Emotion in Psychotherapy

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ABSTRACT: The therapeutic process involves many different types of affective phenomena. No single therapeutic perspective has been able to encompass within its own theoretical framework all the ways in which emotion plays a role in therapeutic change. A comprehensive, constructive theory of emotion helps transcend the differences in the therapeutic schools by viewing emotion as a complex synthesis of expressive motor, schematic, and conceptual information that provides organisms with information about their responses to situations that helps them orient adaptively in the environment. In addition to improved theory, increased precision in the assessment of affective functioning in therapy, as well as greater specification of different emotional change processes and means of facilitating these, will allow the role of emotion in change to be studied more effectively. A number of different change processes involving emotion are discussed, as well as principles of emotionally focused intervention that help access emotion and promote emotional restructuring.

The cognitive revolution in psychology has had a predictable, although initially unanticipated effect—it has brought emotional processes, once relegated to the domain of the subjective, into central focus for empirical and theoretical investigation. There has recently been a rapid expansion of new information relevant to the analysis of emotion (Buck, 1984, 1985; Izard, 1979; Lazarus, 1984; Lewis & Michalson, 1983; Plutchik, 1980; Zajonc, 1980, 1984) and a growing realization that behavior can be initiated and influenced by emotional as well as cognitive processes. In fact, the traditional distinctions drawn among affect, cognition, and behavior have rapidly been breaking down and have been replaced by emerging integrative information processing models of functioning (Buck, 1985; Lang, 1985; Leventhal, 1979, 1984). In these models, emotion is seen as the product of a synthesis of constitutive elements at the physiological and expressive motor level, at the semantic and schematic level, and at the linguistic and conceptual level.

In psychotherapy, a similar trend toward studying affective functioning has recently emerged (Bradbury & Fincham, 1987; Foa & Kozak, 1986; Greenberg & Johnson, 1986a, 1988; Greenberg & Safran, 1981, 1984a, 1987a, 1987b; Guidano & Liotti, 1983; Johnson & Greenberg, 1985a, 1985b; Mahoney, 1984; Rachman, 1980, 1981; Safran & Greenberg, 1982a, 1982b, 1986). We will suggest in this article that emotional processes in psychotherapy are of central importance in understanding and promoting certain types of therapeutic change and that it is now timely and necessary for the psychotherapy field to develop an integrative and empirically informed perspective on the role of emotion in change. This will provide an orienting framework for investigating the diverse array of different emotional phenomena traditionally focused on by different therapy traditions.

Psychotherapeutic Approaches to Emotion

Psychotherapists have long concerned themselves with working with people's emotional experience. Different theoretical perspectives have tended to emphasize different aspects of emotional functioning. As a result, the psychotherapy literature has failed to produce an integrative, comprehensive perspective on emotion capable of illuminating the full array of emotional phenomena relevant to psychotherapy. In this section, we will briefly highlight some of the important themes characterizing three of the major therapeutic perspectives on emotion: psychoanalysis, behavioral and cognitive behavioral therapies, and the experiential tradition.

From the outset, psychoanalysis has had an appreciation of the role of neglected emotion in human affairs. In psychodynamic therapy, affect has played a variety of different roles. Emotion was seen initially as psychic energy. The strangulation of affect was seen as the main cause of hysteria with abreaction as the cure (Freud, 1895). Wilhelm Reich (1949) later emphasized abreaction and the sustained expression of emotion throughout therapy as an important curative factor. Modern cathartic therapies (e.g., Janov, 1970), which evolved from this perspective, have emphasized the expression of emotion, but without the awareness and analysis of defenses that Reich also saw as crucial.

Later Freud (1910) abandoned the abreaction model and theorized that when the quantity of psychic energy became excessive it was discharged in the form of emotion. Thus, emotion came to be seen as a discharge process associated with instinctual impulses rather than as psychic energy. Some modern analysts, following Rapaport (1967), have used this drive discharge model and have hypothesized that given that emotions are a mode of drive discharge, the failure to "express feelings" is tantamount to drive repression and is the cause of neurotic behavior. Although Rapaport (1967) was not completely clear on this point, it appears that he viewed emotional expression as a preferred sublimatory route for drive discharge and believed that psychotherapeutic work should encourage the expression of pent-up feelings to help control instinctual strivings.

Other psychodynamic perspectives emphasize that

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it is the full affective experience of pathogenic conflicts in the transference process that makes for greater therapeutic effectiveness. Either transference interpretations or corrective emotional experience with the therapist are then seen as curative (Alexander & French, 1946; Strachey, 1934). Thus, in these views, fully experiencing affective responses in the context of a therapeutic relationship is seen as a prerequisite for correcting distortions of the object world.

Within the broader psychodynamic arena, object relations and interpersonal perspectives construe affect as a motivational tendency that connects the organism with its environment both through action tendencies and communication (Basch, 1976; Fairbairn, 1962; Sullivan, 1953). Affective experience and expression are seen as being centrally involved in need satisfaction, and the owning of disclaimed action tendencies is seen as therapeutic (Eagle, 1984; Schafer, 1983). In therapy, interpersonal theorists stress interpretations that help people to be attuned to their interpersonal needs and to express them in a spontaneous fashion.

In summary, in the classical psychoanalytic view, emotions are seen generally as drive related and as needing to be discharged or tamed, whereas in interpersonal approaches, emotions are seen as socially adaptive orienting tendencies. Although psychoanalytic therapy has always stressed the importance of acknowledging disavowed affect, recent theoretical developments have come to view this warded-off affect as a form of disclaimed action (Eagle, 1984; Schafer, 1983).

In contrast to psychoanalytic theory, which began by focusing on the pathogenic nature of *repressed or disavowed affect,* behavioral theory focused on the clinical problem of modifying *undesirable affective states,* such as anxiety and depression, and this approach has become paradigmatic of the behavioral tradition.

Two contending themes have dominated behavioral views of emotion. Proponents of the first perspective view the individual as a tabula rasa who learns emotional responses in relation to environmental contingencies (Skinner, 1953). Those who adhere to the second perspective view emotion as stemming at least in part from innate propensities or predispositions (Rachman, 1978). Both of these perspectives have led to the development of treatment strategies involving deconditioning and exposure. In addition to graduated exposure treatments, implosion and flooding have also been used to prevent avoidance behavior and extinguish or habituate anxiety responses. Repeated exposure to fear situations, whether gradual or total, imaginal or in vivo, has been a key ingredient in the behavioral approach to the treatment of anxiety. Thus, in the behavioral perspective, the need for the elimination of maladaptive emotional responses is typically stressed. Rachman's (1980) recent theoretical work on emotional processing attempts to expand the behavioral perspective on emotion to account for affective change phenomena in a variety of different approaches to therapy. Although this perspective is in an early phase of development, it does indicate the growing interest in developing a broader theoretical perspective on the role of emotion in the behavioral tradition.

In the cognitive behavioral approaches, affect has traditionally been seen as a postcognitive phenomena. Cognitive behavioral theory has maintained that the meaning of an event determines the emotional response to it (Beck, 1976; Ellis, 1962). Constructs such as automatic thoughts, irrational beliefs, and self statements have been posited as mediating between events and emotional responses to events, and cognitive therapists have tended to focus on the elimination of emotional responses to faulty cognitions by rationally challenging beliefs, by providing schema-inconsistent evidence, and by providing self-instructional training.

