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UNIVERSITY OF ALBERTA

Measuring Clients' Emotional Experience in Counselling

By

Jody C. A. Sark 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Education

In

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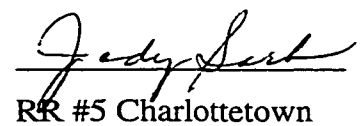

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Abstract

The purpose of this study was the development of a self-report measure of clients' emotional experiencing in counselling, with the intention of accessing the clients' experience of emotion in therapy. Items were derived from client statements from five research studies investigating clients' counselling experiences. They were reviewed by a panel of judges and refined in an administration of the scale to 16 clients, 13 of whom were interviewed about scale. The resulting scale is comprised of three areas of client emotional experiencing: awareness, intensity, and restructuring emotion schemes. Positive correlations among all the subscales were found to be significant, suggesting that the subscales measure the same construct. Initial evidence for internal reliability, content, and construct validity was established. Suggestions for future research include the validation of the scale with other measures of change and with interviews of clients about their emotional experiences in counselling.

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Measuring Clients' Emotional Experience in Counselling submitted by Jody C. A. Sark in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

Barbara Paulson

Dr. Barbara Paulson, Supervisor

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Dr. Robin Everall

Carol Leroy

Dr. Carol Leroy

Date: April 26, 2000

To My Mother:

Whose silent eloquence and patience has shown me the process of life, and in doing so, has provided me with a broader perspective from which to view the counselling process and the therapeutic alliance.

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CHAPTER I: INTRODUCTION

The measurement of therapeutic change is not well understood in the realm of counselling research (Stiles, 1999). At the same time, evidence of the role of emotions in facilitating therapeutic change is becoming more common (Greenberg & Paivio, 1998). Counselling research has undergone three major shifts that suggest the development of an instrument to measure clients' in-session emotional experiences to investigate the role of emotional experience in counselling. They include the shift from (a) investigating outcome to investigating the process of counselling, (b) investigating the therapists' perspective of the counselling process to focusing on the clients' perspective, and (c) investigating cognitive processes as primary facilitators of change to researching emotions as primary facilitators of therapeutic change.

Shifts in Focus

Therapeutic process refers to what happens in counselling while therapeutic outcome refers to changes that occur as a result of the processes of therapy (Hill & Corbett, 1993). Early researchers in counselling focused on process until pressure from health services providers demanded accountability for services (Rogers, 1953). In the mid 1950s, the focus changed to establishing the efficacy of counselling through outcome research (Hills & Corbett) so that research on process would be more meaningful. While research has indicated that counselling does elicit improvement for clients (Asay & Lambert, 1999), less is understood about what causes those changes. Thus, the most recent shift has gone back to investigating the therapeutic process in order to access what is happening within the client in the counselling session that may be responsible for

positive therapeutic change. Thus, research is returning the focus to events that may be responsible for therapeutic outcome (Cummings & Hallberg, 1995; Elliott & James, 1989).

Traditionally, information gleaned about the process of counselling and therapeutic outcome has come from the counsellors' or observers' perspective (Klein, Mathieu-Coughlan & Kiesler, 1986; Rice & Kerr, 1986). Several problems can be identified with these approaches. First, clients' experience can only be assumed from observable characteristics, such as facial expression and other nonverbal behaviors. Internal experiences, such as feelings are less visible. Thus, observer methods limit what can be measured. Second, these approaches are dependent on the observers' ratings, which have been found to be different from the clients' perspective (Elliott & James, 1989; Orlinsky & Howard, 1986). From these findings, questions regarding the validity of raters' perceptions arise.

Recently, the clients' perception of their experience of emotions has been identified as an important component of change in counselling (Beutler et al., 1999) and the need for research that examines clients' constructions and interpretations of their counselling experiences has been identified (Heppner, Rosenberg, & Hedgespeth, 1992; Martin & Stelmaczonek, 1988). Knowledge of the client perspective is necessary in understanding the therapeutic process (Elliott & James, 1989; Heppner et al., 1992) because little is known about how clients make sense of their experiences in counselling or how their internal processes influence their experience of emotions and the resulting motivations and behaviors. The need for understanding the client's experience in

counseling and in particular, emotional experience in the change process in counseling has generated a shift in focus for researchers to placing increased importance in investigating the client perspective.

Specific factors are thought to influence the therapeutic process and may be responsible for therapeutic change. In the past, cognitions have been thought to play a fundamental role in psychological functioning and therapeutic change (Beck, 1976). Muran et al. (1995) provide empirical evidence of the link between cognition and therapeutic change but measures of the role of emotions in creating that change were ignored. Some researchers have favored the role of affect in producing change (Greenberg, 1993) and postulate that the experience of emotions occurs prior to cognitive processes (LeDoux, 1996; Izard, 1991; Zajonc, 1984). It has also been proposed that emotional and cognitive processing work independently of each other (Greenberg & Safran, 1990; Plutchik, 1994).

Psychotherapy researchers have speculated about the role of emotions in positive therapeutic change (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Cohen, 1997; Kosmicki & Glickauf-Hughes, 1997; Mackay, Barkham, & Stiles, 1998; Mills & Wooster, 1987; Pennebaker, 1995; Watson, Greenberg, & Lietaer, 1998) and have concluded that emotions are important in achieving therapeutic change. However, there are limited available tools to verify these speculations from the clients' perspective, especially tools that are easily administered and interpreted.

Since emotions are thought to have mobilizing influences in one's understanding of his or her own experiences, they are especially important in the creation of meaning

and as an adjunct to taking action (Clark, 1996; Cohen, 1997; Greenberg & Korman, 1993; Greenberg & Paivio, 1997, 1998; Greenberg & Paivio, 1998; Greenberg & Pascual-Leone, 1997; Izard, 1991; Korman & Greenberg, 1996; Littrell, 1998; Young & Benmark, 1996). Knowledge of clients' emotional experiences is particularly helpful for therapists concerned with accurately assessing the clients' experience in order to guide the client appropriately and safely (Machado, Beutler, & Greenberg, 1999) and is an indicator of how therapy is progressing (Saunders, 1999).

A deeper understanding of emotional experiencing will provide clinicians with the ability to facilitate client change more effectively across a variety of client concerns. In fact, emotional problems are the main reasons that individuals seek therapy (Lang, Cuthbert, & Bradley, 1998; Mahoney, 1995). Some common problems include feelings of distress (Lang et al., 1998), the pain of negative affect, fear of feeling, emotional numbing, emotional reactions and emotional conflict (Mahoney, 1995). Walborn (1996) expresses the essential role of emotions in therapy when he says, "Effective therapy is usually an emotional experience" (p. 266). Emotions provide clues about how events, states, and other people affect us. Thus, emotions are essential in therapeutic change (Greenberg & Paivio, 1998).

Historically, claims of the therapeutic importance of emotion, including emotional expressiveness and experiencing in therapy, have not been supported by empirical evidence (Stalikas & Fitzpatrick, 1996). Heesacker and Bradley (1997) attribute this gap to the lack of focus on emotion in graduate student education and with psychotherapists and theorists, the lack of suitable research methodologies or presence of external validity

in existing studies, and the lack of consensus regarding theoretical issues. More recently, researchers and theorists have begun to investigate and theorize about emotional experiencing in counselling. While experienced practitioners are familiar with the processes of counselling, the research focus has shifted to identifying clear ways to understanding what we have experienced (Stiles, 1999).

These shifts in counselling research signify the growing acknowledgement of the importance of conducting research on the process of counselling from the clients' perspective. The identification of emotional experiencing as important to therapeutic change further focuses attention towards the same end. That end is to gain information about what causes change to happen so that therapists can focus their efforts on those change mechanisms. Although a growing body of literature exists (Greenberg & Korman, 1993; Horowitz, Ewert, & Milbrath, 1996; Pennebaker, 1995) that supports the utility of emotional experiencing in the therapeutic process, the majority of this information exists, like other investigations regarding counselling, from the therapist or observer perspective. It is hoped that studies investigating not one, but multiple perspectives will generate the necessary understanding needed to improve counselling efforts.

Defining Emotional Experience

Emotional experience is defined herein as a process occurring at the neurological, biological and cognitive levels. It occurs, in part, prior to our conscious awareness. Physiological factors signify the emergence of emotions into awareness and cognitions are necessary to evaluate those emotions. They are motivational and informing agents on what is important. Thus, they are essential ingredients to achieving therapeutic change.

Statement of the Problem

The measurement of emotional experience as it is directly necessary for informing motivation and action, as described in the biological theories of emotion (Izard, 1991; Plutchik, 1984), would inform practitioners and researchers on how clients change (Greenberg & Korman, 1993) and provide empirical evidence for existing models of emotional change (e.g., Greenberg & Paivio, 1997). However, no instruments exist that that concurrently take into account the clients' perspective, the process, and the role of emotional experiencing for the client.

Those instruments that do exist focus on specific symptoms (Symptom Checklist 90 R: Derogatis, 1983), outcome (Outcome Questionnaire: Lambert et al., 1996), the session itself (Session Impacts Scale: Elliott & Wexler, 1994), judges' ratings of visual aspects of emotion (Horowitz et al., 1996), auditory aspects of emotion (Client Vocal Quality System: Rice, Koke, Greenberg, & Wagstaff, 1979), non-therapeutic dynamics of emotions (Affect Intensity Measure: Larsen, Diener, & Emmons, 1986), the intellectual aspects of emotions (Schutte et al., 1998), and moods (Coughlan, 1988). One step toward closing this gap is to develop a valid and reliable measure of clients' in-session experience of emotion.

The purpose of this study is to develop a self-report measure of client's in-session emotional experiencing in counselling and to establish initial evidence for the reliability and validity of the measure. The scale is intended to provide an accurate estimate of clients' in-session experience of emotions for the purpose of investigating the counselling process. The addition of this instrument as a tool in counselling research will provide

information that will increase therapeutic efficacy across a number of domains. They include: (1) decreasing the time and cost of therapy; (2) providing empirical evidence for existing psychotherapeutic theories of emotion; and (3) identifying effective intervention skills for training and practice.

Summary of Chapters

This thesis begins with a critical review of the literature from which the need for the Emotional Experiencing Scale (EES) was generated. It involves the historical antecedents of emotion in psychology's past while identifying the contributions of psychological theories and the common notion among these theories that emotions are basic processes that contribute to individual functioning. The translation of psychological theories of emotions to psychotherapeutic theories of emotion is then delineated. The contribution of psychotherapeutic theories of emotions rests in their direct involvement with people and is characteristically evident in experiential approaches to therapy, although the psychodynamic and cognitive-behavioral therapies have affective components.

Empirical evidence of these theories and their effectiveness in practice is presented. These studies, especially those investigating the effectiveness of psychotherapeutic theories in matters of emotion, are scattered and risk the importance of generalizeability. From this review, an increase in interest of the connection of emotional experiencing to therapeutic change is expected.

The conceptualization of emotional experiencing as having neurological, biological and cognitive components, precedes an overview of specific emotions inherent

in the counselling process and identifies the purposes of emotions in three levels: survival (primary), learned reactions (secondary), and manipulative (instrumental) (Korman & Greenberg, 1996). It is emphasized in this section that emotions cannot easily be distinguished from the process of which they are a part.

Next, empirical evidence of the role of emotions in therapeutic change is described and analyzed. Much of this research stems from investigations of good moments in therapy, important and helpful events in therapy, and the regulation of intensity levels in therapy. These studies suggest that emotions play a major role in gaining therapeutic progress and together, identify concern for the lack of attention to the clients' perspective of what is happening for them emotionally in therapy.

An overview of the historical methods of measuring emotions is presented, most of which involve the biological components of emotion, such as increased heartbeat. Also, research measuring therapeutic change and emotions in and outside of therapy are analyzed and the past predominance of raters' analysis of clients' experience in counselling and emotions is examined. Critical descriptions of the available instruments measuring change, emotions in and outside of the counselling session, and emotions in everyday life, as well as the measurement of moods are presented.

Finally, critical issues in the measurement of emotional experience are presented. In particular, the issues regarding the predominance of observatory methods on a construct that cannot easily be observed is discussed. It follows from this review that no self-report measure of clients' in-session emotional experience exists despite the need expressed in the literature.

Chapter III documents the process by which the EES was developed. It describes the construction of the items from client statements, the design of the scale as self-report with a 5-point response format, the review and revision of the items by counselling psychologists and student clinicians, and the administration and statistical analyses of the instrument using a sample of 16 clients, some of whom were interviewed about their experience completing the scale. The methodology used herein follows recommendations made by Dawis (1987), Likert (1932), and DeVellis (1991).

Chapter IV presents the results of the three phases of scale construction. Revisions to the scale are described. Correlational analysis was found to support the internal reliability of the scale and the use of a theoretical focus (Greenberg, 1993). Concern for the Intensity category is described. Client statements and judges' relevance ratings of the items to categories offer evidence of the content and construct validity of the scale.

A discussion of the results is presented in Chapter V and includes comments on the confirmatory nature of the correlational analysis, the problematic nature of the Intensity subscale, validity and reliability, and concern for the small sample size. Suggestions for future research are presented and include the administration of the revised EES to a larger sample with a measure of change and a trait measure of emotional intensity. Interviews accessing the same clients' verbal reports of their emotional experiences in therapy are also suggested. Other recommendations include the repeated administration of the scale during clients' progression through counselling and the use of

factor analysis to establish further statistical support for the categories. Practical implications are also discussed.

This thesis concludes with a comment on the establishment of emotional experiencing as a measurable construct. The development of a scale to measure clients' in-session emotional experience, as described in this thesis, offers a valuable tool in the investigation of clients' experience in counselling and how that experience relates to change.

CHAPTER II: A REVIEW OF THE LITERATURE

Introduction

This literature review will examine client emotional experiencing from three major perspectives that include (a) the psychological and psychotherapeutic theories of emotion; (b) emotions and psychotherapeutic change; and (c) existing measures of change and emotional experience in counselling. The literature review will demonstrate the need for a feasible measure of emotional experiencing in counselling for both research and practical purposes and that the intended measure, by the nature of the importance of the perspective of the client, is best developed in the form of a self-report. The terms "therapy" and "counselling" will be used interchangeably, throughout.

Psychological Theories of Emotion

Emotions have been a focus of psychology from its initial establishment as a formal discipline. As Psychology evolved from the discipline of Philosophy, so too did the understanding of emotions. Aristotle, for example, saw emotions connected with experiences of pleasure and pain (Strongman, 1996). Descartes saw emotions to be a human experience exclusively, with a cognitive influence according to the emotion's place in other mental processes (Strongman, 1996).

Physiological, Biological and Neurological Theories of Emotion. The movement of emotion from philosophical to psychological thought was clearly delineated in William James' assertion that emotions precede behavior in the form of bodily sensations resulting in motivational effect (Izard, 1991). For James (1884) the physiological and observable or expressive characteristics of emotions were emphasized in one's

experience of emotion. James asserts that the physiological sensations of reactions to situations, such as crying, cause subjective experiences (Greenberg & Safran, 1987). Barbalet (1999) supports James' theory of emotion and clarifies the theory by emphasizing James' assertion that although the emotional reaction ends in the body, the consequences, such as thoughts and actions, do not. The body sensations are only the consciousness part of James' theory of emotions, even though they have been taken historically to mean the entire theory. James' focus on the bodily basis of emotion in the consciousness stage more accurately indicates that the experience is grounded within the self. In this respect, Barbalet communicates his sentiment that James' theory has been critically misunderstood.

