The Alliance as a Prerequisite to Emotional Processing in Psychotherapy

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis including any required final revisions, as accepted by my examiners. I understand that my thesis may be made electronically available to the public.

Abstract

The quality of the therapeutic alliance has been shown to predict treatment outcomes across approaches to psychotherapy. However, the underlying mechanism by which the alliance leads to improvement remains to be clarified. In the emotion-focused therapy framework, it is theorized that a strong alliance facilitates emotional processing, which in turn leads to outcome. The hypothesis that a strong alliance creates the conditions for emotional processing has not been tested. Additionally, while research on emotion-focused therapy has shown that emotional processing predicts outcome over and above the alliance, this finding has not been evaluated within cognitive-behavioural therapy. The primary goals of this study were to 1) test the hypothesis that high levels of emotional processing primarily occur in the context of a strong alliance and 2) examine whether emotional processing predicts outcome over and above the alliance in cognitive-behavioural therapy. Observer-rated measures were used to assess emotional processing and the alliance in working phase psychotherapy sessions from adults who completed cognitive-behavioural therapy at a graduate training clinic. Interquartile ranges and results from one-way ANOVA (n = 31) showed higher means and lower variability in the alliance at high levels of emotional processing, suggesting a threshold. A Pearson correlation yielded a remarkably high association between emotional processing and treatment gains (r = .597). Additionally, hierarchical regression analyses (n = 19) indicated that working phase peak emotional processing predicted treatment gains over and above working phase alliance. The implications of these results for psychotherapy research and practice are discussed.

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Table of Contents

List of Figures

List of Tables

Introduction

Psychotherapy is a first line of treatment for mental illness, which impacts approximately 1 in 5 Canadians during their lifetime (Smetanin et al., 2015). While meta-analyses and reviews of controlled treatment studies generally affirm that psychotherapy is effective at alleviating mental health difficulties (e.g., Lambert, 2004; Nathan & Gorman, 2007; Munder et al., 2018), a critical question is how and why psychotherapy leads to improvement (Kazdin, 2009). Most schools of therapy present a theoretical account for how change occurs (Cuijpers et al., 2019). However, current scientific knowledge of the change process is limited. Researchers have called for greater specificity in not only identifying factors that lead to change but also demonstrating how and when they produce change (Kazdin, 2007). An understanding of how change mechanisms operate could equip therapists with the means to adapt and employ treatment techniques to optimally trigger the change process.

Common Factors

One framework for studying the change process involves identifying *common factors* (Rosenzweig, 1936). Reviews of controlled treatment studies that yield similar results when two or more therapies from different treatment frameworks are compared point to the existence of common factors that account for change (e.g., Lambert & Ogles, 2004). Common factors are thought to reflect higher-order mechanisms of change in psychotherapy as a whole (Wampold, 2015). As noted by Brown (2015, p. 305), “In an age where there are hundreds of types of therapies, and our instruments are very blunt in measuring their effectiveness, it is important to concentrate on the commonalities that may account for similarities.” This is particularly important given that many therapies apply different labels to analogous procedures (Marks, 2000). To date, a number of common factors have accumulated empirical support. The American

Psychological Association's (APA) task force on evidence-based therapy relationships categorized common factors in extant literature as *demonstrably effective* based on the strength of current evidence (the alliance, empathy, and structured client feedback), *probably effective* (e.g., goal consensus), or *promising* (e.g., attachment style) across treatment orientations (Norcross & Wampold, 2011).

Common factors contrast with *specific factors*, which emerge from one framework, such as cognitive restructuring in CBT (cognitive-behavioural therapy; Rosenzweig, 1936). Castonguay et al. (2015) noted that factors considered specific to one framework may in fact be common to many. Referred to as *faux unique factors*, such specific factors may be viewed as wedded to one framework and may therefore be overlooked as common factors. Nonetheless, they may be implicitly "active" in therapies from other frameworks. A few striking examples are meta-analyses on the relation of outcome to insight, originating from psychodynamic psychotherapy (Jennissen et al., 2018); dysfunctional thinking and rumination, core processes in CBT (Cristea et al., 2015; Spinhoven et al., 2018); and emotional processing, central to emotion-focused therapy (EFT; Pascual-Leone & Yeryomenko, 2016); all of which predict outcome across a range of therapeutic frameworks.

Establishing Mechanisms of Change in Psychotherapy

While such findings are encouraging, the complex and multifaceted nature of therapy coupled with methodological considerations prevent straightforward conclusions about even relatively well-studied common factors. For example, psychotherapy studies tend to be underpowered due to low sample sizes, leading to difficulties detecting relationships of interest as well as heterogeneous findings within and between meta-analyses (Spielmans & Flückiger, 2018).

Of particular complexity is delineating the precise nature of relationships between change mechanisms and outcome. Kazdin (2009) outlined criteria for establishing change mechanisms. Of primary importance is a strong association with outcome. A dose-response relationship is also ideal, such that the stronger the "dose" of that common factor, the better the outcome. A caveat to this suggestion is that a nonlinear relationship to outcome does not rule out causality but merely complicates inferences of causality. Of equal importance but often missing is a timeline of the association between common factor and outcome, ideally such that changes in common factor precede changes in outcome. Rare are studies that assess multiple common factors simultaneously and therefore incorporate the potential to rule out alternative mediators. Experimental manipulation of the common factor would further strengthen claims of causality but is often impossible due to ethical considerations. For example, patients in a treatment study cannot ethically be assigned to a low-alliance condition. Instead, psychotherapy outcome studies tend to be correlational in design, which preclude inferences of causality (Norcross & Lambert, 2011). It is also necessary to provide a strong theoretical framework explaining how and why a common factor facilitates change. This is important as conceptualizations of common factors may differ across treatment frameworks, as is the case for example with the therapeutic alliance (Horvath et al., 2011).

Variation in Common Factors Within and Between Sessions

A better understanding of within- and between-session variation in common factors would allow researchers to specify their trajectories in relation to outcome. Common factors are often assessed at only one timepoint, typically using one session-level measurement to capture the course of treatment (Kazdin, 2007). Session-to-session fluctuations in common factors are not well-studied, and even fewer data are available on changes within a single session (e.g.,

Falkenström & Larsson, 2017). Research in the latter area is lacking since common factors are typically measured with self-report tools, which are retrospective in nature and cannot be administered at intervals within a session. Observer ratings represent a promising means for capturing moment-to-moment shifts but are generally underused, despite evidence that observer ratings of some therapy processes better predict outcome than self-reports (e.g., Peluso & Freund, 2018).

In addition, even when the quantity of a common factor varies little over time, the qualitative meaning of items that a rater is responding to may be contextual (Beltz et al., 2016; Luborsky, 1976). To use the alliance as an example, whether a client trusts their therapist might take on a different meaning in a session early in treatment while rapport is still building compared to a later session once the tasks of therapy are underway.

Relationships Between Common Factors

Studies that assess multiple common factors in tandem are needed to both assess overlap in their relation to outcome as well as clarify conceptual and temporal relationships between common factors. However, few studies assess multiple common factors together (Kazdin, 2007). Accordingly, little is known of relationships between common factors nor are comparisons of their contributions to outcomes over time often made. Nonetheless, the association of a common factor and outcome may alter in the context of another common factor. For example, in several studies, the therapeutic alliance no longer predicted outcome when emotional processing was incorporated as a predictor (e.g., Missirlian et al., 2005).

Summary

In the search for common factors that cut across treatment frameworks, persistent challenges complicate the identification of both the factors themselves and their roles in realizing

change. Specific factors grounded in one treatment approach may be overlooked as potential common factors (Castonguay et al., 2015). It may also be the case that the roles of common factors in bringing about change cannot be adequately captured with "single and static" measures (Misserlian et al., 2005). Prior research findings have highlighted the dynamic, contextual nature of common factors and their contributions to outcome over the course of treatment. Furthermore, relationships among common factors are not well-understood as most studies assess one rather than multiple common factors and only at one timepoint. An understanding of the interplay between common factors and outcome, both within a session and across sessions, may advance our theoretical understanding of change in psychotherapy. In practice, this may allow therapists to regulate change processes in a way that is sensitive to temporal dynamics.

The Alliance as a Common Factor

The most well-studied common factor is the therapeutic alliance (Wampold, 2015). The alliance is the strongest known predictor of outcome and is often considered the primary curative factor in adult psychotherapy (Brown, 2015). The term *alliance* refers holistically to the tenor of collaboration between patient and therapist (Bordin, 1979). It is dyadic in nature such that both patient and therapist contribute to its quality. Bordin's conception of the alliance has three components: a *bond* characterized by reciprocal liking and trust; *task*, or consensus on treatment strategies; and *goals*, or consensus on areas targeted for improvement.

The alliance is classified as a *causal facilitative factor*, or a moderator that enhances the effect of a promotive factor on an outcome (Flückiger et al, 2018). A strong alliance can thus be said to augment the impact of psychotherapy on treatment outcomes. A recent meta-analysis of 295 studies (N = 30,000) showed a small to moderate association with outcome (r = .28), explaining 8% of variance in outcome (Flückiger et al, 2018). This effect was robust across

therapeutic frameworks, alliance and outcome measures, rater perspectives, and patient diagnoses. Some evidence for a dose-response relationship with outcome has been established such that the stronger the alliance, the more effective the therapy (Brown, 2015). There is also evidence that changes in the alliance temporally precede symptom changes (e.g., Zilcha-Mano, 2014).

Described as the "quintessential integrative variable" (Wolfe & Goldfried, 1988), the historical centrality of the alliance construct to discourse on common factors has shaped its generally pan-theoretical nature (Flückiger et al, 2018). Although different frameworks emphasize different aspects of the patient-therapist relationship (Horvath et al., 2011), the alliance construct is entrenched in treatment procedures across theoretical frameworks, including psychodynamic (Safran & Muran, 2000), emotion-focused (Greenberg et al., 1993), and cognitive-behavioural (Kazantzis et al., 2017).

Variation in the Alliance Within and Between Sessions

The alliance is typically examined as a static predictor of outcome (Zilcha-Mano et al., 2017). To characterize the alliance over the course of treatment, one session-level alliance measurement is typically taken early in therapy, often from the third or fourth session (Wampold, 2015). Other studies have used an aggregate of session-level ratings (Crits-Cristoph et al., 2013). However, the alliance was originally conceived as innately fluctuating (Zetzel, 1956), and recently theorists have attempted to chart its course over time (Ardito & Rabellino, 2011). In terms of longitudinal unfolding, the alliance fluctuates slightly from session-to-session (Falkenström et al., 2013), and better predicts outcome in the late rather than middle or early phase of therapy (Flückiger et al., 2018). Some theorists have even argued that the early and middle to late alliances are qualitatively distinct (Luborsky, 1976). The early alliance may reflect

the client's trait-like ability to form an alliance generally, while the middle and late alliance may reflect state-like changes in alliance quality resulting directly from interactions during a session (Zilcha-Mano et al., 2017).

Little is known of shifts in the alliance that occur moment-to-moment within a single session (Falkenström & Larsson, 2017). Notably, patterns at a microscopic level may have greater clinical utility than session-level measurements. In a few studies, within-session shifts in the alliance were tracked using observer ratings (e.g., Falkenström & Larsson, 2017; Berk et al., 2020). Researchers have also explored the alliance rupture and repair process within sessions (Safran & Muran, 2000).

In summary, although the alliance is predominantly measured as a static predictor of outcome, the alliance fluctuates within and between therapy sessions. Deciphering interrelations amongst the alliance, other common factors, and outcome both within and across therapy sessions would provide a more fine-grained illustration of the change process.

The Role of the Alliance in Promoting Change

At present, the underlying mechanisms by which the alliance leads to improvement remain to be clarified (Flückiger et al., 2018). Based on Kazdin's (2007) aforementioned criteria for establishing mechanisms of change, a theoretical framework is required to explain the role of the alliance in promoting change (Cuijpers et al., 2019). Theorists have converged on two functions for the alliance, neither of which are currently well-understood (see Zilcha-Mano et al., 2017). The alliance has been conceived as both an end in itself and a means to an end. As an end it itself, the alliance might be curative in its own right. As a means to an end, the alliance might create a context that facilitates the activity of change ingredients. Notably, these functions are not incompatible. Elaborating on these two functions represents a promising avenue for constructing

a theoretical framework that explains how the alliance leads to change.

Most major schools of psychotherapy hold that a strong alliance is a precondition for use of treatment techniques (Zilcha-Mano et al., 2017). In CBT, the therapeutic relationship is primarily conceived as a means to an end, stimulating collaborative use of specific techniques (Giovazolias, 2004). Relationship factors such as warmth and empathy are viewed as "necessary, but not sufficient to produce an optimum therapeutic effect" (Beck et al. 1979, p. 45). Other schools of therapy endorse both roles. In dialectical behavior therapy, the alliance is regarded as a prerequisite for use of treatment strategies as well as important in its own right, such that repairing alliance ruptures may foster conflict resolution skills applicable to other relationships (Burckell & McMain, 2011; Linehan, 1993). Similarly, within the acceptance and commitment therapy framework, the alliance is perceived both to provide the ideal context for implementing treatment strategies and as intrinsically healing when reflective of acceptance for oneself and others (Hayes et al., 1999). In EFT, both functions are to the alliance (Greenberg, 2014). A warm therapeutic relationship is considered an essential change ingredient, facilitating emotion regulation and leading to corrective experiences. A strong alliance is also regarded as necessary for a client to confront and process difficult emotions and memories.

The Alliance as an End in Itself. Some theorists argue that the alliance is active in bringing about change (e.g., Safran & Muran, 2000). A few pan-theoretical means of change have been proposed. A strong alliance may be a source of *corrective experiences*, or experiences that uncover new ways of relating to oneself and others (Alberti et al., 2018; Alexander & French, 1946; Castonguay & Hill, 2012). For example, feeling seen and accepted by a therapist may shift a belief that others will respond to self-disclosures with rejection. Alliance rupture repair may represent a corrective experience, illustrating new ways of resolving conflict

(Eubanks et al., 2021). A warm, validating bond may also enable co-regulation of emotion. Modell (1976) posited that a "holding environment" where a therapist is warm, reliable, and non-judgmental offers space for clients to tolerate distress. In the EFT literature, the provision of a validating relationship is thought to soothe client distress (Greenberg, 2014). Over time, the client may internalize a more rapid reversion to an emotional baseline. One study illustrated that when client emotional arousal increased, therapist emotional arousal decelerated (Soma et al., 2018).

To investigate whether the alliance is intrinsically healing, researchers sought to distinguish state-like changes in the alliance during sessions (the alliance as an end in itself) from the trait-like ability to form an alliance. In these studies, only the former predicted outcome (e.g., Falkenström et al., 2013; Zilcha-Mano & Errázuriz, 2015). Taken together, while research is needed on specific mechanisms by which the alliance effects change, there is evidence that the alliance is healing in its own right.

The Alliance as a Means to an End. Another prevailing hypothesis is that a strong alliance provides the ideal environment for delivery of treatment strategies, which themselves are vehicles of change (Hatcher & Barends, 2006). Accordingly, the alliance might be "necessary, but not sufficient to produce an optimum therapeutic effect" (Beck et al. 1979, p. 45). In support of this notion, while the alliance has been strongly linked to outcome, studies typically yield a greater effect from psychotherapy than from the alliance alone (e.g., Roth & Fonagy, 2006).

Bordin (1979) hypothesized that before treatment can proceed, a bond characterized by mutual trust and regard must be established, in which patient and therapist are assured of each other's commitment to the treatment process. Only on this basis, according to Bordin, can task and goal agreement be attained, setting the stage for use of treatment techniques. He argues that

the alliance contributes to outcome not in itself but as the pathway by which the patient is able to accept, invest in, and participate in treatment. The hypothesis that the alliance is necessary for the success of treatment techniques has not been directly investigated.

If the alliance is a precursor for use of specific techniques, the alliance may play a similar role for common factors. Indeed, in their overview of common factors in extant literature, Lambert and Ogles (2004) categorized the alliance as a *support factor*, or a common factor that sequentially precedes and promotes other common factors. In this framework, support factors are followed by *learning factors*, which involve shifts in thinking, and *action factors*, which involve shifts in behaviour. For example, a strong alliance (support factor) may provide a corrective experience (learning factor) in which the client feels seen and accepted by the therapist, motivating the client to take a risk (action factor) such as confiding in a friend (Huibers & Cuijpers, 2015). These hypothesized roles have yet to receive empirical support.

