responding alone. The client-centered treatment was characterized by the three relational attitudes of empathy, positive regard and congruence and manifested in the therapist's behavior as consistently communicated empathy. The process-experiential treatment included the communication of empathy in addition to the use of Gestalt two-chair dialogue, systematic evocative unfolding, empty-chair dialogue, and experiential responding and focusing. Results at termination and follow-up showed no difference between treatments with respect to reducing depressive symptomatology. However, superior effects were noted at midtreatment and termination with respect to total level of symptoms suggesting the addition of process-experiential interventions hastens and enhances improvement.

Cognitive Paradigm

Empirical evidence emerging from the experiential paradigm suggests that therapeutic procedures aimed specifically at clients' emotional experience hold promise as agents promoting change within the therapeutic process. In contrast to this paradigm, cognitive approaches to counselling differ in their orientation to emotional experience and its facilitative role in client change. Wiser and Goldfried (1993) compared significant sessions from psychodynamic-interpersonal and cognitive-behavioural therapeutic orientations to determine the extent of affective exploration along with therapists' views of these client states. Their findings indicate no difference between the two orientations with respect to degree of emotional experience achieved by clients. Differences emerged, however, with respect to the therapist's clinical view of emotional experience. Among the psychodynamic-interpersonal therapy sessions the emotional process was viewed as a clinically significant part of the change process. In contrast, lower experiencing states in the cognitive-behavioural orientation were seen as the most relevant aspect of the session.

What was not addressed in the above study was how effective these responses were in bringing about therapeutic change. Clarke and Greenberg (1986) compared an affective and a cognitive-behavioural counselling intervention used to aid clients in resolving intrapersonal conflicts related to making a decision. A Gestalt two-chair intervention was compared with a cognitive-behavioural problem solving intervention typically used to help people resolve conflicts. Results suggested that the two-chair

intervention was more effective in reducing indecision than the problem solving intervention or no treatment. The authors report that clients receiving the Gestalt two-chair intervention reported being more decided than those attempting to decide on a logical basis only. These results suggest that attending to affect provides clients with more personally relevant information that needs to be taken into account in the decision making process.

Cognitive therapy researchers have typically not addressed the client's emotional experience. However, in a study exploring the process of change in cognitive therapy for depression Castonguay et al. (1996) measured variables unique to cognitive therapy along with two variables that are shared across various approaches; therapeutic alliance and client experiencing. Client experiencing refers to the client's "ability to focus on and accept their affective reaction" (p. 498). The authors note that the predictive validity of client experiencing has never been studied in cognitive behavioural therapy. Results indicate that both the therapeutic alliance and the client's emotional experience were related to improvement. With regard to the client's emotional experience the authors note these are the first empirical findings emerging from a cognitive orientation that support the value of client's emotional involvement.

Negative Indicators

While the literature provides evidence supporting the position that paying attention to the client's emotional experience is important, results from a number of

studies indicate such attention is not warranted. Millen and Roll (1986) note that one of the common impediments to good psychotherapy is the achievement of a balance between thought and emotion. They question whether clients need an emotional experience in therapy. They state,

> Much of the destructive aspect of the psychotherapeutic relationship comes not from improper training or malice, but rather from the requirement that psychotherapy be an emotional experience if it is to be effective. An intense genuine emotional experience cannot be engendered without confusion, occasional poor judgment, pain and humiliation. (p. 117-118)

Tesser, Leone, and Clary (1978) conducted a study comparing two types of therapeutic interventions on participants with a strong fear of public speaking as assessed by a modified version of the Fear Survey Schedule. Subjects consisted of 26 female introductory psychology students randomly assigned to one of three experimental conditions. Experimental conditions consisted of a control group, a process constraint group in which subjects were asked to explicitly describe their beliefs regarding public speaking and how they derived them, and a catharsis group in which subjects were asked to think about their fear in an unconstrained manner and particularly to focus on how they feel when speaking in public. The researchers predicted the process constraint group would show a decrease in negative affect and that this decrease would be greater than the catharsis group. After being oriented in a particular experimental condition, subjects from each group were asked to speak publicly for a brief period. Anxiety levels were measured using palmer sweat, a physiological index of anxiety, and self-report. Results indicate that

the catharsis group experienced the most negative affect, followed by the control group and process constraint group. This suggests that unconstrained thinking about emotionally-laden material makes cognitions more consistent with initial affect and increases extreme feelings.

In exploring response styles to depression, Morrow and Nolen-Hoeksema (1990) hypothesized that focusing on negative affect associated with depressed mood will increase and prolong the depressed mood. Focusing on negative affect was equated with a ruminative response style. Ruminative responses are defined as "cognitions and behaviours that repetitively focus the depressed individual's attention on his or her symptoms" (p. 519). Examples include, thinking about, writing about, or repeatedly telling others about how one is feeling. In contrast, they suggest that distracting responses, cognitions and behaviours that take one's mind off depressive symptoms will provide relief from depressed mood. In addition the effects of activity level on depression were explored. The authors hypothesized that active responses to depressed mood, i.e., increasing pleasant activities, would remediate depressive symptoms more effectively than passive responses. Subjects were 35 male and 34 female undergraduate psychology students who were randomly assigned to one of four response task conditions. Response tasks were distinguished by degree of rumination and activity level resulting in four distinct conditions: 1) distracting-active, 2) distracting-passive, 3) ruminative-active, and 4) ruminating-passive. Findings indicate that degree of rumination had the greatest

influence on remediating sad feelings with activity level contributing in an additive manner. Subjects in the distracting-active condition experienced the greatest decrease in sad feelings, followed by the distracting-passive condition, ruminative-active condition, and ruminative-passive condition. The authors suggest it is important to alleviate a client's depressed mood prior to undertaking an exploration of the associated negative affect.

Nolen-Hoeksema, Parker, and Larson (1994) undertook a similar study with a bereaved population who had experienced the death of a family member approximately one month prior to the first interview. The authors posit that focusing passively and ruminating on negative emotions aroused by stressful events prolong periods of emotional distress. They examined the relationships between gender, life stressors, social support, rumination, pessimism and depression in a group of 253 adults who had lost a family member to terminal illness. The model outlined by the authors predicts that passive rumination on negative emotions following a stressful event will increase pessimistic thinking and prolong distress. Study results support this model. The authors query how study results fit into the literature when previous studies of bereavement suggest that people who suppress and avoid focusing on their negative emotions struggle with adjusting to their loss. They state

> The simple answer is that suppressing one's negative emotions and ruminating about these emotions may represent the extremes of two different coping strategies, and both of these extremes are maladaptive.

> The more complex answer is that people who try to suppress or avoid their negative emotions may seldom be fully successful and may be prone to lapse into rumination. (p. 102)

In an extensive review article Littrell (1998) examines the research in an attempt to determine if re-experiencing painful emotions in therapy is helpful. From her review she concludes that re-experiencing painful emotions is only beneficial if there is some restructuring of the emotional memory. Those studies lacking a restructuring component to the re-experiencing of painful emotions have mixed results. In some cases results are as good as in other treatments. Other studies, however, indicated an increase in anger, depression and elevations of MMPI pathologies. Overall, studies evaluating therapeutic orientations that evoke emotion in an unsystematic manner often fail to yield positive support for this type of approach. In contrast, good support is found for studies in which emotion is re-experienced in a controlled and structured fashion.

Littrell (1998) states,

> If the positive results, when they occur, are attributable to a relearning process rather than a mere re-experience of emotion the contradiction between the inconsistent findings can be explained. The case can be made that those approaches that produce positive results afford an opportunity to find a new way to regard the emotion-eliciting stimulus. Restructuring is the mechanism through which emotional exposure allows for long-term beneficial impacts . . . the Pennebaker and Beall's (1986) study found that both feelings and thoughts were necessary for a positive effect from the procedure. Focusing on feeling alone was not helpful . . . If a new response to painful material can be achieved, then calling up painful emotion can have a salubrious effect. (p. 94-95)

Limitations in the Literature

While support clearly exists for the usefulness of the emotional experience in therapy, the present literature is restricted by a predominantly quantitative approach that potentially obscures other aspects influencing the role of emotion in the change process. The results of the study conducted by Castonguay et al. (1996) are a case in point. Only when the researchers stepped outside of the imposed theoretical boundaries did the importance of the role of the emotional experience in cognitive therapy emerge. In addition, the importance of emotion in the therapeutic process was recognized by Paulson et al. (1999) because the emerging data was not constrained by investigators' predetermined categories. Mayer and Geher (1996) note that ". . . there is disturbing evidence that a person's feelings and the way a group consensually judges those feelings are different" (p. 109).

As identified in the literature review, the majority of empirical work relating to the utility of the emotional experience in therapy has been conducted using various rating and coding systems and external raters and therapists to judge clients' experiences. For example, in many of the studies previously reviewed the Experiencing Scales (Klein et al., 1986) were used to determine client levels of experiencing. Therefore, outside raters judged the experiencing levels of participants. While outside judges may discriminate differences between participants it does not follow that external observers would be better able to determine participants' experiences than the participants themselves. Angus

(1992) reiterates the importance of this issue when using a predetermined rating system developed by herself and a colleague:

> It is evident that this rating system is based on the implicit assumption that the therapist's job is to provide direction and offer interventions in therapy while the client's job is to follow and respond. This assumption is challenged by the results of the qualitative study . . . At different points in the verbal interaction, all clients and all therapists in this study were found to initiate topics, make interventions and follow the lead of the other participant. Had the four sessions been rated on [this coding system] . . . the activity and reflexivity . . . of the clients would have been rendered invisible by the a priori decision to classify client statements as responses to therapists' interventions. (p. 201)

Thus, while quantitative research may provide us with relevant information with respect to the usefulness the emotional experience plays in the change process it may also limit what is observed.

Summary

Clearly theoretical and empirical support for the importance of the role the emotional experience plays in therapy exists. This review of the literature on emotion and the emotional experience establishes the usefulness of attending to clients' emotional experience in counselling. Emotion theorists articulate the important role emotion plays as an orienting and adaptive function in the lives of individuals. Emotion provides information to individuals about what is important to them and aids in establishing, maintaining or changing relationships. Thus, information is gleaned about the self in interaction with the environment. Since emotions and the emotional experience in

particular provide information and are relational and motivational in nature the client's affective response acts as an important resource and focus in therapy.

Contradictions within the literature also exist. In examining studies that show little support for focusing attention on clients' emotional experience it becomes clear that the emotional experience in therapy is a complex issue. From the literature it is concluded that focusing on or evoking emotion in an unstructured manner may hinder the reduction of distress in clients.

In order to gain a broader understanding of the role the emotional experience plays in therapy there is a need to further explore this area from the client's perspective. As noted by Beck (1976) "Only the person who actually experiences the emotion, idea and image can make and report his introspective observations" (p. 51). The client's experience of this phenomenon is given little attention in the literature and is not well understood. The recognition of the client's frame of reference in the growing body of literature in this area can aid clinicians from a variety of theoretical orientations in working more effectively at an affective level in counselling. The preceding review and critique establishes the framework and rationale for this study, which intends to explore clients' perceptions of their emotional experience in counselling.

Chapter 3

Method

Rationale for Exploratory Research and Qualitative Interviews

The experience of emotion is difficult to measure because it is phenomenological, subjective, and internal. Furthermore, the emotional experience combines the intricately woven components of cognition, physiology and behavior. The study of the emotional experience therefore requires a method that can access and explore the client's inner experience. A number of researchers recommend qualitative or naturalistic approaches for the study of human emotion (Carek, 1990; Hill, 1994; Lazarus, 1991b; Mahrer, 1988).

Lazarus states,

> It is not the physical properties of the environment that count in the emotion process, but its subjective meanings. There, the objective environment, physically speaking, is often irrelevant, and it is subjective meanings that we need to understand. Psychologists should, of course, study the objective world to the extent possible, but not merely as a thoughtless formula with which to castigate theories predicated on subjective appraisals. (p. 831)

Marshall and Rossman (1989) note that exploratory research provides an increased richness, depth and quality to research findings. They state further,

> Survey and experimental research is more appropriate for unambiguous concepts and finely tuned indicators with high levels of reliability . . . However, the researcher may find through the literature review that previous research has raised many questions, that there is a need to explore interactions among variables, that there is a reason to suspect that the content contains important domains that must be explored. By the same token she may find that a descriptive study will yield the most important

> results for theory development. If any of these conditions obtains, then a qualitative study is most appropriate. (p. 42)

In exploring clients' experience of emotion in therapy the client is a primary source of information. Given that individuals' experiences and their interpretations of those experiences occur within the psychological framework of the individual, methods that allow researchers a way to investigate personal experience are crucial. The qualitative approach to research is founded on the assumption that understanding is gleaned through direct interaction with those individuals who have experienced the phenomenon of interest (Patton, 1990). Client interviews allow entrance into and flexible exploration of their perspective and also allow new material about the experience to surface (Patton, 1990).

As Marshall and Rossman (1989) note,

> Interviews have particular strengths. An interview is a useful way to get large amounts of data quickly . . . allows for a wide variety of information . . . allows for immediate follow-up questions and, if necessary, for clarification, follow-up interviews may be scheduled at a later date. (p. 82)

As noted earlier, there are significant differences in clients', therapists', and observers' perceptions of the therapy process, with clients' perceptions being most predictive of outcome. As well, the client's perspective is essential to the exploration of the role of emotion in therapy as the emotional experience occurs inside the client, often hidden from observation. Based on information provided in the literature it is concluded that qualitative interviewing is an appropriate data gathering method for this study.

Rationale for Concept Mapping Analysis

In addition to in-depth interviewing, applying a concept mapping analysis to the research data is appropriate as this method allows for the study of constructs as they are experienced by participants (Daughtry & Kunkel, 1993). This method aids in clarifying the constituent elements and underlying structure of participants' experience of the phenomenon under investigation (Trochim, 1989). The use of concept mapping is advantageous when investigators wish to obtain a relatively unconstrained description of a phenomenon, free of a priori formulations, experienced within a particular population (Daughtry & Kunkel). Participants are collaboratively involved in the process of elucidating the organization and salience of the various elements of their experience.

Concept mapping applies both qualitative and quantitative methods of analysis and involves participants in the sorting of the data. As a result the potential for researcher bias is reduced when compared to qualitative data that are sorted and grouped by an individual researcher. Thus, this approach to the analysis of qualitative data allows for an unconstrained view of the participant's perspective. The results of the data analysis yield a graphic representation in the form of a map that depicts the underlying structure of the phenomenon. With an unrestricted perspective of the domain of participants' experience and information about the latent organization of the constructs investigators can meaningfully relate the subjective experience to other variables of interest.

Theoretical Constructs

Three basic processes constitute the concept mapping procedure: a) generation of ideas, thoughts or experiences by participants about a specific question; b) grouping together of the ideas, thoughts or experiences through an unstructured card sort of the participants; and c) statistical analysis of the card sort results using multidimensional scaling and cluster analysis (Trochim, 1989). Initially, participants' perspectives are obtained through asking open-ended questions or conducting an in-depth interview (Giorgi, 1985) thus producing participant self-reports. Questions are intended to be sufficiently focused to obtain the participants' experience or perspective yet ambiguous enough not to influence the response. Obtaining a participant's response may be conducted in a variety of ways including written responses or through direct interviews. As noted earlier in-depth interviews are an appropriate data gathering method to investigate the research question.

Using Giorgi's (1985) qualitative analysis of text as a procedural guideline participant self-reports are read and reread to gain an overall sense of the participants' experience. Salient elements of each self-report are identified. Potentially relevant material indicative of the participants' experience during therapy are extracted and evaluated within the context of the self-report to identify overlap, uniqueness and redundancy. Extracts from each self-report are distilled into an inclusive set of meaning units (statements) that capture the essence of the participants' experience while retaining their

language. Meaning units are scrutinized by taking into account content and meaning of the response in order to identify statements that represent a discreet idea. Verbatim retention of participants' language is retained as much as possible and altered only to equate verb tense among statements and to retain contextual meaning of the response. This qualitative set of representative meaning units, in the form of individual statements, constitutes items for further analysis.

During the second phase of the concept mapping procedure a second group of participants are asked to participate in a sorting and rating task as described below. Each individual meaning unit is reproduced on an individual piece of paper and through the process of an unstructured card sort, participants group together conceptually similar ideas, thoughts or experiences. Participants are provided a complete set of statements, asked to read through them and sort them into groups according to how they seem to go together. Instructions direct participants to place similar statements into similar groups. Participants are told they may have as many groups as they want but are restricted to not having only one group or having each statement stand alone as its own group. If a participant believes that a statement is unrelated to all of the others they may place it in its own pile. For the rating task each of the qualitative statements are compiled into a rating form and participants indicate how well each item reflects their experience. The purpose of this task is to aid in identifying the relative helpfulness of the various aspects of the experience under investigation.

In the third phase of the process individual similarity matrices are computed for the sorted items. These are ultimately aggregated into a group similarity matrix that is subjected to a nonmetric multidimensional scaling procedure. Multidimensional scaling (MDS) is a quantitative statistical procedure used to spatially represent the interrelations among a set of objects (Fitzgerald & Hubert, 1987). The results consist of a spatial configuration or map that uncovers the "hidden structure of the data" (Kruskal & Wish, 1978) through a graphic representation of the relations among objects. The stimuli are arranged as points in space along orthogonal axes such that the distance between any two points reflects the degree to which they are perceived as similar (Buser, 1989). In relating the use of MDS to counselling research Buser states, "The salient dimension underlying the client's perceptions are then determined by examining the resulting MDS configuration. In a sense, MDS enables the counsellor to understand the client's perceptual world" (p. 420).

The basic data used for MDS is a proximity or similarity matrix wherein each element of the matrix represents the measured similarity between a pair of objects (Davison, Richards, & Rounds, 1986). Fitzgerald and Hubert (1987) note that with respect to data collected in the area of counselling research having participants sort the items of interest results in a proximity matrix where the number of times an item pair was sorted together reflects their measured similarity. Multidimensional scaling reproduces the similarity matrix as points on a map so the original matrix is represented as accurately as

possible. Items frequently sorted together are represented as spatially closer together. In concept mapping nonmetric multidimensional scaling is the first statistical procedure performed. While the number of dimensions on which to display an MDS solution may be determined by the investigators (Davison, et al., 1986) concept mapping uses a two-dimensional MDS solution since the primary purpose is a visual display that also incorporates clustering results. According to Kruskal and Wish (1978)

> Since it is generally easier to work with two-dimensional configurations than with those involving more dimensions, ease of use considerations are also important for decisions about dimensionality. For example, when an MDS configuration is desired primarily as the foundation on which to display clustering results, then a two dimensional configuration is far more useful than one involving three or more dimensions. (p. 58.)

As MDS does not categorize items into groups it is often used in combination with other statistical clustering methods (Miller, Wiley, & Wolfe, 1986; Trochim, 1989). Cluster analysis also analyzes data from a proximity matrix to yield a representation of stimulus structure, but unlike MDS, which represents the underlying structure in terms of quantitative dimensions, the results are represented in terms of qualitative categories (Davison et al., 1986). Essentially cluster analysis is a classification technique in which items are clustered into groups that are more alike than members of other groups within a complex data set (Borgen & Barnett, 1987). A variety of clustering methods and ways of applying them exist. Essentially each method is a set of rules for dividing up a proximity matrix. The sequence of rules or procedures is referred to as an algorithm (Borgen & Barnett). Typically, natural groupings are not known a priori and in using a clustering

algorithm the data is searched in order to partition the items into relatively distinct groups (Borgen & Barnett).

