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**EMPATHY AND EMOTIONAL REGULATION IN THE  
TREATMENT OF DEPRESSION: STUDIES ON THEIR ROLE  
IN THERAPEUTIC CHANGE**

Thesis for obtaining the degree of Doctor in Psychology

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**TÍTULO**

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*“We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know.”*

*(Carl Rogers, 1995, p.13)*



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## Abstract

Psychotherapy is effective for diverse disorders and relapse prevention, but understanding its mechanisms is a complex challenge in process-outcome research. Therapist empathy is key in predicting psychotherapy outcomes, often more influential than specific treatments, yet its precise role in therapy needs better clarification. Empathy's role in fostering a safe environment for emotional exploration is particularly relevant for emotion regulation (ER) in disorders like depression. Current research on the relationship between therapist empathy and client ER is limited. This work, therefore, aims to deepen the understanding of how therapist-expressed empathy and client ER interact to facilitate therapeutic change in depression. To this end, three empirical studies were conducted based on the *ISMAI Depression Study* (Salgado, 2014), a comprehensive randomized clinical trial. The first study involved adapting and creating a Portuguese manual for the *Observer Measure of Affect Regulation* (O-MAR, Watson & Prosser, 2006). This adaptation enables a more detailed observation and measurement of ER in therapy sessions. Subsequently, the second study conducted an intensive case analysis of a good outcome case in Emotion Focused Therapy, examining the relationship between therapist-expressed empathy, client's ER, and the general clinical symptoms. This study revealed a moderate, significant positive association between therapist's empathy and client's ER within the same session, emphasizing the immediate impact of empathy on client's ER. Building on this finding, the third study investigated the joint contributions of the therapists' expressed empathy and clients' ER to the complex psychotherapy outcomes through a mediational model. Results corroborated the mediation role of clients' ER in the predictive effect of therapist empathy. These findings hold significant implications for both psychotherapy research and clinical practice, illustrating one possible way of *how* therapist empathy operates during psychotherapy process, contributing to the clarification of its role in clients' change.

**Keywords:** Depression; emotion regulation; empathy; psychotherapy outcome



## Resumo

Décadas de investigação estabeleceram, inequivocamente, que a psicoterapia é eficaz no tratamento de diversas perturbações mentais, tanto na fase aguda dos sintomas, como na prevenção da recaída. Apesar deste progresso, compreender os processos e mecanismos específicos subjacentes à sua eficácia continua a representar um desafio contínuo, que salienta a importância da investigação de processo-resultado. A investigação empírica tem demonstrado que a relação terapêutica tem um impacto significativo no resultado terapêutico, muitas vezes igualando, ou mesmo superando, o efeito específico de diferentes técnicas de intervenção de diferentes modelos terapêuticos. Entre as variáveis da relação, sabe-se que a empatia do terapeuta desempenha um papel muito importante na terapia, com um forte poder preditivo do resultado terapêutico. Esta ideia é apoiada por uma grande quantidade de estudos empíricos, bem como por meta-análises. No entanto, permanece um debate contínuo sobre como a empatia facilita a mudança terapêutica e como se dá sua influência específica. Por um lado, tem-se admitido que a expressão de empatia por parte do terapeuta tem um papel positivo em si mesmo, levando a que clientes se sintam compreendidos e aceites, abrindo mais espaço à exploração e transformação dos seus aspetos mais vulneráveis. Por outro lado, admite-se que a empatia possa facilitar o desenvolvimento de competências internas dos clientes. A este nível, a dimensão transdiagnóstica e transteórica de regulação emocional (RE) do cliente ganhou uma relevância crescente. Tem havido um consenso crescente entre várias abordagens terapêuticas sobre o papel crucial da RE como elemento fundamental para o sucesso da terapia. A integração da RE nos modelos de psicopatologia tem-se tornado cada vez mais comum, especialmente na compreensão e abordagem de perturbações de ansiedade e do humor, como a depressão. Dada a alta prevalência, e as consequências socioeconómicas da depressão, é crucial entender os fatores que contribuem para seu desenvolvimento e manutenção, bem como desenvolver abordagens de intervenção eficazes e implementar medidas preventivas. A sintomatologia característica da depressão, como o humor negativo persistente e/ou uma incapacidade de experienciar afeto positivo ou prazer (anedonia), sugerem fortemente o envolvimento de um estado de desregulação emocional muito frequente e/ou muito intenso. Por seu turno, dentro de uma relação segura, as emoções têm mais probabilidade de serem abordadas, toleradas e aceites. Desta forma, a empatia ao favorecer um ambiente seguro para a exploração emocional, parece ser particularmente relevante para a RE nos casos de depressão. Aliás, alguns autores, afirmam que uma das funções da empatia é a regulação emocional. No entanto, a investigação atual sobre a relação entre a empatia do terapeuta e a RE do cliente é ainda escassa e esta ligação

carece de apoio empírico mais substancial. Este trabalho, visa aprofundar a compreensão de como a empatia expressa pelo terapeuta e a RE do cliente interagem para facilitar a mudança terapêutica na depressão. Os estudos foram fundamentados na conceção teórica e empírica de que a compreensão da interação destas variáveis poderá contribuir para melhores resultados terapêuticos, e assim, para o desenvolvimento de intervenções terapêuticas mais eficazes. Para a concretização desse propósito, foram realizados três estudos empíricos com base no *ISMAI Depression Study* (Salgado, 2014), um ensaio clínico aleatorizado que investigou e comparou a eficácia da Terapia Focada nas Emoções (TFE) e a Terapia Cognitivo-Comportamental (TCC) no tratamento da depressão. Os estudos envolveram uma avaliação das seguintes variáveis-alvo: a empatia expressa pelos terapeutas, a regulação emocional dos clientes, e a intensidade dos sintomas depressivos e sintomas clínicos gerais. Para a avaliação da empatia expressa pelos terapeutas e a regulação emocional dos clientes foram utilizadas medidas observacionais específicas. O primeiro estudo envolveu a adaptação e criação de um manual em português para a *Observer Measure of Affect Regulation* (O-MAR, Watson & Prosser, 2006). A investigação no âmbito da RE conduziu ao desenvolvimento de várias medidas com fortes propriedades psicométricas, e várias delas estão validadas para a população portuguesa. No entanto, todas as medidas validadas para a população portuguesa, até à altura do desenvolvimento deste primeiro estudo, eram medidas de autorrelato. A adaptação da O-MAR para a população portuguesa procurou colmatar esta lacuna, e simultaneamente permitiu uma observação e avaliação mais cuidada e detalhadas da RE nas sessões de terapia. A escassa investigação sobre o papel preditivo/facilitador da empatia do terapeuta na RE dos clientes e no resultado da psicoterapia tem-se baseado em estudos com amostras, com informações limitadas sobre potenciais padrões idiossincráticos entre essas variáveis, muito relevantes para a prática clínica. Desta forma, no segundo estudo realizou-se uma análise intensiva de um caso clínico de sucesso em TFE, examinando a relação entre a empatia expressa pelo terapeuta, a RE do cliente e os sintomas clínicos gerais. Este estudo revelou uma associação positiva, moderada, e significativa, entre a empatia do terapeuta e a RE do cliente dentro da mesma sessão, evidenciando o impacto imediato da empatia na RE do cliente. Com base nos resultados deste estudo, o terceiro estudo investigou as contribuições conjuntas da empatia expressa pelos terapeutas e da RE dos clientes para os resultados da psicoterapia por meio de um modelo de mediação. O objetivo principal deste estudo foi investigar se a RE dos clientes seria uma variável mediadora na relação entre a empatia do terapeuta e o resultado terapêutico em termos de sintomas depressivos e sintomas clínicos gerais. Em contraste com as investigações anteriores, os dados foram recolhidos em diferentes momentos do processo de terapia. Foram recolhidos dados de 49 clientes, nas sessões

1, 4, 8, 12 e 16, tanto para a TFE quanto para a TCC para depressão. Além disso, para a análise de mediação, recorreu-se à utilização dos Modelos Lineares Mistos, pela sua adequação em termos de análise de dados recolhidos em múltiplos pontos temporais e pela sua capacidade de acomodar a natureza correlacionada de medidas repetidas nos mesmos sujeitos. Esta abordagem metodológica aumenta a capacidade de explorar a interação dinâmica entre a empatia do terapeuta, a RE do cliente e os resultados da psicoterapia. Os resultados deste estudo corroboraram o papel de mediação da RE dos clientes no efeito preditivo da empatia do terapeuta no resultado terapêutico. Esses resultados têm implicações significativas tanto para a investigação em psicoterapia como para a prática clínica, contribuindo para compreender como um processo interpessoal como a empatia facilita o desenvolvimento de uma competência intrapessoal, como a regulação emocional, dando apoio empírico a algumas teorias sobre o funcionamento e benefícios da empatia no espaço da psicoterapia.

**Palavras-chave:** Depressão; empatia; regulação emocional; resultado psicoterapêutico



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## **List of Abbreviations**

<b>APA</b>	American Psychological Association
<b>BDI – II</b>	Beck Depression Inventory II
<b>CBT</b>	Cognitive Behavioral Therapy
<b>CBT-E</b>	Cognitive Behavioral Therapy-Enhanced
<b>CERQ</b>	Cognitive Emotion Regulation Questionnaire
<b>DBT</b>	Dialectical Behavior Therapy
<b>DERS</b>	Difficulties in Emotion Regulation Scale
<b>DSH</b>	Deliberate Self-Harm
<b>DSM</b>	Diagnostic and Statistical Manual of Mental Disorders
<b>ECBT</b>	Emotion-Focused Cognitive Behavioral Therapy
<b>EFT</b>	Emotion-Focused Therapy
<b>EFT-PE</b>	Emotion-Focused Therapy/Process-Experiential
<b>ER</b>	Emotion Regulation
<b>ERP-R</b>	Emotion Regulation Profile – Revised
<b>ERQ</b>	Emotion Regulation Questionnaire
<b>ERSQ</b>	Emotion Regulation Skills Questionnaire
<b>ERT</b>	Emotion Regulation Therapy
<b>ICC</b>	Intraclass Coefficient Correlation
<b>LMM</b>	Linear Mixed Models
<b>MDD</b>	Major Depressive Disorder
<b>MEE</b>	Measure of Expressed Empathy
<b>O-MAR</b>	Observer Measure of Affect Regulation
<b>OQ 10.2</b>	Outcome Questionnaire 10.2
<b>OQ 45</b>	Outcome Questionnaire 45
<b>PE</b>	Process-Experiential
<b>RCT</b>	Randomized Clinical Trial
<b>SMA</b>	Simulation Modeling Analysis
<b>UP</b>	Unified Protocol



## Introduction

Decades of research comparing different psychotherapy approaches have yielded a compelling consensus that all treatments are equally effective, with only marginal differences in their specific symptomatic targets (Lakeman, 2020). This phenomenon, often referred as the "*Dodo Bird Verdict*", inspired by *Lewis Carroll's Alice's Adventures in Wonderland*, where the Dodo declared "*Everybody has won and all must have prizes.*", presented a challenge for the helping professions. It suggested that diverse therapeutic modalities seem to produce equivalent positive outcomes (Lambert & Ogles, 2004; Marcus et al., 2014).

Authors have unequivocally established that psychotherapy is highly effective in treating various disorders (e.g., Cuijpers et al., 2019; Fehlinger et al., 2013; Miller et al., 2013), extending to both the acute phase of symptoms and relapse prevention (e.g., Clarke et al., 2015; Cuijpers et al., 2011; Llewelyn et al., 2016). Notwithstanding this progress, understanding the precise processes and mechanisms underlying the efficacy of psychotherapy remains an ongoing challenge, underscoring the current significance of process-outcome research (Crits-Christoph et al., 2021; Gelo et al., 2015; Llewelyn et al., 2016).

Simultaneously exploring cognitive, emotional, and behavioral elements associated with the client, therapist, dyad, and context, process-outcome studies investigate their collective impact on changing client symptoms, problems, or overall functioning (Crits-Christoph et al., 2013; Llewelyn et al., 2016). This line of research aims to precisely examine and understand the mechanisms and processes supporting therapeutic success. It not only facilitates the improvement of more effective therapies but also significantly contributes to therapist training, holding vital importance from both empirical and clinical perspectives (Gelo et al., 2015; Wampold, 2001).

According to Lambert and Barley (2001), approximately 30% of client outcomes in psychotherapy are attributable to common factors transcending specific therapeutic approaches. Lakeman (2020) extends this perspective, asserting that common factors account for a range of 30 to 70% of the variance in psychotherapy outcomes, while therapy-specific factors explain only 10-15% of the variance (Felice et al., 2019). These "common factors" encompass elements such as the therapeutic relationship, working alliance, positive regard and affirmation, congruence/genuineness, and mentalization (Cuijpers et al., 2019; Malin & Pos, 2015; Norcross & Lambert, 2018).

Norcross and Lambert (2018), as well as Norcross and Wampold (2011), emphasize that irrespective of the specific psychological approach employed, the psychotherapy relationship

consistently and significantly contributes to client outcomes. The therapeutic relationship's influence on client progress equals, if not surpasses, the impact of the specific treatment method. The authors advise that best practice and evidence-based therapy efforts lacking attention to the relationship and responsiveness are inadequately insufficient and may even be deceptive.

The *Task Force Conclusions Regarding the Evidentiary Strength of Elements of the Therapy Relationship and Methods of Adapting Psychotherapy* (Norcross & Lambert, 2018) underscore several relationship variables demonstrably effective. Among them, the *Meta-Analytic Associations Between Relationship Components and Psychotherapy Outcomes* reveals empathy as one of the strongest factors (Effect Size = .28).

Empathy is acknowledged as playing a pivotal and unique role in the therapeutic process. The robust predictive power of empathy in psychotherapy outcomes is evident in numerous studies (e.g., Abargil & Tishby, 2022; Elliott et al., 2011; Greenberg et al., 2001; Hara et al., 2017; Lambert & Barley, 2001; Malin & Pos, 2015; Norcross & Lambert, 2018; Vitinius et al., 2018; Wampold & Imel, 2015; Watson et al., 2014; 2020) and meta-analyses (Elliott et al., 2011, 2018; Greenberg et al., 2001). However, there is an ongoing discussion on *how* empathy leads to change and the nature of its influence (e.g., Hoffart et al., 2012; Malin & Pos, 2015; McClintock et al., 2018; Mlotek, 2013; Moyers et al., 2016; Vitinius et al., 2018; Watson & Geller, 2005; Watson et al., 2014, 2020; Wing, 2010).

