Psychotherapy Research

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tpsr20

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To cite this article: Patrícia Pinheiro, Miguel M. Gonçalves, Daniela Nogueira, Rui Pereira, Isabel Basto, Daniela Alves & João Salgado (2022) Emotional processing during the therapy for complicated grief, Psychotherapy Research, 32:5, 678-693, DOI: 10.1080/10503307.2021.1985183

To link to this article: https://doi.org/10.1080/10503307.2021.1985183

Published online: 18 Oct 2021.

Psychotherapy Research, 2022
Vol. 32, No. 5, 678–693, https://doi.org/10.1080/10503307.2021.1985183

EMPIRICAL PAPER

Emotional processing during the therapy for complicated grief

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(Received 6 July 2020; revised 19 September 2021; accepted 20 September 2021)

Abstract
Objective: Prior research, mainly conducted on depression, observed that clients' improved capability to process their emotions predicted better therapeutic outcomes. The current comparative study aimed to investigate whether emotional processing was related to therapeutic change in complicated grief. Method: We analyzed two contrasting cases (good or poor outcome) treated with grief constructivist therapy. In both cases we investigated the association of emotional processing (Experiencing Scale) to (1) therapeutic outcome (Inventory of Complicated Grief), and (2) change in the type of grief-related emotions (Emotions Episodes). Results: The session-by-session growth of clients' emotional processing and the change of grief-related emotions were qualitatively explored throughout both cases. Compared with the poor outcome case, the good outcome case achieved more improvement in the ability to process emotions. Such improvement occurred alongside a deeper change in the type of grief-related emotions aroused, from maladaptive to more adaptive responses. Conclusion: Our findings suggest that a higher emotional processing capability may be associated with the transformation of grief-related maladaptive emotions and with the improvement of complicated grief condition.

Keywords: Process research; motion in therapy; emotional processing; complicated grief

Clinical or methodological significance of this article: The clients' capability to process their grief-related emotions might be impaired in complicated grieving conditions. The therapeutic facilitation of emotional processing during therapy seems to be associated with (1) changing maladaptive grief-related emotions, (2) adapting to the life without the diseased based on healthy information from adaptive emotions, and (3) achieving symptoms improvement. For psychotherapist, being aware of their clients' level of emotional processing achieved and the type of loss-related emotions aroused during therapy may be clinically valuable.

Emotional Processing During the Therapy for Complicated Grief

The contribution of clients' ability to process their emotions to alleviation of psychopathological symptoms has been widely recognized in psychotherapy research (Baker et al., 2012; Elliott et al., 2013; Foa et al., 2006; Greenberg, 2015; Pinheiro et al., 2020; Whelton, 2004). Difficulties with emotional processing have been associated with the emergence and maintenance of psychopathology (Elliott et al., 2013; Foa et al., 2006; Greenberg, 2015; Whelton, 2004). Improved emotional processing capacity during therapy has been found to relate to better outcomes (Baker et al., 2012; Pascual-Leone, 2018; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020). In the current paper, we explore this association in one good and poor outcome case both treated for complicated grief with meaning reconstruction therapy (Neimeyer, 2001, 2006, 2016).

Grievers suffering with complicated grief have an impaired ability to be aware of, arouse and be in

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live contact with grief-related emotional experiences (Castro & Rocha, 2013; Neimeyer, 2001, 2006), suggesting that difficulties with emotional processing are associated with the development of this condition. To our knowledge, no studies on the specific role of emotional processing in complicated grief have been developed. Actually, since recent studies have focused on the distinctive characteristics of complicated grief (Eisma et al., 2020; Lundorff et al., 2017), little is known about how clients' overcome such a condition during therapy. Research can clarify how such impaired capability may be associated with complicated grief and whether promotion of emotional processing over therapy may contribute to ameliorating clients' suffering. We explored whether the clients' session-by-session change in grief-related emotions related to different therapeutic bereavement outcomes. The results of the current exploratory study may improve our knowledge of how bereaved clients experience and process grief-related emotions over therapy, and whether the enhancement of their emotional processing capability is associated to therapeutic outcome.

Emotional Processing

Humanistic-experiential therapies view clinical problems resulting from impaired ability to process painful emotions (Elliott et al., 2013; Greenberg, 2015; Greenberg & Watson, 2006; Pos et al., 2003). These therapies therefore facilitate such ability. For these approaches, emotional processing is a cognitive–affective continuum that broadly involves (1) being aware of emotions, (2) arousing and tolerating contact with them, (3) exploration and reflection to make sense of the emotional experience, and, finally, (4) transforming maladaptive emotions by accessing more adaptive ones (Elliott et al., 2013; Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006).

According to Greenberg (2010, 2015), maladaptive emotions can refer to: (1) secondary emotions, i.e., responses to primary emotions that are overwhelming, painful, threatening, obscured and avoided (e.g., feeling sadness but expressing anger; expressing a fused global emotional state such as despair, hopelessness, or complaint); or (2) primary maladaptive emotions, i.e., immediate emotional responses that, although activated by the current situation, are overgeneralizations from past unresolved issues that lead the person to dysfunctional actions (e.g., experiencing loss with deep fear of being unable to survive alone; feeling profound sadness and abandoned at minor signs of withdrawal). Therefore, maladaptive emotional experiences may be accessed during therapy to transform them by access to adaptive emotions (Greenberg, 2010; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). Adaptive emotions are primary emotional responses aroused by a current situation that mobilize adaptive action tendencies consistent with the individual's current needs (e.g., anger at boundary violations; sadness in loss). These primary adaptive emotions need to be accessed, explored, and reflected on to activate their innately healthy potential, hence transforming maladaptive emotions and orienting the person to the achievement of core needs (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Herrmann et al., 2016; Pascual-Leone & Greenberg, 2007). The change from maladaptive to more adaptive emotions during therapy has been empirically associated with better outcomes (Herrmann et al., 2016; Pinheiro et al., 2018).

The role of emotional processing has been widely investigated in psychotherapy, mainly on samples of depression (e.g., Auszra et al., 2013; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020). In that literature, different scales are used to operationalize and measure this humanistic-experiential concept during therapy (e.g., Herrmann & Auszra, 2019; Klein et al., 1986; Pascual-Leone, 2018). Consistent results have been found. First, the clients' emotional processing capability improves across therapy (e.g., Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020; Pos et al., 2009; Rudkin et al., 2007); second, the achievement of a higher emotional processing capability predicted a better therapeutic outcome (e.g., Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020; Pos et al., 2009); and third, such results were found not only in the humanistic-experiential approaches, but also in psychodynamic and cognitive–behavioral therapies (e.g., Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020; Rudkin et al., 2007; Watson et al., 2011). These findings from clinical trials, systematic reviews, and a meta-analysis, support the claim that emotional processing works as a transtheoretical factor of clients' change in psychotherapy (Elliott et al., 2013; Greenberg & Pascual-Leone, 2006; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017). However, again, little is known about how emotional processing is associated with complicated grief and whether it is a factor that may help to explain therapeutic change in this condition.