In concept mapping the data obtained from the MDS similarity matrix are subjected to a hierarchical cluster analysis, based on Ward's (1963) algorithm, to sort items into internally consistent clusters with the cluster solution being superimposed on the MDS point plot. Ward's method searches the proximity matrix and groups the two statements with the smallest distance value. It continues to search the data grouping statements based on the distance value between them. The method continues to merge groups in a way that minimizes within-group variance. Ward's minimum variance method optimizes distinctiveness across clusters (Borgen & Barnett, 1987). This results in grouping items into internally consistent clusters. Kunkel and Newsom (1996) note "When used in conjunction with MDS, cluster analysis permits inferences about how items were categorized by participants, in addition to suggesting the underlying dimensions of this categorization" (p. 56).

In addition to MDS and cluster analysis, factor analysis is also a method for identifying the underlying structure in a multivariate data set. In comparing nonmetric MDS with factor analysis, while both represent the structure of the data along quantitative dimensions, nonmetric MDS is viewed as appropriate for a wider variety of proximity data. While nonmetric MDS is capable of analyzing ordinal data, factor analysis has been limited to the analysis of correlation coefficients thereby restricting its

applicability (Davison et al., 1986). In addition, when both types of analyses have been applied to the same data the graphic representation of the MDS solutions are often simpler than those of factor analytic solutions leading to greater ease of interpretation (Davison et al., 1986).

In comparing factor analysis with cluster analysis Borgen and Barnett (1987) note that both are methods that can identify the underlying structure of a data set. In distinguishing between the two methods Borgen and Weiss (1971) note the central difference is treatment of the variance of the variable. Factor analysis usually partitions the variance among several sources or factors, while cluster analysis assigns the total variance to an underlying "source." Thus, cluster analysis yields results where variables are grouped into discrete sets or 'clusters', while the results of the factor analysis are typically less clear, with parts of the variance of each variable attributed to each of the several 'subsets' or factors.

Therefore the application of multidimensional scaling and cluster analysis is preferred over factor analysis for depicting a graphic representation. By employing both MDS and cluster analysis investigator bias is reduced as qualitative data are typically analyzed using nonstatistical approaches. Bias is further reduced as meaning units are sorted by participants, not by researchers using predetermined categories or their own subjective interpretation. As noted by Rosenberg and Kim (1975) this method has...

> the advantage of making it unnecessary for either the respondents or the investigators to specify any of the psychological dimensions or attributes that can provide a basis for judgments of similarity. The identification of underlying dimensions can take place from the structures obtained by scaling and clustering, leaving the respondents judgments uncontaminated by an investigator's preconceptions. (p. 490)

The application of multidimensional scaling and hierarchical cluster analysis to the data yields a visual map of the participants' conceptualization of the phenomenon, which assist in understanding their perceptual experience. Thus, this method is participant-driven and combines both qualitative and quantitative research strategies (Trochim, 1989, 1993).

Map Interpretation

Concept map interpretation involves informed conjecture with respect to the structure imposed by participants in their sorting (Kunkel & Newsom, 1996). Initial examination of the map involves attempts to identify implicit dimensional axes around which points may be configured (Buser, 1989). In addition, potentially related concepts may be identified by evaluating the placement and adjacency of statements and clusters. The adjacency of constructs in the cluster structure suggests the close placement of statements reflects the participants' perception of them as similar. However, as noted by Paulson et al. (1999),

> Because the cluster solution is based on estimated distances between items from the MDS two-dimensional solution, the cluster solution is used as a secondary guide to interpreting the map, with the MDS solution (i.e., the relative distance and position of items on the map) given primary consideration. (p. 321)

As noted earlier, given that the primary purpose of the MDS configuration is to display clustering results the selection of a two-dimensional solution is deemed appropriate (Kruskal & Wish, 1978). The MDS analysis also provides a stress value, which is a numeric value representing the stability of the MDS solution and ranges from zero (perfectly stable) to one (perfectly unstable). A stress value of less than .30 represents a stable MDS solution (Kruskal & Wish).

The number of clusters that provide an appropriate solution, however, is dependent on the judgment of the investigator. The computation of a bridging index can assist the investigator in determining both the number of clusters and their labels (Trochim, 1989). This index aids in determining how well an item on a concept map is represented in its spatial location or whether its location is a compromise of the MDS algorithm. It is calculated as a weighted average of the distance between an item and all other items contained in the MDS solution. Bridging values range from 0 to 1 and indicate the frequency with which items were sorted together. Lower values reflect items sorted together frequently and higher values reflect items sorted together less frequently. Items with a high bridging value indicate that a statement "bridges" two or more areas to which it is related. Statements with a bridging value of 1 suggest that an item could potentially be sorted with every cluster. Lower bridging values are indicative of statements in a particular cluster more frequently sorted with other statements within that cluster than with statements in other clusters (Trochim, 1993). Generally, the lower the bridging value

the more central the statement is for the meaning of the cluster. An average bridging index can also be computed for a cluster with lower values representing a more coherent set of statements. The average bridging values of the clusters are taken into consideration when determining the number of clusters that provide an appropriate solution.

In addition, rating values for each statement and average rating values for each cluster can be computed. Low values reflect statements perceived as less helpful with respect to participants' emotional experience in counselling and high rating values correspondingly reflect statements perceived as more helpful.

Consideration of both bridging values and rating values help the investigator ascertain cluster names. Naming of clusters involves visually inspecting each cluster and its group of statements and takes into account items making up the cluster, consideration of items contributing most of the uniqueness of each cluster with reference to bridging and rating values, and consideration of the distance of each item from other items on the map. The naming of clusters is, therefore, both statistically and conceptually influenced with each cluster given a title that describes the theme depicted by the contents of the cluster.

The final visual representation, or map, reflects the concepts developed in the analysis of the interrelationships among the sorted items. Implicit dimensions are identified for a two-dimensional solution and potentially related concepts and apparent regions of the map examined. Given concept mappings' utilization of MDS and cluster analysis procedures the resulting map can be used to begin identifying the underlying

structure of a phenomenon and inferences made about how items were categorized by participants to aid in developing thematic clusters. In addition, Trochim (1989) contends that each cluster can be viewed as a measurement construct and can be used to provide direction for future research.

Participant Selection

Purposeful sampling was selected as the appropriate sampling strategy to best address the research question. Purposeful sampling specifically selects information-rich participants with first-hand experience of the phenomenon being investigated. Information-rich participants are those who can provide the investigator with an in-depth understanding of the investigated phenomenon (Patton, 1990). Specifically, a criterion-based selection procedure was used (Patton, 1990). This approach to sample selection differs in logic from probability sampling. In contrast to probability sampling, purposeful sampling is not intended to be representative of a larger population, nor are generalizations intended to be made from the sample to a larger population (Patton, 1990). Rather, this approach to sampling allows for in-depth information to be gathered and does not require that understanding of a particular experience be generalized to all cases.

For this study two groups of participants were selected. One group was selected to gather information through an interview process described earlier. A second group was recruited to perform the sorting and rating tasks that are part of the concept mapping

analysis. In determining sample size Lincoln and Guba (1985) recommend sample selection to the point of redundancy. Redundancy is the primary criterion in determining the number of participants and refers to a point in data collection where no new information is forthcoming from the participants.

In the first phase of data collection nine participants who agreed to be interviewed with respect to their emotional experience in counselling were recruited from four private practitioners in the therapeutic community of a large Western Canadian city. An essential criterion for inclusion in the first sample was first-hand experience with the phenomenon of emotional experience in counselling. Criteria included being an adult over 18 years of age who had voluntarily sought counselling services, having explored emotional material within the therapeutic process, a willingness to participate in a one to two hour taped interview that would be transcribed, an ability to describe their experience, being in the termination phase of counselling or having terminated counselling within the last four weeks. The researcher approached five therapists from the local therapeutic community and the study was explained. Four therapists agreed to participant and were asked to provide information packages to clients they believed would be appropriate participants. Information packages consisted of a brief study description, (Appendix A), a consent form (Appendix B) indicating the potential participant consented to being contacted by the researcher and self-addressed postage-paid envelopes for the consent to be mailed to the researcher.

Potential participants were contacted by phone upon receipt of mailed-in forms indicating interest in participating. The study was explained in greater detail including the purpose of the study, confidentiality protection, and the right to withdraw at any point during the study without penalty. A mutually agreed on time to conduct a one to two hour interview was arranged with those participants indicating interest in participating. Consent to participate was reviewed again at the time of the interview (Appendix C).

Demographic data was gathered at the time of the interview. The sample was comprised of three males and six females. Six were married or co-habiting and three were divorced or separated. Participants mean age was 45 years with a range of 35 - 52 years. Participants' mean number of sessions was 43 with a range of 7 - 200. The participant with 200 sessions was an outlier and when the mean number of sessions is calculated without that outlier the mean number of sessions is 21 with a range of 7 - 32. Reasons for attending counselling (with the number of participants reporting each in parentheses) were depression/anxiety (5), relationship issues (3), emotions (2), career (2), substance abuse (1), trauma (3). All of the participants were Caucasian.

Therapists consisted of two female Master's level therapists, one female Ph.D. level psychologist and 1 male Ph.D. level psychologist. Therapists had a range of experience from 5 to 25 or more years and had training in a wide variety of counselling approaches including cognitive behavioural, structural, experiential, emotion-focused, and feminist.

In the second phase of data collection 22 participants was recruited from two large Western Canadian cities and one large Western U.S. city to participate in the sorting and rating task. Inclusion criteria included being an adult over 18 years of age who had voluntarily sought counselling services, having explored emotional material within the therapeutic process, having terminated therapy, and a willingness to participate in the sorting and rating task described. Potential participants were aware of the present study either through previous contact with the researcher or a person known to the researcher. Through an initial phone call the study was explained in greater detail to these targeted participants including the purpose and procedure of the sorting and rating task, confidentiality protection and the right to withdraw at any point in time without penalty. Those contacted who remained interested in participating were sent a sorting and rating package consisting of a study description (Appendix D), consent to participate (Appendix E), demographic questionnaire (Appendix F), sorting instructions (Appendix G), items to be sorted and a rating questionnaire (Appendix H). Of this sample seven were male and fifteen female. Seven were single, ten married or co-habiting, and five divorced or separated. Mean age for this sample was 44 with a range of 21 - 68. Participants mean number of sessions was 16 with a range of 9-26. All participants were Caucasian. Reasons for attending counselling (with the number of participants reporting each in parentheses) were anxiety/depression (13), relationship issues (8), trauma/abuse issues (5), grief (3), and self-esteem (2).

Data-Collection - Phase 1

Data for this study was obtained through direct, in-depth, audio-taped interviews with each participant. Following an open-interview format, the data gathering interview asked the participants to "Please describe the types of emotions you experienced during counselling." Using open-ended, non-judgmental questions the participants were encouraged to describe their experiences in as much detail as possible. The format of the interview was deliberately broad and unstructured in order that the participants elucidate their experience with minimal input or direction from the researcher. As noted by Marshall and Rossman (1989), "... the participant's perspective on the . . . phenomenon of interest should unfold as the participant views it, not as the researcher views it" (p. 82). Participants were encouraged to continue elucidating their experience with the researcher initially asking clarifying questions or questions that would elaborate what participants were describing. Only after participants had exhausted their description of their experience were questions contained in the interview guide addressed (Appendix I). Questions were intended to help interviewees recall, structure and describe their emotional experience in their own words. On average, interviews lasted for one to one-and-a-half hours. The interviews were transcribed immediately following the interview. Transcribed interviews were sent to each participant to check for accuracy of the self-report. Participants were asked to contact the researcher regarding any perceived discrepancies of the account. None of the participants did so.

Case Summaries

As the process of extracting statements from participant self-reports for the concept mapping analysis results in a loss of contextual information, case summaries of all nine participants who participated in the first phase of data collection were developed. These summaries provide qualitative information and a contextual framework against which to view the concept mapping results. Each case presents participant demographic information, presenting issues and a summary of the participant's experience.

Thematic Analysis

In addition to case summaries, common themes that emerged across interviews were developed. A qualitative approach to thematic analysis utilizing discovery-oriented inductive logic was used (Patton, 1990). The data was analyzed using procedures outlined by Colaizzi (1978) as a guideline. Participant self-reports were read and reread to gain an overall sense of the participants' experience. Using van Manen's (1984) highlighting approach, phrases and statements particularly revealing of participants' emotional experience were identified and extracted from the self-report protocols. Extracts were compared across self-reports and conceptually similar extracts were identified and grouped together between participants and named. Essentially, a between-person analysis was conducted in order to allow the emergence of themes common to all participants. Themes were referred back to the original self-reports for validation (Colaizzi). A written synthesis of common themes is presented in Chapter 4.

The purpose of examining the data for common themes was not to undertake an in-depth phenomenological analysis but to provide information regarding overarching themes experienced by the first group of participants. Here the word 'theme' is intended to refer to what the data segment was about as opposed to the phenomenological researcher's equivalent of study results (Tesch, 1987).

As two groups of participants were used in this study, developing common themes across the first group of participants allows the reader to ascertain if experiences described by this group are also found within the map generated by the second group of participants. Thus this provides a method of triangulation. Triangulation is essentially the procedure of obtaining confirming data from more than one perspective (Denzin & Lincoln, 1994). According to Lincoln and Guba (1985) the technique of triangulation is used to improve the probability that qualitative research findings will be found credible.

Concept Mapping Analysis - Phase 1

Using Giorgi's (1985) qualitative analysis of text as a procedural guideline, participants' interviews were read and re-read and relevant material reflective of the participants' experience was extracted from the transcripts. Excerpts were scrutinized taking into account content and meaning of the response in order to identify statements that represented a discrete idea. Participants' language was retained and altered only to equate verb tense among statements and to retain contextual meaning of the response. Contextual or irrelevant material (e.g., And I kept going to a day treatment program) was

separated from statements representing participants' emotional experience in counselling (e.g., I just shut off from my feelings). Excerpts were initially distilled into 113 statements retaining participants' language and reflecting their experience. The original 113 statements were submitted to a three-member research team consisting of two Ph.D. psychologists and one senior level doctoral student. Each member of the research team was provided with the list of statements and asked to analyze the list for redundant statements and provide feedback regarding statement clarity. This process was continued until a final list of 61 qualitative statements was reached.

Data Collection-Phase 2

The second data gathering session involved 22 participants in a sorting and rating task. Prior to involving these participants in this task a second senior level doctoral student was provided with a package containing instructions for the sorting and rating task. She was requested to complete the task as outlined in the package and provide feedback regarding clarity with respect to the instructions. Participant involvement in the sorting and rating task began only after determining that the instructions and task were clear. Participants were provided with a set of statements with each statement reproduced on a piece of paper so that each piece of paper represented a qualitative description of what clients described with respect to their emotional experience in counselling. Sorting instructions asked participants to place the statements in piles according to how they go together (Appendix G). The only restrictions placed on participants' sortings were that

they not place each item alone in a pile or place all items in one pile (Rosenberg & Kim, 1975). The rating task involved compiling each statement into a questionnaire (Appendix H). Participants were asked to rate the statements on how helpful they believed this experience was in counselling. Statements were rated on a 5 point scale from 1 not at all helpful to 5 extremely helpful. The purpose of this task is to aid in identifying the relative helpfulness of the client's emotional experience in counselling.

Concept Mapping Analysis -Phase 2

In the second phase of the data analysis individual similarity matrices were computed for the sorted items using the concept mapping system. These were aggregated into a group similarity matrix, which was subjected to a nonmetric multidimensional scaling procedure described earlier. This procedure arranged the sorted statements, depicted as points, along orthogonal axes with the distance between any two points reflecting the frequency with which the items were sorted together. Thus, points that are relatively close together represent items placed together in particular sorts more frequently and are perceived of as conceptually similar. This procedure is particularly suitable for spatially representing latent relationships among variables (Fitzgerald & Hubert, 1987; Kruskal & Wish, 1978).

The data from the MDS similarity matrix was also subjected to a hierarchical cluster analysis procedure with the cluster solution being superimposed on the MDS point plot. This resulted in grouping items into internally consistent clusters. As noted

by Kunkel and Newsom (1996) "When used in conjunction with MDS, cluster analysis permits inferences about how items were categorized by participants, in addition to suggesting the underlying dimensions of this category" (p. 56).

Clusters were named by taking into account items making up the cluster, consideration of items contributing most of the uniqueness of each cluster, and consideration of the distance of each item from other items on the map. Thus naming the clusters is both statistically and conceptually influenced. The naming process again involved the use of a research team consisting of three Ph.D. level psychologists and the researcher. Clusters were initially named by the researcher and results provided to each member of the research team independently for feedback. Feedback was used to rename clusters, which were again submitted to the research team. Final naming of the clusters was reached when the research team provided no new or original feedback.

Establishing Trustworthiness

Establishing trustworthiness of qualitative data has often led to debates between researchers within the quantitative and qualitative paradigms. Accusations levied against qualitative research for lack of rigor have attacked its credibility. Researchers adhering to a quantitative paradigm have criticized qualitative research for its lack of standard means of assuring reliable and valid results. This critique is bolstered by the fact that existing reliability and validity measures are founded on positivist assumptions that underlie quantitative research (Maxwell, 1992). Counterarguments emerge in the literature denying

the applicability of reliability and validity to qualitative research or redefining the terms used to reflect assumptions within the qualitative paradigm (Dey, 1993; Lincoln & Guba, 1985; Maxwell, 1992; Merrick, 1999; Patton, 1980).

Shimhara (1988) contends that issues of validity and reliability are crucial to all social research no matter what methods are employed. In dealing with research results Dey notes we are dealing with probabilities rather than certainties.

> Just as the criminal justice process culminates in a decision about guilt or innocence, analysis is supposed to result in some conclusions. In both cases, we do not require these conclusions to be certain. It is enough that they should be beyond reasonable doubt. We cannot verify facts or explanations in the way that we can verify the outcome of an arithmetic sum . . . The most we can hope for is to present the best possible account of our data. (p. 232)

Reliability

In order to convince an audience of the reliability of a body of research Dey (1993) contends instead that the researcher must outline the methods used and make explicit precautions taken to reduce researcher bias and error. He states,

> If we cannot expect others to replicate our account, the best we can do is explain how we arrived at our results. This gives our audience the chance to scrutinize our procedures and to decide whether, at least in principle, the results ought to be reliable. (p. 251)

In a similar vein Merrick (1999) notes that within the postpositivist paradigm there is no one truth and that all knowledge is constructed. Reliability, therefore, can be understood to incorporate a definition of "rely" as meaning "to depend upon confidently". She argues for a similar standard to Dey (1993) in outlining explicitly

methods used and precautions taken to reduce researcher bias and error. Reliability in this study was ensured by clearly outlining the method used to collect and analyze data and make explicit the steps taken to reduce researcher bias and error.

Various forms of triangulation were applied including investigator triangulation, theory triangulation, and methodological triangulation to strengthen the study design (Patton, 1990). Investigator triangulation was achieved through the use of several different researchers including a research team and a second group of participants to impose an intuitive conceptualization on the items extracted from the interviews. Theory triangulation was attained through comparison of the results with the literature. The use of multiple methods to analyze the data constitutes methodological triangulation through thematic analysis and concept mapping.

Validity

In assessing the role of validity, Dey (1993) defines a valid account as "one which can be defended as sound because it is well-grounded conceptually and empirically" (p. 253). Hammersley and Atkinson (1983) contend that "data in themselves cannot be valid or invalid; what is at issue are the inferences drawn from them" (p. 283). It is further important to note that if an account can be defended as valid, issues of reliability become moot as validity is dependent on reliability. Consistent with the assumptions of the qualitative paradigm, that there is no one correct objective account of reality, there is then always the possibility for different, equally valid accounts from different perspectives.

