

THERAPIST EXPRESSED EMPATHY ACROSS EXPERIENTIAL TREATMENT FOR
DEPRESSION: ITS GROWTH AND RELATIONSHIP TO OTHER PSYCHOTHERAPY
PROCESSES

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ABSTRACT

Objective: This study examined whether the provision of expressed empathy by therapists increases from the beginning to the working phase of experiential therapy for depression. It also tested relationships among working phase therapist expressed empathy, the working phase alliance, and clients' working phase emotional processing, as well as tested the relationship between therapist expressed empathy and outcome at termination. **Method:** Therapist expressed empathy was assessed using The Measure of Expressed Empathy, a valid and reliable observer-rated measure. The Working Alliance Inventory, Experiencing Scale, and Beck Depression Inventory were used to measure the alliance, emotional processing and outcome respectively. **Results:** A paired samples t-test determined that therapists significantly increased their provision of expressed empathy from session one to the first working phase therapy session. A linear regression determined that improvements in therapist empathy were associated with improvements in the working alliance between these sessions. A path analysis found that working phase therapist empathy indirectly predicted outcome by contributing to more favourable working phase alliances, and a trend was found for therapist empathy to indirectly predict working phase emotional processing through the working phase alliance. **Conclusion:** Therapists do increase in their expression of empathy over the course of experiential therapy. When therapist empathy increases across therapy sessions working alliances tend to improve. Further, higher working phase therapist empathy appears to indirectly contribute to more reductions in depressive symptoms at termination by improving the working phase alliance.

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Overview

Depression, the leading cause of disease burden in high-income countries, is expected to become the leading cause of disease burden worldwide by 2030 (World Health Organization, 2004; Ferrari, et al., 2013). While there are several short-term, empirically validated and equally effective psychotherapies (i.e. interpersonal, cognitive-behavioural, experiential and psychodynamic) for moderately depressed adults, (Dreissen et al., 2010; Elkin, et al., 1989; Shea & Elkin, 1996; Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003); their effects are often modest at 12 and 18 month follow-up (Westen & Morrison, 2001). Therefore, to alleviate the disease burden of depression worldwide, treatments for depressions should still be improved.

One means of improving therapies is for researchers to establish *how* they work. Some suggest that common factors are responsible for the majority of client change in all psychotherapies (Goldfried, 2004; Wampold, 2001). Empathy has been identified as one such common factor (Elliot, Bohart, Watson & Greenberg, 2011), along with the working alliance (see Norcross, 2011; Greenberg & Watson, 2006), narrative change (Angus, 2012) and emotional processing (see Greenberg & Pascual-Leone, 2006 for review; Pos, Greenberg & Warwar, 2009; Teasdale, 1999). However, common factors still are uniquely implemented across different models of treatment, (Goldfried, 2004; Bohart & Greenberg, 1997)). Therefore, researchers must demonstrate that a theoretically-informed implementation of a particular common factor within a specific model of treatment occurs and can predict client improvement (Wampold, 2001). Indeed, psychotherapy process researchers have been attempting to empirically demonstrate the importance of the working alliance (Horvath & Bedi, 2002), autobiographical memory (Boritz, Angus, Monette, Hollis-Walker & Warwar et al., 2008; 2011) and empathy (Elliot, et al., 2011;

Malin & Pos, 2015; Watson & Prosser, 2002) for predicting outcome across various treatment modalities. Experiential therapists have also been investigating another common factor, the effect that increasing emotional processing has on ameliorating depressive symptomatology (Goldman, Greenberg & Pos, 2005; Pos, Greenberg, Goldman & Korman, 2003; Pos, Greenberg & Warwar, 2009) as well as the impact that therapist empathy has on improving emotional processing and the alliance (Malin & Pos, 2015).

The experiential therapy training protocol underlines the importance of empathy in building the working alliance by dictating that therapists provide empathy from the start of therapy in order to build a foundation for fostering a favourable working alliance. Empathy is also assumed to create the safety that clients need to approach and process their inner experience (Greenberg, 2014; Greenberg & Goldman, 1988; Greenberg & Watson, 2006; Greenberg, Rice & Watson, 1994; Rogers, 1975). Indeed, experiential therapy research has shown that higher expression of therapist empathy during first sessions predicts more favourable early working alliances, deeper emotional processing in the working phase of therapy, and reductions in depressive symptoms reported by clients at termination (Malin & Pos, 2015). One lingering question, however, is whether there can be growth and improvements in therapists' provision of empathy over the course of experiential therapy, and if change in expressed empathy across therapy relates to change in the alliance across therapy. These questions were two main foci of the present study. Specifically, I examined whether experiential therapists increase their provision of expressed empathy from session one to the working phase of experiential therapy for depression. The working phase was chosen as it is the phase of therapy showing the strongest process to experiential therapy outcome relationships in past research. This study also examined whether changes in therapist empathy remain closely associated with changes in the alliance

across experiential therapy. This study was the first to explore these questions while utilizing an observer-rated measure of therapist empathy. Additionally, the present study explored the relationships between therapist empathy, the alliance and client emotional processing in the working phase of therapy, as well as the relationship between working phase therapist empathy and outcome at termination. While past research has demonstrated that the working phase alliance predicts working phase emotional processing (Pos. et al., 2009), how therapist expressed empathy in the working phase contributes to the alliance and emotional processing within working phase sessions has not yet been examined. Since client emotional processing during the working phase has been shown to be a key predictor of outcome in experiential therapy (Pos et al., 2009) it is important to establish what processes contribute to it. Therefore, this was a focus of the present study. Lastly, the potential impact of certain client individual differences previously found to impact therapists' expressed empathy during session one was also explored within the working phase.

Therapist Empathy

Empathy has gained attention as a basic relational process across many domains, including within psychotherapy (Elliot & Greenberg, 2007; Goleman, 1995; Rogers, 1959). It is generally considered to involve both cognitive and affective components. While, there is currently no consensual definition; Rogers (1959) has defined empathy as the ability to accurately perceive the internal frame of reference of another, including their emotional components and meanings. Barrett-Lennard (1962), the author of the Barrett-Lennard Relationship Inventory (BLRI) another measure of empathic process, also described it as an active process of desiring to know the awareness of another person, reaching out to receive that person's communication and translating it into experienced meaning. Kohut (1984), a dynamic

writer well associated with the concept of empathy described it as the capacity to think and feel oneself into the inner life of another person.

Since the importance of empathy was first well-articulated by Rogers, a humanistic and experiential writer, I will focus on his views of this concept here. Roger's (1959) considered therapist empathy to be one of three therapeutic relationship conditions (along with unconditional positive regard and genuineness) that are necessary and sufficient to facilitate change in psychotherapy. He described therapist empathy as a process by which the therapist both enters the private perceptual world of the client, and is sensitive to the moment-to-moment emerging and changing experience and meanings of the client. He stated that being empathic involves the therapist taking a non-judgemental stance to sense and uncover meanings that are on the edge of the clients' awareness, and that it is important to frequently check with the client that his or her perceived meanings are accurate (which gives the client agency and authority over his or her own experience, another important experiential therapy value). He theorized that through being empathic the therapist can create a safe therapeutic environment that enables his or her clients to utilize their innate self-actualizing tendencies to resolve their own distress (Rogers, 1975).

Coherent with Rogers' ideas, but also taking them slightly forward, Barrett- Lennard (1981, 1986) conceptualized empathy as an *interpersonal* process between the therapist and client consisting of three stages: empathic resonance, expression of empathy and received empathy. Empathic resonance is the therapist's internal process of listening to the client and developing an understanding of his or her experience; expression of empathy involves the therapist communicating this understanding to the client; and received empathy involves the client perceiving the therapist's empathic response and providing feedback about its accuracy.

As such Barrett- Lennard (1981, 1986) believed that unless empathy was ‘received’ it was not adequately expressed. Greenberg & Bohart (1997) agree. Still, expressed empathy was an important component of Barrett- Lennard’s view of empathy.

Empathy is presently considered a core relationship condition in experiential therapies that is employed to establish the alliance and support emotional processing (Pos, Greenberg & Elliot, 2008). Key components of therapist empathy include: exuding warmth, perspective taking, and mirroring the client (Imel, Barco, Brown, Baucom, Baer, Kircher, & Atkins, 2014). Therapists can exude warmth by smiling, maintaining eye contact, conveying softness, and appearing receptive to their client’s concerns. These behaviours can also interpersonally sooth the client (Geller & Porges, 2014; Watson & Prosser, 2002; Imel et al., 2014). Perspective taking involves therapists conveying an understanding of their clients’ inner experience (Eisenberg & Eggum, 2009; Imel, 2014). By attempting to understand how clients experience their inner worlds and reflecting this understanding back to the client, therapists help to clarify the client’s inner experience and to give rise to new meanings and narrative constructions; both of which can have a healing effect (Bohart & Greenberg, 1997). Mirroring the client involves reflecting back to the client both verbal and non-verbal components of his or her expressed experience. This can include the use of language that is synchronous with that of the client’s or displaying corresponding body language (Imel et al., 2014; Lord, Sheng, Imel, Baer & Atkins, 2015; Watson & Prosser, 2002).

Coherent with Barrett- Lennard’s (1981, 1986) interpersonal conception of empathy several therapist behaviours have been shown to significantly relate to client perceptions of empathy. These many empathic behaviors of therapists include: 1) therapists’ non-verbal behaviours (such as maintaining eye contact, having a concerned expression, and maintaining a

forward lean or head nodding to convey an understanding (D'Augeli, 1974; Dowell & Berman, 2013; Tepper, 1973; Watson & Prosser, 2002); 2) therapists' speech characteristics (such as having similar rates of speech and vocal tones as their clients', responding just ahead of their clients', and not interrupting (Barrington, 1961; Greenberg & Elliott, 1997; Elliot et al., 2011)); and 3) therapists' response modes (such as conveying a sense of interest, having an equal level of emotional involvement as their clients', not conveying detachment or boredom (Caracena & Vicory, 1969; Tepper, 1973), use of emotion words (Barrington, 1961), provision of exploratory responses rather than general advice (Barkham & Shapiro, 1986), and clearly communicated messages (Bohart & Greenberg, 1997; Caracena & Victory, 1969)). Therapists' characteristics such as being non-judgemental, attentive, and open to discussing any topic, have also been shown to be important (Myers, 2000).

Therapist empathy can be measured in several ways, including by client reports or therapist reports. Rogers (1957), consistent with an interpersonal view of empathy, suggested it might also be measured by assessing the congruence between therapist and client perceptions of therapist empathy. Since empathy is defined by many as 'communicated understanding', many suggest expressed empathy be measured by observer-ratings (Elliott et al., 2011; Watson & Prosser, 2002). This is because more might be gleaned by an observer concerning the overt measureable therapist behaviours that clients may refer to when subjectively rating their therapists' empathy using a self-report measure. Those behaviors would become better understood and validated by research if they are observable by raters independent of the client. That observable measureable dimensions of empathy be articulated and validated is also very relevant to training therapist empathy. Still, client reports of empathy have been shown to often best predict psychotherapy outcome, followed closely by observer-rated measures (Elliot et al.,

2011; Watson & Prosser, 2002). Of the client-rated measures of therapist empathy, The BLRI (Barrett-Lennard, 1986) has been the most widely used. A self-report measure, it asks clients to rate the extent to which they experience the therapist as genuine, prizing, or empathic during the therapy session (Elliott et al., 2011). Research (Pos, Oghene & Geller, 2011) has found that client-rated empathy (using the BLRI) is distinct from client-rated therapist presence as measured by Geller's (2001) client-rated Therapeutic Presence Inventory (TPI), as presence predicated a significant additional amount of variance in the alliance over and above empathy. Therefore, empathy has been shown to be distinct from the client's experience of her or his therapist being present, or in the here and now with her or him. This suggests particular therapist modes that may contribute to the client experiencing her or his therapist as empathic versus present. Again, although valid and reliable, client-rated empathy measures such as the BLRI assess clients' global perceptions of empathy rather than capture the specific therapist behaviours that may contribute to clients' perceptions of empathy. Observer measures will have the advantage of implicitly or explicitly capturing such therapists' expressed empathic behaviors.

For the above stated reasons, the present study employed an observer-rated measure: The Measure of Expressed Empathy (MEE; Watson & Prosser, 2002). With this measure, observers evaluate the degree to which therapists engage in empathic verbal and nonverbal behaviour, including speech characteristics and response modes, on 10 distinct dimensions which have each been developed based on various behavioural correlates of empathy already identified in previous research (Barrington, 1961; Bohart & Greenberg, 1997; Caracena & Victory, 1969; D'Augeli, 1974; Elliot et al., 2011; Greenberg & Elliott, 1997; Tepper, 1973; Watson & Prosser, 2002). Further, since empathy can be captured by either a sum of the MEE subscales or via each empathic subscale, the MEE measures therapist empathy at both the level of global empathy as

well as at the level of specific empathic dimensions (see Appendix A for a copy of the MEE). Thus, unlike client-rated measures such as the BLRI that only assess clients' global perceptions of empathy, the MEE measures specific components of expressed empathy (Watson & Prosser, 2002).

Therapist Empathy and Working Alliance Formation

The concept of the therapy alliance was originally introduced by psychoanalysts who proposed that all psychotherapeutic relationships were transference based (that is, would be coherent with previous familiar relationship patterns the client may have experienced, Freud, 1912/1958). Some considered the *true* working alliance to depend on the client's ability to use the healthy part of his or her 'ego' to collaborate with the therapist on therapeutic tasks aimed at healing him/her. Others acknowledged that as the result of this, clients form an attachment, personal bond or "positive transference" with their therapists (Freud, 1912/1958; Greenson, 1967; Sterba, 1934). Later conceptualizations of the alliance were less psychoanalytic in nature. For example, Luborsky (1967) proposed that the alliance is formed in two stages. The first involves the therapist providing a warm and supportive relationship that enables the client to view the therapist as a source of help, while the second involves the client committing to invest and play an active role in the therapy process. Bordin (1979) was the first to introduce a transtheoretical conceptualization of the alliance that could not only be applied to all psychotherapeutic modalities, but could also be generalized to a variety of other non-psychotherapeutic relationships. He coined the term *working alliance*, and defined it as the degree to which clients experience a bond with their therapist as well as agreement with their therapist on therapy tasks and goals. This definition of the working alliance highlighted the

importance of the collaboration between therapist and client during the therapy process (Bordin, 1979; Horvath, Del Rey, Flückiger, & Symonds, 2011).

