Comparing and Contrasting Two Clients in Emotion-Focused Therapy for Generalized Anxiety Disorder across and within four (4) dimensions of: Negative Treatment-of-Self, Positive Treatment-of-Self, Negative Emotions, and Positive Emotions

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts in Counselling and Clinical Psychology
Applied Psychology and Human Development
University of Toronto

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Abstract

The current research paper presents a good-outcome and a poor-outcome case, individuals who were treated with Emotion-Focused Therapy, drawn from the Generalized Anxiety Disorder Pilot study. EFT is an evidence-based treatment for depression, couple distress and trauma and has shown promise for anxiety disorders, interpersonal problems, and eating disorder (Greenberg & Watson, 2006; Paivio & Nieuwenhivs, 2001; Greenberg & Dolhanty, 2009; Mennin, 2004). The purpose of this research study was to track clients’ patterns of emotional change across treatment and within each therapy sessions, and to describe and examine how emotion changes for GAD clients in EFT. Using the individual case comparison methodology (Watson, Goldman, & Greenberg, 2007) and implementing Plutchik’s wheel-of-emotion this study tracks the process of change between these two clients, across the four dimension of: Negative treatment-of-self, positive treatment-of-self, negative emotions, and positive emotions. The results represent certain factors that are specific to good and poor outcome clients.
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Chapter 1
Introduction

Generalized anxiety disorder is increasingly being recognized as a considerable mental health concern. However, it remains a poorly understood and insufficiently treated chronic disorder. Generalized Anxiety Disorder (GAD) affects 3.1% of adults each year, including twice as many women as men (National Institute of Mental Health, 2010). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR; APA, 2013), symptoms include anxious thoughts, irritability, disturbance to sleep, lack of concentration, fatigue, muscle tension, and restlessness. People with GAD often report insecure attachments, consistently search for safety from perceived threats, and report greater marital distress than those individuals with other psychiatric diagnoses (Priest, 2013). Unlike other anxiety disorders like panic disorder (e.g. McNally, 1994), social phobia (e.g. Heimberg & Becker, 2002), or obsessive compulsive disorder (e.g. Swinson, Antony, Rachman, & Richter, 1998), in which considerable advances are evident, GAD remains an understudied (Dugas, 2000), misunderstood (Fresco et al., 2013), and treatment-resistant (Borkovec & Ruscio, 2001) disorder.

Recent conceptualizations have highlighted the role of emotional awareness, acceptance, and regulations as core features of the generalized anxiety disorder (Mennin, 2004). Other researchers have also suggested that understanding emotional regulation can greatly help both researchers and clinicians in treating individuals with anxiety disorders (Mennin, Heimberg, Turk, & Fresco, 2002; Greenberg & Pascual-Leone, 2006). The work of Mennin and colleagues (2002) on GAD also supports the former that emotional dysregulation is an important area that needs to be addressed in working with individuals with GAD.
Emotion and Evolution

The study of evolution of emotions has a long history that dates back to the 19th century. The work of Charles Darwin (in Plutchik, 1980) on the evolution and expression of emotions is one of the earliest works on this subject. Darwin suggested that emotions were evolved and adapted over time (Plutchik, 1980). He noted that our emotions exist because they have an adaptive role and help humans and animals to survive and reproduce (Plutchik, 1980). On a similar note, the modern theorists proposed that emotions are evolutionary and neurologically based tendencies to act resulting from an environmental appraisal in relation to goals, basic and complex needs, values, and concerns (Greenberg & Safran, 1988; Greenberg, 2010; Oatley & Jenkins, 1992; Strout, Sokol, Laird, & Thompson, 2004). Research has further supported that emotions, at the most basic level, are an inherent signalling system and response to the environment in order to maintain the health and safety of individuals (Greenberg, 2010; Greenberg & Safran, 1987; Greenberg & Pavio, 1997, Mulsant, 2011). For example, anger enables an individual to set firm boundaries, respond to violation, and to assert himself/herself (Angus & Greenberg, 2011). Hopelessness and sadness, on the other hand, slow down bodily movement to prevent additional efforts and further losses, and signals to others distress, and the need for comfort and connection (Mulsant, 2011). One of the most influential emotion theorists that greatly contributed to the study of emotion and emotional responses is Robert Plutchik. For the purpose of this research study, Robert Plutchik’s theory of emotion was implemented in classification of our clients’ general emotion responses.

Plutchik’s Psychoevolutionary Theory of Emotion

Plutchik’s psychoevolutionary theory of emotion suggests that emotions are more than just being emotional states. He proposed that emotions are multiple series of events that begin
with a stimulus that activates feelings and impulses that further leads to actions, and goal-oriented behaviour (Plutchik, 2003). Plutchik proposed that emotions are an individuals’ primary and basic survival tool that promote his/her existence (Plutchik, 1980). According to Plutchik, emotions act in a similar to our body organs, they keep us alive. He proposed that the function of emotions is very similar to our organs as it prepares us for our daily activities (Reeve, 2009). From this point of view, all emotions are productive and promote survival as they help us to prioritize our behaviours in order to optimize regulation to the demands of life (Plutchik, 1980; Reeve, 2009).

**Plutchik’s Wheel of Emotions**

Plutchik’s wheel of emotions was proposed in 1980 in order to describe and explain the relations between different emotions. In this model Plutchik has included all of the components of his Psychoevolutionary Theory of Emotion. Plutchik’s wheel of emotions is very similar to a colour wheel. In his model primary emotions can be expressed at different intensities and can also be integrated with other emotions to form different emotions. The intensity of the emotion increases as you move towards the wheel’s centre and decreases as you move away from wheel’s centre. As it is depicted in the color wheel the emotions are more intense when the color is darker and closer to the wheel’s centre (Plutchik, 2003).

Plutchik suggested that there are eight primary emotions. He proposed that these eight primary emotions are all located close to the centre of wheel and between more intense emotions and milder emotions. For example, rage, located at the centre is the stronger form of anger, while annoyance is the weaker form of anger and is located furthest from the wheel’s centre (Plutchik, 2003). Plutchik’s eight primary emotions are joy, trust, fear, surprise, sadness, anticipation, anger, and disgust. Each primary emotion has a polar opposite. For example, joy is the opposite
of sadness, fear is the opposite of anger, anticipation is the opposite of surprise, and disgust is the opposite of trust (Williams, 2013). Plutchik’s wheel of emotion also holds combination emotions, which are combinations of primary emotions that are next to each other on the wheel of emotions (Williams, 2013). For example, love is a combination of two primary emotions of trust and joy. In the current research study Plutchik’s wheel of emotion was implemented to track clients’ emotional change across treatment and within each therapy sessions.

**EFT’s View on Emotions**

EFT distinguishes among primary, secondary, and instrumental emotions: *Primary emotions* are those gut responses, such as flight or fight in times of danger, that can be either adaptive or maladaptive (Greenberg, 2010). According to Greenberg, primary emotions can help us make sense of our surroundings and events (2010). Greenberg argued that when working with clients, primary emotions need to be accessed as they contain adaptive information. An example of a primary emotion is the feeling of happiness you experience when you see a loved one. Primary emotions not only increase individuals’ survival, they also become personalized and customized through individual experiences. For example, a traumatic experience can alter and transform adaptive primary emotion to a maladaptive emotion. It is suggested that primary adaptive emotions need to be accessed for their adaptive information as well as primary maladaptive emotions to be transformed to a more adaptive emotion (Greenberg, 2010).

