Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. **24**, 212–225 (2017)
Published online 11 January 2016 in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.1998

Developing Emotion-Based Case Formulations: A Research-Informed Method

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Objectives: New research-informed methods for case conceptualization that cut across traditional therapy approaches are increasingly popular. This paper presents a trans-theoretical approach to case formulation based on the research observations of emotion.
Methods: The sequential model of emotional processing (Pascual-Leone & Greenberg, 2007) is a process research model that provides concrete markers for therapists to observe the emerging emotional development of their clients. We illustrate how this model can be used by clinicians to track change and provides a 'clinical map,' by which therapist may orient themselves in-session and plan treatment interventions.
Results: Emotional processing offers as a trans-theoretical framework for therapists who wish to conduct emotion-based case formulations. First, we present criteria for why this research model translates well into practice. Second, two contrasting case studies are presented to demonstrate the method.
Conclusions: The model bridges research with practice by using client emotion as an axis of integration.
Key Practitioner Message

- Process research on emotion can offer a template for therapists to make case formulations while using a range of treatment approaches. The sequential model of emotional processing provides a 'process map' of concrete markers for therapists to (1) observe the emerging emotional development of their clients, and (2) help therapists develop a treatment plan. Copyright © 2016 John Wiley & Sons, Ltd.

Keywords: Case Formulation, Emotion, Process, Case Conceptualization, Zone of Proximal Development, Psychotherapy Integration

INTRODUCTION

In this paper we present case studies, using a common theoretical framework that focuses on emotion. A research-based model of emotional processing is applied as a template to two different clients; *Sally* and *Beth* (pseudonyms) benefitted from this approach but were treated using different approaches, emotion-focused therapy (EFT) and dialectical behaviour therapy (DBT), respectively. Consequentially, they both worked with emotion, each in very different ways. Both clients were treated by the first author in the context of psychotherapy research clinics.

First, we develop the rationale for using research-based models of change to inform case conceptualization. Following this, we present a more recent empirically supported process model by Pascual-Leone and Greenberg (2007) which describes a sequential model of emotional processing. A model, which we believe can be fruitfully used as a template to consider and discuss individual clinical cases in a manner that cuts across treatment perspectives to formulate 'emotion-oriented understandings of change.'

Second, we provide two case descriptions in order to demonstrate how this model can be used. For each case we outline (1) the initial assessment information, (2) a formulation of both clinical difficulties and treatment foci, (3) how this process model informed treatment planning for two quite different forms of treatment and (4) the process of exploring relevant interventions from within a given treatment approach. The overall aim of these case presentations is not to present research or outcome data but rather to offer knowledge translation: to illustrate how a model derived from process research can translate into clinical practice for psychotherapists interested in working along an 'axis' of emotional.

RATIONALE FOR BASING CASE CONCEPTUALIZATIONS ON PROCESS RESEARCH

Case Formulation is a Bridge from Research to Practice

It is routinely noted that one of the most challenging issues facing psychologists has been the 'gap' between researchers and practitioners, or the failure to see research

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findings translated into the regular practice of clinicians (Goldfried, 2010a; Teachman *et al.,* 2012). More often than not, research produces global statements about groups of clients, which are difficult to translate directly into ones practice and in working with individual clients (Pascual-Leone *et al.,* 2014). However, using process-based models of change can provide intuitive findings that help bridge this gap.

As Worthen and Lambert (2007) have pointed out with some alarm, a clinician's years of training, experience and even receiving supervision do not seems to produce overall improvements in client outcomes. At the same time, while case formulation is recognized as essential to best practices, it has been surprisingly overlooked as a focus of research. One of the few exceptions to this is the work of Eells and colleagues who demonstrated that using a systematic method for case formulation is what most differentiates expert from novice psychotherapists (showing an effect of $r = 0.55$; Eells *et al.,* 2005). While their study did not relate case formulation directly to client outcomes, very recent work by Kramer, Kolly and colleagues (Kramer *et al.,* 2014) have done just that. By using *plan analysis*, a systematic and contemporary approach to case formulation, they showed that the method of case formulation produced *additional* symptom reductions ($d = 0.64$) and a stronger therapeutic alliance. Findings like this are very promising and point towards the need for more development of empirically based methods of case formulations. However, for this to be maximally useful, case formulations methods must be both supported by process research and should be applicable across different treatment approaches. We believe the emotion-based method presented in this paper holds particular promise. Finally, as suggested by Jose and Goldfried (2008), such methods will be especially useful in training future psychotherapists.

What Makes a Research Model Suitable for Application to Practice?

For a process model to change hands from researchers to clinicians, we believe it must be: (1) grounded in micro-processes that are observable by therapists working in a given session, (2) fluid and dynamic so the model accommodates a range of idiosyncratic client change and even so (3) still be meaningful at the macro-level where psychotherapists do case conceptualization and treatment planning.

Stay Grounded in What is Happening In-Session

For psychotherapy research to be most useful to clinical practice it must be anchored to phenomena that unfold in-session where therapists witness and engage the client's process. However, before research models can become immediately useful, they often must be grounded enough to help therapists observe certain key in-session events. Goldman and Greenberg (2015) referred to this as *process diagnosis*, which is essentially how therapists orient themselves; addressing therapist questions like: 'what is happening right now?' and 'is this particular process useful? Or promising?' Thus, therapists can benefit from the jargon-free operationalization and clinical clarity of process research models. Such models will be most helpful when they speak to processes that are directly observable as in-session events (Pascual-Leone *et al.,* 2014).

Provide a Framework for Anticipating Dynamic Changes

Real changes in emotion or insight are dynamic when they happen in-session. Thus, research models hoping to offer palpable support to a clinician must provide intuitive structure for tracking those dynamic in-session changes moment-by-moment, where intervention matters most. Concretely, this means helping therapist answer questions like: 'Where are we in the process?' and 'what is in the proximal zone of emotional development at this precise moment?' In short, psychotherapy change is not linear, and for research models to translate well into practice 'on the front line' they must be flexible enough to accommodate this dynamic and recursive process.

Be Meaningful on the Macro-Level of Case Formulation and Treatment Planning

Finally, although some research models make sense on a moment-by-moment level, they must also be meaningful at a broader level, so therapists can use them between sessions for treatment planning and developing case formulations. A process model of this kind must provide guidance in directing the treatment, addressing therapist questions like: 'What is the core issue or difficulty of this client?', 'what kind of clinical change would provide the most improvement, and be most feasible, for this client?' and 'What might a good outcome or resolution look like for this particular case?' In short, research that supports case formulation should help a therapist decide what client process (i.e., unhelpful emotions) to bypass and what other processes (i.e., productive emotions) to focus on in the service of treatment goals.

While final treatment outcomes are the end goal, a clinician's actual work happens at the level of single sessions and events. Moreover, while clinicians often alternate between both frameworks (i.e., nesting interventions into their case formulation and treatment plans), many research models appeal to only one level of analysis. Thus, whatever the treatment approach, research models that help a clinician to perceive dynamic in-session processing events, *and also* help them consider a client's overarching treatment needs, will offer the most utility to clinical work. Greenberg (1991) has long argued for an approach to research in which the markers of client process are used as a basis of inquiry and this method lends itself to

empirical models that are meaningful at different scopes of analysis. The advantages to process assessment is that it supports clinicians in both appraising client progress and in ongoing case formulation (Goldman & Greenberg, 2015; Pascual-Leone *et al.*, 2014).

Sequential Patterns of Emotional Processing: Implications for Practice

In the following section we present Pascual-Leone and Greenberg's (2007) trans-theoretical model of emotional processing, focused on the sequential nature of emotions in productive treatment sessions. This process research model of emotion meets the three criteria we have described above as important for bridging the gap between research and practice.

