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Client Experiencing in Cognitive-Behavioral Treatment for Eating Disorders

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Client Experiencing in Cognitive-Behavioral Treatment for Eating Disorders

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A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

Client Experiencing in Cognitive-Behavioral Treatment for Eating Disorders

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Depth of client experiencing has been associated with positive therapeutic outcomes across theoretical orientations. Experiencing describes a particular mode of cognitive-affective processing in which clients use internal felt experience as the basis for self-examination and the resolution of personally significant issues. Given evidence that eating disorders are associated with particular disruptions of cognitive-affective processing, it is likely that experiencing plays a role in the successful treatment of eating pathology. However, no study to date has examined the relationship between experiencing and outcome in eating disorder treatment. The purposes of the current study were to examine depth of client experiencing during cognitive-behavioral treatment for eating disorders and to investigate the relationship between experiencing and outcome. Regression analyses suggested no significant relationship between depth of experiencing and outcome. However, results indicated that a restricted range of experiencing occurred during the treatment, which may have limited the possibility of detecting a relationship. A number of factors that may have contributed to the restricted range of experiencing in the sample are considered and discussed.

Keywords: experiencing, emotional processing, eating disorders

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Table of Contents

List of Tables	vi
Introduction.....	1
The Experiencing Construct	1
Experiencing and Emotional Processing	4
Experiencing and Emotional Expression	5
Cognitive-Affective Processing.....	5
Therapeutic Processes Promoted by Experiencing.....	7
Disruptions of Cognitive-Affective Processing in Eating Disorders.....	9
Experiencing in the Treatment of Eating Disorders	15
Aims and Hypotheses	18
Method	20
Data	20
Participants.....	20
Therapists	22
Treatment	22
Measures	23
Procedure	27
Results.....	32
Descriptive Statistics.....	32
Relationship of EXP to Outcome.....	34
Discussion.....	47

Possible Interpretations	51
Potential for Integration	53
Limitations	56
Conclusion	57
References.....	59

List of Tables

1. Summary of Control and Outcome Variables.....	32
2. Summary of EXP Ratings.....	33
3. Summary of Change in EXP Across Sessions.....	33
4. Summary of Intercorrelations for Modal Ratings of EXP, CHEDS Scores, and LESS Score	34
5. Summary of Intercorrelations for Peak Ratings of EXP, CHEDS Scores, and LESS Score.....	35
6. Summary of Intercorrelations for Change in Modal Ratings of EXP and CHEDS Scores.....	36
7. Summary of Intercorrelations for Change in Peak Ratings of EXP and CHEDS Scores	36
8. Regression of CHEDS Total Score by Baseline EXP	38
9. Regression of CHEDS Total Score by Early Working Phase EXP	38
10. Regression of CHEDS Total Score by Late Working Phase EXP.....	39
11. Regression of CHEDS Body Subscale Score by Baseline EXP.....	40
12. Regression of CHEDS Body Subscale Score by Early Working Phase EXP.....	40
13. Regression of CHEDS Body Subscale Score by Late Working Phase EXP	41
14. Regression of CHEDS Eating Subscale Score by Baseline EXP	41
15. Regression of CHEDS Eating Subscale Score by Early Working Phase EXP.....	42
16. Regression of CHEDS Eating Subscale Score by Late Working Phase EXP	42
17. Regression of CHEDS Total Score by Change in EXP from Baseline to Early Working Phase	43
18. Regression of CHEDS Total Score by Change in EXP from Baseline to Late Working Phase	44

19. Regression of CHEDS Body Subscale by Change in EXP from Baseline to Early Working	
Phase	44
20. Regression of CHEDS Body Subscale by Change in EXP from Baseline to Late Working	
Phase	45
21. Regression of CHEDS Eating Subscale by Change in EXP from Baseline to Early Working	
Phase	45
22. Regression of CHEDS Eating Subscale by Change in EXP from Baseline to Late Working	
Phase	46

Client Experiencing in Cognitive-Behavioral Treatment for Eating Disorders

Experiencing is a well-established construct in the theoretical and empirical literatures on psychotherapeutic change (Bohart, 1993; Klein, Mathieu-Coughlan, & Kiesler, 1986; Pascual-Leone & Greenberg, 2007). Deep levels of in-session client experiencing have been consistently associated with positive psychotherapeutic outcomes (e.g., Hendricks, 2002). Further research is needed with regard to the relationship between depth of experiencing and therapeutic outcome, including investigation of the conditions under which experiencing is likely to occur with therapeutic benefit and the client populations for whom experiencing is most relevant to positive change (Wiser & Arnou, 2001). The current study is an effort to shed light on how experiencing might relate to the change processes and outcomes of cognitive-behavioral treatment for individuals with eating disorders.

First, I will describe the experiencing construct, including its relationship to human functioning and its operationalization in psychotherapy research. Second, I will present a review of literature showing how experiencing relates to models of adaptive cognitive-affective processing. Third, I will review evidence that particular disruptions of cognitive-affective processing contribute to the development and maintenance of eating psychopathology, such that in-session experiencing would seem to be relevant to the alleviation of associated symptoms.

The Experiencing Construct

Experiencing refers to a dynamic process in which internal felt sensations are used as the basis for examination of self and situation (Klein, Mathieu, Gendlin, & Kiesler, 1969; Wiser & Arnou, 2001). An individual engaged in experiencing directs attention inward, identifies emergent feelings, and tries to make sense of how these relate to his or her life and personality (Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Greenberg, Rice, & Elliott, 1993; Hendricks,

2002). This process is thought to promote insight, understanding, and effective problem-solving efforts relative to issues of personal significance (Greenberg, Korman, & Paivio, 2002; Kiesler, 1973; Stalikas & Fitzpatrick, 1997). For example, someone who becomes aware of unexpected anger in a particular situation might attend to and explore the nature of associated feelings and come to understand them in terms of his or her unique history, values, and goals. Such understanding could then be utilized toward re-evaluation and/or behavioral change relative to the evoking situation (McGuire, 1991).

The felt sense. The internal referent of experiencing, often denoted as a felt sense, involves a complex integration of physiological, cognitive, and emotional aspects of the self as they are occurring in the present moment (Gendlin, 1991; Klein et al., 1986). Thus, it entails a preverbal visceral sensing that encompasses the whole of one's phenomenal field, including emotional reactions as well as somatic sensations, cognitive meanings, and reflexive awareness (Gendlin, 1991; Greenberg & Paivio, 1997; Klein et al., 1986). Accordingly, felt senses may be experienced with varying degrees of clarity and complexity (Gendlin, 1991). For instance, when experiencing involves a discrete emotional response to evoking stimuli (e.g., fear at threat, sadness at loss, anger at violation; Gendlin, 1991; Lazarus, 2006), the symbolization of the felt sense may be relatively simple, clear, and action-oriented (e.g., "I feel afraid, and want to run away"). By contrast, when experiencing involves a richer, subtler internal sense (e.g., "I feel down in the dumps," "I feel all washed up"), the implicit meaning of experience may emerge only through more extensive engagement with and elaboration of the initial felt sense (Greenberg et al., 2002).

Relationship to functioning. As the mechanism whereby phenomenological experience is brought into conscious awareness, experiencing is regarded as central to adaptive human

functioning (e.g., Greenberg & Paivio, 1997). Specifically, as internal experience comes to be symbolized and understood in the context of past, present, and future, it lends meaning and continuity to one's living (Gendlin, 1962, 1991; McGuire, 1991; Pos, Greenberg, Goldman, & Korman, 2003); it provides access to critical information about the state of the self relative to the environment (Greenberg et al., 1993; Wiser & Arnou, 2001); and it informs problem-solving, decision-making, and other purposive actions (Gendlin, 1962; Greenberg, 2008; Stalikas & Fitzpatrick, 1997). Insofar as these processes are facilitative of change and health, experiencing is regarded as theoretically relevant across therapeutic contexts and personal growth situations (Klein et al., 1986).

Operationalization. In psychotherapy research, experiencing has been operationalized into measurable verbal behaviors (Klein et al., 1969). Experiencing is conceptualized as a series of stages reflecting progression from abstract impersonal communications with no internal referent, through the investigation and elaboration of felt meaning in conscious awareness. The deepening of in-session experiencing reflects increasing ownership of feelings, self-revelation, and problem orientation in the verbal communications of the client (Klein et al., 1969). Ratings of experiencing represent the phenomenological status of the client, with the recognition that he or she may be more or less able and/or willing to communicate about inner experience in the presence of the therapist (Kiesler, 1973; Klein et al., 1969).

Depth of in-session client experiencing has been shown to have a robust positive association with therapeutic outcome, particularly within humanistic and experiential traditions (Elliott, Greenberg, & Lietaer, 2004; Hendricks, 2002; Klein et al., 1986; Orlinsky & Howard, 1978; Todd & Bohart, 1999). Moreover, initial investigations of experiencing in cognitive-behavioral and psychodynamic therapies (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996;

Silberschatz, Fretter, & Curtis, 1986; Watson & Bedard, 2006) have supported the notion that it represents a key component of change across theoretical orientations (see Greenberg & Pascual-Leone, 2006; Whelton, 2004).

Experiencing and Emotional Processing

Although experiencing is not limited to emotional arousal or expression, it often includes or generates emotions (e.g., McGuire, 1991; Wiser & Arnou, 2001). Accordingly, the experiencing construct has often been central to investigations of emotional processing (e.g., Castonguay et al., 1996; Greenberg & Pascual-Leone, 2006; Watson & Bedard, 2006; Wiser & Goldfried, 1998). At the broadest level, emotional processing refers to all the tacit and explicit processes that influence the generation, experience, and regulation of emotion (Pos et al., 2003; Whelton, 2004). From this perspective, experiencing is viewed as the means whereby emotions can be brought into conscious awareness, evaluated, understood, and used to guide planning, decision-making, and behavior (Greenberg & Paivio, 1997). Emotional processing is thus viewed as a particular mode of experiencing, in which the cognitive elaboration of a felt sense involves a specific emotion (Pos et al., 2003; Pos, Greenberg, & Warwar, 2009).

Indeed, many theories of emotional processing parallel the elaborative processes described by the experiencing construct, emphasizing a progression from initial raw affect, to specific emotions, to conscious meaning-laden feelings (e.g., Greenberg & Safran, 1987; Guidano, 1991; Lazarus, 2006; Leahy, 2002; Pascual-Leone & Greenberg, 2007). In such models, emotional experience begins at a pre-reflective level, and is then processed through levels of increasing differentiation and elaboration, at which emotions are perceived or felt, then attended to, then labeled and interpreted. Disruptions at any stage of this process can lead to

difficulty understanding one's emotional experience and using it to guide behavior in adaptive ways (Kennedy-Moore & Watson, 1999).

Experiencing and Emotional Expression

Theory and research have also emphasized the importance of emotional expression in psychotherapeutic process (e.g., Kennedy-Moore & Watson, 2001). The deliberate expression or non-expression of an emotion follows from evaluation of the emotion as appropriate relative to personal values and perception of the social context (Kennedy-Moore & Watson, 1999).

Accordingly, disruptions of emotional expression may reflect and/or lead to disruptions of the elaborative processing associated with experiencing. Such a caveat underlines the importance of assessing and possibly working to modify client beliefs about the experience and expression of emotion in order to facilitate adaptive emotional processing during therapy (e.g., Leahy, 2002).

Cognitive-Affective Processing

Contemporary theories of dual processing suggest that deeper levels of experiencing promote psychological health and therapeutic change by fostering adaptive integration of affect and cognition (Mahoney, 1991). In this perspective, humans possess two distinct but interacting systems for creating meaning, one affective/experiential and one cognitive/rational (e.g., Epstein, 1994; Guidano, 1991). Processing at the experiential level is global, integrated, and holistic, yielding a subjective felt sense of one's spatial and affective relationship to the environment (Damasio, 1994, 1999; Epstein, 1994). Such processing corresponds to the felt sense at the basis of experiencing. By contrast, processing at the cognitive level is somewhat slower and dominated by logic and reason, facilitating more deliberate, differentiated evaluations of internal and external events (Epstein, 1994; Guidano, 1991; Lazarus, 1991a; LeDoux, 1996, 2007). It is

this level of processing that allows a person to direct attention to and explicate the implicit meaning of an internal felt sense.

