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Strong Feeling in Psychotherapy:

Therapist Uses and Methods of Promotion

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OVERVIEW

Despite the fact that many practitioners of varying theoretical stripes regard in-session strong client feeling as an important lever for psychotherapeutic change, there has been almost no research on how therapists can help bring about these strong feeling events in their sessions, or how they can use them once they have occurred. Nowhere in the current literature are there research-generated, unabridged, richly descriptive category systems designed to show practitioners precise *methods* for promoting strong feeling in the session, and precise ways of *using* it once it occurs. The present study aims to begin filling these conspicuous gaps in the literature by addressing two research questions: (1) What therapist methods, employed under what in-session client conditions, are judged as helpful in promoting strong client feeling? (2) When strong feeling occurs in the session, how do therapists use it?

The research strategy will be an inductive, discovery-oriented approach, emphasizing knowledge generation, rather than explicit hypothesis-testing. The data will consist of audiotaped sessions of individual psychotherapy that contain multiple instances of strong feeling, and that are conducted by distinguished therapists representative of a broad range of therapeutic approaches.

The potential value of the findings for psychotherapeutic practice is that they will offer a richly detailed collection of procedural, technical knowledge that practitioners can readily add to their therapeutic arsenals if they so wish. The findings may also enable theorizing about the relationships between therapist methods, occurrences of strong feeling, and subsequent therapist uses, and provide empirical data that future researchers may confirm and/or extend toward a more scientifically-based technology of how to promote and use strong feeling in the session.

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CHAPTER 1

THE THERAPEUTIC USES OF STRONG FEELING: A REVIEW OF THE LITERATURE

Since Breuer and Freud's (1895/1955) volume, Studies on Hysteria, outlined their "cathartic technique" for treating hysterical symptoms, many psychotherapeutic practitioners of varying theoretical orientations have continued to embrace the notion that it is desirable (valuable, important, useful) for patients to undergo strong feeling in the therapy session (e.g. Daldrup, Beutler, Engle, & Greenberg, 1988; Driscoll, 1987; Farrelly & Brandsma, 1974; Greenberg & Safran, 1987; Greenberg, Rice, & Elliott, 1993; Greenwald, 1987; Jackins, 1978; Lowen, 1975; Mahrer, 1996a; Malone, Whitaker, Warkentin, & Felder, 1961; McGuire, 1991; Nichols & Zax, 1977; Perls, 1969; Pierce, Nichols, & DuBrin, 1983; Reich, 1949; Shorr, 1972; Stampfl & Levis, 1967; Ventis, 1987). The bulk of this chapter will be devoted to reviewing the existing research and clinical literature on the topic of *how* strong feeling has been viewed as therapeutically useful across therapies. Then, at the end of this chapter, a specific research question will be chosen that seems most appropriate given the state of the existing literature. Before proceeding further, however, it seems important to provide a brief introduction to the term "strong feeling" and what it means in psychotherapy.

What is "Strong Feeling"?

In order to introduce what "strong feeling" refers to psychotherapy, it seems appropriate to begin by providing some general, historical context. Thus, what follows is a brief overview of

how emotion has been looked upon, defined, and studied over the course of modern history, and then a more specific discussion of what "strong feeling" means in psychotherapy.

The study of emotion: A historical sketch. Although documentation of the therapeutic value of intense emotional experiences (or *Katharsis*) can be traced back to the writings of Aristotle (384-322 B.C.) (Nichols & Efran, 1985), it is only during the last century that human emotional experience has become widely regarded as a phenomenon worthy of concern to the philosopher, and his offspring, the scientist (Knapp, 1963). Indeed, for most of the past 2000 years, higher education has been dominated by the dualistic notion that man is essentially a soul mysteriously trapped in a material body. In this enduring intellectual climate, emotions were long held in disrepute as part of the lower "material" realm -- as a part of man's animal inheritance, and as alien from man's true, spiritual "self". With this dualism dominating philosophical thought, the study of emotions was, by and large, left to mystics -- or as Brown (1959, p. 31) put it, "to the poet, lunatic, and lover".

Within these mystical circles, the use of cathartic emotional experiences to promote healing survived and flourished throughout the ages. Early Christian healing rites, and the religious healings of magicians, sorcerers, and astrologers in ancient Egypt, Babylonia, Judea, Chaldea, Arabia, Greece, and Rome were based largely on the purification value of cathartic emotional experiences (Nichols & Efran, 1985; Nichols & Zax, 1977). In the book of Psalms, Hebrew poets encouraged emotional expression, and warned that unrecognized feelings would have their revenge. Back to primitive times, and throughout the centuries, and even still in the present day, healing rites and rituals of medicine men -- such as magicians, priests, shamans, witchdoctors, healers -- have endured, generally in the form of cathartic procedures designed to

purge offensive emotions and/or purify the soul (Nichols & Zax, 1977). Nevertheless, until this present century, the predominating intellectual-philosophical dualistic climate continued to hold emotions with contempt.

The Dutch philosopher Spinoza (1632-1677) was an exception to this dualistic tradition. He was one of the first thinkers to deal systematically with emotional processes and to recognize their immense power in determining human behaviour (Knapp, 1963). Spinoza contended that body and mind were both interrelated parts of a single universe. He saw human mental processes and emotional processes as both being natural phenomena subject to nature's general laws. In putting forth this unified view, Spinoza was clearly a spiritual forefather of Darwin and Freud.

Darwin (1809-1882) carried this unified viewpoint further in postulating that emotional phenomena evolved -- as did man himself -- from antecedents in his animal forbears. In addition, Darwin attempted to explain and define emotional behaviour across species by principles such as (a) *associated manifestations* of particular emotions -- e.g. bared teeth as a sign of anger; and (b) *antithesis* -- e.g. fawning, based on submission and fear, as the opposite of aggression. Despite Darwin's contributions, dualistic modes of thought persisted. Most study of emotional processes tended to divide itself between two streams: one physiological, one psychological (Knapp, 1963).

With the turn of this century, the unified modern view finally began to take hold. In the late 1800s, James and Lange independently seized upon physiologic reaction as the essential ingredient in emotional experience. In Vienna, Breuer and Freud (1895) discovered a therapeutic treatment based on the notion that physical symptoms could be cured by having the patient retrieve hidden, repressed memories of early traumatic experiences, and express the concomitant strong emotions-feelings. With Freud's discovery was born (or reborn) a notion that has since

endured in the psychotherapy literature: that strong feeling expression is an important factor in positive psychotherapeutic change. And more generally, by the beginning of this century, with the rise of the view that mental and physical phenemona were united and governed by the same natural laws, emotional behaviour had become regarded as an important area of scientific inquiry that was being pushed forward by early pioneers such as Wundt, Cannon, Pavlov, and others.

What is *strong feeling* in psychotherapy? The phrase "strong feeling" likely conjurs up images of a patient sobbing very hard, laughing heartily, or yelling angrily. However, defining what "strong feeling" actually refers to in psychotherapy is no easy task because, in the psychotherapy literature, there seems to be no well-established, systematic, generally-accepted definition of what "strong feeling" is. In other words, although many writers in the clinical and research literature use terms like "strong feeling" or "catharsis" as if they refer to clear and obvious phenomena, there does not seem to exist any hard, tight definition of what strong feeling really means in psychotherapy (cf. Nichols & Zax, 1977). Indeed, various theorists who talk about strong feeling and its therapeutic value seem often to be referring to different sorts of feelings. From author to author, descriptions of strong feeling seem to variously refer to different sorts of events -- such as fear, anger, sadness, sorrow, grief, crying, joy, laughter, orgasm, trembling, hope, relief, or other emotions -- and yet nowhere in the psychotherapy literature does there seem to be a systematic, agreed upon definition of what "strong feeling" is.

Further complications arise because "strong feeling events" (or similar events) in psychotherapy have gone by a variety of names over the years such as *abreaction* (Breuer & Freud, 1895), *affect* (Breuer & Freud, 1895), *catharsis* (Bohart, 1980; Breuer & Freud, 1895; Guinagh, 1987; McGuire, 1991; Nichols & Efran, 1985; Nichols & Zax, 1977; Pierce et al, 1983),

discharge (Jackins, 1978), *explosion* (Perls, 1970), *primal scream* (Janov, 1970), *historical emotions* (Casriel, 1972), *emotional expression* (Fagan, 1976; Pierce et al, 1983), *emotional re-living* (Volkan, 1981), *venting* (Lowen, 1975), *damage repair processes* (Jackins, 1978), and many more.

Outside the realm of psychotherapy, a number of theorists and researchers have devoted energy to describing and defining emotions, including the strength-intensity of emotions. These writers -- who include Wilhelm Wundt, phylogenetically-centered researchers such as Plutchik, Frijda, Osgood, Nowlis, Izard, Russell, Tomkins, and others such as Lazarus, Davitz, and Watson and Tellegen -- have been chiefly concerned with the larger issue of how to *categorize* and describe different emotions (cf. Ekman, Friesen, & Ellsworth, 1982; Izard, 1991; Lazarus, 1991; Ortony, Clore, & Collins, 1980; Ruckmick, 1936). A common research approach has been to utilize observers' ratings of posed still photographs of human facial expressions which are then factor analyzed to yield empirically-generated categorization schemes or models of emotion. *Strength of feeling* becomes related to this venture because one dimension that has commonly emerged from the factor analyses conducted by these researchers is one that has been variously referred to as degree of excitement or arousal, emotional intensity-control, and activation (cf. Ekman, Friesen, & Ellsworth, 1982; Izard, 1991; Lazarus, 1991; Ruckmick, 1936). These studies, despite bearing on the topic of strength of feeling in general, are far removed from and provide no definition of what "strong feeling" actually means in psychotherapy.

Focusing once again inside the psychotherapy literature, there are a number of existing scales that assess *feeling-related* variables such as *voice quality* (Rice, Koke, Greenberg, & Wagstaff, 1979), *depth of self-exploration* (Kiesler, 1973, Truax & Carkhuff, 1967), *experiencing*

(Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986), *expressiveness* (Wexler, 1975), and *self-reported affect* (Zuckerman & Lubin, 1965). However, the only scale that seems to specifically relate to *strong feeling* is a measure developed by Mahrer and his colleagues (Mahrer, Stalikas, Boissoneault, Trainor, and Pilloud, 1990), which defines strong feeling along four dimensions: (a) degree of loudness and volume; (b) degree of spontaneity; (c) degree of fullness and saturation; and (d) degree of strength and breadth of bodily sensations. According to this scale, strong feeling means that one or more of these dimensions is present to a relatively high degree. Not all four qualities need be present. So, for example, loudness might be high and booming as a client angrily screams. Alternatively, noise level might be low as a client sobs quietly, with saturated and full feeling. This definition appears to have been the only attempt to systematically describe strong feeling in therapy. Its focus, clearly, is on *expressed* (manifest, outwardly shown) *strong feeling* as opposed to *non-manifest* (inner, hidden) *strong feeling*. The measure is not psychometrically-validated, nor is it well-established. Nevertheless, as a way of beginning to describe what strong feeling in therapy is, it seems to provide a useful answer.

The definition of strong feeling, as it will be operationalized in this study, is provided in Appendix F. Let us now move on to a review of the literature on the topic of the therapeutic uses (value, desirability) of strong feeling.

What are the Therapeutic Uses of Strong Feeling?

The following literature review will contain three parts. The first part will review the existing *outcome research* that relates to the question of the therapeutic use (value, desirability) of

strong feeling. The second part will review the existing *psychotherapy process research* that bears on the question of how strong feeling is therapeutically useful (valuable, desirable) in the therapy session. The third part will consist of an extensive review of the *clinical-theoretical literature*, in which I will describe and organize the different ways that various clinical writers have regarded strong feeling as an important part of the process of psychotherapeutic change.

As a preliminary footnote, it should be mentioned that the scope of the following literature review will be limited to writings and studies related to individual adult psychotherapy, as this area accounts for the bulk of theoretical writings and research on strong feeling.

Outcome Research

Most past research related to the therapeutic use (value, desirability) of strong feeling has consisted of outcome studies. Typically, these investigations have included some way of measuring client strong feeling during therapy, pre- and post-treatment assessments of the client's level of psychological well-being -- and conclusions aimed at linking the two. As will be seen below, outcome research has been generally supportive of a link between strong feeling during therapy, and post-therapy client improvement.

(a) Outcome Studies Directly Measuring In-Session Strong Feeling Suggest That It Is Positively Linked to Client Improvement

One of the few noteworthy attempts to directly explore the link between strong feeling and therapeutic outcome was a series of three studies conducted by a group of researchers in Rochester (Nichols, 1974; Nichols & Bierenbaum, 1978; Pierce, Nichols, & DuBrin, 1983).

These studies were unusual in that, through ratings of audiotapes, the precise duration of strong feeling was directly measured for each client in each session. In the first study (Nichols, 1974), an attempt was made to compare the effectiveness of "emotive" therapy (re-evaluation counselling) against "non-emotive" psychoanalytic therapy. Results provided some positive support for the value of "emotive" therapy in general, and strong feeling discharge in particular. The second and third investigations (Nichols & Bierenbaum, 1978; Pierce, Nichols, & DuBrin, 1983) then evaluated the differential effectiveness of emotive therapy for different types of clients. Interestingly, most clients -- regardless of whether their problem was labelled as neurosis, transient situational reaction, personality disorder, or even psychosis -- were found to show significant improvement on a wide variety of outcome measures. So, taken together, this trio of investigations provided some supportive evidence of the therapeutic use (value, desirability) of strong feeling for a wide variety of client problems-conditions.

More supportive evidence comes from Nixon (1982, cited in Greenberg & Safran, 1987), who studied sessions of *primal therapy* using the "emotional voice" category of the client vocal quality scale (Rice, Koke, Greenberg, & Wagstaff, 1979). The "emotional voice" category is a measure of "emotional overflow", tapping how disrupted or distorted the client's speech pattern is. Amount of "emotional voice" was positively correlated with client improvement.

Further friendly data come from studies attempting to assess the effectiveness of *implosive therapy*, an approach emphasizing strong client feeling in the session (Borkovec & Sides, 1979; Kozak, Foa, & Steketee, 1988; Lang, 1977; Orenstein & Carr, 1975). These investigations found that the client's undergoing of heightened levels of anxiety in the session (measured physiologically) predicted positive outcome -- which was defined as a decrease in fear during a

subsequent behaviour avoidance test.

In addition, supportive evidence comes from Hoehn-Saric and his colleagues (Hoehn-Saric, Frank, & Gurland, 1968; Hoehn-Saric, Liberman, Imber, Stone, Pande, & Frank, 1972; Hoehn-Saric, Liberman, Imber, Stone, Frank, & Ribich, 1974), who investigated the link between chemically-induced emotional arousal and attitude change. In each of these studies, it was found that heightened emotional arousal (brought on by giving the clients ether or adrenalin) was linked to heightened suggestibility and attitude change. Using sophisticated research designs involving multiple control groups, the experimenters demonstrated that aroused clients underwent more change than control group clients in attitudes targetted for change by the therapist.

In a vast line of studies stemming from a client-centered perspective (e.g. Fischer & Apostal, 1975, Frank, 1973, Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968; Gendlin, Jenney & Schlien, 1960; Jackson, 1984, Kiesler, 1971; Kiesler, Mathieu, & Klein, 1967; Melnick, 1972; Rogers, Gendlin, Kiesler, & Truax, 1967; Starkweather, 1961; Tomlinson, 1967, Tomlinson & Hart, 1962; Tomlinson & Stoler, 1967), it has been well-established that higher levels of in-session *experiencing* -- as measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986) -- are correlated with positive outcome. However, a high level of *experiencing*, which is characterized by the client having a "synthesis of readily accessible feelings and experiences to resolve personally significant issues" (Klein et al, 1969; cf. Rice & Greenberg, 1991), is not easily comparable with strong feeling. As Greenberg and Safran (1987) state: "Affective reactions of great intensity, such as 'I hate you', would receive low ratings on the Experiencing Scale if they were focused outward and involved no form of internal exploration" (p. 75). Therefore, these findings are only tangentially

related to the question of the therapeutic desirability of strong feeling.

In summary, outcome studies that directly measure in-session strong feeling and relate it to therapeutic improvement offer some general support for the therapeutic use (value, desirability) of strong feeling.

(b) Outcome Studies Indirectly Measuring Strong Feeling Suggest That It Is Linked to Client Improvement

Other outcome studies have relied on more indirect means of measuring strong feeling, and they also provide generally supportive evidence. For example, Orlinsky and Howard (1967, 1975) relied on immediate post-session retrospective ratings by therapists and clients. They found that successful outcome was characterized by therapy sessions being rated as intense affective experiences, and each session being focused on one dominant mood or affect.

A fair amount of supportive data also come from research devoted to demonstrating the therapeutic value of various "emotive" therapies. For example, studies of *primal therapy* (Karle, Corriere, & Hart, 1973) and *feeling therapy* (Karle, Woldenberg, & Hart, 1976; Woldenberg, Karle, Gold, Corriere, Hart, & Hopper, 1976) suggest that clients show reduced tension levels -- measured physiologically through readings of EEG, blood pressure, pulse rate, and rectal body temperature -- after therapy sessions. However, these reduced tension levels do not tend to be maintained at follow-up. Furthermore, studies assessing the effectiveness of *implosive therapy* (Borkovec & Sides, 1979; Crowe, Marks, Agras, & Leitenberg, 1972; Hekmat, 1973; Hogan & Kirchner, 1967; Lang, 1977; Levis & Carrera, 1967; Mealiea & Nawas, 1971; Mylar & Clement, 1972), and *flooding* (Boulougouris & Bassiakos, 1973; Boulougouris, Marks, & Marset, 1971;

Calif & MacLean, 1970; DeMoor, 1970; Girodo, 1974; Rachman, 1966a, 1966b) provide evidence that the client's undergoing of anxiety and fear in the session can be beneficial in treating anxiety disorders such as phobias.

Summary of Outcome Research

Existing outcome studies are generally supportive of the therapeutic usefulness (value, desirability) of strong feeling for a wide band of client problems-conditions. Outcome studies directly measuring in-session strong feeling generally find it to be positively linked to later client improvement. Outcome studies indirectly measuring in-session strong feeling, most notably those assessing the effectiveness of particular "emotive" approaches, generally find the same.

Psychotherapy Process Research on the In-Session Therapeutic Uses of Strong Feeling

Although outcome research findings give the general impression that strong feeling may be therapeutically desirable, they do not give us any answers to the more precise question of *how*. Process studies have begun to provide some answers to this *how* question by identifying particular kinds of valued in-session client events (shifts, changes) that tend to follow (or be promoted by) the prior in-session occurrence of strong feeling.

Specifically, process studies suggest that in-session strong feeling may facilitate the subsequent occurrence of in-session client events such as: *acceptance (welcoming) of an aspect of self that had previously been regarded as problematic* (Greenberg, 1984a; Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Rice, 1981; Mahrer, White, Howard,

Gagnon, & MacPhee, 1992); *attainment of an overall state of heightened well-being* (Mahrer et al, 1992); *attainment of a sense of physical relief* (Labott, Elliott, & Eason, 1992); *the sustaining and maintaining of the strong feeling* (Labott, Elliott, & Eason, 1992; Mahrer, Markow, Gervaize, & Boulet, 1987); *attainment of increased insight and self-understanding* (Labott, Elliott, & Eason, 1992; Mahrer, Nadler, Gervaize, & Markow, 1986); *manifest presence of a qualitatively new personality process-state* (Mahrer Lawson, Stalikas, & Schachter, 1990; Mahrer et al, 1992a); and *commitment to undertake new ways of being-behaving in the imminent extratherapy world* (Mahrer et al, 1986b, 1990a).

These studies begin to open up some answers to the important question of how therapists may *use* strong feeling in the session. But there is still very little research data on this, and what little data there is is scattered across the few, isolated studies mentioned above. What remains conspicuously absent from the literature is an integrated, research-based, practitioner-relevant category system which shows therapists, in rich detail, how they can *use* occurrences of strong feeling in the session.

Clinical-Theoretical Review

My objective in this section is to review and organize the existing clinical-theoretical literature on therapeutic uses of strong feeling. This is a difficult task because -- as was true of the research literature -- the clinical literature also seems to offer no taxonomy of the therapeutic uses of strong feeling.

Greenberg and his colleagues perhaps have come closest to providing one. Over the past decade, they have forwarded four theory-based taxonomies of the therapeutic uses of *emotion-*

feeling-affect. A first scheme (Greenberg & Safran, 1987), based on a review of the psychotherapy literature on emotion-feeling-affect, included four uses: (1) *discharge*; (2) *emotional insight*; (3) *facilitating adaptive emotions*; and (4) *exposure and habituation*. In the same volume (Greenberg & Safran, 1987), the authors also further differentiated these above categories to better capture the actual processes that the client is undergoing in the session, and came up with a second taxonomy including six categories: (1) the *acknowledging* of primary affective responses; (2) the *creation of meaning* through synthesis; (3) the *arousal* of affective responses; (4) *taking responsibility* for affective experience; (5) *modifying dysfunctional affective responses*; and (6) *emotional expression in the therapeutic relationship*. In a subsequent edited volume, they (Safran & Greenberg, 1991b) synthesized the contributors' diverse views on the issue of how emotion is implicated in therapeutic change into a seven-fold categorization scheme of affective change processes: (1) *emotional restructuring*; (2) *catharsis* (a) experiencing compassion for self, (b) completing interrupted emotion/action sequences, (c) releasing inhibiting muscular tension, (d) schematic restructuring; (3) *experiential symbolization*; (4) *facilitating cognitive reorganization*, (5) *motivating adaptive behaviour*, (6) *corrective emotional experience*; and (7) *affect attunement*. Recently, a fourth taxonomy was offered by Greenberg, Rice, & Elliott (1993). This scheme is particular to their *process-experiential therapy* approach, and delineates four different uses of client emotion in the process of change: (1) *attending/awareness*; (2) *experiential search*; (3) *active expression*; and (4) *interpersonal contact* (with the therapist).

Given the absence of any accepted theory-based taxonomy that is specifically on the topic of the therapeutic uses of *strong feeling* in therapy, it is difficult to decide how to organize the

vast amount of clinical writing on the subject. I could choose one of the taxonomies from Greenberg and his co-workers. But then I would be faced with the problem of deciding which of these taxonomies to choose, and also the problem that none of these taxonomies are specifically on the topic of uses of *strong feeling*. Based on these considerations, it seems more attractive instead to look naively at the clinical literature on therapeutic uses of strong feeling, and do my best to organize it into meaningful categories.

It should be clear at the outset that the aim here is not to come up with a competing category system to those forwarded by Greenberg and his colleagues. The aim is also not to come up with careful hypotheses that can be tested later. The aim is simply to organize the clinical literature in a meaningful way so that it can subsequently be compared with a research-based, richly unabridged, and practitioner-relevant category system of the different therapeutic uses of strong feeling -- the generation of which will be a major objective of the present investigation, as will later be explained.

After inspecting the vast amount of clinical writing on uses of strong feeling, it becomes apparent that it could be organized in a variety of ways. It could be organized in terms of *uses across particular therapeutic approaches* (e.g. psychoanalytic, behavioural, experiential); *uses for different kinds of patients* (problem-conditions); or in terms of *uses of different kinds of strong feeling* (e.g. laughter vs. anger vs. sadness). It could also be organized in terms of the general *therapeutic in-session client consequences* (sequelae, outcomes, shifts) that tend to "naturally" and "automatically" follow the prior occurrence of strong feeling; or in terms of what the therapist actively *tries to do* with the strong feeling, once it has occurred, to facilitate the valued consequence that is intended to come next.

In line with these latter two options, I have chosen to focus on the various in-session client consequences (shifts, changes, outcomes) that different clinical theorists seem to value, and that strong feeling has been regarded as helpful in promoting. Many theorists' descriptions of how they use strong feeling are stated more implicitly than explicitly; and in such cases, I have attempted to describe their views as accurately as possible. The result is a framework consisting of five uses of strong feeling (including additional subcategories), and a sixth category which accounts for the views of clinical writers who regard strong feeling as not therapeutically useful, and to be avoided. These categories are somewhat overlapping and at varying levels of abstraction, but this organization is my best attempt to make sense of the literature in its current state.

(a) *Strong Feeling is Helpful in Promoting the Reduction of Bad Feeling (Release of Inhibited Muscular Tension, Reduction of Symptomatology)*

One group of theorists are united in their view that strong feeling is helpful in promoting the dissipation of bad feelings, reduction of symptomatology, or reduction of inhibited muscular tension. Discussed below are three subgroups.

(i) Strong feeling facilitates the retrieval of previously banished memories, and thereby promotes the reduction of bad feeling (Breuer & Freud). In their pioneering book, Studies on Hysteria, Breuer and Freud (1955/1895) hypothesized that "hysterical" symptoms such as muscle contractures, seizures, and lack of feeling in various parts of the body were disguised representations of intensely distressing childhood events which had been banished from memory. They observed that the alleviation of symptomatology tended to occur when these traumatic

memories were rediscovered, put into words, and the attached affect discharged:

> ....we found, to our great surprise at first, that *each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words* (p. 6).

In this process of "abreaction", recollection of traumatic incidents tended to be useful only when accompanied by a revival of the strong affect originally attached to it: "Recollection without affect almost invariably produces no result" (p. 6). Once the memory was uncovered, and the affect discharged, the symptoms tended to go away.

(ii) Strong feeling facilitates the purgation of previously pent-up emotions, and thereby promotes the reduction of bad feeling (Reich, Lowen, Volkan, Janov, Jackins). The idea that the expression of strong feeling leads to a purging of built-up emotions and the subsequent reduction of a bad-feeling state can be traced back to ancient times. For instance, Aristotle viewed theatre as therapeutic because it aroused in theatre-goers feelings of pity and fear, the expression of which accomplished a catharsis and subsequent state of relief, clarity, and peacefulness (Nichols & Efran, 1985). Throughout history, this "purgation" view of strong feeling expression has remained at the root of various therapeutic techniques and healing rituals such as Mesmerism and hypnotherapy; drug-facilitated catharsis designed to overcome traumatic neuroses of war; rituals of mourning; and religious revivals (cf. Nichols & Efran, 1985).

In the field of psychotherapy, the foremost pioneer of this purgation tradition was Wilhelm Reich. His *orgone therapy* (Reich, 1949, 1960) was based on the view that somatic symptomatology, tension, and anxiety all arose from blocked emotion. He viewed patients as

constricted and distorted -- both physically and experientially -- by "characterological armor": "The individual is 'characterologically armored' against the outer world and against his unconscious drives" (Reich, 1960, p. 67). Reich believed that intense discharge of feeling was required to weaken and break through these defences, and restore pure, undistorted, genuine expression (or "plasma pulsation", as he called it).

A number of therapies followed in Reich's wake. Alexander Lowen's (1975) *bioenergetics*, for example, emphasizes the intense expression of rage, sadness, fear, and other emotions in order to help soften and overcome the chronic muscular tension and body rigidities that limit and constrict the person: "...it is our consistent policy to open up and vent these feelings, for their release makes available the energy necessary to the process of change" (Lowen, 1975, p. 121).

Vamik Volkan's (1972, 1981) *re-grief therapy* also follows along these lines. It was designed for bereaved patients who are stuck in a state of "pathological mourning", unable to complete the natural mourning process. Psychological symptomatology, tension, anxiety, and so on, all are presumed to arise from this blocked mourning. The emphasis is on the client's intense expression of blocked emotions in relation to the dead person: "Such abreactions reflect a recurrence of the initial reaction to death and a (re-)commencement of the work of mourning" (Volkan, 1981, p. 208; cf. Volkan, Ciffuffo, & Sarway, 1976). As the mourning process becomes unblocked, the client becomes increasingly able to discharge the feelings of anger, guilt, sadness, and so on, that were being held inside before. As a consequence, the tension, the anxiety, and the bad feeling become reduced: "[Clients] feel free, even excited, with the lifting of their burden, and begin to look for new objects for their love" (Volkan, 1981, p. 210). Clients become able to

finally "let" the dead person "die", and move forward with their own lives.

Primal therapy (Janov, 1970; Janov & Holden, 1975; Rose, 1976), which is also faithful to this "purgation" tradition, is based on the assumption that the repressed pain of the original birth traumas becomes channelled into psychological symptoms. Janov postulates "a primal pool of pain" that needs to be drained (Janov, 1970). Cure comes through "going back" and intensely re-experiencing the original trauma.

Harvey Jackins' (1978) *re-evaluation counselling* views psychological problems as being rooted predominantly in our society's tendency to block (suppress) emotional expression, from infancy to adulthood:

> ....this suppression of discharge is the basic reason why our entire population is so troubled, so unable to live up to their potentials.
>
> One can observe very small children trying repeatedly to let go of their feelings and being repeatedly made to choke them back. As they grow older, they appear to shut off their own discharge as the shame and embarrassment conditioning takes over (Jackins, 1978, p. 86).

Failure to discharge the emotion linked to distressful experiences is seen to progressively limit our capacity to live life with zest and joy. Our behaviour patterns become increasingly chronic, constricted, and filled with "deadness". Therapy (or co-counselling), therefore, focuses on the discharge of intense emotion. Once the client has allowed the pent-up emotion to be discharged, distress gives way to a resurgence of obvious happiness, great enthusiasm and alertness, awareness and outgoingness and activity (Jackins, 1978).

In all these therapies, then, the uniting glue is a belief that symptomatogy, anxiety, tension,

and bad feeling all arise from pent-up, blocked-off emotion, and that the best way to help alleviate these bad feelings is to mobilize the client's intense expression of affect in the therapy session. This perspective has been referred to as the "container model" of catharsis (Guinagh, 1987). Clients are viewed as "emotionally constipated". Strong feeling is their laxative.

(iii) Strong feeling facilitates vivid experiential contact with the feared object or situation, and thereby promotes the reduction of bad feeling (Stampfl; Rachman). In *implosive therapy* (Hogan & Kirchner, 1967; Stampfl, 1976; Stampfl & Levis, 1967, 1968), the key assumptions are that (a) clients' bad feelings -- specifically fears, phobias, anxieties -- are initially acquired from childhood traumatic experiences in which they experienced intense anxiety; (b) through a process of classical conditioning, they paired the anxiety response with a (previously neutral) phobic object related to the bad, traumatic feelings; (c) they subsequently avoided the phobic object because this avoidance kept the anxiety at bay; and (d) the only way for clients to unlearn the fear reaction is to be subjected to conditions similar to those that caused the initial trauma (Hogan & Kirchner, 1967). Consequently, the primary aim of implosive therapy is to "recreate the original trauma -- or at least the presumed trauma" (Rachman, 1969, p. 296). The idea is that if, in the therapy session, the client undergoes extreme anxiety in the context of the recreated traumatic stimulus -- and there is an absence of the real occurrence of the feared consequence -- then what will follow is a reduction in anxiety and bad feeling (Rachman, 1969).

(b) *Strong Feeling is Useful in Promoting Insight-Understanding (Cognitive Reorganization, Emotional Restructuring, Schematic Restructuring)*

Lots of writers of differing theoretical stripes are united by their emphasis on the client

achieving a *change in perspective*, a restructuring of their experience, a modified and broadened insight-understanding into present and past behaviour (cf. Safran & Greenberg, 1991b). Although their languages are often different, the sentiment amongst the writers in this group seems pretty much the same. Four variations on this theme are presented below.

(i) Strong feeling facilitates and signals the emergence of important, previously blocked-off material, and thereby promotes insight-understanding (later Freud; other psychoanalysts). By 1912, when The Dynamics of Transference (Freud, 1912/1959) was published, Freud had abandoned his traumatic childhood event theory of neurosis because he had found that the patient's remembering of traumatic early events did not produce lasting personality change (Nichols & Efran, 1985). In its place, he developed the conflict theory, which postulated that therapeutic change required that repressed, disowned feelings and impulses be *recognized*, *understood*, and *integrated* into the patient's personality. Freud's focus was now on helping patients to reappraise past childhood events and wishes, using their present mature judgement, toward the attainment of greater insight-understanding.

With this shift in focus, the patient's undergoing of strong emotion -- often taking the form of "transference" feelings directed toward the therapist -- was now valued as an effective way for the patient's buried feelings to become manifest so that the therapist could gain more direct access to them for the purposes of analysis (cf. Nichols & Efran, 1985; Silberschatz & Sampson, 1991). Strong feelings were a good indication that important material was coming to the surface. The emergence of this material was desirable because it provided the therapist with the "data" needed to understand and interpret the patient's behaviour, and thereby to help the patient achieve greater understanding.

Many later psychoanalytic theorists also followed in this general vein. Strachey (1934) suggested that emotional expression was a signal that a therapist's interpretation had hit the target. Other analysts used patient's outbursts of strong feeling as ammunition for convincing their patients that powerful, repressed, unconscious impulses really did exist inside them (cf. Bibring, 1954; Fenichel, 1945; Greenson, 1967). Psychoanalysts also considered strong feeling to be a valuable tool since the patient's attainment of insight in the session would be more change-producing and therapeutic if it occurred along with strong feeling (Nichols & Efran, 1985; Sheiner, 1966).

(ii) Strong feeling facilitates the vivid re-experiencing (re-living) of problematic earlier life incidents, and thereby promotes insight-understanding (Pierce, Nichols, DuBrin, Efran; Hart, Corriere, & Binder; Sacks; Shorr; Rice, Greenberg, Safran, Daldrup, Engle, Beutler; Guidano). Therapists belonging to this group also see strong feeling as a useful precursor to insight-understanding. However, their emphasis was less on retrieving buried material, and more on the *intense re-living* of past incidents with strong feeling en route to insight-understanding. As Shorr (1972) explains: "I attempt to bring [past problematic incidents] into the present to be dealt with at this time. But the traumatic incidents have to be refelt as if they were in the past, so that the understanding ... can be clarified" (p. 51).

This use of strong feeling can be explained in terms of a 3-step sequence in which (a) a past scene (situation) is identified in which the client experienced bad feelings; (b) the scene is "re-lived" (re-felt, re-experienced) intensely in the session; and (c) increased insight-understanding occurs. Therapists may identify the problem scene by being alert to times in the session when the client mentions a particular situation when he/she felt bad, upset, or troubled (Rice & Saperia,

1984), or else by identifying an "internal conflict" in the client and asking him/her to recall a past incident that is related to it (Shorr, 1972). Alternatively, the client may identify memories of so-called "unfinished" incidents in which an emotion (signifying a need) rose up in him/her, but the natural push for completion was somehow blocked or interrupted (Daldrup et al, 1988; Engle, Beutler, & Daldrup, 1991; Greenberg, Rice, & Elliott, 1993; Nichols & Efran, 1985; Pierce et al, 1983). Once the problem scene has been identified, the second step is for the client to intensely "revisit" it in the session. In therapy -- unlike in the past, traumatic situation -- the patient is allowed to express strong feeling without being punished or censured. The therapist encourages and allows the patient to fully express the feelings that arise in relation to the problem scene (Hart, Corriere, & Binder, 1975; Karle et al, 1976; Shorr, 1972). Vividly and intensely reliving the unfinished incident in the session unblocks and completes the natural flow of emotional expression that did not occur in the original scene (Daldrup et al, 1988; Nichols & Efran, 1985). What naturally follows from this process is increased insight-understanding: "the schematic emotional memories involved in the experience are restructured in consciousness and perceived with new meaning" (Daldrup et al, 1988, p. 83; cf. Rice & Saperia, 1984; Shorr, 1972). The past's hold on the client is loosened: "....without facing the reality of events from the past, one cannot let go of them; without becoming more feelingful, one cannot take hold of life in the present" (Pierce et al, 1983, pp. 6-7). The client now has more understanding of his/her previously incomprehensible reactions and bad feelings in the problem scene.

(iii) Strong feeling promotes vivid experiential contact with the feared object or situation, and thereby promotes schematic restructuring (Foa & Kozak). Foa and Kozak's (1991) *cognitive-emotional approach* to anxiety disorders is very similar to implosive therapy, except

that its principal aim seems to be to promote insight-understanding in the client (rather than the reduction of bad feeling per se). Foa and Kozak embrace the view that fear is represented as a propositional network in memory, which serves as a program for fear behaviour. Anxiety disorders (pathological fears) are characterized by erroneous elements and/or associations between elements. Psychotherapeutic change, then, involves a schematic change in the pathological network.

In the psychotherapy session, there are five identifiable steps in the change process, and strong feeling places a crucial role. (1) In the first step, the therapist assesses the meaning that the patient ascribes to the feared situation (i.e. the patient's "fear structure") by asking about (a) ideas and situations that provoke fear; (b) the ritualistic behaviours the patient engages in to avoid fear; (c) perceptions about what harm will ensue if he/she does not perform these avoidance behaviours and rituals. (2) In the second step, the therapist exposes the patient to fear cues, either by fear-relevant imagery or in vivo exposure or both, thus evoking intense anxiety and fear. (3) The therapist blocks the patient from "escaping" from the anxiety and fear by preventing him/her from engaging in the ritualistic behaviours or compulsions usually relied on to reduce anxiety. (4) Gradually, during in-session exposure and confrontation with feared objects or situations, the patient's anxiety decreases. (5) Change in the fear structure is promoted. The decrease in anxiety, in the continuing presence of the feared object or situation, is incompatible with the old, pathological fear structure. The fear structure (emotional memory structure) is modified through the incorporation of this new corrective information.

In summary, the patient is exposed in the session to situations or objects that he/she intensely fears. The fear is intensely experienced. When the disastrous, feared consequences do

not ultimately occur, anxiety decreases. Cognitive re-organization results because of this new "corrective" information.

(iv) Strong feeling is useful for promoting a cognitive shift in which the client sees painful life situations in a lighter, more humorous way (Greenwald, Farrelly, Pierce, Driscoll, Killinger, Ventis). In this variation, the valued cognitive shift is one in which the patient moves from seeing everything in a grim manner to seeing things more lightly and humorously: "From the cognitive point of view, one stops thinking about everything in this world as a catastrophe and begins to see the humor in life's events by looking at the world as the divine comedy that it really is" (Greenwald, 1987, p. 53). "We maintain that we can convey the humorous aspects of even painful life situations for clients, thereby challenging them to a new, broader perspective...A spoonful of sugar really *does* help the medicine go down" (Farrelly & Lynch, 1987, p. 87). "Laughter can go a long way towards easing the anguish" (Driscoll, 1987). The client is stimulated by an experience of novelty, surprise, and fresh objectivity, and his/her frame of reference is broadened (Driscoll, 1987; Killinger, 1987; Pierce et al, 1983; Ventis, 1987). In attempting to use strong feeling in this way, the therapist enters the session determined to find something humorous either in the therapist-patient interaction or in the patient's life situations and experience (Farrelly & Lynch, 1987; Greenwald, 1975, 1987). The therapist is also highly willing to use self-directed humor, which serves to lessen the power gap between therapist and patient, guard against the danger of the patient feeling put down, and thus strengthen the therapeutic alliance (Farrelly & Brandsma, 1974; Greenwald, 1987). The chief aim is to help clients begin to see the world and their problems from a lighter, more humorous, broadened perspective.

(c) *Strong Feeling is Useful for Promoting Heightened Experiential Awareness*

(i) Strong feeling promotes heightened awareness of self (Perls; Polster; Enright; Fagan; Greenberg; other Gestalt therapists). Fritz Perls saw people's attempts to control and avoid their emotional experiencing as a cause of psychological dysfunction. Lack of awareness of emotional experiencing was seen as blocking feelings from running their natural course, leading to dysfunction and confusion. "The awareness of, and the ability to endure unwanted emotions are the conditions, the sine qua non, for a successful cure (Perls, 1969, p. 179).

Accordingly, the bedrock of the Gestalt approach is to help the patient attain a *heightened awareness* of what is going on bodily, behaviourally, and emotionally from moment to moment in the session: "The theoretical and therapeutic core of Gestalt therapy is awareness" (Enright, 1975, p. 25; cf. Denes-Radomisli, 1976). The patient is given the difficult task of staying with whatever is there right now in the here-and-now moment of the therapy session, as he/she attends to present experiencing (Harman, 1981; Levitsky & Perls, 1970; Naranjo, 1980; Perls, 1973, 1975a, 1975b; Polster & Polster, 1973; Shepherd, 1976; Yontef & Simkin, 1989; Zinker, 1977).

In the Gestalt approach, strong feeling is valued primarily in the spirit of heightening the client's awareness, rather than in the spirit of modifying meaning structures, or achieving purgation. Unlike Reich, Lowen, and other proponents of the purgation view, Perls did not view the patient's emotions as "disturbers of the peace" that needed to be excreted. On the contrary, he viewed emotions as part of our natural expression, as part of our relating to the world. His primary aim was to undo the avoidance-interruptive process and to help patients become aware of and responsive to the actions toward which their emotions direct them (Greenberg & Safran, 1987; Perls, 1947, 1969; Perls, Hefferline, & Goodman, 1951; Smith, 1976). The postulated use

of strong feeling in Gestalt therapy, then, is that it helps promote the client's heightened awareness of self -- meaning what his/her sensations, needs, tendencies are as they are occurring right now in the therapy session.

(ii) Strong feeling promotes heightened experiential awareness through the symbolization and carrying forward of a bodily felt sense (McGuire; Friedman; Safran, Greenberg). McGuire's (1991) *experiential focusing* approach is a variation on Gendlin's focusing that emphasizes "catharsis as a change factor and almost as a goal of focusing" (McGuire, 1991, p. 227; cf. Friedman, 1982). In McGuire's approach, the welling up of emotion in the client signals the presence of a "trouble spot", an area of unprocessed and repetitive response to pain. The therapist's aim is to persistently bring the client back to this 'sore spot', encouraging more tears, anger, and laughter, but always -- in Gendlinian fashion -- in the context of focusing upon the broader "felt sense" and finding a word or image that can serve as a "handle" to carry the experiencing further. The therapist keeps encouraging the client's strong feeling to flow out from, and keep in touch with, the felt sense: "[without] deeper focusing upon the felt meanings implicit in the emotion ... catharsis will not lead to personality change" (p. 229). As the client keeps focusing on the felt sense, and experiencing strong feeling in relation to it, the felt sense is carried forward and a shift in awareness occurs: "a whole new sense occurs within which the emotion is newly experienced" (p. 229). McGuire suggests that attaining this sort of shift will help break the person's rigid, repetitive, nonproductive emotional responses in extratherapy situations similar to those focused on in therapy. In this approach, then, strong feeling is viewed as an important and desirable part of the change process in which the client's bodily felt sense is symbolized, carried forward, and ultimately transformed.

(d) *Strong feeling is useful in promoting a valued encountering-meeting relationship*

(i) Between therapist and client (Whitaker, Malone, Warkentin, Felder; Farrelly; Cashdan). This use of strong feeling is founded on the premise that therapeutic change is facilitated through an intense, encountering-meeting relationship between the therapist and client: "The issue is not re-experiencing what happened in the past, but rather experiencing very powerful, ongoing feelings [in relation to the therapist] in the present" (Cashdan, 1988, p. 121).

In order to totally engage the client in this powerful way, Malone, Whitaker, Warkentin, and Felder (1961) argue that the therapist must bring his/her "whole person" into the session as well. So the therapist reveals what is occurring inside him/her -- including reactions to the client, the client's behaviour, the therapy situation. The therapist is open, not only with regard to surface material, but also with regard to inner, deeper material. This enables the patient to do the same, to open up more and more, to reveal what is going on deeper inside. The result is an intense interpersonal encounter. In this use of strong feeling, the aim is for the therapist and patient to profoundly and intensely "experience each other" (Warkentin, 1976, p. 30; cf. Malone et al, 1961, 1982a, 1982b, 1982c; Whitaker & Bumberry, 1988; Whitaker & Keith, 1981).

Frank Farrelly's *provocative therapy* follows along similar lines: "It is a fully human existential encounter that at times can be perceived as the psychological equivalent of a Pier Six brawl, or conversely, making love" (Farrelly & Lynch, 1987, p. 85; cf. Farrelly & Brandsma, 1974). The therapist aims to create a therapeutic environment characterized by warmth and acceptance for the client on one level, and direct confrontation and challenge on another level. Within this environment, and through the use of humor, the therapist aims to provoke intense "affective-perceptual experiences" (i.e. strong feeling) in the context of a full, intense

encountering relationship with the therapist (Farrelly & Lynch, 1987).

Between different parts of self (Perls; Greenberg; other Gestalt therapists). In Gestalt empty chair work (Perls, 1969) and two-chair work (Greenberg, 1979, 1984a), an emotionally-charged encounter between two opposing aspects of self is viewed as helpful for achieving a resolution between these opposing sides. The therapist aims to separate two opposing aspects of self, and then create contact between them. First, the subtle aspects of the experience of both sides of the conflict are differentiated and explored. Second, emotional arousal is heightened as the client is encouraged, at different times, to express, embody, and "be" each part. Through this emotionally-charged encountering dialogue, the needs and wants of each part are clarified and asserted to the opposing part. This leads to a softening of the positions of each side of the battle, followed by negotiation, and ultimately a satisfactory agreement that resolves the conflict and creates resolution. The contact between the two parts dissolves the differences between them, and an experientially-grounded new perspective emerges which encompasses aspects of both sides. "By integrating opposite traits we make the person whole again. For instance, weakness and bullying integrate as silent firmness" (Perls, 1970, p. 7)

(e) *Strong Feeling is Useful for Accessing an Inner Experiencing (Deeper Personality Process), Welcoming and Appreciating It, and "Being" It in the Context of Earlier Life Scenes, and Present and Future Extratherapy Scenes* (Mahrer)

These uses of strong feeling are particular to the four-step process of *experiential therapy* (Mahrer, 1996a), and are described below.

(i) Strong feeling is useful for accessing an inner experiencing (deeper personality process). Step 1 of *experiential therapy* (Mahrer, 1996a) involves finding a scene (time, incident, situation) -- real or fantasied, set in the client's recent past, distant past, or future -- in which the feeling is strong. As the first step unfolds further, the aim is for the patient to be wholly living and being in, wholly caught up in and alive in, the precise moment in this scene when the feeling is strongest. As the moment is made more and more alive and vivid, and the person undergoes strong feeling in the context of this moment, a deeper personality process (*inner experiencing*) is activated, raised up a bit. Some precious inner quality, inner possibility, new way-of-being is accessed. The client's undergoing of strong feeling is used in step 1 of Mahrer's therapy as a vehicle to accessing this precious inner experiencing.

(ii) Strong feeling is useful for attaining integrative good relationships with the inner experiencing (deeper personality process). In step 2 of experiential therapy (Mahrer, 1996a), the client's undergoing of strong feeling is used in order to enable the person to welcome, appreciate, embrace, enjoy the new potential way-of-being (inner experiencing) that was accessed in the first step.

(iii) Strong feeling is useful in enabling the patient to "be" the inner experiencing in the context of earlier life scenes. In step 3 of experiential therapy (Mahrer, 1996a), the aim is for the person to disengage from and let go of the ordinary, everyday person that he/she usually is, and tranform thoroughly and completely into a new person, who is the inner experiencing. The person is to do so in the context of an earlier life scene. Undergoing strong feeling in the context of this alive, real, immediate earlier life scene (and other earlier life scenes that subsequently emerge) helps the person fully, totally, and intensely "be" this new, precious way-of-being.

(iv) Strong feeling is useful for enabling the client to "be" the inner experiencing in the context of present and future extratherapy life scenes. In step 4 of experiential therapy (Mahrer, 1996a), the aim is to enable the client to be the qualitatively new person (inner experiencing) in the context of present and prospective future scenes from the extratherapy world, and to enable the client to be free of the scenes of bad feeling that were present in step 1. Undergoing strong feeling in this step allows the client to -- within a backdrop of playful unreality, of complete having fun, going wild -- get a sense of what it might feel like to be the qualitatively new person totally (unabashedly, all the way) in scenes when it might be absolutely unrealistic to actually do so. Undergoing strong feeling in this step also allows the person to rehearse and refine behaviours that he/she might want to actually carry out in the outside world. Undergoing strong feeling -- as the new person -- helps the person vitally experience how it feels to actually be the new person (inner experiencing) in the extratherapy world of the present and prospective future, and helps the person to commit to these selected, rehearsed, and refined new ways of being-behaving in the selected extratherapy present and prospective future scenes.

(f) *Strong Feeling is generally not useful, and should be avoided* (e.g. Berkowitz; Ellis; Bergler, Koestler, Strachey; Whitmont, Kaufmann).

Despite its many proponents over the years, strong feeling has not been without its critics. These opponents tend to vary from those who discard strong feeling as merely trivial to those who see it as potentially dangerous.

Strong feeling has often been dismissed as irrelevant to the process of change, and its occurrence seen as diverting the patient's and therapist's focus away from more important

therapeutic material: "Catharsis is most commonly described as a trivial and incidental feature of psychotherapy -- hardly a sufficient force around which to build a powerful form of treatment" (Pierce et al, 1983, p. 4). For example, some therapists of cognitive and behavioural stripes view strong feeling as obscuring the therapist's and patient's attention away from important material related to shifting reinforcement contingencies and thought patterns, and therefore view strong feeling as an undesirable response to be extinguished or controlled (Greenberg & Safran, 1987). It has also been argued that intense feeling interferes with the proper gathering of diagnostic information (Skodol, 1989), and that although the occurrence of strong feeling may accord some temporary relief to patients, it is not therapeutically useful because its effect is not lasting (Ellis, 1976; Fine, 1973).

Other opponents' indictments are more severe. Some caution that strong feeling (at least particular kinds) can actually be very dangerous and harmful (at least for some patients). Taking a particularly extreme position against the expression of strong anger, for example, is Berkowitz (1973). He proclaims that anger expression in therapy may prompt violence outside, and takes aim at proponents of strong feeling (whom he calls "ventilationists") for opening up a dangerous "bottle" of rage in their patients that, once opened, is not easily closed again:

> Ventilationists believe that their patients, who are overly inhibited to begin with, can 'loosen up' in therapy without being indiscriminantly aggressive in other settings. But can we be sure that aggression will always be kept within 'proper' bounds? Violence has a way of getting out of hand and breeding still more violence ... The evidence dictates now that it is unintelligent to encourage persons to be aggressive, even if, with the best of intentions we want to limit such behavior to the confines of psychotherapy (Berkowitz, 1973, p. 31).

It is important to note, however, that Berkowitz is not a psychotherapist, and that the "evidence" he refers to is not derived from the realm of psychotherapy. Rather, it comes from social psychological studies he conducted in the area of aggression. This research is of questionable relevance to psychotherapy because the aggressive behaviour (or "catharsis" as he called it) that was measured in these studies -- involving subjects being given the opportunity to administer electric shocks to confederates -- might be better called retaliation than catharsis (Nichols & Efran, 1985).

A much more common warning from psychotherapy theorists is that the expression of intense feeling may cause unconscious material (impulses, fantasies, wishes) to erupt into conscious awareness, leading the patient to become overwhelmed and psychologically damaged (e.g. Bergler, 1956; Koestler, 1964; Plessner, 1970; Strachey, 1934; Whitmont & Kaufmann, 1973). Especially for particular kinds of patients (problems-conditions) -- for example, borderline or psychotic patients -- a common warning is that the fragile conscious is not strong enough to assimilate these unconscious eruptions, and the dangerous consequence will either be loss of control and "acting out" (Bergler, 1956; Koestler, 1964; Plessner, 1970; Whitmont & Kaufmann, 1973), or a redoubling of "defenses", making any subsequent expression of emotion much harder for the patient to attain (Strachey, 1934). A gentler approach is favoured, in which the patient expresses some emotion, but not intensely strong emotion.

In fact, even fervent proponents of strong feeling tend to acknowledge potential dangers. Perls (1969) states that he would quickly "back off" if he felt that a potentially uncontrollable feeling might burst through the patient's defensive structure. The developers of *focused expressive therapy*, another "emotive" approach, caution that their method is not advisable for

clients "whose anger is undercontrolled" (Engle et al, 1991, p. 177). Therefore, it seems that even many advocates of strong feeling would tend to agree that it is ill-advised for some patients. It is probably fair to say that most proponents of strong feeling would include "disclaimer clauses" to specify with whom and when they would value occurrences of strong feeling.