*Secondary emotions* are responses to one’s thoughts or feelings rather than to the situation (Greenberg, 2010). Secondary emotions are more evident when working with individuals, as they tend to be undesirable and affect individuals functioning (Greenberg, 2010). It is proposed that in order to facilitate change and transform emotions, secondary emotions can be used to access primary emotions (Greenberg, Pascual-Leone, 2006).
**Instrumental emotions** are other types of emotions that are used to manipulate the environment. As an example, when we cry to escape expected punishment, we are using instrumental emotion. From EFT’s perspective, in order to transform painful and bad emotions to more healthy and adaptive emotions we need to access, acknowledge, and understand primary, secondary, and instrumental emotions (Greenberg & Carryer, 2010).

EFT takes a different approach in working with primary versus secondary emotions in therapy. From EFT’s perspective, it is important to work on clients’ primary emotions as they carry adaptive information that can facilitate change (Greenberg & Pascual-Leone, 2006). With regards to secondary emotions, since they are reactions to primary emotions, clients need to explore them first so that they can later become aware of the underlying primary emotions. It is suggested that therapists should not spend too much of therapy time helping clients to express secondary emotions. Clients should also work on becoming aware of instrumental emotions, which often cause interpersonal problems (Greenberg & Carryer, 2010).

**Emotional Processing**

Emotional processing (EP) is one of the developmental processes that help individuals to understand their internal and external experience (Watson, 2011). The development of emotional processing skills, also known as *affect regulation*, is viewed as an important factor in psychopathology and also an agent of change in psychotherapy (Bradley, 2000; Greenberg & Watson, 2006; Watson, 2007). Affect regulation was defined as clients’ level of awareness of their emotional experience, how clients modulate and express their acceptance of their emotional experience, and their capacity to reflect on that experience (Watson et al., 2010). Research has shown that poor affect regulation is associated with a number of different disorders, including chronic fatigue (Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007), opiate addiction (Giyaur,
Sharf, & Hilsenroth, 2005), bulimia (Stice et al., 1999), complicated grief (Ogrodniczuk et al., 2002), and depression (Greenberg & Watson, 2006). Research has supported that emotional processing in therapy plays an important role to bring about change, not only in experiential treatment but also in psychoanalytic and cognitive-behavioral therapy (Borkovec & Sides, 1979; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Greenberg, Rice, & Elliot, 1993; Mergenthaler, 1996; Stein, 1991). Watson and colleagues (2010) argued that one predictor of a clients’ outcome in therapy is their level of affect regulation. The awareness of feelings and being able to label the feelings are the two most basic levels of emotional processing and affect regulation. On a similar note, emotional reflection, emotional regulation, and emotional transformation are the other components of affect regulation (Gratz & Roemer, 2004; Greenberg, 2002; Watson et al., 2010; Shahar, 2014).

**Emotion Awareness and Reflection**

Emotion awareness and reflection are two of the basic components in psychotherapy that contribute to a healthy emotional processing (Watson & Greenberg, 2015, Greenberg & Pascual-Leone, 2006; Shahar, 2014; Gratz & Roemer, 2004). From EFT’s perspective, in order for clients to become aware of their emotions; whether primary, secondary, adaptive, or maladaptive; they need to access and accept their emotions rather than staying silent or avoiding them. When helping clients with accessing their emotions, therapists need to guide clients to make sense of their experience in order to recognize their emotions. From this point of view, emotions act as tools that help individuals to understand their emotions and help them move to a more adaptive emotions (Greenberg, Pascual-Leone, 2006). Research on the importance of accessing emotions and being able to reflect and symbolize them at a deeper level in therapy session is well established (Watson & Greenberg, 2015; Greenberg, 2002; Samoliov & Goldfried, 2000).
Reflection is possible once clients have symbolized their emotions in awareness (Watson & Greenberg, 2015; Greenberg & Angus, 2004; Greenberg & Pascual-Leone, 1997; Guidano, 1995). Research has shown that individuals who are able to symbolize and write about their painful emotional experiences, had more positive outcomes on their immune functioning, show greater improvement in terms of their immune functioning, emotional health, and autonomic nervous system activity (Pennebaker, 1995).

**Emotion Regulation**

From the EFT perspective, the *regulation of emotions* is the second component of emotional processing. Research has suggested that emotional arousal and expression is not always enough to facilitate or create change (Greenberg & Carryer 2010). When the level of distress is so high that the emotion can no longer inform adaptive action, it is necessary that the emotion be regulated, so the change can happen. In order to help clients with emotion regulation, it is necessary to provide them with a safe, validating, and empathic environment (Greenberg, 2002). Greenberg and Pascual-Leone (2006) proposed that clients benefit from emotion regulation in working with maladaptive emotions such as shame or core sense of vulnerability. Being able to gain some psychological distance from an overwhelming maladaptive emotion can provide clients an opportunity to gain insight about his/her experience and to make sense of them (Greenberg & Pascual-Leone, 2006). This process can ultimately help clients in reducing vulnerability to negative emotions and guide them in transforming bad emotions to a more self-soothing, and adaptive emotion (Greenberg, 2002). Another important aspect of emotion regulation is developing clients’ abilities to soothe the self in times of distress and pain (Greenberg, 2002). Greenberg has suggested that emotion regulation skills can be taught through the process of helping clients in "identifying triggers, avoiding triggers, identifying and labelling
emotions, allowing and tolerating emotions, establishing a working distance, increasing positive emotions, reducing vulnerability to negative emotions, self-soothing, breathing, and distraction to improve coping" (Greenberg, 2010, p. 36).

Emotion regulation also plays a critical role in anxiety and depression disorders. Particularly, the experience of anxiety and depression involve under or over regulation of maladaptive emotions (Watson & Greenberg, 2015; Greenberg & Carryer, 2010; Pascual-Leone & Greenberg, 2006; Mennin, 2004). In the case of depression, typically there is an under-regulated emotion that is surrounding feelings of "shame-based worthlessness, anxious dependence, powerlessness, abandonment, and invalidation" (Angus, Goldman, & Mergenthaler, 2008, p. 630), while anxiety as associated with Generalized Anxiety Disorder (GAD) is considered to be a symptom of emotion dysregulation (Watson & Greenberg, 2015; Pascual-Leone & Greenberg, 2006; Mennin, 2004), as well as negative treatment-of-self (Watson, 2011).

From the EFT perspective, individuals in interaction with their significant others and their environment learn how to treat themselves and their organismic experience in particular ways. Individuals may take on and learn different messages in the interaction with others. People may learn that they will be listened to, heard, appreciated, and their feelings are understood and accepted; or they may learn that their emotions are not heard or accepted, should be neglected, silenced, and managed differently. As a result of repeated exposure to these maladaptive environments individuals may experience difficulty with emotional processing such as feeling overwhelmed by negative emotions or unable to cope, and may develop negative ways of treating themselves (Watson & Greenberg, 2015; Watson, 2011).

**Difficulties with Emotional Processing**
Carl Rogers (1951) proposed that the closer our self-image and ideal-self are to each other, the more congruent one would feel and the higher one’s sense of self-worth would be. On the other hand, *incongruence* is defined when an individuals’ experience is unacceptable to them and is denied or distorted in the real-self. From this point of view, incongruence is when there is a discrepancy between the person’s actual experience and the individual’s view-of-self as it represents that experience (Rogers, 1959). According to Rogers, incongruence is a major source of dysfunction and as a result of conflict between the self-structure and ones needs, it makes people vulnerable to anxiety and depression (1959).

Carl Rogers (1961) used the term incongruence to describe feelings of depression, anxiety, and unhappiness caused by not living the life we really want to. Rogers suggested that individuals could have a good job, marriage and children but still feel anxious, unhappy, and this is a key element in recognizing incongruence. According to Rogers, a critical element to effective therapy is when clients experience a decrease in self-discrepancy (Rogers, 1961).