Maxwell (1992) contends,

> In contrast, a method by itself is neither valid nor invalid; methods can produce valid data or accounts in some circumstances and invalid ones in others. Validity is not an inherent property of a particular method, but pertains to the data, accounts or conclusions reached by using that method in a particular context for a particular purpose . . . validity is always relative to, and dependent on, some community of inquirers on whose perspective the account is based. Validity is relative in this sense because understanding is relative; as argued above, it is not possible for an account to be independent of any particular perspective. (p. 284)

As noted by Altheide and Johnson (1994) for many qualitative researchers, validity is dependent on the audience or "interpretive communities" and goals of the research. Within the qualitative paradigm validity is not about establishing the truth of facts that exist out there, but rather the focus has shifted to understanding by participants and readers (Mishler, 1990; Stiles, 1993).

Descriptive Validity

Descriptive validity concerns the factual accuracy of the account (Maxwell, 1992): The accuracy of what the researcher saw or heard. One of the major threats to descriptive validity is distortion or omission of aspects of the phenomenon. To ensure descriptive validity in this study interviews were tape-recorded and transcribed. Transcribed self-reports were provided to participants to confirm the accuracy of the account. In addition, participants' language was maintained as much as possible in the generation of statements that reflect participants' experience.

Interpretive Validity

Interpretive validity refers to the concept that the account is accurate from the perspective of the participant (Maxwell, 1992). The meaning of the account must be based within the conceptual framework of the participants involved and rely on their own words and understanding. At the heart of interpretive validity is the inference drawn from the words and actions of participants in the situation studied. To meet the standard of interpretive validity a second sample of participants familiar with the phenomenon being studied were asked to provide a conceptualization of the data in the concept mapping sorting and rating task. As noted earlier, using research participants in the sorting and rating task reduces researcher bias. Using a second group of participants to complete this task acts as a method of triangulation and enhances transferability of the findings. In addition, an audit trail was maintained which provides a detailed procedure of data collection and analysis. It allows the reader to examine the researcher's process and understand how the researcher arrived at an interpretation.

Theoretical Validity

Theoretical validity differs from descriptive and interpretive validity in that its purpose goes beyond simply describing the participants' perspectives. Maxwell (1992) contends that theoretical validity refers to an account's function as an explanation of the phenomena. He notes that it is the consensus within the community concerned with the research about the terms used to characterize the phenomena that counts as theoretical

validity. The data in this study were critically evaluated to determine how they fit with the current theoretical perspective about the emotional experience in counselling. This issue is further elaborated in Chapter 5.

External Validity

External validity traditionally refers to the extent a particular account can extend to other persons, times or settings than those directly studied. Typically qualitative studies are not designed to allow generalizability to a wider population. Instead the term transferability is generally used in qualitative research to define generalizability (Denzin & Lincoln, 1994). It refers to the goodness of fit between the reader's and the researcher's interpretations. It is left to the reader to determine whether meaningful connections can be made between the reader's personal experience and the research findings.

Trustworthiness

Many qualitative researchers hold trustworthiness to be the primary criterion for the evaluation of quality. Elements of trustworthiness include "good practice" that are ongoing through the research process (Lincoln & Guba, 1985; Stiles, 1993). In summary, the following procedures were taken to ensure a trustworthy account and to reduce threats to reliability and validity. The methods used for both data collection and analysis were outlined previously. Efforts to reduce researcher bias and error include:

a) recording and transcribing participant interviews and soliciting feedback on the accuracy of the account from participants

b) maintaining the participant's language as much as possible in the generation of statements that reflect participants' experience

c) maintaining an audit trail of excerpts taken from interviews, and statements taken from excerpts. Thus statements can be linked back to excerpts and excerpts to interviews

d) the use of a research team to arrive at a final list of generated statements

e) a pilot test conducted to ensure the sorting and rating task would be clear to the second sample of participants

f) the use of a second sample of participants familiar with the phenomenon in question to impose their conceptualization on the data versus a conceptualization imposed by a single researcher

g) the use of a research team to arrive at cluster names

h) development of case summaries and common themes of the first group of participants which are compared with the concept map generated by the second group of participants. The use of these two forms of presentation allows the reader to ascertain if experiences described by the first group of participants are found within the map generated by the second group of participants. It also provides a method of triangulation

i) periodic debriefing with members of the researcher's supervisory committee

j) checking for the fit between the concepts used in the research and previously established concepts.

It is concluded that concept mapping and the thematic analysis are methods particularly well suited to addressing the questions what was the client's emotional experience in counselling and what was helpful about that experience. There is a need to explore this phenomenon from the client's perspective in order to increase our understanding of the role the client's emotional experience plays in the change process and to help identify how a client's emotional experience can effectively be incorporated into the therapeutic process from a variety of theoretical orientations. This method actively involves participants and combines both quantitative and qualitative research strategies, thereby reducing bias in this study in contrast to employing qualitative methods alone. Given concept mappings' utilization of MDS and cluster analysis procedures a concept map can be used to begin identifying the underlying structure of this phenomenon and inferences can be made about how items were categorized by participants to aid in developing thematic clusters. In addition Trochim (1989) contends that each cluster can be viewed as a measurement construct and can be used to provide direction for future research.

Chapter 4

Results

Results of this study are presented in two forms. Case summaries and a thematic analysis reflecting the emotional experience of the first group of participants are presented. In addition, the conceptualization of the second group of participants on the sorted items is provided in the form of a concept map. The case summaries provide a context for the emotional experience of the first group of participants, the thematic analysis provides information regarding commonalities among participants, and the concept map provides information regarding the underlying structure of that experience. Evaluating the concept map against the case summaries and thematic analysis reflects the participants' process as they dealt with emotional material in therapy.

Overview of Interview Summaries

Case summaries of all nine participants comprising the first group of participants are presented. Each case outlines participant demographic information, presenting issue and a summary of the participant's experience. These summaries provide the reader with qualitative information that provides a context for participants' emotional experience as well as a framework against which to view the concept mapping results. Understanding both the process and the context of clients' experiences is important for increasing our understanding of what happens for clients in therapy. Presentation of interview summaries provides this context.

Summaries

Participant #1

Demographic Information: Female, Age 35, Divorced, 26 sessions

Presenting Issue:

Participant #1 is a single mother of two who sought counselling for what she describes as depression. She participates in counselling at two different times with two different therapists. Her first round of therapy temporarily alleviates her depression, but did not deal with underlying emotional issues that she ultimately identifies as the source of her depression. Upon completing her first round of treatment (12 sessions) this participant is able to again participate in her life, but remains disconnected from her own emotional process. Six months later she returns to counselling again experiencing depression. She complains of continually feeling "down", lacking energy, struggling with insomnia and being unable to attend school or care for her children.

Interview Summary:

This participant sought counselling for what she describes as an overwhelming unhappiness with life that culminates in indifference and apathy. Her indifference is characterized by a lack of emotional reaction to life events and experiencing life as passing her by. She describes herself as generally going through life feeling numb.

Having suppressed her emotions for years she lacks awareness of and connection to her internal emotional process. Her typical coping strategy is an ongoing cognitive

analysis of her life while avoiding any emotional content. Her avoidance of emotion results in physical distress experienced as migraine headaches. She states,

> . . . there were things I just couldn't think out in my head anymore. I used to think and think and think all the time, and it would just – I had migraines for years because I had all this stuff going on in my head, and subconsciously, not consciously, it was going on subconsciously, and so it was trying to get out, and avoiding my emotions was causing me real life physical problems. It was just – it was all a thinking thing and the feelings were all – they were buried so it didn't matter.

Two factors contributing to this participant's change process emerge. She describes a strong therapeutic alliance with her second therapist that was not present in her initial therapy and acknowledgement of distressing emotional material. She identifies the strength of the therapeutic alliance as the beginning point for change.

> There was somebody there that I trusted that could share this experience with me and just in hearing what I had to say. Just in being a sounding board. It was a very safe place for me to let out these emotions and that's something I didn't have anywhere else in the world. Just in that little office I was very safe. And that's what I needed to get things out . . . I had to finally open up and trust somebody. And when I made that connection that started it for me.

"Dealing" with emotions emerges as a process of recognizing and naming the emotion, feeling the emotion, acknowledging the unmet need related to the emotion and accepting versus avoiding the emotion along with the particular life experience it relates to. She describes separating and discriminating among various emotions. As this process occurs there is an internal sense of reorganization. Participant #1 describes the process as,

> It was all that stuff behind that closed door that needed to be dealt with. So it was all the emotions, the feelings, things that I'd built up over the

> years, that was pounding to get out. . . It's just in the talking out process of it and the crying, things come out from behind the door . . . And it gets put in a different spot, but it doesn't get crammed back into this little space like everything had been before. I now have – feel like I have like these little cubby-holes and things get put into the spaces they're supposed to be put into.
>
> It's like also too describing it as a big ball of string. Okay. And you got all of these ends hanging out. And it's just taking them one at a time and pulling them and seeing what comes out. And of course as they unravel from the big ball you can't put them back. They've got to go someplace else . . . That changed a lot because all of a sudden all of these things that are all wound together are being separated.

Part of this reorganizational process includes a sense of integrating cognitive and emotional processes. Prior to this the participant describes herself as experiencing many thoughts without feelings; "empty thoughts." But as the cognitive and emotional processes integrate she experiences change. Though unable to fully articulate how this happens she is aware she is no longer indifferent and that she is responding emotionally to the events in her life.

> But I needed them both to come out and be together, to be united for me to be a whole person again . . . I had the thoughts, but no feelings. So I had to work on bringing the emotions out. I could think till hell freezes over, but without the emotions to go along with it, they were like empty thoughts . . . And they have to be – they have to be joined together in order to have any progress in life for me. I have to be able to feel and think about what I'm doing . . . I was integrating. And all of a sudden – like I don't know how – how they just join together. But they did.

Through this process she indicates that things that are initially unconnected come together. Over the course of therapy this participant moves from an indifferent stance toward life, characterized by a lack of emotional reaction, to feeling her emotions and

acknowledging how they enrich her life experience. As a result she begins treating people differently, shares her emotions with others, and becomes aware of what is important to her. She reports continually paying attention to the emotions she experiences stating "I want to experience life. I want to experience the emotions good, bad or otherwise. They're such a part of me now. I don't want to hide them away, you know."

Participant #2

Demographic Information: Female, Age 44, Married, 23 sessions

Presenting Issue:

Participant #2 is a married professional woman with two children who sought counselling for her anxiety. She describes experiencing increased stress for a variety of reasons including managing the medical treatment for her mother, recent threats to job security, and personal threats made against her life. Anxiety symptoms include insomnia, excessive worry, racing thoughts, muscle tension, and lack of appetite. Specific somatic complaints include nausea, headaches, dry mouth and difficulty swallowing. Her chief complaints are feelings of intense fear and worry and feeling emotionally out of control. She describes feeling emotionally overwhelmed by normal day-to-day responsibilities, and her emotions are experienced as out of proportion to her present situation.

Interview Summary:

While this participant is able to maintain day-to-day functioning, continuing to work, managing her mother's medical appointments and meeting family responsibilities,

she experiences life as increasingly stressful and out of control. She describes her emotions as taking on a life of their own and ruling her life. The intensity with which she experiences her emotions contributes significantly to her discomfort and results in her emotions having an overpowering effect on her capacity to manage her day-to-day affairs. As a result of this increased emotional intensity she describes her emotional reactions as "unrealistic" and out of proportion to her present situation, describing herself as "making mountains out of molehills."

Coping strategies prior to therapy include avoiding acknowledging or addressing emotional distress and carrying on with life. Her emotions intensify internally, resulting in physiological and psychological distress and are experienced by symptoms outlined earlier. She refrains from any outward expression of her emotional distress and describes this avoidance as "hiding and not being truthful to myself." She talks about putting her emotions "in the back of a filing cabinet" as a way to avoid dealing with them. Failure of this coping strategy ensues as her attempts to avoid distressing emotions corresponds with their increasing intensity.

She states,

> The filing cabinet is initially messy, disorganized, and completely out of control . . . The files are in the filing cabinet drawer, and you're able to deal with it. But then you need another drawer because more stuff is happening. And you don't really have time to deal with it properly so it's a little bit astrew [sic]. Then you get to the third drawer and that gets filled up and it just – it keeps coming that you – that I lived, breathed, ate everything popping out of this filing cabinet, and I've already filled up

> four. And I just had so many emotions that sometimes were inappropriately shown. In the midst of something really sad, here I'd start laughing or something like that so – they would just be all amiss.

Participant #2 identifies the relationship with her therapist as significant for her to begin acknowledging distressing emotions in therapy. Though initially dismayed when her therapist directs her toward this exploration, the existence of a strong therapeutic alliance allows her to do so. While this exploration is initially uncomfortable, participant #2 comes to the realization that her emotions "needed to be faced so that I could get on with life."

Therapy involves bringing each distressing situation she is experiencing to the forefront of her awareness. Her therapist directs her to imagine a distressing situation and then directs her attention to bodily sensations that co-occur. In this process she experiences her emotions more intensely during a therapy session and her emotions are accompanied by a range of physiological feelings such as "sick to my stomach, nervous, clog in my throat." Her therapist aids in containing the participant's experience of this exploration by avoiding cathartic expression of emotions and using grounding techniques to aid the participant in tolerating her emotions. Through this process she describes her emotions as reorganizing at a more realistic level and culminating in a sense of relief. She states,

> It was scary because I was meeting up with them. You know, when you're – are used to hiding them [emotions] and not meeting up with them and there, baboom. But because of what my therapist was eliciting I was having to look at it. And that was scary. Repicturing, reliving, refeeling.

> That was scary. But once again is you develop that trust that your therapist is not going to leave you scared. She's going to bring you closure, bring it around or whatever you can meet it face on a little bit better. But that first couple of times, that was scary because she brought it right – right in your face. But it worked. I needed to do that and take a good look at it . . . During it a lot of emotions were brought out, and that was necessary. From intense fear – like if I went into it a bit fearful some of the sessions made me more fearful, but the way they were handled it was like it peaked and then came back down and either I lost the fear or it was a normal amount kind of thing.

She describes the process of addressing emotional material in therapy as being able to remove old files from a filing cabinet, dispose of them, change them or to consciously let them remain with increased understanding and awareness of their existence. As a result the emotional intensity decreases, and participant #2 experiences a greater sense of self-control, emotional awareness, and emotional openness with others. She describes a sense of order and completion with respect to the emotional material explored.

She states,

> It's [emotions] amiss. It's a mess. It's disorganized. Yeah, completely out of control kind of thing. And once we deal with it, it fits. It's organized. It's easier to deal with because it's in order. Some had been ditched. Well, I don't need to hide them [emotions] in the filing cabinet and close them up . . . It's not locked away anymore ... It's not as much of a burden anymore because I can – whether it's related or semi-related to something in an organized filing folder I can relate it and say, okay, you can cope with it.

Participant #2 terminates therapy with increased awareness of the importance of acknowledging her internal emotional process. She feels she has gained skills in accessing her emotions and in being more emotionally open with others. This provides her with a sense of being true to herself and provides an increased sense of self-control over her life.

Participant #3

Demographic Information: Female, Age 42, Married, 25 sessions

Presenting Issue:

Participant #3 presented for counselling due to ongoing difficulties since childhood of feeling emotionally numb. In addition to what she describes as a chronic low-level depressed mood she experiences low self-esteem and feelings of hopelessness. Though able to maintain social relationships she indicates they lack emotional openness and intimacy resulting in an increasing sense of social isolation. Her chief complaint at the time of entering therapy is an oscillation between emotional numbness and feeling emotionally overwhelmed. She experiences this distress as emotionally painful, but is initially unable to identify specific emotions or events they relate to.

Interview Summary:

Prior to seeking therapy, participant #3 describes a growing awareness that her inability to experience her emotions restricts her life experience. She recounts how experiences within her family of origin culminate in her ignoring the experience and expression of emotions. Within her family of origin the expression of emotion was unacceptable and as an adult avoiding experiencing her emotions provides her with a sense of safety in the world. Simultaneously she describes herself as feeling hollow inside. She describes this experience as embodying the Tin Man in the Wizard of Oz.

She states,

> I think that just prior to going into therapy I thought there was something very wrong here. I didn't really know what happiness was. I didn't really get excited about anything . . . Not showing my feelings kept me safe. Kept me very, very safe. But it also kept me in this robot-like mode, where prior to exploring what was happening to me in therapy it was kind of like I was going through the motions of life. But it was empty. It was like the Tin Man in the Wizard of Oz. You just kind of – going through what you do to get by in life. I often think about that – that movie and the Tin Man and having no heart. And it's a very lonely, lonely place.

Concurrent with the realization that she experiences life in an emotionally restricted manner, recent contact with members of her family of origin triggers an intense and overwhelming experience of emotions. She describes a biphasic response oscillating between numbness and being overcome by emotions. Initially unable to describe specific emotions she is able to identify that she is in emotional pain. Her usual coping strategy of avoiding her emotional process fails her at this time, and she experiences her life as out of control. She reports physiological symptoms of nausea that accompany the overwhelming emotion.

In describing her experience she states,

> It's like being in the center of the tornado. I could control all these feelings that were whirling on around me. Being in the center of the tornado, it's like I wasn't even aware of them whirling around me. And then something would trigger these feelings, like a conversation with a family member, and I would be thrown out of the eye of the tornado into all of it. And out of control. Just totally out of control . . . It's like I didn't have a choice. It's like all of these feelings were in me and were bursting to get out, and I didn't have control of them anymore . . . I had no idea what to do with all of these feelings. . . It was like I tried too hard for this period in my life to control my feelings that I felt nothing. And then when – when they started kind of coming forth like that it was like stepping into a tornado . . . And

> it's absolutely terrifying, and I felt totally out of control, and I – kind of thought I was going nuts. I didn't know what was happening to me.

A psychoeducational component provided by participant #3's therapist provides a framework within which she is able to make sense of her experience. Her emotional response is normalized within the context of her family of origin background. She gains an understanding of what her emotions are related to and why she responds the way she does. In addition she learns to identify specific emotions and to attend to the meaning they have for her.

Dealing with her emotions in therapy consists of exploring events from the past in conjunction with the emotions associated with them. She identifies needing to connect to the sensations in her body in order to experience her emotions. Her therapist directs her to her bodily experience that aids her in identifying what bodily sensation goes with what feeling. This process increases her sense of self-awareness and understanding. Events from her past are examine by providing a space for her to experience her emotions and talk about the meaning her emotions give to these events.

> Prior to sort of coming to terms with them [emotions] you start to realize your feelings are in your body, that I was kind of walking around just in my head all the time so when I started to connect with all these feelings there's so many and they're in my body. And they want to get out and it's almost like metaphorically wanting to throw-up . . . So there might be a particular event from my past that I hadn't let myself feel or let myself say things about that needed to be said, and I guess that's one of the things that happened in therapy was I could – I could talk about these things that happened to me now, and the feelings that would come up inside of me . . . it's like they needed to come out instead of stay in the reservoir . . . And I started to learn I guess to pay attention to what – what they meant. What

> was going on, what was I feeling, so that this whole tornado of feelings started to dissipate . . . I think because I started to gain an understanding of what the feelings were, and I became less afraid of what I was feeling that it became okay to have them. Before that it wasn't okay to have them. It's like they were dangerous. It's like I had to protect myself from what I was feeling. And over the course of therapy I learned I didn't have to protect myself from what I was feeling, that it was okay to feel what I was feeling, that it could be important to feel what I was feeling.