As outlined by Norcross and Lambert (2018), it is imperative to explicitly address therapist behaviors that foster and support the therapeutic relationship in both practice and treatment guidelines. Additionally, the authors claim that adapting psychological treatment to transdiagnostic client characteristics is emphasized as a contributing factor to reaching successful outcomes. Numerous clients' internal characteristics (e.g., attachment styles, motivation level) have been suggested to be linked to psychotherapy outcomes (e.g., Fuertes & Nutt Williams, 2017; Llewelyn et al., 2016; Lynch, 2012; Tschuschke, 2022). Clients' internal processes are also crucial to a comprehensive understanding of the effectiveness of psychotherapy but have received comparatively less attention in process-outcome studies (Goldman, 2019; Pascual-Leone et al., 2016; Pascual-Leone & Yeryomenko, 2017).

In the context of psychological disorders and psychotherapy, the transtheoretical and transdiagnostic dimension of client's emotion regulation (ER) gained increasing emphasis (e.g., Brenning et al., 2022; Fernandez et al., 2016; Iwakabe et al., 2023; Khakpoor et al., 2019; Kraiss et al., 2020; Naragon-Gainey et al., 2017). Additionally, there is a consensus across various therapeutic approaches regarding the pivotal role of ER as a fundamental element for achieving

positive therapy outcomes (e.g., Daros et al., 2021; Elliot et al., 2004; Greenberg & Pascual-Leone, 2006; Igra et al., 2023; Peluso & Freund, 2018; Sønderland et al., 2023; Whelton, 2004).

The integration of ER into psychopathology models has become increasingly common (Aldao et al., 2010), especially in understanding and addressing distress disorders like depression (Campbell-Sills & Barlow, 2007; Gross & Munoz, 1995; Mennin et al., 2007). Given the high prevalence and socioeconomic consequences of depression, it is crucial to understand the factors contributing to its development and maintenance, develop effective treatment approaches, and implement preventive measures (Everaert & Joormann, 2019; Joormann & Stanton, 2016; Keshky, 2018; Mehrabi et al., 2014; Visted et al., 2018).

Collaboration between therapists and clients to address avoidance related to focusing on emotions is a crucial aspect (Peluso & Freund, 2018). Within a secure relationship, emotions are more likely to be approached, tolerated, and accepted (Greenberg, 2014). Empathy is crucial to ER, creating a safe environment for addressing and tolerating emotional experiences (Greenberg, 2014, 2021; Malin & Pos, 2015; Paivio & Laurent, 2001; Watson, 2002, 2016, 2018). In fact, several other authors argue that empathy plays a crucial role in assisting clients in the regulation of their emotional states (e.g., Elliott et al., 2004; Fosha, 2001; Paivio, 2013; Paivio & Laurent, 2001; Prosser, 2007; Waston, 2002, 2020).

Although there is an acknowledgment of the relationship between empathy and ER, the current research of this relationship is limited (Thompson et al., 2019; Watson et al., 2020). Watson and colleagues' study (2020) suggested further research to investigate empathy as a mechanism of change, aiming to advance the understanding of its relationship with the development of ER.

Hence, this doctoral thesis, entitled *Empathy and emotional regulation in the treatment of Depression: Studies on their role in therapeutic change*, aimed to contribute to process-outcome research. It specifically sought to deepen the understanding of the role of therapist-expressed empathy in influencing psychotherapy outcomes, a topic which authors suggest still needs clear elucidation, and to explore its interplay with clients' ER. By meticulously examining these dynamics, the thesis aimed to elucidate how therapist empathy and client ER collectively contribute to therapeutic change, with a particular focus on the treatment of depression. The studies were grounded in the theoretical and empirical support suggesting that a detailed understanding of these factors could lead to more effective therapeutic interventions and improved client outcomes. The research presented in this thesis not only addresses the recommendations of theorists and researchers, but also attempts to fill some gaps in current research, offering practical and clinical insights for therapists.

To a better understanding of these main purposes, this thesis comprises two main parts. The first part will present a theoretical framework to contextualize the relevance of the research. In the second part, the three empirical studies will be presented. In the final, will be presented an integrated conclusion of the results, discussed the inherent limitations, and explored implications for research and clinical practice.

The theoretical framework aimed to address the central themes of therapist empathy and client ER in psychotherapy, particularly focusing on Major Depressive Disorder (MDD). This comprehensive review deepened the understanding of these critical factors, laying the foundation for the methodology and direction of the subsequent empirical studies.

The concept of empathy, as conceptualized by Carl Rogers, is explored, highlighting its evolution and diverse definitions. The theoretical framework emphasizes empathy's multifaceted nature within therapeutic settings, including its phases (empathic resonance, communication, and reception) and various empathic responses (such as understanding, affirmation, and evocation). Understanding how empathy operates in psychotherapy helped in determining what aspects of therapist-client interactions should be focus on. This was crucial for defining therapist-expressed empathy in the empirical studies and selecting the appropriate observer measure.

Additionally, the exploration into the complex role of empathy in psychotherapy provided insights into its core functions and its predictive effect on psychotherapy outcomes, identified areas where existing research on empathy in psychotherapy was lacking which were instrumental in guiding the second and third empirical studies.

A particular emphasis was placed on understanding the functions of empathy, especially in relation to clients' internal and emotional processes. It became evident that one of the primary functions of therapist empathy is ER. This recognition underscored the significance of empathy as a therapeutic tool for facilitating effective ER in clients. Accordingly, it was also explored the definitions, and the importance of ER in psychological well-being and psychotherapy outcomes, particularly relevant in addressing the ER challenges often encountered in treating MDD. ER was described as a spectrum of mechanisms for managing emotional responses and discussed various models, including Watson and colleagues' Process Model of Affect Regulation that was fundamental to define the construct of ER to psychotherapy context and to the perspective adopted in this doctoral thesis.

The main observer measures of ER were screened, leading to the foundation of the first study sought to cover the need for reliable, culturally adapted of *Observer Measure of Affect*

*Regulation* (O-MAR, Watson & Prosser, 2006) that was the only observer measure that aligned with the conceptualization of ER adopted in this work.

The theoretical focus on how a therapist's empathy contributes to the client's ability to regulate emotions, and research that sought to investigate this relationship, allowed to understand how these elements could interact and influence therapeutic outcomes and simultaneously to emphasize the need to conduct more research in the field.

The synthesis of existing research findings was instrumental in guiding the formulation of the specific research hypotheses, the methodological choices, the selection of measurement tools, and shaping the overall approach to data collection and analysis in the second and third studies. This alignment with current empirical evidence and theoretical perspectives ensured that the methods adopted not only adhered to the latest standards in the field but also aimed to address identified gaps in the literature and research.

In terms of methodology, this took form in several ways. The second and third studies adopted a longitudinal perspective, allowing to analyze changes and developments throughout psychotherapy process. Additionally, the second study used a mixed-method approach. Here, quantitative analysis was paired with qualitative analyses of therapy session transcripts. This combination was crucial in capturing the nuances of empathic exchanges and the evolution of client ER and symptoms. It provided a richer and more holistic understanding of the dynamics of these variables within psychotherapy process.

In essence, this second part, not only grounded the empirical work in a solid body of existing knowledge but also directed the path and focus of the studies, ensuring they were relevant and contributory to the ongoing discourse in psychotherapy research.

Given the significance of researching the relationship between therapist empathy, client ER, and treatment outcomes, this became a central focus of the dissertation. In the second part, three empirical studies are presented, mainly aimed at exploring the intricate interplay among these variables.

Data for the studies were derived from the *ISMAI Depression Study* (Salgado, 2014), a comprehensive randomized clinical trial (RCT) designed to investigate and compare the efficacy of Emotion-Focused Therapy (EFT) and Cognitive Behavioral Therapy (CBT) in treating MDD. To accomplish the dissertation's main goals, the empirical studies involved a longitudinal assessment of target variables: (1) therapist-expressed empathy, (2) client ER, and (3) depressive and general clinical symptoms intensity. Observational measures were used to collect data on therapist empathy and clients' ER, as these central variables were not initially included into the RCT.

Empathy was assessed by the *Measure of Expressed Empathy* (MEE; Watson, 1999) an observer measure that capture therapist-expressed empathy during psychotherapy sessions. The ER was evaluated by the *Observer Measure of Affect Regulation* (O-MAR; Watson & Prosser, 2006) that allows the assessment of clients' ER in terms of multiple domains and ER and strategies. Self-report measures were used to evaluate symptoms, with a focus on different aspects. *Beck Depression Inventory II* (BDI-II; Beck et al., 1996) assessed depressive symptoms, and general clinical symptoms were assessed through the *Outcome Questionnaire 10.2* (OQ-10.2; Lambert et al., 2005) and the *Outcome Questionnaire 45* (OQ-45; Machado & Fassnacht, 2014).

In light the many criticisms that observer-rated measures often face, particularly concerning insufficient or inadequate rater training (e.g., Sharp, 2016), and to address the lack of specific clinical illustrations for different levels of each domain of ER in the original manual, the first study – *Emotion regulation and psychotherapy: Adaptation and elaboration of an application manual of the Observer Measure of Affect Regulation (O-MAR)* - aimed to adapt, and to create, a Portuguese manual for the O-MAR (Watson & Prosser, 2006). Given that the scale had not been previously adapted to the Portuguese language, an initial translation work was performed. Through consensual discussion on four different cases, two judges and an auditor observed and classified the middle 20 minutes of 20 therapy sessions. Subsequently, two illustrative excerpts were selected by consensus for each level of analysis within the various domains of the scale.

Most process-outcome studies on empathy research have traditionally employed a sample-based approach, offering limited insights into potential idiographic patterns between variables that could be valuable for clinicians and their practice. To the best of our knowledge (until the date), there have been no studies examining the longitudinal relationship between empathy and ER, on a session-by-session basis. Therefore, in the second study - *From empathy to emotion regulation: An intensive case study of Emotion-Focused Therapy for Depression* – it was conducted an intensive analysis of all sessions in a good-outcome case of EFT for depression (Elliott et al., 2004; Greenberg, 2017; Greenberg & Watson, 2006).

This exploratory and idiographic study relied on a longitudinal analysis to explore session-by-session: (1) the evolution of therapist's expressed-empathy, client's ER, and clinical symptoms during the therapeutic process; and (2) the association between (a) the level of therapist-expressed empathy and the intensity of clinical symptoms (b) the level of client ER and the intensity of clinical symptoms (c) the level of therapist-expressed empathy and the level of client ER. The purpose of this longitudinal analysis was to characterize and achieve a deeper

understanding of the evolution and interaction between therapist empathy and the client ER, and their roles in symptomatic changes throughout the sessions.

Researchers have initiated the exploration of the dynamic relationship between therapist empathy and clients' ability to regulate their emotions, offering insights into potential links that may clarify the path to improved therapeutic outcomes (Prosser, 2007; Watson et al., 2020). Although the role of empathy in successful therapeutic outcomes is evident, a closer examination is needed to understand how it interacts with ER processes.

The third study - *Empathy and emotion regulation in Depression: Examining the role of therapists' empathy and clients' emotion regulation on psychotherapy outcome in Depression* - aimed to bridge these essential components and investigate how therapist empathy and clients' ER jointly contribute to complex psychotherapy outcomes. The primary objective was to examine whether clients' ER serves as a mediator in the relationship between therapist empathy and outcomes related to depressive symptoms and overall distress. This study tested the following hypotheses: (a) therapists' expressed empathy predicts clients' outcomes, specifically in terms of depressive symptoms and overall distress at the end of therapy; (b) therapists' expressed empathy predicts improvements in clients' ER ability, as assessed by an observer measure; (c) the association between therapists' expressed empathy and clients' outcomes is mediated by clients' ability to regulate emotions.

A significant strength of this study lies in its adopted methodological strategy, applying Linear Mixed Models (LMM). In contrast to previous studies (Prosser, 2007; Watson et al., 2020) that relied on assessments at limited time points, this study maximized the benefits of longitudinal data collected across multiple therapy sessions. This approach enables a more comprehensive analysis by considering the complete dataset rather than relying on condensed information from isolated or average data points.

In the final of this dissertation, the primary aim was to integrate the main conclusions within the context of the studies' results, viewed through the lens of the theoretical framework that critically informed their interpretation. This integrated approach allowed for the drawing of more meaningful conclusions from the data, particularly in terms of their implications for research, clinical practice, and therapist training programs. It highlighted the importance of developing empathy skills in therapists for more effective emotional support of clients, especially those suffering from MDD. Furthermore, this comprehensive analysis underscored the complexity of therapist-client interactions and the pivotal role of therapist empathy in facilitating client progress. The findings advocate for a more nuanced approach to therapist training, one that encompasses both the theoretical understanding of empathy and practical

skills necessary for its effective application in therapy. This research, therefore, aimed to contribute to the field, offering insights for enhancing therapeutic outcomes in the treatment of MDD and potentially other psychological disorders.

**PART I – THEORETICAL FRAMEWORK**



## 1. Empathy and Psychotherapy

Initially introduced by Carl Rogers in his seminal 1952 work, the concept of empathy has held a central role in the field of therapeutic relationships. It was notably emphasized as a crucial element in psychotherapy, where empathy serves as a mechanism by which the therapist forms a deep bond with the client, facilitating a comprehensive understanding of the client's emotional experiences. According to Rogers (1952), the therapist's ability to empathetically understand the client's perspective was considered a necessary and sufficient condition for fostering therapeutic change. This notion of empathy, as an emotional connection between individuals, has garnered significant attention across philosophical, psychological (Elliott et al., 2011, 2018), and, more recently, cognitive neuroscientific disciplines (Decety & Lamm, 2006).

Person-Centered Therapy developed by Rogers in 1957, consistently underscored the pivotal role of genuine empathy as a determinant of client change. However, research and literature related to empathy have not followed a linear and constant trajectory (Elliott et al., 2011; Nienhuis et al., 2018; Watson, 2002, 2007b). From the 1960s to the early 1970s, psychotherapy literature repeatedly discussed and emphasized the concept of empathy as an effective and necessary helping skill in the therapeutic context (Elliott et al., 2011, 2018; Nienhuis et al., 2018). Consequently, it became an integral component of therapist training programs. In the 1970s and early 1980s, research efforts were conducted to analyze whether empathy alone was a sufficient mechanism for therapeutic change (Elliott et al., 2011). According to authors, empirical studies provided evidence for the significance of empathy as a foundational element within the therapeutic alliance. In the following two decades, from 1975 to 1995, there was an evident dearth of studies focusing on empathy in comparison to other helping skills (Elliott et al., 2018; Watson, 2002). However, since that period, an array of studies exploring empathy from biological, cognitive, developmental, and social perspectives has been published, generating a renewed interest in this subject.