Emotional Processing in Grief

Grief over the loss of a significant figure is a common, challenging experience (Milman et al.,

2017; Neimeyer, 2001). Typically, premature, sudden, or violent loss, or deceased presence of a secure and validating figure needed to maintain the mourner's identity, can assault a mourner's core identity assumption system. Grievers not capable of accommodating the loss may exhibit complicated grief symptoms (Milman et al., 2017; Neimeyer & Sands, 2011; Neimeyer & Thompson, 2014). Approximately 10% to 20% of grievers experience complicated grief, struggling with impairing chronic longing due to their separation from the deceased, accompanied by intense, overwhelming emotional pain (Prigerson et al., 2009).

Prior studies report that sadness and anger, but also fear and shame/guilt are painful emotions that bereaved clients struggle with during complicated grief (Alves et al., 2012; Coifman & Bonanno, 2010; Fernández-Alcántara et al., 2016; Hooghe et al., 2012; Stroebe & Schut, 2010). However, prior research has failed to consider the adaptative or maladaptive function of loss-related emotions and how they are processed during therapy. Understanding how bereaved clients experience and process grief-related emotions during therapy may contribute to clarifying whether emotional processing is associated with the amelioration of complicated grief, and provide relevant information needed to facilitate the change of clients during grief therapy.

So far it is known that a mourner's impaired ability to be aware of, arouse, and tolerate live contact with painful loss-related emotions is associated with the development of complicated grief (Castro & Rocha, 2013; Neimeyer, 2001, 2006; Stroebe & Schut, 2010). This suggests difficulties in the first steps of emotional processing. Based on humanistic-experiential theory, we hypothesize about what type of loss-related emotions are experienced by the grievers (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2016; Pascual-Leone & Greenberg, 2007), and how they are successfully processed throughout therapy. We assume that impairment of the first steps of emotional processing (i.e., being aware of, arousing, and tolerating contact with painful loss-related emotions) prevents grievers from achieving the last steps on the continuum, namely the transformation of maladaptive emotions by accessing core needs and action tendencies associated with adaptive emotions (Elliott et al., 2013; Greenberg, 2010; Greenberg & Watson, 2006). We expect that in initial sessions both good and poor outcome grievers will both struggle with maladaptive emotional experiences, such as intense anger or fear of the loss. However, we also expect there will be difficulty in the poor outcome griever in processing such maladaptive emotions. Accessing adaptive painful sadness may be critical to grief resolution (Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). Therefore we expect to see the good outcome case undoing maladaptive emotional experiences by expressing adaptive sadness of grief. The healthy information associated with adaptive sadness will orient the good outcome grievers to the necessary challenges ahead, i.e., the acceptance and integration of their grief experience, and to their adaptation to a new life without the deceased (cf., Dual Process Model of Bereavement; Stroebe & Schut, 2010). Therefore, we may expect that in good outcome cases, grievers will improve their emotional processing capability during therapy, transforming their maladaptive experiences into more adaptive ones.

The current exploratory comparative study focused on the session-by-session analysis of one good outcome and another poor outcome case of complicated grief—both having received meaning reconstruction grief therapy (Neimeyer, 2001, 2006, 2016). We explored whether the level of emotional processing achieved during therapy was differently associated (1) with outcomes with respect to bereavement (good or poor outcome), and (2) with a change in the frequency of expressed adaptive or maladaptive emotions. Although the meaning reconstruction grief therapy is focused on narrative change (Neimeyer, 2001, 2006, 2016), we can speculate that there is an interplay between the meaning reconstruction of the loss and the emotional processing of such experience (cf., Angus, 2012; Angus & Greenberg, 2011). Both are expected outcomes of good therapeutic processes. The processing of loss-related emotions may be intrinsically linked to the integration of the loss experience based on adaptive emotions underlying healthy information. Therefore, we may expect that this grief therapy (Neimeyer, 2001, 2006, 2016) will improve clients' emotional processing capability and their access to more adaptive emotions while facilitating the meaning reconstruction of the loss.

Method

Participants

Clients. Anna's and Jane's cases were collected in the "Complicated Grief Research Study", an exploratory study conducted by Alves and collaborators (Alves et al., 2012) to investigate the processes of narrative change during grief therapy. People who presented a persistent and impaired reaction

to a loss during at least the six previous months were referred for the study by the local hospital and health centers. Participants were informed about the protocol, aims and procedures of the study before they consented to participate. The study was approved by the ethics committee of the local hospital and followed the principles of both the American Psychological Association and the Portuguese Association of Psychologists (Ordem dos Psicólogos Portugueses).

To ensure that complicated grief was the core clinical issue, participants were assessed using the Structured Clinical Interviews I and II for DSM-IV (First et al., 1997, 2002), and the Inventory of Complicated Grief (ICG; translated and adapted for the Portuguese population from Prigerson et al., 1995 by Frade et al., 2009). Eight clients were included in the study (the small number of participants is due to the exploratory nature of the study, not to the prevalence of the clinical condition). Of these clients, only six completed the treatment. Based on the ICG post-therapy assessment (cut-off = 30; Sousa & Rocha, 2011), clients were categorized into four good and two poor outcome cases. Anna's and Jane's cases were randomly selected from each of these outcome subgroups. Although both clients improved in terms of bereavement symptoms, Anna achieved normative scores on the ICG (pre-test = 61; post-test = 28), while Jane remained in the non-normative population at the post-therapy assessment (pre-test = 51; post-test = 36).

Anna (pseudonym) was a 50-year-old Portuguese housemaid living with two of her three young adult sons. She had lost her husband from cancer 1.5 months post his diagnosis and two years prior to beginning therapy. According to Anna, her husband "saved" her from an abusive and violent childhood, and represented a secure attachment figure for her. She attended 13 therapeutic sessions. In the initial sessions, the client felt angry and struggled with a strong and uncontrollable desire for others to suffer the same pain and grief that she felt. She also described profound bereavement over the loss of her partner.

Jane (pseudonym) was a 20-year-old Portuguese waitress who lived with her father since her older sister left to live abroad. She was in a romantic relationship. Jane had suddenly lost her mother to a stroke one year prior to beginning therapy. She had had a very close relationship with her mother. Jane also attended 13 therapeutic sessions. In the initial sessions, Jane presented intense feelings of loneliness and emptiness. Despite the support of her family and her boyfriend, she felt alone, abandoned, and neglected because they were not able to take care of her as her mother had.

Therapist. Anna's and Jane's both saw the same 28-year-old female PhD student therapist trained in the therapeutic approach. She had 4 years of prior experience as a psychotherapist and had been trained in constructivist grief therapy during the prior two years. The therapist received supervision every two weeks (2–3 hours) by a clinician with 18 years of experience in constructivist psychotherapy to ensure adherence to the therapeutic approach.