One common factor viewed as operating only within a strong alliance is emotional processing. In EFT, the alliance is believed to create the conditions for clients to effectively process emotion, which in turn is necessary for improvement (Greenberg & Watson, 2006). However, this hypothesis has not been fully explored.

Emotional Processing as a Common Factor

Rachman (1980) first defined emotional processing as "...a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behaviour can proceed without disruption" (p. 51). In the EFT literature, the term more broadly encompasses how clients access, experience, label, reframe, and resolve emotions that may have been previously constrained (Greenberg, 2008). Emotional processing overlaps with *emotional arousal*, which is the subjective felt sense of emotion and its physiological manifestations (e.g.,

tone of voice, facial expressions; Carryer & Greenberg, 2010). During processing of emotion, the felt experience is used as a referent for a verbally mediated evaluation in which the individual makes meaning of the emotion and the precipitating issue (Teasdale, 1999; Whelton, 2004; Greenberg, 2002). This process may involve recalibration of attitudes about expression, control, and avoidance of emotion (Leahy, 2007; Greenberg, 2008). Rather than attenuating emotion through catharsis or deemphasis, emotion is transformed or replaced by an incompatible but more adaptive emotion (Greenberg, 2012).

Emotion is central to psychopathology (Rottenberg & Johnson, 2007). Helping clients articulate, differentiate, and transform emotion in the context of a warm, prizing therapeutic relationship has been described as a core change process irrespective of therapeutic framework (Greenberg & Watson, 2006; Hayes et al., 2005). In parallel, Westen (1994) proposed that emotional processing can provide a unifying context for therapeutic approaches considered irreconcilable in the past.

Emotional processing is the primary change mechanism in the EFT framework (Greenberg et al., 1993). However, productive work with emotion may be a common factor that explains outcome across frameworks. A meta-analysis of 42 studies (N = 1711) on emotional expression and outcome found a medium-to-large relation (r = -.39, d = .85; Peluso & Freund, 2018), of greater magnitude than that of the alliance (r = -.29; Flückiger et al., 2018). The association prevailed across measures and treatment frameworks but increased when observer-rated measures were used (r = .45, d = 1.01), possibly due to the retrospective nature of self-reports. Measures used in the included studies were heterogeneous, capturing one or more manifestations of emotional arousal (e.g., facial expressions, tone of voice, body language) or emotional processing. The results should therefore be interpreted with caution.

Another meta-analysis corroborated the relationship between emotional processing and outcome (Pascual-Leone & Yeryomenko, 2016). Emotional processing was measured using the *experiencing* construct, which captures verbal exploration of emotion and use of emotion as a referent for problem-solving (Klein et al., 1969). Across 10 studies (N = 406), a small to moderate association emerged between experiencing and outcome (r = -.25), although experiencing better predicted expert ratings of outcome (r = -.67) than self-reports (r = -.19; Pascual-Leone & Yeryomenko, 2016). The association held across major schools of therapy, including EFT (e.g., Pos et al., 2003), CBT (e.g., Watson & Bedard, 2011), and psychodynamic psychotherapy (e.g., Rudkin et al., 2007). While lower modal experiencing was found in cognitive therapies compared to EFT, treatment orientation did not emerge as a moderator, suggesting experiencing predicted outcome equally well in cognitive therapies.

Accordingly, emotional processing appears to represent a faux unique factor insofar that it is theoretically grounded in the EFT approach yet predicts change across frameworks.

The Alliance as a Prerequisite for Emotional Processing

A possible function of the alliance is the provision of a safe atmosphere needed for clients to accept and engage in treatment tasks (Hatcher & Barends, 2006). The alliance may therefore facilitate other common factors (Lambert & Ogles, 2004). A hypothesis which has garnered support is that a strong alliance creates the ideal therapeutic environment for clients to process emotions, which itself is a core change process (Greenberg & Watson, 2006).

Bordin (1979, p. 254) first emphasized the reciprocal relationship between the alliance and emotion, stating that “some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed.” According to

Bordin**,** processing emotions may strengthen the *bond* component of the alliance but is also contingent on its initial strength.

In the EFT framework, it is theorized that in the context of a warm, empathic relationship, a client will sense unconditional acceptance from their therapist and shift their attention away from relational concerns pertaining to the therapist (Greenberg, 2007). Clients can then attend inward to the tasks of experiencing and reorganizing emotion. Accordingly, a strong alliance is conceptualized as necessary but not sufficient for emotional processing to occur. The alliance may have a conditional relationship with emotional processing, such that a secure alliance offers a safe environment favorable to deeper emotional processing (Paivio & Pascual-Leone, 2010).

The client perspective appears to capture this conditional relationship. Nødtvedt et al. (2019) coded themes across client impressions of the alliance in EFT. One theme underscored the importance of feeling witnessed and receiving explicit validation of emotions from the therapist, which participants believed encouraged them to recognize and articulate feelings. Another theme involved corrective experiences. Clients reported that feeling accepted and understood when being fully vulnerable represented a significant healing experience. Since the alliance is conceptualized differently across treatment orientations, this theme might be limited to EFT. However, Levitt et al. (2016)'s meta-analysis of client experiences in psychotherapy yielded a similar theme where authentic caring from a therapist enabled clients to feel supported emotionally and to be vulnerable with their therapists. Together, these studies provide indirect support for a conditional relationship between the alliance and emotional processing.

Temporal Precedence of Alliance

A central tenet of EFT is that therapeutic work is facilitated by and therefore dependent upon the prior formation of a strong therapeutic relationship (Greenberg et al., 1993). The alliance is therefore purported to temporally precede emotional processing. A few studies have provided support for this order of events. Pos et al. (2009) found that working and termination-phase alliances contributed to outcome indirectly through predicting subsequent improvements in modal EXP. Additionally, therapist expressed empathy in the first session predicted working phase experiencing an average of 8 sessions later (Malin & Pos, 2015).

The Alliance, Emotional Processing, and Outcome

In the EFT framework, emotional processing is considered the primary mechanism of change (Greenberg et al., 1993). In support of this link, several studies from the EFT literature have found that emotional processing predicts outcome over and above the alliance (e.g., Goldman et al., 2005; Auszra et al., 2013; Pos et al., 2003; Pos et al., 2009; Missirlian et al., 2005). As previously noted, meta-analytic results suggest that while emotional processing is lower in CBT compared to other treatments, its association with outcome does not differ based on treatment orientation (Pascual-Leone & Yeryomenko, 2016). It is therefore plausible that the centrality of emotional processing to outcome over the alliance extends beyond the EFT framework.

Objectives

A hypothesis that has generated theoretical support is that the alliance creates the conditions of trust and safety for clients to effectively process emotions, which leads to improvement (Greenberg & Watson, 2006). No studies to date have investigated whether the alliance functions as a prerequisite to emotional processing. An illustration of how the alliance

and emotional processing unfold within the therapy hour provide the means to test this sequence and thereby additionally acquire support for the notion that the alliance provides the optimal environment for other change ingredients. Additionally, the contribution of experiencing to outcome beyond that of the alliance has yet to be replicated in treatment frameworks beyond EFT. Support for these relations in another major school of therapy would provide evidence that the sequence is pan-theoretical. Therefore, my primary goals are to a) test the hypothesis that a strong alliance is a prerequisite for emotional processing and b) examine whether emotional processing predicts change over and above the alliance in CBT. Secondary goals include c) pinpointing the association between the two process variables, d) identifying portions of the therapy hour with higher levels, and e) assessing whether average emotional processing is lower in CBT than other treatments.

a. The Alliance as a Prerequisite to Emotional Processing

The alliance may function as an antecedent of emotional processing. Rather than a correlation, this pattern could manifest as a "threshold effect", such that successively higher iterations of experiencing are associated with decreased alliance variability. That is, higher experiencing variability would be observed only in the context of a strong alliance and rarely when the alliance is poor. While lower levels of emotional processing might be observed in the context of a high alliance (e.g., a client joking about her dog), it is less likely that higher levels of experiencing will occur when the alliance is poor (e.g. a client discussing fears of expressing affection). It is therefore hypothesized that greater alliance variability will occur at low experiencing levels and less alliance variability will be observed at higher experiencing levels.

Bond characteristics (warmth, trust, and mutual liking) are often emphasized in theory as imperative for emotional processing (Norcross & Lambert, 2019), suggesting a high threshold.

However, in CBT, emotional processing may less frequently be an explicit treatment task and goal. Accordingly, it is hypothesized that less variability in bond compared to task/goals will be observed at high experiencing levels.

To explore patterns of emotional processing across alliance levels, mean differences in alliance components at each level of experiencing will also be assessed. While it is anticipated that higher experiencing levels will occur primarily within higher alliance levels, it is unclear whether lower experiencing levels will occur within strong or weak alliances on average. Accordingly, it is unclear whether mean differences will be observed. No specific hypotheses were generated. **b. The Alliance, Emotional Processing, and Outcome**

In several EFT studies involving hierarchical regressions, emotional processing predicted outcome over and above the alliance (e.g., Pos et al., 2003). A meta-analysis on emotional processing and outcome yielded no moderation by treatment framework, suggesting that these patterns may be relevant to CBT (Pascual-Leone & Yeryomenko, 2016). It is therefore hypothesized that emotional processing will predict outcome beyond the alliance.

c. Association Between Alliance Components and Emotional Processing

There is a need for studies assessing multiple common factors over time to better understand how the change process evolves (Kazdin, 2009). The results of one meta-analysis indicate that among the few studies that have assessed emotional processing and the alliance, they are decoupled in the early phase of therapy (*r*s = .00 to .18) then moderately correlated in the working [middle] and termination phases (*r*s = .29 to .32; Pascual-Leone & Yeryomenko, 2016). Two studies which assessed this association in CBT specifically found a moderate association with modal experiencing (Castonguay et al., 1996; Watson et al., 2011). However, these studies, common factors were measured at the level of a session or phase of therapy (early,

working [middle], termination; Pascuale-Leone & Yeryomenko, 2016) rather than segments within a session. In the present study, the magnitude of the alliance-emotional processing association was assessed across segments within the therapy hour.

d. Within-Session Trends in Emotional Processing

Little is known about the trajectory of emotional processing within the therapy hour. One study showed that the 30th minute to 37th minute showed the widest range of experiencing typically (Kiesler et al., 1965). While a few published studies contain data on within-session patterns of experiencing development, these studies were published in the 1970s and may not accurately reflect contemporary psychotherapy. Given the theoretical interest in higher levels of experiencing due to their purported healing value, it may be worth identifying portions of a session characterized by higher EXP. This could inform future efforts to understand the location and context in which high experiencing levels occur. For example, if experiencing is highest in the middle 20 minutes of a session, coding this timeframe may be a priority. No hypothesis was generated as results of this analysis are intended to be used exclusively for the purpose of informing sampling procedures for subsequent studies.

e. **Emotional Processing in CBT**

Watson and Bedard (2006) compared experiencing levels between clients in CBT versus process-experiential therapy (PET). In the working phase, average experiencing levels in CBT (2.78) were significantly lower compared to PET (3.05). This was attributed to a higher percentage of Level 2 statements (no references to feelings) versus Level 3 statements (references to feelings but only in the context of events) across therapy from CBT (59 versus 33 statements) compared to PET clients (41 statements at both levels). This difference held across phases of therapy. Accordingly, one aim of this study was to assess whether these differences

replicate in the present dataset. It is unclear whether the results of this study will more closely match findings from CBT or non-CBT studies since therapists in this study employ techniques from CBT as well as other treatments.

Methods

Participants

Archival videos of psychotherapy sessions were analyzed from 31 clients (15 male, 16 female) who completed psychotherapy at the Centre of Mental Health Research and Treatment (CMHRT), a graduate psychology training clinic within the University of Waterloo in Waterloo, Ontario. The CMHRT offers treatment for presenting problems such as anxiety, depression and other mood difficulties, obsessive-compulsive disorder, interpersonal issues, adjustment issues, behavioral issues, and parenting and family stresses. Exclusion criteria include clients who present with concerns that cannot be effectively addressed by student clinicians under the supervision of licensed psychologists or without access to psychiatrists or full-time clinical staff. The CMHRT does not provide services to clients who present with active substance use, psychotic disorders, eating disorders, or problems associated with a high risk of legal involvement (e.g., violence, criminal behaviour) or frequent and/or severe crises (e.g., chronic self-harm, active suicidality). For inclusion in this study, cases were selected if clients had completed therapy in a minimum of eight sessions. Across cases, 23 were short-term (a maximum of nineteen sessions) while 8 were long-term.

Measures

Alliance

The alliance was measured using Segment Working Alliance Inventory Observer-Based Measure (Berk et al., 2010). This measure is a version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) adapted for thin-slice research, in which measurements of brief segments of a therapy session are aggregated to produce a session average. The measure consists of two items, each reflecting a component of the alliance. *Bond* refers to mutual trust, liking, and

attachment. The *bond* item is "There is mutual liking, respect, appreciation, and trust between participants." As with other observer-rated measures of the alliance (Santirso et al., 2018), the *task/goals* subscale subsumes two previously distinct components of the alliance, which referred to a shared conception of treatment *tasks* (treatment strategies) and *goals* (areas targeted for change). The item measuring *goals* was "There is agreement, collaboration, and productive negotiation, between participants." Each item is rated on a 13-point Likert scale ranging from -6 (Very strong evidence against) to 6 (Very strong evidence for), with a midpoint of 0 (No evidence or equal evidence).

Alliance ratings were taken from an unpublished dataset (Milovanov et al., 2021). Prior to rating, raters were required to complete eight hours of group training. This training consisted of rating segments of therapy sessions from the current dataset and resolving discrepancies in ratings greater than 2 points. Then, one group of four raters and one group of five raters randomly rated segments from different sessions. The two rater groups rated separate halves of the dataset. Session-level alliance ratings were generated by averaging coders' ratings of twelve one-minute segments spaced five minutes apart, which were found to reliably capture the alliance for that session (Milovanov et al., 2021). To assess alliance variability within a session, each one-minute segment will also be taken as an estimate of the alliance for the five-minute segment in which it is centrally situated.

Emotional Processing

The Experiencing Scale (EXP; Klein et al., 1970, 1986) is an observer-rated measure of emotional processing that has been described as the gold standard for good in-session process (Pascual-Leone & Greenberg, 2007). Though developed initially from client-centered therapy, the experiencing scale is pan-theoretical and is the most widely used measure of emotional

processing (Pascual-Leone & Yeryomenko, 2016). The scale represents a continuum of client awareness of feelings, exploration of feelings, and use of feelings as referents for problem-solving (Klein et al., 1969, 1986). Feelings are defined as emotions (e.g., happy, sad) as well as assumptions basic to self-image (e.g., feelings of worthlessness or unattractiveness). An assumption underlying this scale is that how clients verbalize experience both impacts the experiences they have and is an accurate indicator of the quality of their experiencing (Kiesler, 1973). Rating decisions are informed by grammar, style, paralinguistics, and topical content (Klein et al., 1986).

The scale consists of 7 points describing a client's involvement in a therapy session. At the lowest levels of the scale, clients describe events or ideas in an objective, detached, and intellectualized manner (Level 1; e.g., a client might state that he saw his ex-wife at a party) or provide personally significant content without any reference to feelings, such as behaviours, opinions, preferences, abilities, values, or motives (Level 2; e.g., a desire not to see his ex-wife). At the intermediate levels, clients provide internal reactions to events, either in relation to external events (Level 3; e.g., sadness upon seeing his ex-wife) or as the subject of discourse in themselves (Level 4; e.g., hopelessness, devastation, and a desire to forget the relationship). At the higher levels, emotional experiences are used as a referent for problem-solving. The client explores a core problem or hypothesis about the self (Level 5; e.g., a fear of expressing affection), resolves a core problem by identifying its roots in emotional experiences (Level 6; e.g., fear of expressing affection as linked to fear of rejection), or applies such a resolution to other areas as part of an ongoing process of self-understanding (Level 7; e.g., the impact of fear of expressing affection due to fear of rejection on platonic and familial relationships.)

EXP ratings are given for both the mode (most common) and peak (highest) experiencing

levels in a given segment. Brief segments of a therapy session can be rated, with adequate reliability attained for segments ranging from 4-8 minutes in length (Klein et al., 1969). Interrater reliability coefficients range from.76 to .91 (Klein et al., 1986).