For this participant, the result of the therapeutic exploration of her emotions is increased self-awareness and engagement with life. She reports increased emotional openness with others characterized by being able to identify her emotions and express them to others. There is a resulting decrease in her sense of emotional isolation and an increased sense of experiencing life more fully.

She states,

> It's like I'm no longer a robot going through life. It's like I'm part of my life. Before it was like being an observer of my life and now I'm part of my life because I can feel my life. And I guess another way to put it would be before life used to be like it was – like in black and white. And it's not in black and white anymore. Its in colour. It's in all these rich , rich colours. It's like I'm not the empty Tin Man anymore. I'm filling up inside.

Participant #4

Demographic Information: Female, Age 50, Divorced, 200 + sessions

Presenting Issue:

Participant #4 is a divorced woman with two adult children who sought counselling because of a history of childhood sexual abuse from ages 2 to 19. Upon presenting for therapy participant #4 describes experiencing flashbacks and dissociative

states lasting from several minutes to several hours on a daily basis. Her ability to function is impaired to the degree that she is unable to maintain work. Her chief complaint is a sense that she is collapsing emotionally while concurrently feeling completely numb.

Interview Summary:

Involved in extensive long term therapy on and off over a period of four years this participant reports that prior to counselling she feels totally numb. She attributes this historically to a family upbringing where feelings were not expressed, as well as a significant history of ongoing childhood sexual abuse with multiple perpetrators including family members and family friends. In addition to sexual abuse, her family of origin history includes emotional abuse and neglect. She describes the parenting style within the family as authoritarian and punitive. Emotional expression is discouraged through the use of punishment and discounting any expressed emotion. Her initial coping strategy is to ignore and avoid experiencing any emotions related to past events, and by the age of 15 she indicates her emotional experience is deadened. She reports putting events from the past and the feelings associated with those events in a box and closing the lid. She describes herself as being "encased in cement" and the process of connecting with herself internally as "cracking through the shell of a walnut to get inside". The death of participant #4's father triggers an emotional breakdown as her usual coping strategy of avoiding her emotions begins to fail. She states,

> I felt like I was on the edge of a big black hole. And I really didn't want to find out what – what was in that black hole, but I collapsed totally emotionally . . . This hadn't happened to me before and so I couldn't put it in a box because that's what I – you know – put it in a box, close it. It's just a black hole, and it doesn't mean anything. And I think that's when I realized part of me was gone, was void . . . I think about three months into therapy I started to cry . . . but I didn't recognized it [the emotion] as sadness. I had tears rolling down my face, and I felt very guilty because I had tears running down my face . . . I cried, but I didn't feel anything . . . It was like my mind was like a blank wall and most of the time I felt cold. It was just like as if I was in cement, just, you know, nothing was acceptable . . . And you know, it was like cracking a walnut or something and having to get inside because my defence – my defence was 'it's okay, it's okay', because if I said it's okay then it had to be okay. I didn't know what feelings were okay and what feelings weren't okay.

Therapy initially addresses building a strong therapeutic alliance which participant #4 indicates took in excess of three months. She identifies the therapeutic alliance as a starting point for change. Once safety and trust are firmly established her therapist directs the therapeutic process toward an exploration of participant # 4's internal emotional experience both through art and by focusing her attention on her bodily felt sensations that accompany her emotions. From the identification of bodily sensations her therapist begins to provide participant #4 with emotional language for her experience. As she describes the events from her past she is encouraged to experience her internal emotional reactions and those reactions are validated and normalized. This prompts the beginning of an increasing ability to identify and trust her emotional experience.

She identifies a changing relationship with her own emotional experience that she describes as a changing kaleidoscope pattern. Through connecting with herself internally

participant #4 describes a reorganization process in which she gains increased perspective on her emotions. She is able to identify specific emotions and learns to trust her emotional experience as providing information about the meaning events hold for her.

She states,

> I developed a trust in my therapist . . . And so with recognition from my therapist and from her sort of changing the pattern of the kaleidoscope so I could see what, you know, what really was going on . . . Though these things were new feelings nothing was going to explode because of it . . . it's like turning the kaleidoscope . . . And you've got just a jumble there . . . The fear, the anger, the helplessness, the unworthiness, they were like things looming way above me . . . And I didn't know how to really get in touch with them so that then I would be able to manage . . . After my therapist had explored some of the emotions with me I just felt different inside then.
>
> Like, at first it was like my chest was being crushed. There was just so much there. And little by little, talking over the feelings and – and her not judging whatever the feelings were – and she had to help put names to them because I didn't know . . . It was more like we chipped away just to go to all that big encasement. It was just like – just like a sculpture I guess, just chipping away at it . . . I had been able to learn that you could experience feelings that were both negative and positive . . . The big cold chunk that was part of me had rightfully been changed. I had the power to acknowledge and to accept and to change.

As a result of exploring and experiencing her emotions this participant moves from a place of feeling encased in cement and fearing her emotions to one of trusting herself and what her emotions mean to her. She describes an increased sense of integration and an ability to take skills learned in therapy into her day-to-day life. She gains self-soothing skills that aid in decreasing flashbacks and is able to establish and maintain meaningful interpersonal relationships that include conveying her emotions.

Participant #5

Demographic Information: Male, Age 44, Divorced, 7 sessions

Presenting Issue:

Participant #5 presents for therapy struggling with feelings of depression and anxiety. Taking time to provide care for his elderly father results in threats to his job security. After his father's death he experiences increased nervousness and worry, increased irritability, insomnia, difficulty concentrating and a lack of interest and pleasure in previously enjoyable hobbies. Participant #5's chief complaint upon entering therapy is a sense of feeling overwhelmed and an inability to cope.

Interview Summary:

Upon entering therapy, participant #5 describes his experience as a negative downward spiral of feelings of dread, helplessness, hopelessness and increased social isolation. He indicates that he was taught to ignore his emotional experience, and he concurrently experiences himself as increasingly emotionally volatile. He reports being confused by his emotional reaction and berates himself for his emotional experience. His distress and confusion are compounded by his beliefs about masculinity: that as a man he should withhold emotional expression. Instead of acknowledging emotional distress he solves problems without taking into account the meaning his emotional distress holds for him. His confusion emerges when problem-solving fails to reduce his emotional distress. He states,

> Little things would set me off that I'm kind of going this is something that – that is not a big deal, and yet the emotion of not being able to cope with that would make me even more emotional because I'm going well, why is this? Why am I experiencing all these feelings of dread, feelings of hopelessness when it's not a big deal? It shouldn't be a big deal, and yet here I am, well, on the verge of tears. I'm kind of well, geez, you're a man. You shouldn't be doing this. Like, it's not a big deal really. It's something you should be able to handle. And I thought, well, there's something seriously wrong here. You need to re-evaluate your life and get your shit together. I would deny and push away, [my emotions] and go forward with what I needed to do . . . push them [emotions] away. Just say get over it. You're a man. Go do this – like as opposed to stopping and just saying these are the emotions that you actually are feeling; feeling the emotions, recognizing them, accept them and then continue to go ahead as opposed to deny them.

Participant #5 identifies the therapeutic relationship as necessary for ensuing change to occur. His therapist provides an experiential component that assists participant #5 in learning to acknowledge his emotional experience and the meaning it holds. She directs him to imagine distressing scenarios and then asks him to notice physical sensations that corresponded with his emotional experience. Initially he lacks the language necessary to name specific emotions and his therapist provides this for him.

He states,

> The therapist enabled me to put some things that I was feeling into perspective, and also educated me in some of the emotion that I was feeling, that I was keeping inside . . . adding all these little emotions up together to a point where I wouldn't be able to push them aside, and then I'd have a breakdown . . . we go through feeling some of the emotion, um, where the therapist basically asked me to specifically describe emotions. And I have a great deal of difficulty describing them, and I'm still learning how to describe emotions. And then describing situations that make me feel the way I do, and then going through those actual feelings . . Then there's a washing, a cleansing, a – a relief.

As a result this participant recognizes the importance of acknowledging his emotional process. His increased attention to his emotional experience corresponds with a decrease in his emotional volatility, greater self-insight, and greater attention to positive emotional states. In addition he gains an ability to identify what is important to him by recognizing the emotional meaning of particular events. Correspondingly he changes his behavior to reflect congruence with what he identifies as important.

Participant #6

Demographic Information: Female, Age 48, Married, 25 sessions

Presenting Issue:

Participant #6 sought counselling due to marital difficulties. Her marriage of 15 years duration is characterized by a communication style that moves between negative criticism to non-communication and withdrawal. The introduction into the household of participant #6's 16 year old son from a previous marriage exacerbates difficulties within the family. Historically she avoids conflict with her husband in order to help maintain harmony within the household. Her inability to continue avoiding conflict is her chief complaint upon presenting for therapy in addition to an inability to communicate her needs to her husband.

Interview Summary:

Participant #6 enters therapy experiencing an enhanced sense of frustration at her inability to avoid conflict with her husband. While aware of her internal emotional turmoil

she avoids acknowledging the meaning this experience holds for her. She presents an outwardly calm demeanour, withholding emotional expression from others, particularly her husband. She describes this experience as "It's that persona. It's that picture of the mallard they show you sometimes in courses where the mallard is just gorgeous on top, or serene on top, and just paddling underneath. That's what – that's what it was like."

Within therapy participant #6 gains insight into how not acknowledging her emotional experience contributes to her marital problems. Through reflection and direct questioning her therapist focuses attention on and draws out the meaning of participant #6's emotional experience. While initially she remains unwilling to engage in emotional expression she acknowledges the value of paying attention to the meaning of her emotional experience. This acknowledgement allows her to make a conscious choice whether or not to communicate her needs to others. With increased emotional insight she gains awareness that she has a choice to alter her behavior and her communication style with her husband. She states,

> The other thing that was happening in this whole time is there were feelings that I acknowledged within myself. There was an awful lot of acknowledging within myself, and so if – maybe if I didn't show it on the outside in therapy I often had something to mull over with myself after . . . I'm most probably doing myself far greater harm, and I've learned this through the therapy, that I'm most probably doing myself far greater harm by not feeling them [emotions] . . . I think that if I allowed myself to feel the anger more times than none, and if I took the time to make a constructive comment, both at work with my boss and with my husband more often, I'd most probably get a lot more help and a lot more cooperation with things that I want, like to get done. And the other – if I

> was able to feel my frustration or my anger and not just – like, I mean I know that I'm frustrated and I'm angry, but I don't care to feel it enough to say something.

With increased acknowledgement of the meaning of her emotional state there is a decrease in the intensity and volatility with which she experiences her emotions. Understanding the meaning her emotional experience holds provides her with alternate perspectives and she actively develops alternative courses of action from which to choose. In addition she gains increasing understanding with respect to her emotional reactions. As a result of this increased emotional insight she experiences a sense of increased control in her situation. She describes this change as an ability to "let go" of an emotional experience instead of "hanging on to it."

She states,

> Absolutely, that's a difference, where I will say to myself, you know like, you're really ticked off, and like what are you going to do about this? Are you going to let it ruin your day? Can you do something about it or do you just calm down and say this is the way it is. And so – just you know – so I have learned to do that a little bit better. So I'm acknowledging my feelings, and I'm allowing myself to feel the hurt sometimes. That I never did before. Would just pretend that – pretend bad things didn't happen.

While previously aware of her emotions, her lack of acknowledging their meaning contributes to her experience of inner turmoil, confusion, and an inability to act. Acknowledging the meaning of her emotional experience aids this participant in determining the importance of a particular event or situation. Based on this assessment

she is able to make an informed choice regarding what action she will take. With that acknowledgement comes the choice to behave differently.

Participant #7

Demographic Information: Male, Age 42, Married, 27 sessions

Presenting Issue:

Participant #7 begins therapy as the result of a work-related accident. His chief complaint at the beginning of therapy is feeling scared and confused because he is unable to make sense of or control his reaction to the accident. He reports experiencing feelings of fear and helplessness, insomnia, difficulty concentrating, ruminating thoughts and intense anxiety.

Interview Summary:

Upon entering therapy, participant #7 is increasingly distressed at his inability to cope with his emotional response to a work-related accident. The intensity and range of his emotions contributes to his experience of them as overwhelming and himself as emotionally volatile. He describes the experience as being on an emotional roller coaster. Initial coping strategies following the accident include avoidance of his internal emotional process through excessive busyness. The breakdown of this coping strategy leaves participant #7 unprepared for the expression of emotion in therapy.

He states,

> The emotions, I think the biggest thing that I saw was how fast they turn from normal – from a normal day to something out of the blue would spur it, and you'd be upset. You'd be angry. You'd be – total change of emotions, just so fast. I think the biggest things was the range of emotions, from scared to angry to confused a lot of times. Fear was probably the biggest thing. And the uncertainty again, you don't know if you can ever be your normal – normal way you were before an accident or before you had to go in for therapy . . .What do I do? I've got to keep busy. I've got to do things. And if I didn't do it, I was so moody and so antsy . . . As long as I was doing things I was happy. But if I had time to sit and think I'd be right stir crazy . . . emotionwise I'd break down and cry in front of my doctor. I was very scared . . . The emotions would override me sometimes so that I would physically cry and I found it – at first I thought Jesus, this is embarrassing. I don't want to continue. This is bothering me. But until I brought those feelings out I wouldn't be able to deal with it.

His relationship with his therapist is characterized as being of paramount importance. Participant #7 emphasizes the significance of a sense of trust and safety that permeates the relationship. His therapist normalizes his reactions, validates his emotional experience and provides a framework within which participant #7 begins to make sense of his experience. In addition to utilizing specific interventions such as EMDR, his therapist encourages him to remain present with his emotions and explore their meaning and impact. As a result of the strength of the therapeutic alliance therapy becomes a safe place where his emotions are acknowledged and expressed.

Through this exploration he is able to identify and tolerate the experience of his emotions. As this internal emotional process is explored this participant gains additional perspective and emotional insight thereby expanding his understanding of why he

responds the way he does. With increased understanding of his emotional experience comes an increased ability to cope.

He states,

> I guess bring it out in the open and talk about it and from here see all the strings. I looked at it as a big spider web, and all – the center is the problem. And all these things contribute to it. How are they intertwined? How do they relate? What is a way of dealing with this? Why am I feeling this way? Because of this. Why? Because of this. And all these things connected until we dealt with that by talking and maybe pointing it out. Some things were so clear, but you couldn't see the forest through the trees. I feel good. I understand why this is happening. I guess through prodding and pushing and driving in a constructive form you can come to some conclusion that's going to be to your benefit.

While unable to describe more specifically the process of exploring his emotions he experiences the exploration as one of "getting it [emotions] out of my system." The therapeutic hour becomes a place to acknowledge and express the emotions he is experiencing. Increased emotional insight brings increased awareness of what is important to him and influences this participant's decision making process, particularly with respect to deciding whether to return to his previous employment. As a result of this process the intensity of his emotional experience diminishes, and he gains a sense of control over his life.

Participant #8

Demographic Information: Male, age 50, married, 25 sessions

Presenting Issue:

Participant #8 seeks counselling due to intense feelings of anxiety which he habitually self-soothed through the use of alcohol. Alcohol use ceased prior to beginning therapy and without the ability to draw on other coping strategies his anxiety symptoms intensify. In addition to experiencing free floating anxiety and worry, participant #8 describes experiencing significant levels of irritability, muscle tension and restlessness. These symptoms significantly impact his marital relationship as his irritability escalates to anger and frustration, which is expressed within the relationship. His primary complaint at the time of entering therapy is the detrimental role his anger has on his marriage.

Interview Summary:

Participant #8 describes himself as a serious individual whose previous chief coping strategy was the use of alcohol to avoid feelings of anxiety and stress. Upon first entering therapy he is disconnected from his own internal emotional process and is unable to identify any physiological sensations associated with the anxiety. He identifies himself as working in a high-stress job and experiences himself as having a high need for control over his external environment and circumstances. His low tolerance for ambiguity leads to an increase in angry outbursts particularly when alcohol is no longer used to numb his

emotions. As a result he experiences greater marital discord as it is within his marriage that the anger is frequently expressed.

During the course of therapy his therapist provides a framework for understanding anger and emotions often related to anger. Through exploring what other emotions are connected to his experience of anger participant #8 discovers a deep sense of insecurity and fear. He gains an increased awareness of how experiencing anger allows him to avoid experiencing other emotions that are present but difficult to tolerate. His increased awareness of and ability to acknowledge fear and insecurity reduces the intensity of the anger he experiences. He states,

> Anybody I suppose that has to release stress by drinking has got other problems, you know, and one of them I suppose is insecurity, self-centeredness. And that's probably me, ah, insecure. I guess if someone was to ask whether I was insecure – my mother – ask my mother for instance, she would probably say no, absolutely not. Ah, but inside me there's probably insecurity, self-centeredness. So yes, anger did play, and I was very much aware. What I wasn't aware of, I suppose, is the fear. And the fear, part of it probably, um, stemmed or fuelled the anger. I would be, you know, instead of saying, you know, this is really – this is – I'm really concerned about this or I'm very afraid of this, I would probably turn it in, and it would come out as anger. And that I wasn't aware of.

Participant #8's change process includes identifying anger as a cue for further emotional exploration. Through this exploration participant #8 gains increased self-understanding and emotional awareness that contributes to behavior change. Understanding that other emotions are connected to his experience of anger increases his

sense of control and results in a decrease of his angry outbursts. He stipulates the importance of acknowledging these emotions and the meaning they hold.

> When it – when the situation develops, um, where I get or feel angry, I have to look at it and then say okay, why? Why is this making me feel angry? And the bottom – normally the bottom line is that there is other things involved. One is insecurity, which is basically fear. Why, is the question I keep asking myself, and once I get some answers, depending on the situation, I find that the anger subsides. So when the anger subsides, I guess I'm facing the fear . . . And if one can overcome the fear, one then can probably overcome the anger and feel content – feel some kind of – within oneself to feel, hey, that's fine . . . But I think overall I am probably a – a happier individual. I'm a little bit more content with myself.

Part of this participant's reorganizational process includes broadening his emotional experience. His ability to acknowledge underlying fears allows him to make changes to address those fears or to accept things he is unable to change. This aids in expanding his emotional reaction and expression to situations. Increased awareness of his emotional experience enhances his ability to cope.

Participant #9

Demographic Information: Female, age 52, divorced, 32 sessions

Presenting Issue:

Participant #9 is a divorced woman with two adult children in their early twenties. She enters therapy struggling with feelings of intense fear and anxiety. In addition she experiences insomnia, difficulty concentrating and angry outbursts. Her chief complaint upon entering therapy is feeling emotionally numb or emotionally overwhelmed and an inability to exercise control over either response.

Interview Summary:

Participant #9 enters therapy after a recent nightmare triggers memories of previously experienced sexual assaults. This participant was sexually assaulted at ages 3, 6 and again as an adult in her early twenties. Her life was threatened by the perpetrator in each incident. The onset of intense emotions evokes confusion and increased fear due to a lack of understanding regarding her response. Prior to this recent nightmare her life was characterized by a restricted range of emotional experience that she describes as being numb or frozen. She describes herself as an iceberg. It is the intensity of and her inability to exercise control over her emotions that contributes to the experience that her emotions are dominating her life.

