

2013

# The Contribution Of Therapist Empathy To Client Engagement And Outcome In Emotion-Focused Therapy For Complex Trauma

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The Contribution Of Therapist Empathy To Client Engagement And Outcome In  
Emotion-Focused Therapy For Complex Trauma

By

Ashley Mlotek

A Thesis  
Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
in Partial Fulfillment of the Requirements for  
the Degree of Master of Arts  
at the University of Windsor

Windsor, Ontario, Canada

2013

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### AUTHOR'S DECLARATION OF ORIGINALITY

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ABSTRACT

The present study tested a partial mediation model of change in emotion-focused therapy for complex trauma (EFTT), such that therapist empathy during the first therapy session contributes to client emotional engagement with trauma material, which in turn, contributes to client outcome (trauma symptoms and abuse resolution). Archival data (videotaped treatment sessions and self-report measures) collected for an outcome study (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010) were utilized. Clients were men (n=16) and women (n=22) who were dealing with issues related to childhood maltreatment (physical, sexual, or emotional abuse; emotional neglect). The degree of therapist empathy was rated using the Measure of Expressed Empathy (MEE; Watson, 1999). Multiple regression analyses were used to test the partial mediation. Results revealed that higher levels of empathy contributed to greater levels of client engagement and a reduction in trauma symptoms, independent of engagement. Engagement mediated the relationship between empathy and resolution at post-treatment.

## ACKNOWLEDGEMENTS

I would like to express my deepest appreciation to my supervisor, Dr. Sandra Paivio, for her support and guidance. The completion of this project would not have been possible without your enthusiasm, knowledge and dedication. I would like to extend my appreciation to my committee members, Dr. Rosanne Menna and Dr. Betty Barrett, for all of your invaluable insight and encouragement. I would like to express my sincerest gratitude to Shawn Harrington for his contribution to this project. Your hard work and dedication was a pivotal part of this process. Futhermore, I would like to thank Dr. Dennis Jackson for his assistance in this project. I would also like to express my appreciation to my family and friends for their continuous support.

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## CHAPTER 1

### INTRODUCTION

#### **Objectives**

The present study tested a partial mediation model of change in emotion-focused therapy for complex trauma (EFTT) stemming from childhood abuse, such that therapist empathy during the initial stages of therapy contributes to client emotional engagement with trauma material during therapy, which, in turn, contributes to client outcome.

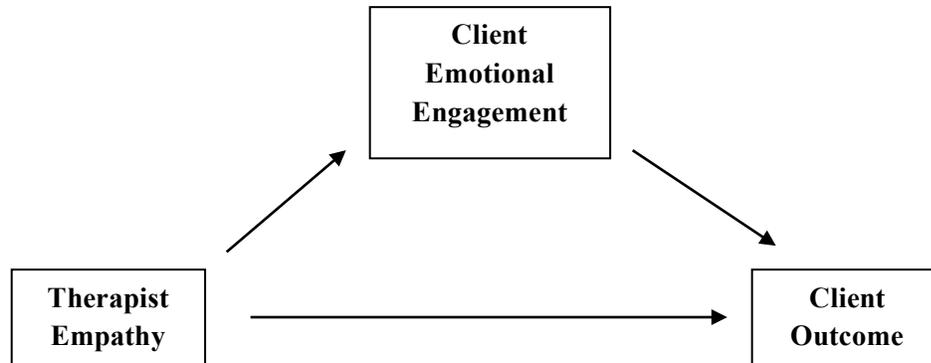
#### **Study Rationale**

Theory and prior research suggest that parental empathy plays a critical role in healthy development (Bowlby, 1979; Gottman, 1997; Sroufe, 1997). The absence of empathy in abusive environments during childhood, when the perpetrator of abuse is a primary attachment figure, has deleterious effects on one's sense of self (Liem, Toole, & James, 1996), interpersonal relationships (Cicchetti & Toth, 1995), and emotional regulation (Gottman, 1997; Paivio & Laurent, 2001). Therapist empathy is important in most approaches to therapy and is particularly central to treatment for survivors of childhood abuse because of the need to counteract the lack of empathy as a result of maltreatment at the hands of an attachment figure (Little, Akin-Little, & Somerville, 2011).

EFTT is an effective treatment for childhood abuse (Paivio et al., 2010; Paivio & Nieuwenhuis, 2001) that posits the therapeutic relationship and emotional processing of trauma material as mechanisms of change (Paivio & Pascual-Leone, 2010). Therapist empathy is thought to play a key role in facilitating these change processes (Paivio &

Pascual-Leone, 2010). Empathy is important throughout therapy but particularly during early sessions because it assists the client in forming an attachment bond to the therapist through therapist acceptance, support, and compassion, which helps foster a sense of safety and security. These elements of therapist empathic responding will help promote client emotional engagement with trauma material throughout therapy, and thus processing of traumatic experiences (Paivio, Hall, Holowaty, Jellis, & Tran, 2001; Chagigioris, 2009). The present study was the first to test EFTT theory about the importance of therapist empathy during early sessions in promoting client change.

The present study tested the mediation model shown in Figure 1. The study is guided by trauma and attachment theories and the theory of change in EFTT, which are presented in the sections that follow.



*Figure 1.* Mediation model of therapist empathy, client emotional engagement and client outcome.

### **Child Abuse Trauma**

The present study examines clients who have experienced child abuse, primarily in the familial context. Maltreatment in childhood is widespread and involves repeated exposure to harm, along with violations of trust in relationships (Paivio & Pascual-Leone, 2010). This can be overt physical or sexual abuse, as well as more subtle emotional abuse or neglect (Paivio & Pascual-Leone, 2010). Physical abuse involves acts of violence towards a child or extreme methods of discipline (Wolfe & Sandler, 1981). Child sexual abuse is defined as the involvement of a child or adolescent as a means to the sexual gratification of an older individual through any sexual behaviours such as penile penetration, masturbation, fondling, grooming, language, and gestures (Sanderson, 2006). Emotional abuse, often occurring in family environments, can include threats of harm or witnessing violence taking place against someone else (Paivio & Pascual-Leone, 2010). Childhood emotional neglect, another form of maltreatment, consists of extremely low parent involvement and failure to be responsive to the child (Akai, 2007). Present in approximately one-third of cases of child abuse or neglect is the co-occurrence of domestic violence (Fleck-Henderson, 2000). A child can be emotionally impacted by witnessing abuse against a parent (Francis, 2008) and such situations can further enhance the damaging consequences of abuse on the child (Carter & Schechter, 1997)

**Prevalence of abuse.** A meta-analysis investigating the international prevalence of child abuse estimated that 7.6% of males and 18.0% of females experience sexual abuse in childhood (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). In Canada, an estimated 85, 440 substantiated investigations of child maltreatment occurred in 2008 (Trocmé et al., 2008). These rates may be underestimated, however,

due to the underreporting of cases, particularly in regards to male victims of abuse (Pereda et al., 2009).

**Risk factors for abuse.** Certain risk factors have been found to be associated with childhood abuse. According to Clark, Freeman Clark, and Adamec (2007), risk factors for abuse include unemployment, poverty, parental stress, families in social isolation, any disabilities of a child, violence in the community, and family history of domestic/ family violence or substance abuse.

### **Effects of Childhood Abuse**

The three main inter-related sources of disturbance related to childhood maltreatment are repeated exposure to trauma, negative experiences in attachment relationships, and reliance on avoidance as a coping strategy. Together, these are associated with a constellation of long-term effects.

**Exposure to trauma.** Trauma, according to the DSM-IV-R criteria, includes a real or perceived threat of physical harm to oneself or others, resulting in emotional reactions of extreme fear, horror or helplessness (DSM-IV-TR, 2000). Terr (1991) has classified trauma into two different types. Type I trauma refers to a single, unexpected extreme episode that has disturbing, long-term effects, and is usually associated with the symptoms of post-traumatic stress disorder (PTSD) as described in the DSM-IV-TR. The three symptoms that are associated with PTSD are intrusion, avoidance, and hyperarousal (DSM-IV-TR, 2000). The symptom of intrusion refers to the re-experiencing of the traumatic event, which can occur in a number of ways including images, thoughts, or dreams. Avoidance refers to efforts to avoid stimuli related to the trauma including places and activities that are associated with the event. Symptoms of hyperarousal

include difficulties sleeping or concentrating, irritability, and an intensified startle response. Type II trauma, also known as complex trauma, pertains to prolonged, repeated exposure to extremely disturbing events (Terr, 1991). When Type II trauma occurs in childhood, it is often in the form of abuse or neglect (Paivio & Pascual-Leone, 2010), and the perpetrators are usually individuals that are known to the child, such as family members or teachers (Terr, 1991). Complex trauma is associated with a constellation of disturbances known as complex PTSD (Courtois & Ford, 2009) or disorders of extreme stress not otherwise specified (DESNOS; Herman, 1992b). The likelihood that symptoms of DESNOS will occur increases the younger the age of victimization and the more the exposure to trauma was prolonged (Van der Kolk, Roth Pelcovitz, Sunday, & Spinazzola, 2005).

Exposure to trauma, according to Siegel (2003) not only has negative psychological effects but has been found to have negative consequences in regards to brain development which impacts cognitive and emotional processes. Traumatic experiences can prevent neural integration between the right and left hemispheres of the brain, which is necessary to formulate a clear narrative of events. The right hemisphere is believed to be responsible for the experience of strong emotions and the retrieval of autobiographical memories, while the left hemisphere processes information linearly, using linguistics through a logical approach. Research has found that in individuals who have experienced abuse in childhood, according to De Bellis and colleagues (1999), there is a reduction of growth of the corpus callosum, which links the two hemispheres together. It is suggested that this can lead to a disturbance in normally integrative processes including memory, identity, perception, or consciousness. Furthermore,

according to Schore (2003), in cases where a secure attachment cannot be formed, the growth of a control system to regulate emotion is hindered. Attachment-related issues are linked to social and biological dysfunctions partly as a result of impaired development of the right hemisphere of the brain, as well as fronto-limbic control systems that have not reached full development (Schore, 2003). Early negative interpersonal experiences during critical periods result in permanent impairments in the limbic system (Post, Weiss, & Leverich, 1994). During the period of brain maturation, the right hemisphere has a greater connection to the limbic system than the left (Coplan et al., 1996; Ladd, Owens, & Nemeroff, 1996; Lewis, Gluck, Beauchamp, Keresztury, & Mailman, 1990), which impacts the regulation of the stress hormones, cortisol and corticotropin releasing factor (Kalogeras et al., 1996; Wittling & Pfluger, 1990). In addition to this, prolonged exposure to stress in infancy alters dopamine activity in the brain, resulting in the reduction of the right prefrontal cortex stress response in adulthood (Brake, Sullivan, & Gratton, 2000).

**Negative experiences with attachment figures.** Attachment theory stresses the central role of attachment relationships in a child's formation of the ability to have healthy perceptions of themselves and others (Bowlby, 1979; Gottman, 1997; Sroufe, 1997). From a social developmental perspective, secure attachment allows the child to establish interpersonal trust, self-confidence, and appropriate regulation of emotions. Beliefs and expectations that were created through the child-caregiver relationship are encoded in mental representations and systems of meaning (object relations) that impact one's behaviours, emotions, and thoughts in adult relationships (Bowlby, 1979). Traumatic childhood experiences in attachment relationships greatly shape the way in which the child perceives the self and others (Liem et al., 1996). When abuse occurs in

childhood, healthy development can be impaired by violations of moral beliefs and betrayals of trust by attachment figures (Paivio & Pascual-Leone, 2010) which can have more damaging effects than if the perpetrator was a stranger (Beitchman, Zucker, Hood, & DaCosta, 1992). Trauma such as this can have particularly severe consequences when the abuse occurs at critical stages of the child's development (Cicchetti & Toth, 1995). These critical stages include the development of a secure attachment bond occurring approximately between the ages of 6 to 12 months (Stroufe, 1979) and the development of an autonomous self between the ages of 18 and 36 months (Lewis and Brooks-Gunn, 1979). Critical periods effected by complex trauma also include the development of symbolic representations of animate and inanimate objects at 18- 30 months (Greenspan & Porges, 1984) and the development of interpersonal relationships, which begins around preschool age (Cicchetti, 1989). The success of each developmental task is largely dependent on the caregiver-child relationship (Stroufe, 1979), and disruptions during critical periods can result in disturbances in adulthood (Cicchetti, 1989).

**Self-related disturbances.** Individuals who were maltreated in childhood frequently develop a negative view of self, such that they feel worthless and unlovable. These individuals can see themselves as deserving of the abuse and as disgusting and as dirty as the actions that were done to them, which in turn can lead to self-destructive behaviours such as self-mutilation, as well as chronic anger and sleep problems (Briere, 1988). They also learn to feel as though they are powerless and ineffective in their environment (Liem et al., 1996). Another consequence of abuse and neglect can be an unclear sense of self in that there is a lack of awareness of one's own internal experience, such as feelings, desires, needs, and values due to the lack of emotional support in family

environments (Paivio & Pascual-Leone, 2010). These individuals can experience identity confusion and chronic feelings of “emptiness” (Briere & Runtz, 1993).