Emotional Processing as an Integrative Focus

In early work, emotional processing was defined from a behavioural perspective as the 'absorption' of a specific emotional experience, such that the emotion is no longer problematic (Rachman, 1980). Based on this definition, emotional processing was essentially conceptualized in the context of exposure therapy (e.g., Foa & Kosak, 1986). Then, Greenberg and Paivio (1997) differentiated between categories of emotion: primary adaptive vs. primary maladaptive emotions, and setting both of these apart from either secondary or instrumental emotions. While this understanding is intuitively useful for theory, a key unanswered question, however, was how these categories of emotion concretely manifest themselves, and how they actually unfold over the course of psychotherapy. In other words: what *specific and observable criteria* can the theory offer to clinicians?

Today, emotion-oriented models of psychotherapy from several approaches refer to a broader definition of emotional processing, as a sequential pattern of emotion and evocation, meaning-making and transformation into a subsequent series of affective-meaning states (for a review see Pascual-Leone *et al.*, in press). Emotion, which entails both affective arousal and meaning-making components, is conceptualized as a dynamic self-organization which emerges at some point in time, and then often subsides, giving way to other subsequent albeit inherently related emotions. Moreover, this client process unfolds sometimes spontaneously and at other times effortfully. As a self-organizing process the client tries both to regulate emotion and to engage it in the search for meaning (Pascual-Leone *et al.*, 2016). From a phenomenological perspective, when a client presents with aroused distress at a given moment in time, features of the next emotional states in a productive process, although nascent, are already implicitly packed into the presenting moment. Thus, the emergence of a new emotional self-organization is freshly created from these tendrils of thought and feeling but they await evocation, unfolding and construction.

The Sequential Model of Emotional Processing

Pascual-Leone and Greenberg (2007) developed Greenberg and Paivio's (1997) conceptualization when they empirically modeled emotional sequences that predicted good outcomes (see Figure 1). The sequence for emotional processing in a productive session begins with (phase 1, Figure 1) 'global distress,' a term they coined to refer to undifferentiated feeling that was high in arousal but low in meaningfulness (a type of secondary emotion, e.g., helplessness, symptomatic anxiety). This distress is then ultimately differentiated into core maladaptive emotions in the form of either fear and/or shame (phase 2, Figure 1) . Their work also highlighted that when sadness and loneliness are truly problematic it is either undifferentiated (global distress) or it ultimately entails a sense of either shame ('I am inadequate/unlovable') or fear ('I am incapable/will not survive alone'). The model also showed how global distress can alternatively lead non-linearly to rejecting and destructive anger (another type of secondary emotion, and with a potentially complex relationship to more primary forms of anger). Next, in a critical step (middle of Figure 1) the model highlights that maladaptive emotion necessarily entails both an 'unmet existential need' (for either attachment or mastery) and a fundamentally 'negative self-evaluation' (i.e., an affectively driven core dysfunctional belief about the self). These two aspects of experience, an unmet need versus a core negative self-evaluation, are in direct contradiction and create a seemingly impossible situation. This is the point where a client's self-critical process (e.g., related to shame, depression, self-doubt, anxiety) is worked through. Finally, (phase 3, Figure 1) identifying a core unmet need and resolving the ensuing contradiction often ushers in a categorically new experience, one that leads the client to a sense of self as deserving and mobilizes him or her to directly address unmet needs.

This final step is an advanced affective-meaning process and takes the form of key emotions that are both primary and adaptive. Namely, on the one hand, these emotions are assertive anger (fighting for some need) or self-compassion and soothing, while in contrast, the client confronts grief over a loss. These are the emotions through which fear and shame are 'undone' and long standing interpersonal difficulties (e.g., complex trauma, unfinished business, attachment issues) are resolved. These, non-linear patterns of emotion have been identified as forms of emotional transformation, leading clients to resolve personal difficulties in the form of letting go and acceptance (bottom of Figure 1).

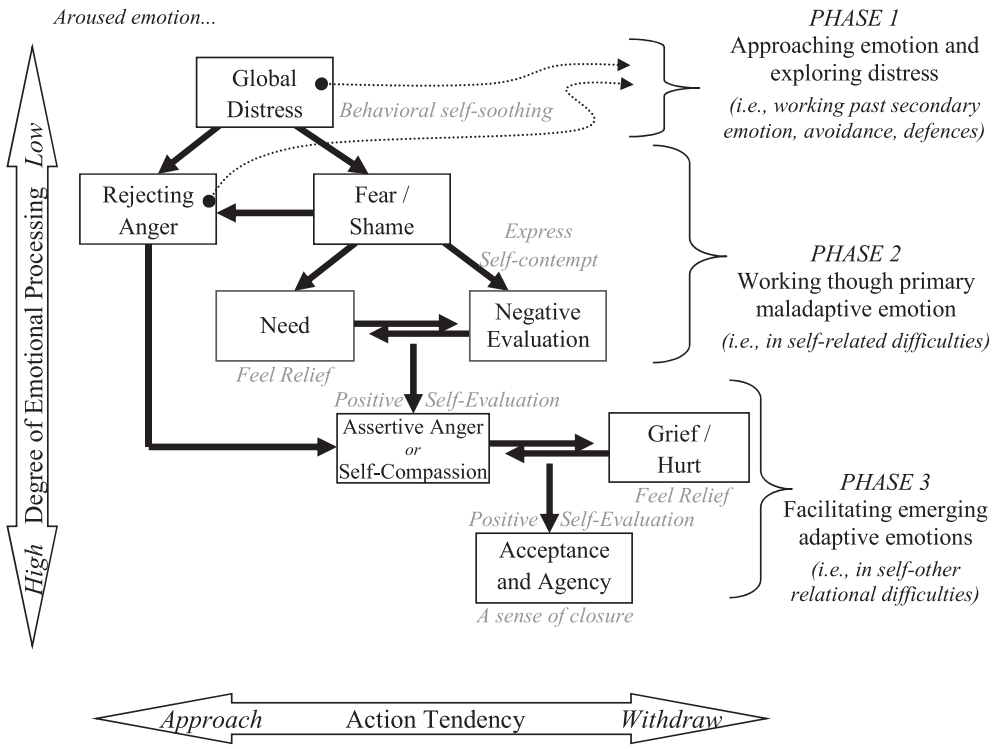

Figure 1. *A sequential model of emotional processing* (modified from Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2005a)

A Trans-theoretical 'Process Map' for Case Formulation

Supporting Research from Across Treatments and Disorders

While the initial research was conducted on experiential therapy, the concrete and observable criteria used in Pascual-Leone and Greenberg's (2007) model are a-theoretical and describe sequences of emotional processing that intuitively appeal to psychotherapists across treatment approaches. The argument that this method of case formulation may apply *trans*-theoretically is based on the study of over 300 clients representing treatment cases from almost in all major orientations, including: emotion focused therapy (Choi *et al.*, 2015; Haberman *et al.*, 2015; Khayyat-Abuaita, 2015; Pascual-Leone & Greenberg, 2007; Timulak & McElvaney, 2015), clarification oriented psychotherapy (Kramer *et al.*, 2015), short-term dynamic therapy (Kramer *et al.*, 2014, 2015), dialectical behaviour therapy (Kramer *et al.*, 2015), attachment-based family therapy (Lifshitz *et al.*, 2015) and even a manualized general psychiatric treatment (Berthoud *et al.*, 2015).

Moreover, these studies of the process model's relationships with outcome have described therapeutic change in cases that also collectively represent a wide range of clinical difficulties, including: major depression, complex trauma, generalized anxiety, social anxiety, adjustment disorder and various personality disorders, among other concerns. In still other work, Pascual-Leone (2009) used the model to track 'resilience' and 'emotional flexibility' as *in vivo observable indicators* of healthy change, demonstrating how clinicians might follow client change using the model as a 'clinical map.' Such maps can help therapist quickly orient themselves in-session and plan their treatment interventions (Goldfried, 2010b).