This is a time of theoretical ferment in the cognitive perspective on emotion. A number of theorists are challenging traditional assumptions about the relationship between emotion and cognition and are exploring the functional role of emotion in the human information processing system (Greenberg & Safran, 1981, 1984a, 1987a, 1987b; Guidano, 1987; Guidano & Liotti, 1983; Liotti, 1986, 1987; Mahoney, 1984, 1987; Safran & Greenberg, 1982a, 1986, in press).

In contrast to those who hold cognitive and behavioral views, experiential and humanistic therapists have always regarded emotion as an important motivator of change. In these traditions, emotions are conceptualized neither as expressions of instinctual impulses nor as learned responses. Rather, affect is seen as an orienting system that provides the organism with adaptive information.

In client-centered therapy, experiencing, defined as all that is going on within the organism that is currently available to awareness (Rogers, 1959), has been a central construct. To experience means to receive the impact of sensory and physiological events occurring in the moment. Feeling was defined by Rogers (1959) as a complex cognitive affective unit composed of emotionally toned experience and its cognized meaning. He claimed that therapeutic change involved experiencing fully in awareness feelings that had in the past been denied awareness or had been distorted.

In gestalt therapy (Perls, Hefferline, & Goodman, 1951), although the experience and expression of emotion is regarded to be of critical importance to change, there is still little systematic theory about its role in the therapeutic process. Emotion is regarded as the organism's direct, evaluative, immediate experience of the organism/environment field, furnishing the basis of awareness of what is important to the organism and organizing action. Dysfunction occurs when emotions are interrupted before they can enter awareness or go very far in organizing action. Gestalt therapists see avoidance of painful feelings and the fear of unwanted emotion as the core of many problems (Perls, Hefferline, & Goodman, 1951).

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In the experiential approaches, feelings are thus a valued aspect of experience, not something to be expelled or discharged. The goal of therapy is not to get rid of feelings but to help clients become aware of their meaning and to become more responsive to the action tendencies toward which feelings prompt them. Whether the technique involves empathic responding to clients' experiencing (Rogers, 1957) or the creation of experiments (Greenberg & Kahn, 1978; Polster & Polster, 1973) to increase clients' awareness of both emotional experience and of processes that interrupt emotional experience (Perls, 1973), the goal is to increase clients' awareness of emotion so that it is available as orienting information to help them deal with the environment.

The views discussed here reflect a wide range of different perspectives on the role of emotions in human functioning and in therapy. This diversity has resulted in the development of different theoretical models of the role of emotion in therapeutic change and different clinical techniques.

Empirical Evidence

The empirical work on emotion in psychotherapy has lagged behind the theoretical and practical developments in this area. Empirical evidence relevant to the understanding of the role and efficacy of different emotional change processes in psychotherapy will be reviewed under three major headings: (a) the role of emotional expression in catharsis, (b) the role of emotional arousal in anxiety reduction, and (c) the role of emotion in experiencing. These three areas represent the major empirical literatures on emotion that have been spawned by each of the three therapy traditions reviewed previously.

Emotional Expression

Research on emotional expression has been hampered by the lack of a clear-cut definition of commonly used terms, such as catharsis, and a lack of a clear theoretical position on the role that expressive processes play in therapy (Greenberg & Safran, 1987a). Nevertheless, a number of empirical investigations indicate that both emotional arousal and affective expression are related to therapeutic change. Nichols and Zax (1977) reviewed a number of analogue studies evaluating the effect of catharsis in analogue therapy situations. Although some provided support for the efficacy of cathartic interventions (Dittes, 1957; Goldman-Eisler, 1956; Haggard & Murray, 1942; Levison, Zax, & Cowen, 1961; Martin, Lundy, & Lewin, 1960; Ruesch & Prestwood, 1949), others were ambiguous (Gordon, 1957; Grossman, 1952; Wiener, 1955), or were negative in their findings (Keet, 1948). It has also been suggested that catharsis involves cognitive as well as expressive factors. For example, Bohart (1977), in an analogue study, demonstrated that subjects who expressed their anger in a role play situation and then responded in the other role showed a greater reduction in anger and hostile behavior than those who only expressed anger. Green and Murray (1975) showed that catharsis involves an expression of feelings and a cognitive reinterpretation.

A number of studies of expressive therapy with actual clients have demonstrated changes on physiological measures (e.g., Karle, Corriere, & Hart, 1973; Karle et al., 1976; Woldenburg, 1976). Recently a manualized gestalt therapy approach for dealing with constricted anger, focused expressive therapy, has shown some promise in relieving depressive and subjective pain symptoms (Beutler et al., in press; Daldrup, Beutler, Engle, & Greenberg, 1988). Finally, a number of studies have been conducted demonstrating that the process of catharsis can bring about self-reported change (Nichols, 1974; Pierce, Nichols, & DuBrin, 1983). The results of these studies are complex, however, suggesting that outcome is moderated by variables such as the client's diagnosis, defensive style, and degree of emotional expressiveness in the session; the nature of the emotional material expressed (e.g., whether previously avoided or not); and whether the client has a cognitive connection to these feelings. These findings highlight the importance of developing a differentiated perspective on the role of emotional experience in therapy, a theme we will take up later in the article.

The Role of Emotional Arousal in Anxiety Reduction

A number of empirical investigations indicate that emotional arousal can facilitate anxiety reduction in fear-avoidance problems. First, a variety of studies have found implosion or flooding to be effective in the treatment of a variety of different phobias (Crowe, Marks, Agras, & Leitenberg, 1972; Hogan & Kirchner, 1967; Levis & Carrera, 1967; Mylar & Clement, 1972). A number of studies have yielded conflicting results, however (e.g., Hekmat, 1973; Mealiea & Nawas, 1971), suggesting the importance of clarifying under what conditions emotional arousal techniques will or will not facilitate fear reduction, as well as discovering the precise mechanisms of change.

In addition, a series of studies suggests that clients who experience physiological and/or subjective emotional arousal when undergoing various fear-reduction procedures (e.g., flooding, desensitization) benefit more than those who do not (Borkovec & Grayson, 1980; Borkovec & Sides, 1979; Lang, 1977; Michelson, Mavissakalian & Marchione, 1985; Orenstein & Carr, 1975). These studies highlight the importance of clarifying the underlying change processes in therapeutic events rather than focusing exclusively on the surface features of interventions.

Research on Experiencing

Reviews of the process and outcome literature are fairly consistent in concluding that high levels of client experiencing are related at least in some therapeutic approaches to good outcome in psychotherapy (Klein, Mathieu-Coughlin, & Kiesler, 1986; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Orlinsky & Howard, 1978, 1986).

Luborsky et al. (1971) concluded that of all process measures, experiencing was the most repeatedly successful in predicting outcome. A number of studies examining the relationship between increases in experiencing level during therapy and outcome have also produced positive

results (Fishman, 1971; Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968; Kiesler, Mathieu, & Klein, 1967; Tomlinson, 1967; Tomlinson & Hart, 1962). On the basis of their comprehensive review of the literature relating process to outcome, Orlinsky and Howard (1978) concluded that "in client-centered therapy at least, high levels of process functioning and especially 'experiencing' in patient communications are consistently predictive of therapeutic outcome" (p. 305).