In recent years, as emphasized by Elliott and colleagues (2018), empathy has undergone a reconsideration and is now regarded as a pivotal element in various domains, including social neuroscience (Decety & Lamm, 2006). This redefined perspective on empathy has transcended the boundaries of psychology and found applications in fields like medicine, where it has become an active focus in various medical interventions. The resurgence of interest in empathy has led to a substantial increase in research efforts over the past two decades, reaffirming its status as a fundamental component in the context of psychotherapy (Elliott et al., 2018). As the concept of empathy evolved over time, various definitions emerged, reflecting its multifaceted

nature. However, there remains a lack of consensus regarding the precise definition of empathy, largely due to the myriad perspectives within empathy research across different disciplines and different approaches in psychotherapy (Batson, 2009; Elliott et al., 2018; Nienhuis et al., 2018; Thwaites & Bennett-Levy, 2007).

### 1.1. Scope and Definition

In psychotherapy, empathy is often described as the therapist's capacity to *step into the client's shoes* (e.g., Abargil & Tishby, 2022; Prosser, 2007). This involves adopting the client's perspective, understanding their inner world, motivations, and behavioral patterns. Among various definitions, Roger's formulations are regarded as some of the most comprehensive and illuminating in the field (Sharp, 2016). Roger's (1957) initial efforts to establish a clear and quantifiable definition of empathy stimulated a substantial body of research and extensive discussions on the topic.

Initially, Rogers defined empathy as the ability to "*(...) perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the 'as if' condition.*" (1959, p. 210, cit. Sharp, 2016). A similar definition was offered by Kohut (1984, p. 82, cit. Thwaites & Bennett-Levy, 2007), who defined it as "*(...) the capacity to think and feel oneself into the inner life of another person.*". However, over the years, even Rogers refined his definition of empathy. Later, he described it as "*(...) the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view.*" (Rogers, 1975, p. 85), and as "*(...) being sensitive, moment by moment, to the changing felt meanings which flow in this other person.*" (Rogers, 1975, p. 142).

This dynamic aspect of empathy is characterized by an ongoing effort to gain insight into the personal and subjective experiences of others, involving an active awareness of the client's meaning changes, which allows for an accurate understanding (Bohart & Greenberg, 1997; Prosser, 2007). This attempt has been referred to as "*communicative attunement*" (Bohart & Greenberg, 1997), or alternatively labeled as "*expressed empathy*" (Watson & Prosser, 2002, cit. Prosser, 2007) or "*responsive attunement*" (Prosser, 2007). It requires the therapist to focus on the client's immediate and ongoing meanings and experiences, and effectively conveying this understanding back to them. Essentially, it entails adopting a perspective different from one's own, empathetically immersing oneself in the client's experiences and viewpoints, and

effectively communicating this acquired understanding on a moment-by-moment base (Prosser, 2007).

From neuroscience perspective, there are also various definitions of empathy. Decety and Lamm (2006) have provided examples of possible definitions of empathy, such as: a complex form of psychological inference that combines observation, memory, knowledge, and reasoning to gain insights into the thoughts and feelings of others; an affective response that is more suited to someone else's situation than to one's own; an other-oriented emotional response that aligns with the perceived well-being of the other person; an affective response that arises from understanding another's emotional state or condition, resembling what the other person is feeling or would be expected to feel in that situation. Similarly, Danziger and colleagues (2006) argue that neurosciences define empathy as a "(...) *complex form of psychological inference that enables us to understand the personal experiences of another person through cognitive, evaluative and affective processes*" (p. 2494).

In response to the presence of numerous potential definitions for the construct, and the need to organize the field, Batson (cit. Bošnjaković & Radionov, 2018; Nienhuis et al., 2018; Soto, 2017) identified and categorized eight, although, distinct phenomena that have been called empathy: a) the process of gaining knowledge about another person's thoughts and emotional state; b) adopting the other person's posture or aligning with their neuronal responses; c) feeling how the other person feels; d) projecting ourselves into the situation of the other; e) imagining how the other feels or thinks; f) imagining how we would act, think and feel in the place of the other; g) experiencing distress when witnessing the suffering of another; h) feeling empathy for the other person who is suffering. So, there is a diverse of possibilities to define empathy.

This multifaceted understanding of empathy highlights its complexity and the challenges it poses to therapists aiming to understand their clients on a profound level. Regardless of the specific definition, Lakeman (2020) emphasizes that being fully present with another person, moment-by-moment, is fundamental for understanding through active listening. Lakeman (2014) underscores the importance of adopting a humble, interested, or "unknowing" attitude, setting aside preconceived notions and paying close attention to the other person.

The exploration of therapist empathy takes us into various dimensions, ranging from theoretical formulations to practical manifestations. As we explore the practical aspects of therapist empathy, as proposed by Barrett-Lennard (1997), the process unfolds through distinct phases.

Barrett-Lennard (1993, cit. Nienhuis, 2014; Watson, 2007a) proposed a conceptualization of therapeutic empathy that involves three distinct phases: *empathic*

*resonation, empathic communication, and subsequent received/perceived empathy.* According to this perspective, therapists should initially establish a resonance with their clients' experiences, using their own bodily and inner experiences to understand the emotions and significance associated to these experiences. Empathic resonance, as defined by Barrett-Lennard (1967, cit. Watson, 2016), involves the ability to understand others' emotional states, fully understand the meaning of events for them, and understand how people regulate and express their emotions in their relationships with others and within themselves. Subsequently, therapists must effectively convey their understanding to their clients. Ultimately, it is crucial for clients to recognize and accept the empathy expressed by their therapists, acknowledging that they are genuinely understood.

Therefore, therapist empathy goes beyond active listening. It also encompasses the ability to emotionally connect and understand the experiences of others (Singer & Lamm, 2009). As a result, empathy becomes a dynamic, fluid, and complex process characterized by constant interactions between the therapist and the client, challenging the therapist's ability to understand the client's subjective experience and communicate it in a compassionate manner.

This intricate nature of empathy is underscored by its multi-faceted structure, leading several authors to regard it as a complex construct comprised of various interconnected components (e.g., Decety & Holvoet, 2021; Elliott et al., 2018; Gibbons, 2011). According to Milovannov (2017), the empathic process involves three main interconnected components: the ability to *understand and adopt another's perspective*, to *feel* what the other is feeling, and to *regulate the emotions* being experienced.

In the same line, and to a better understanding, recent neuroscience studies have identified three primary brain correlates or subprocesses of empathy as discussed by several authors (e.g., Cuff et al., 2016; Decety & Jackson, 2004; Eisenberg & Eggum, 2009; Feinstein et al., 2015). These subprocesses involve a *simulation process*, which relies on the other's body experience (with brain activation predominantly centered in the limbic system, including the amygdala, insula, and anterior cingulate cortex), a more *conceptual process*, focused on adopting another person's perspective (localized in the medial and ventromedial areas of prefrontal cortex and the temporal cortex), and a *process of emotional regulation* that mobilizes compassion and aids in alleviating the pain / discomfort of others (probably based in orbitofrontal cortex, as well as in the prefrontal and right inferior parietal cortex) (Cuff et al., 2016; Decety & Holvoet, 2021; Decety & Jackson, 2004; Eisenberg & Eggum, 2009; Feinstein et al., 2015).

Given the complexity and multifaceted nature of empathy, its expression within psychotherapy involves a diverse array of manifestations.

## **1.2. Expressing Empathy**

Understanding the diverse facets of empathy is vital, yet it all begins with the fundamental act of listening to the client. Indeed, listening to the client constitutes the initial and fundamental step in therapeutic empathy (Vyskocilova et al., 2011).

While many people often compare hearing and listening, it's important to recognize that true listening goes beyond merely hearing and understanding what is being said. It also involves attentiveness to nonverbal cues, context, connections, specific word choices, metaphors, and the meaning of imagery, among other elements (Elliott et al., 2011; Vyskocilova et al., 2011; Watson, 2016). This comprehensive listening process underscores the foundational role of empathy in establishing connections with others and understanding their experiences, thus emphasizing the dynamic and complex nature of empathy.

Listening, as the initial step in therapeutic empathy, lays the foundation for a comprehensive empathic exchange (Watson, 2016). This, in turn, prepares for a combination of verbal and nonverbal therapist behaviors that express empathy effectively. According to Watson (2002, 2016) to effectively express empathy, therapists should exhibit qualities as receptiveness, warmth, attentiveness, involvement, concern, responsiveness, attunement, and an exploratory approach in their interactions with clients. Non-verbal behaviors like showing a concerned facial expression, leaning forward to demonstrate involvement, maintaining direct eye contact with clients, and adopting a sensitive vocal tone all contribute to conveying empathy (e.g., Abargil & Tishby, 2021; Lynch, 2012; Malin, 2016; Malin & Pos, 2015; Moore, 2006; Sharpley et al., 2006; Watson, 2016). This comprehensive combination of verbal and nonverbal expressions serves as the base for creating an authentic and empathic therapeutic environment. According to Malin (2016) and Malin and Pos (2015) therapist behaviors that have been shown to strongly correlate with clients' perceptions of empathy include:

- a) Non-verbal behaviors: keeping eye contact, showing care, and leaning or angling forward their head forward to express understanding.
- b) Speech characteristics: using speech and voice tonalities similar to their clients, responding slightly ahead of their clients, and refraining from interruptions. The vocal tone should be natural, gentle, and tentative.

c) Response modes: demonstrating interest, maintaining an emotional involvement that matches with their clients, avoiding detachment or boredom, employing emotion words, offering exploratory responses rather than basic recommendations, and effectively communicating their messages.

d) Therapists' traits: non-judgmental attitude, attentiveness, and willingness to engage in discussions on any issue.

This comprehensive set of therapist behaviors and traits underscores the multifaceted nature of empathy within the therapeutic context, shedding light on the complex interplay between verbal and non-verbal expressions of understanding and support (Malin & Pos, 2015; Prosser, 2007). These therapist behaviors and traits serve as the basis for creating an authentic and empathic therapeutic environment. Recognizing this multifaceted nature of empathy, therapists are required to demonstrate qualities such as warmth, involvement, attentiveness, genuine concern, and responsive attunement to effectively convey empathy and gather such perceptions from their clients.

In therapeutic settings, clients perceive empathy as the feeling of being “(...) *understood, accepted, and prized in a way that is meaningful (...)*.” (Lambert & Barley, 2001, p. 359). This sense of profound understanding and acceptance by an actively engaged and empathic listener encourages clients to share their most emotionally significant personal experiences with their therapist (Angus & Kagan, 2007). Additionally, this approach empowers therapist to respond effectively, fostering the development of trust, non-defensiveness, and willingness on the part of the client to share personal information within the therapeutic relationship (Greenberg & Elliott, 1997; Horvath, 2001; Lambert & Barley, 2001; Lemmens et al., 2017).

When it comes to expressing empathy, a range of empathic responses comes into play. Moreover, according to Prosser (2007), the function/purpose of an empathic response, can also be used to classify it.

### **1.2.1. Types of Empathic Responses**

According to Prosser (2007), empathic responses serve various purposes, that includes: showing understanding, validating clients' perspectives, encouraging clients to explore their feelings and thoughts, amplifying their experiences using vivid, evocative, concrete, and connotative language, challenging clients' perceptions, and assumptions in a safe and constructive manner, and revealing what is implicit in clients' narratives or what lies just

beyond the periphery of their awareness. As a result, different types of responses have been identified to express empathy: *understanding*, *affirmation*, *evocation*, *exploration*, *conjecture*, *refocusing* (Elliott et al., 2011; Goldman et al., 2021; Thwaites & Bennett-Levy, 2007; Watson, 2002), and more recently *empathic doubling* (Watson, 2016).

*Empathic understanding* refers to simple responses that demonstrate an understanding of what the client has said (Elliott et al., 2011; Goldman et al., 2021; Thwaites & Bennett-Levy, 2007; Watson, 2002). According to authors, *empathic affirmations* consist of comments intended to support the client's viewpoint. *Empathic evocations* involve responses that utilize rich, emotive, specific, and connotative language to vividly depict the client's experiences throughout the session. *Exploration responses* have a probing and exploratory nature, enabling a deeper examination of the edges and suppressed depths of the client's experiences. *Empathic conjectures* reflect the therapist's efforts to clarify what is implicit in the client's narratives, particularly concerning their emotional states or experiences in specific events. While maintaining the client's perspective, *empathic refocusing* offers an alternative viewpoint. According to Watson (2016), the attempts to articulate the clients' thoughts and emotions as they describe the effects of their experiences, and their attempts to express these, are referred to as an empathic doubling response. These responses can be particularly helpful, especially in exercises such as empty chair work.

Understanding the diverse forms of empathic responses illustrates how therapists can accurately convey empathy. Despite the acknowledged importance of therapist empathy to therapeutic outcomes, its mechanisms, and contributions to change remain unclear, making it crucial to understand empathy's main functions in the psychotherapeutic context.

### **1.3. Empathy Functions**

When considering the impact of therapist empathy to change of client's internal processes that contribute to positive outcome there are several proposals. Rogers (1957) proposed that the therapist's empathic behavior positively influences clients' internalized sense of self-worth and contributes to psychological well-being. This well-being is based upon an individual's acceptance and receptivity toward their internal experiences.

Therapist empathy has been recognized by several authors as a catalyst for change across diverse dimensions of clients' psychological processes. It influences clients' internal self-perceptions (Bohart & Greenberg, 1997; Kohut, 1984, cit. Watson et al., 2014), contributes

to the clients' self-organizations (e.g., Watson et al., 2014, 2020), helps in the deconstruction of clients' worldviews, that in turn fosters awareness of the subjectivity of their perceptions (Watson, 2002), facilitates emotional reprocessing (Greenberg & Paivio, 1997), generates positive outcome expectations (Angus & Kagan, 2007), and plays a role in prompting changes in attachment styles (Watson et al., 2014).