Knowledge Translation: Application of the Model

Three books to date, each on clinical practice, have used the sequential model of emotional process as a main interpretive lens to help clinicians map out their client's emotional change in emotion focused therapy (Kramer & Ragama, 2015; Paivio & Pascual-Leone, 2010; Timulak, 2015). Following this budding direction, a number of papers have explicitly elaborated how to use this sequential model of emotional change for specific case formulations in working with depression (McNally *et al.*, 2014), unresolved interpersonal trauma (Timulak & Pascual Leone, 2014), generalized anxiety disorder (Timulak & McElvaney, 2015), adjustment disorder (Kramer *et al.*, 2014) and borderline personality disorder (Kramer & Pascual-Leone, 2012). It is critical to understand that a process model focused on affect is not exclusively, or even necessarily tied to, an emotion-

focused approach, even if it was inspired by and contributes to that body of research. Indeed, in tandem with the advent of affective neuroscience, many contemporary psychodynamic and third-wave cognitive behavioural therapies have come to put increasing emphasis on emotion (Pascual-Leone *et al.,* 2016). Furthermore, empirical support cited above demonstrates the applicability of this model to other treatment approaches. Finally, given that a substantial number of psychotherapists report being integrative or eclectic in their practice (Norcross, 2005), our method of case formulation offers a trans-theoretical framework that can be assimilated into practice or training (i.e., Pascual-Leone & Andreescu, 2013) across a number of different treatment perspectives.

Using the Research Model as a Heuristic in-Session

A model of emotional change can provide concrete direction to therapists in an empirically informed manner. The development of Pascual-Leone and Greenberg's (2007) process model was carried out by observing live video recordings, and this method easily transfers directly to clinical practice. The real-time observations made by researchers from video reflect observations that therapists could also make while working with a client in-session (Pascual-Leone, 2009). To that end, the model indicates a pattern of change, the immediate history of which represents a client's *zone of proximal development*: A moving average position representing a client's emotional state with upper and lower limits. Following the work of Vygotsky (1924/1978); Leiman and Stiles (2001) described this *zone* as the client range for which targeted therapist interventions would best facilitate change. This implies that for therapists to be maximally effective in facilitating process, they should monitor (i.e., track) client levels of emotional differentiation and aim to match it or move only slightly beyond it. Overextending the client's process, however, might precipitate a dropping back in progress (a collapse, setback) as a result of moving beyond the shifting zone of proximal development (Caro Gabalda & Stiles, 2013; Pascual-Leone, 2009).

Thus, the main contribution here is that the model provides a research-informed 'process-map' pointing the route towards positive change. This is much like how topographical maps of a landscape or city can help travellers (1) orient themselves to their current location and (2) relate that location to target destinations. However, as in the use of any map, this model does not prescribe the interventions or treatment approach that therapists should use to get from one point to another: That is beyond the strict scope of case formulation and extends into the domain of treatment manuals. However, implicit in the notion of a 'process map' is the idea that the model helps therapists stay within the client's *zone of proximal emotional development* (i.e., Caro Gabalda & Stiles, 2013) by orienting therapist as to what moment-by-moment changes are likely within reach, given the provision of some support by the therapist.

In short, the model is useful to clinicians from various approaches as a flexible and contemporary way of thinking about psychotherapy cases along an 'emotional axis,'—which is not exclusive to, and yet compliments, most treatment approaches. It offers a process heuristic: allowing therapists to first orient to features of client emotion and second focus on emotional experiences that seem to be missing from a client's process. This model supports a therapists working with emotion by anticipating process goals in terms of 'where to go next?'

CONDUCTING THE CASE FORMULATIONS

Using the emotional processing model as a template for case formulation follows a four-step procedure, in a method similar to the model-building phase of task-analysis (Pascual-Leone *et al.,* 2009) or to procedures for conducting theory-building case studies (Stiles, 2007). In step 1, the therapist gets acquainted with the original model as explained above and assesses the client's emotional processes and problems from this framework. Next, step 2, the therapist 'prunes' the original model and tailors it to best represent the client's personal processes and problems. Step 3 focuses on identifying promising directions for emotional development; the therapist goes back to the original model and uses it to makes inferences about hereto uncharted process for the treatment planning of a specific client. Finally, in step 4, armed with a personalized model of client process (i.e., which processes are problematic, which will potentially be productive), therapists have drawn on their knowledge of intervention to systematically facilitate the targeted client process.

In the sections that follow, we demonstrate this application by using the model for two different clients, each presenting with different emotional problems, and given different treatments (i.e., emotion focused therapy, dialectical behaviour therapy). The first author was the therapist in both cases, and the case formulation method we outline was applied to both cases during the course of their treatment, influencing the treatment direction in a manner that complimented each of the different psychotherapy approaches (Pascual-Leone, 2005b; Pascual-Leone & Kramer, 2014). However, in keeping with the *application of research* to practice this is a demonstration of initial case formulation and treatment planning; beyond that purpose the course and outcome of treatments as such are not directly relevant. Thus, the objective is to present a new approach to case formulation, one that helps clinicians to anticipate a client's moment-by-moment emotional process and reveals related opportunities for intervention.

Step 1: Initial Case Assessment and Attending to Affective Markers

Identifying Presenting Problem, Narrative and Attachment History

'Sally,' was in her 40s, Caucasian and married with two children. She enjoyed an upper–middle level of socio-economic status, was college-educated as a registered nurse and at the time of therapy, she was not working. The contrasting case, 'Beth' was in her late 30s, Caucasian and lived with her partner and her two children. She was part of a lower socio-economic stratum, had not completed High School but at the time of treatment was about to start a college entrance course. Beth worked part-time doing basic clerical work.

'Sally'

At intake, Sally met the DSM-IV-TR diagnostic criteria for major depression and dysthymia (see American Psychiatric Association, 2000). For over 10 years, she suffered depressive mood, on more days than not, low self-esteem and feelings of hopelessness. Over the 3 months prior to seeking treatment, all the above worsened and in addition, she presented with anhedonia or loss of pleasure in activities, disturbed sleep, feelings of worthlessness and of inappropriate guilt, difficulty concentrating and recurrent thoughts of death, including passive suicidal thoughts. When asked about her presenting problems, Sally described a long history of depressive problems and of anxiety. She also felt isolated by her husband and her children, and reported having poor relations with her siblings.

Sally's attachment history included the major event of her mother's passing away from cancer when the client was six years old. Discussing this death was always a taboo in the family particularly after Sally's father remarried. She described her father as withdrawn and said the same was true about her two siblings. Her father only brought out photos of her deceased mother for the first time when Sally was an adult. Later in life when the client was 30 years old, her step-mother also died of cancer.

Sally reported that her father and step-mother often fought when she was growing up. In this family context, the client felt ignored as a child and developed a sense of dread and family shame. Sally's step-mother made it clear that she had never wanted children, which left the client feeling rejected. Because of her sense of shame, Sally rarely told anyone that her birth mother had died. She described an occasion when during the course of her work as a nurse, she was making small-talk with one of the patients at a drop in clinic. The patient made a joke about overprotective mothers, saying: 'well, you know how mothers are!' which caught Sally of guard. She immediately thought to herself, 'No, I don't know how mothers are…', and the poignancy of her loss led her to stifling her tears in a back room of the clinic.