Summary of the Research and Clinical Literature on the Therapeutic Uses of Strong Feeling

The preponderance of outcome studies evaluating the therapeutic use (desirability, value) of strong feeling provide general supportive evidence of a link between strong feeling in therapy and post-treatment client improvement. However, this "macro" level conclusion tells us essentially nothing about *how* -- from a more bare-bones, in-session standpoint -- strong feeling actually promotes important in-session changes. Fortunately, some psychotherapy process studies have begun to shed some light on how strong feeling can be therapeutically used in the session by identifying valued in-session client consequences that tend to follow the prior in-session occurrence of strong feeling. However, what is conspicuously absent from the literature is a research-based, detailed, unabridged, practitioner-relevant category system of the in-session uses of (different kinds of) strong feeling -- one that tells therapists, much like a richly descriptive, how-to-do-it manual, how they can actually *use* occurrences of strong feeling in their sessions.

In the absence of any such research-based system like this, or even a well-accepted theory-based category system organizing the therapeutic uses of strong feeling, the clinical-theoretical literature on the topic was reviewed and organized into six main uses (and additional subcategories). The 6-fold framework of strong-feeling uses attempted to include and integrate writings of theorists from a wide variety of psychotherapeutic orientations, and it is interesting to

note that the collection of strong-feeling-proponents boasts representatives from (what are generally acknowledged as) the four main families of therapy -- psychodynamic-psychoanalytic, humanistic-experiential, cognitive-behavioural, and integrative-eclectic. It is also noteworthy that the theorists included span a variety of eras -- from Freud and Breuer in the 1890s, to Reich in the 1940s, to Whitaker, Malone, Warkentin, and Felder in the 1950s, and through to a host of contemporary theorists.

This 6-fold framework of strong-feeling uses should not be seen as my attempt to prepare hypotheses that will later be tested in this study. These relatively loose, somewhat overlapping categories were intended only to serve as a basis for discussing and comparing the clinical literature on uses of strong feeling with a richly descriptive, practitioner-relevant, research-based category system -- the generation of which will be a major objective of the present study.

The Proposed Research Question: *When Strong Feeling Occurs in the Session, How Do Therapists Use It?*

Nowhere in the current literature does there seem to be anything like a research-generated, unabridged, descriptive category system that shows therapists -- much like a technical, "how-to" manual -- how they can *use* in-session instances of strong feeling in their sessions. Thus, one major objective of this study is to provide one by investigating the following research question: *When strong feeling occurs in the session, how do therapists use it?* The key focus, therefore, is on how therapists tend to *use* instances of strong feeling in their sessions. Moreover, as a secondary interest, the present study will also investigate the question of whether in-session *therapist uses* of strong feeling tend to vary across: (a) different kinds of strong feeling; (b)

different psychotherapeutic approaches; and (c) different temporal eras-decades (e.g. sessions from the 1980s vs. 1970s vs. 1960s).

An explanation of the proposed research strategy will follow in the third chapter. At this point, let us turn to the second main focus of this study: investigating therapist methods for *promoting* the occurrence of strong feeling.

CHAPTER 2

THERAPIST METHODS OF PROMOTING STRONG FEELING: A REVIEW OF THE LITERATURE

Despite the wide acceptance of strong feeling events as valuable, there is almost no research on how to bring them about. The absence of research has been flagged as a problem by leading figures in the clinical research field: "In the future it will be important to clarify systematically the different interventions that can be employed to activate these [strong feeling] processes" (Safran & Greenberg, 1991b, p. 360; cf. Greenberg & Safran, 1987; Labott, Elliott, & Eason, 1992). Indeed, at this point, although some psychotherapy process studies have provided some useful data about therapist methods that may be linked to heightened feeling expression (Mahrer, Stalikas, Fairweather, & Scott, 1989; Mahrer, White, Howard, & Lee, 1991), strong feeling in general (Mahrer et al, 1986b, 1992a; Nichols, 1974; Nichols & Bierenbaum, 1978), and strong laughter in particular (Gervaize, Mahrer, & Markow, 1985; Mahrer, Markow, Gervaize, & Boulet, 1987), nowhere in the research literature has there been an attempt to come up with an organized set of richly detailed, practitioner-relevant, "how-to-do-it" descriptions of actual *methods* that therapists can employ to help promote occurrences of (different kinds of) strong feeling in their sessions.

Furthermore, quite apart from research, there does not even seem to be a theory-based categorization scheme of therapist methods linked to strong feeling. Clinical contributions consist mainly of isolated case vignettes, therapy excerpts, and theoretical discussions by authors of particular approaches. Nowhere in the theoretical literature is there an organized set of

descriptions of therapist methods of promoting strong feeling. The sole exception seems to be a theory-based categorization of therapist methods linked to *strong laughter* in particular (Mahrer & Gervaize, 1984) -- a valuable contribution, but limited to only one kind of strong feeling event. In short, it seems that no one has pulled together the literature on strong-feeling-promoting therapist operations in a way that makes it available and usable to practitioners.

Therefore, this chapter will be devoted to reviewing and organizing the existing theory and research pertaining to the topic of therapist methods of promoting strong feeling. Then, on the basis of this review, a second research question will be chosen to be addressed in the present study.

Therapist Methods for Promoting Strong Feeling

In the absence of any accepted research-based or theoretical category systems, I have done my best to group the literature into meaningful categories. The list of 21 methods presented below comes essentially from the clinical-theoretical literature. In some cases, though, research has had something to say about the effectiveness of a particular method for promoting strong feeling, and where applicable, research findings will be mentioned.

The list is organized in a "homogeneous" fashion -- describing methods that have been postulated as helpful in promoting strong feeling *in general*, whatever the particular variety. This is unfortunate but necessary because when most authors talk about intensifying affect, they rarely make reference to a particular kind of strong feeling. Where authors do make these distinctions, I will highlight these within the general categories.

Before proceeding, I would like to make it clear up front that these methods are <u>not</u> intended to constitute careful hypotheses that I intend to test later as effective vs. ineffective for

promoting strong feeling. As will be seen, these categories are somewhat loose, somewhat overlapping, and at varying levels of abstraction. In presenting these methods here, the aim is simply to organize the existing literature so that it can later be compared with our research-based findings -- which will consist of an organized set of richly detailed, practitioner-relevant, "how-to-do-it" descriptions of classes of *methods* that therapists can employ to help promote occurrences of strong feeling in their sessions. Here, then, are 21 therapist methods discussed in the literature as helpful in promoting strong client feeling.

(1) *Encouraging the client to repeat affect-laden phrases or expressive movements with heightened intensity*. A vast array of clinical writers (e.g. Daldrup et al, 1988; Engle et al, 1991; Lowen, 1975; Jackins, 1978; Janov, 1970; Lowen, 1975, Mahrer, 1989a; Perls, 1969; Pierce, Nichols, & DuBrin, 1983; Shorr, 1972) have described various forms of this technique for promoting strong feeling. Typically, this method involves directions such as "say it again, louder", or directions to hit, kick, or pound with increased feeling expression. In effect, the therapist is encouraging the client to "let go" (Nichols & Efran, 1985), to let the emerging feeling "show and grow" (Mahrer, 1989a). Here is an excerpt from Shorr (1972), that demonstrates his use of this technique with a client named Phil:

Phil: (talking to his father): "Listen to me, I have something I want to tell you."
Shorr: "Are you saying this with feeling, though?"
Phil: "No."
Shorr: "Do you want to try it with feeling?"
Phil: "I don't know, I can't."
Shorr: "Say the words or the phrases first."
Phil: "Don't tune me out, listen to me. I am important. As important as anybody else you know."
Shorr: "As important as anybody else you know."

Phil: "I was going to say, 'More important than anybody else you know'."
Shorr: "Can you now say that to him with feeling?"
Phil: (Screams): "DON'T TUNE ME OUT. LISTEN TO ME. I'M IMPORTANT. THERE ISN'T ANYBODY ELSE THAT IS MORE IMPORTANT THAN ME." (Shorr, 1972, p. 54)

In applying this technique, some theorists argue that it is useful to include additional components beyond the mere "feel-it-more" instruction. For instance, it may be important to (a) *explicitly give the client permission to express strong feeling*: "Giving clients the permission to feel is probably the most direct way to encourage catharsis" (Pierce et al, 1983, p. 61; cf. Daldrup et al, 1988). So, for example, the therapist might say something like this: "I think there's more sadness in there. Stay with it...You've been told not to cry or be angry, but that advice has hurt you. It's really good to show your feelings, especially in here" (Pierce et al, 1983, p. 61).

It may also be important and effective to (b) *highlight the client's readiness, willingness, and choice* to express strong feeling or not. So the therapist might say this: "Only you can do this... If you are ready and willing to let it happen, then let it. It is all up to you. Is this all right? Are you ready? ... Yes? No?" (Mahrer, 1989a, p. 53). This lets the client know that he/she has the full right to be ready and willing or not.

It may also be useful to (c) *assess the client's immediate performance* (Mahrer, 1989a; Pierce et al, 1983; Shorr, 1972). So the therapist might say, "Good. Good. That's the way. Keep it up. Good" (Mahrer, 1989a, p. 32). Or he/she might say, "That was not very good. There is a lot more feeling there inside. This time let it happen more" (Mahrer, 1989a, p. 32). The gist here is for the therapist to communicate that he/she is "standing by" the client, aligned with the client, and essentially saying, "Okay so far. Keep going. I'm with you" (Pierce et al,

1983, p. 61).

In the research literature, a few studies have supported the effectiveness of this technique in promoting strong feeling. For example, Nichols (1974) found that clients paired with "emotive" therapists -- who frequently used this particular technique -- were more likely than clients paired with "non-emotive" therapists to attain levels of strong feeling in the session. In a second study, Gervaize et al (1985) analyzed over 300 hours of audiotaped therapy sessions, and found this method to be effective in promoting strong laughter.

(2) *Instructing the client to exaggerate his/her unwillingness to express strong feeling*. In this method, the therapist tells the client to try hard not to undergo strong feeling (Hart, Corriere, & Binder, 1975; Pierce et al, 1983). Paradoxically, as the client intensely experiences his/her own ways of holding back and squelching feeling expression, strong feeling will tend to burst through. There seems to be no research data regarding the effectiveness of this method in promoting strong feeling.

(3) *Offering challenging and confrontational interpretations to the client's in-session behaviour*. In the Gestalt clinical literature, offering confrontational interpretations is frequently mentioned as a way of promoting the client's awareness of how he/she is behaving in the here-and-now of the therapy session, and of facilitating the undergoing of strong feeling (e.g. Perls, 1969, 1975b). Research evidence points to the value of this method specifically in the promotion of strong anger. In two studies that analyzed the in-session process of Gestalt sessions conducted by originator Fritz Perls (Mahrer et al, 1991a, 1992a), it was found that strong client anger tended to follow therapist statements such as the following: "You are buttering me up left and right ... If you play dumb and stupid, you force me to be more explicit ... You are a phony ... You are

putting on a performance for me ... You are playing stupid" (Mahrer et al, 1991, p. 20).

(4) *Intentionally shifting, switching, and diverting the focus of the client's immediate attention*. This technique is also frequently mentioned in the Gestalt clinical writings (e.g. Perls, 1969, 1975b) as effective for heightening the client's level of feeling in the session. Research evidence (Mahrer et al, 1991a, 1992a) suggests that this method may be useful in the promotion of strong anger. In sessions conducted by Fritz Perls, strong client anger tended to be promoted by therapist statements such as the following: "What are you doing with your feet now? ... Are you aware of your smile? ... You did something with your hair there ... Now play Fritz passing judgement" (Mahrer et al, 1991, p. 21). Diverting the client's attention in this way was judged to be useful in heightening the client's feeling level from a neutral level to a level of strong anger.

(5) *Giving feeling-focused interpretations or reflections*. A very common method mentioned by experientially-oriented therapists is to offer feeling-focused interpretations and reflections related to the client's in-session behaviour. These interpretations may be more implicit such as calling attention to the client's body posture and relating it to unexpressed feelings ("Notice how your head is lying on your left shoulder. Tell your husband what that is about."), or calling attention to overt bodily expressions ("I hear the words you are saying, and I'm most drawn to the tears in your eyes.") (Daldrup et al, 1988, pp. 128-129). Other interpretations may be more explicit: "I have a hunch that you constrict your anger because you are afraid of it. Is that true?" (Daldrup et al., 1988, p. 129; cf. Engle et al., 1991; Nichols & Efran, 1985; Sheiner, 1966).

In a recent process study that analyzed an intense "weeping" event (Labott, Elliott, & Eason, 1992), feeling-focused reflections were judged to have been helpful in promoting the

occurrence of the event. According to the judges, this method worked because it provided a safe therapeutic situation in which the client felt understood and supported, and which thus facilitated the intensification of the client's immediate sadness and pain.

(6) *Instructing the client to focus on bodily sensations, and to experience the feelings related to them*. This method involves the client focusing inwardly on present, emerging bodily sensations, and experiencing the related feelings. Here is an example from McGuire's (1991) experiential therapy of how the therapist can use this method:

> Wait. Let's just stop for a moment and see if you can feel this issue in your body ... Can you stop and just feel into the sense of that whole upsetness (pp. 238-239).

The aim is to produce "moments of direct reference", moments when the client is in touch with bodily felt experiencing. Once these moments occur, strong feeling may spontaneously happen as a "felt shift" in the bodily felt experiencing (McGuire, 1991). This type of method may also be used to help the client along as he/she attempts to express feelings. So the therapist might say this: "Go back to the knot in your stomach and see how it is doing as you express your anger." (Daldrup et al, 1988, p. 128). This method is designed to increase the client's awareness of the present moment, and thus facilitate the process of reaching strong feeling.

Gendlin (1991), in describing his focusing approach, also implies that getting the client in touch with bodily felt experiencing can lead to strong feeling. However, he seems to espouse a more passive approach than McGuire (1991). Rather than trying directly to induce strong feeling by bringing the patient back to bodily experiencing, Gendlin suggests that the possibility of strong feeling should be communicated to the patient as an open, known, included possibility -- but beyond this it should not be engendered, and should be allowed to unfold on its own (or not) as

the person focuses on carrying forward bodily felt experiencings in the session.

There appears to be no existing research data pertaining to the usefulness of this kind of method in promoting strong feeling.

(7) *Instruct the client to speak specifically and directly about his/her feelings*. This means instructing the client to speak in specific terms about his/her feelings, rather than in more global and general terms: "The specificity of language...enhances and intensifies experience" (Daldrup et al, 1988, p. 128). So, for example, the therapist asks the patient to change global complaints (e.g. "You always say things to hurt me.") to specific resentments (e.g. "I am hurt when you tell me my feelings are silly."). In a similar vein, the therapist assists the client in moving from tentative statements (e.g. "I feel a little resentful when you put me down.") to direct, unqualified statements (e.g. "I resent you for putting me down."). Moreover, the therapist instructs the client to assume responsibility for his/her feelings by speaking in "I" language instead of "it" language (Daldrup et al, 1988, p. 128). So the therapist may instruct the client to say "I feel sad...", rather than "it feels sad..." or "you feel sad..."

The research literature offers no data on the usefulness of this method for promoting strong feeling.

(8) *Instructing the client to vividly describe a distant or recent life situation (or imaginary situation) in which he/she experienced heightened feelings*. Some authors (e.g. Mahrer, 1989a, 1989b; Pierce et al, 1983; Rose, 1976; Shorr, 1972) write about the usefulness of vivid description (by the client) of emotionally-loaded situations in facilitating strong feeling. In using this method, the therapist coaches the client to describe a feeling-laden situation in increasingly vivid detail, and as the client does so, the client will begin to "live" in the scene in the

here-and-now, and the feeling level will tend to increase: "The attendant feeling will tend to increase as you show the patient how to clarify the situation, make feature after feature more specific and concrete" (Mahrer, 1989a, p. 35). The identified scene will generally be one from the past in which the client experienced bad feelings. Possible scenes include the worst behaviour he/she ever committed; the most evil, immoral thing he/she has ever done; or the most humiliating, shameful day in his/her life (Mahrer, 1989b; Shorr, 1972). Alternatively, however, past scenes may be ones in which the client experienced heightened good feeling (Mahrer, 1989a, 1989b). In order to enhance the effectiveness of this method in promoting feeling, some writers suggest that it may also be helpful to instruct the client to close his/her eyes (Mahrer, 1989a; Mahrer et al, 1986b; Nichols & Efran, 1985; Pierce et al, 1983).

No research data exists on the question of whether or not this method is helpful for promoting strong feeling.

(9) *Instructing the client to talk directly to a significant other*. Lots of clinical authors have talked about the usefulness of this method for arousing strong feeling (e.g. Daldrup et al, 1988; Engle et al., 1991; Greenberg, 1979; Greenberg & Safran, 1987; Mahrer, 1989a, 1989b; Perls, 1969, 1973; Sacks, 1976; Shorr, 1972; Yontef & Simkin, 1989). A much written about form of this technique is the "empty chair" (cf. Greenberg, 1979; Greenberg, Rice, & Elliott, 1993), in which the therapist instructs the client to imagine a significant other sitting in an empty chair in the therapy room, and then encourages the client to talk directly to this person (object, part of self). As the client talks to this other person or part, the level of feeling tends to increase. A variation postulated by Shorr (1972) is the "your face in my hands" technique, in which the client is told to imagine holding a significant other's face in his/her hands; to look at the person's

face, and describe it; and then to talk directly to the face.

Research support for the effectiveness of this method for promoting strong feeling comes from Mahrer et al (1986b), who conducted an analysis of a single therapy session (containing strong feeling) conducted by Robert Pierce -- one of the originators of *feeling-expressive therapy* (Pierce, Nichols, & DuBrin, 1983). The investigators judged that Pierce's use of this method was instrumental in both promoting and sustaining a strong client feeling event in the session. Just prior to the client's strong feeling, the therapist told the client what words to say, how to say them, and directed the client to say the words directly to her dead mother: "Tell your Mommy what's going on...Tell her; say it to her ... Now let yourself be mad at her. Say, 'I'm really mad at you 'cause you won't be at my wedding" (Mahrer et al, 1986b, p. 79). Moments later, the client was expressing, directly toward her dead mother, an intense sense of hurt, anger, and anguish.

(10) *Instructing the client to "be" (role-play) some other person, personality part, or object*. Many clinical authors have cited this method as useful for promoting strong feeling (e.g. Casriel, 1972; Daldrup et al, 1988; Fagan, 1976; Jackins, 1965; Levitsky & Perls, 1970; Mahrer, 1989a; Malamud, 1976; Naranjo, 1976; Perls, 1970, 1973; Pierce et al, 1983; Shorr, 1972; Yontef & Simkin, 1989). As Pierce et al (1983) put it, "...role-playing is designed to counter defenses and promote the expression of feelings ... Role-playing promotes spontaneity and enlivens sessions with emotional action and interaction" (p. 64).

In applying this method, the therapist directs the client to shift out of the ordinary person that he/she is, and to "be" another person (part of self, or object). Often the procedure also involves the client shifting back and forth between the "other" and "self" until heightened feeling level occurs. Commonly in Gestalt therapy, this "self" vs. "other" role-play involves the client

physically shifting from one chair to another, and hence is often referred to as the *two-chair technique* (Greenberg, 1979, 1980; Yontef & Simkin, 1989).

Regardless of the specific form that this exercise takes, however, the key reason that strong feeling seems to ensue may be the element of *riskiness* (threat, newness) that is involved in being the other entity (Casriel, 1972; Jackins, 1965; Malamud, 1976; cf. Mahrer & Gervaize, 1984). For example, in working with a client who is highly perfectionistic and self-critical, Malamud (1976) instructs her to "be" God, and talk to herself, to her mother, and to her father as God. When the client assumes this risky, unusual role of playing God, she soon bursts into strong laughter.

Turning to the research literature, Nichols (1974) found empirical support for the effectiveness of role-playing techniques in promoting strong feeling. However, another study testing the effectiveness of this particular method in promoting strong laughter (Gervaize et al, 1985) found no supportive evidence.

(11) *Directing the client to carry out a risky (anxiety-provoking) interpersonal behaviour*. In the clinical literature, this method has been cited as an effective way of promoting strong client feeling in general (Downing & Marmorstein, 1973; Jackins, 1965, 1978; Pierce, Nichols, & DuBrin, 1983; Shorr, 1972), and also strong laughter in particular (Downing & Marmorstein, 1973; Mahrer & Gervaize, 1984; Shorr, 1972).

This method involves the therapist instructing the client to carry out a risky (anxiety-provoking, threatening) behaviour in relation to some significant other person. The client is to do the behaviour right now, in the therapy session, within an imagined scene involving the significant other person (cf. Mahrer & Gervaize, 1984). Elements of "riskiness" in the behaviour may

include the following: feelings of guilt for screaming a gut-level truth, fear of the possible retaliation from the other person, and the need to do "penance" for daring to change the balance of the relationship with the other person (Shorr, 1972). The risky nature of the behaviour, the sheer sense of threat and newness that accompanies the behaviour, presumably leads the client to experience strong feeling, in the doing of it, or even the mere thought of doing it.

Shorr (1972) presents a number of interesting variations of this technique. One variation is the "impossible scream", in which the client is instructed to scream the most forbidden thing he/she could ever say to the significant other person. Another variation is the "my life or his" scenario, in which the client is instructed to engage in a "fight to the death" with a significant other. A third variation is the "accuse the accusers" scenario, in which the client is instructed to imagine himself/herself in a witness box, imagine the accusations that certain people are directing toward him/her, and then to "turn the tables" and fervently accuse them with strong angry feeling. A fourth variation is the "eyeball to eyeball" scenario -- in which the therapist (a) tells the client to imagine a scene in which he/she is facing (at very close range) a significant other who has "power" over the client, who "defines" him/her, and then (b) instructs the client to openly and forcefully confront that other person (Shorr, 1972). All of these methods involve the therapist directing the client to carry out risky behaviours in relation to another person. The postulated and desired consequence is strong client feeling.

Turning to the research literature, Gervaize et al (1985) did find supportive evidence for the effectiveness of this method in promoting strong laughter.

(12) *Directing the client to carry out a risky (threatening, anxiety-provoking) behaviour toward the therapist*. This method has been cited as useful for promoting strong feeling in general

(Bugental, 1976; Friedman, 1982; Jackins, 1965, 1978; Lowen, 1975; Perls, 1969 Pierce et al, 1983; Whitaker, Warkentin, & Malone, 1959), and strong laughter in particular (Mahrer & Gervaize, 1984). In employing this method, the therapist may tell the client to push or hit him, yell at him, hug or squeeze him, or be sexual or aggressive toward him (Mahrer & Gervaize, 1984). For instance, after the client complains about other people evaluating and assessing him, the therapist might say, "OK, now reach over, take my hand, look at me, and assess me right now. Give me a thorough evaluation!" (Mahrer & Gervaize, 1984, p. 513). The therapist may block a doorway, challenging the client to push and struggle in order to win passage through the door. Or, the therapist may push the client into a corner, encouraging him/her to push back (Pierce et al, 1983). In any case, the aim and postulated consequence of these sorts of techniques is to facilitate the client's direct, full verbal and/or physical expression of feelings directly toward the therapist.

Research support for the effectiveness of these sorts of methods in promoting strong laughter comes from Gervaize, Mahrer, and Markow (1985).

(13) *Vividly describing-clarifying a threatening (anxiety-provoking, frightening) situation involving the client*. In the clinical literature, authors from behavioural approaches (Foa & Kozak, 1991; Stampfl, 1976, 1990; Stampfl & Levis, 1973) have cited this method as helpful for promoting strong feeling. In Stampfl's behaviourally-based *implosive therapy*, for example, this method involves the therapist describing, in increasingly precise detail, a situation that the client finds threatening, anxiety-producing, and frightening. The therapist's aim is to intensely expose the client, in the session, to this feared situation. "In therapy ... I am going to try to reproduce what [the client] is afraid of" (Stampfl, 1976, p. 65). As threatening situations are vividly

described, the client experiences strong feeling.

An entertaining clinical example is found in Stampfl (1976), in which this method is employed with a female client who has a long-standing phobia of bugs, and also has an intense fear of marriage. The therapist guides the client through a fantasy in which (a) she encounters a vividly-described, repellent black bug; (b) she tries to kill it with her shoe, but oddly the bug increases in size, and suddenly hundreds of other bugs appear; (c) she becomes engulfed by bugs -- they swarm into her mouth and ears and nose; (d) she meets a vividly-described giant, hideous, king bug who hates her, embraces her with his tentacles, and repeatedly kisses her; (e) she herself is transformed into a bug; (f) she is married to a bug in a formal ceremony complete with a bug minister and all-bug wedding party; and finally (g) "with cinema-scopic veracity and attention to detail, she imagines herself living with the insect who, sure enough, turns out to be a particularly cruel and vicious bug husband" (Stampfl, 1976, p. 67). During this process, the client becomes immersed in the threatening situation, and experiences intensely strong feeling.

There seems to be no research that has looked at the helpfulness of this method in promoting strong feeling.

(14) *Vividly describing-clarifying a risky (impulsive, shocking, threatening) behaviour as if it were being carried out by the client*. In the clinical literature, authors from existential-experiential approaches (Close, 1970; Farrelly & Brandsma, 1974; Shorr, 1972; cf. Mahrer & Gervaize, 1984) have cited this method as effective in promoting strong feeling -- particularly in the form of strong laughter. This method involves the therapist offering a concrete, detailed description of a threatening (risky, outlandish, unusual) behaviour as if it were being carried out by the client. The therapist is to describe it with pleasurable, impulsive, good feeling. The

therapist's tone and manner conveys a sense of enjoyment at the client doing the behaviour. The postulated client consequence is strong laughter.

Research evidence (Gervaize et al, 1985; Mahrer et al, 1987) suggests that this therapist method does tend to facilitate strong hearty laughter. Here is an example taken from an actual studied session:

> T: So you tell your parents, right there at the table, "I'm gay!"
> P: (Strong laughter.) That's it! They'd die! Hell, I'd die! (Strong laughter.) (Mahrer et al, 1987, p. 85).

In this instance, strong laughter was judged to have been promoted by the therapist's prior descriptions of a risky (anxiety-provoking) behaviour as if the client were carrying it out.

(15) *Carrying out (acting out, role-playing) a risky behaviour as/for the client*. This technique is designed to spur the client to strong feeling by giving him/her a vicarious taste of what it would be like to carry out behaviours that are risky (threatening, tempting) to the client. For example, Shorr (1972) writes about "The Therapist's Scream", in which the therapist forcefully screams out threatening (tabooed, risky) words that the client wants to say to another person, but is afraid to. Once the therapist has carried out the threatening behaviour, it then may be easier for the client to 'take the plunge' and join in with strong full feeling (Shorr, 1972; cf. Daldrup et al, 1988). In a similar vein, Mahrer (1989a) talks about the usefulness of the therapist being the expressive voice of the feeling:

> You can increase the feeling by being the expressive voice. Whatever the feeling, you give it direct and straightforward expression. Say it as if you are the patient. In this sense, you are being the model or exemplar, showing the patient how to express the feeling, how to give it voice (Mahrer, 1989a, p. 28).

In the research literature, Gervaize et al (1985) found that strong laughter tended to follow when therapists employed this method. Nichols (1974) also found evidence for the usefulness of role-playing techniques such as this in promoting strong feeling.

(16) *Explicitly stating something that the client is implicitly feeling (thinking, experiencing), but is reluctant to say*. This technique is used frequently in *provocative therapy* (Farrelly & Brandsma, 1974; Farrelly & Lynch, 1987), and is geared specifically for promoting strong laughter. It involves the therapist saying the unsayable, making explicit what the client is feeling inside but is reluctant or afraid to say. Farrelly and Lynch (1987) describe this as an extension of Rogers' reflection technique (Farrelly & Lynch, 1987), but it is clearly a quite vast extension. Here is a very poignant example taken from a *provocative therapy* workshop involving Frank Farrelly working with a very distraught female client (a therapist who recently has lost two of her own clients through suicide):

> **T:** (touching her knee, in a loud, nonchalant tone of voice) OK, Frieda, what's the problem?
> **C:** (in a trembling voice) Uhm...I've had...(catches her breath) two suicides within the last 3 weeks and I've been primary therapist...responsible.
> **T:** (flatly) Yeah.
> **C:** Uhm, and they both did it after they left the hospital.
> **T:** (flatly) Yeah.
> **C:** (struggles on painfully) And I've had this lump in my throat for the past (her voice breaks) 2 days. Friday I went to the second -- (struggles for emotional control; audible intake of breath), and uh, (pauses, sharp intake of breath) I haven't... I told the mother (her voice breaks piteously) that I was sorry...(long pause; on the verge of tears, she smiles fleetingly, raises her hands, palms upward, and lets them fall helplessly in her lap, continues in a choking but perky and jaunty tone of voice) That's it.
> **T:** (maintaining eye contact steadily; abruptly, in a flat tone of voice) So you killed them.
> **C:** (astounded, bursting out laughing in a choked tone of voice) Oh, shit!

(gasping and laughing; several in audience laugh uneasily) Give me a break!
(half crying, half laughing) I mean, damn! (gasping with lump-in-the-throat laughter)
T: (interjecting laconically, slowly) Well, "give me a break"??
I mean Frieda, for God's sake...
C: (gasping with astonishment and laughter) OH! Shi---
T: (continuing blandly) Sounds like your therapy is like cyanide.
C: (doubling over with laughter) Ohhh!....
T: (finishing nonchalantly) For God's sake.
C: (continuing to gasp with laughter)
T: ("innocently") Huh? (Farrelly & Lynch, 1987, p. 92).

There seems to be no research data on the usefulness of this method for promoting strong laughter in particular, or strong client feeling in general.

(17) *Responding with excited pleasure (welcoming, approval) following the client's carrying out of a risky (wicked, unusual, tabooed) behaviour*. According to Farrelly & Brandsma (1974), strong feeling -- specifically in the form of strong laughter -- tends to ensue if the therapist expresses sheer delight and excitement at the client's actually carrying out of a risky (unusual, threatening) behaviour in the session. Farrelly gives an example of a client who typically comes to her therapy sessions looking "lost" and acting unsure, and who has difficulty deciding which chair to sit in. One session, as she is meekly trying to choose a chair, she suddenly blurts out, "Pt: (straightening up, frowning, loudly and forcibly) 'Aw, go to hell! I'll sit where I want!!' " (p. 181). The therapist expresses sheer welcoming and excited pleasure at this unusual, risky behaviour, which sends the client into bursts of strong laughter (Farrelly & Brandsma, 1974; cf. Mahrer & Gervaize, 1984).

Research support for the effectiveness of this method in promoting strong laughter is provided by one study (Gervaize et al, 1985).

(18) *Offering a playfully exaggerated (ridiculous, absurd, theatrical, caricatured) explanation/description/interpretion of the client*. In the clinical literature, a number of writers (e.g. Ansell, Mindess, Stern, & Stern, 1981; Farrelly & Brandsma, 1974; Farrelly & Lynch, 1987; Greenwald, 1975; Killinger, 1987; Kopp, 1964; Mahrer & Gervaize, 1984; Pierce et al, 1983; Poland, 1971; Searles, 1963; Whitaker et al, 1962) have described the usefulness of this method in promoting strong feeling -- specifically in the form of strong laughter. This method involves the therapist offering (or even acting out) a highly exaggerated, wild, caricatured, burlesqued description of the client.

In the research literature, one study (Gervaize et al, 1985) looked at the usefulness of this method for promoting strong laughter, and findings were supportive.

(19) *Engaging in an emotionally-charged (encountering) interaction with the client*. One variation of this method involves the therapist openly exposing, revealing, or disclosing his/her genuine reactions to the client, the client's behaviour, and the therapy situation. The therapist is open with the client, is ready and willing to "encounter" the client and to engage in emotionally-charged interactions with the client (Farrelly & Lynch, 1987; Malone et al, 1961; Schutz, 1973; Whitaker et al, 1959). Another variation (cf. Cashdan, 1988) is for the therapist to first identify the role that the patient (through his so-called "projective identifications") seems to be trying to force-manipulate the therapist into playing, and then to intentionally not play this role. The therapist's refusal to comply with the patient's will create a therapeutic atmosphere that brings the therapist-patient encountering relationship to centre-stage, and is postulated to induce frustration, anger, and other strong feeling reactions in the patient.

Although the notion that these sorts of "encountering" methods are useful for promoting

strong feeling is a relatively established one in terms of the clinical-theoretical literature, the research literature does not seem to have addressed this issue at all.

(20) *Making humorous comments, gestures, or jokes.* In the clinical literature, some writers (e.g. Ansell et al, 1981; Farrelly & Brandsma, 1974; Greenwald, 1975, 1987; Killinger, 1987; Pierce et al, 1983; Rose, 1969; Shorr, 1972) assert that strong laughter can be facilitated if the therapist is able to capture the humorous side of the here-and-now moment -- especially at times in the session when the client is attending to material that is anxiety-provoking or conflictual:

> At such times, ...any comment that shifts the client's perspective -- that suddenly lightens or relieves anxiety -- is experienced as funny... At times like these, ...even raising a finger, or repeating a word may be enough to prolong the laughter for several minutes (Pierce et al, 1983, p. 67).

A therapist's joke or gesture will tend to facilitate client laughter, then, to the extent that it spurs a sudden shift in the client's perspective. In a disguised way, humorous comments or gestures by the therapist can help "circumvent the client's defenses, allowing expression of wishes and feeling that would otherwise remain hidden" (Pierce et al, 1983, p. 67; cf. Ansell et al, 1981; Farrelly & Lynch, 1987; Shorr, 1972).

No direct research appears to exist on the effectiveness of this method for promoting strong laughter in particular, or strong client feeling in general.

(21) *Touching, holding, or engaging in physical contact with the client.* Holding and touching the client has been cited by some clinical authors (e.g. Casriel, 1972; Farrelly & Lynch, 1987; Lowen, 1975; Pierce et al, 1983) as useful in promoting strong feeling, especially in forms such as crying, anger, and fear: "The expression of both fear and sadness is greatly facilitated by

close, warm body contact. Again and again, clients who are not expressing their feelings fully begin to do so when they are held" (Pierce et al, 1983, p. 73). For example, in Casriel's (1972) bonding technique, the therapist gently lays on top of the client, thus providing the client with a feeling of safety and support, and enabling intense emotional expression. "Although strange to imagine from a written account, this technique can be a very powerful cathartic tool" (Pierce et al, 1983, p. 41).

Alternatively, the therapist may use his/her body as an "object" or "environment" against which the client can safely achieve direct, full physical expression of feelings such as anger or self-assertion. For example, the therapist may block a doorway, challenging the client to push and struggle in order to gain passage through the door. Or, the therapist may push the client into a corner, encouraging him/her to push back (Pierce et al, 1983). In using physical contact in this way, the therapist can effectively promote the expression of strong client anger, defiance, and strength.

Another postulated useful way of promoting strong feeling is for the therapist to touch areas of the client's body that the therapist views as chronically tense and rigid in order to release blocked feeling. This way of evoking strong client feeling is commonly used in body therapies such as *bioenergetics* (Lowen, 1975) and *feeling-expressive therapy* (Pierce et al, 1983). For example, the therapist might "unblock" chronic muscular "expressions" of anger in a client's jaw or forehead by gently pressing his/her thumbs against the rigid, tense muscles until an emotional release occurs. In touching the client in this way, the therapist invites the client to "... give voice to the feeling that previously had been 'shut up' inside" (Pierce et al, 1983, p. 74).

There seems to be no research on whether this method helps to promote strong feeling.

In-Session "Client Conditions" Related to Therapist Methods of Promoting Strong Feeling

Many clinical theorists and researchers talk about the importance of *timing* in the effective application of therapist methods for promoting strong feeling (e.g. Greenberg & Safran, 1987; Labott, Elliott, & Eason, 1992; Mahrer et al, 1986b; Pierce, Nichols, & DuBrin, 1983; Shorr, 1972). In the field of psychotherapy process research, investigators have addressed this *timing* issue by using the notion of "in-session client conditions" to refer to how the client is being-behaving at a particular point in the session (Grater & Claxton, 1976; Mahrer, 1988; Wampold & Kim, 1989). This process meaning of the term "client condition" contrasts sharply from the common meaning of the term "client condition" -- i.e. the client's psychiatric diagnosis at the outset of therapy.

Timing is clearly a crucial element in the application of the 21 methods in the preceding list. In fact, in many of the 21 methods, there was an inherent "client condition", usually stated more implicitly than explicitly, referring to when the therapist was to employ a particular method for promoting strong feeling. Thus, it seems important here to include a subsection that reviews the "in-session client conditions" discussed in the clinical and research literature as they relate to the useful application of strong-feeling-promoting therapist methods. Given that the existing literature typically lacks precision on this issue, the four "in-session client conditions" described below are more or less broad, global, and indistinct.

(a) *The client is experiencing a sense of safety, and is experiencing a strong alliance, (therapeutic relationship) with the therapist*. One pre-condition mentioned by many authors is that the client must feel safe: "[Clients] need to feel safe in their relationship with the therapist if they are to discharge their feelings" (Pierce, Nichols, & DuBrin, 1983, pp. 42-43; cf. Butler &

Strupp, 1991; Daldrup et al, 1988; Greenberg & Safran, 1987; Guidano, 1991; Rice & Greenberg, 1991; Safran & Greenberg, 1991b; Shorr, 1972; Silberschatz & Sampson, 1991). "Through the affirming, prizing, nonjudgemental attitudes of the therapist the person feels able to allow the feeling" (Rice & Greenberg, 1991, p. 202). "When the client is feeling safe..., feelings bubble forth and seek expression with surprising force" (Pierce, Nichols, & DuBrin, 1983, p. 56). Empirical support for this notion comes from Silberschatz (1986), who found a significant correlation between the degree to which a therapist's behaviours and interpretations increase the patient's sense of safety and the patient's level of feeling expression (cf. Gassner, Sampson, Brumer, and Weiss, 1986; Silberschatz, Fretter, & Curtis, 1986). Moreover, in a recent study in which an in-session "weeping" event was analyzed (Labott, Elliott, and Eason, 1992), it was judged that an important pre-condition for the event's occurrence was that the client was experiencing a sense of safety, and a strong alliance with the therapist.

(b) *There is some measure of feeling already present in the client's words*. Many authors who talk about strong client feeling speak about listening for the client's feeling, and using various techniques to amplify that already-present feeling (e.g. Dosamantes-Alperson, 1981; Greenberg & Safran, 1987; Kutzin, 1980; Pierce, Nichols, & DuBrin, 1983; Mahrer, 1989a; Sacks, 1976; Sheiner, 1966). Research support for this notion comes from Mahrer et al (1986b) who studied a session in which strong client feeling occurred, and found that an important pre-cursor to the strong feeling was that client was *communicating expressively*. They called this client condition "experiential readiness".

(c) *The client is in the near vicinity of being-behaving some way which is risky (ordinarily blocked or avoided, excitedly threatening, wickedly impulsive).* This pre-condition is

cited in an empirical study of in-session strong client laughter (Gervaize et al, 1985), and is implied in many of the 21 methods stated above. In this client condition, the client is close to doing something and being some way that is unusual, risky, threatening, impulsive.

(d) *The client's attention is centered on a strong-feelinged scene-situation*. This pre-condition has been cited by Mahrer (1989a, 1996). In this client condition, a large degree of the client's attention is centered on a scene-situation -- past, present, future, or fantasied -- that is emotionally-charged, compelling, and feeling-laden.

Summary of the Clinical and Research Literature on Therapist Methods of Promoting Strong Feeling

Given that many practitioners value strong feeling events in their sessions, it is surprising and unfortunate that there has been so little research on how therapists can bring them about. Leading figures in the psychotherapy process research field have acknowledged this as a problem, and are calling for more systematic, empirical research (cf. Greenberg & Safran, 1987; Labott, Elliott, & Eason, 1992; Safran & Greenberg, 1991b).

In the absence of any research-based category system delineating therapist methods helpful for promoting strong feeling, or even a theory-based one, the existing literature was organized into a list of 21 different therapist methods -- coming almost exclusively from clinical writings as opposed to research -- that have been cited as helpful in promoting strong client feeling, either in general, or in specific forms (e.g. laughter, anger, fear, sadness). Furthermore, because *timing* was clearly a crucial implied element in the application of the 21 methods, a subsection was included reviewing four "in-session client conditions" mentioned in the clinical and research

literature as important "pre-cursors" to the useful application of strong feeling therapist methods.

It is noteworthy that the list of 21 strong-feeling methods includes writings of theorists from a wide variety of psychotherapeutic orientations. In fact, the list includes authors from all four of (what are generally acknowledged as) the main families of therapy -- psychodynamic-psychoanalytic, humanistic-experiential, cognitive-behavioural, and integrative-eclectic.

The 21 therapist methods are somewhat overlapping, and at varying levels of abstraction. In presenting them, the aim was not to articulate testable hypotheses. The aim was simply to organize the literature so that it could later be compared with richly detailed, research-based, practitioner-relevant descriptions of therapist methods of promoting strong feeling -- the generation of which will be the second major objective of the present investigation.

The Proposed Research Question: *What Therapist Methods, Employed Under What In-Session Client Conditions, are Judged as Helpful in Promoting Strong Client Feeling?*

A conspicuous gap in the current literature seems to be an organized set of richly unabridged, research-based, practitioner-relevant, "how-to-do-it" descriptions of actual *methods* that therapists can employ to help promote occurrences of strong feeling in their sessions. Thus, this study aims to begin filling this hole by addressing the following research question: *What therapist methods, employed under what in-session client conditions, are judged as helpful in promoting strong client feeling?* The key focus, therefore, is on describing therapist methods of promoting in-session occurrences of strong feeling. Moreover, as an additional, secondary interest, the present study will investigate whether strong-feeling-methods tend to vary across: (a) different kinds of strong feeling; (b) different psychotherapeutic approaches; and (c) different

temporal eras-decades (e.g. sessions from the 1980s vs. 1970s vs. 1960s). An explanation of the research strategy will follow in the next chapter.

CHAPTER 3

METHODOLOGY

The purpose of this study is to investigate two research questions -- (a) *What therapist methods, employed under what in-session client conditions, are judged as helpful in promoting strong client feeling?*; and (b) *When strong feeling occurs in the session, how do therapists use it?*

With these research questions formulated, the aim in this chapter is to describe and justify the chosen methodology for answering them. Toward this end, the bulk of this chapter is devoted to discussing and weighing various methodological options, with an eye on previous research. This will be followed by a detailed presentation of the methodology employed in this study. The chapter will close with a description of the format that will be used to present the results.

Weighing and Choosing Methodological Strategies

Some key methodological issues, as they relate to our particular research questions, are: (a) what general research strategy to use; (b) how to arrive at the most useful kind of data; (c) whether to select sessions with single and/or multiple instances of strong feeling; (d) whether or not to include intake (assessment, diagnostic) sessions; (e) whether to select a relatively large group of varied therapists vs. a group of therapists representing a single therapeutic approach; (f) whether to study experienced vs. relatively inexperienced therapists; (g) the number and kind of judges to use; (h) how to categorize sessions according to family of psychotherapy; (i) whether or

not to include severely "unhealthy" patients; (j) how to identify the occurrence of in-session strong feeling events; (k) how to obtain precise, clinically-relevant descriptions of the nature of these strong feeling events (once they have been initially flagged); (l) how to group/categorize different kinds of strong feeling; (m) how to describe the antecedent therapist methods that seemed to facilitate the occurrence of each strong feeling event; (n) how to describe how the therapist, after the occurrence of each strong feeling event, seemed to use it subsequently in the session; and (o) how to group/categorize different therapist methods and therapist uses linked to strong feeling.

The purpose of this section is to discuss each of these methodological issues, with an eye on previous research, so that we can describe and justify the strategies that we chose to answer our two research questions.

(a) What General Research Strategy to Use

Keeping in mind our research questions, and the methodologies employed in previous psychotherapy process studies, there seemed to be three general strategies from which to choose: an outcome design, a hypothesis-testing process design, and a more discovery-oriented, knowledge-generating strategy.

An Outcome-Focused Research Design. This type of strategy would involve pre-post measures of client improvement. As was indicated in chapter one, the bulk of past research relating to the *therapeutic use* (value, desirability, importance) of strong feeling has adopted this sort of strategy. However, this kind of approach does not fit with our chosen research questions.

Our questions limit the focus and scope of our investigation to what occurs in the therapy session itself. Therefore, adopting any sort of outcome design -- in which the client's level of adjustment (health, functioning) is measured at the start and end of a course of treatment -- would have been impractical. If we had adopted an outcome design, we could not have answered our research questions.

A Hypothetico-Deductive Strategy. This method emphasizes theory verification, hypothesis-testing, and quantification. It involves deducing hypotheses from existing theory and/or research, and then testing them. Translated in terms of our research questions, this strategy would have involved framing *therapist methods* of promoting strong feeling, and *therapeutic uses* of strong feeling in terms of concrete hypotheses, and then putting these hypotheses to the empirical test.

At first blush, this type of strategy appeared potentially workable. In fact, to investigate therapist methods of promoting client events (such as strong feeling), some past studies have adopted this sort of research strategy. Greenberg and his colleagues (Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Rice, 1981) adopted a hypothesis-testing design in attempting to identify therapist methods effective in promoting client resolution (integration) of two previously opposing aspects of self. Even closer to our particular topic, Gervaize, Mahrer, and Markow (1985) used a hypothesis-testing strategy to test the effectiveness of therapist methods, derived from theory, postulated to be effective in promoting strong laughter. So, some previous researchers have selected hypothesis-testing designs to study questions similar to ours.

Nevertheless, in terms of addressing our research questions, there was a compelling

argument against choosing this sort of method. Quite simply, in order to adopt a hypothetico-deductive strategy, we would need precise, useful, testable hypotheses (cf. Bakeman & Gottman, 1986; Elliott, 1984; Greenberg, 1984b; Rennie et al., 1988). Indeed, a hypothesis-testing strategy assumes that answers to the research questions already exist in the literature, and need only to be verified in laboratory conditions (cf. Ashe, 1977). Here, this was far from the case. Clearly, the lists of 21 *therapist methods* and 6 *therapeutic uses* outlined in the earlier chapters were my best attempts to organize the existing literature -- in the absence of research-based category systems of therapist methods and therapeutic uses linked to (different kinds of) strong feeling. The categories in these lists were relatively unrefined, somewhat overlapping, at varying levels of abstraction, and often quite vague and unspecific. It would thus have been very difficult or impossible to frame them as meaningful, useful hypotheses.

Here are some further, related considerations. First, if we had chosen to frame hypotheses, given the imprecision of the existing literature, they would have been speculative at best, and therefore the probability of their falsification would have been inflated. Second, for most of the 21 described therapist methods, there were implicitly or explicitly stated *in-session client conditions* under which these methods were to be applied. Hypothesis-testing would almost certainly have led us to ignore these important contextual intricacies -- the collaborative, interlocking, time-specific interplay between therapist and client -- which are an integral part of the application of these methods. This would have been a major sacrifice; consideration of the precise *timing* of therapist operations is crucial if our findings are to be relevant to practitioners and to contribute to the advancement of process theory (cf. Elliott, 1983a, 1984; Greenberg,

1984b, 1986; Labott et al., 1992; Mahrer, 1988; Rice and Greenberg, 1984). In order to pay adequate attention to this important factor of context (in-session client conditions) within a hypothesis-testing design, it would have been necessary to frame hypotheses with so many cumbersome provisions that phrasing the hypotheses would have become next to impossible. A third problem with testing the lists of 21 *therapist methods* and 6 *uses* as hypotheses is that refutation of the null hypothesis would not seem to sensibly apply in their case. For instance, if we test a given method of promoting strong feeling against the null hypothesis, we are postulating that strong feeling is the only (or major) effect that will be caused by this particular method. Based on the literature, there is no basis to assume this. In fact, given the complexity of therapist-client interactions, there might well be multiple consequences to be expected from the application of any of the 21 methods, of which strong feeling is but one. Moreover, if we test a given method of promoting strong feeling against the null hypothesis, we are erroneously assuming that we believe these methods will always (or even usually) work effectively to bring about strong feeling. It might be, for example, that applying a given method is followed by strong feeling 25% of the time. Is this grounds for rejecting the null hypothesis, and concluding that a method is effective for promoting strong feeling? Perhaps not. But from a practitioner-relevant standpoint, this finding could represent the beginning of a more careful dissection of what made this method effective 25% of the time, and how these successful applications were different from the 75% which were not effective. This is opposed to a hypothesis-testing approach, in which the method would be statistically dismissed as insignificant, and discarded.

Based on these considerations, we decided not to adopt a hypothesis-testing strategy as a

way of answering our research questions. To put it simply, if we selected a hypothesis-testing strategy, we would be assuming that answers to our research questions were somehow already buried in the existing literature, and that all we must do is verify what is already there (cf. Ashe, 1977). For our subject area, this is just not true. An alternative strategy seemed more appropriate.

A Discovery-Oriented Strategy. This kind of strategy emphasizes *knowledge generation (discovery)* over *verification*. The focus is on inductive examination of the data, an empirical "hunt" for new knowledge, on letting the phenomena under study uncover themselves to the researcher -- instead of the more traditional approach of using data to test and verify existing theory and research (cf. Elliott, 1984; Greenberg, 1984a; Mahrer, 1988, 1996b; Rennie et al., 1988; Rice & Saperia, 1984; Von Eckartsberg, 1971). Such an approach provides an opportunity to develop knowledge in subject areas that are difficult to access with traditional research methods, and is regarded as essential in subject areas that are in their "infancy", where the existing knowledge is akin to a dark, cluttered attic (Rennie et al., 1988). Increasingly in recent years, psychotherapy process researchers have argued that, if psychotherapeutic practice is to ever progress from its present state as an art form based on conjecture and intuition toward a determinate science, researchers must abandon (for now at least) verification, hypothesis-testing procedures (cf. Elliott, 1984; Greenberg, 1984b; Mahrer, 1988).

Thus, in recent years, there has been a conspicuous influx of discovery-oriented and qualitative approaches into the field of psychotherapy process research. Some examples are *grounded analysis* (Glaser & Strauss, 1967; Rennie et al., 1988), *discovery-oriented research*

(Mahrer, 1985, 1988), *interpersonal process recall* (Elliott, 1984), and *task analysis* (Greenberg, 1984a; Rice & Greenberg, 1984; Rice & Saperia, 1984). These strategies have been used in describing the client's subjective experience of psychotherapy (Rennie et al., 1988). They have also been used to study therapist methods facilitative of significant client events in therapy (Elliott, 1983; Greenberg, 1984a; Mahrer et al., 1986b, 1992a, 1993), including strong feeling events (Labott, Elliott, & Eason, 1992; Greenberg, 1984a; Mahrer et al., 1991, 1992a).

Given the relatively barren state of the literature on in-session therapist methods and therapeutic uses linked to strong feeling, it seemed appropriate to choose a research strategy offering a systematic, powerful means for spurring knowledge-development and hypothesis-generation. An appropriate choice seemed to be a research methodology close to the general spirit of grounded analysis (Rennie et al., 1988), but specifically the methodology of discovery-oriented research (Mahrer, 1988, 1996b). The emphasis thus would be placed on an intensive, inductive analysis of the data.

It should be noted that -- although we did not actually test the 21 therapist methods of promoting strong feeling reviewed in chapter one, or the 6 therapeutic uses of strong feeling reviewed in chapter two as actual hypotheses -- this did not mean that this existing literature was disregarded or dismissed as irrelevant. On the contrary, existing theory and research provided a valuable point of comparison to what emerged in our research findings. To the extent that our findings would overlap with (corroborate, relate to) existing therapist methods and uses, these findings would tend to lend some mild empirical support to existing theory and research. Where our findings would depart from (extend, augment) the existing literature, we would be discovering

something new. In any case, the focus would be on leaving the door wide open to uncovering new methods and uses that had not been mentioned in previous theory or research, rather than using the existing, sparse literature for generating hypotheses to be put to a rigorous test of verification.

(b) The Most Appropriate Form (Source) of Data To Use

Previous research seemed to offer three possibilities: data from an *analogue* psychotherapy situation; data from a contrived "real" psychotherapy situation; and data from recordings of actual therapy sessions containing instances of strong feeling. These three options are discussed below.