The James-Lange theory is an advancement of James' initial emphasis on the sequential order of events in the experience of emotion combined with Lang's recognition that the sequence of events is initialized by the perception, followed by a motor response of organic nature and then by the emotion (Trettien, 1935). This sequence is illustrated in the calmness one experiences during an emergency, only to experience the wave of emotion when danger has subsided. According to this theory, neurological and affective reactions are an interrelated system that allows for the experience of emotions. According to the James-Lang theory, people know they are frightened because they feel their racing heart and run away.

With respect to biological theories, primary emotions, such as anger and fear, are seen to be the informing agents that evaluate stimuli by providing bodily sensations and action tendencies about situations (Frijda, 1993). They are necessary components in the

integration of cognition and motivation (Greenberg & Korman, 1993). This evaluation allows the individual to assess the situation in order to react accordingly.

Frijda (1993) views the evaluation process as being automatic and therefore non-conscious. His theory takes into account the social and cognitive aspects of emotion, as well as regulation. His conceptualization of emotional experience primarily concerns the awareness of the experience as pre-determined by a diagnosis, an evaluation, and physiological change. According to Frijda (1986), emotions have a biological and thus survival function within a framework of regulatory processes influenced by both the event and the propensities of the person. These postulations are set in an information-processing model whereby events are evaluated according to past experiences in terms of their degree of relevance, difficulty and seriousness. A plan of action is generated and physiological sensations are experienced.

Plutchik's (1998) psycho-evolutionary perspective of emotions takes into account the entire bodily reaction inherent in the experience of emotions. This reaction is experienced and readily observed by others and takes into account the hypothetical nature of verbal reports of emotions. In this regard, Plutchik's psycho-evolutionary theory of emotion stresses the importance of both communicative and survival functions. Plutchik (1993) emphasizes the multidimensionality of the construct. For him, emotions can vary in intensity and their similarity to other emotions.

Other theorists focus on the interplay of brain mechanisms, sensory-perceptual processes, and thought processes. Heilman (1997) proposes a neurological model for emotional experience whereby the frontal lobes and right hemisphere are important for

mediating beneficial and detrimental emotions, and arousal and motor activation, respectively, with regulatory activity from the cortex in the limbic system, basal ganglia and reticular systems.

LeDoux (1996) also emphasizes the role of the brain in our experience of emotions. According to him, emotions are seen as less a psychological construct than a biological or neurological construct with an evolutionary function. He postulates that the behavior and physiological responses to stimuli occurring as part of the emotion have an underlying system connected to the generation of conscious feelings in much the same way that other states of consciousness are elicited. In this system, emotions influence cognitions as a parallel occurrence to the amygdala influencing the cortex. Thus, emotions are felt when brain functions become activated. Those pathways run independently to the neocortex, which is responsible for higher cognitive thinking.

Greenberg and Safran (1989) suggest a more contemporary biological/ evolutionary perspective on emotions. This perspective rests on the assumption that expressive motor behaviors correspond to primary emotions. Both of these have a predetermined neurological status for which one's development and memory enhance more advanced interpretations of primary emotions. They also enhance capability for secondary and instrumental emotions, such as love, pride, and humility. The reflexive nature of these emotions is based on biological and psychological survival functions.

Cognitive Theories of Emotion. Cognitive theories evolved from the philosophy of Aristotle, Aquinus and Kant and emphasize the rational stature of man, the negative stature of emotions, and the fact that reason should be substituted for emotions (Izard,

1991). Cognitive-behavioral therapeutic models view emotions as occurring after the creation of meaning of an event or situation. In this respect, the focus of therapy tends to be on the belief or thought that creates the emotional response. In this process, the reduction of emotional experiencing is encouraged.

Leventhal's theory of emotion is based on an information processing model composed of a hierarchy of three levels of processing: (1) the expressive motor level; (2) the schematic or perceptual memory level of emotional situations, experiences, and reactions; and (3) a conceptual level for processing those situations, experiences, and reactions (Leventhal & Tomarken, 1986). Like others before him, Leventhal views emotions as informants on how the environment affects us. These levels involve a biological cue that forms a representation on which to form a belief or perception, such as the clients' perception of their experience in therapy.

Cognitive arousal theories assume that the interaction between physical arousal and cognition produce an emotional state, with the former determining only the intensity of the emotion and the latter determining the quality of the emotion (Leventhal & Tomarken, 1986). Cognitive appraisal theories, such as the one set forth by Arnold (1968), emphasize the evaluative function of emotions from which our memory of past experiences and imagination play a role. The intensity of the tendency to act is defined as the emotion in this process. Similarly, Lazarus (1991) asserts that the appraisal defines the emotional response and the action tendency becomes a learned response from other experiences.

One of the central matters in many theories of emotion is the sequence of cognition, behavior and physiological experience. Recently, the commonly held view that favored the primacy of cognition over emotion has been challenged and the independence of these processes has been proposed (LeDoux, 1996; Greenberg & Safran, 1990; Plutchik, 1994; Zajonc, 1984). Lazarus (1991, 1984) on the other hand, views this sequence to occur simultaneously. Along with stressing the importance of cognitive factors of emotion, Lazarus' theory of emotion incorporates biological and cultural factors, such as the learned conditions under which we experience grief.

Further discussion of the sequence of cognition, behavior and physiological experience is apparent in multi-level models of emotion. Power and Dalgleish (1999) present a multi-level cognitive theory of emotion for use in therapy. This model begins with the initial processing of stimuli in sensory systems. Output from this system enters the remaining three systems in parallel. These systems include (1) the semantic level whereby emotion-laden names of events trigger feelings, (2) the associate level, taking the form of various modularized connectionist networks, and (3) the schematic or prepositional level, from which the evaluation of the sensory stimuli triggers the emotion. At this point, two routes of emotion exist as options. The first route is automatic and has a direct effect on the individual, such as the survival function of running away upon the presentation of a snake. The second route has a less immediate effect and favors an appraisal or evaluative function. This line of thinking, which is similar to that of Zajonc (1984), has a direct effect on the therapeutic process and suggests the potential danger in assuming a solitary route to emotion.

The value of these theoretical approaches to emotion is that they act as informants on the potential role that emotions play in psychotherapy. Individual theories, by themselves, do not take into account the complexity of emotional experience. Each theory of emotion differs in its emphasis on the role of cognitions, bodily sensations, and neurological factors. They each contribute information about the process of emotions. They all endorse the point that emotions are basic processes that contribute to our functioning as individuals. This adaptive and survival aspect of emotion is important to psychotherapy because therapy deals with the needs, goals, and concerns of clients, as well as the preparation for action and change. In this respect, emotions become a guiding structure in informing the individual about what is important to them (Korman & Greenberg, 1996).

Psychotherapeutic Theories of Emotion

Emotional experiencing is considered an essential process in various theories of psychotherapy (Wiser & Goldfried, 1993). Psychological theories of emotion easily translate into psychotherapeutic theories of emotion by using emotions to inform us on the meaning of events to the individual. This meaning, when it is recognized, is important in the organization of actions (Greenberg, 1993; Littrell, 1998). Both the experience of emotions and the resulting organization of reactions to those emotions are frequently dealt with and experienced in therapy. Generally, psychotherapeutic theories of emotion may be distinguished according to their premise that emotions may be either experienced or suppressed or both.

Psychoanalytic Approach to Emotion. Although there is no consensus for a theory of emotion in psychoanalytic approaches there is a clear view that affect and emotions are important in therapy, especially with respect to resistance and transference. In psychoanalytic therapy, therapy goals include the reconstructing the personality through accessing unconscious material and overcoming resistances to the awareness of that material (Parrott, 1997). For Freud (1910), high levels of emotions were observed to distinguish hysteria from non-hysteria and emotion emerged from being seen as a psychic energy to being seen as a discharge process. This catharsis was considered the central process in therapy to restoring normal functioning. Emotions, in this perspective, consist of the drive or change of the affect as well as the expressive nature of emotions (Izard, 1991). Clients' emotional experiences are also utilized in helping the client to understand transference (Saunders, 1999).

Cognitive-Behavioral Psychotherapeutic Approach to Emotion. In the last fifteen years, the view that emotional experiences are mediated by cognitive processes is becoming less common. However, the process of experiencing emotions does have a cognitive component and the cognitive theories provide valuable information about that component.

Cognitive approaches to therapy usually emphasize that the meaning of an event causes the emotional experience (Beck, 1976). Some cognitive-behavioral therapists focus on the influence of irrational thoughts and beliefs as causes of psychological disturbances (Ellis & Dryden, 1997). Rational-Emotive Behavior Therapy (REBT), for example, focuses on changing clients' irrational thoughts that are disruptive or self-

defeating (Ellis, 1986). Change is thought to occur by (1) increasing the clients' awareness of their role in creating their disturbance, (2) helping clients to understand that those disturbances stem from irrational thoughts, and (3) teaching clients to dispute those thoughts and implement effective beliefs (Ellis & Dryden).

Other cognitive-behaviorists focus on the influence of automatic thoughts and note that emotions are "logically connected to the content of the automatic thought" (Beck, 1995, p. 76). The emotion may even be more profound than the thought. Therapeutic goals resemble those of REBT and include evaluating automatic thoughts and emotions and modifying dysfunctional beliefs (Beck).

Clarke (1996) presents evidence for the use of a model for emotional experiencing that resembles cognitive interventions. According to Clarke, the creation of meaning is essential in processing emotional experiences in therapy. It involves the use of language in describing the experience in order to explore what the client felt and why they felt that way. These steps act as a precipitant to the decision to maintain or revise the belief resulting from the feeling. Validation of this model identified four essential steps in distinguishing between successful and unsuccessful creations of meaning. They include (1) the challenge of a cherished belief, (2) the emotional reaction, (3) the hypothesis of the origin of the initial belief, and (4) the evaluation of the belief.

The role of emotions is beginning to emerge in therapies formally attending to cognition and behaviors (King, 1998; Kiser, Piercy & Lipchik, 1993). This is the case with solution-focused therapies. King offers a solution-focused approach to therapy with the involvement of emotions. This novel approach to solution-focused therapy involves

setting the stage for emotional experiencing. King explains that this context may be obtained with the therapists' empathy. This empathic nature allows him or her to immerse in the clients' experience and become an involved co-developer in creating meaning for the client. In setting goals, the counsellor is intended to meet the client at an emotional level from which behavioral indications can be constructed. This process signifies the recognition of the important role of emotion in therapies formally focusing on cognition and behavior.

Experiential Psychotherapeutic Approach to Emotion. The Experiential tradition (Perls, Hefferlene, & Goodman, 1951; Rogers, 1957) views emotional experiencing as a necessary component in achieving therapeutic change. In this approach, the importance of emotion is characterized by its role as a motivating agent for change. Experiential therapies emphasize awareness, discovery, inner experience, and the creation of meaning, all of which lead to motivational tendencies toward development and change (Greenberg, 1993). Dysfunction is viewed to follow from (1) the disorientation a person feels when failing to acknowledge his or her immediate experience and (2) the activation of maladaptive beliefs (Paivio & Greenberg, 1998).

The importance of emotions in therapy, according to contemporary theorists of existential therapies (Greenberg & Paivio, 1998), stems from the clients' awareness of the adaptive functions of emotions as postulated in biological theories (Fridja, 1993; Lazarus, 1991). This physiological component is connected to previous experiences, beliefs, and motivation. The resulting structure is defined as an emotion scheme from which the entire process of emotional experiencing can be described (Greenberg & Paivio). Therapeutic

modification, thus happens through the activation of these emotion schemes (Greenberg & Paivio).

Emotionally-focused therapy (EFT) evolved from a combination of experiential, biological, and evolutionary theories of emotion whereby emotions organize us for action by informing us about how the environment is or could be affecting us (Greenberg & Paivio, 1997). In this process-experiential approach, the experience of emotions is seen as a multi-component process consisting of physiological changes, meaning, and action tendencies (Greenberg, Rice, & Elliott, 1993). Much like cognitive therapy, EFT focuses on restructuring experience. The difference with EFT is the perception of the usefulness of intensifying and expressing emotions. The focus of EFT rests on "bodily experience, situational cues, memories, needs, goals, expectations, and the person's sense of efficacy that leads to the thoughts, rather than the thoughts themselves" (Greenberg & Paivio, 1997, p. 22). Emotional intelligence is required to evaluate these latter stages, thus involving a cognitive component (Paivio & Greenberg, 1998).

Emotionally-focused interventions involve synthesizing emotions, evoking emotions, restructuring emotions, and accessing state-dependent core beliefs emerging from the evocation of emotional experiences (Greenberg & Safran, 1989). More specifically, therapeutic interventions may include acknowledging emotions, evoking and intensifying emotions and restructuring emotion schemes (Greenberg, 1993), depending on the stage of therapy the client is in and the direction of regulation desired.

From a therapists' point of view, the treatment process in EFT involves three phases as described by Greenberg and Paivio (1997). The first phase concerns the

therapeutic relationship. In this alliance, the therapist attends to, empathizes with and validates the clients' feelings, along with developing a collaborative focus.

The second phase deals primarily with the emotions and the regulation of intensity through evoking and exploring those emotions and overcoming avoidance of emotions. This stage concerns the desired intensity levels for allowing emotional experiences that are orchestrated according to the readiness of the client to handle such allowing. It is in this stage that the optimal level of emotional experiencing for eliciting change is sought. This may involve either increasing or decreasing the intensity level of the session.

The third phase consists of restructuring emotions by accessing maladaptive schemes, challenging the beliefs inherent in those schemes, supporting and validating adaptive schemes and creating new meaning through reflection and perspective-building. This awareness occurs through three processes: " a change in internal relations, a re-owning of experience, and an increased sense of agency" (Greenberg & Paivio, 1998, p. 59).

From this overview of psychotherapeutic theories of emotion, it is clear that emotions are thought to play an important role in psychotherapeutic change. The contribution of psychotherapeutic theories of emotion rests on the fact that they are grounded in their direct involvement with people. In this respect, they are different from psychological theories. While emotional experience has been characteristic of experiential approaches to therapy, other approaches, such as psychodynamic and

cognitive-behavioral therapy have recently incorporated affective components (Arnkoff & Glass, 1992; Clark, 1992; King, 1998).

Empirical Evidence of Psychotherapeutic Approaches to Emotion In Practice

In recent years, few researchers have provided empirical evidence for the effectiveness of specific therapeutic approaches to the experience of emotion in therapy. Existing studies concerning psychotherapeutic approaches to emotion focus on (1) specific emotion events, (2) comparisons of various approaches according to their effectiveness and attention to emotions by therapists, and (3) specific psychotherapeutic approaches.

With respect to specific emotion events, MacKay et al. (1998) report on an anger event of a client in psychodynamic-interpersonal therapy. These researchers used raters' recordings of audiotaped sessions and the client's perception of the impact and helpfulness of the sessions as well as her level of depression throughout the process. Findings indicated that the client identified the expression of her anger as having a helpful impact on the outcome of therapy. As the anger was repeatedly re-experienced, it changed to a pattern of pleasure and arousal through a process of reorganizing the experience.

Regarding comparisons of psychotherapeutic approaches to emotion, the following studies included emotionally-focused interventions in their investigations. In the first (McQueeney, Stanton, & Sigmon, 1997), the following combination of measures was used to assess emotionally-focused interventions for clients with fertility problems: coping strategies, perceived control over infertility, current psychological adjustment to

the fertility problem as perceived by the participant, psychological adjustment, depression, distress and well-being, parental status, and treatment credibility. Emotion-focused group therapy was shown to be especially useful. It elicited greater improvement in clients when compared with problem-focused therapy, although both therapies elicited change when compared to controls (McQueeney et al., 1997).