In-session, Sally presented as an energetic and active woman, albeit self-deprecating and emotionally fragile. She was tearful during her first meeting with the therapist, sobbing at times. She often slouched in her chair. There was a child-like quality to her presenting sadness. Even so, Sally presented with little emotional range and wept bitterly, without wiping her tears. At the same time, she clearly presented with a high level of psychological mindedness and was insightful. In terms of working alliance markers, she presented with very needy, desperate pleas, but quickly developed rapport with the therapist, including a good sense of interpersonal boundaries. It was concluded that Sally would benefit from emotion focused therapy, and that the underlying issues may take some time to resolve.

'Beth'

Beth was referred to a clinic for the treatment of anger problems and concurrent substance abuse. Following a structured clinical interview, Beth met DSM-IV-TR diagnostic criteria for borderline personality disorder, alcohol dependence (drinking heavily three times per week) and partially remittent crack-cocaine dependence (every 4–6 weeks at the time of assessment; with daily use three years earlier; see American Psychiatric Association, 2000). Her symptoms included frantic efforts to avoid abandonment, impulsive substance abuse, and dependency related behaviours, reckless driving, self-mutilation, (i.e., wrist cutting, punching herself in the head), affective instability for one to three hours at a time, inappropriate intense anger (i.e., frequent angry temper, recurrent fist fights) and stress-related transient episodes of paranoia and dissociation. The latter two were monitored throughout therapy but not targeted. Beth reported her target issues as being: anger problems, suicidal urges and self-harming behaviours, along with her unstable housing situation.

Regarding Beth's background and attachment history, she had been in foster-care for several years at a young age and was later adopted. She experienced physical abuse at home, as well as severe sexual abuse in the neighbourhood including, 'being passed around.' She reported having distant family relations and being homeless at times. Beth had a history of suicide attempts, self-harm and violence. Her last attempted suicide was three years earlier, by stabbing. She also reportedly beat up her previous therapist, at age 20, when that therapist persistently inquired about sexual abuse. When Beth's partner left her for another woman, Beth became intensely jealousy, which led to a 3-day binge on crack, and culminated in her beating up her partner, kicking him as he lay in the bathtub.

Beth, a stocky woman of 190 pounds moved quickly and energetically. She presented as a lively women with whom it was easy to engage, but who did not readily disclose intimate matters. She was emotionally labile and easily distracted during her first meeting with the therapist, at times giggling with discomfort. As she sat, Beth was often fidgeting in her chair and persistently chewed on her finger nails. At times, she presented with child-like playfulness and innocence. Most importantly, Beth fluctuated between playing gravely serious (i.e., holding up her fists threateningly), and joyful; however, when the conversation got serious, she became quiet and fidgeted more than ever.

In-session Beth appeared as highly avoidant, then at times very emotionally dysregulated. She often had little insight into her own functioning, but she understood the rationale for being in a behaviour therapy. Finally, regarding the working alliance, she seemed very nervous, sometimes spaced-out, slow to warm up, then very engaged and joking. We underline that the process of de-shaming about her need for treatment was an important factor in building a therapeutic alliance. Overall, Beth was motivated to change, looking to build a new life, and a good candidate for dialectical behaviour therapy.

Using the Model as a Template and Populating It with Client Data

As the therapist considers the initial assessment of different cases such as these, he or she must be particularly attentive to the affective nature of reported difficulties (e.g., client feeling socially disconnected), as well as in-session observations of emotion and regulation (e.g., client's lack of eye contact, or being easily overwhelmed), and the client's capacity to elaborate on the meaning of affective experiences (e.g., client is able to make use of and deepen empathic conjectures offered by the therapist). Contemplating the cases in this way is structured by considering the relevant components in Figure 1, which can tentatively be used as a template to describe a client's core difficulties. To that end, therapists using the model for case formulation are encouraged to directly insert their observations from case notes, or to take key client statements, and quote them directly in the boxes of Figure 1 (for a detailed example of this see Timulak & Pascual Leone, 2014). In short, the data and observations relevant to case formulation are used to populate the model in Figure 1, which acts as an initial template.

Step 2: Tailoring the Case Formulation to Model a Clients' Personal Processes

Despite some initial similarities the cases of Sally and Beth have substantial differences in not only diagnosis, but also in their basic emotion experiencing. This is particularly clear when one uses the same process model as a heuristic in order to compare the two emotional presentations from an overall case formulation perspective. In particular, we assessed the style of processing emotions (i.e., the level of in-session experiencing and of arousal) and specific painful aspects of emotional experience (i.e., assessment of the core painful contents), along with contributing issues to emotion experiencing.

Sally: A Case of Over-Regulated Emotion

After making clinical observations and tentatively organizing them in term of the sequential model of emotional processing, the therapist now tailors the model (now populated with clinically-relevant observations) to describe the emotional difficulty of a specific case. For the most part, Sally presented with emotions of global distress, shame, with underlying negative self-evaluation that were relatively easily for her to articulate (see Figure 2; dark grey boxes). Global distress in this client was expressed in a vague sense of dread, i.e., 'poor me,' and feelings of worthlessness and guilt.

Her feelings of shame were associated with feelings of being unlovable, and also of being completely worthless and ignored, along with a fearful anticipation that, 'Something bad will happen…' The underlying negative evaluation is usually a quintessential component of primary maladaptive shame and usually is articulated along the lines of: 'I am worthless [and/or] unlovable.' Of course, the notion of negative evaluation has its counterparts in other psychotherapy approaches. Cognitive therapists might speak about core dysfunctional belief characterized by cognitive distortions, whereas psychodynamically oriented therapists would conceptualize the negative evaluation as part of a core conflictual relationship theme, in particular the internalized response of the self-object.

Finally, based on the information the client presented, case formulation using the model of emotional processing suggests that Sally's underlying pain is about the loss of a nurturing and protective care giver in so many forms. Also, more currently, feeling ignored by husband and children provokes similar pain in her experience. In addition, the tentative exploration of emotion with Sally in-session (process assessment) suggested that Sally is also angry in some ways, and using the model as a template helps organize this observation as one of two possibilities (see rejecting anger vs. assertive anger in the original template: Figure 1). The therapist notes non-verbal markers of this in the form of her making 'little kicks' with her feet and in having a tone of protest in her voice. Even so, Sally does not verbally acknowledge this anger as part of her experience.

Given this initial presentation of the client's process, the therapist used empathic responding to explore Sally's experience of her husband and her parents. This process

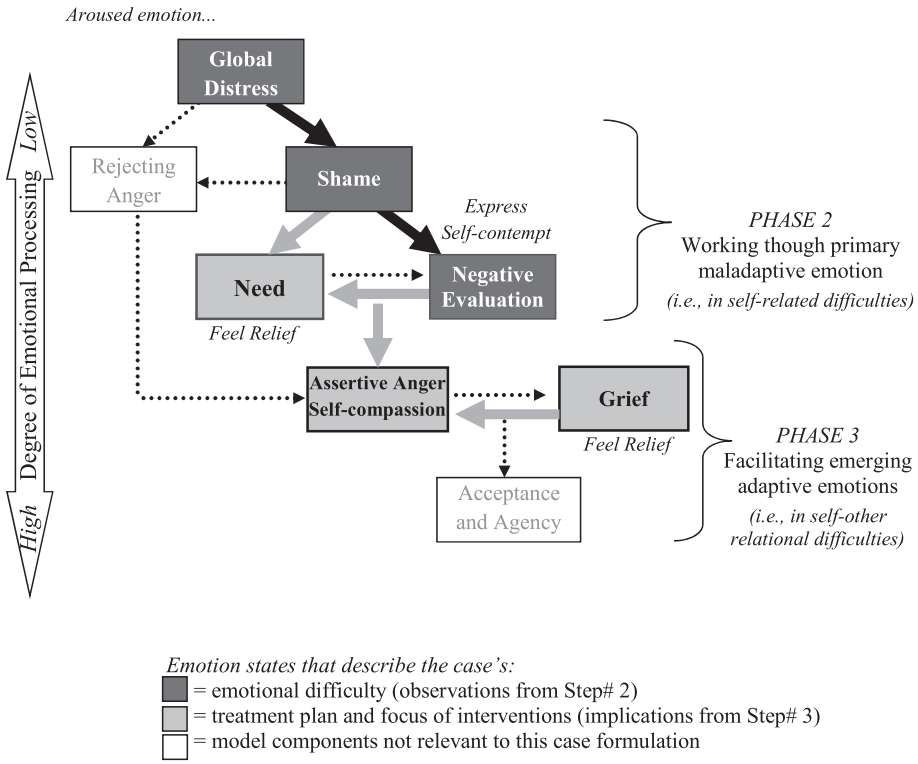

Figure 2. *Sally's difficulty and treatment focus* (modified from Pascual-Leone & Greenberg, 2007)