In their more updated review of the experiencing literature, Klein et al. (1986) drew somewhat more moderate conclusions but nevertheless interpreted the evidence to suggest that "experiencing reflects a process of productive engagement in the work of therapy that is related to the ultimate outcome of therapy" (p. 52). A number of studies have found that when client experiencing level is averaged across or over sessions, it is positively correlated with outcome (Gendlin et al., 1968; Kiesler, 1971; Kiesler, Mathieu, & Klein, 1967; Kirtner, Cartwright, Robertson, & Fiske, 1961; Stoler, 1963; Tomlinson & Hart, 1962; Tomlinson & Stoler, 1967; van der Veen, 1967; Walker, Rablen, & Rogers, 1966). Not all studies are consistent with this trend (e.g., Custers, 1973; Richert, 1976; Tomlinson, 1967). As Klein et al. (1986) concluded, positive results are more likely to emerge when sessions are sampled toward the end of therapy than toward the beginning of therapy.

Studies investigating the relationship between changes in experiencing level over the course of therapy and outcome have been somewhat less decisive, but are generally supportive of the idea that experiencing plays an important role in change (e.g., Gendlin et al., 1968; Greenberg & Rice, 1981; Kiesler et al., 1967; Tomlinson, 1967; Tomlinson & Hart, 1962).

In general then, the evidence suggests that experiencing is related to outcome. What is less clear is whether it is a capacity that clients bring to therapy or a performance variable affected by therapy. In addition, it appears that experiencing varies across and within sessions, and it is more a matter of defining when in therapy deeper experiencing is productive than claiming that deep experiencing is a blanket requirement for therapy to be effective (Rice & Greenberg, 1984).

A Differential Approach

As the preceding brief review suggests, the empirical evidence does indicate that emotion can play a role in therapeutic change. The research reviewed, however, highlights the importance of a more differentiated view of emotional change that distinguishes between various types of emotional processes rather than lumping them together under a common rubric such as catharsis, deconditioning, or experiencing.

Emotion has been treated in various ways by different therapies: It has been viewed as irrational, as destructive, as an epiphenomenon, or as an aspect of adaptive biological functioning. Clearly, all of these are possible. If we are to have a comprehensive understanding of emotion in therapy, a more differentiated, multifaceted view of emotion and its function in the process of change is required. No single therapeutic perspective can encompass all of emotional functioning in therapy. Attempts to do so have led to unnecessary disagreements and conceptual confusion because different investigators have been discussing emotion in general but have been focusing on different affective phenomena without being aware of it (Greenberg & Safran, 1984a, 1984b, 1987a). Greater precision in the area of affective assessment is greatly needed in order to deal with this problem.

In addition to suggesting that assessment of different forms of emotional processing in therapy is greatly needed, we also suggest that different types of emotionally focused interventions be used for different types of emotional processing problems. Different methods of working with affective processes already exist in a variety of therapeutic orientations. What is needed is a clear delineation of these different methods, specification of the type of problems they best address, and an explication of the processes of change involved in different emotionally focused change events (Greenberg, 1986; Greenberg & Webster, 1982; Rice & Greenberg, 1984). Emotion does not play a simple, uniform role in all psychotherapeutic change. We should not ask a question as global as "Does emotional experience in therapy lead to change?" Rather we should be asking "What type of emotional processing problem in therapy can best be corrected by what kind of intervention?"

The second limitation apparent in psychotherapy literature on the role of emotion in psychotherapy is the failure to forge systematic links with theory and research in mainstream experimental psychology. This type of theoretical isolation from the mainstream of psychology has resulted in too much therapeutic dogma, development of too many esoteric languages, and the inability to compare and evaluate different views of therapeutic change. In the next section we will elaborate on an integrative theory of emotional processing now emerging in the literature that could help provide the needed framework for understanding emotional processes in therapy.

A Constructive Theory of Emotional Processing

A number of psychological investigators have begun to demonstrate that certain primary emotions, identified by facial and gestural expressions, are widely generalized within the human species (Ekman, 1972; Izard, 1977; Tomkins, 1962). Demonstrations that human facial expressions of emotion bear resemblances to certain animal emotional expressions, as well as evidence of cross-species similarity in emotion physiology (Gray, 1982; Panskepp, 1982), suggest that emotions are products of evolution. These investigators hypothesize that primary emotions are biologically adaptive responses that reflect survival needs and promote survival oriented problem solving.

Early on, Arnold (1960) argued that emotions were not simply subjective internal events but rather were biologically adaptive action tendencies. Currently, a number

of theorists (Izard, 1977; Plutchik, 1980) have stressed the biologically adaptive nature of emotions. Lang (1985) has referred to emotions as dispositions to act. Emotions are thus viewed as motivational in nature, generating rapid, immediate action tendencies. In humans, these tendencies are mediated by higher level information processing that elaborates the action tendencies into conscious emotional experience and intended actions. In this view, emotions are seen as a synthesis of different levels of emotional processing that can potentially motivate adaptive behavior (Lang, 1985; Leventhal, 1982, 1984).

Although there is some disagreement among emotion theorists as to which emotions are primarily biologically based and which emotions are more complex and culturally derived, there is agreement among all theorists who hold a biological/evolutionary perspective on emotion that the structure for certain primary core emotions is wired into the human organism. Consistent with theorists such as Arnold (1960) and Leventhal (1979, 1982), we hypothesize that the neurological substrate for emotional experience is wired in and that it includes a code for specific configurations of expressive motor behaviors that correspond to specific primary emotions including at least the six emotions with identifiable facial expressions—fear, anger, sadness, surprise, disgust, and joy (Ekman, 1972; Ekman & Friesen, 1975). We are not claiming, however, that emotional experience in the adult human being is in any sense restricted to these simple, primary emotions and associated expressive motor configurations. Rather, our perspective is that the basic neurological template for emotional experience becomes elaborated in the human being into subtle blends of emotional experience, such as love, pride, envy, and humility, that are characteristic of human functioning.

In this model of emotion, the human organism is seen as responding to the environment in an immediate, reflexive fashion. The type of immediate appraisals (Arnold, 1970; Zajonc, 1980) humans make of the environment relate to biological and psychological survival. People engage in immediate perceptual motor appraisals of environmental events, which are not dependent on a prior stage of conceptual appraisal. These events are, however, subjected to an ongoing conceptual appraisal as they take place. This conceptual appraisal becomes increasingly sophisticated as the organism develops. As this parallel appraisal process takes place, people accumulate memory stores consisting of images of eliciting environmental events, evoked expressive motor responses, associated autonomic arousal, and conceptual appraisals. Emotional experience thus becomes coded in memory structures or networks that incorporate components from expressive motor, schematic, and conceptual levels of the information processing system (Leventhal, 1982). When an individual either attends to information or generates information internally that matches one of the components of the network, the probability increases that other associated components will become activated. As Lang (1983) maintained, an emotion network (or as he called it, an emotion prototype) becomes automatically activated and processed when an individual attends to information that matches sufficient coded propositions in the prototype. Once the right propositions or combinations thereof are matched in a stimulus array, the entire emotion prototype is automatically activated and processed. The individual thus experiences an emotion consciously, resulting from the preattentive integration of autonomic/expressive motor, schematic, and conceptual components of the network. The experience of emotion thus indicates that a cognitive–affective network has been activated and is currently operating.

A number of different problems can arise in this type of system, however. One set of problems is the inability to synthesize certain immediate expressive motor responses and primary appraisals. Another set of problems can arise from the automatic cuing, at a preattentive level, of schematic emotional memories without these being fully processed consciously. This automatic processing can lead to inexplicable problematic feelings. Problems can also arise from discrepancies between levels of processing, particularly when the conceptual level contains injunctions against material in schematic memory or against certain expressive motor responses. Finally, schematic memories can be repositories of negative emotional associations and response sequences.