Client-centered and process-experiential treatments were compared according to client process and therapeutic outcome in a study of therapeutic change in clients with depression (Watson & Greenberg, 1996). This study utilized a combination of observer-rated and self-report measures. Results favored the effectiveness of the process-experiential treatment on measures of experiencing, vocal quality, expressive stance, and problem resolution in two chair and empty chair interventions. Further, problem resolution correlated with depth of experiencing and sustained resolution, providing additional evidence for regulating the intensity of the session. These results support contentions made by Beutler et al. (1999) concerning the necessity of regulating intensity levels of emotions.

Greenberg and Paivio (1998) provide further empirical evidence for the process-diagnostic approach for evaluating emotional experience in therapy (Greenberg & Paivio, 1997; Greenberg & Safran, 1989), discussed previously. Using data collected in interpersonal process recall (IPR) interviews, the clients were asked to review videotapes of sessions and recall their internal experiences regarding important moments. Their qualitative descriptions, which resemble the model, include the following categories: avoidance, allowing, owning, interruptive belief, relief, and self-affirmation. Although

this study was instrumental in gaining support for the theoretical aspects of the process-diagnostic approach, the methodology involved a time-consuming procedure that may otherwise be captured in self-report scale.

Other investigators have focused their energies on comparing the psychotherapeutic approaches to emotion according to the therapists' theoretical approach to counselling. In an investigation of emotional experiencing in psychodynamic-interpersonal and cognitive-behavioral therapies viewed observer-rated instruments, such as the Experiencing Scale (Klein et al., 1986) Wiser and Goldfried (1993, 1998) found that psychodynamic-interpersonal therapists associated high levels of emotional experiencing as critical to the change process. Conversely, cognitive-behavior therapists did not associate high levels of experiencing with the healthy change process. However, both therapies were found to have equal amounts of affective experiencing in sessions identified by the therapists as significant (Wiser & Goldfried, 1993).

Studies focusing on specific psychotherapeutic approaches include Castonguay, Pincus, Agras, and Hines' (1998) investigation of clients' emotional experience regarding group cognitive-behavioral therapy for binge eating disorder. This study used a 12-week manualized treatment plan. Weight, binge eating, physical exercises and clients' ratings of sessions were used as measures. It was found that negative emotions were most prevalent in the middle phase of treatment and subsequent positive feelings and perception of positive group climate were related to positive outcome.

These studies represent the beginning of an expected increase in attention of the efficacy of emotional experiencing in psychotherapy. However, concerns of

generalizeability are apparent for those investigations focusing on specific client concerns (Castonguay et al., 1998; McQueeney et al., 1997). Further, the use of observer-rated instruments, especially in the absence of clients' reports of their perception of their experiences in counselling in these studies is perilous.

Conceptual Issues: Defining the Construct of Emotional Experience

The main difficulty in defining emotions is deciding whether they can be described by making a distinction between them and the very process that they are part of. It follows from an examination of psychological and psychotherapeutic theories that emotions cannot be distinguished from their process. For instance, the feeling of fear does not occur without a stimulus or thought or reaction. Emotions, or rather, the experience of emotions will be described using components from the psychotherapeutic theories and the psychological theories that provide the basis for psychotherapeutic theories.

At the neurological level, sensory stimuli provide information to the amygdala and the thalamus. These areas of the brain deal with emotions and become enabling agents in evaluating emotions (LeDoux, 1993), suggesting that a great deal of the processing of emotions occurs prior to our conscious awareness (Korman & Greenberg, 1996). The presence of physiological arousal is indicative of the emotion coming into our conscious awareness. These biological features of the process become survival functions and thus inform our behaviors (Greenberg & Paivio, 1997). The emotions are then in a position to influence motivation and action for which cognitions are necessary (Frijda, 1993; Greenberg & Paivio). Accordingly, emotions become adaptive agents (Paivio &

Greenberg, 1998) in our interaction with the environment. In this process, emotions may be seen to be automatic but as having a major influence on our construction of events and of manipulating those events with our resulting decisions. Plutchik (1984) proposes a definition that considers all of these dimensions:

> An emotion is an inferred complex sequence of reactions to a stimulus and includes cognitive evolutions, subjective changes, autonomic and neural arousal, impulses to action, and behavior designed to have an effect upon the stimulus that initiated the complex sequence (p. 217).

Greenberg and Paivio (1997) place emotions in a natural process of feeling consisting of "emergence, awareness, owning, expressive action and completion, followed again by the emergence of a new feeling, thereby beginning the cycle again" (p. 27). Interference with this process leads to dysfunction. For this reason, Greenberg and Paivio suggest that therapeutic goals be connected with the stages of process of feeling to encourage healthy emotional experiencing.

From this we may conclude that emotions cannot easily be distinguished from the process of which they are a part. They play a central orienting and adaptive function and they provide information to individuals about what is important to them. At the same time, emotions are the basis of maladaptive or dysfunctional behavior. This deficit in growth and healthy functioning occurs when we are removed from the "adaptive information inherent in emotion" (Paivio & Greenberg, 1998, p. 229). Therefore, emotional processes provide an important focus for change in psychotherapy.

Emotions may be categorized according to their referral to the self or referral to others. The former may be thought of as being explored and the latter may be thought of as being expressed (Greenberg & Paivio, 1997). Within this framework, Korman and Greenberg (1996) distinguish between primary, secondary, and instrumental emotions, with each group consisting of emotions classified as either adaptive or maladaptive. There is no empirical evidence for this framework, to date.

Primary emotions are characterized by genuine feelings and may include sadness, fear, joy and anger (Korman & Greenberg, 1996). For instance, an adaptive primary emotion may be sadness at a loss and a maladaptive primary emotion may be a fear of heights. They last a relatively short time and seem to have accompanying bodily experiences (Greenberg & Safran, 1987).

Secondary emotions may be identified as reactions to primary emotions and are sometimes seen as disruptive to problem solving, especially in behavior therapies (Greenberg & Safran, 1987). Korman and Greenberg (1996) describe secondary emotions as learned reactions, expressions, and coping strategies, such as that involved in the anger felt in response to underlying sadness. Some primary feelings may be recognized as secondary feelings, as is the case when anger causes secondary sadness characterized by depressive symptoms (Greenberg & Safran). Some examples of secondary emotions include anger, hopelessness, despair, panic, dysphoria, hurt, disappointment, annoyance, and despondency (Greenberg & Safran). Clinical judgment is required to distinguish between primary and secondary emotions in counselling in order to ensure focus on the primary experiences.

Instrumental emotions involve the same learned behaviors as secondary emotions, with a degree of manipulation, such as the use of crying to induce sympathy (Korman & Greenberg, 1996). Instrumental emotions are conditioned or learned in order to influence or manipulate. They include the more complex emotions such as pride and jealousy (Korman & Greenberg). Their duration is longer than primary or secondary emotions and they tend to characterize themselves in clients' descriptions of feeling miserable, unhappy, helpless, or inadequate. They are less a reaction to the environment than they are part of the personality (Greenberg & Safran, 1987) and may be distinguished from secondary emotions in this manner.

Although clients experience a vast range of emotions in counselling, some emotions are more prevalent in the counselling process than others. An exhaustive list of the emotions experienced in counselling is almost incomprehensible. The more common emotions include anger, sadness, fear, anxiety and shame. Pleasure emotions commonly experienced in counselling include happiness, joy and excitement. The following is a brief overview of each of these emotions as a summary to Greenberg and Paivio's (1997) account of specific emotions experienced in counselling. It is important with each of the following emotions to use clinical judgment in differentiating their status as primary, secondary, or instrumental as discussed in the example of anger.

The complexity of the experience of anger is inherent in its function as either primary or secondary status and may even be suppressed or avoided by the individual. In counselling, it is necessary to differentiate the status of anger in order to intervene and guide the client appropriately. Anger is characterized by changes in breathing, voice,

muscular, and facial response, although it may be characterized by feelings of helplessness and depression or crying, numbing and intellectualization if it is suppressed. Secondary anger is usually caused by underlying primary emotions, except in cases of survival. Interventions relevant to anger include attending to the bodily experience, perhaps through the two-chair technique, symbolizing and intensifying the experience, increasing awareness of the internal experience. Similar interventions are recommended for the remaining emotions.

Sadness is usually associated with some sort of loss. Like anger, sadness must be distinguished from non-primary experiences of pain, hurt, grief, and depression. Its bodily senses include a decrease in energy, relaxed muscles and posture, and a non-confident voice. Fear and anxiety may be differentiated according to their stimulus. The former is elicited from an immediate physical danger and the latter is elicited from feelings of uncertainty. Shame is characterized by the feeling of being inferior or looked down upon by others. It is characterized by a sense of worthlessness by oneself and others.

Greenberg and Paivio's (1997) presentation of the pleasure emotions, such as interest and excitement, happiness and joy and love, are often related to the therapeutic relationship in counselling. In this sense, they may be contributors to motivations for change. Interest and excitement are usually associated with change or novelty and can be characterized by either breathlessness or rapid breathing and increased attention to the object or topic. Happiness and joy are also pleasurable experiences and are associated with laughing and smiling. Love is an emotion that connects us to others and may be of a

romantic, passionate, compassionate or platonic quality and is less a momentary emotion than many of the other emotions.

Emotions as Agents of Change

Many theorists and researchers have attested to the contribution of emotional experiencing in psychotherapeutic change (Clarke, 1996; Greenberg & Paivio, 1997; Greenberg & Safran, 1987). Support for the contribution of emotions in bringing about therapeutic change stems from investigations of good moments in therapy, important and helpful events in therapy, and intensity levels in counselling.

Good moments in therapy may be defined according to patient change, improvement, progress, or movement (Mahrer, White, Howard, Gagnon, & MacPhee, 1992). In their examination of audiotapes and transcripts of sessions representing the Gestalt approach to therapy, Mahrer, White, Howard, and Lee (1991) identified 'heightened feeling expression' and 'increased confrontation strength' as significant client change processes in Gestalt therapy. Similar methodology was used in the identification of the following instances of good moments in therapy: "(a) movement from neutral to strong feeling; (b) extra therapy behavior change intention; (c) strong expression directly toward therapist; (d) new, deeply felt personality process-state; (e) acceptance of problem-self; and (f) state of general well-being" (Mahrer et al., 1992, p. 263), all of which relate directly or indirectly to the clients' experience of emotions.

A similar study examined client-centered, rational-emotive and experiential therapy for the hypothesized relationship between the intensity of the feeling, the type of therapy, and the occurrence of good moments in therapy (Mahrer, Lawson, Stalikas, &

Schachter, 1990). Results from this study suggest that more intense feeling experiences were judged to exist in audiotapes of experiential therapy. Moreover, a significant correlation was found for the relationship between feeling intensity and the occurrence of good moments, suggesting that the experience of emotions in counselling is productive.

Saunders (1999) explored clients' affective experience during therapy and the relationship of this experience to change using the Therapy Session Reports. This instrument is designed to be a general survey of the experiences that clients have in individual therapy with respect to how they felt and their perception of the therapists' experience (Orlinsky & Howard, 1986). Measures of session quality and effectiveness were also taken. Results indicated that clients' reports of their emotional state in the session was related to the impact of the session. More specifically, clients rated the session quality as higher when they felt less distressed and inhibited or re-moralized.

Other studies investigating helpful impacts in counselling identified 'Emotional Awareness-Insight' as one of four factors having a helpful impact in a principal-components analysis (Kivilighan, Multon, & Brossart, 1996) and of "Emotional Relief" emerging as a cluster in a concept-mapping account of clients' perception of their experiences in counselling (Paulson, Truscott, & Stuart, 1999). In another study investigating client and counsellor perception of important events in counselling, interviews with counsellor and client dyads identified "descriptions and explorations of feelings" as important events (Martin & Stelmaczonek, 1988).

The role of emotional experiencing in influencing change in therapy has also been documented by Castonguay et al. (1998) in an investigation of cognitive behavior therapy

for Binge Eating Disorder, as discussed previously. In this study, positive feelings, such as hope and relief were found to elicit therapeutic change in group therapy. Further support for clients' emotional involvement (experiencing) as a predictor of client improvement in counselling was found in a study of the effects of cognitive therapy for depression (Castonguay et al. 1996).

A different approach to the investigation of the role of emotions in therapy utilized an English version of the Affective Dictionary Ulm, a dictionary of emotion terms mentioned within therapy (Holzer, Pokorny, Kachele, & Luborsky, 1997). These investigators found that transcripts of more successful therapies were characterized by more emotion words than therapies identified as least successful.

In a study of the relationship between patient variables and treatment outcome, Beutler et al. (1999) investigated the possibility that positive therapeutic outcome was related to high levels of subjective distress and that patients experiencing high levels of distress would respond better to treatment with low levels of session intensity. Although levels of distress were related to improvement, they were not related to outcome when considering the level of session intensity. This type of intervention or session structuring resembles the processes of affect regulation thought to occur within the individual (Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997). More than anything, an examination of this study suggests the complexity of the relationship between the intensity of the emotional experience of the client and the selection of appropriate interventions for those levels.

It is clear from these studies that emotions play a major, if not synonymous role in achieving therapeutic change in the identification of emotional processing as helpful or important by clients (Castonguay et al., 1998; Kivlighan et al., 1996; Mahrer et al, 1992; Paulson et al., 1999; Saunders, 1999). They are suggestive of the inclusion of emotional expression and experiencing as necessary functions in counselling (Korman & Greenberg, 1996). Concern for this relationship is evident when considering the finding that many clients do not talk about their emotional experience in therapy (Regan & Hill, 1992).

The Measurement of Emotions

Traditionally, the measurement of emotions in psychology's history has involved (1) the galvanic response method, (2) electromyography (EEG), (3) finger temperature (Cassel, 1994), (4) the word-association method for which confusion or otherwise peculiar reactions to a word is seen to indicate emotional tension, (5) the examination of sugar levels in the blood or urine following an emotional event (Trettien, 1935), and (6) other physiological recordings of bodily changes, such as blood pressure and pulse rate (Cassel; Plutchik & Conte, 1989; Trettien). Other measures include ratings of the behavior of the individual or the product of someone's behavior (Plutchik & Conte, 1989). All of these methods may provide insight into a portion of the experience of emotions but none take into account the person's perceptions of their own experience of emotions.

The measurement of emotions for therapeutic purposes usually involves ongoing assessment of the clients' states, as described by Greenberg and Paivio (1997). This

ongoing assessment begins with empathic attunement with the feelings of the client, attention to nonverbal cues, knowledge of universal human responses to similar episodes, and knowledge of clients' emotional framework, perhaps through their history. From these measures, the clients' experience of their emotions can only be assumed. There are no measures that take into account individual differences and situation specific emotional experiences in the counselling session.

The investigation of emotions may be differentiated according to the measurement of emotions for non-psychotherapeutic use and the measurement of emotions for psychotherapeutic research or practice. The latter will be discussed according to the therapists' perception of the clients' experience of emotion and the clients' perception of their own experience of emotion. This discussion will be preceded by an overview of instruments used to measure change in therapy. The importance of considering measurements of change stems from the speculated relationship between therapeutic outcome and emotional experience in therapy (Watson et al., 1998).

Measuring Change in Therapy. Research concerning the change process in counselling has reflected the presence of emotions as the center of this process, as discussed previously. Many instruments have been developed to measure change in the psychotherapeutic process, however few in any standard instruments for measuring therapeutic change exist (Schauenburg & Strack, 1999). These instruments are of importance when considering the role that dealing with emotions has on the process of change. Existing instruments may be categorized according to (a) their use of raters'

trained perceptions of the clients' experience, and (b) their use of clients' self-report measures of their experience.