Therapy

Anna and Jane were treated within the framework of Neimeyer's meaning reconstruction grief therapy (Neimeyer, 2001, 2006, 2016). This narrative therapy aims to help clients make meaning of their loss experiences, and promotes the integration of such events into their orienting core assumptions system (Burke & Neimeyer, 2013). Such accommodation of the loss involves looking back on the story shared with the deceased but also looking to the present and future to reengage with a world changed by the absence of the loved one and reconstructing an ongoing bond with the deceased (Stroebe & Schut, 2010). A mourner's ability to make meaning from loss has been associated with better bereavement outcomes (Bellet et al., 2016; Milman et al., 2017; Neimeyer, 2016; Rozalski et al., 2017). A meaning reconstruction interview was used to orient the initial exploration of both clients' stories of loss, exploring the details related to the death and the inner experience of grief (Neimeyer, 2001, 2006, 2016; Neimeyer et al., 2010). Throughout treatment, the main therapeutic meaning-oriented activities used in Anna's and Jane's cases were narrative retelling and imaginal conversations with the deceased to reduce the pain associated with the grief episodes and facilitate the construction of a new and more adaptive post-loss relationship with the deceased (Burke & Neimeyer, 2013).

Process Measures

Experiencing scale (EXP). The EXP is a seven-point scale that assesses the degree to which clients experience and explore their inner experiences to make sense of them, and use such inner information to solve personal problems in a meaningful way (Klein et al., 1986). The application of the EXP (Klein et al., 1986) to emotionally loaded segments of the therapeutic discourse, i.e., Emotion Episodes (EEs; Greenberg & Korman, 1993; Korman, 1991), has been recognized as a sound measure of the cognitive–affective continuum of emotional

processing in prior research (Pinheiro et al., 2018, 2020; Pos et al., 2009). The initial EXP levels are focused on the description of external events: EXP level 1—the clients are not involved in the described situations; EXP level 2—the involvement is behavioral or intellectual; and EXP level 3—the references to feelings and emotions are brief, circumscribed reactions to the situations described. At the intermediate and final EXP levels, the clients' discourse is inwardly focused: EXP level 4—description of feelings, emotions, and personal assumptions or problems that clearly show the client's inward experience; EXP level 5—exploration of hypotheses about feelings, emotions and personal assumptions and problems; EXP level 6—vivid description of the new emotions, self-experiences and meaningful resolution of personal problems; and EXP level 7—new and expanded self-understanding to a wider range of life contexts due to the employment of new and more adaptive inner experiences. Although the EXP does not account for the type of emotions aroused, clients achievement of higher EXP levels is associated to the transformation of maladaptive emotions into more adaptive ones (Pascual-Leone, 2009; Pinheiro et al., 2018). Namely, the EXP level 6 may work as a proxy for emotional transformation (cf., Pinheiro et al., 2018).

The EXP presents good reliability and validity indices (Klein et al., 1986). According to the EXP Manual (Klein et al., 1986), the rating involves the identification of the highest EXP level (peak level) and the most frequent level achieved (modal level) during segments of the psychotherapeutic discourse (EEs in the current study). To reduce the complexity of the data analysis, in the current study we will only report the EXP peak level achieved by the clients. The EXP peak level picks up clients' emotional processing higher achievement during the EEs (Klein et al., 1986). When compared with the EXP modal level, the peak level seems to be more sensitive to improvements, depicting the clients' achievement of a higher capability to process their emotions over therapy. Therefore, the EXP peak level seems to fit better our aim of comparing Anna's and Janes' cases.

Emotion episodes (EEs). EEs (Greenberg & Korman, 1993; Korman, 1991) are segments of the psychotherapeutic discourse during which clients express an emotion (e.g., sadness) or an associated action tendency (e.g., crying) in response to a situation, context or event (e.g., death of a loved one). According to the EEs Manual (Korman, 1991), these segments may be categorized based on the expressed emotional responses (emotions and action tendencies) into EEs of Love, EEs of Joy, EEs of Fear, EEs of Anger, EEs of Sadness, and EEs of Guilt/Shame. Tracking the EEs during therapy may provide information about clients' loss-related emotions and allow us to identify changes in such emotional responses. The codification of EEs involves the following: (1) identification of an emotional response and the trigger situation, context, or event in the clients' speech; (2) definition of the beginning and end of the EE by tracking backward and forward in the clients' discourse until the emotional response, the trigger and the speech theme change; and (3) categorization of the EEs based on the emotional responses expressed into one of the following basic emotions—Love, Joy, Fear, Anger, Sadness, and Guilt/Shame. This measure presented strong reliability and validity in prior studies (e.g., Greenberg & Korman, 1993; Pinheiro et al., 2018; Pos et al., 2003).

Procedures

EEs. Raters were a PhD and a master's student in clinical psychology. Over approximately 3 months (2 h per week), the raters were trained on the EEs Manual (Korman, 1991) via (1) reading and discussion of the manual's coding procedures; (2) coding of the manual excerpts; and (3) coding of videotaped psychotherapy sessions (not from Anna's or Jane's case) until a good level of reliability with respect to the identification of EEs and categorization of the basic emotions (*Cohen's kappa* $\geq .65$) was achieved. In the current study, coding of EEs in the sessions was performed independently by the raters. The inter-rater agreement was high. For the presence/absence of EEs Cohen's kappa was .88 and for the emotion categorization of each EE Cohen's kappa was .92. Raters discussed disagreements and reached consensus on final coding. Raters familiar with and trained on Greenberg's (2010) criteria for an EE being coded as adaptive or maladaptive made this EE distinction based on clinical judgment. The inter-rater agreement was excellent — Cohen's kappa was .93. Consensus was reached between raters after disagreements were discussed. Finally, we computed for each session of each case the (1) frequency of EEs of Love, Joy, Fear, Anger, Sadness, and Guilt/Shame, and (2) the frequency of adaptive and maladaptive EEs.

EXP. Raters were a PhD student and a PhD and a master's in clinical psychology. All were trained over approximately 4 months (2 h per week), the raters were trained based on the EXP Manual (Klein et al., 1986). The EXP Manual involved: (1) reading and discussion of the manual's rating

procedures; (2) rating of the manual's clinical excerpts; and (3) rating of previously delimitated EEs (identified by a different pair of raters) from videotaped psychotherapy sessions (not from Anna's or Jane's case) until a good level of reliability with respect to the identification of the EXP peak level (*Intraclass Correlation Coefficient—ICC* [2,1] ≥ .65) was achieved. In the current study, the PhD student was paired with each of the two others raters to rate a randomly assigned case. Each rater independently rated the EXP peak level for the previously identified EEs. The inter-rater agreement was .81 (*ICC* [2,2] = .81) and .95 (*ICC* [2,2] = .95). The final rating resulted from discussion of any disagreements and the reaching of a consensus between each pair of raters. The final EXP ratings were averaged for each session of Anna's and Jane's cases.