**Disturbances in interpersonal relationships.** Negative relationships with attachment figures, according to Cichetti & Toth (1995) can lead to a dysfunctional pattern of interpersonal relationships in adulthood caused by internal representations that have been formed during the time of the abuse. This pattern can, in turn, lead to negative expectations regarding the behaviour of others in relation to the self, as well as one’s own success in relating to others. For example, women who have experienced childhood abuse have a greater likelihood of exhibiting emotional avoidance, fear of intimacy (Davis, Petretic-Jackson, & Ting, 2001), boundary issues (Briere & Runtz, 1993) and sexual dysfunction (Maltz & Holman, 1987). Social isolation is more common in those who have been abused than those who have not (Harter, Alexander, & Neimeyer, 1988). Abuse in childhood may also result in feeling that one is unworthy of healthy, positive relationships with others (Conte & Schuerman, 1987).

**Reliance on avoidance as a coping strategy.** Children learn to regulate affect through an emotional connectedness with their parents that is based on affection and understanding and is communicated through parental empathetic responses that assist in managing emotions that arise (Gottman, 1997). When a parent displays empathy towards a child by responding to the child’s feelings or needs, the child will learn to identify and describe emotions that they experience (Sroufe, 1997) and develop the ability to sooth themselves (Gottman, 1997). According to Gottman (1997), affect regulation skills are taught to children through the “emotion coaching” provided by attachment figures. Emotion coaching consists of attending to and labelling the feelings

of the child, which is important in the development of appropriate expression of emotion. Without this type of coaching, children will not acquire healthy emotional regulation capacities and may alternate between the two inter-related extremes of under-regulation and over-control and avoidance of their emotions (Paivio & Laurent, 2001).

Underregulation occurs as a result of child abuse experiences, where emotions such as anger and shame are intensely felt and overwhelming to the individual (Paivio & Laurent, 2001). Overwhelming environmental stimuli can have a disorganizing effect on thoughts and behaviour, impacting the individual's interpersonal relationships, learning, and performance (Paivio & Pascual-Leone, 2010). Issues related to underregulation include rage, shame, anxiety, depression, and a sense of worthlessness (Herman, 1992a). In the absence of emotion coaching and support, the child learns to rely on avoidance as a coping strategy. Many psychological disorders can be viewed as forms of experiential avoidance, which refers to one's unwillingness to engage in certain private experiences, such as memories, emotions and bodily sensations (Hayes, Wilson, Gifford, & Follette, 1996). Overcontrol can occur in individuals that meet PTSD criteria by the effortful numbing of emotion in order to reduce distress caused by arousal and intrusive symptoms (Feuer, Nishith, & Resnick, 2005). For example, these individuals may engage in maladaptive efforts to regulate emotion such as substance abuse in order to numb the feelings associated with the abusive experience (Briere, 2001). It also has been found that those who do not have effective strategies to handle emotions are more likely to engage in self-harm behaviours (Gratz & Roemer, 2008). Avoidance of affective experience will hinder access to the associated adaptive meanings that contributes to well-being (Greenberg, 2002). For example, unexpressed anger at those involved in the

victimization can build up inside the individual and can lead to further social withdrawal, self-hatred, self-harm, and suicidality (Herman, 1992b). Social anxiety and somatization also are associated with difficulties in identifying and describing emotions, referred to as alexithymia (Taylor, Bagby, & Parker, 1997). Most importantly, there is expert agreement that avoidance of trauma feelings and memories perpetuates trauma symptoms and interferes with emotional processing of traumatic experiences, integration of these experiences into current meaning systems, and recovery (Briere & Conte, 1993; Courtois, 1988; Foa, Rothbaum, Riggs, & Murdock, 1991; Paivio & Laurent, 2001). Thus most treatments for trauma include strategies to help clients access and process previously avoided trauma material.

**Risk factors for disturbance.** Approximately 25% of individuals who develop a traumatic event eventually develop PTSD (Breslau, Davis, Andreski, & Peterson, 1991). One-third of the approximate 13% of American women that have experienced rape at some point in their lifetime, ultimately develop PTSD (Kilpatrick, Edwards, & Seymour, 1992). According to Breslau, Davis, Andreski, Federman, and Anthony (1998), violence that consisted of assault produced the highest rate of PTSD compared to other types of traumatic experiences. Prior victimization, particularly in childhood, is a salient risk factor in the development of PTSD following rape (Resnick, Kilpatrick, Best, & Kramer, 1992). Certain individual characteristics, such as avoidant or antisocial personalities, are associated with greater risk for developing PTSD symptoms following a traumatic event (Schnurr, Friedman, & Rosenberg, 1993). There has also been evidence found to support a genetic diathesis towards PTSD demonstrated by findings of higher prevalence in monozygotic twins exposed to a trauma compared to dyzygotic twins (True et al., 1993).

**Resilience to disturbance.** The personality variable of internal locus of control has been associated with a decreased likelihood of developing PTSD symptoms when exposed to extreme stress (Wilson, 1989). Protective factors for the development of PTSD symptoms are associated with perceived economic and social resources, self-disclosure (Wilson & Raphael, 1993), family cohesion and social support (Rutter, 1990)

### **Treatments for Complex Trauma**

Psychological treatments for complex trauma address the above constellation of disturbances. The psychodynamic approach, according to Kudler, Blank, and Krupnick (2000), is rooted in a psychoanalytic framework, which emphasizes client growth by understanding perceptions and responses to the external environment. The client is encouraged to verbalize anything that he or she is thinking, even if it does not appear relevant to the trauma. Using the material expressed by the client, the therapist then makes connections with transference, countertransference, dreams, as well as the psyche of the individual, which consists of a complex network of memories, wishes, ideas, and fears. The therapist is seen as a facilitator in the treatment process, while the client analyzes the self and his or her world. The client arrives at new understandings of the ways in which interactions between the psyche and traumatic events contribute to current dysfunctions.

Another treatment modality used to treat complex trauma is cognitive behavioural therapy (CBT). According to Brewin, Dalgeish, and Joseph (1996), emotional processing in CBT consists of both the activation of memories that are not in consciousness, as well as consciously searching for meanings and an understanding of the event. The purpose of this is to diminish negative emotions and to reinstate a sense of control and safety in the

client's environment. CBT employs a number of exposure-based techniques to address trauma symptoms (Rothbaum, Meadows, Resick & Foy, 2000). One approach is *imaginal exposure* which consists of recalling memories of the trauma, or *in vivo*, which includes facing actual situations associated with the trauma. In addition, therapy may consist of *desensitization*, which is increasingly gradual exposure to trauma material, or *flooding*, which consists of submerging the client into highly frightening trauma memories. By confronting stimuli that elicit extremely negative emotions, anxiety is reduced. Another technique in CBT is cognitive restructuring, involving the altering of trauma-related thoughts and beliefs (e.g. blame). Also included in CBT is stress inoculation training that focuses on managing anxiety.

Dialectical behaviour therapy (DBT) for trauma is also guided by a cognitive-behavioural orientation. According to Wagner & Linehan (2006), DBT aims to gain control over maladaptive behaviours such as self-harm or substance abuse, and address issues related to emotion dysregulation and symptoms related to the trauma. These goals are achieved through problem solving (e.g. exposure and contingency management), therapist validation, self-monitoring and skills training (mindfulness, emotional regulation, distress tolerance, and successful interpersonal relationships).

Another mode of therapy used for treatment of complex trauma is eye movement desensitization and reprocessing (EMDR) therapy, which is an integrative approach grounded on an adaptive information processing model (Shapiro, 2001). This model posits that healthy functioning is rooted in an internal memory network consisting of sensory perceptions and cognitive factors of experience, integrated into a physiological information-processing system. Present dysfunctions are viewed as a result of

unprocessed memories and stored perceptions of traumatic events. According to Shapiro (2002), treatment addresses memories, perceptions, emotions, and cognitions associated with trauma by the reprocessing of events. A main component of EDMR is the identification of somatic sensations in the body while retrieving memories. Treatment includes a dual stimulation procedure during which clients attend to trauma material while simultaneously being presented with repeated tones, taps or eye movements. The rapid processing involved in this technique is thought to change sensory experiences, provoke new associations and insights, and elicit a greater sense of self-efficacy.

An integrative self-trauma model (Briere, 2002) posits that maltreatment during early stages of life interferes with the development of self-capacities particularly in regards to emotional regulation. This model includes cognitive, behavioural, psychodynamic, and self-psychology theoretical frameworks. Although largely guided by a cognitive-behavioural perspective, the model places as much importance on implicit memories as those that are explicit. Implicit memories are extremely traumatic events that are recollected on a sensory level later in life (e.g. flashbacks). This is due to the impact that overwhelming emotions, associated with the event, have on processes in the brain responsible for encoding explicit narratives, which causes a less integrative, largely nonverbal memory (Siegel, 1999; Van der Kolk, McFarlane, & Weisaeth, 1996). The model also recognizes that emotions are as important as cognitions in treating the effects of child abuse. In accordance with this, the treatment process includes identifying events related to child abuse, exposure to trauma material (implicit and explicit), the activation of conditioned trauma-related emotional responses and cognitions, distinguishing between the traumatic memories and present environment, and cognitive-emotional

processing. The latter refers to the simultaneous processing of both cognitions and emotions related to trauma material. Emotional processing refers to the emotional expression that accompanies exposure techniques, as well as habituation and desensitization, which decreases the intensity of the response over time. Cognitive processing is defined as the access and integration of new information, the development of a narrative that creates meaning, and changing negative cognitive structures.

Division 56 of APA has established a working group of experts in the field (Courtois et al, in progress) to specify best practice guidelines for complex trauma. Common features of most recognized approaches to trauma identified by this group include an emphasis on the therapeutic relationship and emotional processing of trauma material, which are the focus of the present study. In these approaches, the development of safety in the therapeutic relationship provides conditions that can be generalized to other interpersonal relationships. Additionally, the self, others, and traumatic memories are all explored within the security of the therapeutic relationship. Treatments for complex trauma place emphasis on assisting the client in emotional regulation. This includes attending to states of arousal, understanding thoughts, labelling feelings, or managing extreme behaviours when aroused. Additionally, treatments for complex trauma work towards changing the client's tendency to avoid experiences that may activate arousal, the re-experiencing of trauma memories, or emotional numbing, into more effective coping mechanisms.

Treatments for complex trauma typically consist of three phases, but are subject to modification as therapy progresses and individual needs become apparent (Courtois et al., in progress). The first of these phases focuses on establishing safety and a secure

therapeutic relationship, and assessment of treatment needs. This phase also enhances certain capacities, including maintaining safety in interpersonal relationships, as well as personal safety, affect regulation, behaviour control, self compassion, self soothing, and the ability to form and maintain interpersonal relationships. The enhancement of these capacities is facilitated through the empathy of the therapist (Pavio & Pascual-Leone, 2010). The first phase provides the necessary conditions for the second phase, which focuses on the information processing of trauma material in order to better understand the effects of these events (Courtois et al., in progress). In the third phase, with a new understanding of the influence of the trauma, the client works towards moving past its impact (Courtois et al.).

### **Emotion-focused Therapy for Complex Trauma**

Emotion-focused therapy for trauma (EFTT; Paivio & Pascual-Leone, 2010) is a short-term, experiential approach that is based on the principles of the general model of emotion- focused therapy (Greenberg & Paivio, 1997) applied to complex trauma. A main focus of EFTT is to resolve emotional injuries related to particular abusive and neglectful others, usually attachment figures.

Emotion-focused therapies, including EFTT, are based on current experiential therapy, which draws on emotion theory and research that view emotion as an adaptive orienting system (Frijda, 1986; Damasio, 1999; LeDoux, 1996). Accordingly, emotions are viewed as a source of adaptive information that aid in healthy functioning. Basic emotions such as anger, sadness, fear, and shame are direct responses to environmental stimuli that are observed cross-culturally and typically emerge at certain stages in development (Ekman & Friesen, 1975). Emotions provide information regarding one's

responses to the environment through evaluating situations and relating it to one's own concerns (Fridja, 1986). Emotions enable appraisals of the environment to be explored, along with one's goals and needs (Greenberg & Korman, 1993). They serve to organize thoughts and actions by establishing goals that guide cognitions and conduct (Fridja, 1986). These goals are mainly associated with an individual's social bonds, such as the emotion of love for the goal of cooperation and anger for the management of boundaries with others (Greenberg & Paivio, 1997).

Emotional experiences are generated by the activation of emotion structures or schemes (Greenberg, Rice & Elliot, 2003), which are multi-modal information networks comprised of bodily sensations, memories, learned beliefs, environmental cues, and associated meanings. According to Greenberg & Paivio (1997), the activation of emotion schemes guides perceptions and behaviour. For example, experiencing fear due to a threat will orient an individual to flee from danger. Maladaptive emotions, on the other hand, are learned dysfunctional emotional responses to the environment and associated maladaptive information. Examples of maladaptive emotions include feelings of shame and worthlessness for having been abused. In therapy, maladaptive emotions are explored and changed. According to Paivio & Pascuale-Leone (2010), EFTT aims to access previously inhibited primary adaptive emotions, such as anger at violations of trust or sadness at loss, so that the meanings associated with these emotions can be used to help modify maladaptive meaning associated with emotions, such as fear and shame. This is the process of emotional transformation.

EFTT also integrates attachment and trauma theories and research described in earlier sections. Attachment theory (Bowlby, 1979) stresses the importance that

attachment relationships play in the development of emotional competence, as well as healthy self and interpersonal functioning. This is fundamental to EFTT (Paivio & Pascual- Leone, 2010) because current client issues that are of focus in treatment are viewed as a consequence of negative attachment relationships. Key objectives in EFTT are to promote healthy self-development, including emotion regulation capacities, and resolve issues with particular abusive/neglectful others, usually attachment figures. As noted above, the acceptance of the therapist, as well as assisting the client to experience and express adaptive anger and sadness, can help to transform a core sense of self as worthless and help restore the capacity for interpersonal relatedness.