Outcome Rating Scale. Outcome was measured with the Outcome Rating Scale (ORS; Miller et al., 2003). The ORS is a 4-item self-report outcome measure that captures client perceptions of therapeutic progress when administered session-by-session. Items reflect client functioning in terms of personal well-being, close interpersonal relationships (e.g., family), broader social interactions (work, school, friendships), as well as a global sense of well-being. The ORS–R shows high internal consistency (α = .93 to .97) as well as test–retest reliability (r = .80) and concurrent validity with the Outcome Questionnaire (r = .54 to .69; Bringhurst, et al., 2004; Miller et al., 2003).

Procedures

Treatment Procedure

Therapy was conducted by 19 doctoral clinical psychology students at the University of Waterloo (15 female, 4 male), of whom 8 treated multiple clients. Therapists received foundational training in cognitive-behavioural therapy with some having additionally received supplementary training in EFT, family systems therapy, and/or compassion-focused therapy. The course of treatment begins with two to three assessment sessions involving a diagnostic assessment.

Sampling Procedure

Session Selection. Three consecutive sessions were selected for analysis from the working phase of therapy, which constitutes sessions five onward until the third session prior to termination (Pascual-Leone & Yeryomenko, 2016). Compared to the early (sessions one to four)

and termination phases (final two to four sessions), the working phase is characterized by higher modal experiencing levels. Since higher experiencing levels are infrequently observed, sampling from this phase increases the chance of capturing greater variation in experiencing levels. The working phase is also longest, permitting a greater number of sessions from which to sample. Use of treatment strategies may also be more typical of the working phase than the early phase, which is focused on goal-setting and rapport-building, or the termination phase, which is focused on reviewing treatment progress (Klein et al., 1986). On this basis, a decision was made to sample from the fourth to sixth sessions subsequent to a diagnostic assessment, which requires two to five sessions, and a feedback session. Accordingly, the sessions used were typically taken from the seventh to ninth sessions. For several client-therapist dyads, a session was missing or unusable due to change of format (e.g., a family session). The previous three consecutive sessions prior to the missing session were then used. For example, if the sixth session was missing, the third to fifth sessions were used.

Segment Selection. The middle portion of a session may be more typified by "working" than by session "warm-up" or homework review and planning of future sessions (Klein et al., 1969). In one study, the beginning of the 30th minute to 37th minute showed greater range of experiencing typically (Kiesler et al., 1965). Accordingly, we coded experiencing levels in the 25-minute portion spanning the 17.5th minute to the 42.5th minute. As for the length of each segment, equivalent reliabilities and relation to outcome have been found for segments of 2 to 16 minutes in length, and segments of 4 to 8 minutes were recommended to reduce fatigue and complexity (Kiesler et al., 1964; Klein et al., 1969). Five-minute segments were chosen as the one-minute alliance measurements are spaced five minutes apart and would therefore fall in the centre of each segment. Using shorter segments additionally ensured that the one-minute alliance

measurements capture a greater proportion of the segment and therefore better represent its mean alliance level. In summary, five segments were coded from the middle 25 minutes of three consecutive sessions (typically between sessions seven to nine) from 32 clients, resulting in a total of 480 segment ratings per process variable. Alliance ratings were based on one-minute segments while experiencing ratings were based on five-minute segments. Figure 1 illustrates the location of segments and sessions used for alliance and experiencing ratings.

Pretreatment and Posttreatment Outcome. Pretreatment levels of functioning were assessed using ORS ratings. The earliest session with available ORS data was used if it occurred within the assessment or feedback sessions or within the first 15% of all treatment sessions in that case (typically the first 1-4 sessions). Posttreatment functioning was assessed using ORS ratings from the final sessions of all clients with available ORS data. If ORS data from the final session was unavailable, the lattermost session with available ORS data was used if the session occurred after 75% of all sessions in that case were completed.

Training Procedure

Selection. Prior studies demonstrated near equivalent reliabilities for experiencing ratings made by clinically naive (undergraduate) and sophisticated (psychologist) raters (Kiesler, 1970; Kiesler, Klein, & Mathieu, 1967). On this basis, undergraduate students were employed as raters. Potential coders were selected based on recommended criteria listed in the experiencing Scale Training Manual, including language skills, maturity, discretion, and lack of prior counselling or coding experience (Klein et al., 1969). Strong language skills were the primary selection criterion since the experiencing Scale requires coders to understand the scale concepts and apply them to the manifest verbal content of client communications. Due to the sensitive nature of the data, coders with volunteering or work experience that required discretion and maturity were

prioritized. Following a 10-minute interview to assess motivation, maturity, conscientiousness, research experience, and interest in psychotherapy research and practice, potential coders used a simplified version of the Experiencing Scale (See Appendix A) to rate a list of statements generated for the purposes of this study (See Appendix B). Further selection decisions were made based on the interview and the task.

At the end of the selection process, fourteen undergraduates (2 male, 12 female) were selected for training. Twelve coders were psychology majors and two were science majors. Two had prior coding experience and three had prior training in counselling. All coders received instruction on the importance of confidentiality and signed a confidentiality agreement. Coders were kept blind to study hypotheses and prior research on experiencing Scale correlates from previous research.

Training. Of fourteen coders selected, five coders discontinued training prior to completion. Nine coders completed the standardized training procedure outlined by Klein and colleagues (1969, 1986). Over a period of 7 weeks, coders independently reviewed the experiencing Scale and practiced rating 90 sample audio-recordings of therapy segments and accompanying transcripts taken from the experiencing Research and Training Manual. Twelve 1-1/2 hour biweekly meetings were held to discuss ratings in relation to expert ratings. To supplement their learning, additional training materials were created for the purposes of this study. This included a coding guide consisting of an expanded version of the experiencing scale with examples as well as guidelines for distinguishing scale levels (Appendix C), an assignment involving writing a summary of the scale levels (Appendix D), and an assignment involving generating examples for challenging levels (Appendix E). Raters also met as a group to collaboratively generate examples of levels 5 and 6. In addition, to establish shared

interpretations of coding concepts with the present dataset, all coders as well as the lead author rated and discussed a set of 12 segments from the dataset as a group prior to independent coding.

Rating Procedures

Eight of nine coders who completed training elected to continue on to code the dataset. experiencing levels were scored using both transcripts and videotapes of sessions. Segments were presented in a randomized order. Raters coded approximately 20 segments per week and were encouraged to take breaks of 15 minutes after two consecutive hours of coding. Following the start of independent coding, coders as well as the lead author additionally rated and discussed 4-5 segments as a group on a triweekly basis. This setup provided continual skill maintenance. For all group-coded segments, the lead author's ratings were used in analyses.

In the first round of coding, each segment was rated by two random raters. In the second round, segments with discrepant ratings were re-rated by a third rater. Since high-level ratings (Levels 5-7) are less frequent and are of theoretical interest, a decision was made to prioritize accuracy for higher-level ratings. Our data suggests that inter-rater reliabilities are lower for Levels 4 to 7 and that instances of Levels 5 to 7 are often underrated as Level 4s. Additionally, one circumstance in which higher-level segments might be misidentified is when an instance of a high level runs across multiple segments. Levels 5 to 7 each include several criteria which take up a large portion of a five-minute segment and may therefore continue from a prior segment or onto a subsequent segment. Therefore, in the third round of rating, either the lead author of this study or the rater who demonstrated the highest proficiency with the Experiencing Scale during training re-rated any segment rated Level 4-7 by at least one rater. For each segment that was re-rated, the previous and subsequent segment were reviewed to determine whether the high level rating should extend to an adjacent segment or whether criteria were met for a higher level than

the original rating.

Units of Analysis

Alliance ratings were one minute in length and spaced 5 minutes apart throughout the therapy hour. Alliance ratings were averaged across raters if a minimum of four raters provided data for a given segment. Each one-minute segment with an alliance rating within the middle 25 minutes of a session mapped onto a five-minute segment which was coded to generate experiencing ratings. **Experiencing** ratings were averaged across all coders. Since the experiencing levels represent discrete categories, ratings were rounded to the nearest whole number. Modal and peak experiencing ratings were analyzed separately as they possess distinct informational value (Klein et al., 1969). For both common factors, ratings at the segment level were taken as the unit of analysis for within-session comparisons. For phase-level comparisons, segment-level ratings from the middle 25 minutes of three sessions included were aggregated. Finally, to assess correspondence between alliance ratings at the segment and session level, session-level alliance ratings were generated by averaging ratings of twelve one-minute segments spaced throughout the entirety of each session (Milovanov et al., 2021).

Results

Data Cleaning

Frequency counts for alliance and experiencing ratings were inspected for suspicious entries. On this basis, rater data from one client was excluded from all subsequent analyses. After exclusions, a total of 473 segment-level ratings from 31 clients were retained for analyses involving experiencing alone. Due to incomplete rater data, a total of 384 segments with both experiencing and alliance data were available for analyses involving both process variables. Additionally, for two clients, ORS data from the final session was unavailable. Accordingly, the lattermost session with available ORS data was used if the session occurred after 75% of all sessions in that case were completed. This rule was applied to two cases. Accordingly, a total of 19 clients were included in analyses involving outcome. For detection of outliers, skewness and kurtosis were checked for all process and outcome variables and none were elevated.

Psychometrics

Interrater Reliabilities for Process Variables

To assess interrater reliabilities for alliance ratings, a two-way mixed, single-measures intraclass correlation coefficient, consistency was calculated. For the first group of raters, adequate agreement was achieved for the *bond* (ICC (3,1) = .71) component while agreement for the *task/goals* component fell slightly below the threshold (ICC (3,1) = .69; Shrout & Fleiss, 1980). The Spearman-Brown formula was used to estimate the number of additional raters needed for excellent reliability (0.8). Results suggest that increasing the number of raters from four to seven would yield excellent reliability for both *bond* and *task/goals*. For the second group of raters, adequate agreement was attained for both *bond* (ICC (3,1) = .77) and *task/goals* (ICC (3,1) = .76).

A two-way, mixed, single-measures intraclass correlation coefficient, absolute agreement was computed for all pre-consensus group experiencing coding following training. Adequate agreement was attained for modal (ICC(3,1) = .77) and peak (ICC(3,1) = .76) experiencing ratings.

Convergence between Segment and Session Alliance

To assess correspondence between segment- and session-level measurements of the alliance, Pearson correlations were computed. A total of 58 sessions with complete data from 24 clients were included. Segment-level bond and task/goals were both moderately associated with session-level aggregates, $r(726) = .69$, $p < .001$ and $r(726) = .57$, $p < .001$, respectively. The composite of both components was also moderately related at the segment and session levels, $r(726) = .66$, $p < .001$.

Mean Modal and Peak Experiencing in CBT

Table 1 displays frequency counts for modal and peak experiencing ratings at the segment level. As anticipated, frequency counts indicate that a larger proportion of segment-level modal experiencing ratings were Level 2 (51.6%) compared to Level 3 (22.2%). Levels 5 (5.7%) and 6 (1.5%) were notably rare, while Level 7 was not observed. Table 2 presents descriptive statistics and correlations between segment level experiencing and alliance ratings. Mean modal and peak experiencing were consistent with prior findings on experiencing in CBT at 2.63 and 3.36, respectively.

Development in Experiencing Within a Session

Table 3 depicts average modal and peak experiencing across segments. A one-way *ANOVA* was computed to assess the effect of segment location on peak EXP. Differences in peak experiencing were found according to segment location, ($F(4,449) = 2.318$, $p = .04$). Levene's

test for homogeneity of variances was non-significant, suggesting equal variances across segment location ($F(4,449) = 1.327$, ns). Peak experiencing was slightly lower in the 37.5th and 42.5th minute in a session. Post hoc comparisons using the Tukey HSD test indicated that mean peak experiencing in the lattermost 5-minute portion spanning the 37.5th to 42.5th minute (M = 3.37, SD = 0.99) was significantly lower than the three 5 minute portions spanning the 22.5th minute to the 27th minute (M = 3.61, SD = 0.90), the 27.5th to 32.5th minutes (M = 3.48, SD = 1.15) as well as the 32.5th to 37.5th minutes (M = 3.34, SD = 0.94).

Correlations between Segment-level Alliance and Emotional Processing

Consistent with prior literature, modal experiencing was weakly related to the alliance (r = .171) as well as bond (r = .186) and task/goals (r = .134). Peak experiencing was weakly associated with the alliance (r = .245) as well as bond (r = .256) and task/goals (r = .206).

Emotional Processing Across Levels of Bond and Task/goals

Since modal experiencing levels above Level 4 were infrequent (7.2% of ratings), only peak experiencing ratings were used (11.4%). Level 1 was excluded from analyses due to limited sample size (n = 3). Results for Level 6 should also be interpreted with caution given limited sample size (n = 18). Box and violin plots illustrating segment levels of bond and task/goals across peak experiencing are shown in Figure 2. Variability was assessed using the interquartile range (IQR), which represents the difference between observations at the 75^{th} and 25^{th} percentiles. Notably, *IQR* comparisons that follow are descriptive in nature and no significance tests were performed.

As hypothesized, bond variability was lowest at Level 6 (*IQR* = 0.85), followed by Levels 4 and 5 (*IQRs* = 1.00), while Level 3 (*IQR* = 1.25) and Level 2 (*IQR* = 1.275) exhibited greater variability. Similarly, for task/goal agreement, variability was lowest at Level 6 (*IQR* =

0.50) and appeared more restricted than for bond. Level 4 (*IQR* = 0.75) displayed the second-least variability. Variability was approximately equal for Level 5 (0.975) and Levels 2 and 3 (*IQRs* = 1.00). Taken together, these results suggest that Level 6s may occur above a threshold for both bond and task/goals. While Levels 4 and 5 exhibited relatively lower bond variability than lower levels, Level 4 but not Level 5 was comparatively less variable for task/goals.

Notably, for both Levels 2 and 3, the lowermost quartile (25^{th} percentile) of observations encompassed poor alliances (rated below 0). In constrast, only one outlier at Level 4 was observed at 0, and only a small proportion of Levels 5 or 6 occurred within weak alliance ratings of (below 1) with none below 0. Accordingly, while low experiencing levels often occur within weak as well as poor alliances, experiencing levels above 4 rarely appear within weak alliances and do not appear within poor alliances. This pattern of results suggests a threshold alliance level above which high experiencing levels can occur.

A one-way *ANOVA* was conducted to explore differences in bond and goals across peak EXP. For bond, Levene's test of homogeneity of variances indicated unequal variances across groups ($F(4,378) = 3.099$, $p = 0.16$). Welch's one-way *ANOVA* for groups with unequal variances was used (Field, 2013). Bond differed according to peak EXP, ($F(4,71.589) = 7.593$, $p < .001$). Post-hoc tests using the Games-Howell test for unequal variances (Field, 2013) are summarized in Table 4. Mean bond at Level 2 ($M = 1.165$, $SD = 0.863$) was lower than at Level 4 ($M = 1.783$, $SD = 0.661$; $p < .001$), Level 5 ($M = 1.788$, $SD = 0.729$; $p = .006$), and Level 6 ($M = 1.757$, $SD = 0.539$; $p < .017$). Mean bond at Level 3 ($M = 1.462$, $SD = 0.779$) was also lower than at Level 4 ($p = .003$). Taken together, Level 2s, and to a lesser extent Level 3s, occur at lower levels of bond. Next, a one-way *ANOVA* was conducted to examine differences in task/goals across peak EXP. Levene's test was not significant, ($F(4,378) = 1.822$, $p = .124$).

Task/goals differed across peak EXP, ($F(4,378) = 4.467$, $p = .002$). Post-hoc tests using the Bonferroni test are summarized in Table 5. Mean task/goals at Level 2 ($M = 1.251$, $SD = 0.697$) was lower than at Level 3 ($M = 1.473$, $SD = 0.709$; $p = .004$) and Level 4 ($M = 1.653$, $SD = 0.660$; $p = .029$).

Overall, these results indicate that Level 6s occurred exclusively within strong alliances and at higher mean bond compared to lower levels. Predominantly, successively lower experiencing levels exhibited greater alliance variability. Additionally, mean bond and task/goals were usually but not always lower at Level 2 compared to Levels 4 and above.