Bordin (1979) considered the working alliance to be one of the most important, if not *the* most important, change processes in individual psychotherapy across all psychotherapeutic modalities. In fact, Bordin theorized that it would be more important for outcome than any specific intervention implemented. Although transtheoretical in its conception, Bordin (1979) stated that while equally important in all therapies, it would be uniquely implemented in each approach. For example, in psychoanalysis the task of free association might be used to address the goal of exploring the unconscious conflicts contributing to the client's current distress. Conversely, in behaviour therapy the task of observing and documenting the frequency, duration and circumstances surrounding a problematic behaviour might be utilized to address the goal of behaviour change. In experiential therapy empathy helps clients access their inner experience in the service of their congruence and adaptive functioning. Additionally, Bordin (1979) proposed that the depth of the bond, or human relationship between therapist and client, would depend in part on the depth at which accessing internal experience was emphasized in a particular approach; with deeper emotional processing requiring a stronger bond. Furthermore, he emphasized that both client and therapist factors, as well as the match between therapist and client personality styles were all factors likely to influence the working alliance.

At present, the working alliance has been identified as a robust predictor of outcome across a variety of psychotherapy modalities for a variety of presenting problems, including depression (Horvath & Bedi, 2002; Horvath, Del Rey, Flückiger, & Symonds, 2011). Furthermore, a recent meta-analysis found that it accounts for 7.6% of the variance in treatment outcome (Horvath, et al., 2011). In experiential therapy, clients' reports of the alliance after the

first session have been shown to directly predict outcome on numerous measures (Pos et al., 2009). Therefore, during experiential therapies alliance related factors that are important for clients' final outcomes are developing or operating within the very first hour of therapy.

Relationship between Therapist Empathy and the Working Alliance. Therapist empathy refers to the therapist's ability to accurately perceive the internal frame of reference of the client (Rogers, 1959), whereas the working alliance refers to the bond and agreement on tasks and goals between the therapist and client (Bordin, 1979). Experiential theory assumes that therapists' provision of empathy is an important foundation upon which the alliance is constructed from the first moment of therapy (Greenberg & Watson, 2006; Rogers, 1975). It is therefore an experiential therapist's prime directive to immediately engage from the first moment of therapy in providing an empathically attuned relationship for the purpose of promoting safety and facilitating the development of a strong alliance (Rogers, 1975). Again, research has shown that therapists who are rated by observers as being more empathic during the first session of experiential therapy tend to have clients who rate the alliance more favourably after that session (Malin & Pos, 2015). Pos et al. (2009) also found, within 52 experiential therapy client-therapist dyads, that client-rated empathy using the BLRI and the alliance rated by clients with the Working Alliance Inventory (WAI: Horvath & Greenberg, 1987) were correlated strongly within sessions 9 and 12.

The experiential therapy assumption is that the collaborative bond between a therapist and client will consistently be strengthened when a therapist is empathic. As such, it is not surprising that significant positive associations between therapist empathy and the working alliance later in therapy have been demonstrated across a number of therapeutic approaches (Horvath, 1981; Mosely, 1993; Salvio et al., 1992; Wing, 2010). Specifically, Salvio et al.,

(1992) found significant moderate to large positive correlations between clients' ratings on the BLRI empathy subscale and the WAI after session 20 for clients with depression receiving therapy from a variety of modalities. Horvath (1981) and Mosely (1983) found large positive correlations between the BLRI empathy subscale and WAI after session three for clients receiving various types of therapy. Additionally, consistent with Pos et al. (2009), Watson & Geller (2005) found large positive correlations between BLRI scores during sessions 9 and 12, and WAI scores in a trial that included 16 sessions of either cognitive-behavioural or process-experiential therapies. Lastly, Wing (2010) found significant moderate positive correlations between therapist empathy and the working alliance during session three of psychodynamic therapy as assessed by observer-rated measures (the MEE (Watson & Prosser, 2002) and Truax-Carkhuff Accurate Empathy Scale (Truax & Carkhuff, 1967), and the Observer-rated WAI (Wang & Anderson, 2010) and Global Alliance Rating (Wang & Anderson, 2010) respectively). The current study sought to examine the relationship between empathy and the alliance using an observer measure of empathic process.

Therapist Empathy and Client Emotional Processing

Emotional processing is a complex process that is made up of many components or subskills. Two of these essential components are emotional awareness and emotion regulation. Emotional awareness has been defined as the spontaneous sensing of what arises in an individual (Perls, Hefferline & Goodman, 1951). It involves both attending to emotion and subsequently understanding that emotion (e.g., Coffey, Berenbaum, & Kerns, 2003; Gohm & Clore, 2000, 2002). Awareness is an important initial step in emotional processing because it increases access to emotional experience (Paivio, 2013). In some cases awareness of emotional experience in and of itself can, through increasing a client's orientation to his or her internal world, provide a

soothing function, while in other cases such awareness can focus a client on his or her pain and perhaps intensify emotion (Prosser, 2007; Silvia, 2002). It has been suggested that when a client agrees that emotional awareness is a vehicle through which emotion can be regulated and complex goals achieved, she or he is more likely to mitigate and tolerate her or his experience of emotional intensity. As well, when emotional awareness is viewed as maintaining a connection with experiences and feelings that foster self-determination, that awareness is more likely to be productively heightened (May 1967; Prosser, 2007).

Emotion regulation is a complex process in itself whereby clients and their therapists can influence the emotions clients experience and clients can express emotions they are aware of (Gross, 1998; McMMain, Pos & Iwakabe, 2010). Individuals can utilize specific strategies to increase, maintain, or decrease emotional responses (Boden & Thompson, 2015; Gross, 2007; Gross & John, 2003). These strategies are often articulated from a cognitive, behavioural or social perspective, and may include: problem solving, expressing one's emotions, or seeking interpersonal support respectively (Prosser, 2007). In dialectical behaviour therapy, a therapy designed for clients with severe disturbances in emotion regulation (Linehan, 1993), strategies encompass multiple elements of the emotion regulation system and are designed to ameliorate the intensity of unhelpful emotional reactions over time (McMain, Korman & Dimeff, 2001)

In experiential therapy empathy is viewed as playing an important emotion regulating function. By providing safe contact, empathic understanding, unconditional positive regard the therapist can meet unmet needs for acceptance, connection and support and thereby regulate clients' deep feelings of isolation, shame, and helplessness. These experiences can transform the client's old interpersonal maladaptive emotion schemes over time (McMain, Pos & Iwakabe, 2010). It is the transformation of emotional experience that is a core goal in experiential

therapies, that is, emotional processing (EP) is considered to be a core change process in experiential therapies, and EP is a particular focus in emotion-focused therapy (Pascual-Leone & Greenberg, 2007; Pos, Greenberg, Goldman, & Korman, 2005; Pos et al., 2009). When EP has been measured as client experiencing during their emotion narratives in therapy, increased emotional processing has been found to be an important direct (Pos et al., 2009) predictor of good outcomes. Experiencing measured randomly has also been shown to be an indirect (Watson, McMullen, Prosser & Bedard, 2011) predictor of outcome.

Emotional processing was initially a term coined by Rachman (1980), and was defined not as a process but as a small ‘o’ (Greenberg & Safran, 1984) outcome of sorts, as it was thought to be indicated by a decrease in problematic and subjectively experienced fear states through repeated exposure to those states. Foa and Kozak (1986) expanded on this conceptualization and described it as an increase or decrease in emotional responding due to exposure to both a fear state and the information consistent with an activated cognitive-affective fear structure (Pos, et al., 2009). Within experiential psychotherapy, emotional activation is generally viewed as a potential source of both problematic and adaptive information (Greenberg & Safran, 1984; Pos, Greenberg, & Elliot, 2008). Adaptive emotional processing is seen as involving an integration of cognitive and affective components (Greenberg, 2002) and as consisting of a series of stages (Pos et al., 2003; Pos & Greenberg, 2007). These stages consist of clients first approaching their emotions by attending to their emotional experiences, and secondly of clients allowing and tolerating contact with these emotions. Once contact is made with emotional experience, clients must then cognitively orient to the information, explore, reflect and make sense of it. Finally, clients can transform emotion by accessing adaptive emotional resources (Pos & Greenberg, 2007). Through this process new emotional reactions and meanings

can emerge that can be integrated into and thereby transform cognitive-affective meaning structures (Pos, Greenberg, & Goldman, 2005). As such, in order to process emotions well client experience must be emotionally regulated (Pos, Paolone, Smith & Warwar, in prep.). In other words emotional arousal is most helpful when it is 'optimal' (Greenberg, Auszra & Herrmann, 2007). Therapist empathy is thought to play an important role in this process. For this reason therapist expressed empathy and clients' emotional processing would be expected to be related in these therapies.

In experiential therapies therapist empathy is assumed to facilitate this emotional processing in a number of ways. First, therapist empathic responses can increase awareness of emotional experience by helping clients to identify and explore what they are feeling (Paivio, 2013). Second, it is argued that therapists' empathic attunement provided from the start of therapy creates the safety that clients need to access their emotions, and thirdly, it also aids clients in developing more effective emotion regulation strategies (Malin & Pos, 2015; Paivio & Laurent, 2001; Pos, 2006; Watson, 2002; Watson, Goldman, & Vanaerschot, 1998). The empathic psychotherapeutic relationship is, in fact, believed to provide a soothing and affect regulating bond which is eventually internalized by the client and contributes to enhanced self-soothing and emotion regulation capacities (Greenberg, 2014). As such, the working alliance, emotional processing and empathy are likely to all be found to correlate, as both the alliance and empathy should contribute to better emotional processing through the safety and experiential access these two processes are theorized to provide. The importance of empathy is underlined when working with trauma survivors. Psychologists working with trauma agree that therapist empathy can facilitate emotional processing and believe that it does so by helping to heal empathic failures that were experienced during childhood (Paivio & Laurent, 2001).

The importance of empathy for the development of affect regulation capacities is also underlined by human developmental researchers who assert that infants' self-soothing capacities are formed during early development via the internalization of soothing from protective others (Stern, 1985). Indeed research shows that when infants interact with an empathic other emotion regulation centers in the brain become activated (Schoore, 2001). Infants who receive inconsistent empathic attunement may experience social interactions ambivalently or distressingly, while those who receive consistent empathic attunement are more likely to experience the social world as safe and pleasurable. Research by Van den Boom (1994) found that infants who had less responsive mothers were more likely to be anxiously attached, and that an intervention aimed at teaching these mothers to be more sensitively responsive resulted in infant attachment gains (Van den Boon, 1994 as cited by Pos, 2003). Early attachment experiences have also been demonstrated to influence emotion regulation capacities later on in life. Securely attached individuals tend to develop adaptive emotion regulation skills while insecurely attached individuals tend to use less adaptive strategies (Fuendeling, 1998; Shaver & Mikulincer, 2007). Therefore, parental empathy appears to influence attachment which then influences later emotional processing.

Rogers (1963) suggested that by interacting with an accepting and understanding therapist, clients' awareness and acceptance of their own internal experience is enhanced. Consistently, therapist empathy is believed to improve emotional processing by fostering self-empathy (Barrett-Lennard, 1997), and contributing to acceptance of one's inner experience, self-enhancing action, and self-protection and nurturing (Greenberg, 2014; Watson, 2011). Indeed, research has shown that in cognitive-behavioural and emotion-focused therapies clients who perceive their therapists as more empathic tend to experience structural changes in their internal

models of self and other, and improvements in their interpersonal attachments (Steckely, 2006; Watson, Steckely, & McMullen, 2013). Specifically, they come to view themselves less negatively, and become less destructive, controlling, oppressing, critical, rejecting, careless and neglecting of others by the end of therapy. Additionally, clients who perceive their therapists as empathic have been found to report feeling less mistrustful of others' caring and supportive behaviours, less worried about gaining others' approval, more comfortable with closeness, and more worthy of interpersonal relationships (Steckely, 2006). Furthermore, improvements in clients' treatment of themselves, their experiences, and their interpersonal attachments resulting from working with an empathic therapist are associated with more favourable outcomes on a variety of measures (Steckely, 2006; Watson et al., 2013).

Assessing Client Emotional Processing. It should be noted that there are many different ways to measure client emotional processing. Some measures commonly used in process research include: The Observer Rated Measure of Affect Regulation (Watson & Prosser, 2004), The Levels of Emotional Awareness Scale (Lane, Quinlan, Schwartz, Walker & Zeitlin), The Classification of Affective Meaning States (Pascual Leone & Greenberg, 2005) and The Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986).

The O-MAR (Watson & Prosser, 2004) assesses clients' *affect regulation* (read emotional processing) based on a number of components identified in the theoretical and empirical literature as being related to affect regulation and emotional processing. It consists of five scales that evaluate: 1) awareness and labeling of arousal/experience, 2) modulation of arousal/experience, 3) modulation of expression, 4) acceptance of experience, and 5) reflection on experience. Each scale is rated on a 7 point likert scale, with lower scores reflecting lower

levels of functioning on a particular scale. Ratings can be made based on clients' descriptions of their current level of functioning as well as in session processes (Prosser, 2002).

The Levels of Emotional Awareness Scale (Lane, Quinlan, Schwartz, Walker & Zeitlin, 1990) assesses client emotional awareness within a cognitive-developmental framework. It conceptualizes emotional awareness as a cognitive skill that can differ in terms of development across individuals. The scale proposes five different levels of emotional awareness at increasing levels of complexity. These are: 1) physical sensations, 2) action tendencies, 3) single emotions, 4) blends of emotions, and 5) blends of blends of emotions. Individuals are presented with 20 scenes described in two to four sentences that are constructed to elicit anger, fear, happiness or sadness at the five levels of emotional awareness. They are then asked "how would you feel?" and "how would the other person feel?". Response are rated from 0 - 5 based on the level of awareness that they correspond to.