Watson (2011) proposed that individuals not only need to experience a decrease in self-discrepancy, but should also develop adaptive ways to regulate their affect. Watson (2011) further elaborated that when individuals experience difficulty with emotional processing, they may also have difficulty acknowledging or being aware of what is happening in their bodies, or may get overwhelmed or overpowered by it, or have difficulty labeling and symbolizing it, or have difficulty moderating their emotional arousal. As a result, in order to help individuals with incongruence therapist need to work on decreasing self-discrepancy and also on developing a more adaptive, and self-soothing ways of emotional processing. One of the conditions that contribute to the development of incongruence is when individuals in interaction with others and their own experience define their condition-of-worth.
Condition of Worth in Emotional Processing

Rogers (1959) stated that the personality is like a triangle made up of the real self, the perceived self, and ideal self. According to Rogers, when there is a good fit between all three components then there is no gap between the ideal-self and the real-self. Rogers further identified that individuals develop conditions of worth when they need to balance their bodily emotions and the demands of their environments. For example, when we as children receive positive regard from significant people, for example our parents, we may feel we have to behave in certain ways to be accepted and loved. As a result, a child may feel that she/he is loved when she/he is told that she/he is being a "good boy/girl", but not when she/he has misbehaved. This ultimately creates conditions of worth. In the above example, the child feels that she/he becomes worthy of love only when her/his actions are consistent with what is expected of her/him. Watson (2011) proposed that in order to help individuals who are experiencing incongruence, the focus of psychotherapy needs to be on resolving discrepancies between the ideal-self and the real-self, and in developing adaptive ways of emotional processing.

Negative Treatment of Self

Watson (2011) proposed that impaired treatment-of-self can result from being silenced, abandoned, neglected, dismissed, oppressed, and can affect the ways one modulates and regulates emotions and emotional processing. Watson (2011) extended Rogers’s model of condition-of-worth and proposed that the conditions-of-worth not only impact the individuals’ awareness of their experience, but go beyond that in ways of how individuals regulate, comfort, and soothe themselves, and how they communicate and express their feelings to others. The proposed model suggests that negative and positive ways of treating the self-develop in interaction with environment and specifically significant others (Watson, 2011). People learn to
treat themselves depending on how others respond to their emotional experience and their ways of emotional expression (Watson, 2011). For example, individuals may be told to be strong and not to express grief or sadness when in reality they are sad and are going through an emotionally painful experience. Research suggests that negative treatment-of-self can lead people to be neglectful, ashamed, oppressive, and unforgiving of themselves (Watson, Goldman, Greenberg, 2007). This pattern is evident in many people who suffer from depression, addiction, and eating disorders (Watson, Goldman, & Greenberg, 2007).

Watson and Greenberg (2015) proposed that individuals with GAD often suffer from a fragile, weak, and negative sense-of-self. They further argued that being repeatedly exposed to situations or people that hurt them physically, emotionally, sexually, or verbally without protection may potentially lead to the development of anxiety (Watson & Greenberg, 2015). From this perspective, when individuals feel overwhelmed with negative emotions without adequate support and comfort they may develop a fragile and vulnerable sense-of-self. They further tend to avoid situations that trigger negative emotions such as rejection, shame, inferiority, and rejection in order to protect themselves. These individuals tend to neglect, dismiss, minimize, deny, or silence their emotional experience. They also develop negative ways of relating to the self and to their emotional experience as they lack other ways to soothe or regulate their emotions in ways that are more adaptive. Watson and Greenberg (2015) proposed that this is at the root of worry in individuals with generalized anxiety disorder.

**Emotion Transformation and Tracking the Process of Change**

According to Greenberg the last component of emotional processing is the transformation of emotion (Gratz & Roemer, 2004; Greenberg, 2002; Watson et al., 2010). It is proposed that “emotion can be used as a tool to change another emotion” (Greenberg & Pascual-Leone, 2006,
p. 618). From this point of view, we can use emotions when working with maladaptive emotions in an attempt to undo the negative, maladaptive emotion and transform it to a more adaptive emotion. Recent research by Tugade & Fredrickson has found that experiencing positive emotions, such as joy and trust, help accelerate cardiovascular recovery in comparison to neutral experience (Greenberg & Pascual-Leone, 2006). Studies by the same researchers have also found that one common factor among resilient individuals is that they use positive emotions as a coping mechanism when experiencing negative emotions (Greenberg & Pascual-Leone, 2006). Research study by Davidson (2000) shows that from a neuropsychological perspective, when emotion is silenced from one side of a brain it can be transformed by accessing it from another part of the brain. All these research studies suggest that emotion can be used as a dynamic system and a tool to transform and change emotion.

**Objectives and Hypotheses**

The purpose of this research study was to track changes in clients’ positive and negative emotions across treatment and within each therapy sessions using Plutchik’s wheel of emotion, and to describe changes in clients’ self-treatment, either positive or negative, in clients treated for GAD using EFT. Clients in this research study were diagnosed with Generalized Anxiety Disorder (GAD) and had received brief Emotion-Focused Therapy (EFT). The clients were selected based on divergent outcome and were compared across 4 dimensions including: negative emotions, positive emotions, negative self-statements, and positive self-statements.

**Chapter Two:**

**Methodology**

**Case-Comparison Methodology**
For the purpose of this study, the case comparison methodology was implemented to track clients’ emotional change across treatment and within each therapy sessions (Watson et al., 2007). Case-comparison provides in-depth and rich information that can help both researchers and clinicians to examine events across time and in comparison to the other cases. Case comparison methodology is one of the most practical forms of psychotherapy research (Fishman, 2005; Watson, 2013). Case studies, in general, have significantly contributed to the improvement and innovation in psychotherapy practice, and treatment delivery (Edwards, Dattilio, & Bromley, 2004). In general, case-comparison methodology is implemented when researchers need to compare and contrast two or more clients that received the same form of treatment by the same therapist or similar therapists under comparable conditions or similar concerns, but are presenting with different outcomes (Watson, Goldman, & Greenberg, 2007). The case-comparison method can also provide researchers with the opportunity to systematically compare two or more cases based on specific questions about conditions that are linked to good or poor therapeutic outcomes. Identifying factors or conditions linked with divergent outcomes can further guide researchers in improving treatment manuals and treatment outcomes.

In the current study the two cases were compared and contrasted across four (4) dimensions of: Negative emotions, positive emotions, negative treatment-of-self, and positive treatment-of-self. The two cases are drawn from Watson’s Pilot study at the University of Toronto. Clients, with Generalized Anxiety Disorder (GAD), received 16-to-24 psychotherapy session from trained Process-Experiential (PE) therapists. The EFT treatment manual was used (Elliott, Watson, Goldman, & Greenberg, 2004). The current study aimed for a detailed and in-depth comparison of a good and a poor outcome client focusing on specific aspects of therapeutic process, as well as client characteristics, in order to identify factors that were
common between the good and the poor outcome clients, as well as the ones that differentiate them.

**Subjects**

The data for this research study is drawn from a pilot study in which participants received Emotion Focused Therapy (EFT) in the treatment of GAD (Watson, 2011). The sample is comprised of 2 female clients with an average age of 30. The clients met the minimum Diagnostic and Statistical Manual of Mental Disorder (4th ed.; DSM-IV; American Psychiatric Association, 1994) criteria for generalized anxiety disorder. Each client was seen by a trained therapist, who had previous clinical experience. Individuals received one hour of individual psychotherapy once a week for 16 weeks. The outcome cases are selected on a basis of divergent outcomes, one client with a good and one client with a poor outcome. For the purposes of this research, the clients were compared on the 4 identified dimensions over the course of therapy.