Use data from an *analogue* psychotherapy situation. Using analogue data involves the creation of a laboratory situation in which non-clients and non-therapists are involved in an interaction that is taken to be generalizable to an actual psychotherapy situation (e.g. Bohart, 1977; Hudgins & Kiesler, 1987; Kazdin & Krouse, 1983; cf. Nichols & Zax, 1977). For example, in a study that related to strong feeling, Bohart (1977) used an analogue design to test the therapeutic effectiveness of various methods (including participants' discharge of strong feeling) for reducing anger. The advantage of analogue studies is that they enable the generation of data that is the result of controlled, experimental manipulation. This sort of data is highly conducive to the testing of pre-selected hypotheses. However, this kind of data would be inappropriate in a non-experimental study such as this, in which there are no pre-determined hypotheses, and no variables undergoing manipulation.

Use data from a real psychotherapy situation that is manipulated to address our research questions. This research method involves a hypothesis-testing, controlled manipulation, in which clients are exposed to controlled, specific treatment conditions, and the effects of the treatment measured in some way. Psychotherapy process studies that have used this source of data have been geared toward the experimental testing of hypotheses about psychotherapeutic methods or aspects of theory (e.g. Nichols, 1974). In our case, selecting this sort of strategy might have involved, for example, exposing clients to particular strong-feeling-promoting methods, and testing whether or not they were effective in getting strong feeling. Clearly, however, this methodology would beg our research questions. If we knew how to manipulate the psychotherapy situation, then we would already know the answers to our research questions. We would already have access to hypotheses (i.e. particular therapist methods, and particular therapeutic uses) that we feel are testable, precise, and concrete. If this were the case, we would have already answered our research questions.

Use data consisting of recordings of *actual psychotherapy sessions* that contain instances of strong feeling. Other process researchers have elected to analyze recordings of actual psychotherapy sessions that contain client events regarded as valuable (significant, useful) in order to study therapist-client interactions preceding and following these events, or therapist methods related to the occurrence of these events (e.g. Elliott, 1983; Gervaize et al., 1985; Greenberg, 1984b; Greenberg & Rice, 1981; Labott, Elliott, & Eason, 1992; Mahrer et al., 1986b, 1989, 1990a, 1991a, 1992a, 1994).

For the purposes of answering our research questions, choosing this source of data

seemed wholly appropriate. Indeed, given the aims to investigate how therapists promote strong feeling events, and how they use them once they have occurred, it seemed natural to study actual psychotherapy sessions in which strong feeling events occurred. Using this source of data would provide us with a bounty of actual, naturally-occurring instances of strong feeling, and would thus provide a fertile ground from which to intensively study these events (and the therapist-client interactions surrounding them) in order to answer our research questions.

(c) Selection of Sessions: Whether to Include Sessions with *Single* vs. *Multiple* Occurrences of Strong Feeling

The issue here was to decide whether to select sessions that included *single*, isolated occurrences of strong feeling, or whether to limit selection to sessions containing ***multiple*** instances of strong feeling. For a number of reasons, the latter choice seemed to be more advantageous.

One reason relates to the prevailing theme in the literature (as discussed in chapter 1) that most therapists do not value strong feeling at all times, with all patients. The implication is that most therapists likely value strong feeling in some, not all, of their sessions. Therefore, for the purposes of this study, it seemed important to select tapes in which the possibility was minimized that we would be studying sessions in which the therapist was not valuing (welcoming, desiring) occurrences of strong feeling. It seemed reasonable to presume that choosing sessions with multiple instances of strong feeling might provide a relatively good safeguard in this respect. Indeed, it is logical to assume that sessions with multiple instances of strong feeling (as opposed

to sessions with one single instance of strong feeling) would more likely be ones in which the therapist was emphasizing strong feeling's occurrence, and was actively working with strong feeling. In sessions with one sole instance of strong feeling, the probability would likely be somewhat higher that the occurrence of strong feeling was spurious (accidental, inadvertent), as opposed to actively promoted (valued, welcomed).

A second, closely-related reason stems from our aim of maximizing our yield of therapist methods and therapist uses related to strong feeling. It would seem that our yield would be enhanced if we selected sessions where the therapist seemed to be clearly valuing, promoting, and actively working with strong feeling. Given that we were aiming to identify concrete methods that promoted strong feeling, and concrete uses of strong feeling, it seemed sensible to select sessions in which the chances were enhanced that the therapist was actively trying to promote and work with strong feeling. Indeed, if we studied spurious (inadvertent, random) strong feeling events, chances are that our yield would have been very low in terms of therapist methods and uses. In short, it seemed likely that our potential "pay-off", in terms of maximizing our yield of methods and uses, would be higher with sessions with multiple instances of strong feeling as opposed to single, isolated instances.

A third reason is that including both "single" and "multiple" strong feelings sessions would likely have necessitated analyzing the results in terms of whether these two kinds of tapes differed in terms of the therapist methods and therapist uses found. Indeed, given our reasons to suspect that "single" vs. "multiple" tapes might differ according to whether strong feeling events were spurious (accidental, unwelcome) vs. intentional (desired, valued), it would have been necessary

to check the results systematically for differences. Rather than creating the necessity of such a comparison, it seemed more reasonable to limit study at the outset to the more homogeneous group of tapes where strong feeling occurs on multiple occasions.

A fourth reason stems from the clinical literature (as reviewed in chapter 1) suggesting that the therapeutic uses of strong feeling often imply a *carrying forward* or *sustaining* of strong feeling over the course of a session. Indeed, although not exclusively the case, many of the described processes of using strong feeling seemed to include an element of keeping the strong feeling going, having it occur over an extended duration, or having it happen repeatedly over the course of the session. In the light of this literature, and given that this study aims to understand as much as possible about the processes by which strong feeling is used, it would seem imprudent to have selected tapes that, by definition, excluded the possibility of investigating how strong feeling might be carried forward, sustained, and used in this way. Indeed, it would seem that choosing tapes with multiple instances of strong feeling would better enhance the possibility of understanding the processes by which strong feeling is used in the session.

In summary, based on the reasons stated above, the choice was to limit our selection to sessions that included ***multiple*** instances of strong feeling -- and to exclude sessions with *single*, isolated instances of strong feeling.

(d) Selection of Sessions: Whether to Include Initial, Intake Sessions

The issue here was whether to include or exclude intake sessions that were the first in a series of sessions, and that emphasized the gathering of diagnostic-historical information. For the

same sorts of reasons just used to argue against the inclusion of sessions with "single" strong feeling instances, the inclination was to exclude intake (assessment, diagnostic) sessions.

Given our aims of identifying concrete methods that promote strong feeling, and concrete uses of strong feeling, it seemed sensible to select sessions in which the chances were enhanced that the therapist was actively trying to promote and work with strong feeling. Based on this criterion, intake sessions would likely not be particularly good sessions to study. After all, intake sessions typically involve the collection of diagnostic-historical data, and strong feeling occurrences may be regarded as interfering with this information gathering process (Skodol, 1989). So, with intake (assessment, diagnostic) sessions, it seemed that the possibility of spurious (inadvertent, random, unwelcome) strong feeling events might be increased, and the possibility of obtaining valued (intentionally facilitated) strong feelings might be lowered. Assuming that this is the case, intake sessions would tend to have less potential for yielding strong-feeling-methods and strong-feeling-uses than would actual "working" sessions.

Moreover, if we had elected to include both "intake" and "non-intake" sessions, it would have been important to analyze the results in terms of whether these two kinds of tapes differed in terms of the therapist methods and therapist uses found. Indeed, given our reasons to suspect that "intake" vs. "non-intake" tapes might differ according to whether strong feeling events were spurious (accidental, unwelcome) vs. intentional (desired, valued), it would have become necessary to check the results systematically for differences. Rather than creating the necessity of such a comparison, it seemed more reasonable to limit study at the outset to the more homogeneous group of "non-intake" tapes.

Therefore, in order to address our research questions, we wanted to select sessions that would tend to enhance our potential for identifying therapist methods and therapist uses related to occurrences of strong feeling. Our inclination was to exclude intake (assessment, diagnostic) sessions because it seemed likely that therapists might be less focused (than in later sessions) on actively promoting and working with strong feeling, and might tend to view strong feeling occurrences as an impediment to the primary goal of gathering diagnostic-assessment information. In our view, it seemed that our potential "pay-off", in terms of maximizing our yield of methods and uses, would be increased if we limited our study to "non-intake" sessions in which there was heightened probability that therapists were clearly valuing, promoting, and actively working with strong feeling.

(e) Therapists: A Relatively Large Group Representing Different Therapies vs. A More Narrow Group Representing One Single Therapeutic Approach

Some psychotherapy process studies have limited their analysis to sessions involving therapists from one therapeutic approach (e.g. Elliott, 1984; Greenberg, 1984b; Hill & O'Grady, 1985; Labott et al. 1992; Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984; Mahrer et al., 1986b, 1992a; Marmar, Wilner, & Horowitz, 1984; Martin, Martin, & Slemon, 1987), while others have included a variety of therapists representing different therapies (e.g. Gervaize et al., 1985; Mahrer et al., 1987, 1989, 1990a, 1994). In answering our research questions, we wanted to be able to provide practitioners with a maximum "yield" of different *therapist methods* of promoting strong feeling and *therapeutic uses* of strong feeling. Thus, it seemed reasonable to

include a relatively large group of therapists representing a broad spectrum of therapies. Likely, a maximum "yield" of diverse methods and uses would come from studying a relatively broad variety of therapists, rather than a narrow band. Furthermore, we were swayed by the likelihood that our findings would be more generalizable if they came from studying the work of a relatively large, varied group of therapists (cf. Rennie, Phillips, & Quartaro, 1988).

(f) Therapists: Experienced vs. Relatively Inexperienced?

Another issue was whether to use trainee, graduate student therapists (cf. Labott et al., 1992), or whether to study more established, experienced, seasoned therapists (cf. Elliott, 1984; Mahrer et al, 1986b, 1989, 1991, 1992a). It seemed reasonable, for our purposes, to focus on more experienced, distinguished therapists. As stated above, our aim was to obtain a large yield of diverse methods of promoting and ways of using strong feeling. Experienced therapists are likely more competent at getting and using strong feeling, and thus it seemed probable that studying their sessions would provide more bountiful findings. Indeed, it seemed that studying a sample of distinguished therapists would be the best resource for investigating therapist methods and uses related to strong feeling because they, as opposed to more inexperienced practitioners, would just be more likely to produce these strong feeling events in their sessions, and to use them in skillful ways.

(g) Judges: Who, and How Many?

Regarding the *number* of judges to use, some previous studies have used one to three

judges (e.g. Elliott, 1983, 1984b; Greenberg, 1984a; Labott, Elliott, & Eason, 1992; Martin, Martin, & Slemon, 1987; Nichols, 1974; Rice & Saperia, 1984); whereas others have used four to eight or more (e.g. Hill, Carter, & O'Farrell, 1983; Hoyt, 1980; Kiesler, 1971; Mahrer et al., 1986b, 1989, 1990a, 1991a, 1992a, 1993; Wiser & Goldfried, 1993). Regarding *who* to use as judges, some studies have included only experienced clinicians (Hoyt, 1980; Nichols, 1974); others have used clinically naive undergraduate students (e.g. Kiesler, 1971); others have used a more varied group of judges -- including the client, the therapist, and the investigators (e.g. Elliott, 1983, 1984; Labott, Elliott, & Eason, 1992); and still others have used a varied group of clinically sophisticated judges including experienced clinicians, graduate students, and/or undergraduate students trained in the use of procedures (Hill, Carter, & O'Farrell, 1983, Mahrer et al., 1986b, 1989, 1990a, 1991, 1992a, 1994).

Given that we wanted our findings to be high in terms of both *objectivity* and *clinical relevance* of the obtained data, it seemed that using a small group of judges -- whether they were clinically sophisticated or not -- might be problematic (cf. Mahrer, Paterson, Theriault, Roessler, & Quenneville, 1986). Indeed, using a small group of *unsophisticated* judges might provide the appearance of hard objectivity through high interjudge agreement, but the results might tend to be devoid of genuine clinical relevance: "In the pursuit of high reliability and interjudge agreement, the serious problem is that researchers are busy studying clinically meaningless and irrelevant concepts. A sensitive concept such as therapist self-disclosure becomes objectified into the therapist's use of a first-person declarative sentence" (Mahrer et al., 1986c, p. 58). So, using a small group of clinical unsophisticated judges might provide objectivity at the expense of clinical

relevance. The opposite problem would have come into play if a small group of clinically *sophisticated* judge had been used: clinical meaningfulness may be higher, but objectivity will be sacrificed. A seasoned clinician is likely to be entrenched in the concepts of his/her own approach, and will naturally "see" the data (i.e. the therapist-client interactions in the session) through the lens of his/her particular theory. Response biases become a problem. Depending on the homogeneity or heterogeneity of the small group, interjudge agreement would tend to be artificially inflated or deflated. So, a small group of psychoanalytic judges might tend to obtain high interjudge agreement, but the results would be highly skewed in the direction of their particular therapeutic outlook. A more heterogeneous small group -- consisting of, say, a psychoanalyst, a feminist therapist, and a desensitization therapist -- might see things so differently that interjudge agreement would be extremely low. In sum, using a small group of judges, whether they were clinically sophisticated or unsophisticated, might have created problems in terms of maximizing both objectivity and clinical relevance of the findings.

Our reasoning was that, by using a large group of clinically sophisticated judges representing a broad band of therapies, these potential problems might be reduced. The objective rigor of the obtained data could be strengthened without diluting its clinical meaningfulness and relevance. The judges' clinical sophistication would allow for findings rich in clinical utility. Using a large and varied group could attenuate and cancel out response biases, and strengthen the objectivity of the findings (cf. Labott, Elliott, & Eason, 1992; Mahrer et al, 1986c).

(h) Categorizing Sessions According to *Family of Psychotherapy*

In order to assess whether our findings would vary for different families of psychotherapy, it would be necessary to categorize each session in terms of family of psychotherapy. More specifically, the issue was how to place sessions into a small number of meaningful categories of therapy -- given our intention of conducting quantitative analyses to describe potential relationships between therapist methods, uses, and families of psychotherapy. In terms of how to proceed methologically, there appeared to be two main options.

The first option would be to categorize tapes based on the self-identified orientation of the therapist. For example, a session by Fritz Perls would simply be categorized as Gestalt therapy on the basis of the name and known orientation of the therapist. Although this approach might seem viable at first blush, substantive problems might arise if this sort of strategy were chosen. This is because most therapists are not exemplars of approaches in the way that Fritz Perls is, and thus placing them in categories by self-identification might be a far less clear-cut procedure. Furthermore, there are currently so many different brands of therapy that being faithful to each therapist's self-professed, particular approach might conceivably mean using a separate orientation for just about each therapist.

A second, more attractive option would be to adopt a category system containing a relatively small number of larger therapeutic families, and to use the clinically-sophisticated ratings of the research team to place sessions into different categories. Although there exists no standardized category system of different families of psychotherapy, the most well-accepted categorization likely contains these four main groupings: *psychoanalytic-psychodynamic,*

cognitive-behavioural, *humanistic-experiential*, and *integrative-eclectic*. Using a broad, well-accepted 4-fold categorization such as this, it seemed viable and appropriate to rely on the clinical knowledge of the research team, and a high criterion level of inter-rater agreement, to arrive at a consensually correct designation of each tape according to its *family of psychotherapy*. As an added check to ensure meaningful, valid placement of each tape, it also seemed useful to ask the judges to state their level of certainty about their ratings.

(i) Patients: Inclusion vs. Exclusion of Patients Who Appear to Be Severely Unhealthy

The review of the literature of the therapeutic uses of strong feeling (included in chapter 1) revealed that most proponents of strong feeling would include "disclaimer clauses" to specify with whom and when they would value occurrences of strong feeling. Perhaps the most common stipulation was that it is unwise and risky to attempt to bring about strong feeling with patients who are relatively unhealthy, unstable, fragile -- for example, borderline patients, psychotic patients, undercontrolled patients (cf. Bergler, 1956; Engle et al, 1991; Koestner, 1964; Whitmont & Kaufmann, 1973). As I have mentioned a number of times, our aim was to maximize our yield of therapist methods and uses related to strong feeling, and to do this it seemed prudent to limit our study to psychotherapy sessions in which the chances were maximized that the therapist in question was actively valuing and working with strong feeling. Given the evidence in the literature that many or most "emotive" therapists would tend not to value or intentionally facilitate strong feeling with severely unhealthy patients, it seemed likely that sessions with these sorts of patients would not be especially good ones for us to study. In these sessions, our potential yield

for "methods" and "uses" related to strong feeling would probably be lower that it would be in sessions with more healthy, stable patients. Indeed, it seemed unlikely that such sessions would contain many instances of strong feeling that (a) would have been promoted by active, intentional therapist methods, or (b) would be viewed by the therapist as welcomed, desirable, or useful once they happened.

Accordingly, it would seem to make good sense to exclude sessions with patients who are exhibiting signs of severe psychopathology (e.g. psychosis, personality disorders). Because our data would consist of audiotaped sessions of therapy with patients who are anonymous, and whose psychiatric diagnosis (if applicable) was seldom available, it would be necessary to rely on the clinical judgement of the research team to exclude patients whose in-session behaviour suggested signs of severe psychopathology.

(j) Identifying the Occurrence of In-Session Strong Client Feeling Events

Any study that designates a client event for intensive process analysis must find a way of flagging the occurrence of the event. Previous studies -- some concerned with strong feeling, and some concerned with identifying other designated client events -- gave us different methodological options to consider.

Use physiological measures to identify the strong feeling event. Some past studies have attempted to measure increases in strength of feeling with *physiological measures* such as EEG, blood pressure, and pulse rate (e.g. Borkovec & Sides, 1979; Kozak, Foa, & Steketee, 1988; Lang, 1977; Orenstein & Carr, 1975). The patient's psychophysiological responses are recorded

throughout the session, and sufficient rises in the above measures are taken as instances of strong feeling or heightened anxiety. For this study, this could have been a potentially viable strategy for identifying strong feeling, especially if our interest were limited to identifying heightened client anxiety or fear reactions. Nevertheless, practically speaking, it would be very hard for us to exercise this option because it would have required that we abandon our chosen data pool of audiotaped sessions, and use instead another form of data which would give us access to clients' physiological reactions during sessions. It came down to a choice of trying to get physiological measures, or enjoying the advantages of using taped sessions. Our inclination was to choose the latter option.

Ask the client to identify the strong feeling event. Some previous studies (Elliott, 1983; Greenberg, 1984a; Labott, Elliott, & Eason, 1992) have used the client's input to determine the special, significant event. Identification of the event is obtained by asking the client to review a tape of the session, and to indicate the precise beginning and end of the designated helpful event. This option may seem like a viable one, although it does pose formidable problems. First, there is the practical problem of access. Assuming that we wanted to retain our chosen data pool of audiotaped sessions, it would be extremely expensive in terms of time and money to track down the clients on the tapes. Second, even if these practical obstacles were overcome, and the clients were found and interviewed, we would still need to contend with the risks that the client's input would be contaminated by (a) the interviewer-client interaction, (b) the client's general feelings-thoughts about the course of therapy with the therapist, and (c) the passage of time between the session in question and the time of interview. And, considering that many of the tapes in our data

pool are upwards of 10-25 years old, the passage of time would be, shall we say, an extended one! In short, the risk is that the client's input would be less "grounded" to the data -- i.e. the therapist-client interaction on the tape -- than it would be to other factors. We were faced with a choice of trying to track down clients and solicit their input, and control for the inherent risks, or to select another way of identifying strong feeling events. Our inclination was not to get input from the clients.

Use a panel of judges to identify the strong feeling event. In other studies, the identification of the target event has been determined by providing a panel of judges with careful descriptions of the event, asking them to listen to audiotapes of therapy sessions believed to contain the event, and then relying on a high-level of inter-rater agreement to flag the presence of the event in these sessions (Gervaize et al, 1985; Mahrer et al, 1992a, Mahrer et al, 1994; Nichols, 1974; Nichols & Bierenbaum, 1978; Pierce, Nichols, & DuBrin, 1983).

This seemed to be the most viable option for our needs. It seemed highly practical to give judges careful descriptions of strong feeling, and to rely on a high level of inter-judge agreement to flag the occurrence of strong feeling events in taped sessions.

(k) Obtaining Precise, Clinically-Relevant Descriptions of the *Nature* of the Strong Feeling Events (once they have been initially identified)

The next methodological issue relates to how to obtain clinically-useful, precise descriptions of the *nature* of the strong feeling events. The issue was to select a way of getting detailed, clinically-relevant descriptions of the strong feeling events -- so that we would be able to

address, in a clinically meaningful way, how therapists *promoted* particular kinds of strong feeling events, and how they *used* them once they occurred. Previous research seemed to offer three possibilities.

Ask the client to describe the event. Some previous researchers (Elliott, 1983; Labott et al., 1992; cf. Rennie, Phillips, & Quartaro, 1988) have obtained description of client events by asking the client to give his/her perspective (description) of the event. Using this approach, the client may be asked to view or listen to a tape of the session; and to verbalize his/her account (understanding, experience) of a particular event under study. Then, the investigator obtains a final description of the event through a process of transcribing, analyzing, and categorizing the clients' verbatim responses (cf. Rennie et al., 1988). As discussed on the previous page, the option of soliciting client input seemed attractive at first blush. However, it would have posed enormous practical problems: getting access to clients, taking the time to interview them, raising the money to travel to where they were. And, over and above the practical obstacles, the client's input risks being contaminated by (a) the interviewer-client interaction, (b) the client's general feelings-thoughts about the course of therapy with the therapist, and (c) the passage of time between the session in question and the time of interview. Once again, the risk is that the client's input would be less "grounded" to the data -- i.e. the therapist-client interaction on the tape -- than it would be to these other, more general factors. Because of these practical problems and methodological limitations, our inclination was to reject this option.

Ask the therapist to describe the event. Some previous process researchers (Elliott, 1983; Labott et al., 1992) have used the therapist's input to help obtain a description of the target event.

In these investigations, the employed strategy was to pool the input of multiple judges of whom the therapist was one. For our study, there would have been serious problems inherent if we had chosen to solicit input from the therapist in describing the strong feeling event. First, there would have been the formidable practical problems -- travel, expense, time. Second, the therapist's description of the client's strong feeling would tend to have been contaminated by (a) the therapist's interaction with the person interviewing him/her, and (b) the therapist's particular theory-bound therapeutic approach, general feelings about the process of the therapy with the client in question, and his/her therapeutic relationship with the client. In a nutshell, the risk was that the therapist's input would have relatively little to do with what, concretely and objectively happened on the tape, and a lot more to do with his/her more general theoretical framework, and thoughts-feelings about the overall process of therapy and therapeutic relationship between him/her and the client. For the purposes of our study, the practical and methodological downside of seeking therapist input seemed to outweigh the potential gains.

Use category systems to describe the strong feeling event (once the event has been initially flagged/identified). Some researchers have used single or multiple category systems of valued (important, significant) client events in order to obtain descriptions of facets of the target event under study (e.g. Elliott, 1983; Greenberg, 1984a; Hill et al., 1983; Labott, Elliott, & Eason, 1992; Mahrer et al., 1989). For example, Labott, Elliott, and Eason (1992) used the client vocal quality and client experiencing scales to get a process description of a client weeping event.

For our purposes, though, we required a method that would allow us to obtain highly detailed, precise, clinically meaningful descriptions of strong feeling events -- not broad-brushed

categories of client behaviours related to the strong feeling event. Therefore, this option was not useful for our needs.

Combine independent judges' descriptions of the strong feeling events. In psychotherapy research studies, an increasing common strategy for describing client events is to pool the input of multiple judges. This method has been used in constructing a multiperspective description of significant events in psychotherapy (Elliott, 1983, 1984; Labott, Elliott, & Eason, 1992; Labov & Fanshel, 1977; Luborsky & Auerbach, 1969; Mahrer et al., 1992a, 1994); producing category systems of in-therapy events (Mahrer, Nadler, Gervaize, Sterner, & Talitman, 1988; Rice & Saperia, 1984); and identifying therapist methods promoting specific in-session client events (Labott, Elliott, & Eason, 1992; Mahrer et al, 1986b, 1988, 1991b, 1992a; Rice & Greenberg, 1984). The logical grounds for pooling the input of multiple judges is the belief that this procedure will yield more comprehensive, clinically relevant, and valid representations of in-therapy events than individual raters' descriptions alone (cf. Labott, Elliott, & Eason, 1992; Mahrer et al., 1986c). In this type of strategy, individual judges' perspectives are pooled according to overlapping themes, and similarity of meaning, and the result is thus an inductively generated, composite description of the client event (cf. Labott, Elliott, & Eason, 1992; Mahrer et al, 1992a; Rennie, Phillips, & Quartaro, 1988).

Given our particular research questions, and our need to find a way of rigorously, concretely, and precisely describing strong feeling events, this method seemed to be a highly workable choice. This method can yield highly precise descriptions of strong feeling events, and would thus allow us to address -- in a way that was clinically meaningful -- our key questions of

how therapists *promote* particular kinds of strong feeling events, and how they *use* them once they have occurred.

(1) How to Group/Categorize Different Kinds (Forms, Manifestations) of Strong Feeling Events

Given that the research questions involve the differential therapist methods and therapist uses related to *different kinds* of strong feeling, we had to wrestle with the issue of how to group different kinds of strong feeling. In the psychotherapy reseach literature, there is no empirically-generated taxonomy of different kinds of strong feeling that occur in psychotherapy sessions. Therefore, it was hard to decide on what basis to divide different subgroups of strong feeling. To look for a well-accepted basis for categorizing different kinds of strong feeling, we thought that it might be fruitful to consult research outside the field of psychotherapy. Unfortunately, as will be seen below, no well-accepted category system seems to exist there either.

Attempts Outside of Psychotherapy to Categorize Different Kinds of Feelings and Emotions. Outside of psychotherapy, there has been a long history of attempts to identify feelings and emotions that are regarded as basic and primary. *Primary emotions* are understood as being genetically and evolutionarily based, and biologically adaptive in the sense that they help ensure the preservation and survival of the organism. So, each basic emotion is associated with a primary, adaptive life task such as the emotion of *anger* associated with attack, or *fear* associated with avoidance and flight (cf. Ekman, 1992; Lazarus, 1991; Plutchik, 1962). The relationship between *primary emotions* and other emotions is seen as analogous to how primary colours (e.g. blue and yellow) combine to form secondary colours (e.g. green), or how chemical elements (e.g.

hydrogen and oxygen) mix to form compounds (e.g. water) (Ortony, Clore, & Collins, 1988).

Attempts to categorize primary feelings have a long history, including early taxonomies by Aristotle, Aquinas, Hobbes, Descarte, and Spinoza, later ones by Darwin, Feleky, and Watson, and relatively recent ones by Plutchik, Izard, and Ekman (cf. Mahrer & Bilodeau, 1995). But all along and up to to the present day there has been relatively little agreement among theorists and researchers about what constitute the basic emotions (cf. Mahrer & Bilodeau, 1995). For example, in terms of more recent lists, Plutchik (1980) includes eight primaries (*acceptance, anger, anticipation, disgust, joy, fear, sadness,* and *surprise*), while Izard (1972) includes ten (*interest-excitement, enjoyment-joy, surprise-startle, distress-anguish, anger-rage, disgust-revulsion, contempt-scorn, fear-terror, shame-shyness-humiliation,* and *guilt-remorse*) and Ekman (1971) includes six (*happiness, fear, surprise, anger, distress,* and *disgust*). This lack of convergence is not a welcomed state of affairs because, if there are in fact basic emotions, theorists and researchers should be able to arrive at some reasonable agreement about how many and what they are (cf. Lazarus, 1991; de Sousa, 1980; Ortony, Clore, & Collins, 1988; Mahrer & Bilodeau, 1995; Mandler, 1984).

So, research from outside the field of psychotherapy did not provide us with a well-accepted taxonomy of kinds of strong feeling that we could adopt for use in this investigation.

Attempts to Categorize Feelings and Emotions in the Field of Psychotherapy. In the field of psychotherapy itself, there have been some attempts to categorize different kinds of feelings-emotions; but, unfortunately, no well-accepted theory-based -- let alone research-based -- category system exists of the *strong* feelings that seem to occur in therapy.

As reviewed by Mahrer and Bilodeau (1995), psychoanalytic writers have categorized affects as *primitive* and *undifferentiated* (Engel, 1963), *defensive* or *active* (Heller, 1979), *pleasurable* or *unpleasurable* (Brenner, 1980), or as warning signals of drives seeking discharge (Engel, 1963; Rapaport, 1960). In terms of trying to actually name different feelings, Engel (1963) proposed an explicit 13-fold system: *anxiety, depression-withdrawal, shame, guilt, disgust, sadness, helplessness, hopelessness, contentment, confidence, joy, pride,* and *hope*. Brenner (1980), however, repudiated the notion that affects can be objectively and sharply differentiated from one another, arguing that affects are extremely individual in nature, and not uniform from person to person. Brenner contended that an accurate differentiation of affects required a successful application of the psychoanalytic method, including exploration of the pleasurable vs. unpleasurable experience of the feeling, and the patient's associated significant (often unconscious) ideas. So, in short, psychoanalytic theorists provide us with no well-accepted theoretical taxonomy of different kinds of feeling-emotions or strong feelings. The psychoanalysts' systems are diverse even among themselves; and, in any case, the psychoanalytic systems are derived from and applicable only within a psychoanalytic framework (Novey, 1963).

Outside of the psychoanalytic framework, a three-fold category system of feelings -- *primary, secondary,* and *instrumental* feelings -- has been proposed which is based on a synthesis and integration of various theories of emotion (e.g. Daldrup et al., 1988; Engle et al, 1991; Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987; Pierce, Nichols, & DuBrin, 1983). Within, this framework, *primary* feelings are postulated as authentic, adaptive responses to specific situations. *Secondary* feelings are viewed as reactions to primary ones. *Instrumental*

feelings are understood as learned means of achieving something, influencing or manipulating others. Unfortunately, this framework also provides no solid basis for actually naming feelings in psychotherapy because different overt manifestations of feeling -- e.g. frustration, annoyance, anger, pain, sadness, disappointment -- could fall under any of these three categories (*primary*, *secondary*, or *instrumental*), and only expert clinicians would be able to make the subtle distinctions necessary to tell the difference: "[deciding] is a matter of clinical judgment and requires both training and clinical experience (Greenberg & Safran, 1987, p. 177).

So, this brings us back to the main question: how do we group general occurrences of strong feeling into different categories. Researchers outside of the field of psychotherapy offer many systems, but none is widely agreed upon. Some theorists within the field of psychotherapy have provided notions about how to distinguish between different classes of feelings, but none of these systems is generally-accepted, nor do any provide a solid basis for naming actual feelings that occur in the therapy session. In the absence of any clear direction regarding how to group and categorize different kinds of strong feelings, it seemed that another option should be considered.

Identify different kinds of strong feeling by generating an empirically-based category system. Given that there was no clear research or theoretical basis for categorizing strong feelings a particular way, an alternative option was to adopt a strategy that would allow us to generate a category system using our own data. One option that presented itself was something in the general spirit of the grounded analysis approach described by Rennie, Phillips, and Quartaro (1988). In this approach, a group of judges closely inspects the data -- in our case, composite

descriptions of naturally-occurring strong feeling events -- and generates categories through a systematic process of inductive content analysis of this data. Using this strategy, the intent would be to generate a categorization scheme of different kinds of strong feeling using a relatively large number of strong feeling instances. This would seem like a viable strategy for our needs.

To review, the methodological choices discussed so far include (i) the identification of strong feeling events using a panel of judges; (ii) the further description of these strong feeling events by combining judges' descriptions of these events; and (iii) the empirical generation of a category system of different kinds of strong feeling using a strategy of grounded, content analysis. The final methodological choices relate to our two main research questions, which address how therapists *promote* the occurrence of (different kinds of) strong feeling events, and how they *use* them in the session once they have occurred.

(m) How to Describe/Identify the Antecedent *Therapist Methods* (Employed Under Particular In-Session Client Conditions) that Seem to Facilitate the Occurrence of the Strong Feeling Events

The issue is this: how to go about describing the *therapist methods* that seemed to promote the occurrence of each strong client feeling event. Previous studies offered us a number of possible approaches to consider.

Use category systems of therapist methods. In order to obtain description of therapist methods, one option would have been to use category systems of the major, common therapeutic methods (Elliott, 1985; Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987; Hill, 1985; Nichols, 1974), therapist modes of response (Goldberg et al, 1984; Hill et al, 1981; Stiles, 1979,

1986), therapist intentions (Hill & O'Grady, 1985), therapist empathy and therapist level of regard scales (Barrett-Lennard, 1962) or other scales of therapist in-session behaviour. The logic in using such an approach would be to investigate whether strong feeling tends to be preceded by particular kinds of therapist operations included in a particular category system. A number of previous studies have used category systems such as these in order to identify therapist methods associated with the occurrence of valued in-session client events (cf. Gervaize et al., 1985; Hill, Carter, & O'Farrell, 1983; Labott, Elliott, & Eason, 1992; Rice & Saperia, 1984).

For our purposes, though, these category systems were not appealing for two reasons. First, these category systems tend to be comprised of a relatively small number of *general* categories such as asking questions, providing information, giving reflections, and offering interpretations. None were designed to identify the level of concretely specific therapist operations that we aim to describe in this investigation. Indeed, our intent is to provide a high enough level of clinical detail for a practitioner to have a pretty clear picture about which specific method may work, under which particular in-session client conditions, to promote a given kind of strong feeling. To maximize the clinical relevance and meaningfulness of the findings in this way, it would simply not be sufficient to provide practitioners with findings that tell them merely to "ask a question" or "give a reflection" or "give an interpretation". We want to say much more than this. We want to be able to tell the practitioner when to ask the question, what precise kind of question to ask, how to word it, what tone of voice or style use in delivering it, etc. Second, using these category systems would limit our findings to the categories already in these lists of methods. We would not retain the possibility of discovering new methods that are not already

present in the category system. In short, for our needs, the option of using existing category systems of therapist methods was wholly unappealing.

Attempt to verify the effectiveness of therapist methods derived from existing theory and research. This approach would have involved deriving, on the basis of existing theory and research, therapist methods postulated as linked to the promotion of strong feeling, and then empirically testing them as hypotheses. If this option were chosen, it would have entailed testing, as hypotheses, the 21 therapist methods for promoting strong feeling that were outlined in the previous chapter. But, as discussed earlier, this option was not appealing or appropriate. The main reason is that we would be assuming that the answers to our research question of how therapists promote strong feeling are somehow already buried in the existing literature -- i.e. in those 21 methods -- and that all we must therefore do is verify what is already there (cf. Ashe, 1977). This is not the case, given the lack of organized theory, and almost total absence of research on this topic.

Combine independent judges' descriptions of therapist methods antecedent to strong feeling. An alternative strategy is the same one outlined earlier for describing strong feeling events: pooling the input of multiple judges. This method has been used in a number of recent psychotherapy process studies that have sought to discover therapist methods facilitative of significant events in therapy (Elliott, 1983; Greenberg, 1984a; Mahrer et al., 1986b, 1992a, 1993), and strong feeling events in particular (Labott, Elliott, & Eason, 1992; Greenberg, 1984a; Mahrer et al., 1991, 1992a). This strategy is appealing because it can enable the generation of precise, concrete, and clinically-relevant descriptions of therapist methods judged as helpful in promoting

strong feeling. Moreover, because this strategy involves combining multiple judges' individual descriptions of the therapist methods into composite summaries that are faithful to the shared ideas of the group, this procedure would allow for more comprehensive, consensually-valid representations of therapist methods than would be obtained if we used individual raters' descriptions alone (cf. Labott, Elliott, & Eason, 1992; Mahrer et al., 1986c).

(n) How to Describe/Identify the Therapeutic Uses of Strong Feeling

This issue is central to the second main aim of the study: to identify how therapists are judged to *use* strong feeling events in the session, once they have occurred. Some possible strategies, based on previous research, are considered below.

Solicit input from the client and/or therapist. One approach that has been used in the past is to ask the client and/or therapist, after the session, to rate the therapeutic impact of a designated client event (cf. Elliott, 1983; Labott, Elliott, & Eason, 1992). Once again, given our data pool of taped psychotherapy sessions, the practical and methodological problems inherent in soliciting client and/or therapist input made this an unattractive option.

Use category systems of valued in-session client events. A second possible way of identifying therapist uses of strong feeling would have been to employ research-based category systems of in-session client change events -- moments in the session that are regarded as indications of client process, improvement, movement, or change. For example, Mahrer and his colleagues (Mahrer et al., 1989, 1990a, 1991a) analyzed client statements using two measures -- client strength of feeling, and the list of good moments in psychotherapy (Mahrer & Nadler, 1986)

-- and were able to demonstrate that the different levels of strength of feeling were associated with the occurrence of particular kinds of good moments. More recently, Mahrer et al (1992a) analyzed client statements in Gestalt sessions using a category system of client *very good moments* (Mahrer, Gagnon, Fairweather, & Coté, 1992), and found that one kind of very good moment (*a state of strong, full feeling*) tended to be followed by other kinds of very good moments such as the *client's intention to carry out post-session behaviours*, and the client undergoing of a *new, deeply felt personality process-state*. These studies begin to delineate for practitioners what the particular uses of stronger levels of feeling might be, in terms of the good or very good moments that seem to be facilitated by the occurrence of strong feeling. This raised the possibility that further fruitful findings pertaining to uses of strong feeling might come from adopting a similar method in the present study.

However, this strategy would have been too limiting in terms of clinical relevance of the findings. Indeed, these existing category systems are not precise enough to identify and describe the level of concrete, specific therapeutic uses of strong feeling that this study seeks to identify and describe. The aim in our study is to provide a high enough level of clinical detail to give practitioners a relatively clear picture about how they may therapeutically *use* particular kinds of strong feeling. We want to go beyond telling practitioners, for example, that a strong feeling moment can be used to promote "insight-understanding".

Furthermore, our priority, given the state of the current literature, is to leave the door open to discovering new uses not yet mentioned in the literature. If we decided to use an existing category system of valued client events, we would be closing the door to new discoveries, and

essentially engaging in the hypothesis-testing of a list of vaguely defined "uses" already present in the literature. Clearly, using category systems would preclude the chance of discovering new categories or extending (augmenting, adding to) existing ones.

Attempt to verify the effectiveness of therapeutic uses derived from existing theory and research. This option would have involved testing the 6 therapeutic uses of strong feeling that were presented in the first chapter. As argued earlier, though, the barren state of the literature on this topic necessitates the use of a method that enables hypothesis-generation, not hypothesis-verification. Indeed, if we set out to test the 6 therapeutic uses outlined in chapter one -- which are relatively vague, somewhat overlapping, and at varying levels of abstraction -- then we would be assuming that the answers to our research question of how therapists use strong feeling are somehow already buried in that existing literature -- i.e. in those 6 uses -- and that all we must therefore do is empirically test what is already there (cf. Ashe, 1977). This is not the case, given the lack of well-established theory, and almost total absence of process research on this topic. It seemed far more appropriate, given the sparse amount of knowledge in this area, to adopt a strategy that put a premium on discovering new uses (as well as extending, augmenting, and more comprehensively describing ones that have already been mentioned in the literature).

Combine independent judges' descriptions of therapeutic uses of strong feeling. Once again, an appealing strategy that has basis in previous research (e.g. Elliott, 1983; Greenberg, 1984a; Labott et al. 1992; Labov & Fanshel, 1977; Mahrer et al., 1986b, 1991, 1992a, 1994; Rennie, Phillips, & Quartaro, 1988) would be to describe the therapeutic uses of strong feeling by pooling the input of multiple judges. In this strategy, individual judges' perspectives would be

pooled according to overlapping themes to generate an inductively-based, composite description of the therapeutic uses of instances of strong feeling (cf. Rennie, Phillips, & Quartaro, 1988). Given that our aim is to obtain precise, concrete, and clinically-relevant descriptions of therapists' uses of strong feeling, this strategy seemed highly appropriate. It would leave the door open to discovering new uses not hitherto mentioned in the literature, and would also enable us to augment and more comprehensively describe the (often vaguely defined) uses already mentioned in the literature.

(o) How to Group/Categorize Different *Therapist Methods* of Promoting Strong Feeling, and Different *Therapist Uses* of Strong Feeling

The final main issue -- and one that bears squarely on the two research questions -- is how to take the pool of composite descriptions of *therapist methods* and *therapist uses* of strong feeling, and to group (simplify) them into different classes or categories. Our research questions are geared toward identifying the kinds of *methods* that therapists employ to promote strong feeling, and the kinds of ways that therapists *use* strong feeling in the session after it occurs. To answer these questions, we had to find a strategy for coming up with different categories of methods and uses. Given, once again, that there were no clear directions provided by the research or clinical literature about how to categorize *methods* and *uses*, an appropriate option seemed to be to generate empirically-based categories using our own data. Thus, the proposed strategy was similar to the one outlined earlier for the purpose of generating a category system of different kinds of strong feeling (cf. Rennie, Phillips, & Quartaro, 1988). In this approach, a group of

judges would closely inspect our raw findings -- i.e. a relatively large pool of composite descriptions of therapist methods and therapist uses related to strong feeling -- and generate two richly detailed, practitioner-relevant category systems through a systematic process of inductive content analysis of these data. A detailed explanation of this strategy will follow later in this chapter.

A Brief Overview of the Methodology

To conclude this section, here is a brief summary of the methodological directions chosen for this investigation. The general research strategy would be an inductive, discovery-oriented approach emphasizing knowledge generation and new discovery. The data would consist of naturally-occurring instances of strong feeling occurring in audiotaped sessions of psychotherapy. The therapists would consist of a relatively large group of experienced clinicians, representative of a fairly broad range of approaches. Selected sessions would be with individual adult patients, and would include multiple instances of strong feeling. A research team would consist of a relatively large group of clinically sophisticated judges. Each selected tape would be categorized according to *family of psychotherapy* and temporal *era* (i.e. decade in time when the session was produced). Instances of strong feeling would be flagged based on a high level of inter-rater agreement of the team of judges. Careful descriptions of (a) the *nature* of each strong feeling event, (b) the *therapist methods* judged as helpful in promoting each event, and (c) the *therapist uses* of each event would be obtained by a strategy of pooling individual judges' descriptions into composite summaries which reflected the shared ideas of the group. Ultimately, these three sets of

composite descriptions would be simplified further into different classes of -- (1) *different kinds of strong feeling*, (2) *therapist methods* of promoting strong feeling, and (3) *therapist uses* of strong feeling -- through a rigorous procedure of content analysis of the original composite descriptions.

The principal findings would consist of unabridged, practitioner-relevant, concrete descriptions of different classes of *therapist methods* and *therapist uses*. The findings would be akin to technical, "how-to" manuals showing therapists precisely how they can promote and use strong feeling in their sessions. Secondary results would consist of how these classes of therapist methods and therapist uses vary across *different kinds of strong feeling*, *different families of psychotherapy*, and *different eras of session*.

Methodology

In this section, I will describe the data pool and team of judges for this investigation. Following this, I will provide a detailed description of the procedure.

Data Pool

The data pool consisted of two extensive audiotape libraries housed at the University of Ottawa. First, there were the holdings of the tape library of the American Academy of Psychotherapists, which is recognized as among the foremost, classical libraries of tapes of exemplary, renowned therapists. Most of the tapes were from the 1960s. Second, there were the holdings of the tape library of the University of Ottawa, a more recent collection of sessions, most of which occurred in the 1970s and 1980s. The combined holdings included approximately 450

audiotapes of psychotherapy sessions of 85 therapists. Most sessions were with individual adult clients. Some were initial or early sessions, and the majority consisted of sessions later in the therapy process. The therapists represented the various psychotherapy-related professions, and all were relatively distinguished and experienced. They represented a broad spectrum of therapeutic orientations. If orientations were grouped into families of psychoanalytic-psychodynamic, humanistic-experiential, cognitive-behavioural, and integrative-eclectic, no one family predominated.

Judges

The judges were members of the University of Ottawa Psychotherapy Research Team -- a team of 14 individuals experienced in the conduct of psychotherapy process research. Team members' experience with psychotherapy process rating ranged from approximately 50-500 hours, with a mean of approximately 200 hours experience. The judges included five professional clinicians, six doctoral students in clinical psychology, and three persons with an honours degree in psychology and experience as members of the psychotherapy research team. Seven judges were male, seven were female, and the mean age was approximately 36 years. Of the four families of psychotherapy, the judges were evenly split among psychoanalytic-psychodynamic, humanistic-experiential, cognitive-behavioural, and integrative-eclectic orientations.

Procedure

Phase I: Identification of Strong Feeling Events

The aim of this step was to flag the location of strong feeling events on audiotapes of actual sessions of psychotherapy. There were two steps.

Step 1: Preliminary choosing of tapes meeting the tape selection criteria. The aim of this preliminary step was to go through the entire data pool of 450 tapes in order to flag tapes that appeared to meet the selection criteria imposed to allow us to address our chosen research questions. The first criterion was to obtain tapes that seemed to contain a minimum of two instances of strong feeling, and to exclude tapes that did not. Tapes with more than one instance of strong feeling were be sought in order to maximize the probability of acquiring sessions in which therapists were 'emphasizing' strong feeling -- rather than obtaining isolated, perhaps chance (spurious, unintentional) occurrences of strong feeling. It was reasoned that our potential yield of *therapist methods* and *therapist uses* would be maximized if we limited study to tapes with multiple instances of strong feeling. The second criterion was to only include sessions with individual adult patients -- as opposed to sessions with groups, couples, or children. The third criterion was to obtain only complete sessions -- as opposed to excerpts of sessions. The fourth criterion -- imposed so that we would not be acquiring sessions in which the therapist was concentrating on diagnostic assessment -- was to exclude initial-intake sessions that were the first in a series of sessions and/or sessions in which the therapist seemed to be emphasizing the gathering of assessment/evalution information. The fifth criterion was to exclude sessions with patients who appeared to be exhibiting signs of being severely unhealthy (e.g. psychotic, personality disordered). In the absence of clear evidence in this regard, the default option was to assume that the patient was not severely unhealthy. A sixth criterion was to ensure that the final

pool of tapes (selected for further analysis by the full research team) included an equivalent number of tapes from each therapist studied. This was to prevent sampling bias, enhance the generalizability of the results, and guard against the possibility of arriving at a skewed pool of sessions comprised of a large number of tapes by certain therapists, and only single or few tapes from other therapists.

In this initial sweep, one judge, a Ph.D. student in clinical psychology listened to the entire data pool of 450 taped sessions. Using the scale of strong feeling as a guide (see Appendix F), he rated each tape as "yes" or "no" -- with "yes" signifying that the tape appeared to meet the tape selection criteria. In this initial run-through, the judge was relatively liberal in including all sessions that seemed to contain multiple instances of strong feeling events. Tapes marked "no" were excluded from further study. Tapes marked "yes" were retained and listened to by a second judge who again used the definition of strong feeling as a guide, and kept in mind the specific tape selection criteria. On a rotating basis, various continuing members of the psychotherapy research team served as "second judge" for these tapes. If the second judge deemed that the tape did not meet the selection criteria, then that tape was re-designated as "no", and was excluded from further study. However, if the second judge agreed that a minimum of two instances of strong feeling might have occurred during the session, and that the other selection criteria seemed to be met, then this tape kept its designation of "yes", and was retained for further study.

At the end of this preliminary step, the initial data pool of 450 tapes had been reduced. At this stage, however, we still has no specific information regarding where strong feelings may have happened on any of these tapes, or any descriptions of the strong feeling that may have occurred.

All we had were a number of tapes marked "yes", meaning that they had been judged as containing multiple instances of strong feeling, and as meeting the other selection criteria.

Step 2: Selection of the *location* of strong feelings on each tape. In this step, the aim was to make decisions about *where* strong feeling events seemed to occur on the retained "yes" tapes. Two judges, again using the measure of strong feeling as a guide, listened independently to each retained "yes" tape for the presence of strong feeling. Each judge wrote down the precise counter numbers on the cassette where strong feelings seemed to occur, and also noted key words by the client at these moments of strong feeling to help identify the precise spots on the tape. Then, both judges compared ratings. The key question here was whether a given event qualified as strong feeling. For an event to qualify, a stringent criterion of 100% agreement between the two judges had to be attained. If there was agreement between the two judges, then the places of the selected events were noted and retained for further, later analysis by the entire research team. If there was disagreement, with one judge detecting strong feeling at a particular place and the other not, then each judge again listened independently to that spot on the tape. If one judge still said "no", then this event (or entire tape, if necessary) was excluded from further study. At the end of this step, decisions had been made regarding where strong feelings seemed to have occurred on all of the retained "yes" tapes. (These decisions were somewhat provisional, however, because later in the study, the larger research team would still have the option of vetoing a designated strong feeling event if the majority of them deemed that it should not have qualified as such.)

Phase II: Analysis of Tapes by the Full Research Team

Now that decisions had been made about which tapes met the selection criteria, and the strong feeling events had been provisionally identified and located on each tape, the next step was to subject each tape to further analysis by the full research team.

Tapes were presented to the research team one at a time in random order. As each tape was presented in turn to the research team, each judge was also given verbatim transcripts depicting the portions of the session designated (as per step 1b above) as containing strong feelings. So, if the first tape had been previously judged to contain three strong feeling events, then each judge would receive three verbatim transcripts -- each about one page in length, presenting the therapist-client statements before, during, and after the designated strong feeling event. On each transcript, the particular client statement(s) judged as containing strong feelings were typed in **bold**.

In order to maintain task-centeredness, judges were assigned one strong feeling event at a time. In other words, each strong feeling event on each tape was analyzed to its completion (according to steps 4-6, as outlined below) before turning to the next event. Furthermore, only after all strong feeling events on a tape had been analyzed did we proceed to the next tape.

In order to go at a manageable pace, one or two steps of the protocol were assigned to the judges each week. Team members submitted their findings in writing at the weekly meetings of the research team.

Step 1: Placement of each tape in a category of *family of psychotherapy*. Before studying the strong feeling events on each tape, the first preliminary step was to use the input of the

research team, comprised as it was of clinically-sophisticated judges, to arrive at a consensually correct designation of each tape according to its *family of psychotherapy*. Each judge was asked to listen independently to the entire session, and answer the following question: (1) *Based on your assessment of the therapist's behaviour (methods, interventions, working principles) in this session, into which one major family of psychotherapy -- psychoanalytic-psychodynamic, humanistic-experiential, cognitive-behavioural, or integrative-eclectic -- would you tend to place this session?* For a tape to be successfully designated into a category, the minimum level of inter-rater agreement was 65%. (If any tape did not meet criterion, it would be excluded from the later analyses regarding whether strong feeling methods and uses varied according to family of psychotherapy.) Furthermore, in order to assess the research team's level of certainty about their ratings, the judges were also asked to answer, using a 4-point Likert scale, a second question: (2) How confident are you that this session truly belongs in the category you have chosen? (1= not confident at all; 2 = slightly confident; 3 = confident; 4 = very confident).

Step 2: Placement of each tape into a category of *era of session*. A further preliminary step -- which did not actually require any ratings from the research team -- was to designate each session according to its *era*. This was done by consulting the catalogued summary information about each tape available from the A.A.P. and University of Ottawa Tape Libraries. On the basis of this catalogued information, each tape was placed into one of three categories: *1965-1974*, *1975-1984*, or *1985-1994*.

Step 3: Final check to exclude any sessions with severely unhealthy patients. The final preliminary step was to have the full research team listen to each session in order to confirm the

judgements of the principal investigator and second judge (from Phase I, step 1) that the patient was not exhibiting signs of being severely unhealthy (e.g. psychotic, personality disordered). In the absence of clear evidence in this regard, the default option was to assume that the patient was not severely unhealthy.

Step 4: Description of the feeling in each identified strong feeling event. The purpose of this step was to use the input of multiple judges in order to generate a consensually correct, composite description of each identified strong feeling moment.