The Classification of Affective Meaning States (CAMS; Pascual Leone & Greenberg (2005) differs from the O-MAR and LEAS in that it assesses the presence of specific types of client emotion states. It also assesses changes in clients' flow of emotions from 'less productive' to 'more productive' emotion states, when they are engaged, emotionally involved and aroused. Some emotions assessed by the scale include: adaptive anger, negative evaluation anger, maladaptive fear and shame, and adaptive hurt/grief. Each emotion state is evaluated based on emotional tone, the degree of emotional involvement and meaning.

Finally, a common measure of emotional processing used in experiential therapy process research is the Experiencing Scale (Klein et al., 1986). It measures the degree to which clients approach, articulate, deepen, reflect and ascribe meaning to their emotional experiences. Client experiencing is rated on a 7 point likert scale in which lower levels of experiencing are marked

by abstract and superficial narrative content. In intermediate levels clients refer to, bodily feelings and inner experiences described in detail, while in and advanced stages clients express fluid emotional exploration in which emotions guide problem solving. Experiencing has been found to predict good outcome in a number of client populations and within several models of intervention (Hendricks, 2002; Orlinsky & Howard, 1978; Pos et al., 2009). This study utilized archival client experiencing data during emotion episodes obtained by Pos et al., (2009) to explore emotional processing. This valid, extant and convenient measure of emotional processing in these therapies had been previously obtained for the first working phase sessions of the clients in the current study sample. It also facilitated testing concurrent relationships among therapist empathy, the working alliance, emotional processing and outcome as well as comparing these relationships at different times during the course of therapy. Experiencing during EEs had already been shown to predict psychotherapy outcomes in numerous studies (Pos et al., 2009).

Experiential Therapy Research on Therapist Empathy and Client Emotional Processing. The relationship between therapist empathy and emotional processing in experiential therapy for depression has been explored in a number of studies. First, using the York Therapist Process Measure (Toukmanian and Armstrong, 1998) it has been demonstrated that during segments of therapy in which clients tended to experience higher levels of experiencing and perceptual processing, therapists were rated by observers as being more tentative and empathically attuned to the client's inner experience. Therapists were also rated by clients on the BLRI as being more empathic during these segments (Gordon & Toukmanian, 2002; Macaulay, Toukmanian & Gordon, 2007). Second, Prosser (2007) found that client-rated therapist empathy as assessed by the BLRI facilitated client affect regulation as assessed by the O-MAR (Watson & Prosser, 2004) across both process-experiential and cognitive-behavioural

treatments for depression. Additionally, this increased affect regulation lead to more favourable treatment outcomes on a variety of measures (Prosser, 2007). Third, Mlotek (2013) demonstrated that higher therapist empathy in emotion-focused therapy for complex trauma contributed to greater levels of client engagement, and reductions in trauma related symptoms. Lastly, Sachse & Elliott (2002) found that clients were more likely to accept constructive guidance to deeper emotional processing if they felt understood by their therapist. Higher client experiencing is also associated with clients perceiving their therapists as being more congruent and empathic (Van der Veen, 1967). As such, it appears that empathy may scaffold client engagement in emotional processing tasks that are the focus of many experiential therapies. Also possible is that client engagement in emotional processing evokes more empathic responses from therapists.

Empathy and Specific Models of Experiential Therapy

Since the inception of Client-centered Therapy (CCT) empathy has been considered a trainable skill. Initial training approaches focused on mastery of empathic reflection (Carkhuff, 1971; Egan, 1982; Goodman, 1984; Guerney, 1984), which was largely equated with empathy at the time. However, Rogers (1986) opposed this and emphasized the importance of teaching therapists to check their understanding of the client's experience rather than mechanically parroting or paraphrasing what was said. Consequently, client-centered therapists are now trained to focus on conveying an understanding of their client's experience and to promote a safe psychotherapeutic environment for this experience to emerge (Bohart & Elliot, 1997).

According to Rogers (1957) being optimally empathic from a client-centered perspective consists not only of accurately sensing the feelings and personal meanings that the client is experiencing and communicating this back to the client, but also being so much "inside the private world of the other that he or she can clarify not only the meanings of which the client is

aware but even those just below the level of awareness". In CCT therapist empathy is used primarily for facilitating the client's own self-discovery to reduce the discrepancy between the client's ideal and actual selves, and to increase clients' feelings of self-worth. Additionally, therapist empathy is assumed to enhance clients' attunement to and compassion for their own inner experiences, as well as increase their emotional awareness and self-acceptance (Rogers, 1975).

In Emotion Focused Therapy (EFT), as well as the functions stated above, an additional function of empathy exists over and above the function of empathy in CCT. In EFT therapists provide client-centered conditions of empathy, unconditional positive regard and congruence to help facilitate the formation of a psychotherapeutic relationship as well as engagement in emotional evocative tasks which are conducive to enhancing clients' emotional processing. An empathic psychotherapeutic relationship is viewed as a vehicle through which enhanced self-soothing and emotional transformation can occur (Watson & Greenberg, 2006; Greenberg, 2014). This is consistent with CCT; however, empathy is also an important intervention when a client emits a particular marker of feeling emotionally vulnerable. As such, the function of empathy as providing safety in the relationship is also highlighted in EFT.

Also as in CCT, an EFT therapist is expected to be highly present, respectful and responsive to the client as he or she shares his or her experience. However, in EFT therapists initially focus on empathically following the client and attuning to his or her emotional experience and then are more directive with their empathy as they guide the client using process-directives to deepen his or her emotional experience. As in CC, throughout the process the client is viewed as an expert on his or her own experience. Thus, process-directives in EFT are provided in a tentative and curious manner (Greenberg, 2014). Therefore, empathy is a central

change process in both CCT and EFT that is theorized to contribute to a safe and supportive therapeutic relationship. However, in EFT, therapist empathic attunement to client process markers that indicate client readiness for engagement in specific interventions, is essential to deepen clients' emotional processing or help them to solve cognitive-affective problems (Watson & Greenberg, 2006).

Past Research on Therapist Empathy in Experiential Therapy for Depression:

Remaining Questions and Current Study Research Goals

Although experiential therapists consider empathy to be a capacity that can be improved through training (Greenberg & Goldman, 1988; Greenberg & Watson, 2006; Watson, Goldman & Vanaershot, 1998), this has yet to be empirically tested. My Master's thesis (Malin & Pos, 2015) utilized the MEE (Watson & Prosser, 2002) to rate 30 client first sessions provided by 16 therapists during experiential therapy for depression. The majority (88%) of therapists who treated more than one client were rated as either consistently high or low on empathy. A key question that emerged from this finding was whether therapist empathy remains static throughout the course of therapy or whether it improves over time.

How consistent a particular therapist's empathic responses are across different clients, as well as differences in empathy between therapists independent of client variability in interpersonal problems, might be considered to be indirect measures of therapist empathy as a trait. A therapist's capacity to increase his or her empathic responding across therapy may reflect a number of variables: a learning curve emerging from the experiential therapy supervision sessions, a therapist's increased familiarity and comfort with a client over time, a client's increased capacity to disclose vivid personal memories which enhances therapist empathic attunement, and work being accomplished within a particular stage of therapy which may impact

the expression of empathy. Thus, changes in provided empathy over time across clients may provide some evidence that the provision of empathy is tractable to change that would be consistent with any of the above, potentially including therapist improvement. The current study wished to examine whether expressed empathy in therapists does increase from the first to the first working phase session.

My Master's thesis also tested experiential assumptions that therapist empathy expressed from the beginning of therapy contributes to favourable early working alliance development and deepened client emotional processing later in therapy. The findings would provide additional empirical support for experiential theory assumptions. Specifically, therapist empathy during session one was moderately positively correlated with clients' post session one alliance reports. This was the case when empathy was assessed both as a global MEE score and on each of the 10 MEE dimensions. The empathic therapist behaviours most positively associated with the session one alliance were the degree to which the therapist's vocal response quality appropriately matched and/or held the intensity of emotion that the client was experiencing, the extent to which the therapist conveyed warmth and interpersonal safety, and the extent to which the therapist tracked and responded to the client's moment-to-moment experience.

While therapist empathy has been shown to relate to the alliance throughout the course of other psychotherapeutic modalities, questions remain whether the relationship between empathy and the alliance will also be strong in the working phase of experiential therapy, and whether it will be stronger within phases than between phases of this therapy. While Pos et al. (2011) examined empathy and alliance relationships in sessions 9 and 12 during 52 experiential therapies using the BLRI and the WAI, no specific observer measure of empathy (e.g. MEE) has been related to mid or late therapy alliance measures. Therefore, the relationship between

observer-rated therapist empathy and the working alliance over the course of experiential therapy remains unexamined. Understanding whether empathy plays a consistent role in working alliance development across therapy is an important question; and, while the working alliance from the first hour of therapy has been shown to be a direct predictor of outcome in experiential therapy for depression (Pos et al., 2009) increases in the alliance by the working phase of therapy have been shown to predict sustained recovery from depression once therapy has terminated (Pos & Thompson, 2010). If empathy plays as important a role in alliance building as suggested by experiential theory and my early research (Malin & Pos, 2015), the relationship between empathy and the working alliance is expected to be maintained across the whole therapy path. Testing for a consistent relationship of this sort between empathy and the alliance has yet to be demonstrated and was one goal of investigation in the current study. Horvath and Bedi (2002) argue that specific therapist processes and behaviours that could contribute to favourable alliance formation should be studied. Examining these relationships across therapy is consistent with these goals.

Malin & Pos (2015) also found that therapists' session one expressed empathy predicted later client emotional processing. As with the alliance, this was true for specific empathic behaviours as well as global empathy. The specific session one therapist empathic behaviours most positively associated with clients' working phase emotional processing included: therapists' vocal expressiveness and the extent to which the therapist conveyed a global understanding of, and gentle appreciation for, the client's inner emotional experience. What remains to be seen is if therapist expressed empathy in experiential therapy also persists as a predictor of emotional processing within later phases of therapy. If empathy is an important predictor of emotional processing, the relationship between these two processes should remain 'close' throughout

therapy. Examining the relationships among specific empathic behaviors and emotional processing in the working phase was therefore also a goal of the present study.

The Influence of Client Individual Differences on Therapist Expressed Empathy

Another important consideration is the possibility that some clients may be more difficult to empathize with than others. This potential ‘client effect’ on the provision of empathy is captured by variability in therapists’ provision of empathy dependent on particular types of clients. For example, Wong & Pos (2014) found that clients that score high in pre-therapy non-assertiveness (as measured by the Inventory of Interpersonal Problems; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) reported poorer first session alliances in experiential therapy. These clients interestingly also tended to have therapists that were rated by observers (blind to clients’ interpersonal problems) as being significantly less empathic (Malin & Pos, 2012). However, while Malin & Pos (2015) lacked sufficient statistical power to test whether therapist or client effects were at work within some of these empathy to outcome relationships, it nonetheless remains possible that therapists’ provision of empathy may depend on clients’ characteristics, or on a complex interaction between therapist and client effects (Baldwin, Wampold & Imel, 2007; Del Re, Flückinger, Horvath, Symonds, & Wampold, 2012). Research has indeed suggested that therapists’ provision of empathy can depend on therapist and client attachment styles (Rubino, Barker, Roth & Fearon, 2000).

The Present Study

To explore the question of whether therapist expressed empathy can increase over time; the current study examined mean differences in therapist expressed empathy between early and working phase therapy sessions. Therapists’ level of rated expressed empathy during these sessions on both global and specific empathic behaviours was examined. It was hypothesized

that therapist expressed empathy would increase across therapy providing some initial coherent support for the possibility that the experiential assumption that empathy can be either learned or improved through increasing collaboration with clients and/or supervision is a valid assumption.

The current study also examined the relationship between observer-rated therapist empathy and client-rated working alliances during working phase sessions and between the first session and working phase. Given that a correlation between empathy and the alliance is expected in experiential theory, and was found to exist in the first session of experiential therapies (Malin & Pos, 2015), this relationship between empathy and the alliance was expected to be maintained across therapy. Therefore, it was considered likely that working phase therapist empathy would more strongly relate to the working phase alliance than the first session alliance.

I also examined the aforementioned question while taking into account particular subscales of the alliance within a given phase of therapy. While Malin & Pos (2015) did not find differential relationships between empathy and alliance subscales early in therapy it has been suggested by alliance scholars such as Gelso (1985) that the bond component of the alliance is more important to other processes in the early phases. As such, and with the addition of more subjects and therefore more power, it was expected that therapist empathy would more strongly predict the bond component in initial sessions when the relationship is forming than in the working phase. In the working phase of therapy when emotional processing appears to be most active, it was hypothesized that expressed empathy would more strongly predict agreement on tasks (i.e. emotional processing). Therefore, the relationship among expressed empathy and subcomponents of the working alliance scale was also considered this study.

Another important question is whether increases in therapist empathy are necessary for increases in clients' alliance reports. Specifically, for some clients with low session one

alliances, significant improvements in their alliances occurred by the working phase of therapy (Pos & Thompson, 2010). It is unknown whether increases in therapists' expressed empathy necessarily preceded such increases and therefore the current study also explored this question. A related hypothesis pertaining to the empathy-alliance relationship was that therapist/client dyads with low session one alliances would significantly improve their client-reported alliances after working phase therapy sessions if increases in therapist expressed empathy between the first and working phase sessions also occurred. Thus, I hypothesized that increases in empathy and the alliance co-occur across experiential therapy.

I also examined the relationship between therapist empathy and client emotional processing during the working phase of therapy. Since client emotional processing during the working phase has been shown to be a key predictor of outcome in experiential therapy (Pos et al., 2009) it is important to establish how multiple processes contribute to it. For example, how do therapist empathy, the alliance, and client emotional processing all concurrently relate to predict outcome? It is already established that the working phase alliance predicts working phase emotional processing; however, how later therapist expressed empathy contributes to both processes within working phase sessions remains unclear. Investigating this question was also a goal of the current study. Given that empathy has been shown to directly predict the alliance within the early phase and emotional processing in the working phase, no clear hypothesis emerged as to whether empathy would directly or indirectly (through the alliance) impact emotional processing in the working phase. This was explored.