leads to the identification of specific unresolved issues as the foci of treatment. In particular, she described unprocessed (primary) anger with her father, along with unprocessed (primary) grief over the loss of her mother. These unprocessed primary emotions bias her, unwillingly, in her everyday life and cause collapses into despair and distress as forms of secondary emotion which the client is unable to adequately regulate or soothe. Conceptualizing Sally's emotional experience organized the therapist's perceptual framework: aspects of the original model highlighted what was most relevant for understanding (and perceiving) Sally's emotional difficulties (Figure 2). Moreover, this formulation seemed consistent with the family norms she reported after her mother died, which made grieving or even discussing her mother a taboo topic during her upbringing (for father it was too intense and would send him drinking; for step-mother, any talk of Sally's birth mother was disruptive and unwelcome).

Beth: A Case of Under-Regulated Emotion

When considering data in the context of the emotional processing model and in-session observations from the second case, the therapist's observations and notes suggests a very distinct core emotional difficulty. Beth's presenting emotion at the time of assessment was rejecting anger, which she also reportedly expressed through the use of self-harming behaviour and substance abuse. This specific emotion process of dysregulation was also present in several of her narrated situations, for example when she came home and found the door locked she yelled at her partner's sister and kick at the door, damaging the deadbolt. She conveyed a story where at some point she was in a shopping mall and got very angry at her partner because she did not want to shop. At the time, she explained to him that she 'felt down,' depressed and weak, in particular when confronted with 'difficult memories related to Christmas.' However, in actuality, Beth had impulsively spent all her Christmas money on crack cocaine, which left her feeling vulnerable and ashamed about what she had done. Her getting angry at her partner in the mall, can be understood as a secondary emotion, which served to energize her, and more importantly, to defensively displace her core shame about her being bad and inadequate (see Figure 3; dark grey boxes). Another particularly illustrative example of this emotional shift was when Beth was completing homework for a training program and had asked her partner for help. However, he expressed reservations saying he felt tired and eventually declined to help, which left Beth feeling vulnerable, 'stupid' and inadequate for school, as well as feeling uncared for by him. However, her outward response at that time was to

explode and yell at him (rejecting anger) and then to isolate herself and engage in self-harming behaviours.

From a behavioural perspective, we can explain Beth's changing emotions and affective lability based on learned contingencies (i.e., negative reinforcement), where rejecting anger is reinforced by the reduction in shame (Pascual-Leone *et al.*, 2013). This process motivated the client to produce more anger which progressively becomes a self-reinforcing process. From a psychodynamic perspective, this form of anger expressed by Beth may alternatively be understood as a defence mechanism against the 'dreaded state' of shame. From an experiential perspective, the component of rejecting anger can be thought of as characterological in some way, which is one definition of primary maladaptive anger (Pascual-Leone *et al.*, 2013). Figure 3, represents the client's problematic process both in terms of dysregulation and in terms of its underlying difficulties.

Step 3: Referring Back to the Model, Making Inferences and Planning Treatment

After client data and therapist observations have been used to develop a customized model/formulation of a client's problematic emotional processes, only some parts of the model will have been used. So, the therapist refers back to the original research model to further case formulation and treatment planning. Given presenting issues, client–therapist processes will have explored certain areas, and not others, of the relevant process. Those parts of the 'process map' that have been clearly observed now become even more self-apparent; however, an empirically supported process model also provides insight to the therapist about tacit, or *potential processes*, that are relevant but have simply *not yet been fully explored*. Those, 'unexplored' areas of the process map, now point the direction for new growth.

Thus, in step 3, hereto unidentified or partially observed components in Figure 1 are used to make inferences about underlying process that may nonetheless be in the client's proximal zone of emotional development and therefore quite relevant to the client's recovery. While in earlier steps, the therapists used the model as a perceptual lens for *observing* the client, this is where therapists leverage what they know from the model about 'good process' by *anticipating* it in-session. To that end, therapists follow their understanding of a client's problematic processes by making 'prediction' about what target processes would be most helpful. Treatment planning based on the original

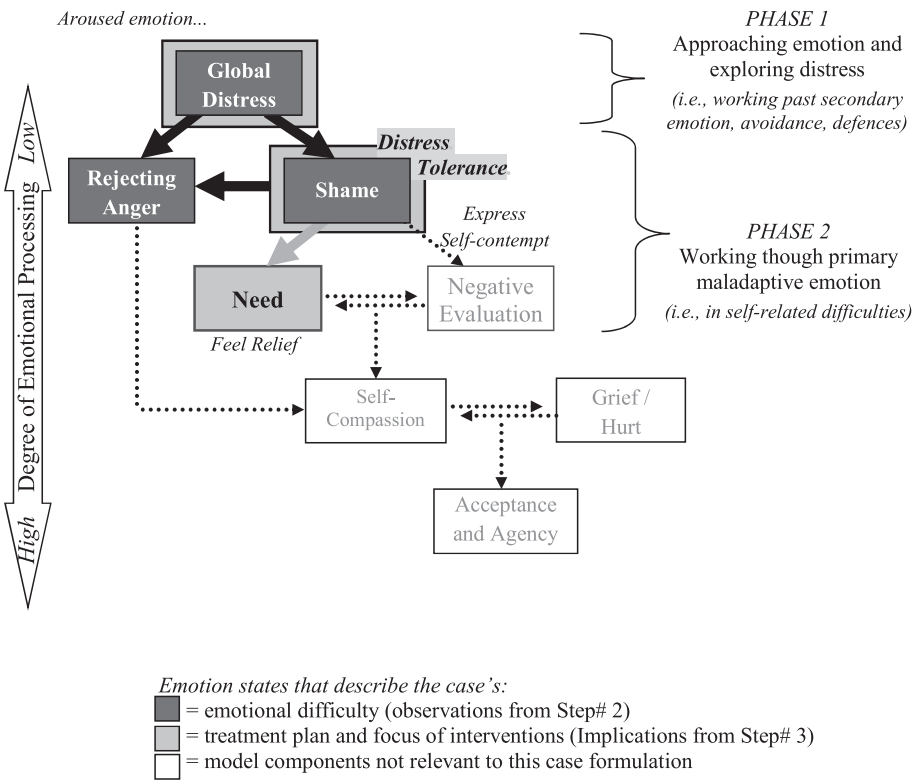

Figure 3. *Beth's difficulty and treatment focus* (modified from Pascual-Leone & Greenberg, 2007)

model in this way should converge with initial process observations that the therapist has made in step 1.

Sally: Treatment Objective and Focus of Intervention

Using Pascual-Leone and Greenberg's (2007) model as a template, the transformational path for Sally's treatment would likely consist of transforming her sense of maladaptive shame by accessing an existential need, and then to access and allow assertive anger (at the father) and hurt-grief (over the loss of the mother; see figure 2; light grey boxes). In the process, Sally would likely have to develop ways to sooth and be compassionate to herself, particularly given the absence of soothing figs. in her life. This is consistent with fragile efforts the client made in her assertion of existential needs but that have ended in emotional collapse (e.g., 'I deserved to be loved!… maybe… but then again, maybe not').