Participant #9 identifies the relationship with her therapist as significant in that it provides her with a sense of safety. Her therapist provides her with psychoeducational information that aids this participant in making sense of her emotional experience, and she has a strong desire to remember her past traumatic experiences. She identifies the importance of needing to acknowledge her emotional experience, but describes doing so anchored in a position of safety and in a non-cathartic manner. She is aware of her therapist containing her process and the speed at which it unfolds. Her therapist denies her request to use hypnotic interventions to speed up the process. In addition her therapist validates her experience and normalizes her response. These factors contribute to participant #9 gaining a growing sense of empowerment and increased hope.

Though she is able to identify moving through her initial fear and anxiety, she has difficulty finding language to describe her experience in therapy and factors that contribute to her change process. However, she describes a reorganization and broadening of her original emotional response and increased awareness that she is integrating fragmented parts of herself. She states,

> I know that I've been completely numb because the experiences that – that particular experience plus others that I've had in my childhood, and in adolescence and as an adult are such that have left me thinking that I feel – thinking that I must be someone, you know, like everyone else, but yet knowing that I am numb . . . I'd become aware of my feelings, that the numbness is beginning to thaw, that I specifically felt that, and that I know that's happening because, you know, as I described to you before that it was – that it is like an iceberg that is melting. And I can feel the sun kind of shining on it, and it's dripping . . . And it isn't that I have no feelings or that I don't – because I'm capable of feeling sympathy and empathy for other people . . . But this time it seemed different. It felt like a new beginning . . . It really is like there's pieces of me all over the place that I'm aware of, and it's pulling them into one picture and that's doable.

Within the parameters of a safe therapeutic relationship participant #9 explores events from her past and acknowledges associated emotions. As her fear begins to subside her range of affect begins to broaden contributing to a sense of increased vitality that she describes as a "spark that is expanding and filling me with a sense of wonderfulness." As a result, this participant now approaches her life with a renewed sense of hope.

Commonalties Among Interviews

As outlined in the previous chapter, a thematic analysis of the self-reports generated by the first group of participants was conducted. A between-persons analysis

allowed for the emergence of themes common to all participants. These include participants' description of the breaking down of coping strategies, concurrently feeling emotionally overwhelmed or emotionally numb, the importance of the therapeutic alliance, undertaking a process of acknowledging and dealing with their emotions, and an internal sense of reorganization of difficult emotional experiences.

Initially many participants report a breaking down of coping strategies. One coping strategy that is reported by the majority of participants is that of avoiding difficult and conflictual emotions. Rather than allowing themselves to experience this emotional material participants actively avoid it using a variety of strategies. Participants 1, 3, 4, 7 and 9 suppressed their emotional experience and instead experienced a sense of emotional numbness. Participants 2 and 5 initially deny any emotional distress in their lives. Participant 6 avoids conflict while participant 8 avoids experiencing feelings of insecurity, which are instead masked by his anger. Common to all participants is that strategies previously employed begin to fail. As these strategies fail the majority of participants describe feeling emotionally distressed. This is characterized by participants feeling they have minimal control over their emotional reactions. It is the failure of these strategies and the corresponding sense of feeling emotionally distressed that prompt participants to seek therapy.

Within the context of therapy the therapeutic alliance is acknowledged as important. Many participants indicate that therapists directed them to the emotions they

were avoiding. Participants report that their trust in their therapist along with a sense of safety within the relationship allowed them to begin acknowledging and experiencing previously avoided emotions. They describe an increased ability to recognize and name their emotions as part of the process of dealing with them. They report paying attention to bodily experiences related to their emotional state. In addition they describe an increased ability to feel an emotion versus avoiding feeling uncomfortable emotional material. Many participants reported that therapists aided this process by providing information and language related to emotion.

As participants' engage in this process many describe an internal sense of reorganization with respect to their relationship with their emotions. This reorganizational process is reported to have an integrative quality. Participants state that previously disconnected aspects of their experience come together. At the same time they describe increased emotional awareness and perspective along with a greater sense of control and trust in their emotional experience. Correspondingly they report a decrease in emotional distress and an improved quality of life outside of therapy.

In addition to providing a context against which to view the concept mapping results it can be seen through a presentation of these summaries that common experiences for participants begin to emerge. These themes are further elucidated within the concept map. While the interview summaries provide the reader with qualitative information the

concept mapping results outline the underlying structure associated with participants' emotional process.

Concept Map Results

As described in the previous chapter, statements reflecting participants' perceptions of their emotional experience in counselling were extracted from self-reports generated by the first group of participants. These statements were sorted and rated by the second group of participants and a nonmetric multidimensional scaling (MDS) procedure was performed on sorted items. The concept map of the 61 statements representing participants' emotional experience in counselling is presented in Figure 1. The results consist of a spatial configuration or map in which MDS arranges points representing sorted items along orthogonal axes such that the distance between any two points reflects the frequency with which the items were sorted together and are perceived as similar. Each of the 61 items derived from the participants' responses are represented as a point on the map. Points that are closer together represent items that were more frequently sorted together; points further apart represent items less frequently sorted together. Results of the MDS analysis based on a two-dimensional solution revealed an acceptable MDS stress value of .27 (Kruskal & Wish, 1978).

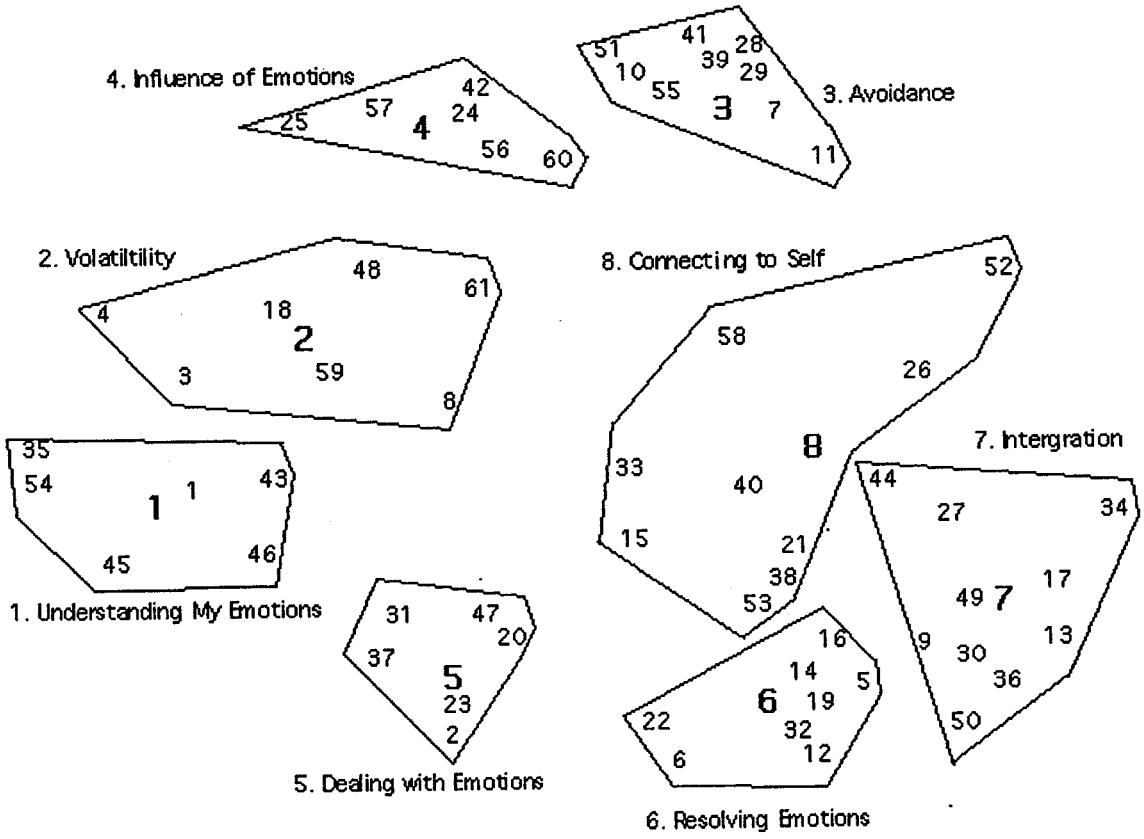

Figure 1: Concept map of 61 elements clients identified as their perception of emotional experience in counselling (based on multidimensional scaling and cluster analysis of 22 clients' card sort of these elements).

Hierarchical cluster analysis of the MDS solution was then used to group items into internally consistent clusters that were superimposed on the MDS axes. A number of cluster solutions were examined in conjunction with the research team and an eight-cluster solution ultimately chosen based on the average cluster bridging values. The cluster boundaries around groups of points represent items that were more frequently sorted together in the same pile and less often sorted with items in other piles. A descriptive and justifiable name for each cluster was reached by visually inspecting each cluster and its group of statements. Clusters were initially named by the researcher taking into account items comprising each cluster, consideration of items contributing most of the uniqueness to each cluster with reference to bridging and rating values, and consideration of the distance of each item from other items on the map. Cluster names are, therefore, both statistically and conceptually influenced with each cluster given a title that describes the theme depicted by the contents of the cluster. Named clusters were submitted to the research team for feedback regarding the clarity and appropriateness of cluster names. This process continued until agreement on cluster names was reached. Analysis of the data resulted in eight aspects identified by participants as being part of their emotional experience. Participant statements within each cluster are presented with descriptive statistics in Table 1.

Table 1:

Eight Aspects of Emotional Experience Identified by Counselling Clients

Statement	Bridging Value	Rating Value
Cluster 1 Understanding My Emotions		
43. I had to deal with the bad emotions before I could experience some of the good ones.	0.71	3.09
1. I looked more intensely at my emotions.	0.72	3.50
46. I dealt with my feelings one at a time.	0.72	3.00
54. I had to tease out what was all in this bubbling brew of emotions.	0.77	3.09
35. Sometimes I had to dissect what the emotions were because there's usually more than one.	0.83	3.32
45. All of these feelings that were wound together were being separated.	0.85	3.64
Cluster Average:	**0.77**	**3.27**
Cluster 2 Volatility		
61. The biggest thing was how fast my emotions would change.	0.46	2.45
59. Sometimes when I experienced an emotion it was stronger.	0.51	2.91
48. When my emotions first came out I didn't know exactly what to expect.	0.57	2.45
8. I couldn't put my emotions in a box anymore.	0.58	3.50
18. My emotional state changed from week to week.	0.65	2.64
3. Sometimes I needed to feel my emotions more deeply.	0.71	3.68
4. I needed to face my emotions so that I could get on with life.	0.85	4.05
Cluster Average:	**0.62**	**3.10**

Statement	Bridging Value	Rating Value
Cluster 3 Avoidance		
28. I just shut off from feeling.	0.00	1.95
39. I put my feelings on hold.	0.01	2.14
41. I didn't want to deal with my emotions.	0.01	2.00
29. Not showing my feelings kept me safe.	0.03	1.91
55. I couldn't sort out my feelings.	0.10	2.23
10. I was terrified that there would be retaliation for my feelings.	0.16	2.00
51. I used to keep everything all tightly bottled up inside.	0.16	2.32
7. I didn't know what feelings were okay and what feelings weren't okay.	0.27	2.55
11. I didn't think it would ever be okay to trust my feelings.	0.50	2.27
Cluster Average:	**0.14**	**2.15**
Cluster 4 Negative Influence of Emotions		
42. Avoiding dealing with my emotions was causing me real life physical problems.	0.24	2.62
60. Something that's very small would make me really angry.	0.28	2.27
24. I would push away recognizing the physical aspects of my emotions.	0.32	2.50
56. The pain was a mishmash of all these feelings that I didn't understand.	0.37	2.36
57. My emotions were ruling my life.	0.37	2.32
25. I primarily focused on the negative emotions.	0.67	2.41
Cluster Average:	**0.37**	**2.41**

Statement	Bridging Value	Rating Value
Cluster 5 Dealing with Emotions		
20. As I dealt with my emotions they became less intense.	0.41	3.55
47. Eventually dealing with the feelings was easier because it was a much smaller little ball.	0.51	3.27
2. I reached a more realistic level of emotion.	0.68	3.45
23. I can let go of my feelings a lot easier when I acknowledge them.	0.73	3.82
31. I can identify my emotions.	0.79	4.05
37. Understanding that fear is behind my anger probably helped me to let go of my anger.	0.84	3.91
Cluster Average:	**0.66**	**3.67**
Cluster 6 Resolving Emotions		
14. After I had explored some of my emotions I just felt different inside.	0.11	3.77
16. The big cold chunk that was part of me had been changed.	0.13	3.50
5. My emotions aren't locked away anymore.	0.19	4.09
19. My emotions seem to have fallen into place.	0.20	3.14
12. I can put my emotions in perspective.	0.24	3.55
22. The hurt is there, but it's not something I dwell on.	0.31	3.00
6. My situation didn't change, but my emotions related to it changed.	0.32	3.82
32. Because I know what my emotions are related to I'm not so scared of them anymore.	0.32	4.00
Cluster Average:	**0.23**	**3.61**

Statement	Bridging Value	Rating Value
Cluster 7 Integration		
9. I got so that I was okay with anything I felt.	0.17	3.86
50. My emotions are such a part of me now.	0.23	4.05
36. It's like I'm part of my life now because I can feel it.	0.28	4.27
49. As I started letting my emotions out I started dealing with life.	0.29	3.95
30. I learned how to deal with my feelings.	0.32	3.91
13. I learned that none of my feelings are wrong.	0.45	4.14
27. When I was in touch with my emotions, I became less volatile.	0.47	3.77
44. As I would deal with my feelings the knot in my stomach would decrease.	0.47	3.64
17. I learned that my feelings are valid.	0.59	4.27
34. I learned I didn't have to protect myself from what I was feeling.	0.79	3.91
Cluster Average:	**0.41**	**3.98**
Cluster 8 Connecting to Self		
53. When I began to feel, it felt like a new beginning.	0.17	3.86
38. As the numbness began to thaw, I began to feel.	0.19	3.77
21. Once I brought out my feelings I could deal with my situation.	0.26	4.14
40. As I dealt with the feelings, things came out that I never realized were there.	0.37	3.77
15. I could experience feelings that were both negative and positive.	0.42	3.68
33. I started to pay attention to what my feelings meant.	0.44	3.86
58. The fear shifted to sadness.	0.57	2.68
26. I tuned into my body to experience my feelings.	0.70	3.82
52. I have these little cubbyholes, and my feelings get put into the spaces they're supposed to be put into.	1.00	2.45
Cluster Average:	**0.46**	**3.56**

Note: Participants rated each item according to its perceived helpfulness in counselling on a 5-point scale ranging from 1 (not at all helpful) to 5 (extremely helpful).

Interpretation of the map involves identifying the dimensional axes around which points are configured (Buser, 1989). In addition, evaluating the placement and adjacency of statements and clusters identifies apparent regions and potentially related concepts. Initial inspection of the map reveals a negative process at the top of the map moving along a continuum to the bottom of the map, which is characterized, by a correspondingly more positive process. Statements reflecting participants negative process include: 28) I just shut off from my feelings; 42) Avoiding dealing with my emotions was causing me real life physical problems; and 51) I used to keep everything all tightly bottled up inside. Statements describing participants' positive process include 12) I can put my emotions in perspective; 2) I reached a more realistic level of emotion; and 20) As I dealt with my emotions they became less intense.

Examination of the map from left to right is characterized by a continuum that reflects participants' break down and scrutinizing of their emotional experience on the left side of the map to one of reconstructing their experience on the right side of the map. Statements depicting participants' inspection of their emotional experience include 35) Sometimes I had to dissect what my emotions were because there's usually more than one; 54) I had to tease out what was all in this bubbling brew of emotions; and 4) I needed to face my emotions so I could get on with my life. Statements reflecting participants reconstruction include 34) I learned I didn't have to protect myself from what I was

feeling; 17) I learned that my feelings are valid; and 13) I learned that none of my feelings are wrong.

Further analysis of the map identified three distinct regions: Breakdown of Coping Strategies, Increased Emotional Awareness, and Reorganization. Breakdown of Coping Strategies includes Cluster 3, Avoidance; Cluster 4, Negative Influence of Emotions; and Cluster 2, Volatility. These depict client processes that produce emotional distress. Increased Emotional Awareness consists of Cluster 1, Understanding My Emotions and Cluster 5, Dealing with Emotions. These represent client processes that involve acknowledging and experiencing their emotions. The remaining clusters, Cluster 6, Resolving Emotions; Cluster 7, Integration; and Cluster 8, Connecting to Self encompass a region of the map that reflects participants' Reorganization with respect to their relationship with their emotional experience.

Examination of the clusters reveals the following:

Cluster 1, Understanding My Emotions, has an average cluster bridging value of 0.77 with a range from 0.71 to 0.85. This is the highest bridging value of all the clusters. As described before bridging values can range from 0 to 1 and depict how frequently statements were sorted together. Statements with high bridging values indicate that a statement bridges two or more clusters to which it is related. Statements with a bridging value of 1 suggest that this item could potentially be sorted with every cluster. A low bridging value means that the statements in the cluster were more frequently sorted with

statements within that cluster than with statements in other clusters. The high bridging value of Cluster 1 suggests that participants had difficulty deciding where to place these items. From this it can be inferred that understanding emotions impacts many aspects of the participants' emotional experience. Examples of statements reflecting this theme include 43) I had to deal with bad emotions before I could experience some of the good ones, 1) I looked more intensely at my emotions, and 46) I dealt with my feelings one at a time.

Rating values range from 1 to 5 and reflect how helpful participants believed each particular experience was. A value of 1 reflects an experience that was not at all helpful while 5 reflects an experience that was extremely helpful. The average rating value for Cluster 1 is 3.27 with a range from 3.00 to 3.64.

Cluster 2, Volatility, has an average cluster bridging value of 0.62 with a range from 0.46 to 0.85. Rating values range from 2.45 to 4.05 with an average cluster rating of 3.10. When naming this cluster statements with low bridging values were given the greatest consideration. Examples of statements given more weight in the naming process include 61) The biggest thing is how fast my emotions would change, 59) Sometimes when I experienced an emotion it was stronger, and 48) When my emotions first came out I didn't know what to expect. This cluster reflects participants' experience of their emotions as unpredictable.

Avoidance is the theme that emerges from the statements contained in Cluster 3. The average bridging value of this cluster is 0.14 with a range from 0.00 to 0.50. The low bridging value of this cluster highlights the consistency with which participants' identified avoidance when describing their emotional experience in counselling. Examples of items making up this cluster include 28) I just shut off from feeling, item 39) I put my feelings on hold, and 41) I didn't want to deal with my emotions. Rating values range from 1.91 to 2.55. The overall low rating value of 2.15 for this cluster reflects participants' experience that avoiding their emotional experience is a less helpful aspect of the therapeutic process.

The theme identified for Cluster 4 is Negative Influence of Emotions with an average cluster bridging value of 0.37 and a range from 0.24 to 0.67. This theme reflects participants' experience of how emotions were impacting their lives prior to dealing with them in a therapeutic context. Rating values range from 2.27 to 2.62 with an average rating value of 2.41. Statements reflecting this theme include 42) Avoiding dealing with my emotions was causing me real life physical problems, 60) Something that's very small would make me really angry, and 24) I would push away recognizing the physical aspects of my emotions.

Cluster 5, Dealing with Emotions, has an average cluster bridging value of 0.66 with a range from 0.41 to 0.84. The average rating value of 3.67 is the second highest among all the clusters indicating that participants experienced Dealing with Emotions as a more helpful aspect of their emotional experience in counselling. Rating values range from

3.27 to 4.05. Items reflecting the theme of this cluster include 20) As I dealt with my emotions they became less intense, 47) Eventually dealing with the feelings was easier because it was a much smaller little ball, and 2) I reached a more realistic level of emotion.