Additionally, this study also investigated the relationship between working phase therapist empathy and outcome. Empathy has been demonstrated to be a moderately strong predictor of outcome and to account for approximately 9% of its variance across numerous

psychotherapeutic modalities (Elliot et al., 2011). Furthermore, empathy has been demonstrated to account for as much variance in outcome as or more variance in outcome than specific psychotherapeutic interventions (Bohart et al., 2002). Since first session therapist empathy in experiential therapy for depression was previously found to indirectly predict outcome (Malin & Pos, 2015), and working phase therapist empathy occurs closer to outcome than first session therapist empathy, it was expected that working phase therapist empathy would directly predict outcome.

A final last thread was to investigate further the possible client effect found in Malin & Pos (2012); that is, the potential role of clients' pre therapy non-assertiveness on therapists' provision of empathy across therapy. An analysis of clients' non-assertiveness scores pre-treatment and at termination revealed that slopes of clients' growth curves were not significantly different from zero and thus clients' non-assertiveness scores remained unchanged throughout the course of therapy. Therefore, therapists with these 'more difficult' clients had the opportunity to acclimate to these particular clients and increase their provision of empathy from session one to the working phase. However, if expressed empathy remained low across therapy when working with non-assertive clients this could provide some evidence for a potential limiting client effect of non-assertiveness on therapist expressed empathy. Consistent with the view that empathy can be improved over time, it was hypothesized that therapists would show increases in expressed empathy from session one to the working phase even when working with non-assertive clients.

Summary of Hypotheses

1. Therapist MEE scores will significantly increase from session one to the working phase of therapy during experiential therapy for depression.

2. Therapists' working phase MEE scores will positively predict clients' working phase WAI ratings, and working phase MEE scores will better predict working phase WAI ratings than session one MEE scores.
 - a. Session one MEE scores will most strongly relate to the bond subscale of the WAI, while working phase MEE scores will most strongly relate to the therapy task subscale of the WAI.
3. Increases between session one and the working phase in both global MEE scores and the alliance will be positively associated.
4. Higher working phase therapist empathy will predict higher working phase emotional processing either directly or indirectly mediated by the working phase alliance.
5. Higher working phase therapist empathy will be directly related to significant reductions in depressive symptoms at termination.
6. Therapists' expressed empathy will increase from session one to the working phase even when working with non-assertive clients.

Method

Participants

The final sample consisted of 35 out of 74 York I and II clients who had the lowest and highest post session-one alliance ratings (rationale provided below). All clients received short term (16-20 sessions) treatment in two York University trials of experiential psychotherapy (client-centered therapy or emotion-focused therapy) for depression (Greenberg & Watson, 1998; Goldman, Greenberg, & Angus, 2006). There were initially 36 cases utilized in this study; however, one was removed because it was identified as a statistical outlier, and was also the only case for which a session two psychotherapy video was rated instead of a session one (session one

video and audio were unavailable). All clients met criteria for Major Depressive Disorder on the Structured Clinical Interview (SCID; Spitzer, Williams, Gibon, & First, 1989) for the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; APA, 1987) and completed treatment.

The inclusion criteria were: a score of 16 or greater on the Beck Depression Inventory (BDI-LF; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a score greater than 50 on the Global Assessment of Functioning on the DSM-III-R, and being between the ages of 18 and 65 at the time of assessment. Exclusion criteria were: bipolar or psychotic disorder; current eating disorder, antisocial or borderline personality disorder; current drug or alcohol abuse; recent suicide attempts; a past history of incest; the loss of a significant other in the past year; or involvement in an on-going violent relationship. These criteria assured that severely depressed, functionally impaired subjects were excluded (Elkin, et al., 1989).

Rationale for Participant Selection. The participants in this study were chosen based on having the highest and lowest first session alliance ratings from the larger sample. The reason for this was that the present study was explorative and the examination of the relationship between empathy and the alliance was considered to be more statistically powerful within clients with more extreme alliance scores. The criteria for evaluating whether clients were considered to have high or low alliances came from previous research by Pos & Thompson (2010) who using a latent class growth analysis of clients' WAI scores across therapy found two main (good versus poor) alliance groups. If clients' alliance scores were 5 or higher on the working alliance inventory (WAI) by mid therapy, they were in the high alliance group, while clients whose alliance scores never reached 5 by mid therapy were in the low alliance group. The meaning of a WAI score of 5 indicates that a client is experiencing a bond and/or agreement on therapy tasks and goals with his or her therapist "often" while a score of 4 indicates that he or she is

experiencing these things “sometimes”. Additionally, Pos & Thompson (2010) found that clients with mid-therapy working phase alliance scores above 5 tended to have more favourable long-term outcomes than those with alliance scores below 5. In this study, all clients with first session alliance scores less than 5 constructed the low alliance group, while clients with the highest first session alliance scores were chosen to represent the high alliance group. The final sample were $n=16$ low alliance clients and $n = 19$ high alliance clients. The fact that there were more clients with high alliances makes sense given the focus on alliance building in these therapies.

Clients ($n =19$) in the high alliance (HA) group ranged in age from 22 to 55 ($M= 39.47$, $SD= 9.94$) and clients in the low alliance (LA) group ($n =16$) ranged in age from 26 to 63 ($M= 46.06$, $SD= 12.27$). Clients in the LA group were 69 % ($n= 11$) female and 31% ($n= 5$) male, while those in the HA group were 74 % ($n= 14$) female and 26 % ($n= 5$) male. No significant differences were found between HA and LA groups in terms of marital status, gender, age or type of therapy received (CC or EFT). Significant differences were found between HA and LA groups in terms of education status. Specifically, clients in the HA group tended to have higher education statuses than those in the LA group, $p <.05$. However, since education status did not predict any other therapy process measures it was not included as a predictor in any analyses.

Therapists

There were 18 therapists in this study: 4 males and 14 females. Thirteen were clinical psychology doctoral students (two male, 11 female), two (one male and one female) were psychiatrists, and three (one male and two female) were psychologists. Four therapists had clients in both HA and LA groups, while seven therapists had clients in the HA group only and seven therapists had clients in the LA group only. Therapists received 40 hours of manual-based training, supervision by licensed psychologists, and adherence monitoring.

Treatments

Client-centered therapy (CCT; Rogers, 1957, 1975; Rice, Greenberg, & Watson, 1994) and Emotion-focused therapy (EFT; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006) were the two experiential therapies used in the York I and II outcome studies. Clients were randomly assigned to one of the two treatment approaches.

Client-centered Therapy (CCT). The therapy utilized in the York I and II studies followed a manual of CCT based on Rogers (1957, 1975; Rice, Greenberg, & Watson, 1994). Therapists are trained to provide the three facilitative relationship conditions: unconditional positive regard, empathy, and congruence. Therapists also follow the clients' internal track, communicate empathy, facilitate exploration, encourage symbolization of core meaning and increase emotional awareness.

Emotion-focused Therapy (EFT). In this therapy therapists use marker-guided, process directive interventions from gestalt and experiential therapy within the context of a client-centered relationship. The first three sessions focus on facilitating a client-centered relationship. Then, while still maintaining this relationship style, therapists attend to specific emotional problem markers to determine when to use matched interventions thought to best resolve a given problem. Four interventions commonly used are: two-chair dialogue for self-evaluative conflict; empty-chair dialogue for unfinished business with a significant other; focusing on an unclear felt sense (Gendlin, 1997); and systematic evocative unfolding for problematic reactions. Currently there are two manuals for this therapy (Greenberg, Rice, & Elliott, 1993; and Greenberg & Watson, 2006).

Although, in EFT specific tasks can be utilized to promote emotional processing, not all EFT working phase sessions utilized in this study employed these tasks. As such, a number of EFT sessions would not have substantially differed from CCT sessions in the working phase

Process Measures

Measure of Expressed Empathy (MEE; Watson & Prosser 1999, 2002). The MEE is an observer-rated measure of therapist communicated empathy that evaluates therapists' verbal and non-verbal behaviours, speech characteristics, and response modes. It consists of 10 dimensions that are rated on a 9-point Likert scale (from 0 = 'never' to 8 = 'all the time') based on the percentage of time that the behaviour was present during the rated segment. Therefore, if a therapist is determined to be exhibiting a given behaviour 50% of the time she or he would receive a score of 4 for that MEE dimension, while if a therapist is determined to be exhibiting that behaviour 75% of the time she or he would receive a score of 6 (see Appendix A). A global empathy score is calculated as the average of the 10 subscale ratings. Internal consistency for the scale, as assessed by scale developers, is high ($\alpha = .88$). Construct validity is provided by a large and significant correlation ($r = 0.66, p < 0.01$) with client ratings of empathy, as measured by the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962), a well validated client-rated measure of empathy, and the fact that it is based on empirically validated behavioural predictors of empathy.

The 10 therapist expressive dimensions assessed by the MEE are: 1.) *vocal concern*: the extent to which the therapist's voice has a soft resonance with a grounded open quality; 2.) *vocal expressiveness*: the extent to which the expressiveness in the therapist's voice varies appropriately in energy, colour and pitch to respond to the nature of the client's subject matter; 3.) *vocal matching*: the degree to which the therapist's vocal response quality appropriately

matches and/or holds the intensity of emotion that the client is experiencing; 4.) *warmth and interpersonal safety*: the degree to which the therapist communicates an atmosphere of warm safety through soft expressiveness, smiling and eye contact; 5.) *responsive attunement*: the extent to which the therapist tracks and responds to the client's moment-to-moment experience (including facial and/or non-verbal behaviours that may differ from verbal content); 6.) *look of concern*: the extent to which the therapist appears caring, engaged and involved (not bored or disinterested); 7.) *responsiveness/following*: the extent to which the therapist adjusts responses to follow the client's track rather than lead session content; 8.) *understanding experience*: the degree to which the therapist generally communicates sensitive understanding of the significance of the client's inner world of emotional meaning relating to events being discussed; 9.) *understanding cognitive meaning*: the degree to which the therapist conveys accurate understanding of the client's cognitive meaning framework by following and understanding both their clients' narratives as well as the client's idiosyncratic construals explicit or implicit in these narratives; 10.) *therapist genuineness/acceptance*: the extent to which the therapist communicates valuing and prizing of the client and appears sincere, authentic, and genuine (Watson & Prosser, 1999).

Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989). The WAI is a 36-item measure of the therapeutic alliance rated on a 7-point Likert scale. It is composed of three subscales that each assess the client-therapist bond and client-therapist agreement on the tasks and goals of therapy. The internal consistency of the entire scale is reportedly high (.87 to .93) as is it for the individual subscales (.92 for Bond, .90 for Task, and .89 for Goal) (Horvath & Greenberg, 1986, 1989). There is a short form (12-item) version with comparable psychometric

properties (Tracey & Kokotovic, 1989). Client-rated short form ratings were used in this study and were archival data from Pos et al. (2009).

The Experiencing Scale (EXP; Klein, et al., 1986). EXP measures the degree to which clients orient to, symbolize, and use internal felt experience to inform problem solving. Ratings are given on a 7-point ordinal rating scale and are assigned to segments of psychotherapy based on grammatical, expressive, paralinguistic, and content distinctions indicative of different degrees of experiencing. Ratings from 1-4 describe the progressive movement of orientation from external to internal referents, while ratings from 5-7 describe the progressive use of experienced inner perspectives in affective problem solving. Inter-rater reliability coefficients have been reported to range from .76 to .91, and rating re-rating coefficients of .80 have been reported (Pos et al., 2009).

Pre-treatment Outcome Measures

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988). The IIP is a 64-item self-report measure that assesses difficulties in interpersonal functioning. Each item is rated on a 5-point scale. It consists of eight subscales: Domineering, Vindictive, Cold/Distant, Socially Inhibited, Non-assertive, Overly Accommodating, Self-Sacrificing, and Intrusive/Needy. Test-retest reliability has been reported between .89 to .98 and internal consistency ranging from .89 to .94. In this study clients were categorized as being high versus low on non-assertiveness according to a median split. Those scoring over 16 were considered to be high on non-assertiveness, while those scoring 16 or below were considered to be low on non-assertiveness.

Session Outcome Measures

General Session Evaluation Questionnaire (GSEQ; Watson & Greenberg, 1996).

This questionnaire consists of five 7-point Likert items: three taken from Orlinsky and Howard's

(1975) therapy session evaluation measure (inter-item reliability was .75) and two items tapping a factor reflecting task helpfulness (Elliott, 1985) in therapy (inter item was reliability .83; Warwar, 1995). These questions asked: (a) how clients globally felt about the session that had occurred, (b) the degree to which they found their therapist helpful, (c) the degree of progress they felt they were making as a result of the session, (d) the degree to which that they experienced a change or shift as the result of the session, and (e) the degree to which they felt they wanted to take a new course of action as a result of the session.

Client Task Specific Measure (CTSM). The CTSM tracks post session progress on the main tasks of treatment (Greenberg & Safran, 1991; Greenberg, Rice & Elliot, 1993). It consists of 12 items that are rated by clients on a 7-pt Likert scale. Three items each are related to: self-critical processes, problematic reactions, unfinished business with a significant other, and experience of the therapist's client-centeredness respectively.

Outcome Measures

The Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck 1972). The BDI is a 21-item self-report inventory designed to measure severity of depression. Higher scores reflect greater severity of depression (range = 0-63). Beck, Steer and Garbin (1988) report validity coefficients ranging from .66 to .86, and internal consistency coefficients ranging from .73 to .93. Outcome scores for the BDI in this study were clients' residual gain scores calculated from the larger combined York 1 and 2 sample.

Procedure

MEE Training. Raters received 40 hours of training from MEE experts and Jeanne Watson, the scale developer, from the University of Toronto, and were determined to have been

reliable with experts. Inter-class correlation coefficients between trained raters and experts ranged from .89-.99 (excellent).