Trauma theory emphasizes the impact of childhood abuse in regards to cognitive distortions (perceptions of the self, others, and the world), disturbances in emotionality, alterations in interpersonal functioning, avoidance, and an impaired sense of self (Briere & Runtz, 1993). Also important to trauma theory are the effects of violations of power, interpersonal trust and betrayal resulting from child abuse (Freyd, 1997). Trauma theory emphasizes emotional processing in therapy, which involves re-experiencing the intense feelings that are related to the trauma rather than solely focusing on external events (Briere, 1992). By providing an in-depth narrative of the event, the memory can be reconstructed through a sense of understanding and development of new meanings, and the new transformation can be integrated into the life story of the client (Herman, 1992a). Interventions utilized in EFTT are largely based on these principles.

**Development of EFTT.** EFTT has been developed through a program of process and outcome studies that began with research on the general model of EFT and later specifically focused on EFT with victims of trauma (Paivio & Pascuale-Leone,

2010). Initially, Greenberg and Foerster (1996) empirically tested and verified the client process that occurs during the resolution of “unfinished business” using an empty-chair dialogue technique, derived from Gestalt therapy. This procedure involves the client engaging in a dialogue with an imagined negative other and is intended to promote the expression of previously constricted feelings (anger and sadness) in the safety of the therapeutic environment. Steps in the process that discriminated clients who resolved issues from those who did not included the expression of adaptive emotion (anger, sadness) and associated meanings, entitlement to unmet needs, increased self-acceptance and self-assertion, and a more differentiated perspective of the other and holding the other responsible for harm. An outcome study (Paivio and Greenberg, 1995) with a general clinical sample supported the effectiveness of therapy using his model and technique for resolving unfinished business. The sample in the Paivio and Greenberg study included a subgroup of clients who were in treatment for issues related to childhood abuse.

Based on the observations and findings in the Paivio & Greenberg (1995) study, the general treatment model was refined to specifically target child abuse trauma. Refinements included an explicit focus on trauma material and reframing the empty-chair intervention in terms of *imaginal confrontation* of abusive or neglectful others. This procedure was now seen as involving both interpersonal and exposure processes. Refinements also included an additional focus on decreasing fear, avoidance, and shame that were evoked by the imaginal confrontation intervention. In order to accomplish this, treatment length was extended from 12 to 20 sessions.

EFTT is typically comprised of 16 to 20 one-hour weekly sessions, but may vary in length according to the individual needs of the client (Paivio & Pascual-Leone, 2010). In the standard protocol, imaginal confrontation is the primary re-experiencing procedure used to explore and resolve issues with abusive and neglectful others. A recently developed alternative *empathic exploration* procedure will be described in the research section below.

Treatment is structured in four phases. The first phase, which typically consists of the first three therapy sessions, focuses on the cultivation of a strong therapeutic alliance. This is accomplished by establishing a secure attachment bond which provides a safe and trustworthy environment for the client. The therapeutic alliance also involves collaboration, which is agreement between the client and therapist on therapeutic goals, and particularly, an understanding of the value of re-experiencing feelings and memories related to the trauma. The primary intervention used in this phase of therapy is empathic responding to client feelings and needs. Therapist empathy is particularly important in the initial phase of EFTT, beginning in the first session, which is described in detail below.

Introduction of the imaginal confrontation (or empathic exploration) procedure takes place in session four and evokes material that becomes the focus of the second phase of therapy. Thus the second phase of treatment focuses on reducing self-related disturbances such as fear and avoidance of painful and threatening emotional experiences, as well as shame and self-blame for the abuse. The third phase of the treatment model focuses on resolving issues with particular perpetrators of the abuse or neglect. By accessing previously avoided adaptive feelings and meanings related to these

issues (e.g., anger at violation and betrayal, sadness at deprivation and loss), the client is able to develop a more adaptive view of the self, abusive others, and traumatic events. As the client develops more self-esteem and confidence, they also develop a more differentiated perspective of abusive/neglectful others, view them as more human, less powerful, and appropriately hold them (rather than the self) responsible for harm. The final termination phase of EFTT involves integration of therapy experiences and bridging to the future.

**Posited mechanisms of change in EFTT.** EFTT posits two primary change processes in therapy (Paivio & Pascual-Leone, 2010). The first of these mechanisms is the therapeutic relationship, which is defined in EFTT by the bond and collaboration between therapist and client. The bond includes affective elements in the relationship such as trust and a positive view of one another. Collaboration consists of agreement on the therapeutic goals, as well as the processes and techniques that will be utilized in order for the desired goals to be reached.

According to Paivio & Pascuale- Leone (2010), the therapeutic relationship serves two main inter-related functions. The first is to provide safety so that clients can explore painful child abuse experiences. Here the relationship is indirectly curative in that the empathy of the therapist facilitates client engagement with trauma material. The therapeutic relationship therefore plays an essential role as a medium through which change processes can occur. This element is similar to that seen in cognitive-behavioural approaches, where the therapeutic relationship is analogous to anaesthesia during surgical procedures, inferring that the procedure is indirectly curative (Gaston, Goldfried, Greenberg, Hovarth, Raue, & Watson, 1995). In EFTT, therapist empathic responding is

the primary intervention used to provide understanding and safety. The second function of the therapeutic relationship is to provide a corrective interpersonal experience with the therapist (Paivio & Pascual-Leone, 2010). Here the relationship is directly curative. This is consistent with attachment theory (Bowlby, 1979) and contemporary relational treatment models (Mitchell, 1988). Here again, therapist empathic responding will aid in correcting for the lack of empathic responsiveness on the part of past attachment figures (Paivio & Pascual-Leone, 2010). The client internalizes the support that is present in the therapeutic relationship, thus facilitating compassion for the self, self-growth, and interpersonal trust that had been hindered by the abuse. The role of therapist empathy in cultivating the relationship is a main focus of the present study and will be presented in more detail in a later section.

The second posited mechanism of change is emotional processing of trauma material (Paivio & Pascual-Leone, 2010). As described in earlier sections, emotional processing is defined as the integration of new information into current emotion structures through principles of exposure (Foa & Kozak, 1986). In EFTT, according to Paivio & Pascual-Leone (2010), this involves re-experiencing feelings and memories of traumatic events so that this information will be available for exploration. From this new information, the client is able to construct more adaptive meanings and develop of a new perspective of the self, others and traumatic experiences. In order to arrive at these new meanings, memories have to be internally processed and symbolized in words. As described previously, the transformation of maladaptive emotions in EFTT occurs through the simultaneous access of adaptive emotions. For example, maladaptive shame and self-blame can be changed by accessing adaptive anger at the abusive individual.

The transformation of emotions related to feelings toward the perpetrator of abuse is facilitated in the IC and EE procedures where contrasting emotions can be evoked. Client engagement with trauma material during these enactments again is supported by an empathic and collaborative relationship, where the therapist displays compassion and genuineness, creating a safe environment for the client to explore experiences and emotions that may not be fully in awareness. The empathy displayed by the therapist in facilitating client emotional engagement with trauma material is another main focus of the present study.

**Distinctive Features of EFTT.** EFTT shares features with other treatments for complex trauma, including an emphasis on the therapeutic relationship and use of exposure-based procedures to promote emotional processing of trauma material. EFTT also has a number of distinguishing features. First, EFTT promotes change by accessing restricted adaptive emotions and creating new meanings from the information that these emotions provide.

Another distinguishing feature of EFTT is its focus on resolving issues with particular perpetrators and attachment figures (Paivio & Pascual- Leone, 2010). EFTT recognizes present difficulties stemming from childhood abuse but views these difficulties as stemming from painful memories, unmet needs, and inhibited feelings (“unfinished business”) concerning specific others. The two described re-experiencing procedures, IC and EE, are used in EFTT to resolve these issues. Once these thoughts, feelings and needs are acknowledged, expressed, and explored in therapy, resolution of these issues generalizes to current functioning. EFTT is uniquely based on the empirically verified model of step in the resolution process, described above.

Another distinguishing feature of EFTT is client “experiencing” as the primary source of new information in emotional processing. Experiencing is a central feature of all experiential therapies and consists of directing attention to internal subjective experience (thoughts, feelings, bodily sensations) and constructing meaning from this process (Gendlin, 1997). According to Pavio & Pascuale- Leone (2010), in order to construct new meanings, feelings and memories are explored and previously inaccessible features are re-experienced, such as the feeling of helplessness from the inability to protect oneself from the abuse. Core beliefs developed at the time of the trauma are accessed, examined and questioned. Again, the meanings associated with adaptive emotion help to transform maladaptive meanings. Research supports the contribution of experiencing to outcome across therapeutic orientations (Kiesler, 1971; Goldman, 1997; Goldman, Greenberg, & Pos, 2005; Silberschatz, Fretter, & Curtis; 1986; Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996). In contrast, cognitive-behavioural approaches use techniques such as challenging maladaptive cognitions or skills training to address current emotion regulation and self and interpersonal difficulties (Sheldon, 2011). Also in contrast to EFTT, interpersonal approaches focus on present symptoms and how they relate to difficulties in current relationships with an emphasis on preventing these relational problems in the future (Weissman, Markowitz, & Klerman, 2000). Similarly, relational cognitive processing therapy emphasizes the development of skills to reduce problems related to the self and interpersonal relationships (Chard, 2005).

Additionally, a distinguishing feature of EFTT is specification of in-session markers and associated tasks (Paivio & Pascual-Leone, 2010). Markers refer to identified emotions and related difficulties in processing, each of which is associated with

therapeutic interventions to address the processing difficulty. In EFTT, tasks are utilized that are specific for child-abuse issues. The first of these are empathy-based tasks that involve responding to markers of vulnerability with acceptance and compassion for the suffering of the client. The second type is relational tasks, which address disturbances associated with attachment figures and the anxiety related to partaking in therapy. Thirdly, experiencing tasks consist of assisting the client in exploring affective experiences, as previously described. These tasks are often implemented when feelings and meanings are unclear, the client is numb to emotions, or the client is primarily focused on external events. Fourth, reprocessing tasks, include focusing on painful and frightening trauma memories. This involves revisiting negative feelings towards attachment figures, as well as re-experiencing oneself as worthless, unloved, or neglected. Cultivating a safe therapeutic relationship and promoting experiencing are central to all of these tasks, and therapist empathic responding, in turn, play a crucial role in these processes.

In summary, distinguishing features of EFTT include the focus on the promotion of adaptive emotions and related meanings, the use of experiencing to explore trauma material and construct new meaning, the emphasis placed on resolving issues with attachment figures and perpetrators of abuse and neglect, and the empirically-verified model of resolution that forms the basis of therapy (Paivio & Pascual-Leone 2010). Importantly, EFTT uniquely emphasizes therapist empathic responding as a main intervention that is used to accomplish these processes.

**Research on EFTT.** An outcome study (Paivio & Nieuwenhuis, 2001) found that EFTT with imaginal confrontation produced significant improvements for a sample

that consisted of clients (N=32) who had experienced multiple types of childhood abuse (emotional, physical, sexual). Clients improved on multiple dimensions, including symptomatology, current abuse-related disturbances, interpersonal problems, self-esteem, and resolution of issues with specific perpetrators. On average, pre- post- effect sizes across seven domains was 1.53 standard deviations and post-treatment effects were maintained at nine-months follow up. These pre-post effects of therapy surpassed the American Psychological Association's standard (0.8 SD's) for treatment efficacy.

Approximately 25% of clients in the Paivio et al (2001) study, however, were unwilling or unable to participate in the imaginal confrontation (IC) intervention over the course of therapy. Thus an alternative, less stressful empathic exploration (EE) procedure was developed for clients who had difficulties engaging in IC (Paivio et al., 2010). EE was identical to IC in terms of model of resolution and intervention principles, only without the empty-chair. In this procedure, trauma material is explored exclusively in interaction with the therapist and the client imagines perpetrators in their "mind's eye." Clients are encouraged to explore trauma feelings and meanings through the empathic responding of the therapist and from this process new meanings are constructed.

A comparative outcome study (Paivio et al., 2010) found that both versions of EFTT (with IC or EE) were comparable in regards to efficacy of treatment. Clients in both conditions significantly improved on 10 measures of disturbances related to childhood abuse, including PTSD symptom distress, interpersonal issues, self-esteem, and trauma resolution. The average pre-post effect size was Cohen's  $d=1.67$  for EFTT with IC and  $d=1.24$  for EFTT with EE .

Research also supports the posited mechanisms of change in EFTT. Paivio and Patterson (1999) examined alliance quality in clients (N=33) who completed EFTT using the Working Alliance Inventory (WAI: Horvath & Greenberg, 1989). Clients were able to form therapeutic relationships (M= 5.74 SD= .66 at Session 3) comparable to those found in a general clinic population (Paivio & Bahr, 1998), even though they had extensive histories of early abusive relationships, as well as current interpersonal dysfunctions. In the Paivio & Patterson study, weaker therapeutic relationships in the early stages of therapy were associated with severity of abuse in childhood, ( $r = -.31$ ,  $p < .05$  for emotional/physical abuse,  $r = -.28$ ,  $p < .05$  for emotional neglect, and  $r(32) = -.27$ ,  $p < .05$  for physical neglect), as well as Axis II pathology,  $r = -.32$ ,  $p < .05$ . However, alliances improved over the course of therapy and these effects were not associated with outcome. Additionally, alliance quality contributed to improvements in self-esteem,  $r = .44$ ,  $p < .01$ , and reduction in trauma symptoms  $r = -.32$ ,  $p < .05$  at outcome.