(4a) Judges' individual written descriptions. Using the provided transcript, the judges were instructed to listen independently to each strong feeling event. Their task was to provide a written description of the nature, content, or kind of strong feeling (emotion, affect) that seemed to be present (see Appendix G for protocol). They were instructed to emphasize the strong feeling that was actually evident, rather than the feeling that the client might be *referring to* or saying he/she was having. In formulating their written descriptions, judges were instructed to state their answers simply and clearly, with a minimum of jargon or clinical interpretation from any given therapeutic vocabulary. In addition, judges were instructed that they were completely free to decide that the event in question did not qualify as strong feeling, as based on their clinical judgement and the scale of strength of feeling provided to guide them (see Appendix F). If a majority of judges deemed that the event should not qualify as strong feeling, then that particular event would be dropped from the study.

(4b) Obtaining the composite description. At the next weekly meeting of the research team, judges submitted their written descriptions. Then, working independently, the principal

investigator and the second judge each performed a careful content analysis of the words, terms, themes contained in the team members' individual answers. In this procedure, (a) the 14 individual written descriptions were broken down into components; (b) these components were grouped together on the basis of similarity of meaning, overlapping themes; (c) whenever a "theme" (shared idea) was echoed by 70% or more of the judges, a descriptive phrase was retained which reflected it; and (d) these retained descriptive phrases were arranged into a coherent, composite description of the strong feeling event (cf. Rennie, Phillips, & Quartaro, 1988). Using this procedure, each of the two judges arrived at a composite summary that was their best description of the nature (content) of the strong feeling event in terms of its faithfulness to the shared ideas of the group. Care was taken to avoid using technical jargon terms from any particular therapeutic approach.

Then, the two judges worked together to formulate a single composite description by coherently arranging and combining the common themes present in their two respective summaries. Any disagreements were resolved with the inclusion of an available third judge. This product was then presented to the research team at the next weekly meeting. A criterion of 70% agreement was required for the composite description to be considered finalized. If criterion was not met, the objections were discussed, and the principal investigator and second judge amended the composite based on the team's input.

Step 5: Description of the *therapist methods* (and *client conditions*) antecedent to the strong feeling. The purpose of this step was to describe the antecedent therapist methods, carried out under specific client conditions, that were judged to have helped promote the occurrence of

the strong feeling event. The procedure consisted of two substeps.

(5a) Judges' individual descriptions. Judges were given the composite description of the strong feeling event, told to listen to the audiotape again (aided by the provided transcript), and to provide a written description of the (i) therapist methods that seemed to help promote the strong feeling, and (ii) the way the client was being-behaving (*in-session client conditions*) when these therapist methods were employed. Judges were told that they could listen as far back in the session as they wished in answering the question, and could identify all therapist and client statements that they regarded as relevant. Judges were free to describe a simple client condition and subsequent therapist method, or to provide a more complicated interconnected series of client conditions and therapist methods preceding the strong feeling.

In any case, judges were instructed to describe the therapist-client interaction in terms of "*when* the client is doing this and being this particular way in the session (*client condition*), the *therapist operations* that seemed to help promote the strong feeling were this and that." Judges were instructed to answer this question simply and clearly, with a minimum of jargon or clinical interpretation. Judges were also given the option of reporting that they were not able to identify any therapist operation (or client condition) preceding the target event (see Appendix H for protocol).

(5b) Obtaining composite descriptions. In order to generate composite descriptions of the antecedent therapist methods and client conditions, the identical procedure was followed as was described earlier in obtaining composite descriptions of the strong feeling event (phase II, step 4b).

Step 6: Description of the *therapist uses* subsequent to the strong feeling. The purpose of this step was to obtain a composite summary describing how the therapist *used* each strong feeling event. There were again two substeps.

(6a) Judges' individual descriptions. Judges were asked to listen once again to the audiotape, using the accompanying transcript, and to describe how the therapist seemed to *use* the strong feeling, after it occurred. Judges were told that, in identifying the *therapist's use* of the strong feeling, they had the option of focusing on one or more of the following things. First, they might focus on an impressive client sub-outcome of the strong feeling. This refers to a client event occurring after the strong feeling, that the judge viewed as related to the strong feeling, and that the judge considered, based on his/her clinical opinion, to be a significant (impressive, valuable) shift, indicative of therapeutic movement or improvement. Second, judges could choose to focus on what they believed the therapist was *trying to accomplish* subsequent to the strong feeling moment. The emphasis here would not be so much on what the client did after the strong feeling, but where the therapist seemed to be "going" with it, what the therapist seemed to be trying to do with it. Third, the judge would be free to report that the therapist did not seem to use the strong feeling moment at all. In answering the question, judges were instructed to examine as many subsequent therapist and client statements as they deemed useful, and to identify all aspects of the therapist's and client's behaviour subsequent to the strong feeling event that they deemed particularly relevant and noteworthy. They were also told to answer the question simply and clearly, with a minimum of jargon or clinical interpretation (see Appendix I for protocol).

(6b) Obtaining composite descriptions. In order to generate composite descriptions of the

therapist uses of the strong feeling, the identical procedure was followed as was outlined earlier in obtaining composite descriptions of the strong feeling event and therapist methods.

Phase III: Further Simplification of the Three Sets of Composite Descriptions into a Consensually-Valid Category System of *Kinds of Strong Feeling*, and Detailed, Unabridged, Technical, Consensually-Valid Descriptions of Different Categories of *Therapist Methods*, and *Therapist Uses*

After phase II, for each strong feeling event, there would now be three composite descriptions -- one pertaining to the *nature (content, kind)* of the strong feeling moment, another outlining the *therapist methods* judged as helpful in promoting it, and a third describing the way that the therapist was judged to have *used* the strong feeling moment. So, as we studied one strong feeling event after another, we were building up these three sets of composite descriptions. These three sets would be the basis for this final phase. In this phase, two judges simplified, reduced, and content analyzed the composite descriptions into groups. The composite descriptions of the *nature of strong feeling events* were reduced into a category system of *kinds of strong feeling*. The composite descriptions of *therapist methods* and *therapist uses* were also simplified into two category systems -- but these systems, the key findings of the study, took the form of unabridged, detailed "how-to" manuals of different ways of promoting and using strong feeling.

This phase began once a fair number of strong feeling events (about 30) had been analyzed in phase II. The reasons for beginning to form the three category systems at this mid-point in the

data collection were twofold: (i) to get provisional, substantial category systems that could then be continually modified, verified, and refined using subsequent data; and (ii) to have some basis later to check if new categories were continuing to emerge, or whether little or nothing new was being added to the category systems as new composite descriptions were generated by the research team.

Step 1: Generation of a category system of *kinds of strong feeling*. This purpose of this step was to obtain a categorization scheme of different kinds of strong feeling. There were two substeps.

(1a) Provisional generation of the category system. Once about thirty composite descriptions summarizing the nature of each strong feeling event had been accumulated, two judges studied them independently.

Their first task was to organize the composite descriptions into no less than four and no more than eight categories of strong feelings. These numbers were somewhat arbitrary. The main reason for imposing them was to allow for maximum economy (simplicity) and clinical utility. To be useful to the practitioner, the category system should not be overly simple and vague, nor should it be overly complex and muddled with detail. Generating a category system of four to eight categories seemed to strike an adequate balance based on these considerations.

In order to complete this first task, each judge broke down the content of each composite description into meaning units, and arranged the composite descriptions into clusters (categories) on the basis of similar, overlapping themes (cf. Rennie, Phillips, & Quartaro, 1988). Each judge's categorization was to include all composites, i.e. not leave any out. Each category was to include

one or more composite descriptions falling under it. The second task of the two judges was to name each emergent category. The naming was to be based on the themes (content) of the composite descriptions falling under each category.

This procedure yielded two independently generated category systems -- one from each judge -- of kinds of strong feeling. Any differences in the number and in the named categories were resolved by discussion among the two judges. If agreement could not be reached, differences were to be resolved by the inclusion of a third judge's independent categorization, followed by discussion among the three judges.

(1b) Subsequent refinement of the category system. Once this provisional category system was in place, subsequent refinement came from comparing additional composites -- generated as data collection continued -- with the existing category system, and revising it as necessary. As each additional composite description was generated, the two judges, working independently, decided if it fit nicely under an existing category, and if so, inserted it into this category. If the new composite did not seem to fit well under an existing category, then the judges independently attempted to modify the category system to accommodate the new composite -- either by adding a new category, or revising or renaming existing categories to better represent the new data set. Disagreements between the two judges were to be resolved by discussion -- and, if necessary, with the inclusion of a tie-breaking third judge.

At the next research team meeting, the remaining 12 judges agreed or disagreed with the judges' decisions, with 70% criterion required for approval. If criterion was not met, amendments were to be made by the two judges, with consideration of the team's input.

Step 2: Generation of a Detailed, Unabridged, Practitioner-Relevant, Consensually-Valid Category System of *Therapist Methods* of Promoting Strong Feeling. The purpose of this step was to take the set of composite descriptions of therapist methods, and simplify them into a number of descriptive categories, with the heavy emphasis on making them relevant and usable to practitioners. The aim was to end up with concrete, unabridged, "how-to-do-it" descriptions of methods for promoting strong feeling, so that a practitioner reading the findings would know, with relative precision, what to do, and when to do it. The aim was to give sufficient detail so that practitioners would be able to reproduce the methods in their sessions. There were three substeps.

(2a) Provisional generation of the category system. Once about thirty composite descriptions summarizing the therapist methods antecedent to strong feeling had been accumulated, the first task of two judges was to study them independently, and arrange the composites into categories on the basis of similar, overlapping themes. In each judge's arrangement, there were to be between four and eight category headings, and perhaps subcategories under each. The reason for the inclusion of subcategories was to enable more precise descriptions of different variations of therapist methods, which would enhance the relevance of the category system for the practitioner. Under each category and subcategory there was to fall one or more composite descriptions (which constituted actual examples of how to apply that kind of therapist method). The second task of the two judges would be to name each emergent category, based on the themes of the composite descriptions falling under each category.

(2b) Subsequent refinement of the category system. With this provisional category system now in place, as each additional composite description was generated, the category system would be refined using the same procedure outlined above in refining the category system of different kinds of strong feeling (phase III, step 1b).

(2c) Final version of the category system. In its final version, the category system was to include main headings and subcategories (if any). Furthermore, each category and subcategory would be presented so as to include detailed, unabridged material -- pulled together and organized from the subsumed composite descriptions -- that showed practitioners precisely how to carry out the method, different alternative ways of employing the method, and the in-session client conditions under which to perform it. There would be sufficient detail to enable the practitioner to reproduce the method in his/her sessions.

Step 3: Generation of a Detailed, Unabridged, Practitioner-Relevant, Consensually-Valid Category System of *Therapist Uses* of Strong Feeling. The purpose of this step was to take the set of composite descriptions of *therapist uses*, and simplify them into four to eight descriptive categories, with the heavy emphasis on making them relevant and usable to practitioners. Indeed, the aim was to end up with concrete, unabridged descriptions of how therapists could *use* strong feeling, so that a practitioner reading the findings would know, with relative precision, what to do if he/she wanted to *use* strong feeling in a particular way in the session. There were three substeps.

(3a) Provisional generation of the category system. Once about thirty composite descriptions summarizing the therapist uses subsequent to strong feeling had been accumulated,

two judges studied them independently. The procedure followed was identical to that outlined above in generating the category system of therapist methods of promoting strong feeling (see phase III, step 2a).

(3b) Subsequent refinement of the category system. With this provisional category system now in place, as each additional composite description was generated, the category system was refined using the same procedures outlined above to refine the category system of therapist methods (see phase III, step 2b).

(3c) Final version of the category system. In its final version, the category system of therapist uses was to include main headings and subcategories (if any). Furthermore, each category and subcategory was to include detailed, unabridged material -- pulled together and organized from the subsumed composite descriptions -- showing practitioners precisely how to *use* strong feeling in particular ways. There would be sufficient detail to enable the practitioner to know, with some precision, what to do if he/she wanted to *use* strong feeling in a particular way.

What Would Determine When Sufficient Data Had Been Collected?

Our main aim in conducting this study was to identify and describe how therapists can *promote* and *use* various kinds of strong feeling in their sessions. If, as we continued collecting data, we kept making new discoveries -- in the form of new categories or subcategories of therapist methods and/or therapist uses and/or kinds of strong feeling -- then the inclination would be to keep proceeding. If, however, the conducting of additional protocols -- for example, 10-12 consecutive protocols -- yielded no new categories or subcategories of therapist methods,

therapist uses, or kinds of strong feeling, this would be taken as an indication of two important things. First, it would be taken as an indication that the "pay-off" of conducting further protocols was dropping off towards zero, and that we were no longer "breaking new ground". Second, it would suggest that the existing category system was one in which we could have some solid confidence. Indeed, if we continued finding that new composites fit quite handily under existing categories, then we would be getting more and more confirmation for the existing framework, developing increasing confidence in the substantiality of the existing framework, and building a growing sense of certainty that we were coming up with something valuable to tell practitioners about how to *promote* and *use* (different kinds of) strong feeling in their sessions. In the research strategy of grounded analysis, this rationale has been referred to as the concept of "theoretical saturation" (cf. Rennie, Phillips, & Quartaro, 1988).

A second element that would factor into the question of when to stop collecting data related to the labour intensive, arduous nature of the research protocol. Practical limitations -- specifically, the time constraints and resources of the research team -- would play a part in the decision of when to end the study. Taking all factors into consideration, we expected to study in the neighbourhood of 45-65 instances of strong feeling. This would provide a balance between our aim to generate findings based on a relatively large sample of strong feeling events, and the practical limitations inherent in a labour intensive study such as this.

Format of Presentation of Results

As answers to our two main research questions, our principal findings would consist of

two richly detailed, practitioner-relevant, consensually-valid category systems: *therapist methods* of promoting strong feeling, and *therapist uses* of strong feeling. In each system, all categories and subcategories would include detailed, unabridged, "how-to-do-it" instructions -- pulled together and organized from the subsumed composite descriptions -- designed to show practitioners precisely how to *promote* and *use* strong feeling in various ways. There would be sufficient detail to enable the practitioner to reproduce these methods and uses in his/her sessions.

Our secondary results would address whether our generated categories of strong-feeling *methods* and *uses* appeared to differ according to (a) *different kinds of strong feeling*; (b) *different families of psychotherapy*; and (c) *different eras*. To present these findings, we would include six frequency distribution tables. Inspection and analysis of these frequency data would enable us to address the question of whether particular therapist methods and uses seemed to be associated with different kinds of strong feeling, families of therapy, and/or eras of session.

Presentation of the Principal Findings

Therapist methods of promoting strong feeling. With regard to how therapists promote strong feeling in general, we will present the empirically-generated category system consisting of 4-8 main categories, and additional subcategories. In presenting the category system, we will include a main heading for each category, and under it a detailed description of what that method entails. This description will be in-depth and unabridged, and will be pulled together from the content of the composite descriptions under that category. The description will tell the practitioner precisely how to carry out the method, different optional ways of carrying it out, and

when to carry it out (i.e. relevant in-session client conditions). Under this description of the category (or subcategory), and to further show how the method can be carried out, we will include examples taken from the actual data. These examples will be descriptions of the psychotherapeutic operations, along with any attached client conditions, that fell under this main category. For instance, a main category called "Be exceedingly blunt in directing the client" might include under it the following example:

> When the client indicates that his way of being-behaving seems silly or ridiculous to him/her, then the therapist can (a) playfully agree with the client; (b) verbally create an exaggerated picture-fantasy of the client actually being this way in a concrete scene from his/her life, and (c) break into outright laughter.

As you can see, the format is in terms of when the client is doing this (i.e. antecedent client condition), then the therapist does that and that (i.e. therapist operation). The unstated client consequence is strong feeling. Presenting the category system in this way will give practitioners who are interested in promoting strong feeling concrete examples of how they might do so. In short, the results will be categorized, organized and presented in practitioner-relevant terms, and will include examples taken from the actual data.

Therapist uses of strong feeling. The category system of *therapeutic uses* of strong feeling will be presented in a similar format. It will again include 4-8 main categories, and additional subcategories. Under each main heading will be a detailed description of what that *therapist use* entails. This description will be in-depth and unabridged, and will be pulled together from the content of the composite descriptions under that category. It will be designed to show the practitioner precisely what the *use* is, and what different variations of the *use* are. Under this

description of the category (or subcategory), we will then include examples -- composite descriptions -- taken from the actual data. To demonstrate, suppose that we arrive at a main category of *therapist use* named "To sustain the strong feeling" that includes a subcategory called "To sustain the emotional encounter between therapist-client". In the results, we would provide a detailed description of the main category -- which would consist of a pulling together of all the themes inherent in all the composites under that category. Under that, we would provide a detailed description of the subcategory, and under that provide examples taken from our actual data to show how the therapists in our sample actually employed this *use*. The examples, taken from the actual data, will be the composite descriptions under that subcategory generated by the research team.

In summary, by presenting the two practitioner-relevant category systems in this way, we will be able to give concrete, detailed, unabridged, clinically meaningful answers to how therapists *promote* and *use* strong feeling in general. A further presentation of the results will allow us to focus more specifically on how therapists promote and use *different kinds* of strong feeling.

Presentation with a Focus on Different *Kinds of Strong Feeling, Families of Psychotherapy,* and *Eras of Session*

The focus here will be on how particular methods and uses are linked to different categories of strong feeling, families of therapy, and eras of session. This will be done through six frequency distribution tables: (1) *kinds of strong feeling* vs. *therapist methods*; (2) *kinds of strong feeling* vs. *therapist uses*; (3) *families of therapy* vs. *therapist methods*; (4) *families of therapy*

vs. *therapist uses*; (5) *eras of session* vs. *therapist methods*; and (6) *eras of session* vs. *therapist uses*.

Example (1): Therapist methods of promoting different kinds of strong feeling. As an example, I will illustrate the format of presentation for the first frequency distribution, which will plot *kinds of strong feeling* vs. *therapist methods*. Recall that, once data collection is complete, each strong feeling event will be tagged according to a particular *kind of strong feeling* and a particular *therapist method*. This will provide us with some simple frequency data about which kinds of strong feeling were judged as being promoted by which kinds of therapist methods. This frequency data will be presented in a format like Table X (see below). Table X presents data from a fictitious sample of 60 strong feeling instances.

Table X. Frequency distribution of a sample of 60 strong feeling events in terms of *kind of strong feeling* and the *therapist methods* judged as facilitating their occurrence

Therapist Methods	Kind of Strong Feeling				
	A	B	C	D	E
1	10	1	0	1	0
2	0	8	1	0	0
3	8	5	0	0	0
4	4	0	1	0	4
5	1	2	1	7	1
6	0	0	4	1	0
	23	16	7	9	5

In inspecting Table X, our interest will be in terms of which methods seem to associate with which kinds of strong feeling. So, if we look at strong feeling A, for example, it appears that, for our sample of therapists, methods 1 and 3 were the ones used most often to facilitate that kind of strong feeling. In addition, there were also instances in which methods 4 and 5 were employed to promote strong feeling A.

In looking at these patterns, and keeping in mind our research questions, we would be concerned with two things. First, we would want to statistically check, where possible, which therapist methods are linked with which kinds of strong feeling. Based on the frequencies in Table 1, we would not have a large enough sample size to conduct a full chi-square analysis. Indeed, if we were interested in doing a full chi-square analysis of this 5 x 6 table, we would need far more strong feeling instances -- 150 instances to be precise, given that chi-square requires that each of the 30 cells have an expected frequency of 5 (Spence, Cotton, Underwood, & Duncan, 1983). However, our interest is not in conducting "tight-fisted" statistical analyses. Our interest is merely to look at how the numbers seem to arrange themselves, and to describe the patterns statistically where possible. Therefore, our strategy will be to look for where we have enough data to do some more limited chi-square tests by collapsing some categories. For instance, looking down the column for strong feeling A, it would be possible to collapse the frequencies into three cells -- *method 1*, *method 3*, and *all other* -- and statistically test whether the observed frequencies for method 1 and method 3 deviate significantly from what would be expected by chance. For other strong feeling kinds, such as strong feeling C, there would not be enough data to conduct any statistical test. So, if and where possible, in order to answer our secondary

research question of which therapist methods are helpful for promoting which kinds of strong feeling, we will attempt to use chi-square analyses.

Second, beyond the statistical considerations, we would be interested in flagging where particular methods were employed at all in promoting particular kinds of strong feeling. Indeed, in cells in which even one sole instance of this occurs, we will consider that we have found something of potential clinical relevance. In all non-zero cells, we will have found that, in our sample, a method worked in promoting strong feeling. We would not dismiss a frequency of 1 as "insignificant". On the contrary, it can be seen that if a practitioner likes to employ *therapist method 1* and values *kind of strong feeling B*, then our findings show that he/she may be able to use that method to facilitate that kind of strong feeling. The cell frequency of "1" means that, for one strong feeling event in our sample, the therapist successfully did this. However, if that same practitioner (who likes to employ *therapist method 1*) also values *kind of strong feeling C*, then, based on our findings, we would have to tell that practitioner that we literally do not know if *strong feeling C* can be facilitated by *therapist method 1*. The cell frequency there is "0". This means that we found no evidence that this method does work. We have no idea if it works or not. All we know is that this combination did not occur in our sample of 60 strong feeling instances. So, in short, we would be interested in any instances in which categories of therapist methods "worked" to promote particular kinds of strong feeling. In non-zero cells, this will be the case, and we will have found something clinically important about which therapist methods can be employed to promote given kinds of strong feeling.

Example (2): Therapist uses linked with different kinds of strong feeling. To give a

second example, I will illustrate the format of presentation for the second frequency distribution, which will plot *kinds of strong feeling* vs. *therapist uses*. Again, recall that once data collection is complete, each strong feeling event will be tagged according to a particular *kind of strong feeling* and a particular *therapist use*. This will provide us with frequency data that can be presented in a format like Table Y (see below). Table Y shows data from a fictitious sample of 60 strong feeling instances. By looking at the frequency patterns in Table Y, it may be possible to examine our question of which therapist uses are associated with which kinds of strong feeling.

Table Y. Frequency distribution of a sample of 60 strong feeling events in terms of *kind of strong feeling* and identified *therapist uses*

Therapist Uses	Kind of Strong Feeling				
	A	B	C	D	E
1	10	0	0	1	0
2	0	13	1	0	0
3	3	3	4	4	0
4	0	0	1	1	4
5	10	2	1	3	1
	23	16	7	9	5

If we look at *strong feeling B*, for example, it looks like, for our sample of therapists, *use 2* is most commonly associated, although *strong feeling B* was also used according to *use 3* and *use 5*. If and where possible, we would be interested in statistically checking these patterns, using

collapsed chi-square analyses. Again, we would not have a large enough sample size to conduct a full chi-square analysis, but would have enough to do some more limited chi-square tests. For instance, looking down the column for strong feeling B, it might be possible to collapse the frequencies into two cells -- *use 2*, and *all other* -- and test statistically whether observed frequency of 13 for *use 2* deviates from what would be expected by chance.

In addition, once again, beyond the statistical considerations, we would be interested in flagging where particular uses occurred at all in our sample, in relation to particular kinds of strong feeling. In non-zero cells, where even one sole instance of a *therapist use* occurs, then we have found something that may be clinical meaningful to practitioners. We will have found that, in our sample of therapists, a particular kind of strong feeling was used in a particular way. So, if a practitioner values *strong feeling C* and *therapist use 2*, then our findings suggest that he/she may be able to use that kind of strong feeling in that particular way. The cell frequency of "1" means that, for one strong feeling event in our sample, a therapist did this. However, if that same practitioner (who likes to employ *therapist method 1*) also values *kind of strong feeling D*, then based on our findings we would have to tell that practitioner that we literally do not know if *strong feeling D* can be used according to *therapist use 2*. The cell frequency there is "0". This means that we found no evidence that this use can be employed for that kind of strong feeling. We have no idea based on our data if it can be done or not. All we know is that it did not happen in our sample of 60 strong feeling instances. So, in short, we would be interested in any instances in which categories of therapist uses occur in conjunction with particular kinds of strong feeling because they may provide information that is relevant to practitioners.

In summary, inspection and analysis of frequency tables similar to those provided above -- i.e. *kinds of strong feeling* vs. *therapist methods*; and *kinds of strong feeling* vs. *therapist uses* -- may enable us to answer the question of whether, for our sample of therapists, particular therapist methods and uses are associated with particular kinds of strong feeling. The issues of whether strong-feeling methods and uses vary according to *family of psychotherapy* and *era of session* will be addressed using frequency tables in the same way.

CHAPTER 4

RESULTS

The bulk of this chapter is devoted to presenting the principal findings: descriptions of *therapist methods* judged as facilitating occurrences of strong feeling, and subsequent *therapist uses* of strong feeling. Also reported in this chapter will be the secondary findings, which examine whether these therapist *methods* and *uses* seemed to vary according to *kind of strong feeling*, *family of psychotherapy*, and *era (decade, time-period) of session*. However, before presenting these main and secondary findings, I will proceed through reporting the quantity of sessions that were available for study; descriptions of these sessions; the number of strong feeling events found; our finding that the data set was sufficiently large to answer our research questions; the distribution of tapes according to *family of psychotherapy*; the distribution of tapes according to *era of session*; and the generated category system of *kinds of strong feeling*.

Rarity of Tapes Containing Multiple Instances of Strong Feeling

As previously described in the methodology chapter, the initial phase of the research protocol involved the principal investigator and a second judge (a function played, on a rotating basis, by various members of the psychotherapy research team) listening to the entire data pool of 450 tapes in order to identify sessions that met the tape selection criteria imposed to allow us to address our chosen research questions. As explained in the methodology, the tapes chosen for study were to be limited by the

following constraints: (a) sessions were to be included only if they were judged to contain a minimum of 2 instances of strong feeling; (b) the final pool of tapes, in order to prevent sampling bias, and enhance the generalizability of the results, was to include an equivalent number of tapes from each therapist studied -- thus guarding against the possibility that we would end up with a skewed sample comprised of a disproportionate number of tapes from certain therapists, and only one or a few tapes from other therapists; (c) only sessions with individual adult patients were to be included, as opposed to sessions with groups, couples, or children; (d) only complete psychotherapy sessions were to be included, as opposed to excerpts of sessions; (e) sessions were to be excluded if patients were judged to be exhibiting signs of serious psychopathology, such as psychoses or personality disorders; and (f) sessions were to be excluded if they were intake sessions that were the first in a series of sessions and/or sessions appearing to emphasize the gathering of assessment/evaluation information.

Based on the initial phase of the research protocol, the number of tapes meeting these stated selection criteria were far fewer than we expected to find at the outset. More specifically, the main obstacle was meeting the first selection criterion (i.e. obtaining tapes judged as containing multiple instances of strong feeling). Indeed, in our original data pool, only 20 (or 4.4%) of the entire 450 tapes studied were judged as containing 2 or more instances of strong feeling. In regard to the second criterion (i.e. that an equal number of tapes be chosen from each represented therapist), the reader should be reminded that the original data pool included 85 therapists representing a broad spectrum of therapeutic approaches. Of these 85 therapists, only 14 (or 16.4%) had sessions that

qualified as containing a minimum of 2 instances of strong feeling. Of these 14 therapists, 12 therapists were represented by 1 session each, 1 therapist was represented by 2 sessions, and 1 therapist was represented by 6 sessions. In order to equalize the number of tapes for each therapist, the available pool of tapes was thus reduced to 14 tapes -- one session from each of the 14 therapists. Each of these 14 remaining available sessions met the final four criteria, as stated above. In other words, all 14 sessions were complete sessions of individual adult psychotherapy, none were intake sessions, and none included patients judged as exhibiting signs of serious psychopathology.

Thus, the initial phase of protocol yielded an available data pool of 14 psychotherapy sessions. This sample of sessions represented a group of 14 different therapists. This number of available sessions was less than we had expected to find at the outset, and this was mainly because so few tapes were judged as containing multiple instances of strong feeling. In summary, only 20 (or 4.4%) of the 450 tapes in the original data pool were judged as containing multiple instances of strong feeling. Moreover, our final available pool of sessions is only 14 because only 14 (or 16.4%) of the 85 therapists in the original data pool had tapes that qualified as containing multiple instances of strong feeling.

Further Description of the Available Sessions and Therapists

In regard to the 14 therapists, 10 were psychologists, 3 were psychiatrists, and 1 was a social worker. In terms of gender, 11 were male, and 3 were female. Six of the sessions were of male therapists and female patients, 5 were of male therapists and male

patients, 2 were of female therapists and female patients, and 1 was of a female therapist with a male patient. The sample of therapists included names such as Fritz Perls, Harold Greenwald, Erving Polster, Neil Friedman, Donald Meichenbaum, Robert Pierce, Frank Farrelly, Lita Berg, and others. In terms of where in the course of therapy the available 14 sessions fell, it was the soft impression of the judges that most came from the middle to later stages of therapy -- although the limited available descriptive information made it, in most cases, difficult or impossible to verify this.

Final Identification of the Data Set of Strong Feeling Events

As discussed in the method chapter, the initial phase of the research protocol involved two judges -- the principal investigator and co-investigator -- provisionally identifying and locating all strong feeling events that occurred in the 14 retained tapes. For an event to qualify, a stringent criterion of 100% agreement between the two judges had to be attained. In total, 52 strong feeling events were provisionally identified by the co-investigators. These provisionally identified 52 instances were subsequently rated by the full research team, with a minimum of 70% agreement required for each to meet final qualification as a strong feeling event. All 52 instances met criterion, and the mean inter-judge agreement was 88.2%.

In terms of the distribution of 52 strong feeling events across the 14 sessions, one session contained 8 strong feeling events, four sessions contained 5, one session contained 4, four sessions contained 3, and four sessions contained 2.

The Available Data Pool Appears to Have Been Sufficiently Large to Answer our Research Questions

As described in the methodology, our original intent was to continue collecting data, if possible, until we were quite confident that the probability of making new discoveries -- in the form of new therapist *methods* and *uses* linked with strong feeling -- was dropping towards zero. Our reasoning was that, if a large number of consecutive protocols (perhaps 10-12) yielded no new categories or subcategories of *therapist methods* or *therapist uses* related to strong feeling, then this would taken as an indication that (a) the probability of making new discoveries with further data collection was dropping toward zero; (b) the existing findings were ones that we could hold with some solid confidence; and (c) data collection could be ceased.

However, because we had access to only 14 tapes, and the number of strong feeling events yielded was relatively low (52), the research team studied all available strong feeling events. In other words, the entire available data set was exhausted. This raised the issue of whether our research questions were adequately answered with the available data. The trend depicted in Figure 1 below suggests that, although our data pool was small, it seems to have been large enough to generate categories of therapist *methods* and *uses* that we can hold with some solid confidence. Figure 1 shows the frequency of discovery of new *therapist methods* and *therapist uses* occurring over the course of studying the 52 strong feeling events. It is evident that the bulk of new discoveries occurred over the course of studying the first 19 strong feeling moments. Indeed, over this period, 4 different categories of *therapist methods* were identified, as were 4 different

categories of *therapist uses*. A fifth *method* category and a fifth *use* category were added between protocols 27-32. The final 20 protocols, however, all confirmed and refined the fabric of the existing category systems, rather than adding any substantively new categories.

Thus, although it would have been preferable to have a larger data pool at our disposal, Figure 1 suggests our limited pool of 52 strong feeling events may be sufficient to generate categories of *therapist methods* and *therapist uses* that we can hold with some confidence. Indeed, the fact that, even with our small pool of data, the final 20 consecutive protocols added no substantively new categories indicates that the pay-off of studying more instances of strong feeling may have been minimal. Nevertheless, it is still possible that whole new categories might have emerged if we had had access to and studied further instances of strong feeling.

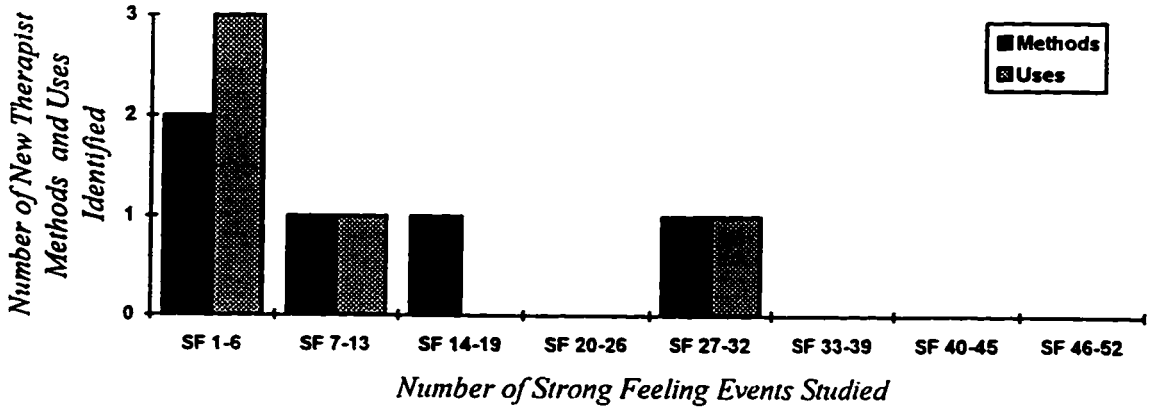

Figure 1. Number of New Categories of Therapist Methods and Therapist Uses Found Over the Course of Data Collection

Distribution of Tapes According to *Family of Psychotherapy*

In order to allow us to look at the data in terms of whether strong feeling methods and uses varied according to different families of psychotherapy, each of the 14 sessions was categorized according to *family of therapy*.

As described in the methodology, each of the 14 sessions was placed into a category of *family of therapy* based on the research team judges' answers to the following question: (1) *Based on your assessment of the therapist's behaviour (methods, interventions, working principles) in this session, into which one major family of psychotherapy -- psychoanalytic-psychodynamic, humanistic-experiential, cognitive-behavioural, or integrative-eclectic -- would you tend to place this session?* For a session to be successful placed in a category, the minimum level of inter-rater agreement was set at 65%. All 14 sessions met this criterion, and the mean inter-judge agreement was 72.6%. The 14 tapes were placed into therapeutic families as follows: *psychoanalytic-psychodynamic* (2 sessions); *humanistic-experiential* (5 sessions); *cognitive-behavioural* (3 sessions); and *integrative-eclectic* (4 sessions).

Furthermore, in order to assess the research team's level of certainty about their ratings, the judges were also asked to answer, using a 4-point Likert scale, a second question: (2) *How confident are you that this session truly belongs in the category you have chosen?* (1 = not confident at all; 2 = slightly confident; 3 = confident; 4 = very confident). It was found that the judges' confidence in their ratings was consistently low. Indeed, averaged over the 14 sessions, the mean confidence rating on a 4-point Likert

scale was 1.87 (sd = 0.46), which indicates that the judges had, on average, less than "slight confidence" in their decisions about which tapes belonged to which families of psychotherapy.

In summary, although each session was placed into a category of family of therapy with an adequate level of inter-rater agreement, the research team's confidence in their ratings was consistently low.

Distribution of Sessions According to *Era*

In order to allow us to look at whether strong feeling methods and uses differed according to the era of the session -- i.e. the time or year when the session took place -- each of the 14 sessions was categorized according to its era. Using catalogued summary descriptions from the A.A.P. and University of Ottawa Tape Libraries, the 14 sessions were placed as follows: *1965-1974* (4 sessions), *1975-1984* (6 sessions), and *1985-1994* (4 sessions).

Category System of Kinds of Strong Feeling

As described in the methodology, all judges independently examined each of the 52 instances of strong feeling, and provided written descriptions of the nature and content of each strong feeling event. Then, another pair of judges arrived at -- by pooling together the individual descriptions -- a single composite description for each instance of strong feeling. Once 30 composite descriptions had been accumulated, the pair of judges studied them independently, with the objective of organizing the composite descriptions -- on the

basis of similar, overlapping themes -- into a provisional category system of between 4 and 8 categories.

The results indicated that both judges arrived at 5 categories, and that there was an almost perfect agreement in the naming of each of the 5 categories. The final phase was the subsequent refinement of the category system with the inclusion of the additional composite descriptions -- generated as data collection continued. The results indicated that each additional composite fit under the fabric of existing five categories, and that little subsequent revision of the category system was necessary.

What follows is the empirically-generated 5-fold category system of the strong feelings that were judged as occurring in the sample of 52 strong feeling events. For a complete list of all 52 composite descriptions, one for each strong feeling event, including the strong feeling category to which each composite belongs, please see Appendix C.

1. Good-Feeling Happiness-Pleasure-Laughter

This includes feelings of joyful, unabashed happiness and pleasure, and hearty, good-feelinged laughter.

Example: After the patient mentions that he saw a particular woman the day before, the therapist says, "Did you fuck her?". The patient says, "No. I was thinking of it, though." Then, he undergoes a sudden, short, outburst of hard, hearty, pleasurable laughter that seems related to his abruptly saying, "No. I was thinking of it though," in answer to the therapist's question.

Example: The patient undergoes a full, hearty burst of strong laughter as he enjoys the therapist's good-humored, buddy-to-buddy, mocking of the patient's cavalier, man-of-the-world demeanor.

2. Mixed-Feeling Laughter

This includes laughter that is laced with bad feelings; that has components of

tension, anxiety, pressure; that is not purely happy and pleasureable.

Example: The patient is engrossed in a planned sexual escapade with a special partner, suddenly stops and yells, "But what do we do if ...?!!", and explodes in shrieks of laughter filled with tension and anxiety, and interspersed with the words, "I'd die!" Oh no!! I couldn't handle it!! Oh God!!"

3. Defiance-Opposition, Strength-Toughness, Frustration-Exasperation

This includes hard feelings of strength, toughness, firmness; of refusal, defiance, opposition; of frustration, exasperation, disgust, irritation, attacking. The target may be the therapist or other person or agent, and the feeling may be pleasureable or painful.

Example: The patient yells and screams directly at the therapist, "You are a sadistic bitch!!"

Example: The patient belts out, in a high-volumed vigor, "I won't do it!! I won't!! No one can make me do it!!".

4. Bad-Feeling Hurt-Pain-Anguish

With or without crying, this includes feelings of painful blame, hurt, pain, anguish, complaining, accusation, helplessness, vulnerability, loss.

Example: The patient is moaning and groaning in tearful anguish and pain, attention riveted on her father, as she hurtfully pleads: "It's not my fault! No! I'm not to blame! Please, please, leave me alone!"

Example: The patient is almost choking with hard, wracking sobbing, and feeling openly vulnerable, shameful, bad, guilt-ridden.

5. Good-Feeling Love-Caring-Closeness

This includes good, warm feelings of love, caring, cherishing, closeness, being one with, friendship, nurturance.

Example: The patient is telling about a conversation that he had with his daughter in which she told him how hard it was for her when he was absent every third weekend. The patient cries lightly in caring love for his daughter -- during and after he recites the words that she said to him during that conversation: "Daddy, you can have your every third weekend, but you don't know how hard that is for me."

Distribution of the 52 Strong Feeling Events Across Categories of Strong Feeling

The distribution of the 52 instances of strong feeling over these five categories of strong feeling was: category 1 (*good feeling happiness-pleasure-laughter*), 25.0%; category 2 (*mixed-feeling laughter*), 7.7%; category 3 (*defiance-opposition, strength-toughness, frustration-exasperation*), 36.5%; category 4 (*bad feeling hurt-pain-anguish*), 26.9%; and category 5 (*good feeling love-caring-closeness*), 3.8%.

Descriptions of Therapist Methods of Promoting Strong Feeling

The first main objective of this study was to identify, describe, and categorize the *therapist methods* judged as facilitating the occurrence of strong feeling. Study of the 52 instances of strong feeling resulted in the identification and description of 5 distinct therapist methods. Furthermore, for all 5 methods, the research team was able to identify one or more specific, in-session *patient conditions* under which each method was applied. In other words, none of the therapist methods were judged as occurring incidentally and randomly -- outside of any identifiable and relevant in-session patient context. The therapist methods and patient conditions found by the research team constitute half of the principal findings of this study -- fulfilling the aim of identifying how therapists promote the occurrence of strong feeling events.

What follows is the empirically-generated description of 5 therapist methods (including identified patient in-session conditions) judged as occurring in the sample of 52 strong feeling events studied. Each method will be presented and described in the following way. First, each method is headed by a label which was decided upon by the

consensus of the research team. Second, a description is provided of the specific patient condition(s) under which each method was employed, exactly as finalized by the research team. Third, a concise definition of each method is provided -- precisely as generated, modified, and finally approved by the research team. Fourth, in order to enhance the clinical usefulness of the findings for practitioners, specific examples of each therapist method -- taken from the actual verbatim session transcripts -- will be included. These examples will be accompanied by further commentary and clarifications based on the soft impressions-observations of the principal investigators and the research team. For a compact summary of these results, please refer to Appendix A. Furthermore, for a complete list of all 52 composite descriptions of the identified therapist methods (and in-session patient conditions), as well as a specification of the particular method category under which each composite was placed, please see Appendix D.

1. ***Direct Provocation of Strong Feeling***

The therapist directly provokes the patient into a state of strong feeling. There are two subheadings.

1.1 Instruct patient to repeat feeling-laden phrases or movements.

Patient Condition: When the patient is already undergoing a moderate level of feeling,

Therapist Method: The therapist persistently, feelingfully, and forcefully instructs the patient to repeat the feeling-laden words and/or bodily movements again and again.

1.2 Push-oppose patient with good humour.

Patient Condition: When the patient is hesitant-reluctant (i) to carry out a new, anxiety-provoking, risky, extratherapy behaviour (advocated or prescribed by the therapist); or (ii) to be open, direct, and forthcoming in response to therapist's

probing questions,

Therapist Method: The therapist -- with playful, confrontational, crisp, blunt humour -- persistently continues to push-persuade the patient to do what the therapist wants him to do, and tenaciously opposes-punctures the patient's apparent reasons for being hesitant-reluctant.

Examples and Further Commentary

Example 1:

Patient Condition: When the patient is already undergoing a moderate level of feeling.
Therapist Method: Instruct patient to repeat feeling-laden phrases or movements (*method 1.1*).

P: (bangs, yelling at ex-boyfriend in role-play) You bastard!

(*Commentary*: The patient is now undergoing a moderate level of feeling. In the service of promoting strong feeling, the therapist will now be exceedingly persistent and forceful in instructing her to say the feeling-laden words again and again.)

T: Uh huh. (yells) You bastard! Again!
P: Out! Out of my life! You bastard!
T: Tell him! Give it to him. Say it again louder!
P: Out! Out! Out! (speaks directly to therapist) There's a lot of anger there.
T: Just sense what's there now.
P: I feel sad.
T: Just feel it.
P: (pause) (banging) I wasted a lot of time on you! Incompetent! I'm not the problem! The problem is you!
T: Yeah. Yeah! Do it again. (yells) My problem is you! Louder! Feel it more!

(Now the patient undergoes an extended burst of strong feeling.)

P: **(yelling, with strong feeling) Oh my problem is you! Don't tell me I can't love! You're the one who can't love, you promiscuous bastard!! You're so dumb and simplistic!!**
T: You're not good enough for me!!
P: **Yeah, you're not good enough! (banging) And you didn't like colour! (angry tears) No colour in your life! No feeling! Rigid! (pauses) (shrieks) Aaah!! I feel like I'm gonna do something wild! Unpremeditated! Absolutely wild!**

Example 2:

Patient Condition: When the patient is hesitant-reluctant to carry out a new anxiety-provoking extratherapy behaviour
Therapist Method: Push-oppose patient with good humour. (*method 1.2*)

P: (sighs) I really enjoyed going out with him. I'd really like to see him again.
T: And how can you make that happen?
P: Well. Shit, I don't want to initiate anything, but if I want something, then I guess I need to do that.
T: So how can you make that happen?
P: By getting in contact with him... (pause)
T: Smoke signals, or ...?? (chuckles)
P: (chuckles in protest) I just thought I might give him a little time in case he wanted to call me, you know! Umm. Uh. (groans) Aah! (chuckles) Or, (squirmingly) Shit, yeah, I know... I have to call him up. But....

(*Commentary*: The in-session patient condition is as follows: on the one hand, the patient wants to see this man again; on the other hand, she feels anxious and hesitant about the prospect of actually calling him up on the phone and asking him out for a second date. The therapist is starting to push the patient to carry out the behaviour, and to oppose the patient's hesitation. Notice also that there is an air of playfulness and humour in the therapist's way-of-being.)

T: Be real specific with me, OK. (P groans with trepidation) I want to know exactly when you're going to call him (P laughs), and exactly what you're going to say to him when you do.
P: (slowly, nervously) And, so.... I'm gonna, aah, call him up, or ....
T: (abruptly) When?
P: Shit. (sighs) Oohh ... (chuckles) Maybe ....
T: ("upping the ante") Just call him right this minute ...?
P: (pause) (nervously, unconvinced) Well, I could.

(*Commentary*: The therapist has incrementally upped the ante -- first by trying to get the patient to commit to a specific time when she'll do the behaviour, and then by pushing the patient to agree to do the behaviour right this minute. The patient remains hesitant, and nervous. In the ensuing moments, the therapist will continue to persistently push-persuade the patient to do the behaviour. This will culminate in a burst of strong feeling in which the patient defiantly yells at the therapist.)

T: (forcefully, matter-a-factly) So, why don't I leave the room, and you call him --
P: (protesting) Nooo...!
T: -- and then I'll come back in and we can discharge how awful that was or how wonderful that was.
P: Oh shit, no. I don't want to do that. (sighs) Oh don't you do that to me! (laughs nervously)
T: It's like you figure I'm gonna get something out of this?!
P: **(with strong feeling) You are!!**
T: I am? What?
P: **You sadistic bitch!!**
T: I ... (chuckles)
P: **You just want to watch me squirm!!** (sighs)

Example 3:

Patient Condition: When the patient is hesitant to be open and direct in response to therapist's probing questions.

Therapist Method: Push-oppose patient with good humour. (*method 1.2*)

(*Commentary*: The patient has already disclosed in the session that he has vaguely contemplated suicide over the past months, and that his relationship with his wife has deteriorated to the point that they almost never have sex together. The therapist has been brashly interrogating the patient about his masturbation habits, and why he'd rather masturbate than have sex with his wife. The patient is chuckling, and seems coyly hesitant to answer the therapist's probing questions.)

T: (brashly, tough, buddy-buddy like) OK, Billy Bob. Let me get this straight. You fuck-your-fist -- you shake-the-snot-out-of-the-one-eyed-worm -- two or three times a week! And you've done that for years.
P: I suppose.
T: (toughly) Not I suppose!
P: (coyly) Yes. (chuckles)
T: (sarcastically) "Yes". (playfully jostling-attacking) Look how cooperative he's being. Now I'm not tricked or fooled by this. I know how this routine works. Haah! You think you've got an agreement -- turns out you don't! Haah!
P: (says nothing)

(*Commentary*: The therapist is pushing-opposing the patient with an air of playful, buddy-buddy humour. As this excerpt continues, notice the therapist's exceeding bluntness in tenaciously (a) pushing the patient to answer his questions, and (b) puncturing-opposing the patient's apparent reasons for withholding. It will culminate into two bursts of strong hearty laughter -- noted in bold-typed face.)

T: Let the record show that I'm getting a meaningful existential stare, while he's treading water mentally and trying to figure out a response to this.
P: That's correct. **(bursts out into strong hearty laughter)**
T: (forcefully, brashly) So, Billy Bob. What's better about fuckin'-your-fist than getting it on with the aging matron?
P: (chuckles) (doesn't answer)
T: Gawdd! (Gasps playfully) Look at -- you're just so existentially weary. You should be carved on a monument or something. You got your little strawberry blonde dirt and, you know, that irresistible receding hairline. It just looks so existentially weary and stuff -- the way you .... the whole thing. Where'd you learn that little facade?
P: (chuckles) I guess I've practised it all my life.
T: (playfully) I'll bet you have. It's pretty smooth. It's a little thin. When we get to the nerve-points, Billy Bob -- (P and T both chuckle) -- it drops off real fast.
P: (chuckles)
T: (loudly, playfully) Now, Billy Bob. I'll ask you again! Before your last will and testament, and your last words before you smash yourself up against a tree or blow your brains out all over the living room ceiling, or whatever the shit -- what's better about fucking your fist than fucking your wife?!
P: (hesitantly, quietly) Aaah .... (chuckles)
T: (loudly, playfully, with good tough humor) C'mon -- A lot of guys do this! You didn't invent this, "few brains"!
P: **(bursts out into an extended round of strong hearty laughter)**

2. *Welcoming-Encouragement of Strong Feeling*

In applying this method, the therapist quietly, relatively passively welcomes-encourages the emergence of strong feeling.

Patient Condition: When the patient is already undergoing a moderate level of feeling,

Therapist Method: Quietly welcome-encourage its occurrence. Provide the atmosphere and/or physical props for expression of strong feeling, and when feeling begins to occur in the patient, quietly welcome-encourage its expression.

Example and Further Commentary

(*Commentary*: In this example, the therapist has provided physical props, such as a pillow, that allow for the expression of feeling. Beyond this, in the research team's judgement, the patient has, pretty much on her own, reached a moderate intensity of feeling. Once the patient has reached moderate feeling, the therapist quietly accepts the patient's expression -- and this culminates in a moment of strong feeling.)

P: (angry, frustrated) It's impossible for me to trust. Impossible! I run from it. I push it away if it comes too close. I'm afraid of it. When things are going peacefully, then I can just take so much of that before I'm gonna look for trouble. And then I find it. (pauses) (speaking with more frustration) I'll get this out of me now. Out of my head! (starts punching a soft pillow or bag that the therapist has provided) (feeling level is now moderate)

T: (quietly encouraging) Uh huh.

P: Oh boy! That's good to get that out! (continues punching) And it didn't hurt anybody.

T: Uh huh.

P: **(with strong feeling) Oh, I just love to punch! (punches more) I just love to punch!**

T: (encouragingly) Uh huh.

3. *Intensification of Patient-Therapist Encounter*

The therapist intensifies the patient's expression (experiencing, undergoing) of feeling in the context of the therapist-patient encounter (relationship, interaction). There are two subheadings.

3.1 Make patient's implicitly-conveyed feelings explicit.

Patient Condition: When patient seems to be having feelings toward the therapist, but is only indirectly expressing (hinting at) them,

Therapist Method: The therapist bluntly, directly, and forcefully explicates (highlights, suggests) what the patient seems to be really saying-feeling right now toward the therapist.

3.2 Refuse patient's interpersonal request-demand.

Patient Condition: When the patient is openly critical of the therapist, and how the therapist is being-behaving

Therapist Method: The therapist frustrates the patient either by (a) openly disagreeing with the patient's opinion of the therapist; or (b) ignoring or not responding to the specific content of the patient's criticism.

Examples and Further Commentary

***Example 1*:**

Patient Condition: When patient seems to be having feelings toward the therapist, but is only indirectly expressing them,

Therapist Method: Make patient's implicitly-conveyed feelings explicit. (*method 3.1*)

P: You make me feel like ...
T: Like what?
P: (sighs) Like I could tell you. Oh, I'll try to tell you. I'll try. (pause) (slowly, quietly) You see, it's like ... (sighs) ... there are things about you that I think aren't nice.

(*Commentary*: The patient condition is established here -- with the patient mentioning having negative feelings toward the therapist, but doing so in a tentative, indirect way. The therapist now will induce the patient to more direct, intense expression of her feelings toward the therapist. He will do so by bluntly rephrasing-interpreting -- with plenty of feeling -- what he believes the patient is really meaning and saying, and then is encouraging when the patient begins to respond in a more direct, open way.)

T: (loudly and forcefully) You're being kind again! There are things about me that are lousy!
P: They're terrible.
T: Right. Now you're being truthful.
P: **(with strong feeling) But I mean you're phony!**
T: That's right.
P: **And you're insincere!**
T: Right.
P: **And you say things that aren't nice!**

***Example 2*:**

Patient Condition: When patient is openly criticizing-attacking the therapist.

Therapist Method: Refuse patient's interpersonal request-demand. (*method 3.2*)

P: But did you ever think that there might be something lacking in how *you* are? You are blaming.

(*Commentary*: The patient condition is now established: the patient has just leveled a criticism at the therapist, accusing her of being blaming. The therapist now begins to frustrate the patient by refusing to accede to the patient's insistent interpretation of what she is like. The result is an intensification of the patient-therapist encounter with the patient eventually exploding in a burst of strong-feelinged anger --

noted in bold-typed face.)