The dialectical interplay of cognitive and experiential processing over the course of individual development is thought to yield increasingly sophisticated and idiosyncratic representations of phenomenological experience and conceptual knowledge, which can promote more thorough, deliberate, and efficient marshaling of resources relative to stimuli of personal significance (Damasio, 1999; Epstein, 1994; Epstein, Lipson, Holstein, & Huh, 1992; Greenberg et al., 1993; Lazarus, 2006; Lazarus & Folkman, 1984). Moreover, adaptive development toward meeting biopsychosocial needs is characterized by balanced integration between cognitive and experiential processing (e.g., Lazarus, 1991a, 1991b; Pascual-Leone, 1991). As noted by Kennedy-Moore and Watson (2001), “Relying solely on rational processing means that one is cut off from a rich source of information about oneself and the impact of the environment, whereas relying solely on experiential processing entails being driven blindly by diffuse affective responses” (p. 194). Thus, given its emphasis on the elaboration of felt experience in conscious awareness, experiencing in therapy is viewed as promoting well-being, in part, by fostering balanced integration of affect and cognition (e.g., Greenberg et al., 1993).

This contention is consistent with evidence from across therapeutic orientations that the cognitive elaboration of in-session affective experience can promote adaptive behaviors and positive, enduring change (Bohart & Tallman, 1999; Borkovec, Roemer, & Kinyon, 1995; Greenberg & Safran, 1987; Guidano, 1991). For instance, in a recent review of research across humanistic-experiential, behavioral, psychodynamic, cognitive, and health psychology orientations, Whelton (2004) argued that therapeutic change is promoted when processes of emotion are facilitated through structured sequences of attention, articulation, reflection,

exploration, and meaning creation. Noting that such sequences are central to research on well-established constructs such as experiencing and emotional processing, he concluded that the deepest transformations in therapy result from processing that combines emotional arousal with cognitive reflection on the significance and meaning of emotional experience (Whelton, 2004).

Therapeutic Processes Promoted by Experiencing

Wiser and Arnow (2001) have provided a cogent framework for understanding how client experiencing promotes enduring therapeutic change. Drawing on contemporary emotion theory, these authors suggest that experiencing helps clients gain access to critical information about the self in relation to the environment, which information can be utilized toward the formation of adaptive behavioral responses and the resolution of personally meaningful issues. Specifically, they argue that access to experiential information promotes two important processes: (a) the evaluation and potential modification of tacit belief systems, and (b) the initiation of new behaviors prompted by adaptive action tendencies (Wiser & Arnow, 2001).

In psychotherapy research, facilitating client experiencing has frequently been viewed as promoting the uncovering, explication, evaluation, and potential modification of tacit meaning systems (e.g., Greenberg, 2008; Greenberg & Paivio, 1997; Teasdale, 1993). As noted by the authors of the Experiencing Scale, the basic construct of experiencing is an internal felt sense, which includes the implicit meanings that structure the sensations and feelings that arise in interaction with the environment (Klein et al., 1986). Many theorists have suggested that such implicit meanings are generated by networks of densely integrated cognition and affect, synthesized through individual experience and learning (e.g., Clark, Beck, & Alford, 1999; Greenberg & Safran, 1987; Teasdale, 1993). These cognitive-affective networks have thus been identified as targets for therapeutic intervention (Greenberg, 2008; Pos et al., 2003).

Consistent with these arguments, Wiser and Arnow (2001) hold that a central goal of all therapies is the promotion of enduring and adaptive shifts in clients' tacit frameworks for perceiving and understanding self, others, and situations. They note that such frameworks tend to be strongly associated with behavior, and may be inaccessible to rational exploration without affective engagement (see also, Samoiloov & Goldfried, 2000). In light of related evidence, Wiser and Arnow (2001) assert that insofar as experiencing includes engagement with pre-verbal affective material in combination with active cognitive exploration of associated systems of meaning and belief, it is likely to promote enduring and adaptive shifts in the way clients perceive and understand themselves, others, and situations.

In addition, Wiser and Arnow (2001) suggest that experiencing promotes therapeutic change by fostering stronger connections with biologically driven action tendencies. This contention draws on theory and research characterizing emotion as a fundamentally adaptive, orienting, and meaning-producing system, which has evolved to promote self-preservation and self-enhancement (Greenberg et al., 2002; Greenberg & Safran, 1989; Lazarus, 1991b, 2006; Mahoney, 1991). In this view, emotions are thought to inform people of the significance of events to their well-being, to organize them for rapid action, and to constitute a primary signaling system for regulating interpersonal interaction (Frijda, 1986; Izard, 1991; LeDoux, 1996; Oatley & Jenkins, 1992; Sroufe, 1996). A number of theorists have thus emphasized that access to emotions and their associated action tendencies is crucial for adaptive responding to an ever-changing array of biological, psychological, and social exigencies (e.g., Greenberg et al., 1993; Mahoney, 1991; Tomkins, 1963). Accordingly, Wiser and Arnow (2001) assert that experiencing allows clients to more fully experience the self-preservative action impulses

associated with felt senses, which impulses provide motivation to cease maladaptive behaviors and/or initiate more functional, self-enhancing ones.

Finally, Wisner and Arnow (2001) provide some tentative guidelines as to which clients might be most and least likely to benefit from the facilitation of experiencing. Relative to the first group, they suggest that clients who selectively or habitually avoid emotional experiencing, clients who exhibit maladaptive behavioral responses, and clients whose frameworks of meaning have been shattered should be helped to access the critical information and novel meaning construction that experiencing can provide. By contrast, they categorize clients who become confused, dysregulated, or overwhelmed by emotional experience; clients who cope with heightened experiencing in destructive ways; clients who are not engaged in fundamentally adaptive emotional responses; and clients who do not experience trust in the therapeutic relationship as those who might derive the least benefit from experiencing. Nonetheless, Wisner and Arnow (2001) note that the facilitation of experiencing in order to uncover and clarify feelings, beliefs, and meanings may still be indicated for clients in the second group, especially if such clients are first trained to regulate their internal experience through the use of adaptive coping strategies.

Disruptions of Cognitive-Affective Processing in Eating Disorders

Individuals with eating disorders have long been cited as a population that has difficulty making sense of internal experience and using it to guide behavior (e.g., Bruch, 1962; Fox, 2009). Affective and emotional factors have received particular attention, with evidence suggesting a double bind in which eating-disordered individuals not only experience elevated levels of negative affect compared to controls (Whiteside et al., 2007; Wolff, Crosby, Roberts, & Wittrock, 2000), but are also ill-equipped to process such affect in adaptive ways (Fox &

Harrison, 2008; Gilboa-Schechtman, Avnon, Zubery, & Jeczmierny, 2006; Meyer, Leung, Barry, & De Feo, 2010; Meyer, Waller, & Waters, 1998; Stice, 2001). Indeed, research among individuals with eating disorders has identified a number of factors that would be expected to disrupt cognitive-affective processing at the levels of perception, attention, interpretation, and elaboration described by the experiencing construct (e.g., Bydlowski et al., 2005; Fox & Harrison, 2008; Geller, Cockell, Goldner, & Flett, 2000; Gilboa-Schechtman et al., 2006; Harrison, Sullivan, Tchanturia, & Treasure, 2009).

Investigation of such disruptions is crucial to the effective treatment of these disorders, given that cognitive-affective processing appears to be of central relevance in the etiology and maintenance of eating psychopathology (Bydlowski et al., 2005; Fox & Power, 2009). In fact, some authors have even suggested that eating disorders might be characterized as a subtype of emotional disorders (Gilboa-Schechtman et al., 2006). To begin with, there is ample evidence that negative affective and emotional states often precipitate episodes of disordered eating behavior (Meyer et al., 2010; Stice, 2001). Moreover, a growing body of empirical literature supports the notion that restriction, bingeing, and purging behaviors function as strategies to suppress, modify, and/or manage emotional experience (Cooper, Wells, & Todd, 2004; Corstorphine, Mountford, Tomlinson, Waller, & Meyer, 2007; Fairburn, Cooper, & Shafran, 2003; Fox, 2009; Harrison et al., 2009; Overton, Selway, Strongman, & Houston, 2005; Sim & Zeman, 2004). In combination, such findings highlight the importance of understanding how individuals with eating disorders respond to and process internal experience, particularly affect and emotion, and how associated deficits may contribute to the development and maintenance of the disorders themselves (Corstorphine et al., 2007; Fox & Power, 2009).

A wealth of evidence suggests that disordered eating is associated with limited capacity to clarify one's affective states. For example, research has consistently shown a relationship between disordered eating and alexithymia, which is characterized by limited ability to identify feelings and differentiate them from other bodily sensations, limited ability to describe and communicate feelings to others, and externally oriented thinking (Bydlowski et al., 2005; Lawson, Emanuelli, Sines, & Waller, 2008; Speranza et al., 2005; Taylor, Parker, Bagby, & Bourke, 1996; van Strien & Wuwens, 2007). Eating psychopathology has also been linked with a number of related constructs, including low emotional awareness (Gilboa-Schechtman et al., 2006) and poor interoceptive awareness (Merwin, Zucker, Lacy, & Elliott, 2010), each of which describes not only low tendency to attend to internal experience, but also limited ability to differentiate somatic and affective states. Taken together, such findings suggest that individuals with eating disorders are likely to manifest cognitive-affective processing deficits at levels of perception and attention, which may prevent internal experience from being adequately differentiated and/or symbolized.

Not surprisingly, lack of clarity with regard to internal experience among eating disordered individuals has been associated with interpersonal difficulties, including impaired ability to judge the internal experience of others (Bydlowski et al., 2005), and with poor treatment outcome (Speranza, Loas, Wallier, & Corcos, 2007). In light of aforementioned research on experiencing and cognitive-affective processing (e.g., Whelton, 2004), one might suspect that this latter finding reflects, at least in part, a limited capacity on the part of the treated individuals to engage in the sort of verbal processing thought to characterize effective psychotherapy.

Moreover, deficiencies in the ability to differentiate bodily states and/or relate them to affect may play a direct role in maintaining disordered eating behaviors. For instance, recent theory and research suggest that, in individuals with eating disorders, body dissatisfaction and “feeling fat” come to function as proxies for negative affect in general (Fairburn, 2008). In this view, a tendency to mislabel certain emotional states (e.g., boredom, loneliness, or sadness) and bodily experiences (e.g., feeling full, hot, or sweaty) as feelings of “fatness” is thought to trigger efforts to resolve such feelings through strategies focused on eating, shape, and weight (Fairburn, 2008; Fox & Power, 2009). A similar process is thought to result when somatic and affective states are adequately identified, but routinely misattributed to fatness or body dissatisfaction (Kearney-Cooke & Striegel-Moore, 1997; Sim & Zeman, 2005). From such perspectives, deficits in the ability to clarify internal states are thought to result in displacement of negative feelings onto the body (e.g., Dolhanty & Greenberg, 2009), and disordered eating behaviors represent an indiscriminate approach to coping with somatic and affective responses that are ambiguous and/or misunderstood (Fox & Power, 2009).

Individuals with eating disorders also appear to view certain internal states in an exceptionally negative light. For instance, increased levels of eating psychopathology have been associated with fear and guilt regarding affective experience (Merwin et al., 2010) and with perceptions of threat from emotions, especially anger (Ioannou & Fox, 2009). Associated research also suggests that such views often manifest in negative attitudes and beliefs relative to the expression of internal experience (e.g., Lawson et al., 2008). For instance, women with concerns about eating, shape, and weight have been found to be significantly more likely to believe that expressing emotions is a sign of weakness, that emotions should be kept under control, and that emotional displays would lead to negative social consequences (Lawson et al.,

2008; Meyer et al., 2010). Findings of this nature not only suggest a lack of acceptance relative to the experience and expression of certain internal states, but again highlight emotional experience as particularly problematic within an eating disordered population.