Paivio et al. (2001) assessed the independent contributions of alliance quality and client emotional engagement with trauma material during IC. Engagement was operationalized on the observer-rated Levels of Engagement Scale (Paivio et al., 2001) in terms of client psychological contact with the imagined other (e.g., looking at the imagined other rather than the therapist, use of I-you language), spontaneous elaboration and involvement in the process (rather than strictly compliance with therapist directives), and verbal and non-verbal indicators of emotional expressiveness. Results supported the independent contribution of engagement in the IC procedure to abuse resolution and trauma symptom reduction, beyond contributions made by the therapeutic alliance. A recent study (Chagigioris, 2009) assessed alliance quality and engagement during both IC

and EE procedures using observer-ratings and client self-report measures of engagement. Again, results supported the independent contributions of alliance quality and emotional engagement with trauma material to outcome in both conditions. Thus findings supported the posited mechanisms of change in EFTT.

The following section addresses the role of therapist empathy in facilitating mechanisms of change in EFTT. Empathy serves to establish the necessary conditions that will foster client growth and development throughout the treatment process.

### **The Centrality of Empathy in EFTT**

Empathy is an essential component of every approach to psychotherapy (Burns & Nolen-Hoeksema, 1992; Berger, 1987; Greenberg et al., 2003; Linehan, 1997). Empathic attunement refers to the therapist's understanding of the client's inner world and emotional experiences (Meissner, 1996). In contrast, empathic responding refers to a complex, active technique consisting of the therapist reflecting the expressions of the client, used as a means to assist the client in making sense of their experiences (Greenberg & Paivio, 1997).

The central role of therapist empathy is common to most therapeutic approaches. From a client-centered perspective (Rogers, 1975), for example, empathy is a process through which one enters the inner world of another, acquiring the ability to sense the felt meanings that are changing for this other individual from moment to moment, and communicating that understanding to the other. Psychoanalytic approaches define empathy as "vicarious introspection" (Kohut, 1984, p.96). This consists of the therapist attending to the inner life of the client while maintaining the position of an objective observer (Kohut, 1984). The therapist's empathy expands across the range of the client's

internal experience, including unconscious material that may not be in the client's full awareness, which helps to facilitate insight and interpretation (Eagle & Wolitzky, 1997). The cognitive-behavioural approach to therapy emphasizes genuineness in displaying empathy, in order to provide honest, constructive feedback to the client that allows for the formulation of solutions (Wright, Basco, & Thase, 2006). Empathy in cognitive-behavioural therapy includes an intellectual element that helps the therapist in understanding the client's feelings and reasons for unproductive behaviours (Beck, Rush, Shaw, & Emery, 1979).

Empathy also is recognized across therapeutic approaches as an especially important component in therapies for trauma, particularly complex trauma. In therapy for child abuse issues, empathy provides the opportunity for healing to take place by the demonstration of the deep compassion that the therapist has for the suffering that the client has experienced and the difficulty in recovering from this (Pearlman & Caringi, 2009). Psychodynamic approaches to the treatment of trauma, for example, view empathy as a central component, whereby PTSD symptoms are transmitted unconsciously to the therapist during treatment, enabling the therapist to become attuned to the client's psychological state and therefore make accurate interpretations to the client (Wilson & Thomas, 2004). Trauma-focused cognitive-behavioural therapy (TF-CBT), an evidence-based treatment (Chadwick Center for Children and Families, 2004), places emphasis on the use of empathy and acceptance to reinstate the client's functioning and trust after prolonged exposure to trauma (Little, et al., 2011). Dialectical Behavior Therapy for borderline personality (Linehan, 1997), which is highly co-morbid with trauma, emphasizes the relationship between empathy and validation of client feelings and

perceptions. Empathy and validation help to counteract the effects of severe invalidation characteristic of abusive environments. In EDMR, somatic empathy is essential to all somatic interventions. This consists of the therapist attending to the bodily experience of the client, either through verbal descriptions or through the intuition of the therapist and experiencing the felt sense in his or her own body (Paulsen & Lanius, 2009).

Client-centered and experiential approaches to therapy have emphasized not only empathic attunement, but the importance of explicit empathic responding to client feelings and meanings. Empathic responding is thought to assist in the facilitation of a safe environment that provides the clients with the opportunity to use their own self-actualizing tendencies to heal. In experiential therapies, therapist empathy involves responding accurately to the implicit meanings within the expressions of the client, assisting the client to move forward in terms of meaning construction processes (Watson, Goldman, & Vanaerschot, 1998). According to Watson (2001) empathy serves interpersonal, cognitive, and affective functions in psychotherapy. Interpersonally, empathy helps the client feel understood and safe during the therapy session. This contributes to the cultivation and maintenance of the therapeutic alliance which in turn contributes to outcome. Cognitively, empathy helps the client deconstruct and challenge maladaptive views regarding the world, self, and others. This is accomplished through the therapist's reflections of the meanings expressed by the clients, which help the client to clarify and explore these thoughts, beliefs, and perceptions. Affectively, empathy helps the client to become aware of and learn to regulate emotions by helping the client label emotions and feel supported and understood when painful emotions are experienced.

Therapist empathic responding to client painful emotional experience can facilitate the development of self-soothing and self-affirming responses.

Greenberg & Paivio (1997) discuss the importance of therapist empathy from an emotion-focused perspective. First, empathy is essential in forming a strong therapeutic relationship. Through empathic responding and highlighting underlying troublesome feelings and cognitions, the focus of therapy is established. Therapist empathy contributes to the therapist and client collaboratively determining the goals of treatment and the ways with which to resolve the identified issues. Therapist empathic responding, also plays a very important role in helping the client to attend to their internal experience so that they can be further explored. These responses assist the client in moving from feelings that are present on the surface, to exploring the underlying feelings and meanings. Exploring consists of symbolizing the felt meanings that are related to client moment-by-moment experience, which he or she may not yet be completely aware of. According to Bohart and Greenberg (1997), the empathic responding of the therapist assists in deepening client experiencing. Higher levels of experiencing have been associated with therapeutic outcome across treatment approaches (Goldman, 1997; Robichaud, 2004; Castonguay et al., 1996). Greenberg & colleagues (e.g., 1997) also have developed a taxonomy of empathic responses and associated functions. These include affirmation of vulnerability, meaning exploration, and emotion regulation.

According to Paivio and Laurent (2001), empathy, though important in all types of treatment, is particularly important in therapy for child abuse due to the stress of re-experiencing trauma-related material. In general, the empathy of the therapist in EFTT serves to help correct for the lack of empathy of caregivers in childhood and also serves

to facilitate emotional experience in the re-experiencing of traumatic events (Paivio & Pascual-Leone, 2010). Paivio & Laurent specify several specific advantages over questions and directives in therapy for complex trauma. For example, empathic responses (1) help the therapist follow rather than direct the client's process which promotes a sense of control and safety; (2) assist in the collaboration between therapist and client by ensuring a correct understanding of the client's expressed struggles; (3) convey acceptance which helps to reduce the client's fear of negative evaluation and promote disclosure; (4) model compassion, emotional authenticity, and openness to experience, and (5) model emotional regulation when the therapist is affected by the client's emotional distress but does not become overwhelmed.

Paivio and Laurent (2001) also identify the main functions of empathic responding that assist the client in regulating emotions and re-processing trauma material. Emotion regulation is understood as involving three main capacities: (1) to access and label all emotions, (2) to modulate emotion, and (3) to appropriately express emotional experience (Gross, 1999). Therapist empathy assists in all these capacities. First, empathic responses increase client awareness and understanding of affective experiences by directing the client's attention to their emotional experience. Empathic responses also validate the client's feelings or thoughts as important and of interest to the therapist. This counters the client's learned view of his or her feelings, thoughts, and desires as worthless, bad, or insignificant. In addition, through empathic responding, therapists teach their clients to accurately label experiences, which helps facilitate understanding of these experiences. Empathic responses serve to direct the client's attention to the

centrality of what they have expressed and assist the client in symbolizing or verbally expressing their affective experiences and the meanings attached to them.

According to Paivio and Laurent (2001), the second function of therapist empathy is to modulate emotional intensity. The communication of understanding and support will serve to reduce the client's distress and feelings of isolation when painful feelings are expressed. Clients can better tolerate painful and difficult emotions when an attachment figure is demonstrating compassion and understanding. The client's ability to handle strong emotions will be increased through internalization of the therapist's empathic acceptance and responsiveness. Evocative empathic responses can also increase arousal of suppressed emotion. Evocative empathic phrases highlight and amplify the core aspects of what the client has said (e.g. "you must have been outraged"), which activates emotion structures or schemes and associated information. Evocative empathic responses also be used to indirectly challenge extreme views of the client, (e.g. "so you will die if you talk about what happened"). The third function of therapist empathy is to implicitly teach the client ways in which to communicate emotions. By learning how to communicate emotions that are beyond the scope of the experiences of most individuals, feelings of isolation will be decreased. The modeling of affective communication will assist in restoring the client's capacity for interpersonal connectedness, which will first occur with the therapist and then can later extend beyond the therapeutic setting.

According to Paivio and Pascual-Leone (2010), empathic responding plays a particularly critical role in the first phase of EFTT, beginning in session one when the main goal is create a secure and collaborative therapeutic relationship and facilitate

disclosure, sometimes for the first time, of painful traumatic experiences. In EFTT there is no distinction between the assessment and treatment phases of therapy so that client disclosure allows for assessment of core client processes (e.g., emotion awareness, regulation) that will be the focus on therapy. Empathy that communicates understanding of client feelings and needs helps with collaborative formulation of treatment goals. These goals emerge from client expressions of distress and desires for change (e.g., Cl: I don't want to continue blaming myself. Th: Yes, that's very painful and not right – we want to make sure that this changes, you put the blame where it belongs). Empathic responding reduces distress because it communicates understanding and compassion for the suffering of the client and validates their perceptions of the events. For many clients, this may be the first interpersonal interaction that is affirming and supportive. Empathy which conveys acceptance and safety, strengthens the attachment bond and collaboration on treatment goals and tasks, which will then assist in productive processes later in treatment.

This emphasis is consistent with research on the importance of high quality early processes. For example, Pos, Greenberg, Goldman, and Korman (2003) found that session one alliance predicted outcome in EFT for depression. Another study found that empathy of the therapist in the first session, based on therapist ratings, was associated with decreased distress throughout schema-focused cognitive therapy of personality problems for patients with panic disorder and/or agoraphobia (Hoffart, Versland, & Sexton, 2002).

Therapist empathic responding during early sessions also is critical to later client engagement with trauma material during the primary re-experiencing procedures used in

EFTT (engagement will be defined in the Methods section). The IC and EE interventions are typically introduced during session four of EFTT (Paivio & Pascual-Leone, 2010). According to Paivio & Pascual-Leone (2010), high quality engagement during this early session is important in that it sets the course for the exploration of trauma material for the rest of the therapeutic process. This first experience with the intervention should be productive and reinforcing in order to generate willingness in the client to participate in the procedure and emotional processing of trauma material during later sessions. Post-treatment questionnaires and interviews with EFTT clients (Holowaty & Paivio, 2012), revealed that the first IC was identified as one of the most helpful experiences in therapy in that it facilitated the realization of the extent to which the trauma had affected them. Research also has shown that the quality of engagement in EFTT from early to later sessions remains fairly consistent supporting the importance of engagement quality during the first re-experiencing procedure (Chagigiorgis, 2009; Paivio et al., 2001). Thus, therapist empathic responding during early sessions indirectly facilitates client change via client emotional engagement with trauma material during the primary re-experiencing procedures.

**Research on empathy and outcome.** Past research supports the relationship between therapist empathy and therapeutic outcome. A meta-analytic study examining 115 studies that assessed the association between empathy and therapeutic outcome across therapeutic orientations found a positive relationship between the two variables in 54% of the studies (Orlinsky, Grawe, & Parks, 1994). Wing (2010) found that in psychodynamically-oriented treatment, observed therapist empathy, using the Measure of Expressed Empathy (*MEE*; Watson., 1999), was associated with therapeutic outcome for a

sample of clients with various Axis I diagnoses, and this relationship was partially independent of the alliance. Steckley (2006) reported that client perceived therapist empathy contributed to a decrease in negative perceptions and behaviours towards the self in cognitive-behavioral treatment for depression. This finding suggests that viewing the therapist as compassionate and understanding was associated with positive changes in internal working models of the self and others. These changes increased interpersonal functioning due to a decrease in attachment anxiety, which provided clients with more of a sense of security in their relationships. It was found that in client-centered therapy, client processes are facilitated by responses of therapists that point to critical elements in what is expressed by the client, which deepens the exploration of meaning (Sachse, 1990). Therapeutic relationships that were client-centered and empathic were found to be effective in the reduction of depressive symptoms (Greenberg & Watson, 1998).