T: No. I don't blame anybody.
P: Yes you do. Don't give me that crap!
T: No. No.
P: Yes you do!
T: No. I don't blame.
P: What is that? What the hell do you mean, "I don't blame"?
T: I don't blame that you are how you are...
P: (sarcastically) Oh, that's so accepting of you.
T: No, I'm not accepting... I --
P: You're goddam right you're not. So why do you say, "I don't blame"?
T: I don't blame. I just look at what I see--
P: Condescending.
T: No.
P: **(with strong angry feeling) Yes! That's exactly what I experience from you!**
T: No I'm not condescending.
P: **You sure as hell are!**

***Example 3*:**
Patient Condition: When patient is openly criticizing-attacking the therapist.
Therapist Method: Refuse patient's interpersonal request-demand. (*method 3.2*)

P: (accusingly, and also sounding concerned about therapist) I think you drink. I think you're sick.

(*Commentary*: The patient condition is established as the patient criticizes the therapist -- accusing him of being a sick drunkard. Instead of reassuring the patient that he is not "sick" (as it sounds like the patient is inviting him to do), the therapist frustrates the patient by somewhat outrageously deflecting her attention in another direction. This maneuver promotes a burst of intense anger -- noted in bold-typed face -- directed at the therapist.)

T: Yeah. You see, you said before that you think you're stupid -- yet most of the other patients haven't realized how sick I am. I think that's great. As a matter of fact, if you must know, one of the reasons why I kept you at a lower fee, and why I like your telephone calls and so on, is because I think that you might be able to help me -- because you've helped me already.
P: **(with strong feeling) Oh, when you say things like that -- that's part of what I can't stand!!**
T: What are you talking about!?
P: **How could I help you?!**
T: By telling me that I come across sick.
P: **-- I can't help you!**
T: Why not?

4. Enlivening Scene of Strong Feeling

This method involves the therapist heightening the patient's feeling in the context of an emotionally-laden, charged, painful scene-situation.

Patient Condition: When the patient's attention is already partly centered on an emotionally-compelling scene-situation that is frought with bad feelings,

Therapist Method: The therapist enlivens the strong-feelinged part of the scene by (a) describing it in a highly detailed, immediate manner; (b) enacting, with strong feeling, the complementary role of the provocative other person in the scene who elicits bad feeling in the patient; and (c) intermittently switching over to the role of the reassuring therapist-guide who tells the patient what to do, and how to do it.

Example and Further Commentary

Patient Condition: When the patient is already partly attending to a bad-feeling scene-situation.

Therapist Method: Enliven scene of strong feeling.

(*Commentary*: The scene -- that the therapist and patient are beginning to enact in the following excerpt -- involves the patient's father, who, in the patient's experience, insults and rejects her whenever she seeks closeness with him. The therapist makes the scene alive and real, alternating between enacting the role of the pain-inducing father, and the supportive therapist-guide.)

T: Reach out to me, really trusting, c'mon. (Patient tries to reach out, and therapist physically pushes her away, enacting the patient's father's pain-inducing way-of-being)
P: That's mean.
T: Uh huh. C'mon. Reach out again. C'mon.
P: (laughs) You're gonna push me away again, aren't you?! (Patient reaches out, and is pushed away) Why?!
T: Feel it. (pause) (as father) You're dumb.
P: No I'm not.
T: Yeah, you are. You're dumb.
P: Why?
T: You're dumb and stupid. 'Cause you're a woman, I don't know why. You're just dumb and stupid. (talking now as the supportive therapist) Reach out again. (as father) Get away, just get away. Tsk. Tsk. (as supportive therapist) Let yourself feel it. Reach toward me. Look at me and reach toward me.

(*Commentary*: Notice that the therapist has alternated between roles. In the role of supportive therapist-guide, he tells the patient what she is to do in the scene, and encourages her to express the feelings that emerge as they act out the scene. In the role of the pain-inducing father, the therapist criticizes the patient and physically pushes her away after inviting her to reach out to him. This therapist method promotes an extended moment of painful strong feeling in the patient -- noted in bold-typed face.)

P: (begins to cry)
T: (as supportive therapist) Say, "this is hurting me." Say it to me
P: **(sobbing with strong feeling) This is hurting me. This is hurting me.**
T: Uh huh. You're reaching out, and I'm holding you away, saying bad things to you. Tell me it's hurting you.
P: **(crying hard) It's hurting me.**
T: Uh huh. That's right. There's sobs in there. Let them out. That hurt you didn't it? How does it feel when I push you away?
P: **It feels awful! It feels awful!**
T: (provocatively) You want me to do that again?
P: **(crying hard) No! Please don't ever do that again! Don't ever do it!**
T: Shake me real hard and tell me loud.
P: **Don't ever do it again!**
T: You want me to do it some more?! We'll do it again pretty soon, huh?
P: **(crying and pleading) No! Please don't do that again.**
T: Stand up. Shake the shit right out of me. Look right at me.
P: **(sobs loudly) I don't wanna do it again! Please, no more!**

5. *Intensification of Patient-Other Encounter*

In applying this method, the therapist heightens the patient's feeling in the context of the encounter-interaction with a significant other (person, part of self).

Patient Condition: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),

Therapist Method: The therapist (a) instructs the patient to say the feeling-laden words directly to the other (person, part of self); and (b) is persistent and consistent in keeping the patient immediately involved in the direct encounter with the other. The therapist may also (c) enact the role of the other person to whom the patient is uttering the feeling-laden words. When the feelings become relatively strong, the therapist may (d) tell the patient to switch roles and be (speak as) the other person.

Examples and Further Commentary

***Example 1*:**

Patient Condition: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),

Therapist Method: Intensification of patient-other encounter.

P: (exclaiming, as he talks about his father, who deserted the family when patient was a child) He had the brains and the intelligence and resources if he only could have used them!

(*Commentary*: The patient is saying feeling-laden words about his father. The therapist now applies the method of *intensifying the patient-other encounter*: he tells the patient explicitly to say these same words now directly to his father. Almost immediately, the patient's feeling level increases to strong -- as noted in bold-typed face.)

T: Say this to him now.
P: You had the brains... **(starts to cry, with strong feeling)...if only you could have used them. If only you could have used them. (cries) Oh God, if only you could have used them. (sobs)**
T: Can you tell him that he betrayed you to your mother, sold you out to your mother.
P: **You ran off and you left me with that stupid woman! I wasn't big enough then to sort it out and realize what a jackass she was. (sobs)**

Example 2:

Patient Condition: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),

Therapist Method: Intensification of patient-other encounter (*by persistently keeping the patient involved in the direct encounter*)

(*Commentary*: The patient has just been speaking directly to the "collective man" in an empty chair exercise. She just said directly to the "collective man" how angry she is at him. Then, she begins to feel sad. She pulls out of the patient-other encounter, and addresses the therapist directly.)

P: (sounding sad, speaking to therapist) I'm tired of being angry.

(*Commentary*: The therapist will not let the patient pull out of the patient-other encounter. He is persistent in keeping the patient immediately involved in the direct encounter with the other, telling her to say the feeling-laden words to the other.)

T: Tell him.
P: (starts to cry) This is why -- I guess.... I don't want to cry.
T: (supportively) It's all part of it.
P: (whispers) I'm tired.
T: What's happening to your hands? Do your tears keep you from telling him how pissed you are?
P: **(cries intensely, with strong feeling) No!! I am so pissed but it doesn't do any damn good anyway!**
T: For whom.
P: **(through tears) For the coll -- collective woman.**
T: That's right. But what does it do for you? Let's see what happens. You don't know yet. Speak even though you're crying, and even though you're pissed.
P: **(crying with strong feeling, directly addresing the "collective man") None of you are ever going to do it to me again, I know that. And I know how not to be your victim anymore. And I have as much power as you do.**

***Example 3*:**
Patient Condition: When the patient's feelings have become relatively strong and the patient is already directly encountering (interacting with) the "other"
Therapist Method: Intensification of patient-other encounter (*by telling patient to switch roles and be-enact the other*).

P: You see my "will" right now is holding me back! (laughs) I'm looking at my will.
T: Fine. Fine. Fine. OK. OK. Good.
P: It keeps screaming inside, "No. No. No."

(*Commentary*: The patient has been directly addressing a part of self -- her "will" -- and is undergoing a substantive level of feeling right now in describing this part of self, and what it is like. The therapist applies the method of heightening the patient-other encounter by instructing the patient to switch roles and actually "be" this part of self.)

T: OK. Now I want you to be your will. Scream that. Just say NO. Shout. Exactly the way you were doing it. Just do it right now.
P: Like a 2 year-old?
T: That's right. I want you to say it, right now.
P: No!
T: Louder!
P: No!
T: Louder!
P: **(with strong feeling) NO!!**

Distribution of the 52 Strong Feeling Instances Across Categories of *Therapist Methods*

The distribution of the 52 strong feeling instances in terms of these five kinds of *therapist methods* was: method 1 (*direct provocation of strong feeling*), 40.4%; method 2 (*welcoming-encouragement of strong feeling*), 3.8%; method 3 (*intensification of therapist-patient encounter*), 26.9%; method 4 (*enlivening scene of strong feeling*), 11.5%; and method 5 (*intensification of patient-other encounter*), 17.3%.

Descriptions of Therapeutic Uses of Strong Feeling

The second main aim of this study was to identify, describe, and categorize the *therapist uses* of occurrences of strong feeling. Analysis of the 52 instances of strong feeling resulted in the description of 5 distinct therapist uses. The therapist uses found by the research team thus constitute the second half of the principal findings of this study.

What follows is the empirically-generated description of 5 therapist uses judged as occurring in the sample of 52 strong feeling events studied. Each use will be presented and described in the following way. First, each use is headed by a label which was decided upon by the consensus of the research team. Second, a concise definition of each use is provided -- precisely as generated, modified, and finalized by the research team. Third, in order to enhance the clinical usefulness of the findings for practitioners, specific examples of each therapist use -- taken from the actual verbatim session transcripts -- will be included. These examples will be accompanied by further commentary and clarifications based on the soft impressions-observations of the principal investigators and the research team. For a compact summary of these results, please refer to Appendix B. Moreover, for a complete list of all 52 composite descriptions of the identified therapist uses, as well as a specification of the particular use category under which each composite was placed, please see Appendix E.

1. ***Sustain (Prolong, Intensify) the Strong Feeling***

   The therapist induces the patient to keep undergoing-showing the strong feeling with sustained or even fuller intensity. The therapist may (a) forcefully instruct the patient to keep expressing the feeling; or (b) playfully oppose-attack the patient for having the strong feeling, which also paradoxically pulls for the patient to feel the feelings even more. When the patient's strong feeling is directed

(in role-play) toward a significant other person, the therapist may sustain-intensify the patient's feeling by (c) feelingfully enacting the role of that other person, engaging-provoking-opposing the patient in the immediate, charged interaction.

Examples and Further Commentary

Example 1:

Therapist Use: Sustain the strong feeling (*by playfully opposing-attacking the patient for having the strong feeling*).

P: **(with strong angry feeling) I'm gonna say something I shouldn't say! (laughs)**

(*Commentary*: The patient is in a state of strong feeling. Her attention is on her ex-boyfriend, and she is undergoing intense anger. In the following excerpt, the therapist persistently and playfully opposes her and criticizes her for having the feelings she is having -- and yet the message he is conveying through it all is, "Yes. Good. Feel it more!" The net result is that the patient's strong feeling is prolonged and sustained.)

T: (playfully) Oh don't! Don't Mary! Don't do that!
P: **(laughing) Oh yes!**
T: No, stay controlled! Stay premeditated!
P: **(forcefully, angrily) No! No!**
T: Plan everything out Mary!
P: **No!!**
T: (provocatively) Yes. Yes. You're in control.
P: **No! No!**
T: You're in control. Be controlled.
P: **(toughly, defiantly) No! I'm gonna say what I feel!**
T: (quietly, playfully) Not too aggressive. Be controlled.
P: **(screaming more intensely) AND I DON'T CARE IF I THREATEN YOU OR NOT!! IF YOU DON'T LIKE IT, LEAVE!!!**

Example 2:

Therapist Use: Sustain the strong feeling (*by playfully opposing-attacking the patient for having the strong feeling*).

(*Commentary*: In the early part of the session, it has been apparent that the patient is upset about something, but she won't tell the therapist what. She is generally being sullen and defiant toward the therapist. When she finally hints that she is upset because her boyfriend has just "broken up" with her, she starts to cry. The therapist uses this strong feeling to heighten-prolong-sustain it. He does this by humorously and provocatively opposing-attacking-prodding the patient for having the strong feeling.)

P: **(starts crying)**
T: (brashly, humorously, sounding alarmed) Oh don't, don't cry. For crying' out loud, it just makes me all nervous if you do that. (pauses) You gonna cry? I'll get a piece of cardboard here for ya (chuckles). Ah, just a second. (Gets up and "looks" for cardboard in his desk) Oh hell, well there's nothing.
P: **(cries intensely)**
T: (pushing, prodding patient) Well is that it, huh? Your boyfriend went away and that

kind of stuff, huh? Do you think that might be why you're, you know, so goddam depressed? Huh?

P: **(sobs)**

T: (loudly, unsympathetically, comedically).... Ah, go ahead cry, it all comes with the fee if you want to.

P: **(continues crying)**

T: (with good humour) My, my. We do have feelings after all, don't we?

P: **(through tears) I don't know what you're trying to prove!**

T: Trying to prove? I'm not trying to prove anything! All I'm saying is, you're depressed -- "A", number one. "B" -- you say you just kind don't feel one way or the other about much of anything, bla, bla, bla -- and it turns out you do feel something about something, don't ya?

P: **I didn't deny that I did.**

T: Well what hurts, sweetheart?

Example 3:

Therapist Use: Sustain the strong feeling (*by enacting the role of the other person with whom the patient is interacting*)

(*Commentary*: As the following excerpt begins, the patient starts to sob -- in hurt and anguish -- as the therapist enacts, with strong intensity, the role of the patient's punishing-attacking, guilt-inducing mother who accuses the patient of having shameful sexual desires. In using the strong feeling moment, the therapist is relentless in continuing to prolong-sustain the patient's painful feelings, forcing the patient to wallow in the terrible feelings of this powerful encounter.)

T: ...(speaking as P's guilt-inducing mother) You wanna be your momma's little man, don't ya? Huh? Can't be your momma's little man if you go around playing with your dingus all the time. That's a naughty, nasty thing to do and I'm glad you've stopped... **(P sobs with strong feeling)** ... But don't let me ever catch you playing with your dingus...or you'll be very sorry because that's a nasty, dirty, bad thing to do...**(P cries more)**. Good little fella. We have a deal, huh? You can be my little fella, as long as you don't ever play with your dingus. Huh? Isn't that right, sweetie pie? Are you momma's pumpkin, huh? (cruelly attacking) YOU HAVEN'T BEEN PLAYING WITH THAT DIRTY THING, HAVE YOU!? HAVE YOU BEEN PLAYING WITH THAT DIRTY THING!?...**(P sniffs, tries to whisper something, sighs, sniffs)**...Billy!...**(P sobs loudly)**...Are you feeling remorseful for what you've done?...**(P sobs)**...Are you feeling bad for what you've done, Billy?...**(P keeps crying)**...Have you been bad again?...**(more sobbing)**...Have you had sexual thoughts?...**(more crying)**...

2. ***Neutralize (Diminish, Reduce) the Strong Feeling***

The therapist neutralizes (diminishes, reduces) the strong feeling. There are two subheadings.

2.1. Avoid-deflect patient's critical confrontation. Negative feelings expressed toward the therapist are neutralized by the therapist's avoidance of the patient's direct critical confrontation. Instead of responding to the direct attack, the therapist may (a) welcome the patient's ability to disclose and reveal; (b) agree with the patient's criticism; (c) praise the patient for his/her perceptiveness; or (d)

defend himself with clever logic that is sufficiently baffling to sway the patient from her confrontational stance.

2.2. Gentle the strong feeling. Feelings toward the therapist are defused (gentled) by the therapist's supportive acknowledgement of the quality and intensity of the patient's immediate feeling.

Examples and Further Commentary

Example 1:

Therapist Use: Avoid-deflect patient's critical confrontation (*Use 2.1*)

(*Commentary*: In the moments leading up to the strong feeling moment, the patient has been telling the therapist that she is worried that if she gets "better", the therapist will terminate the therapy, and she doesn't want this to happen. She then says she feels nervous -- and the therapist's response elicits a burst of anger in the patient.)

P: (shakily) I am feeling nervous.
T: The more nervous you are, the longer you'll stay here -- so let's not worry about that.
P: **(with strong feeling) I can't stand it when you say those things to me!**

(*Commentary*: The therapist now uses this angry outburst to *neutralize-diminish it.* Instead of reacting to the patient's direct critical confrontation, he avoids it by responding with pretzel-twist logic that is confusing enough to sway her from her angry stance.)

T: Look, if you get well, you'll leave me, right?
P: Yeah. That's what I'm afraid of.
T: If you remain nervous, then you'll stay here. So, when I make you nervous, I'm showing you how much I care for you.

Example 2:

Therapist Use: Gentle the strong feeling (*Use 2.2*).

(*Commentary*: The therapist has been persistently pushing-encouraging the patient to carry out a difficult, anxiety-provoking behaviour -- call up a prospective boyfriend and ask him for a date. In the moment of strong feeling, the patient feels cornered and pushed, and lashes out in a burst of tough anger at the therapist. The therapist then *gentles the strong feeling* by acknowledging the quality and intensity of the patient's immediate feeling.)

P: **(with strong feeling) (angrily) Dammit that you have to push me like that! (sighs) I just feel like I've gotten into so much agony -- and it's all your fault! I mean it's been good, but..... Dammit!**
T: (with good feeling, accepts the outburst) You'd think I'd let up a little.
P: (with less intensity) Yeah, right! (chuckles)
T: Push! Push! Push!
P: Right. (chuckles)
T: You'd think you could walk in here one week, huh, and be able to just relax?
P: Right.

3. ***Resolve the Painful Feeling***

The therapist helps the patient resolve (finish out) the bad, painful feeling by having the patient open up (show, express) the bad feeling -- in the context of an alive, painful scene-situation -- and then having the patient learn and feelingfully enact-rehearse more effective (constructive, self-enhancing) ways of coping-dealing with the scene-situation that was previously so painful.

Example and Further Commentary

P: (sobbing intensely, anguished -- talking about her father) **He doesn't listen! He just builds walls, puts me on the other side! Builds them higher! And then he waits for my walls to come down so that he can hurt me all over again! (continues crying)**

T: He just wants to hurt you all over again.

P: **(sobbing) All over again. And he does! He does! And I keep going back. And he does it again. I don't want to go back anymore. (sobs)**

(*Commentary*: During the previous few minutes in the session, the patient and therapist have been enacting a highly-charged scene in which the therapist played the patient's pain-inducing, rejecting father, and the patient experienced strong, anguished, painful feelings. The encounter involved the patient reaching out to her father for affection only to be rejected, put-down, and pushed away -- a recurring and painful scenario in the patient's relationship with her father. Now, near the end of the session, the therapist uses the patient's strong feeling here to help her resolve the bad feeling -- to be stronger, tougher, and less vulnerable to the father's cruel behaviour.)

P: **I don't want to go back anymore!**

T: Say, "No more!"

P: **No more! I don't want to go back anymore! I gotta stop! (sobs) I don't need it!**

T: Say it again!

P: **I don't need it! I don't need to waste my time on him! It's fruitless!**

T: (provocatively) Why don't you reach out once more to a man who pushes you away? Reach out again...Go ahead....

P: **(toughly, strongly) No!!**

T: (quietly taunting her, egging her on) Hah? C'mon. Give him another try.

P: **NO!**

T: I betcha this time will be different.

P: **No! No! No! 'Cause it's not gonna work! I don't want to! I don't need to anymore!**

T: Say, "NO!"

P: **(surely, strongly) NO! I don't need it anymore! It's not the same now! I won't let him hurt me again! NO!**

T: (quietly, provocatively) Yes you will. One more chance. He deserves another chance.

P: **(toughly, forcefully) NO! I WON'T!**

T: (supportively) No more hurting you, huh?

P: **(firmly) No! I won't let him ruin me anymore.**

(*Commentary*: The patient's bad feeling has moved towards being resolved as she becomes firmly committed to a new way of being-behaving in relation to her father.)

4. Develop the Emergent Material

The therapist uses the strong feeling to help carry forward, explore, further develop the material that is emerging-present now in the patient. There are three subgroups.

4.1. Carry forward whatever material is now present. The therapist encourages the patient to explore whatever material -- e.g. feelings, thoughts, memories -- seems to be immediate and present.

4.2. Penetrate further into personal-private material. The therapist uses the strong feeling as an indication that the patient is ready and willing to continue answering the therapist's probing, provocative questions with regard to highly personal-private topics.

4.3. Promote integrative feelings toward fended-off part of self. The therapist welcomes and carries forward a way-of-being that is (a) immediately present, and expressed-shown with emotional charge in the moment of strong feeling; and (b) not fully welcomed-accepted by the patient.

Examples and Further Commentary

Example 1:

Therapist Use: Carry forward whatever material is now present (*Use 4.1*).

P: **(with strong feeling) NO WAY! NO!! NO!! NO!!** (pause) (chuckles)
T: What are you experiencing right now?

(*Commentary*: The patient repeatedly yelled "No" with strong feeling, and then chuckled. The therapist then used the strong feeling moment to invite the patient to explore whatever material was now immediately present.)

Example 2:

Therapist Use: Carry forward whatever material is now present (*Use 4.1*).

P: **(defiantly, loudly, intensely screaming, and physically hitting a prop) I won't! I won't! I won't do it! I won't do it! I won't! I won't! I won't!**
T: Bring anything back? Bring any memories back to you?

(*Commentary*: In this moment of strong feeling, the patient was defiantly, toughly screaming and yelling at the therapist. The therapist attempted to carry forward and develop this material by asking the patient if this strong feeling expression triggered any related memories.)

Example 3:

Therapist Use: Penetrate further into personal-private material (*Use 4.2*).

T: (interrogating patient about his masturatory habits) How often do you pull it off?
P: **(laughs heartily, with strong feeling)**
T: Huh?

P: (sheepishly) I don't know.
T: Sure you do, you liar!
P: **(laughs heartily, with strong feeling)** Two or three times a week.

(*Commentary*: The therapist has been interrogating the patient, in a humorous way, about his masturbatory habits. The patient bursts out laughing. The therapist uses the strong feeling as an indication that the patient is ready and willing for the therapist to continue probing into the private-personal material related to this topic.)

T: Oh, you fuck-your-fist two or three times a week.
P: Okay.
T: (bluntly) And that's 'cause you don't want to waste your "come" on [your wife], right?!
P: I guess. (chuckles)
T: (chuckles and playfully needles the patient) Well you're sure a fuckin' weasel, now aren't you, Billy Bob?
P: That's correct. **(laughs heartily, with strong feeling)**
T: You're just a little evader and avoider.
P: Yes. (chuckles)
T: (continuing to push patient to reveal personal, private information) So what's better about fucking-your-fist than fucking [your wife], huh Billy Bob?

Example 4:
Therapist Use: Promote integrative feelings toward fended-off part of self (*Use 4.3*).

(*Commentary*: The patient has said earlier in the session that when she was younger she used to be a fun-loving kind of person -- but in recent years, she no longer considers herself a "fun" person. Just as this following excerpt begins, the therapist highlights that this "fun" part seems to be emerging now in the session. Notice how the therapist carries forward her being this "fun" way into a moment of strong feeling -- and then keeps developing and welcoming this part of self after the strong feeling.)

T: (lightheartedly, talking about the patient's lost capacity for having fun) Maybe it's just like riding a bike. After 10 years, you get on, and you just ... start again.
P: (laughs) I --
T: (chuckles, playfully) See, you're just starting --
P: (chuckles) Yeah.
T: Some things are like that, you know. You just get right back on, and there it is -- like you never left it.
P: (sighs happily) Yeah. It's been a long time since I've allowed myself to relax this much.
T: Do you like it?
P: I do.
T: Can you think of anything that you might say now that might be fun? Just whatever pops into your head..?
P: I can't think of anything very fun right now. (pause) (chuckles) Well, this is fun! You're fun!
T: Don't you think that was a terrible question of me to ask you?
P: (lightheartedly) It kinda put me on the spot.
T: (playfully) Terrible. Yeah. It was a stupid question. You don't just snap your fingers, and make fun.
P: (chuckles) (T chuckles) **(with strong feeling) Well, sometimes you do! (starts laughing heartily)**

T: (laughs)
P: **That's what fun is, isn't it? (laughs) Spontaneous?**

(*Commentary*: The strong feeling event has just happened -- in the form of strong hearty laughter. The therapist will now use the strong feeling to further carry forward the patient's integratively being-behaving this fun way. He joins with the patient in an enjoyable, playful, pleasant sharing of her new way-of-being, and invites the patient to check and explore the immediate new feelings.)

T: (laughs) Ah yeah! (chuckles) (making fun of himself) I had to think about that for a moment. (chuckles) What are you feeling now?
P: Comfortable.
T: (lightheartedly, warmly) Nice. I realize that this is a kind of basis of your existence -- this potentiality for fun.

5. ***Promote Insight and Self-Understanding***

The therapist uses the strong feeling to help the patient attain increased insight-understanding into the nature (characteristics, workings) of either (a) past or present relationships with significant other people (or parts of self); or (b) ongoing patterns of being-behaving that tend to be troubling-problematic for the patient.

Examples and Further Commentary

Example 1:

Therapist Use: Promote insight and self-understanding

P: (talking to his father, in role-play) You're so proud, and so frightened. (long pause) **(cries hard with strong feeling for an extended period)**

(*Commentary*: The patient has been exploring his feelings about his parents. Just now, he has been talking to his father, in role-play, about how he wished his father would have protected him from his self-centered mother. A moment of intense bad-feeling anguish occurs. The therapist uses strong feeling to broaden the patient's insight and self-understanding about the nature of the patient's relationships with his parents.)

T: This seems to be a very important quality.....That the enemy is your mother.
P: Yes, I feel that, certainly between the two of them, my mother was the real enemy. She exacted a reverence contract, and gave very little...even...I could say to you -- nothing. (Spontaneous begins speaking directly to the mother) You set up a reverence contract, and you gave nothing back.
T: This is important. You see -- your father wanted you to comply. In other words, do something positive. But I hear your mother always saying "no, no, no".
P: Or when she did say yes...the yes was eat a little more, when I'd had too much. (cries)
T: That's a "no". Don't listen to your appetite.

Example 2:
Therapist Use: Promote insight and self-understanding

(*Commentary*: The patient says that he feels angry in many extratherapy situations, and that this is troubling for him. A strong feeling moment occurs -- in bold-typed face below.)

T: Let's say someone does something that irritates you. They pressure you. You know -- they don't behave the way you think they should. They cut you off on the freeway. And you get angry and pissed off. How does one handle that? What do you do in those situations?
P: Give 'em a piece of your mind. Tell the son of a bitch to go to hell.
T: (yells, enacting role of other person) C'mon Bill! Don't tell me to go to hell!
P: **(screams intensely at the other, with strong feeling) SHUT UP!!**

(*Commentary*: The strong feeling moment has just occurred. The therapist uses its occurrence to help the patient gain more insight-understanding into the dysfunctionality of his current way-style of expressing anger.)

T: (calmly, disapproving) You could yell, that's clearly one possibility. But perhaps there are other ways to express your feelings -- of letting people know what it is about what they've done that you find so upsetting. What I want to focus on is to better understand what other ways there might be to express this anger.

Distribution of the 52 Strong Feeling Instances Across Categories of *Therapist Use*

The distribution of the 52 strong feeling instances in terms of the five kinds of subsequent *therapist use* was: use 1 (*sustain the strong feeling*), 26.9%; use 2 (*neutralize the strong feeling*), 15.4%; use 3 (*resolve the painful feeling*), 5.8%; use 4 (*develop the emergent material*), 21.2%; and use 5 (*promote insight and self-understanding*), 30.8%.

Therapist Methods and Uses Associated with Different Kinds of Strong Feeling

In addition to the principal findings, a secondary aim was to investigate whether *therapist methods* and *therapist uses* varied across *different kinds of strong feeling*.

In regard to the frequency distributions plotting *therapist methods* by *kind of strong feeling* (Table 1) and *therapist uses* by *kind of strong feeling* (Table 2), it should be noted at the outset that there is only enough data to highlight soft impressions in some areas. Unfortunately, there is not enough data to conduct collapsed chi-square tests even on the most populated regions of the distributions. Apriori, we did not want to rule out the possibility of describing the emergent patterns statistically if and where possible. However, given how the generated data have actually come out, the calculated expected frequencies (shown in brackets in Tables 1 and 2) are simply too small -- considering that all expected frequencies must exceed 5 for chi-square tests to be allowable. In fact, in the light of how these distributions have patterned themselves, it appears that a far larger data pool would have been needed -- not just a few more strong feeling instances, but perhaps at least double the current amount -- to achieve expected frequencies high enough to conduct statistical tests. In short, what we have available is only enough data to provide some soft impressions (where data is plentiful enough), but no statistical description. These impressions should in no way be regarded as hard, tight findings. They are merely possibilities and hypotheses that are raised by how the distributions have emerged, and that might be worthy of further exploration in future investigations.

A. Therapist Methods Associated with Different Kinds of Strong Feeling

Table 1 plots *therapist methods* against *different kinds of strong feeling*. Soft impressions about the frequency patterns in Table 1 are highlighted below.

(1) Looking down the columns of Table 1, it appears that (a) strong laughter (either "good-feeling" or "mixed-feeling") is more linked with method 1 (*direct provocation of strong feeling*) than other methods; and (b) "defiance-opposition, strength-toughness, anger-exasperation" and "bad feeling hurt-pain-anguish" may both be linked with a variety of different methods.

(2) Looking across the rows, the frequencies suggest that (a) method 1 (*direct provocation of strong feeling*) is linked to a variety of kinds of strong feeling, although it may be particular associated with the occurrence of "strong laughter" -- either in the form of "good-feeling" or "mixed-feeling" laughter; (b) method 3 (*intensification of therapist-patient encounter*) may be linked more with the occurrence of "defiance-opposition" and "bad-feeling hurt-pain-anguish" than other strong feelings; (c) method 4 (*enliven scene of strong feeling*) may be linked more with the occurrence of "bad-feeling hurt-pain-anguish" than other strong feelings; and (d) method 5 (*intensification of patient-other encounter*) may be associated more with the occurrence of "defiance-opposition" than other strong feelings.

In conclusion, the main finding here is that our distribution precludes any careful statistical analyses -- and thus the preceding impressions must be approached as tentative possibilities-hypotheses, rather than as hard results.

Table1

Therapist Methods Plotted Against *Kinds of Strong Feeling*

	Kind of Strong Feeling					
Therapist Method	Good-Feeling Happiness-Laughter	Mixed-Feeling Laughter	Defiance Opposition Strength-Anger	Bad-Feeling Hurt-Pain-Anguish	Good-Feeling Love-Caring	*Total*
1. Direct Provocation	**10** (4.4)	**3** (1.6)	**6** (8.4)	**2** (5.7)	**0** (0.8)	*21*
2. Welcoming Encouragement	**0** (0.4)	**0** (0.1)	**1** (0.8)	**0** (0.5)	**1** (0.1)	*2*
3. Intensification of of T-Pt. Encounter	**0** (3.0)	**0** (1.1)	**9** (5.3)	**5** (3.8)	**0** (0.6)	*14*
4. Enlivening Scene of Strong Feeling	**0** (1.3)	**0** (0.5)	**0** (2.5)	**5** (1.6)	**1** (0.2)	*6*
5. Intensification of Pt.-Other Encounter	**1** (1.9)	**1** (0.7)	**5** (3.6)	**2** (2.4)	**0** (0.3)	*9*
	11	*4*	*21*	*14*	*2*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

B. Therapist Uses Associated with Different Kinds of Strong Feeling

Table 2 plots *therapist uses* against *different kinds of strong feeling*. Some soft impressions about the frequency patterns in Table 2 are highlighted below. Once again, these impressions are presented tentatively because our data did not permit careful statistical analyses.

(1) What is most striking about this distribution, upon coarse visual inspection, is that there are almost no apparent trends at all in terms of different uses for different kinds of strong feeling. Indeed, if one looks down the columns of Table 2, in order to see if *different kinds of strong feeling* are connected distinctly with particular *uses*, the indication seems to be no. Most strong feelings occurred in conjunction with a variety of different uses -- and, in relatively equivalent proportions, if we take into account expected frequencies (shown in brackets).

(2) Looking across the rows, the frequencies suggest that (a) use 1 (*sustain strong feeling*), use 2 (*neutralize the strong feeling*), use 4 (*explore emergent material*), and use 5 (*promote insight and self-understanding*) occurred in association with a variety of *kinds of strong feeling*, and in relatively equivalent proportions (taking into account the expected frequencies); and (b) use 3 (*resolve painful feeling*), by definition, exclusively went with the occurrence of "bad-feeling hurt-pain".

In short, based on our limited amount of data, there are virtually no hints to suggest that different kinds of strong feeling may associate with different kinds of uses.

Table 2

Therapist Uses Plotted Against *Kinds of Strong Feeling*

	Kind of Strong Feeling					
Therapist Use	Good-Feeling Happiness-Laughter	Mixed-Feeling Laughter	Defiance Opposition Strength-Anger	Bad-Feeling Hurt-Pain-Anguish	Good-Feeling Love-Caring	*Total*
1. Sustain the Strong Feeling	**3** (3.0)	**1** (1.1)	**6** (5.7)	**4** (3.8)	**0** (0.5)	*14*
2. Neutralize the Strong Feeling	**0** (1.7)	**0** (0.6)	**4** (3.2)	**3** (2.2)	**1** (0.3)	*8*
3. Resolve the Painful Feeling	**0** (0.6)	**0** (0.2)	**0** (1.2)	**3** (0.8)	**0** (0.1)	*3*
4. Explore Emergent Material	**3** (2.3)	**1** (0.8)	**4** (4.5)	**2** (3.0)	**1** (0.4)	*11*
5. Promote Insight and Self-Understanding	**5** (3.4)	**2** (1.2)	**7** (6.5)	**2** (4.3)	**0** (0.6)	*16*
	11	*4*	*21*	*14*	*2*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

Therapist Methods and Uses

Associated with Different Families of Psychotherapy

A further secondary interest was to look at the findings in terms of how different *therapist methods* and *therapist uses* seemed to arrange themselves according to *different families of psychotherapy*.

Once again, given the way that the frequency distributions plotting *therapist methods* by *family of psychotherapy* (Table 3) and *therapist uses* by *family of psychotherapy* (Table 4) have taken shape, there is only enough data to highlight some soft impressions in some areas. There is not enough data to conduct collapsed chi-square tests even on the most populated regions of the distributions. Moreover, the findings here must be approached with added caution because the research team lacked confidence in its placement of sessions into particular *families of psychotherapy*.

The Research Team's Lack of Confidence in Their Placement of Sessions into Particular Families of Psychotherapy

As mentioned earlier in this chapter, the research team judges were successfully able to, with adequate average inter-judge agreement (x = 72.6%), place each of the 14 sessions into one of the four main families of psychotherapy as follows: *psychoanalytic-psychoanalytic* (2 sessions); *humanistic-experiential* (5 sessions); *cognitive-behavioural* (3 sessions); and *integrative-eclectic* (4 sessions).

However, the judges' confidence in these decisions was consistently low -- with them collectively averaging, over the 14 sessions, a rating of only 1.87 (sd = 0.46) in response to the question, "*How confident are you that this session truly belongs in the category you have chosen?*" (1 = not confident at all; 2 = slightly confident; 3 = confident; 4 = very confident). The research team's lack of certainty means that this section of the findings must be approached with added caution.

A. Therapist Methods Associated with Different Families of Psychotherapy

The findings were looked at in regard to whether different *therapist methods* seemed to vary across different *families of psychotherapy* (see Table 3). Some soft impressions about the frequency patterns (taking into account the calculated expected frequencies) are highlighted below.

Table 3

Therapist Methods Plotted Against *Family of Psychotherapy*

	Family of Psychotherapy				
	Humanistic-Experiential-	Psychoanalytic-Psychodynamic	Integrative-Eclectic	Cognitive-Behavioural	
Therapist Method					*Total*
1. Direct Provocation of Strong Feeling	**3** (5.7)	**0** (3.2)	**10** (7.7)	**8** (4.4)	*21*
2. Welcoming-Encouragement	**1** (0.5)	**1** (0.3)	**0** (0.7)	**0** (0.5)	*2*
3. Intensification of T-Pt. Encounter	**3** (3.8)	**7** (2.1)	**3** (5.1)	**1** (2.9)	*14*
4. Enlivening Scene of Strong Feeling	**0** (1.6)	**0** (1.0)	**5** (2.2)	**1** (1.3)	*6*
5. Intensification of Pt.-Other Encounter	**7** (2.4)	**0** (1.4)	**1** (3.3)	**1** (1.9)	*9*
	14	*8*	*19*	*11*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

(1) A coarse inspection of Table 3 reveals that most *families of psychotherapy* applied most of the *therapist methods* on one or more occasion. In fact, the *psychoanalytic-psychodynamic* family was the only orientation that did not apply at least 4 (of the 5) different methods at least once.

(2) Looking down the columns of Table 3, in order to look at the method "preferences" of particular psychotherapies, it appears that (a) the *humanistic-experiential* therapists in our sample, although they used a variety of different methods in promoting strong feeling, may have tended to rely more often on method 5 (*intensification of patient-other encounter*) than other methods; (b) the *psychoanalytic therapists* appeared to rely more often on method 3 (*intensification of therapist-patient encounter*) than the other methods; (c) the *integrative-eclectic* therapists seemed to rely most often on method 1 (*direct provocation of strong feeling*) and method 4 (*enliven scene of strong feeling*); and (d) the *cognitive-behavioural* therapists appeared to rely most heavily of method 1 (*direct provocation of strong feeling*).

(3) Looking across the rows, the frequencies provide soft indications that (a) method 1 (*direct provocation of strong feeling*) was used by the *integrative-eclectic* and *cognitive-behavioural* therapists in greater proportion than it was by other therapists; (b) method 3 (*intensification of therapist-patient encounter*) cut across all therapies, although it may have been associated partcularly with *psychoanalytic therapists*; (c) method 4 (*enliven scene of strong feeling*) was used more often by the *integrative-eclectic* group than by other therapists; and (d) method 5 (*intensification of patient-other encounter*) was used more often by the *humanistic-experiential* therapists than other

therapists.

In summary, the main conclusion here again is that the distribution precludes any careful statistical analysis -- and thus the impressions provided above must be regarded only as soft, tentative possibilities-hypotheses, rather than as hard results.

B. Therapist Uses Associated with Different Families of Psychotherapy

The findings were looked at in regard to whether different *therapist uses* seemed to arrange themselves differently according to *family of therapy*. Soft impressions about the frequency patterns in Table 4 (taking into account the calculated expected frequencies) are highlighted as follows.

(1) What is most apparent about this distribution, upon coarse visual inspection, is that it is difficult to identify any clear trends whatsoever regarding different uses for different families of psychotherapy. With the exception of only a few cells, the actual frequencies are close to the expected frequencies.

(2) Looking down the columns, in order to see any kind of potential patterns that might characterize each of the four therapeutic families, the only soft impression worthy of note is that the *psychoanalytic-psychodynamic* sessions might have been characterized more by the occurrence of use 2 (*neutralize the strong feeling*) than by other uses. For the rest of the columns, the actual frequencies look close enough to the expected frequencies to preclude any indication of meaningful leanings or trends.

Table 4

Therapist Uses Plotted Against *Family of Psychotherapy*

	Family of Psychotherapy				
	Humanistic-Experiential-	Psychoanalytic-Psychodynamic	Integrative-Eclectic	Cognitive-Behavioural	
Therapist Use					*Total*
1. Sustain the Strong Feeling	**2** (3.8)	**1** (2.2)	**6** (5.1)	**5** (3.0)	*14*
2. Neutralize the Strong Feeling	**0** (2.2)	**6** (1.2)	**2** (2.9)	**0** (1.7)	*8*
3. Resolve the Painful Feeling	**0** (0.8)	**0** (0.5)	**3** (1.1)	**0** (0.6)	*3*
4. Carry Forward Emergent Material	**5** (3.0)	**0** (1.7)	**1** (4.0)	**5** (2.3)	*11*
5. Promote Insight and Self-Understanding	**7** (4.3)	**1** (2.5)	**7** (5.8)	**1** (3.4)	*16*
	14	*8*	*19*	*11*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

(3) Looking across the rows, the frequencies suggest that (a) use 1 (*sustain strong feeling*), use 4 (*carry forward emergent material*), and use 5 (*promote insight and self-understanding*) seem to occur in similar proportions across families of psychotherapy; (b) use 2 (*neutralize the strong feeling*) may be more associated with the *psychoanalytic-psychodynamic* sessions than other sessions; and (c) use 3 (*resolve the painful feeling*)

does not contain enough data to conclude anything about potential differences across families of psychotherapy.

In summary, the main conclusion once again is that the distribution precludes any careful statistical description, and thus the preceding impressions must be regarded as speculative possibilities, not as hard results. Moreover, the research team's lack of confidence in its placement of sessions into particular families of psychotherapy means that these preceding soft impressions should be approached with even further tentativeness.

Therapist Methods and Uses Associated with Different Eras

As mentioned earlier in this chapter, in order to allow us to look at the data in terms of whether strong feeling methods and uses varied according to the *era* of the session, each of the 14 sessions was categorized -- based on catalogued summary descriptions from the A.A.P. and University of Ottawa Tape Libraries -- as follows: *1965-1974* (4 sessions), *1975-1984* (6 sessions), and *1985-1994* (4 sessions).

Once again, there is only enough data here to tentatively highlight impressions in some areas, not enough to conduct collapsed chi-square tests even on the most populated regions of the distributions.

A. Therapist Methods Associated with Different Era of Session

(1) Looking down the columns of Table 5, in order to look at the method "preferences" of particular eras, it appears that (a) the *1965-1974* sessions were more populated by instances of method 3 (*intensification of therapist-patient encounter*) and

method 5 (*intensification of patient-other encounter*) than by other methods; (b) the *1975-1984* sessions were more characterized by instances of method 1 (*direct provocation of strong feeling*), and possibly by method 4 (*enliven scene of strong feeling*); and (c) the *1985-1994* sessions show no clear indications of leanings to particular methods.

Table 5

Therapist Methods Plotted Against *Era of Session*

	Era of Session			
Therapist Method	1965-1974	1975-1984	1985-1994	*Total*
1. Direct Provocation of Strong Feeling	**1** (6.1)	**18** (11.3)	**2** (3.6)	*21*
2. Welcoming-Encouragement	**1** (0.6)	**0** (1.1)	**1** (0.3)	*2*
3. Intensification of T-Pt. Encounter	**7** (4.1)	**4** (7.6)	**3** (2.4)	*14*
4. Enlivening Scene of Strong Feeling	**0** (1.7)	**5** (3.2)	**1** (1.0)	*6*
5. Intensification of Pt.-Other Encounter	**6** (2.6)	**1** (4.9)	**2** (1.6)	*9*
	15	*28*	*9*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

(2) Looking across the rows, in order to get more specific impressions about potential differences across the 3 *eras*, the frequencies suggest that (a) method 1 (*direct provocation of strong feeling*) was more prevalent during the *1975-1984 era* than the other two time-periods; (b) method 3 (*intensification of therapist-patient encounter*) cut across all 3 eras, in frequencies close to what would be expected by chance; (c) method 5 (*intensification of patient-other encounter*) may have been particularly prevalent in the sessions from the *1965-1974 era.*

In summary, as has been the case for all preceding distributions, the main conclusion here is that the pattern of the distribution precluded any careful statistical analysis -- and thus the above impressions should be considered only tentative hypotheses-possibilities, rather than hard results.

B. Therapist Uses Associated with Different Era of Session

The findings were looked at in regard to whether different *therapist uses* seemed to arrange themselves differently according to the *era of session* (see Table 6). Some soft impressions about the frequency patterns (taking into account the calculated expected frequencies) are highlighted below.

(1) What is most apparent about this distribution, upon coarse inspection, is the absence of apparent trends in terms of different uses for different eras. When the actual frequencies for each cell are compared to the expected frequencies, they are in most cases close to equivalent. Thus, in general, based on the limited amount of data, there is little evidence suggesting that different uses might be associated with different session eras.

(2) Looking down the columns, in order to identify potential patterns that might characterize each of the 3 eras, the only soft impression worthy of note is that the *1975-1984* sessions might have been characterized particularly by the occurrence of use 1 (*sustain the strong feeling*).

Table 6

Therapist Uses Plotted Against *Era of Session*

	Era of Session			
Therapist Use	1965-1974	1975-1984	1985-1994	*Total*
1. Sustain the Strong Feeling	**1** (4.1)	**11** (7.6)	**2** (2.4)	*14*
2. Neutralize the Strong Feeling	**4** (2.3)	**2** (4.3)	**2** (1.4)	*8*
3. Resolve the Painful Feeling	**0** (0.9)	**3** (1.6)	**0** (0.5)	*3*
4. Carry Forward Emergent Material	**4** (3.2)	**5** (6.0)	**2** (1.9)	*11*
5. Promote Insight and Self-Understanding	**6** (4.6)	**7** (8.6)	**3** (2.8)	*16*
	15	*28*	*9*	*52*

Note. Actual frequencies are in bold. Calculated expected frequencies are in brackets.

(3) Looking across the rows, the frequencies suggest that (a) use 1 (*sustain strong feeling*) may be more associated with the *1975-1984* sessions as compared to sessions from the other eras; (b) use 2 (*neutralize strong feeling*), use 4 (*carry forward emergent material*), and use 5 (*promote insight-understanding*) seem to occur in similar frequencies across eras; and (c) use 3 (resolve painful feeling) does not contain enough data to conclude anything about differences across eras.

In short, despite a few tentative leanings -- principally in regard to the apparent prevalence of *sustain the strong feeling* in the *1975-1984* sessions -- there is on the whole little evidence here to suggest that different uses may vary across different temporal eras.

Soft Impressions of the Research Team

In addition to the findings obtained through the formal research protocol, the judges forwarded some pertinent but more speculative impressions regarding how practitioners promote and use strong feeling in psychotherapy. These impressions will be reported and discussed where relevant in the subsequent chapter.

CHAPTER 5

DISCUSSION

The principal aim of this study was to investigate two research questions: (1) What *therapist methods* (employed under which in-session patient conditions) are judged as helpful in promoting strong feeling? (2) Once strong feeling occurs in the session, how do therapists seem to *use* it? The purpose of the study was not to test any particular set of hypotheses, or to evaluate a given theory, but rather to analyze actual sessions in order to generate descriptions of therapist *methods* and *uses* related to the occurrence of strong feeling. The principal findings of the study thus consist of these generated descriptions of psychotherapeutic methods and uses. Other issues addressed in the discussion are secondary to these principal findings.

This chapter will include discussion of (a) the apparent rare occurrence of strong feeling events in actual sessions; (b) the *therapist methods* we identified and described; (c) the *therapist uses* we identified and described; (d) the secondary findings in regard to how therapist methods and uses may have varied depending on *kind of strong feeling*, *family of psychotherapy*, or *era of session*; (e) the degree to which this study was successful in addressing its main research questions; (f) practical implications of the findings; (g) theoretical implications of the findings; (h) limitations and weaknesses of the study; and (i) suggestions for future research.

The Apparent Rarity of Strong Feeling in Actual Psychotherapy Sessions

The review of the literature in chapter 1 included a multitude of clinical theorists representing many different orientations -- experiential, psychoanalytic, object relations, gestalt,

cognitive, behavioural, client-centered, and others -- who asserted that it is good therapeutic practice (at least under certain conditions) to have the patient undergo strong feeling in the session. In the light of this widespread "praise" for strong feeling, it was surprising that strong feeling seemed to occur so rarely in the 450 sessions that comprised the original data pool. Indeed, in our original large data pool, it is fair to say that sessions emphasizing strong feeling were not plentiful. If a session emphasizing strong feeling was defined -- as it was for the purposes of this study -- as a session containing two or more strong feeling events, then only 20 of the 450 sessions qualified. This represented a proportion of less than 5%.

One possible explanation for the low incidence of tapes emphasizing strong feeling is that -- despite clinical theorists' abundant writings about strong feeling's importance -- it may be that, in terms of actual practice, strong feeling's occurrence is only plentiful in a tiny proportion of particular therapeutic approaches. In other words, perhaps only a small proportion of therapists representing particular kinds of approaches emphasize having the patient attain levels of strong, powerful feeling in the session. In fact, perhaps what most theorists are actually referring to when they talk about "strong feeling", and what is far more common in psychotherapy sessions, are events of *moderate* or *mild* intensity of feeling. Soft support for this idea comes from the impression of the principal investigators that feeling events in the low-moderate intensity range were present in far more tapes -- perhaps 30-40% of the initial data pool.

A second, related explanation for the apparent rarity of strong feeling is that, in the eyes of most therapists from most approaches, strong feeling may not be regarded as very helpful for facilitating their particular valued in-session goals. Perhaps, for most therapists, strong feeling is rare because it does not help them "get" the kinds of in-session patient events (changes,

outcomes) that they value in their sessions. Once again, as mentioned in the previous point, instances of mild to moderate intensity of feeling may be valued and obtained far more frequently by these therapists.

A third explanation is that our method of identifying strong feelings, which was limited to manifest (expressed, outwardly shown) feeling as opposed to non-manifest feeling, was insensitive to occurrences of strong feelings that may have been present but non-manifest in these sessions. This is certainly a possibility, and was a limitation of our research methodology. However, it seems unlikely that experienced but hidden strong feeling was somehow a pervasive phenomenon in our data pool; if it had been, there would likely have been more manifest forms of strong feeling "leaking out" in these sessions.

A fourth, alternative explanation for the apparent rarity of strong feeling is that there are in fact many practitioners cordial to the idea of working with intensely "strong feeling" but they lack technical knowledge regarding how to promote it and use it in their sessions. In other words, perhaps there are in fact many practitioners who do value strong feeling, but it occurs rarely in their sessions because they presently lack the skills and knowledge regarding how to promote it and use it in their sessions. In short, perhaps at present, therapist techniques related to strong feeling represent an important, but *remarkably neglected* area of practice.

A fifth possibility that should be raised is whether the apparently low incidence of strong feeling is merely an artifact of our particular sample. This is certainly a possibility, but does not seem a particularly compelling one. After all, our original data pool included a relatively large number of sessions (approximately 450) and psychotherapists (approximately 85), and these practitioners were representative of a relatively broad spectrum of approaches. Indeed, from

gestalt therapy to R.E.T., from client-centered to behavioural therapy, from direct decision therapy to provocative therapy, from classical psychoanalysis to hypnotherapy, from cognitive therapy to experiential therapy, from bioenergetics to existential therapy -- to name a few -- there were representative therapists in our data pool. It seems somewhat unlikely, given this relatively large and diverse sample of tapes, that the apparent rarity of strong feeling is not at least partially reflective of therapeutic practice at large. However, this possibility of course cannot be ruled out.

In conclusion, it was surprising that so few tapes from our original data pool contained multiple instances of strong feeling. Regardless of the potential reasons why, it is quite remarkable that an in-session event such as strong feeling -- which has been widely written about as important and therapeutically desirable -- could have been found so rarely in our sample. To the extent that this finding reflects a general disinclination (disinterest) among most practitioners to promote and use strong feeling in their actual sessions, our findings may have little to offer most practitioners. On the other hand, given the large body of clinical theory and research testifying to the importance of strong feeling, it may be that there are in fact many practitioners cordial to the idea of working with strong feeling but, for whatever reason -- perhaps a lack of technical knowledge in our field about how to promote it and use it -- they do not currently obtain it much in their sessions. To the extent that this is the case, the strong feeling sessions that we analyzed were a precious and rare resource that could potentially have yielded valuable secrets -- of interest to quite a large proportion of therapists -- about how to *promote* strong feeling in sessions, and how to *use* it therapeutically once it occurs.