Beth: Treatment Objective and Focus of Intervention

In some sense, the path to recovery and self-development for the case of Beth is less complex than that of Sally. For Beth, the capacity for emotion regulation and the rejecting anger component, in particular, was so poorly regulated that improving self-regulation presented itself as the first objective and would have to come before exploring meaning and doing more transformation process in the narrower sense (see Pascual-Leone *et al.*, 2015). So, in the case of Beth, emotion regulation would become the core focus of treatment, and this is consistent with the therapist's observation that exploring the meaning of emotions that appear at the bottom of Figure 1 were too evocative and distressing for Beth to be fruitful.

Thus, the treatment would help Beth assess, recognize and tolerate shame within the therapeutic encounter, as well as in everyday life. In Figure 3 (light grey boxes), two potentially helpful pathways are anticipated. (1) Anger management strategies would have to be implemented, to help slow down the process and reduce the intensity of her expression of interpersonal anger. (2) Working on the tolerance of distress, and of shame in particular. During this step of case formulation, the use of Mindfulness and other awareness-increasing techniques (from the therapist's approach; DBT) were important in assessing the shame that seemed to underlay Beth's anger and probing her limited capacity for self-soothing and strategies for self-care.

Notice that emotional states of deeper meaning making in the model were not within the client's immediately available repertoire (i.e., out of her development reach, or not tolerable on account of dysregulation). Thus, Beth often was not capable of exploring the potentially healthy and deeper lived experiences of hurt/grief (i.e., acknowledging she never felt valuable in relationships) or adaptive assertive anger (i.e., setting personal boundaries and asserting wishes without resorting to violence), or agency and acceptance (i.e., admitting the past while keeping focused on the future). In sum, the model suggested to her therapist that Beth would not be able to activate and engage those states without a substantial amount of support, because they are located several model components away from her presenting state. As such, research suggests that explicit support/direction of this kind from the therapist will not lead to lasting change until further intermediary steps are accomplished (Pascual-Leone, 2005a, 2009). Therefore, Beth's healing process would be expected to evolve from maladaptive shame via the use of distress tolerance and management techniques to basic self-soothing skills, which do not elaborate specific and idiosyncratic meanings, so as to avoid being too emotionally evocative.

Step 4: Finding Interventions that Facilitate the Target Client Process

Creating a Map for Guiding Clinical Intervention

In step 4, the therapist uses his or her chosen treatment approach to facilitate the client's process using specific treatment techniques and then evaluates their effectiveness in facilitating the target process for a given clinical case. Thus, our approach to case formulation helps a therapist be responsive to a client's needs by clarifying client process in terms of difficulties and potential process solutions. However, it will be up to the therapist to find suitable and effective tasks for intervening. This fourth step of contemplating and experimenting with possible interventions to address the target concerns is similar to that described by Goldfried (2010b). In the end, the ensuing process validates or further informs one's case formulation.

Treatment, Process and Outcome

Both clients were treated by the first author, according to two different therapy models; Sally was treated with EFT (Greenberg, 2002), a humanistic and experiential therapy in which therapists tentatively guide the client process to deepen meaning and feeling. In contrast, Beth was in DBT (Linehan, 1993), a relatively structured treatment in which therapists direct the client to make use of skills training and develop new more adaptive behaviours. Both treatments are empirically supported, and both focus on emotion in some specific ways.

Sally's Course of Treatment

As identified by the case formulation (Figure 2), Sally's treatment aimed to help her access and articulate a need (i.e., for nurturing love, and to feel valued and special) and allow assertive anger (i.e., to fight against others dismissals of her as well as her own self-disparagement) and hurt or grief, specifically over the loss of her mother(s). In order to do this, Sally was in

EFT for almost four years. Initially, this client took part in the York Forgiveness study (see Greenberg *et al.*, 2003). At the end of the study's brief treatment (16 sessions), the client was identified as a poor outcome, although from the perspective of both therapist and client their work had only begun. After the end of the study, treatment continued with the same therapist and the client eventually emerged as a positive outcome in clinical practice and according to standard research measures. The full treatment of this case is considered to have a good outcome and is discussed as a case study in Paivio and Pascual-Leone (2010).

In using the model for ongoing treatment planning, five areas for intervention were identified by the therapist. These were:

a *Create interpersonal encounters* (i.e., T: 'Can you look at me and say that?', 'When you turn away, I feel disconnected from you… what's it like for you?');
b *Facilitating self-soothing and self-compassion* (i.e., T: 'What's it like for you to hold your face in your hands right now?', 'Be the loving mother, what would she say to Sally?… or hearing this pain, what would you say to your own children?');
c *Facilitating assertive anger* (i.e., by way of chair-work for self-criticism, unfinished business and defending the universal child);
d *Transforming maladaptive shame* (i.e., accessing assertive anger and self-compassion in the face of dreaded states when feeling shamefully unlovable);
e *Psychoeducation and explicitly coaching the client through her feelings* (i.e., on being your own existential therapist; promoting meta-awareness of her own emotional collapses and resilience i.e., T: 'What was that? Something just happened as you took a deep sigh and sunk back. What just happened inside?').

On a relational level, Sally had never developed a sufficient sense that her needs, to be acknowledged and loved, were legitimate. Therefore, the therapist's first objective was to provide relationship conditions that build safety, and solidify the working alliance. This was accomplished by the therapist being genuine as a person, creating an interpersonal encounter and by being attentive to any micro-ruptures in the alliance that may occur through Sally's withdrawals or subtle attacks. In this process, both the content of the client's narrative and the quality of her affective-cognitive processes continuously impact on the case formulation and thus the choice of tasks for reaching the process goals. For example, if she expressed a global, disoriented sense of distress this suggested a focusing task to symbolize and clarify her internally felt experiences. In addition to suffering grief over family losses, Sally occasionally puts herself down with disparaging self-criticism. Thus, any positive appraisals were usually met with a familiar feeling of anxiety and dread about the potential disaster and disappointment that wound ensue. These markers of self-criticism, or lingering feelings of grief towards her mother, were used to introduce chair dialogues typical of EFT. The aim of these tasks was to evoke target emotions and help synthesize new meaning.

Beth's Course of Treatment

As developed in her case formulation (Figure 3), Beth's treatment aimed to help regulate her rejecting anger and to gently address her sense of shame using specific self-soothing and emotion regulation strategies that are not too evocative (Pascual-Leone *et al.*, 2015). These process goals are arguably more suggestive of a behavioural approach, and as it happens, Beth was in treatment using DBT. The general aim for regulating anger while working with Beth was broken down into five specific treatment domains:

a *Facilitate self-soothing and distress tolerance skills* (i.e., in keeping with a behavioural treatment this was largely a directive process: skills group, homework, transfer and generalization to everyday life);
b *Create interpersonal experience of stability and support* (i.e., empathic but non-evocative validation, using the relationship as a contingent reward to positively reinforced in-session behaviours, providing a caring and reliable relationship experience: e.g., Beth was encouraged to practice using a 24-hour pager and asking for help from her therapist);
c *Regulate anger using behavioural strategies* (i.e., changing the contingencies related to Beth's expressions of anger: e.g., therapist disengaged from dialogue when Beth attempted to bully, therapist held his ground on expectations, use DBT's irreverential interventions to derail the escalations of Beth's angry attacks);
d *Regulate shame using behavioural strategies* (i.e., structured exposure to personal vulnerability/shame in the context of a caring relationship, teaching and guidance in the deliberate use of skills to regulate arousal adaptively at these painful moments, transfer of skills training to everyday life by way of deliberate practice);
e *Treat substance abuse using behavioural strategies and psychoeducation* (i.e., given its relationship to problem anger, alcohol was targeted first; self-monitoring and keeping a behavioural diary, psycho-education about substance abuse, support in identifying and managing cues for risky situations, relapse prevention).