Clearly, negative beliefs about the expression of affect and emotion would be expected to inhibit verbal processing, such as might take place with a supportive friend, family member, or counselor. At a more implicit level, the evaluation of internal experience as undesirable, threatening, or otherwise unacceptable would be expected to inhibit attention to that experience, preventing further differentiation, elaboration, and understanding (Kennedy-Moore & Watson, 1999). Indeed, among eating disordered individuals, the presence of negative attitudes toward affect and emotion has been associated not only with inhibited emotional expression, but also with aforementioned deficits in describing one's feelings to others (Geller et al., 2000; Ioannou & Fox, 2009; Lawson et al., 2008).

Furthermore, there is growing consensus that negative evaluations of affect and emotion (e.g., as problematic, uncontrollable, etc.) are not only associated with simplistic understanding of internal experience, but may also mediate aforementioned connections between emotional distress and disordered eating behaviors (Fox, 2009; Leahy, 2002). Specifically, evidence suggests that it is not merely the presence or quantity of negative affect that predicts disordered eating, but rather, the interpretation of such affect as intolerable and/or ego-dystonic (Fox & Power, 2009). Thus, while theory and research suggest numerous reasons why individuals with eating disorders might experience negative affect (e.g., failure to live up to distorted ideals of body image, Stice, Presnell, & Spangler, 2002), it appears that negative perceptions of the affect itself can sometimes determine whether that experience will precipitate disordered eating behaviors.

Such findings link eating psychopathology to the construct of experiential avoidance, which refers to a process in which the negative evaluation of internal events, such as thoughts, feelings, and bodily sensations, is associated not only with an unwillingness to remain in contact with these events, but also with deliberate efforts to control, suppress, or escape from them (Chawla & Ostafin, 2007; S. C. Hayes, Wilson, Gifford, Follette, & Strosahl, 1996).

Experiential avoidance presents a conceptual counterpart to the notion of experiencing, and would, by definition, be expected to disrupt associated processes of attention and elaboration.

Evidence suggests that experiential avoidance is a common function served by a number of maladaptive behaviors (e.g., substance use, high-risk sexual behavior), and may be particularly relevant in the development and maintenance of eating disorders (Chawla & Ostafin, 2007; Hayaki, 2009; S. C. Hayes et al., 1996; Kingston, Clarke, & Remington, 2010; Koff & Sangani, 1997; Rawal, Park, & Williams, 2010). For instance, binge eating is thought to serve a numbing function relative to negative affect (e.g., Overton et al., 2005). Similarly, restriction appears to facilitate avoidance or “blinking out” of emotional states (Serpell, Treasure, Teasdale, & Sullivan, 1999, p. 180). In addition, associated research tends to underscore the motivation to avoid experiencing among individuals with eating disorders, as noted in Reindl’s description of a sample of women who “had not been sensing self-experience because when they focused inward they felt unbearable inadequacy and shame and experienced unmanageable chaos and fragmentation” (Reindl, 2001, p. 34).

Findings such as these dovetail with the notion that disordered eating behaviors reflect a desire to escape from self-awareness (Heatherton & Baumeister, 1991; Meyer et al., 1998).

From this perspective, individuals with eating disorders experience themselves as failing to live up to rigid standards, yielding unflattering evaluations of the self, accompanied by intense

emotional distress. Disordered eating behaviors—including bingeing, purging, and, to some extent, dieting—are thought to entail a narrowing of attention to immediate sensations, which prevents the conscious experience of these aversive thoughts and feelings (Heatherton & Baumeister, 1991). In addition, given that the physiological consequences of disordered eating behaviors (e.g., inadequate nutrition, electrolyte imbalance, low blood glucose levels, etc.) have been shown to impair perception, mental processing, and mood regulation (Reindl, 2001), such evidence suggests a vicious cycle in which the avoidance of aversive internal experience through disordered eating behavior diminishes one's capacity to process subsequent cognitive and affective material in adaptive ways (Heatherton & Baumeister, 1991).

In summary, disordered eating is associated not only with a lack of clarity regarding internal experience, but also with a lack of acceptance relative to certain kinds of internal experience, particularly affect and emotion (Merwin et al., 2010). This lack of acceptance may involve negative views regarding the experience and/or expression of affective and emotional states, as well as deliberate efforts to avoid these states through maladaptive behaviors, such as restriction, bingeing, and purging. Deficiencies of cognitive-affective processing thus appear not only to play a role in the development and maintenance of eating disorder symptomatology (Bydlowski et al., 2005; Gilboa-Schechtman et al., 2006), but also to impact an individual's ability to effectively engage in psychotherapeutic treatment through adaptive emotional expression (Ioannou & Fox, 2009).

Experiencing in the Treatment of Eating Disorders

In light of the above findings, the processes of attention, differentiation, symbolization, and elaboration described by the experiencing construct are regarded as particularly relevant to the treatment of individuals with eating disorders (Dolhanty & Greenberg, 2009; Fox & Power,

2009; Merwin et al., 2010). Indeed, Reindl (2001) not only describes a profound disconnection from internal experience as a defining feature of eating psychopathology, but also characterizes recovery, in part, as “a process of learning to sense one’s self, to attune to one’s subjective physical, psychic, and social self-experience” (p. 5).

Deep levels of experiencing would be expected to promote greater clarity, acceptance, and understanding of affective and emotional states (Watson & Bedard, 2006; Whelton, 2004; Wisner & Arnow, 2001; Wisner & Goldfried, 1998), which could prevent recourse to maladaptive eating behaviors as a means of addressing perceived problems and/or avoiding associated affect. Experiencing would also be expected to facilitate the uncovering and modification of tacit meaning systems, including negative views toward emotion (Meyer et al., 2010) as well as dysfunctional schemes for evaluating self-worth in terms of body shape and weight (Stice et al., 2002). In addition, contemporary emotion theory suggests that deep levels of experiencing could help clients with eating disorders to access adaptive urges associated with avoided affect, which could aid in the determination, initiation, and maintenance of goal-directed actions related to changing disordered eating behaviors (Wisner & Arnow, 2001).

Consistent with such reasoning, recent years have seen calls for increased promotion of cognitive-affective processing in eating disorder treatment, especially interventions that help clients to attend to and explore aversive thoughts, feelings, and bodily sensations (Merwin et al., 2010). For example, it has been suggested that therapy for eating psychopathology should facilitate conscious reflection on the in-session experience of painful emotion in order to promote greater self-awareness and the development of new schematic models about internal experience (Fox & Power, 2009). This recommendation closely parallels the conceptualization of deep-level experiencing in terms of both process (cognitive elaboration of the felt sense in

conscious awareness) and positive corollaries (increased awareness, reorganization of internal cognitive-affective networks) (Greenberg, 2008; Klein et al., 1969).

Unfortunately, there have been few investigations as to the relationship between cognitive-affective processing and outcome in the treatment of eating disorders. Although the late 1980s saw numerous efforts to develop experiential therapies for eating disorders (see Hornyak & Baker, 1989), the foundations of such therapies were characterized as more theoretical than empirical (Perri, 1989). Similarly, some contemporary therapies (e.g., Acceptance and Commitment Therapy, Dialectical Behavior Therapy) have sought to address cognitive-affective processing deficits through strategies related to acceptance and mindfulness; however, empirical research as to the effectiveness of these treatments with eating disordered clients has thus far been limited (Merwin et al., 2010).

One notable exception is a study of group CBT for binge eating disorder, in which both positive and negative emotions were found to play a role in therapeutic outcome, depending on the point in treatment (Castonguay, Pincus, Agras, & Hines, 1998). Although this study assessed emotional experience in terms of self-reported feelings and perceived group climates, rather than experiencing per se, the pattern of results nonetheless supported the therapeutic value of integrated cognitive-affective processing, as noted in the subtitle of the resultant article: When things have to feel worse before they get better (Castonguay et al., 1998).

In addition, Dolhanty and Greenberg (2009) published a study of Emotion-Focused Therapy in a case of anorexia nervosa, in which they described the successful implementation of a treatment that aimed specifically to increase awareness of, and capacity to manage, affective experience. At 18 months, the client had maintained weight gained during hospitalization prior to treatment, and showed improvement on measures of depression, alexithymia, and emotional

awareness (Dolhanty & Greenberg, 2009). These results represent a direct application of theory on cognitive-affective processing in the successful treatment of an individual with an eating disorder.

Thus, initial findings are consistent with the notion that depth of experiencing is related to positive outcome in eating disorder treatment. Nonetheless, there is an ongoing need to supplement theoretical understanding of cognitive-affective processes in eating disorders with empirical evidence as to the relationship of such processes to treatment outcome (Castonguay et al., 1998; Corstophine et al., 2007; Dolhanty & Greenberg, 2009; Fox, 2009; Gilboa-Schechtman et al., 2006; Sim & Zeman, 2005).

Aims and Hypotheses

The current study was designed to investigate the relationship between in-session client experiencing and outcome in a sample of eating disorder clients treated using Enhanced Cognitive Behavior Therapy for eating disorders (CBT-E; Fairburn, 2008). The study had three specific aims:

Aim 1: Describe the degree to which in-session experiencing occurred during the treatment of the individuals sampled to provide an initial indication of how much experiencing is likely to occur in CBT-E.

Aim 2: Examine the relationship between levels of in-session experiencing and three indicators of post-treatment outcome: eating-related thoughts, feelings, and behaviors; body-related thoughts, feelings, and behaviors; and overall outcome as measured by the combination of these.

Aim 3: Examine whether perceptions of the experience and expression of emotion moderate the relationship between experiencing and outcome.

Relative to these aims, the following hypotheses were made: Based on previous findings regarding levels of experiencing during cognitive therapy (Castonguay et al., 1996; Watson & Bedard, 2006; Wiser & Goldfried, 1993), it was expected that experiencing would be present in the sessions selected, with variability among clients across therapy. However, because the Experiencing Scale had never been utilized in an investigation of emotional processing in eating disorders, this hypothesis was exploratory (Aim 1).

Experiencing was predicted to show a relationship with outcome similar to that in past studies. Specifically, it was expected that individuals who reached deeper levels of experiencing and/or those who showed increased levels of experiencing over the course of treatment, would have better outcomes (Bohart, 1993; Hendricks, 2002). Thus, higher levels of experiencing were predicted to be associated with decreased post-treatment eating disorder symptomatology (i.e., fewer eating-related and body-related thoughts, feelings, and behaviors), and clients who showed an increase in depth of experiencing across therapy were predicted to show better treatment outcomes (Aim 2).

Finally, given evidence that negative attitudes toward emotion are associated with decreased emotional processing (Kennedy-Moore & Watson, 1999; Lawson et al., 2008; Leahy, 2002; Meyer et al., 2010), it was predicted that views of emotion would moderate the relationship between depth of experiencing and outcome, such that individuals who reported more positive views of the experience and expression of emotion at intake would show a stronger positive relationship between experiencing and outcome (Aim 3).

Method

Data

Data was obtained from Spangler's (2009) efficacy study of cognitive-behavior therapy for eating disorders. All sessions from this study were videotaped. The study also incorporated an assessment battery relative to eating disorder symptomatology.

Participants

Participants in the initial treatment study (2009) were recruited through fliers, newspaper ads, and referrals to the Brigham Young University (BYU) Comprehensive Clinic. Following an initial telephone screening, potential participants underwent an in-person diagnostic assessment using the Eating Disorders Examination, an established interview-based diagnostic measure for eating disorders. Assessors received weekly on-site training and supervision from Dr. Diane Spangler.