The Research Team was Successful in Identifying Therapist Methods Linked to the Occurrence of Strong Feeling

The research team was successful in identifying and describing therapist methods that, in their judgement, promoted the occurrence of strong feeling. The research team also was successful in accomplishing its aim of organizing these specific therapist methods into different categories. Furthermore, also in keeping with the goals and intentions that the research team initially held when they embarked on this study, the generated *therapist method* descriptions (a) comprise an empirically-based list of methods in an area where little previous research exists; (b) can be held with confidence; (c) are derived from what therapists *actually did* in their sessions, and thus are sufficiently detailed and concrete for practitioners to be able to apply the methods in their sessions; and (d) are all tied to particular *in-session patient conditions*. In short, in terms of these above specific aims and criteria, the research team can be regarded as having been quite successful in identifying, describing, and organizing therapist methods linked to in-session occurrences of strong feeling.

The research team generated an empirically-based list of strong-feeling-methods in an area where little previous research exists. As described in chapter 2, apart from a few psychotherapy process studies, nearly all of the existing literature on strong-feeling-methods comes from clinical-theoretical writings, and not from actual research. The research team's provision of an empirically-derived list of strong feeling methods, organized into a workable number of categories, is thus a noteworthy addition to a sorely neglected area of research. This is, to our knowledge, the first research-generated set of categories of therapist methods of promoting strong feeling.

There is basis for having confidence in the findings. Although we studied a fairly limited number of tapes (14) and strong feeling events (52), the volume of data we had was sufficient to come up with a categorized list of methods that we can hold with some solid confidence. Our confidence is based on a number of factors. First, our findings were based on input from a large team of clinically sophisticated judges, and the therapist methods generated were subject to verification, modification, and final approval by the research team. Second, the two principal investigators (when they each independently generated provisional category systems of therapist methods at the mid-point of data collection) had a strong sense of agreement about what should comprise the main categories and subcategories. Third, we were able to chart and assess that, over the last 20 protocols, no new therapist method categories were identified. This meant that the five main categories of therapist methods that we had provisionally identified were ones that we could hold with increasing firmness and conviction. Each subsequent protocol was adding to our confidence that this existing framework had some measure of reliability, as well as clinical meaningfulness and utility.

The therapist methods are derived from what therapists *actually did* in their sessions, which enhances the practitioner-relevance of the findings. The research team's focus was on identifying *concrete*, *overt* therapist interventions-behaviours prior to the occurrences of strong feeling, and describing these interventions-behaviours in a jargon-free, simple fashion. The net result is that our list of methods was based almost entirely on a "close-up analysis" of what therapists *actually did* in their sessions -- an approach conducive to our methods being quite rich in detail and highly practitioner-relevant. Our richly detailed findings might be contrasted with the more general, less practically-useful findings that likely would have resulted if we had focused,

for example, (a) on what therapists, discussing their interventions from the vantage point of their own particular theories, might say they did; or (b) on testing particular hypotheses about whether relatively general, well-accepted therapist methods (e.g. reflections, interpretations) tended to precede occurrences of strong feeling. In short, the kind of focus we took was useful for generating descriptions that were quite rich in detail, and highly practitioner-relevant.

All methods are tied to particular *in-session patient conditions*, which enhances the practitioner-relevance of the findings. As discussed in chapter 2, the existing literature generally lacks precision on the issue of *context* and *timing* in regard to the application of strong-feeling-methods. In other words, the existing literature is generally not explicit about the particular in-session patient conditions that constitute a ripe time for the application of particular therapist method(s). This study provides a research-based list of in-session client conditions -- included within the therapist method categories -- which offer practitioners specific direction regarding when it may be appropriate to apply a particular strong feeling method. Indeed, all of the identified methods are explicitly linked to particular, empirically-derived *in-session patient conditions*. The implication is that -- at least for the therapist methods we found -- these therapist methods are not applied willy-nilly, at any random time in the session. On the contrary, we found that there are identifiable "markers" -- in-session patient conditions -- that signify an appropriate time to carry out each particular strong feeling method. This kind of specificity and precision makes our findings highly relevant and useful to practitioners interested in promoting strong feeling.

In summary, then, the research team was successful in identifying and describing specific therapist methods that, in their judgement, promoted the occurrence of strong feeling, and was

able to organize these therapist methods into different categories. Moreover, the research team was successful in generating findings that can be held with some solid confidence, and that make an empirically-based, practitioner-relevant contribution to an area of research that has received little previous attention.

The Identified Therapist Methods Both Confirm and Extend the Existing Literature

The aim of this section is to discuss the findings in the light of the previous literature on therapist methods that was reviewed in chapter 2. This section will include a discussion of which methods seem to qualify as newly-discovered methods, and which methods seem to confirm and/or extend previous literature. In addition, I will discuss how the in-session antecedent *patient conditions* identified by the research team appear to augment the existing literature.

Which Methods Are Newly Discovered?

Deciding whether a method is new is, to some degree, a judgement call. For example, in some cases, a method described by the research team might not correspond closely to *one* previously cited method -- but might pull together a number of methods from the more diffuse clinical literature into a more succinct, generally-applicable, and workable therapist method. It is a judgement call whether this would qualify as new. Furthermore, some of the methods might have been mentioned offhandedly in the clinical literature, but the present study is the first instance of research-based confirmation. Does this make them new? Moreover, in other cases, a method described by the research team might resemble a previously-cited method, but extends the previous literature by adding a new component: a specific *in-session patient condition* that marks

an appropriate time for therapists to apply the method. Is this new?

Somewhat arbitrarily, the criterion of "new" in this discussion is that the method found by the research team either (a) has not been proclaimed before, to our knowledge, in previous theory or research as useful for promoting strong feeling, or (b) pulls together (combines) previously cited material in a substantive, unique enough way to justify its inclusion as a new method.

1. *Direct Provocation of Strong Feeling*

1.2 Push-oppose the patient with good humour.

Patient Condition: When the patient is hesitant-reluctant (i) to carry out a new, anxiety-provoking, risky extratherapy behaviour (advocated or prescribed by the therapist); or (ii) to be open, direct, and forthcoming in response to therapist's probing questions,

Therapist Method: the therapist -- with playful, confrontational, crisp, blunt humour -- persistently continues to push-persuade the patient to do what the therapist wants the patient to do, and tenaciously opposes-punctures the patient's apparent reasons for being hesitant-reluctant.

The essence of this method is for the therapist to meet the patient's hesitation-reluctance -- either to carry out a new extratherapy behaviour, or to respond openly to therapist's probing questions -- with persistent, humorous opposition of the patient via (a) continued pushing-persuading for compliance, and (b) tenacious puncturing-opposition of the patient's apparent reasons for being hesitant-reluctant. Some methods previously described in chapter 2 seem to capture elements of this operation, but in other ways this operation identified by the research team appears to be quite different, and thus is included here as a "newly discovered method".

In terms of the overlap between this method and previously-described operations, there seems to be some overlap with *offering a playfully exaggerated explanation/description/interpretation of the client*, which involves the therapist exaggerating (caricaturing, burlesquing) the client and his behaviour in some way in the service of promoting

strong laughter (cf. Ansell, Mindess, Stern, & Stern, 1981; Farrelly & Brandsma, 1974; Farrelly & Lynch, 1987; Gervaize, Mahrer, & Markow, 1985; Greenwald, 1975, Killinger, 1987; Mahrer & Gervaize, 1984). Moreover, five other previously-described methods also seem to capture partial elements of this "humorous pushing-opposing" method described by the research team: *making humorous comments, gestures, or jokes* (Ansell et al, 1981; Farrelly & Brandsma, 1974; Greenwald, 1975, 1987; Killinger, 1987; Pierce et al, 1983; Rose, 1969; Shorr, 1972); *vividly describing a risky behaviour as if it were being carried out by the client* (Close, 1970; Farrelly & Brandsma, 1974; Mahrer & Gervaize, 1984; Shorr, 1972); *directing the client to carry out a risky in-session interpersonal behaviour* (Downing & Marmorstein, 1973; Jackins, 1965; Mahrer & Gervaize, 1984; Pierce, Nichols, & DuBrin, 1983; Shorr, 1972); *directing the client to carry out a risky behaviour toward the therapist* (Friedman, 1982; Jackins, 1965, 1978; Lowen, 1975; Perls, 1969; Pierce et al., 1983; Whitaker, Warkentin, & Malone, 1959); and *offering challenging and confrontational interpretations to the client's in-session behaviour* (Perls, 1969; cf. Mahrer et al., 1991a, 1992a). This collection of methods, taken as a group, seems to at least partially capture two essential aspects of the research team's method: (i) the notion of pushing-attacking-describing the patient in a way that playfully pressures him to be-behave in a different, new, risky way; and (ii) the notion that this therapist "pushing" will elicit a strong feeling reaction in the patient. However, none of these methods alone appears to precisely match the operation described here by the research team.

One difference is that the therapist method described by the research team specifies -- in a way that previously-established methods do not -- precisely *what* the practitioner is to *humorously attack-oppose* in the patient. Previous methods include the notion of pushing or making fun of

the patient, but they do not tell us exactly *what* to make fun of, or to be pushy about. The research team's method is quite specific in this regard. The therapist is specifically to humorously attack-oppose the patient's *apparent reasons for hesitating* (a) to agree to carry out a new, risky behaviour, or (b) to answer the therapist's probing questions. Note that the therapist is not to poke fun, or puncture just anything about the patient's behaviour. The therapist is to focus specifically on, and to playfully attack-oppose-puncture, these particular elements of the patient's in-session behaviour.

A second difference, implied in the previous point, is that the method described by the research team provides specific direction regarding the timing of applying this method. The therapist is to "strike" specifically when the patient is hesitant-reluctant to agree to a new behaviour, or to answer probing questions. This inclusion of an explicit client condition marking when to apply the method is also a new addition to the literature.

A third difference is that the research team's method includes the notion that pushing the client to actually *commit* to carry out a new, risky, extratherapy behaviour can facilitate strong feeling. No previous methods include this element, at least not specifically. Other methods -- e.g. *vividly describing a risky behaviour as if it were being carried out by the client* (Close, 1970; Farrelly & Brandsma, 1974; Mahrer & Gervaize, 1984; Shorr, 1972), and *carrying out (enacting) a risky behaviour as/for the client* (Daldrup et al., 1988; Gervaize et al, 1985; Mahrer, 1989a; Shorr, 1972) -- imply that strong feeling may result if the therapist moves-pushes the client *in the direction* of considering new, risky, anxiety-provoking behaviours. But no methods include the element of promoting a strong-feeling reaction by actively soliciting the client's *commitment* to carry out a new behaviour.

In summary, then, this method may be viewed as a newly-discovered method because, although it somewhat resembles methods talked about in the existing clinical literature, it seems to possess differences and add new elements that have not been talked about before.

2. *Welcoming-Encouragement of Strong Feeling*

Patient Condition: When the patient is already undergoing a moderate level of feeling,
Therapist Method: Quietly welcome-encourage its occurrence. Provide the atmosphere and/or physical props for expression of strong feeling, and when feeling begins to occur in the patient, quietly welcome-encourage its expression.

This is the only method the research team found that is essentially passive, indirect, and leaves the initiation of strong feeling pretty much entirely up to the patient. All the therapist does is to convey to the patient that there is an open possibility for expression of strong feeling, and when moderate feeling emerges, the therapist quietly welcomes it -- which facilitates the patient's jump to a level of strong feeling.

None of the methods described in chapter 2 seem to closely resemble this method. All of those methods -- although many include an element of "welcoming" strong feeling -- involve a relatively *active* attempt by the therapist to elicit feelings in the patient. This method is quite different. It is not active. The route is passive and indirect. The therapist creates an atmosphere that is welcoming to strong feeling's occurrence, and then waits and welcomes it when (and if) it comes. In fact, the only method described in chapter 2 that might bear some resemblance to "welcoming-encouragement of strong feeling" is Gendlin's (1991) version of *instructing the client to focus on bodily sensations, and to experience the feeling related to them*. Gendlin (1991) seems to capture much of the spirit of the method identified by the research team when he writes:

> My way is not to decide for someone whether or not catharsis should happen. But I do indicate that it might come, and that it

> will be welcome if it comes. At some point, early, I say, "You know, you can scream into one of these pillows, if that ever feels right to you." I might even demonstrate it, if the client doesn't believe that such a thing could be. Or, I might say, "You can tip that mattress up against the wall, and kick it" and actually show how the mattress tips up, and demonstrate the motions. "That may feel right to do, sometime, or it might not".
>
> This opens up many possibilities....I believe that catharsis should be an open, known, and included possibility. Beyond that I don't believe I should engender it (p. 266).

The passivity of the research team's identified method does seem to fit well with this idea. A difference, though, is that Gendlin stops short of suggesting that his method is one that he would actually employ with the expressed *intent-goal* of promoting strong feeling. Gendlin seems to want to open the possibility for strong feeling, but not try to actually engender its occurrence. The method that the research team identified, though passive and quiet, seems to go somewhat further than Gendlin's method in terms of the therapist taking concrete action to heighten the patient's moderate feeling once it begins to emerge in the session. Although Gendlin might want only to convey that strong feeling would be welcomed if it happened, the method of *welcoming-encouragment of strong feeling* involves the therapist quietly (but conspicuously) appreciating the emergence of feeling in the patient once the patient initiates its occurrence in the session.

4. Enlivening Scene of Strong Feeling

> *Patient Condition*: When the patient's attention is already partly centered on an emotionally-compelling scene-situation that is frought with bad feelings,
> *Therapist Method*: the therapist enlivens the strong-feelinged part of the scene by (a) describing it in a highly-detailed, immediate manner; (b) enacting, with strong feeling, the complementary role of the provocative other person in the scene who elicits bad feeling in the patient; and (c) intermittently switching over to the role of the reassuring therapist-guide who tells the patient what to do, and how to do it.

This method involves the therapist -- when the patient's attention is focused on a bad-feelinged scene -- enlivening that scene by doing three things: (a) describing it vividly; (b)

feelingfully enacting the role of the other person in the scene who elicits bad feeling in the patient; and (c) intermittently switching from this "pain-inducing" role over to the role of the supportive therapist who encourages-coaches the patient to keep (i) responding affectively to the other, and (ii) expressing and undergoing whatever feelings are present now in the moment. While there is some overlap between this method and previously-established methods, there are also enough important differences to qualify this method as "newly-discovered".

In terms of overlap with the previous literature, it is certainly true that many clinical theorists have talked about the importance of "reliving" emotionally-charged, bad-feelinged scenes. And, in this general sense, the research team's method corresponds to the established method, discussed in chapter 2, called *instruct the client to vividly describe a distant or recent life situation (or imaginary situation) in which he/she experienced heightened feelings* (cf. Mahrer, 1989a, 1989b, 1996; Pierce, Nichols, & DuBrin, 1983; Rose, 1976; Shorr, 1972). However, there are also marked differences between the research team's method and this previously-established one. First, in the research team's method, the therapist (not the patient) vividly describes the scene of strong feeling. Second, the research team's method involves the specific, new element of the therapist enacting the role of the "pain-inducing" other person in the strong feeling scene. Third, the research team's method includes the specific, additional element of the therapist occasionally pulling out of this "antagonist" role, and moving into a more supportive role of therapist guide-coach who helps encourage the client to act out and stay involved in the scene in a vital, feelinged way. Fourth and perhaps most importantly, the method "enlivening the scene of strong feeling" identified by the research seems to comprise a relatively complex, integrated sequence of interventions that -- taken together as a "gestalt" -- seem to

qualify it as a distinct package quite separate from any methods previously described in the literature.

In summary, these aforementioned methods -- method 1.2 (*push-oppose the patient with good humour)*, method 2 (*welcoming-encouragement of strong feeling*), and method 4 (*enlivening scene of strong feeling*) -- all appear to qualify as "newly-discovered" methods for promoting strong feeling.

Which Methods Confirm and/or Extend Those Reported in the Existing Literature?

The following methods overlap more substantively with those reported previously in the clinical and/or research literature, and thus do not qualify as new. As such, our findings here tend to confirm and extend the previous literature in the following kinds of ways: (a) by providing research-based support for methods that already have some establishment in the clinical literature, but little or none in terms of research; (b) by specifying-adding details important for the clinical application of a method that the previous literature may have lacked; and/or (c) by linking particular methods with explicit in-session antecedent patient conditions where no clear reference to patient conditions existed before in the literature.

1. ***Direct Provocation of Strong Feeling***

1.1 Instruct patient to repeat feeling-laden phrases or movements.
Patient Condition: When the patient is already undergoing a moderate level of feeling,
Therapist Method: the therapist persistently, feelingfully, and forcefully instructs the patient to repeat the feeling-laden words and/or bodily movements again and again.

The essence of this method is -- when the patient is showing signs of some feeling-expression -- to openly and forcefully instruct the patient to "feel it more", "say it again, louder", "keep doing it even more intensely", etc. This method compares closely to a previously-described

method -- *encourage the patient to repeat affect-laden phrases or expressive movements with heightened intensity* -- that is perhaps the most widely-established of all strong-feeling-methods in the clinical literature (e.g. Daldrup et al, 1988; Engle et al, 1991; Lowen, 1975; Jackins, 1978; Mahrer, 1989a; Nichols & Efran, 1985; Perls, 1969, Pierce, Nichols, & DuBrin, 1983, Shorr, 1972), and whose value has also been supported by some research (cf. Gervaize, Mahrer, & Markow, 1985; Nichols, 1974).

The method described by the research team, however, adds some interesting new components to the existing literature. First, our method highlights the importance of the therapist's giving her instructions *forcefully* and *feelingfully*. The therapist's delivery is not removed, dead, neutral; rather, it is strong, forceful, and filled with feeling. Second, our method highlights the importance of the therapist's *persistence*. In applying the method described by the research team, the therapist should be willing to give the instruction a number of times, rather than just once. Third, our method explicitly identifies an *in-session patient condition* -- that the patient is in a moderate state of feeling intensity -- that serves as a cue to therapists who might want to apply the method.

3. Intensification of Patient-Therapist Encounter

3.1 Make patient's implicitly-conveyed feelings explicit.
Patient Condition: When patient seems to be having feelings toward the therapist, but is only indirectly expressing them,
Therapist Method: the therapist induces the patient to directly express these feelings by (a) forcefully voicing the feeling-laden words that the patient seems to want to say; and/or (b) behaving toward (talking about) herself in a manner congruent with how the patient seems to want to.

3.2 Refuse patient's interpersonal request-demand.
Patient Condition: When the patient is openly critical of the therapist, and how the therapist is being-behaving,
Therapist Method: the therapist frustrates the patient by persistently either (a) disagreeing with the patient's opinion of the therapist, or (b) ignoring (not directly responding to) the specific content of the patient's criticism.

These two subcategories both correspond somewhat to methods previously described in the clinical literature. Neither would seem to qualify as altogether new. For example, method 3.1 (*make patient's implicitly-conveyed feelings explicit*) seems to closely relate to a therapist operation previously described in the clinical literature -- *explicitly stating something that the client is implicitly feeling, but is reluctant to say* (cf. Farrelly & Brandsma, 1974; Farrelly & Lynch, 1987). In Farrelly's method, the therapist promotes strong feeling by making explicit what the patient seems to be feeling inside but not saying openly. As such, our findings provide research-based confirmation for the usefulness of this method in promoting strong feeling.

A difference worth highlighting, however, between Farrelly's stated method and the one described by the research team is that our method specifically includes intensification of the patient's feelings *toward the therapist* in the present patient-therapist encounter-interaction, whereas Farrelly's method is not limited to this. Farrelly's method includes the therapist "explicating the patient's implicitly-stated feelings" with regard to essentially any topic -- including the patient's feelings toward the therapist, but also with regard to the patient's feelings toward other people, for example. Our method is thus more specific in application. Therefore, our findings provide research-based support for the effectiveness of this previously described method, but our confirmation is limited to the realm of patient's direct feelings toward the therapist.

Method 3.2 (*refuse patient's interpersonal request-demand*) involves the therapist meeting an open critical attack from the patient with some kind of refusal to accede to the patient's implied interpersonal request or demand -- with the net result being an intensification of the patient's level of feeling. In the first option "(a)" of this method, the therapist "holds her ground" and remains steadfast in her point-of-view, which is in direct opposition with the

patient's. In the second option "(b)", the therapist does not explicitly acknowledge or respond to the patient's critical attack, which also has the net effect of intensifying the patient's feelings to a level of strong feeling.

In comparison to the therapist methods reviewed in chapter 2, this method would also seem to correspond somewhat with previously described methods. First, the refusal of the therapist to do what the patient seems to want the therapist to do may overlap with Cashdan's (1988) method -- designated in chapter 2 as *engaging in an emotionally-charged (encountering) interaction with the client* -- that involves the therapist first identifying the interpersonal role (based on the patient's pathological "projective identifications") that the patient is trying to manipulate the therapist into playing, and then actively frustrating the patient by responding-relating in a manner very different from what the patient wants. Although our "third party" vantage point leaves us largely blind to the therapists' motivations underlying their opposition of the patient, it seems that the method identified by the research team might have been related to this kind of previously-reported, strong-feeling-enhancing method. Second, method 3.2 (*refuse patient's interpersonal request-demand*) also seems related to another previously-reported method: *intentionally shifting, switching, and diverting the focus of the client's immediate attention*. This method was postulated by Perls (1969, 1975b) as effective in promoting strong feeling, and found by previous research (Mahrer et al., 1991a, 1992a) to be effective in promoting strong client anger. Method 3.2 is similar to this in a sense in that the therapist frustrates the patient by not acknowledging his criticism, and the therapist may try to overtly divert the patient's focus onto something else other than the criticism.

So, both subcategories of *intensification of patient-therapist encounter* seem to

correspond somewhat to methods previously described in the clinical literature, and as such do not appear to qualify as altogether new. The research team's findings do, however, provide research-based confirmation for the usefulness of these methods in promoting strong feeling. In addition, our identification of methods 3.1 and 3.2 extends the previous literature by (a) explicating precise in-session patient conditions that cue practititioners to precisely when these methods can be applied; and (b) concretely specifying how practitioners can undertake the in-session application of these kinds of methods.

5. Intensification of Patient-Other Encounter

> *Patient Condition*: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),
> *Therapist Method*: the therapist (a) instructs the patient to say the feeling-laden words directly to the other (person, part of self); and (b) is persistent and consistent in keeping the patient immediately involved in the direct encounter with the other. The therapist may also (c) enact the role of the other person to whom the patient is uttering the feeling-laden words. When the feelings become relatively strong, the therapist may (d) tell the patient switch roles and be (speak as) the other person.

This method closely relates to two methods already well-established in the clinical literature -- *instructing the client to talk directly to a significant other* (e.g. Daldrup et al, 1988; Engle et al., 1991; Greenberg, 1979; Greenberg & Safran, 1987; Mahrer, 1989a, 1989b; Perls, 1969, 1973; Pierce et al., 1983; Sacks, 1976; Shorr, 1972; Yontef & Simkin, 1989); and *instructing the client to "be" some other person, personality part, or object* (e.g. Casriel, 1972; Daldrup et al., 1988; Fagan, 1976; Greenberg, 1979, 1980; Jackins, 1965; Levitsky & Perls, 1970; Mahrer, 1989a; Malamud, 1976; Naranjo, 1976; Perls, 1970, 1973; Pierce et al., 1983; Shorr, 1972; Yontef & Simkin, 1989).

Thus, our findings add to the modest base of existing research confirmation (cf. Mahrer et al., 1986b; Nichols, 1974) for the feeling-enhancing utility of these kinds of role-playing exercises

correspond somewhat to methods previously described in the clinical literature, and as such do not appear to qualify as altogether new. The research team's findings do, however, provide research-based confirmation for the usefulness of these methods in promoting strong feeling. In addition, our identification of methods 3.1 and 3.2 extends the previous literature by (a) explicating precise in-session patient conditions that cue practititioners to precisely when these methods can be applied; and (b) concretely specifying how practitioners can undertake the in-session application of these kinds of methods.

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> *Patient Condition*: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),
> *Therapist Method*: the therapist (a) instructs the patient to say the feeling-laden words directly to the other (person, part of self); and (b) is persistent and consistent in keeping the patient immediately involved in the direct encounter with the other. The therapist may also (c) enact the role of the other person to whom the patient is uttering the feeling-laden words. When the feelings become relatively strong, the therapist may (d) tell the patient switch roles and be (speak as) the other person.

This method closely relates to two methods already well-established in the clinical literature -- *instructing the client to talk directly to a significant other* (e.g. Daldrup et al, 1988; Engle et al., 1991; Greenberg, 1979; Greenberg & Safran, 1987; Mahrer, 1989a, 1989b; Perls, 1969, 1973; Pierce et al., 1983; Sacks, 1976; Shorr, 1972; Yontef & Simkin, 1989); and *instructing the client to "be" some other person, personality part, or object* (e.g. Casriel, 1972; Daldrup et al., 1988; Fagan, 1976; Greenberg, 1979, 1980; Jackins, 1965; Levitsky & Perls, 1970; Mahrer, 1989a; Malamud, 1976; Naranjo, 1976; Perls, 1970, 1973; Pierce et al., 1983; Shorr, 1972; Yontef & Simkin, 1989).

Thus, our findings add to the modest base of existing research confirmation (cf. Mahrer et al., 1986b; Nichols, 1974) for the feeling-enhancing utility of these kinds of role-playing exercises

that have been so widely-described in the clinical literature. In addition, in the light of previous literature postulating the effectiveness of the *two-chair technique* in promoting strong feeling (cf. Greenberg, 1979, 1980; Greenberg, Rice, & Elliott, 1993), it is noteworthy that the research team's method includes a combination of both *speak directly to the other* and *switch and "be" the other"*. As such, our findings would seem to further bolster the notion that strong feeling can be facilitated through the use of methods such as the *two-chair technique*. Moreover, the method described by our judges provides research-based support for the importance, already discussed elsewhere by clinical authors (e.g. Greenberg, Rice, Elliott, 1993), of the therapist being *persistent* in keeping the patient immediately involved in the encounter, and blocking the patient's attempts to "escape" it by, for example, speaking directly to the therapist.

In terms of how our findings extend the existing literature, the research team's method appears to add at least two elements that are somewhat new. First, the research team's method adds an explicit in-session patient condition -- i.e. *the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self)* -- that can serve as a cue to practitioners about <u>when</u> specifically to apply the method. Second, the research team's method includes the optional element of the therapist taking on the role of the other (person, part of self) to whom the patient is uttering the feeling-laden words, as a way of intensifying the patient-other encounter. Neither of these elements have been, to our knowledge, specified in the previous literature.

In summary, these aforementioned methods -- method 1.1 (*instruct patient to repeat feeling-laden phrases or movements)*, method 3 (*intensification of patient-therapist encounter*), and method 5 (*intensification of patient-other encounter*) -- all overlap substantively with

previously-reported therapist operations. As such, our identification and description of these therapist methods tends to confirm and extend the previous literature by (a) providing research-based support for methods that already have some establishment in the clinical literature, but little or none in terms of research; (b) specifying-adding details important for the clinical application of a method that the previous literature may have lacked; and/or (c) linking particular methods with explicit in-session antecedent patient conditions where no clear reference to patient conditions existed before in the literature.

The In-Session Patient Conditions Identified By the Research Team Extend the Existing Literature

In chapter 2, a review of the small volume of existing clinical writing and research data on the subject of *in-session client conditions* antecedent to strong feeling revealed that most of the literature related to strong feeling methods said little or nothing directly about in-session client conditions, but that some writers flagged the importance of paying attention to context-timing in the application of strong feeling methods. From these rare contributions, four relatively broad in-session client conditions were identified: (a) *the client is experiencing a sense of safety, and a strong therapeutic alliance*; (b) *there is some measure of client feeling already present*; (c) *the client is in the vicinity of being-behaving in some way which is risky (ordinarily blocked or avoided, excitedly threatening)*; and (d) *the client's attention is centered on a strong feelinged scene-situation*. In comparing the research team's findings to these previously mentioned in-session client conditions, several of the preconditions identified by the research team would seem to constitute new discoveries. Although there is clear overlap between the in-session patient

conditions identified in this study and those previously discussed in the literature, the newness of our contribution lies in the fact that: (a) each precondition is tied explicitly to a particular method (or submethod); and (b) the in-session conditions identified by the research team are more specific-detailed, and thus their clinical applicability is enhanced. Let me begin by discussing the in-session patient conditions identified by the research team that overlap with those previously-reported in the literature, and then discuss those preconditions that would seem to qualify as "newly discovered".

In-Session Client Conditions Identified By the Research Team That Confirm and Extend Those Reported in the Existing Literature

First, our findings support the applicability of the condition "*there is some measure of feeling already present in the client's words*" that has been previously flagged by clinical writers (e.g. Dosamantes-Alperson, 1981; Greenberg & Safran, 1987; Kutzin, 1980; Pierce, Nichols, & DuBrin, 1983; Mahrer, 1989a; Sacks, 1976; Sheiner, 1966) and researchers (Mahrer, 1986b). Specifically, we found that this antecedent client condition was explicitly tied to the application of two therapist methods we identified: method 1.1 (*instruct patient to repeat feeling-laden phrases*) and method 2 (*welcoming-encouragement of strong feeling*).

Second, our findings provide the first research-based confirmation for a client condition reported in the clinical literature: "*the client's attention is centered on a strong feelinged scene-situation*" (Mahrer, 1989a, 1996). This precondition corresponds closely to one identified by the research team and linked specifically to method 4 (*enlivening scene of strong feeling*): "when the client's attention is already partly centered and riveted on an emotionally-compelling scene-

situation that is frought with bad feelings".

Third, our findings support the applicability of the condition "*the client is in the near vicinity of being-behaving some way which is risky (ordinarily blocked or avoided, excitedly threatening)*" which was previously cited in a research study of in-session strong laughter (Gervaize, Mahrer, & Markow, 1985). Specifically, the client precondition linked to the application of method 1.2 (*pushing-opposing the patient with good humour*) is that "the client is hesitant-reluctant (i) to commit to carry out a new, risky extratherapy behaviour; or (ii) to respond openly to therapist's probing questions". This precondition seems to include the element of the client being in the vicinity of doing or considering new, risky, anxiety-provoking behaviours (either in the imminent extratherapy world, or the present interaction with the therapist). Also in the same ballpark is the precondition to the application of method 3.1 (*make patient's implicitly-conveyed feelings explicit*): "the client seems to be having feelings toward the therapist, but is only indirectly expressing them". This in-session client precondition also may involve the client being on the edge of being-behaving in a risky, new way in relation to the therapist. However, even though there are similarities between what we found and what has been mentioned in previous literature, the specificity of our identified client conditions seems to add something important to the more vague notion of the client being close to doing something risky or new.

It is worth noting that the only precondition discussed in previous literature that was not found by the research team was the first one -- that the *client is feeling safe in the therapist-patient relationship*. It is likely that, even if this condition had existed in the clients on our tapes, our methodology would not have been sensitive to its presence, since it is difficult for "feeling safe" to be conveyed in terms of overt words on an audiotape. In other words, our research

strategy which focused on relatively specific, localized, patient-therapist interactions in sessions was likely relatively insensitive to global patient conditions -- such as feelings of safety, or experiencing a strong therapeutic alliance. Thus, the absence of this client condition in our results should not be taken as a disconfirmation of the applicability or importance of this client condition.

In summary, the research team's findings provide research-based confirmation for three of these four client conditions discussed previously in the literature. Our findings also add to the literature in terms of their specificity and their explicit linkings of particular client conditions to particular methods -- something that was previously lacking in the literature.

In-Session Client Conditions Identified By the Research Team That Seem to Qualify As "Newly-Discovered"

The client conditions linked to methods 3, 4, and 5 all seem to qualify as new on the grounds that they include a key, new element -- *where the patient's feelinged-attention is directed* -- that has important implications for the applicability of particular strong-feeling-methods. More specifically, these client conditions all combine the general notion that the client is "undergoing a moderate level of feeling" with the more specific element of where (upon whom, or about what) the patient's moderate feeling is focused. And, importantly, different methods are appropriate depending on where the patient's feeling is focused. For example, if the patient's moderate feeling is *directed at the therapist*, then method 3 (*intensification of patient-therapist encounter*) is appropriate. If the feeling is *directed on a particular scene-situation*, then method 4 (*enlivening scene of strong feeling*) is appropriate. If the feeling is *directed at another (person, part of self)*, then method 5 (*intensification of patient-other encounter*) is appropriate.

In summary, in terms of the client conditions tied to methods 3-5, our findings constitute new discoveries not previously reported in existing theory or research on strong feeling. Specifically, our findings extend the well-established notion that strong-feeling-methods should be applied when the client is "undergoing a moderate level of feeling" to include the more precise, new element of *where* (upon whom, or about what) the patient's moderate feeling is focused. According to our findings, the appropriate strong feeling method differs according to where the patient's feelinged-attention is focused.

Summary of How the Therapist Methods Identified By the Research Team Compare to Those Reported in the Previous Literature

A summary is included here to conclude discussion of how the therapist methods described by the research team compare to those described in the previous literature that was reviewed in chapter 2. In terms of "newly-discovered" methods of promoting strong feeling, three methods identified by the research team seemed to be sufficiently new to qualify: method 1.2 (*push-oppose the patient with good humour)*, method 2 (*welcoming-encouragement of strong feeling*), and method 4 (*enlivening scene of strong feeling*). In regard to "previously-established methods", three methods identified by the research team seemed to overlap substantively with previously-reported operations: method 1.1 (*instruct patient to repeat feeling-laden phrases or movements)*, method 3 (*intensification of patient-therapist encounter*), and method 5 (*intensification of patient-other encounter*). In these cases, our identified methods tend to confirm and extend the previous literature by (a) providing research-based support for methods that already have some establishment in the clinical literature, but little or none in terms of research; (b) specifying-adding details important for the clinical application of methods was

lacking in the existing literature; and/or (c) linking particular methods with explicit in-session antecedent patient conditions where no clear reference to patient conditions existed before in the literature.

The Research Team was Successful in Identifying Therapist Uses Linked to the Occurrence of Strong Feeling

Over the course of data collection, the research team's consistent impression was that incidences of strong feeling were being *used* afterward in particular, identifiable ways by our therapists -- as opposed to being ignored, passed over, not used. Furthermore, also in keeping with the goals and intentions that the research team initially held when they embarked on this study, the generated *therapist use* descriptions (a) comprise an empirically-based list of uses in an area where little previous research exists; (b) can be held with confidence; and (c) are derived from what therapists *actually did* in their sessions, and thus are sufficiently detailed and concrete for practitioners to be able to apply these uses in their sessions. In short, in terms of these above specific aims and criteria, the research team can be regarded as having been quite successful in identifying, describing, and organizing *therapist uses* linked to in-session occurrences of strong feeling.

This is a research-generated list of *uses of strong feeling* in an area where little previous research has been done. Previous psychotherapy research offered no integrated, empirically-based, practitioner-relevant categorization describing, in concrete detail, how strong feeling can be *used* in the session. In fact, nearly all of the existing data on in-session strong-feeling uses, as described in chapter 1, was found in the clinical-theoretical literature, and not from actual

research. Moreover, even the existing clinical writings offered no organized categorization of the therapist uses of strong feeling. Our identification and description of 5 uses of strong feeling thus helps to begin filling this conspicuous gap in the literature -- providing a research-based list of strong-feeling-uses, organized into a workable number of categories. This is, to our knowledge, the first research-based set of categories of therapist uses of strong feeling.

There is basis for having confidence in these findings. Although the number of tapes (14) and strong feeling events (52) we studied was somewhat low, the amount of data we had was sufficient for us to generate an organized list of *therapist uses* that we can hold with some confidence. Our confidence is based on the following factors. First, the therapist uses were generated based on a high level of inter-rater agreement among a relatively large team of clinically sophisticated judges, and the therapist uses were subject to the verification, modification, and final approval by the research team. Second, the two principal investigators (when they each independently generated provisional category systems of therapist uses at the mid-point of data collection) had a strong sense of agreement about what should comprise the main categories and subcategories. Third, we were able to ascertain that, over the last 20 protocols, no substantively new categories were generated -- meaning that the five categories of therapist uses that we had provisionally come up with were ones that we could hold with increasing firmness and conviction. Each subsequent protocol was adding to our confidence that this category system had some measure of reliability, as well as clinical meaningfulness and utility.

The therapist uses are derived from what therapists *actually did* in their sessions, which enhances the practitioner-relevance of the findings. The research team's focus was on identifying *concrete*, *overt* therapist interventions-behaviours subsequent to occurrences of strong feeling,

and describing these interventions-behaviours in a jargon-free, simple fashion. The net result is that our list of strong-feeling-uses is based almost entirely on what therapists *actually did* in their sessions, rather than what therapists, discussing their interventions from the vantage point of their own particular theories, might say they did. This kind of focus was useful for generating descriptions that were quite rich in detail, and highly practitioner-relevant. Indeed, the strong-feeling-use categories generated consist of relatively specific, concrete, and jargon-free descriptions of what therapists can do to use strong feeling after it occurs -- as opposed to global, theory-laden descriptions that tell the practitioner little about what to actually do in the session. This is noteworthy given that most of the previous technical knowledge on how to use strong feeling is found only in isolated clinical writings that discuss these issues in a relatively global fashion from the perspective of each particular theorist's own psychotherapeutic orientation.

In summary, then, the research team was successful in identifying and describing specific therapist uses that, in their judgement, followed occurrences of strong feeling, and was successful at organizing these therapist methods into different categories. Moreover, the research team was successful in generating findings that can be held with some solid confidence, and that make an empirically-based, practitioner-relevant contribution to an area of research that has received little previous attention.

The Identified Therapist Uses Both Confirm and Extend the Existing Literature

Perhaps the most striking thing about how the strong-feeling-uses we found compare to the previous clinical and research literature is that none of the uses we came up with is substantively new. In fact, if we define "new" as a use not previously postulated in the clinical

literature, then none of the 5 main uses identified by the research team would seem to qualify as entirely new. One use ("resolve the painful feeling") might arguably be regarded as new, although the processes it involves overlap somewhat with ones previously-reported in the clinical literature. So, in general, it is noteworthy that the strong-feeling-uses identified all seem, at least somewhat, to resemble uses described in chapter 1.

Discussing the research team's findings in the light of the existing literature, however, brings up a number of interesting issues that should be raised before looking specifically at how each identified use confirms and/or extends the existing literature. Accordingly, let me highlight some relevant points that arise when one attempts to compare our findings to the previous literature.

It is often hard to compare the research team's strong-feeling-uses with those previously-reported in the literature because the research team's uses tend to be at a more *micro*-level. In general, the uses reviewed and organized in chapter 1 tend to comprise relatively broad, "macro" change processes involving strong feeling. Although the clinical writers in question did not usually talk explicitly about the time-frame over which these processes were postulated or supposed to occur, the strong-feeling-uses to which they refer are "big" enough that most would probably take an entire session or series of sessions to accomplish. In contrast, the uses identified by the research team tend to be much more at a "micro-level". Our judges tended to focus on what the therapist (and patient) actually did and said in the immediate seconds and/or minutes subsequent to a strong feeling occurrence, and to base their strong-feeling-use descriptions on this -- with a minimum of theorizing. Consequently, our results tend to be precise, time-compressed, and based on actual therapist and patient behaviour.

The key point here is that our strong-feeling-uses tend to point to relatively "micro" change processes whereas the uses reviewed in chapter 1 tend to comprise more broad, "macro" processes -- and this creates some problems when it comes to trying to compare these two sets of uses. While the previously-reported uses tend to be theory-laden and focused on the *larger* picture of change involving strong feeling, our strong-feeling-uses tend to be precise and focused on the *smaller*, immediate picture.

The *micro*-focus of our strong-feeling-uses means that they often fruitfully augment-complement the previous literature. Because previously-reported uses tend to concentrate more on the larger picture of change, and our uses tend to be more precise and restricted to epochs in a session, our findings tend to productively complement-extend the previously literature. In other words, our uses seem to fill in important technical gaps and specifics that are absent, implied, or glossed over in previously-reported uses. For example, while many uses in the previous literature include as a sub-part the element of "*sustaining-prolonging the patient's strong feeling*" -- they characteristically offer little specific direction to therapists about how to accomplish this. In this regard, our findings complement the previous literature by providing concrete technical descriptions to practitioners about *how* to "sustain strong feeling". It is almost as if the previous literature -- with its general, theory-based, broader categories -- provides the larger picture of various strong-feeling-uses, and that our findings begin to fill in the blanks related to the behavioral specifics of how to put each use (or part of each use) into practice. The previous literature tends to be more like a view of the landscape from a helicopter. Our findings are more a view from the ground. The two complement each other.

A number of the research team's uses confirm and overlap with *parts of uses* talked about

in the previous literature. Once again, because our strong-feeling-uses tend to be at a "micro-level", many of them overlap with *sub-parts* of uses reviewed in the previous literature. For example, consider the use "sustaining strong feeling" which was identified by the research team. When we look at how this use relates to previously-reported uses, we notice first that no category called "sustaining strong feeling" is included there, but also that "sustaining strong feeling" is an element that is implied and *cuts across a large number* of the uses discussed and reviewed in chapter 1. As such, "sustaining strong feeling", as it relates to the previous literature, can be seen as a kind of sub-use, overlapping with parts of uses contained in the previously-existing literature.

With these preliminary comments concluded, the objective of this section is to discuss each use identified and described by the research team in the light of the previous clinical and research literature. Specific comparisons will be made between the uses identified by the research team and the previous literature as reviewed in chapter 1. Although none of the main five categories of uses identifed by the research team is an altogether new addition to the literature, the research team's findings typically extend and add to the existing literature in the following ways: (a) the uses described by the research team constitute, in many cases, the first research-based confirmation of the existence of these uses in actual sessions of psychotherapy; (b) the uses are defined in a succinct, practitioner-relevant fashion, that provides therapists with valuable direction about how to apply this use in the session; and (c) some of the uses we identified frame previously-reported uses into a more generally-applicable, and more workable form for therapist application. In these ways, the findings of the present study both confirm and extend what is present in the existing, reviewed literature.

1. Sustain (Prolong, Intensify) the Strong Feeling

> The therapist induces the patient to keep undergoing-showing the strong feeling with sustained or even fuller intensity. The therapist may (a) forcefully instruct the patient to keep expressing the feeling; or (b) playfully oppose-attack the patient for having the strong feeling, which also paradoxically pulls for the patient to feel the feelings even more. When the patient's strong feeling is directed (in role-play) toward a significant other person, the therapist may sustain-intensify the patient's feeling by (c) feelingfully enacting the role of that other person, engaging-provoking-opposing the patient in the immediate, charged interaction.

This use involves the therapist attempting to keep the strong feeling going -- to prolong-intensify-sustain it in some way. This use has been reported before both in previous clinical theory and research. In terms of previous research, two process studies (Labott, Elliott, & Eason, 1992; Mahrer, Markow, Gervaize, & Boulet, 1987) have reported that therapists used strong feeling to *sustain and maintain* it. As such, the findings lend further confirmation. In terms of previous theory, although this category of therapist use was not identified as its own category in the clinical review in chapter 1, the notion of *sustaining strong feeling* was a sub-theme that flowed through many of the uses included there. For example, previous clinical writers have talked about the importance of recovering previously-banished memories and discharging the entire quantity of strong affect originally attached to them (Breuer & Freud, 1895; Janov, 1970); intensely and consistently discharging feeling to break through characterological defences (Jackins, 1978; Lowen, 1975; Reich, 1949, 1960); or promoting sustained, anxiety-filled, vivid experiential contact with the feared, phobic object or situation (Stampfl, 1976; Stampfl & Levis, 1967). Clearly, as these examples illustrate, the notion of *sustaining strong feeling* has an established heritage in clinical theory on how strong feeling is used.

What our findings seem to contribute, therefore, is added research-based confirmation of the existence of this use in actual sessions of psychotherapy. Our results also define this use in a

succinct, practitioner-relevant way that offers therapists concrete direction -- three precise, detailed options, in fact -- about how to apply this use in the session.

2. Neutralize (Diminish, Reduce) the Strong Feeling

2.1. Avoid-deflect patient's critical confrontation. Negative feelings expressed toward the therapist are neutralized by the therapist's avoidance of the patient's direct critical confrontation. Instead of responding to the direct attack, the therapist may (a) welcome the patient's ability to disclose and reveal; (b) agree with the patient's criticism; (c) praise the patient for his/her perceptiveness; or (d) defend himself with clever logic that is sufficiently baffling to sway the patient from her confrontational stance.

2.2. Gentle the strong feeling. Feelings toward the therapist are defused (gentled) by the therapist's supportive acknowledgement of the quality and intensity of the patient's immediate feeling.

This use involves the therapist engaging in maneuvers that reduce the patient's strong feeling. Rather than intensifying or drawing out the strong feeling, therapists who applied this use seemed to be trying to go in the opposite direction.

In comparing this finding to previous clinical literature on strong feeling, it appears that this "neutralization" use may correspond and overlap (at least in part) with the widely-established notion in the clinical literature that some strong feeling events -- at least at some times, with some patients -- are not viewed by practitioners as therapeutically desirable (cf. Bergler, 1956; Berkowitz, 1973; Engel et al, 1991; Koestler, 1964; Perls, 1969; Skodol, 1989; Whitmont & Kaufmann, 1973). As outlined in chapter 1, it is relatively common for clinical writers (even those who are proponents of strong feeling) to say that -- at some times, with some patients -- strong feeling material may be undesirable, or at least less important (therapeutic) than other kinds of patient material.

In comparison to the previous clinical-theoretical literature, then, this "neutralization" use does not seem to qualify as altogether new. What our findings do seem to contribute to the existing literature, however, is (a) the first research-based confirmation of the existence of this use

(or non-use) in actual sessions; and (b) concrete directions for practitioners about different ways that "neutralization" of strong feeling can be accomplished in the session -- based on data drawn from the work of experienced therapists' in actual sessions of psychotherapy.

3. Resolve the Painful Feeling

> The therapist helps the patient resolve (finish out) the bad, painful feeling by having the patient open up (show, express) the bad feeling -- in the context of an alive, painful scene-situation -- and then having the patient learn and feelingfully enact-rehearse more effective (constructive, self-enhancing) ways of coping-dealing with the scene-situation that was previously so painful.

This use involves the therapist helping the patient to resolve and finish out a painful feeling by first having the patient open up strong feeling in the context of a highly-charged, painful scene, and then having the patient discover and enact-rehearse more effective (less painful) ways of behaving in that kind of scene-situation. While "resolve the painful feeling" may overlap somewhat with previously-reported uses in the clinical literature, it seems to be predominantly new in terms of research.

In terms of research, our identification of "resolve the painful feeling" appears to be a new addition to the literature. Previous studies have indicated that strong feeling occurrences may facilitate, later in the session, *an overall state of heightened well-being* (Mahrer et al., 1992) or *a sense of physical relief* (Labbott, Elliott, & Eason, 1992), but these two uses -- although they may appear similar to "resolve the painful feeling" -- are in fact quite different from it. Indeed, "resolve the painful feeling" *may* involve the client feeling better in the session, or expressing a sense of relief or well-being, but this is not the essence of this strong-feeling-use. The essence is the patient's enactment-rehearsal -- in an emotionally-charged way -- of new, potentially more effective behaviours in situations-interactions that have previously brought pain to the patient.

Therefore, our identification of "resolve the painful feeling" as a strong-feeling-use seems to be a new addition to the literature in terms of research.

In terms of how "resolve the painful feeling" compares with uses that have been previously-reported in the clinical-theoretical literature, a reasonable case could be made that this "resolve the painful feeling" qualifies as new. At this same time, it does seem to bear some partial resemblance to previously-reported uses. For example, a group of clinical authors (e.g. Daldrup et al., 1988; Pierce, Nichols, & DuBrin, 1983; Nichols & Efran, 1985; Shorr, 1972) who appear to use strong feeling as a means for promoting increased *insight-understanding* seem to accomplish this use by going through in-session steps that bear some resemblance to "resolve the painful feeling". Specifically, these authors suggest that the patient's becoming vividly, feelingfully immersed in a bad-feeling ("unfinished") scene-situation will tend to help unblock the natural flow of emotional expression (that presumably did not occur in the original scene) -- and that this process will tend naturally to facilitate increased insight-understanding in the patient. "Resolve the painful feeling" seems to involve some similar processes-steps to this. However, "resolve the painful feeling" does <u>not</u> emphasize the enhancement of insight-understanding -- which seems to be the chief objective for the clinical authors cited above. Therefore, it is difficult to say whether "resolve the painful feeling" should qualify as new or not in relation to the previous clinical literature. Points of overlap can be identified, but a case can also be made that "resolve the painful feeling" differs enough from previously-reported uses to qualify it as a new, distinct package.

In short, then, "resolve the painful feeling" may qualify as relatively new in comparison to the previous clinical-theoretical literature. In terms of research, our identification of this use

provides, to our knowledge, the first research-based confirmation for the applicability of this strong-feeling-use in psychotherapy. Moreover, our findings further extend the previous literature by providing therapists with concrete direction about how to put this use into practice in their sessions.

4. Develop the Emergent Material

4.1. Carry forward whatever material is now present. The therapist encourages the patient to explore whatever material -- e.g., feelings, thoughts, memories -- is now immediate and present.

4.2. Penetrate further into personal-private material. The therapist uses the strong feeling as an indication that the patient is ready and willing to continue answering the therapist's probing, provocative questions with regard to highly personal-private topics.

4.3. Promote integrative feelings toward fended-off part of self. The therapist welcomes and carries forward a way-of-being that is (a) immediately present, and expressed-shown with emotional charge in the moment of strong feeling; and (b) not fully welcomed-accepted by the patient.

This strong-feeling-use unites 3 subcategories under the common fabric of "develop the emergent material". Subcategory 4.1 involves further exploration of whatever material -- e.g. feelings, thoughts, or memories -- might have just emerged from the strong feeling. Subcategory 4.2 involves more directive probing -- and consists of the therapist inviting the patient to further reveal personal-private material. Subcategory 4.3 involves the therapist's active attempt to carry forward a somewhat new way-of-being that has begun to emerge in the moment of strong feeling, and that the patient may not readily acknowledge as a part of self.

The idea of using strong feeling to "develop the emergent material" does not seem to qualify as entirely new in relation to previous clinical-theoretical writing. Indeed, "develop the emergent material" may overlap somewhat with using strong feeling to *promote heightened experiential awareness of self* (Perls, 1969; Polster & Polster, 1973; Yontef & Simkin, 1989; Zinker, 1977), or to *promote heightened experiential awareness through the carrying forward of a bodily felt sense* (Friedman, 1982; Greenberg & Safran, 1987; McGuire, 1991). However, it

should be noted that the use defined by the research team may be more general in that it is not limited to related affective, bodily-felt material -- but also may include the carrying forward of thoughts, memories, ways-of-being, or highly personal-private information related to the strong feeling.

In terms of research, "develop the emergent material" does appear to be predominantly new. As such, our findings may constitute the first research-based confirmation for a strong-feeling-use previously-established in the clinical literature.

In summary, the finding that strong feeling can be used to "develop the emergent material" does not seem to be altogether new in relation to previous clinical-theoretical writing, but does seem to provide, to our knowledge, the first research-based confirmation for the applicability of this strong-feeling-use in psychotherapy. Moreover, our findings further extend the previous literature by providing therapists with concrete direction about three relatively distinct ways to put this use into practice in their sessions.

5. Promote Insight and Self-Understanding

> The therapist uses the strong feeling to help the patient attain increased insight-understanding into the nature (characteristics, workings) of either (a) past or present relationships with significant other people (or parts of self); or (b) ongoing patterns of being-behaving that tend to be troubling-problematic for the patient.

In applying this use, the therapist tries to help the patient use the affective material in the strong feeling moment to achieve heightened insight-understanding into the workings of either her (a) relationships (with other people, or parts of self) or (b) characteristic (problematic) ways of being-behaving. Stated differently, this strong-feeling-use tended to involve the therapist helping the person to change-enhance her conscious, articulated sense of who she is, why she behaves the

way she does, and how she came to be-behave this way.