Correlations between Working Phase Alliance, Emotional Processing, and Outcome

Table 6 presents descriptive statistics and Pearson correlations for working phase process variables and outcome. Working phase modal experiencing was moderately associated with working phase alliance ($r = .350$), as well as working phase bond ($r = .366$) and task/goals ($r = .317$). Similarly, working phase peak experiencing was moderately linked to working phase alliance ($r = .459$), bond ($r = .477$), and task/goals ($r = .419$).

For correlations involving ORS data, a subsample of 19 clients with available ORS data was used. Since one aim of this study was to replicate prior EFT studies, change in outcome was calculated with the same method. Outcome was measured as residualized change calculated as the standardized residuals of regressing final ORS scores onto pretreatment ORS scores (Cronbach & Furby, 1970). This metric controls for clients' functioning prior to treatment. Outcome was associated with both working phase modal ($r = .525$) and peak experiencing ($r = .598$). A moderate association was also found between working phase alliance and outcome ($r = .457$). Outcome was moderately related to working phase bond ($r = .480$) and task/goals ($r = .418$).

Hierarchical Regressions Predicting Outcome from Emotional Processing and the Alliance

Hierarchical regression analyses were carried out to assess contributions of working phase experiencing and alliance to predicting change. Table 7 presents a summary of regression results. Replicating past research, working phase alliance significantly predicted change, β = -.457, $t(18) = 2.118$, $p = .49$, in a model explaining 21% of variance in change, $R^2 = .209$, $F(1, 17) = 4.49$, $p = .049$. A second regression model including both working phase alliance and experiencing was compared with the previous model. Peak experiencing significantly predicted change, β = .457, $t(17) = 6.53$, $p = .048$. However, working phase alliance no longer predicted change, β = -.196, $t(17) = 0.851$, $p = .407$. This model explained 38.5% of variance in change, $R^2 = .385$, R^2 change = .176, $F(2, 16) = 5.00$, $p = .021$. Accordingly, the alliance no longer predicted outcome once emotional processing was incorporated.

Discussion

Although the effectiveness of psychotherapy is firmly established, questions remain about how and why therapy leads to change (Kazdin, 2009). Researchers have sought to pinpoint common factors that account for outcome across treatment frameworks (Norcross & Lambert, 2011). According to Kazdin (2007), compelling evidence that a common factor indeed produces change includes a theoretical framework explaining its function, a timeline for its development in therapy, and knowledge of interrelations with other common factors. To date, the alliance is the common factor most consistently associated with outcome (Brown, 2015). However, a theoretical framework is needed for its role in change (Cuijpers et al., 2019). The primary aims of this study were to a) test the hypothesis that a strong alliance is necessary for deeper emotional processing and b) replicate EFT studies in which emotional processing contributed to outcome over and above the alliance within a sample of CBT clients.

Alliance as a Prerequisite to Emotional Processing

Two possible functions of the alliance have accumulated theoretical support. The alliance may effect change because it is inherently healing, facilitative of other change ingredients, or both (Zilcha-Mano et al., 2017). While the former has received empirical support, the latter requires investigation. Results of the present study tentatively support the interpretation that the alliance provides a safe therapeutic environment needed to proceed with treatment techniques.

The main goal of this study was to explore the hypothesis that a client's ability to process emotions within a therapy session is contingent on the quality of the alliance. A threshold effect was hypothesized, such that a strong alliance was necessary for higher levels of emotional processing while lower levels of emotional processing could occur regardless of alliance strength. Results supported this notion, such that the highest level of emotional processing

occurred within a stronger alliance while lower levels occurred within strong and poor alliances. These findings align with qualitative research on client perspectives of the alliance (e.g., Nødtvedt et al., 2019). Since the conditional relationship between the alliance and emotional processing is a central tenet of emotion-focused therapy, evidence for this link provides support to its theoretical framework (Greenberg, 2014).

Emotional Processing, the Alliance, and Outcome

The predictive power of emotional processing over the alliance in a CBT sample replicates results from prior EFT studies (e.g., Missirlian et al., 2005) in addition to meta-analytic findings that experiencing predicts outcome across treatment frameworks (Pascual-Leone & Yeryomenko, 2016). The association between experiencing and outcome was unexpectedly high (r = .597) compared to meta-analytic results on experiencing (r = .24 for peak EXP) as well as observer-rated emotional arousal and processing (r = .45, Peluso & Freund, 2018). The magnitude also exceeds results from meta-analyses on the self-reported (r = .25) and observer-rated alliance (r = .23; Flückiger et al., 2018). The study is underpowered, for which reason limited sample size (n = 19) might have led to an inflated result.

A possible contributing factor to this discrepancy is the rater training method. While the standardized training protocol for the experiencing was used, several additional training resources and assignments were created to clarify concepts from the scale. All segments were rated by two raters at minimum, while in most studies raters overlapped on only a subset of segments (typically 33%; Pascual-Leone & Yeryomenko, 2016). The rater who demonstrated greatest proficiency during training or the lead author on the study additionally reviewed all instances of higher levels. If construct validity improved as a result of these procedures, the relation to outcome may have been stronger due to a decrease in measurement error compared to

prior studies.

The finding that emotional processing predicts outcome over and above the alliance suggests that in CBT, emotional processing is important to outcome and this importance is not simply due to conceptual overlap with the therapeutic alliance. Further research is necessary to clarify whether the relationship between emotional processing and outcome is causal in nature or whether emotional processing is itself facilitative for another important change mechanism which primarily leads to outcome. Evidence for causality would provide support for the change process outlined in the EFT literature, in which emotional processing leads to outcome (Greenberg et al., 1993). If replicated in other treatment orientations, this sequence could contribute to a unifying theoretical framework explaining the roles of these common factors in bringing about change. Further support for this sequence could necessitate a paradigm shift insofar that emotional processing rather than the alliance may be conceptualized as principally responsible for change. This shift could critically inform the construction of therapies for different psychological disorders, which typically include procedures for building and maintaining a strong alliance. A greater emphasis on emotional processing would also be necessary in therapist training.

Interestingly, the strength of the EXP-outcome relation exceeded the magnitude in prior EFT studies despite lower average emotional processing. Average emotional processing may have been lower given the emphasis of CBT on cognitions and its central tenet that cognitive restructuring mediates change (Clark et al., 1999). It has been theorized that clients in CBT take an intellectual rather than explorative approach to emotions (Mackay et al., 2002), which may explain clients' preferences for Level 2 statements over Level 3 statements in the present dataset

as well as prior research (Watson & Bedard, 2006). Nonetheless, results suggest that emotional processing factors prominently in successful CBT.

While exploration of emotional experiences may appear antithetical to a focus on recalibrating cognitions, the experiencing construct bears considerable conceptual resemblance to cognitive restructuring. It is first important to note that in the experiencing Scale, the definition of feelings includes emotions (e.g., anger, joy) in addition to assumptions basic to self-image (e.g., feelings of inadequacy or unattractiveness; Klein et al., 1969) which, in the CBT framework, are of primary interest and might be classified as hot thoughts or core beliefs (Clark et al., 2013). In addition, the experiencing scale captures emotional processing, which integrates affect with cognition, rather than emotional arousal, which represents affect only (Greenberg, 2002). Researchers have identified two pathways for emotion, the faster amygdala-driven pathway and the slower neocortex-driven pathway, in which emotion is organized by thought (LeDoux, 1998). EFT theorists argue that the reflection on emotion strengthens the second pathway (Greenberg, 2010). Correspondingly, research suggests that CBT outcome may be mediated by downregulation of the amygdala, in which cognitive processing is prioritized over emotional arousal (Rubin-Falcone et al., 2018).

Additionally, techniques in CBT may elicit high experiencing levels. A client completing a thought record might identify a connection between a thought pattern and an emotion, leading to a shift in perception (Level 6). A thought record with this outcome would likely be viewed as a great success by the therapist. Similarly, collaborative case conceptualization involves mapping out a constellation of thoughts, feelings, and behaviours (Kuyken et al., 2009). A client who is highly engaged in this process might contribute suggestions, adding additional points to the constellation (Level 5). Overall, it is not so surprising that experiencing predicts change in CBT

as the construct may promote and overlap with cognitive restructuring and other elements of CBT.

Observer Ratings of the Alliance and Outcome

Another unexpected result of the present study was that the magnitude of the alliance-outcome relation was stronger (r = .457) than in extant data. This finding should be interpreted with caution, as the sample size was limited at 19 clients. If replicated, this finding is striking. A key implication is that the alliance, often regarded as the primary curative factor in psychotherapy, may in fact be more curative than previously thought (Brown, 2015).

The magnitude detected in the present study exceeds meta-analytic results on self-report alliance ratings (r = .25) as well as observer ratings (r = .22; Flückiger et al., 2018). One explanation is that observer ratings offer a greater ceiling for accuracy than self-reports. One meta-analysis showed that observer ratings of emotional processing (r = .45) were substantially more predictive of outcome than self-reports (r = .20; Peluso & Freund, 2018).

Thin slice ratings, which are observer-rated by definition, may have the potential to maximize rater accuracy. Therapist- and self-reports are retrospective, for which reason recency bias is a risk. A client or therapist's impression of the alliance rated immediately after a session ends may overvalue the latter portion of a session at the expense of minute variations that occurred during the session. Clients and therapists might also have affective reactions to their sessions that influence ratings. In particular, salient events such as ruptures might be privileged as evidence of alliance quality. While observers rating full therapy sessions are uninvolved in the session, raters might still prioritize salient events or events at the end of a session.

In comparison, the thin slicing method can be used to produce observer ratings of segments spaced across a session that capture variation. In this study, segments from various

sessions were rated in random order, controlling for the timing of segments and preventing contamination of ratings from earlier parts of the session. Multiple raters can also provide data, while client or therapist ratings are given by one individual. Although use of multiple raters is possible for observer-rated measures of full therapy sessions, having a large pool of raters rate one full 60-minute session may be time- and resource-intensive. In comparison, many raters can efficiently rate twelve one-minute segments of one session.

Overall, theorists have hitherto interpreted the predictive advantage of self-report alliance measures as evidence that the client's perception of the alliance is most influential to change (Bohart & Tallman, 2010). It may instead be that objective shifts in the alliance throughout a session better predict success.

Trends in Emotional Processing within a Session

A tertiary goal of this study was to assess trends in emotional processing within a session. A previous study found that experiencing was highest during the 30^{th} – 37^{th} minute of the therapy hour. The results of this study found similar experiencing levels between the 18.5^{th} to 37.5^{th} minutes. However, experiencing dropped at the 37.5^{th} minute. These results suggest either that most of the timeframe sampled in the present study is ideal for mapping experiencing patterns or that experiencing patterns vary little within the middle of a session.

Limitations

A number of limitations were present in this study. Since the original sample size of 31 was reduced to 19 clients for outcome analyses due to limited availability of ORS data, results should be interpreted with caution. While the larger sample was used to generate boxplots, high levels of experiencing were still infrequent, for which reason boxplots should be interpreted with caution. Different samples were used for different analyses, limiting generalizability of findings

across analyses. Additionally, alliance data was partially incomplete at the time of analysis, and a different set of raters rated each half of the dataset.

The thin slicing method for the alliance also currently lacks data on psychometric properties, most notably its correspondence with the self-reported alliance. Inter-rater reliabilities were adequate for bond and fell slightly below the acceptable threshold for task/goals. Additionally, segment and session ratings were only moderately correlated. However, very high correspondence between a segment and session might suggest that the measure is not sufficiently sensitive to detect variations within a session, indicating that little non-redundant information is added by measuring multiple segments. Since thin slicing is intended to capture within-session shifts in the alliance, less consistency is expected compared to a post-session measure intended to capture a client's overall sense of the alliance during a session. Additionally, the correlation between working phase alliance and modal experiencing (r = .35) closely matches the correlation found in another CBT study between self-reported working phase alliance and peak experiencing (r = .29; Watson et al., 2011). Accordingly, some results with this measure converge with prior findings. More data is needed for stronger conclusions.

Another possible limitation is that segment lengths differ between process variables. It is unclear how accurately one-minute alliance ratings characterize the alliance throughout the five-minute segments in which they are situated. (Data to address this question is currently being collected). Fluctuations outside the one-minute window would be missed, while low ratings due to brief ruptures within the window would be generalized to the rest of the segment. Nonetheless, this method offers improved precision beyond the standard practice of using one session-level alliance to describe the alliance across the course of therapy.

Shared method variance is a risk since observational rating methods were used for both

process variables. However, the associations between segment levels of the alliance and modal (r = .171) and peak experiencing (r = .245) were weak. Since the segments used to rate process variables overlap temporally, the two variables would be expected to correspond highly if shared method variance was a concern. In the context of adequate interrater reliabilities attained for the alliance measure, this suggests that shared method variance may not be a concern.

Another limitation of this study is that multiple clients were treated by the same therapist. This represents an uncontrolled source of dependency as observations would not be independent. Additionally, long-term therapy cases were not distinguished from short-term cases when they may in fact be qualitatively different. The sample size for long-term cases was inadequate to perform a *t*-test comparing process levels based on case length.

Conclusions and Future Directions

The results of this study provide tentative support for the hypothesized change process outlined in the EFT literature, such that the alliance facilitates emotional processing, which itself is necessary for outcome (Greenberg & Watson, 2006). Results underscore the importance of emotion as a common factor that plays an active role in change in CBT. Indirect support was also found for the notion that the role of the alliance includes facilitation of other change ingredients. Results also support the utility of observational ratings of common factors within thin slices throughout a session for mapping variation over the therapy hour. More broadly, this research produced data linking within-session shifts in common factors and their interplay, which is generally lacking and particularly absent in research on the alliance (Brown, 2015).

Further research is needed to refine the conceptual relationships between emotional processing and the alliance. A more stringent test of alliance variability across experiencing is necessary for stronger conclusions. It may be interesting to also isolate which components of

bond (e.g., warmth, mutual liking, trust) are most critical for deeper emotional processing. Another interesting direction may be disentangling the relative importance of client and therapist contributions to the alliance in promoting emotional processing. Other compelling questions include the impact of alliance stability on emotional processing. A stable alliance may be required before deeper emotional processing can occur. Alternatively, a contemporaneously strong alliance might suffice. Individual differences may also influence the extent to which characteristics of the therapeutic relationship facilitate emotional processing. For example, high therapist empathy can be counterproductive to clients lacking treatment motivation, and might similarly inhibit emotional processing (Elliot et al., 2018).

Replicating the interplay of emotional processing, alliance, and outcome across treatment frameworks would further support the notion that emotional processing pan-theoretically predicts outcome beyond the alliance. Additionally, the present study used the ORS to assess outcome, which is a relatively blunt instrument intended to measure a client's overall impression of well-being in a few domains (Miller et al., 2003). Results should be replicated with longer, multidimensional outcome measures that provide a more nuanced picture of functioning in different domains.

Further research is needed to determine whether emotional processing has a causal relationship to outcome. Strong evidence of causality includes demonstration that changes in the common factor precede changes in outcome (Kazdin, 2007). This has yet to be studied with emotional processing. There is also a need to clarify whether there is a dose-response association with outcome. For example, Carryer and Greenberg (2010) illustrated a U-shaped curve between emotional arousal and outcome. There may be a corresponding optimal level of emotional processing for outcome.

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Appendices

Tables

Table 1

Frequencies of Segment-level Modal and Peak Emotional Processing

	Modal EXP		Peak EXP	
Level	*n*	%	*n*	%
1	32	6.8	4	.8
2	244	51.6	71	15.0
3	105	22.2	219	46.3
4	58	12.3	125	26.4
5	27	5.7	36	7.6
6	7	1.5	18	3.8

Table 2

Descriptives and Correlations for Segment level Emotional Processing and Alliance

	1	2	3	4	5	*M*	*SD*
1. Modal EXP	-					2.630	1.066
2. Peak EXP	.764**	-				3.360	0.982
3. Alliance	.171**	.245**	-			1.51	0.710
4. Task/Goals	.134*	.206*	.942**	-		1.503	0.711
5. Bond	.186**	.256	.953*	.797**	-	1.518	0.788

*$p < 0.05$ ** $p < 0.01$.