MEE Rating Procedure. Forty two psychotherapy videos, including 36 working phase sessions and six first sessions, were segmented into five minute time bins and rated in their entirety (i.e. 1 hour video = 12 five minute time bins) by the first author of this study and another graduate student. Thirty first session videos used in Malin & Pos (2015) previously rated approximately four years earlier by the first author of this study and a professor were utilized as archival MEE data in this study. Therefore, the data sample consisted of 36 first session videos and 36 first working phase session videos. Raters independently and fully rated all five minute time bins within a session video on each of the 10 scale dimensions. Disagreements were discussed and consensual ratings were obtained and used in the analyses. Rater's pre-consensual ratings were used to establish reliability. Raters were blind to therapist and client scores on all process, outcome and pre-treatment measures. Inter-rater reliability for the 42 psychotherapy videos rated for this study was excellent for global MEE scores (ICC = .88) and MEE dimension scores (ICCs ranged from .79 to .94). Inter-rater reliability was also excellent for global MEE scores (ICC = .85) and ranged from good to excellent for MEE dimension scores (ICCs ranged from .62 to .82) for the 30 archival first session videos from (Malin & Pos, 2015) used in this study (Portney & Watkins, 2000; Shrouf & Fleiss, 1979).

In Pos et al., (2009) each client had two working phase sessions identified by clients as being the most helpful to them. Helpfulness was defined as that session having resulted in the most progress, the highest degree of shift or change (on the GSEQ) and the highest degree of task resolution (on the CTSM). The first working phase session occurred on average during session eight and the second on average during session 11. Clients' first working phase sessions

were rated with the MEE in this study because, being more distal to outcome, expressed empathy from these first working phase sessions was expected to provide a more rigorous test of the empathy-outcome relationship, as well as might more rigorously test increases in expressed empathy.

MEE Coding Procedure. In order to arrive at session level empathy ratings for the MEE dimensions, the ratings for all time bins for each dimension across the session were averaged. A global empathy score was calculated as an average of the dimension scores.

Scoring Emotional Processing. Emotional processing ratings used in this study were archival from Pos et al., (2009). EP was measured as Experiencing during emotion episodes (EE-EXP; see Pos et al., 2009). Emotion episodes (EEs; Greenberg & Korman, 1993) are segments of psychotherapy in which clients speak about having experienced emotion in response to a real or imagined situation (see Pos, Greenberg, Goldman & Korman, 2003; Greenberg & Korman, 1993). There are five components of an EE which include: 1) the situation; 2) an emotional response; 3) a tendency toward behaviour or action associated with emotion; 4) an appraisal of the self or situation; and, 5) a related concern or need. However, only components 1-3 are required for an EE to be identified (Greenberg & Korman, 1993). When the narrative theme changes or a new emotional response emerges the EE is complete. Therefore, EEs can vary in length. They tend to be between one to two and one half transcript pages in length, although some are longer and can range from three to four pages. Reliability between raters for sampling EEs was excellent. Pos et al. (2009) reported that raters agreed 92% of the time on the identified EE and its protocol. Emotional processing in the present study was defined in both modal (most frequently expressed) and peak (deepest emotional processing expressed) EE-EXP terms, averaged across all EEs during each client's first working phase session from Pos et al. (2009).

The average inter rater reliability reported for EE-EXP ratings was excellent (weighted Cohen's Kappa reported = .79; Pos et al., 2009).

Statistical Analyses

T-tests determined if there were significant differences in therapist empathy between the CCT and EFT treatment groups. Consistent with the experiential theory underpinning both approaches no differences were found for either session one ($t = -.51, p = .62$) or the first working phase session ($t = 1.21, p = .24$). Data from both therapy groups was therefore combined for all statistical analyses. Paired samples t-tests tested whether therapist empathy (MEE scores) and working alliance scores increased between session one and the working phase. Previous to modeling procedures, and consistent with their requirements, Pearson correlations first examined relationships among therapist empathy, client non-assertiveness, working alliances, emotional processing, and outcome. General multivariate models then tested relationships between MEE scores and WAI subscales in session one and the working phase, while a linear regression examined the relationship between MEE and WAI change scores. A path analysis tested for indirect effects of therapist empathy on emotional processing and outcome. To control for client non-assertiveness when exploring the increases in therapist expressed empathy, a general linear model was conducted. Assumptions of normality, homogeneity of variance and linearity were satisfied prior to conducting any statistical analyses. Multicollinearity was also determined not to be an issue. Unstandardized B coefficients were reported for all regression analyses and standardized β coefficients were reported for the path analysis to increase ease of interpretability. The criterion for statistical significance for all analyses was a one-tailed alpha of 0.05 except for the univariate analyses in the general multivariate model which was a Bonferroni corrected alpha of 0.017. The use of one tailed tests

were considered valid due to the directionality of hypotheses. However, a two-tailed alpha of 0.05 was used for the paired samples t-tests.

Results

Descriptives

See Table 1 for means of all process and outcome variables for high and low early alliance groups.

Hypothesis One: Therapist MEE scores will significantly increase from session one to the working phase of therapy during experiential therapy for depression.

Means and standard errors of observer ratings of therapist expressed empathy, measured as a global MEE score as well as by MEE dimensions for both session one and the working phase are presented in Table 2. MEE difference scores, reflecting differences in therapist empathy between session one and the working phase are also presented in Table 2. A paired samples T-test indicated significant increases from session one to the working phase in global therapist MEE scores, $t(34) = -7.81, p < .001$. Therapists also displayed significant increases from session one to the working phase for each of the 10 MEE dimensions ($p < .005$, Bonferroni corrected). Consistent with the assumed importance of empathy outlined in experiential theory, mean ratings of therapist expressed empathy across therapists were high in both phases. Mean ratings in session one were greater than 6 and during the working phase, greater than 7 (see measure description in the Appendix A for help interpreting these scores).

Hypothesis Two: Therapists' working phase MEE scores will positively predict clients' working phase WAI ratings, and working phase MEE scores will better predict working phase WAI ratings than session one MEE scores.

The relationships among first working phase session global as well as MEE dimensions and clients' alliance reports after the first working phase session are presented in Table 3. Due to the focal hypotheses (i.e. not all correlations were of interest) these Pearson correlations were not corrected for family-wise error and should be interpreted accordingly. In support of hypothesis two, higher therapist MEE scores during the first working phase session related to clients' reporting more favourable alliances with their therapists after that session. This was the case for global MEE ratings and ratings on all MEE dimensions. Also in support of the second hypothesis, session one MEE scores were not significantly associated with the alliance post the first working phase session ($r(33) = 0.19, p = 0.14$).

Hypothesis Two(a): Session one MEE scores will most strongly relate to the bond subscale of the WAI, while working phase MEE scores will most strongly relate to the therapy task subscale of the WAI.

Two general multivariate models (one for each phase of therapy) tested the relative strength of therapists' global MEE scores in predicting particular WAI subscales. For session one, the overall 'corrected' model indicated that therapist global MEE scores during the first session significantly predicted all three WAI subscales reported by clients after session one (WAI bond ($F(1, 31) = 11.05, p = 0.002$), task ($F(1, 31) = 7.02, p = 0.013$), and goals ($F(1, 31) = 7.02, p = 0.013$)) accounting for 23.9%, 15.8%, and 15.8% of the variance on each subscale respectively. Even after applying a Bonferroni correction ($p = 0.05/3$ subscale tests) therapist global MEE scores were still significantly related to clients' post session one ratings on all three

subscales. The model also indicated that in session one an increase in therapist global empathy of one point resulted in post session one reported increases in the alliance subscales of 1.30 for the bond subscale, 0.99 for the task subscale, and 1.12 for the goal subscale. Therefore, therapist global MEE scores during the first session appear to impact client reports of the alliance on all three WAI subscales after that session. While numerically, therapist global MEE scores in session one appeared to account for the most variance in the WAI bond in session one when compared to the variance accounted for in the tasks and goals subscales, a Steiger's Z Test indicated that this difference was not statistically significant, $z = 0, p = 1$.

For the first working phase session, the overall 'corrected' model again indicated that therapist global MEE scores significantly predicted all three WAI subscales reported by clients after the first working phase session (WAI bond ($F(1, 33) = 15.74, p = 0.000$), task ($F(1, 33) = 9.23, p = 0.005$), and goals ($F(1, 33) = 12.35, p = 0.001$) accounting for 30.2%, 19.5%, and 25.0% of the variance on each subscale respectively. Even after applying a Bonferroni correction therapist global MEE scores were still significantly related to clients' post session one ratings on all three subscales. The model also indicated that during the first working phase session an increase in therapist global empathy of one point resulted in increases in the alliance subscales of 1.33 for the bond subscale, 0.99 for the task subscale, and 1.10 for the goal subscale. Therefore, as was the case for session one, therapist global MEE scores during the first working phase session related to more favourable client reports of the alliance on all three WAI subscales after that session. Again, however, contrary to my hypothesis therapist global MEE scores appeared to account for the most variance in the WAI bond. Still, however, a Steiger's Z Test was conducted and indicated that this was not a statistically significant difference, $z = 0.71, p = .48$.

Hypothesis Three: Increases between session one and the working phase in both global MEE scores and WAI scores will be positively associated.

Before testing whether increases between session one and the working phase for the MEE and the WAI were significantly related, I confirmed that significant increases in the alliance had occurred between session one and the first working phase session using a paired samples T-test ($t(34) = 5.02, p < 0.001$). Therefore, as with therapists' MEE scores, clients' post session WAI reports significantly increased between session one ($M = 5.18, SD = 1.12$) and the first working phase session ($M = 5.88, SD = 0.85$).

Further, whether increases in clients' post session WAI reports were associated with increases in therapists' global MEE scores was examined in a number of ways. A linear regression predicted change scores on the WAI with MEE change scores (reflecting differences in therapist empathy between the first and first working phase session). The final model was significant $F(1, 33) = 5.29, p = 0.03$ and accounted for 13.8% of variance in differences in clients' WAI reports between session one and the working phase. MEE difference scores were significantly positively related to WAI difference scores, $B = 0.51, t(33) = 2.30, p = 0.03$, such that a one point increase in therapists' global MEE scores between the first session and working phase was associated with a 0.5 point increase in WAI scores between those sessions. Therefore, the third hypothesis, that assumed that therapists who increased in their expressed empathy between session one and the working phase also tended to experience improvements in their alliances with their clients over that time, was supported on average.

However, there were individual clients whose alliances with their therapists improved despite their therapists' empathy not measurably increasing, as well as some therapists whose empathy increased who did not experience clients' having improved alliance scores (see Figure

1). This was further investigated at the level of individual therapists in Table 4. Generally, the cases for which alliances decreased despite increases in therapist empathy were those that had high session one alliances (5.5 or higher) that despite decreasing somewhat remained high. Conversely, the cases for which alliances increased despite decreases in therapist empathy were those that had low client-reported session one alliances and therapists high in empathy in both sessions, but higher in session one. Therefore, overall the relationship between increases in empathy and the alliance co-occurring was supported, but with these exceptions.

Hypothesis Four: Higher working phase therapist empathy will predict higher working phase emotional processing either directly or indirectly mediated by the working phase alliance.

Given that Malin & Pos (2015) found that session one therapist empathy predicted working phase emotional processing it was surprising that global therapist MEE and MEE dimension scores in the first working phase session were not significantly related to any measure of emotional processing in the first working phase session ($p > .21$, see Table 5 for global MEE emotional processing relationships). However, a positive trend towards a correlation between the MEE dimension of ‘responsiveness’ and modal working phase emotional processing ($r = .27, p = .06$) was found. The relationship between clients’ WAI ratings post the first working phase session and peak EE-EXP scores during the first working phase session was also a positive trend ($r(33) = .27, p = .057$). However, inconsistent with past research (Pos et al., 2009), modal EE-EXP scores were not significantly related to WAI ratings post the first working phase session ($r(33) = .23, p = .097$). Therefore, higher working phase therapist empathy was generally not associated with deeper client emotional processing in the working phase when EP was measured as EE-EXP.

Whether working phase therapist empathy indirectly contributed to deeper client emotional processing via the working phase alliance was still a question to examine. A path analysis using AMOS (Arbuckle, 2007) and Sobel tests examined the indirect effects of working phase therapist empathy on working phase emotional processing mediated by the alliance. Working phase WAI scores were significantly associated with working phase MEE scores. Working phase WAI scores and working phase EE-EXP scores were also significantly associated with outcome. While MEE scores were not directly correlated with outcome they were directly correlated with working phase WAI scores, and a trend indicating a correlation between working phase WAI scores and EE- EXP scores was also present. As such, minimum requirements for using a more powerful path analysis to test indirect relationships between therapist empathy and EP through the working alliance in the working phase were met. Since both modal and peak EE-EXP correlated with BDI outcomes the path between EE-EXP and BDI was also modeled (see Figure 2.)

Peak EE-EXP scores were utilized in this model because they had the largest numerical association with first working phase session WAI scores. The hypothesized AMOS model had good fit statistics (see Table 6 for fit statistics with acceptable values). The path diagram for this analysis is presented in Figure 2. In partial support of hypothesis four, the findings showed a trend of an indirect effect of therapist empathy on emotional processing via the working phase alliance in the first working phase session, Sobel $z = 1.49$, $p = .07$.

Hypothesis Five: Higher working phase therapist empathy will directly predict significant reductions in depressive symptoms at termination.

Pearson correlations of the relationships between therapists' expressed empathy, the working alliance, client emotional processing in the first working phase session, and clients' scores on the Beck Depression Inventory (BDI) at termination are presented in Table 5.

Hypothesis five was not supported. Therapist's global MEE scores during the first working phase session were not significantly correlated with BDI residual gain scores at termination, $p = .37$.

This was also the case for all MEE subscales; however, there was a trend of the dimension 'responsiveness' being positively related to BDI scores ($r(33) = -.27, p = .06$).

Since the first working phase session alliance was significantly positively associated with outcome on the BDI at termination, a potential indirect effect of working phase empathy on reductions in depressive symptoms at termination via the working phase alliance was possible and also examined in the path analysis in Figure 2. A Sobel test indicated that there was a significant indirect effect of working phase therapist empathy on BDI residual gain scores mediated by the working phase alliance, Sobel $z = -1.63, p = .05$.

Hypothesis Six: Therapists' expressed empathy will increase from session one to the working phase even when working with non-assertive clients.

Another area of interest was whether therapists who worked with non-assertive clients, clients previously found to generally be more difficult to empathize with (Malin & Pos, 2012), significantly increased their empathic expression between session one and the working phase. Consistent with previous research (Malin & Pos, 2012; Wong & Pos 2014), correlational analyses showed that clients who scored more highly on pre-treatment non-assertiveness tended to have therapists rated with lower MEE scores during session one ($r(30) = -0.41, p = 0.01$).