**Participants: Good and Poor Outcome Clients**

Participants gave consent to receive one hour of individual psychotherapy once a week for 16 weeks. In the current study the poor outcome client received 16 sessions of individual psychotherapy, whereas the good outcome client received individual psychotherapy for 24 weeks as it was requested by the client and the therapist was able to accommodate the extra eight sessions. The selected clients for this study had received individual psychotherapy from two different therapists. There were no significant differences between therapists in terms of years of therapy experience or age. Both clients signed consent form and gave consent stating that the collected data may be used for research and/or supervision purposes.
The good and poor outcome cases were identified based on their performance on Beck Anxiety Inventory (BAI), State Trait Anxiety Inventory (STAI), and their score on Working Alliance Inventory (WAI) (see Table 1). The good outcome client scored 23 pre-therapy on the scale of Beck Anxiety Inventory and scored two at the post-therapy session. This client started therapy with moderate level of anxiety on the BAI scale and ended therapy standing on a score of two which indicates a very low level of anxiety. Scores that are between 16-to-25 are considered to be on the moderate range and any scores below 15 (15 is a cut-off score) considered to be in the low range on BAI scale (BAI; Beck, Epstein, Brown, & Steer, 1988). Individuals whose scores are equal or above 26, are considered to be in the clinically significant range on BAI scale (Beck, Epstein, Brown, & Steer, 1988). The good outcome client’s score decreased by 21 points on BAI scale which indicates a high change in the client’s symptoms of anxiety. On the Trait Anxiety Inventory (STAI) scale, the good outcome client obtained the score of 57 in pre-therapy session and 41 after termination. Scores on STAI range from 20-to-80. A cut point of 45 has been suggested to detect clinically significant symptoms (Spielberger, 1983). The good outcome client’s score dropped by 16 points at the end of therapy moving her from the clinical range to the non-clinical range in terms of severity.

In contrast, the poor outcome client presented with a high level of anxiety pre-therapy with a score of 36 on the BAI scale. Any score equal or above 25 suggests that the client is experiencing significant level of anxiety (Beck et al., 1988). The poor outcome client’s score dropped by 19 points and placed her in the moderate range of anxiety. Despite the marked reduction on her score she was still on a moderate range. On the measure of STAI the poor outcome client scored 46 pre-therapy, and obtained a score of 45. Her score only dropped by 1 point and left her on a clinically significant range (cut-off 45>). This pattern suggests that the
poor outcome client was experiencing stress and anxiety almost at the same level as when she entered therapy.

The good and poor outcome client obtained mean scores of 18.67 and 24 on WAI pre-therapy on the total of the following subscales: Bond subscale, Task subscale, and Goal subscale. At the post-therapy, their obtained mean scores increase for both good and poor outcome clients with scores of 21.67 and 27. The level of increase in WAI mean scores indicated that the quality of therapeutic relationship improved for both clients.

Table 1

*Good and Poor Outcome (measures)*

<table>
<thead>
<tr>
<th>Measures</th>
<th>Good Outcome Client (Maya) 24 Sessions</th>
<th>Poor Outcome Client (Rebecca) 16 Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>Pre 23</td>
<td>Post 2</td>
</tr>
<tr>
<td>STAI</td>
<td>Pre 57</td>
<td>Post 41</td>
</tr>
</tbody>
</table>
Emotion Focused Therapy (EFT) treatment followed the *learning Emotion-Focused Therapy: the process-experiential approach to change* manual (Elliot, Watson, Goldman, & Greenberg, 2003) which outlines moment-by-moment process diagnoses and markers for therapeutic interventions. In Emotion Focused Therapy, there is an emphasis on therapist’ being empathically attuned to their clients, being nonjudgmental, and conveying positive regard. The treatment tasks included: experiential focusing for an unclear felt sense, systematic evocative unfolding at a marker of a problematic reaction point, empathic affirmation at a marker of intense vulnerability, two chair dialogue for self-evaluative and self-critical splits, and empty chair work for unfinished business. Typically, the first three sessions entailed building the therapeutic alliance through the use of empathy and formulating therapeutic tasks with the client. Tasks were introduced after the third session and were employed with the clients’ agreement.

**Measures**

**Process Measures**

**Plutchik’s Wheel of emotion**

Plutchik's wheel of emotions is an infograph that uses the color wheel to illustrate variations in human affect and the relationship among emotions. Psychologist Robert Plutchik (1980) created the 2D wheel and a conical 3D version as a tool for understanding his psychoevolutionary theory of emotion (Appendix A). Plutchik identified eight primary emotions, which he coordinated in pairs of opposites: joy versus sadness; trust versus disgust; fear versus anger and anticipation versus surprise. Intensity of emotion and indicator color increases toward the center of the wheel, and decreases outward. For instance; fear is a primary emotion which in mild-form becomes apprehension and an in extreme form becomes terror. Secondary emotions
are displayed as combinations of the primary ones and tertiary emotions are displayed as combinations of secondary emotions.

In order to track the client’s changes in negative and positive emotion statements, Plutchik’s wheel of emotions was used to identify and code all those statements that clients used emotion words. The identified emotion statements were then assigned to one of Plutchik’s identified primary emotions. In the next phase, each client’s emotion statements were categorized as either positive or negative emotion.

**Negative Treatment-of-Self and Positive Treatment-of-Self**

The good and poor outcome clients were compared in brief Emotion-Focused Therapy for generalized anxiety disorder using “Measure of Client Productive Process” (Watson & McMullen, 2010; MCPP). In order to track the client’s changes in negative and positive treatment-of-self, the definitions of negative and positive self-treatment in MCPP were used and followed. Negative treatment-of-self is defined as negative ways people relate to themselves and their internal experiences (Watson, 2011). It is also the negative ways people try to adjust and soothe themselves and the maladaptive ways they express and communicate their emotions to themselves and others. Clients’ tendency to negatively evaluate themselves, their experience, or dismiss, deny, and ignore their experience are all defined as negative treatment of self (Watson, 2011). For example, negative self-treatment was coded when the client was blaming, shaming, criticizing, silencing, avoiding, controlling, suppressing, neglecting, deprecating his/her experience (e.g. there is something wrong with me, I’m going to look stupid, when he sees the real me, he will leave me). On the other hand, positive treatment-of-self is identified based on how people actively own their good qualities, their healthy adaptive course of action, and supporting values that are meaningful to them (Watson, 2011). Positive treatment of self
represents action tendencies that indicate clients are valuing, protecting, soothing, respecting, accepting, validating, and attending to her/his needs, wants, and experience (Watson, 2011).

**Outcome Measures**

**Generalized Anxiety Disorder 7-items (GAD-7) Scale:**

GAD-7 (Spitzer RL, Kroenke K, Williams JB, Lowe B, 2006) is a self-report questionnaire for screening and determining the severity of generalized anxiety disorder (GAD). GAD-7 has seven items, which measure severity of various signs of generalized anxiety disorder according to reported response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day.” Final score is indicated by the total score, which is made up by adding together the scores for the scale all seven items. GAD-7 is a sensitive self-administered test to assess generalized anxiety disorder, however, it cannot be used as replacement for clinical assessment and additional evaluation should be used to confirm a diagnosis of GAD. Evidence supports reliability and validity of the GAD-7 as a measure of anxiety in the general population. A 7-item anxiety scale (GAD-7) had good reliability, as well as criterion, construct, factorial, and procedural validity (Spitzer, Kroenke, Williams JB, & Lowe, 2006).