Emotionally Focused Intervention

We believe in the importance of explicating a significant domain of therapeutic practice, rather than in promoting a new school of therapy. Thus, we have been attempting to map out and study the parameters of emotionally focused therapy within the preceding framework of a network theory of emotion, both for individuals (Greenberg & Safran, 1981, 1984a, 1987a, 1987b; Safran & Greenberg, 1982a, 1982b, 1986, in press) and couples (Greenberg & Johnson, 1985, 1986a, 1986b, 1988; Johnson, 1986; Johnson & Greenberg, 1985a, 1985b). Taking an emotionally focused approach to therapy involves viewing particular classes of emotion as allies in a change process rather than as negative or undesirable aspects of client performance to be bypassed or extinguished. As Simon (1967) has noted, it is generally adaptive to give a high priority, in terms of attention and cognitive processing, to goals or information with which emotion is associated, particularly when it is intense. The blocking or avoidance of potentially adaptive emotions and the information associated with them can thus lead to poor problem solving, whereas the complete processing of specific emotional experience can lead to the emergence of new, more adaptive responses.

Emotional intervention can be seen to fall into a number of different classes, each involving different procedures and promoting different processes of change. Five general processes of change are (a) synthesizing and acknowledging previously unacknowledged emotional responses in order to increase awareness of adaptive response information; (b) the evocation and intensification of emotion to motivate new behavioral responses; (c) emotional restructuring, that is, evoking the network un-

derlying problematic responses in order to restructure the network; (d) accessing state-dependent core beliefs; and (e) modifying maladaptive emotional responses.

In the first category, *synthesizing emotion,* we are referring to a process of long-standing significance in the practice of psychotherapy, one of bringing into awareness emotionally laden information that was previously not in awareness. As is generally recognized, it can be therapeutically useful for people to "get in touch" with affective responses that are not normally attended to (Davison, 1980; Wexler, 1974) and to own disclaimed action tendencies (Eagle, 1984; Schafer, 1983) associated with the feelings. The importance of the acknowledgment of affect is based on the adaptive nature of primary affective responses and on the importance of accessing this information to aid problem solving. Organisms that ignore their own affective feedback are not well situated to behave adaptively. Acknowledging affective responses that were previously disallowed makes certain reactions and moods more understandable and acknowledging disclaimed tendencies provides new impetus for action and need satisfaction. Acting in the world to satisfy certain needs is a sine qua non of competence and satisfaction. Without acknowledgment of feelings and desires, people feel empty, confused, and often fragmented, and they lack the impetus from the action tendencies to motivate action.

One of the thorny questions regarding the acknowledgment of emotion has been whether the emotion existed in some form out of awareness prior to acknowledgment. On the basis of a constructive theory of emotional processing, we argue (Greenberg & Safran, 1987a) that emotional experience is a conscious experience. This experience comes into consciousness by a tacit synthesis of subsidiary information. Acknowledgment of emotion is thus the process of synthesizing subsidiary information (not in awareness) in the present in a particular fashion to produce conscious experience. Prior to acknowledgment, these conscious emotions exist only as potentials. Subsidiary components, such as the expressive motor response, however, do actually exist outside of awareness and can be more or less accurately synthesized. Thus, acknowledgment is a process both of discovery and creation in which certain constitutive elements, such as expressive motor responses, schematic memories, and tacit rules are synthesized along with perception of the situation into a particular current self-organization. Certain self-experiences such as feeling vulnerable or angry emerge as present constructions.

Often in therapy, this synthesis involves the client's allowing into awareness an organization of experience previously regarded as unacceptable and then accepting this experience. With the acceptance of the feeling comes the recognition of the action tendency associated with it. Fully accepting the feeling implies accepting the want or desire that goes with it. Wants and desires need to be symbolized in awareness and their implications explored. The acknowledgment and experience of emotion brings relief mainly when the action organized by the emotion can be expressed in some acceptable form.

In the second category, *evocation of emotion,* increasing emotional arousal is used as a means of changing behavior (Greenberg & Johnson, 1988; Greenberg & Safran, 1987a). In this process, emotion is intensified using expressive methods. Thus, the experiences of anger can be evoked in therapy to promote assertiveness (Kahn & Greenberg, 1980), sadness to promote contact or comfort seeking behavior, and fear and vulnerability to promote less dominant or less aggressive behaviors (Greenberg & Johnson, 1985, 1986a, 1986b, 1988). In this process, specific emotions are evoked in order to access the action tendency associated with them. The action tendency is then elaborated into the behavioral response that the client is lacking or that would help alleviate the assessed distress. The emotional experience and the associated action tendency can be evoked by various means of emotional stimulation, both verbal and nonverbal. Often, expressive nonverbal means of stimulation such as use of imagery, enactments, music, and drawing are most effective, but verbal means such as repetition and exaggeration of certain key phrases by the client can also be effective in arousing emotion.

In the third category, *emotional restructuring,* the underlying problematic response program needs to be accessed and run in order to make it amenable to restructuring. As Lang (1983) has pointed out, the more the stimulus configuration matches the prototype or internal structure, the more likely it is that the network will be evoked. The presence of the emotional responses themselves, such as the experience of fear, sadness, or anger, is necessary before the experience can be restructured. The therapeutic situation needs to be used as a laboratory for evoking and reprocessing reactions in order to restructure the cognitive/affective/behavioral network or scheme. Restructuring is achieved by admitting new information to the scheme, thereby altering its organization. Interventions ranging from evocative responding (Rice, 1974; Rice & Saperia, 1984) to the use of focusing (Gendlin, 1981) and imagery (Shorr, 1974) to enactments and gestalt two chair dialogues (Greenberg, 1984; Greenberg & Safran, 1987a) help access and set in motion the affective, cognitive, and behavioral response patterns that need to be modified. Once the cognitive–affective network is amenable, different processes of change including awareness, provision of new evidence, generation of schema-inconsistent information, success experience, positive conditioning, and creation of new meanings can all be used to produce restructuring. In our experience, the activation of the network for conscious reevaluation and working through of its contents is highly therapeutic (Greenberg & Safran, 1987a).

In the fourth category, *accessing state-dependent core beliefs,* evocation of emotional experience makes previously inaccessible beliefs available to consciousness. Once available, these state-dependent cognitions and the maladaptive cognitive–affective sequences associated with them become amenable to cognitive modification. As we have elaborated elsewhere (Greenberg & Safran, 1984a, 1984b, 1987a; Safran & Greenberg, 1982a, 1986), it is

often the accessing of the "hot," state-dependent cognitions that is important in cognitive therapy. Thus, by deepening the emotional experience of particular events and intensifying relevant emotional states, the full impact of the beliefs and their effect on experience become available. Once the experience is sufficiently deepened and the core beliefs become accessible, they can be understood both in terms of how they came about and how they act to structure current experience.

The fifth change process involves the *modification* of primary emotional responses. Notwithstanding the biologically adaptive nature of primary emotion, there are instances in which primary responses have become dysfunctional or maladaptive. There are a variety of occasions in therapy when certain entrenched affective responses can present major problems. For example, a negative learning history may have led to a type of conditioned evaluative response (Greenberg & Safran, 1987b; Levey & Martin, 1983), such as fear of harmless stimuli or anger in response to affection. In our view, it is possible to modify the expressive motor response and primary appraisal by modifying the network. This can be done by using a variety of modification procedures, such as exposure to the feared stimuli, restructuring of cognitions, and practice and reinforcement of new responses. The difference between our view and a simple conditioning model is that we regard the learning process as involving the conditioning of subjective evaluations. These subjective evaluations are intrinsically linked to expressive motor responses as components in a total network.