The idea that strong feeling can be used to enhance insight-understanding is relatively well-established in previous theory, but not well-validated in terms of previous research. In terms of research, only two previous studies (Labott, Elliott, & Eason, 1992; Mahrer, Nadler, Gervaize, & Markow, 1986) appear to have linked in-session client *attainment of increased insight and self-understanding* to the prior in-session occurrence of strong feeling. In terms of previous clinical theory, however, the idea that heightened feeling can be used to enhance insight-understanding has a long, established tradition beginning with Freud (cf. 1912), and carried forward and adapted by a wide variety of theorists representing psychoanalytic, experiential, cognitive, and other therapeutic orientations (e.g. Daldrup et al., 1988; Farrelly & Lynch, 1987; Fenichel, 1945; Foa & Kozak, 1991; Greenberg, Rice, & Elliott, 1993; Greenwald, 1987; Nichols & Efran, 1985; Pierce, Nichols, & DuBrin, 1983; Shorr, 1972). Recently, furthermore, categories of *emotional insight*, *creation of meaning through synthesis*, and *facilitating cognitive reorganization* have been included in theoretically-based taxonomies of the uses of heightened feeling-affect-emotion in psychotherapy (Greenberg & Safran, 1987; Safran & Greenberg, 1991b). So, in short, the notion that heightened levels of feeling can be used to promote "insight-understanding" has a well-established history in terms of clinical theory, but has received only a scanty amount of attention in terms of previous research.

In the light of the previous literature, one contribution of our findings, then, is that they provide further research-based confirmation for the applicability of this strong-feeling-use in psychotherapy. Indeed, while the idea of using strong feeling to promote insight-understanding is relatively established in the realm of clinical theory, there has been almost no research-based

evidence for this. Our findings add some. Furthermore, our findings lend further confirmation to the existing clinical-theoretical literature, and also extend this literature by providing practitioners with concrete direction regarding how to apply this kind of use in their sessions.

Summary of How the Strong-Feeling-Uses Identified By the Research Team Compare to Those Reported in the Previous Literature

In comparison to uses previously reported in the clinical-theoretical literature, none of the five uses identified by the research team seemed to qualify as altogether "newly-discovered". The only potential exception was "resolve the painful feeling", which was arguably a distinct enough package (sequence) of processes to qualify it as new.

In terms of how our findings compared to previous research literature, they typically extended it by (a) providing initial or added research-based confirmation for the applicability, in actual psychotherapy sessions, of strong-feeling-uses previously-reported in the clinical literature, but not as well-established in terms of research; and (b) framing previously-reported uses into a more generally-applicable, and more workable form for therapist application.

To What Extent Was This Study Successful in Answering Its Main Research Questions?

This study resulted in the successful identification, organization, and description of 5 types of *therapist methods*, plus additional subcategories, judged as facilitating the occurrence of strong feeling. This study also successfully yielded 5 types of *therapist uses*, plus additional subcategories, of strong feeling. This demonstrates, as previous studies have before it (e.g.

Elliott, 1983; Gervaize, Mahrer, & Markow, 1985; Greenberg & Clarke, 1979; Labott, Elliott, & Eason, 1992; Mahrer et al., 1986b, 1991a, 1991b, 1992a, 1994), the productivity of using a research strategy that focuses on identifying what therapists actually do in real sessions of psychotherapy.

In terms of answering its main research questions, it appears that this study was largely successful. First, regarding *therapist methods*, the research team's findings confirmed and extended the previous literature in at least four ways: (a) by identifying and describing a number of strong-feeling-methods never before reported in the clinical or research literature; (b) by providing research-based support, where little or none existed before, for the applicability of strong-feeling-methods previously-reported in the literature; (c) by providing a workable list of succinct, clinically-relevant and applicable therapist methods, thus adding clarification to the more diffuse collection of methods available in the previous clinical/technical literature; and (d) by linking particular methods with explicit in-session antecedent patient conditions where no clear reference to patient conditions existed before in the literature.

Second, regarding *therapist uses*, the research team's findings confirmed and extended the previous literature in at least four ways: (a) by identifying and describing one strong-feeling-use not previously-reported in the clinical or research literature; (b) by providing initial or added research-based confirmation for the applicability of strong-feeling-uses previously-established in the clinical literature; (c) by fruitfully complementing-augmenting the previous literature through filling in technical gaps and specifics that were previously absent, lacking, or glossed over in the existing literature; and (d) by framing previously-reported uses into a more generally-applicable, and more workable form for therapist application.

It is concluded that, in terms of the main research questions, this study has been successful in attaining its goal of contributing to the body of knowledge on therapist methods and therapist uses related to the in-session occurrence of strong client feeling.

Discussion Points Related to the Secondary Findings

This section will highlight noteworthy issues that relate to the secondary findings of this study -- specifically, those connected to our analysis of how therapist methods and uses appeared to vary (or not vary) according to *different kinds of strong feeling*, *different families of psychotherapy*, and *different temporal eras*.

A. Different Kinds of Strong Feeling

In regard to our study's consideration of "different kinds of strong feeling", two points emerge as particularly noteworthy issues for discussion. First, our findings raise the speculative possibility that some *therapist methods* might vary according to *kinds of strong feeling*, but that *therapist uses* might not. Second, our findings call into question what seems to be the popular belief that working with strong feeling means working mostly with bad (unpleasureable, negative) feelings.

Our Findings Raise the Speculative Possibility that Some *Therapist Methods* Might Vary According to *Kinds of Strong Feeling*, but that *Therapist Uses* Might Not

As highlighted previously in the results chapter, our data set was not large enough to allow any statistical description of our distributions plotting *therapist methods* by *kind of strong*

feeling (Table 1) and *therapist uses* by *kind of strong feeling* (Table 2). Thus, any conclusions drawn from these distributions must be approached as highly speculative in nature.

Given these disclaimer clauses, it still seems worth noting that *therapist methods* did show some signs of varying across different categories of strong feelings, whereas *therapist uses* showed essentially no signs of this whatsoever. Our findings raise the possibility that -- if enough data had been collected to allow for precise statistical analyses -- some particular *therapist methods* might have been found to vary significantly across particular *kinds of strong feeling*, whereas this may not have been found to be the case with *therapist uses*. To push this point one step further, it could be speculated that therapist methods may be tailored (at least to some extent) specifically for different kinds of strong feeling, but that therapists may tend to *use* strong feeling in ways that have little to do with the particular kind of strong feeling that occurs. To give a specific example from our data, it might be found that a particular kind of strong feeling (e.g. *good-feeling happiness-laughter*) tends to be linked with a particular therapist method (e.g. *direct provocation*) (see Table 1), but not with any particular strong-feeling-use (see Table 2).

Practitioners Who Emphasize Strong Feeling May Work With Both Good (Pleasureable, Positive) Feelings and Bad (Negative) Feelings

In the clinical literature on *methods* and *uses* related to strong feeling, it is evident that the majority of writings are talking about how to promote and work with *negative* feelings -- such as pain, anger, hurt, loss, grief, etc. After all, there are relatively extensive writings, for example, on the importance of discharging pent-up bad feelings, heightening anger, or gaining insight into behaviour in painful situations. Much less writing seems to be focused on working with strong

feelings such as laughter, for example. There are exceptions of course, but mainly what comes though in the literature is the message that to work with strong feeling means to work predominantly with bad (negative, unpleasurable) feelings.

Our data suggests, interestingly, that working with strong feeling may mean working frequently with both good and bad feelings. Indeed, in our sample, "good" feelings and "bad" feelings occurred in relatively equivalent frequencies. Not only did our five categories of strong feelings -- (1) *good-feeling happiness-pleasure-laughter*; (2) *mixed-feeling laughter*; (3) *defiance-opposition, strength-toughness, anger-exasperation*; (4) *bad-feeling hurt-pain-anguish*; and (5) *good-feeling love-caring-closeness* -- include both good (pleasant) and bad (unpleasant) feelings, but in terms of how frequent good vs. bad feelings were in our sample, there was a relatively even split. The predominantly "good" feeling categories -- the two laughter categories, and the *good-feeling love-caring-closeness* category -- collectively accounted for 33% of all strong feeling occurrences. Instances of *defiance-opposition* -- which often consisted of at least partly good-feelinged expressions of toughness-firmness -- comprised 40% of the sample. In fact, purely "bad" feelings of *hurt-pain-anguish* made up only 27% of our sample of strong feelings.

So, in short, if our sample of practitioners is any indication, then it may be that working with strong feeling in the session does not mean that all (or even most) strong feelings will tend to be bad (negative, unpleasureable) feelings. Contrary to what seems to be the popular belief, one may be working with laughter, delightful toughness, or tender caring just as often as feelings of pain, anguish, and rage.

B. Different Families of Psychotherapy

Based on our results and the soft impressions of the research team, two main points are highlighted here. First, it bears further mention that the research team had low confidence in its classification of tapes according to *family of psychotherapy*, and therefore the results in this regard must be approached with caution. Second, our results raise the possibility that the whole idea of different orientations may not be particularly relevant when it comes to looking at how therapists promote and use strong feeling in the session.

The Research Team Did Not Have High Confidence in its Classification of Tapes According to *Family of Psychotherapy*

As indicated in the results chapter, the research team often had a difficult time placing sessions, with confidence, into a particular *family of psychotherapy*. Indeed, the research team -- although they were able, with adequate interjudge agreement, to place each of the 14 sessions into one of the four main families (*psychoanalytic-psychodynamic*; *humanistic-experiential*; *cognitive-behavioural*; or *integrative-eclectic*) -- often expressed a serious lack of confidence and certainty in their ratings. The prevailing theme among the judges was that, in studying the actual moment-to-moment therapy process in the 14 sessions, it was often very difficult to make hard-and-fast distinctions, for example, between "psychoanalytic" vs. "experiential" vs. "cognitive" therapeutic interventions. Indeed, after the formal ratings were collected, discussions between the team members highlighted the fact that it was quite easy to make a reasonable case that a given tape could have been placed in *one* or *two* or even *three* different families of therapy, depending on what particular elements of the session the judge focused on, or how each judge interpreted the

general contours of a given session. The research team's difficulty was perhaps compounded by the fact that few of the therapists we studied were true exemplars or inventors of particular approaches -- on the level of, for example, a Fritz Perls. Most of the practitioners we studied were distinguished, relatively well-known clinicians -- but not pure exemplars of particular kinds of therapy.

In short, the research team found it difficult to, with reasonable confidence, place the 14 tapes into different categories of family of psychotherapy. This makes it difficult when it comes to interpreting and discussing the results, because all of our findings must be taken with a large grain of salt.

Perhaps the Whole Idea of *Different Orientations* Is Not Particularly Relevant When We Look at How Practitioners Actually Work In the Session With Strong Feeling

Our findings raise the possibility that the whole idea of different families of therapy is not particularly relevant when we are looking at how therapists promote and use strong feeling in the session. First, consider the research team's inability to place, with high confidence, different sessions into particular families of psychotherapy. Second, consider that we found almost no hints of differences across different families of psychotherapy in their *therapist uses* of strong feeling (see Table 4). Third, in terms of association between family of therapy and *therapist methods* of promoting strong feeling (see Table 3), the most striking characteristic of the distribution is that *most* of the therapeutic families applied *most* of the methods on one or more occasions. Fourth, consider the soft impression of the judges that the therapists who were applying the same sorts of methods and uses were a pretty "varied lot"; in other words, the

research team was struck by their impression that therapists of seemingly different therapeutic stripes used many of the same sorts of methods in promoting strong feeling.

If we put all these results and impressions together, it seems surely evident that none of the therapeutic families have anything resembling a "monopoly" on particular strong feeling methods or uses. In fact, most of the therapeutic families seemed to apply the majority of the methods and uses on one or more occasions. It seems thus reasonable to entertain the possibility that the whole notion of talking about "different families of therapy" is not particularly relevant in conjunction with working with strong feeling in the session. Therapists of different orientations may promote and use strong feeling in similar ways. In short, in terms of strong feeling, perhaps the usual ways of distinguishing between different types of therapists do not matter much.

C. Different Eras of Session

Distinct trends were difficult to find when we looked at how therapist *methods* and *uses* related to strong feeling might vary across different time periods. In terms of *therapist uses*, no obvious clues emerged. For *therapist methods*, however, one soft impression is worth raising as a speculative possibility. Specifically, if the therapists in our sample are indicative of wider trends, perhaps *direct provocation of strong feeling* came into fashion in the 1970s and early 1980s, but perhaps has fallen out of favour since then. Moreover, perhaps *intensification of the patient-therapist encounter* -- i.e. heightening the patient's feelings toward the therapist -- is a method that is more stable-enduring-classic in therapeutic practice.

While *Direct Provocation of Strong Feeling* May Fall In and Out of Fashion, *Intensification of Patient-Therapist Encounter* May Be More "Classic" in its Application

The strong-feeling-method of *direct provocation* was applied 21 times in our sample, and interestingly 18 (or 86%) of these instances were from the *1975-1984* sessions (see Table 5). Although expected frequencies were too small to allow chi-square tests, it is impressive that *direct provocation* seemed to be so common in the tapes of this particular decade, and so seemingly rare in the decades previous and subsequent. Although purely speculative, this finding raises the possibility that *direct provocation* was a method that fell in and out of fashion. Perhaps in the 1970s -- a decade of experimentation, and a time when emotive "encounter" groups and direct cathartic methods were in vogue -- practitioners gravitated more to direct, provocative methods of inducing strong feeling. Perhaps more recently, with the increased concerns with therapist accountability and ethical responsibility, liberal methods like these have become more rare.

In this regard, it is also interesting to note that *intensification of patient-therapist encounter* was, in our sample, relatively stable and enduring in terms of frequency of occurrence across the three time-periods (see Table 5). Although the numbers are far too small to go beyond speculation, it may be this method is a more "classic" one. Perhaps the stable trend in our findings is reflective of the fact that most therapies regard working with the patient-therapist relationship as an essential part of the therapeutic process -- and therefore, this type of relationship-focused method might be less subject to "fashion" changes than a method like *direct provocation*.

Practical Implications

The purpose of this section is to discuss how practitioners may make use of our findings in their attempts to promote strong feeling, and to use it therapeutically once it has occurred. In other words, this section will highlight a variety of "helpful hints" and practical suggestions -- based on our formal findings and the soft impressions of the research team -- that may aid practitioners in their in-session application of strong-feeling methods and uses.

A. Therapist Methods

1. Strong-Feeling-Methods Have Multiple Interlocking Parts

The methods identified by the research team cannot be summed up in a couple of words, or a short phrase. They tend to be more complex than that. They tend to be relatively detailed and precise, and often contain steps and sequences. Generally speaking, if a practitioner wants to apply the methods we identified, she must be willing to do two (or sometimes three or four) different sub-interventions in a kind of sequential, back-and-forth pattern.

2. Strong-Feeling-Methods Involve the Therapist and Patient Working Together

The methods generally involve a dynamic interplay between the therapist and patient that extends over a period of seconds or minutes in the session -- and culminates in strong feeling. In other words, strong-feeling-methods are akin to a "dance" that goes like this: when the patient does this, then the therapist does that, which the patient then reacts to, which the therapist then in turn responds to by doing this, etc. The implication here for practitioners, once again, is that strong-feeling-methods do not involve one clean intervention and that is it. Strong-feeling-methods involve a moving to and fro with the patient that unfolds something like this -- in patient

condition X, the therapist does Y, which the patient responds to with X_1 or X_2, and depending on which the therapist then reacts with Y_1 or Y_2, which culminates in patient consequence Z (strong feeling).

3. Be Persistent

Therapists are probably more likely to be successful in bringing about strong feeling if they are persistent in their application of methods. In fact, for many of the methods, the notion of persistence is an explicit part of the definition of the method and how to apply it. Even for methods where persistence was not explicitly part of the formal definition, the research team was struck by how tenacious and unyielding therapists often were in their application of methods. Generally, they did not begin applying a method, and then let it drop if strong feeling failed to occur after one or two therapist statements. They kept going for three, four, five, sometimes more therapist statements until strong feeling occurred. The implication for practitioners is that persistence will likely pay off.

4. Practitioners of Different Therapeutic Approaches Can Apply These Strong-Feeling-Methods

Our list of therapist methods came from a relatively broad group of practitioners, representing a variety of different therapeutic approaches. In other words, our strong-feeling-methods were not generated from a narrow group of therapists representing only one kind of therapy. Moreover, *most* of the psychotherapeutic families we studied applied *most* of the strong feeling methods on our list, at least to some extent. The implication for practitioners is that our findings provide a list of five methods (plus subcategories) that therapists of different approaches can add to their armamentarium if they so choose. For practitioners who value strong feeling, and

wish to promote its occurrence in their sessions, this study provides five options to consider, pretty much regardless of the practitioner's particular therapeutic approach.

5. It is Important to Apply Particular Strong-Feeling-Methods Depending on Particular *Antecedent Patient Conditions*

Each strong-feeling-method that we identified and described was linked explicitly to a particular in-session *antecedent patient condition*. None of the methods we identified appeared to be "context-free" in its application. Accordingly, it is important to remember that particular methods are applicable at particular times in terms of the patient's here-and-now in-session behaviour. The implication for practitioners is that there are particular patient behaviours that therapists can learn to recognize as "markers" (cf. Greenberg & Clarke, 1979; Greenberg, Rice, and Elliott, 1993; Rice & Saperia, 1984) that signify that the appropriate time for the application of a particular strong-feeling-method.

6. Let the *In-Session Patient Condition* Be Your Guide in Applying Different Methods

As just mentioned, all of the methods described by the research team were explicitly tied to particular, *in-session patient conditions* signaling an appropriate time for the application of each method. Three implications are discussed as follows.

(a) Wait until the patient is undergoing moderately intense feeling. Two of the methods -- method 1.1 (*instruct patient to repeat affect-laden phrases*) and method 2 (*welcoming-encouragement of strong feeling*) -- include the general condition that the patient is already having moderately intense feeling. The implication for practitioners who want to promote strong feeling in their sessions is that they have a choice -- *when the patient is undergoing moderate*

feeling -- to do one of two things. They may wish to actively provoke the patient to stronger levels of feeling by directly and forcefully instructing the patient to repeat the emotionally-charged words and bodily movements. Alternately they may wish to take the more passive approach of quietly welcoming the feeling expression that is now present. In this regard, it was the soft impression of the research team that the method of *direct provocation* might have a higher "hit-rate" of producing strong feeling -- e.g. consider that, in our sample, *direct provocation* was judged to work to promote strong feeling on 21 occasions, whereas *welcoming-encouragement* occurred on merely 2 occasions. Nevertheless, if our results are any indication, practitioners who are more comfortable with a more passive, quiet approach to promoting strong feeling may still find some success in applying the *welcoming-encouragement* method.

(b) Let the patient's feelinged *attentional-centre* guide you to the appropriate method. Three methods -- method 3 (*intensification of patient-therapist encounter*), method 4 (*enlivening scene of strong feeling*), and method 5 (*intensification of patient-other encounter*) -- tended to be differentially applied depending on where the patient's feelinged-attention was directed prior to the therapist application of the method. For all three methods, the common link was that the therapist "struck" when the patient was *in a state of moderate feeling*. However, the applied method tended to shift depending on whether the patient's feeling is directed at the therapist, an emotionally-compelling scene, or a significant other (person, part of self). The implication for practitioners is that -- if they wish to apply these methods -- it is important to let the patient's feelinged attentional-centre be the guide. If the patient's attention is on the therapist, then apply *intensification of patient-therapist encounter*. If the patient attention is on an emotionally-compelling scene, then apply *enlivening the scene of strong feeling*. If the patient's attention is on

a significant other, then apply *intensification of patient-other encounter*.

(c) *When the patient is being "resistant"* (by not answering your questions openly, or by being reluctant to try out new behaviours), and you want to promote *strong laughter*, then try *humorously pushing-opposing* the patient. One subcategory of the method of "direct provocation" is to *push-oppose the patient with good humour* -- a method that, in the research team's soft impression, was particularly useful for bringing about strong hearty laughter in the patient. According to our findings, this provocative method was appropriate in a particular patient context: when the patient is hesitant-reluctant to (i) carry out a new, risky extratherapy (advocated or prescribed by the therapist), or (ii) to be open, direct, and forthcoming in response to the therapist's probing questions. The implication for practitioners is that, if they value strong feeling (and in particular strong laughter), then they may wish to use this strong-feeling-method in this particular patient condition.

7. The Patient Likely Won't Have Strong Feeling If the Therapist's Level of Feeling is Dead-Neutral

Almost without exception, the strong-feeling-enhancing methods discovered by the research team involved the therapist being animated, expressive, and feelingful in his application of the methods. The implication for practitioners is that they will likely tend to be more successful at promoting strong feeling if they are willing to feel and show relatively strong feelings themselves. If therapists want to help their patients to dive into the pool of strong feeling, then they should also be willing to get wet -- and, even better, to jump into the pool first.

8. Be Playful and Exceedingly Blunt in Your Humour

One subcategory of *direct provocation of strong feeling* is to "push-oppose the patient

with good humour". In applying this method, the therapists we studied tended to be adopt a playful, exceedingly blunt, outrageous, shocking, confrontational, and humorous attitude in relating to the patient. The implication for therapists who value strong feeling -- especially strong laughter -- is that they might think about taking on this kind of role with their patients. Here is an example from our data. Consider that you, the therapist, are seeing a patient whose stated extratherapy goal is to initiate a sexual relationship with a particular woman to whom he is attracted -- but consider also that this patient views this prospect as risky, and he is anxious about approaching this woman. Moreover, let us assume that you are in favour of the patient's desire to carry out this risky behaviour. In the session, when the patient mentions that "he saw this woman the other day", you -- in applying the pushing-opposing provocation method -- should be willing to snappily say something confrontational and playfully blunt such as "Did you fuck her??!!", rather than something more benign and conservative like "Did you speak to her?". Farrelly and Brandsma (1974) seem to strike at the heart of this point when they write about their use of language in provocative therapy:

> When we as beginning therapists entered the field, our language would have certainly been acceptable at any upper class tea and crumpet session. However...we now talk in a much more gutsy, affectively charged, connotatively loaded language. We have found this to be effective because the kinds of things clients are struggling with are to them emotional dynamite; their conflicts do not fit into polite, socially correct terminology (p. 120).

In summary, the implication for therapists who value strong feeling -- especially strong laughter -- and who want to try this pushing-opposing method, is that they should be willing to go beyond "tea and crumpet" language, and provoke the patient with playfully blunt humour.

9. Be Willing to Assume-Enact Different Roles

Two methods identified by the research team -- *enlivening scene of strong feeling* and *intensification of patient-other encounter* -- involve the therapist switching out of the ordinary role that she usually plays, and assuming-enacting a much different role in relation to the patient. In the former method, the therapist feelingfully enacts the role of the antagonistic, pain-inducing other person in the context of a bad-feelinged scene from the patient's life. In the latter method, somewhat similarly, the therapist assumes-enacts the role of the other (person, or part of self) in relation to whom the patient is having feelings, and encounters the patient directly from within that role. Clearly, these kinds of therapist techniques push well beyond the usual meaning of "good working alliance" (therapist-patient relationship). Instead of remaining in the "usual", empathic, supportive therapist-as-self role, the therapist shifts freely between the role of the accepting-encouraging therapist and roles of other pain-inducing people in the patient's life.

The implication for practitioners is that, if they wish to apply these methods, they should be willing to go beyond the "usual" meaning the therapist-patient alliance, and to move in and out of two roles: (a) the other person or part of self, and (b) the more or less ordinary therapist role of supporting-guiding-instructing the patient. Indeed, the research team's findings seem to corroborate the assertion made by Pierce, Nichols, and DuBrin (1983) when they write: "...role-playing is designed to counter defenses and promote the expression of feelings ... Role-playing promotes spontaneity and enlivens sessions with emotional action and interaction" (p. 64). In this spirit, therapists who wish to apply the methods of *enlivening scene of strong feeling* and *intensification of patient-other encounter* should be willing to assume-enact different roles, and to do so with strong feeling.

10. Push-Oppose the Patient

Central in two methods identified by the research team -- method 1.2 (*push-oppose the patient with good humour*) and method 3.2 (*refuse patient's interpersonal request-demand*) -- is the notion of the therapist pushing-opposing-obstructing the patient. In the former method, the therapist does so in a blunt humorous way -- in response to the patient's reluctance to try out new behaviours, or to respond openly to therapist's questions. In the latter method, the therapist meets a critical attack from the patient with a refusal to accede or back down. The implication for practitioners who want to try these methods is that they should be willing to play the role of a sort of "obstacle" in the way of the patient's will, anxiety, fear, or point-of-view. In applying these two methods, the therapist does not easily bend and acquiese when the patient criticizes the therapist (method 3.2) or when the patient is reluctant to comply with what the therapist wants the patient to do (method 1.2). On the contrary, the therapist who wants to promote strong patient feeling using these two methods should be willing to stick to his guns, and oppose-push the patient with some persistence.

11. Consider Relying on Some Methods More Than Others

In our sample of 52 strong feeling moments, some therapist methods were used more often than others. Indeed, a chi-square analysis indicated that the distribution of therapist methods (see Table 1) departs significantly from a chance distribution (x^2=20.9, *df*=4, p<.01). More specifically, two therapist methods -- *direct provocation of strong feeling* (21 occurrences) and *intensification of patient-therapist encounter* (14 occurrences) -- occurred the most frequently, collectively accounting for 67% of all the strong feeling events in our sample. The implication for practitioners is that, if they wish to take "advice" from the therapists in our sample,

they may wish to rely more on these two methods than the other three. This does not mean that the other methods would necessarily be less effective in promoting strong feeling. But, given the findings we came up with, practitioners may want to start with using *direct provocation of strong feeling*, and *intensification of therapist-patient encounter*, if of course these methods fit with the practitioner's therapeutic preferences and style.

12. For Powerful-Extended Strong Feeling Moments,

Try *Enlivening the Scene of Strong Feeling*

The method *enlivening scene of strong feeling* did not occur particularly frequently in our sample of strong feeling moments -- accounting for only 6 (or 12%) of the 52 strong feeling instances we studied. However, the soft impression of the research team judges was that this method was the one that facilitated the most powerful and extended strong feeling moments in patients. Thus, for therapists who want to help patient to experience powerful and prolonged moments of strong feeling in the context of vivid, compelling scenes, this method may be the one of choice.

13. Soft Impressions About Different Methods Linked to

Different Kinds of Strong Feeling

(a) If you want *strong laughter*, try using *direct provocation*. Of the 15 times that strong laughter occurred in our sample, 13 of them (or 87%) were promoted by the therapist method of *direct provocation*. The implication for practitioners is that, if they are interested in facilitating client laughter, this may be the one to try.

(b) If you want to promote *defiance-opposition*, a variety of methods may work. This kind of strong feeling was promoted on multiple occasions by three methods: *intensification of*

patient-therapist encounter, *intensification of patient-other encounter*, and *direct provocation*. The implication for practitioners is that, if and when they want to facilitate "defiance-opposition", any of these three methods may be effective. Moreover, it can be loosely speculated from the numbers in our sample that *intensification of patient-therapist encounter* may provide the highest "hit-rate" of promoting this particular kind of strong feeling because this method -- relative to the other two methods -- seems to be more uniquely geared to mobilizing "defiance-opposition" as opposed to other kinds of strong feeling (see Table 1).

(c) If you want to facilitate *bad-feeling hurt-pain*, try *enlivening the scene of strong feeling*. *Enlivening the scene of strong feeling* was one of the lesser-used methods, but when it was applied it appeared to be especially powerful at mobilizing the strong expression of *bad-feeling hurt-pain*. In fact, of the 6 times that this method was judged to have been used, it facilitated this kind of strong feeling 5 times (83%). Although the numbers are too small to go beyond the realm of speculation, our findings raise the possibility that this strong feeling method may be particularly powerful for facilitating bad feelings of this kind. The implication for practitioners interested in promoting these kinds of strong feelings is that they may wish to try using this method.

B. Therapist Uses

1. Apply Any of these 5 *Uses* That Fit With Your Personal Therapeutic Approach

We identified 5 ways of using strong feeling that (a) were generated from a sample of therapists representative of a broad spectrum of therapies, and that (b) were applicable, in most

cases, to a variety of different kinds of strong feeling. Furthermore, we did not find any clear evidence (based on our limited volume of data) to suggest that different *therapeutic families* might tend to "prefer" different ways of using strong feeling (see Table 4). Indeed, all four therapeutic families applied at least 3 different uses; one family applied all 5 uses once or more; and inspection of the frequency distribution suggested no clear trends regarding different uses for different families of psychotherapy (see Table 4).

The implication for practitioners who are trying to decide whether or not to add particular *uses* to their therapeutic arsenals is that they should be guided chiefly by their own personal approach, and sense of what fits best for them. Other factors -- such as the larger therapeutic family with which practitioners might identify themselves -- seem, based on our findings, to be secondary.

2. Go Beyond Merely *Promoting* Strong Feeling to *Using* It In One or More of These Ways

The practitioners in our sample were not content to just promote strong feeling and stop at that. On the contrary, the therapists we studied tended to actively, and in 5 identifiable ways, *use* strong feeling once it happened. In other words, the research team's impression was that therapists regarded strong feeling's occurrence as a cue that it was now time to help move the client toward some valued, desirable in-session goal -- e.g. toward enhancing insight-understanding, or carrying forward emergent material, or sustaining-intensifying the strong feeling.

The implication for practitioners is that they should consider going beyond the mere promotion of strong feeling toward *using* it as a springboard to promote other kinds of valued, in-

session client events.

3. Consider Using Strong Feeling in More Than One Way Over the Course of a Psychotherapy Session

Recall that we included sessions only if they included *multiple* instances of strong feeling. Therefore, it was possible to get some indication of whether therapists tended to "play one note" in terms of how they used strong feeling, or whether they tended to use strong feeling in different ways over the session. It is interesting to note that none of the 14 therapists we studied limited their uses of strong feeling to one sole use in the session. All therapists used strong feeling in at least two ways, and some used it in three different ways over the course of the session. The implication for practitioners is that they may wish to consider using strong feelings in different ways during the session -- rather than employing the same use over and over.

4. Strong Feeling Material Can be Used In the Same Ways That Many Other Kinds of Clinical Material Are Used

The research team was struck by their impression that many of the therapeutic uses we identified (in relation to strong feeling) apply to many different kinds of clinical material -- not just *strong feeling* material. In other words, although the uses we identified in this study apply and relate directly to strong feeling, it is clear that strong feeling material holds no "monopoly" over these kinds of therapist uses. For example, other kinds of clinical material apart from strong feeling -- e.g. dysfunctional cognitions, irrational beliefs, transference disruptions, bodily sensations, non-verbal cues, etc. -- are surely used by various therapists to "promote insight", or "develop emergent material", or "resolve painful feelings", for example. It does not appear that strong feeling "corners the market" on any of the uses we generated. The only exception would

seem to be *sustain-intensify the strong feeling* -- which, by definition, is unique to strong feeling.

The implication for practitioners is that strong feeling material can be approached and used in the same ways that most other kinds of material are approached and used. Strong feeling material does not seem to be material that is far afield from other kinds of clinical material in terms of what therapists tend to do with it. Our findings raise the possibility that strong feeling is just one of many kinds of clinical material that can be used to promote common kinds of valued, in-session goals -- like insight, reduction of bad feelings, and deepening present material. In short, strong feeling may not be that different at all from other kinds of clinical material in terms of what it can be used for in the session.

Theoretical Implications

In this section, the objective is to discuss how the findings of this study may make a contribution to the theoretical body of knowledge related to strong feelings in psychotherapy. The points below will bear on two broad theoretical issues: the role that strong feeling may play in the process of therapeutic change; and ways to conceptualize what is "going on" in the patient when strong feeling is occurring.

1. The Mere Having of Strong Feeling May Not Be the Potent Change-Producing Agent: It May Be an *Intermediate Link* in a Chain of In-Session Events that Facilitate Positive Change

Existing outcome research, as reviewed in chapter 1, is generally supportive of the therapeutic value of strong feeling, and tends to find a positive link between in-session strong

feeling and later client improvement. More simply stated, outcome studies seem to say that getting strong feeling to happen in the session is a good thing -- and that, in terms of long-term outcome, strong feeling is likely change-enhancing.

Our findings permit us to speculate further on this issue. It is interesting that the therapists in our sample did not seem to be "content" with the *mere* occurrence of strong feeling. These therapists did not seem to be operating on the principle that strong feeling *on its own* was the key, or the "pot at the end of the rainbow". Time and time again, our therapists actively *used* strong feeling, apparently viewing it as a springboard toward achieving other kinds of (presumably more important) in-session objectives -- like promoting insight, resolving painful feelings, or developing emergent material, etc.

The implication of this for theory is that strong feeling, on its own, may not be the active change-producing agent. Strong feeling may help pave the way for change, but may not, by itself, be the key, active ingredient. So, if strong feeling is linked with positive outcome -- which prior evidence suggests that it is -- our study may open up some new empirically-based ideas about *why* it may be linked to change. To restate, it may be that the *mere having of strong feeling is not the key event*. It may be that the potent change-producing agents are the in-session patient events that follow strong feeling -- the ones that the therapists in our sample seemed to be intent on facilitating subsequent to strong feeling. Our findings raise the possibility that strong feeling may be a link *in the middle* of a chain culminating in positive change.

2. Instead of Asking, "*Is Strong Feeling Valuable (Good, Change-Producing)*?", The More Relevant Question May Be, "*How are In-Session Uses of Strong Feeling Linked to Therapeutic Change (Post-Treatment Outcome)*?"

Most previous research on strong feeling has tried, in somewhat different ways, to test the general question of whether or not strong feeling is "good" (valuable, change-producing)? Research questions have tended to focus on the following issues: "Is in-session strong feeling linked to post-treatment positive outcome?" (cf. Nichols, 1974; Nichols & Bierenbaum, 1978; Pierce, Nichols, & DuBrin, 1983); or "Is this kind of emotive therapy valuable (effective, change-producing)?" (cf. Borkovec & Sides, 1979; Boulougouris et al, 1971, 1973; Calif & Maclean, 1970; Crowe et al, 1972; Hogan & Kirchner, 1976; Karle et al, 1973, 1976; Rachman, 1966a, 1966b; Woldenberg et al, 1976). Our findings contest the relevance of asking these kinds of general questions, and suggest that more specific theoretical questions about particular paths of changes (involving strong feeling) may be more relevant.

Once again, recall that we consistently found that therapists were <u>not</u> content with the mere occurrence of strong feeling. Rather than operating on the working principle that strong feelings themselves were "good", therapists seemed to regard strong feelings as useful tools for achieving particular kinds of therapeutic objectives -- like enhancing insight, resolving painful feelings, or developing emergent material, etc. Strong feelings were a "link in a chain", not the final prize. The theoretical implication, therefore, is that general questions about the value of strong feeling might be well replaced by more specific questions along the lines of the following: "How are in-session *uses* of strong feeling linked to therapeutic change? In short, our findings raise the possibility that future researchers should be guided by theoretical questions that are sensitive to paths-sequences of changes involving strong feeling.

Interestingly, this perspective fits quite well with the existing clinical theory on the usefulness of strong feeling, which has (sometimes explicitly, but usually more implicitly) pointed

toward particular *paths* of change in which strong feeling may play a helpful part. Recall from the clinical review in chapter 1, for example, that a number of theorists have regarded strong feeling as helpful for promoting the *reduction of bad feeling* -- and that different theorists have conceptualized the change process as occurring via the retrieval of previously blocked-off material (Breuer & Freud, 1895), purgation of pent-up emotions (Jackins, 1978; Janov, 1970; Lowen, 1975; Reich, 1949; Volkan, 1981), or vivid experiential contact with a fear object or situation (Rachman, 1969; Stampfl, 1976; Stampfl & Levis, 1967, 1968). Our findings, in accord with this previous theory, imply that a theoretically-sound understanding of strong feeling and its value in psychotherapy should focus on how strong feeling is linked with subsequent in-session events which are more linked with post-treatment change, rather than focusing on a *direct* link between strong feeling and post-treatment outcome.

3. If Strong Feeling is Used in the Same Ways That Other Clinical Material is Used, Then Why Should Practitioners Bother Working With Strong Feeling?

The therapists in our sample used strong feelings in the same sorts of ways that other kinds of clinical material are commonly used -- e.g. to promote insight, develop emergent material, or reduce-resolve painful feelings. This raises the interesting theoretical question of whether strong feeling material deserves any special recognition at all in terms of its unique power or importance in facilitating the occurrence of the *uses* we identified and described in this study. Maybe strong feeling has nothing special and unique to offer in promoting therapeutic change?

There are many non-emotive therapists of cognitive, behavioural, psychoanalytic, and other stripes who would regard the kinds of *uses* we identified as therapeutically important, but

who presumably obtain these kinds of goals without using strong feeling as a facilitatory tool. For example, helping patients get relief from bad feelings and achieving insight (cognitive reorganization) into their thoughts, feelings, and behaviour is central to therapies that do not emphasize strong feeling (e.g. Ellis, 1976; Fine, 1973). Client-centered and focusing therapies are devoted to the carrying forward and exploration of emergent material -- and yet inducing strong feeling is not generally regarded as a key technical aspect of these approaches (cf. Gendlin, 1991; Greenberg & Safran, 1987). Maybe the kinds of therapeutic goals that strong feeling can help facilitate can also be facilitated by other kinds of clinical material -- e.g. dysfunctional cognitions, irrational beliefs, bodily sensations, non-verbal behaviour, etc. It seems at least to be a distinct possibility. Our findings provide no answers to these kinds of questions. But, our discovery that strong-feeling-uses do <u>not</u> seem, in our sample anyway, to be peculiar to strong feeling material raises the possibility that strong feeling is not indispensable, essential, or fundamental to the process of attaining commonly-valued in-session goals such as insight, developing emergent material, and resolving painful feelings.

In terms of theoretical implications, then, our findings raise the possibility that strong feeling is not unique, indispensable, or special clinical material. The inroads that strong feeling opens up for change may be obtainable using other kinds of clinical material as well. This is not to denigrate strong feeling as not a potentially valuable tool. But perhaps using strong feeling material is merely one way to promote "insight" in the patient, or "develop emergent material", or "resolve painful feelings". Perhaps other ways are better, worse, just as good, or simply different in their ways of facilitating the same classes of therapeutic goals.

4. What Might There Be About Strong Feeling that *is* Special (Unique, Indispensable)?: Strong Feeling May Provide *Special Ways of Achieving* The Uses We Identified

In response to the argument just posed that strong feeling may not be special, let me now discuss the other side of the coin. It seems sensible to wonder if strong feeling material may be special (unique, indispensable) in *how* it facilitates in-session goals such as *insight*, *develop the emergent material*, and *resolve the painful feeling*. Perhaps the change paths-processes that culminate in valued events like *insight*, for example, would tend to be quite different when they include strong feeling along the way than if they do not. Perhaps strong feeling does open up potential avenues of change that could not be attained -- at least in quite the same way -- with other kinds of clinical material.

Strong feeling may be special-indispensable in its way of allowing for ventilation (catharsis) of pent-up feeling. A number of clinical writers have espoused the idea that strong feeling's value lies in its capacity to allow for a therapeutic purging of pent-up emotions (e.g. Breuer & Freud, 1895; Jackins, 1978; Janov, 1970; Lowen, 1975; Reich, 1949; Volkan, 1972). On the basis of our findings, it is hard to dismiss this as a legitimate possibility. Indeed, consider that *sustain-prolong-intensify the strong feeling* was a highly prevalent use in our sample -- accounting for 27% of all strong feeling events in our sample. Furthermore, consider that other uses (e.g. *resolve painful feeling*, and *develop the emergent material*), both by formal definition and according to the soft impressions of the research team, often included a *sustain-prolong-intensify* component to them. Suffice it to say that intensifying-sustaining was a major part of how strong feeling seemed to be used by the therapists we studied.

This would seem to provide some soft support for notions that (a) strong feeling is considered special (or at least usable, solid) material for allowing for "ventilation" of the patient's emerging feelings, and that (b) "ventilation" may be implicated in (helpful for) the attainment of other kinds of in-session goals -- such as resolution of painful feelings, or carrying forward emergent material.

Strong feeling (expressed in context of a bad-feeling-scene) may facilitate the spontaneous emergence of a new "behavioural possibility" -- and thus provide a unique way of facilitating "resolve the painful feeling". As described in our findings, "resolve the painful feeling" involved the patient (a) undergoing strong feeling in the context of an alive, immediately, painful scene-situation (involving a key other person); and then (b) identifying-learning and rehearsing-enacting new, more functional ways of behaving in that problem scene-situation. It was my impression from studying instances of this use that the patient's ability to obtain the pay-off from this process -- i.e. to gain access to better ways of behaving -- was greatly enhanced by the painful first part in which strong bad feeling (in the context of a painful scene) was opened up and expressed with high and prolonged intensity.

In fact, in some of the instances we studied, I was struck by the presence of what seemed like a natural and powerful 2-step process: (a) the patient went far into the bad feeling, lapsing intensely into the bad-feeling way-of-being with the other person; and then (b) spontaneously underwent an affective shift in a new direction, in which a new course of action, a new sense of resolution became almost instantaneously clear. Let me explain further by way of an example from our data. In one session we studied, a female patient endured a prolonged-extended moment of strong anguished feeling in a scene involving her rejecting, denigrating father (enacted

by the therapist). In the context of this scene, the patient's tears and anguish lasted for a long time, and she seemed to be feeling utterly helpless and weak. She seemed agonizingly torn in two directions. On the one hand, she seemed to be desperate to hang onto the hope that, if she continued trying, her father might stop being cruel to her, and might tell her he loved her. On the other hand, she seemed also utterly and sadly convinced that he simply would never and could never be reached by her. As she remained in the excruciating scene, and kept interacting with her pain-inducing father (enacted by therapist), spontaneously the quality of her feeling shifted perceptibly. She, all of a sudden, assumed a firm, strong stance, and sounded steadfast in her conviction that, for her own self-preservation, she simply must let go of the hope that her father would respond to her. In my impression, this new direction seemed almost to *flow naturally* out of the process of acting out of the bad feeling scene -- and now her course of action was clear: she would not "let him do it anymore", she would no longer "offer" herself to be rejected and pushed away from her father.

In this example and others, strong feeling seemed to play an important part in allowing the patient to identify-access and become resolved-committed to following a new, more functional behaviour in the bad feeling scene. I was struck on some occasions by how convinced and resolved the patient seemed to be about the new course of action, and I wondered if a large part of this came from the fact that the new push for behaviour seemed to come *so spontaneously* out of an intense strong-feelinged scene enactment. I would suspect that this way of accessing new behavioural possibilities might be more powerful and convincing to the patient than, for example, intellectualizing or brainstorming about potential behavioural options.

Clinical theory on the therapeutic use of reliving strong-feelinged "unfinished incidents"

(cf. Engle, Beutler, & Daldrup, 1991; Greenberg, Rice, & Elliott, 1993; Nichols & Efran, 1985; Pierce et al., 1983) seems to be quite reminiscent of the impressions I have just described. Inherent in the notion of "unfinished business" is the idea that an emotional need in the person was unprocessed in an earlier (bad-feelinged) scene, and it is in the intense "revisiting" of it in the session that unblocks the natural flow of emotional expression, and opens up the patient's ability to see her way clear to new ways of behaving. The change process in Mahrer's (1996) experiential approach also seems to bear similarities here in that he argues that having the patient undergo strong feeling (in the context of a vivid, alive scene) is the most effective way of spontaneously accessing a new, deeper potential way of being-behaving, which he then uses as the wellspring for being-behaving in different, more functional ways.

In summary, it may be that strong feeling provides special material for the attainment of the in-session goal of "resolving the painful feeling". It may be that -- through immersing themselves in a bad-feeling scene and enduring the painful feelings that accompany it -- patients may spontaneously and powerfully access a new possibility for behaving more functionally and better in the scene that had previously been so painful.

Strong feeling may be special in its ability to allow for the emergence and carrying forward of a fended-off part of self. Within the "develop the emergent material" use identified by the research team was a subcategory entitled "promote integrative feelings toward fended-off part of self". This use occurs when, in the moment of strong feeling, a somewhat new way-of-being seems to emerge in the patient -- a part of self that the patient does not completely embrace -- and the therapist then welcomes this way-of-being, and tries to help the patient stay with and further explore this part. It seems likely that, in regard to this use, strong feeling material may be special

and unique because, as I just described, it is in the *actual having* of strong feeling that this new way-of-being seems to initially and clearly show itself (and thus present itself as new material to be carried forward). In other words, without the strong feeling moment, the therapist might not be as likely to gain access to this fended-off part-of-self, and therefore would have not have been able to use and "carry forward" this clinical material. In short, maybe it is easier to access something ordinarily out of awareness -- i.e. like a fended-off part-of-self -- if you can get the patient into a heightened state of strong feeling.

Strong feeling may provide for special kinds of "insight-understanding". Clinical authors have previously argued that "insight-understanding" is more powerful and change-producing if it occurs along with strong feeling (e.g. Bibring, 1954; Fenichel, 1945; Greenson, 1967; Sheiner, 1966; Strachey, 1934). Based on our findings, it seems impossible to even guess whether the insights propelled via strong feeling would be somehow better than insights coming from other kinds of clinical material might be.

However, what we can say with some certainty is that the therapists in our sample did regard strong feeling as useful material for insight-promotion. Indeed, "promote insight-understanding" was the most prominent of all the uses of strong feeling in our sample -- accounting for 31% of our entire pool of strong feeling events. So, almost one in three of all strong feeling we studied were used, in the judgement of the research team, in the service of promoting insight. Although we cannot speculate about whether insight via strong feeling is better or worse than other kinds of insight, we can say that a sample of experienced therapists seem to regard strong feeling at least as solid material for promoting insight.

Furthermore, based on my analysis of the strong feelings we studied, it seems self-evident

that the kinds of insights stemming from strong feeling would at least tend to be *different* (although not necessarily better) than insights coming from other kinds of clinical material. In my impression, the kinds of insights promoted by the therapists in our sample tended to be *directly connected* to the strong feelings-affects-emotions that the patient was undergoing in the session -- and by this mere fact, the emergent insights would tend to be at least partially unique to strong feeling. For example, an insight via strong feeling -- such as insight into how deep sadness felt by the patient in the session might connect to childhood interaction patterns with mother -- would likely differ substantially from the kinds of insight that an R.E.T. therapist would foster, who was not working with strong feeling, and who was interested in shifting the client's "irrational beliefs" surrounding interactions with his mother, for example.

So, in summary, although we cannot say based on our data whether strong feeling is better than other kinds of clinical material for promoting insight, we can say (a) that the therapists in our sample did prominently regard strong feeling as useful material for insight-promotion; and suggest (b) that the kinds of insights derived from strong feeling would at least tend to be somewhat different than insights stemming from other kinds of clinical material.

Limitations and Weaknesses of the Study

The aim of this section is to acknowledge the limitations of our research strategy and our findings. Limitations of our results may suggest potentially fruitful avenues for future research, and shortcomings in our methodology may help illuminate possible improvements that future investigators could make.

1. Although cause-effect relationships are implied in our identification of *therapist*

methods of promoting strong feeling and *therapist uses* of strong feeling, the causal certainty of our findings is fairly limited. Given our research strategy, it was not possible to arrive at hard confirmation as to whether (a) the methods we identified *actually* caused strong feeling occurrences, or (b) the uses we identified were a *direct effect* of the prior occurrence of strong feeling. Sound confirmation would require the use of methodologies designed for such a task.

2. The research strategy was focused mainly on relatively specific, localized micro-events in psychotherapy sessions -- i.e. concrete therapist-patient interchanges preceding and following strong feeling occurrences. This micro-focus likely rendered our findings relatively insensitive to more global (broad, far-reaching) *patient conditions*, *therapist methods*, and *therapist uses* related to strong feeling. For example, in regard to patient conditions, our strategy would likely have been insensitive to broad conditions such as the presence of a strong therapist-patient alliance.

Similarly, in terms of methods and uses, because our methodology limited us to analysis of one session from a larger course of therapy, our hypotheses about what facilitated strong feeling, and how therapists used strong feeling might have been limited by our lack of wider context. More global or remote methods, that we did not detect, may have had an impact of the occurrence of strong feeling. More distal, global uses of strong feeling, that we did not identify, may have occurred in later sessions.

3. Because we studied only a relatively small number of sessions, patients, and therapists, our results are limited in terms of generalizability. This is a limitation concomitant to any methodology using a small sample size.

4. Also because the sample size is small, the lists of generated *methods* and *uses* suffer from not being exhaustive and complete lists of methods and uses related to strong feeling.

Presently, they function only as practitioner-useful descriptions of therapist methods and uses that could function as *starting-points* for the construction of exhaustive, complete category systems for quantitative research. In short, because our small sample size renders our findings potentially incomplete, presently our lists of therapist methods and uses do not comprise exhaustive, research-ready category systems.

5. The results were based on audiotaped sessions (accompanied by verbatim transcripts), not video recordings. Although the use of audiotapes, as discussed earlier, has advantages, it also left the judges blind to potentially important information such as non-verbal communication. For example, it is noteworthy that most of the strong feeling events that we identified were loud, conspicuous -- i.e. almost none were quiet, saturated moments of strong feeling. It might have been that such occurrences were present but undetectable using audiotaped data. Videotapes might have made it more possible for the research team to detect strong feeling occurrences that were more subtle and quiet.

6. Given how the data emerged, the sample size was too small to permit quantitative analyses to adequately test whether strong feeling methods or uses varied according to (i) kind of strong feeling, (ii) family of therapy, or (iii) particular era of session. Consequently, any suggestions we made in relation to trends in this regard must be approached as predominantly speculative.

7. In terms of studying whether *strong-feeling-uses* varied according to *kind of strong feeling*, our strategy was limited to studying single isolated pairs of strong feeling events and uses. This narrow focus did not permit the possibility of studying whether the *pattern-sequence* of uses across the session tended to differ depending on the *particular kind* of strong feeling that

occurred first in the session. Indeed, in studying simple isolated pairs, as we did, no association seemed evident between *kinds of strong feeling* and *strong-feeling-uses*. But perhaps identifiable patterns would have been found if we had expanded our analysis to include *sequences of uses* across the session (in relation to different kinds of strong feeling).

8. Although an effort was made to arrange the methods and uses we described into distinct and separate categories, there may be some conceptual overlap between the categories within each list. This kind of conceptual overlap is to be expected in qualitative investigations (Hycner, 1985), but quantitative analyses such as chi-square are called into question to the extent that categories are not mutually exclusive.

9. The "third party perspective" used in this methodology, despite having a number of advantages as discussed in chapter 3, has its limitations. Our findings were based solely on hypotheses made by judges who were essentially "eavesdropping" from the outside on psychotherapy sessions between therapists and patients. Our results are thus limited by their exclusion of the subjective experience of the patients and therapists. For instance, our capacity to understand therapists' various motivations in applying at least one strong-feeling-method ("refuse patient's interpersonal request-demand") was limited by the fact that we had no *direct* knowledge of the therapist's subjective intent in blocking the patient. And in terms of our lack of access to the patient's experience, it is noteworthy that most of the occurrences of strong feeling in our sample were loud, conspicuous outbursts -- as opposed to quiet, internally-full, more subtle strong feeling moments. Perhaps our third-party methodology was only sensitive enough to detect more conspicuous, ostentatious expressions of strong feeling, and we missed less "visible" instances that we would have detected if we had somehow been privy to the patient's subjective

experience.

In short, our findings are limited by their exclusion of subjective input from the actual patients and therapists involved in the therapy sessions. Such input might have further added to the richness and practitioner-relevance of our findings.

10. The theoretical bias of two primary investigators may have entered into their generation of the composite descriptions, despite the safeguards we employed to minimize such a risk. Indeed, although pooling the input from a team of judges with varied backgrounds and theoretical perspectives on psychotherapy seemed like a fairly good precaution for minimizing theory-slanted findings, it is still possible that the theoretical positions of the two researchers could have skewed the findings in the direction of their particular perspectives.

Suggestions for Future Research

Future research could productively complement and extend the findings of this investigation by remedying methodological limitations or by studying issues-questions that our findings raise as potentially fruitful lines of further investigation.