Resolving Emotions is the theme that emerges from the statements within Cluster 6. This cluster has an average bridging value of 0.23 with a range from 0.11 to 0.32. The average rating value is 3.61 with a range from 3.00 to 4.09. Items reflecting this cluster's theme include 14) After I explored some of my emotions I just felt different inside, 16) The big cold chunk that was part of me has been changed, and 5) My emotions aren't locked away anymore. This cluster reflects how participants' emotional experience begins to change after dealing with their emotions in counselling.

Integration constitutes the theme depicted in Cluster 7, which has an average cluster bridging value of 0.41 with a range from 0.17 to 0.79. The cluster also has the highest average rating value of 3.98 indicating that integration of participants' emotional experience was perceived of as more helpful. Rating values range from 3.77 to 4.27. Participants' identified items 9) I got so that I was okay with anything I felt, 50) My emotions are such a part of me now, and 36) It's like I'm part of life now because I can feel it, as reflective of their sense of integrating their emotional experience.

The theme identified in Cluster 8 is Connecting to Self with an average cluster bridging value of 0.46 with a range from 0.17 to 1.00. Item 52 with a bridging value of 1.00 appears as an outlier that could potentially be placed in any cluster and its bridging

value increases the cluster average. When the bridging value is recalculated excluding item 52 the average bridging value drops to 0.39. Rating values range from 2.45 to 4.14 with an average cluster value of 3.56. Connecting to Self is exemplified by items 53) When I began to feel, it felt like a new beginning, 38) As the numbness began to thaw, I began to feel, and 21) Once I brought out my feelings I could deal with my situation. This cluster further reflects a sense of newness participants experience with respect to their relationship with their emotions.

An analysis of the map from the perspective of counselling process reveals that participants may move through a process that begins with avoidance of their emotional experience as depicted by Cluster 3. This process, as related to client's emotional experience, then appears to move in a counter-clockwise flow around the map to Cluster 4, Negative Influence of Emotions; Cluster 2, Volatility; Cluster 1, Understanding my Emotions; Cluster 5, Dealing with Emotions to Cluster 6, Resolving Emotions, followed by Cluster 7, Integration and ending with Cluster 8, Connecting to Self.

Relationship Between Concept Map and Summaries

The results presented are provided by two different groups of participants. Presentation of the interview summaries depicts the experience of the first group of participants with respect to their emotional experience in counselling. Presentation of the concept map shows how the second group of participants imposed their conceptualization on the data extracted from the transcripts of the first group. In

comparing the results from both groups similarities emerge. The three distinct regions identified within the concept map - Breakdown of Coping Strategies, Increased Emotional Awareness, and Reorganization - are themes that simultaneously emerge as common experiences across interview summaries.

Both the concept map and participant interviews highlight the theme of participants' initial avoidance of their emotional experience. The cluster containing this theme, Cluster 3, is situated within the Breakdown of Coping Strategies region of the map. The first group of participants identify avoidance as their predominant coping strategy. They describe the breakdown of this strategy, and the corresponding experience of feeling either emotionally overwhelmed or uncomfortably numb. Concept mapping results appear to further identify aspects of this process embedded within the interview summaries as depicted by Cluster 4, Negative Influence of Emotions and Cluster 2, Volatility.

Further commonalties among interviews identified that participants engage in a process of acknowledging and dealing with their emotions. Themes that emerge from the interviews with respect to this process include identifying the bodily experiences that correspond to their emotion, the ability to identify and name an emotion and the ability to accept rather than avoid the emotional experience. Similar themes are contained within the concept map within the region identified as Increased Emotional Awareness, which contains Cluster 1, Understanding My Emotions and Cluster 5, Dealing with Emotions.

Themes emerging from participants' transcripts that depict their reorganizational process include participants' increased emotional self-awareness and perspective on their emotional experience, their changing relationship to their emotional experience along with an increased sense of emotional integration and decreased emotional distress. These themes are further refined within Cluster 6, Resolution; Cluster 7, Integration; and Cluster 8, Connecting to Self which comprises the clusters within the Reorganization region of the map.

A commonality that emerged across interviews that is not contained within the concept map is the importance of the therapeutic alliance. Statements indicative of the importance of the alliance were not extracted from the transcripts, as they did not directly address the goals of this study. As no statements indicative of the importance of the therapeutic alliance were contained within the statements to be sorted it is impossible for this data to be reflected within the results of the concept map.

By presenting the study results both through case summaries and the concept map the reader is provided with information regarding both the context and the process of participants' emotional experience. In order to increase our understanding with respect to the role the emotional experience plays in counselling information regarding both process and context are needed. Case summaries reflect stories that provide a context for participants' emotional experience. Concept mapping results aid in identifying an

underlying structure and the constituent elements of the phenomenon and elucidate how the emotional experience unfolds within the therapeutic process.

Chapter 5

Discussion

There is strong agreement that emotional distress is the single most salient reason that clients come to therapy (Korman & Greenberg, 1996; Lane & Schwartz, 1988; Peake & Egli, 1982). Researchers contend that clients frequently experience this distress as a state of diffuse discomfort that they are unable to articulate or differentiate (Korman & Greenberg; Lane & Schwartz; Peake & Egli). The purpose of the present study was to examine clients' perceptions of their emotional experience in counselling in order to increase our understanding of its potential benefit in reducing emotional distress. The emotional experience is subjective, and it is clients who possess information regarding their experience. Therefore, this study asked clients directly what was their emotional experience in counselling and what was helpful about this experience.

Research Findings

Through in-depth interviews and concept mapping data about participants' emotional experience in counselling were gathered and analyzed. Through these analyses common themes were identified. Major findings of this study are briefly outlined and then discussed in further detail within the context of the study, the existing literature and the researcher's clinical experience. Findings of this study are:

- Participants experience emotion in therapy as part of a process. While researchers have referred to various components of this process, the process itself has not

previously been identified. Results of this study, therefore, make explicit a process that is, at best, implicitly known. Three major components of this process were identified: Breakdown of Coping Strategies, Increased Emotional Awareness and Reorganization.

- Breakdown of Coping Strategies - This component is contained in the region of the map consisting of Clusters 2, Volatility; 3, Avoidance; and 4, Negative Influence of Emotions. Further, it is consistent with themes identified in participants' interviews. Here participants identified that they had coping strategies in place for managing emotion in their lives. However, due to past experiences and present life circumstances typical ways of coping no longer work and participants' emotional experiences begin to impact their lives in negative ways. Often this is simply labelled as emotional distress.
- Increased Emotional Awareness - As participants moved through this process they indicated it was necessary to examine and inspect their emotional experience and acknowledge and accept their emotions. This is captured in Cluster 1, Understanding My Emotions and Cluster 5, Dealing with Emotions. In the interview data, participants identified this process as an increased ability to recognize and name their emotions. Emotion researchers identify the benefit of increased insight when clients attend to their emotional experience (Carek, 1990; Maroda, 1999; Raingruber, 2000).

However, they do not identify the examination and inspection of the emotional experience as identified by participants in this study.

- Reorganization - As participants explored the material they originally avoided prior to entering therapy they experienced change. This aspect of the emotional experience is captured by Cluster 6, Resolving Emotions; Cluster 7, Integration; and Cluster 8, Connecting to Self, whereas in the interview data, participants describe a similar process encompassing integrating disconnected aspects of their experience. Participants in this study confirm what emotion researchers hypothesize: that when clients attend to their emotional experience there is a corresponding internal reorganization (Greenberg, et al., 1993; Maroda, 1999; Stein, 1995).
- Although the therapeutic relationship was not identified in the concept mapping as part of participants' inner emotional process, it was identified in the interview data as a necessary precursor for engaging with difficult emotional material. The importance of the therapeutic relationship has been established by psychotherapy researchers (Horvath & Symonds, 1991; Lambert, 1992).

Integration with the Literature

Emotional Experience as Process

While each individual participant in this study experienced specific emotions and had a personal context within which they experienced emotional distress, overall they identified their emotional experience as a process. Counselling provided the framework

through which participants experienced that process. Essentially participants were able to identify what was difficult and distressing, that their inclination was to not deal with what was difficult and distressing and, despite this inclination, that doing so was necessary. Successfully negotiating difficult emotional material provided participants with a sense of integration and a different experience with respect to their lives. Importantly, this conceptualization is identified by people who experienced this process. While external observers may hypothesize about this process individuals who experience it can confirm it.

The identification of the emotional experience as a process is important because it provides clinicians with information regarding how to conceptualize clients' experiences. As well, it is one of many pieces of information clinicians may use in deciding how to proceed. For example, clients may want to continue to avoid distressing emotional material, but participants in this study identified the necessity of dealing with their emotions as part of resolving their emotional distress. If clinicians unilaterally follow clients' lead in this regard a potentially beneficial aspect of therapy is avoided. However, by understanding the emotional experience as a process clinicians are able to determine where clients are positioned within this process and, based on client readiness, direct clients toward an exploration of difficult emotional material. Many clinicians may already implicitly understand this process. However, study results make the process explicit and available to clinicians from various therapeutic orientations.

Breakdown of Coping Strategies

This experience begins prior to therapy and is the impetus for participants' seeking relief through therapy. Thus the client's emotional experience in counselling appears to begin here. Participants' descriptions of their initial experience are consistent with the literature that emotional distress is the single most salient reason clients come to therapy (Korman & Greenberg, 1996; Lane & Schwartz, 1988; Peake & Egli, 1982) and that clients' coping strategies frequently take the form of avoidance and distraction (Korman & Greenberg, 1996; Rachman, 1980). Avoidance and distraction are predominant ways in which clients disconnect from their emotional experience (Korman & Greenberg, 1996; Rachman, 1980). As noted by Korman & Greenberg avoidance of painful emotional material is a natural response to perceiving that the emotional experience is unbearable. They state

> Understandably, then, attempts at coping often take the form of avoidance. In therapy these avoidances must be bypassed or overcome so that new forms of coping can be implemented . . . In so doing clients realize that the pain can be endured, thus laying the groundwork for the reprocessing and integration of unresolved experiences. p. 9

As identified by participants in this study, the very act of avoidance contributes to participants' experience of things getting worse. Little attention has been paid to how this impacts clients and is often discussed simply as emotional distress (Lane & Schwartz, 1987; Peake & Egli, 1982). Yet participants clearly identified the over and under-regulation of emotion as problematic. Participants who over-regulated emotion

describe feeling emotionally numb while participants who under-regulated emotion felt emotionally overwhelmed. In either case, participants identified that their emotions began to impact their lives in negative ways. This is consistent with Rachman's contention that if a distressing emotional event is incompletely processed signs of distress become evident. Rachman notes that,

> The central, indispensable index of unsatisfactory emotional processing is the persistence or return of intrusive signs of emotional activity (such as obsessions, nightmares, pressure of talk, phobias, inappropriate expressions of emotion that are out of context or out of proportion, or simply out of time) p. 51.

Generally participants did not perceive this aspect of their emotional experience as helpful. Particularly they spoke about how avoiding their emotions ultimately did not work. However, it may be that they were only able to identify this in retrospect after gaining increased awareness about their emotional experience. Interestingly, Cluster 2, Volatility, has a higher helpfulness rating than might be anticipated. Again it may be the retrospective nature of the study that influences obtaining a higher helpfulness rating. Although the interview participants described the changeability of their emotional experience in negative terms, it is this experience that ultimately captures participants' attention and provides information that something is wrong and leads them to find resolution. Participants may, therefore, attribute positive connotations to this aspect of their experience.

Increased Emotional Awareness

Participants in this study went on to describe their emotional experience as one of beginning to identify and articulate their undifferentiated experience. From the participants' perspective this process was comprised of examining and inspecting their emotional experience. However, participants' description of this process has not previously been identified. Correspondingly, they gained an increased ability to acknowledge and experience their emotions. They reported needing to sort out what was going on at an emotional level in a contained manner. Paradoxically, as they explored and expressed difficult emotions the emotional intensity decreased. This aspect of participants' experience is consistent with the research literature that maintains clients' attention needs to focus on their distress and causes of that distress (Korman & Greenberg, 1996; Lane & Schwartz, 1987; Rachman, 1980). Through understanding their emotional experience in a contained manner they can identify, acknowledge and tolerate their negative emotions. Participants, in retrospect, identified the necessity of this process.

Emotion researchers hypothesize that attention to the client's emotional experience is a necessary but insufficient aspect of the change process. In addition to attention to the client's emotional experience restructuring of that experience must also occur (Greenberg, 2002; Littrell, 1999). Within the literature emotional restructuring is held to be comprised of a number of aspects including emotional arousal, reflection on the

arousal for the purpose of integrating reason and emotion, and the promotion of new meaning making with the corresponding result of a reorganization of the client's perception of reality. Initially emotional arousal is necessary for emotional restructuring to occur (Greenberg, 2002; Hill et al., 1988; Hunt, 1998; Korman & Greenberg, 1996; Mackay et al., 1998; Rosner et al., 2000; Watson, 1996). Lang (cited in Rachman, 1980) states, " . . . the critical requirement . . . is that at least partial response components of the affective state must be present if an emotional image is to be modified" (p. 863). This is consistent with the well-established principle of conditioning that in order to eliminate a fear it must first be experienced. Therefore, a precursor to changing emotion is to experience it.

In addition to a certain level of emotional arousal it appears that aiding clients in differentiating their inner subjective experience aids in restructuring that experience (Greenberg, 2002; Littrell, 1998; Raingruber, 2000; Watson, 1996). Raingruber notes that when clients stayed with their emotional experience they gained clarity with respect to their original diffuse state. Clients recognized insights not previously recognized. According to Maroda (1999) the acquisition of insight depends on a unique emotional experience antecedent to the insight.

While participants in this study did not directly identify arousal as part of their emotional experience they did so indirectly (e.g., item 1, "I looked more intensely at my emotions"). Further, through examining their emotions they were able to differentiate their

subjective experience (e.g., item 35, "Sometimes I had to dissect what the emotions were because there's usually more than one", and item 31, "I can identify my emotions"). Participants in this study perceived the aspect of Increased Emotional Awareness as helpful.

Reorganization

Reorganization reflects an aspect participants identified as integrating disconnected parts of themselves as a result of experiencing their emotions. While Increased Emotional Awareness is identified by participants as how change occurred, Reorganization reflects what changed. In essence, when participants perceived this aspect of their emotional experience they were able to tangibly identify what had changed. Participants experienced themselves and their emotions differently. They described disconnected aspects of their experience coming together and no longer avoided their emotional experience. Instead there was increased attention to emotion. In addition, they described a sense of internal congruence along with an increased sense of being involved in life. This is consistent with researchers' hypothesis that attending to the emotional experience results in an internal restructuring (Greenberg, et al., 1993; Maroda, 1999; Stein, 1995). Further, it supports the contention that paying attention to clients' emotional experience allows for an assimilation and synthesis of dissociative aspects of experience (Korman & Greenberg, 1996; Rachman, 1980).

Participants perceived Reorganization of the emotional experience to be the most beneficial part of their emotional experience. This makes sense given participants' experience of increased internal congruence and corresponding decrease in emotional distress. Essentially participants identified that attending to emotions helped change their experience of emotional distress. This suggests that people change after they experience emotion.

As noted by Greenberg and Pascual-Leone (1997),

> Changes in psychotherapy in our view results from the symbolization in awareness of truly novel experiential synthesis that occur tacitly. By attending to and reprocessing experience, new felt experience is synthesized and people just feel differently. (p. 166)

Researchers further posit that, in addition to attending to the emotional experience, reflecting on it provides clients with more personally relevant information and aids in the process of creating new meaning (Carek, 1990; Clarke & Greenberg, 1986; Greenberg, 2002; Greenberg & Pascual-Leone, 1997; Maroda, 1999; Mergenthaler, 1996; Raingruber, 2000; Warwar & Greenberg, 2000).

According to Greenberg et al. (1993) the goal in attending to client's emotional experience is to increase emotional awareness and to integrate reason with that emotional awareness. Within a safe environment clients are encouraged to attend to their internal emotional experience and to symbolize it into words. The aim of this process is to aid in solving specific distressful cognitive-affective problems. They contend that this is the key process in meaning construction. In an effort to resolve emotional dissonance clients

create a new experience. Creation of personal meaning therefore involves bringing together reason and emotion. Although participants did not articulate this process in terms of integrating reason and emotion, they did report the creation of new personal meaning.

Therapeutic Relationship

It is important to note that in participants' interviews they identified the therapeutic relationship as a necessary component that allowed them to overcome their initial avoidance of negative emotion. While the therapeutic relationship was not an aspect of the participants' emotional experience identified by the concept map it is a clearly identified and salient element of the therapeutic change process as identified by researchers and interview participants. Participants reported a strong therapeutic relationship allowed them to acknowledge and deal with distressful emotions that were previously avoided. For therapeutic progress to occur an exploration of the client's emotional experience must take place while anchored in a strong therapeutic relationship (Beutler, Clarkin, & Bongar, 2000; Greenberg, 2002; Iwakabe, Rogan & Stalikas, 2000). According to Greenberg (2002) "A safe collaborative relationship with a therapist as well as the therapist's attunement to clients' feelings are important preconditions for working with emotion" (p. 7). Clients must experience a sense of safety and trust within the therapeutic relationship before they will begin to tolerate the pain associated with the emotional experience. In addition, there is growing literature that contends that emotional arousal and depth of experience relate to good outcome (Hill et al., 1998; Hunt, 1998;

Greenberg, 2002; Littrell, 1998; Watson, 1996). However, a strong therapeutic relationship is emerging as pivotal within this process. Psychotherapy researchers show that emotional arousal is predictive of good outcomes only within the context of a strong therapeutic relationship (Beutler et al., 2000; Iwakabe et al., 2000).

Reflections on Clinical Experience

As a clinician my experience of clients' emotional experience in counselling dovetails that of the research literature and the results of this study. Consistent with both, clients seem to enter therapy as a result of emotional distress that is difficult to articulate. Their ability to identify the source of their distress varies. Some clients are able to identify situational causes for their suffering while others remain at a loss to explain their emotional state or their particular reactions to distressing circumstances. Often a distressful situation they thought would improve with time has worsened taxing their typical way of coping.

Clients appear to present in one of two ways. They may present as overwhelmed by intense and unpredictable emotional reactions, which they are at a loss to control. Such clients are often described as emotionally labile. Frequently they are distressed at their own inability to contain their emotional reaction. In contrast, clients may present as emotionally over-controlled. They may be able to speak about their distress, analyzing and problem-solving from a cognitive perspective, but are disconnected from their emotional experience and the potential information it provides. Emotionally over-

controlled clients often present as emotionally numb with a blunted and restricted range of affect. In each case clients are distressed and appear to lack either cognitive meaning for their emotional distress or emotional information from their cognitive analysis.

Many psychotherapy researchers contend that successful treatment is attained through focusing on clients' distress and sources of that distress along with a dialectical synthesis of emotion and reason. From my clinical experience, emotionally overwhelmed clients often benefit from learning self-soothing strategies as well as a cognitive exploration of their emotional distress that aids them in identifying the unmet need related to their emotional distress. As they are able to work toward getting their needs met there appears to be a corresponding ability to contain emotional reactions along with an increased ability for affect regulation. In contrast, emotionally over-controlled clients appear to benefit when therapeutic work focuses on aiding the client in accessing their emotional experience. Helping clients tolerate their emotional experience by deliberately focusing on that experience in a contained manner provides clients with previously ignored information. Through an increased ability to explore their emotional experience clients again appear able to identify their unmet need and work toward having that need met.