In this article, we have identified a number of classes of emotional change processes. Some of these processes and the therapeutic methods used to promote them have recently begun to be investigated (Beutler et al., in press; Clarke & Greenberg, 1986; Greenberg, 1984, 1986; Johnson & Greenberg, 1985a, 1985b; Pierce, Nichols, & DuBrin, 1983). Further research is needed to evaluate these processes and to establish when and with whom the various classes of emotionally focused interventions are useful.

General Therapeutic Principles

Some of the general principles governing emotionally focused intervention are summarized here to provide an idea of the type of therapeutic style suggested in working with emotion. First, assessment of the ongoing client process is of great significance in working with emotional processes in psychotherapy. Before one chooses whether to access, stimulate, modify, or bypass different expressions, one must make a process diagnosis (Greenberg, 1986; Rice & Greenberg, 1984) as to the current type of processing used by the client. Second, on the basis of this assessment of the client's current state, the therapist intervenes so as to direct the client's internal processing in ways that will change the client's emotional state.

We have suggested (Greenberg & Safran, 1984b, 1987a) that for the purpose of intervention, distinctions initially need to be made at least between the following four broad categories of emotional expression: (a) adaptive primary emotion, (b) secondary emotion, (c) instrumental emotion, and (d) maladaptive primary emotion. We will consider each of these in turn.

Biologically adaptive primary affective responses. These experiences provide information to the organism about its responses to situations. Emotions such as anger at violation, sadness at loss, and fear in response to danger provide adaptive action tendencies to help organize appropriate behavior. Anger mobilizes people for fight, fear for flight, and sadness for recovery of that which has been lost and for reparative grieving. These emotions are often not initially in awareness and are to be accessed and intensified in therapy and used as aids to problem solving.

Secondary reactive emotional responses. These responses are often problematic and are not the organism's direct response to the environment. Rather, they are secondary to some underlying, more primary generating process or are reactions to the thwarting of primary responses. Defensive or reactive responses, such as crying in frustration when angry or expressing anger when afraid, are secondary emotional responses to underlying emotional processes. In addition, emotions such as fear in response to anticipated danger or hopelessness in response to negative expectations are secondary emotional responses to underlying cognitive processes. Secondary reactive responses of these types are not to be focused on or intensified in therapy; rather, they are to be bypassed or explored in order to access underlying processes. Secondary emotions are generally readily available to awareness and often are part of the presenting problem.

Instrumental emotional responses. These responses are emotional behavior patterns that people have learned to use to influence others. These emotions are expressed in order to achieve some intended effect, such as crying in order to evoke sympathy or expressing anger in order to dominate. Instrumental expressions of this type are not information about responses to situations but attempts to influence. In therapy, these expressions are best bypassed, confronted, or interpreted, not explored or differentiated to access adaptive information.

Learned maladaptive primary responses to the environment. Such maladaptive responses include fear in reaction to harmless stimuli or anger in response to caring. As we have suggested, although the emotional response system generally plays an adaptive role in human functioning, maladaptive responses can be learned as a function of trauma or strongly negative environmental contingencies in childhood. These emotions then need to be accessed in therapy, but they are to be modified, rather than used for orientation.

Assessing the type of emotion being expressed in therapy thus provides the clinician with a notion of what to do and when. Primary and maladaptive expression, as opposed to secondary and instrumental expression, need to be accessed in therapy, and for different purposes. Primary adaptive emotion is accessed for its orientation information, whereas maladaptive emotion is accessed to make it more amenable to modification and restructuring.

Secondary and instrumental expression are bypassed and often dampened in order to get at underlying experience.

When the therapist, on the basis of an assessment of the client's current mode of emotional processing, decides that it is therapeutically appropriate to access emotion, the following general principles of intervention are used (Greenberg & Safran, 1987a): (a) directing attention to inner experience, (b) refocusing on inner experience, (c) encouraging present centeredness, (d) analyzing expression, (e) intensifying experience, (f) symbolizing experience, and (g) establishing intents. These principles are based on a distillation of the essential therapist operations involved in the practice of emotionally focused interventions (Gendlin, 1981, Greenberg & Safran, 1987a; Perls et al., 1951; Polster & Polster, 1973; Rogers, 1959). These principles of therapeutic process guide the moment-by-moment interventions of the therapist in an approach to therapy that is highly attuned to shifts in the ongoing experiential process in the client.

Working with these principles, the therapist directs the client's information processing in particular ways, and this deepens experience and promotes the generation of new meaning. The primary operation involves directing attentional allocation. Emotion is accessed by directing clients to *attend* to their internal experience. The therapist can direct the client's attention by directly suggesting that the client attend to what he or she is feeling, or by asking "what are you experiencing?" or by directing a response at the client's internal experience, such as "I hear some sadness as you say this." If and when clients move their attentional allocation away from their internal experience, the therapist *refocuses* the clients' attention inward to attend to bodily felt experience (Gendlin, 1981). Refocusing involves noticing when clients deflect from a description of an internal experiential track and redirecting them to this inner track. The focus in accessing affect is predominantly on what is occurring in the *present* in clients' experience. Affect is being synthesized in the present from elements that are currently activated. The therapist therefore brings clients' attentional focus to what is occurring internally right now. Whatever is currently occurring is of greatest interest, be it a memory of the past, a present sensation, or an anticipation of the future: Its present liveliness is of greatest importance. In addition to focusing on current bodily felt experiences, the therapist carefully analyzes clients' manner of verbal and nonverbal *expression,* as it is occurring, as an important source of information about affective states. Facial, postural, and vocal expression convey a great deal about what a person is feeling. How things are said is often as informative as what is being said. Sighs, gestures, glances, and movements all convey a vast amount of information about a person's state. It is important for the therapist to use these as cues for refocusing the client on his or her concerns. The client is thus directed to attend to and use this information. It is often the more indirect observation of a nonverbal expression that is most effective. Rather than saying directly "Become aware of your face or your posture," the therapist will ask "What do you feel as you curl your lip, or as you hang your head?" Asking clients what they feel as they sigh can often rapidly connect them to a well of inner experience.

Emerging experience is *intensified* by increasing the person's general level of arousal. This makes the experience more vivid and clear. Arousal can be increased by engaging clients in physical activities such as hitting, yelling, or moving or by increasing the vividness of imaginal representations. Experience can also be intensified by enacting what is being talked about; for example, a client can curl up into a ball or take on a pleading position to heighten the relevant experience. Exaggeration or repetition of phrases such as "I needed someone to take care of me" or gestures such as wagging a scolding finger also serve to intensify experience. Indiscriminate intensification of emotion without accurate assessment of the correct primary emotion to intensify, however, can be highly unproductive and often harmful. Intensification should therefore be used only by therapists comfortable with and knowledgeable about working with emotion. The final principles involve working with clients toward *symbolizing* their current experience and *stating intentions* based on needs or wants. The latter two principles serve to promote the creation of new meaning and the provision of a sense of direction for action in the world. Symbolization of experience makes the inner world more amenable to clarification and elaboration and more available for recall. In this process, patterns of meaning are drawn from, rather than imposed on, experience. After the client has become aware of feelings and begun to symbolize experience, the therapist moves the client toward statements of intent. It is only after the feelings are in awareness that the action tendency associated with them can be sensed. The therapist often asks what the client needs or wants based on newly experienced feeling in order to get at the directional tendency of the emotion. This action tendency is then integrated with goals, plans, and reality assessments of the situation to form an intention. The establishment of intentions forms the bridge between subjective experience and action in the world.