These non-assertive clients also tended to rate the post-session one alliance less favorably ($r(30) = -0.41, p = 0.01$). However, a quadratic regression analysis showed that the more non-assertive clients were at the onset of therapy the greater the increase in expressed empathy that their therapists tended to demonstrate (Quadratic $r(30) = 0.30, p = 0.02$) between the first and first working phase sessions (see Figure 3). Furthermore, by the working phase, client pre-treatment non-assertiveness scores were no longer negatively associated with therapist expressed empathy ($p = .34$). Therefore, in support of hypothesis six, therapists working with non-assertive clients were able to increase their empathy by the working phase and even ‘catch up’ in their empathy to therapists who were working with more assertive clients.

To address this question further, a general linear model was also conducted comparing therapists’ global MEE scores in session one to therapists’ global MEE scores during the working phase after controlling for clients’ pre-treatment non-assertiveness scores. A potential interaction between MEE difference scores and client pre-treatment non-assertiveness scores was also tested in this model. In the final model, the difference in therapist empathy between the first and first working phase sessions was still found to be significant after controlling for client non-assertiveness, Wilks $\lambda = .80, F(1, 29) = 7.37, p = 0.01$. Thus, therapists tended to significantly increase their provision of expressed empathy regardless of whether their clients were high or low on pre-therapy non-assertiveness. A significant interaction between differences in therapist empathy and client non-assertiveness was also present however, Wilks $\lambda = .82, F(1, 29) = 6.53, p = 0.02$. This indicates that a client’s level of non-assertiveness affected how much of an increase in therapist empathy there was. Consistent with the earlier finding, therapists working with more highly non-assertive clients tended to experience greater increases in their empathy scores.

Discussion

Experiential therapists and trainers consider therapist empathy to be a multidimensional behaviour that is improvable through supervision and feedback (Greenberg & Goldman 1998; Greenberg & Watson, 2006; Watson et al., 1998). This study examined whether therapist empathy increases over the course of experiential therapy for depression. It also examined changes in empathic process for therapists while considering client non-assertiveness. When clients were high in this interpersonal problem independent empathy raters had found that therapist expressed empathy in session one with these clients was relatively low. This suggested the possibility that non-assertive clients might be generally difficult to empathize with and this issue was, therefore, further explored in the present study. Finally, this study also tested the relationships among working phase therapist empathy, the working phase therapeutic alliance, clients' working phase emotional processing and outcome at termination; relationships all assumed by experiential therapy theory to be positive.

Can Therapist Empathy Improve Across Experiential Treatment?

Consistent with experiential theory and as originally hypothesized, therapists showed significant increases in their expressed empathy from the first to first working phase session. Therefore, on average therapists, including those rated by observers as being relatively less empathic at the beginning of therapy, exhibited increases and expressed more consistent empathy by the first working phase therapy session. Further, this was found to be the case for overall empathy and all ten specific empathic dimensions measured by the MEE. The largest increases on the MEE's empathic dimensions occurred for 'attunement', followed closely by 'matching', 'responsiveness' and 'understanding meaning'. Interestingly, these are also among the therapist behaviours that tend to receive much focus in experiential therapy supervision (Greenberg &

Goldman, 1988) as they are thought to epitomize empathy from an experiential perspective. It could be argued therefore that increases over time on these dimensions may reflect the cumulative impact of both experiential therapy training and supervision.

It may also be possible, however, that increases on the particular MEE subscales of ‘matching’ and ‘attunement’ could also result from growing familiarity and synchrony between the client and therapist evolving over time (Angus & Kagan, 2007; Imel et al., 2014). These issues require further investigation. Still, the smallest increases noted were on the dimensions ‘vocal concern’ and ‘vocal expressiveness’ which suggests the possibility that these behaviours more consistently reflect innate vocal characteristics, or communicative traits of the therapist. If so they would be less amenable or likely to change. How a therapist expresses increased attunement with a client will be an important future area of research which likely will require finer tuned and perhaps qualitative investigation.

Although the development of therapist empathy is a strong focus in experiential therapy training programs, it is also possible that instead of improving empathic skill through training that therapists’ increase their expressed empathy over the course of therapy as a result of their clients becoming easier to empathize with over time. This is a particularly reasonable possibility given that therapist empathy in this study was measured during the first session when the client is new to the therapist, and during a middle phase session, that was not only likely preceded by much psychotherapeutic work, but also by much time spent with the client. It is possible that therapists became more familiar with their clients during the sessions leading up to the working phase and became more adept through that familiarity to enable them to attune in language and other modes of communication by the working phase. This in fact is an assumed purpose of empathy from the experiential perspective (Rice, 1974). Parsing out which comes first,

expressiveness of the client versus empathic expressiveness of the therapist will require stronger modeling of the autoregressive structural equation modeling variety within which causality can be more strongly demonstrated. This of course will also require larger sample sizes. Only such models will be able to allow an exploration of whether both familiarity with the therapist and prior work may enable clients to be more engaged during later working phase sessions and whether this increased client engagement results in providing therapists more opportunity or 'client fodder' to empathize with. For example, client narratives may become more complex over time which might elicit increased empathic responding from the therapist (Angus, Lewin, Bouffard & Rotondi-Trevisan, 2004). In addition, in the working phase of these therapies prior directive chair work tasks or therapist empathy could have deepened clients' experiencing or increased their capacity for experiencing, providing the therapist with more emotionally salient content to further empathize with. Thus, it is plausible that increases in therapist expressed empathy may actually be a client and therapist interaction effect masquerading as therapist growth in empathic skill.

This above discussion is particularly suggestive when one considers that even non-assertive clients found to be more difficult to empathize with at the onset of treatment, but who did not significantly change in terms of their non-assertiveness (Malin & Pos, 2012; Wong & Pos, 2010) still ended up having therapists who increased their expressed empathy. If a client such as this became more comfortable with the therapist over time and with the therapist relationship style offered he or she might have felt freer to express his or her inner world. In that process he or she would have provided his or her therapist with more content to empathize with over time.

The mechanism by which clients who reported remaining non-assertive still ended up receiving greater expressed empathy over time remains an important question for future research. For example, it would be interesting to note whether their self-reported continuation of problems with non-assertiveness with others would be observable in the therapy relationship over time. This is especially of interest given that these clients tend to have difficulty expressing their needs in therapy because they fear disapproval and negative evaluation and are vulnerable to poorer session one alliances (Wong & Pos, 2014). Future research could address this question by utilizing the Structural Analysis of Social Behaviour (SASB; Benjamin, 1974), a measure of interpersonal behaviour, on dimensions of affiliation and interdependence. Using these dimensions one could examine whether non-assertive clients exhibited changes in self-disclosure between session one and the first working phase psychotherapy session. If client self-disclosure did not change between these sessions, this would provide support for the notion that therapist empathy can improve over time because increases in client self-disclosure would not be facilitating increases in therapist expressed empathy. However, to garner additional support for this notion, it would also be important to examine whether other client processes that could potentially impact therapists' expression of empathy, such as client experiencing, changed between these two sessions.

I would still like to underline that of further significance to the issue of growth of therapists' expressed empathy over time is the finding that therapists who were working with more difficult 'non-assertive' clients were the therapists who showed the greatest increases in empathy (given that they had been rated the lowest in expressed empathy at session one). That is, by the first working phase session higher client non-assertiveness no longer predicted lower therapist expressed empathy (as it had in session one). There were also no significant differences

in empathy between therapists with non-assertive and assertive clients at that first working phase session. Therapists who were found to be less empathic while working with non-assertive clients therefore increased or ‘caught up’ in their provision of empathy by the working phase to those therapists evaluated as more empathic at the start of therapy (who were working with less difficult clients). This provides added support for the notion that improvements in therapist empathy may occur over time. Nevertheless, there are a number of alternative explanations as to why therapists improved and examining how this improvement occurred, controlling for client disclosure or expressiveness, will be an important future area of research.

Therapist Empathy and the Working Alliance

This study also examined whether the positive relationship found between therapist empathy and working alliances during the first session of experiential therapy (Malin & Pos, 2015) maintained itself into the working phase. This was indeed the case, and therapists who were rated as being more consistently empathic during their client’s first working phase session also tended to have clients who rated the alliance more favourably after that session. This was true for global empathy and specific empathic dimensions.

Research shows that considering WAI subscales separately is also of importance because they may contribute more strongly to outcome at different times over the course of therapy (Gelso & Carter, 1985; Pos, Greenberg & Warwar, 2009). For this reason I also examined the relationships among expressed empathy and specific components or subscales (experienced bond, agreement on tasks and goals) of the working alliance over time. Additionally, since a prime focus during initial sessions of experiential therapy is on establishing a favourable psychotherapeutic relationship, I argued that empathy may more strongly predict the bond in first sessions. During the working phase however, when the emphasis is on engagement in

psychotherapeutic tasks, such as emotional processing, I argued that empathy would be most predictive of agreement on tasks. This was not the case however, and therapist empathy expressed during both the first and first working phase sessions contributed to all three WAI subscales. Empathy appeared to contribute most to the formation of the bond between client and therapist; however, not to a statistically significant degree. Nevertheless, this could be a consequence of limited power associated with the relatively small sample size utilized in this study. Therefore, it still remains a possibility that the ‘relationship’ component of the working alliance may be what therapist empathy is most important for establishing and maintaining.

Consistent with experiential theory, this finding supports experiential assumptions that suggest that therapists’ provision of empathy provides the security, safety and support that clients need to satisfy unmet relationship needs, thus providing a corrective emotional experience (Greenberg, 2014; Steckely, 2006). However, this finding could also be a consequence of the measure of the alliance utilized as the WAI does not capture the degree to which a client makes meaning of the empathy that he or she receives. Specifically, clients may be more conscious of empathy in terms of feeling more bonded to a therapist who provides it, and not be as aware of the role that empathy plays in helping them to reach their therapeutic goals. This may be particularly likely in experiential therapies where conveying safety, support and validation is a prime focus of each session and frequent explicit focus on revisiting goals is less central. Much remains to be explored concerning how empathy and the alliance are related. A future qualitative study of clients’ subjective experiences of empathy could be important for addressing this question.

Are Increases in Therapist Empathy and the Working Alliance linked across Therapy?

Therapists who increased in their expressed empathy between the first session and first working phase sessions tended to also show increases in their working alliances with their clients between those sessions. There were some exceptions to this trend however. Specifically, when examining therapists individually, some therapists whose empathy increased from the first to first working phase session had clients who did not report improved alliances between those sessions (often because their early alliances had started very high and ceiling effects might have been impacting their later alliance ratings). Additionally, some therapists whose empathy decreased over time had clients who reported improved alliances. In these cases, session one alliances had been low while session one therapist empathy had been observed to be high and remained in the high range (albeit lowered) into the working phase (likely not significantly). Improvements in these working alliances from session one to the working phase could be argued to perhaps be an artifact of regression to the mean, a tendency of an initially ‘interpersonally careful’ client to need consistent empathy over time before rating the alliance more strongly, or could be an effect of improved mood interacting with clients’ alliance ratings. Therefore, while the general finding is that there is a positive relationship between expression of empathy by therapists and clients reporting strong alliances across therapy, there is some variability noted in these relationships that may be important for future research to explore.

Working Phase Therapist Empathy and Working Phase Emotional Processing

Therapist empathy was not directly related to clients’ emotional processing during the first working phase session. This was surprising given the role that empathic language is assumed to play in deepening clients’ access to their experiences including emotion, and given that emotional processing was measured in this study by EE-EXP. However, there was one

exception in that a trend of a positive association was found between the empathic dimension of responsiveness and deeper working phase emotional processing. This may suggest that the presence of a non-directive therapist who follows the client's track and responds to what he or she says may help him or her to access and process painful emotions. Future research however is needed to validate this finding.

Still, by helping improve the working phase alliance it appeared that global working phase therapist empathy indirectly contributed to more favorable emotional processing (see path analysis). Perhaps therapist empathy fosters feelings of bonded safety that can scaffold a client's capacity to process feelings. This is consistent with experiential theory (Greenberg, 2014; Watson, 2002; Watson et al., 1998). Although the indirect relationship between therapist empathy and emotional processing did not reach conventional values of statistical significance (Bangalore & Messerli, 2006) this could potentially be due to the reduced variability associated with examining these relationships within a single working phase session. This could also be due to the fact that emotional processing was measured by EXP within EEs. It is possible that empathy aids the client to move away from more intellectual processing of experience to deeper emotional levels. By measuring EXP within EEs which by definition focuses EXP within a client's emotional material, the study may have inadvertently limited the range of EP captured (no Level 1 EXP) as well as missed the opportunity to demonstrate such a role for empathy in deepening EP from Level 1 to 2 or 3. This is particularly likely given the direct relationships among the working phase alliance, working phase emotional processing, and reductions in depressive symptoms at termination that have already been established in previous research (Pos et al., 2009).

Another possibility is that the relationship between working phase therapist empathy and emotional processing may also be influenced by what might be rated as therapist non-empathic responses when being directive in chair work by asking the client to disclose specific, vivid and emotionally salient autobiographical memories (ABMs). It has been shown that when experiential therapists ask clients to disclose and elaborate these ABMs this tends to increase clients' emotional arousal and facilitate the development of a strong therapeutic bond. This can subsequently increase both therapists' empathic capacity and clients' emotional processing since having an empathically attuned therapist enables clients to explore and ascribe meaning to emotional pain that arises from disclosure of these ABMs (Angus, et al., 2004; Boritz et al., 2011). Therefore, future research may investigate whether, as with the alliance, client disclosure of ABMs is a mediator of the relationship between working phase therapist empathy and client emotional processing.

Therapist Empathy and Outcome

Hypothesis five that working phase therapist empathy would directly predict termination outcomes was not supported. No direct relationships between working phase therapist empathy and reductions in depressive symptoms at termination were found. There was however a trend of higher therapist *responsiveness* relating to reductions in depressive symptoms at termination. It is interesting that therapist responsiveness was also the only therapist behaviour that was found to be marginally associated with deeper working phase client emotional processing. Therefore, having a non-directive and responsive therapist during the working phase, when the most psychotherapeutic 'emotional processing' is being done, may be a key ingredient for helping to improve clients' mood. It may also be that other client centered relationship conditions such as being genuine and non-judgemental may play a more important direct role in outcomes for

depression, especially if a client's depression has interpersonal roots, and corrective interpersonal experiences are what are most important.