Results

Figure 1(a and b) illustrate the session-by-session frequency of EEs aroused throughout Anna's and Jane's cases, respectively. In 1a for all sessions the frequency of EEs categorized in each of the emotion categories is displayed. A total of 71 EEs ($M = 5.56$, $SD = 1.98$) were identified during Anna's good outcome case (Figure 1(a)). EEs of Joy ($n = 31$; 44%) were the most frequent, followed by EEs of Sadness ($n = 19$; 27%) and Anger ($n = 16$; 23%). EEs of Guilt/Shame ($n = 3$; 4%) and Fear ($n = 2$; 3%) presented a very low frequency and only emerged in the initial sessions (S1 and S3). Jane's poor outcome case (Figure 1(b)) had a total of 97 EEs ($M = 7.46$ EEs; $SD = 2.50$). EEs of Sadness were the most frequent ($n = 36$; 37%), followed by EEs of Anger ($n = 23$; 23%), EEs of Joy ($n = 22$; 23%), and EEs of Fear ($n = 15$; 15%). We only identified one EE of Guilt/Shame ($n = 1$; 1%). In both cases, no EEs of Love were identified.

In Figure 2(a and b) bars illustrate the frequency of adaptive and maladaptive EEs and lines show the growth of the EXP average level throughout Anna's and Jane's cases, respectively. Eighty three percent of the EEs (58 of 71 EEs) identified during Anna's good outcome case were categorized as adaptive (Figure 2(a)). Adaptive EEs appeared in all the therapeutic sessions, most frequent during the first and the second half of therapy. Only one of maladaptive EEs was found in the second half of therapy (sessions 8 to 13). Regarding Jane's poor outcome case (Figure 2 (b)), 56% of the EEs were categorized as maladaptive (54 of 97 EEs). We identified both adaptive and maladaptive EEs in all therapeutic sessions. Although there were fewer than in the first half of therapy (sessions 1 to 7), the maladaptive EEs were still frequent during the second half of therapy.

Regarding the EXP growth, during Anna's good outcome case we rated EXP level 2 to 6. Anna achieved EXP level 6 during the first (session 1 to 7) and the second half (session 8 to 13) of therapy. The average EXP levels ranged from 3.3 to 5 and tended to increase across therapy (Figure 2(a)). During Jane's case (the poor outcome) the client almost exclusively achieved EXP level 3, while in the second half of therapy, sporadically reached EXP level 5. Average EXP levels ranged from 2.8 to 3.8. This also slightly increased across therapy (Figure 2(b)). Next, we describe and provide clinical vignettes to illustrate the EXP growth and the change in the type of EEs aroused during therapy in both good and poor outcome case.

Anna's Good Outcome Case

Sessions 1 to 7. During the initial sessions (sessions 1 to 3), in addition to adaptive EEs of Sadness associated with the grieving of her husband, Anna presented maladaptive EEs of Anger, Fear, and Guilt/Shame. EEs of Anger were associated with feelings of anger, loathing, and jealousy toward others, all secondary emotional responses to grief. The "unacceptable" desire that people who had the same illness as her husband would also die was associated with secondary emotional responses of Guilt/Shame and Fear about being punished by God.

Even in the first session, during these maladaptive EEs of Anger, Guilt/Shame, and Fear, Anna reached EXP level 4 and, sporadically, EXP level 5. The client described her experiences and issues from an inward perspective (EXP level 4) and explored her feelings, emotions, and problems (EXP level 5). The following clinical vignette retrieved from an EE of maladaptive Anger (session 1), rated as EXP level 5, illustrates such inner work. Anna described her desire to know that other people also grieved and felt pain and hypothesized that such feelings of Anger were associated with her pain and her difficulty accepting the death of her husband, achieving EXP level 5.

> **Anna:** I got mad at people. Sometimes I feel like I want to hear bad news about other people. Oh my God, it's a wrong way of thinking, but that's how I feel.
>
> **Therapist:** I'm not seeing a bad person, I see you as a human being who has stumbled upon a painful situation and is trying to get a sense of what happened.

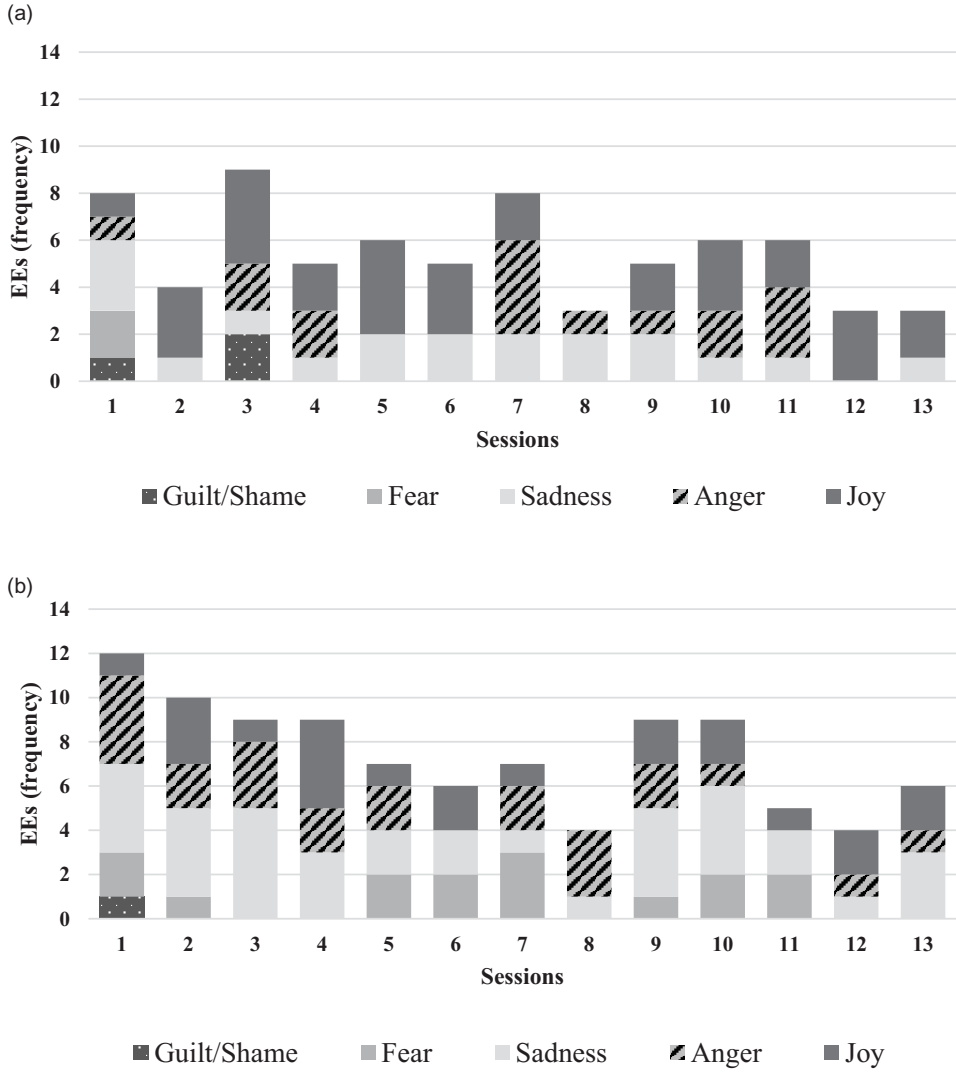

Figure 1. Frequency of Emotion Episodes (EEs) of Guilt/Shame, Fear, Sadness, Anger, and Joy throughout (a) Anna's case (good outcome case) and (b) Jane's case (poor outcome case).