The Vanderbilt Process Measures, including The Vanderbilt Psychotherapy Process Scale and The Vanderbilt Negative Indicators Scale, use uninvolved raters' perceptions of either audio- or videotapes of sessions using 80 items Likert scale items, and 42 Likert scale items, respectively (Suh, Strupp, & O'Malley, 1986). The VPPS was developed to assess helpful and harmful aspects of the patients' and therapists' experience and the VNIS focuses on the harmful effects of therapy. The decision to use uninvolved raters was a response to concerns with previous scales using self-report measures. It seems that we have come full circle. The most recent scales have been developed as self-reports.

Lambert et al. (1996) designed the Outcome Questionnaire (OQ) to assess client progress in therapy by repeated administration during treatment. It is a 45-item self-report measure of subjective discomfort, interpersonal relationships and social role performance. The questionnaire instructs clients to identify the extent to which the items describe their current situation. It also includes forms for parents. Support for the concurrent and construct validity of the OQ has been established in a sample of psychiatric inpatients and outpatients, counselling clients, and community subjects, with some emerging interpretive cautions (Umphress, Lambert, Smart, Barlow, & Clouse, 1997).

One self-report scale allows clients to evaluate their sessions according to their effectiveness, worth, comfort and distress (Session Evaluation Questionnaire: Stiles &

Snow, 1984) and includes mood ratings by therapists. This instrument consists of 24 adjective scales (e.g., relaxed-tense) with which the client indicates their feeling on a seven-point semantic differential scale. Although it focuses on the impact of sessions, the SEQ takes into account many emotions in its descriptive adjectives. It focuses on how the client feels about the session as opposed to how the client feels in the session. Evidence of reliability and validity has been established.

Similarly, the Session Impacts Scale (SIS: Elliott & Wexler, 1994) measures clients' immediate subjective effects of the session and includes 16 descriptions of which the client matches statements, such as "more aware of or clearer about feelings, experiences" (Stiles et al., 1994, p. 177). Clients are instructed to rate these items on a five-point scale. The SEQ and SIS are highly correlated, with few exceptions (Stiles et al., 1994). Although these instruments are useful for the purposes they are concerned with, their focus is on the session and not the client.

Derogatis (1983) developed a self-report measure to assess the outcome of psychotherapy. This approach involves measuring symptoms instead of session quality. The resulting Symptom Checklist 90 R (SCL-90-R) is a measure of the psychological symptom status and consists of items dealing with somatization, obsessiveness, social insecurity, hostility, phobic anxiety, depression, anxiety, paranoia, and psychoticism. Patients are asked to rate each item on a five-point scale of distress for the last week. General distress may also be calculated using the Global Severity Index. This index is considered to be the best indicator of the level and depth of disturbance. This self-report measure demonstrates acceptable reliability and evidence for validity and serves in

numerous languages as an international standard. Recent research using the instrument has established cut off points for distinguishing between functional and dysfunctional populations and their change after therapy (Schauenburg & Strack, 1999). This instrument, in its focus on symptoms may not be as suitable for measuring client change in non-clinical settings for issues such as problems in living.

Heppner et al. (1992) addressed the methodological concerns in measuring the therapeutic process. They identified and explored three methods in a single-subject design of three counsellor-client dyads. The first method examined was the Guided Inquiry Questionnaire that is intended for clients. It is an open-ended questionnaire inquiring about important, helpful, hindering, and cognitive aspects of the counselling process. The second method consists of assessing the content of thought listening in which both clients and counsellors are instructed to write down the first and second thoughts that come to their mind about the session as well as their thoughts during the session. The third method consists of a comparison of the client and counsellors' memorable thoughts during the session. Clients also rated their counsellors on expertness, attractiveness, and trustworthiness. Both client and counsellors rated the relationship according to empathic understanding, congruence, level of regard, and unconditionality of regard. The results indicated support for the Guided Inquiry Questionnaire and thought listening methodologies but future validation research is required. The nature of the instruments as being open-ended also makes the methodologies time-consuming for both administration and interpretation.

Measuring Emotions in Therapy Studies enlisting the use of raters' interpretations are characterized by their use of videotaped or audiotaped sessions. Horowitz et al. (1996) developed a feasible method for categorizing patient states and control of emotion during psychotherapy by having judges score videotapes of five clients according to four states: smooth flow of emotional expression (well modulated), controlled expression (overmodulated), dysregular expression (undermodulated), or shimmering expression (combination of emotional expressions with evidence of stifling). Horowitz et al. reported satisfactory inter-observer reliability for this scale. The instrument is intended to assist beginning therapists in anticipating shifts in states in order to prevent inappropriate emotional flooding. This focus on regulating the intensity levels of sessions has also been addressed by other researchers (Beutler et al., 1999; Greenberg & Paivio, 1997; Westen et al., 1997) and has been identified as a concern in the use of raters' judgments by Machado et al. (1999).

The relationship between emotionality and affective exchange in relation to treatment outcome was investigated using the Emotional Facial Action Coding System (EMFACS) and the Differentielle Affekt-Skala (DAS: Merten, Anstadt, Ullrich, Krause, & Buchheim, 1996). The first instrument utilizes raters' measures of movements in the face relevant to affect and the second instrument is a self-report of the clients' and therapists' ratings of his or her feelings during the session, in the German language. Results demonstrated evidence for the relationship between facial expressions and affective experience. The successful and unsuccessful psychoanalytic therapies for which the study was centered differed in that the former consisted of a therapist reacting

complementarily to the emotions while the therapist in the failed therapy responded reciprocally.

Westen et al. (1997) report on the development of an observer-based assessment, the Affect Regulation and Experience Q-Sort (AREQ). This instrument consists of cards with items that are sorted by observer judges according to how applicable or descriptive the items are to the observed, by using a numerical score from one to nine. Items were derived from clinical experience, the Diagnostic and Statistical Manual, research on defenses, self-report questionnaires on emotional experience and other self-report measures. The item set was refined by a group of senior clinicians.

Factor analysis of the AREQ revealed two categories consisting of three factors each. The first category, Affective Experience, consisted of Socialized Negative Affect, Positive Affect, and Intense Negative Affect. The second category, Affect Regulation, consisted of Reality-focused responses, Externalizing Defenses and Avoidant Defenses. Evidence for convergent and discriminant validity was supported by an examination of Q-sort profiles of a clinical sample of patients sharing diagnoses.

Other researchers enlist the use of auditory methods. For example, a psychometric instrument measuring the affective process include the Client Vocal Quality (CVQ) system (Rice et al., 1979) which is designed to distinguish patterns based on the degree of focus, externalization, limiting or holding back nature, and emotion in clients' accentuation, pace, contours and perceived energy (Rice & Kerr, 1986). The emotional component is characterized by trembles or breaks in the voice. The main problem with

this approach is that the client's voice does not take into account gestures or intent. Predictive validity and reliability have been established for this scale.

Another instrument designed for use with auditory data include the Experiencing Scales (Klein et al., 1986), which study affective processes in therapy. For example, the Patient Experiencing (EXP) Scale consists of a seven-point scale designed for raters' scoring of tape recordings or transcripts of therapy. The seven stages focus on the progression of the client through processes identified as impersonal, superficial, externalized/limited references to feelings, direct inner referents, questioning unclear inner referent, focusing with a step of resolution, and facilitated focusing. The scale developers emphasize flexible applications of the scale as long as the researcher defines the limits. The instrument demonstrates high levels of reliability. Its validity is questionnable validity in that it is more a measure of reflective or self-observational style than expressiveness (Klein et al.). A review of the research using this scale (see Greenberg & Safran, 1987) provides evidence of the relationship between experiencing and outcome in therapy.

More recently, Greenberg and Korman (1993) addressed the difficult task of measuring emotion in psychotherapy. Their measure is based on the levels of processing evident in network theories of emotional experience. Greenberg and Korman identified measurable and observable emotion episodes in transcripts of therapy as having four components: (1) the emotional response; (2) the situation; (3) the appraisal; and (4) the concern. Qualitative data from therapy sessions were identified and organized into a protocol with the above four categories. A validity and reliability assessment of the

presence of emotion episodes in transcripts revealed that raters could discriminate emotion episodes from controls as similarly judged by different raters. In this study, Greenberg and Korman provided evidence that emotional experiencing is measurable and their instrument serves in the identification of emotion episodes in therapy according to the raters' perspective.

Measuring Emotions for Non-psychotherapeutic Purposes. Several researchers developed instruments to measure distinct aspects of emotions for non-psychotherapeutic purposes. They include measures of awareness of emotions, intensity of emotions, moods, and the expression of emotions. Measures of awareness of emotions include the Attention to Feeling subscale (AFS: Salovey, Mayer, Goldman, Turvey, & Palfai, 1995). It is a 13-item measurement of one's perception of how much attention they pay to their emotions according to a 5-point Likert scale. Internal consistency, convergent and discriminant validity for this instrument have been established.

Measures of the intensity of emotions include the Affect Intensity Measure (AIM: Larsen et al., 1986). The AIM was developed to assess the strength or intensity with which individuals experience emotions. It is a 40-item questionnaire that distinguishes between the frequency and intensity of emotional experience with respect to bodily responses, cognitive performance, and interpersonal relations. Although this measure demonstrates acceptable psychometric properties, it was constructed for the purpose of exploring emotions in everyday life events as opposed to counselling situations. An examination of the content of the items revealed some double-barreled tendencies and

potentially difficult words (e.g., euphoric). This measure is more likely a measure of moods than emotion.

Bachorowski and Braaten (1994) developed the Emotional Intensity Scale (EIS) to measure the intensity of emotional states without the interference of the frequency of those states, as seems to be measured by the Affect Intensity Measure. The EIS is a self-report measure consisting of 30 items for which respondents indicate their felt level of intensity on a five-point sale. Some items include contextual information. This instrument was validated with a sample of undergraduate students and demonstrated reliability. It provides evidence for the integration of personality and emotional experience in correlation with Extroversion and Neuroticism scales.

The Emotional Expressivity Scale (EES: Kring, Smith & Neale, 1994) is a 17-item scale measuring self-reported disposition toward expressed emotion using a 6-point Likert scale. Internal reliability, test-retest reliability, discriminant validity, convergent validity and construct validity have been established for this scale. The samples for the preliminary analysis for the AFS and the EES consisted of undergraduate students.

Other researchers focused their attention on developing measures of emotional intelligence. For instance, Schutte et al. (1998) developed an instrument to measure emotional intelligence. Their instrument is based on the theoretical model of emotional intelligence developed by Salovey and Mayer (1990) who emphasize adaptive abilities as including appraisal and expression of emotion, regulation, and utilization of emotion in solving problems. The resulting 33-item scale allows respondents to express the degree to which items describe them using a five-point scale. Validation measures indicate that (a)

some of the theoretical constructs, such as, attention and clarity of feelings, optimism, and impulse control correlated with the scale, (b) the scale predicted college grades, (c) the measures were higher for females and therapists, and (d) the measure was not related to cognitive ability. Thus, emotional intelligence may, in part, determine the ease and style with which individuals experience and work through emotions.

With regard to mood scales, Coughlan (1988) reports on the development and validation of the Wimbledon Self-Report Scale (WSRS) which is intended to appraise emotional state and identify mood disturbances in either the general population or hospitalized population. The intentions for the development of this scale were to overcome difficulties in using other instruments that involved inquiry into somatic symptoms, thereby causing difficulty in differentiating the physiological nature of emotions and the physiological effects of an illness. The scale comprises of 30 adjectives and phrases of pleasant and unpleasant feelings for which the subject is asked to rate according to its pervasiveness in the past week on a four-point scale. Although this instrument demonstrates adequate reliability, it has sacrificed the necessary components of emotion – cognition and physiology in favor of making the scale feasible and meaningful for multiple populations.

Salovey et al. (1995) developed the Trait Meta-Mood Scale (TMMS) to identify individual differences in persons' reflections and management of their emotions. The scale is composed of three factors: Attention to Feelings, Clarity of Experience of Feelings, and Mood Repair. The developers suggest that the scale may assist in identifying characteristics of emotionally intelligent individuals. Subjects respond to 48-

items on a five-point scale ranging from strongly disagree to strongly agree. Although this instrument is appropriate for gaining insight into how persons think they are feeling, it does not inquire into what they are feeling. Some evidence of reliability has been established for the TMMS.

Watson, Clark, and Tellegen (1988) report on the development of two 10-item mood scales that comprise the Positive and Negative Affect Schedule (PANAS). These scales were constructed to reflect terms that had independent strong loadings on either the positive or negative affect. Subjects are asked to rate the degree to which they felt different emotions over various time periods on a five-point scale. Psychometric validation was obtained through undergraduates and university staff from which the scales showed internal consistency and stability. The scales were also shown to correlate with related external factors. It seems that the PANAS scales measure intensity of both emotions and affect, depending on the length of time the feeling was felt. However, they are abstract in the sense that they do not provide a context for experiencing emotions, thus potentially confusing the respondent.

In their examination of the attributes that lay persons assign to emotional experience, Ben-Artzi and Mikulincer (1995-6) developed a self-report instrument from a content analysis of a sample of university students' qualitative accounts. Factor analysis revealed two orthogonal theories consisting of both the threat and benefit appraisals of emotions. Some items derived from this method include "Emotions give meaning to experiences", "Emotions intensify experiences", and "Emotions guide actions". They

seem to resemble some of the psychological and psychotherapeutic theories of emotion (Greenberg & Paivio, 1997; Izard, 1991).

Individual factors were named Experiential significance, Disturbance, Unstability, Bizarreness, Cognitive Interference, Intensity, Motivational Power, and Uncontrollability. The strength of the development of this instrument is the manner in which it is grounded in peoples' descriptions of their emotional experience. The instrument was found to be internally valid, reliable over time, and concurrently valid. It correlated with other measures of affect and personality traits.

Summary

From the literature we have learned that emotions have been an interest of psychology since its establishment as a discipline. Increased interest in the role of emotions in peoples' lives is apparent in psychotherapeutic theories of emotion, both in the creation of new therapeutic approaches (e. g., EFT: Greenberg & Paivio, 1997) and in the revision of existing therapeutic approaches formally focusing on behaviors and cognitions (e. g., King, 1998). Recent evidence of the effectiveness of psychotherapeutic interventions suggests that the inclusion of an emotional component relates to therapeutic change (Beutler et al., 1998; Castonguay et al., 1998, Greenberg & Paivio, 1998; McQueeney et al., 1997). Other studies investigating good moments, important events, and helpful events in therapy (Castonguay et al., 1998; Kivlighan et al., 1996; Mahrer et al., 1992; Paulson et al., 1999; Saunders, 1999) attest to the inclusion of emotional experiencing as a necessary component in therapy.

It is clear from an examination of psychological and psychotherapeutic approaches to emotion that the concept of emotion is multifaceted and cannot be distinguished from the process of which it is a part. Thus emotional experiencing consists of neurological and physiological informing features, as well as evaluative cognitive functions that prepare us for action. Interference with the process of experiencing emotions may cause dysfunction. Thus, emotions may be classified as adaptive or maladaptive.

While it is clear from the review of existing research that emotions contribute to therapeutic change, the danger in using raters' perceptions of clients' experiences, direct concern toward the future of accessing information about the therapeutic process from the clients' perspective. The lack of empirical studies validating psychotherapeutic approaches to emotion and examining the role of emotion in psychotherapeutic change is expected to rise given the recent attention of emotion in the psychotherapeutic theories of emotion. The development of valid and reliable instruments focusing on the clients' perspective in sessions will facilitate this expected interest.