**Beck Anxiety Inventory (BAI)**

The BAI (BAI; Beck, Epstein, Brown, & Steer, 1988) is a 21-item self-report inventory assessing severity of anxiety in adults focusing on somatic symptoms. Researchers report high internal consistency, high test-retest reliability, high content validity, high construct validity, evidence of discriminant validity, and high concurrent validity in clinical and nonclinical populations (Beck et al., 1988; Creamer et al., 1995; Fydrich et al., 1992; Osman et al., 1993, 1997, 2002).
State-Trait Anxiety Inventory (STAI-T)

This (STAI-T; Spielberger, 1983; Spielberger et al., 1989; Barnes et al., 2002) is a self-report measure assessing how respondents feel in general. This instrument demonstrates high internal consistency (Barnes et al., 2002) and concurrent validity (Spielberger et al., 1989). The STAI also demonstrated excellent convergent validity with other tests of personality. This instrument evaluates how respondents feel at a particular time in the recent past and how they anticipate they will feel either in a specific situation that is likely to be encountered in the future or, in a variety of hypothetical situations. The STAI-T is found to be a sensitive indicator of changes in transitory anxiety experienced by clients in counseling, psychotherapy, and behavior-modification programs.

Post-Session Measure

The Working Alliance Inventory (WAI)

The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) is based on Bordin’s (1979) tri-partite conceptualization of the client-therapist relationship as comprised of goals, tasks, and bonds. The inventory consists of 12 items, 4 from each subscale. Each item is designed to tap the agreement between therapist and client on goals, the degree of concordance on tasks, or the strength of the bond. Internal consistency for the scale ranges from .87 to .93 and is high for subscales (.89 for Goal, .92 for Task, and 92 for Bond) (Bordin, 1989). Reliability data for the WAI has revealed a test-retest index of .83 (Bordin, 1989). This measure was administered once before therapy started and once at the end of the last session.

Procedure
The cases were selected on the basis of good and poor outcome on measures of BAI, STAI, DERS, and OQ45. Clients filled out the measure for generalized anxiety disorder (GAD-7) and Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) before treatment started. The measure of the Difficulties in Emotion Regulation scales (DERS) was administered before treatment started, after the 16th therapy session, and post therapy. The Beck Anxiety Inventory (BAI), the Outcome Questionnaire (OQ-45.2), and the State Trait Anxiety Inventory-Trait (STAIT-T) were administered to clients before treatment started and after the 4th, 9th, 12th, 16th, and post therapy. Clients were asked to complete these measures with regard to the session that they just had completed.

The original video and audio tapes of the recorded sessions for identified clients were used to transcribe each session. To make sure of the matching of the original words of the client and the therapist, each session was transcribed and checked further with a second and third reader. Finally, the final transcripts were checked with the videotaped sessions by the writer and were used for the next phase: coding.

In order to track a client’s negative and positive emotion statements across and within therapy sessions, Plutchik’s wheel of emotions was used. Not every client talk-turn or statements received a coding. Each client’s emotion statements that contained emotion word; (e.x. I feel sad, I felt anxious and panicky), emotion statements that came the through therapist’s reflections and were confirmed by the client (e.x. T: I’m sorry that you went through this, you must felt so….felt so sad? C: Yeah, I felt so sad.), and client use of metaphor as a way of expressing one’s feeling (e.x. I feel blind, I’m like a bird in a cage) were coded as emotion. The identified emotion statements were then assigned to one of Plutchik’s identified primary emotions. In the next phase, each client’s emotion statements were categorized as either positive or negative emotion.
We identified fear, sadness, anger, and disgust as negative emotions, and joy and trust as positive emotions. Emotion statements for anticipation and surprise were also recorded, and were later coded as either positive or negative emotion depending on the context in which the client experienced them. On a similar note, because we believed shame is also a primary emotion and plays a critical role in any form of anxiety related disorder, we decided to rate it as a separate category. This way we were able to code the client’s emotion statements that express shame (e.x., guilt, ashamed, humiliated, embarrassment, I felt like a dirt, I felt so small) under the category of shame and keep track of them over the course of therapy. These emotion statements were further coded as negative emotion as well.

It was also determined that each client’s statements, if applicable, would be rated on negative or positive self-treatment. Not every client’s talk turn or statements received a coding. Negative and positive treatment-of-self was identified as judgments about the self (e.x. I don’t measure up, I believe in myself), ones’ behaviour towards the self (e.x exercising, challenging yourself despite fear, over drinking alcohol, dismissing the problem), and self-worth (e.x I’m loveable, I don’t deserve it). In the next phase, scores for both negative and positive self-treatment were obtained and tracked over time to compare differences between good and poor outcome cases.

For the purposes of this study, each emotion rating based on the Plutchik’s model was categorized as a score that reflects either a positive or negative emotional state, and also reflects the intensity of each emotion rating. Also, each client’s ratings on negative or positive self-treatment were recorded for each session and over the course of therapy. Raw scores were used rather than calculating derived scores (i.e., percentage of negative emotions out of percentage of total number of emotion ratings) due to the concern that derived scores might change the
meaning of construct. Scores for each identified category were obtained in each session and depicted in a graph in order to compare scores of the good and poor outcome cases of each identified dimension across therapy sessions.
Client Factors

A case comparison observation of the clients presented in this research study reveals a number of factors that they share, including difficulty with affect regulation, difficult early environment, and anxiety as well as characteristics that differentiate the two clients such as lack of social support, length of therapy, therapeutic alliance, and psychological mindedness.

Case Description

Good Outcome Client

Case Notes:

Early Environment

The good outcome client, Maya, was an adult woman in her mid-30s. She sought help with coping with a high level of anxiety in a variety of social and interpersonal interactions, as well as performance situations. Her score on the Beck Anxiety Inventory (BAI) was 23 and in a moderate range (a cut-off of 15 and above reflects a significant level of anxiety). With respect to her early childhood environment and relationships with caretakers, Maya reported that she had experienced neglect, verbal abuse, and caretakers who were critical and invalidating. Her early home life lacked adequate warmth, nurturing, and safety that would have allowed her to flourish and realize her potential. The good outcome client experienced her parents as demanding, restrictive, distant, and disapproving. She felt abandoned by her parents because they seemed to value her brothers more than she and her sister. Maya also shared that due to cultural expectations her mother had to take care of her highly critical mother-in-law. Maya reported that despite her mother’s continuous effort to please her mother-in-law she was emotionally and
verbally abusive to her. Maya shared that it was painful and stressful seeing her mother being bullied and abused by her grandmother every day while she could not do anything about it. She further claimed that her father did not stand up for her mother, was disengaged, and ignored the situation. Consequently, Maya never felt safe with her grandmother and silenced her stress and anger as she tried to avoid her wrath. During therapy sessions Maya expressed resentment and anger towards her deceased grandmother. Maya came from a traditional family who placed great value on their traditions and religious activities. She noted that expressing emotions and crying was not a welcome and acceptable reaction in the family. She shared that she came from a background in which her feelings did not receive attention and were dismissed. Maya further reported that no one, especially her mother, had attended to her emotional needs when she was a child. As an adult she continued to take care of others’ needs, putting their needs ahead of her own to her detriment. Maya shared that she felt conflicted especially in her career path. She reported feeling uncertain of her direction and her value to others. She expressed high levels of anxiety when she saw a job posting and experienced difficulties applying for them as they all seemed overwhelming and unobtainable.

Affect regulation

The awareness of feelings and being able to label the feelings are the two most basic levels of emotional processing and affect regulation. On a similar note, modulation of emotional arousal, reflection on emotion, and expression of emotion are the other components of affect regulation (Gratz & Roemer, 2004; Greenberg, 2002; Watson et al., 2010). During the early phase of therapy, Maya was not able to identify her range of emotions and represent them symbolically. Although she did not have difficulty labeling her emotions, she had difficulty modulating her level of arousal effectively. She reported that sometimes she gets afraid of the
intensity of her emotional reactions to events is often perplexed about the reasons behind her behaviour. Maya also had difficulties expressing her feelings, and needs appropriately to others. She needed to learn how to access her adaptive feelings and reflect on her feelings to solve difficulties as opposed to suppressing, and silencing them, or overreacting. Maya was aware of her sadness and her fear of losing her close friend. She was not aware that due to her fear she tended to put her needs and wants behind and go out of her way to please other people in her life. She was later disappointed and hurt when her actions were not acknowledged and her needs were not met. She then developed a sense of shame as she felt she was “not measuring up to others expectations” or “not good enough for you.” Maya was very self-critical and described being harsh with herself for hours after events that she perceived as personal failures. She shared that she tends to hold herself responsible for others feelings and puts herself down. For example, she blamed herself for disclosing some personal information about her friend’s previous ex-husband to her family.