### **The Present Research**

Based on literature reviewed above, therapist empathic responding, particularly during the early phase of therapy, is critical to client change in EFTT. Disturbances related to the self, interpersonal relationships, and affect regulation stem from early experiences with the abusive or neglect attachment figures. These experiences were characterized by a lack of parental empathy. Empathy in therapy helps to counteract these early experiences and provide safety for exploring painful traumatic experiences. Emotional engagement with trauma material is recognized across therapeutic orientations as essential for “emotional processing” and recovery from traumatic experiences. This is thought to be facilitated by the compassion and warmth of the therapist communicated through empathic responding. In sum, empathic responding assists in the formation of a

strong therapeutic relationship, which in turn, also facilitates emotional engagement with trauma material. Empathic responses are particularly crucial in the first phase of treatment, because this sets the foundation for the interventions that will be used throughout the duration of treatment. Research has found that engagement during IC and EE contributed to client change and successful therapeutic outcome (Paivio et al., 2001; Chagigiorgis, 2010) but therapist operations that contribute to client engagement have not been examined. The present study is the first to test a model of client change whereby therapist empathy during the first therapy session predicts later client engagement with trauma material and thus outcome (see Figure 1).

**Hypotheses.** The proposed study will test the following hypotheses. (1) Higher levels of therapist empathy during the first therapy session will contribute to greater levels of client emotional engagement with trauma material over the course of therapy. (2) Higher levels of therapist empathy during the first session will contribute to greater reduction of trauma symptoms and higher resolution at post-treatment. (3) Client emotional engagement will contribute to reductions in trauma symptoms and greater resolution at post-treatment. (4) Client emotional engagement will mediate the relationship between therapist empathy and outcome.

## CHAPTER 2

### METHODS

The present study used archival data that was collected between 2002 and 2006 at the University of Windsor under the supervision of Dr. Paivio. The data included videotaped therapy sessions and clients' self-report measures, administered pre-treatment, post-treatment and after every therapy session starting in session 4. The following information regarding the participants and procedures was reported in the original study (Paivio et al., 2010).

#### **Participants**

**Recruitment.** As reported in Paivio et al., (2010) participants were recruited through newspaper advertisements, posters in clinics, and referrals. Participants were offered free psychotherapy for problems related to abuse in childhood in exchange for participating in research. Participants consented to taping of therapy sessions and completion of self-report questionnaires. The original study was approved by the Research Ethics Board of the University of Windsor.

**Exclusion criteria.** Individuals with problems related to extreme emotional dysregulation, or a risk of harming themselves or others were excluded due to the emotionally evocative nature of the treatment. Respondents to ads also were excluded if they were undergoing additional therapy at the time, were under the age of 18 years, or had recently changed type or dosage of psychotropic medication. Additional exclusion criteria were the presence of an incompatible diagnosis (e.g. psychosis), substance abuse with less than six months of abstinence, suicide intent or self-harm behaviours, abuse occurring in the present, or a score of less than 50 on the Global Assessment of

Functioning (American Psychiatric Association, 1994).

**Inclusion criteria.** Respondents were included in the study based on their capacity to form a therapeutic relationship, motivation to participate in the treatment process, and willingness to focus on past experiences of childhood abuse or neglect in therapy.

**Screening.** Graduate students in clinical psychology, supervised by S. Paivio, conducted screening procedures. Procedures to assess the inclusion and exclusion criteria first consisted of a structured, 30-minute telephone interview. Those who fit the initial criteria then participated in a 90-minute semi-structured interview assessing the appropriateness of therapy. Interviews focused on mental health, interpersonal, and abuse history; current functioning, symptoms and previously assigned diagnoses. Additionally, potential clients were given the PTSD Symptom Severity Interview (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993). The inclusion or exclusion of potential clients was based on clinical judgment. Following screening procedures, 56 participants were accepted into the treatment program, and 45 clients completed therapy and post- treatment questionnaires.

**Participant characteristics.** Participants who completed therapy in the original outcome study (Paivio et al., 2010) were 53.4% female and 46.6% male . Participants were individuals who were dealing with maltreatment in childhood (physical, sexual or emotional abuse, as well as emotional neglect). The mean age was 45.62 (SD=12.99). Most clients were of European descent and 48.9% were married.

Paivio et al. (2010) reported that most clients had experienced more than one type of abuse but were asked to identify a primary focus (abuse type and perpetrator) for

therapy. As the primary emphasis in therapy, over half of the clients focused on sexual abuse. Sexual abuse ranged from one episode to repeated events over the span of years, and multiple perpetrators. Emotional abuse involved threats of harm, verbal debasement, or being a witness to violent acts. Physical abuse ranged between harsh modes of physical punishment and violent acts that resulted in severe injuries and hospitalization. The most common perpetrators were father or father figures (44.5%) and mothers (31.1%). The remaining perpetrators included babysitters, relatives, and brothers. All clients identified unresolved issues with attachment figures as the main focus in therapy. Paivio et al. (2010) reported pre-treatment scores on the Childhood Trauma Questionnaire (CTQ) that were above thresholds for severe abuse (Bernstein & Fink, 1998). Additionally, 62.2% of the clients met criteria for PTSD assessed on the PSSI.

### **Therapy**

Treatment conditions in the Paivio et al. (2010) study adhered to the treatment model of EFTT, as previously outlined. Two versions of EFTT were employed in the study that differed in terms of the primary intervention used to resolve issues with abusive and neglectful others - imaginal confrontation (IC) and empathic exploration (EE). Both of these procedures were introduced during session 4. Both interventions varied in length and frequency based on individual client processes and needs.

**EFTT with IC.** Imaginal confrontation (IC) involves imagining the perpetrator of childhood abuse or neglect in an empty chair and expressing thoughts, feelings, and needs directly to the imagined other. The procedure is based on the empirically-verified model of resolution described earlier (Greenberg & Foerster, 1997). Therapist operations during the IC intervention (Paivio et al., 2010) consisted of promoting client

psychological contact with the imagined other (e.g. the use of I-you language, and looking at the imagined other), promoting the recollection of memories associated with the trauma, evoking emotional experience and expression, assisting the client in overcoming barriers to experiencing, differentiating feelings and related meanings, encouraging entitlement to unmet needs, and facilitating the exploration of perceptions of self and the abusive other.. Two chair enactments were also used in combination with IC to explore issues related to the self (e.g., self-criticism).

**EFTT with EE.** The evocative empathy (EE) procedure is identical to IC in regards to goals, process steps in the model of resolution (Greenberg & Foerster, 1998), and therapist operations specified above, except that abuse issues are addressed solely through interaction with the therapist (Paivio et al., 2010). Clients are encouraged to imagine perpetrators and traumatic events in their “mind’s eye”. Through empathic responding of the therapist, the client can explore feelings and meanings related to the abusive events, as well as perceptions of self and others.

### **Therapists**

The Paivio et al. (2010) study included 11 therapists (seven women and four men) ranging from the ages of 25-57 years. The therapists were one master’s level student and six doctoral level students in clinical psychology, as well as four postdoctoral clinical psychologists. All the therapists in the study had previous clinical experience with the population examined in the study and were trained in the treatment model. On average, training took place over a 26- week period, during which there were approximately 39 hours of training that varied depending on therapist experience and skill level. Training was conducted by S. Paivio and included review of the treatment manual and videotaped

therapy sessions with expert therapists, as well as role-play. Once therapies began, therapists participated in individual and group supervision that consisted of weekly meetings and review of their videotaped sessions. All cases were supervised and monitored for quality of service by S. Paivio , who was a registered psychologists with greater than 20 years of clinical experience..

### **Therapy Processes**

Paivio et al (2010) reported data on therapy process in both versions of EFTT. Treatments were comparable in terms of processes. The mean number of sessions for clients in the imaginal confrontation (IC) condition was 16.90 ( $SD= 1.65$ ), and 16.80 ( $SD=1.83$ ) in the evocative empathy (EE) condition. Both conditions had excellent adherence rates, moderate levels of therapist competence with the IC and EE procedures, high levels of client engagement with trauma material, and strong alliance quality. Treatments differed in terms of the number of sessions that contained IC ( $M=5.35$ ,  $SD= 1.63$ ) or EE ( $M=8.81$ ,  $SD= 2.64$ ).

### **Outcome Measures in the Present Study**

Eight outcome measures that assessed symptom distress (trauma, depression, anxiety), target complaints, self, and interpersonal difficulties were administered in the original Paivio et al. (2010) outcome study. Paivio et al. reported no difference between EFTT with IC and EFTT with EE in terms of outcome on any measure. The present study used the following two of these measures because these are thought to capture the primary foci of treatment – trauma symptom severity and the degree of resolution of issues with particular identified abusive/neglectful others.

**Impact of Event Scale (IES; Horowitz, 1986).** The IES measures symptoms of

intrusion and avoidance associated with a specific trauma (see Appendix A). The scale consists of 15 items rated on 4-point Likert scale that assess the frequency of symptoms present in the previous week (0=not at all, 3=often). Construct validity for the measure was found with a factor analysis (Weiss & Marmar, 1997) and subscale alphas were found to range from .79 to .92 (Corcoran & Fischer, 1994).

**Resolution Scale (RS; Singh, 1994).** The RS measures the degree of negative feelings, unmet needs, and feelings of worthlessness in association with a particular perpetrator of abuse identified on the questionnaire (see Appendix B). The scale consists of 11 items rated on 6-point Likert scale (0=Not at all, 5=very much). Singh found test-retest reliability of .81 with a clinical sample over the period of one month. It was also reported that the RS correlated highly with other outcome measures. Paivio et al. (2001) found alpha reliability to be .82 with an EFTT sample (n=51). In the original outcome study (Pavio et al., 2010), 92% of the clients completed two RS questionnaires for each individual that was focused on in therapy. These two individuals were often the perpetrator of abuse and an individual that they felt had failed to protect them. Means of the two questionnaire scores were averaged for analyses, which is indicative of the client's resolution of child abuse issues.

### **Process Measures in the Present Study**

The original Paivio et al. (2010) outcome study administered two post-session self-report measures to assess alliance quality and engagement with trauma material during the preceding session. The present study used only the engagement measure. Additionally, the present study will use an observer-rated measure to assess therapist empathy during session one.

**Client Post Session Questionnaire (PSQ; Paivio et al., 2010).** The PSQ was developed for the original Paivio et al. outcome study to assess the quality of client emotional engagement with trauma material during the IC and EE interventions (see Appendix C). The PSQ was completed by both therapists and clients following each session beginning in session 4 when in-depth trauma work began. The scale consists of four items that are rated on a 7-point Likert scale. One of the four items evaluates the degree to which issues related to childhood abuse were emphasized in the session (1=not at all, 7=all the time). The other three items assess the degree of psychological contact with the imagined individual, one's capacity to express affect, and any difficulties that occurred in the exploration of trauma material. For the IC condition, an additional item is included that assesses the degree of difficulty participating in the imaginary dialogue. Paivio et al. (2010) found that convergence on the PSQ between therapist and client ratings was  $r = .48$  in a sample of 45 EFTT clients, and Chagigiorgis (2009) reported a significant association between PSQ and observer ratings of engagement with 47 EFTT clients.

**Measure of Expressed Empathy (MEE; Watson, 1999).** The MEE is an observer-rated measure that provides ratings for five-minute segments of therapy sessions based on the empathy conveyed by the therapist towards the client, including both verbal and nonverbal behaviours, features of speech, and modes of responding (see Appendix D). The MEE consists of 10 items that are rated on a 9-point scale according to frequency of the behaviour (Never = 0, All the Time=8), with total scores ranging from 0 to 80. Interrater reliability for this scale was found to be  $r = .87$  ( $p < 0.01$ ; Steckley, 2006). Convergent validity ( $r = .66$ ) was established with a client-rated version of the

Barrett-Lennard Relationship Inventory- Empathy Scale (Barrett-Lennard, 1986; Watson & Prosser, 2002). Internal consistency for the items (Cronbach's alpha) was found to be .92 (Wing Jr., 2010).

### **Procedures**

**Original outcome study.** In the original Paivio et al. (2010) study, outcome questionnaires were administered pre-treatment, mid-treatment (following Session 8), post-treatment, and 6-months follow-up. The PSQ was administered after each therapy session (beginning in session 4). Completed self-report questionnaires were kept confidential from the client's therapist.

Therapists and clients were matched based on compatibility of scheduling. Following session 3 and before the introduction on IC/EE in session 4, clients were randomly assigned (coin toss) to one of two therapy conditions. Of the 45 clients, 20 completed EFTT with imaginal confrontation (IC) and 25 completed EFTT with empathic exploration (EE). Each therapist received an equal number of clients in each condition. Sessions were conducted and audiotape recorded at a clinic in the University of Windsor Psychology Department.

**Present study.** The present study utilized the MEE to rate the quality of therapist empathy during the first therapy session (videotapes) and analyze the associations between empathy and client reported emotional engagement and therapeutic outcome. Because treatments were found to be comparable in terms of processes and outcome (Paivio et al., 2010), treatment conditions were combined for analyses.

**Rater training.** Two graduate student raters (including the author) were trained on the MEE using an unpublished training manual (Watson, Prosser, Steckley, & Hiebert,

2003) and a series of published therapy videos that present various types of therapy conducted by well-known psychologists (Shostrom, 1965, 1977, 1986, & 1993). The manual provides segments of the videos to be rated, as well as expert ratings of each of these segments. Expert ratings were used to understand the constructs in each of the items and the appropriate ratings that should be provided under various observed conditions. Following this, the two graduate student raters rated segments individually and compared their ratings with those of the expert ratings in the manual. Discrepancies were discussed and resolved until both raters developed an understanding of the items that corresponds with the expert ratings. In addition to guidelines provided in the MEE manual, a list of rating rules were developed throughout training, to clarify the criteria required for each item (see Appendix E). Raters also consulted with an expert in empathy (S. Paivio). At the end of training the intraclass correlation coefficient between the raters and the expert ratings for entire sessions was equal to .815 ( $p=.02$ ) with a 95% confidence interval of .159 to .978.