The purpose of this study is to develop a self-report measure of clients' "in-session" emotional experiencing to assist in recent investigations of the counselling process. This instrument will be intended as an aid in investigations of psychotherapeutic theories of emotion, psychotherapeutic change and process, and in identifying effective therapeutic strategies, consequently decreasing the time and cost of therapy.

Critical Issues in Measuring Emotional Experience. Emotions, in their very nature are difficult to measure. First, they are sometimes not tangible or observable

(Trettien, 1935) or understood on the part of both the beholder and the observer. Second, they are inseparable from one's entire experience of events (Trettien). Thirdly, the "privacy of subjectivity" (Lang et al., 1998) further imposes limits to our understanding of clients' experience of emotion in therapy. As the experience of emotions tends to be private, it follows that researchers must be more focused and direct in accessing information about emotional experience from clients. It seems less likely that clients will volunteer that information unless asked directly.

Apart from Greenberg and Korman (1993) no researchers have attempted to measure in-session emotional experiencing. Existing methodologies, in their focus on observational techniques, clinical populations, and outcome as opposed to process, have escaped the importance of seeking insight into the clients' perception of their experience of emotions in the therapy session. Thus, a valid instrument must attempt to take into account the entire experience in a sensitive manner that allows for comfortable disclosure.

The use of visual and auditory methods in accessing information about client's emotional processes seems to be a good research tool and supervisory and teaching device but it is less useful for efficient and practical therapeutic purposes, apart from showing tapes to clients to increase their awareness of their own behaviors. Observational measures tend to have complex scoring systems that require trained raters (McLeod, 1994). This use of standardized techniques is time-consuming and difficult to use in a regular practice (Saunders, 1999). However, they do allow an alternative method of inquiry for gaining answers to questions that are difficult to ask.

Self-report measures are the most widely used instrument in the research on counselling from the clients' perspective (McLeod, 1994). McLeod identifies several considerations in using self-report measures. They include the possibility of faking or distortion by participants, the difficulty of usage for participants with literacy issues, and the fact that validity is always questionable. Self-report methods are also problematic in this area of research, especially when participants are asked to make judgments on whether their experience is normal, or they may be asked to reveal information about emotions that have a negative connotation (Westen et al., 1997). Furthermore, participants do not have a frame of reference with which to report other than their own experience. This aspect of self-report measures further hampers the validity of such instruments. Regardless, they are easily administered and interpreted and may be less threatening than a videotape or audiotape as the client has more control over the interpretation.

Despite these limitations, self-report measures have merit in investigating the therapeutic process, especially considering the lack of knowledge about how clients make sense of their experiences in counselling. It follows that an understanding of clients' experiences, from their perspective is becoming the focus of research, (Elliott & James, 1989; Heppner et al., 1992; Lietaer, 1992; Paulson et al., 1999; Sells, Smith & Moon, 1996). The resolution that self-report methods are the most important method stems from the idea that the client's experience can only be assumed in observation and auditory methods.

Much of the existing literature regarding the measurement of emotional experiences either focuses on (1) the experience independent of the therapy context, (2) the non-client population, or (3) the clinical population. Many of these instruments measure moods or traits and are therefore not suitable for investigating in-session experiencing inherent in emotional experiencing. The existing measures of psychotherapeutic outcome are presumptuous in their nature because they do not take into account the process by which a positive, negative, or neutral outcome was achieved. Without knowledge of in-session experiences and processes of change, it is difficult to delineate successful interventions.

This literature review provides a context from which to begin the development of a self-report measure of clients' experience of emotion in individual therapy intended for persons within the normal range of behavior who seek therapy to resolve problems in everyday living. The current scale development intends to overcome the above issues by constructing statements that do no require the participant to make judgments on their experiences or inquire about specific emotions for the sake of that may have either a positive or negative connotation. As far as having a frame of reference for responding, the nature of the proposed scale is concerned with the perception of the client with regard to where he or she feels, as opposed to the clients' perception of how those feelings compare to other clients. It also intends to overcome the presumptuous nature of observation methods.

Rationale for the Construction of the Scale. From the examination of available instruments and methods in investigating client change and emotions, it is clear that no

instrument exists to measure clients' in-session experiencing of emotions in counselling. From this review of the literature it is also clear that there is theoretical and empirical support for the importance of clients' experience of emotions in counselling. Yet, the available evidence of emotional experience in counselling is predominantly existent in observational methods for which raters' responses were endorsed. These methods risk the exclusion of valuable information about the internal processes of clients.

The importance of accessing the clients' perspective of their experience is strengthened by knowledge that the clients' perspective often differs from the therapists' perspective (Elliott & James, 1989; Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988; Orlinsky & Howard, 1986). It has been found that clients' perceptions of the therapeutic process better predict the outcome of therapy when compared with counsellors' perceptions (Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Orlinsky & Howard, 1986). Thus, it seems logical to focus inquiries on the clients' perception of emotional experience in counselling. Regardless of the accuracy of the report, it must be the clients' perception of their experience that is dealt with in therapy sessions. Thus, it is their report that is necessary in inquiries.

The need for an instrument to measure clients' emotional experiencing about counselling stems from the very reasons for which emotions are important in counselling. For instance, emotions (1) aid in our meaning-generating systems regarding events, (2) allow for the restructuring of maladaptive sense of ourselves in the world, (3) provide useful information to aid cognitive functions and motivation by adding focus to therapy,

(4) lead to behavioral change, (5) regulate, and (6) provide balance to our experiences (Korman & Greenberg, 1996).

The instrument will be intended for use as a therapeutic tool in the identification of effective strategies. It is also intended for use as a measure of therapeutic change and to provide insight to the client who is already engaged in the therapeutic process. Finally, the instrument will be designed to serve as a research tool in the investigation of psychotherapeutic change. Information gained from its use as a research tool in the investigation of therapeutic change is intended to inform and improved the training of psychotherapists, especially with respect to identifying effective intervention skills.

The instrument may also serve communicative purposes in counselling in two respects. First, not all clients can verbally express their emotions and experiences in order to make changes in their lives. For instance, some clients may have a limited vocabulary that raises barriers to communicating their emotions (Schwartz & Kline, 1995) in therapy. The construction of an instrument to measure emotional experience is intended to allow expression in the therapeutic process for those experiencing difficulty or those predicted to experience difficulty in this respect. Thus, the instrument will have a low reading level. Second, given that therapists are not always accurate in their perception of clients' emotional experiences (Machado et al., 1999) the instrument will also serve as a process measure to facilitate the communicative aspects of counselling. Finally, the intended feasibility of the administration and interpretation of the instrument for both the client and the counsellor will aid in minimizing the time, money, and disruption to the counselling process.

On a broader level, the need to develop an instrument to measure clients' emotional experiencing in counselling is grounded in an examination of the literature from three perspectives: (a) first, there is a lack of empirical evidence for the psychotherapeutic theories of emotion; (b) second, investigation is needed into the perceived role of emotions in psychotherapeutic change; and finally (c) there is no self-report measure of emotional experience in counselling. The last perspective stems from the lack of feasibility of observation methods and the disruption that more extensive and time-consuming methodologies cause to the therapeutic process. It has been demonstrated that there is a need for a feasible measure of emotional experiencing in counselling for both research and practical purposes and that the intended measure, by the nature of the importance of the experience of the client, is best developed in the form of self-report.

CHAPTER III: METHODS AND PROCEDURE

Introduction

The development of the scale measuring in-session emotional experiencing was carried out in three phases consisting of (1) the construction of items, (2) the review and revision of items by a panel of therapists, and (3) the administration of the items to a sample of clients. These phases were used to select and revise items for a more reliable and valid instrument. A description and justification for the types of validity and reliability investigated and for the methods chosen precedes these phases.

Validity and Reliability

Validity and reliability are necessary considerations for the development of any scale or instrument. Validity refers to the extent to which the underlying variable is the cause of item covariation (DeVellis, 1991). In other words, validity is the degree to which the scale measures clients' in-session emotional experiences. The three types of validity (DeVellis, 1991) include: (1) content validity, which is the extent to which the items reflect clients' in-session emotional experiencing; (2) criterion-related validity, which is often referred to as predictive or concurrent validity and concerns the extent to which the scale is associated with some criterion, such as the relationship between emotional experiencing and therapeutic change; and (3) construct validity, which concerns the theoretical relationship of a variable to other variables, such as the relationship between items on the Emotional Experiencing Scale (EES) and Greenberg's (1993) emotionally-focused approach to interventions.

This study focused on establishing initial evidence of content and construct validity for the EES. As described below, the content validity was obtained by generating statements for items from clients' reports of their emotional experiences in counselling as well as from feedback from expert and student counsellors on item content. Construct validity was investigated by matching the items to an existing theoretical focus of emotionally-focused interventions (Greenberg, 1993) and was strengthened with feedback from expert and student counsellors on the relevance of items to the theory. Criterion-referenced validity was not investigated in this early stage of scale development. It is intended for future validation research when the scale will be more refined and ready for such investigations.

Reliability refers to "the proportion of variance attributable to the true score of the latent variable" (DeVellis, 1991, p. 24). In this study the latent variable is emotional experiencing. Two main approaches to establishing the reliability of scales include: (1) internal consistency, which is concerned with the homogeneity of the items in a scale; and (2) alternative forms reliability, which involves administering the same or separate versions of the scale to the same people on multiple occasions (DeVellis, 1991). In this stage of scale development the focus was on establishing internal consistency. As described below, this was accomplished by computing item-total correlations for each of the subscales. Future investigations of alternative forms of reliability are intended once the internal reliability of the scale is established.

Overview of Methodology

The construction of the Emotional Experiencing Scale (EES) follows recommendations by Dawis (1987) on scale development for counselling research, DeVellis (1991), and resembles the Likert (1932) method in its procedures. A more detailed account of the application of the methods and procedures follows a description of the methodology.

First, the variable must be clearly defined. The latent variable is the underlying phenomenon that a scale is intended to measure (DeVellis, 1991). In this study, the latent variable is emotional experiencing, as defined below.

Second, the self-report method was chosen to access the internal systems by which an individual experiences emotions and was defined by the nature of the construct as being somewhat invisible to the observer. Observer rater and therapist rated instruments and methods were rejected on the basis that the internal systems and feeling can only be assumed using these methods. The self-report method was also chosen for its feasibility in administration, scoring, and interpretation.

Third, Dawis (1987) suggests conducting interviews with representative subjects in order to generate statements. This data was previously collected in other studies and used to construct statements for the EES, as described below. The use of descriptions of clients' emotional experience in counselling contributes to the scales' validity by providing a degree of authenticity and level of understanding of the items to the participant (Dawis). The relevance of these items to theoretical categories was assessed by therapists.

The following scale format was chosen. Item stems consisted of short sentences. A 5-point response format was chosen on the basis that this number of scale points are reducible and generate more variability than a smaller number of scale points, which increases the scale's reliability (Dawis, 1987).

Dawis (1987) presents an overview of three scaling methods used to select items from the initial item pool: Stimulus-centered scale methods, response scale methods, and subject-centered scale methods. The subject-centered scale method was chosen for the EES because it focuses on individual differences. The remaining two methods focus instead on stimuli or reproduction and prediction.

The subject-centered scale methods involve the Likert (1932) method, the use of factor analysis, and the semantic differential. The semantic differential uses bipolar adjectives that do not allow for the presentation of a context in which an emotion is felt and was rejected for this reason. Moreover, the semantic differential was not appropriate because the focus on specific emotions would decrease the interpretability of the scale. Instead, the Likert method was utilized for scale development. Factor analysis is planned for future validation studies in which a larger sample will warrant its use. It defines the loadings of items from a principle components analysis. Since the nature of this thesis is on the development of the EES, the Likert method was chosen for its focus on internal consistency. A combination of methods is intended for use in future validations of the scale.

The Likert (1932) method was also chosen for the present study on the basis of the convenience it offers in data analysis. It involves the construction of items to

represent the construct with an accompanying 5-point rating format designed so that the subject can express the degree of their feeling in this case. Following administration, it involves (a) computing the total score, (b) computing item-total score correlations, and (c) computing alpha reliability. Based on this analysis, the best items are selected for the scale. Item-total correlations provide information about the internal consistency of a scale and produce an alpha which is defined as "the proportion of a scale's total variance that is attributable to a common source, presumably the true score of the latent variable underlying the items (DeVellis, 1991, p. 27). This method can easily be employed with the Statistical Package for the Social Sciences (SPSS) program. The EES was developed following these guidelines to ensure internal consistency in a scale that can be easily and quickly administered and scored.

Phase 1: Construction of Items and Scale Design

Defining the Construct. For the purpose of this study, the latent variable, emotional experiencing, is defined as having three components (see Greenberg, 1993). Although emotions involve the integration of cognition, motivation, and behavior at the theoretical level, Greenberg and Korman (1993) emphasize the possibility of focusing on these three processes at the level of intervention.

The first component, Awareness, is concerned with the blocking or allowing of the emotion as it comes into consciousness. The second component, Intensity, refers to the level at which the emotion is actually felt and may be a result of whether the person allows the emotion. It involves the degree to which emotions are evoked. The third component, Restructuring Emotion Schemes, refers to the resolution of pressing

emotional matters. The physical experience of emotions, such as that felt in an increased heartbeat, is also important to the construct as defined by biological theories of emotion, and was added to the scale. Together these components describe the construct of emotional experiencing and thus, individual categories were expected to strongly correlate with each other. They may or may not occur concurrently in any one individual.

The scale was constructed to reflect these three phases in order to practically assist counsellors and researchers with recommendations upon interpretation of the scale. The stages reflect the principles of intervention set forth by Greenberg and Safran (1987). They include: (1) directing attention to inner experience; (2) refocusing attention to inner experience; (3) focusing on the present; (4) analyzing experiences; (5) intensifying experiences; (6) symbolizing experiences; and (7) establishing intents.

In clarifying the construct to be measured, it is useful to consider what it is not (Dawis, 1987). The proposed scale is not intended to measure specific emotions, expressed emotions, or clinical entities such as depression or anxiety. Instead, it is intended to measure the degree to which the client feels emotions in the therapeutic session, their level of awareness of those feelings, and the level at which the client is working through emotional matters, all of which make up the construct of emotional experiencing.

Generation of Items. The first phase of scale construction involved generating a pool of items thought to measure clients' emotional experience in counselling. Individual items were derived from five sources of data collected from previous research. The first three sources included data from separate studies investigating the helpful and hindering

aspects of therapy and counselling experiences of suicidal clients (see Paulson et al., 1999; Paulson, Truscott, Everall, & Stuart, 1998; Paulson, 1998). All three studies used a concept-mapping approach, which involves the generation and grouping of ideas and experiences by participants and a statistical analysis of the same. The remaining sources consisted of qualitative studies of clients' emotional experience in counselling, one conducted by the principle investigator of this study (Sark, unpublished raw data) and the other was conducted by a doctoral student (Stuart, unpublished raw data).

Statements descriptive of clients' experience of emotions were extracted from these data sources and used to formulate items for the scale. These statements were identified according to any feelings or lack of feelings the clients reported having in the counselling session. Statements regarding feelings outside the session or about the session were not extracted. These statements were reworded into short sentences. Items generated from this method were assessed according to recommendations made by DeVellis (1991) regarding the length of items, reading difficulty level (Fry, 1977), including both positively and negatively worded items, avoiding doule-barrelled items, avoiding pronoun references and multiple negatives, and attending to the representativeness of the underlying construct.

Scale Design. The protocol was designed with placements for (1) the identification number transformed from the clients' names in order to protect confidentiality, (2) age, (3) gender, (4) number of sessions completed, (5) reason for seeking counselling, and (6) an inquiry about health problems. This last question was

included for interpretative purposes so that health problems would not be confused with bodily sensations caused by emotional experiencing.