Anna: I've never been like this. (**Therapist:** Hum um.) I got so sick that two years after his death I still can't accept that it happened.

Therapist: So, do you think this difficulty in accepting is related to your anger?

Anna: Yes. Maybe this anger means I'm not accepting his death … Maybe I go through the obituaries in the newspaper to realize that it wasn't just my husband who died. I need to know that the same happened to other people to be able to accept it.

Following further therapeutic facilitation of inner work on the meaning of her feelings of Anger, during session 3 Anna achieved, for the first time, EXP level 6 in a maladaptive EE of Anger regarding the same theme. The excerpt below was taken from that EE. Anna achieved EXP level 5 when she identified her Anger towards others as problematic and explored the meaning of this emotion in her mourning experience. The therapist-guided exploration of the client's inner experiences resulted in the achievement of EXP level 6 when the client described the underlying process associated with the transformation of her secondary feelings of guilt about being angry. Anna acknowledged her anger as an emotional response to the painful and premature death of her husband. Furthermore, in the final part of the excerpt, Anna focused on her feelings of grief instead of on the maladaptive anger.

Anna: When I hear that someone has died, I think, "that's just the way it is".

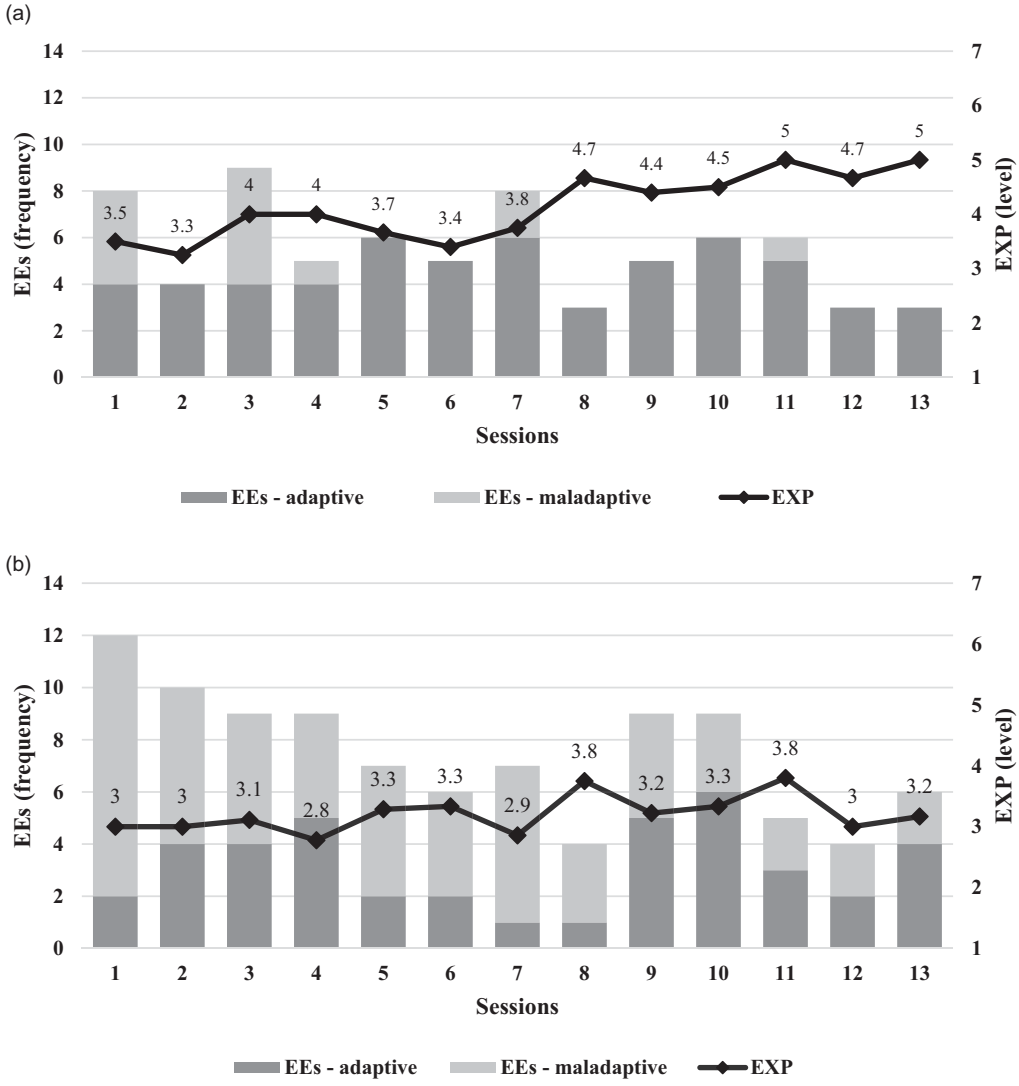

Figure 2. Frequency of EEs categorized as adaptive and maladaptive and average level of EXP throughout (a) Anna's case (good outcome case) and (b) Jane's case (poor outcome case).

Therapist: What would you tell someone who tells you that you are cruel?

Anna: What happened to me wasn't cruel also? I have a reason to be angry.

Therapist: Okay. What is the role of this anger in your experience of mourning?

Anna: I've never been a person to conform to the idea that God is in charge.

Therapist: You are telling me that you have the right to have a voice in what happened to you: "this revolt is in response to my husband's passing".

Anna: Yes. I consider this to be the salt of my life. If I do not feel this anger, it seems that I'm not doing any justice to my husband's death, it seems as if I accepted it.

Therapist: How do you imagine your life keeping that salt, that nonconformity?

Anna: Now I don't feel so guilty for thinking this way because I realized I'm not harming others. I just feel comfort in knowing that I'm not the only one experiencing loss. I'm a grieving person who has the right to feel anger because a part was removed from me. I'm suffering for having lost him.

After session 3, the maladaptive EEs of Anger, Guilt/Shame and Fear regarding this theme disappeared. Instead, Anna accessed and explored the adaptive EE of Sadness over her loss. As can be seen in the following excerpt, retrieved from the beginning of session 4 (EE of Sadness), the client

elaborated on the transformation of her feelings of secondary Anger into adaptive Sadness due to the loss of her husband, achieving EXP level 6.