***Selection of sessions and episodes for rating.*** Following training, the first videotaped therapy session for 45 clients who completed therapy was located. Eight clients were not included in the sample because the videotape of their first session was truncated and could not be effectively rated using the MEE. Most sessions were approximately 50 to 60 minutes in length. In these cases, the middle 30 minutes of the session was rated. When a session was 40 minutes or less in length, the middle 20 minutes were rated. Since this is considered the working phase of a session, it was thought that this sampling procedure yielded a representative sample of therapist behaviour. Five minute segments were rated, then the average of the MEE scores on

these segments was calculated.

**Rating procedure.** Raters were blind to therapeutic outcomes and scores on measures completed by the client. For each therapist utterance within a five-minute segment to be rated, it was decided whether or not the utterance was empathic, that is, whether the therapist intended to communicate understanding of what the client is expressing and the internal experience of the client (feelings, meanings, bodily experience, or perceptions). If it was decided that the utterance was empathic, the statement was rated for the quality of empathy according to the presence or absence of each of the 10 dimensions of the MEE scale (see Appendix F for examples of therapist utterances and dimension ratings). Each utterance was therefore recorded and was only rated on each dimension if it was an empathic response. To compute scores for each dimension in a 5-minute segment, the number of utterances present on a dimension was divided by the total number of utterances in the segment, and then converted to a 9-point scale. Scores on each of the 10 dimensions were then summed to create an MEE score for the five-minute segment. The average MEE score of all the segments for the session was calculated for each client and used in the statistical analyses.

Each rater rated two-thirds of the sessions and overlapped ratings for one third of the sessions in the sample. Since the MEE is an established measure with adequate psychometric properties, this strategy is considered adequate to establishing inter-rater reliability. Throughout the rating process, raters alternated between two overlapping and two non-overlapping sessions. Non-overlapping sessions were rated by only one rater. For overlapping video sessions, raters came together in order to maintain agreement. During the rating of these sessions, each utterance was rated independently by the two

raters. To control for rater drift, ratings for each utterance were discussed, discrepancies resolved, and consensual agreement on ratings to be used in the analyses was determined. Reliability was calculated on overlapping segments, using an intraclass correlation coefficient. The intraclass correlation coefficient for ratings of entire sessions, calculated on one-third of the sample (12 clients), was equal to .984 ( $p < .001$ ) with a 95% confidence interval of .946 to .995.

**Analyses.** Correlational and regression analyses were used to test hypotheses. The alpha was set at .05 for all analyses. For mediation analyses, using the Indirect test,  $p$  values were divided in half to create one-tailed tests of significance due to the testing of directional hypotheses, since the Indirect test analyzes data with a two-tailed test of significance.

## CHAPTER 3

### RESULTS

Results are reported for 11 therapists and 38 clients who completed treatment and had first sessions of sufficient length to be rated effectively on the MEE. Hypotheses were tested using correlational and regression analyses. The alpha was set at .05 for all analyses.

#### **Data Screening**

Prior to conducting data analyses, the data were examined for missing data. A missing data analysis revealed that all main variables in the analysis had less than 3 percent of their data missing. Little's MCAR test was not significant, indicating that data was missing at random. When less than 5% of data points are missing and data are missing at random, most methods of handling data are applicable and will provide comparable results (Tabachnick & Fidell, 2006). Expectation maximization (EM) was used to replace missing items because it is considered the best method of handling missing data when only a small amount is missing and the data are missing at random (Cohen et al. 2003).

The data were then examined to test whether the assumptions for the reported data analyses were met. Importantly, the assumption of independence of observations was violated due to most therapists providing therapy to more than one client, so that therapist characteristics, in addition to empathic responding skills, influenced the process and outcome of more than one therapist-client dyad. To address the non-independence of observations, therapists were treated as groups and the variance for each therapist was centred around the group mean. Group mean centering is considered the most appropriate strategy for handling this problem with small samples such as that in the present study (Tabachnik & Fidell, 2006). Group mean centring involves calculating the mean score for the group for each variable and

subtracting each individual score in a group from the mean (Field, 2009). Each group's mean therefore becomes zero (Cohen et al., 2003). This improves the violation of the assumption of independence of observations by subtracting out the means of each group and therefore removing differences between the groups at the mean level (Cohen et al., 2003). This type of centering was used on all variables (MEE, PSQ, IES and RS pre- treatment and post-treatment) in the analyses and with the 11 therapists as the groups. Centering the scores of the clients of each therapist around the therapist's mean assists in reducing between-therapist variance. The data was analyzed with both the centred and raw data and some differences in results were observed. However, only results using the more valid centered data will be reported. For ease of interpretation, raw scores will be reported for descriptive data only.

The assumption of adequate sample size was also examined. According to Stevens, (2007), there should be 15 cases for each predictor in the model. Since there are 38 cases and 3 predictor variables in the model (MEE, PSQ, and IES and RS pretreatment), sample size is not adequate according to Stevens' criteria and serves as a limitation in the present study. Next, the data was examined for both univariate and multivariate outliers. To test for univariate outliers, data were converted to z-scores. Z scores with absolute values greater than 3.29 are possible outliers for continuous variables (Tabachnick & Fidell, 2006). None of the z-scores for both the raw and centred data were higher than 3.29, therefore there were no outliers. The data were then examined for multivariate outliers using Mahalanobis distance. To test for multivariate outliers, Mahalanobis distance is examined at  $p < .001$  using a  $\chi^2$  square critical value with the number of variables in the analysis as the degrees of freedom (Tabachnick & Fidell, 2006). No Mahalanobis distance statistics were above the critical value for this model,  $\chi^2 (4) = 18.467$ , and thus none of the cases were multivariate outliers.

Next, the data were examined for the assumption of normally distributed errors. This was assessed using the Shapiro-Wilk test and by examining skewness and kurtosis of each variable included in the analyses. First, process variables (MEE and PSQ) were assessed for both raw and centred data. Results of the Shapiro-Wilk test indicated that none of the process variables were significantly different than the normal distribution ( $p > .05$ ). In addition to this, all skewness and kurtosis values were in the normal range. Next, outcome variables (IES and RS post-treatment) were examined for normality. For the raw data, the Shapiro-Wilk test indicated that RS post-treatment was not significantly different than the normal distribution ( $p > .05$ ), however, IES post-treatment was not normally distributed ( $p = .002$ ). For the centred data, the Shapiro Wilk test indicated that IES post-treatment was normally distributed ( $p > .05$ ), however, RS post-treatment was significantly different than the normal distribution ( $p = .032$ ). Nonetheless, all skewness and kurtosis values for outcome variables were in the normal range, which is considered sufficient to establish normality for the present data due to small sample size.

The data were then examined for the independence of residuals using the Durbin-Watson statistic. For both raw and centered data, all Durbin-Watson values were within the acceptable ranges specified by Field (2009).

The data were then tested for the assumption of homoscedasticity, which indicates that the variance of residuals are equal at each level of predictors in the model. First, the Breusch-Pagan test for heteroscedasticity was performed and was found to be significant, indicating that there is homoscedasticity. This occurred for both raw and centered data. The Koenker test for heteroscedasticity, which is more appropriate for small sample sizes, also was significant for both raw and centered data, confirming homoscedasticity. Next, the data was

tested to determine whether there is multicollinearity, which occurs when predictor variables are highly correlated. This was done using VIF and tolerance statistics (Field, 2009). All values were in the appropriate ranges.

### **Demographic Characteristics**

Client demographic characteristics for 38 clients in the sample are presented in Table 1. Clients' ages ranged from 21-71 years and over half were female. Most clients were of European origin and had at least one child. The majority of clients were employed and had completed a high school education. Most clients met criteria for PTSD and had previous therapy experience.

Table 1.

*Client Demographic Characteristics*

Variable	M	SD
Age	46.11	12.46
Children	2.03	1.94
	n	%
Sex		
Male	16	42.1
Female	22	57.9
Ethnic Origin		
European	34	89.5
Aboriginal	1	2.6
Other	3	7.9
Marital Status		
Single	7	18.4
Common law	3	7.9
Married	17	44.7
Separated/divorced	11	28.9
Children (>=1)	18	73.7
Employment Status		
Full-time	19	50
Part-time	9	23.7
Unemployed	10	26.3

Table 1 continued.

*Client Demographic Characteristics*

Variable	M	SD
Annual Household Income		
<\$20,000	4	10.5
\$20,000-\$39,000	12	31.6
\$40,000-\$59,000	8	21.1
>60,000	14	36.8
Level of Education Completed		
High school	9	23.7
Undergraduate	23	60.5
Postgraduate	6	15.8
Previous Therapy	33	86.8
PTSD Diagnosis	23	60.5
Medication (Yes)	10	26.3

Note: N=38

## **Types of Abuse**

Client abuse characteristics are presented in Table 2. Although most clients reported experiencing multiple forms of abuse, one type of abuse was identified by each client as the primary focus of therapy (Paivio et al., 2010). As is presented in Table 2, over half of the clients primarily focused on sexual abuse. Clients also identified primary perpetrators of abuse who were the focus of therapy. As indicated in Table 2, fathers and mothers (attachment figures) were the main perpetrators. Subscale scores on the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which measures the extent (severity x frequency) of different types of abuse, were above thresholds for severe abuse.

Table 2.

*Abuse Characteristics*

Variable	<i>N</i>	%
<b>Abuse Type</b>		
Sexual	20	52.6
Emotional	8	21.1
Physical	5	13.2
Neglect	5	13.2
<b>Primary Abuser</b>		
Father	18	47.4
Mother	11	28.9
Other	5	13.2
Relative	4	10.5
Measure	<i>M</i>	<i>SD</i>
<b>CTQ</b>		
Total	76.90	17.90
Emotional Abuse	18.95	4.48
Physical Abuse	13.22	5.18
Sexual Abuse	13.27	7.80
Emotional Neglect	19.46	3.51
Physical Neglect	11.64	4.12

Note: *N*=38; CTQ= Childhood Trauma Questionnaire

### **Process and Outcome**

Table 3 presents the means and standard deviations for the process and outcome data on the measures included in the main analyses. Table 3 indicates considerable variability in observer-rated therapist empathy (MEE), no substantial difference between client-reported early and average emotional engagement with trauma material over the course of therapy, and large client reports of pre-post reductions in trauma symptoms (IES) and distress from abuse issues (RS).

Table 3.

*Means and Standard Deviations of Process and Outcome Variables (Raw Scores)*

Measure	<i>M</i>	<i>SD</i>
Process		
MEE	50.03	9.06
PSQ Session Four	33.14	8.56
PSQ Average	32.41	7.07
Outcome		
IES Pre-treatment	25.55	7.79
IES Post-treatment	9.64	8.04
RS Pre-treatment	39.55	6.89
RS Post-treatment	25.40	9.06

Note: MEE=Measure of Expressed Empathy; PSQ= Client Post Session Questionnaire;  
 IES= Impact of Event Scale; RS= Resolution Scale

### Relationships Among Variables

Table 4 presents the inter-correlations among process and outcome variables (centered data) in the main analyses. Contrary to expectations, no significant association was found between therapist expressed empathy (MEE) and client emotional engagement (PSQ) in session 4 or averaged across sessions. However, client emotional engagement (PSQ) at session 4 was associated with emotional engagement averaged across sessions, suggesting that client engagement at session 4 is representative of their engagement throughout treatment. There was no significant association between the MEE and IES at pretreatment, suggesting that therapist empathy during the first session was not influenced by the severity of client trauma symptoms. However, as expected, there was a negative association between therapist expressed empathy (MEE) and reduced client trauma symptoms (IES) at post-treatment (controlling for IES at pre-treatment). Also as expected, client emotional engagement with trauma material (PSQ) at session 4 and averaged across sessions were negatively associated with reduced trauma symptoms (IES) post-treatment (controlling for IES pretreatment) and with resolution of abuse issues (RS) post-treatment (controlling for RS pretreatment).

Table 4.

*Intercorrelations Among Process and Outcome Variables with Centred Data*

Measure	Correlation						
	1	2	3	4	5	6	7
<b>Process Measures</b>							
1. MEE	-	.29	.09	.05	-.44**	.09	-.31
2. PSQ Four	.29	-	.43**	-.08	-.46**	.02	-.64***
3. PSQ Average	.087	.43**	-	.30	-.30	-.28	-.48**
<b>Outcome Measures</b>							
4. IES (Pre)	.05	-.08	.30	-	.30	.210	-.095
5. IES (Post)	-.44**	-.46**	-.30	.30	-	-.161	.501**
6. RS (Pre)	.09	.02	-.28	.21	-.16	-	.37*
7. RS (Post)	-.31	-.64***	-.48**	-.10	.50**	.37*	-

Note: MEE=Measure of Expressed Empathy; PSQ= Client Post Session Questionnaire; IES= Impact of Event Scale; RS= Resolution Scale; Pre= Pre-treatment; Post= Post-treatment

\* $p < .05$  \*\* $p < .01$  \*\*\* $p < .001$

## Hypothesis Testing

To test hypotheses, analyses of the mediation were performed using the Indirect test, which estimates path coefficients in mediator models for indirect effects of predictors on outcome variables via a mediator, and allows for the inclusion of a covariate (Preacher & Hayes, 2008). The Indirect test was chosen over the Baron and Kenny steps (Baron & Kenny, 1986), which have been commonly used to establish mediation, due to several shortcomings that have been found to be present in the Baron and Kenny model of mediation (Preacher & Hayes, 2004). The Indirect test also allows for a covariate to be included in the analysis (pre-treatment scores), which was required in the present model to assess client change.