> The directions to the participant appeared next on the protocol. They read:
>
> Read each item carefully. Regardless of how your felt before the session, indicate the extent to which these items describe you in the last session by circling the appropriate number, with 1 not describing you at all and 5 describing you very well.

Following the directions, the response scale was placed before the list of items. It was also placed at the top of each subsequent page as a reminder.

Descriptors for the response scale were chosen for each of the values in order to eliminate the chance of different people having different conceptualizations or values for the numbers. The standard agree/disagree continuum was rejected for use in the development of this scale because the agree/disagree format would have required the participant to make two decisions about each item – "does it describe me" and "do I agree that it describes me". From the left side of the scale, the predetermined descriptors read "does not describe me at all" for one, "barely describes me" for two, "describes me somewhat" for three, "describes me well" for four, and "describes me very well" for five.

Phase II: Review by Panel of Judges

Procedure. In the second phase of the process, the item list was reviewed and revised by a segment of a counselling process research team consisting of two experienced counselling psychologists and three student counsellors. Discussions were audio-taped in order not to lose important comments. Items were assessed according to

clarity and how well they represented the construct of emotional experiencing. In this process, items that required the client to make a judgment on their experience as well as items bordering on concerns of social desirability were deleted. Items using psychological connotation or jargon were also discarded.

The items were then assessed for reading difficulty according to Fry's (1977) method for qualifying reading level. The desired Grade Six reading level was obtained by limiting each item to 16 words and a total of 20 syllables with attention toward utilizing short words and short sentences.

The revised questionnaire was structured into the categories described above and given to eight members of the same counselling process research team, including those therapists involved in the first revision, to assess whether the individual items reflect the categories in which they were placed (see Appendix A). Each judge was given a description of the categories and asked to rate each item on a five-point response scale according to how well they thought the item was descriptive of the category. A rating of one indicated that the item was not perceived to describe the category and a rating of five indicated that the item described the category very well. Those items that were selected as describing the category well or very well by a majority of the judges were kept in their respective categories. Items with a mean relevance rating less that 4.0 were assessed and either restructured, reworded, moved to another category, or eliminated.

Phase III: Administration to Clients

Participants. Participants were recruited from a university-based counselling training clinic that offers counselling services to the general public. A letter identifying

the researchers and purpose of the study (see Appendix B) was attached to a brief questionnaire that clients regularly fill out prior to their session. They were invited to inform their counsellor if they were interested in participating. Sixteen adult clients who were interested in the study were able to stay after their session to fill out the questionnaire and 13 of those clients participated in an interview about the questionnaire. These participants consisted of 13 Caucasian females and three Caucasian males between the ages of 22 and 68 with a mean age of 34. Their time in counselling with the current therapist ranged from two to 31 sessions, with a mean of 14.38. Therapists consisted of student clinicians from the Masters and Doctoral Program at the same university.

Procedure. The third phase of scale construction consisted of administering the 74-item scale to a sample of adult clients and interviewing 13 of those participants about their experience of completing the scale. These individuals were not clients of the principle researcher or of any other researchers involved in the project. After explaining the study, confidentiality, other participant rights, and obtaining consent (see Appendix C), participants were instructed to complete the scale (see Appendix D). Following this administration, 13 participants were asked to respond to queries regarding the clarity of the items, the identification of ambiguous or irrelevant items, and the absence of any items that they felt were important to their experience of emotions in counselling.

Summary

Thus, the development of the Emotional Experiencing Scale was undertaken in three stages. First, it is imperative in constructing any instrument to be clear about defining what is to be measured (Dawis, 1987; DeVellis, 1991). This stage involved

connecting the scale to a theoretical focus and structuring the scale to reflect reports of clients' emotional experience. Along with gaining the input from clients, therapists were also involved in the revision of items. Together, these stages contribute to the construct fidelity and establish initial evidence for construct and content validity. The last phase involved the initial administration of the scale to a sample of clients following the counselling session.

CHAPTER IV: RESULTS

Introduction

The results are presented in the three phases in which scale development was undertaken. First, the initial item pool is described. Second, the feedback from the two panels of experts is described and the resulting changes to the scale are outlined. Items receiving a mean subscale relevance rating greater than 4.0 on the 5-point response scale were kept in their respective categories and the remaining items were further assessed. Interview data is described in the third phase and the resulting changes to the scale are outlined. These investigations were used to establish content and construct validity for the scale. Data from the administration of the scale were subjected to a correlational analysis.

Scoring and Statistical Procedures. The Likert (1932) method was utilized in the development of the scale in order to facilitate administration and scoring, as described previously. Pearson product-moment correlations were computed among the subscales to determine construct validity with respect to establishing support for the association between the scale and the theoretical focus (Greenberg, 1993). This data was also used to establish support for the internal consistency of the scale. Items were subjected to a preliminary reliability analyses. In particular, item-total correlations were computed to determine the internal consistency within each of the subscales. Due to the small sample size, decisions about discarding items were not made solely on the basis of the statistical analysis. Instead, the elimination of items was decided upon according to a combination

of client feedback from the interviews, judges' ratings of construct fidelity, the rationale of the principle investigator, and statistical analysis.

Recommendations by Cohen (1988) were used to interpret the strength of the results of the correlational analyses. According to Cohen, a small relationship occurs when r^2 is .01 (r = .10 or -.10). A medium relationship occurs when r^2 is .09 (r = .30 or -.30). A large relationship occurs when r^2 is .25 (r = .50 or -.50). Small relationships are considered weak in strength and large relationships are considered strong.

Phase 1: Results

One hundred and thirty one items were generated from the first phase of scale development. These items were temporarily placed within five categories. The first three categories, "Awareness", "Intensity" and "Restructuring Emotion Schemes", follow the intervention process proposed by Greenberg (1993) and Greenberg and Safran (1987). The remaining categories consisted of items dealing with specific emotions and items dealing with bodily sensations connected to various emotions. Items were phrased both positively and negatively in order to control for potential response bias. Negative items were reverse-scored. Of the original items, 27 were reverse scored. At this point, 24, 27, and 20 items were generated for the three scales respectively, and 44 items for specific emotions and 16 items for bodily sensations.

Phase II: Results

The following changes were made to the scale after discussions from the first panel of judges. Due to the difficulty of creating an exhaustive list of specific emotions and the length of the scale as a result, most of the items concerning specific emotions

were excluded, except in cases where the items were of a general nature that could be included with the intensity category. They were discarded because their inclusion potentially hampers the interpretability of the scale. Considering that some clients may experience only one emotion very intensely, that person ends up with a low intensity score, even though their level of intensity in the session was high. As a result of their extraction the scale is suitable for more general needs and escapes problems resulting from having items that may only be meaningful to some clients.

Items concerning bodily sensations were deleted except for those regarding body temperature, heart rate, energy, and stomach difficulty. These items were seen to represent physiological experiences that are frequently associated with emotions (Korman & Greenberg, 1996). As a result, the general nature of the items in this category are compatible to the experience of many emotions. The remaining items in each category were collapsed into one scale consisting of 74 items.

Ratings By Judges. The following "Awareness" items were calculated to have an average relevance rating of less than 4.0 by the eight judges: "I didn't feel safe" and "I felt lost". Both items were deleted due to their specificity to particular emotions.

The following "Intensity" items were calculated to have a relevance rating of less than 4.0 by the panel of judges: "I allowed myself to feel again", "I couldn't make my therapist understand how I felt", and "I wanted to crawl in a hole". The first two items were deleted because of their focus on what is influencing emotions. The last item was discarded on the basis of the cultural specificity of the saying.

The restructuring of items having a relevance rating of less than 4.0 in the same category resulted in the following: "I talked about how I felt" replaced "I could talk about how I felt" and "It was hard to describe how I felt" replaced "I had difficulty describing how I felt".

The following items were moved to the "Awareness" category on the basis of low relevance ratings and suggestions by judges: "I felt disconnected", "I was detached", and "I felt numb". The following items were moved to the "Restructuring Emotion Schemes" category: "I knew how to express my feelings" and "I am learning how to express my feelings".

The following items secured an average relevance rating of less than 4.0 for the category "Restructuring Emotion Schemes": "I came to some realizations", "I couldn't cope", "I am determined to work things out", "I felt like I was on the right track". The first two items were deleted and the last item was kept (see item-total correlations). The item "I wasn't feeling ready to open up yet" yielded an average relevance rating of less than 4.0. It was reworded to "I didn't feel ready to open up" and moved to the Intensity category.

All the items in the "Bodily Sensations" category received average relevance ratings of greater than 4.0. The replacement of the items into different categories according to relevance ratings was used as a guide in categorizing items for the correlational analyses.

Phase III: Results

The scale took an average of eight minutes for clients to complete. Interviews lasted between five and thirty minutes. Reliability analyses and Pearson correlations were computed using the Statistical Program for the Social Sciences (SPSS 9.0).

Interview Data. Altogether, thirteen clients participated in the interview following the administration of the questionnaire. Generally, the participants reported appreciating the short length of the items and the items considering bodily sensations. Some participants took the researcher through an item-by-item discussion of why they responded the way they did while others identified specific items that they had difficulty with.

Three participants commented on the impact of the therapist and the style of the therapist on their emotional progress in counselling, for which no items were included. While the therapeutic alliance and the orientation of the therapist are important aspects of the counselling process, it was decided not to include items regarding these aspects. Otherwise, an exhaustive inclusion of the influences of progress would be needed. Without these items, the scale remains true to the construct.

The remaining general considerations reported by individual participants included (1) suggestions for the inclusion of items asking clients if they feel that they have enough time with their therapist, (2) the influence of the clients' attitude toward therapy in responding to items, (3) the influence of the stage of counselling and the stage of the session one has in mind when responding to the questionnaire, (4) the suggestion of a checklist inquiring about what works the best in therapy according to the client, (5) the

need for items regarding analyses clients made about counselling, and (6) the need for more positive statements.

Three items were reported to present difficulty by at least three of the participants. The first item "I experimented with responses to my feelings" was identified as ambiguous or not clear to participants and was reworded as "I responded to my feelings". The second item "I could tell the difference between what I was thinking and what I was feeling" was also identified as ambiguous and reworded as "My thoughts and my feelings were different". The third item presenting difficulty was "My feelings fell into place'. This item was identified as ambiguous and dropped from the scale.

Some participants were concerned about knowing the source or influence of the statements for them. For example, the item "I felt disconnected" was confusing to one participant who was unclear about whether the item was meant for the session or in counselling overall. Thus an additional component was added to the directions. It reads "Choose your responses according to how you felt in the session". It is hoped that this sentence will provide clarity. Instructions directing the participants not to differentiate between the causes of their responses were not included for the purpose of keeping the directions short and avoiding confusing those who were not initially confused.

Individual participants presented concerns over the following items. The item "I was exhausted" elicited confusion over the kind of exhaustion intended. This item was split into two items consisting of "I was physically exhausted" and "I was emotionally exhausted". The item "I was able to let myself feel my emotions" was identified as unclear and reworded as "I was able to feel my emotions". The item "I am determined to

work things out" which appears twice to access consistency, was assumed by one participant to be answered affirmatively by most everyone. This item, which also received a relevance rating of less than 4.0 by the judges, was deleted.

Three items were identified as difficult to answer because they were seen by the participant to represent a process that does not occur in one session. They included "I developed skills to deal with my feelings", "I felt a sense of completion", and "I developed healthier ways to express my feelings". These items were not deleted and the decision was based on the flexibility of the Likert scale in allowing participants to express the part of the process they were in.

Participants made the following suggestions for potential new items: "I expressed my emotions", "I became aware of my feelings", "My feelings confused me", "I didn't express my feelings", "I focused my emotions". All of these items were added to the revised scale.

Statistical Analysis. Pearson product-moment correlations were computed among the three main categories as determined by the judges as well as with items concerning "Bodily Sensations". All three main categories, "Awareness", "Intensity", and "Restructuring Emotion Schemes" correlated positively with the total score ($r = .84$, $p < .01$; $r = .85$, $p < .01$; $r = .98$, $p < .01$, respectively).

Significant positive relationships were also found between each of the categories with the other categories (see Table 1). In other words, high scores in one category correlated with high scores in both of the other categories. These results suggest that the three categories are measuring the same latent variable. There was also a significant

negative correlation between "Bodily Sensations" and all the remaining categories (see Table 1). Thus, low levels of the physical experiences of emotions correlate with high levels of awareness, intensity, and resolution of emotional matters

Table 1

Correlations Among the Four Categories of the Emotional Experience Scale (N=16)

Emotional	Awareness	Intensity	Restructuring Emotion Schemes	Bodily Sensations	Total
Awareness	--	.62*	.86**	-.85**	.84**
Intensity		--	.79**	-.54*	.85**
Restructuring			--	-.69**	.98**
Bodily Sensations				--	-.59*

Note: * indicates significant r value, $p < .05$
**indicates significant r value, $p < .01$

Reliability analyses were computed for the items in each category. However, due to the small sample size, especially when considering the number of items in the scale, the results from this analysis are questionable and no decisions on discarding items were made from it. Item-total correlations were computed for all of the items in the first three categories. The alpha coefficient obtained for the 58 items in these three categories was .94.

The alpha coefficient obtained for the 13 items in "Awareness" was .93 (see Table 2). The following item "I paid a lot of attention to my feelings" correlated negatively with five other items, three of which were previously deleted according to the relevance ratings (items 55 and 74) and the interview data (item 18). This item generated a weak correlation with the total category score ($r = .09$) and would increase alpha to $r = .90$ if

deleted. The item, which appeared first in the scale, was moved to the middle of the revised scale.

Table 2

Reliability Analysis: Item-Total Statistics for Awareness and Intensity Categories

AWARENESS ITEM*	Item-Total Correlation	Alpha If Item Deleted	INTENSITY ITEM**	Item-Total Correlation	Alpha If Item Deleted
1	.0850	.8991	2	.2728	.3565
6	.5169	.8831	7	-.6652	.5301
9	.7321	.8759	11	.3770	.3051
13	.6935	.8754	14	-.3536	.4729
18	.3663	.8895	17	-.0761	.4311
28	.6305	.8775	19	.2714	.3327
32	.5012	.8843	20	.5095	.2700
41	.6545	.8782	21	-.2325	.4460
55	.7585	.8708	23	.4124	.2928
62	.7128	.8760	25	.6884	.2361
65	.6993	.8757	26	.4652	.2891
68	.6391	.8771	27	.1665	.3675
74	.7000	.8749	31	.2449	.3394
			35	.2562	.3303
			27	-.1893	.4727
			40	.4073	.3125
			44	.6099	.2491
			59	.0154	.4041
			66	-.4170	.5124

Note: *Alpha for Awareness = .8883 for 13 items; **Alpha for Intensity = .3899 for 19 items

The alpha coefficient obtained for the 19 items in "Intensity was .39 (see Table 2). The correlations for items in the "Intensity" category ranged from $r = -.67$ to $r = .69$, indicating concern for the reliability of this category with the current sample. Although the reliability coefficients for this category are less meaningful considering the sample size, the results coincide with the number of relevance ratings below 4.0 from the panel

of judges. However, when the items yielding a relevance rating of less than 4.0 were removed from this scale, the alpha decreased ($r = .16$).

The negative correlations for this category included the following items: "I was able to let myself feel my emotions", "I felt like I was going to explode", "I was very emotional", "I was able to control my emotions", "My emotions were overwhelming", and "I felt like I was on a roller coaster". These items were checked to ensure proper use of reverse coding procedures. The stronger items in this category were as follows: "I couldn't make my therapist understand how I was feeling", "I avoided feeling any emotions", 'I had an emotional release", and "I felt relieved".