Breaking down and examining clients' emotional experience allows them to deal with and tolerate one aspect of their distress at a time, ultimately making it more manageable. Accessing emotional information aids in identifying an unmet need while a

cognitive evaluation helps to determine how best to meet that need. As clients experience change after acknowledging and dealing with unresolved emotions there appears to be a reorganization of their experience characterized by both greater flexibility in their emotional response and greater affect regulation. With increasing congruence between what clients think and feel there is a corresponding decrease in their emotional distress. As clients experience and resolve incompletely processed emotions they begin to experience life in a more integrated manner.

Implications for Counselling

The themes derived from this research provide a conceptualization that informs practitioners how to proceed in therapy when dealing with emotions. Counselling practitioners must be able to conceptualize the emotional experience of their clients against a framework that guides the counselling process. It is important for counsellors to know that initially clients may want to avoid this exploration. However, this does not necessarily mean clients should avoid emotionally laden material.

When aiding clients in exploring negative emotions, it is important for counsellors to provide containment for their client's emotional experience. This is done through a strong therapeutic relationship, providing an orientation to the emotional process and knowledge of skills that facilitate the expression and integration of emotion with cognition. Initially, the therapeutic environment provides clients with a sense of safety and trust that allows them to risk confronting and experiencing threatening emotions.

In previous research clients indicated that not having an orientation to counselling hindered their progress in therapy (Paulson, Everall & Stuart, 2001). Distressing emotions are part of clients' experience in counselling. Therefore, clinicians need to be informed regarding the emotional experience in counselling in order to provide an orientation to clients. Such an orientation to the role of emotions in therapy and the potential benefits of exploring versus avoiding the emotional experience is likely to be beneficial and increase clients' willingness to undertake this process.

Frequently counsellor training does not address clients' emotional process. In order to work effectively with the client's emotional experience, counsellors may need to undertake further training in this area. Skills may need to be developed for helping clients both access affective states and restructure the emotional experience through integrating cognitions with emotion. Frequently therapy is about talking; the symbolization of experience into words. Additional training in expressive therapies using nonverbal modalities to symbolize meaning could also improve therapist effectiveness.

Clearly the results of this research study show the importance of integrating emotion and cognition. The professional literature has consistently debated the relative importance of cognition over emotion. As a result clinicians may have ignored one side of the process to the detriment of their clients. Yet, findings of this study indicate that not only is expression of emotion important but so is the integration of emotion with cognitive processes in therapy.

Limitations

In this study clients were asked to impose a structure on their experience resulting in a thematic conceptualization of their emotional experience in counselling. However, it is critical to keep in mind that this structure is not static. The thematic clusters that describe clients' emotional experience move beyond traditional theoretical conceptualizations, capturing the basic elements that are crucial to a positive outcome. To focus solely on one thematic component is to miss the inter-relatedness of the various parts of the overall process. The results presented here are in no way held out to be an invariant stage theory. Rather the results reflect that clients' emotional experience in therapy as a process.

It is not known whether taking another similar client group and replicating this study would produce a similar map. The retrospective nature of this study and its reliance on self-reporting of participants introduces many of the problems that typically arise when research is approached this way. Clients may not remember particular aspects or events in therapy or their reports may be biased by response sets, pre-existing beliefs and ideas, and self-presentation style. Further, interview summaries from which statements were extracted and sorted are reflective of the first group of participants' ability to report their experience. Problems with clients deliberately or unconsciously limiting and distorting information have been noted (Elliott & James, 1989).

With a concept mapping analysis various contextual components of the participants' experience were lost. For example, without contextual information, the

second group of participants had difficulty deciding where to place item 52, "I have these little cubbyholes, and my feelings get put into the space they're supposed to be put into". In addition, the first group of participants described the therapeutic relationship as a component that allowed them to explore their emotional experience. Yet this was not captured in the concept map, as the focus of the study was clients' perceptions of their emotional experience in counselling. This study also did not take into account what therapists did beyond creating a safe therapeutic relationship that aided participants in exploring their emotional experience and resolving incompletely processed emotion.

Participants in this study all appeared to have successful outcomes. This is likely due to the volunteer nature of the study, as clients not experiencing success in therapy may have dropped out. In addition, clinicians may have been biased in whom they solicited for the study. They may have picked clients who were successful upon termination of therapy as opposed to clients who terminated without success or who were referred. Thus results do not reflect the experience of clients whose emotional experience in counselling was negative.

Despite these limitations, the richness and breadth of information that results when clients are involved in the course of investigating the process of therapy warrants further research in this area. Researchers have established the importance of understanding the client's perception of the therapeutic experience and the importance of the role of the emotional experience as an element of the therapeutic change process.

Future Research

Given the growing body of research elucidating the importance of the role of the clients' emotional experience in the therapeutic change process, future research is warranted. An exploration investigating how this process is similar or different for various types of clients may help refine our understanding of the process. For example, do emotionally overwhelmed clients experience a different process than emotionally over-controlled clients? Research needs to be done on the possibility that some clients need distance from their emotions rather than more experience with them. Scheff (1981) discussed the concept of obtaining the appropriate distance from one's emotions and posits that clients need different amounts of distance from their emotions at different times.

Results of this study can only be viewed within the context of an adult population. Further investigation could explore the emotional process in children and youth. The therapeutic change process and the role of the emotional experience in children and youth are not well understood. With an increased understanding of how the emotional process unfolds for children within a therapeutic context differences and similarities between an adult population and a child population could be explored.

Researchers contend that emotional restructuring occurs through the dialectical synthesis of reason and emotion. They emphasize the importance of putting the emotional experience into words. But the relationship between emotion and cognition

remains unclear. In addition there exists growing popularity for expressive therapies that use nonverbal modalities to symbolize meaning. These therapies are particularly popular with children and are also used with adults. Future research could focus on exploring the emotional process for both an adult population and a child population using nonverbal modalities. Exploring similarities and differences in clients' emotional process for a variety of client populations will provide additional information that can be of benefit to clinicians.

Future research might examine the relative importance of the relationship between varying aspects of the therapeutic alliance, the client's emotional process and immediate and long-term outcomes. Also, the items identified by the participants could form the basis of an emotional experiencing scale to be used in future counselling process and outcome research. The clusters comprising the theme of Reorganization clearly indicate an internal restructuring that participants identified as helpful. These clusters may provide the basis for future research on integration of emotional experience.

Conclusion

Results of this study depict the process participants went through as part of their emotional experience in counselling. These findings support and expand on the existing literature that posits that clients change when they restructure their emotions. Participants indicate that the emotional experience is a process beginning with a Breakdown of Coping Strategies moving to Increased Emotional Awareness and resulting

in an internal Reorganization that is tangibly experienced as change. For therapists who value and attend to clients' emotional experience in counselling the study results make explicit a therapeutic process implicitly known. For clinicians unfamiliar with the role of emotion in the therapeutic change process it provides an expanded framework for understanding what clients experience in therapy. The concept map and thematic analysis depict the underlying structure of clients' emotional experience in counselling and provides information about the latent organization of these constructs.

References

Allen, J. G. (1980). Adaptive functions of affect and their implications for therapy. The Psychoanalytic Review, 67, 217-230.

Angus, L. E. (1992). Metaphor and the communication interaction in psychotherapy: A multimethodological approach. In S. G. Toukmanian & D. L. Rennie (Eds.), Psychotherapy process research. Paradigmatic and narrative approaches (pp. 187-210). Newbury Park, CA: Sage.

Arnkoff, D. B., & Glass, C. R. (1992). Cognitive therapy and psychotherapy integration. In D. K. Freedheim, H. J. Freudenberger, J. W. Kessler, S. B. Messer, D. R. Peterson, H. H. Strupp, & P. L. Wachtel (Eds.), History of psychotherapy: A century of change (pp. 657-694). Washington, DC: American Psychological Association.

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In Denzin, Norman K. & Lincoln, Yvonna S. (Eds.), Handbook of Qualitative Research (pp. 485-499). Thousand Oaks, CA.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. Psychotherapy, 25, 227-240.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. New York: International University Press.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). Guidelines for the systematic treatment of the depressed patient. New York: Oxford University Press.

Borgen, F. H., & Barnett, D. C. (1987). Applying cluster analysis in counseling psychology research. Journal of Counseling Psychology, 34, 456-468.

Borgen, F. H., & Weiss, D. J. (1971). Clusters analysis and counseling research. Journal of Counseling Psychology, 18, 583-591.

Bower, G. H. (1981). Mood and memory. American Psychologist, 36, 129-148.

Buser, S. J. (1989). A counseling practitioner's primer to the use of multidimensional scaling. Journal of Counseling and Development, 67, 420-423.

Cannon, W. B. (1987). The James-Lange theory of emotions: A critical examination and an alternative theory. American Journal of Psychology. Special Issue: 100 years of the American Journal of Psychology.100(3-4), 567-586. (Reprinted from Cannon, W. B. (1927). The James-Lange theory of emotion: A critical examination and an alternative theory. American Journal of Psychology, 39, 106-204.)

Carek, D. J. (1990). Affect in psychodynamic psychotherapy. American Journal of Psychotherapy, 44, 274-282.

Caskey, N., Barker, C., & Elliott, R. (1984). Dual perspectives: Clients' and therapists' perceptions of therapist responses. British Journal of Clinical Psychology, 23, 281-290.

Castonguay, L. G., Goldfried, M. R., Wiser, S. L., Raue, P. J., & Hayes, A. M., (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. Journal of Consulting and Clinical Psychology, 64, 497-504.

Clark, D. A. (1995). Perceived limitations of standard cognitive therapy: A consideration of efforts to revise Beck's theory and therapy. Journal of Cognitive Psychotherapy: An International Quarterly, 9, 153-172.

Clarke, K. M. (1989). Creation of meaning: An emotional processing task in psychotherapy. Psychotherapy, 26, 139-148.

Clarke, K. M. (1996). Change processes in a creation of meaning event. Journal of Consulting and Clinical Psychology, 64, 465-470.

Clarke, K. M., & Greenberg, L. S. (1986). Differential effects of the Gestalt two-chair intervention and problem solving in resolving decisional conflict. Journal of Counseling Psychology, 33, 11-15.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valee & M. King. (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford Press.

Daughtry, D., & Kunkel, M. A. (1993). Experience of depression in college students: A concept map. Journal of Counseling Psychology, 40, 316-323.

Davison, M. L., Richards, P. S., & Rounds J. B. (1986). Multidimensional scaling in counseling research and practice. Journal of Counseling and Development, 65, 178-184.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage.

Dey, I. (1993). Qualitative data analysis: A user-friendly guide for social scientists. New York: Routledge.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. Journal of Counseling Psychology, 32, 307-322.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. Clinical Psychology Review, 9, 443-467.

Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Lyle Stuart.

Fialkow, N. J., & Muslin, H. L. (1987). Working through: A cornerstone of psychotherapy. American Journal of Psychotherapy, 41, 443-452.

Fitzgerald, L. F., & Hubert, L. J. (1987). Multidimensional scaling: Some possibilities for counseling psychology. Journal of Counseling Psychology, 34, 469-480.

Freud, S. (1910). Five lectures on psychoanalysis (Vol. 2; Standard ed.). London: Hogarth.

Frijda, N. H. (1980). The emotions. New York: Cambridge University Press.

Frijda, N. H. (1994). Emotions are functional, most of the time. In P. Ekman & R. J. Davidson (Eds.), The nature of emotion: Fundamental questions (pp. 112-122). New York: Oxford University Press.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. Psychotherapy, 27, 143-153.

Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L., & Gagnon, R. (1998). Alliance, technique and their interactions in predicting outcome of behavioural, cognitive and brief dynamic therapy. Psychotherapy Research, 8, 190-209.

Gershefski, J. J., Arnkoff, D. B., Glass, C. R., & Elkin, I. (1996). Clients' perceptions of treatment for depression: 1. Helpful aspects. Psychotherapy Research, 6, 233-247.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), Phenomenology and psychological research (pp. 12-28). Pittsburgh, PA: Duquesne University.

Goldfried, M. R. (1980a). Converging themes in psychotherapy. New York, Springer.

Goldfried, M. R. (Ed.). (1980b). Some views on effective principles of psychotherapy. Cognitive Therapy and Research, 4, 269-324.

Goldfried, M. R. (1995). From cognitive-behavior therapy to psychotherapy integration: An evolving view. New York: Springer.

Greenberg, L. S. (1993). Emotion and change processes in psychotherapy. In M. Lewis & J. M. Haviland (Eds.), Handbook of emotion (pp. 499-508). New York: Guilford Press.

Greenberg, L. S. (2002). Emotion-focused therapy: Coaching clients to work through their feelings. Washington, DC: American Psychological Association.

Greenberg, L. S., & Clarke, K. M. (1979). Differential effects of the two-chair experiment and empathic reflections at a conflict marker. Journal of Counseling Psychology, 26, 1-8.

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. Journal of Consulting and Clinical Psychology, 64, 439-446.

Greenberg, L. S., & Korman, L. M. (1993). Assimilating emotion into psychotherapy integration. Journal of Psychotherapy Integration, 3, 249-265.

Greenberg, L. S., & Paivio, S. C. (1997). Working with emotions in psychotherapy. New York: Guilford Press.

Greenberg, L. S., & Pascual-Leone, J. (1997). Emotion in the creation of personal meaning. In M. Power & C. R. Brewin (Eds.), The transformation of meaning in psychological therapies. Integrating theory and practice (pp. 157-173). New York: Wiley & Sons.

Greenberg, L. S., & Rice, L. N. (1981). The specific effects of a Gestalt intervention. Psychotherapy: Theory, research and practice, 18(1), 31-37.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). Facilitating emotional change: The moment-by-moment process. New York: Guilford Press.

Greenberg, L. S., & Safran, J.D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. Cognitive Therapy and Research, 8, 559-578.

Greenberg, L. S., & Safran, J. D. (1987). Emotion in psychotherapy: Affect, cognition and the process of change. New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. American Psychologist, 44, 19-29.

Greenberg, L. S., & Safran, J. D. (1990). Emotional change processes in psychotherapy. In R. Plutchik & H. Kellerman, Emotion: Theory, research and experience. Vol. 5. Emotion, psychopathology and psychotherapy (pp. 59-85). New York: Academic Press.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. Psychotherapy Research, 8, 210-224.

Greenberg, L. S., & Webster, M. C. (1982). Resolving decisional conflict by Gestalt two-chair dialogue: Relating process to outcome. Journal of Counseling Psychology, 29, 468-477.

Hammersley, M., & Atkinson, P. (1983). Ethnography: Principles in practice. London: Tavistock.

Heppner, P. P., Rosenberg, J. I., & Hedgespeth, J. (1992). Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic process versus actual therapeutic events. Journal of Counseling Psychology, 39, 20-31.

Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. Journal of Counseling Psychology, 35, 222-233.

Hill, C. E. (1994). From an experimental to an exploratory naturalistic approach to studying psychotherapy process. In R. L. Russell (Ed.), Reassessing Psychotherapy Research (pp. 144-165). New York, Guilford.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. Journal of Counseling Psychology, 38, 139-149.

Howard, K. I., & Orlinsky, D. E. (1972). Psychotherapeutic process. Annual Review of Psychology, 615-668.

Hunt, M. G. (1998). The only way out is through: Emotional processing and recovery after a depressing life event. Behaviour, Research & Therapy, 36, 361-384.

Iwakabe, S., Rogan, K. & Stalikas, A. (2000). The relationship between client emotional expressions, therapist interventions, and the working alliance: An exploration of eight emotional expression events. Journal of Psychotherapy Integration,10(4), 375-402.

Izard, C. E. (1977). Human emotions. New York: Plenum Press.

Izard, C. E. (1992). Basic emotions, relations among emotions, and emotion-cognition relations. Psychological Review, 99(3), 561-565.

Izard, C. E. (1993). Four systems for emotion activation: Cognitive and noncognitive processes. Psychological Review, 100(1), 68-90.

Jacobsen, N. S. (1984). The modification of cognitive processes in behavioural marital therapy: Integrating cognitive and behavioural intervention strategies. In K. Hahlweg & M. Jacobsen (Eds.), Marital interaction: Analysis and modifications (pp. 285-308). New York, Guilford.

James, W. (1984). What is an emotion? Przeglad Psychologiczny, 27(4), 863-885. (Reprinted from James, W. (1884). What is emotion? Mind, 19, 188-205).

James, W. (1998). The principles of psychology. In J. M. Jenkins, K. Oatley, & N. L. Stein (Eds.), Human Emotions: A reader (pp. 21-29). Malden, MA: Blackwell Publishers. [Reprinted from James, W. (1950). The principles of psychology. London: Dover Publishers (Original work published in 1890, New York: Henry Holt)]

Kennedy-Moore, E., & Watson, J. C. (1999). Expressing emotion: Myths, realities and therapeutic strategies. New York, Guilford Press.

Kiesler, D. J. (1971). Patient experiencing and successful outcome in individual psychotherapy of schizophrenics and psychoneurotics. Journal of Consulting and Clinical Psychology, 37, 370-385.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. S. Greenberg & W. Pinsof (Eds.), The psychotherapeutic process: A research handbook (pp. 21-71). New York: Guilford Press.

Korman, L. M., & Greenberg, L. S. (1996). Emotion and therapeutic change. Advances in biological psychiatry, 2, 1-25.

Kruskal, J. B., & Wish, M. (1978). Multidimensional scaling. Beverly Hills, CA: Sage.

Kunkel, M. A., & Newsom, S. (1996). Presenting problems for mental health services: A concept map. Journal of Mental Health Counseling, 18, 53-63.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of psychotherapy integration (pp. 94-129). New York: Basic Books.

Lane, R. D., & Schwartz, G. E. (1987). Levels of emotional awareness: A cognitive-developmental theory and its application to psychopathology. American Journal of Psychiatry, 144, 133-143.

Lawhead, C. A. (1994). When therapists intend to facilitate deep emotional experiencing: From the client's perspective (change events). (Doctoral dissertation, State University of New York at Albany, 1994). Dissertation Abstracts International AAT 9504099.

Lazarus, R. (1991a). Emotion and adaptation. New York: Oxford University Press.

Lazarus, R. S. (1991b). Progress on a cognitive-motivational-relational theory of emotion. American Psychologist, 46, 819-834.

LeDoux, J. (1987). Emotion. In F. Plum (Ed.), Handbook of physiology: Sec. 1. The nervous system: Vol. 5. Higher function of the brain (pp. 419-459). Bethesda, MD: American Physiological Society.

LeDoux, J. E. (1994). Emotional processing but not emotions, can occur unconsciously. In P. Ekman & R. J. Davidson (Eds.), The nature of emotion: Fundamental questions (pp. 291-292). New York: Oxford University Press.

LeDoux, J. (1998a). The emotional brain. In J. M. Jenkins, K. Oatley, & N. L. Stein (Eds.), Human emotions: A reader. Malden, MA: Blackwell Publishers.

LeDoux, J. (1998b). The emotional brain: The mysterious underpinnings of emotional life. New York: Simon & Schuster.

Levenson, R. W. (1994). Human emotion: A functional view. In P. Ekman & R. J. Davidson (Eds.), The nature of emotion: Fundamental questions (pp. 123-126). New York: Oxford University Press.

Leventhal, H. (1984). A perceptual-motor theory of emotion. Advances in Experimental Social Psychology, 17, 117-182.

Lewis, M. (1993). The emergence of human emotions. In M. Lewis & J. M. Haviland (Eds.), Handbook of Emotions (pp. 223-235). Guilford Press. New York.