Participants were excluded from the study if they had comorbid psychosis, bipolar disorder, a medical condition that significantly impacts weight (e.g., thyroid conditions), or a history of bariatric surgery. In addition, participants were not allowed to participate concurrently in any other type of psychotherapeutic treatment. Concurrent medication use was allowed, as long as the dosage remained constant throughout treatment. Informed consent was obtained from all participants for participation in the study, audio-visual recording, and completion of the measures. All participants received therapy at no cost.

The resultant sample consisted of 59 participants, of whom 97% were Caucasian and 3% were Hispanic. Ninety-four percent of participants were female. All participants were outpatients, 18 years of age or older ($M: 26.3$, $SD: 10.5$, Range: 18-65), and met criteria for an eating disorder according to the Diagnostic and Statistical Manual of Mental Disorders (4th

edition, text revision; DSM-IV-TR; American Psychiatric Association, 2000). Most participants (89.8%) were diagnosed with bulimia nervosa and eating disorder not otherwise specified. Remaining participants (9.2%) were diagnosed with anorexia nervosa. These percentages were consistent with prevalence rates for eating disorders and with sample characteristics in other studies.

For the purposes of the present study, a subset of participants was excluded from further analysis. Specifically, because treatment lasted twice as long for individuals diagnosed with anorexia nervosa, these participants were excluded to ensure that data was gathered when all clients were at similar points in therapy. The resultant sample comprised 53 participants, 92% of whom were female. Participants ranged in age from 18 to 65 ($M: 25.17, SD: 10.06$). Eighty-one percent were unmarried. All participants were Caucasian.

Attrition and missing data in the original treatment study further reduced the sample size. Specifically, video recordings of the initial session existed for 50 of the above participants. Of these, twelve individuals dropped out before the early working phase of treatment, and five more dropped out before the late working phase of treatment. One individual completed all phases of treatment, but video recordings were not available beyond the initial session. Thus, levels of experiencing were obtained for 50 individuals at baseline, 37 individuals at early working phase, and 32 individuals at late working phase. In addition, five more participants dropped out before the final session, leaving a total of 27 individuals who completed treatment. All were both female and Caucasian. Twenty-six were unmarried. Their ages ranged from 18 to 55 ($M: 27.67, SD: 10.49$).

Therapists

In the initial treatment study, therapy was conducted by four female Ph.D. candidates in clinical psychology. All four had received prior training in cognitive behavioral theory and interventions, and had been practicing cognitive behavioral therapy under supervision for at least one year. All therapists were trained by Dr. Diane Spangler in the use of the CBT-E treatment protocol prior to beginning treatment with study clients. This training included seeing pilot clients until competency in delivering the treatment protocol was reached. While seeing study clients, therapists received weekly on-site supervision, during which videotaped sessions were reviewed. In addition, fidelity checks with the treatment protocol were completed by therapists at the end of each therapy session.

Treatment

Treatment was administered in 20 individual therapy sessions over 20 weeks. Each session was 50 minutes in length. For the first three weeks, sessions were held twice per week. For the next 11 weeks, sessions were held once per week. For the last six weeks of treatment, sessions were held once every two weeks.

Treatment was administered according to Fairburn's (2008) protocol for Enhanced Cognitive Behavioral Treatment for Eating Disorders (CBT-E). This protocol is divided into four stages, each of which focuses on specific aspects of eating disorder symptomatology. Stage one is focused on reducing and eventually eliminating excessive dietary restriction, binge eating, and compensatory behaviors. Stage two is focused on assessing changes made in stage one, identifying any barriers for change, and planning stage three. Stage three is focused on modifying client dysfunctional beliefs about body shape and weight. Stage four is focused on maintenance of treatment gains and relapse prevention. The protocol specifies agenda items,

assessments, and clinical forms to be used at each session. Detailed descriptions of the treatment protocol are provided by Fairburn (2008). Although treatment closely followed the course and procedures specified in the manual, effort was also made to tailor the sessions to the specific needs and symptoms of individual clients.

Measures

Leahy Emotional Schema Scale (LESS). The Leahy Emotional Schema Scale (Leahy, 2002) was designed to assess how clients conceptualize and deal with their feelings and emotions. It was developed as part of an explicit attempt to integrate an emotion-focused model of emotional processing with a meta-cognitive model. The LESS is a self-report scale consisting of 50 items, which are rated on a 6-point Likert scale (1=very untrue of me, 6=very true of me). Scale items reflect fourteen dimensions related to one's appraisals of and responses to emotion: Validation by Others, Comprehensibility, Guilt, Simplistic View of Emotion, Higher Values, Controllability, Numbness, Demand for Rationality, Duration, Consensus, Acceptance of Feelings, Rumination, Expression, and Blame. The measure is highly face valid. Although the LESS is relatively new, correlational studies among clients with depression and anxiety have supported the views that: (a) emotional expression alone may be insufficient for therapeutic change, and (b) the greater the degree to which emotional expression facilitates acceptance, understanding, decreased guilt, and greater differentiation of emotions, the greater the impact on treatment outcome (Leahy, 2002). In the treatment study, the LESS was administered at intake, again at the completion of treatment, and once more at six-month follow-up.

For the analyses in the present study, the 14 dimensions of the LESS were divided into two categories based on Leahy's (2002) characterizations of each as either promoting or inhibiting emotional processing. Validation, Comprehensibility, Higher Values, Controllability,

Consensus, Acceptance of Feelings, and Expression were categorized as “adaptive,” while Guilt, Simplistic View of Emotions, Numbness, Demand for Rationality, Duration, Rumination, and Blame were categorized as “maladaptive.” Maladaptive dimensions were reverse-scored for conceptual clarity; specifically, higher values represented more adaptive approaches to emotional experience. These scores were regarded as a rough indication of the adaptive value of a given participant’s views of emotion. Six aggregate LESS scores were then derived for each participant: pre-treatment total, post-treatment total, pre-treatment adaptive total, pre-treatment maladaptive total, post-treatment adaptive total, and post-treatment maladaptive total.

Change in Eating Disorder Symptomatology (CHEDS). The Change in Eating Disorder Symptoms Scale (Spangler, 2010) is a 35-item, comprehensive measure of primary eating disorder symptomatology. The CHEDS is divided into two subscales. The first measures thoughts, feelings, and behaviors related to eating, and the second measures thoughts, feelings, and behaviors related to the body. Previous studies have evaluated the reliability and validity of the CHEDS with promising findings. The CHEDS was found to consist of seven factors, identified as: eating concerns/preoccupation, restriction, body preoccupation, body dissatisfaction, body checking, vomiting, and binge eating. These seven factors accounted for 72% of the variance. Internal reliabilities for the CHEDS factors ranged from .85 to .93, with the exception of vomiting, which had a reliability of .73. However, it should be noted that this latter factor consisted of only two items. Internal reliability for the overall scale was shown to be high, with a coefficient alpha of .96 (Spangler, 2010).

The CHEDS has also demonstrated construct validity in that the subscales correlated in expected patterns with other measures, discriminant validity in that the scale discriminated between eating disordered and non-eating disordered groups, and concurrent validity in that the

scale correlated with other eating disorder measures (Spangler, 2010). In addition, the CHEDS has been shown to be sensitive to change, with items changing in the theoretically proposed direction over the course of treatment (Hwang, under review). In the treatment study, the CHEDS was administered at every treatment and follow-up session. For the present analyses, the CHEDS was utilized as a measure of post-treatment outcome.

Burns Depression Checklist. The Burns Depression Checklist (BDC; Burns, 1984, Revised 1996, 1997; See Appendix) assesses symptoms of depression in four categories: Thoughts and Feelings, Activities and Personal Relationships, Physical Symptoms, and Suicidal Urges. It is a self-report measure consisting of 25 items, which are rated on a 5-point Likert scale (0=not at all, 1=somewhat, 2=moderately, 3=a lot, 4=extremely). In the treatment study, the scale was administered at intake, at session 7, at the completion of treatment, and again at six-month follow-up. For present analyses, the BDC was utilized to control for client level of depression.

The Experiencing (EXP) Scale. The Experiencing (EXP) Scale is a 7-point scale designed to measure the quality of a client's working engagement in therapy as rated from recordings or transcripts of client speech during therapy sessions (Klein et al., 1969). EXP represents the operationalization of the phenomenological construct of experiencing, and is thus described as the verbal manifestation of a process of looking inward, finding a felt sense, and using that felt sense as the referent for exploration and self-analysis. The seven levels of the scale represent steps in a progression from remote or impersonal communication of personal subjective experience, through stages of tentative sensing and questioning of subjective feelings, to fluid communication in which inner referents are a comfortable basis for reflection and problem resolution. Thus, gradual change from lower to higher stages on the scale represents

increased awareness of, attention to, and elaboration of felt experience toward the resolution of significant issues in a client's life. The stages of the EXP scale may be summarized as follows:

Stage 1: The client provides impersonal, detached, abstract descriptions of events or ideas. No personal referent is established.

Stage 2: The client's personal perspective emerges somewhat, such that her interest or involvement in the narrative is clear, but superficial. The client's communications do not refer to or define her feelings.

Stage 3: The client provides clear but limited descriptions of feelings and personal reactions. Communications of personal interest are confined to behavioral terms and rooted in external circumstances.

Stage 4: The client communicates directly about feelings and personal experiences. There is a clear shift to subjective felt sense as the referent, although this sense is not the focus of purposeful reflection or elaboration.

Stage 5: The content of the client's communication is exploratory and elaborative relative to problems or propositions about the self. Exploration is clearly feelings-based, with clear inner referents that have the potential to expand awareness of in-the-moment experiencing.

Stage 6: The client gains awareness of previously implicit feelings and meanings, with a felt sense that there is more to what is felt than can be immediately thought or named.

Stage 7: The client's communication reveals an evolving series of felt senses that emerge steadily and fluidly. Inner referents are readily attended to and integrated in the present experiential moment. Felt nuances function as springboards for further exploration and self-understanding (stage descriptions adapted from Klein et al., 1986).

The EXP Scale has been referred to as the “gold standard of good experiential process” (Pascual-Leone & Greenberg, 2007, p. 881). It has been extensively studied and validated with reference to speech fluency, perceptual concreteness, differentiation of cognitive meanings, and personality (Klein et al., 1986). As noted, high EXP ratings have been shown to predict therapeutic gain across theoretical orientations. The reliability of the scale has been evaluated relative to such variables as sampling procedure, rater sophistication, segment length, and mode of training. Reported interrater reliability coefficients range from .76 to .91, with reported rate-rater coefficients of .80 (Klein et al., 1986). The Experiencing Scale was used to code videotapes of sessions obtained from the aforementioned treatment study. Resultant scores were utilized as a measure of integrated cognitive-affective processing.

Procedure

Rater selection. Five potential raters were recruited from among research assistants in Diane Spangler’s lab. As per guidelines in the EXP Scale manual (Klein et al., 1969), screening criteria for potential raters included: (a) Sophomore standing or above, (b) Major in the humanities or social sciences, (c) Commitment to specified number of hours per week, (d) GPA of 3.0 or higher. A personal interview represented the last phase before selection. Working policies addressed during the interview included: (a) agreement to participate through the entire training period, (b) understanding that the final selection of raters would be made at the end of training based on ability to use the scale, (c) acceptance of work schedule, including expected number of hours per week (5-10) and specification of limits on time spent in a single rating session (minimum: 30 minutes, maximum: 2 hours without a 10-15 minute break), (d) agreement to receive minimal information regarding research design and use of the scale until the close of the project, and (e) agreement to participate in on-going review and re-orientation sessions.

The psychological sophistication, verbal skills, discretion, and maturity of raters were considered. Particular attention was devoted to issues of confidentiality, and prospective raters signed a copy of the Code of Ethics included in the EXP Scale manual.