Table 3

Mean Modal and Peak EXP Within a Session

Minutes in Session	Modal EXP	Peak EXP
17.5 - 22.5	2.632	3.400
22.5 – 27.5	2.594	3.510
27.5 – 32.5	2.809	3.468
32.5 – 37.5	2.630	3.348
37.5 – 42.5	2.490	3.094

Table 4

Post-hoc Comparisons: Mean Differences in Bond Across Levels of Peak Emotional Processing

	2	3	4	5
Level 2	-			
Level 3	-0.297	-		
Level 4	-0.618*	-0.321*	-	
Level 5	-0.623*	-0.326	-0.005	-
Level 6	-0.591*	-0.295	0.031	-0.312

*$p < 0.05$.

Table 5

Post-hoc Comparisons: Mean Differences in Task/Goals Across Levels of Peak Emotional Processing

	2	3	4	5
Level 2	-			
Level 3	-.222	-		
Level 4	-.402*	-.180	-	
Level 5	-.468*	-.246	-.066	-
Level 6	-.516	-.294	-.114	-.047

*$p < 0.05$ ** $p < 0.01$.

Table 6

Descriptives and Correlations for Working Phase Emotional Processing, Alliance, and Outcome

	1	2	3	4	5	*M*	*SD*
1. ORS change	-					.00	0.972
2. Phase Modal EXP	.525*	-				2.543	0.456
3. Phase Peak EXP	.597**	.935**	-			3.274	0.489
4. Phase Alliance	.457*	.350*	.459**	-		1.518	0.548
5. Phase Task/Goals	.418	.317	.419*	.978**	-	1.485	0.49
6. Phase Bond	.480*	.366*	.477**	.984**	.925**	1.55	0.620

* $p < 0.05$ ** $p < 0.01$. $N = 19$ for all correlations involving ORS change. $N = 31$ for all other correlations.

Table 7

Regression Analysis Summary for Working Phase Alliance and Peak Emotional Processing Predicting Outcome

Process Variable	R_{total}	R^2_{total}	β	t	p	F
(Intercept)				-1.995	.062	$F(1, 17) = 4.49$,
Phase Alliance	.457	.209	.457	2.118	.049	$p = .049$
(Intercept)				-2.867	.011	
Phase Alliance			.194	.851	.407	$F(2, 16) = 5.00$,
Phase Peak EXP	.620	.385	.494	2.139	.048	$p = .021$

* $p < 0.05$ ** $p < 0.01$

Figures

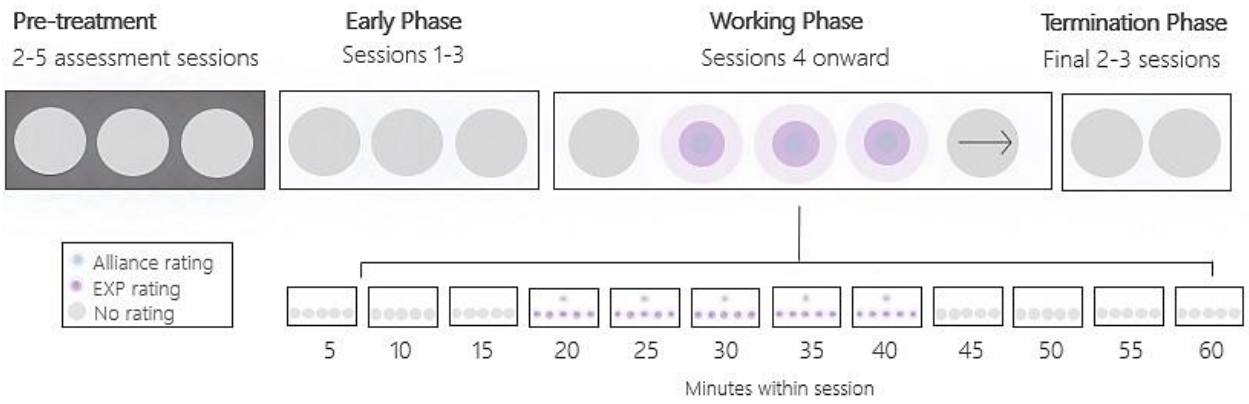

Figure 1. Diagram depicting location of segments and sessions over the course of treatment. The middle 25 minutes of three working phase sessions were used. One-minute segments rated for the alliance were centrally situated within five-minute segments rated for EXP.

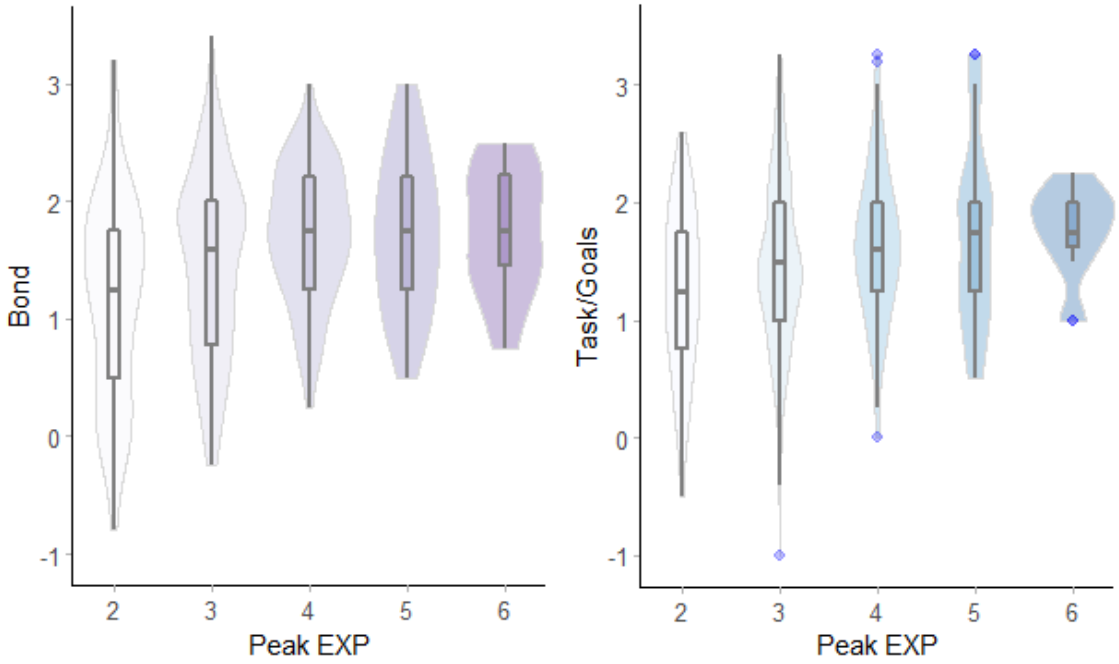

Figure 2. Box and violin plots depicting bond and task/goals across levels of Peak EXP. Outliers are included as dots. Box plots display the median and interquartile range. The vertical line indicates the maximum and minimum values >1.5 times the interquartile range. Outliers are shown when the datapoint falls 1.5 times the interquartile range beyond the nearest quartile.

Appendix A: Rater Selection Materials: Simplified EXP Scale

Experiencing is the extent to which a client uses **internal referents** (feelings, states of mind, aspects of self-image, private perceptions, etc.) to solve problems. It is rated on a scale from 1 to 7 (Level 7 is excluded from this document for simplicity).

At the lower levels, the person describes events objectively and neutrally, with no or few references to private reactions. At the middle levels of the scale, the speaker shares personal reactions (emotions, states of mind) in increasing detail. At the higher levels, the speaker uses **internal referents** to solve personally meaningful problems.

For example, a speaker might go from describing a visit to a friend (Level 1), sharing that they did not enjoy the visit (Level 2), sharing that they felt anxious during their visit (Level 3), to describing in depth the feelings of anxiety they experienced at the visit (Level 4). They might then speak broadly about how they experiences anxiety around friends (Level 5) and then draw a connection between the feelings of anxiety and a tendency towards self-criticism (Level 6). They might then apply this newly understood relationship between anxiety and self-criticism to their behaviour at work (Level 7).

STAGE ONE: objective, neutral, impersonal description of events OR intellectual discourse

Level 1: One day the doctor called me and said, "1'm afraid she won't last long. She's spreading like wildfire." They couldn't get all of it. They hadn't detected it earlier but it was there all the time. ← objective, neutral description of events

Level 1: I think my generation doesn't exercise much. Hardly anyone I know really cares about it. In the countryside exercise is part of life because there is always labour to do. I'm sure you

know what I mean. ← intellectual discourse. He says "I think", but hasn't expressed that the topic is relevant or significant to him.

Level 1: My brother plays soccer on the weekends and he does basketball after school, I pick him up after work. My sister takes him to our grandmother's house every Friday. He complains but he always goes. He's a responsible kid. <- the narrative is about the brother and not the speaker.

STAGE TWO: personally relevant but superficial: wishes, attitudes, abilities, motives**,** values, behavioural account of events, or personally significant description of events

A. **NARRATIVE:** Events- behaviour (what I did) without references to emotions/reactions/private experiences. Or, the speaker might describe events and express that they are personally significant.
B. **SELF-DESCRIPTION**: preferences, wishes, attitudes, moral evaluations, abilities, opinions

- **INTELLECTUALIZED FEELINGS:** if there is emotion, it is weakened by being:
    - attributed to others *("One might feel sad about this" vs. "I feel sad")*
    - hypothetical *("I would feel sad if that happened")*
    - tentative *("I guess I might be a little upset.")*
    - spoken impersonally e.g. *("Who wouldn't be rattled by this?")*

Level 2: I'm lucky I've had good doctors so far ← opinion relevant to speaker. Frankly, I suspect my uncle's doctor was totally incompetent. And one is naturally a little biased after this sort of tragedy. ← impersonalized feelings. if I were a doctor, I'd do my job properly because I would take it seriously ← attitude. I wish I went into healthcare just so I could help people for

real ← wish. When I took science courses they seemed interesting ← preference, and I did well in school ← ability. I would probably be happy if I went into the sciences. ← hypothetical feelings

STAGE THREE: behavioural/external description of events or self + sparse internal details

A. **NARRATIVE:** Behaviour (what I did) + some references to emotions/reactions/private experiences:

- emotion at the time *("I felt x")*
- state of mind ("I was a nervous wreck"
- assumption/perception ("I knew x at the time"), ("I did it knowing it was foolish"),
- motive "(I had wanted to defend myself")

B. **SELF-DESCRIPTION:** Behaviour (my typical role/behaviour) in **one** domain of life (e.g. as a parent, at work, when I am angry)

Level 3: I was very much disturbed ← emotion at the time because this was a very serious conversation, and I knew that their marriage was at stake ← assumption/perception at the time. They were going through a lot at that point. They had problems with the kids too and the kids were struggling. So there was a lot of fighting. My poor daughter. She loved him so much. It was a stressful time for her. I was worried ← emotion at the time because I knew they really loved each other ← assumption/perception at the time. Overall, she shares feelings and perceptions but events rather than feelings are the main focus of the story.

Level 3 I was the class clown, I could never concentrate in class. I didn't really do my homework and I skipped school ← behaviour pattern. My parents told me if I didn't work hard I wouldn't

reach my potential so I didn't really try very hard ← pattern of behaviour. I was a nervous wreck during big tests though. ← emotion. Overall, this is a self-description about the speaker's behaviour in one domain of life (school) with only one reference to the speaker's internal experiences.

STAGE FOUR: Feelings or other internal experiences are the subject rather than behaviours/events

A. **PERSONAL NARRATIVE:** Narrative of events completely from own perspective + details of feelings, reactions, and assumptions → detailed picture of what it was like

- Detail on internal state at the time or current feelings toward a past situation, such as:
    i. detailed feelings *("I feel like I am boiling over whenever I see her")*
    ii. reactions to feelings *("I feel angry, and I feel guilty for getting angry.*
    iii. feelings in a range of situations *("At school and even at home I get frustrated and I want to be alone"),*
    iv. self-descriptive comments deal with internal/personal aspects of the speaker, not moral evaluations or external or behavioral characteristics (*"When I get angry, I lose control and I don't know how to calm myself down and think clearly"* vs. *"When I get angry, I throw things")*
        - **Note:** Abstract terms need detail to be 4 (e.g. "*My ego was shattered* = 3, *"My ego was shattered; it felt like no one would ever notice me"* = 4)

B. **SELF-CHARACTERIZATION**: Detailed picture of what it feels like to be the speaker, explaining feelings, personality, assumptions, motives, goals, and private perceptions (see above for examples).

Level 4. I am constantly wondering if there's something wrong with me, am I just not capable of connecting with people? It feels like I am disappearing sometimes, being alone all the time with no one to talk to. All I care about is that feeling of getting a good grade because everything else makes me feel disappointed in myself. It feels like everyone else is happy while I'm just miserable and isolated. ← Self-characterization

Level 4. I thought about going yesterday but I would have had to confront the fact that dance isn't my whole life and my greatest passion anymore because for so long being sick has been my whole life. It's so painful – I called and talked to my old friends but it just feels like everyone else has gotten ahead of me in life while I'm just watching… I know it's not good to get discouraged and I want to stop feeling sorry for myself. I was just completely miserable all afternoon, and then I felt guilty for being miserable. ← Narrative completely from personal perspective

STAGE FIVE: define problem about self (in terms of feeling, private reaction, inner process, behaviour pattern, assumption basic to self-image) + explore problem (cause, implications, examples – WITH internal referents)

1. **PROBLEM STATEMENT:** **general, broad** problem/hypothesis about self in terms of an inner referent (a feeling, private reaction, inner process, behaviour pattern, assumption basic to self-image). The problem statement can be any of these:

- Feeling, reaction, inner process, or behavior pattern, stated as problematic/conflicting with other feelings or aspects of self *("My anger is the problem", "Why am I so angry?")*
- Question extent of feeling *("Do I really feel angry?" = Stage 5, vs. "What do I feel?"* = Stage 3-4)
- Cause of a feeling/its implications *("Do I get angry when I feel inadequate?")*, or its position in a sequence of inner events *("My getting angry means I've lost control of myself")*, or its mode of expression *("I get angry the way my mother used to.")*
- Comparison of feelings and internal processes

2. **EXPLORE PROBLEM with inner referents**

   A few examples of what exploration might look like, using the problem statement of "Why do I constantly compare myself to others?")

   - Cause *("I always compared myself to my best friend since we were kids")*
   - Personal implications *("It makes me defensive and I feel like I'm competing with everyone")*.
   - Examples in different settings/different times *("When he got first place, I felt worthless and lost all my motivation to play sports, I wanted to give up because I was obviously not good enough.")*
     i. Relevance to main problem must be explicit, else it reverts to **Stage 4**

Level 5 I feel like I am keeping my identity from the people I love, out of fear. ← problem statement**.** I'm scared of what they'll think. But I'm hiding the part of me that I see as most integral to who I am, and then I resent them for not understanding me. <- implication But the

idea of letting someone read a chapter of my novel or submitting my work somewhere makes me freeze up because what if they judge me? <- example. And yet I want to do these things, I want to be close to the people I love, I want them to really know me. So I'm conflicted.

Differentiating the Middle Stages:

Level 3: "I'm scared my boyfriend will leave me. I tend to check my phone constantly, and text him way too much" ← emotion + behaviour in one domain

Level 4: "I'm scared my boyfriend will leave me. I am constantly on edge, which makes me feel guilty. I keep questioning whether he loves me, and how much he loves me, and our relationship is suffering because I'm too insecure to believe he likes me. ← detailed feelings

Level 5: "I am afraid of my boyfriend leaving me because I don't understand why anyone would want me. I'm afraid of being abandoned, but I want to be loved. ← problem stated in terms of feeling I suppose because my mom wasn't around much when I was little and I couldn't depend on her, I felt I had to be independent. ← cause My boyfriend is supportive but I still panic whenever he does something that makes me doubt how much he loves me, even if it's something really small. ←example

STAGE SIX: speaker identifies a relationship between a feeling and another aspect of experience and describes the impact of this relationship (either a new feeling OR a new conclusion)

1. **FEELING:** Feeling or change in feeling. *(“I feel extremely alone… I feel really isolated from everyone, I feel like I can’t connect with people.” “I’m starting to feel more relaxed about our relationship than before… Less panicky and stressed.”)*
2. **RELATIONSHIP:** Relationship revealed between new feeling and other inner referent (another feeling, self-image, private perceptions, motives, assumptions, even external aspects like behavior).