The clinical research setting required Beth to make 6-month contracts for working with a therapist. In the first 6 months, Beth made steady improvements in treatment. She needed to be managed to some degree and was ambivalent about making commitments to homework or other concessions to problematic behaviours (e.g., concrete goals for decreasing substance abuse). However,

she said she looked forward to her sessions and begrudgingly tried new ways of engaging her difficulties. Self-harm, angry behaviour and substance abuse behaviours were all reduced, although she still felt unbearably ashamed about these issues. These initial changes held promise although she still had serious difficulties with coping and thus extended her treatment contract for another 6 months. However, before the completion of one year of treatment Beth reported going into a drunken rage and breaking things in her house. Because there were children living in the house and they were deemed at risk, the therapist was legally required to report this to authorities. He discussed this issue with Beth who was angry and resentful, creating a relationship rupture. Beth dropped out of treatment the next session and then rebuffed attempts from the therapist and clinic encouraging her to return to treatment. Ultimately, case formulation anticipated the way Beth might have reacted to the therapist's actions: She felt ashamed about being a risk for child abuse and she responded with rejecting anger towards her therapist and unfortunately abandoned treatment.

DISCUSSION: TRANSLATING EMOTION PROCESS RESEARCH INTO PRACTICE

Where is the Proximal Zone of Emotional Development?

While the idea of locating a client on a 'process map' is intuitive to many clinicians (Goldfried, 2010b; Pascual-Leone & Andreescu, 2013), research models are needed to help clinicians make empirically informed decisions about what intervention opportunities may lay just beyond the client's immediate experience. Being familiar with the moment-by-moment process model presented in this paper will help orient therapists to emotional developments that are within a client's reach. The usefulness of this process map is that it helps a therapist stay within a client's zone of proximal emotional development and this was seen in examples from both cases. On several occasions, Beth (Figure 3) was in an emotional state which was highly distressed and very global (undifferentiated) in its symbolic meaning. She reported that when she was instructed to do a specific self-soothing exercise it was comforting to her. Even so, as soon as the client was left without the explicitly structured task and directive support of the therapist, Beth collapsed once again into global distress (regressing to the top of Figure 3; phases 1, and 2). Thus, when she was in a state of undifferentiated distress and managed to progress forward into a more meaningful and specific state of self-compassion (shadowed box, bottom of Figure 3), that more adaptive state always remained very precarious and was often untenable (even with the help of the therapist). In this case, a heavily therapist-directed task is better thought of as the *therapist's* soothing or validation of the client, rather than the client's own *self*-soothing or validation vis-à-vis herself.

In contrast, the painful emotion experienced by Sally (Figure 2) was more likely to be well differentiated (i.e., specific in meaning and anchored in idiosyncratic narratives, rather than global and inarticulate). Although the feelings at times like this were also very aroused and painful, they were specific and differentiated experiences of either maladaptive shame or specific and adaptive grief (depending on the occasion), in which she related her bodily feelings to relational issues and contextual meaning (Figure 2; phases 2, and 3). At these moments, when the therapist introduced a specific task for self-soothing or compassion, this client was more able and prepared to independently elaborate and explore the emotionally laden meaning of that target state. Under the presenting circumstances of differentiated affective-meaning, Sally was more able to take ownership of the self-soothing exercise and carry it forward with a sense of agency—even when the therapist was no longer directly facilitating the task (—something Beth was unable to do). Thus, when Sally came from a state that was more specific and differentiated (in terms of meaning and affective experiences), the self-compassion state was within her proximal zone of emotional development. As a result she was more able at those moments to sustain the newly emerging state of self-compassion with just minimal support and structuring from her therapist. If this task is introduced at a time when the presenting state is specific enough then there is a shift in emotional state—an internal emotional regulation (rather than an interpersonal regulation)—such that the client clearly becomes the source of agency in her own experience of self-compassion.

In short, clients can make some types of emotional shifts more successfully than others, depending on their overall emotional repertoire *and* on the emerging windows of opportunity, i.e., how they are emotionally oriented and engaged at a given moment. In the preceding examples, Sally was more able to move from feelings of fear and shame to a state of self-compassion than Beth was able to move from global distress to any comparably well-articulated state of self-compassion. For the therapist who is attentive to moment-by-moment process, Pascual-Leone and Greenberg's (2007) sequential model of emotional processing offers some powerful insights into efficient emotional processing. It means that certain emotional states can be used as markers for interventions that would facilitate the next more adaptive state within the client's proximal zone of development.

Any time clients become emotionally aroused and elaborate on their experience (i.e., of an emotional injury) there are several possible facets of that experience (i.e., hurt, assertion, disgust, hopelessness…) which a therapist might choose to highlight or empathically focus on. *However*,

not all facets of that experience have equal potential. Some direct the client towards a proximal zone of emotional processing, which holds the most potential for client progress, whereas others are less fruitful because they extend the client's resources beyond their limits and are therefore unsustainable and untenable. Identifying this zone to work in is an important part of case formulation. The model we have presented can serve as a conceptual guide for therapists to consider which of the incipient alternative emotion states presented by a client may be most accessible to the client for further development. Otherwise said, the model can be used to inform what type of empathic reflections, interpretations or skills training interventions will be most fruitful according to the client's proximal zone of development at any given time.

Concluding Remarks

The current contribution aimed at using a specific process-model of emotion as a template for case formulation and demonstrating its application to two different clinical cases. Using process research-informed procedures for case formulation ultimately helps address the problem that outcome research findings offer little to clinicians grappling with the uniqueness of individual cases. This is particularly the case if the research-informed case formulations meet the three criteria we initially identified for the optimal translation of research-to-practice.

The emotion-based case formulation we propose may help psychotherapist to (1) perceive client's process characteristics more accurately, (2) adjust clinical intervention accordingly and (3) target what has been identified as key emotional difficulties for a given client. We have also shown that this approach to modeling cases is useful on a moment-by-moment level of intervention as well as on a broader perspective of case formulation and planning. Finally, we have discussed the notion of proximal zones of emotional development and shown how the model helps discern which clients will most benefit from what intervention (based on process research) and depending on their particular patterns of change.

REFERENCES

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed.). *DSM-IV-TR*. Arlington, VA: American Psychiatric Pub.

Berthoud, L., Kramer, U., Caspar, F., & Pascual-Leone, A. (2015). Emotional processing in a ten-session general psychiatric treatment for borderline personality disorder: A case study. *Personality and Mental Health*, *9*, 73–78. DOI:10.1002/pmh.1287.

Caro Gabalda, I., & Stiles, W. B. (2013). Irregular assimilation progress: Reasons for setbacks in the context of linguistic therapy of evaluation. *Psychotherapy Research*, *23*, 35–53.

Choi, B., Pos, A. E., & Magnusson, M. (2015). Emotional change process in resolving self-criticism during experiential treatment of depression. *Psychotherapy Research*. DOI:10.1080/10503307.2015.1041433.

Eells, T. D., Lombart, K. G., Kendjelic, E. M., Turner, L. C., & Lucas, C. P. (2005). The quality of psychotherapy case formulations: A comparison of expert, experienced, and novice cognitive-behavioral and psychodynamic therapists. *Journal of Consulting and Clinical Psychology*, *73*, 579–589.

Foa, E. B., & Kosak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*, 20–35.

Goldfried, M. R. (2010a). The future of psychotherapy integration: Closing the gap between research and practice. *Journal of Psychotherapy Integration*, *20*, 386–396.