A. Confirm-Extend our Findings By Studying More Therapists and More Strong Feeling Events

It would be interesting to see if another research team -- using the same research strategy but different strong-feeling-sessions and a different team of judges -- would arrive at similar categorizations of strong feeling methods and uses to the ones generated by our research team. One would not necessarily expect, in studies of this kind, that the same list of methods and uses

would be generated as a result. However, overlap between our findings and that of another study would provide further confirmation and extension of our results.

Furthermore, studying a greater number of sessions would open up the posssibility of doing careful statistical analyses to test whether strong feeling methods and uses differ depending on kind of strong feeling, family of therapy, or particular therapists.

A problem we faced was finding a large sample of tapes that emphasized strong feeling. Perhaps future researchers could increase the probability of obtaining strong feeling tapes by concentrating on studying certain therapists who particularly value and obtain strong feeling in their sessions. This might be a more efficient strategy for obtaining a sample of tapes than using a general library of session tapes as we did.

B. Study *Series of Consecutive Sessions* with the Same Therapist and Patient

Our methodology limited us to analysis of single sessions taken from larger courses of therapy, and thus our findings may have been limited by their lack of a wider "context". After all, in hypothesizing about how our therapists had promoted and used strong feelings, our judges were essentially blind to what had already occurred in each larger course of therapy, and what might happen later on in the therapy. If our judges had had access to this information, our findings might have been enriched.

In the light of this, future researchers might consider analyzing a number of consecutive sessions with the same therapist and patient. Such an approach might better facilitate the identification of more global (broad, remote, far-reaching) *patient conditions*, *therapist methods*, and *therapist uses* related to strong feeling.

C. Study *Sequences of Uses* of Strong Feeling Over the Course of Entire Sessions

Although we did not study this directly, we gathered soft impressions that strong feeling uses may have occurred in *identifiable sequences* over the course of entire sessions. For example, it appeared that *sustain-prolong-intensify strong feeling* was the use of choice early in the session, but that later in the session, strong feeling tended to be used to *develop emergent material*, and later still to *promote insight-understanding* or *resolve painful feelings*. Moreover, we had soft hints that different kinds of strong feeling -- although they were not used differently in terms of individual occurrences -- may have been used in different kinds of patterned sequences over the course of entire sessions. In other words, an initial occurrence of laughter in the session might set a particular pattern of uses into motion, whereas an occurrence of bad-feeling hurt might set another kind of sequence in motion. We have no statistical proof that such patterns existed, but did get the soft impression from our data that this might be a research question to investigate further.

D. Conduct a Process-Outcome Study Which Investigates How In-Session *Uses* of Strong Feeling May Relate to Post-Treatment Measures of Therapeutic Improvement (Progress, Outcome)

There is a substantive difference between seeing how strong feelings are used in the session, and seeing if strong feelings are useful in getting some kinds of post-treatment outcomes. On the other hand, it is noteworthy that -- with the exception of intensifying strong feeling -- all of the in-session uses we identified were consistent with traditional post-treatment outcomes: neutralizing and resolving strong feelings, developing emergent material, and enhancing insight.

This apparent consistency raises the possibility that future researchers might conduct process-outcome studies looking specifically at how these kinds of in-session uses relate to post-treatment measures of therapeutic improvement.

E. Further Study On *Therapist Methods* Linked With *Different Kinds of Strong Feeling*

Although our data set was too small to arrive at firm conclusions on this issue, there were soft hints that different methods may promote different kinds of strong feeling. Further study on this question, using a larger number of strong feeling events may allow more clarification on this issue.

F. Consider Using a Research Strategy that Allows for (Includes) the Subjective Viewpoints of the Actual Therapists and Patients

In our research strategy, we adopted the position of third-party observers -- trying to infer and describe the "working principles" by which distinguished therapists conduct their sessions. We attempted to identify general, orderly principles-rules on the issues of *when* therapists choose to apply strong feeling methods, *what kinds of methods* they apply at those times, and *what kinds of uses* they tend to select following the occurrence of strong feeling. Despite its strengths, our outside, external position precluded the possibility of accessing the subjective experience of the therapist -- and thus identifying rules guiding her conduct that would remain hidden to third-party observers. For example, a fruitful research strategy that would allow for these subjective viewpoints is Interpersonal Process Recall (Elliott, 1983, 1984; Labott, Elliott, & Eason, 1992).

Conclusion

Analysis of 52 in-session instances of strong feeling -- occurring within a rigorously selected group of 14 audiotaped, complete sessions of psychotherapy (with individual adult patients) conducted by 14 distinguished practitioners representative of a variety of therapeutic approaches -- resulted in the successful identification, organization, and description of 5 types of *therapist methods* (plus additional subcategories) judged as facilitating the occurrence of strong feelings, and 5 types of *therapist uses* (plus additional subcategories) of strong feeling. These findings comprise a detailed collection of technical, "how-to", procedural knowledge -- concretely describing (a) particular *therapist methods* that may be helpful in promoting strong feeling (under particular *antecedent patient conditions*), and (b) particular ways that therapists may subsequently *use* strong feelings in the session after they have occurred.

The 5 identified main categories of *therapist methods* were: *(1) direct provocation of strong feeling*; *(2) welcoming-encouragement of strong feeling*; *(3) intensification of patient-therapist encounter*; (4) *enlivening scene of strong feeling*; and (5) *intensification of patient-other encounter*.

The 5 identified main categories of *therapist uses* were: (1) *sustain (prolong, intensify) the strong feeling*; (2) *neutralize (diminish, reduce) the strong feeling*; (3) *resolve the painful feeling*; *(4) develop the emergent material*; and *(5) promote insight and self-understanding*.

It is thus concluded that this study was successful in achieving its principal aims of identifying and describing therapist *methods* and *uses* related to in-session strong feelings. It is also concluded that our findings constitute a significant addition to the body of knowledge on promoting and using strong feeling in psychotherapy. Indeed, with regard to *therapist methods*,

most of the methods we identified had not been reported in the research literature, and a number of them had not been reported in the clinical literature either. Furthermore, our successful linking of particular strong-feeling-methods to explicit *in-session antecedent patient conditions* extends the current body of technical knowledge since virtually no clear references to patient preconditions had existed before in the literature. In terms of *therapist uses*, our findings both confirmed and extended the previous literature by providing research-based confirmation for the applicability of strong-feeling-uses previously reported in the clinical literature; clarifying technical details that were previously absent, lacking, or glossed over in the existing literature; and framing previously-reported uses into a more generally-applicable, and more workable form for therapist application. Once again, it is concluded that these findings significantly add to the body of knowledge on promoting and using strong feeling in psychotherapy.

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Appendix A

Therapist Methods of Promoting Strong Feeling

1. Direct Provocation of Strong Feeling

1.1 *Instruct patient to repeat feeling-laden phrases or movements.*

Patient Condition: When the patient is already undergoing a moderate level of feeling,

Therapist Method: the therapist persistently, feelingfully, and forcefully instructs the patient to repeat the feeling-laden words and/or bodily movements again and again.

1.2 *Push-oppose patient with good humour.*

Patient Condition: When the patient is hesitant-reluctant (i) to carry out a new, anxiety-provoking, risky extratherapy behaviour (advocated or prescribed by the therapist); or (ii) to be open, direct, and forthcoming in response to therapist's probing questions,

Therapist Method: The therapist -- with playful, confrontational, crisp, blunt humour -- persistently continues to push-persuade the patient to do what the therapist wants him to do, and tenaciously opposes-punctures the patient's apparent reasons for being hesitant-reluctant.

2. Welcoming-Encouragement of Strong Feeling

Patient Condition: When the patient is already undergoing a moderate level of feeling,

Therapist Method: Quietly welcome-encourage its occurrence. Provide the atmosphere and/or physical props for expression of strong feeling, and when feeling begins to occur, quietly welcome-encourage its expression.

3. Intensification of Patient-Therapist Encounter

3.1 *Make patient's implicitly-conveyed feelings explicit.*

Patient Condition: When patient seems to be having feelings toward the therapist, but is only indirectly expressing (hinting at) them,

Therapist Method: The therapist bluntly, directly, and forcefully explicates (highlights, suggests) what the patient seems to be really saying-feeling right now toward the therapist.

3.2 *Refuse patient's interpersonal request-demand.*

Patient Condition: When the patient is openly critical of the therapist, and how the therapist is being-behaving,

Therapist Method: The therapist frustrates the patient either by (a) openly disagreeing with the patient's opinion of the therapist; or (b) ignoring or not responding to the specific content of the patient's criticism.

4. Enlivening Scene of Strong Feeling

Patient Condition: When the patient's attention is already partly centered on an emotionally-compelling scene-situation that is frought with bad feelings,

Therapist Method: The therapist enlivens the strong-feelinged part of the scene by (a) describing it in a highly-detailed, immediate manner; (b) enacting, with strong feeling, the complementary role of the provocative other person in the scene who elicits bad feeling in the patient; and (c) intermittently switching over to the role of the reassuring therapist-guide who tells the patient what to do, and how to do it.

5. Intensification of Patient-Other Encounter

Patient Condition: When the patient is having feelings, and saying words as if they could be said directly to the other (person, part of self),

Therapist Method: The therapist (a) instructs the patient to say the feeling-laden words directly to the other (person, part of self); and (b) is persistent and consistent in keeping the patient immediately involved in the direct encounter with the other). The therapist may also (c) enact the role of the other person to whom the patient is uttering the feeling-laden words. When the feelings become relatively strong, the therapist may (d) tell the patient switch roles and be (speak as) the other person.

Appendix B

Therapist Uses of Strong Feeling

1. Sustain (Prolong, Intensify) the Strong Feeling

The therapist induces the patient to keep undergoing-showing the strong feeling with sustained or even fuller intensity. The therapist may (a) forcefully instruct the patient to keep expressing the feeling; or (b) playfully oppose-attack the patient for having the strong feeling, which also paradoxically pulls for the patient to feel the feelings even more. When the patient's strong feeling is directed (in role-play) toward a significant other person, the therapist may sustain-intensify the patient's feeling by (c) feelingfully enact the role of that other person, engaging-provoking-opposing the patient in the immediate, charged interaction.

2. Neutralize (Diminish, Reduce) the Strong Feeling

2.1. Avoid-deflect patient's critical confrontation. Negative feelings expressed toward the therapist are neutralized by the therapist's avoidance of the patient's direct critical confrontation. Instead of responding to the direct attack, the therapist may (a) welcome the patient's ability to disclose and reveal; (b) agree with the patient's criticism; (c) praise the patient for his/her perceptiveness; or (d) defend himself with clever logic that is sufficiently baffling to sway the patient from her confrontational stance.

2.2. Gentle the strong feeling. Feelings toward the therapist are defused (gentled) by the therapist's supportive acknowledgement of the quality and intensity of the patient's immediate feeling.

3. Resolve the Painful Feeling

The therapist helps the patient resolve (finish out) the bad, painful feeling by having the patient open up (show, express) the bad feeling -- in the context of an alive, painful scene-situation -- and then having the patient learn and feelingfully enact-rehearse more effective (constructive, self-enhancing) ways of coping-dealing with the scene-situation that was previously so painful.

4. Develop the Emergent Material

4.1. Carry forward whatever material is now present. The therapist encourages the patient explore whatever material -- e.g. feelings, thoughts, memories -- is now immediate and present.

4.2. Penetrate further into personal-private material. The therapist uses the strong feeling as an indication that the patient is ready and willing to continue answering the therapist's probing, provocative questions with regard to highly personal-private topics.

4.3. Promote integrative feelings toward fended-off part of self. The therapist welcomes and carries forward a way-of-being that is (a) immediately present, and expressed-shown with emotional charge in the moment of strong feeling; and (b) not fully welcomed-accepted by the patient.

5. Promote Insight and Self-Understanding

The therapist uses the strong feeling to help the patient attain increased insight-understanding with respect to the nature (characteristics, workings) of either (a) past or present relationships with significant other people (or parts of self); or (b) ongoing patterns of being-behaving that tend to be troubling-problematic for the patient.

Appendix C

Composite Descriptions of the 52 Strong Feeling Events In Terms of the Content and Kind of Strong Feeling

#1

The patient says that he saw Tammie yesterday, and the therapist says, "Did you fuck her?". The patient says, "No. I was thinking of it, though." The strong feeling occurs as a sudden, short, outburst of hard, hearty, pleasureable laughter that seems related to his abruptly saying, "No. I was thinking of it though," in answer to the therapist's question. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#2

The patient seems to be hitting and kicking with his feet as he is saying, "I won't do it! I won't! I won't!" forcefully and with loudness and volume. He has been saying these words again and again, as the therapist is saying, "You are going to have to do it!" *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#3

The patient is laughing. It is a short, hard, almost explosive outburst of strong, loud laughter. Another burst of laughter occurs shortly after. He is not saying anything while this is occurring. It seems to have occurred right after the therapist says something to the patient. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#4

He is saying, " I won't...I won't!", and doing this repeatedly, with high strength and energy, loudness and volume. At the same time, he is kicking and hitting, using his body. The words are being said in large part directly to the therapist. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#5

After the therapist asks, "How do you get it to happen so often?", the patient breaks into a sudden outpouring of laughter that is relatively full, with most of the patient involved in the laughter. He is not saying anything during the laughter. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#6

At first, he breaks into relatively strong, somewhat pressured laughter (along with the therapist, right after saying, "I don't know what's going on, but it's goofy!"), and then again (after the therapist mentions what the patient might say at a bar). In both outbursts of strong laughter, the patient is talking with the therapist about a topic fraught with somewhat negative feeling. *(Category 2 -- Mixed-Feeling Laughter)*

#7

The patient breaks into strong hard laughter in relation to the therapist's suggested notion that the patient has an inclination to tell the therapist to "eat shit", as the therapist presses the patient to have sex with a woman at a particular motel. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#8

The patient breaks into sudden, hard laughter. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#9

The patient is yelling directly at the therapist. She is fighting back against the therapist's direct pushings, and calling the therapist a "bad" name, in an almost wholesomely uninhibited manner. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#10

The patient has a short, sudden outburst of frustration, irritation, yelling at the therapist about what the therapist is doing. ("Dammit! You have to do that!") *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#11

The patient erupts into a sudden outburst of open, playful yelling at the therapist, indicating that she does not want to do what the therapist wants her to do. ("Oh bull shit! That's bull shit!...That ain't no deal!") *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#12

The patient has been engaged in being "in charge", in a conversation with a fellow, role-played by the therapist, and then pulls back and out by saying to the therapist, with strong feeling, "But what do we do it ...?!" and then has a momentary burst of being overwhelmed with risky, tension-filled, laughter-anxiety. *(Category 2 -- Mixed-Feeling Laughter)*

#13

There is (a) an outburst of tension-filled laughter and frustration as (b) the patient pulls out of the role-playing with the therapist. *(Category 2 -- Mixed-Feeling Laughter)*

#14

The patient is pounding-hitting something while yelling and crying out a package of feelings toward another person, mainly feelings of accusation, anger, and frustration, as well as righteousness at being openly uncontrolled. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#15

The patient is pounding-hitting as she is yelling, with some almost hurt-whimpering, as she is addressing other people, and she is belting out her feelings, leveling accusations, being indignant, noncompliant, standing up for herself, forthrightly telling each what she believes. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#16

The patient is lightly crying in caring love. He is telling about a conversation with his daughter, and the crying is when he says what she says to him, "Daddy, you can have your every third weekend, but you don't know how hard that is for me." It is during and after his saying her words. *(Category 5 -- Good-Feeling Caring-Love)*

#17

The patient is being aggressively insistent, openly attacking the therapist with a short hard blast of toughness. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#18

The patient is engaging in a short, hard blast of anger at the therapist, and is being direct, confrontative, insistent, accusatory, mixed in with some hurt. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#19

The patient is being hurt, unappreciated, frustrated by the therapist's lack of loving, attentive concern. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#20

The patient is directly and openly criticizing and attacking the therapist. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#21

The patient is yelling at the therapist in anger, frustration, and helplessness. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#22

She is expressing critical displeasure and dislike at the therapist for the way the therapist is being with her. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#23

The patient is being firm, sure of self, assertive, and somewhat annoyed-frustrated (in saying "Yes!" about being sure that she is not dirty). *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#24

The patient is yelling "No" at her "will", and doing it in a way that conveys toughness, firmness. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#25

The patient is punching, using some props, and having joyful, unabashed pleasure at punching. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#26

She is first talking about and then talking directly to a part of herself. She is yelling at that part, scolding it, exasperated at, disgusted with, and accusatory of, that part of herself. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#27

The patient is crying, sobbing, showing hurt, showing and protesting, "you hurt me," directly to the therapist. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#28

She is crying and sobbing, hurting, pleading, and being helpless and vulnerable, in relation to the therapist and the therapist in the role of her father. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#29

She is continuing the crying and sobbing as she is hurtfully complaining about her father, the way he is with her, and her own inability to stay away from being hurt by him. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#30

The patient is having a burst of strong laughter. He is enjoying the therapist's good-humored, buddy-to-buddy, mocking of the patient's cavalier, man-of-the-world demeanor. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#31

The patient has a sudden, hearty outburst of laughter. He is momentarily enjoying the raucous humor of the therapist. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#32

At first, he has a short, pointed outburst of somewhat embarrassed, sheepish laughter, and then harder and more hearty laughter. *(Category 2 -- Mixed-Feeling Laughter)*

#33

The patient is having a good-feelinged, sudden, explosive outburst of laughter. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#34

The patient is having an outburst of hearty, good-feelinged laughter. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#35

She is having a sudden, explosive outburst of laughter that is good-feelinged as she is being playfully light and almost silly. *(Category 1 -- Good-Feeling Happiness-Laughter)*

#36

She is exploding in sudden, good-feelinged laughter as she is giving voice to the tough other "self". *(Category 1 -- Good-Feeling Happiness-Laughter)*

#37

The patient is shouting, yelling, being forceful, powerful, insistent; and is doing this with some caring, loving, closeness, and concern for and about the therapist. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#38

The patient is crying in father-son closeness, laced with anguish, sadness, and disappointment. The patient is in the role of his father, talking to his little son, who is role-played by the therapist. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#39

The patient is crying hard and sobbing, with feelings of hurt, pain, anguish, loss, all in relation to him and a parent. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#40

The patient is crying hard, hurting, pleading, piteous, painful, in close-confrontative contact with another person. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#41

The patient is crying, and yelling out his frustrations, accusations, directly and powerfully at the other person. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#42

She is laughing as she is somewhat disagreeing with the therapist in a spontaneous, playful, fun-filled way. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#43

She is being hurt, tearful, frustrated; angry, challenging, defiant. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#44

The patient is crying, sobbing in hurt, anguish, shame, guilt, and utter defenseless vulnerability. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#45

The patient is undergoing hard, wracking sobbing in utter defenselessness, weak helplessness, and is unable to push away the relentlessly attacking therapist. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#46

He is almost choking with hard, wracking sobbing, and feeling openly vulnerable, shameful, bad, guilt-ridden. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#47

The patient is softly crying, being pulled in, quiet, not giving, withdrawn, and a little sulky. *(Category 4 -- Bad-Feeling Hurt-Pain-Anguish)*

#48

The patient is sulkily fighting-opposing the therapist, standing up to, and escalating the argumentative encounter with the therapist. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#49

She is being defiant, fighting, opposing, standing up to the therapist, and even downright snappy mad. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#50

She is standing right up to the therapist, bawling him out, being directly critical of him. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

#51

The patient is choked up, tearful, on the verge of crying, and having a sense of caring for, showing love and concern. *(Category 5 -- Good-Feeling Caring-Love)*

#52

The patient is yelling in a short, hard, explosive burst of high-volumed anger. *(Category 3 -- Defiance-Opposition, Strength-Toughness, Anger-Exasperation)*

Appendix D

Composite Descriptions of the 52 Strong Feeling Events In Terms of Therapist Methods of Promotion

#1

When the patient cites a scene (situation), the therapist asks if the patient carried out a specific behaviour that is tempting, exciting, appealing, outrageous, far-out. The therapist does this immediately, crisply, with good feeling, and in good humor. The therapist also does this repeatedly, persistently, each consecutive time the patient brings up the appropriate scene or situation. *(Category 1 -- Direct Provocation of Strong Feeling)*

#2

When the patient says or does something toward the therapist that the therapist regards as important, then the therapist tells the patient to say it again, does this repeatedly, and tells the patient to accompany this with energetic physical strong movements. The therapist also voices the role of the provocative antagonist, and does this repeatedly, forcefully, persistently, and with strong feeling. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#3

When the therapist believes that the patient is saying something important, but is not substantively acknowledging doing so, (a) the therapist rephrases, interprets what he believes the patient is really meaning and saying. He does this repeatedly and consistently. He does this by revising and modifying what the therapist believes the patient is really saying and meaning. He does this by phrasing the interpretation in a quite blunt, direct, confrontative, open manner, as if the patient's statement is personally directed right at the therapist. He also does this with plenty of feeling, rather than being feeling-neutral. (b) The therapist tells the patient to say the words directly to the therapist, especially since what the patient is saying is directed straight at the therapist. *(Category 1 -- Direct Provocation of Strong Feeling)*

#4

When the patient is already hitting and kicking, and saying "I won't" over and over again, with some strength of feeling, the therapist carries out the role of the one with whom the patient is directly interacting. The therapist carries out the role of being the direct, provocative antagonist so that the patient is saying "I won't", and the therapist is saying "You will". Furthermore, the therapist does this (a) persistently and repeatedly, (b) loudly and forcefully, with tough good humor, and a rising crescendo of feeling, and (c) with lots of variations in what he says -- all directed at opposing, provoking, getting more and more of a rise out of the patient. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#5

When the patient is concerned about a particular set of situations in which others mistreat him and make him feel bad, the therapist crisply, pointedly, briskly, directly, and confrontationally asks a question about how the patient gets it to happen so often. *(Category 1 -- Direct Provocation of Strong Feeling)*

#6

When the patient says that a way he is being-behaving is crazy, absurd ("It's crazy; here I am going out and trying to get laid so you won't turf me out of therapy"), the therapist (a) in a playfully, cajoling way, rephrases, accentuates, and corroborates the patient's conclusion that the way he is being-behaving is crazy and absurd; (b) caricatures, burlesques, exaggerates a concretely specific picture-fantasy of the patient actually carrying out this crazy-absurd behaviour in a concrete-specific situational context, and with concrete-specific behaviors-words; and then (c) breaks into outright laughter. *(Category 1 -- Direct Provocation of Strong Feeling)*

#7

When the therapist pushes the patient into carrying out a specific behaviour in a specific situational context, and when the therapist believes the patient is absolutely reluctant to carry out the therapist's prescription, explicitly state what that absolutely reluctant part of the patient would like to say directly and bluntly to the therapist (i.e. "Eat shit!"). *(Category 1 -- Direct Provocation of Strong Feeling)*

#8

The therapist humorously, lightheartedly, playfully chides (kids, teases) the patient about some concern that the patient brought up earlier, and that is separate from the more serious core concerns of the session. *(Category 1 -- Direct Provocation of Strong Feeling)*

#9

In the early part of the session, when the patient mentions a behavior she intends to carry out ("I'm going to call him"), the therapist immediately pushes the patient to carry out the behaviour ("When?...When will you do this?"), and when the patient is openly hesitant to be cornered into doing it, the therapist can directly, forcefully, persistently, and playfully force the patient to carry out the behaviour right now ("Could you call him right this minute?...Why don't I leave the room and you call him?"). *(Category 1 -- Direct Provocation of Strong Feeling)*

#10

When the patient expresses hesitation and reluctance to carry out the extratherapy behavior the therapist wants to patient to do, the therapist continues the encouragement/pressure by indicating that she (the therapist) will continue to watch over the patient and insure that nothing bad happens. *(Category 1 -- Direct Provocation of Strong Feeling)*

#11

When the patient shows that she can have sudden outbursts, especially at the therapist, and is reluctant to do what the therapist wants the patient to do, push and pressure the patient to do what you want her to do. Do this with unswerving persistence. Cap it off by pressuring the patient to carry out a very risky extratherapy behaviour right now in the session. Do this in a pushy-playful, co-conspiratorial, bribing-bargaining, manipulative way ("I'll make a deal with you. You can make this phone call, and I won't ask you another hard thing next week.") *(Category 1 -- Direct Provocation of Strong Feeling)*

#12

Have the patient role-play a risky-exciting conversation with a fellow. The therapist enacts the role of the fellow and does so by pressing the patient to be explicit and concrete, and by keeping the patient in the role-playing conversation with the fellow. *(Category 5 -- Intensification of Patient-Other Encounter)*

#13

When the patient is engaged in role-playing with the therapist in the role of the other person, and when the patient is somewhat hesitant, pulling back from being-behaving the way the therapist wants the patient to be-behave, the therapist persists in forcing the patient to be concrete, specific, and involved. *(Category 1 -- Direct Provocation of Strong Feeling)*

#14

When the patient seems to be schooled, experienced, and ready to go ahead, almost on her own, directing attention onto another person and engaging with quite strong feeling in a role-play situation with that other person, the therapist directly instructs the patient to have strong feeling, telling her to do it again, saying the words as the patient, providing the words she is to say, and playfully chiding, teasing, and disapproving of the way the patient is actually being (e.g. openly uncontrolled). *(Category 1 -- Direct Provocation of Strong Feeling)*

#15

When the patient is already being in a strong feelinged state of yelling and crying out a package of feelings toward the other person, mainly feelings of accusation, anger, hurt, and frustration, as well as righteousness at being openly uncontrolled, the therapist (a) persistently and repeatedly, playfully opposes and chides the patient for being openly uncontrolled, and does so in roles of therapist, of other person, and the opposing, controlled part of the patient; (b) welcomes (encourages, enjoys) her being this way; (c) instructs-tells her to enact-be another part or way-of-being; and (d) invites her to sense and to be-show-express whatever is here now in her. *(Category 1 -- Direct Provocation of Strong Feeling)*

#16

When the patient is not having feeling, but is instead only "talking about" incidents and feeling, highlight this in a way that points the patient toward having feelings, and then give the patient plenty of silent room to have and undergo strong feeling pretty much on his own. *(Category 2 -- Welcoming-Encouragement of Strong Feeling)*

#17

When the patient directly challenges the therapist, accusing the therapist of being a certain way, the therapist sustains and escalates the encounter by (a) not answering, flatly disagreeing, arguing, and not giving in, and (b) doing this consistently and persistently. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#18

When the patient is insistent on attacking the therapist, putting the therapist on the spot, forcing the therapist to accept the patient's interpretation of how the therapist is being, the therapist consistently and persistently resists, argues with, quibbles with, and does not accept the patient's insistent interpretation of what the therapist is like. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#19

When the patient asks an emotionally-laden question as if the therapist is to provide the right answer, avoid providing the invited answer, and, instead ask the patient to answer her own question. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#20

When the patient pussyfoots, hints at, teases about having negative feelings about the therapist, the therapist (a) explosively and loudly criticizes-attacks himself, and virtually yells at and induces the patient to criticize-attack him; and (b) praises her when she starts to criticize-attack him. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#21

When the patient openly and directly levels a specific charge, criticism, attack at the therapist, (a) do not acknowledge or respond to the specific content of the charge, criticism, attack; instead, (b) deflect attention onto some other aspect of what the patient was not talking about. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#22

When the patient is already upset and bothered by the therapist's not being sincere and direct with her, continue upsetting her by being outrageous in not doing what she wants, and by mockingly toying with her feelinged concerns. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#23

When the patient seems to like the therapist, the therapist teases her and persistently cultivates her uncertainty about things she believes she knows are true. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#24

When the patient describes a personality part of being a certain way, the therapist tries to have the patient speak as the personality part, and to say what the personality part is saying. The therapist accomplishes this by (a) telling the patient to scream and shout it out; (b) being persistent in telling the patient to do it and say it louder and louder; and (c) being approving-welcoming of patient's doing what the therapist wants. *(Category 5 -- Intensification of Patient-Other Encounter)*

#25

Provide the atmosphere and physical props for expression of strong feeling. When the strong feeling begins to occur, quietly welcome its expression. *(Category 2 -- Welcoming-Encouragement of Strong Feeling)*

#26

When the patient alternates between addressing a part of her self, and talking to the therapist about that part of her self, the therapist is relatively persistent in encouraging the patient to say these particular things directly to that part of her self. *(Category 5 -- Intensification of Patient-Other Encounter)*

#27

When the therapist gets an idea of what the situation is in which the patient has bad feelings, (a) the therapist tells the patient that they are going to act out the scene, tells the patient what she is to do and the reasons or goals for what this is to accomplish, and prepares the patient by telling her what he will do in the scene. (b) The patient and therapist-as-other-person enact the scene of bad feeling. (c) Once the scene is real and the patient has strong bad feelings, the therapist alternates between playing the role of the other person, and being the reassuring therapist who tells her what to do, how and why to do it. The therapist keeps this up for some time. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#28

When the patient is already in a state of strong feeling (e.g., crying, sobbing, showing hurt directly to therapist), but it is beginning to wane, (a) explain how important it is for the patient to do what the therapist wants the patient to do, and (b) be persistent and forceful, with a context of reassurance, in getting the patient to say and to carry out the feelinged way directly to the therapist. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#29

When the patient is already having strong feelings in regard to her father, heighten the strong-feelinged part of the scene, make it more and more immediate, present, and alive, and do this over and over again, with strong feeling. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#30

When the patient seems coyly reluctant to provide what the therapist wants, the therapist (a) mocks-kids-teases the patient about his coy reluctance, and (b) does so in a context of far-out, bludging, blunt openness. *(Category 1 -- Direct Provocation of Strong Feeling)*

#31

The therapist is exceedingly blunt, direct, and embarrassing puncturing of ordinary interpersonal taboos. When the patient is provoked to chuckle or laugh, the therapist is comedic and funny in drawing attention to the laughter. *(Category 1 -- Direct Provocation of Strong Feeling)*

#32

When the patient is talking about a risky-tabooed subject and uses a phrase that has a double meaning, then the therapist (a) is startlingly blunt and gross in going right into the highly private-personal material, and (b) attacks the patient in a friendly, humorous, buddy-buddy manner. *(Category 1 -- Direct Provocation of Strong Feeling)*

#33

When the patient seems to be silent, hesitant, reluctant to talk about "it", the therapist punctures the patient's apparent reasons for withholding, and does so openly, directly, persistently, with plain and blunt talk, humorously, playfully, and with a comedian's knack for delivery. *(Category 1 -- Direct Provocation of Strong Feeling)*

#34

When the therapist and patient have settled into a routine of provocative comedian and provokable patient, the therapist (a) flagrantly argues and disagrees with the patient; (b) is openly and humorously insulting to the patient; and (c) is humorously direct and open about tabooed personal topics. *(Category 1 -- Direct Provocation of Strong Feeling)*

#35

When the patient has been talking about killing herself, but is no longer feeling so bad, and is describing a stress-causing prospective scene, the therapist asks, innocently and matter-of-factly, and with a straight face, about her plans in that scene, including killing herself. *(Category 1 -- Direct Provocation of Strong Feeling)*

#36

When the patient is plotting and squaring off against her mean boss, the therapist tries to get the patient to give voice to a nicer, friendlier part that the therapist sees as available. *(Category 5 -- Intensification of Patient-Other Encounter)*

#37

When the patient is earnestly giving his impression of how you are, the kind of person you are, how you are changing lately, take the patient seriously, and talk about yourself in a way that indicates that the patient is probably correct in what he says about you. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#38

When the patient is talking about a father and what he wants from a father, the therapist asks the patient to role-play his father -- this kind of (ideal) father, talking with this son. The therapist role-plays the son (the patient), playing the role in the way that the therapist believes the patient was or could-should have been in relating to his father. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#39

When the patient is having substantive feelings in talking about his father, (a) tell the patient to talk directly to his father; (b) provide the words the patient is to say to his father; and (c) when the scene is relatively vivid and the feelings relatively strong, tell the patient to "be", speak as, the father. *(Category 5 -- Intensification of Patient-Other Encounter)*

#40

When the patient is relatively skilled in having strong feelings in imagery scenes, and when the patient seems to be having relatively strong feeling in talking almost directly to the other person right now, then simply tell the patient to say that directly to the other person right now. *(Category 5 -- Intensification of Patient-Other Encounter)*

#41

When the patient is already crying rather hard, and saying words as if they are being said to a particular person, tell the patient to say these words directly to the particular person. *(Category 5 -- Intensification of Patient-Other Encounter)*

#42

When the therapist seems to be seeking to get the patient to allow herself to be a particular way, and when the patient seems close to being ready to do so, then the therapist openly and exaggerately is this way toward himself, in a playful manner that invites the patient to go ahead and join in. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#43

When using the 2-chair method, show and tell the patient how and what to be and say in one role. When a feeling seems to be present, draw attention to it, and when the patient begins to show this feeling, encourage stronger expression. *(Category 5 -- Intensification of Patient-Other Encounter)*

#44

The therapist is the strong-feelinged voice of the patient's mother, in hammering the patient in regard to a feeling-laden topic. When the patient is having strong feeling in the live interaction with the therapist (as mother), the therapist is unusually persistent in further hammering away at the patient, and doing so with strong feeling. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#45

When the patient is already in a strong-feelinged state of the helpless victim to the therapist (as the attacking, parental figure), the therapist hammers away at the patient's pain-center, and does so relentlessly, for a very long time. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#46

When the therapist has repeatedly attacked the patient (in the role of attacking, parental figure of mother), and the patient is in a state of pain and hurt, (a) force the patient to admit to gross, deeply personal feelings (e.g. homosexual) toward the therapist; and then (b) go back and forth between the role of the other person, who attacks the patient mercilessly for having such vile feelings, and the role of the nice therapist who is here to help the patient. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#47

When the patient is being pulled in, withdrawn, and sullen, (a) pick at, push, criticize, and provoke the patient in suggesting why she may be that way. When the patient starts to cry, then (b) continue to push, prod, jostle, and provoke the patient in an open, crude, direct way that is laced with a whiff of humour. *(Category 1 -- Direct Provocation of Strong Feeling)*

#48

(a) Push, pick at, criticize, and berate the patient. When the patient is provoked and starts to fight back, then (b) keep on, and include mocking, caricaturing, and burlesquing the patient. *(Category 1 -- Direct Provocation of Strong Feeling)*

#49

When the patient and therapist are engaged in a one-on-one argumentative fight, and the patient issues a far-out challenge, wholly accept the challenge, and do so by grossly, daringly, and provocatively breaking ordinary patient-therapist role boundaries and rules. *(Category 3 -- Intensification of Therapist-Patient Encounter)*

#50

When the therapist is trying to get the patient to agree to sign up for therapy, and when they are sparring-fighting with one another, be aggressive in taunting and mocking the way you presume the patient thinks. *(Category 1 -- Direct Provocation of Strong Feeling)*

#51

When the patient is concerned about a scene, the therapist frames in the scene in a way that pulls in the patient's behaving in a meaningful and feeling-inducing way. *(Category 4 -- Enlivening Scene of Strong Feeling)*

#52

When the therapist defines a scene that pulls for the feeling the patient is concerned about, and the patient is beginning to undergo this feeling, the therapist plays the role of the provocative antagonist, and does so with strong feeling, and challenges the patient in direct confrontation. *(Category 5 -- Intensification of Patient-Other Encounter)*

Appendix E

Composite Descriptions of the 52 Strong Feeling Events In Terms of Therapist Use of Strong Feeling

#1

The therapist laughs along with the patient, and uses the strong feeling to prolong and sustain the patient's laughter expression. *(Category 1 -- Sustain the Strong Feeling)*

#2

The therapist seems to sustain and maintain the patient's saying "I won't do it! I won't! I won't!", after the moment of strong feeling. The therapist seems to want to use what is occurring in the moment of strong feeling by using it to elicit memories. The therapist asks, "Bring anything back, bring any memories back to you?" *(Category 4 -- Carry Forward Emergent Material)*

#3

After both strong-laughter outbursts, the therapist seems to use it to provide the patient with an interpretation or descriptive statement of how the patient relates to the therapist; specifically, that the patient is being critical, challenging toward the therapist, saying that he achieves more and does better with another therapist. *(Category 5 -- Promote Insight and Self-Understanding)*

#4

The therapist uses the strong feeling moment (a) to sustain and intensify the strong feeling; (b) to see what then emerges ("I feel like I want to hug you"); and (c) to gain further understanding of how the patient was being, what the patient said and did before, during, and after the moment of strong feeling. *(Category 5 -- Promote Insight and Self-Understanding)*

#5

The therapist helps the patient understand and make sense of the new feelings(of tenseness, loneliness)that seem to here now. *(Category 5 -- Promote Insight and Self-Understanding)*

#6

The therapist tries to help the patient understand what propels him to be-behave in this way. *(Category 5 -- Promote Insight and Self-Understanding)*

#7

The therapist uses the strong feeling to understand what makes him so anxious to have sex with a woman that he is sexually attracted to. *(Category 5 -- Promote Insight and Self-Understanding)*

#8

The therapist uses the strong feeling to help the patient explore why he is now reluctant to carry out a new extratherapy behaviour that he had previously already agreed to carry out. *(Category 5 -- Promote Insight and Self-Understanding)*

#9

The therapist uses the strong feeling moment to further provoke-push the patient to do an exciting, but anxiety-laden behaviour (telephoning a man she is attracted to) right now in the session. *(Category 1 -- Sustain the Strong Feeling)*

#10

The therapist puts into words what the patient must be feeling toward and about the therapist ("You'd think I'd let up ... Push, push, push"), and thereby accepts the outburst, but continues to push-encourage the patient to carry out the tempting, anxiety-provoking behaviour right now. *(Category 2 -- Neutralize the Strong Feeling)*

#11

The therapist accepts the outburst with a chuckle, and continues to supportively, playfully but persistently push the patient to -- right now in the session -- telephone the man she is attracted to and ask him for a date, and risk the rejection that might happen if she does so. *(Category 2 -- Neutralize the Strong Feeling)*

#12

The therapist seems to use it as an indication that the patient is no longer being the way the therapist wants the patient to be, and is pulling out of the conversation with the therapist (in role of key other person), and turning to the therapist instead. The therapist proceeds to return the patient to being in the conversation with the therapist (as key other), and toward being the way the patient had been prior to pulling out. The therapist accomplishes this by gently disapproving of the maneuver ("Oh no ... oh no ... I want to hear you being in charge ..."), and in effect telling the patient to stay in there, keep at it, stick to it. *(Category 1 -- Sustain the Strong Feeling)*

#13

The therapist uses the strong-feelinged moment (a) to point out what there is about the patient that leads her to pull away from the new, risky way of being-behaving, and (b) as a sign that the patient is reluctant to be a particular way in the role-playing interaction. (c) The therapist then uses it to redirect the patient back into the role-playing. *(Category 5 -- Promote Insight and Self-Understanding)*

#14

Throughout the extended moment, the therapist encourages, sustains, heightens, and carries forward her being this way. *(Category 1 -- Sustain the Strong Feeling)*

#15

The therapist uses it (a) to keep her undergoing the strong feeling and to continue doing what she is doing; (b) to see what other, or further feeling is there now, is now present; (c) to help her to continue trying to make sense of her relationship with the other fellow, her boyfriend; and (d) to heighten her acceptance of being this openly expressive way. *(Category 5 -- Promote Insight and Self-Understanding)*

#16

Be quiet. Say and do nothing for a sustained period, until the patient starts talking again. *(Category 2 -- Neutralize the Strong Feeling)*

#17

The therapist sustains the feeling-laden encounter by (a) remaining quietly firm, continuing the argument; and (b) defensively trying to justify her position. *(Category 1 -- Sustain the Strong Feeling)*

#18

The therapist is pleased and encouraging of the patient's strong feeling expression, and thereby (a) avoids dealing with the direct attack, while (b) regaining the one-up superior position. *(Category 2 -- Neutralize the Strong Feeling)*

#19

The therapist points out the apparent contradiction between the content of what the patient has just said, and the unhappy feeling that is now present. *(Category 5 -- Promote Insight and Self-Understanding)*

#20

The therapist sidesteps, deflects, and defuses the patient's criticism and attack by (a) welcoming her being able to disclose and to reveal, (b) artfully accepting the concrete content of the criticism and attack, and (c) praising the patient's acute perceptiveness in discerning the qualities that were criticized and attacked. *(Category 2 -- Neutralize the Strong Feeling)*

#21

The therapist loudly, forcefully engages with her in sticking to the point she is trying to make, while avoiding the direct content of her outburst. *(Category 2 -- Neutralize the Strong Feeling)*

#22

The therapist dodges and defends himself by first using clever, pretzel-twist logic, and then using ingenuous-sounding justification. *(Category 2 -- Neutralize the Strong Feeling)*

#23

The therapist becomes a little softer, less biting, somewhat caring, almost as a token of how the patient wanted him to be throughout much of the session *(Category 2 -- Neutralize the Strong Feeling)*

#24

To enable the patient to know, see, understand, be aware of, or explore some emerging aspect of her self. *(Category 4 -- Carry Forward Emergent Material)*

#25

The therapist tries to get her to see or understand that she can express her anger and related feelings without punching or hurting someone or herself. *(Category 5 -- Promote Insight and Self-Understanding)*

#26

The therapist uses it to (a) continue her feelinged direct interaction with that part of her self; (b) lighten, soften, make less painful her relation with that part of her self; and (c) yield a fuller, broader understanding of her self and the way that part has affected her and her life. *(Category 5 -- Promote Insight and Self-Understanding)*

#27

The therapist tries to prolong, sustain, heighten and increase the feeling, and to get the patient to say and show it more directly to the therapist, and to the therapist in the role of the significant figure. *(Category 1 -- Sustain the Strong Feeling)*

#28

The therapist uses it to enable the patient to open up and have and show the awful feelings (a) in a way that feels all right, not so awful, and and (b) to learn a more effective way of coping-dealing with the painful situation in which the awful feelings were present. *(Category 3 -- Resolve the Painful Feeling)*

#29

The therapist tries to get her to have and show anger toward a significant other person, and to be firm in letting him know "that is enough". *(Category 3 -- Resolve the Painful Feeling)*

#30

The therapist furthers the playfully good-humoured mocking-kidding-teasing of the patient, in a way that is provocative, activating, enlivening to the patient, and gets the personal information he seeks. *(Category 1 -- Sustain the Strong Feeling)*

#31

The therapist uses it as a cue to continue being blatantly coarse and provocative in trying to pry and open up the patient. *(Category 1 -- Sustain the Strong Feeling)*

#32

To probe further inside the "tabooed" topic that the laughter indicates the patient may be ready to talk about. *(Category 4 -- Carry Forward Emergent Material)*

#33

As an indication that the patient is somewhat cooperative and willing for the therapist to pursue the specific matter further. *(Category 4 -- Carry Forward Emergent Material)*

#34

To go further into the funny images and scenes around the tabooed topic the patient is laughing about. *(Category 4 -- Carry Forward Emergent Material)*

#35

The therapist uses the good-feelinged shift in state as a welcomed change from the painful state, and does this by (a) regarding the patient as having let go of the painful state, (b) joining with the patient in laughing, and (c) siding with the patient in the way the patient sees the problematic part of her world. *(Category 4 -- Carry Forward Emergent Material)*

#36

When the patient plays the role of one self, the therapist tries to have the patient see her other selves, including selves that are present and available in her. *(Category 5 -- Promote Insight and Self-Understanding)*

#37

The therapist is passive, happily acquiescent, like a little boy, in being the way the patient powerfully, caringly, and forcefully insists that the therapist be. *(Category 1 -- Sustain the Strong Feeling)*

#38

The therapist uses it to further open and develop the patient's being his father in talking to and relating to his son, the patient (role-played by the therapist). *(Category 4 -- Carry Forward Emergent Material)*

#39

The therapist uses the strong feeling to try and help the patient move on to and understand more about another important figure (his mother), and the part this other person played in his life. *(Category 5 -- Promote Insight and Self-Understanding)*

#40

The therapist uses the strong feeling to try and get the patient to show and say directly to the other person something that the therapist believes the patient is really feeling toward the other person. *(Category 4 -- Carry Forward Emergent Material)*

#41

The moment of strong feeling is used for the patient to culminate with his strong-feelinged understanding of how he really feels about important issues in his life, a better and more accurate understanding of himself and his relations with his parents. *(Category 5 -- Promote Insight and Self-Understanding)*

#42

The therapist joins with the patient in an enjoyable, playful, pleasant sharing of her new way-of-being; pokes fun at his immediate state in a simple, disarming, winsomely charming manner; and then invites the patient to check the immediate new feeling. *(Category 4 -- Carry Forward Emergent Material)*

#43

The therapist invites the patient to talk about her feelings, to understand and show what seems to be here now. *(Category 5 -- Promote Insight and Self-Understanding)*

#44

The therapist uses the strong feeling to prolong, draw out, and intensify the present strong feeling in the interaction with the other person (enacted by therapist). *(Category 1 -- Sustain the Strong Feeling)*

#45

The therapist forces the patient to wallow incessantly and intensively in the terrible feelings in this powerful encounter. *(Category 1 -- Sustain the Strong Feeling)*

#46

The therapist uses the strong feeling to get the patient to admit-show the bad thoughts and feelings directly to the therapist (as therapist), and to do so with less pain and anguish. *(Category 3 -- Resolve the Painful Feeling)*

#47

The therapist gets the patient to move to a further, heightened, one-against-one argumentative encounter in which the therapist is pushing, attacking, prodding, provoking the patient in a way that is open, direct, and laced with a whiff of humor. *(Category 1 -- Sustain the Strong Feeling)*

#48

To continue the back-and-forth encounter, the therapist does the "I'll provoke you and you try to stand up to me." *(Category 1 -- Sustain the Strong Feeling)*

#49

The therapist engages in a downright out-and-out argumentative fight, with a tone of trying to be playful, charming, buddy-buddy, to further promote the patient being confrontative and standing up for herself. *(Category 1 -- Sustain the Strong Feeling)*

#50

The therapist becomes somewhat put off guard by her dominant role, thereby pulling the patient to be dominant, in charge. *(Category 4 -- Carry Forward Emergent Material)*

#51

The therapist seemed to use this to emphasize the presence of seemingly contradictory feelings, especially the feeling that seemed to be present in the moment of strong feeling. *(Category 4 -- Carry Forward Emergent Material)*

#52

The therapist tries to get the patient to see that blasting out is only one way to deal with anger, and that there are other ways that the patient could and should use. *(Category 5 -- Promote Insight and Self-Understanding)*

Appendix F

Instructions for Judges for the Identification of Strong Feeling

The purpose of these instructions is to help explain how to identify instances of strong feeling in the taped sessions. To decide if strong feeling occurs on a tape, you will use your own clinical judgement, assisted by the guidelines provided below, which are taken from the *scale for assessing strength of client feeling* (Mahrer, Stalikas, Boissoneault, Trainor, & Pilloud, 1990). In listening for strong feeling, listen for the presence of four dimensions: (a) the degree of volume (charge, force, energy, loudness) in the client's voice; (b) the degree of spontaneity vs. restraint; (c) the degree of fullness and saturation; and (d) degree of strength and breadth of bodily sensations (that <u>you</u> feel as you listen to the client's words and behaviour, and let yourself be affected by them). Here is a more detailed description:

> Feeling is quite powerful, intense, high, robust, all-pervasive. There is a strong degree of charge, force, and energy, and a high degree of loudness and volume. There is virtually open and unrestrained spontaneity and freedom from control. Feeling is full and saturating. Bodily sensations are quite strong, quite compelling and conspicuous, and generally extended over the entire body.
>
> Laughter may occur as sheer gales of hard and essentially unrestrained outbursts. Crying and sobbing may be hard and full, quite unrestrained with wailing and moaning. There may be screamings, yellings, sharp and shrill outcryings, shriekings, piercing outbursts, or roarings. Speech may be very rapid, highly pressured and rushed, with little choice of words, repetition of words and phrases in a manner that is quite jumbled, fragmented, broken, and disorganized. Loudness and volume may be booming, explosive, and powerful. Bodily sensations may include almost uncontrolled shaking and trembling, faintness or weakness, hot or cold flashes, a sense of floating or elevation or falling or forward movement, muscular contraction or clenching, gasping for breath (Mahrer, Stalikas, Boissoneault, Trainor, & Pilloud, 1990, pp. 110-111).

Remember that all four qualities do <u>not</u> need to be present for you to judge that the client is undergoing strong feeling. Volume may be booming and explosive. Or it may not be. Noise level may be quiet, and you still may judge that the feeling level is internally full, saturating.

Regarding the length of the strong feeling event, it could be quite short or relatively long in duration. It could over a short period of just a second or two. It could also extend continuously over a few minutes.

Appendix G

Instructions for Judges for the Written Descriptions Of the Kind (Nature) of Feeling in Each Strong Feeling Event

You have been given a transcript presenting the therapist-client statements before, during, and after the strong feeling event. The part judged as containing strong feeling is typed in **bold**.

Your job is to listen to the tape, using the transcript to help you, and answer this question: *How is the client being, and what is the client doing in the moment of strong feeling?* Your answer will be your written description of the nature, content, or kind of strong feeling (emotion, affect) that seems to you to be present. In your description, pay attention to the strong feeling that is actually evident and present, rather than the feeling that the client may have been referring to or saying he/she was having. Try to describe the client feeling in terms of what is actually happening on the audiotape -- rather than straying too far into loose, global, abstract speculations about what the client is undergoing.

Work by yourself. In writing your answer, use plain English. Stay away from jargon words specific to a particular school of psychotherapy.

You completely free to decide that the event in question does <u>not</u> qualify as a strong feeling event -- as based on your clinical judgement, and the definition of strong feeling that has been given to you. If a majority of judges decides this, then this client event will be dropped from the study.

Appendix H

Instructions to Judges for Description of Antecedent Therapist Methods (and Client Conditions)

You have been provided with the composite description which summarizes how the team described the kind (nature, content) of the strong feeling for this particular strong feeling event. You job now is to go back and listen the audiotape again (aided by the provided transcript) and to describe what you believe the therapist and client did to help bring about the strong feeling moment.

Start by listening to the strong feeling moment (in **bold** on your transcript). Then, go back as far as you believe is necessary to answer the question. You could go back one or two therapist statements, or you could go back much earlier. You are looking for what the <u>therapist</u> said and did that seemed to be important in promoting the client's strong feeling. You are also looking for how the client was being, and what the client was saying or doing, at the specific point when the therapist did whatever he/she did to promote the strong feeling.

As much as possible, formulate your answer in this format: "*When* the client is doing this and being this particular way in the session (*client condition*), the *therapist methods* that seemed to help promote the strong feeling were this and that." Imagine that you are writing this answer for a practitioner who may want to reproduce this kind of strong feeling moment. He/she would want to know <u>when</u> to carry out the method, and <u>what method</u> to carry out.

Work by yourself. Answer in plain English. Avoid jargon from a specific therapeutic approach. Remember also that you are free to report that you were <u>not</u> able to identify any therapist operation (or client condition) preceding this strong feeling event.

Appendix I

Instructions to Judges for Description of the Therapist's Subsequent Use of the Strong Feeling

You have been provided with the composite description which summarizes how the team described the kind (nature, content) of the strong feeling for this particular strong feeling event. You job now is to go back and listen the audiotape (aided by the provided transcript) and to answer this question: *How did the therapist use the strong feeling, once it occurred?*

Start by listening to the strong feeling moment (in **bold** on your transcript). Then, listen further ahead, as far as you believe is necessary to answer the question. You could go forward a little, or much further -- right till the end of the session, if you wish.

In identifying the *therapist's use* of the strong feeling, think in terms of the following things: (1) You may identify an impressive client sub-outcome of the strong feeling. This refers to a client event -- occurring after the strong feeling, and that you believe is related (tied to, flowing from) to the strong feeling -- that you consider to be a significant (impressive, valuable) shift, that you consider to be indicative of therapeutic movement, change, improvement. (2) You may focus on what the therapist seemed to be *trying to accomplish* subsequent to the strong feeling moment. The focus here is not so much on what the client did after the strong feeling, but where the therapist seemed to be going with it, what the therapist seemed to be intending to accomplish.

Work by yourself. Try to answer the question in simple English, avoiding jargon terms from particular therapeutic approaches. Remember that you are always free to report that the therapist did <u>not</u> seem to use the strong feeling moment at all.