Rater training. Raters were trained on the Experiencing Scales according to the manual published by the authors (Klein et al., 1969). Training took place during eight 2-hour sessions, each of which involved rating 10 practice segments. Ratings were compared with criterion ratings and justifications provided by the authors of the scale. At the end of training, rater reliabilities were computed for a block of 20 segments. Reliabilities for modal and peak ratings were calculated, and the three raters who achieved reliability with the expert ratings of .8 or higher were selected to code the sessions for the study. In order to address potential rater drift once coding for the study had begun, all raters re-read the scale, re-rated selected practice segments, and re-read the justifications provided on a bi-weekly basis. Ultimately, the two raters who achieved the highest reliability were used for the analyses.

Selection of sessions. In the absence of reliable information regarding trends in experiencing for an eating disorder population, and in order to minimize variability due to treatment stage, treatment dosage, and other associated variables, it was determined that segments from common points in therapy should be coded for each client. Based on Dr. Diane Spangler's knowledge of the treatment protocol, as well as her familiarity with the arc of treatment from supervising the therapists, sessions 0, 12, and 16 were selected as those to be rated. Because session 0 consists of an assessment interview prior to the beginning of the treatment proper, ratings of clients' answers to open-ended questions during this session were viewed as providing an indication of baseline experiencing without the potentially confounding influence of treatment effects. Thus, along with pre-treatment LESS scores, these ratings

provided an indication as to clients' general approach to cognitive-affective processing, including their ability, willingness, and tendency to engage in exploration of emotional experience in a help-seeking context.

Segments from sessions 12 and 16 were coded because these sessions fall in phase 3 of CBT-E, during which the focus is on modifying clients' dysfunctional beliefs about body shape and weight. It is likely that clients were dealing more directly with personally significant issues than in those sessions devoted to psychoeducation or treatment planning. Therefore, the experiencing level of clients might be expected to change or reach deeper levels as a function of the techniques employed at this point in the treatment protocol. The decision to code these sessions is also consistent with prior research suggesting that EXP ratings during the working phase of treatment are most predictive of outcome (Klein et al., 1986; Pos et al., 2009). Because session 12 falls a few sessions into treatment phase 3, it is likely that preliminary education and introductions to new treatment elements had been completed, and the focus was on real therapeutic "work." Similarly, session 16 falls one session prior to the conclusion of treatment phase 3, providing a second time point within the working phase of therapy. In the event that a session was not recorded or was lost due to technical difficulties, a contiguous session was coded (i.e., if session 12 was missing, session 13 was coded; if session 16 was missing, session 15 was coded). Session 12 (or 13) was designated "early working phase," and session 15 (or 16) was designated "late working phase."

Selection of segments. There is evidence that EXP ratings of brief segments are representative of experiencing across a full hour of therapy, with ratings of 4-, 6-, and 8-minute segments corresponding to ratings of the entire session (Kiesler, Mathieu, & Klein, 1964). It was determined that 8-minute segments would be rated in order to best represent the range of

experiencing in the sample. In the absence of data regarding trends in EXP over the course of a therapy hour for CBT-E, it was determined that segments would be drawn from various time points across the selected sessions. It was further reasoned that this sampling procedure might provide some indication as to moments in CBT-E during which internal felt experience is likely to become the basis for communication and self-understanding. Given that the beginning and end of each session generally involved logistical aspects of treatment, such as “checking in,” setting agendas, reporting on homework, and assigning new homework, it was determined that the first five minutes and the last five minutes of each session would not be rated. Eight-minute segments were thus drawn from the remaining 40 minutes of the selected sessions. To minimize the confounding effects of time, a random start point within the selected sessions was used.

Rating procedures. Segments were rated according to procedures in previous research. Raters summarized their ratings by two scores: a modal rating characterizing the average (most frequently occurring) scale level of the segment, and a peak rating representing the highest scale level reached within the segment. For segments in which these distinctions were unclear, modal and peak ratings were distinguished according to guidelines provided by the authors of the scale.

Data analysis. Interrater reliability was evaluated using an intraclass correlation (ICC) with raters as a fixed factor. ICCs at each of the three time points were .58, .67, and .81 for modal ratings, and .61, .67, and .80 for peak ratings. These results indicate questionable reliability for ratings of baseline EXP, acceptable reliability for ratings of early working phase EXP, and good reliability for late working phase EXP. Descriptive statistics were calculated for in-session experiencing across participants and point in treatment (Aim 1). Bivariate correlation analyses were used to examine relationships between variables without distinction between independent and dependent variables.

To evaluate whether depth of experiencing predicted treatment outcome, a number of regression analyses were performed. First, a regression was calculated with total post-treatment CHEDS score as the outcome variable and baseline EXP as the predictor, controlling for age, BMI, baseline depression (pre-treatment BDC), baseline eating disorder symptomatology (pre-treatment CHEDS), and initial views of emotion (pre-treatment LESS). Regressions were then calculated using early working phase EXP and late working phase EXP as predictors, controlling for age, BMI, baseline depression, baseline eating disorder symptomatology, initial views of emotion, and baseline level of experiencing.

These analyses were then repeated using more narrowly specified outcome variables, namely post-treatment scores on the two CHEDS subscales (eating-related thoughts, feelings, and behaviors; body-related thoughts, feelings, and behaviors), and using change in EXP (from baseline to early and late working phases) as the predictor variable. All analyses used the average rating of each segment across raters. Modal and peak ratings were analyzed separately (Aim 2).

To evaluate whether views of emotion moderated a relationship between EXP and outcome, the above analyses were repeated with baseline LESS score as both a main effect and as an interaction with the EXP variable. The interaction term was the primary test of the moderation effect (Aim 3).

It should be noted that the sample size for regression analyses was limited by attrition and missing data in the initial treatment study. Specifically, of the 50 participants for whom video recordings were available, only 27 completed treatment. Among these, nine were missing pre-treatment data for BMI, BDC score, LESS score, and/or CHEDS score. Under a listwise deletion approach to missing data, this meant that regression analyses utilizing post-treatment

CHEDS scores were limited to 18 observations. Results were thus compared against bivariate correlations and the results of models in which missing values were dropped or substituted with means.

Results

Descriptive Statistics

Table 1 presents aggregated means, standard deviations, and ranges for control variables (age, pre-treatment BMI, pre-treatment depression, pre-treatment eating disorder symptomatology, initial views of emotion) and outcome variables (post-treatment eating disorder symptomatology). Table 2 presents descriptive statistics for levels of EXP at each of the three time points. Table 3 presents descriptive statistics for change in EXP from baseline to the early working phase of treatment and from baseline to the late working phase of treatment.

Table 1

Summary of Control and Outcome Variables

Variable	<i>n</i>	<i>M (SD)</i>	Min	Max
Age	53	25.17 (10.06)	18	65
BMI	47	25.14 (8.70)	0	52.8
BDC	29	47.97 (18.48)	14	82
LESS	44	2.59 (3.32)	-8.61	8.53
Pre-Treatment CHEDS				
Total	48	94.65 (20.85)	41	127
Body Subscale	49	54.12 (10.99)	21	71
Eating Subscale	51	41.22 (11.56)	10	61
Post-Treatment CHEDS				
Total	27	33.41 (24.05)	0	86
Body Subscale	28	21.32 (14.70)	0	52
Eating Subscale	27	12.26 (10.06)	0	34

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, LESS = Leahy Emotional Schema Scale, CHEDS = Change in Eating Disorder Symptomatology.

Table 2

Summary of EXP Ratings

Time Point	<i>n</i>	<i>M (SD)</i>	Min	Max
Baseline				
Modal	50	2.36 (0.58)	2	4
Peak	50	2.45 (0.63)	2	4
Early Working Phase				
Modal	37	2.95 (0.84)	1.5	5
Peak	37	2.96 (0.84)	2	5
Late Working Phase				
Modal	32	3.00 (0.94)	1	5
Peak	32	3.03 (0.92)	1	5

Note. EXP = The Experiencing Scale.

Table 3

Summary of Change in EXP Across Sessions

Treatment Interval	<i>n</i>	<i>M (SD)</i>	Min	Max
Baseline to Early Working Phase				
Modal	37	0.58 (0.98)	-2	2.5
Peak	37	0.53 (1.05)	-1.5	2.5
Baseline to Late Working Phase				
Modal	32	0.64 (0.94)	-1	2.5
Peak	32	0.67 (0.93)	-1	2.5

Note. EXP = The Experiencing Scale.

Levels of experiencing. It was predicted that client experiencing would be present in the rated sessions, with variability among clients and across phases of therapy. The first part of this hypothesis was satisfied. However, mean values of EXP were typically low and ranged only from 2.36 ($SD = .58$) to 3.03 ($SD = .92$). This restricted range of EXP scores diminished the likelihood of detecting potential relationships between EXP and other variables, particularly

given the relatively small sample size. Results of subsequent analyses should thus be considered in light of the finding that EXP in the sample occurred with limited variability.

Relationship of EXP to Outcome

Correlations. Correlational analyses were conducted to investigate relationships between modal and peak ratings of EXP, treatment outcome (CHEDS total score, CHEDS Body Subscale score, and CHEDS Eating Subscale score), and views of emotion (pre-treatment LESS score). There was no significant correlation between post-treatment CHEDS and level of EXP at any of the three time points, indicating that depth of experiencing was not associated with post-treatment eating symptomatology. Nor were correlations observed between pre-treatment LESS score and levels of EXP, indicating that clients who initially endorsed more positive views of emotion were not more likely to reach deeper levels of experiencing. In addition, there were no significant correlations between pre-treatment LESS score and post-treatment CHEDS scores, suggesting that initial views of emotion were not associated with post-treatment eating symptomatology. These results are presented in Tables 4 and 5.

Table 4

Summary of Intercorrelations for Modal Ratings of EXP, CHEDS Scores, and LESS Scores

Variable	1	2	3	4	5	6	7
1. EXP Time 1	-						
2. EXP Time 2	0.08	-					
3. EXP Time 3	0.32	0.26	-				
4. CHEDS Total	0.17	-0.17	-0.24	-			
5. CHEDS Body Subscale	0.06	-0.23	-0.28	0.97***	-		
6. CHEDS Eating Subscale	0.31	-0.05	-0.15	0.94***	0.84***	-	
7. LESS	0.00	0.21	0.08	-0.28	-0.37	-0.13	-

Note. EXP = The Experiencing Scale, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale.

*** $p < .001$

Table 5

Summary of Intercorrelations for Peak Ratings of EXP, CHEDS Scores, and LESS Scores

Variable	1	2	3	4	5	6	7
1. EXP Time 1	-						
2. EXP Time 2	-0.02	-					
3. EXP Time 3	0.27	0.23	-				
4. CHEDS Total	0.20	-0.20	-0.26	-			
5. CHEDS Body Subscale	0.10	-0.25	-0.31	0.97***	-		
6. CHEDS Eating Subscale	0.32	-0.09	-0.16	0.94***	0.84***	-	
7. LESS	0.03	0.19	0.11	-0.36	-0.13	-0.28	-

Note. EXP = The Experiencing Scale, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale.

*** $p < .001$

Bivariate correlations did suggest an association between change in EXP and outcome. Specifically, change in EXP from baseline to the late working phase of treatment was moderately correlated with post-treatment CHEDS total score (Modal: $r = -.46$, $p = 0.02$; Peak: $r = -.48$, $p = .02$), post-treatment CHEDS Body Subscale score (Modal: $r = -.41$, $p = .04$; Peak: $r = -.43$, $p = .03$), and post-treatment CHEDS Eating Subscale score (Modal: $r = -.46$, $p = .02$; Peak: $r = -.47$, $p = .02$). Consistent with study hypotheses, these results suggested that individuals whose levels of experiencing increased from baseline to the late working phase of treatment were more likely to endorse lower levels of eating psychopathology at the end of treatment. Nonetheless, given the small sample size and the finding that EXP and outcome were otherwise uncorrelated, these results should be interpreted with caution. Correlations between change in EXP and outcome variables are presented in Tables 6 and 7.