   "Now I'm beginning to see that my feeling of guilt is caused by my ideas about work”

   “You know, I've always kept my anger bottled up because I've been afraid of losing control of myself.”
3. **IMPACT:** The speaker reports EITHER a new experience OR a resolution.
   A. **New experience:** The speaker feels something new *("Now I'm beginning to see that my feeling of guilt is caused by my ideas about work, and it makes me much **less worried** about that sense of guilt. What a **relief**!")*
   B. **Conclusion:** The speaker may further unpack their understanding of this relationship. *("You know, I've always kept my anger bottled up because I've been afraid of losing control of myself. Now I realize it wouldn't be so bad if I did; maybe I'd yell or throw something, that's all."*)

Appendix B: Rater Selection Materials: EXP Rating Task

1. Yesterday I saw a cat on my window.
2. I think I feel sad, I'm not sure.
3. I feel miserable.
4. I really don't think I'm responsible enough for this job.
5. I am happy because my new cast-iron pan came in the mail.
6. I'm going later because traffic looks bad.
7. I didn't ask about the trip because it seemed at the time that she wanted to think it over first.
8. I am overjoyed. I feel hopeful and I feel very at peace with myself.
9. I am pretty disorganized. I leave my books lying around and I don't clean much. I also tend to forget my laundry.
10. I always loved camping. What I love is the challenge. It makes me feel exuberant and full of life. Seeing how far I can push my capacities for survival, testing myself.
11. I get upset easily. I always get frazzled when I meet someone new, especially at work. I start obsessing over whether I've made a good impression, doubting myself. With my old friends I am much more relaxed, but I still find myself overthinking a little afterwards.
12. I used to read. My favourite book was from this series about magic. The characters were mostly young kids and they would go around finding ancient relics. The series had 6 books.
13. Why did I freak out? It felt like a big deal at the time.
14. I believe it is important to take care of your family first.
15. There is corruption at every level of society. Wherever you go it's there. I don't think it's possible to find any profession where everyone is perfectly good and kind and is never tempted by greed.

16. I was getting down about myself all the time. Disliking myself. Now I feel oddly hopeful. I think I am a bit more optimistic because I have been able to get my life on track, I've been more disciplined. I find when I am more disciplined there is less stress and general I sleep better too because I'm not worrying about things I need to be getting done.
17. I am a good babysitter.
18. Well she was accusing me and I wanted to make myself clear. So I stood up for myself.
19. I was angry. Then the anger became sadness.
20. If I were there, I would have been ecstatic.
21. I am almost always lonely. Even around people I like. I am finding it hard to like people as well, and it's hard to connect.
22. I love books. I read almost every night to relax. And I go through books very quickly. I switch between genres all the time too. I did a lot more nonfiction this year than usual. Oddly enough it's spy novels that help me decompress.
23. I know you want me to talk about my health. But I don't want to talk about it right now.
24. My uncle is so kind. He is the backbone of the family. Looks after all the cousins and my grandparents too. Everyone is lucky to have him.
25. I didn't really know what my path was this year.
26. I tend to get discouraged really easily. The slightest negative thing happens and I slide into this negative space. I don't understand where it started. I know I was like this as a teenager. I used to get down anytime my family was fighting. Or when I was struggling with my girlfriend, I would keep thinking there's no way she could like me, she will leave me and I will be alone. It's been like this awhile really. And even now when I am working on a job

and something goes off I blame myself and feel my efforts are wasted and everything is useless. I don't really know what to do about it.

27. I don't know why I'm so lazy. Like I don't feel motivated. It feels like everything is a waste of time.
28. I always obsess over assignments. I think I get really panicky whenever there are any expectations placed on me. I never feel like I can meet them. I end up doubting myself thinking how am I going to do anything important to me? When I was in college for nursing I would always go back and forth reading everything 5 times and of course I couldn't finish everything so I ended up not doing a lot of my work... It was pretty bad overall. I don't really know why I do that.
29. Last week I was feeling a lot more relaxed about the situation. I was going crazy with stress for the longest time. I think I just learned to control my feelings and calm down a bit. And so whenever I worry I remind myself she is tough and it's no use fretting, or I use a mindfulness strategy. Then I relax a little. It's a relief actually, to not be panicking all the time.
30. I find it hard to show emotions. I hate it. It makes it hard to be close to people. I was like that with my family, I never wanted to tell them what was going on. That's just how I am.
31. I always doubt I’m attractive enough to have a boyfriend. I feel unattractive. I can be really self-critical about my looks. I think it’s because I compare myself to other girls alot. I have these ideas in my head about how I want to look and I compare myself to people who look that way. It's not really a good habit. Like beating myself up and comparing myself to people won't change anything.

Appendix C: Rater Training Materials: Coding Guide

Introduction to the Coding Guide

This document is meant to supplement but not replace the original EXP scale. Ultimately, ratings should be assigned based on the original scale and the training segments. The document contains four sections:

1. Expanded EXP Manual with Examples This section consists of an expanded version of the original Experiencing Scale manual, elaborating on rating concepts that are encompassed both in the original EXP scale manual as well as justifications for expert ratings that accompany the training segments. Included are original examples created for the purposes of this document as well as the names of examples from the training segments (highlighted in yellow; e.g., E4). Training segments themselves are not included in this document.

2. **Internal Referents** This section contains a description of types of internal referents and examples of when they appear.

3. Guide to Differentiating the Stages This section contains an in-depth guide for how to distinguish between successive levels of EXP. In this section, training segments with more detailed annotations have been included.

4. Rating EXP in Cognitive-Behavioural Therapy The EXP Scale training segments were taken from therapy sessions based on the humanistic tradition of psychotherapy. This section contains suggestions for applying coding concepts to the present dataset, primarily centered around coding cognitive-behavioural strategies (e.g., case conceptualization, thought records) as well as mindfulness strategies.

Note: There are several versions of this guide, one created for each set of segments in the training manual. This is so that coders have access to a version of this guide at each step in

training without seeing the correct ratings of training segments they have not yet attempted to rate independently. Ensure you are using the correct version of the guide. This version of the guide contains no annotations of training segments.

All material in this guide is based on the original Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970; Klein, Mathieu-Coughlan, & Kiesler, 1986)

Expanded EXP Manual with Examples

STAGE ONE: objective, impersonal description of events that could be told from third person OR abstract/intellectual discourse with no reference to personal significance of events.

Mode 1, Peak 1: *The nurse said that he hadn't spoken at all this week. That he was struggling to get even a single word out. They hadn't realized earlier but there may be something wrong.* ← *objective and neutral*

Mode 1, Peak 1: *I think my generation doesn't exercise much. We just watch TV. In the country it was part of life because there was always labour to do. I'm sure you know what I mean.* ← *intellectual discourse;* he says "I think", but hasn't made it clear that the topic is relevant to him at all, and hasn't expressed that it's significant to him. It would be rated as a 2 if he added "I don't exercise much either" (personal relevance) or "I want to exercise more" (desire).

Mode 1, Peak 2: *My brother plays soccer on the weekends and he does basketball after school, I pick him up after work. He's in the 7th grade and he's pretty athletic. I drive him because the buses here are always delayed and I want to make sure my little brother gets home safe* ← peak of 2 – the speaker briefly explains a motive for his action, bringing the topic back to himself. *Our parents have been travelling the past few years, it has mostly been my sister looking after him. She mostly does the cooking and helps him with his homework. She also takes him to our grandmother's house every Friday. He complains but he always goes. He's a responsible kid.* <- The rest of the narrative is about the brother and not the speaker, warranting a rating of 1.

STAGE TWO: personally relevant but superficial: abstract/intellectual/behavioural description of wishes, attitudes, abilities, motives, or behavioural account of events

A. **NARRATIVE:** Behaviour (what I did) without references to emotions/reactions

B. **SELF-DESCRIPTION**: preferences, wishes, attitudes, moral evaluations, abilities, opinions if relevant to speaker

- **IF THERE IS EMOTION:** evident from manner only, or attributed to others *("One feels" vs. "I feel")*, or spoken impersonally e.g. *("Who wouldn't be rattled by this?")*

Mode 2, Peak 2: *I'm lucky I've had good doctors so far, very kind ones* ← opinion relevant to speaker. *But the bad apples do a lot of damage. Frankly, I suspect my uncle's doctor was totally incompetent and that's why he didn't make it. And one is naturally a little biased after this sort of tragedy.* ← impersonalizing feelings. We can **infer** that he resents doctors and is upset by this "tragedy" with his uncle, but he hasn't told us explicitly. *if I were a doctor, I'd do my job properly because I would take it seriously* ← attitude. *I wish I went into healthcare just so I could help people for real* ← wish. *When I took science courses they seemed pretty interesting* ← preference, *and I did pretty well in school* ← ability. *I was a good note-taker* ← ability. *And I did think the sciences called to me* ← ability.

STAGE THREE: behavioural/external narrative or self-description + some reactions limited to situation with little elaboration; the focus is on events, and the client speaks "about" rather than "from" experiences

A. **NARRATIVE:** Behaviour (what I did) + some references to emotions/reactions/private experiences at that time:

- emotion *("thinking about it now makes me feel x")*
- state of awareness e.g. assumption ("I knew x at the time"), motive "(I had wanted to defend myself"), perception ("I did it knowing it was foolish"), state of

mind (“I was a nervous wreck/I was really out of it at the time”, “I feel helpless, like when you don’t know where you stand.”

- connection to other private experience e.g. a state (“I often feel x when I am tired” or memory ““it reminded me of x as a child”)

B. **SELF-DESCRIPTION:** Behaviour (what I typically do/how I act/my role) in one domain of life (e.g. as a parent, at work, when I am angry)

- References to private experiences (see examples from A) are limited to one domain - they don't explain what they're like generally, e.g. how they are responsible as a parent rather than how they are responsible as a parent and as a student.

C. **EMOTION FOLLOWING DIRECT QUESTION FROM THERAPIST**:

- Must know without reading therapist’s words

Mode: 3, Peak: 3: *We had a very long conversation about the whole thing. I had never seen her so confused about her future before, she always seemed so confident in herself. I was honestly quite saddened to see her like this.* ← emotion at the time. *And her cooking was something so important to her! I had been trying to help her sort things out because this was clearly a big deal to her* ←assumption/perception at the time. *Then she said she was thinking of quitting! When she said that she was going to drop out, at first I was fairly certain it was just in the heat of the moment, but as she kept talking I wasn’t so sure….* ← assumption/perception at the time. *She even said she started packing. I was disappointed in myself for not paying attention to my own daughter’s school life.* ← emotion at the time. *Overall, most of this segment contains a narrative of events, but there are scattered references to the speaker’s reactions (e.g., feelings, perceptions). These are parenthetical to the events of the narrative which are the primary focus.*

Feelings are not elaborated to give us a more detailed picture of how the speaker feels, which could merit a 4. We don't know what "disappointment" feels like to her. She also has not given more detail on her feelings that would paint a picture of who she is more broadly, which could also warrant a 4.

Mode: 3, Peak: 3 *I was the class clown, I could never concentrate in class. I didn't really do my homework and I skipped school. My parents told me if I didn't work hard I wouldn't reach my potential so I didn't really try very hard. But what could I do? I couldn't* ***concentrate*** *for more than a few minutes at a time* ← patterns of behaviour. *I was a wreck during big tests though.* ← state of mind. *Overall, a self-description in limited domain and behavioural in nature, and he doesn't describe what he's like more generally outside of school OR what it was like for him internally.*

STAGE FOUR: Feelings or internal experiences are the subject rather than behaviours/events giving a detailed picture of interior perspective (what it's like to be them).

A stage 4 goes beyond a stage 3 through inclusion of the following possible elements:

- Detail on internal state at the time or current feelings toward a past situation, such as:
    i. multiple feelings *("I felt angry yet happy, and also sad.")*
    ii. detailed feelings *("I feel like I am boiling over whenever I see her")*
        - **Note:** Abstract terms need detail to be 4 (e.g. "*My pride was obliterated* = 3, *"My pride was obliterated; it felt like I was going to be a mess forever"* = 4)

iii. new feelings *("I used to feel so sad when I went there, but this time I felt kind of peaceful.")*

iv. feelings in a range of situations *("At school and even at home or with my girlfriend I just get frustrated constantly and I want to be alone so I don't make a fool of myself by getting angry")*,

v. reactions to feelings *("I feel angry, and I feel guilty for getting angry."*

vi. reactions related to self-image *("It makes me think I don't have self-control")*.

vii. self-descriptive comments dealing with internal/personal aspects of the speaker, not moral evaluations or external or behavioral characteristics; level 4 (*"When I get angry, I lose control and I don't know how to calm myself down and think clearly"* vs. level 3 *"When I get angry, I throw things")*

Here are the various forms that a stage 4 can take, with the above elements included.

A. **PERSONAL NARRATIVE:** Narrative of events completely from a personal perspective, rich with details of feelings, reactions, and assumptions, culminating in a detailed picture of what it felt like for the speaker. For example, a description of a wedding, including details on the speaker's feelings of alienation, resentment, and isolation, as well as perceptions during challenging social interactions.

B. **SITUATION WIDENED BY SELF-REFERENCES** A narrative of a specific situation widened and deepened by self-references (see above) to illustrate what the speaker is like more generally (in other areas of life) or more personally. For example, a speaker might describe their behaviour as a student, touching on his feelings of inspiration and joy while

learning about his field, and expand this description by speaking about the student's determination to work hard for a better life more generally.

C. **SELF-CHARACTERIZATION**: Personal perspective, explaining feelings, personality, assumptions, motives, goals, and private perceptions. This gives a detailed picture of what it is like to be the speaker. For example, *("I am very hostile. I tend to assume the worst of everyone and get very defensive. I explode at my family all the time and then there's fighting and I get even more hostile and it's a cycle")*.

- **Note:** Feelings are listed but not interrelated or used as the basis for systematic self-examination (as in **Stage 5**).

Mode: 3, Peak: 4. *Since I started university, I haven't really had friends. I spend all my time alone studying. I go to a big school and there are so many people that I don't really know how to make actual lasting friendships here. I talk to people in my classes but then we never really talk again or hang out. If I do make friends and then I never see them again and I end up feeling disappointed.* ← *Stage 3 I am constantly wondering if there's something wrong with me, am I just not capable of connecting with people? It feels like I am disappearing sometimes, being alone all the time with no one to talk to. All I care about is that feeling of getting a good grade because everything else makes me feel disappointed in myself. It feels like everyone else is happy while I'm just miserable and isolated.* ← *The second half is Stage 4. Compare the 2 halves of this segment: at 3, it is a lot of behavioural patterns, and there is one reference to emotion, but since there's only one and it's too sparse for a rating of four, and her behaviours are still the main focus. In the 2nd half of this segment, the focus is the speaker listing their feelings of isolation in relation to their self-image. However, these feelings aren't formulated into a problem, which could bring it to stage 5.*

Mode: 4, Peak: 4. *It's been so long since I got injured and now I'm scared because of how much it will hurt me if I've forgotten everything. I don't want to confront the fact that dance isn't my whole life and my greatest passion anymore because for so long being sick has been my whole life. It's so painful whenever I talk to my old friends from dance because it just feels like everyone else has gotten ahead of me in life while I'm just watching… I know it's not good to get discouraged. I've just been so miserable these days and then I feel guilty for being miserable because I mean at least I survived the accident. It's just been so overwhelming with all these doctor's appointments, one after the other.* ← *Challenge yourself and see if you can find the elements of a level 4. Note that feelings are listed in great detail but are never formulated into a problem.*

STAGE FIVE: define problem about self in terms of an inner referent (feeling, private reaction, inner process, behaviour pattern, assumption basic to self-image) + explore problem (nature, cause, implications, examples, location in sequence of inner events, mode of expression) **with** internal referents)

1. **PROBLEM/HYPOTHESIS STATEMENT:** problem/hypothesis about self in terms of an **inner referent**
    - Feeling, reaction, inner process, or behavior pattern, stated as problematic/conflicting with other feelings or aspects of self *("My loneliness is getting to be a problem", "Why am I so miserable all the time?")*

    A problem statement might look like one of the following:

- Question extent of feeling *("Am I actually happy?" = Stage 5, vs. "What am I even feeling right now?"* = Stage 3-4)
- Cause of a feeling/its implications *("Do I get irritated when I feel insecure?")*, or its position in a sequence of inner events *("When I feel really emotionally burnt out, I start being self-critical")*, or its mode of expression *("When I'm stressed, I take it out on other people.")*
- Comparison of feelings and internal processes