Lietaer, G. (1992). Helping and hindering processes in client-centered/experiential psychotherapy: A content analysis of client and therapist postsession perceptions. In S. G. Toukmanian & D. L. Rennie (Eds.), Psychotherapy process research: Paradigmatic and narrative approaches (pp. 134-162). Newbury Park: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Littrell, J. (1998). Is the reexperience of painful emotion therapeutic? Clinical Psychology Review, 18, 71-102.

Llewelyn, S. P., Elliott, R., Shapiro, D. A., Hardy, G., & Firth-Cozens, J. (1988). Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. British Psychological Society, 27, 105-114.

Lyons, W. (1999). The philosophy of cognition and emotion. In T. Dalglesh & M.J. Power (Eds.), Handbook of cognition and emotion (pp. 21-43). New York: John Wiley.

Mackay, H. C., Barkham, M., & Stiles, W. B. (1998). Staying with the feeling: An anger event in psychodynamic-interpersonal therapy. Journal of Counseling Psychology, 45, 279-289.

Mahoney, M. J. (1991). Human change processes: The scientific foundations of psychotherapy. New York: Basic Books.

Mahrer, R. R. (1988). Discovery-oriented psychotherapy research: Rationale, aims, and methods. American Psychologist, 43, 694-702.

Mandler, G. (1975). Mind and emotion. New York: Wiley.

Maroda, K. J. (1999). Seduction, surrender and transformation: Emotional engagement in the analytic process. Hillsdale, NJ: Analytic Press.

Marshall, C, & Rossman, G. B. (1989). Designing qualitative research. Newbury, Park, CA: Sage.

Maxwell, J. A. (1992). Understanding and validity in qualitative research. Harvard Educational Review, 62, 279-300.

Mayer, J. D., & Geher, G. (1996). Emotional intelligence and the identification of emotion. Intelligence, 22, 89-113.

McQueeney, D. A., Stanton, A. L., & Sigmon, S. (1997). Efficacy of emotion-focused and problem-focused group therapies for women with fertility problems. Journal of Behavioural Medicine, 20, 313-331.

Mergenthaler, E. (1996). Emotion-abstraction patterns in verbatim protocols: A new way of describing psychotherapeutic processes. Journal of Consulting and Clinical Psychology, 64(6), 1306-1315.

Merrick, E. (1999). An exploration of quality in qualitative research. In M. Kopala & L. A. Suzuki (Eds.), Using qualitative methods in psychology. Thousand Oaks: Sage.

Messer, S. B. (1986). Behavioural and psychoanalytic perspectives at therapeutic choice points. American Psychologist, 41(11), 1261-1272.

Millen, L., & Ross, S. (1986). Common impediments to good psychotherapy - or hell is other people. Journal of Contemporary Psychotherapy, 16, 115-120.

Miller, D. M., Wiley, K. E., & Wolfe, R. G. (1986). Categorization methodology: An approach to the collection and analysis of certain classes of qualitative information. Multivariate Behavioural Research, 21(2), 135-167.

Mishler, E. (1990). Validation in inquiry-guided research: The role of exemplars in narrative studies. Harvard Educational Review, 60, 415-442.

Morrow, J., & Nolen-Hoeksema, S. (1990). Effects of response to depression on the remediation of depressive affect. Journal of Personality and Social Psychology, 58(3), 519-527.

Munn, N. L. (1961). Psychology: The fundamentals of human adjustment. London: Harrap.

Newman, C. F. (1991). Cognitive therapy and the facilitation of affect: Two case illustrations. Journal of Cognitive Psychotherapy, 5, 305-316.

Nolen-Hoeksema, S., Parker, L. F. & Larson, J. (1994). Ruminative coping with depressed mood following loss. Journal of Personality and Social Psychology, 67, 92-104.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving "unfinished business": Efficacy of experiential therapy using empty-chair dialogue. Journal of Consulting and Clinical Psychology, 63, 419-425.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury, CA: Sage.

Paulson, B. L., Everall, R. D., & Stuart J. (2001). Client perceptions of hindering experiences in counselling. Counselling and Psychotherapy Research 1(1), 53-61.

Paulson, B., Truscott, D., & Stuart, J. (1999). Clients' perception of helpful experiences in counseling. Journal of Counseling Psychology, 46(3), 317-324.

Peake, T. H., & Egli, D. (1982). The language of feelings. Journal of Contemporary Psychotherapy, 13, 162-174.

Plutchik, R. (1985). On emotion: The chicken-and egg problem revisited. Motivation and Emotion, 9, 197-200.

Plutchik, R. (1990). Emotions and psychotherapy: A psychoevolutionary perspective. In R. Plutchik & H. Kellerman (Eds.), Emotion: Theory research and experience, Vol. 5. Emotion, psychopathology and psychotherapy (pp. 3-41). New York: Academic Press.

Plutchik, R. (1994). The psychology and biology of emotion. New York: Harper Collins.

Powell, D. H. (1988). Spontaneous insights and the process of behavior therapy: Cases in support of integrative psychotherapy. Psychiatric Annals, 18, 288-294.

Rachman, S. (1980). Emotional processing. Behavior, Research and Therapy, 18, 51-52.

Raingruber, B. (2000). Being with feelings as a recognition practice: Developing clients' self-understanding. Perspectives in Psychiatric Care, 36(2), 41-50.

Rosenberg, S., & Kim, M. P. (1975). The method of sorting as a data-gathering procedure in multivariate research. Multivariate Behavioural Research, 12, 1-16.

Rosner, R., Beutler, L. E., & Daldrup, R. J. (2000). Vicarious emotional experience and emotional expression in group psychotherapy. Journal of Clinical Psychology, 56(1), 1-10.

Safran, J. D., & Greenberg, L. S. (1991). Emotion in human functioning: Theory and therapeutic implications. In J. D. Safran & L. S. Greenberg (Eds.), Emotion, psychotherapy, and change (pp. 3-15). New York: Guilford Press.

Safran, J. D., & Muran, J. C. (1995). Resolving therapeutic alliance ruptures: Diversity and integration. Session-Psychotherapy in Practice, 1, 81-92.

Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behavior. Journal of Psychotherapy Practice & Research, 7, 126-143.

Saunders, S. M. (1999). Clients' assessment of the affective environment of the psychotherapy session: Relationship to session quality and treatment effectiveness. Journal of Clinical Psychology, 55, 597-605.

Schacter, S., & Singer, J. (1962). Cognition, social and physiological determinants of emotional state. Psychological Review, 69, 379-399.

Scheff, T. J. (1981). The distancing of emotion in psychotherapy. Psychotherapy: Theory, Research and Practice, 18(1), 46-53.

Shimhara, N. (1988). Anthroethnography: A methodological consideration. In Robert R. Sherman & B. Rodman (Eds.), Qualitative Research for Education: Focus and Methods. London: Falmer Press.

Stein, R. (1995). The role of affects in the process of change in psychotherapy. Israel Journal of Psychiatry and Related Sciences, 32, 174-183.

Stiles, W. B. (1993). Quality control in qualitative research. Clinical Psychology Review, 13, 593-618.

Tesch, R. (1987). Emerging themes: The researcher's experience. Phenomenology & Pedagogy, 5, 230-241.

Tesser, A., Leone, C., & Clary, E. G., (1978). Affect control: Process constraints versus catharsis. Cognitive Therapy and Research, 2(3), 265-274.

Trochim, W. (1989). An introduction to concept mapping for planning and evaluation. Evaluation and Program Planning, 12, 1-16.

Trochim, W. M. K. (1993). The concept system. Ithaca, NY: Author. (Computer software manual)

van Manen, M. (1984). Practicing phenomenological writing. Phenomenology & Pedagogy, 2, 36-72.

Ward, J. H. (1963). Hierarchical groupings to optimize an objective function. Journal of the American Statistical Association, 58, 236-244.

Warwar, S., & Greenberg, L. S. (2000). Advances in theories of change and counseling in S. D. Brown & R. W. Lent (Eds.), Handbook of counseling psychology (pp. 751-600). New York: Wiley & Sons.

Watson, J. C. (1996). The relationship between vivid description, emotional arousal, and in-session resolution of problematic reactions. Journal of Consulting and Clinical Psychology, 64, 459-464.

Watson, J. C., & Greenberg, L. S. (1996). Emotion and cognition in experiential therapy: A dialectical-constructivist position. In H. Rosen & K.T. Kuehlwein (Eds.), Constructing Realities: Meaning-making perspectives for psychotherapists (pp. 253-274). San Francisco: Jossey-Bass.

Wiser, S., & Goldfried, M. R. (1993). Comparative study of emotional experiencing in psychodynamic-interpersonal and cognitive-behavioural therapies. Journal of Consulting and Clinical Psychology, 61, 892-895.

Wiser, S., & Goldfried, M. R. (1998). Therapist interventions and client emotional experiencing in expert psychodynamic-interpersonal and cognitive-behavioural therapies. Journal of Consulting and Clinical Psychology, 66, 634-640.

Young, M. E., & Bemak, F. (1996). The role of emotional arousal and expression in mental health counselling. Journal of Mental Health Counselling, 18, 316-332.

Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. American Psychologist, 35, 151-175.

Zajonc, R. B. (1984). On the primacy of affect. American Psychologist, 39, 117-123.

Appendix A

Study Description

The following is a brief description of the research being conducted for my doctoral thesis and outlines your involvement in this study. I am conducting this study in order to gain insight into people's emotional experience during counselling. This study is being supervised by Dr. Barbara Paulson of the Department of Educational Psychology at the University of Alberta.

Your participation in the study will be in the form of a taped interview of approximately one hour in length. In this interview you will be asked to describe your emotional experience in counselling in as much detail as possible. This interview will be transcribed for later analysis. All people mentioned will be given a pseudonym (i.e., false name) and any details that might identify you or any persons mentioned will be changed during the transcribing. Any emotional discomfort you experience as a result of the interview will be discussed with the interviewer and, if necessary, appropriate referrals made.

All information about you will be kept strictly confidential. Your participation in this study is completely voluntary and you may withdraw at any time without penalty. If you decide that you no longer want to participant in the study, all information about you will be destroyed. Upon completion of this study, if you are interested, the findings will be made available to you.

Appendix B

Session Questionnaire

To: Janice Stuart

Re: Study on experiencing emotions in counselling

I am willing to be contacted with respect to participating in your study

Name:_____

Contact Phone Number(s) _____

_____

It is okay to leave a message at this number: Y _____ N_____

The best time to contact me is:_____

Appendix C

Consent to Participate

I am aware that the purpose of this study is to understand my emotional experiences during counselling. During an interview, I will be asked to describe my experiences in as much detail as possible. I understand that it is hoped that this information will be helpful in understanding how experiencing emotion during counselling influences the course of therapy. I understand that the present study is being conducted as a doctoral thesis by Janice Stuart, under the supervision of Dr. Barbara Paulson of the Department of Educational Psychology at the University of Alberta.

I agree to participate in this study, and I am willing to share my experiences with the researcher. I am aware that one interview of approximately one hour in length will be tape recorded in order that it can be transcribed for later analysis. I realize that my participation is completely voluntary and that I can withdraw at any time without penalty. If I choose to withdraw, any information about me or any data that I provide will be destroyed. I understand that if I am receiving counselling from the Education Clinic at the University of Alberta, withdrawal from the study will not impact my access to counselling.

I am aware that all information associated with this study is strictly confidential and that my identity, or that of any persons that I mention, will be known only by the interviewer and will not be revealed to anyone, including my counsellor, at any time. I understand all people mentioned will be given a pseudonym (i.e., false name). Any details in the recorded interview that might identify me or any persons that I mention will also be changed during the transcribing. Any emotional discomfort I experience as a result of the interview will be discussed with the interviewer and, if necessary, appropriate referrals made.

Signature _____

Date _____

Witness _____

Appendix D

Study Description

The following is a brief description of the research being conducted for my doctoral thesis and outlines your involvement in this study. I am conducting this study in order to gain insight into people's emotional experience during counselling. This study is being supervised by Dr. Barbara Paulson of the Department of Educational Psychology at the University of Alberta.

Your participation in the study will be in the form of a sorting and rating task, which will take approximately 60 - 90 minutes to complete. You will be given a set of statements provided by clients who have received counselling and asked to sort them into groups that seem to go together. After sorting the statements into groups you will be asked to rate the relative helpfulness of each statement.

All information about you will be kept strictly confidential. Your participation in this study is completely voluntary and you may withdraw at any time without penalty. If you decide that you no longer want to participate in the study, all information about you will be destroyed. Upon completion of this study, if you are interested, the findings will be made available to you.

Appendix E

Consent to Participate

I am aware that the purpose of this study is to understand people's emotional experiences during counselling. I understand that it is hoped that this information will be helpful in understanding how experiencing emotion during counselling influences the course of therapy. I understand that the present study is being conducted as a doctoral thesis by Janice Stuart, under the supervision of Dr. Barbara Paulson of the Department of Educational Psychology at the University of Alberta.

I agree to participate in this study and am aware that my participation is voluntary. I understand that I can withdraw my participation at any time without penalty. If I choose to withdraw from the study any information about me or any data that I provide will be destroyed. I am also aware that if I have received counselling at the Education Clinic, withdrawing from the study will not impact my access to counselling. I understand my participation in this study will involve reading statements provided by clients who have received counselling and sorting the statements into groups that seem to go together. Following this I will be asked to rate the relative importance of each statement. I understand this sorting and rating task will take approximately 60 - 90 minutes. I understand that only the results of the statistical analyses of the sorts from all the research participants will be shown to anyone besides the researcher. Any emotional discomfort I experience as a result of completing this task will be discussed with the researcher and, if necessary, appropriate referrals made.

Signature _____

Date _____

Witness _____

Appendix F

Demographic Information

Name:_____ Age:_____

Gender: M F

Ethnicity: White Asian Black East Indian First Nations Hispanic
(please circle)
Mixed Ethnicity Other_____

Highest Level of Education of the adult(s) in the household:
(please circle)

a. Graduate/professional education
b. College/university degree
c. Partial college/university
d. Certificate in a trade/technology
e. High school diploma/GED
f. Partial high school training
g. Junior high school graduate
h. 8 years of schooling or less

Approximate combined annual income of your household
(please circle)

a. Less than $10,000
b. $10,000 to $20,000
c. $20,000 to $30,000
d. $30,000 to $40,000
e. $40,000 to $50,000
f. $50,000 or more

Appendix G

Sorting Instructions

1. Please read through these slips of paper and sort them into groups according to how they seem to go together. Please note: You may or may not have experienced the event described on the slip of paper.
2. Place similar statements together in the same groups.
3. You can have as many groups as you want, but you cannot have only one group, and you cannot have each slip of paper on its own as a group.
4. There are no right or wrong groups. You are to choose the way, which seems best to you.
5. If you believe that a statement is unrelated to all of the others you may place it in its own pile.

Appendix H

Sorting and Rating Questionnaire

The statements listed below are based on interviews of participants who have described observations or descriptions of what happened with the feelings or emotions they experienced in counselling. Please rate the following statements on how helpful you believe this experience is in counselling using the scale below. Even though you may not have personally experienced what is described, please rate each statement to the best of your ability.

1 = not at all helpful
2 = somewhat helpful
3 = moderately helpful
4 = very helpful
5 = extremely helpful

1. I looked more intensely at my emotions. _____
2. I reached a more realistic level of emotion. _____
3. Sometimes I needed to feel my emotions more deeply. _____
4. I needed to face my emotions so that I could get on with life. _____
5. My emotions aren't locked away anymore. _____
6. My situation didn't change, but my emotions related to it changed. _____
7. I didn't know what feelings were okay and what feelings weren't okay. _____
8. I couldn't put my emotions in a box anymore. _____
9. I got so that I was okay with anything I felt. _____
10. I was terrified that there would be retaliation for my feelings. _____
11. I didn't think it would ever be okay to trust my feelings. _____
12. I can put my emotions in perspective. _____

13. I learned that none of my feelings are wrong. _____
14. After I had explored some of my emotions I just felt different inside. _____
15. I could experience feelings that were both negative and positive. _____
16. The big cold chunk that was part of me had been changed. _____
17. I learned that my feelings are valid. _____
18. My emotional state changed from week to week. _____
19. My emotions seem to have fallen into place. _____
20. As I dealt with my emotions they became less intense. _____
21. Once I brought out my feelings I could deal with my situation. _____
22. The hurt is there, but it's not something I dwell on. _____
23. I can let go of my feelings a lot easier when I acknowledge them. _____
24. I would push away recognizing the physical aspects of my emotions. _____
25. I primarily focused on the negative emotions. _____
26. I tuned into my body to experience my feelings. _____
27. When I was in touch with my emotions, I became less volatile. _____
28. I just shut off from feeling. _____
29. Not showing my feelings kept me safe. _____
30. I learned how to deal with my feelings. _____
31. I can identify my emotions. _____
32. Because I know what my emotions are related to I'm not so scared of them anymore. _____
33. I started to pay attention to what my feelings meant. _____
34. I learned I didn't have to protect myself from what I was feeling. _____

35. Sometimes I had to dissect what the emotions were because there's usually more than one. _____

36. It's like I'm part of my life now because I can feel it. _____

37. Understanding that fear is behind my anger probably helped me to let go of my anger. _____

38. As the numbness began to thaw, I began to feel. _____

39. I put my feelings on hold. _____

40. As I dealt with the feelings, things came out that I never realized were there. _____

41. I didn't want to deal with my emotions. _____

42. Avoiding dealing with my emotions was causing me real life physical problems. _____

43. I had to deal with the bad emotions before I could experience some of the good ones. _____

44. As I would deal with my feelings the knot in my stomach would decrease. _____

45. All of these feelings that were wound together were being separated. _____

46. I dealt with my feelings one at a time. _____

47. Eventually dealing with the feelings was easier because it was a much smaller little ball. _____

48. When my emotions first came out I didn't know exactly what to expect. _____

49. As I started letting my emotions out I started dealing with life. _____

50. My emotions are such a part of me now. _____

51. I used to keep everything all tightly bottled up inside. _____

52. I have these little cubbyholes, and my feelings get put into the spaces they're supposed to be put into. _____

53. When I began to feel, it felt like a new beginning. _____

54. I had to tease out what was all in this bubbling brew of emotions. _____

55. I couldn't sort out my feelings. _____

56. The pain was a mishmash of all these feelings that I didn't understand. _____

57. My emotions were ruling my life. _____

58. The fear shifted to sadness. _____

59. Sometimes when I experienced an emotion it was stronger. _____

60. Something that's very small would make me really angry. _____

61. The biggest thing was how fast my emotions would change. _____

Appendix I

Interview Guide

1. Please describe the types of feelings and emotions you experienced during counselling.
2. Tell me about any significant moments regarding the feelings/emotions you experienced that stand out for you.
3. What is it that made experiencing that feeling significant?
4. What enabled you to have this experience?
5. Can you describe any thoughts you had at the time?
6. What bodily reactions/sensations, if any, were you experiencing?
7. Paying particular attention to your thoughts, feelings, and bodily reactions, can you describe what you were experiencing in counselling prior to feeling this emotion?
8. Can you tell me what you experienced in counselling after you experienced this emotion?
9. What, if any, positive impact did experiencing these feelings in counselling have for you?
10. Can you describe any negative impact, if any, of this experience?
11. What made having these feelings in counselling significant for you?
12. Is there anything about experiencing the feelings you did that made a difference for you?
13. Is there anything I haven't asked you about this experience that would be important for me to know?