Table 6

Summary of Intercorrelations for Change in Modal Ratings of EXP and CHEDS Scores

Variable	1	2	3	4	5
1. ΔEXP: Baseline to Early Working Phase	-				
2. ΔEXP: Baseline to Late Working Phase	0.34	-			
3. CHEDS Total	-0.24	-0.46*	-		
4. CHEDS Body Subscale	-0.22	-0.41*	0.97***	-	
5. CHEDS Eating Subscale	-0.24	-0.46*	0.94***	0.84***	-

Note. EXP = The Experiencing Scale, CHEDS = Change in Eating Disorder Symptomatology.
* $p < .05$, *** $p < .001$

Table 7

Summary of Intercorrelations for Change in Peak Ratings of EXP and CHEDS Scores

Variable	1	2	3	4	5
1. ΔEXP: Baseline to Early Working Phase	-				
2. ΔEXP: Baseline to Late Working Phase	0.34	-			
3. CHEDS Total	-0.32	-0.48*	-		
4. CHEDS Body Subscale	-0.29	-0.43*	0.97***	-	
5. CHEDS Eating Subscale	-0.29	-0.47*	0.94***	0.84***	-

Note. EXP = The Experiencing Scale, CHEDS = Change in Eating Disorder Symptomatology.
* $p < .05$, *** $p < .001$

In additional exploratory analyses, a moderate positive correlation was found between baseline modal EXP and post-treatment LESS score, $r = .51$, $p = .006$, indicating that clients who reached deeper levels of experiencing at baseline were more likely to endorse positive views of emotion at the end of treatment. Late working phase EXP was also significantly related to post-treatment LESS score, with moderate positive correlations for both modal ratings, $r = .43$, $p = .03$, and peak ratings, $r = .46$, $p = .02$. These results suggest that clients who reached deeper

levels of experiencing during the late working phase of treatment were more likely to endorse positive views of emotion at the end of treatment.

Regression analyses. A primary aim of this study was to examine the influence of depth of experiencing on treatment outcome. To address this aim, a series of regression analyses was conducted, where post-treatment CHEDS score was regressed on observer-rated level of EXP. Contrary to hypotheses, results generally suggested that level of experiencing did not predict post-treatment outcome.

As noted above, regression analyses in the study were based on a limited number of observations, which limited the potential to detect relationships among variables. Indeed, despite a general lack of significance, R^2 values tended to be high, indicating that the models were likely too complicated for the amount of available data. Nonetheless, given that bivariate correlations showed no significant relationship between post-treatment CHEDS and depth of EXP at any stage of treatment, it appears that the lack of an observed relationship in the regression models was not due solely to the limited amount of data. Because analyses yielded similar results when missing values were dropped or substituted with mean values, the results presented below are based on the 18 complete case observations.

First, total post-treatment CHEDS score was regressed on baseline EXP, controlling for age, pre-treatment BMI, pre-treatment depression, baseline symptomatology, and initial views of emotion. Then total post-treatment CHEDS score was regressed on early working phase EXP and on late working phase EXP, controlling for baseline EXP, age, pre-treatment BMI, pre-treatment depression, baseline symptomatology, and initial views of emotion. None of these analyses yielded statistically significant results, suggesting that level of EXP did not predict overall post-treatment outcome. These results are summarized in Tables 8, 9, and 10.

Table 8

Regression of CHEDS Total Score by Baseline EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-0.519	[-99.34, 98.30]	1.293	[-101.13, 103.72]
Age	-1.109	[-2.97, 0.74]	-1.023	[-2.92, 0.88]
BMI	1.599	[-0.34, 3.53]	1.507	[-0.49, 3.51]
BDC	-0.605	[-1.42, 0.21]	-0.631	[-1.45, -0.19]
Pre-treatment CHEDS	0.232	[-0.51, 0.98]	0.250	[-0.51, 1.01]
LESS	1.168	[-3.39, 5.72]	1.251	[-3.38, 5.88]
EXP Time 1	9.595	[-7.86, 27.05]	8.541	[-9.78, 26.87]
R^2	0.40		0.38	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.
None of the effects were significant.

Table 9

Regression of CHEDS Total Score by Early Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-1.438	[-113.54, 110.66]	1.322	[-114.15, 116.79]
Age	-1.058	[-3.28, 1.16]	-0.938	[-3.20, 0.37]
BMI	1.589	[-0.62, 3.80]	1.462	[-0.84, 3.76]
BDC	-0.575	[-1.53, 0.38]	-0.592	[-1.55, 0.37]
Pre-treatment CHEDS	0.274	[-0.64, 1.19]	0.307	[-0.61, 1.22]
LESS	1.533	[-4.50, 7.56]	1.724	[-4.17, 7.61]
EXP Time 1	9.702	[-10.40, 29.81]	8.682	[-12.35, 29.72]
EXP Time 2	-1.917	[-20.52, 16.69]	-2.876	[-20.60, 14.85]
R^2	0.40		0.38	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.
None of the effects were significant.

Table 10

Regression of CHEDS Total Score by Late Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	0.722	[-90.70, 92.14]	0.120	[-97.65, 97.89]
Age	-0.779	[-2.55, 0.99]	-0.704	[-2.58, 1.17]
BMI	1.639	[-0.15, 3.43]	1.484	[-0.42, 3.39]
BDC	-0.546	[-1.30, 0.21]	-0.558	[-1.35, 0.23]
Pre-treatment CHEDS	0.172	[-0.52, 0.87]	0.234	[-0.49, 0.96]
LESS	1.679	[-2.58, 5.94]	1.925	[-2.60, 6.45]
EXP Time 1	19.617	[-0.82, 40.05]	16.81	[-4.38, 37.99]
EXP Time 3	-13.463	[-30.30, 3.37]	-11.74	[-28.71, 5.23]
R^2	0.55		0.50	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Analyses were then repeated utilizing each of the CHEDS subscales as the outcome variable. Analyses that used CHEDS Body Subscale score did not yield significant results for EXP at any stage of treatment. Analyses that used CHEDS Eating Subscale score did not yield significant results when baseline EXP or early working phase EXP were used as the predictor. When CHEDS Eating Subscale score was regressed on late working phase EXP, the overall model was significant (Modal: Adjusted $R^2 = .48$, $F(7, 10) = 3.24$, $p = .045$, Peak: Adjusted $R^2 = .47$, $F(7, 10) = 3.14$, $p = .0498$); however, the regression coefficient for late working phase EXP was not significant for either modal or peak ratings.

Thus, taken together, results of regression analyses utilizing the CHEDS subscale scores as a measure of outcome suggested that depth of experiencing did not predict change in body-related symptomatology or eating-related symptomatology. Results of analyses using the

Table 11

Regression of CHEDS Body Subscale Score by Baseline EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	15.911	[-44.95, 76.77]	18.793	[-43.38, 80.96]
Age	-0.694	[-1.86, 0.47]	-0.674	[-1.85, 0.51]
BMI	0.930	[-0.35, 2.21]	0.908	[-0.40, 2.22]
BDC	-0.336	[-0.84, 0.16]	-0.347	[-0.85, 0.16]
Pre-treatment CHEDS Body Subscale	0.102	[-0.60, 0.80]	0.101	[-0.61, 0.81]
LESS	-0.248	[-3.10, 2.60]	-0.232	[-3.11, 2.65]
EXP Time 1	3.486	[-7.99, 14.96]	2.522	[-9.46, 14.51]
R^2	0.33		0.56	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Table 12

Regression of CHEDS Body Subscale Score by Early Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	15.947	[-53.22, 85.12]	18.932	[-51.78, 89.64]
Age	-0.703	[-2.08, 0.67]	-0.661	[-2.06, 0.74]
BMI	0.933	[-0.53, 2.40]	0.901	[-0.61, 2.41]
BDC	-0.342	[-0.95, 0.27]	-0.341	[-0.95, 0.27]
Pre-treatment CHEDS Body Subscale	0.091	[-0.77, 0.95]	0.112	[-0.75, 0.97]
LESS	-0.311	[-4.06, 3.44]	-0.174	[-3.84, 3.49]
EXP Time 1	3.424	[-9.90, 16.74]	2.590	[-11.30, 16.48]
EXP Time 2	0.401	[-11.81, 12.61]	-0.437	[-12.06, 11.18]
R^2	0.32		0.31	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Table 13

Regression of CHEDS Body Subscale Score by Late Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	13.102	[-43.18, 69.38]	15.830	[-44.01, 75.68]
Age	-0.448	[-1.56, 0.67]	-0.459	[-1.64, 0.72]
BMI	0.960	[-0.22, 2.14]	0.899	[-0.36, 2.16]
BDC	-0.314	[-0.78, 0.15]	-0.309	[-0.79, 0.18]
Pre-treatment CHEDS Body Subscale	0.097	[-0.55, 0.74]	0.119	[-0.56, 0.80]
LESS	0.188	[-2.50, 2.88]	0.251	[-2.61, 3.11]
EXP Time 1	10.060	[-3.31, 23.43]	7.822	[-6.14, 21.78]
EXP Time 3	-8.827	[-19.77, 2.11]	-7.453	[-18.57, 3.66]
R^2	0.49		0.44	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Table 14

Regression of CHEDS Eating Subscale Score by Baseline EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-18.506	[-49.26, 12.24]	-19.530	[-51.27, 12.21]
Age	-0.278	[-0.97, 0.41]	-0.208	[-0.91, 0.49]
BMI	0.593	[-0.07, 1.26]	0.519	[-0.16, 1.20]
BDC	-0.318*	[-0.61, -0.02]	-0.332*	[-0.63, -0.04]
Pre-treatment CHEDS Eating Subscale	0.504	[-0.06, 1.07]	0.542	[-0.03, 1.11]
LESS	1.575*	[0.01, 3.14]	1.636*	[0.06, 3.21]
EXP Time 1	5.600	[-0.39, 11.59]	5.591	[-0.61, 11.79]
R^2	0.63		0.62	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

Table 15

Regression of CHEDS Eating Subscale Score by Early Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-17.737	[-51.23, 15.76]	-17.773	[-52.38, 16.83]
Age	-0.217	[-1.00, 0.57]	-0.145	[-0.93, 0.64]
BMI	0.566	[-0.17, 1.30]	0.476	[-0.28, 1.23]
BDC	-0.282	[-0.61, 0.05]	-0.297	[-0.63, 0.03]
Pre-treatment CHEDS Eating Subscale	0.576	[-0.06, 1.22]	0.611	[-0.02, 1.25]
LESS	1.937*	[0.02, 3.86]	1.972*	[0.10, 3.84]
EXP Time 1	5.610	[-0.98, 12.20]	5.533	[-52.38, 16.83]
EXP Time 2	-2.053	[-7.88, 3.77]	-2.145	[-7.70, 3.40]
R^2	0.66		0.65	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

Table 16

Regression of CHEDS Eating Subscale Score by Late Working Phase EXP

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-16.783	[-46.49, 12.92]	-18.551	[-49.17, 12.07]
Age	-0.215	[-0.89, 0.46]	-0.128	[-0.81, 0.55]
BMI	0.620	[-0.02, 1.26]	0.519	[-0.14, 1.18]
BDC	-0.285	[-0.57, 0.00]	-0.298*	[-0.59, -0.01]
Pre-treatment CHEDS Eating Subscale	0.420	[-0.14, 0.98]	0.493	[-0.06, 1.05]
LESS	1.670*	[0.15, 3.18]	1.809*	[0.27, 3.35]
EXP Time 1	8.709*	[-46.49, 12.92]	8.328*	[1.04, 15.61]
EXP Time 3	-4.036	[-10.14, 2.06]	-3.845	[-9.70, 2.01]
R^2	0.69		0.69	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

CHEDS Body Subscale are summarized in Tables 11-13. Results of analyses using the CHEDS Eating Subscale are summarized in Tables 14-16.