2. **EXPLORE PROBLEM with inner referent.**

   Using the problem statement of "Why do I constantly compare myself to others?") as an example, here are some ways the problem might be explored, with the inner referents highlighted in turquoise:

   - Nature or cause *("I can't tell if I'm acting out because I'm self-centered or just feeling insecure.")*
   - Personal implications *("It makes me defensive and it affecs my relationships")*.
   - Relation to other inner processes or reactions *("I get into a cycle where I feel like I'm competing with everyone")*.
   - Examples explicitly linked back to problem/hypothesis *("When he got first place, I felt worthless and lost all my motivation to play sports, I wanted to give up because I was obviously not good enough.")* Examples may show how the problem manifests across settings. **NOTE:** Relevance to main problem must be explicit, otherwise it reverts to **Stage 4.**

- **Note:** If the problem is not based strongly on an inner referent and is moreso based on something external (e.g., undesired behaviours [e.g., yelling] or styles [e.g., assertiveness], possible external antecedents of behaviour or feelings [e.g., being around family], or a temporal sequence of feelings [e.g., I get angry and then I get self-destructive], then the exploration requires extensive inner referents **(See Stage 6 example with Mode 5 Peak 6)**
- **Note:** If speaker describes a shift in perception about one of the inner referents, consider **Stage 6**). If speaker is just listing feelings without trying to examine/understand them in any way, it is **Stage 4.**

Differentiating the Middle Stages:

Stage 3: *"I'm scared my boyfriend will leave me. I always get anxious whenever he doesn't text me back."* ← *explicit emotion, self description in one domain*

Stage 4: *"I'm scared my boyfriend will leave me. I am constantly on edge, which makes me feel guilty.* ← *sequence of feelings I keep questioning whether he loves me, and how much he loves me, and I feel like our relationship is suffering because I'm too insecure to believe he really likes me* ← *situation widened by self-references; perspective on what it's like to be her. Overall, this is purely descriptive, no real formulation or exploration*

Stage 5: *"I am afraid of my boyfriend leaving me because I don't understand why anyone would want to be with me. I really just can't believe that I'm worthy of love. I'm afraid of being abandoned, but I want to be loved.* ← *problem stated in terms of inner referents - takes the speaker beyond the situation at hand This has been going on for some time. Why am I so afraid of being left? I suppose because my mom wasn't around much when I was little and I couldn't depend on her, I felt I had to be independent.* ←*cause with inner referent My boyfriend is*

supportive but I still panic whenever he does something that makes me doubt how much he loves me, even if it's something really small. ← *example with inner referent*

STAGE SIX: issue is restructured: feelings and experiences are synthesized in a new way, which impacts the speaker (new feeling OR resolution to an issue)

1. **FEELING:** Feeling **or** change in feeling is vividly expressed.
    - "*When I talked to her, I felt a lot less nervous about her judging me. Usually it's so terrible I can't even speak.*"
    - "*I tried the exercise and I actually felt really calm. Like it got rid of the angry feeling."*
2. **RELATIONSHIP (aka Restructuring):**
    - Relationship revealed between new feeling and other inner referent (another feeling, self-image, private perceptions, motives, assumptions, even behavior).

      "*When I talked to her, I felt a lot less nervous about her judging me. Usually it's so terrible I can't even speak.*

      I'm starting to think I isolate myself because I'm scared no one will like the real me, and that there's something wrong with me."

      "I tried the mindfulness exercise and I actually felt really calm. Like it got rid of the angry feeling. Really, I think it helped getting some distance from how I feel. Like slowing down to actually separate how I'm thinking, from how I'm feeling. I didn't know I could do that."
3. **ACCEPTANCE** If they don't reject the relationship (e.g. say, "this can't be right"), then there is acceptance

4. **IMPACT: ANOTHER NEW EXPERIENCE OR RESOLUTION**:

New experience: As a result of working with these inner referents and exploring their relationship to each other, the speaker has a new feeling *("When I talked to her, I felt a lot less nervous about her judging me. Usually it's so terrible I can't even speak. I'm starting to think I isolate myself because I'm scared no one will like the real me, and that there's something wrong with me. I guess that makes me a little less worried about how much I distance myself from people, because rationally I know that my friends and family love me for who I am.")*

A. **Resolution:** Alternatively, an issue may be resolved, a new conclusion reached, or the relationship further unpacked *(""I tried the mindfulness exercise and I actually felt really calm. Like it got rid of the angry feeling. Really, I think it helped getting some distance from how I feel. Like slowing down to actually separate how I'm thinking, from how I'm feeling. I didn't know I could do that. I realize I probably can control it when I get into a rage."*)

   i. If the initial problem is concrete or external, the feelings must be presented as part of his present experience and the emergent formulation must change his perception of the problem in some way.

   ii. Solution may have external, behavioral, or intellectual elements (e.g. a decision to act in a different way).

      - Still, these elements must be clearly a result of the immediate feelings to be part of the 6. If they seem off-topic, they are not part of the impact criteria.

- **Note:** Simply describing a relationship between two internal referents, or stating that a problem has been resolved, is not sufficient for a six. The underlying experiences of the restructuring process must be described or relived.

STAGE SEVEN: shifts in understanding in one area of experience broadened (a range of conclusions, situations, or through a broader formulation)

Speaker moves from one inner referent to another, modifying his conceptions of himself, so that each new level of self-awareness functions as a springboard for further exploration.

Meets criteria for **Stage 6** + one of the following:

A. Starts with internal problem, explores it, and reaches conclusion that is then applied to other problems.
B. Starts with internal problem, arrives at several related solutions, and reintegrates them. Any self-analysis is followed by a more comprehensive or extensive synthesis.
C. Uses several different formulations about himself, each meeting stage six criteria, then integrates, relates, or reduces them to a more basic or general formulation
D. Starts with a Stage 6 conclusion and applies to a range of situations, each with inner referents explicit, to show how the general principle applies to a wide area of his experience.

Stage 7: *I just lost my motivation to do a lot of things this year. Because for so long I've just felt, everything has been going so badly that I don't want to try anything, I don't want to try or get invested in anything because why should it turn out differently? I've been avoiding everything, so all I've been feeling is empty… and I want to stop feeling all this emptiness and feel something for real, even if it was sadness or anger. Sometimes I feel hopeful when I start to feel something. The other day I saw a picture of my ex and I cried. It was so nice to cry. I needed to know that I*

could still feel things and still care about them, and to let it out, even just for a few minutes. It makes me think that maybe my emotions are there but I just can't find them. I actually felt kind of hopeful. It made me want to start feeling things again. I have always told myself that emotions are a distraction, so I end up not suppressing everything. And now I think it's at least important to know where they are and when they're there and to deal with them because otherwise they are just lying there underneath making it impossible for me to feel anything else. When my girlfriend broke up with me I didn't cry at all and she told me I was heartless. At the time I thought, whatever, but I felt so empty afterwards…In every relationship I've always felt so disconnected and it always seemed like they were the ones chasing me, I couldn't let them know that I cared because then they wouldn't respect me … And when my parents divorced in senior year I just started drinking to numb everything and I made all kinds of bad decisions, but I know I was angry underneath all that, and I still am, I still don't pick up my dad's calls because I can't forgive him for breaking up our family, but I tell myself I just don't care about him…With my girlfriends and my dad I was angry, I was sad too, but I just pushed it all down and ignored it and it just festered. If I had dealt with everything made it would have been better. Have I been avoiding these things my whole life? That could be why I just can't get myself to care about anything these days. I think at the bottom of all that is just more fear. Fear of being disappointed. I think I'm afraid of feeling happy and then having it go away, and getting invested in something and then watching it fail. But being engaged in life probably means I have to take risks and learn to accept the lows. ← *See if you can pick out the criteria. This is an example of "D" from Stage 7, but there are elements from the other types of Stage 7 too.*

Internal Referents

Internal referents:

- Aspects of internal experience
- Levels 2+: Motives, desires, private perceptions, states of mind
- Levels 3+ Feelings, aspects of self-image

What levels do they come up?

- All over the scale – levels 2 to 7
- The difference is the QUALITY, TYPE, FREQUENCY, and CONTEXT in which they come up

Do higher levels have more internal referents?

- This is a good rule for low levels. From levels 1-4, we move from zero internal referents to a focus on internal referents.
- This is not a perfect rule for levels 5-7. A level 5 needs to have lots of inner referents, but a very short level 6 might only have a few.

Possible contexts

- In relation to external events
- In relation to speaker's behaviour
- In relation to other internal referents

- **Levels 1-4:** With what quality and quantity of internal referents are they describing their internal experience?
- **Levels 5-7:** Where is the client in the process of exploring, successfully answering, and extending the answer to a question about their internal experience?

How do internal referents come up in Level 2?

- Motives, attitudes, desires, but always very externally oriented – *"I bought a cat because I like them"*
- Low quality feelings – tentative, hypothetical, attributed to others, impersonalized, ambiguous - *"I guess maybe I felt kind of upset?" "One would feel devastated by this"*

How do internal referents come up in Level 3?

- Type = Level 3 or higher, any type of internal referent can appear
- Contexts:
    - In relation to external events or speaker's behaviour
    - In one situation ("Getting my cast-iron pan made me happy")
    - Rarely, a few vague broad statements across situations that are too vague for a level 4 *"I haven't had any experiences, good or bad"*
- Low quality and low quantity
    - Type
        - Any, as long as it's low quality and sparse
            - Generic feeling "*I'm sad," "I felt humbled"*

- Vague pattern of feelings *"It was just a feeling I get when I'm overworked"*
- State of mind/awareness *"I knew I wanted to defend myself"*
- Memories *"It reminded me of something similar that happened when I was a teenager"*
- Significance *"It meant a lot to me because of what my job was like at the time."*

- Quantity
  - Sparse
  - Or the same emotion just repeated, e.g. a description of external events/behaviour in soccer where the speaker repeatedly states that they are "happy". It's one emotion over and over so not quite a 4
- Quality
  - Vague/generic: *"I'm sad", "I was fuming" "My ego was shattered""I haven't had any experiences, good or bad"*

How do they come up in Level 4?

- Very frequently (+50% of the time in the 4 portion, even if lower quality, as long as it's not just the same internal referent) or higher quality
- Quantity and quality

  Any of the following:

        - A single instance of high quality internal referents (new feelings, reactions to feelings, multiple feelings, etc. See level 4 description for more examples)
        - Lots of internal referents for one situation
        - Lots of internal referents across many situations
        - One internal referent in detail across many situations
            - one feeling in multiple situations
            - *e.g.* description of different ways someone feels sadness at home, at work, and at school

How do they come up in Level 5?

- Problem statement: Minimum of 1
    - Quality: explicit not vague, and about the self broadly.
        - "How angry am I, really?" vs **"I don't know how I feel" or "I don't know what my motives are" doesn't tell us what the internal referents are – the speaker doesn't even know**
- Exploration:
    - Must have internal referents
    - If problem-statement is weak, there should be even more internal referents in the exploration

Context makes a *motive* internal or external

- Level 2: I got a cat because I wanted some company.
- Level 3: I asked her out because she made me happy. I'm grateful I met her.

- Level 4: I don't really understand my motives when it comes to my relationship. I always find myself doing things and then thinking later, why on earth did I do that? I find it really hard to understand myself.
    - **OR** When I'm playing soccer I'm trying to prove myself… just that feeling of being on the podium and knowing my coach is proud of us makes me feel so connected to my team, they are like family to me. This sport brings me so much happiness… I want to do my best to make my coach proud, I want to keep getting better
- Level 5 (problem statement only): What I don't get is why I still want to lash out at my friends. (This must be followed by exploration to qualify as a level 5).

Context makes an *attitude* internal or external

- Men commit the most violent crime. ← Level 1, intellectual discourse
- I don't like having male friends. I think my female friends have always been much more caring. ← Level 2 Attitude/opinion about external world
- For whatever reason, I think I tend to distrust men. I'm not interested in sports so I never get along with most guys from my hometown. So I assume I won't relate them. At university I didn't talk to most of the guys on my floor in residence, I just made female friends. It's the same at work now. ← Level 3 Self-description in one domain.
- I don't really trust men. I think on some level, I just feel defensive, probably from having so many negative experiences. I know that's not fair, but that's how I've been. ← Level 4, self-characterization

Differentiating the Stages: Common Mistakes

Stage 1 vs 2

- **Stage 1 when the speaker is not the subject**
    - Consider what the actual subject of the discussion is. Is it the speaker's experience, or something external? For example, is the subject a hockey arena the speaker is describing, or the speaker's experiences and behaviours there?
        - How a person's hockey team celebrates victories = external, how a person celebrates victories with their hockey team = personally relevant
        - Is the subject the speaker's wife's life history, or is the speaker telling you about his wife to explain how their marriage works?
        - Is the subject the external properties of their body (e.g. "*my leg is broken*") or expressing the significance of their body to something internal (e.g. a desire – *"my leg is broken – I wish I could run again*")?
- **Stage 1 mode and peak 2 when only part of content is personally significant even if the topic is similar**
    - A speaker might say, *"I don't get how this diet is supposed to be helping me"* followed by intellectual discourse on the scientific merits of the diet that seems to abandon its original relevance to the speaker. The mode is Stage 1 if the content clearly loses its relevance to the speaker for most of the segment. If it's brought back to the speaker's own diet at the end, you could give it peak of 2.
- **Stage 2 when personal significance is expressed**

- *"Should I should talk to my professor?"* followed by description about her professor's receptiveness to questions in a way that is clearly relevant to her decision.

Stage 2 vs 3

- **Stage 2 rather than Stage 3 when the feelings are too impersonalized** often occurs with the following kinds of Stage 2 feelings:
  - **Feelings attributed to someone else** *"One might be hurt by this"*
  - **Tentative feelings:** "*I suppose it bothers me, I imagine it might be upsetting on some level"*
  - **Hypothetical/predicted feelings:** *"He wouldn't talk to me if I were upset." "When the shelf breaks, it will be me who gets frustrated fixing it"* ← If instead the client stated, "I'm going to get frustrated, I tend to get frustrated when I'm fixing things", it would be a 3.
  - **Incomplete statement of feelings:** *"I don't like my barber. I'm so agitated when…. I've had a lot of barbers, they often don't know how to work with my hair."* ← Unfinished statement; remainder of statement is evaluative with no inner referents
  - **Implicit feelings:** *"Why did I take that job? It's awful. You have no idea what it's like. How did I think this was good for my resume? It's a waste of time."* ← Level 2, as no inner referents are directly stated despite the speaker's inferred anger
  - **Denials of self-descriptions** without any further comment about how the speaker does operate

        - "I'm not pessimistic, you know, because it's not going to do anything." ← Speaker denies a descriptor and gives a motive (motive is level 2)
        - "I'm not pessimistic, you know, I'm grateful for what I went through." ← Level 3 as the speaker's actual experience is specified
    - **Intellectualized metaphor**: If the metaphor is intellectualized and the speaker's feelings are not woven in, it is a level 2
    - **Feelings undermined through being stated as opinions:** *"I find the work satisfying – I strongly believe everyone should help others".* ← The speaker **undermines** what could otherwise be a feeling by following it up with a moral evaluation/platitude about what people generally should do.
- **Stage 3 rather than 2 when internal referents are given that are not feelings**
    - **State of mind** is often mistaken for Stage 2 when an explicit feeling word is not used but the state of mind is described, and it ends up sounding behavioural e.g.
        - *"I was in a total frenzy in every way"*
        - *"I was in a dark place"*
        - *"It was like I just didn't have any direction, no idea where I was going"*
- **Stage 2 self-description that is superficial, abstract, generalized, intellectualized vs 3 self-description – style of reactions or behaviour in circumscribed area**
    - **Mode 2 peak 3: self-description that is superficial, abstract, generalized, intellectualized** Superficial list of motives, abilities, moral evaluations and attitudes.
        - *"I don't see anything wrong with the things that I've done, I think I was in the right"* ← Moral evaluation about self

        - *"The school isn't great. But I do want to stay. If the other teachers they had were very irresponsible, and I won't be, I do want to stay because I want to help to these kids."* ← Shallow external motive anchored to behaviour
        - *"I've learned to be self-sufficient".* ← *Too vague for 3 – abstract self-description*
    - **Stage 3: Self-description in circumscribed area of life**
        - E.g., a list of behaviours that the speaker engages in at soccer practice
- **Stage 2 narrative of events in which person is involved vs Stage 3 behavioural narrative with personal remarks**
    - **Stage 2: narrative of events in which person is involved**
        - *"I was with my uncle and we were at the dock, there was a huge fish, a good one, it took effort but we caught it. I think it's the biggest fish I've ever caught. Was a nice moment, I guess.* ← *We* see the speaker's ideas and intentions as evidence of involvement, but not much more.
    - **Stage 3: narrative of events with personal remarks**
        - E.g., a description of exam questions with several mentions of the student's stress level

Stage 3 vs 4

- **Stage 3 multiple feelings added to embellish a situation vs Stage 4 list of feelings**
    - If you have 1-2 different feelings tacked onto a behavioural narrative, it's level 3

- If you have 3+ feelings (i.e., you're getting a detailed picture) or the feelings are the focus, it's level 4

- **Stage 3 feeling vs stage 4 feeling with internal detail added** (often metaphor, imagery, or any additional description of what that feeling is like for them"
  - "My ego was shattered" vs "My ego was shattered. I felt I was nothing, as if no one would ever notice me."
  - "I felt sad" "I felt this wave of misery wash through me and it felt like I was never going to feel happy again."
- **Stage 3 behavioural narrative with personal remarks vs Stage 4 narrative completely from internal perspective**
  - **Stage 3:** Internal referents are sparse, or the same ones are reiterated. A few feelings are provided but they are scattered, several assumptions/perceptions at the time; still fairly behavioural/external and about their reactions to external things
  - **Stage 4**: Rich focus on emotions and inner perspective, focus is feelings in themselves and not external events
- **Stage 3 Self-description of behaviour in circumscribed situation vs Stage 4 situation widened by self-references:**
  - **Stage 3 description of behaviour in circumscribed situation**: focused on behaviour
  - **Stage 4 Situation widened by self-references** in-depth description of one situation, where internal referents are more frequent than behaviours/events or widened to show what person is like more generally

- **Stage 4 Self-characterization –** what the speaker is like generally but from an internal perspective

Stage 4 vs. Stage 5

- **Stage 4 rather than 5 when there's not much of a problem statement and it's more of self-characterization (a list of disorganized feelings without systematic examination).**

  If it's deeply internal but reads as a disorganized, disjointed list of feelings rather than a cohesive, systematic exploration of a part of themself, and you can't clearly tell how things they say are linked, it's probably a 4.