The Indirect test assesses the null hypothesis that the indirect effect of X on Y is equal to zero, by testing the magnitude of the effect. The indirect effect is equal to the product of the  $a$  path and the  $b$  path, as is presented in Figure 2. The  $c$  path is the total effect of X on Y and the  $c'$  path is the direct effect of X on Y, controlling for M. Thus  $ab$  is usually equal to  $(c - c')$ . The Indirect test therefore assesses mediation by comparing the total effect ( $c$ ) to the indirect effect ( $c'$ ) and testing the null hypothesis that this difference is equal to zero (Preacher & Hayes, 2004).

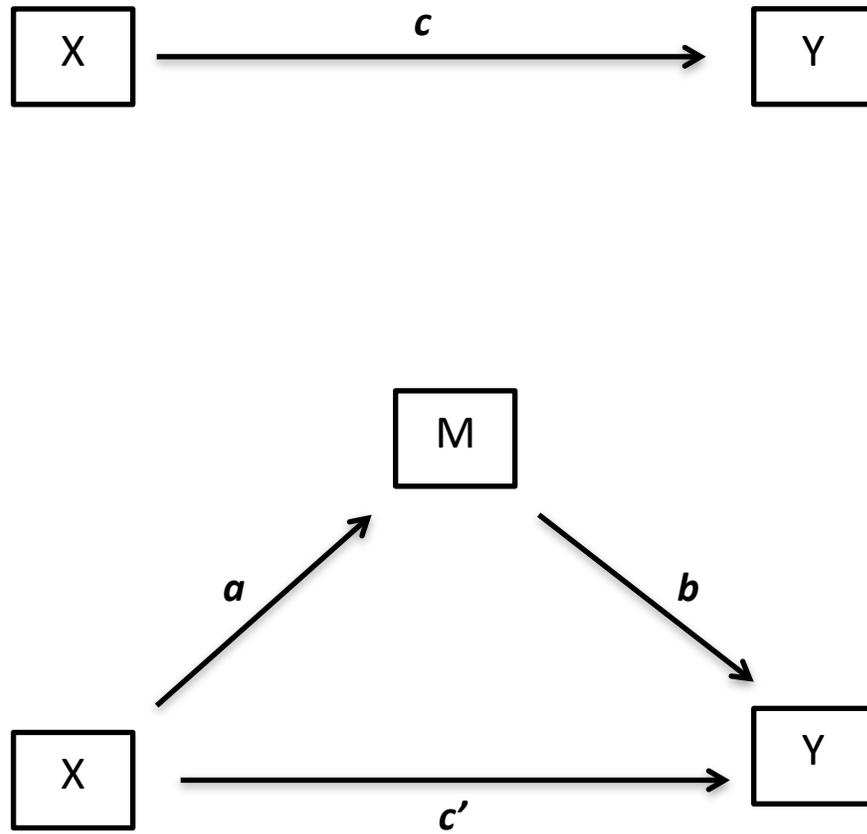


Figure 2. Mediation model as measured by the Indirect test

Two separate analyses were conducted for each of the two outcome variables (IES and RS). Since PSQ scores for session four were correlated with the average PSQ scores across therapy, session four scores were considered representative of emotional engagement throughout the therapy process. Therefore, mediation analyses were conducted using PSQ- 4 scores. Pretreatment outcome scores were entered as covariates. Since the Indirect test analyzes data with a two-tailed test of significance,  $p$  values were divided in half to create one-tailed tests of significance due to the testing of directional hypotheses.

The following summarizes results of analyses with IES and RS as outcome variables. Results of the Indirect test of mediation (Preacher & Hayes, 2008) are presented in Table 5.

**Analysis 1 (with IES as outcome variable).**

*Path a.* The association of MEE with PSQ is equal to .297 ( $p=.04$ ) with a 95% confidence interval of -.038 to .632 a small effect size ( $r= .291$ ).

*Path b.* The association of PSQ to IES post-treatment, controlling for IES pre-treatment is equal to -.288 ( $p=.009$ ) with a 95% confidence interval of -.525 to -.052 and a medium effect size ( $r=-.374$ ).

*Path c.* The total effect of the MEE on IES post-treatment is equal to -.348 ( $p=.004$ ) with a 95% confidence interval of -.595 to -.101 and a medium effect size ( $r=-.435$ ).

*Path c'.* The direct effect of MEE on IES post-treatment, controlling for RS pre-treatment, is equal to -.262 ( $p=.017$ ) with a 95% confidence interval of -.504 to -.021 and a medium effect size ( $r=-.354$ ).

*Partial effect of control variable on outcome variable.* The association of IES pre-treatment and IES post-treatment is  $-.253$  ( $s.e. = .121$ ,  $\beta = .285$ ,  $t = -2.093$ ,  $p = .044$ ) with a 95% confidence interval of  $.007$  to  $.498$  and a medium effect size ( $r = .338$ ).

*Mediation.* Together MEE and PSQ Session 4 account for a significant amount of variance in IES post-treatment ( $p = .001$ ). Bootstrap results, using 5000 iterations, show that the indirect effect of the therapist empathy (MEE) on client trauma symptom reduction (IES) post-treatment through client engagement with trauma material (PSQ) is not significant (confidence interval contained zero) and therefore results did not support that PSQ mediates the relationship between MEE and IES post-treatment.

In sum, results provide support for hypotheses 1 (higher levels of therapist empathy during the first therapy session will contribute to greater levels of client emotional engagement with trauma material over the course of therapy), 2 (higher levels of therapist empathy during the first session will contribute to greater reduction of trauma symptoms at post-treatment), and 3 (client emotional engagement will contribute to reductions in trauma symptoms at post-treatment), but do not support hypothesis 4 (client emotional engagement will mediate the relationship between therapist empathy and outcome).

#### **Analysis 2 (with RS as outcome variable).**

*Path a.* The association of the MEE with PSQ is equal to  $.293$  ( $p = .044$ ) with a 95% confidence interval of  $-.045$  to  $.631$  and a small effect size ( $r = .285$ ).

*Path b.* The path from PSQ to RS post-treatment, controlling for RS pre-treatment, is equal to  $-.528$  ( $p = .0001$ ) with a 95% confidence interval of  $-.767$  to  $-.287$  and a large effect size ( $r = -.643$ ).

*Path c.* The total effect of the MEE on RS is equal to .281 ( $p = .03$ ) with a 95% confidence interval of -.574 to .012 and a medium effect size ( $r = .313$ ).

*Path c'.* The direct effect of MEE on RS post-treatment controlling for RS pre-treatment is not significant with a small effect size ( $r = -.177$ ).

*Partial effect of control variable on outcome variable.* The association of RS pre-treatment and RS post-treatment is .495 ( $s.e. = .153$ ,  $\beta = .391$ ,  $t = 3.247$ ,  $p = .003$ ) with a 95% confidence interval of .185 to .805 and a medium effect size ( $r = .487$ ).

*Mediation.* Together the MEE and PSQ Session 4 account for a significant amount of variance in RS post-treatment ( $p = .000$ ). Bootstrap results, using 5000 iterations, show that the indirect effect of the therapist empathy (MEE) on increased resolution (RS) post-treatment through client engagement with trauma material (PSQ) is equal to -.159 with a 95% confidence interval of .339 to -.002, and therefore support was found for PSQ mediating the relationship between MEE and RS post-treatment. Although the mediation was significant, the relationship between therapist empathy and emotional engagement was weak.

In sum, results of this analysis provide support for hypotheses 1 (higher levels of therapist empathy during the first therapy session will contribute to greater levels of client emotional engagement with trauma material over the course of therapy), 2 (higher levels of therapist empathy during the first session will contribute to higher resolution at post-treatment), 3 (client emotional engagement will contribute to greater resolution at post-treatment), and 4 (client emotional engagement will mediate the relationship between therapist empathy and outcome).

Table 5.

*Indirect Test with Centred Data*

Path	Estimate	s.e.	$\beta$	<i>t</i>	<i>R</i>	$\Delta R^2$	<i>F</i> (3, 34)
Analysis 1 (IES as outcome variable)					.37	.32	6.79**
<i>A</i>	.30*	.17	.29	1.80			
<i>B</i>	-.29**	.12	-.35	-2.50			
<i>C</i>	-.35**	.12	-.42	-2.86			
<i>c'</i>	-.26*	.12	-.31	-2.21			
Analysis 2 (RS as outcome variable)					.51	.47	11.77***
<i>A</i>	.29*	.17	.29	1.76			
<i>B</i>	-.53***	.12	-.56	-4.47			
<i>C</i>	-.28*	.14	-.29	-1.95			
<i>c'</i>	-1.3	.12	-.13	-1.05			

Note: N= 38; Estimate= unstandardized regression coefficient,  $\beta$ =standardized regression coefficient

\* $p < .05$  \*\* $p < .01$  \*\*\* $p < .001$

### **Exploratory Analyses**

Pearson correlations were conducted on additional variables to determine whether therapist expressed empathy differed according to variables that could influence the process and outcome of therapy. Correlations were conducted between MEE and treatment condition (IC and EE), therapist experience, gender, and type of abuse. None of these correlations were significant, suggesting that therapist expressed empathy did not differ as a function of any of these variables.

CHAPTER 4

DISCUSSION

**Summary of Findings**

The present study examined the contribution of therapist expressed empathy during the first therapy session to client emotional engagement with trauma material in session 4 and outcome in emotion-focused therapy for complex trauma. The sample consisted of men and women who had experienced childhood sexual, physical, and/or emotional abuse. Primary constructs were defined as follows. Therapist expressed empathy was defined as a complex intervention that goes beyond attunement (Paivio & Pascual-Leone, 2010) and was measured on an observer- rating scale (MEE). Emotional engagement was defined as the client's maintenance of psychological contact with the imagined others during primary re-experiencing procedures used in therapy (imaginal confrontation, empathic exploration), involvement in the exploration process, and emotional expressiveness. Engagement was assessed on a client self-report questionnaire (PSQ) administered following session four. Outcome in the present study was defined in terms of two dimensions -- a reduction in trauma symptoms (intrusion and avoidance) measured on the IES, and resolution of issues with particular perpetrators of abuse and neglect, measured on the RS. Resolution is defined as the degree of distress from unmet needs, negative feelings such as anger and sadness, and feelings of worthlessness that are related to particular perpetrators of abuse and neglect.

Regression analyses were used to examine a mediational model of change, such that therapist empathy contributes to client emotional engagement with trauma material,

which then contributes to a decrease in trauma symptoms (IES) and increased resolution of issues with particular perpetrators (RS).

Results showed that higher levels of therapist empathy (MEE) during the first therapy session contributed to greater levels of client emotional engagement with trauma material (PSQ) during session 4, though the relationship between these two variables was weaker than originally predicted. Findings showed that therapist empathy contributed to a reduction in trauma symptoms (IES) at post-treatment, both together with the contribution of client emotional engagement (PSQ) and independent of emotional engagement. Therapist empathy (MEE) contributed to higher resolution of abuse issues (RS) together with the contribution of client emotional engagement (PSQ). Empathy did not significantly contribute to abuse resolution independent of engagement. It was also found that client emotional engagement with trauma material (PSQ) contributed to reductions in trauma symptoms (IES) and greater abuse resolution (RS) at post-treatment. Client emotional engagement (PSQ) mediated the relationship between therapist empathy (MEE) during session one and resolution (RS) at post-treatment, although the relationship between empathy and engagement was weak. Contrary to expectations, emotional engagement did not mediate the relationship between therapist empathy and trauma symptoms (IES) at post-treatment. Therapist empathy did not differ as a function of gender, type of abuse experienced by the client, therapist experience, or treatment condition.

### **General Discussion**

**Variability of empathy in the data.** Although therapists were supposed to be very empathic, as is consistent in the treatment model, empathy likely varied according to

therapist skill and other factors such as their theoretical orientation and specific training in empathy (e.g., CBT versus client-centered/humanistic). Variability in therapist empathy also likely was partly a function of the client, such as personality pathology and initial resistance to treatment, as well as the issue at hand during the session (e.g., crisis).

**Validity of results using centered data.** Results using centred data are more valid than those using raw data because centering helps to correct for lack of independent observations across therapists who provided therapy to more than one client. Due to therapists seeing more than one client, a grouping effect is created. Centering the scores of the clients of each therapist around the therapist's mean assists in reducing between-therapist variance.

**Empathy and client change.** Results support EFTT theory on the importance of empathy (MEE) in treatment and its role in client processes and change. Specifically, findings support empathic responding as an active intervention that goes beyond empathic attunement and helps client articulate and make sense of trauma experiences (Paivio & Pascual-Leone, 2010). This is particularly important with traumatized clients who have difficulty in labeling and communicating emotions (alexithymia). Therapist empathic responding helps clients label their feelings, symbolize the meaning of feelings, and regulate affect (soothe distress and evoke avoided emotion), which facilitates interpersonal communication by first connecting with the therapist, then with others outside of therapy (Paivio & Pascual-Leone, 2010). Results support the direct contribution of empathic responding to reduced trauma symptoms (avoidance and intrusion on the IES) and suggests that empathic responding may be comparable to explicit emotion regulation skills training and exposure procedures. This suggests that

empathy in EFTT is thus not just a contextual factor, but also a sophisticated multidimensional intervention.