Greenberg and colleagues (2001) highlight that empathy serves multiple crucial functions within the therapeutic context. According to authors, it not only establishes a positive relationship function but also acts as a corrective emotional experience, a cognitive-affective processing condition, and a facilitator of the client's self-healer role. Termed as a "*corrective relational/emotional experience*", this direct learning emphasizes the transformative impact of clients feeling comfortable expressing their emotions and needs within the therapeutic relationship. As clients experience the validation of their feelings and needs, they gradually develop a sense of self-worth, realizing that they deserve respect, and that their emotions and behaviors hold significance (Greenberg et al., 2001). This process, in turn, contributes to reducing feelings of isolation and strengthening the client's self-esteem.

As previously mentioned, empathy plays a pivotal role in encouraging exploration, facilitating productive experiencing, supporting emotional reprocessing, and enhancing clients' cognitive abilities, ultimately fostering meaning creation. According to Greenberg and colleagues (2001) this comprehensive impact underscores why empathy is regarded as a cognitive-affective processing condition. The empathic setting, characterized by client involvement and openness, allows therapists to select strategies and interventions aligned with the client's frame of reference. This not only promotes the client's capacities for self-healing but also reinforces the client's active role in his/her therapeutic process.

In considering empathy as a key component in the process of change, Watson (2016) suggests categorizing four important functions of empathy: (a) interpersonal, (b) deconstructive, (c) facilitating the development of positive introjects, and (d) facilitating emotion regulation.

**a) The interpersonal function of empathy:** When clients are empathically listened, they feel safe (e.g., Angus & Kagan, 2007; Lynch, 2012; Watson, 2002, 2016, 2018). Within this secure environment, they not only feel supported, understood, and heard but also find the freedom to concentrate on addressing problems during the therapeutic hour. According to authors, empathy, as a facilitator, not only encourages exploration but also provides clients with

the opportunity to analyze and consider aspects of their experience that might have been previously dismissed or rejected.

Greenberg and colleagues (2001) posit that empathy's positive relationship function is intricately linked to the profound sense of being understood it elicits. This understanding prompts a heightened feeling of safety within the therapeutic relationship, creating an environment that encourages self-disclosure and the open sharing of difficult or problematic issues. As clients experience increased comfort with self-expression, there is a subsequent improvement in satisfaction with the therapeutic process. This heightened satisfaction, in turn, translates into increased compliance, commitment, and maintenance in therapy.

In addition to fostering a safe therapeutic environment, therapist's empathy plays a pivotal role in the establishment and maintenance of the working alliance, along with achieving agreement on treatment tasks and goals (Castonguay & Beutler, 2006; McClintock et al., 2018; Nienhuis et al., 2018; Watson & Geller, 2005). The connection between empathy and the working alliance is a longstanding one (Watson, 2002, 2011; Watson & Geller, 2005). Numerous authors assert that empathy not only facilitates the development and maintenance of a positive working alliance but is also consistently correlated with the alliance itself, which further correlates with positive treatment outcomes (Castonguay & Beutler, 2006; Horvath et al., 2011; McClintock et al., 2018; Nienhuis et al., 2018; Watson & Geller, 2005).

**b) The deconstructive function of empathy:** According to Rogers (1975) and Watson (2016) empathic responses play a crucial role in the process of deconstructing client's worldviews, conceptions, and assumptions regarding themselves and others. Therapists are perceived as actively involved in disclosing the meanings and goals of their clients. The deconstructive of their worldviews and the recognition of the subjective nature of their perceptions enables clients to adopt a more hypothetical approach in formulating their understanding of events, ultimately expanding their range of possible actions (Watson, 2016).

**c) Facilitating the development of positive introjects:** When an empathic therapist listens, respects and accepts client's experiences, they serve as a model of self-empathy (e.g., Barrett-Lennard, 1997; Greenberg, 2004a; Watson, 2016). According to authors, empathic relationships assist clients in creating positive, nurturing introjects and affirming, accepting, protecting, and soothing ways of responding to themselves. Over time, this leads to clients becoming less critical of themselves and more self-confident, thus changing their self-concepts.

**d) The affect-regulating function of empathy:** Rogers (1963) asserted that therapists who effectively communicate understanding and acceptance towards their clients' inner experiences can facilitate the clients' awareness and acceptance of their own emotions. In fact, several other authors argue that empathy plays a crucial role in assisting clients in the regulation of their emotional states (e.g., Elliott et al., 2004; Fosha, 2001; Paivio, 2013; Paivio & Laurent, 2001; Prosser, 2007; Watson, 2002; Watson et al., 2020) and the development of self-soothing abilities (e.g., Greenberg, 2008; Greenberg & Pascual-Leone, 2006; Mlotek, 2013). Individuals seeking therapy frequently present with acute and chronic disorders that are associated with dysregulation in their emotional systems. Empathic response has been found to facilitate the regulation of clients' emotions, both in the immediate context of the therapy session and over an extended period (Paivio, 2013; Watson et al., 2020).

Considering the vital role of this empathy function in achieving the central aim of this work, a subsequent section will offer a more in-depth exploration of this crucial aspect, enlightening its profound implications and integral contribution to the overall framework.

Understanding these functions is indispensable for their integral role in overall therapeutic outcomes, laying the groundwork for a comprehensive exploration of empathy and psychotherapy outcome research in the next subsection. By bridging the theoretical insights into empathy functions with empirical evidence, we aim to gain a holistic understanding of how empathy operates as a dynamic process in promoting the success of psychotherapeutic interventions.

#### **1.4. Therapist Empathy and Outcome Research**

To comprehensively explore the intricate relationship between therapist empathy and psychotherapeutic outcomes, it is imperative to explore empirical evidence and research findings. Despite methodological variances, a persistent theme in the literature underscores the positive correlation between therapist empathy and the effectiveness of psychotherapy.

The significance, and functions of therapist empathy, to psychotherapy outcomes was demonstrated by early research, such as the investigations conducted by Barrett-Lennard (1962, cit. Rogers 1975) and Tausch (1973, cit. Rogers, 1975). These early studies put forward the notion that early empathy in therapy was predictive of therapeutic success. This concept subsequently prompted the notion that the measurement of empathy right from the beginning

of therapy might serve as a preventive measure against unsuccessful therapeutic outcomes. After 60 years of psychotherapy research, as noted by Lakeman (2020), it is recognized that Rogers's conditions are not sufficient for effective therapy but are still considered necessary.

Presently, it is well established that empathy plays a pivotal and unique role in the therapeutic process, standing as a key, central, critical, fundamental, and essential element in achieving successful outcomes across various therapeutic approaches (e.g., Abargil & Tishby, 2022; Elliott et al., 2018; Hara et al., 2017; Norcross & Lambert, 2018; Soto, 2017; Watson, 2018; Watson et al., 2020). Numerous researchers (e.g., Elliott et al., 2011, 2018; Greenberg et al., 2001; Hara et al., 2017; Malin & Pos, 2015; Moyers, 2014; Vitinius et al., 2018; Watson et al., 2014, 2020) have demonstrated empirical evidence setting the status of therapist empathy as one of the most robust predictors in the psychotherapy literature and research. Furthermore, Norcross and Lambert (2018), in their comprehensive review of findings from the *Third Interdivisional APA Task Force on Evidence-Based Relationships*, reiterate the efficacy of empathy within psychotherapy. This growing body of evidence continues to underscore the influence of empathy, surpassing the impact of specific treatment interventions, in therapeutic outcomes.

Research has shown that the use of empathy, even in a limited number of sessions, can facilitate the therapeutic process and improves treatment outcomes (e.g., Moyers, 2014). According to Elliott and colleagues (2018), empathy can be viewed as a general predictor across different therapeutic approaches, treatment formats, and client severity levels. In the past twenty-three years, three separate meta-analyses have investigated the relationship between empathy and treatment outcome (Elliott et al., 2011, 2018; Greenberg et al., 2001). While there were slight discrepancies in their results, a consistent finding was the moderate predictive power of empathy concerning psychotherapy outcomes.

In their initial meta-analysis, comprising 47 studies, Greenberg and colleagues (2001) identified a relationship with a corrected  $r$ -value of .30, indicating a medium effect size. They also observed that factors such as the length of therapy, treatment format, perspective of the measurer, and therapist experience acted as moderating variables. Particularly, empathy was less predictive of positive outcome in individual therapy compared to group therapy, especially in longer treatments and when the therapist had more experience. When considering the rater's perspective, all perspectives demonstrated positive relationships with treatment outcomes ( $r$ -values ranging from .20 to .32), with the strongest correlation found in client-rated perspective ( $r = .32$ ). Empathic accuracy did not exhibit a significant moderating effect.

Subsequently, Elliott and colleagues (2011) conducted a follow-up meta-analysis with 59 samples from 57 studies. They also found a moderate relationship between empathy and treatment outcome ( $r = .31$ ), indicating that empathy, as a whole, accounted for nearly 10% of the observed outcome variance. The theoretical approach did not serve as a moderator variable, but the perspective of empathy rater did. Client measures were the best predictors of outcome (mean uncorrected  $r = .25$ ), marginally though not significantly, better than observer-rated measures ( $r = .23$ ) and therapist-rated measures ( $r = .18$ ). Once again, measures of empathic accuracy showed no significant relationship with outcome ( $.08$ ;  $n = 5$ , ns).

In their most recent meta-analysis (Elliott et al., 2018), which included additional 24 studies, the results continued to indicate that empathy is a moderately strong predictor of therapy outcome ( $r = .28$ ). This finding remains consistent across various theoretical approaches and for clients with diverse problems. Once again, client, observer, and therapist measures of empathy proves to be better predictors of client outcome compared to empathic accuracy measures.

Recent research unequivocally supports the significant role of empathy in therapeutic outcomes (e.g., Elliott et al., 2018; Malin & Pos, 2015; McClintock et al., 2018; Norcross & Lambert, 2018; Watson et al., 2020). However, the ongoing discourse turns around *how* empathy leads to change, and the *nature* of empathy's influence, whether it is a direct (e.g., Moyers et al., 2016; Vitinius et al., 2018) or indirect contributor to therapeutic outcomes (e.g., Hoffart et al., 2012; Malin & Pos, 2015; McClintock et al., 2018; Mlotek, 2013; Watson & Geller, 2005; Watson et al., 2014, 2020; Wing, 2010). This debate underscores the need of research on empathy, particularly a deeper understanding of how it operates during psychotherapy process (e.g., Watson et al., 2020). Subsequently, we present some studies that clearly support this need.

Moyers and colleagues (2016) conducted a study focusing on the role of common factors, including therapist empathy, in the treatment of addictive behaviors. One of their analyses aimed to assess the relationship between therapist empathy and alcohol treatment outcomes using data from a large, multisite, randomized controlled trial. The results of their analysis revealed that in the within-therapists analysis, therapist empathy was a significant predictor of client drinking at the end of the treatment. Specifically, therapist empathy was inversely associated to client drinking at the end of treatment ( $B = .381$ ,  $SE = .103$ ,  $p < .001$ ). As mentioned by Moyers and colleagues (2016), these findings provide support for the view that therapist empathy makes an independent contribution to the overall success of the intervention.

Vitinius and colleagues (2018) conducted a follow-up study to identify predictors of therapy success, measured by decrease in depressive symptoms, within an inpatient psychotherapy context. In their study on inpatient psychotherapy, perceived empathy significantly predicted therapy success, indicating that higher levels of perceived empathy among therapists were associated with greater success.

Illustrating the lack of a consensus regarding the predictive role of empathy on therapy outcomes, one can examine the report of the study conducted by Watson and colleagues in 2014. The primary objective was to examine whether clients' self-reported perceptions of therapists' empathy contributed to changes in their attachment styles and self-treatment behaviors following 16 weeks of either CBT or Emotion-Focused Therapy/Process-Experiential (EFT-PE) for depression. Watson and colleagues found a significant direct relationship between therapists' empathy and outcome as well as a significant indirect effect was found at the end of therapy. According to authors therapists' empathy was associated with significant improvement in clients' reports of secure attachment in close interpersonal relationships and significant decreases in negative ways of treating themselves and their experience. This in turn in turn, influenced various outcome measures, including dysfunctional attitudes, self-esteem, and levels of distress and depression. This indirect effect contributes to the understanding how empathy contributes to clients' change. Specifically, the study identified that therapists' empathy directly influenced changes in how clients treated themselves and had an impact in their attachment styles. Subsequently, these changes, triggered changes in dysfunctional attitudes, self-esteem, interpersonal difficulties, levels of distress, levels of depression, and consequently, overall treatment outcomes.

Mlotek's study (2013) investigated the impact of therapist empathy during the first therapy session on client's emotional engagement with trauma-related material and how this, in turn, affected client outcomes, specifically trauma symptoms and the resolution of abuse-related problems. The results revealed that higher levels of therapist empathy were associated with increased levels of client engagement and a subsequent reduction in trauma symptoms, independently of the levels of engagement, demonstrating a partial direct effect. Additionally, client engagement partially mediated the relationship between therapist empathy and the resolution of trauma-related problems post-treatment, showing a partial indirect effect.

In the same line, Malin and Pos (2015), focusing on experiential therapy for depression found that therapists' expressed empathy during the first session emerged as a predictor of therapeutic outcome, both directly and indirectly. The authors reported that empathy in the initial session exerted a direct positive effect on the therapeutic alliance within the same session,

and on deeper emotional processing by clients during the working phase, that in turn, had (both) a direct predictive effect to therapeutic outcome.

Consistent with this perspective and providing substantial evidence that empathy operates as a catalyst for changing various internal client processes, and influencing other crucial psychotherapy variables, there exists a body of research that underscores the intricate nature of this phenomenon.

Watson and Geller (2005) conducted a study on a sample of depressed clients who received CBT or EFT-PE to examine the relationships among clients' ratings of relationship conditions (e.g., empathy), psychotherapy outcomes (depressive symptoms, self-esteem, interpersonal problems, and dysfunctional attitudes) and the working alliance. The results showed that empathy was a predictor of treatment outcome for depression across the four outcome measures. However, its impact on these outcomes was found to be *mediated* through the working alliance on three of the four outcome measures, with the interpersonal problems being exception. These findings support the perspective that empathy predicts outcomes, although the effect is indirect. The study results underscored the significance of empathy in fostering the development of a positive working alliance, which, in turn, contributes to better outcomes. The study found no significant differences between CBT and EFT-PE in terms of clients' ratings of therapist empathy, supporting the universality of empathy's across different therapeutic approaches.