Throughout therapy Maya became aware of her maladaptive reactions and was able to access her shame by grieving the loss of her boyfriend. She was able to stand back, observe his behaviour, and reflect on it. For example, Maya reported that she tried so hard to please her boyfriend for years. She tended to ignore her needs and whenever she was treated unfairly or disrespected by him she ignored it. She shared in one session that “he did not bother returning my calls, he did not show up for family celebration and did not even text me, like I am not even worth a phone call or text.” On another session she shared that “I know he will leave me soon cause I don’t measure up to his standards.”

She also shared that she often felt anxious with potential romantic partners. She was able to connect that to her early environment and upbringing. She shared that her parents especially
her father rarely hugged or kissed her and now this is something alien and intimidating for her. In the middle phase of therapy, Maya reported that she was often left alone. She reported feeling scared, trapped, and restless. She was never able to get the comfort she needed from her mother, who would dismiss her fears. Despite not getting the validation she needed from her mother, she was able to make a reflection that “now I understand why I feel so anxious when I am with potential partners, I feel tapped and it makes me feel that I’m going to get hurt”.

Maya tended to use her adaptive feelings as a guide to her behaviour, listening to her feelings of discomfort with her boy-friend decided to change the nature of their relationship and to use her own sense of excitement to find direction in terms of her career path. As Maya approached the termination phase she was able to not only actively acknowledge and process her emotions but also to reflect on them and on her behaviour to develop alternative ways of being. She initially resisted participating in Emotion-Focused Therapy tasks such as two-chair, empty-chair work, and focusing. She eventually became more aware of the advantage of working with her maladaptive emotions and reactions in a session and became an active participant. She also shared that her previous experience in therapy has been helpful and positive for her and she is hopeful to learn more about herself in the course of therapy.

Anxiety

Maya described that in anxiety provoking situations that she could not avoid, she tended to distance herself from the experience that she could not remember much of the event. She described being harsh and critical to herself after events and blaming herself for reacting in such a way. Romantic dating situations as well as dealing with interpersonal conflicts were her primary source of anxiety. Maya’s anxiety and fear of rejection during dates and interpersonal interactions were accompanied by submissive behaviours such as being hesitant, suppressing her
emotions, putting her immediate needs behind, attending to other person’s needs, and downplaying her achievements. This cycle often led to her most feared and avoided response, rejection. Throughout therapy Maya acknowledge that she needs to value her emotional experiences and saw them as important. She tried to understand and reflect on her fears in different situations and became upset that she silenced herself with her close-friend, dating partners, and her siblings. She eventually tried not to avoid confrontation and conflict, and actively worked to be more self-disclosing, and to be more assertive.

**Therapeutic Alliance**

One of the critical steps in working with individuals with anxiety is creating a safe and validating relationship (Horvath, 1991, Watson & Greenberg, 2012, Kramer et al., 2013, Shahar, 2014). The role of the working alliance in facilitating positive outcome in psychotherapy, and particularly in emotion-focused therapy, is well documented (Lambert & Barley, 2001). The first few sessions (usually the first three sessions) are devoted to establishing a strong therapeutic alliance. One of the critical components in establishing a strong alliance is empathic responses. This is also critical component during other interventions and tasks as it helps clients deepen and explore their emotions and reduces their emotional blocking (Watson & Steckley, 2005). In the first few sessions, Maya described her anxiety, sadness, shame, and the situations that tended to provoke them. Using Plutchik’s wheel of emotions we were able to track Maya’s negative emotion statements across and within her therapy sessions over time. As Maya expressed and described her difficult experiences, her therapist responded empathically and was attuned to Maya’s emotions. Her therapist validated her experiences which may have contributed to strengthening the bond between them. Client’s improvement on WAI on Bond Subscale supported this observation as the quality of alliance within this subscale increased from 21 to 23.
It was also observed that due to cultural differences the therapist needed to develop a better understanding of the processes that generated her symptoms, reactions, and how they were embedded within her narrative. The therapist’s active exploratory stance and patience through the course of therapy may also have contributed to client’s feeling of being understood and heard. Therapist’s empathic responses helped Maya to bring the experiences of anxiety and fear more alive in the session and connect them with her early childhood experiences. For example when Maya shared that she always feels scared and panicky when in enclosed space, the therapist was able to guide Maya using focusing technique to stay with her fear in a session. Maya was able to access her fear and shared that she was left alone, and she felt trapped when she was a child. These interventions may have also enabled Maya to increase her awareness of her feelings and led them to explore other emotions that were below the surface, such as shame, inferiority, and loneliness.

Psychological Mindedness

The good outcome client, Maya, was able to identify her goals more clearly as she progressed in therapy. Despite her initial resistant to engage in different tasks in a session she became an active participant. Maya further displayed more agentic behaviour as therapy progressed and tried to be proactive outside of therapy too. For example, she decided to set boundaries with one of her long standing girl friends who dismissed her needs and disrespected her on several occasions. She began to set limits with her demanding parents and siblings and felt better doing that. Maya actively attempted to challenge her inner self-critic outside of therapy and was eager to put her needs, and wants ahead of others.

Negative Emotions and Negative Treatment-of-Self
Maya initially presented with a high number of negative emotion statements. She initially started with the score of 43 on negative emotion statements and the score of seven on negative self-treatment (see Figure 1). As depicted in the graph after session seven and eight the number on negative emotion statements decreased significantly to 15, and continued to decline throughout therapy. On the measure of negative treatment-of-self Maya presented with the score of 7 at the initial session. As illustrated (see Figure 1) her score fluctuated throughout therapy and reached its peak in session 15 with a score of 10. She then presented with a decline on the number negative self-statements in the rest of the sessions and reached her lowest number one, in her last two sessions. At session 16 Maya’s score on negative self-treatment was seven followed by the scores of eight and six for session 17, and 18. Her scores continued to decrease with no downfalls in the last eight sessions. Her lowest score of one was presented in her last two sessions.

On the similar note, after session 16 her scores on a measure of negative emotions continued to drop with few downfalls. The downfalls were shorter compared to the ones at the early and mid-phase of therapy. She presented her lowest score of one on a measure of negative emotions in her last session. Overall, Maya showed a decrease in both categories of negative self-statements and negative emotion statements over the course of therapy. Similarly, her trajectory of change in negative emotion statements is more distinct as her score dropped by 49 points at the termination session (see Figure 1).

**Good Outcome Client (Negative TOS & NES)**
Figure 1: Good Outcome changes in # of NE’s statements and Negative TOS across the 24 sessions of therapy.

- Average value of NE’s statements and negative TOS were replaced for sessions that were not recorded.

**Fear and Shame**

The good outcome client presented with the score of 26 on fear as she started therapy. As it is presented in the graph (see Figure 2) her score on expressing fear and fear related emotion statements fluctuated till session six, and dropped to a score of five at session seven. Her score continued to stay in this range throughout the rest of therapy. With regards to shame and shame related emotion statements, the good outcome client presented with the score of 13 at the beginning of therapy and continued to stay in the same range until session eight when she expressed two shame statements. Her score on shame and shame related emotion statements
continued to fluctuate within the same range, but eventually decreased at the termination phase. Compared to her trajectory on fear statements, the good outcome client appeared to be more expressive of her fear and fear related emotion statement than her inferiority and shame related emotion statements.