Findings support the theory and literature on the critical role of emotional engagement and emotional processing in the reduction of trauma symptoms and resolution of issues with perpetrators of abuse (RS). Emotional engagement is important to outcome because re-experiencing feelings and memories facilitates exploration and the development of new adaptive meanings (Paivio & Pascual- Leone, 2010). Thus present findings are consistent with expert agreement across therapeutic modalities that re-experiencing and emotional processing of trauma material contributes to trauma recovery (Jaycox, Foa, & Morral, 1998; Foa Hembree, & Rothbaum, 2007; Rachman, 2001).

The relationship between empathy and client engagement was weaker than was hypothesized in the present study. Possible explanations for this may relate to the measurement of empathy, the small sample size used in the study, or the method of centring used in statistical analyses.

**Therapist empathy in the first session.** Findings support EFTT theory on the importance of empathy in the first session (Paivio & Pascual- Leone, 2010). The therapeutic model maintains that it is critical to build a secure relationship early in treatment so that disclosure of very painful trauma experiences can be facilitated. Additionally, acceptance and safety promotes collaboration on treatment goals and tasks, which will facilitate therapeutic processes later in treatment. The present study demonstrates a long-term effect of empathy in the very first session of EFTT that impacts the remainder of the treatment process over time. Present findings are consistent with previous research, using different populations and other therapeutic modalities, which

found that high quality early processes (therapist empathy and cultivation of the alliance) are associated with outcome (Hoffart, Versland, & Sexton, 2002; Pos et al., 2003; Sexton, Littauer, Sexton, & Tommeras, 2005).

**Observed versus perceived empathy.** Findings are consistent with those from a meta-analytic study by Orlinsky et al. (1994) that investigated 115 studies, all examining various therapeutic modalities. A positive relationship was found between therapist empathy and outcome in 54% of the examined studies. When this was measured from the client's perspective, 72% showed a positive relationship. Lafferty, Beutler, Cargo (1991) found that the best predictor of therapist affectiveness was clients' perceptions of empathy. Burns and Nolen-Hoeksma (1992) similarly found that client perceived therapist empathy in cognitive therapy was associated with outcome. Lorr (1965) also found that client's perceptions of their therapists as understanding was the most highly correlated variable with improvement. The present study extends this research by demonstrating that observed empathy is also an important predictor of outcome, and not only client perceptions. This again supports empathic responding as an active intervention that goes beyond contextual factors.

Present findings are consistent with a study by Wing (2010), that assessed expressed therapist empathy, using the MEE, in psychodynamically-oriented treatments for individuals who have been diagnosed with various Axis I disorders. Wing found that therapist empathy contributed to a reduction in client distress and symptom severity, partially independent of the therapeutic alliance. Present findings extend this research by demonstrating expressed empathy as a mechanism for change in EFT specifically for trauma.

**Mediational effects and differential effects on outcome.** The present study found that client emotional engagement (PSQ) mediated the relationship between therapist empathy (MEE) during session one and resolution (RS) at post-treatment. It is important to note, however, that the relationship between empathy and engagement was weak. Engagement did not mediate the relationship between therapist empathy and trauma symptoms (IES) at post-treatment. These results suggests that resolution of issues with specific perpetrators requires not only empathy but interventions that facilitate emotional engagement that were designed to address those issues (IC and EE). Thus this finding is consistent with the treatment model. High quality engagement during the initial re-experiencing procedures is critical and sets the foundation for engagement for the remaining course of therapy. This is consistent with previous research, which found that the first IC was identified by clients as one of the most helpful experiences in therapy (Holowaty & Paivio, 2012). Previous research has also found that the quality of engagement was consistent from early to later sessions (Chagigiorgis, 2009; Paivio et al., 2001), which supports the importance of high quality early processes. Present findings therefore support the indirect contribution of therapist empathy to resolution of issues with perpetrators via client emotional engagement with trauma material during the first re-experiencing intervention.

### **Strengths of the Present Study**

A main strength of the present study is its demonstration of empathic responding in trauma processing and resolution. Furthermore, the present study supports the importance of empathy in the very first session, and its long-term effects in therapy, as is consistent with the theory of the treatment model. Results are consistent with the

importance of empathy in therapy in general, and extended to emotion-focused therapy for complex trauma. Additionally, the present findings support empathic responding as a multidimensional construct and sophisticated intervention that goes beyond attunement. Another strength of the present study is the size of effects detected given the small sample and reduced variance due to centering.

### **Limitations of the Present Study**

Several factors limit the conclusions that can be drawn from this study. The small sample size of 38 clients serves as a limitation to the conclusions that could be drawn from this study, which increases chances of Type II error and decreases statistical power. An additional limitation in the present study is the issue of dependence of observations. Each therapist provided therapy to more than one client, causing cases to lack independence from one another. Statistical procedures of centering were conducted to remove the variance between therapist groups, yet dependence of observations still remains as a limitation in the study. Centering may not necessarily capture the variability in quality of empathy given that two therapists can have the same scores but very different quality of empathy due to method of centering by therapists as the group. An additional limitation involves a possible sampling bias due to the exclusion of 7 clients out of the total 45 clients that completed treatment and post-session questionnaires. It is unknown whether the inclusion of these clients would have had a significant impact on the results of statistical analyses. The present study also used a specific population of clients who have experienced childhood trauma, which limits generalization of findings to other populations.

Another limitation of the present study is related to rating therapy videos using the MEE measure. Expert rating provided in the MEE manual were used to learn the constructs of the 10 different dimensions. There was difficulty during training, however, in achieving precise concordance with the expert ratings because there was no opportunity for discussion with expert raters and very limited guidance in the manual. Nonetheless, consultation with an expert in empathy (S. Paivio) was utilized and an intraclass correlation coefficient equal to .815 was achieved with the expert ratings. In addition, the intraclass correlation coefficient between the two raters on overlapping sessions was equal to .984.

### **Implications of Findings**

Findings have important implications for therapist training and practice in the treatment of complex trauma. The present findings suggest that training for novice therapists in EFTT, or any therapy with this population, should potentially emphasize empathic responding as a tool for facilitating client change. Further research is required to further explore the relationship between therapist empathy and client engagement. Present findings also have implications for other therapeutic approaches that address emotional dysregulation and utilize exposure. Training should include empathy as an intervention, not just a contextual factor, with emphasis placed on effective empathic responding in addition to attunement.

### **Future Directions**

Future research should replicate the present study with another sample of clients that experienced a different degree of trauma. Future research should also replicate the study

with a larger sample, in order to increase power. The present study should also be replicated with assessing empathy independent of the therapeutic alliance. Future research should test effects of therapist empathy on client disclosure and outcome. Future research should also assess the ways in which client factors affect therapist empathy (e.g. personality pathology) and whether this has an effect on outcome. Similarly, future research should assess the ways in which therapist factors contribute to empathy and outcome. Finally, future research should compare expressed empathy and client perceived empathy, as well as determine whether the way in which empathy is measured has an effect on results in regards to outcome.

## **Conclusions**

Results of the present study suggest that therapist empathic responding in EFTT plays a role in therapeutic outcome. Therapist empathy has an impact over time, from the very first session to the end of therapy. The data support empathy as an active change agent and main intervention in reducing avoidance and arousal symptoms. The present findings also support the indirect effect of empathy on resolution with perpetrators via emotional engagement, though more research is required to explore this model. Therapist training for EFTT, and treatment for this population in general, should emphasize therapist empathy in the very first session, which can increase the effectiveness of treatment.

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## APPENDICES

## Appendix A

## Impact Of Events Scale (IES)

The “event” refers to the early experiences of childhood trauma/abuse for which you sought therapy. Below is a list of comments made by people after stressful life events. Please read the list below, and for each item, circle the number indicating how frequently these comments were true for you during the *past seven days*. If they did not occur during that time, please mark the “not at all” column.

0= Not at all

1= Rarely experienced

2= Sometimes experienced

3= Often experienced

1.	I thought about it when I didn't mean to.....	0	1	2	3
2.	I avoided letting myself get upset when I thought about it or was reminded of it.....	0	1	2	3
3.	I tried to remove it from my memory.....	0	1	2	3
4.	I have trouble falling asleep or staying asleep.....	0	1	2	3
5.	I have waves of strong feelings about it.....	0	1	2	3
6.	I had dreams about it.....	0	1	2	3
7.	I stayed away from reminders of it.....	0	1	2	3
8.	I felt as if it hadn't happened or it wasn't real.....	0	1	2	3
9.	I tried not to talk about it.....	0	1	2	3
10.	Pictures about it popped into my mind.....	0	1	2	3
11.	Other things kept making me think about it.....	0	1	2	3
12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.....	0	1	2	3
13.	I tried not to think about it.....	0	1	2	3
14.	Any reminder brought back feelings about it.....	0	1	2	3
15.	My feelings about it were kind of numb.....	0	1	2	3

## Appendix B

## Resolution Scale (RS)

*Instructions:* The following questions ask you how you feel now in terms of your unfinished business with the significant other person whom you specified at the beginning of therapy. Please circle the number on the scale that best represents how you currently feel.

1. I feel troubled by my persisting unresolved feelings (such as anger, grief, sadness, hurt, resentment) in relation to this person.

1	2	3	4	5
Not at all				Very much

2. I feel frustrated about not having my needs met by this person.

1	2	3	4	5
Not at all				Very much

3. I feel worthwhile in relation to this person.

1	2	3	4	5
Not at all				Very much

4. I see this person negatively.

1	2	3	4	5
Not at all				Very much

5. I feel comfortable about my feeling in relation to this person.

1	2	3	4	5
Not at all				Very much

6. This person's negative view or treatment of me has made me feel badly about myself.

1	2	3	4	5
Not at all				Very much

7. I feel okay about not having received what I needed from this person.

1	2	3	4	5
Not at all				Very much







Appendix D

Measure Of Expressed Empathy (MEE)

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?**

(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.

0 .....2.....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

Appendix E

Measure Of Expressed Empathy (MEE) Rating Rules

**General Rules**

- Every therapist utterance will be examined separately in each five-minute segment. For every utterance, it will be recorded whether the dimension of empathy was present or not.
- An utterance is defined as any statement with two or more words.
- For every utterance, it will be decided whether it meets the definition of empathy.
  - Communicate understanding of what the client is expressing
  - Focus on the internal experience of the client (feelings, meanings, bodily experience, or perceptions)
- Identity the type of empathic response (e.g. following or tracking, affirming or validating, elaboration or exploring meaning, regulating (intensify or sooth), directing client attention).
- If the utterance is not empathic it will not be rated but it will be noted that there was an utterance and it will be included in the total number of therapist utterances.
- At the end of each five-minute segment, for each dimension, the total number of utterances in which this dimension is present will be summed. The total number of utterances (including the non-empathic ones) will be summed. The total number of utterances for each dimension divided by the total number of utterances will be converted to the 9-point scale.

- Any nodding, one word responses, or expressions of understanding (e.g. “mhmm”) will be included in the rating of the next utterance.

**Item 1**

- Concern cannot only be expressed in terms of content but also in tone of voice (soft, calm voice)

**Item 2**

- Tone varies (cannot be monotone)

**Item 3**

- Therapist cannot be significantly louder or more energetic than client.
- Therapists expressions fit well with the displayed affect of the client
- Vocal tone should convey that the therapist’s affect meets the same level of the client’s

**Item 4**

- Therapist has to be making an effort to express warmth to client and is open to what client is saying, therefore presenting a sense of caring
- Two of the following criteria must be present:
  - Eye contact
  - Engagement
  - Softness in facial expressions
  - Softness in tone of voice

**Item 5**

- Therapist has to display understanding of what the client is saying by reflecting it back to them
- Therapist's utterance has to go somewhat beyond what the client has expressed, or put it in a new perspective, and cannot merely be a repeat of what the client has just said.

**Item 6**

- The focus of this item is facial expressions regardless of content of speech or tone of voice.
- Facial expression could not be blank or listless, and must show concerned interest.

**Item 7**

- Therapist responds to what the client is saying rather than guiding the conversation his/herself
- Going in client's direction, at the client's pace, and not attempting to move therapy forward at a faster speed than the client appears to be ready to move.
- Therapist validates what is said by the client and does not disagree with the client's feelings, beliefs, or perspectives.

**Item 8**

- Therapist has to convey an understanding of the client's emotion
- Has to display understanding by putting the client's expressed emotion into alternative words.

**Item 9**

- Understanding of thoughts, perceptions
- Has to display understanding by putting the client's perspective into other words.

**Item 10**

- No statements of disapproval or rejection
- Open to what the client has to say
- Has to have one of the following:
  - Authenticity
  - Openness
  - Prizing
  - Validating

## Appendix F

## Rating Sheet Example

Utterance	1	2	3	4	5	6	7	8	9	10
So it's like you have to feel your eyes always have to be open incase something sneaks up on you.	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
So it was like you somehow you became the black sheep.	✓	X	✓	✓	✓	✓	✓	X	✓	✓
Keep hoping that something will change, somehow they will come around... I think there is a part of you that still needs and wants that.	✓	✓	✓	X	✓	✓	✓	X	✓	✓
So you feel helpless and you want to feel strong and like you can to accomplish anything.	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
You don't feel like you're loved.	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
So some of the things that happened to you when you were small really stayed with you and you just became a little stuck... you still feel hopeless, worthless, and stupid.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
It sounds like you're still thinking if that was a good strategy.	✓	✓	X	X	✓	✓	✓	X	✓	✓

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