Thus, in an emotionally focused intervention, the therapist tracks the client's moment-by-moment experience. The therapist works continually to highlight and develop aspects of the client's experience, focusing on a phrase here or a gesture there. A particular vocal quality may serve to indicate a direction for deepening an experience, a sigh may suggest the client's sense of sadness, or the shape of the mouth may indicate tearfulness. All these emerging experiences are supported by the therapist until an experientially based core scheme emerges. The accessing of emotion is thus primarily a process of directing the client to attend to internal information and supporting the construction of new meaning structures based on the newly accessed experiential information.

These principles describe a style of therapeutic intervention that, guided as it is by the emerging experience of the moment, is inherently nonlinear. Accessing feeling is not a method of intervention that operates according to normal rules of interaction in which there is a logical

linear interchange. Rather, the therapist responds to the client's expressions of the moment, to a sigh, a gesture, a poignant phrase, a tone of voice, or a vivid memory fragment as each emerges. From this nonlinear base of the client's parallel processing, momentary experience is focused on and elaborated to build toward an integrative coherent new meaning. In this way, the therapist brings out clients' essential experience of the moment and helps them create new meanings based on the experience.

In order for these principles and style of therapy to be effective, therapists need to create particular types of relationship contexts that will support the intense inner concentration needed for focusing on emotion. Therapists need to establish good therapeutic alliances (Bordin, 1979) with their clients, alliances in which the emotional bonds between them will promote the exploration of clients' internal experience. Without a relationship bond in which clients feel accepted, safe, and supported, they will not enter into exploration of their feelings.

In addition to this sense of acceptance in the "safe enough" environment, a good working alliance requires that clients sense they are working together with their therapists to overcome the obstacles in their paths and that clients feel hopeful or optimistic that what they are doing in therapy will help (Alexander & Luborsky, 1986; Greenberg & Pinsof, 1986). In order to promote affective work in therapy, clients must feel that they are in agreement with their therapists as to the goals of therapy and that the affective tasks in which they are engaged are relevant to these goals (Bordin, 1979; Horvath & Greenberg, 1986). Without these relationship conditions, no amount of focusing an affect will produce the experiential process that we have described.

Conclusion

The role of emotion in psychotherapeutic change is both vitally important and complex. No single concept such as "catharsis" does it justice. Possibly, because of the apparent inexplicability of the "passions," theorists and therapists alike have until recently stayed away from attempting to explain and investigate this most human of all phenomena. As investigators begin to explicate different categories of emotional expression in therapy, different processes of affective change, and different principles of intervention, we hope that the fog that has shrouded the role of emotion in psychotherapy will begin to lift and allow us to specify and measure how emotion is involved in therapeutic change. Unless we grapple with the role of emotion in therapy, our understanding of the human change process will remain hollow, missing some of the vital elements of what makes psychotherapy a potentially powerful change process.

REFERENCES

Alexander, F., & French, T. (1946). *Psychoanalytic therapy.* New York: Ronald.

Alexander, L., & Luborsky, L. (1986). The Penn. Helping Alliance Scales. In L. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325–366). New York: Guilford Press.

Arnold, M. B. (1960). *Emotion and personality* (Vols. 1–2). New York: Columbia University.

Arnold, M. B. (1970). *Feelings and emotions.* New York: Academic Press.

Basch, M. F. (1976). The concept of affect: A re-examination. *Journal of the American Psychoanalytic Association, 26,* 759–777.

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

Beutler, L., Daldrup, R., Engle, D., Oro-Beutler, M., Meredith, K., & Boyer, J. (in press). Effects of therapeutically induced affect arousal on depressive symptoms, pain and endorphins among rheumatoid arthritis patients. *Pain.*

Bohart, A. (1977). Role playing and interpersonal conflict reduction. *Journal of Counseling Psychology, 24,* 15–24.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Borkovec, T. D., & Grayson, J. B. (1980). Consequences of increasing the functional impact of internal emotional stimuli. In K. R. Blankenstein, P. Pliner, & J. Polivy (Eds.), *Assessment and modification of emotional behavior.* New York: Plenum.

Borkovec, T., & Sides, J. (1979). The contribution of relaxation and expectancy to fear reduction. *Behaviour Research and Therapy, 17,* 529–540.

Bradbury, T., & Fincham, F. (1987). Assessment of affect in marriage. In K. D. O'Leary (Ed.), *Assessment of marital discord* (pp. 121–168). Hillsdale, NJ: Erlbaum.

Buck, R. (1984). *The communication of emotion.* New York: Guilford Press.

Buck, R. (1985). Prime theory: An integrated view of motivation and emotion. *Psychological Review, 92,* 389–413.

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

Crowe, M. J., Marks, I. M., Agras, W. S., & Leitenberg, H. (1972). Time-limited desensitization, implosion and shaping for phobic patients: A crossover study. *Behaviour Research and Therapy, 10,* 319–328.

Custers, A. (1973). De manier van ervaren in het terapeuitisch process. *Psychologica Belgica, 13,* 125–138.

Daldrup, R., Beutler, L., Engle, D., & Greenberg, L. (1988). *Focused expressive psychotherapy: Freeing the overcontrolled patient.* New York: Guilford Press.

Davison, G. (1980). Psychotherapy process. *Cognitive Therapy and Research, 6,* 269–306.

Dittes, S. J. (1957). Extinction during psychotherapy of GSR accompanying "embarrassing" statements. *Journal of Abnormal and Social Psychology, 54,* 187–191.

Eagle, M. (1984). *Recent developments in psychoanalysis.* New York: McGraw-Hill.

Ekman, P. (Ed.). (1972). *Darwin and facial expression: A century of research in review.* New York: Academic Press.

Ekman, P., & Friesen, W. V. (1975). *Unmasking the face.* Englewood Cliffs, NJ: Prentice Hall.

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

Fairbairn, W. R. (1962). *An object relations theory of personality.* New York: Basic Books.

Fishman, D. (1971, September). *Empirical correlates of the Experiencing Scale.* Paper presented at the meeting of the American Psychological Association, Washington, D.C.

Foa, E., & Kozak, M. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20–31.

Freud, S. (1895). *Studies on hysteria* (standard ed., Vol. 2). London: Hogarth Press.

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

Gendlin, E. T. (1981). *Focusing.* New York: Bantam.

Gendlin, E. T., Beebe, J., Cassens, J., Klein, M., & Oberlander, M. (1968). Focusing ability in psychotherapy, personality, and creativity. In J. M. Schlein (Ed.), *Research in psychotherapy* (Vol. 3). Washington, DC: American Psychological Association.

Goldman-Eisler, F. (1956). A contribution to the objective measurement of the cathartic process. *Journal of Mental Science, 102,* 78–95.

Gordon, J. E. (1957). Leading and following psychotherapeutic techniques with hypnotically induced repression and hostility. *Journal of Abnormal and Social Psychology, 54,* 405–410.