> **Therapist:** What do you want to do with that emotion, with that salt of your life?
>
> **Anna:** The way I feel now about my husband's death, I think it's not even anger anymore … I feel hurt with everything that's happened to me. I don't think it's fair, it didn't do justice to what happened to me, to us. So, I'm disappointed, but I'm not like I was in the beginning when I was blaming everyone. Now it's not … I feel sad and hurt with what happened to me, to us. I miss him, and I know I will always miss him, but I'm more at ease with that pain. I'm trying to accept and adjust myself to my new life.

Alongside this internal work in accepting her mourning, Anna embraced her post-loss life. For instance, she donated her husband's clothes and engaged in a new professional project. Beginning in session 4, Anna confronted others' expectation that she should be a widow who should be fulfilled by being a mother and a grandmother. The client began to identify others' pressure as an issue during adaptive EEs of Anger. Throughout the first half of therapy, the client mostly achieved EXP level 3 in these EEs, briefly describing and accessing the emotional impact of others' pressure.

Sessions 8 to 13. During the second half of therapy, Anna reached EXP level 5 in the EEs of adaptive Anger regarding others' intrusion in her life. In the following excerpt from an EE of adaptive Anger (session 8), the client described the conflict between conforming to others' pressure to fill the role of a widow and asserting her own needs (EXP level 4). Anna achieved EXP level 5 when she described the inner impact of such issues and stated her personal value and right to choose the life she wanted to have after her husband's death.

> **Anna:** People think that any random thing will please me now, I can even stay in a corner in the smallest room of my house. I could follow that thought, "ok, now I'm alone, anything works for me", but on the other hand I don't think I should. Thinking of me, I want to create a space for myself where I feel good. This revolts me because I'm not something that's stuck in a corner. People tell me, "now you have your grandbabies". It sounds like I'm worthless, that I have no rights as I did before because my husband is no longer at my side. It's like they're telling me that it's over for me.
>
> **Therapist:** Hum hum. Regarding your rights, how would you respond to them?
>
> **Anna:** I'd say that I'm the person I've always been. I just don't have him by my side, but I'm still me. (**Therapist:** Hum hum) Of course, now it's different because I have this constant grieving, but I'm me. I'm trying to feel comfortable and to feel better with this new life that I'm embracing.

Adaptive EEs of Joy related to Anna's investment in her new life and to a greater acceptance of her husband's death emerged during this second phase of therapy. The client frequently achieved EXP levels 5 and 6. In the following excerpt of an EE of Joy rated EXP level 6 (session 12), Anna presented a synthesis of the evolution of her post-death relationship with her husband, resulting in a less painful ongoing connection.

> **Anna:** I begin to see him in everything that is not material. (…) I miss him a lot, but it is less painful, I already accept my life much better. I now realize that it is not those things, like the furniture in my room, that connect me to him … He is always there. When I decided to change my bedroom's furniture, I was afraid to do it because it represented our life, so many beautiful and good moments. I thought it was going to disturb me a lot, but that didn't happen. Then, I realized that he is always with me, even if many of his objects, or the ones used by him, are gone. (**Therapist:** Hum hum) He's in my house, he's still the center of my attention.
>
> **Therapist:** Hum … It's interesting, you are saying that he's still the center of attention. This relationship with your husband now seems much less painful, seems freer because it is not confined to specific objects.
>
> **Anna:** I feel it. I seem to be freer to think of him. It's as if I was stuck on a schedule, with things that depressed me, and now I'm not, I feel free. (**Therapist:** Hum hum) I miss him, I miss him a lot, but I feel glad for having him with me with less pain.

Jane's Poor Outcome Case

Sessions 1 to 7. During the first half of therapy, Jane presented mostly maladaptive EEs of Sadness, Anger, and Fear. The EEs of Fear were maladaptive primary emotional responses associated with the client's perception of her inability to survive without her mother's support. The maladaptive EEs of Sadness were frequently overwhelming secondary reactions, namely, under-regulated feelings of being lost, helpless, and alone in response to her mother's death and the lack of familiar support felt. We also identified maladaptive EEs of Anger in response to these events. Jane frequently expressed destructive anger and complaints regarding her family as a secondary emotional response to the

pain of having lost her closest relationship. During these initial maladaptive EEs, Jane achieved almost exclusively EXP level 3, as illustrated by the excerpt below from an EE of Sadness (session 1). Jane focused on describing the episode of loss, presenting behavioral and intellectual involvement with her experience (EXP level 2). Jane achieved EXP level 3 when, in response to the therapist's intervention, she referred to global feelings of despair and loss.

Jane: My mother was sleeping with me, and when she got up, she fell. I immediately saw that something was happening to her. I was completely overwhelmed. I called the ambulance, and we went to the hospital. I was so shaken up. (…) Before I left the hospital, she just opened her eyes, looked at me and touched my tummy … (Cries)

Therapist: Jane, this is a very strong image.

Jane: It was the last time I saw her.

Therapist: Ok … What does this memory symbolize for you?

Jane: Despair. I'm feeling completely lost. (Cries)

Sessions 8 to 13. During the second half of therapy, Jane continued to present maladaptive EEs of Anger associated with secondary responses to her grief over her mother, resulting in responses of accusatory and destructive anger toward others. Although EXP level 3 remained the most frequent level reached by the client during this phase of therapy, Jane achieved EXP level 4 more frequently and reached EXP level 5 (highest level achieved during therapy) for the first time. The following excerpt was retrieved from the first EE of maladaptive Anger in which Jane achieved EXP level 5 (session 8). In addition to identifying feelings of Anger towards others as a problem, she caught her first glimpse of the association between this feeling and the sadness of her mourning, reaching EXP level 5.

Jane: I've been irritated with people …

Therapist: And this irritation, what is its meaning for you?

Jane: I don't know … Maybe it has to do with my longing for my mother …

Therapist: Ok! We have seen that longing is one of the ingredients that flavors the experience of mourning. (**Jane:** Hum um) Right now, maybe your sadness and longing are covered in irritation. Is that it?

Jane: Maybe … When I go to my boyfriend's house, the affection of his mother toward him reminds me of when I also had that care, the talking, the support … And for example, I went to the dentist and (**Therapist:** Hum hum) not having her company, as always, I think that's what made me feel more fragile and sometimes even angry.

In addition to the maladaptive EEs of Anger, adaptive EEs of Sadness and Joy emerged during this second half of therapy. The EEs of secondary maladaptive Sadness almost disappeared. Instead, Jane presented adaptive responses of Sadness regarding the irreversible loss of her mother. The client achieved EXP levels 3 and 4 during these EEs. Next, we present an excerpt from an adaptive EE of Sadness (session 10) associated with Jane's grief. The client achieved EXP level 4, as she was internally focused on the description of her grief as an actual experience of longing. Although Jane described her experience with internal references, she avoided contact with such painful emotions, preventing her from achieving higher EXP levels.

Therapist: How do you think your grief experience is right now?

Jane: At this moment I think my grieving experience is about longing, completely!

Therapist: What does it mean to you, "my grieving experience is about longing"?

Jane: I miss her, her support, her affection … I feel a longing for my mom.

Therapist: Hum hum. And how have you been dealing with that longing?