Similarly, in a study conducted by Wing (2010) involving a sample of 30 clients participating in the *Vanderbilt 2 Psychotherapy Study*, each diagnosed with various Axis I disorders, and receiving treatment with a psychodynamic-oriented approach, the results emphasized the mediating role of the working alliance in the relationship between empathy and therapy outcomes. Notably, no direct effect of empathy on treatment outcomes, independent of the working alliance, was identified in this study.

In a more recent study by McClintock and colleagues (2018), the focus was on exploring the impact of early experiences of therapist empathy, specifically within the first session, on the overall treatment outcome through the working alliance, measured as averaged scores from sessions 2 to 5. The study involved a sample of 56 clients diagnosed with depression who received five sessions of evidence-based psychotherapy. The findings from this study revealed that early experience of therapist empathy strengthened the working alliance. This, in turn, facilitated positive changes in depressive symptoms and overall psychological well-being.

Exploring the complex context of therapist empathy and its profound impact on psychotherapeutic outcomes, naturally leads to the field of measurement. The understanding of

empathy's core features and functions, as outlined earlier, forms the foundation for a closer examination of how these crucial therapeutic elements are quantified. This exploration not only enhances the empirical investigation ability but also contributes to refining the understanding of empathy's role in the therapeutic process.

## **1.5. Measuring Therapist Empathy**

Measuring therapist empathy is complex due to its historical foundations, nuanced definitions, and practical manifestations. Measurement methods vary in diversity and scope, including self-rated, client-rated, observer-rated (Decker et al., 2014; Elliott et al., 2018; Sharp, 2016), and written analogue tasks (Decker et al., 2014). Observer measures, crucial for evaluating therapeutic processes and outcomes, play a significant role, especially when exploring the relationship between therapeutic processes and change (Llewelyn, 2016). These assessments aim to evaluate the factors believed to be involved in effecting change, a dimension that was also aimed to be explored in this work.

Schwartz and colleagues (2023) emphasize a key advantage of observational measures, highlighting their unique ability to offer insights and data that are otherwise inaccessible through alternative methods. For this reason, and given the inherent nature of therapeutic practice, in this work, the assessment of therapist-expressed empathy was exclusively possible through observer measures. The following subsection provides a concise overview of the main observer measures used for this purpose.

### **1.5.1. Observer Measures of Therapist Empathy**

Psychotherapeutic dynamics involve complex nuances, and observer measures offer a valuable tool for capturing in-session changes, focusing on therapist empathy during therapist-client interactions. These measures provide real-time observations, avoiding reliance on retrospective self-report assessments, enabling direct observation of client and therapist moment-to-moment verbal/non-verbal interactions. They not only offer objective information for research but also facilitate supervisory feedback (Decker et al., 2014).

Observer measures of empathy vary in assessing cognitive, emotional, or combined components (Sharp, 2016), and have evolved to consider broad perspectives, evaluating multiple facets of empathic responses (Elliott et al., 2018). However, conceptual and assessment

confusion arises as many measures overlap with other therapeutic relationship elements (e.g., genuineness, positive regard, compassion, presence).

Considering these aspects, and considering the comprehensive review by Sharp (2016) of empathy measures, and the latest meta-analysis on the relationship between therapist empathy and psychotherapy outcomes by Elliott and colleagues (2018), there are three main observer measures of therapist-expressed empathy: the *Accurate Empathy Scale* (Truax & Carkhuff, 1967), the *Response Empathy Rating Scale* (Elliott et al., 1982), and the *Measure of Expressed Empathy* (Watson, 1999). These observer measures were developed with a deep understanding that empathic responses involve various elements, consequently, they assess multiple facets of empathy (Sharp, 2016).

**a) *Accurate Empathy Scale (AES; Truax & Carkhuff, 1967)*** - The first empathy scale that reliably operationalize empathy into distinct behaviors and statements. The scale is administered by an observer (or team of observers) who listens to recordings of a clinical interaction, and it was primarily designed for teaching and training empathy to students in helping professions (Butters, 2010). Originally categorized into nine empathy stages, it was later revised (Carkhuff, 1969, cit. Butters, 2010) into five-point. A rating of one indicates low levels of empathic responding, while a rating of five signifies high levels of empathy. Truax and Carkhuff (cit. Sharp, 2016) defined "accurate empathy" as the therapist's sensitivity to the client's current affect and the ability to verbally express understanding of the client. The author suggests that the form of empathy being measured is cognitive empathy.

This scale has been extensively validated and used and remaining prevalent in social work education teaching and training in empathy (Butters, 2010). However, it's noteworthy that outside of professional training programs, the Carkhuff and Truax scales are no longer the selected instruments.

**b) *Response Empathy Rating Scale (Elliott et al., 1982)*** - According to Elliot and colleagues (1982) the *Response Empathy Rating Scale* achieved three primary objectives: it deconstructs the empathy concept into distinct components that assess various facets of empathic behavior; it provides more detailed clarification of the construct; and it focus on evaluating the empathic qualities demonstrated in individual counselor responses. Objective raters assess therapist responses using a 5-point Likert Scale (0 = No, definitely; 4 = Yes, definitely) across 9 distinct components. These components include: the therapist's intention to enter the client's frame of reference, the therapist's ability to make inferences about and clarify

the client's frame of reference, the plausibility of the therapist's inference, reference to the client's present moment experience(s), the extent to which the therapist refers to the main topic, the linguistic characteristics the therapist uses (e.g., richness), the quality of therapist's voice, the degree to which the therapist is exploratory, and the impact of the practitioner on the client (Sharps, 2016). In terms of the type of empathy measured, the scale attempts to assess different components of empathy.

Watson and Prosser (2002, cit. Decker et al., 2014) affirmed that the *Accurate Empathy Scale* (Truax & Carkhuff, 1967) and the *Response Empathy Rating Scale* (Elliott et al., 1982) offered valuable insights. Nevertheless, the authors acknowledged certain limitations, including the scales' potential restrictions in capturing specific elements of therapist empathy and their focus on client responses.

Beside this background, Watson (1999) identified several observable therapist behaviors indicative of empathy, and developed the *Measure of Expressed Empathy* that includes overlapping components of therapist's empathy.

**c) *Measure of Expressed Empathy (MEE; Watson, 1999)*** - The MEE is an observer-rated measure of therapist-expressed empathy that evaluates therapists' verbal and non-verbal behaviors, speech characteristics, and response modes. Based on the percentage of time that one behavior is present during the rated segment, it consists of 10 dimensions that are rated on a 9-point Likert scale (from 0 = 'never' to 8 = 'all the time'). A global empathy score is calculated as the average of the 10 subscale ratings. According to Elliott and colleagues (2011) these items were conceived to collectively involve processes that integrate therapist empathy as a higher-order category, as they conceptually intersect with each other (Elliott et al., 2011). The type of empathy measured is referred to as expressed empathy (Sharp, 2016).

As mentioned earlier, one of the primary aims of this work was to investigate the impact of therapist-expressed empathy on psychotherapy outcomes. The conceptualization of therapist empathy as a higher-order process, incorporate various nested aspects/dimensions. The *Measure of Expressed Empathy* (MEE; Watson, 1999), as it was described, includes overlapping components of therapist empathy. Additionally, data were collected from sessions employing two different therapeutic modalities. Decker and colleagues (2014) indicate that MEE was designed to be utilized across various psychotherapy protocols or approaches, similar

to broad treatment-based integrity rating systems. The MEE, due to its efficiency and relevance to the study's aims, was selected for assessing therapist-expressed empathy.

Regardless of the specific measure employed, the extensive body of research consistently underscores the pivotal and multifaceted role of empathy in shaping psychotherapy outcomes. While ongoing exploration and debate surround the precise mechanisms of its influence, there exists a compelling body of theoretical and empirical support for the profound impact of therapist empathy on various internal client processes. The understanding of how clients' internal processes contribute to change is also a subject of debate.

Exploring these characteristics and their role in modeling the psychotherapeutic process, clients' ER emerges as a critical aspect of mental health and a central ingredient in therapeutic contexts. Moving forward in this exploration, the focus will shift to clients' ER. This shift aims to further understanding of how empathy operates in relation to clients' emotional regulation.

## 2. Emotions and Emotion Regulation

According to Greenberg (2019), emotions play a vital role in adaptation, a perspective shared by numerous authors in the field of emotion theory (e.g., Darwin, 1872, Izard, 1991, Lazarus 1991, Tomkins 1962-3, cit. Fosha, 2001). From a bio-evolutionary perspective, emotions play a critical role in ensuring survival. They communicate information about circumstances that are personally relevant, and their intensity increases in proportion to the individual's perceived significance of these circumstances (Peluso & Freund, 2018). This information serves to facilitate and direct actions that enhance self-care. Emotions are intricately linked to everyone's core needs and goals, signaling what is important for their well-being and mobilizing them to achieve it (Elliott & Greenberg, 2016; Greenberg, 2002, 2019). Thus, emotions constitute inherent adaptive processes, supported by a system of meaning that informs of the importance of events to overall well-being and effectively organizes individuals for immediate adaptive reactions (Greenberg, 2008).

Humanistic-experiential approaches conceptualize emotions as an innate and essential source of meaning and information for human functioning (e.g., Elliott et al., 2004; Greenberg, 2004b, 2010, 2019). Emotions function as conveyors of information regarding an individual's perception of their environment, focusing attention on salient aspects, and stimulating self-directed actions while eliciting responses from others (Fosha, 2001; Greenberg, 2002; Greenberg & Pascual-Leone, 2006). From the moment of birth, emotions serve as fundamental signaling mechanisms that communicate intentions and regulate social interactions (Greenberg, 2008). So, emotions primarily supply information relating to an individual's self in relation to others, handling a fundamental role in self-regulation and the regulation of others, filling life with profound significance.

This recognition of emotion as an adaptive resource has markedly transformed our understanding of its interplay with cognition and its function in human functioning and psychotherapy (Fosha, 2001). However, despite the adaptive character, emotions can emerge as pleasant or unpleasant, euphoric, or dysphoric (Barrett & Wager, 2006; Greenberg, 2002), or profoundly distressing and overwhelming experiences (Fosha, 2001). While various psychotherapy models have distinctive perspectives on understanding and addressing emotions, a common aim across all approaches is to assist individuals in alleviating their emotional distress (Greenberg, 2019). In this way, and as stated by Gross (2002, p. 281), "*One of life's great challenges is successfully regulating emotions.*"

Considering the aforementioned, a pretherapy feature that has received increasing attention in psychotherapy literature is the clients' ability to regulate their emotions. According to several authors (e.g., Aldao et al., 2010; Gross, 2002; Keshky, 2018; Lopes et al., 2005; Sumida, 2012), the ability to effectively regulate one's emotions is regarded as a fundamental element of typical human development and is closely linked with achieving optimal psychological well-being.

## **2.1. Emotion Regulation, Psychological Disorders and Psychotherapy Outcomes**

ER is recognized as a pivotal component in most emotion theories, as posited by Sumida (2012). The association between successful ER and improved interpersonal relationships, improved academic and occupational performance, and positive outcomes has been supported within theoretical models (Aldao et al., 2010).

In the context of psychotherapy, different theoretical models on the origin and significance of emotions recognize and agree on the importance of "emotional work" and ER as crucial elements for successful therapy outcomes (e.g., Daros et al., 2021; Elliot et al., 2004; Greenberg & Pascual-Leone, 2006; Igra et al., 2023; Peluso & Freund, 2018; Sønderland et al., 2023; Whelton, 2004). In Whelton's (2004) empirical study into emotions, it was demonstrated that clients who exhibit higher levels of ER tend to experience greater improvements in psychotherapy.

A comprehensive review by Greenberg and Pascual-Leone (2006) that explored process and outcome research on emotions, established that the cognitive-affective processes associated with ER predicts positive therapy outcomes. Remarkably, this predictive effect remains its significance, even when accounting the impact of the therapeutic alliance on the overall outcome (Greenberg & Pascual-Leone, 2006). Slee and colleagues (2008) conducted a mediator analysis within the context of an RCT that explored the effectiveness of CBT in treating young individuals who engage in Deliberate Self-Harm (DSH). Their study's results indicated that changes in ER difficulties partially mediated changes in DSH, including difficulties with impulse control and engagement in goal-directed behaviors. Another study by Watson and colleagues (2011), found that clients' level of ER predicted therapy outcomes for depression, even when accounting for the quality of the therapeutic relationship in the later stages of the treatment.

Conversely, the presence of difficulties in ER has been extensively correlated with numerous psychological disorders and poor outcomes in psychotherapy. ER has emerged as a significant target in contemporary mental health, and psychotherapy research, and has progressively been integrated into models of psychopathology (Grant et al., 2018). Research has demonstrated that individuals facing difficulties in effectively regulating their emotions are more vulnerable to the development psychopathological disorders (Campbell-Sills & Barlow, 2007; D'Avanzato et al., 2013; Hofmann et al., 2012; Mennin & Farach, 2007; Schipper & Petermann, 2013). It is widely suggested that deficits in the ability to regulate emotions effectively contribute to the intensification and maintenance of unwanted emotional states. Consequently, these deficits are believed to be implicated in the emergence and persistence of emotional symptoms, as well as physical symptoms linked to emotional experiences, within the context of psychopathology (Grant et al., 2018).

Empirical evidence (e.g., Berking et al., 2019; Grant et al., 2018; Igra et al., 2023; Keshky, 2018) indicates the existence of a cross-sectional association between deficits in ER and symptoms of various psychological disorders, such as MDD (e.g., Aldao & Nolen-Hoeksema, 2010, 2012; Daros et al., 2021; Visted et al., 2018), attention-deficit hyperactivity disorder (e.g., Walcott & Landau, 2004, cit. Berking et al., 2008a), borderline personality disorder (e.g., Gratz et al., 2006), and a range of other conditions. These empirical findings support the idea that the development, maintenance, and treatment of psychological disorders are linked to ER ability.

According to Berking and colleagues (2008b) cross-sectional research has established a correlation between psychopathology and deficits in various ER abilities. Additionally, longitudinal studies have indicated that the capacity to regulate emotions serves as a significant predictor of future psychological health outcomes, and mediational and experimental studies have demonstrated that the impact of a stressor on the emergence of psychopathological symptoms is mediated by ER skills.