Gray, J. A. (1982). Precis of the neuropsychology of anxiety. *The Behavioral and Brain Sciences, 5,* 464–534.

Green, R., & Murray, E. (1975). Expression of feeling and cognitive reinterpretation in the reduction of hostile aggression. *Journal of Consulting and Clinical Psychology, 43,* 375–383.

Greenberg, L. S. (1984). A task analysis of intrapersonal conflict resolution. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 67–123). New York: Guilford Press.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54,* 4–9.

Greenberg, L. S., & Johnson, S. (1985) Emotionally focused couples therapy: An affective systemic approach. In N. Jacobson & A. Gurman (Eds.), *Handbook of clinical and marital therapy* (pp. 253–276). New York: Guilford Press.

Greenberg, L. S., & Johnson, S. (1986a). Affect in marital therapy. *Journal of Marital and Family Therapy, 12,* 1–10.

Greenberg, L. S., & Johnson, S. (1986b). When to evoke emotion and why. *Journal of Marital and Family Therapy, 12,* 19–23.

Greenberg, L. S., & Johnson, S. (1988). *Emotionally focused therapy for couples.* New York: Guilford Press.

Greenberg, L. S., & Kahn, S. (1978). Experimentation. A gestalt approach to counselling. *Canadian Counsellor, 13,* 23–27.

Greenberg, L. S., & Pinsof, W. (Eds.). (1986). *The psychotherapeutic process: A research handbook.* New York: Guilford Press.

Greenberg, L. S., & Rice, L. N. (1981). The specific effects of a Gestalt intervention. *Psychotherapy: Theory, Research and Practice, 18,* 31–37.

Greenberg, L. S., & Safran, J. D. (1981). Encoding and cognitive therapy: Changing what clients attend to. *Psychotherapy: Theory, Research and Practice, 18,* 163–169.

Greenberg, L. S., & Safran, J. D. (1984a). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive therapy and research, 8,* 559–578.

Greenberg, L. S., & Safran, J. D. (1984b). Hot cognition: Emotion coming in from the cold. A reply to Rachman and Mahoney. *Cognitive Therapy and Research, 8,* 591–598.

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

Greenberg, L. S., & Safran, J. D. (1987b). Emotion, cognition and action. In H. Eysenck & I. Martin (Eds.), *Foundations of behavior therapy* (pp. 295–314). New York: Plenum Press.

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

Grossman, D. (1952). An experimental investigation of a psychotherapeutic technique. *Journal of Consulting Psychology, 16,* 325–331.

Guidano, V. (1987). *Complexity of the self.* New York: Guilford Press.

Guidano, V. F., & Liotti, G. (1983). *Cognitive processes and emotional disorders.* New York: Guilford Press.

Haggard, E. A., & Murray, H. A. (1942). The relative effectiveness of three therapy procedures on the reduction of experimentally induced anxiety. *Psychological Bulletin, 39,* 439–441.

Hekmat, H. (1973). Systematic versus semantic desensitization and implosive therapy: A comparative study. *Journal of Consulting and Clinical Psychology, 40,* 202–209.

Hogan, R. A., & Kirchner, J. H. (1967). A preliminary report of the extinction of learned fears via short term implosive therapy. *Journal of Abnormal Psychology, 72,* 106–111.

Horvath, A., & Greenberg, L. S. (1986). The development of the working alliance inventory. In L. S. Greenberg & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: Guilford.

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

Izard, C. E. (Ed.). (1979). *Emotion in personality and psychopathology.* New York: Plenum Press.

Janov, A. (1970). *The primal scream.* New York: Dell.

Johnson, S. M. (1986). Bonds or bargains: Relationship paradigms and their significance for marital therapy. *Journal of Marriage and Family Therapy, 12,* 259–267.

Johnson, S. M., & Greenberg, L. S. (1985a). The differential effects of experiential and problem solving interventions in resolving marital conflict. *Journal of Consulting and Clinical Psychology, 53,* 175–184.

Johnson, S. M., & Greenberg, L. S. (1985b). Emotionally focused marital therapy: An outcome study. *Journal of Marital and Family Therapy, 11,* 313–317.

Kahn, S., & Greenberg, L. (1980). Beyond a cognitive-behavioral approach: Congruent assertiveness training. In C. S. Adamec (Ed.), *Sex roles: Origins, influences and implication for women* (pp. 127–138). Toronto: Eden Press.

Karle, W., Corriere, R., & Hart, J. (1973). Psychophysiological changes in abreaction therapy. Study I: Primal therapy. *Psychotherapy: Theory, Research and Practice, 10,* 117–123.

Karle, W., Corriere, R., Hart, J., Gold, S., Maple, C., & Hopper, M. (1976). The maintenance of psychophysiological changes in feeling therapy. *Psychological Reports, 39,* 1143–1147.

Keet, C. D. (1948). Two verbal techniques in a miniature counselling situation. *Psychological Monographs, 62,* No. 294.

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

Kiesler, D. J., Mathieu, P. L., & Klein, M. H. (1967). Patient experiencing level and interaction-chronograph variables in therapy interview segments. *Journal of Consulting and Clinical Psychology, 31,* 224.

Kirtner, W. L., Cartwright, D. S., Robertson, R. J., & Fiske, D. W. (1961). Length of therapy in relation to outcome and change in personal integration. *Journal of Consulting Psychology, 25,* 84–88.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. (1986). The Experiencing Scales. In L. S. Greenberg, & W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook.* New York: Guilford.

Lang, P. J. (1977). Imagery in therapy. An information processing analysis of fear. *Behavior Therapy, 8,* 862–886.

Lang, P. J. (1983). Cognition in emotion: Concept and action. In C. Izard, J. Kagan, & R. Zajonc (Eds.), *Emotion, cognition and behaviour* (pp. 192–226). New York: Cambridge University Press.

Lang, P. J. (1985). The cognitive psychophysiology of emotion: Fear and anxiety. In A. H. Tuma & J. D. Maser (Eds.), *Anxiety and the anxiety disorders* (pp. 130–170). Hillsdale, NJ: Erlbaum.

Lazarus, R. S. (1984). On the primacy of cognition. *American Psychologist, 39,* 124–129.

Leventhal, H. (1979). A perceptual-motor processing model of emotion. In P. Pliner, K. Blankstein, & I. M. Spigel (Eds.), *Perception of emotion in self and others* (Vol. 5, pp. 1–46). New York: Plenum Press.

Leventhal, H. (1982). The integration of emotion and cognition: A view from the perceptual-motor theory of emotion. In M. S. Clarke & S. T. Fiske (Eds.), *Affect and cognition: The 17th Annual Carnegie Symposium on Cognition* (pp. 121–156). Hillsdale, NJ: Erlbaum.

Leventhal, H. (1984). A perceptual-motor theory of emotion. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 117–182). New York: Academic Press.

Levey, A., & Martin, I. (1983). Cognitions, evaluations and conditioning: Rules of sequence and rules of consequence. *Advances in Behaviour Research and Therapy, 4,* 181–195.

Levis, D. J., & Carrera, R. N. (1967). Effects of 10 hours of implosive therapy in the treatment of outpatients: A preliminary report. *Journal of Abnormal Psychology, 72,* 504–508.

Levison, P. K., Zax, M., & Cowen, E. L. (1961). An experimental analogue of psychotherapy for anxiety reduction. *Psychological Reports, 8,* 171–178.

Lewis, M., & Michalson, L. (1983). *Children's emotions and moods.* New York: Plenum Press.