The alpha coefficient obtained for the 29 items in "Restructuring Emotion Schemes" was .93 (see Table 3), indicating support for the internal reliability of this category. The correlations for items in the "Restructuring Emotion Schemes" category ranged from $r = .09$ to $r = .81$. The stronger items in this category were as follows: "I understand more about the way I am feeling about things", "I am beginning to heal", "I developed healthier ways to express my feelings", "I felt like I was on the right track", "I couldn't handle all my feelings", "I developed skills to deal with my feelings", "I wasn't feeling ready to open up yet", "I couldn't cope", and "It felt like it was going to be Ok". The weaker items consisted of the following: "I knew how to express my feelings", "I experimented with responses to my feelings", and "I am determined to work things out", the second of which was reworded and the last of which was deleted according to the judges' ratings.

Table 3

Reliability Analysis: Item-Total Statistics for Restructuring Emotion Schemes and Bodily Sensations Category

RESTRUCTURING ITEM*	Item-Total Correlation	Alpha If Item Deleted	BODILY SENSATIONS**	Item-Total Correlation	Alpha If Item Deleted
3	.2697	.9345	4	.2663	.8457
5	.0888	.9364	8	-.5941	.8718
10	.5390	.9322	22	.7401	.8077
12	.4758	.9324	34	.5927	.8211
15	.3941	.9332	39	.7234	.8058
16	.7196	.9301	43	.0207	.8595
24	.8069	.9283	47	.7632	.8144
29	.4606	.9333	51	.6165	.8161
30	.7717	.9286	57	.5956	.8194
33	.2880	.9340	64	.7583	.8083
36	.7577	.9298	67	.8188	.8979
38	.3729	.9341	69	.7157	.8335
42	.7286	.9290	73	.7748	.8129
45	.7382	.9292			
46	.7358	.9293			
48	.6958	.9297			
49	.6324	.9307			
50	.3506	.9335			
51	.5425	.9316			
53	.6496	.9304			
54	.7041	.9293			
56	.7282	.9290			
58	.4811	.9325			
60	.4277	.9334			
61	.6915	.9297			
63	.4825	.9323			
70	.6201	.9306			
71	.5809	.9311			
7.2	.4780	.9329			

Note: *Alpha for Restructuring Emotion Schemes = .9337 for 29 items
**Alpha for Bodily Sensations = .8376 for 13 items

Table 4

Revised Emotional Experiencing Scale

Emotional Experiencing Scale

Client ID:_____ Age: _____
Gender: Male Female Number of Sessions Completed: _____
Reason for Seeking Counselling: _____
Have you experienced any health problems in the last week? Yes No
If yes, please describe: _____

Directions: Read each item carefully. Regardless of how you felt before the session, indicate the extent to which these items describe you in the last session by circling the appropriate number, with 1 not describing you at all and 5 describing you very well. Choose your responses according to how you felt in the session.

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
1. I expressed my emotions.	1	2	3	4	5
2. I talked about how I felt.	1	2	3	4	5
3. I knew how to express my feelings.	1	2	3	4	5
4. I was emotionally exhausted.	1	2	3	4	5
5. I responded to my feelings.	1	2	3	4	5
6. I felt disconnected.	1	2	3	4	5
7. I was able to feel my emotions.	1	2	3	4	5
8. I felt lighter.	1	2	3	4	5
9. I became aware of what I was feeling.	1	2	3	4	5
10. I used my emotions effectively.	1	2	3	4	5
11. I kept my feelings all bottled up.	1	2	3	4	5
12. I felt like I was making progress.	1	2	3	4	5
13. I knew exactly what I was feeling.	1	2	3	4	5
14. I felt like I was going to explode.	1	2	3	4	5
15. I am learning to express how I am feeling.	1	2	3	4	5
16. I understand more about the way I am feeling about things.	1	2	3	4	5
17. I was very emotional.	1	2	3	4	5
18. My thoughts and my feelings were different.	1	2	3	4	5
19. It was hard to describe how I felt.	1	2	3	4	5
20. I was physically exhausted.	1	2	3	4	5
21. I was able to control my emotions.	1	2	3	4	5
22. My heart was racing.	1	2	3	4	5
23. I got all my feelings out.	1	2	3	4	5
24. I am beginning to heal.	1	2	3	4	5

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
25. I paid a lot of attention to my feelings.	1	2	3	4	5
26. I avoided feeling any emotions.	1	2	3	4	5
27. I vented my feelings.	1	2	3	4	5
28. I was detached.	1	2	3	4	5
29. I was confused about my situation.	1	2	3	4	5
30. I developed healthier ways to express my feelings.	1	2	3	4	5
31. I wanted to curl up in a ball.	1	2	3	4	5
32. I felt numb.	1	2	3	4	5
33. I focused my emotions.	1	2	3	4	5
34. My stomach was upset.	1	2	3	4	5
35. I tried not to show my feelings.	1	2	3	4	5
36. I felt like I was on the right track.	1	2	3	4	5
37. My emotions were overwhelming.	1	2	3	4	5
38. I discovered new feelings.	1	2	3	4	5
39. My body was stiff.	1	2	3	4	5
40. I had an emotional release.	1	2	3	4	5
41. I made a connection between my feelings and my experiences.	1	2	3	4	5
42. I could handle all my feelings.	1	2	3	4	5
43. I had no energy.	1	2	3	4	5
44. I felt relieved.	1	2	3	4	5
45. I developed skills to deal with my feelings.	1	2	3	4	5
46. I felt ready to open up.	1	2	3	4	5
47. I felt cold.	1	2	3	4	5
48. I got to know myself better.	1	2	3	4	5
49. I felt stuck in my situation.	1	2	3	4	5
50. I could deal with my feelings better than before.	1	2	3	4	5
51. My chest felt tight.	1	2	3	4	5
52. I felt like things were getting resolved.	1	2	3	4	5
53. I became aware of my feelings.	1	2	3	4	5
54. My feelings confused me.	1	2	3	4	5
55. I expressed my feelings.	1	2	3	4	5
56. It felt like it was going to be all right.	1	2	3	4	5
57. My cheeks flushed.	1	2	3	4	5
58. I wanted to crawl in a hole.	1	2	3	4	5
59. My feelings changed from before.	1	2	3	4	5
60. I felt a sense of completion.	1	2	3	4	5
61. My emotions were all mixed up.	1	2	3	4	5
62. I confronted my feelings.	1	2	3	4	5
63. I was sweating.	1	2	3	4	5
64. I paid attention to my feelings.	1	2	3	4	5
65. I felt like I was on a roller coaster.	1	2	3	4	5

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
66. My body was tense.	1	2	3	4	5
67. I was confused about how I felt about things.	1	2	3	4	5
68. It felt like a weight was lifted off me.	1	2	3	4	5
69. I couldn't make sense out of how I was feeling.	1	2	3	4	5
70. I had difficulty breathing.	1	2	3	4	5
71. I felt like I was on the right track.	1	2	3	4	5

The alpha coefficient obtained for "Bodily Sensations was .84 (see Table 3), indicating support for the consistency of the items within this category. The correlations between items in the "Bodily Sensations" category ranged from $r = .02$ to $r = .77$. A negative correlation was found for one of the items in this category, "I felt lighter", suggesting that it may need to be reverse coded. Stronger items emerged as "I felt cold", "I was sweating", "My body was tense", and "I had difficulty breathing".

The revised scale appears in Table 4 . This table is based on the revisions from client feedback, judges' feedback, and the statistical analysis presented above. These revisions reflect the content and construct validity of the scale, as well as the internal consistency of the scale. In particular, both the use of (1) clients' reports of their emotional experiences in counselling and (2) expert judges' feedback on the content of the items in relationship to the latent variable established preliminary evidence of the content validity of the scale. The judges' relevance ratings of the items to categories representative of a theoretical structure of emotionally-focused interventions established preliminary evidence of the construct validity of the scale. Finally, the correlational

analysis lends support to both the theoretical structure of the scale (Greenberg, 1993) and the internal consistency of the scale.

The reliability analyses, although confirmatory in nature, presents difficulties in interpretation with respect to the small sample size. The risks involved in using too few subjects stem from the potential instability of patterns of covariation among the items, the potential inaccurate picture of internal consistency, the increased influence of change, and the representativeness of the sample (DeVellis, 1991). Thus, the influence of the small sample size is important in interpreting the reliability analyses. Namely, the item-total correlations must be interpreted with caution, as a sample size of 16 is not sufficient to ensure confidence in accessing the entire continuum of individual differences on the four categories within the scale.

Summary

The results of the feedback from both clients and therapists supports the contention that the scale indeed measures clients' in-session emotional experiencing. The statistical analyses also offers support for the internal reliability of the scale, especially with respect to the positive relationships among the categories. However, the small sample size hinders in-depth interpretation, especially with respect to the Intensity category, where the variability of the correlations in this category and the resulting low alpha scores are problematic.

CHAPTER V: DISCUSSION AND IMPLICATIONS

The development of a scale to measure clients' in-session emotional experience, as described in this thesis, offers a valuable tool in the investigation of clients' experience in counselling and how that experience relates to change. The scale is designed to measure individual differences in clients' emotional experiencing in a counselling session for the purpose of measuring emotions as a part of the therapeutic process. With this knowledge, researchers can decrease the time and cost of therapy by identifying effective intervention skills for training and practice and by providing empirical evidence for existing psychotherapeutic theories of emotion from which interventions are developed. While more research is needed to validate the instrument, the feedback from clients and experts and the preliminary statistical analyses offer preliminary confirmatory evidence of the internal structure of the scale.

The findings obtained in the development and preliminary analyses of the Emotional Experiencing Scale (EES) are discussed below. Thereafter, suggestions for a more extensive validation of the scale and implications for its use in research and practice are explored.

Most noteworthy is the confirmatory nature of the correlational analyses among the four components expected to make up clients' experience of emotions. At the same time, persons experiencing minimal physical aspects of emotions were found to be more aware of their emotions and tended to be in the advanced stages of the process of working through emotional matters. The results are also suggestive of the tendency for clients to feel their emotions on levels other than the physical level, as evidenced in the negative

relationship between physical experiencing of emotions and the intensity with which those emotions are felt.

The Intensity category is problematic considering the variability of the item-total correlations. The main source of difficulty may lie in the connotations of the content of some of the items. Some items that were found to yield negative correlations with the category total score are descriptive of the extreme end of the continuum of intensity, such as "I felt like I was going to explode", "I was very emotional", and "My emotions were overwhelming", and may divert clients from expressing their level of intensity on the continuum in their response. Instead they may see the item as dichotomous and choose that it does not describe them at all. Social desirability may be a working factor within these items.

Overall, these findings offer preliminary support for the structural make-up of Greenberg's (1993) emotionally-focused intervention processes. In particular, the positive correlations among the three areas upholds the contention that the allowing and awareness of feelings is related to the resolution of emotional matters. As a result, the current study provides evidence of the utility of Greenberg's theory in counselling.

Strengths and Limitations of the Study

The EES overcomes problems associated with using self-report measures (McLeod, 1994; Westen et al., 1997). It requires a low reading level of Grade Six on the part of the client. It was also designed to avoid items with negative connotations and to reduce the risk of asking clients to make judgments on their experiences.

Content and Construct Validity. The confidence associated with the content and construct validity of the scale, in its revised form, was established by the use of three valuable and credible sources. First, the items of the scale were based on clients' qualitative accounts of their experience of emotions. Second, the derived items were subjected to two valuable sources of inquiry involving both groups of people involved in the counselling process, the clients and the therapists, the latter of who consisted of members of a counselling process research team. Finally, the scale is embedded in a theoretical structure of the experience of emotions in counselling (Greenberg, 1993). The combination of these sources used to determine the construct validity of the scale offers assurance that the scale is reflective of clients' in-session emotional experiencing.

Reliability. The main limitation of this study is the small sample size. The small sample size, however, was appropriate for the analyses of interview data and discussions from the panel of judges. Although a sample size of 16 is appropriate for investigating various forms of validity, a larger sample is required to ensure confidence in statistical investigations of both the reliability and validity of the scale.

The second limitation of the present study stems from the solitary administration of the scale to each participant, thus yielding information about emotional experiencing in one session without a frame of reference from which to guide interpretations, such as the consideration of where the client feels he or she is at emotionally and how they respond emotionally in other areas of their life. While the scale is designed to measure emotional experiencing in one session, the validation for future use depends upon (1) documenting the process of emotional experiencing across the entire length of

counselling, and (2) gaining insight into the personality traits of the client in order to better understand how the persons' current situation is affecting them.

Implications for Future Research

The validation of newly developed psychometric instruments is an ongoing process. Directions for future research involve expanding investigations of the reliability and validity of the EES. Of specific importance will be the administration of the scale to a larger number of clients, along with a measure of change and a measure of how the client normally responds emotionally. Interviews may also be conducted with participants regarding their emotional experience over the process of counselling.

Administration to Larger Sample. The administration of the scale to a larger number of clients will allow for a more representative sample from which to draw conclusions and provide further assessment for the measure's reliability and validity. Dawis (1987) recommends 100 participants for this administration. This research may involve the inclusion of a Social Desirability Scale in order to investigate the discriminant validity of the EES. This scale may involve items already in existence in the EES, such as, "I was very emotional", "I was able to control my emotions", and "My emotions were overwhelming". These items yielded negative correlations with the Intensity subscale and may provide evidence of the social desirability of the scale.

Also relevant in this respect is the repeated administration of the scale to the same clients throughout their progression in therapy. Charting this progression with the scale will be important in establishing support for the theoretical basis of the scale (Greenberg, 1993) and for understanding the relationship between emotions and therapeutic change.

Attempts should be made to access similar demographics as those who seek therapy in the setting for which the administration is to happen.

Validity. Support for the relationship between therapeutic change and the experience of emotions may be obtained through the concurrent administration of the Emotional Experiencing Scale and another measure of change, such as the Outcome Questionnaire (Lambert et al., 1996), the Symptom Checklist 90 R (Derogatis, 1983), or the Session Impacts Scale (Elliott & Wexler, 1994). This concurrent administration is expected to shed light on the role of emotions in therapeutic change as postulated in recent theoretical approaches to emotion (Greenberg & Paivio, 1997). Clients' experience of emotions is expected to facilitate therapeutic change (Greenberg, 1993). Without the reorganization of emotional experience, when it is dysfunctional, therapeutic change is expected not to occur.

Validity may also be obtained by conducting interviews with participants about their experience of emotions during the counselling process. These interviews may be conducted during therapy and at the end of therapy. Thematic analysis of the interview data may be compared with the results of the EES in the same sample. Potential interview questions may consist of asking the client to describe his or her experience of emotions in counselling, their perception of when their circumstances improved or declined, factors they associate with change or lack of change. Interviews and EES data may be compared on a session to session basis and at the end of counselling but it is recommended that the order in which the interview and administration of the EES be alternated so that any influence of one method over the other can be investigated.

Individuals' tolerance of emotional experiencing (Beutler et al, 1999; Westen et al, 1997) and their tendency to experience particular emotions and express them in different ways (Westen, 1995) are important considerations in gaining evidence of validity and interpreting the findings of the scale. In using the scale, researchers must have a frame of reference of how the individual normally experiences emotions. Thus, it is imperative that the scale be administered with other scales measuring emotional tendencies. For this reason tools measuring more stable traits, such as the Emotional Intensity Scale (EIS: Bachorowski & Braaten, 1994) or the Affect Intensity Measure (AIM: Larsen, 1984) are recommended for administration along with the EES and measure of change. It follows that interpretations of the scale to the client should be made with consideration of how that person usually responds.