In psychotherapy research, Watson and Bedard (2006) conducted a comparative analysis of clients' emotional experiences in CBT and Process-Experiential psychotherapies (PE), in cases of positive and negative outcomes. The results showed that good outcome cases made a deeper exploration of emotions, more frequent reference to their emotional state, and more extensive reflection on their emotional experiences, in contrast to poor outcome cases. Aldao and Nolen-Hoeksema (2010) investigated the relationship between cognitive ER strategies and the presence of symptoms related to eating disorders, anxiety disorders, and depression. According to their research, the findings suggested a negative correlation between effective ER

strategies and psychopathological symptoms, while revealing a positive correlation between ineffective ER strategies and these symptoms, with the latter correlation being more pronounced.

Thus, the integration of ER has become increasingly common within psychopathology models (Aldao et al., 2010). Depression and anxiety, often categorized as 'distress disorders', are frequently attributed to difficulties in regulating emotions (Campbell-Sills & Barlow, 2007; Gross & Munoz, 1995; Mennin et al., 2007). Several theorists posit that individuals who struggle to effectively regulate their emotional reactions to everyday stimuli are predisposed to experience prolonged and intensified episodes of distress, potentially manifesting as clinically diagnosable conditions such as depression or anxiety (Mennin et al., 2007; Nolen-Hoeksema et al., 2008). Some authors (e.g., Kring & Werner, 2004; Mehrabi et al., 2014; Werner & Gross, 2010) have mentioned that ER difficulties manifest as a prevalent feature across more than 75% of the diagnostic categories outlined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). Angell (2017) has extended this perspective, declaring that they are associated with almost all mental disorders encompassed within the fifth version (DSM-5; American Psychiatric Association, 2013).

Consequently, in the context of clinical psychology, these findings emphasize the transdiagnostic dimension of ER in psychological disorders (e.g., Brenning et al., 2022; Fernandez et al., 2016; Iwakabe, 2023; Khakpoor et al., 2019; Kraiss et al., 2020; Naragon-Gainey et al., 2017). According to Khakpoor and colleagues (2019), several psychopathological theories have been advanced to address these issues, searching for the underlying factors contributing to the co-occurrence and comorbidities among emotional disorders. According to these theories, the commonalities among these disorders exceed their distinctions (Aldao et al., 2010; Fernandez et al., 2016). Thus, it becomes apparent that directing interventions towards these common underlying factors can yield substantial advantages when compared to diagnosis-specific therapies. The determination of whether clients are under- or over-regulated, along with the identification of the specific emotions requiring regulation and the strategies employed for regulation, assumes pivotal significance within any therapeutic intervention (Greenberg & Pascual-Leone, 2006).

Acknowledging the growing recognition of the significance of ER in the past two decades, theorists and researchers have engaged in extensive debates on this subject. Despite this growing recognition of ER's significance, achieving a consensus on its precise mechanisms

and components remains challenging due to diverse theoretical traditions and the complex nature of this construct.

## **2.2. Definition of Emotion Regulation**

Thompson (1994, cit. Sloan & Kring, 2007, pp. 27–28) stated that ER “*Consists of intrinsic and extrinsic processes responsible for monitoring, evaluating and modifying emotion reactions, especially their intensive and temporal features, to accomplish one’s goals.*”. In the same line, Rottenberg and Gross (2007) characterize ER as individuals’ efforts to manage when, how, and to what extent they experience and express emotions. This regulation over emotions may involve adjusting both negative and positive emotions in terms of their intensity. Although, traditionally viewed as primarily a conscious activity, recent research indicates that ER can also take place automatically or involuntarily. Several authors (e.g., Aldao et al., 2010; Eisenberg & Spinrad, 2004; Joormann & Stanton, 2016) argue that the concept of ER encompasses a spectrum of mechanisms, including intentional and unconscious processes or strategies that influence the occurrence, intensity, duration, and expression of emotional responses.

Berking and colleagues (2008a, 2008b, 2014) proposed a theoretical framework, conceptualizing adaptive ER through the interaction of nine skills: (a) consciously process emotions/be aware of emotions, (b) identify and label emotions, (c) interpret emotion-related body sensations, (d) understand the triggers of emotions (e) to be compassionate or support oneself in emotionally distressing situations, (f) actively modify negative emotions in order to feel better, (g) accept emotions, (h) be resilient to /tolerate negative emotions, and (i) confront emotionally distressing situations in order to accomplish important goals.

Despite definitional uncertainties, a consensus on core components of ER exists, emphasizing the ability to tolerate, differentiate, and modulate emotional states to pursue goals and meet needs (e.g., Berking et al., 2008a; Gratz et al., 2015; Watson et al., 2011). Reflecting this perspective and considering the paradoxical consequences of attempts to avoid or control emotions, Gratz and Romer’s (2004) therapeutic definition is formulated with a specific emphasis on therapeutic application. Tailored towards informing treatment development and modification, their definition places a focal point on cognitive processes such as awareness, understanding, and acceptance of emotions. Additionally, it underscores the behavioral ability to regulate actions in the face of emotional pain, aligning with existing literature.

Gratz and Romer's perspective aligns with the integrative model, proposed by Watson and colleagues (cit. Elliott et al., 2004; Prosser, 2007; Rodrigues, 2010), that is particularly relevant in the psychotherapy context. According to this model adaptive ER involves a sequence of steps, including *awareness* of emotional arousal, accurate *labeling* of emotional experiences, *valuing and accepting* emotions, *modulating* emotional arousal and expression to meet personal needs and goals, and *reflecting* on and integrating emotional experiences with various aspects of the self and the environment. Consequently, in the context of this work, ER was conceived as the *process* "(...) *how people process, modulate, and express their emotional experience.*" (Watson et al., 2011, p.86).

The fundamental concept of this model proposes that the ability in engaging in each of these processes is believed to lead to successful and adaptive ER. Conversely, difficulties in these abilities and/or intentional efforts to modify or suppress one's level of involvement in cognitive-affective processes are expected to lead to disturbances and conflicts in the regulation of emotions. In fact, individuals' ability to recognize and sustain emotions to approach and/or distance themselves from emotions like sadness and discouragement, to interpret physiological arousal, to develop effective self-control skills, and to understand emotions are extremely important dimensions influencing their success in regulating emotions (Greenberg, 2004b; Gross & Thompson, 2007). Acknowledging the importance of this perspective in this work, a succinct overview of the model will now be presented.

### **2.2.1. The Process Model of Affect Regulation**

Watson and colleagues (cit. Elliott et al., 2004; Prosser, 2007; Rodrigues, 2010) proposed a model involving a sequence of cognitive-emotional processes through which emotional experiences are expressed and modulated. This model is particularly relevant when evaluating how clients articulate their emotional experiences in psychotherapy. As mentioned by Rodrigues (2010), it is essential to recognize that although the model outlines a sequence of regulatory processes influencing and influenced by emotional experiences, regulation may not necessarily occur in a linear manner. ER often involves repetitive, recursive, and/or simultaneous processes.

#### **a) Awareness of bodily and emotional experiencing**

The initial stage addressed in this model refers to the awareness of emotionally arousing stimuli. As outlined by Prosser (2007), the concept of regulating one's emotions cover responses that can occur both outside conscious awareness and within conscious awareness. In this phase, an individual quickly and automatically evaluates the significance of an emotional stimulus and subsequently becomes consciously aware of it. The objective during this stage is to facilitate or enhance clients' emotional awareness, particularly regarding their primary adaptive emotions (Greenberg, 2008; Prosser, 2007).

This awareness serves as an indicator that a significant internal event is unfolding or occurring within the individual, demanding attention and/or potentially action. According to Prosser (2007), from the authors' perspective, this process is integral to effective ER because, to successfully regulate emotions, it's imperative to first be aware of their presence. The absence of this awareness hinders individuals from achieving emotional accessibility, thereby blocking their ability to regulate their emotions effectively.

While emotional awareness is considered indispensable, it is not sufficient for effectively regulating one's emotional state. This is because the successful regulation of emotions requires the individual to attribute some form of meaning to their bodily and emotional experiences.

### **b) Labelling and symbolization of emotional experiencing**

Regulating one's emotions involve the processing and understanding of emotionally arousing information. During this phase, individuals engage in cognitive processing to gain a deeper understanding of the significance of their emotional experiences (Prosser, 2007; Rodrigues, 2010). The ability to label and symbolize emotions is widely acknowledged as a crucial skill for effective ER (Paivio & Laurent, 2001).

Expressing emotions in words allows previously non-symbolized experiences to be assimilated into the person's consciousness, facilitating reflections on what is felt and the creation of new meanings (Greenberg, 2008; Greenberg & Angus, 2004). Often, this labelling stage poses a challenge for clients, requiring them not only to think about their emotions but also 'feel the feeling' in awareness (Greenberg, 2010). This challenge arises because distinct emotions require specific regulatory and coping strategies.

According to Watson and colleagues (cit. Elliot et al., 2004; Rodrigues, 2010), the more capable is an individual at differentiating and labeling their emotional experience, the more information they have available to focus on and explore those emotions. Increased

differentiation and labeling provide individuals with valuable information about their needs and the corresponding action tendencies, allowing them to effectively apply this information to adaptively use their emotions in addressing their needs.

### **c) Acceptance of emotional experiencing**

The value of verbalizing emotions depends on the actual emotional experience. Hence, it is crucial for therapists to help clients in developing strategies/skills to approach, tolerate, and accept their emotions. This step in ER involves accepting emotional experiences rather than attempting to avoid or suppress them (Greenberg, 2008; Prosser, 2007).

In contrast to strategies such as avoidance or ignoring, which impede adaptive ER (Sumida, 2010), individuals in this stage engage in a cognitive process where they assess their emotional experiences in relation to their beliefs and goals, ultimately determining the appropriateness/acceptability of their emotions. According to Watson and colleagues (cit. Elliot et al., 2004), it becomes evident that the acceptance and validation of emotional experiences play a crucial role in the effective regulation of emotions. This is primarily because such acceptance facilitates the integration of emotional experiences, including awareness and understanding.

### **d) Modulation of arousal and expression of emotional experiencing**

The modulation of arousal and expression stands as another crucial element in ER. This involves the ability to vary, modify, and adapt the intensity of arousal and expression of one's emotional experiences (Prosser, 2007; Rodrigues, 2010). In this stage, individuals employ diverse regulatory strategies to achieve an appropriate level of emotional arousal and expression that is adaptable for both them and the surrounding context.

According to Watson and colleagues (cit. Elliot et al., 2004; Prosser, 2007), the core aspect of successful ER lies in the capacity to regulate emotional arousal and expression. In clinical contexts, individuals are often categorized as either over-regulated or under-regulated (Greenberg & Bolger, 2001). Over-regulation is characterized by a tendency to restrict and control emotional experiences and expressions (Greenberg & Bolger, 2001; Prosser, 2007). Clients with this tendency often demonstrate a lack of awareness and acceptance of emotions, an inability to tolerate unpleasant emotions, and a reliance on repressive or suppressive strategies to manage increased arousal (Greenberg, 2010). Conversely, and more frequently in

the psychotherapy context, under-regulated individuals, frequently struggle with emotional overwhelm and manifesting limited control to effectively regulate their emotional expressions.

#### **e) Reflection on emotional experiencing and regulatory process**

This phase is associated with the capacity to engage in reflection on emotional experiences and the subsequently analyze the preceding phases of ER retrospectively. The process of reflection plays an important role in effectively managing of one`s emotions, allowing individuals to consider and address questions related to their emotional experiences, understand the meaning of these experiences, and ultimately achieve a deeper insight into their wants, needs, and goals, along with the most appropriate actions to fulfill them (Elliot et al., 2004; Greenberg & Watson, 2006). Through reflection, individuals can explore their emotions and behavioral patterns, acquiring new insights and developing new behaviors in relation to themselves, others, and difficult circumstances.

A crucial aspect of the role of reflection in the ER process is its contribution to the development of profound experiential self-knowledge (Elliot et al., 2004; Greenberg & Watson, 2006). The meaning and importance we attribute to our emotional experience significantly contribute to the creation of our identity. Understanding an emotional experience invariably involves transforming it into a narrative structure (Greenberg, 2008).

Reflection is positioned as the final step in the series of processes related to ER because, for the process of reflection to occur, emotions must initially be symbolized in awareness. Engaging in reflective analysis of emotional experiences is impossible unless these emotions are first brought to conscious awareness and organized into coherent narratives (Greenberg, 2008; Greenberg & Angus, 2004). The recursive quality of reflection, according to Prosser (2007), implies that the act of reflecting can modify the way emotions were initially elicited and the subsequent emotional experiences. For instance, perceiving sadness as understandable and tolerable can reduce its intensity, while perceiving it as a weakness can elicit feelings of guilt.

In the previous subsections, the theoretical bases of ER were explored, scrutinizing its core components and exploring some of the diverse perspectives, including the integrative model proposed by Watson and colleagues (2011). Transitioning from theoretical frameworks to practical or pragmatic applications, the next subsection will focus on measures of ER, specifically observer measures. This shift recognizes the imperative need to translate theoretical

constructs into practical tools that offer factual insights. Through the examination of select measures, the aim is to bridge the theoretical understanding established in the previous subsections with insights that prove not only vital in psychotherapy research but also essential in clinical practice.

### **2.3. Measures of emotion regulation**

Given the growing focus in psychotherapy literature on emotions and clients' ability to regulate them, several measures have been developed to assess these dimensions. Numerous measures for assessing ER can be valuable not only in psychotherapy research but also in clinical practice. As highlighted by Sloan and Kring (2007), the inclusion of such measures enables the ongoing supervising of progress throughout psychotherapy. This serves as a crucial feedback source for therapists, offering insights into the accuracy of their case formulations, the effectiveness of intervention strategies, and as an overall indicator of therapy effectiveness.

While self-report measures dominate ER assessment, they might overlook natural variability and suffer from recall bias (Girard & Cohn, 2016; Schwartz et al., 2023). As mentioned in the earlier discussion on empathy, due to the characteristics of this study, the exploration of clients' ER was limited to observational measures since it was not a variable considered in the RCT from which data were collected.

According to Iwakabe and colleagues (2023), four observer-rated ER measures with satisfactory interrater reliability are highlighted: the *Client Emotional Productivity Scale-Revised* (Auszra et al., 2013), the *Classification of Affective-Meaning State* (Pascual-Leone & Greenberg, 2005), the *Achievement of Therapeutic Objectives Scale* (Berggraf et al., 2012), and the *Observer Measure of Affect Regulation* (Watson & Prosser, 2006). Next, a brief overview of each of them it's provided.