Jane: I don't, I try to pass by, and not be in contact. Even going to the cemetery, I'm like, "I'm going! No, I'm not going".

Therapist: Hum hum. How would it be for you to give yourself the opportunity to go?

Jane: I think it is going to be a painful time for me (**Therapist:** Hum hum). I want to get out of this situation. But sometimes it's complicated and I just start to cry.

The EEs of adaptive Joy were mainly associated with emotional responses of relief, satisfaction, and empowerment regarding the therapeutic support and validation of the client's suffering. Jane mostly achieved EXP level 3 during the adaptive EEs of

Joy. In the final excerpt, retrieved from the last session, Jane reached EXP level 3 when she briefly referred to inner experiences of security and confidence due to therapy. However, she did not clarify how these feelings were inwardly experienced by her (EXP level 4).

> **Jane:** I enjoy coming to therapy; I leave feeling more secure and confident. Talking about and expressing what distresses me and puts me down makes me feel better.

Discussion

The current intensive comparative case study explored the role of emotional processing in a good and poor outcome of complicated grief treated by meaning reconstruction therapy (Neimeyer, 2001, 2006, 2016). We explored changes in the clients' loss-related emotional experience tracking how these two clients suffering from complicated grief, experienced and processed their loss-related emotions throughout therapy. This exploratory comparative case study may contribute to theory building (Stiles, 2015), and increase our understanding of the change process in grief, specifically the role of emotional processing as a possible mechanism of change associated with improvement in bereavement.

Emotional Processing and Therapeutic Outcome

Both clients enhanced their capacity to process grief-related emotions throughout therapy, however, Anna's good outcome case "achieved" more improvement. Jane's poor outcome case averaged an EXP levels range of 2.8 to 3.8, presenting a slight increasing tendency, but throughout Anna's case the average EXP levels ranged from 3.3 to 5, showing a clear increasing tendency. The comparative analyses of these two cases suggests that clients experiencing complicated grief struggle with difficulties in processing their loss-related emotions (Castro & Rocha, 2013; Neimeyer, 2001, 2006; Stroebe & Schut, 2010). Also, clients' emotional processing capability seems to be promoted during constructive grief therapy (Burke & Neimeyer, 2013; Neimeyer, 2006, 2016). In other words, therapeutic work focused on producing a higher level of emotional processing of loss-related experiences seems to be productive to overcome complicated grief. Such findings are consistent with prior research on other clinical conditions and therapeutic approaches (Auszra et al., 2013; Malin & Pos, 2015; Pascual-Leone, 2018; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2020; Rudkin et al., 2007; Watson et al., 2011). Therefore, emotional processing may be a transtheoretical factor of change in psychotherapy (Elliott et al., 2013; Greenberg & Pascual-Leone, 2006; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017), applied to different problems and a diversity of models of intervention.

Emotional Processing and Changes in the Type of Emotions Aroused

During both Anna's and Jane's cases, we identified EEs of Sadness, Anger, Joy, Fear, and Guilt/Shame, suggesting that these are emotions associated with the grief experience. These grief-related emotions have been identified in the literature (Alves et al., 2012; Coifman & Bonanno, 2010; Fernández-Alcántara et al., 2016; Hooghe et al., 2012; Stroebe & Schut, 2010). Prior studies did not categorized emotion's adaptive or maladaptive function, neither how they are processed during grief therapy.

We found that although both clients experienced the same categories of emotions, there were differences in the (1) frequency of EEs categorized as adaptive and maladaptive, and (2) the EXP levels achieved during these EEs. First, the good outcome case presented a higher frequency of adaptive EEs than the poor outcome case (82% and 44%, respectively). Although the frequency of maladaptive EEs decreased from the first to the second phase of therapy in both cases, the poor outcome case maintained a higher frequency of maladaptive EEs throughout treatment. Second, Anna's good outcome case reached higher EXP levels during both adaptive and maladaptive EEs, which we hypothesized would be associated with a productive emotional transformation, and a better therapeutic outcome. These results are consistent with theoretical and empirical literature regarding emotional processing (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2016; Pascual-Leone & Greenberg, 2007; Pinheiro et al., 2018). Our findings suggest that in complicated grief a productive transformation of maladaptive emotional experiences and accessing more adaptive emotions may be associated with better therapeutic outcome.

A thorough analysis of the type of loss-related emotions aroused and the EXP levels achieved throughout therapy may be informative regarding the therapeutic change on complicated grief. As expected, both cases experienced maladaptive emotions at the beginning of therapy. From the initial sessions, Anna deeply accessed, experienced,

and explored her maladaptive responses of Anger, Guilt/Shame, and Fear regarding the death of her husband (EXP level 5), which may have contributed to accessing underlying adaptive Sadness on her loss (EXP level 6). In contrast, Jane presented brief access (EXP level 3) to maladaptive loss-related emotions of Fear, Sadness, and Anger. Just later in therapy, and sporadically, Jane engaged in exploring and reflecting upon the meaning of her experiences of maladaptive Anger towards others, catching her first glimpse of its link to the sadness she felt for the loss of her mother (EXP level 5). There were similarities and differences between cases in the maladaptive loss-related emotions experienced and in the level of emotional processing they achieved. First, our results suggest that in initial sessions the therapeutic work was mainly on EEs associated with maladaptive emotional experiences. Therapeutic work in these maladaptive loss-related experiences seems to be important for the client to be able to later access to more adaptive emotions. This indicates the feeling maladaptive pain is important in resolving grief (Greenberg & Goldman, 2019). Second, a highly frequent and deep inner work on maladaptive emotions, specifically on Anger, seemed to be critical to change these experiences and to access underlying adaptive Sadness for the loss. Although Jane sporadically explored loss-related maladaptive Anger (achieving EXP level 5 during this exploration) this did not seem sufficient to deeply transform such experiences. A deeper inner work would be necessary to facilitate emotional transformation, as rated by EXP level 6. Achieving EXP level 6 suggests a change from maladaptive to a more adaptive experiences of Sadness in Anna's case, supporting that this level may function as a proxy for a productive emotional transformation (Pinheiro et al., 2018).

Our finding also supports the unique role of experiencing adaptive Sadness in grief. Maladaptive emotional experiences are transformed by accessing the innately healthy information derived from the adaptive emotions (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2016; Pascual-Leone & Greenberg, 2007). Repeated work with adaptive Sadness during grief may be important to mobilize clients to accept the irreversible loss and invest in a new life without the presence of the deceased (Greenberg, 2010; Greenberg & Watson, 2006). However, accessing and occasionally experiencing adaptive Sadness (EXP level 3 and EXP 4), as occurred in Jane's case, does not seem to be sufficient to deeply transform maladaptive loss-related emotions, neither to overcome a complicated grief condition. On the contrary, like in Anna's case exploring and reflecting upon adaptive Sadness is necessary to achieve new meanings on loss and to transform the maladaptive experiences (Greenberg, 2010; Greenberg et al., 2007; Greenberg & Watson, 2006; Pascual-Leone & Greenberg, 2007). Anna's increased ability to explore and make sense (EXP level 5) of her adaptive Sadness (and Joy at a later phase of therapy), mobilized the client to meet her core needs based on the healthy information associated to adaptive emotions (EXP level 6). Such healthy information moved the client to rebuild her life, which included an ongoing and less painful relationship with her husband, as rated by EXP level 6. The achievement of EXP level 6 during adaptive EEs seems to be associated with a successful emotional transformation and with a productive use of the healthy information provided by adaptive emotions in grief resolution. As we observed in the current comparative case study, accessing the healthy information from adaptive emotions has been associated with greater therapeutic change, such as proposed by the humanist-experiential theory (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2014; Pascual-Leone & Greenberg, 2007).