**Fear and Shame Statements in Good Outcome Client**

(Maya)

![Figure 2: Good Outcome changes in # of fear and shame statements across the 24 sessions of therapy.](image)

- Average number of fear and shame statements was replaced for sessions that were not recorded.

**Poor Outcome Client**
Case Notes:

**Early Environment**

The poor outcome client, Rebecca, was an adult woman, who sought help coping with significant level of anxiety in a variety of social, performance, and work-related situations, and in her daily life. Her score in Beck Anxiety Inventory (BAI) was 36 and in a severe range (a cut-off of 25 and above reflects a clinically significant level of anxiety). With respect to her early childhood environment and relationships with caretakers, Rebecca reported that she had experienced neglect, and had caretakers who were critical, demanding, and invalidating. Her early home life lacked adequate warmth, nurturing, and safety that would have let her to grow and discover her potential. The poor outcome client experienced her parents as highly demanding, critical, and disapproving. She felt abandoned by her parents because they were preoccupied with her younger brother who was sick most of his childhood. Throughout therapy she reported that her brother had a painful condition and sometimes when he was sick he would cry out loud as her parents attended to him. Rebecca recalled being scared when he was sick. She noted that her parents especially her mother was busy taking care of her brother while she tried to disappear.

Further in her therapy sessions, Rebecca shared that she hates being sick and even the possibility of catching a simple cold provokes a lot of stress and anxiety for her. She observed that she had been pushed to be independent from an early age. Rebecca used to pack her own lunch to school every day, which she wished her mother have done for her. Her father died when Rebecca was quite young, but she did not talk about how she dealt with this her therapy sessions.

**Affect Regulation**
Rebecca was preoccupied with her bodily sensations. She struggled with consciously labeling her emotions in the session. For example, during one session Rebecca reported that she had just broken up with her boy-friend of several years. She did not seem upset when she reported this.

Rebecca was highly independent individual both at work and in her personal life. She was highly successful legal clerk, who was highly respected at work. She shared that her mother always encouraged her to be independent and “be her own boss” from an early age. She further noted that it is difficult for her to ask for help or to rely on others for support. Rebecca had not married and lived alone. She felt a deep sense of shame as she believed there was something physically wrong with her, which made it difficult for her to disclose her feelings. For example, that she feels embarrassed and ashamed of herself if someone figures out she is experiencing anxiety and needs time-off to get help with this. Overall, Rebecca did not talk about her feelings.

**Anxiety**

Rebecca started therapy presenting with a high level of anxiety (BAI=36). She reported that she tended to avoid some daily activities such as grocery shopping, driving, and meeting with friends due to fear of having unexpected panic attacks. In anxiety provoking situations that she could not avoid, she tried to distract herself by talking to herself and assuring herself that she can do it. Work related events and going to shopping malls/stores were her primary sources of anxiety. She reported that every time that she goes to work she has to convince herself that nothing bad will happen to her; “She would give herself pep talks in front of the bathroom mirror saying you can do it., Things will be fine.” Rebecca suffered from chest and stomach pains. She wished that her doctor could recommend a treatment. She was focused on her physical symptoms. She was cut off from her feelings and observed that even during work related
situations, she tends to force herself to go through the events while actively ignoring her emotions.

**Therapeutic Alliance**

Rebecca gave the impression that she always knows what works best for her and despite the therapist’s suggestions to focus her on her emotions, she wanted to find a medical remedy. She also thought that a change of place and a new career might help. Later in one of her sessions, she shared that she had the belief that if there is something wrong with her it must be physical and not related to her psychological well-being. As it was presented earlier, Rebecca was constantly encouraged to be self-reliant and to take care of herself without asking for help. Her early upbringing environment suggested that she did not have someone who supported or cared for her, and she learned to rely on herself from early on, and take care of her needs. This might have made it difficult for her to rely and trust her therapist for help and guidance. This was another area that was not explored in therapy.

**Feeling Inferior**

Rebecca reported that she feels anxious whenever she needs to take time off work. She shared that she is afraid that her colleagues would figure out that she has anxiety. She was ashamed of herself, and her experience. For example, she reported that “nobody knows I have anxiety, I hide it well, I don’t want them to know, it would be embarrassing.”

**Lack of Social Support**
Rebecca gave the impression that despite being social and having lots of friends she does not feel comfortable relying on anyone for help and support. It was evident early in therapy that Rebecca lacked adequate social support. She was able to meet with her old friends, perform highly at work and engage in social meetings, but actively tried not to reveal herself. She also shared that nobody knew about her anxiety other than her romantic partner whom she dated for the past year. Early in therapy she reported that she ended the relationship as she felt it was one sided. Rebecca felt that he was not good enough for her. She described him as very dependent which she found unappealing and unattractive. She further shared that she wants someone more independent in her life, yet she was not welcoming of anyone who was independent as she felt competitive and had the tendency to dominate them. Reflecting back on her early upbringing she felt conflicted and perplexed about what she needs and wants in a romantic partner.

Length of Therapy and Previous Experience

Rebecca completed 16 treatment sessions. She had no previous experience being in therapy and this was her first exposure working on her psychological well-being. After completing the 16th session, Rebecca still experienced a considerable amount of anxiety. Although her anxiety symptoms dropped to 17 on Beck Anxiety Inventory (BAI), she was still in the clinical range and was experiencing symptoms of anxiety in her daily life. She did not request referral or any further treatment after termination.

Negative Emotion Statements and Negative Treatment-of-Self

The poor outcome client received and completed 16 therapy sessions. She initially presented with a high number of negative emotion statements (score of 31) and fluctuated throughout the course of therapy (see Figure 3). As presented in the graph her scores on negative
emotion statements fluctuated throughout therapy and ended around the same range as she entered therapy. A similar pattern was observed with her negative self-treatment scores. She presented with a score of six and her scores fluctuated throughout therapy. She terminated therapy on a score of 11 which was higher than her initial score on the negative self-statements scale. The poor outcome client ended therapy on both scales in a similar range to that when she entered therapy.

**Poor Outcome Client (Negative TOS & NES)**

![Figure 3: Poor Outcome changes in # of NE’s statements and Negative TOS across the 24 sessions of therapy.](image)

- Average value of NE’s statements and negative TOS were replaced for sessions that were not recorded.

*Fear and Shame*
The poor outcome client entered therapy with the score of 25 on fear. Her scores stayed quite consistent, only slightly decreasing throughout therapy. She ended therapy with the score of 14 on fear (see figure 4). As presented in case notes compared to the good outcome client she was less expressive of her emotions and less expressive of her inferiority. The poor outcome client presented with a score of five on shame as she started therapy and stayed quite consistent until termination where she obtained the score of zero (see Figure 4).

**Fear and Shame Statements in Poor Outcome Client (Rebecca)**

![Poor Outcome Client changes in # of fear and shame statements across the 24 sessions of therapy.](image)

- Average number of fear and shame statements was replaced for sessions that were not recorded.

**FEAR Statements in Good Outcome vs. Poor Outcome Client**
Figure 5: good and poor outcome clients’ changes on fear emotion statements across therapy.

- Indicates the average value of fear statements for each client replace for unrecorded sessions.
- Indicates the average value for fear statements on the further 8 sessions if the poor outcome client continued on therapy.

SHAME Statements in Good Outcome vs. Poor Outcome Client
Figure 6: good and poor outcome clients’ changes on shame emotion statements across therapy.

- Indicates the average value of shame statements for each client replaced for unrecorded sessions.