A third set of regression analyses was used to investigate whether outcome was predicted by change in EXP from baseline to the early working phase of treatment and/or from baseline to the late working phase of treatment. Analyses were calculated for total CHEDS score and for each of the CHEDS subscales. Bivariate correlations had suggested an association between increases in EXP from baseline to late working phase and decreases in post-treatment CHEDS scores. However, none of the models utilizing change in EXP as the predictor variable yielded statistically significant results, indicating that change in experiencing from baseline to the working phase of treatment did not predict post-treatment eating disorder symptomatology. These results are summarized in Tables 17-22.

Table 17

Regression of CHEDS Total Score by Change in EXP from Baseline to Early Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	10.143	[-90.99, 111.28]	11.813	[-88.05, 111.68]
Age	-0.948	[-3.05, 1.15]	-0.903	[-3.04, 1.23]
BMI	1.593	[-0.53, 3.71]	1.497	[-0.68, 3.67]
BDC	-0.579	[-1.50, 0.34]	-0.592	[-1.50, 0.32]
Pre-treatment CHEDS	0.341	[-0.51, 1.19]	0.341	[-0.51, 1.20]
LESS	2.189	[-3.21, 7.59]	2.109	[-3.23, 7.44]
Δ EXP	-5.461	[-19.39, 8.47]	-5.232	[-18.70, 8.23]
R^2	0.37		0.37	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Table 18

Regression of CHEDS Total Score by Change in EXP from Baseline to Late Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	16.588	[-61.87, 95.05]	13.583	[-64.72, 91.89]
Age	-0.748	[-2.47, 0.97]	-0.819	[-2.51, 0.87]
BMI	1.697	[-0.04, 3.43]	1.742*	[0.02, 3.47]
BDC	-0.594	[-1.32, 0.13]	-0.543	[-2.51, 0.87]
Pre-treatment CHEDS	0.162	[-0.51, 0.84]	0.186	[-0.48, 0.85]
LESS	1.809	[-2.32, 5.94]	1.994	[-2.14, 6.12]
Δ EXP	-15.059	[-30.89, 0.77]	-14.79	[-29.95, 0.37]
R^2	0.52		0.52	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

Table 19

Regression of CHEDS Body Subscale by Change in EXP from Baseline to Early Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	22.929	[-36.11, 81.96]	23.330	[-34.48, 81.14]
Age	-0.668	[-1.96, 0.63]	-0.656	[-1.97, 0.66]
BMI	0.941	[-0.45, 2.33]	0.916	[-0.50, 2.33]
BDC	-0.336	[-0.91, 0.24]	-0.339	[-0.91, 0.23]
Pre-treatment CHEDS Body Subscale	0.125	[-0.68, 0.93]	0.125	[-0.67, 0.92]
LESS	-0.032	[-3.40, 3.33]	-0.048	[-3.36, 3.26]
Δ EXP	-1.313	[-10.52, 7.89]	-1.298	[-10.14, 7.55]
R^2	0.30		0.30	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

None of the effects were significant.

Table 20

Regression of CHEDS Body Subscale by Change in EXP from Baseline to Late Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	16.459	[-28.63, 61.55]	15.395	[-30.36, 61.15]
Age	-0.441	[-1.49, 0.61]	-0.499	[-1.54, 0.55]
BMI	0.970	[-0.14, 2.08]	0.999	[-0.12, 2.12]
BDC	-0.324	[-0.75, 0.11]	-0.292	[-0.50, 0.72]
Pre-treatment CHEDS Body Subscale	0.091	[-0.51, 0.70]	0.108	[-0.50, 0.72]
LESS	0.210	[-2.32, 2.74]	0.292	[-2.28, 2.86]
Δ EXP	-9.141	[-19.14, 0.85]	-8.691	[-18.44, 1.06]
R^2	0.49		0.48	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale. None of the effects were significant.

Table 21

Regression of CHEDS Eating Subscale by Change in EXP from Baseline to Early Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-12.170	[-42.41, 18.07]	-11.49	[-7.81, 0.86]
Age	-0.151	[-0.90, 0.60]	-0.114	[-0.88, 0.65]
BMI	0.555	[-0.16, 1.27]	0.488	[-0.25, 1.22]
BDC	-0.290	[-0.61, 0.03]	-0.301	[-0.62, 0.02]
Pre-treatment CHEDS Eating Subscale	0.646*	[0.04, 1.25]	0.657*	[0.05, 1.27]
LESS	2.232*	[0.48, 3.99]	2.195*	[0.45, 3.94]
Δ EXP	-3.589	[-8.07, 0.89]	-3.472	[-7.81, 0.86]
R^2	0.62		0.62	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

Table 22

Regression of CHEDS Eating Subscale by Change in EXP from Baseline to Late Working Phase

Variable	Modal		Peak	
	<i>b</i>	95% CI	<i>b</i>	95% CI
Constant	-6.332	[-34.96, 22.29]	-7.296	[-35.05, 20.46]
Age	-0.174	[-0.89, 0.55]	-0.191	[-0.89, 0.50]
BMI	0.661	[-0.03, 1.35]	0.676*	[0.01, 1.34]
BDC	-0.332*	[-0.63, -0.03]	-0.309*	[-0.61, -0.01]
Pre-treatment CHEDS Eating Subscale	0.442	[-0.16, 1.04]	0.450	[-0.13, 1.03]
LESS	1.814*	[0.19, 3.43]	1.887*	[0.31, 3.46]
Δ EXP	-5.170	[-11.55, 1.21]	-5.472	[-11.40, 0.46]
R^2	0.60		0.63	

Note. BMI = Body Mass Index, BDC = Beck Depression Checklist, CHEDS = Change in Eating Disorder Symptomatology, LESS = Leahy Emotional Schema Scale, EXP = The Experiencing Scale.

* $p < .05$

A final aim of the study was to investigate whether views of emotion moderated the relationship between EXP and outcome. As noted, previous analyses indicated no relationship for views of emotion to moderate. Nonetheless, this aim was addressed by repeating the regression analyses with baseline LESS score included both as a main effect and as an interaction with the EXP variable. The interaction term was the primary test of the moderation effect.

Analyses that included the interaction of EXP and pre-treatment LESS score and used CHEDS total score as the outcome variable did not yield significant results, regardless of whether baseline EXP, early working phase EXP, or late working phase EXP was used as the predictor. Likewise, analyses that included the interaction of EXP and pre-treatment LESS score and used CHEDS Body Subscale score as the outcome variable did not yield significant results for EXP at any stage of treatment.

Analyses that included the interaction of EXP and pre-treatment LESS score and used CHEDS Eating subscale score as the outcome variable did not yield significant results when baseline EXP and early working phase EXP were used as the predictor. However, when CHEDS Eating Subscale score was regressed by late working phase EXP, with the interaction term included, the overall model was significant for both modal and peak ratings (Modal: Adjusted $R^2 = .58$, $F(8, 9) = 3.94$, $p = .03$, Peak: Adjusted $R^2 = .58$, $F(8, 9) = 3.95$, $p = .03$). The regression coefficients (b) for late working phase EXP were also significant for both modal and peak ratings (Modal: $b = -6.482$, $p = .046$, Peak: $b = -6.647$, $p = .039$). Nonetheless, the regression coefficient for the interaction term was not significant for either modal or peak ratings of EXP, suggesting that, consistent with the above analyses, views of emotion did not moderate a relationship between late working phase EXP and post-treatment score on the CHEDS Eating Subscale.

Discussion

Results of the present study generally suggested no significant association between client experiencing and post-treatment outcome. There were glimpses of a relationship, particularly negative bivariate correlations between change in EXP and post-treatment CHEDS scores. Nonetheless, regression analyses suggested that neither depth of experiencing nor change in depth of experiencing predicted post-treatment eating symptomatology. Such results run counter both to study hypotheses and to previous research suggesting that deeper levels of experiencing are associated with positive treatment outcomes. However, it appears likely that analyses were affected by limited variability in the sample. Specifically, the restricted range of EXP scores may have limited the statistical detection of a potential relationship, particularly given the relatively small sample size. This restricted range, although unfortunate, was somewhat anticipated given the nature of the sample and the treatment protocol used in the study.

A number of factors may have contributed to the restricted range of experiencing in the study. First, the range of experiencing may have been restricted due to aforementioned processing difficulties associated with eating disorders (Bydlowski et al., 2005; Taylor et al., 1996). From this perspective, participants in the current study may have been less willing and/or able to engage in—let alone articulate—the sort of integrated cognitive-emotional processing described by the experiencing construct.

The sampling procedure used in the study introduces a second set of factors that may have contributed to the restricted range of EXP scores. The rationale for applying a random sampling procedure has been previously described; however, it is possible that this procedure missed moments of significant emotional processing that took place during the study. For instance, it has been suggested that experiential processing over the course of cognitive behavioral treatment may take place outside the therapy sessions, while clients are engaged in homework assignments and other between-session activities (Boswell, 2011; Castonguay et al., 1996). It has also been noted that this between-session processing may be particularly likely when homework involves observation and analysis of thoughts, feelings, and behavior (Samoilov & Goldfried, 2000). Given that such homework assignments were initiated at the outset of CBT-E, continued throughout treatment, and emphasized as equal in importance with client attendance of the sessions (Fairburn, 2008), it may be that treatment promoted between- rather than in-session experiencing for the clients in this study.

Research on the verbal content of experiencing suggests another possible sampling issue. Goldman, Greenberg, and Pos (2005) found that experiencing was most strongly associated with outcome in experiential therapy for depression when clients were expressing emotion related to core themes of their treatment. These themes were related to specific intrapersonal and

interpersonal experiences, such as conflict between critical and vulnerable aspects of the self, feelings of hopelessness about the future, or unresolved anger toward a spouse or child (Goldman et al., 2005). Given that such themes were not identified or incorporated into the design of the current study, it may be that a more selective sampling procedure, which focused on the idiosyncratic experiences of each client, would have yielded more relevant instances of verbal expression to be rated on the EXP scale.

The restricted range of experiencing in the study may also reflect conceptual difficulties stemming from limitations of the definition and/or operationalization of the construct. For instance, the EXP Scale deliberately focuses on verbal communications for the sake of reliability (Klein et al., 1986); however, it is clear that other non-verbal and physiological aspects of expression may be relevant (Kennedy-Moore & Watson, 1999). It may be that emphasis on verbal expression in the rated segments missed other potential indicators of cognitive-affective processing, such as vocal, facial, and postural displays. Indeed, there have been efforts to develop more inclusive measures of emotional processing, such as the Client Emotional Productivity Scale (Greenberg, Auszra, & Herrmann, 2007), which assesses both verbal and non-verbal elements of client communication, including content of speech, tone of voice, facial expression, gesture, and other physical movement. The use of such a measure in the present study may have yielded more variability in the coded sessions.

Along similar lines, it may be that the descriptions of stages and markers on the Experiencing Scale too narrowly reflect the theories, processes, and techniques of the humanistic and person-centered traditions in which they were developed. From this perspective, although experiencing is generally regarded as a common factor across therapeutic approaches, it might be more adequately investigated in CBT using measures that reflect cognitive approaches to theory

and research. For instance, the Change and Growth Experiences Scale (CGES), subtitled A Measure of Insight and Emotional Processing (A. M. Hayes, Feldman, & Goldfried, 2007), represents an attempt to incorporate ideas from across psychotherapy literatures, including notions of emotional processing and meaning-making, as well as cognitive distortion and schema change. As noted by the authors, this integrative approach maps imperfectly onto past research, requiring modified designations for constructs of interest (e.g., the distinction of insight-processing from emotional processing); therefore, associated measures might be regarded as supplements to, rather than replacements for, the Experiencing Scale (A. M. Hayes et al., 2007). Nonetheless, with regard to the present study, it is possible that use of the CGES, or a similarly integrative measure, might have yielded more nuanced or conceptually consistent results relative to cognitive-affective processing in CBT-E.