**a) *Client Emotional Productivity Scale-Revised*** (CEP-R; Auszra et al., 2013) – The CEP-R assesses client emotional productivity (CEP), indicating the extent to which a client experiences primary emotions in an effective and constructive manner. For primary emotions, coders must determine whether the emotion is processed in a contactfully or mindfully aware manner, guided by seven criteria: attending, symbolization, congruence, acceptance, regulation, agency, and differentiation.

**b) *Classification of Affective-Meaning State*** (CAMS; Pascual-Leone & Greenberg, 2005, cit. Iwakabe et al., 2023) – CAMS is an observer-based rating system that measures the occurrence of ten discrete and specific emotional processing states during psychotherapy sessions (Pascual-Leone, 2018). It categorizes a client's affective-meaning states on a continuum from less to more productive emotional processing, encompassing: (1) Global distress, (2) Fear/shame, (3) Rejecting anger, (4) Negative evaluation, (5) Need, (6) Relief, (7) Grief/hurt, (8a) Assertive anger, (8b) self-compassion, and (9) Acceptance & agency. These categories are distinguished by variations in emotional tone, involvement, arousal, and meaning making.

**c) *Achievement of Therapeutic Objectives Scale*** (ATOS; Berggraf et al., 2012) – The ATOS measures the client's observable achievement of common therapeutic objectives through the observation of changes in their behavior related to seven specific goals: gaining insight into maladaptive patterns and defenses, motivation for therapeutic change, activating affects (previously referred to as "exposure"), inhibitory affects, acquiring new emotional learning between sessions, developing a sense of self (compassionate self-image), and sense of others (compassionate image of others) (Berggraf et al., 2012).

**d) *Observer-Measure of Affect Regulation*** (O-MAR; Watson & Prosser, 2006) – O-MAR is an observer measure that allows the assessment of clients' ER in terms of multiple domains and emotion regulation strategies. Clients' ER is assessed based on five subscales of emotional processing: 1) Level of Awareness; (2) Modulation and Arousal; (3) Modulation and Expression; (4) Acceptance of Affective Experience; and (5) Reflection on Experience (Watson & Prosser, 2006). Each of the subscales is rated on a seven-point Likert scale with lower scores reflecting lower levels of functioning.

As emphasized by Sloan and Kring (2007), several factors should be considered when selecting measures for use in psychotherapy research and practice. According to the authors, a crucial aspect of measurement involves how the targeted emotion construct is conceptualized. When choosing measures, it is imperative to have a clear understanding of the chosen definition, in this case, of ER, and then select a measure that aligns most closely with that conceptualization. As highlighted by Burt (2013), many commonly used measures either assess related constructs (e.g., CEP-R evaluating client emotional productivity) or concentrate on specific facets of ER (e.g., CAMS, which assesses specific emotional processing states).

Considering the measures presented earlier, it was recognized that O-MAR was the only measure that serves as a practical manifestation of the theoretical foundations of this work, especially the definition of ER adopted. Aligned with Watson and colleagues' Process Model of Affect Regulation, the fundamental aspects of ER find practical application in the O-MAR, offering a lens into how individuals manage the complexities of their emotional experience. The O-MAR (Watson & Prosser, 2006) is an observer measure that allows the assessment of clients' ER, in real-time, evaluating multiple domains and strategies during the assessment process. This observer tool serves as a bridge between theory, measurement, and practice.

Giving the importance to connect theory, measurement, and practice, in the next section it will be done an in-depth exploration of ER's role in depression. This bridge is crucially relevant in the context of depression, a domain full of challenges in ER. Difficulties in ER, including challenges in recognizing, understanding, and modifying emotions, resonate with experiences of depression.

## **2.4. Major Depressive Disorder and Emotion Regulation**

MDD stands out as one of the most prevalent psychological disorders globally (e.g., Everaert & Joormann; 2019; Mehrabi et al., 2014), characterized by profound emotional distress and a compromised ability to function effectively (e.g., Everaert & Joormann, 2019; Keshky, 2018; Kessler et al., 2003). At the societal level, MDD exerts significant economic burdens. These include reduced productivity, lower educational completion rates, higher unemployment rates, diminished marital relationship quality, increased medical conditions and suicide rates, and heightened utilization of healthcare resources (e.g., Greenberg et al., 2015; Joormann & Stanton, 2016; Liu & Thompson, 2017; Visted et al., 2018). Lifetime prevalence rates for MDD and dysthymia, approximately 16.6% and 2.5%, respectively, as reported by Kessler and colleagues (2005), underscore the substantial impact of these conditions. Berking and colleagues (2014) recognized MDD as the foremost cause of disability, ranking fourth in terms of illness burden across medical and psychological disorders. The estimated economic burden associated with MDD in the United States reached to \$210.5 billion in 2010, marking a 21.5% increase compared to 2005 figures (Greenberg et al., 2015).

In Portugal, as indicated by the first report of the *National Epidemiological Study of Mental Health* (Almeida & Xavier, 2013), mood disorders have a prevalence of 7.9%. More recently, the *Mental Health in Times of Pandemic (SM-COVID19) study*, led by the Department

*of Health Promotion and Prevention of Non-Communicable Diseases at the National Institute of Health Dr. Ricardo Jorge* (Almeida et al., 2021), aimed to assess the impact of COVID-19 on mental health and well-being. This study reveals alarming findings with 26% of individuals in the general population exhibiting symptoms of depression.

Given the high prevalence and significant socioeconomic consequences of depression, it becomes imperative to investigate the factors contributing to its development and maintenance. Equally important is the need to develop effective treatment approaches to facilitate recovery from depressive episodes and implement preventive measures (Everaert & Joormann, 2019; Joormann & Stanton, 2016; Keshky, 2018; Mehrabi et al., 2014; Visted et al., 2018). From an intuitive perspective, one can argue that emotion plays a fundamental role in the expression and diagnostic features of depression (Rottenberg, 2017).

As outlined in the *DSM* (5th ed.; DSM–5; American Psychiatric Association, 2013), MDD is categorized as a mood disorder. It is characterized by two primary symptoms linked to affective disturbances: persistent and intense feelings of sadness (negative affect) and/or a significant reduction in the ability to experience pleasure (positive affect). Additionally, individuals diagnosed with MDD often exhibit heightened volatility in negative emotions compared to individuals without the disorder (Liu & Thompson, 2017). The hallmarks of depression, characterized by a persistently negative mood and/or an inability to experience positive affect or pleasure (anhedonia), strongly suggest the involvement of emotional dysregulation in this condition (e.g., Berking & Wupperman, 2012; Everaert & Joormann, 2019; Joormann & Stanton, 2016; Prosser, 2007; Visted et al., 2018).

Consequently, numerous authors (e.g., Campbell-Sills & Barlow, 2007; D'Avanzato et al., 2013; Kring & Werner, 2004; Liu & Thompson, 2017; Mehrabi et al., 2014; Pos et al., 2009), propose that ER serves as a substantial conceptual framework for understanding mental disorders, particularly mood disorders like depression. Joormann and Gotlib (2010) suggest that individuals susceptible to depression, as well as those who are not, differ in their ability to recover from a subsequent negative emotional state rather than in their initial reaction to an adverse event. The effective management of unpleasant emotions is believed to play a pivotal role in maintaining a sense of control in challenging circumstances, interfering with information processing mechanisms contributing to the development of depression (Berking et al., 2014). Therefore, difficulties associated with ER contribute to the risk and maintenance of MDD (Liu & Thompson, 2017).

It's important to note, as suggested by Prosser (2007), that dysregulation in depression doesn't necessarily indicate a complete absence of regulation. A consistently depressed mood

doesn't necessarily signify unregulated emotions, but rather an individual regulating their emotions dysfunctionally or ineffectively (e.g., under-regulation of feelings of sadness and over-regulation of feelings of anger). Effective ER skills have the potential to prevent, reduce, or shorten the severity or duration of dysphoric states (Berking et al., 2013), which can reactivate patterns of depressive thinking and contribute to the (re)occurrence of depression.

Therefore, there has been significant discussion about the potential effectiveness of addressing ER difficulties as an effective strategy in the treatment of depression (e.g., Berking & Wupperman, 2012; Everaert & Joormann, 2019; Keshky, 2018; Visted et al., 2018). Some authors even suggest that from this perspective, it's worth considering the diagnostic characteristics of ER strategies, their predictive value for mental disorders, their role as mediators in treatment, and their potential status as treatment outcomes (e.g., Pos et al., 2009; Rottenberg & Gross, 2007).

Consistent with this hypothesis, empirical research has shown that individuals with depression encounter difficulties in effectively using adaptive strategies for regulating their emotions (Berking et al., 2014).

#### **2.4.1 Emotion Regulation, Depression and Psychotherapy Outcome**

Recent research has underscored the pivotal role of difficulties in ER as plausible risk factors in the development and maintenance of MDD (e.g., Berking et al., 2019). Epidemiological data suggest that initial occurrences of MDD often align with adverse life events (Joormann & Stanton, 2016). When exposed to negative induction, depressed individuals are noted to use less effective ER strategies compared to their non-depressed counterparts (Ehring et al. 2010). Several cross-sectional self-report studies establish a correlation between symptom severity and difficulties in identifying emotions, self-soothing, and adaptively modifying negative emotional experiences (Berking et al., 2014). Additionally, difficulties in accepting, tolerating, and adaptively modifying negative emotions have been associated with depression (Campbell-Sills et al., 2006). Longitudinal studies further reveal that difficulties in ER are not merely symptomatic features but are probably the most risk factor for the development, maintenance, and severity of depressive disorder (Berking et al., 2013, 2014; Grant et al., 2018).

Treatment outcome studies highlight the effectiveness of therapies targeting ER difficulties in MDD treatment. In a study by Watson and colleagues (2011), ER at the end of

therapy predicted treatment outcomes, independently of other factors. Experimental studies in this domain show that individuals with depressive disorder are more prone to using maladaptive ER strategies that impede recovery (Berking et al., 2013). Additionally, research indicates that those struggling with ER during difficult circumstances are less likely to achieve high effectiveness in CBT for MDD (Berking et al., 2014). A comprehensive review by Mehrabi and colleagues (2014) examined existing literature on the impact of ER in depression, concluding that ER could potentially function as a mediator or moderator in the development of depression.

Fehlinger and colleagues (2013) assert that, compared to other skills, the ability to regulate emotions stands out as a critical determinant of the intensity of depressive symptoms. This underscores the importance of prioritizing ER in treatment approaches alongside disorder-specific interventions to alleviate depression symptoms. Various therapeutic modalities approach this aspect differently, with experiential and psychodynamic approaches focusing on reducing avoidance of rejected emotions and encouraging healthy expression (Prosser, 2007). Conversely, cognitive and behavioral treatment approaches place greater emphasis on strategies to manage and control the intensity and chronicity of emotions. Notably, Berking and colleagues (2008a) demonstrated that the effectiveness of typical cognitive-behavioral treatment can be enhanced by incorporating interventions specifically targeting the improvement of ER skills.

Interventions focusing on ER components have shown promise in reducing depressive symptoms (e.g., Berking et al., 2008a, 2019; Mehrabi et al., 2014; Radkovsky et al., 2014). A diverse range of interventions has been developed to help individuals develop adaptive skills for regulating their emotions (Prosser, 2007). Preliminary evidence supporting this concept comes from research illustrating the effectiveness of Dialectical Behavior Therapy (DBT) in addressing several disorders, including borderline personality disorder, persistent depression, substance use disorder, and eating disorders (Berking et al., 2019). DBT primarily emphasizes teaching emotion management skills to individuals. Furthermore, other therapeutic interventions for treating mental disorders include Cognitive Behavioral Therapy—Enhanced (CBT-E), Emotion-Focused Cognitive Behavioral Therapy (ECBT), EFT, Emotion Regulation Therapy (ERT), and the Unified Protocol for the treatment of emotional disorders (UP). Fosha (2001) argues that emotional experience and its regulation serve as important catalysts for transformation in psychotherapy. According to the author, a primary goal of psychotherapy should be to target and repair such difficulties.

A crucial integrative insight, as highlighted by Whelton (2004), underscores that the most significant therapeutic shift occurs when emotions are sufficiently controlled, facilitating

both the processing and encouragement of feelings, as well as a critical thought about their meaning. This perspective aligns with Greenberg's (2004a) three fundamental principles of emotional change – emotion regulation, emotion awareness, and emotion transformation – supported by empirical evidence. Focusing on emotions yields numerous benefits, aiding clients in becoming less critical and self-rejecting, and fostering greater self-compassion (Watson et al., 2014). Several authors (e.g., Berking et al., 2008a; Goldman et al., 2005; Watson et al., 2011, 2019) argue that integrating ER is crucial for achieving effective outcomes in psychotherapy.

Peluso and Freund (2018) emphasize the importance of therapists collaborating with clients to address and overcome avoidance related to focusing on emotions. Therefore, psychotherapeutic approaches targeting depression should prioritize emotion regulation as a key mechanism. It is essential to note that effective ER can only occur within the context of an authentic and validating therapeutic relationship. For clients to genuinely experience and express their emotions, the presence of an effective therapeutic relationship is essential. Hence, the initial level of intervention aimed at reducing naturally generated underregulated distress involves providing a secure, validating, supportive, and empathic environment (Angus & Kagan, 2007; Greenberg 2008; Greenberg & Pascual-Leone, 2006).

This question forms the basis for revisiting the exploration of one aspect of therapist empathy: its role in ER. The main goal of this exploration is to understand how therapists' empathic responses can serve as a crucial factor in supporting clients navigate and regulate their emotions during the therapeutic process.

## **2.5. The Emotion Regulation Function of Empathy**

According to Porges (2007), affect is viewed as a biobehavioral process, and is modulated through interpersonal means. Through life, individuals can cope with difficult situations by interacting emotionally with supportive and empathic figures (Fosha, 2001). Whether in parent-child, therapist-patient, or romantic partner dyads, reciprocal emotional communication is inherent (Fosha, 2001). In some way, therapist empathy shares structural and functional similarities with the responsive attunement (or empathy) of a caregiver, potentially assisting clients in regulating their emotions (Paivio & Laurent, 2001). Positive social interactions and interpersonal behaviors that contribute to the regulation of bodily sensations and behaviors are considered fundamental to effective psychotherapy (Porges, 2007).