Liotti, G. (1986). Structural cognitive therapy. In W. Dryden & W. Golden (Eds.), *Cognitive behavioral approaches to psychotherapy* (pp. 92–128). London, Harper & Row.

Liotti, G. (1987). The resistance to change of cognitive structures: A counterproposal to psychoanalytic metapsychology. *Journal of Cognitive Psychotherapy: An International Quarterly, 1,* 87–104.

Luborsky, L., Chandler, M., Auerbach, A. H., Cohen, J., & Bachrach, H. M. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. *Psychological Bulletin, 75,* 145–185.

Mahoney, M. (1984). Integrating affect and cognition: A comment. *Cognitive Therapy and Research, 8,* 585–589.
Mahoney, M. (1987). The cognitive sciences and psychotherapy: Patterns in a developing relationship. In K. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 357–386). New York: Guilford Press.
Martin, B., Lundy, R., & Lewin, M. (1960). Verbal and G.S.R. responses in experimental interviews as a function of three degrees of "therapist" communication. *Journal of Abnormal and Social Psychology, 60,* 234–240.
Mealiea, W. L., & Nawas, M. M. (1971). The comparative effectiveness of systematic desensitization and implosive therapy in the treatment of snake phobia. *Journal of Behavior Therapy and Experimental Psychiatry, 2,* 85–94.
Michelson, L., Mavissakalian, M., & Marchione, K. (1985). Cognitive and behavioral treatments of agoraphobia: Clinical, behavioral, and psychophysiological outcomes. *Journal of Consulting and Clinical Psychology, 53,* 913–925.
Mylar, J. L., & Clement, P. W. (1972). Prediction and comparison of outcome in systematic desensitization and implosion. *Behaviour Research and Therapy, 10,* 235–246.
Nichols, M. P. (1974). Outcome of brief cathartic psychotherapy. *Journal of Consulting and Clinical Psychology, 42,* 403–410.
Nichols, M. P., & Zax, M. (1977). *Catharsis in psychotherapy.* New York: Gardner Press.
Orenstein, H., & Carr, J. (1975). Implosion therapy by tape recording. *Behaviour Research and Therapy, 13,* 177–181.
Orlinsky, D. E., & Howard, K. I. (1978). The relation of process to outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). New York: Wiley.
Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311–381). New York: Wiley.
Panskepp, J. (1982). Toward a general psychological theory of emotions. *The Behavioral and Brain Sciences, 5,* 407–467.
Perls, F. S. (1973). *The Gestalt approach and eye witness to therapy.* Palo Alto, CA: Science and Behavior Books.
Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy.* New York: Dell.
Pierce, R. A., Nichols, M. P., & DuBrin, J. R. (1983). *Emotional expression in psychotherapy.* New York: Gardner Press.
Plutchik, R. (1980). *Emotion: A psychoevolutionary synthesis.* New York: Harper & Row.
Polster, E., & Polster, M. (1973). *Gestalt therapy integrated.* New York: Brunner/Mazel.
Rachman, S. (1978). *Fear and courage.* San Francisco: Freeman.
Rachman, S. (1980). Emotional processing. *Behaviour Research and Therapy, 18,* 51–60.
Rachman, S. (1981). The primacy of affect: Some theoretical implications. *Behaviour Research and Therapy, 19,* 279–290.
Rapaport, D. (1967). *The collected papers of David Rapaport* (M. Gill, Ed.). New York: Basic Books.
Reich, W. (1949). *Character analysis.* New York: Noonday Press.
Rice, L. (1974). The evocative function of the therapist. In D. Wexler & L. Rice (Eds.), *Innovations in client-centered therapy* (pp. 289–311). New York: Interscience.
Rice, L., & Greenberg, L. (1984). *Patterns of change: Intensive analysis of psychotherapeutic process.* New York: Guilford Press.
Rice, L. N., & Saperia, E. (1984). A task analysis of the resolution of problematic reactions. In L. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapeutic process* (pp. 29–66). New York: Guilford Press.
Richert, A. J. (1976). Expectations, experiencing and change in psychotherapy. *Journal of Clinical Psychology, 32,* 438–444.
Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95–103.
Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science* (Vol. 3, pp. 184–256). New York: McGraw-Hill.
Ruesch, J., & Prestwood, A. R. (1949). Anxiety: Its initiation, communication and interpersonal management. *Archives of Neurology and Psychiatry, 62,* 527–550.
Safran, J., & Greenberg, L. S. (1982a). Cognitive appraisal and reappraisal: Implications for clinical practice. *Cognitive Therapy and Research, 6,* 251–258.
Safran, J., & Greenberg, L. S. (1982b). Eliciting "hot cognitions" in cognitive therapy. *Canadian Psychology, 23,* 83–87.
Safran, J. D., & Greenberg, L. S. (1986). Hot cognition and psychotherapy process: An information processing/ecological approach. In P. Kendall (Ed.), *Advances in cognitive-behavioral research and therapy* (Vol. 5, pp. 143–177). New York: Academic Press.
Safran, J. D., & Greenberg, L. S. (in press). The treatment of anxiety and depression: The process of affective change. In P. C. Kendall & D. Watson (Eds.), *Anxiety and depression: Distinctive and overlapping features.* Orlando, FL: Academic Press.
Schafer, R. (1983). *The analytic attitude.* New York: Basic Books.
Shorr, J. E. (1974). *Psychotherapy through imagery.* New York: Intercontinental Medical Corp.
Simon, H. A. (1967). Motivational and emotional controls of cognition. *Psychological Review, 74,* 29–39.
Skinner, B. F. (1953). *Science and human behavior.* New York: Macmillan.
Stoler, N. (1963). Client likeability: A variable in the study of psychotherapy. *Journal of Consulting and Clinical Psychology, 27,* 175–178.
Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *International Journal of Psychoanalysis, 15,* 127–159.
Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.
Tomkins, S. S. (1962). *Affect, imagery, consciousness, Vol. 1. The positive affects.* New York: Springer.
Tomlinson, T. M. (1967). The therapeutic process as related to outcome. In C. R. Rogers, E. T. Gendlin, D. J. Kiesler, & C. B. Truax (Eds.), *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison: University of Wisconsin Press.
Tomlinson, T. M., & Hart, J. T. (1962). A validation of the process scale. *Journal of Consulting Psychology, 26,* 74–78.
Tomlinson, T. M., & Stoler, N. (1967). The relationship between affective evaluation and ratings of therapy process and outcome with schizophrenics. *Psychotherapy: Theory, Research and Practice, 4,* 14–18.
van der Veen, F. (1967). Basic elements in the process of psychotherapy. *Journal of Consulting Psychology, 31,* 295–301.
Walker, A., Rablen, R. A., & Rogers, C. R. (1966). Development of a scale to measure process change in psychotherapy. *Journal of Clinical Psychology, 16,* 79–85.
Wexler, D. A. (1974). A cognitive theory of experiencing self actualization and therapeutic process. In D. A. Wexler & L. N. Rice (Eds.), *Innovations in client-centered therapy* (pp. 49–116). New York: Wiley.
Wiener, M. (1955). The effects of two experimental counseling techniques on performance impaired by induced stress. *Journal of Abnormal and Social Psychology, 51,* 565–572.
Woldenburg, L. (1976). Psychophysiological changes in feeling therapy. *Psychological Reports, 39,* 1059–1062.
Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist, 35,* 151–175.
Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist, 39,* 117–123.