The notion of conceptual differences underlines a crucial fourth consideration: the restricted range of emotional experiencing may reflect the cognitive-behavioral emphases of the treatment protocol at both theoretical and practical levels (Fairburn, 2008, p. 12). The CBT-E protocol defines the psychopathology of eating disorders as “essentially cognitive” in nature (Fairburn, 2008, p. 12), and outlines the process of recovery as the establishment of more realistic, balanced, and accurate ways of thinking about shape, weight, and self-worth (Fairburn, 2008). Accordingly, interventions (e.g., psychoeducation, exploratory questioning, and analyzing the effects of strategic behavior changes) are implemented toward the explicit goal of producing change at a cognitive level (Fairburn, 2008, p. 96). Insofar as such interventions engender an attitude of intellectual curiosity and objective rational analysis, they would not be expected to promote deep experiencing during treatment sessions. This notion is consistent with available evidence suggesting that emotional experience is less emphasized in CBT than in other

psychotherapies, that clients in CBT are more distant from their emotional experience, and that CBT therapists often seek to control or reduce in-session emotional arousal (Mackay, Barkham, Stiles, & Goldfried, 2002; Watson & Bedard, 2006; Whelton, 2004).

Thus, the manner in which components of CBT-E are defined, conceptualized, and implemented with clients would be expected not only to maintain a focus on cognitive aspects of experience, but also to yield distance from and/or diminution of immediate emotional experience. The treatment in the present study may therefore have facilitated a mode of processing that was qualitatively different than that described by higher levels of the EXP scale, which emphasize deep engagement with and elaboration of internal feelings (Klein et al., 1986). Given these considerations, it appears likely that a primary reason for the limited degree of emotional experiencing is simply that it was not emphasized, elicited, or encouraged.

Possible Interpretations

Because experiencing has only rarely been measured in CBT, and has never been examined in the treatment of eating disordered clients, even the finding of an attenuated range provides potentially useful data relative to the construct of interest. For instance, the relative absence of “high” EXP scores (5, 6, or 7) in the present sample suggests that clients engaged in virtually no deep-level experiencing over the course of CBT-E. Nonetheless, as noted previously, the treatment benefitted a majority of the participants in the study, with an average difference score of 62.25 on the CHEDS. In light of these findings, there are at least three ways to interpret the lack of an observed relationship between experiencing and outcomes in the study.

First, it may be that experiencing as here described is not relevant in cognitive-behavioral treatment of eating disorders. In this case, it would not matter whether moments of deep experiencing occurred because experiencing would be assumed to have no significant impact on

the effectiveness of the treatment. However, such an interpretation is inconsistent with past research suggesting that even low levels of EXP and incremental increases are related to positive treatment outcome (Fitzpatrick et al., 1999). Moreover, while no relationship was detected between experiencing and outcome in the present, this result must be considered in light of the restricted range of EXP scores and the limited sample size, which generally prevent any strong conclusions with regard to a potential relationship.

The second interpretive possibility is that the observed levels of experiencing were appropriate to the nature of the treatment. From this perspective, the observation of positive outcomes despite an absence of deep level experiencing would suggest that client emotional involvement as described by levels 2-3 of the Experiencing Scale is sufficient for the effective delivery of interventions within CBT-E. For instance, at Stage 2, the client's interest in the narrative is "clear, but superficial" and she does not "refer to or define her feelings." At Stage 3, descriptions of feelings and personal reactions are "clear but limited," while communications of personal interest are "confined to behavioral terms" (Klein et al., 1986). These statements may describe a degree of cognitive and emotional engagement not inconsistent with interventions that target distorted thinking and/or promote restructuring through the presentation and provision of contradictory or corrective information.

Under this interpretation, experiencing might still be viewed as a common factor (Castonguay et al., 1996), but it would be regarded as playing a different role in therapeutic change, and thus having a different relationship to outcome. For instance, it might be said that experiencing matters in a broad sense, but is more subtle and/or peripheral in CBT treatment of eating disorders. This interpretation would acknowledge emotional factors as playing a role in

the treatment of eating disorders, while remaining in line with strong evidence for the therapeutic benefit of cognitive-behavioral approaches (Wilson & Fairburn, 2002).

A third interpretive possibility is that experiencing is relevant in CBT treatment of eating disorders, but its therapeutic benefits were not fully realized in the treatment under investigation here. Under this interpretation, the restricted range of EXP scores would reflect an undesirably low level of emotional experiencing over the course of the treatment. The basic implication of such an interpretation is that the therapeutic effects of CBT-E could be further enhanced through more explicit or direct attention to affective and emotional processes. This position is in line not only with previous research on the relationship between depth of experiencing and outcome (Greenberg & Pascual-Leone, 2006), but also with recent calls for greater integration of emotional processes in eating disorder treatment (Fox & Power, 2009) and in CBT generally (Mahoney, 1991; Mischel, 2004; Samoilov & Goldfried, 2000). Moreover, there is some precedent in the development of the current CBT-E protocol for increasing attention to emotional factors. Specifically, the chapter on mood intolerance began as a separate module, but has since been incorporated into the main “focused” version of the treatment, at least in part due to the prevalence of mood-triggered changes in eating (Fairburn, 2008, pp. 95, 142).

Potential for Integration

It may be that other elements within the CBT-E framework (e.g., promotion of in-the-moment awareness, injunctions to resist habitual escape behaviors) could be expanded to increase the degree of integrated cognitive-affective processing during treatment. However, integrative theoretical formulations, along with their implications for treatment, would need to be very carefully considered. Indeed, Fairburn cautions against “[combining] CBT-E with conceptually, or procedurally incompatible treatments” (Fairburn, 2008, p. 30). The explicitly

cognitive emphasis of the CBT-E protocol provides a compelling and comprehensible rationale for treatment, maintains a clear focus for intervention, and produces therapeutic benefit. Thus, injudicious or unsystematic efforts to incorporate more integrative or affectively oriented techniques within this framework might create confusion and/or jeopardize the therapeutic effects of treatment. For example, direct efforts to deepen in-session experiencing would diverge from (though not necessarily conflict with) the general cognitive focus of CBT-E, and might therefore seem jarring or inconsistent to clients if an appropriate and equally comprehensible rationale for such interventions had not been provided.

As these caveats demonstrate, the notion of increasing emotional processing in CBT-E raises important questions about the compatibility of experiential and cognitive approaches and the feasibility of their combination. Could cognitive behavior therapy accommodate increased attention to and therapeutic focus on emotion? If so, how would relevant principles be conceptualized and incorporated into the treatment? Could interventions around emotional processing be appended to CBT in module form? Or would CBT theory and case conceptualization have to be modified? Can the construct of “emotional processing” be defined in a way that allows for consistent and meaningful research across theoretical orientations? Or are the different theoretical approaches too dissimilar in their conceptualization of problems and therapeutic processes?

Such questions are at the heart of recent efforts to refine understanding of affective processes in CBT. These include empirical studies that incorporate emotion-focused measures and techniques (e.g., Castonguay et al., 1996; Castonguay et al., 1998), as well as integrative reviews that seek to identify common emotional processes across treatment orientations (e.g., Greenberg & Pascual-Leone, 2006; Whelton, 2004) and/or synthesize research findings on

processing dynamics as they relate to CBT (e.g., Mischel, 2004). Although further investigation is needed, these recent endeavors have yielded a growing number of viable avenues for expanding theory and research on the role of emotional processes in the practice of CBT (Samoilov & Goldfried, 2000), and for preventing hasty conclusions or haphazard deployment of interventions (e.g., Westen, 2000). Taken altogether, the fruits of these labors suggest that with continued research and exploration of relevant implications, it may be possible to lay a foundation such that in-session emotional processing can, like the mood intolerance component of CBT-E, “be readily and appropriately incorporated” during cognitive behavioral treatment (Fairburn, 2008, p. 142).

In addition, it is instructive to revisit some of the issues raised by Wisner and Arnow (2001) relative to clients for whom experiencing might be more or less beneficial. Their analysis would suggest that special care may be warranted relative to facilitating experiencing with eating disordered clients, given that the arousal and/or expression of intense, painful, or distressing emotion could trigger overwhelming feelings and/or maladaptive coping strategies (2001). Most contemporary eating disorder treatments, including the CBT-E protocol, are carefully structured to help clients regularize their eating behaviors prior to initiating more focused interventions, precisely to avoid recourse to maladaptive behaviors during the course of treatment (Fairburn, 2008). Nonetheless, the possibility that clients might become confused, dysregulated, or overwhelmed by experiencing is a concern that deserves careful consideration, particularly in cases where dysfunctional behaviors, including binge eating, vomiting, and over-exercising, are precipitated by episodes of emotional upset (Fairburn, 2008). Paired with consistent associations between disordered eating and emotional processing difficulties (Bydlowski et al., 2005; Taylor et al., 1996), these caveats underline the importance of adopting a thoughtful approach to

facilitating the expression and elaboration of in-session emotional experience with this uniquely vulnerable population.

Limitations

This study has a number of limitations, many of which are related to the size and homogeneity of the sample. First of all, the initial study included a relatively small number of eating disordered individuals, further reduced in the present study by the exclusion of clients diagnosed with anorexia nervosa. Second, there was a lack of demographic variability among treated individuals, with Caucasian females being overrepresented. This homogeneity in the sample limits the generalizability of findings to the larger population of eating disordered individuals. Third, because post-treatment CHEDS scores were used to represent outcome, the sample size was further restricted by attrition and data irregularities in the initial treatment study. Thus, while experiencing data was generated for the majority of participants, missing data in many cases precluded analysis relative to post-treatment outcome.

A fourth limitation was relatively low reliability between raters, particularly for ratings of baseline EXP. This result may reflect methodological issues related to rater training, as well as even more restricted range of experiencing, given that baseline ratings were made during an interaction prior to the initiation of treatment proper. Nonetheless, regardless of its source, low inter-rater reliability clearly limited the precision of statistical analyses, and thus, our ability to draw valid inferences relative to the phenomena of interest.

Finally, specific disruptions of cognitive-affective processing (e.g., alexithymia, experiential avoidance) were not measured directly, preventing assessment of their impact on outcome and other aspects of treatment, including the restricted range of experiencing. Although LESS data represented some consideration of some similar processes, and the EXP scale itself

has been described as “[placing] insight-processing, rumination, and avoidance on the same continuum as a single variable” (A. M. Hayes et al., 2007), these measures offered less conceptual clarity than would construct-specific instruments, and thus, supported only hesitant and/or tangential claims with regard to processing difficulties in the current sample.

Conclusion

This study contributes to knowledge regarding emotional processes in cognitive-behavioral therapy for eating disorders. Specifically, results showed an attenuated range of in-session client experiencing during CBT-E for eating disorders (Fairburn, 2008). Although this restricted range limited the utility of statistical analyses, it also suggested that in-session feelings rarely became the immediate focus of deep reflection and elaboration during CBT-E. This finding is consistent with other investigations of emotional processing in cognitive behavior therapy, and raises questions about the role of affective and emotional factors in therapeutic change for different populations and across different orientations to treatment.

Future studies of emotional processing in eating disorder treatment should incorporate measures that account for both verbal and non-verbal aspects of communication. It will also be important to expand investigation to populations with greater diversity in terms of age, ethnicity, and other demographic variables. Direct assessment of core processing deficits associated with eating disorders could provide greater opportunity not only to ascertain their impact on treatment processes and outcomes, but also to investigate whether treatment interventions have ameliorative effects relative to such deficits. In addition, it may be useful to identify and code segments of therapy during which clients are processing material relative to core themes of their treatment.

It's still an open question whether outcomes could be enhanced by incorporating more affective and emotional factors into the conceptualization and implementation of CBT-E (and other cognitive behavioral treatments). Theory and research regarding common factors and unique population characteristics should continue to inform and refine relevant discussions and efforts toward integration.

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