Higher global working phase therapist empathy did, however, indirectly contribute to reductions in clients' depressive symptoms at termination by contributing to more favourable working phase alliances. Thus, therapist empathy, by helping to create a safe and collaborative relationship, appears to help clients feel less depressed by the end of therapy. This may be echoing the results of Steckley (2006) who found that therapist empathy impacts client relationship processes and outcomes, especially because depression is known to have many relationship associations (Greenberg & Watson, 2006). Therefore, paralleling results found in Malin & Pos (2015) working phase empathy indirectly impacted outcome in two ways, by impacting the alliance as well as emotional processing.

Future Directions

Although this study demonstrated that therapists show increases in their expressed empathy over the course of experiential therapy, due to sample size it did not examine therapist or client factors other than non-assertiveness that may influence therapists' empathic capacity or development of empathy over time. We still do not know the mechanism by which increases in therapist expressed empathy occur, or whether this finding can be generalized to different kinds of therapists. Future research could explore how therapists differ in their capacity to both provide and learn to increase their expressed empathy, and the characteristics that influence their ability to improve this skill over time. In addition, it would likely be important to examine additional client characteristics that have been shown to adversely influence alliance formation, such as client social inhibition (Wong & Pos, 2014), as these could also potentially influence therapist empathy throughout the course of therapy. It may also be that differences in client problems (e.g.

personality disorders, anxiety) may play a role in how well some therapists empathize with a client. Furthermore, it would also likely be important to examine the impact of clients' personality characteristics on the degree to which they like or benefit from therapist empathy as this could also affect a therapist's ability to empathize. For example, research has shown that client personality style as assessed by the NEO Personality Inventory (Costa & McRae, 1992) relates to preferences for certain therapist empathic behaviours (Goode, 2008). Understanding these issues may further our capacity to parse the causal relationships between client and therapist effects (or their interaction) that influence the expression of empathy. In addition, examining how the emerging interpersonal process between the therapist and client contributes to therapists' empathy over the course of therapy would also be important. This would provide a more fine grained understanding of empathy as a potential interpersonal process as it emerges in real time, as well as the factors impacting the emergence of empathic contact between therapist and client.

Additionally, in order to more meticulously examine the therapist, client, and relationship factors that influence improvements in therapist empathy over time, future research would need to utilize a sample in which each therapist had several different clients and each client attended therapy for several sessions (ideally more than five). Furthermore, if measures of therapist empathy were collected at several time points throughout the course of therapy (e.g. two early sessions, two mid sessions and two late sessions) then growth curves could be obtained for each therapist across sessions and clients, and changes in therapist empathy could then be related to therapist and client characteristics.

Another potential area of importance for future research would be to examine the role of empathy in alliance rupture and repair. Safran, Muran & Samstag (1994) identify empathy as an

important ingredient in the repair of alliance ruptures. They suggest that an empathic psychotherapeutic environment enables clients to feel safe enough to disclose difficult feelings about problems in the therapeutic relationship itself in order to facilitate ruptures being processed and resolved. Additionally, Watson & Greenberg (2000) suggest that heightened attunement during the middle of experiential therapy when tasks are being implemented could help identify potential ruptures that clients do not explicitly disclose. Furthermore, they propose that through empathizing with clients they may feel more comfortable to disclose their concerns and feel less vulnerable, anxious and interpersonally isolated in session. Thus, future research may examine whether or not therapist empathy in fact can repair the experiential therapy working alliance after it has been ruptured.

Additional research is also needed to investigate whether relationships found between therapist empathy, other psychotherapeutic change processes and outcome in experiential therapy are generalizable to other models of therapy. Therapist empathy has been identified as a common factor and moderately strong predictor of outcome ($r = .31$) across a variety of psychotherapeutic modalities (Norcross et al., 2011). Therefore, it is possible, and even likely, that the findings concerning therapist empathy in this study are applicable to other modalities as well.

Another concern is that as good as the MEE is for capturing expressions of empathy, it does so strictly within a humanistic framework. As such, if a client needs a more directive approach and the therapist intuits this empathically and provides such direction or even advice, the therapist may receive lower MEE ratings for not engaging in a non-directive relationship (even though he or she may be expressing and providing a warm understanding of what the client wishes for). Therefore, since the MEE has emerged from a humanistic clinical context this may

limit our ability to examine ‘empathy’ as it is conceptualized by another clinical context, for example within DBT treatment (see Greenberg & Bohart, 1997 for a discussion of multiple perspectives on empathy). As such, empathy within this dissertation has been conceptualized from a strict humanistic perspective and thus other measures and a continuing conversation about what empathy means may be both valid and important for broadening our understanding of this important therapy process.

Lastly, in this study emotional processing was measured globally by the experiencing scale which does not consider specific types of emotions. Therefore, future research is needed to examine in a more finely tuned manner whether therapist empathy is particularly important for facilitating specific types of emotion processes (e.g. adaptive emotion versus evaluation of needs). Future research could also examine whether therapist empathy is more important for facilitating client emotional processing at particular moments within specific psychotherapeutic tasks (e.g. when clients are being vulnerable during chair work).

Limitations

Although a sample of 35 clients is comparable to samples typically used in psychotherapy process research (Critchfield, Henry, Castonguay, & Borkovec, 2007; Henry, Schacht, & Strupp, 1986, 1990; MacDonald, Cartwright, & Brown, 2007), small samples can limit statistical power and do not allow for exploration of therapist effects or exploration of autoregressive models between variables that can strengthen causal arguments (Selig & Little, 2012). Still, power in this study was adequate to test my hypotheses and significant results were found, despite the relatively small sample size. That being said, it is likely that with a larger sample size the sizable effects found in the path analysis would have reached statistical significance.

A second limitation is that the sample used in this study included clients with the highest and lowest first session alliance scores. Therefore, these results may not apply to clients with average alliances. However, the main focus of this study was to determine whether therapist empathy could increase over the course of therapy and whether relationships between therapist empathy, working alliances, client emotional processing and outcome previously established for first session empathy (Malin & Pos, 2015) were maintained into the working phase. Future studies including larger samples with more variable alliance scores will be needed to explore whether these findings apply to cases with “average” early alliances.

A third limitation is that measuring average experiencing during emotion episodes restricted the range of client experiencing data. Emotion episodes by definition are client narratives during which emotion is being expressed, and therefore, level 1 experiencing was not present in this sample. Additionally, level 7 experiencing requires that more than one emotion episode be present. Since the averages of experiencing scores only considered individual emotion episodes, level 7 was also not present in this sample. This limited range of client experiencing data may have contributed to the non-significant relationship between therapist empathy and client experiencing. Utilizing another measure of emotional processing, such as the OMAR or CAMS in future research would likely capture a broader range of client emotional processing. Furthermore, rating both therapist empathy and client emotional processing during each five minute increment of a psychotherapy session video would allow for a more meticulous examination of how the two relate within a session.

Lastly, given that emotional processing in this study was measured exclusively during emotion episodes in working phase sessions, it could be argued that the relationship found between therapist empathy and emotional processing may not be generalizable to non-working

phase sessions. Additionally, since the sample utilized in this study consisted of individuals with major depressive disorder, it is unknown whether the findings concerning therapist empathy can be generalized to treatments for other disorders.

Conclusion

This study has demonstrated that therapists can increase their expressed empathy over the course of experiential therapy, even when working with potentially more difficult clients. The findings also suggest that therapist empathy contributes to more favourable working alliances and that by strengthening the working phase alliance therapist empathy helps to improve clients' mood at termination.

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Appendix A

Measure of Expressed Empathy (MEE) (Watson, J. C., 1999)

Unpublished Measure, Department of Adult Education & Counselling Psychology
OISE/University of Toronto, Ontario, Canada

Five-minute segments should be rated. Each segment is given a global rating on a nine-point scale on therapist's behaviours that reflect aspects of expressed empathic communication. To score the measure add the items and calculate the mean.

1. Does the therapist's voice convey concern?

(Listen for high energy, colour (expressive of the emotions that it is trying to convey, flexible, musical), **soft resonance** that matches the verbal expression of concern; calmness, a grounded, open quality to the therapist's voice. The voice should not sound rigid)

0.....2.....4.....6.....8
Never 25% Half the time 75% All the time

2. Is the therapist's voice expressive?

(Listen for high energy, colour, **varied pitch**; is it expressive where it needs to be?)

0.....2.....4.....6.....8
Never 25% Half the time 75% All the time

3. Does the therapist's vocal tone or response match the intensity of the client's feelings?

(Listen for high energy, colour, emphasis, pitch variation that matches intensity of client's feelings). Note: There are neutral states and in that case the therapist would match that state – doesn't necessarily have to be highly emotional or filled with intense feeling. (The vocal tone should convey a sense that therapist can meet the client at the same level of intensity; voice should show that therapist can handle the intensity and can hold client's feelings e.g. show comfort when client is depressed; A score of 0 = nonchalant, non-caring attitude captured in vocal tone or complete mismatch between the subject matter that the client is conveying and the therapists response (e.g. vocal tone worried or flat if client excited).

0.....2.....4.....6.....8
Never 25% Half the time 75% All the time

4. Does the therapist convey warmth and an atmosphere of safety?

(Does the therapist smile, maintain eye contact, convey softness, and appear receptive to the client's concerns (receptiveness is not involvement; more low key – respectful, open.); (0 = "cold fish"; blank); (Does the therapist communicate an atmosphere of safety, of "holding" for the client?)

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

5. Is the therapist responsively attuned to the client's inner world moment by moment in the session?

(Does the therapist provide moment-to-moment acknowledgements, not let things go by; pick up the live edges of the client's experience; fine-tune their responses to fit with their client's? Is the therapist attuned to client's facial and /or non-verbal behavior that may be different from the content of client's responses? Is the therapist attentive to nuances of meaning and feeling (doesn't package what was said and just reiterate it back)? Responses are not just a reflection of surface content but show an understanding of the client's inner world. (Inner world is defined as client's feelings, perceptions, memories, construals, bodily sensations (felt sense), and core values.)

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

6. Does the therapist look concerned?

(Does the therapist look engaged and involved and maintain eye contact, or does the therapist look bored, disengaged, blank, and listless? Being attentive is an aspect of concern)

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

7. Is the therapist responsive to the client?

(Does he or she adjust his/her responses to follow the client's track?)

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

8. Do the therapist's responses convey an understanding of the client's feelings, and inner experience?

(Do the therapist's responses show a sensitive appreciation and gentle caring for the client's feelings and inner world? Do the therapist's responses convey an emotional understanding of the client's inner world, for example – "so, you're just like a little girl in the corner"? Does the therapist convey the emotional meaning and emotional significance of events?). Feelings are not just labels of anger, sadness, etc. but can also be metaphors. Keep in mind that if the therapist hasn't said much in a 5-minute segment that that may be appropriate.

02.....4.....6.....8
 Never 25% Half the time 75% All the time

9. Do the therapist's responses convey an understanding of the client's cognitive framework and meanings?

(It is expected that most therapists will show an understanding of what their clients are saying. To score 0 one person would have to be saying the sky is blue and the other talking about loud music so that there is no overlap in content or continuity between the participants) Ask yourself "Are they on the same page"? Is there a back and forth quality to the interaction? Is the therapist following what the client is saying? To score highly the therapist captures the client's construal/or idiosyncratic perception.

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

10. Is the therapist accepting of the client's feelings and inner experience?

(8 = sincere i.e. conveying that you mean what you say – being authentic, open, prizing, genuine; 0 = invalidating of the client's experience and dismissing their perspective or being insincere, putting on an act; trying to appear empathic but coming across as inauthentic.)

0.....2.....4.....6.....8
 Never 25% Half the time 75% All the time

Table 1

Mean Scores for Pre-treatment, Process and Outcome Variables as a Function of Early Alliance

Group

Variable	<u>High Alliance</u>		<u>Low Alliance</u>	
	Mean	SE	Mean	SE
Non-assertiveness	13.75	1.63	15.88	1.09
Session One Empathy	6.97	.072	6.53	.139
Working Phase Empathy	7.65	.076	7.39	.120
Working Phase Modal EE-EXP	2.96	.075	2.84	.095
Working Phase Peak EE- EXP	3.45	.061	3.34	.073
Working Phase Alliance	6.28	.167	5.39	.206
BDI	-.42	.249	.502	.212

Note. n = 19 for High Alliance and n = 16 for Low Alliance. Non-assertiveness, client pre-treatment IIP non-assertiveness scores. Empathy, therapist MEE scores. EE-EXP, client experiencing scores during emotion episodes during the first working phase session. Working Phase Alliance, client WAI reports post the first working phase session. BDI, client Residual gain scores at termination.