- **Stage 4 rather than 5 when there's an incomplete problem statement (no internal referent, or referent is too vague) so it's more of a Stage 4 self-characterization (a list of disorganized feelings without systematic examination)**
  - Mentioning a problem exists or using the word problem is not sufficient. It must be defined in terms of something internal (a feeling, aspect of self-image, pattern of behaviour) and specifically enough that the internal issue is clear.
  - *"I don't know how I feel" or "I don't know what my motives are" doesn't tell us what the internal referents are – the speaker doesn't even know*
    - *"I don't know who I am"* vs *"I used to be so happy, but I lost that part of myself… why?"*
    - *"I lost myself"* vs *"I just completely lost the confidence I used to have in who I am, why?"*
    - *"I don't understand my motives"* Vs. *"I don't understand why I always hurt the people I care about, I*

        - *feel awful…"*
        - *"I don't trust women"* vs. "*I don't trust women – it always feels like they're going to take advantage of me and make me regret it."*

- **Stage 4 rather than 5: problem statement without exploration (cause/implications/linked examples) so it's more of a Stage 4 self-characterization (a list of disorganized feelings without systematic examination).**
    - Without exploration, they're not in problem-solving mode, just self-characterizing.
        - *"My problem is I don't know how to connect - no matter how many friends I have, I feel isolated. I guess it is what it is."* ← If he stops here, he's not exploring the problem. Level 4 self-characterization: descriptive, not exploratory. This person is openly justifying the way he is by saying "it is what it is" rather than exploring it, trying to formulate and understand it more thoroughly.
    - After a problem statement, possible examples are listed that seem kind of irrelevant or are not linked back to the problem.
        - *"My problem is I don't know how to connect with people I care about - no matter how many relationships with people there are in my life, I always feel isolated. I made lots of friends at university, they weren't really friends though. Was always going out. Knew everyone. Kind of a strange time, really.*" □ If he stops here, the example is not clearly illustrative of the problem, and not enough feeling references to really call it illustrative. More Level 4 self-characterizing than Level 5 exploratory. Not really

trying to formulate the problem, define it, just goes off topic and tells us something that he doesn't link back to the main problem.

- **When Stage 5 criteria are broken up and interrupted by therapist speech, it might not be recognized as a 5.** This can occur at the higher levels (6 and 7 as well). This is another example of why **it's important to understand the segment as a whole.**

  Example:

  S: "When I come back, you know, like when I see an old coworker, why do I feel like this?"

  I: "Tell me more about what you're feeling."

  S: "Like, disconnected… does that make sense?" ← *problem statement 1/2*

  I: "It's understandable given that your life was uprooted so suddenly. You're feeling disconnected?"

  S: "Yeah, like, you know, from my old self. From the person I used to be, outgoing and happy." ← *problem statement 2/2 (note internal referent in statement)*

  *I: *long validating speech from therapist**

  S: "Yeah… Since I left for Windsor, it's felt that way whenever I come back. I used to be so sociable. I let go of all my friends when I left, you know. I left that version of myself behind and I put my career first instead." ← *cause + internal refreents*

  *I: *more therapist speech**

  *S: *client responds to therapist**

  *I: *more therapist speech**

S: "It's made it so painful to go to my apartment you know. Just looking at everything and remembering how happy I was when I had a big social circle, when I was connecting with people, making the effort to." ← *impact + internal referents*

Overall, it's easy to miss a 5 like this because it's a bit broken up.

Level 6 checklist:

Most of these are simply guiding questions. The only strict criteria are feeling, relationship, acceptance, and impact. (In the examples below, a different version of the checklist was used).

- Self-characterization (descriptive) or actively trying to understand their inner workings?
- Is it clear what the inner issue is?
- Intellectualized or basis in feelings? Are they intellectualizing to the point that you can't identify the inner referents involved and what their relationship is without inferring? yes/no
- Feeling/new feeling?
- Relationship revealed between feeling and other inner referent, such that inner workings of the speaker are made clear? (another feeling, self-image, private perceptions, motives, assumptions, even external aspects like behavior):
- Evidence of acceptance? (do they not outright reject it?)
- Impact: new experience/solution?
- If behavioural/external elements of solution, are they grounded in immediate feelings?

Using the checklist:

- **Does the speaker specify the inner issue**? (Be careful here – it's easy to infer!)

- If it's an external issue, t can count for 6 when the related feelings are presented as part of his present experience and the emergent formulation (i.e., the relationship) must shift the speaker's understanding of the problem.

- **If the impact is behavioural or external components, they must be grounded in feelings**
  - If parts of the "impact" criteria are behavioural/external (e.g., a resolution to change one's behaviour) they must be clearly relevant to the vivid feelings discussed and the restructuring process overall.
  - e.g. After realizing that feelings of loneliness (vivid feeling) connect back to a fear of rejection (restructuring), the speaker might then describe how these feelings have affected past relationships (impact) and decide to start being more open with friends (behavioural impact). This behavioural part only qualifies as part of the level 6 because it is evidently a result of the prior restructuring. If instead the speaker only expressed an intention to be more conscientious, it would not be relevant to the restructuring process and would therefore not be considered part of the level 6.

Stage 5 vs Stage 6:

- **A 5 and 5 rated is mistaken for a 5 and 6 because some 6 criteria appear to be met:** The speaker gives a level 5 formulation then mentions a possible cause of the problem. Suggesting a cause can make it feel like there's a change in perception representative of 6. However, mentioning a possible cause is not sufficient to meet all 6 criteria. A cause can be part of the level 5 exploration. Other parts of the Level 5 exploration can superficially seem like 6 criteria, and vice versa.

- **Missing the Peak: A 5 and 6 is rated as a 5 and 5** Stage 5 formulation that peaks at a 6, but the 6 is missed because the vivid feelings and change in relationship to those feelings are interpreted as parts of the 5 formulation, as sometimes a 6 may contain some exploration-like elements of a 5 that may actually just be evidence of acceptance and impact. May happen when some of the 6 criteria are weaker, e.g. perhaps the feelings are vividly presented but it doesn't "feel" like a shift in perspective. A Mode 5 and Peak 6 is where a problem is posed and elaborated upon, and then answered. They may simply be answering the question posed by the Stage 5 problem statement.
- **A 6 and 6 is rated as a 5 and 5:** The segment may start off briefly with a level 5 problem statement and then shift rapidly into Stage 6 where it stays. For example, the clients might briefly discuss a fear of loneliness then suggest it represents an underlying fear of rejection. She may start with a brief level-5-like formulation of fear of loneliness, after which the majority of the segment is spent on level 6 criteria (impact, resolution, maybe examples) explaining the new perspective (fear of rejection) which are mistaken for Stage 5 exploration because we think she's still talking about the original perspective (fear of loneliness).

Stage 4 vs. 6

- **Level 4 when new feelings are detailed and the impact of these feelings is given, but the restructuring process is not revealed**
    - A speaker might discuss new feelings of confidence and describe how she is more open to expressing herself around others. However, no restructuring occurs, as the

feelings of confidence are not linked to anything else. Accordingly, we do not have a precise picture of what exact relationship the speaker has identified.

- **Level 4 when vivid feelings are detailed but they are disorganized and not clearly linked to one another and it is unclear which feelings exactly are involved in the restructuring**
    - A speaker might elaborate upon feelings of insecurity, a tendency toward self-criticism, and a tendency to be critical of others, without clarifying the relationships between these feelings. We need to know exactly what relationship was identified and precisely how it impacted the speaker.

Rating EXP in Cognitive-Behavioural Therapy

Trends in this dataset

- Since this is a different type of therapy, there will be many ambiguous segments where it is necessary to rate use your best judgment and holistic understanding of each level
- The therapist takes on a very active, directive role, and more frequently interjects commentary. The client's statements should be taken as a whole even if broken up by statements from the therapist.
- Since the segments are longer, running ratings may be helpful for keeping track.

Rating Treatment Components from Cognitive-Behavioural Therapy

- Thought records involve breaking down a situation where a client feels highly distressed. The client lists feelings and thoughts that emerged in that situation and gathers evidence for or against the thought that drives most of the distress. The client may be writing. The

therapist may ask the client to generate a sentence that represents a thought or that elicits the most distress. Many comments here may in fact be hypothetical. For example, if the client asks the therapist what they would tell a friend in their situation, it is a level 2 as the comment is personally relevant but does not reflect the client's own experience.

- Exposures involve behaviourally confronting anxiety-provoking situations to practice tolerating anxiety, such as increasing heart rate to bring on panic attack-like symptoms (panic disorder) or touching a dirty surface (OCD).
- Mindfulness Exercises involve breathing exercises, progressive muscle relaxation, or mental imagery. Do your best to rate what the client says while remembering the following questions. Is the client focusing on their physical state or their emotional state? Are they treating their body as an object, such that third person narration could be used, or are they not?
- Case conceptualization**:** When the therapist is presenting their "impressions" or "formulation" about the client's symptoms, often speaking at length. Usually, the client says little during such segments. **Rate this as you would any other segment**, keeping in mind the suggestions listed below under "Rating segments where the therapist is primarily speaking"

Rating segments where the therapist is primarily speaking

- The client may primarily speak in "yes" or "mhms" when the therapist is providing psychoeducation, a diagnosis, or case conceptualization; the rating would then be based on the degree of this, as well as context. Some transcripts of a session may include all of

these minimal comments; other transcripts may exclude them. Referring to the audio or video of a segment is helpful for determining where they are and in what context.

- Therapist is speaking for **all** of the segment, and the client **exclusively** says "yes" and "mhm" is rated as a Level 1,
- Therapist is speaking for **most but not all** of the segment, and based on the video you can tell that the client is saying "mhm" simply because they're listening, rate the client's speech as if it were the mode and peak.
- Therapist is speaking **most but not all** of the segment and based on the video, the therapist is asking questions and the client is providing terse, unelaborated responses (e.g, responding "I don't know" to an open-ended question from the therapist), rate it a Level 1

What level are thought patterns?

- Clients often discuss "thought patterns" or "automatic thoughts" "core beliefs"
  - **A thought pattern is a private perception. It's essentially a pattern of reactions, which are stage 3. It will probably be a level 3 or higher – rate it normally based on its breadth and depth with that in mind.**
    - *"I have a tendency to assume people are judging me"*
    - *"I have all these negative thoughts whenever I think about grades"*
    - *"My automatic thought is that people will laugh at me"*
    - "I think I have a core belief that I am unlovable"

Rating the Therapist's text

- You can use the therapist's words as **context** to understand what the client is **referring to**, but do not rate the therapist's text.
- The client has to use the emotion/feeling word for it to count, or reiterate it. If the client uses it earlier or later in the segment, it counts.

Specific terms that are challenging

"Avoidance"

- Rate depending on the context and the way it's used. It can be a behaviour or state of mind.
- "I avoided that kind of job" – Level 2, narrative event, behavioural
- "I'm pretty sure I wasn't doing anything about it out of avoidance." – Level 3, state of mind
- "I tend to avoid people who are too gregarious, I always feel like they think I'm somehow weak or incompetent because I'm too quiet, and it makes me feel really awful about myself, like I just can't measure up." – Level 4, behaviour with accompanying internal referents

"Energy level" and "tension"

- Based on context, we can do our best to infer whether they're referring to mental or physical energy/tension

Appendix D: Rater Training Materials: High EXP Levels Assignment

EXP Training Assignment – Scale Summary

- Create a summary of the Experiencing Scale in your own words. You do not need to include Level 7. The end product will resemble an abbreviated version of the original scale.
    - The following elements should be included in your scale summary:
        - The main variants of each level of the scale
        - Any specific criteria needed to meet a level
        - Any additional rules specified in the manual for distinguishing levels
- Write one or more original examples for each level of the scale.
    - Please annotate the examples sentence-by-sentence with brief explanations of which elements of a stage are visible. For levels 5 and 6, please be specific about the criteria and use the criteria template provided in the guide.
- In terms of formatting, point form is acceptable. You are encouraged to use colour coding. (For example, in the coding guide, necessary criteria for a stage are included as a numbered list, while different variants for each stage are letterd [i.e., A, B, C, etc.]

Appendix E: Rater Training Materials: Scale Summary Assignment

EXP Training Assignment – Levels 5 and 6

1. **Choose one past training segment with a mode, peak, or mode and peak of 5. Choose another segment that you gave a mode, peak, or mode and peak of 5 for which the correct rating was different.**
2. **Fill in the criteria below for each example.**
    - The manual answers are available to you for reference. Your task is to lay out the criteria in an organized way. Ensure you are defending the reasoning from the manual rather than using justification based on any idiosyncratic interpretations of scale concepts.
    - Refer to annotations of training segments from the coding guide for examples of how the criteria are filled out.
    - Ensure you explain your answers fully. For each question, provide quotes from the training segment that you chose. Justify your reasoning for why this segment meets each criteria for the level you chose.
        - e.g. “This segment is Exploratory rather than descriptive because the speaker is trying to understand the origin of her guilt about ____”.
        - e.g. “The speaker defines an internal problem/hypothesis – her feelings of guilt around not being married - based on an internal referent, guilt.

Level 5 criteria

1. Exploratory rather than descriptive
2. Problem statement based on internal referent
3. Exploration (specify which type of exploration) with internal referents

Level 6 criteria

1. At a level 6, a speaker successfully "connects the dots" between a feeling and another aspect of their internal experience, or in some cases a behavioural pattern. Has the speaker done this? Alternatively, is the speaker being descriptive and simply self-characterizing? Or, is the speaker being exploratory, in the sense that they are still attempting to understand an aspect of their internal experience?
2. Is the inner issue at hand clear?
3. Has the speaker described vivid feelings? Are these new or changed feelings?
4. Has the speaker revealed a relationship between this vivid feeling and another inner referent or inner referents?
5. Is there evidence that the speaker accepts that this relationship is accurate? Alternatively, have they rejected it, or perhaps reached a conclusion but then changed the subject rather than demonstrating impact?
6. How does the speaker's novel understanding of this relationship impact them? Do they form a new conclusion/solution or have a new emotional experience as a result of uncovering this relationship?
7. Are there behavioural/external elements to the solution that are grounded in immediate feelings?