In the current study, the judge's assessment involved ranking the relevance of each item to a category pre-selected by the researcher. In order to control the potential bias involved in this method and to allow for the assessment of new and revised items, it is recommended that judges determine the appropriate subscale for each item, in addition to determining the clarity and relevance of each item. This procedure may be undertaken in two steps, with revisions calculated from determining the appropriate scales as a basis for determining relevance rating of individual items to particular subscales.

Validation for existing psychotherapeutic approaches to emotion is recommended with the use of the EES. In the past, investigations of psychotherapeutic approaches to emotion have been hindered by the lack of appropriate instruments to measure clients' experience of emotions and their effect on change across various approaches (Greenberg

& Paivio, 1998; MacKay et al., 1998; Wiser & Goldfried, 1993, 1998). This investigation may involve the inclusion of different therapeutic approaches in the validation study for which analysis of variance statistical procedures would be appropriate.

Future Statistical Analysis. This scale is based on three phases of intervention proposed by Greenberg (1993) along with the consideration of how emotions feel in the body. A factor analysis of the data following a larger administration would ascertain the saliency of the items as well as increase our understanding of the degree of independence of each of the categories. As a combination of methods is usually practiced in the development of such instruments (Dawis, 1987), reliability analysis may also be utilized.

Future research may further investigate the relationship among the intensity of emotional experience, the intensity level of the session, and treatment outcome, as suggested by Beutler et al. (1999) by means of correlational analysis. At this point, the relationship among these factors is poorly understood.

Implications for Practice

These results are important for practical purposes because they inform us how emotions play a major role in therapeutic change, thereby guiding therapists in their utilization of effective therapeutic strategies. Further, the ease of administration and scoring make this tool realistically applicable in the everyday practice of counselling. Since the scale only takes a few minutes to complete and score, it offers minimal disruption to the counselling process and does not require additional personnel to administer, score, or interpret. It will be especially useful for identifying clients who find it difficult to verbalize his or her feelings. In a practical sense, the tool may either be used

as a communicative tool, a diagnostic tool following validation with clinical populations, and a screening tool for matching the client with appropriate interventions.

Following future validation research on the scale, the practical applications of the instrument involve its use in identifying the stage of emotional experiencing the client is in. This information will allow counsellors to focus their interventions. For example, if a client scores low on the awareness category, interventions suggested by Greenberg and Safran (1987) may be considered in order to assist the client in allowing themselves to experience their emotions so that they can work through them. A high score in Restructuring Emotion Schemes may identify either the clients' denial that they still have issues to deal with or it may suggest that therapy is coming to a close.

Conclusion

The current study involved the development of a self-report measure of clients' in-session emotional experiencing. It addressed the need for such an instrument as a response to the interest in the role that emotions play it therapeutic progress. On the whole, the Emotional Experiencing Scale was easily administered, easy to understand, and was completed quickly by participants. While more evidence is required to ascertain the content of the items in the Intensity category, the initial results lend support for the establishment of emotional experiencing as a measurable phenomenon.

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Appendix A

Letter to Judges

Jody Sark

10160-114 Street Apt 617, Edmonton, Alta T5K 2L2 (780) 488-5106 jsark@ualberta.ca

March 21, 2000

Counselling Process Project Judges:

Again, I am requesting your help in refining the scale with your expertise. Since our last meeting, I revised the scale to include 74 items from the initial 131 items. Currently, I am administering the scale to clients in the clinic and interviewing them about the clarity and content of the items. In order to continue to the statistical stage, I need your expert opinion regarding whether the items reflect the categories under which they are presently placed. The first three categories are taken from Greenberg's (1993) three types of intervention processes (see attached descriptions).

If you have the time, indicate the extent to which you think that the item describes the category in which it is placed by placing the number representing your choice on the line beside the item. If at all possible, please have the completed scale returned to my mailbox (clinic or grad lounge) by the end of the day so that I may begin statistical analysis tomorrow (first thing tomorrow morning would also be very generous on your part). If you have suggestions for another category that a given item should belong, please indicate your preference directly beside the item. Again, the scale is intended to measure clients' "in-session" emotional experiencing in counselling. Any other comments you have about the scale will be welcomed.

1	2	3	4	5
Does Not Describe Category At All	Barely Describes the Category	Describes the Category Somewhat	Describes the Category Well	Describes the Category Very Well

Awareness

1. I paid a lot of attention to my feelings. _____
9. I became aware of what I was feeling. _____
13. I knew exactly what I was feeling _____
18. I could tell the difference between what I was thinking and what I was feeling. _____
41. I made the connection between my feelings and my experiences. _____
55. I didn't feel safe. _____
62. My emotions were all mixed up. (rc) _____
65. I didn't pay much attention to my feelings. (rc) _____
68. I was confused about how I felt about things. (rc) _____
74. I felt lost. _____

Intensity

2. I could talk about how I felt. _____
3. I knew how to express my feelings. _____
6. I felt disconnected. (rc) _____
7. I was able to let myself feel my emotions. _____
11. I kept my feelings all bottled up. (rc) _____
14.I felt like I was going to explode. _____
15. I am learning to express how I am feeling. _____
17. I was very emotional. _____
19. I had difficulty describing how I felt. (rc) _____
20. I allowed myself to feel again. _____
21. I was able to control my emotions. (rc) _____
23. I still didn't get all my feelings out. (rc) _____
25. I couldn't make my therapist understand how I was feeling. (rc) _____
26. I avoided feeling any emotions. (rc) _____
27. I vented my feelings. _____
28. I was detached. (rc) _____
31. I wanted to curl up in a ball. (rc) _____
32. I felt numb. (rc) _____
35. I tried not to show my feelings. (rc) _____
37. My emotions were overwhelming. _____
40. I had an emotional release. _____
44. I felt relieved. _____
59. I wanted to crawl in a hole. _____
66. I felt like I was on a roller coaster. _____

Restructuring Emotion Schemes

5. I experimented with responses to my feelings. _____
10. I used my emotions effectively. _____
12. I felt like I wasn't making any progress. (rc) _____
16. I understand more about the way I am feeling about things. _____
24. I am beginning to heal. _____
29. I was confused about my situation. (rc) _____
30. I developed healthier ways to express my feelings. _____
33. I am determined to work things out. _____
36. I felt like I was on the right track. _____
38. I discovered new feelings. _____
42. I couldn't handle all my feelings. (rc) _____
45. I developed new skills to deal with my feelings. _____
46. I wasn't feeling ready to open up yet. (rc) _____
48.. I got to know myself better. _____
49. I felt stuck in my situation. (rc) _____
50. I could deal with my feelings better than before. _____
52. I didn't feel like anything was resolved. (rc) _____

53. I came to some realizations. _____
54. I couldn't cope. (rc) _____
56. I felt like I was going to be Ok. _____
58. I am determined to work things out. _____
60. My feelings changed from before. _____
61. I felt a sense of completion. _____
63. I confronted my feelings. _____
70. My feelings fell into place. _____
71. It felt like a weight was lifted off me. _____
72. I couldn't make sense out of how I was feeling. (rc) _____

Bodily Sensations

4. I was exhausted. _____
8. I felt lighter. _____
22. My heart was racing _____
34. My stomach was upset. _____
39. My body was stiff. _____
43. I had no energy. _____
47. I felt cold. _____
51. My chest felt tight. _____
57. My cheeks flushed. _____
64. I was sweating. _____
67. My body was tense. _____
69. I had goosebumps. _____
73. I had difficulty breathing. _____

Appendix B

Letter to Clients

Department of Educational Psychology
6-123H Education North
University of Alberta
Phone: 488-5106

Principle Researchers: Jody Sark and Dr. Barbara Paulson

My name is Jody Sark and I am a Masters' student conducting research for my thesis under the supervision of Dr. Barbara Paulson, the Director of Counselling Services at the Education Clinic. I am currently looking for clients to help me with the development of a questionnaire about clients' experience of emotions in counselling.

The purpose of this study is to gain insight from clients regarding the development of a questionnaire to measure clients' emotional experiencing in counselling. It is hoped that this information will be helpful in revising the existing questionnaire so that is may become more feasible and user-friendly.

Participants will be asked to fill out the questionnaire in its present state. The questionnaire contains items about the emotional experience to which the participant will be asked to indicate how well the items describes him or her in the last therapy session. Following this administration, the researcher will interview the participant about the content of the questions. In particular, the researchers will be interested in any items that the participant had difficulty answering or understanding. **This is a voluntary project.** As a participant, you have the right to withdraw from participation at any time, without penalty. Your name and identity will not be given out to anyone. **The questionnaire and interview should take approximately 15 minutes**, following your counselling session today. The confidentiality and anonymity of all participants will be protected by placing a number in the client identification blank, instead of the participant's name. There may be some risk that talking about emotional experiences may create some discomfort and therefore additional counselling will be available if you wish.

If you are interested and have 15 minutes at the end of your session today, let your counsellor know so that I can meet with you.

Thank you,

Jody Sark
Masters' Student (Counselling)
(780) 488-5106
jsark@ualberta.ca

Appendix C

INFORMED CONSENT FORM

Department of Educational Psychology
6-123H Education North
University of Alberta
Phone: 488-5106

Principle Researchers: Jody Sark and Dr. Barbara Paulson

The purpose of this study is to gain insight from clients regarding the development of a questionnaire to measure clients' emotional experiencing in counselling. It is hoped that this information will be helpful in revising the existing questionnaire so that is may become more feasible and user-friendly. Participants will be asked to fill out the questionnaire in its present state. The questionnaire contains items about the emotional experience to which the participant indicates how well the item describes him or her in the last therapy session. Following this administration, the researcher will interview the participant about the content of the questions. In particular, the researchers will be interested in any items that the participant had difficulty answering or understanding. As a participant, you have the right to withdraw from participation at any time, without penalty. The confidentiality and anonymity of all participants will be protected through the use of numbers to replace names.

I have an understanding of:

i) the purpose and nature of the project,
ii) the expected benefits,
iii) the tasks involved,
iv) the inconveniences and risks,
v) the identity of those involved in the project,
vi) who will receive information,
vii) how the information will be used,
viii) the right to give or withhold consent for participation,
ix) the right to withdraw at any time during the process,
x) how confidentiality will be maintained.

I give my informed consent for my participation in the project.

_____ _____

Date Name of Participant

_____

Name of Researcher

Appendix D

Emotional Experiencing Questionnaire

Client ID:_____ Age: _____
Gender: Male Female Number of Sessions Completed: _____
Reason for Seeking Counselling: _____
Have you experienced any health problems in the last week? Yes No
If yes, please describe: _____

Directions: Read each item carefully. Regardless of how you felt before the session, indicate the extent to which these items describe you in the last session by circling the appropriate number, with 1 not describing you at all and 5 describing you very well.

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
1. I paid a lot of attention to my feelings.	1	2	3	4	5
2. I could talk about how I felt.	1	2	3	4	5
3. I knew how to express my feelings.	1	2	3	4	5
4. I was exhausted.	1	2	3	4	5
5. I experimented with responses to my feelings.	1	2	3	4	5
6. I felt disconnected.	1	2	3	4	5
7. I was able to let myself feel my emotions.	1	2	3	4	5
8. I felt lighter.	1	2	3	4	5
9. I became aware of what I was feeling.	1	2	3	4	5
10. I used my emotions effectively.	1	2	3	4	5
11. I kept my feelings all bottled up.	1	2	3	4	5
12. I felt like I wasn't making any progress.	1	2	3	4	5
13. I knew exactly what I was feeling.	1	2	3	4	5
14. I felt like I was going to explode.	1	2	3	4	5
15. I am learning to express how I am feeling.	1	2	3	4	5

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
16. I understand more about the way I am feeling about things.	1	2	3	4	5
17. I was very emotional.	1	2	3	4	5
18. I could tell the difference between what I was thinking and what I was feeling.	1	2	3	4	5
19. I had difficulty describing how I felt.	1	2	3	4	5
20. I allowed myself to feel again.	1	2	3	4	5
21. I was able to control my emotions.	1	2	3	4	5
22. My heart was racing.	1	2	3	4	5
23. I still didn't get all my feelings out.	1	2	3	4	5
24. I am beginning to heal.	1	2	3	4	5
25. I couldn't make my therapist understand how I was feeling.	1	2	3	4	5
26. I avoided feeling any emotions.	1	2	3	4	5
27. I vented my feelings.	1	2	3	4	5
28. I was detached.	1	2	3	4	5
29. I was confused about my situation.	1	2	3	4	5
30. I developed healthier ways to express my feelings.	1	2	3	4	5
31. I wanted to curl up in a ball.	1	2	3	4	5
32. I felt numb.	1	2	3	4	5
33. I am determined to work things out.	1	2	3	4	5
34. My stomach was upset.	1	2	3	4	5
35. I tried not to show my feelings.	1	2	3	4	5
36. I felt like I was on the right track.	1	2	3	4	5
37. My emotions were overwhelming.	1	2	3	4	5

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
38. I discovered new feelings.	1	2	3	4	5
39. My body was stiff.	1	2	3	4	5
40. I had an emotional release.	1	2	3	4	5
41. I made a connection between my feelings and my experiences.	1	2	3	4	5
42. I couldn't handle all my feelings.	1	2	3	4	5
43. I had no energy.	1	2	3	4	5
44. I felt relieved.	1	2	3	4	5
45. I developed skills to deal with my feelings.	1	2	3	4	5
46. I wasn't feeling ready to open up.	1	2	3	4	5
47. I felt cold.	1	2	3	4	5
48. I got to know myself better.	1	2	3	4	5
49. I felt stuck in my situation.	1	2	3	4	5
50. I could deal with my feelings better than before.	1	2	3	4	5
51. My chest felt tight.	1	2	3	4	5
52. I didn't feel like anything was resolved.	1	2	3	4	5
53. I came to some realizations.	1	2	3	4	5
54. I couldn't cope.	1	2	3	4	5
55. I didn't feel safe.	1	2	3	4	5
56. It felt like it was going to be Ok.	1	2	3	4	5
57. My cheeks flushed.	1	2	3	4	5
58. I am determined to work things out.	1	2	3	4	5
59. I wanted to crawl in a hole.	1	2	3	4	5

	Does Not Describe Me At All	Barely Describes Me	Describes Me Somewhat	Describes Me Well	Describes Me Very Well
60. My feelings changed from before.	1	2	3	4	5
61. I felt a sense of completion.	1	2	3	4	5
62. My emotions were all mixed up.	1	2	3	4	5
63. I confronted my feelings.	1	2	3	4	5
64. I was sweating.	1	2	3	4	5
65. I didn't pay much attention to my feelings.	1	2	3	4	5
66. I felt like I was on a roller coaster.	1	2	3	4	5
67. My body was tense.	1	2	3	4	5
68. I was confused about how I felt about things.	1	2	3	4	5
69. I had goosebumps.	1	2	3	4	5
70. My feelings fell into place.	1	2	3	4	5
71. It felt like a weight was lifted off me.	1	2	3	4	5
72. I couldn't make sense out of how I was feeling.	1	2	3	4	5
73. I had difficulty breathing.	1	2	3	4	5
74. I felt lost.	1	2	3	4	5

Appendix E

Means and Standard Deviations for Categories

Table 7

Means (S. D.) for Subscales of Emotional Experience (N= 16)

Category	M	SD	no of items
Awareness	49.69	9.16	13
Intensity	64.94	6.78	19
Restructuring	107.25	17.67	29
Bodily Sensations	26.81	8.47	13
Total	248.69	25.71	74