Table 2

MEE Mean Total Scores, Scale Scores, and Scale Difference Scores for all Clients Across Therapy

MEE Dimension	<u>Session One</u>		<u>Working Phase</u>		<u>MEE</u>
	Mean	SE	Mean	SE	<u>Difference Scores</u>
MEE Total	6.75	.081	7.53	.067	0.78**
Vocal Concern	6.72	.076	7.34	.089	0.62**
Vocal Expressiveness	6.62	.077	7.23	.084	0.61**
Matching	6.58	.10	7.44	.091	0.86**
Warmth/Safety	6.71	.093	7.50	.095	0.79**
Attunement	6.59	.111	7.47	.093	0.88**
Looking Concerned	6.99	.061	7.76	.040	0.77**
Responsiveness	6.89	.075	7.75	.048	0.86**
Understanding Experience	6.78	.092	7.56	.083	0.78**
Understanding Meaning	6.79	.095	7.65	.074	0.86**
Genuineness/Valuing	6.83	.093	7.60	.086	0.77**

Note. N=35. MEE, Measure of Expressed Empathy; MEE Difference Scores = Therapist mean working phase MEE score - session one mean MEE score. ** $p < .0046$ (after Bonferroni correction for family wise error)

Table 3

Pearson Correlations among First Working Phase Session Expressed Empathy and First Working Phase Session Working Alliances

Working Phase Variables	1	2	3	4	5	6	7	8	9	10	11	12
1.) WAI-post WP1	—	.54**	.47**	.37*	.52**	.49**	.49**	.40**	.48**	.55**	.54**	.38*
2.) MEE Total-WP1	—	—	.88	.69	.99	.97	.95	.57	.71	.94	.89	.93
3.) Vocal Concern-WP1	—	—	—	.57	.86	.90	.80	.45	.63	.77	.65	.83
4.) Vocal Expressiveness-WP1	—	—	—	—	.67	.68	.57	.26	.25	.52	.51	.67
5.) Matching-WP1	—	—	—	—	—	.97	.93	.54	.64	.93	.87	.93
6.) Warmth/Safety-WP1	—	—	—	—	—	—	.89	.48	.62	.88	.81	.96
7.) Attunement-WP1	—	—	—	—	—	—	—	.46	.70	.96	.91	.82
8.) Looking Concerned-WP1	—	—	—	—	—	—	—	—	.61	.51	.52	.46
9.) Responsiveness-WP1	—	—	—	—	—	—	—	—	—	.69	.68	.61
10.) Und. Experience-WP1	—	—	—	—	—	—	—	—	—	—	.95	.82
11.) Und. Meaning-WP1	—	—	—	—	—	—	—	—	—	—	—	.78
12.) Genuine/Valuing-WP1	—	—	—	—	—	—	—	—	—	—	—	—

Note. N=35. WAI = Working Alliance Inventory; WP1 = first working phase session; MEE = Measure of Expressed Empathy. MEE dimensions: Vocal

Concern, Vocal Expressiveness, Matching, Warmth/ Safety, Attunement, Looking Concerned, Responsiveness. Und Experience, Und Meaning,

Genuine/Valuing; * $p < .05$, ** $p < .01$. When not corrected for family-wise error, simple Pearson $r > .37$ is significant at $p = .05$, $r > .40$ is significant at $p = .01$

Table 4

Empathy and Alliance scores for Cases in which Therapist Empathy and Working Alliances did not Concurrently Improve

Case	S1_Empathy	WP_Empathy	S1_Alliance	WP_Alliance
4	6.7	7.3	6.4	6.1
20	6.6	6.3	3.0	4.7
102	6.3	7.9	6	5.8
104	6.8	7.8	5.5	5.1
304	6.9	7.8	5.8	5.3
413	7	7.2	5.9	5.8
421	7.3	7	4.4	5.1

S1_Empathy, therapist average MEE scores during session one; WP_Empathy, therapist average MEE scores during the first working phase session; S1_Alliance, clients WAI reports post session one; WP_Alliance, clients WAI reports post the first working phase session. Blue = cases in which MEE scores *decreased* and WAI scores *increased* between session one and the working phase; Green = cases in which MEE scores *increased* and WAI scores *decreased* between session one and the working phase.

Table 5

Correlations between the Working Phase Alliance, Working Phase Experiencing and Outcome

Variables	1	2	3	4	5
1.)WP_Empathy	—	.54**	.06	.11	-.06
2.)WP_Alliance	—	—	.27 ^{tr}	.23	-.37*
3.)WP_Peak_EXP	—	—	—	.77**	-.38*
4.)WP_Modal_EXP	—	—	—	—	-.27 ^{tr}
5.) BDI	—	—	—	—	—

Note. N = 35. WP_Empathy = therapist average MEE scores during the first working phase session; WP_Alliance = clients working alliances ratings after the first working phase session; WP_Peak_EXP = peak experiencing during the first working phase session; WP_Modal_EXP, modal experiencing during the first working phase session; BDI = Residual gain scores on the Beck Depression Inventory at termination.

Table 6

Summary of Goodness of Fit Indices for the Path Analysis Model

Model	p for χ^2	RMSEA	CFI	SRMR
BDI	.56	.00	1.00	.05

Note. Good fit indicated by a chi-square p value greater than .05, a root-mean-square error of approximation (RMSEA) value less than or equal to .05 (<.08 indicating reasonable fit), a comparative fit index (CFI) greater than .90 (>.95 very good fit), and a standardized root-mean-square residual (SRMR) less than .05 (<.08 for reasonable fit). BDI= Beck Depression Inventory

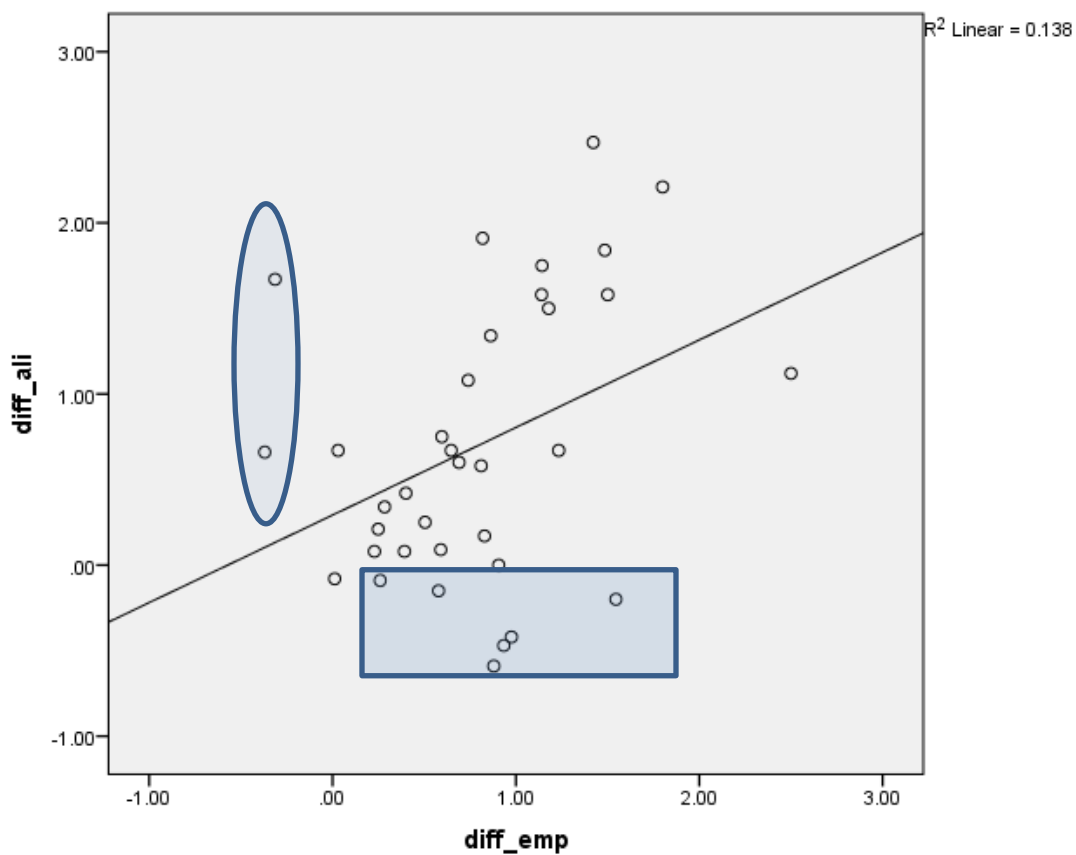


Figure 1. Differences in therapist empathy from session one to the first working phase session predicting differences in clients' post session WAI reports from session one to the first working phase session. Blue oval = cases in which MEE scores decreased and WAI scores increased. Blue rectangle = cases in which MEE scores increased and WAI scores decreased.

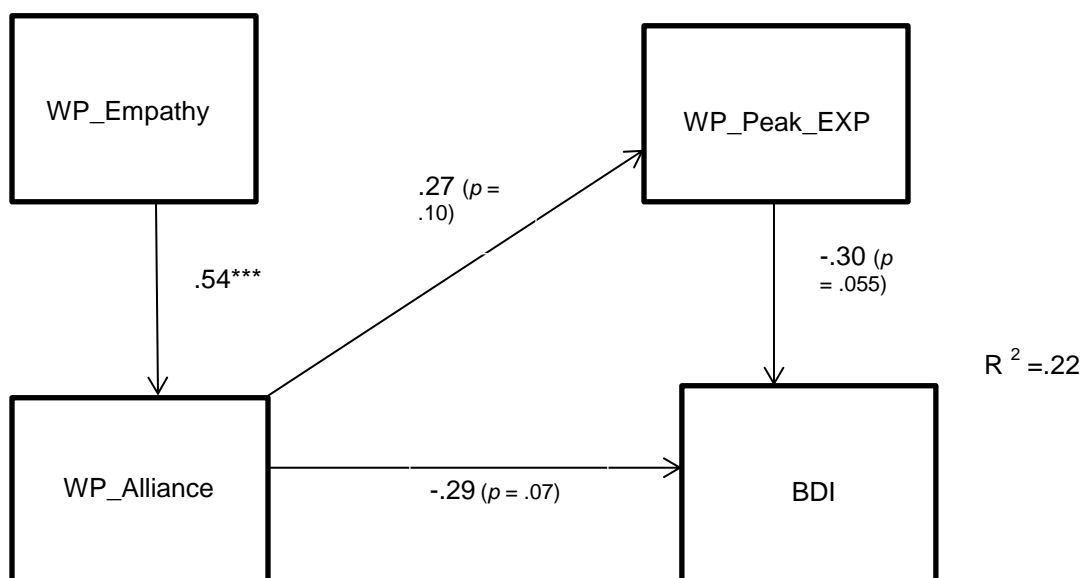


Figure 2. Path Analysis predicting peak working phase experiencing and BDI residual gain scores. WP_Empathy, first working phase session average MEE scores; WP_Alliance, first working phase session WAI scores; WP_Peak_EXP, first working phase session peak experiencing scores; BDI, BDI residual gain scores at termination. Significant indirect effect of WP_Empathy on BDI through WP_Alliance, Sobel $z = -1.63$, $p = .05$. Indirect effect of WP_Empathy on WP_Peak_EXP through WP_Alliance at slightly above conventional levels of significance, Sobel $z = 1.49$, $p = .07$. $*** p < .001$.

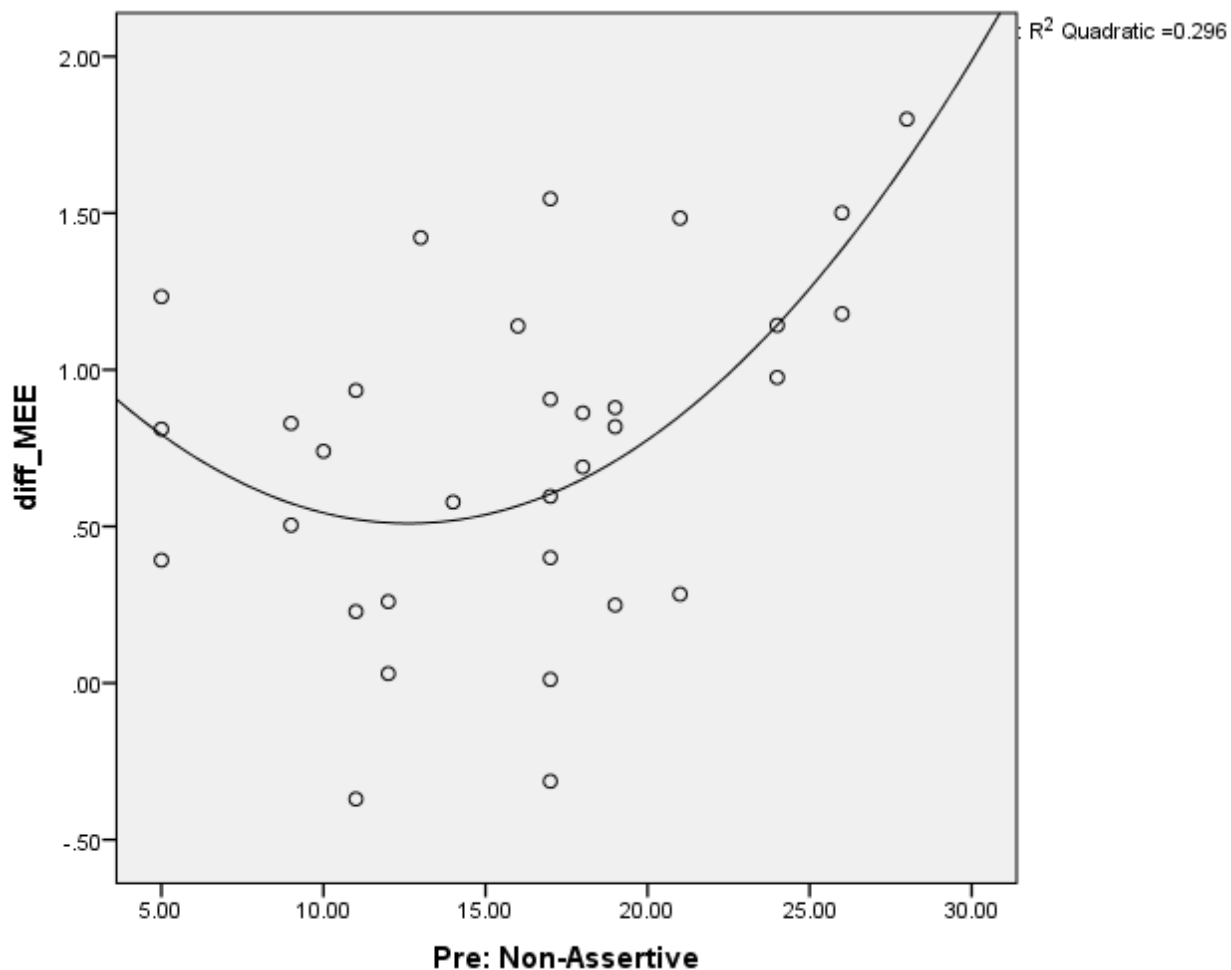


Figure 3. Differences in therapist MEE scores from the first to first working phase session as a function of pre-therapy client non-assertiveness scores. diff_MEE = differences in therapist MEE scores from the first session to first working phase session; Pre: Non-Assertive = clients' pre-treatment non-assertiveness scores.