Individual Differences and Risk Factors for Grief

Therapy was more productive for Anna than for Jane. We are aware of risk factors for complications in the grieving process that may have contributed impairment of the integration of the loss into Jane's meaning system, when compared with Anna (Burke & Neimeyer, 2013; Neimeyer, 2006, 2016). Namely, (1) Anna's loss occurred longer ago, although not long or sudden, (2) she was older, and had already experienced other significant losses. Conversely Jane's mother seemed to be the core securing and validating figure for the client's identity. Further research is needed to understand the impact of such differences on grief therapy. Still, based on the current comparative case study, we may consider that important differences may have contributed to the fact that Jane and Anna started therapy at different points of preparation to deal with their loss and these will be important to empirically understand.

Still, in relation to emotional processing Jane achieved lower levels of EXP in the first sessions, which may suggest deeper difficulties in accessing and being in contact with her painful loss-related experiences. We may consider that Jane's emotional-avoidance style may have contributed to making therapy less productive for her. Jane experienced her mother's loss with a deep Fear of being unable to survive without her. Although activated by the current loss, such primary maladaptive Fear may be

an old, familiar experience for Jane, associated with a self-experience of vulnerability and incompetence (Greenberg, 2010, 2015; Greenberg & Goldman, 2019). Such self-experience may explain why the client struggled with difficulties in access, be in live contact, and exploring the painful loss-related emotions (both maladaptive and adaptive). We hypothesize that further therapeutic work would be necessary to transform the primary maladaptive Fear and the underlying self-experience of vulnerability and incompetence (cf., Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). The exploration of the meaning of primary maladaptive emotions would be crucial for Jane to achieve an empowered self-experience and feel more capable to engage in a deeper contact with her loss painful experiences. Therefore, difficulties in accessing and being in contact with painful loss-related experiences during initial sessions may work as a red flag for therapists. The therapeutic work needed to promote emotional processing may be more challenging for clients who initiate therapy with lower levels of EXP.

Limitations and Further Research

Our findings may result from the idiosyncrasies of the cases, and from the therapeutic and methodological approaches adopted. In the current study we worked with the clients' higher level of emotional processing (EXP peak level). This option allowed us to respond to the aim of the current comparative study. Even though, we are aware that the analysis of the most frequent EXP level achieved (EXP modal level) would provide important complementary information to understand the growth of the emotional processing during the poor outcome case. Higher EXP levels were reached sporadically during this case which does not seem to be sufficient to deeply transform maladaptive loss-related emotions, neither to overcome the complicated grief condition.

The EXP scale measures the degree to which clients are involved in accessing, experiencing, and exploring their emotional experience while solving inner problems in therapy, but it does not measure the emotion states experienced by the clients. Although we have rated EXP levels during EEs to account for the emotions category experienced, we have not captured the moment-by-moment emotional processing change. Considering this limitation of the EXP scale, further research is needed to develop a model for successful emotional processing in grief resolution. Task analysis may fit this objective as it is a useful approach to study complex processes of change in therapy (see Greenberg, 2007).

Further research is needed to clarify whether emotional processing is one of the mechanisms of change activated throughout therapy that may contribute to clients' improvement in cases of complicated grief. Considering that accessing the painful Sadness for the loss seems to be a core task for clients experiencing grief, further research is needed to understand how clients process such emotional experience. Also, outlining indicators that signal those clients who have greater difficulties in processing their emotions can be useful, especially for clinical practice. This is an avenue that deserves further empirical exploration, allowing therapists to adjust the interventions to the needs and capabilities of each client. Although they do not allow the generalization of the findings, case studies (cf., Stiles, 2015) can be useful for the development of a more comprehensive knowledge in this field.

Conclusion and Clinical Implications

The current exploratory study may improve our knowledge about clients' change process during grief therapy. The capacity for emotional processing might be impaired in complicated grief, and its facilitation throughout therapy may be associated with (1) changing maladaptive loss-related emotions, and (2) coping with grief and adapting to the new life based on the healthy information provided by adaptive emotions. Furthermore, the improvement of the emotional processing capability seems to be associated with (3) a better therapeutic outcome.

Considering that the humanist-experiential emotional processing may work as a transtheoretical change factor, being aware of clients' type of loss-related emotions that are aroused during therapy and the level of EXP achieved may provide useful leads for grief therapists. Learning to deepen clients' level of emotional processing may prepare clients to deal with the loss-related experiences. The humanistic-experiential approaches can provide insightful theoretical and specific therapeutic tasks for therapists to deepen the level of emotional processing in grief (see Greenberg, 2010, 2015). For the clients who started therapy with lower levels of EXP, a longer and emotionally focused therapeutic work may be useful to facilitate the clients' access, live contact, and transformation of loss-related maladaptive experiences. Therapists should focus clients' attention on the core and painful aspects of their experience (maladaptive primary emotions), since these are usually not completely aware, and helping them to make meaning of such experiences (Greenberg, 2010, 2015; Greenberg & Watson, 2006; Pascual-Leone et al., 2018). The primary maladaptive emotional experiences need to

be addressed to change the client's core self-experiences and facilitate the integration of the loss experience. Such maladaptive emotions are transformed by the activation of adaptive responses to the same events (Greenberg, 2010, 2015), such as Sadness in grief. The healthy potential of adaptive Sadness in grief is achieved by the frequent exploration and meaning making of such experience. Finally, the clients' achievement of EXP level 6 throughout therapy may work as micro-outcome indicator for therapists regarding a successful change on maladaptive loss-related experiences and a productive use of the healthy information provided by adaptive emotions to overcome complicated grief. The therapists being aware of their clients' moment-by-moment EXP level may be informative regarding the therapeutic change process, helping them to adjust clinical interventions.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Funding

This study was conducted at Psychology Research Center [UID/PSI/01662/2013] of the University of Minho, supported by the Portuguese Foundation for Science and Technology (FCT) and the Portuguese Ministry of Science, Technology and Higher Education through national funds and co-financed by FEDER through COMPETE2020 under the PT2020 Partnership Agreement [POCI-01-0145-FEDER-007653]. This research was also supported by a PhD studentship grant [SFRH/BD/93696/2013] from the FCT.

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