- Indicates the average value for fear statements on the further 8 sessions if the poor outcome client continued on therapy.

Negative Treatment-of-Self in Good Outcome vs. Poor Outcome Client
Figure 7: good and poor outcome clients’ changes on negative TOS across therapy.

■ Indicates the average value that was replaced for negative TOS for the good outcome client for sessions that were not recorded.

■ Indicates the average value for fear statements on the further 8 sessions if the poor outcome client continued on therapy.

Number of Negative Emotion Statements in Good Outcome vs. Poor Outcome Client
Figure 8: good and poor outcome clients’ changes on negative emotion statements across therapy.

■ Indicates the average value that was replaced for negative emotion statements for the good outcome client for sessions that were not recorded.

■ Indicates the average value for fear statements on the further 8 sessions if client continued on therapy.
Discussion

Comparing and Contrasting: Good Outcome vs. Poor Outcome Clients

A comparison of the two cases reveals a number of different factors that we observed in the process of their treatments. As presented in case notes, some of the observed factors were common in both poor and good outcome clients. With regards to their early environment and relationships with their main caregivers, both poor and good outcome clients described that they had experienced neglect, emotional and verbal abuse, and felt that their needs were unmet and their experiences invalidated. Both Rebecca and Maya described their parents, particularly their mothers, as highly critical and demanding. They also conveyed that their early childhood environments lacked warmth, affection (both emotionally and physically), and safety. Throughout therapy they both conveyed that no one had attended to their emotional needs which were also confirmed in therapy. The good outcome client, Maya, was able to eventually become aware of the connection between her early childhood environment and her current problematic emotional reactions. The good outcome client was also able to identify her grandfather who provided love and support for her in her early childhood, and also her cousin friend who had been a good friend since elementary school. The poor outcome client, on the other hand, could not recall anyone who provided her with some form of support and safety in her childhood. She shared that her family, especially her mother, was focused on her brother protecting him and providing him with care and comfort. Rebecca felt neglected and scared of her brother’s illness.

With respect to affect regulation both poor and good outcome clients had difficulties modulating their level of arousal, labeling and reflecting on their emotions. In comparison to the poor outcome client, the good outcome client was more receptive to working on her emotions and exploring them more in depth. The good outcome client was more psychologically minded.
She kept journaling every night at the end of her day, she was insightful in the session, and knew what area she wanted to focus on more in each session. The poor outcome client, on the other hand, was less psychologically minded and was more prone to use physical and medical models to help herself. As an example, she tended to go to different medical practitioners and different medical appointments in order to heal her anxiety. She also tended to overly focus on her bodily sensation and had difficulty expressing and symbolizing her feelings in a session.

As it is presented in the graph (see Figure 5), both good and poor outcome clients entered therapy presenting with the same level of fear statements (26 and 25). Throughout therapy the good outcome client’s fear statements decreased as we can see a big drop after session five, whereas the poor outcome client’s scores on fear statement fluctuated throughout therapy without much of a change on her last three sessions. Although both clients started therapy within almost the same score on fear, they ended therapy standing on different points. The poor outcome client ended therapy at session 16 and the good outcome client completed another eight sessions where it shows that her fear statements were decreased by 25 points in the last session (see Figure 5).

The good outcome client was more expressive in regards to shame and shame related statements (see Figure 6). Her score dropped by 11 point after session seven and despite the fact that it fluctuated throughout therapy, it continued to decrease. The poor outcome client was much less expressive of her inferiority and started therapy on the score of five and ended therapy on scores of three and zero on the last two sessions (see Figure 6).

In regards to negative treatment-of-self in the course of therapy, both good and poor outcome clients have a close starting point (7 and 6). As depicted in the graph, the good outcome client’s scores fluctuated across therapy sessions and declined slightly after session 19 (see
Figure 7). Her scores continued to decrease and reached its lowest score of one in the last two sessions. In contrast, the poor outcome client’s scores fluctuated unpredictably across sessions and she ended therapy (session 16) close to the same point where she entered therapy (see Figure 7). The good outcome client’s trajectory on negative emotion statements across the completed 24 therapy sessions suggest a significant decrease in client’s negative emotion (see Figure 8). The good outcome client started therapy with the score of 43 and reached her highest score on negative emotion statements on session five (score=54). Her score dropped by 28 points on session seven and continued to decrease throughout therapy where she ended with the score of one in the last session. The poor outcome client, on the other hand, entered therapy with the score of 31. As it is depicted on the graph, her scores fluctuated unpredictably throughout therapy and she ended therapy standing on the score of 26 on the measure of negative emotion statements (see Figure 8).

As discussed earlier, the good outcome client received 24 individual psychotherapy sessions, while the poor outcome client received 16 individual psychotherapy sessions. In contrast to the poor outcome client at session 16, the good outcome client presented with lower scores on both measures of negative emotion and negative self-treatment. Her scores continued to drop in the last eight sessions and she presented with her lowest score of one on both measures of negative emotions and negative self-statement in her last session (see Figure 1).

Conclusion
In conclusion, the findings after comparing and contrasting the good and the poor outcome clients suggests that certain factors that are specific to good and poor outcome clients. The factors such as client readiness to access and acknowledge painful affect, engage in emotion processing tasks, length of therapy, social support, being psychologically minded, and most importantly being able to access shame, and work with it in session, all played an important role in clients outcomes. Emotions, in general, appeared more volatile and were subject to change than individual’s action tendencies and behaviors.

It was observed in both good and poor outcome clients’ negative emotion statements’ trajectories that they both had moments of improvement in processing their negative emotions. These improvement moments were followed by moments of downfalls and fluctuated throughout therapy. However, the good outcome client presented different trajectory in a sense that the gap between each session’s downfalls became shallower as therapy progressed, whereas it remained unpredictable for the poor outcome client. This might suggest that the good outcome client have experienced and built more resiliency as therapy progressed, and as a result were more welcoming on working on her negative emotions.

Another factor that might have contributed to a successful completion of the good outcome client is the length of therapy. The good outcome client ended therapy at session 24, had previous experience being in therapy, and also was more psychologically minded. In contrast, the poor outcome client ended therapy at session 16 with no previous experience of being in therapy and was less psychologically minded. This can lead us to the explanation that the good outcome client was perhaps further along in the healing process and more receptive of working with her emotions. This further suggests that had the poor outcome client been given more therapy, she might have been able to "catch up" and experience less negative emotions as
therapy progressed. It is also proposed that if the poor outcome client had received some sort of care and affection from another person (e.g., grandparents, teacher, and friend) where she had the chance of exploring her emotions, she might have been more receptive and more ready to engage in process tasks. With regards to client’s negative treatment-of-self, it is proposed that if both clients had more sessions, we might have been able to observe more positive changes in regards to their negative self-treatment.

Future research studies might benefit from process measures that could measure deficits in emotion awareness, arousal, and clients’ capacity and readiness on engaging in therapy. These measures can potentially address certain areas that clinicians can focus and spend more time exploring with clients such as accessing emotions or working with shame. The overall examination of the presented cases suggests that the effective treatment or positive outcome in therapy does not solely depend on how well that particular type of treatment was delivered. As it was examined, clients’ characteristics as well as external factors (e.g., early environment, social support, previous experience in therapy) can either support or thwart clients’ progress in therapy.

In general, working with emotions and tracking processes of change in clients with divergent outcomes using case-comparison methodology provides both researchers and clinicians with detailed and qualitatively rich information. One of the strengths of this approach is that due to its in-depth, multi-sided approach, case-comparison studies can shed light on aspects of human thinking, emotion, and behaviour that would otherwise be impractical to study in other ways. This can further provide both researchers and clinicians with high levels of detail that allows for greater insight into the clients’ moment-by-moment change.
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