Goldfried, M. R. (2010b). An evolved cognitive-behavioral view of the case of David. *Journal of Psychotherapy Integration*, *20*(1), 72–80.

Goldman, R. N., & Greenberg, L. S. (2015). Case formulation in emotion-focused therapy. Co-creating clinical maps for change. Washington, D. C: American Psychological Association.

Greenberg, L. (1991). Research on the process of change. *Psychotherapy Research*, *1*, 14–24.

Greenberg, L. S. (2002). Coaching clients to work with their feelings. Washington, D. C: American Psychological Association.

Greenberg, L. S., & Paivio, S. C. (1997). Working with emotions in psychotherapy. New York: Guilford Press.

Greenberg, L. S., Warwar, S., & Malcolm, W. M. (2003). Differential effects of emotion-focused therapy and psychoeducation in facilitating forgiveness and letting go of emotional injuries. *Journal of Counseling Psychology*, *55*, 185–196.

Haberman, A., Diamond, G. M., & Shahar, B. (2015). The expression of primary adaptive emotions and shame among individuals with social anxiety in emotion focused therapy. Philadelphia: Society for Psychotherapy Research.

Jose, A., & Goldfried, M. R. (2008). A transtheoretical approach to case formulation. *Cognitive and Behavioral Practice*, *15*, 212–222.

Kramer, U., & Pascual-Leone, A. (2012). Emotional processing across long-term psychotherapy in a patient presenting with borderline personality disorder: A case study. Geneva, Switzerland: Presentation at the 42nd EABCT-Congress.

Kramer, U., Pascual-Leone, A., Berthoud, L., de Roten, Y., Marquet, P., Kolly, S., Despland, J.-N., & Page, D. (2015). Assertive anger mediates effects of dialectical behavior-informed skills training for borderline personality disorder: a randomized controlled trial. *Clinical Psychology and Psychotherapy*. DOI:10.1002/cpp.1956.

Kramer, U., Pascual-Leone, A., Despland, J.-N., & de Roten, Y. (2014). Emotion in an alliance rupture and resolution sequence: A theory-building case study. *Counselling Psychotherapy Research: Linking research with practice*, *14*(4), 263–271.

Kramer, U., Pascual-Leone, A., Despland, N., & de Roten, Y. (2015). One minute of grief: Emotional processing in short-term dynamic psychotherapy for adjustment disorder. *Journal of Consulting and Clinical Psychology*, *83*(1), 187–198.

Kramer, U., Pascual-Leone, A., Rhode, C., & Sachse, R. (2015). Emotional processing, interaction process, and outcome in clarification-oriented psychotherapy for personality disorders: A process-outcome analysis. *Journal of Personality Disorders*, *29*, 1–19.

Kramer, U., & Ragama, E. (2015). La psychothérapie centrée sur les émotions. Issy-les-Moulineaux: Masson.

Kramer, U., Kolly, S., Berthoud, L., Keller, S., Preisig, M., Caspar, F., *et al*. (2014). Effects of motive-oriented therapeutic relationship in a ten-session general psychiatric treatment of borderline

personality disorder: A randomized controlled trial. *Psychotherapy & Psychosomatics*, *83*, 176–186.
Khayyat-Abuaita, U. (2015). Changes in quality of emotional processing in trauma narratives as a predictor of outcome in emotion focused therapy for complex trauma, unpublished doctoral dissertation. University of Windsor.
Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research*, *11*, 311–330.
Lifshitz, C., Diamond, G. S., Kobak, R. R., Krauthamer, S. E., & Diamond, G. M. (2015). Sequence of affective states over the course of attachment based family therapy (ABFT) for suicidal adolescents. Philadelphia: Society for Psychotherapy Research.
Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.
McNally, S., Timulak, L., & Greenberg, L. S. (2014). Transforming emotion schemes in emotion focused therapy: A case study investigation. *Journal of Person Centered and Experiential Psychotherapy*, *13*(2), 128–149.
Norcross, J. C. (2005). A primer on psychotherapy integration. In Norcross, J. C., & Goldfried, M. R. (Ed.), Handbook of psychotherapy integration (2nd ed. pp. 3–23). New York: Oxford.
Paivio, S. C., & Pascual-Leone, A. (2010). Emotion-focused therapy for complex trauma: An integrative approach. Washington, D. C: APA.
Pascual-Leone, A. (2005a). Emotional processing in the therapeutic hour: Why the only way out is through. Unpublished doctoral thesis. York University, Toronto.
Pascual-Leone, A. (2005b). Shame and Anger: Two contrasting cases. Invited lecture, University of Windsor.
Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology*, *77*, 113–126.
Pascual-Leone, A., & Andreescu, C. (2013). Repurposing process measures to train psychotherapists: Training outcomes using a new approach. *Counselling and Psychotherapy Research*, *13*(3), 210–219.
Pascual-Leone, A., Gillespie, N. M., Orr, E. S., & Harrington, S. J. (2015). Measuring subtypes of emotion regulation: From broad behavioral skills to idiosyncratic meaning making. *Clinical Psychology and Psychotherapy*. DOI:10.1002/cpp.1947.
Pascual-Leone, A., Gillis, P., Singh, T., & Andreescu, C. (2013). Problem anger in psychotherapy: An emotion-focused perspective on hate, rage, and rejecting anger. *Journal of Contemporary Psychotherapy*, *43*(2), 83–92.
Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through". *Journal of Consulting and Clinical Psychology*, *75*, 875–887.
Pascual-Leone, A., Greenberg, L. S., & Pascual-Leone, J. (2009). Developments in task analysis: New methods to study change. *Psychotherapy Research*, *19*, 527–542.
Pascual-Leone, A., & Kramer, U. (2014, April). Using the sequential model of emotional processing to inform case conceptualizations: A demonstration using two contrasting cases. Paper presented at the Conference of the Society for the Exploration of Psychotherapy Integration (SEPI) Montreal, Canada.
Pascual-Leone, A., Paivio, S., & Harrington, S. (2016). Emotion in psychotherapy: An experiential-humanistic perspective. In Cain, D., Rubin, S., & Keenan, K. (Ed.), Humanistic psychotherapies: Handbook of research and practice (2nd ed.) (pp. 147–181). Washington, DC, US: American Psychological Association.
Pascual-Leone, A., Singh, T., Harrington, S., & Yeryomenko, N. (2014). Psychotherapy progress and process assessment. In Hopwood, C. J., & Bornstein, R. F. (Ed.), Multimethod clinical assessment of personality and psychopathology (ed. pp. 319–344). New York: Guilford Press.
Rachman, R. (1980). Emotional processing. *Behaviour Research and Therapy*, *18*, 51–60.
Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research*, *7*, 122–127.
Teachman, B. A., Drabick, D. A., Hershenberg, R., Vivian, D., Wolfe, B. E., & Goldfried, M. R. (2012). Bridging the gap between clinical research and clinical practice: Introduction to the special section. *Psychotherapy*, *49*(2), 97–100.
Timulak, L. (2015). Transforming emotional pain in psychotherapy: An emotion-focused approach. New York: Routledge.
Timulak, L., & McElvaney, J. (2015). Emotion-focused therapy for generalized anxiety disorder: An overview of the model. *Journal of Contemporary Psychotherapy*. DOI:10.1007/s10879-015-9310-7.
Timulak, L., & Pascual Leone, A. (2014). New developments for case conceptualization in emotion-focused therapy. *Clinical Psychology and Psychotherapy*. DOI:10.1002/cpp.1922.
Vygotsky, L. S. (1924/1978). Mind and society: The development of higher psychological processes. Cambridge, MA: Harvard University Press.
Worthen, V. E., & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research*, *7*(1), 48–53.