From Greenberg and Watson's perspective (2006), psychotherapeutic interaction serves dual purposes. First, the therapeutic relationship itself yields a therapeutic impact on the client by regulating their emotions, a process that could be internalized over time. This is achieved by fostering a soothing and attuned relationship marked by the therapist's presence, empathic emotional attunement, acceptance, and congruence. Additionally, the relationship functions as a mechanism to achieve specific therapeutic goals. Within a secure relationship, emotions are more likely to be approached, tolerated, and accepted (Greenberg, 2014).

Understanding empathy's role in ER is not difficult. Empathy creates a safe environment for addressing and tolerating emotional experiences (Greenberg 2014, 2021; Malin & Pos, 2015; Paivio & Laurent, 2001; Watson, 2002, 2016, 2018). It facilitates understanding, acceptance, and the revelation of unknown needs (Malin, 2016). Prosser (2007) outlines empathy's key roles: create a secure interpersonal environment; foster awareness and differentiation; challenge beliefs; and directly regulate arousal levels during therapy.

So, therapist empathy goes beyond creating a secure emotional environment for clients, facilitating continuous and moment-to-moment emotional communication (Fosha, 2001; Paivio & Laurent, 2001). It provides a soothing effect as individuals experience empathic understanding of their internal states (Angus & Kagan, 2007; Elliott et al., 2004; Fosha, 2001; Watson, 2002, 2007a). By creating an atmosphere of safety and support, the therapist can encourage clients to explore their thoughts and feelings freely, without fearing judgement or rejection (Elliott et al., 2004; Greenberg, 2014; Kim, 2018; Malin & Pos, 2015; Watson, 2016), reducing anxiety (Greenberg, 2004a), promoting a profound sense of relief (Watson, 2007a).

Empathic listening empowers clients to increase awareness and label cognitive and emotional experiences, allowing controlled modulation of their experiences and expressions (Greenberg & Watson, 2006; Malin, 2016). Empathic responses guide clients in the transition from surface-level for a more profound exploration of emotions and their associated meanings (Watson, 2002). Effective ER involves balancing emotional experience, avoiding overwhelm yet responding adequately (Prosser, 2007). The client's self-reflection, essential for constructing new meanings, involves expressing and symbolize primary adaptive emotions and fundamental beliefs (Angus & Kagan, 2007). Identifying emotions needing regulation and determining how to regulate them are crucial aspects of treatment (Greenberg, 2008).

Empathic responses direct client's focus, enhancing awareness and validating feelings (Paivio, 2013; Prosser, 2007; Watson, 2002; Watson et al., 2014). This process improves their overall functioning and facilitates their goal achievement (Paivio, 2013; Prosser, 2007; Watson, 2002; Watson et al., 2014, 2020), especially when clients hold learned beliefs of their emotions

as insignificant, immoral/bad, or worthless (Paivio, 2103; Watson, 2002). As clients progress, the need to suppress components of their psychological lives diminishes (Fosha, 2001). Emotions become controllable within the dyadic context, reducing reliance on avoidance strategies (Greenberg, 2014). The process of learning to self-soothe, restore emotional equilibrium, and strengthen the self seems intricately linked to receiving empathy from another person (Greenberg, 2008, 2014).

Watson (2011) expanded Rogers's Process Model suggesting that clients internalize how others treat and respond to their inner experiences and perceptions. This process fosters ER, self-empathy, and adaptive coping strategies (Greenberg, 2004a). This engagement results in a new interpersonal experience of emotional support and soothing, gradually becoming internalized over time (Fosha, 2001; Watson, 2011). The therapist's empathic responses become internalized, building positive and nurturing internal representations and patterns of self-response that affirm, accept, protect, and sooth (Watson, 2018; Watson et al., 2014). Through the therapy relationship, clients vicariously experience a model of ER (Greenberg, 2008). These internalized representations contribute to improvements in the clients' self-concepts. Through this transformative process, clients develop a reduced tendency to criticize themselves and their experiences, while simultaneously enhancing their confidence (Watson, 2018).

The presence of an engaged and empathic listener enables clients to openly share significant emotional experiences, fostering understanding and acceptance (Greenberg, 2008). Transforming experiences into narratives allows clients to create psychological distance from internal systems, facilitating problem-solving and development of empowering personal meanings (Greenberg, 2008; Watson 2018).

Regardless of this growing recognition of the mutual importance of the relationship between empathy and ER, the current research of this relationship is limited (Thompson et al., 2019; Watson et al., 2020). The intricate mechanisms through which empathy contributes to clients' ER and change processes are subjects of ongoing debate. Despite limited research on the role of empathy in enhancing clients' ER abilities experiential theorists argue (e.g., Paivio & Laurent, 2001; Watson et al., 2014), and empirical evidence supports (Prosser, 2007; Watson et al., 2020), the notion that therapists' empathic responses aid in accessing emotions, identifying needs, and developing effective ways to regulate emotions.

In a study conducted by Prosser (2007), the researcher used a path analysis to explore the relationship between therapist empathy, ER, and treatment outcomes. The data for this study were derived from the treatment study of depression conducted by Watson and colleagues in

2003. The study sample was comprised of 66 clients who had been diagnosed with MDD in accordance with the criteria outlined in the DSM-IV. The findings shed light on a particular aspect of the therapist-client interaction. It was revealed that therapist empathy exerted its influence on treatment outcomes through a mediated process involving changes in clients' ER.

In a recent study by Watson and colleagues (2020), the primary aim was to examine whether changes in clients' ability to regulate emotions mediated the impact of therapists' empathy on therapeutic outcomes. Additionally, the study aimed to explore whether the strength of this association differed between clients exhibiting more insecure attachment styles and those with securely attached styles. The study involved depressed clients who engaged either CBT or EFT. The results revealed significant findings: therapist empathy emerged as a robust predictor of positive changes in various outcome measures and client ER. Particularly significant was the mediating effect of changes in clients' ER, which relates to their ability to be aware, accept, modulate emotional arousal and expression, and reduce emotional suppression and reactivity. This mediated relationship was particularly pronounced concerning depressive symptoms, self-esteem levels, and dysfunctional attitudes, although did not extend to interpersonal problems. Additionally, the study emphasized the impact of clients' perceptions and experiences of their therapists as empathic, predicting changes in clients' ER capacities, as well as changes in their depression levels, interpersonal problems, dysfunctional attitudes, self-criticism, neediness, and self-esteem, within both CBT and EFT.

These findings strengthen the idea that clients' perceptions of their therapists as empathic contribute to increased awareness, symbolic representation, and modulation of emotions (e.g., Fosha, 2001; Paivio, 2013). In alignment with this, Schore and Schore (2014) have proposed that the subjective experience of empathy in the presence of negative emotions enhances the regulation of emotional arousal and expression.

As established in the exploration of the ER function of empathy, the intricate interplay between therapist empathy and client ER, and its relationship to psychotherapy outcome, were the theoretical foundations, to the empirical studies in this dissertation. These studies will be presented in the next part.



## **PART II – EMPIRICAL STUDIES**



## Study 1\*

### Emotion regulation and psychotherapy: Adaptation and elaboration of an application manual of the *Observer Measure of Affect Regulation (O-MAR)*

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**Abstract:** *The aim of this work was to adapt and develop a Portuguese manual for the Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006), an observational measure of clients' emotion regulation in psychotherapy. Since the scale has not yet been adapted to Portuguese, initially a translation was performed. Then, to elaborate the manual, the middle 20 minutes of 20 therapy sessions were observed and classified and 2 illustrative excerpts were selected by consensus for each level of analysis of the various domains of the scale. All these videotaped sessions were collected in a randomized clinical trial carried out in Portugal for the treatment of depression, comparing 2 empirically supported models for the treatment of this disorder – cognitive behavioral therapy and emotion-focused therapy. All the participants were initially evaluated and diagnosed with mild or moderate major depressive disorder, and they attended 16 sessions of psychotherapy.*

**Keywords:** Emotion regulation, psychotherapy, O-MAR.

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## 1.1. Introduction

After a period during which emotions were regarded as a mysterious phenomenon and inaccessible to scientific research (Gross, 2007), currently there are no doubts about their importance to individuals' lives. In recent decades several scientific works have been conducted (Greenberg, 2002) in an attempt to understand the set of processes linked to emotions and their role in terms of physical and mental health (Davidson, Scherer, & Goldsmith, 2003; Fredrickson & Cohn, 2008; Gross, 2007).

Over their life cycle, human beings are faced with several challenges, difficulties, and distress situations, and emotions play a key role in adapting to these demands by organizing actions (Reeve, 2009). According to Greenberg and Pascual-Leone (2006), emotions inform individuals that a particular purpose or need may be favorable or unfavorable, reflecting a biological trend determined to act according to our assessment of a situation based on goals, needs, or concerns. In this way, through emotions, the individual carries out an initial assessment of the situation, a key feature that informs the individual of the importance of events, preparing him or her for rapid adaptive action and directing his or her behavior (Greenberg, 2002). Consequently, the role of emotions in human psychological functioning is fundamental since they provide vital functions, such as guiding, communicating, preventing, signaling, and preparing for action.

Despite this adaptive character, emotions can emerge as pleasant or unpleasant, euphoric or dysphoric yet adaptive or maladaptive experiences according to what is appropriate in each situation experienced by individuals (Barrett & Wager, 2006; Greenberg, 2002). In this way, and as stated by Gross (2002, p. 281), "*One of life's great challenges is successfully regulating emotions.*" In the field of scientific research, there do not seem to be any doubts about the importance of emotion regulation in the various dimensions of people's lives. Emotion regulation is a core competence in social interaction, influencing emotional expression and behavior (Lopes, Salovey, Cote, & Beers, 2005). It is an important factor in determining the well-being and adaptive functioning of human beings (Cicchetti, Ackerman, & Izard, 1995), preventing high levels of stress and maladaptive behaviors in emotionally demanding situations (Gross, 1998).

In spite of the substantial amount of research attention paid to emotion regulation in recent years, there are different definitions of this construct. For instance, Thompson (1994, cit. Sloan & Kring, 2007, pp. 27–28) stated that emotion regulation "Consists of intrinsic and extrinsic processes responsible for monitoring, evaluating and modifying emotions reactions,

especially their intensive and temporal features, to accomplish one's goals." Similarly, Gross (1998, p. 275) defined emotion regulation as the process by "which individuals influence which emotions they have, when they have them, and how they experience and express these emotions." Considering the functional nature of emotion responses, Gratz and Roemer (2004, cit. Berna, Ott, & Nandrino, 2014; Slee, Spinhoven, Garnefski, & Arensman, 2008) defined emotion regulation from a more clinical perspective, integrating five dimensions into this process: awareness and understanding of emotions; acceptance of emotions; ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions; and ability to use contextually appropriate emotion regulation strategies to modulate emotional responses as desired to meet individual goal and situation demands. Despite the lack of consensus, there are common points to the several conceptions of emotion regulation. For Berking and colleagues (2008) and Watson, McMullen, Prosser, and Bedard (2011), regulating emotions comprises the ability to process, model, and express the emotional experience. It is this perspective that underlies the development of this work.

The way in which we regulate our emotions is fundamental to our lives and therefore may be adaptive or maladaptive. According to Bridges, Denham, and Ganiban (2004), to be able to regulate their emotions, individuals need flexibility and the ability to adapt to the current circumstances and modulate their emotions. Such skills suggest, for instance, the initiation or maintenance of positive emotional states and the attenuation of negative emotional states. From this perspective, Cole, Martin, and Dennis (2004) reported that emotion regulation is associated with changes in activated emotions, taking into account their nature, intensity, and duration, or psychological processes such as memory and social interaction. Nevertheless, authors like Eisenberg and Spinrad (2004) supported a more specific view, suggesting that the concept of emotion regulation should be directed to the regulation of emotions and not to the regulation of cognitive, behavioral, and relational processes of emotions. Thus, the authors argued that emotion regulation may be understood as the process of initiating, avoiding or maintaining, and modulating the occurrence, form, intensity, or duration of the emotional states.

Individuals' capacity to recognize and sustain emotions, to approach and/or move away from emotions like sadness and discouragement, to interpret the physiological activation, to develop effective self-control skills, and to understand emotions as an enhancing factor of performance are extremely important dimensions of their success in regulating emotions (Greenberg, 2004b; Gross & Thompson, 2007). According to Greenberg (2004b), it is essential to recognize and sustain emotions because only then can we eventually tolerate pleasant or unpleasant emotions. At this level Elliott, Watson, Goldman, and Greenberg (2004b) underlined

that the immediate difficulty that could arise is becoming disconnected from one of the emotion dimensions. For instance, a person can have difficulties in accessing the bodily experience of emotions or fail in the process of symbolizing them.

Currently emotion regulation research is considered to be extremely relevant to multiple areas of psychology. The importance of emotion regulation has been well documented, for instance in cognitive psychology, social psychology, and psychobiology, among other areas. However, being fundamental to the adaptive functioning and mental health of human beings, emotion regulation represents an extremely relevant field for clinical psychology and specifically for psychotherapy (Greenberg, 2004b; Gross, 1998; Watson et al., 2011). In fact, as human beings, we constantly try to make sense of our experiences (Greenberg & Pascual-Leone, 1995). We seek to explain them and give them meaning by narrating them in a way that enables us to tell a continuous story about the person's life path. Giving words to emotions allows the non-symbolized previous experience to be assimilated in the person's consciousness and then facilitates reflections on what is felt, the creation of new meanings, and eventually the construction of a coherent story (Greenberg, 2008). The meaning that we take from our emotional experiences makes us what we are. All emotions stem from stories or significant events, and all events or stories involve significant emotions (Greenberg & Angus, 2004).

In fact, difficulties in emotion regulation are a common factor in the development and maintenance of several psychological disorders, and their treatment involves promoting emotion regulation skills (Berking, Wupperman, Reichardt, Pejic, Dippel, & Znoj, 2008; Fowler et al., 2014). While a person with depression fights not to cry during dinner at home, an obsessive-compulsive person feels intense anxiety and washes his or her hands many times before dinner. As Werner and Gross (2010) argued, despite the differences between disorders, many of them are characterized by the experience of negative emotions and the attempt to regulate them (e.g. suppressing the experience or the expression). The authors stressed that more than 75% of the diagnostic categories of psychopathology in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV; American Psychiatric Association, 1994) are characterized by problems with emotion or with emotion regulation, so it is not surprising that emotion regulation deficits are integrated into many psychopathology models (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Berking & Wupperman, 2012; Forkmann et al., 2014). Depression, complicated grief, opiate addiction, bulimia, chronic fatigue (Watson, McMullen, Prosser, & Bedard, 2011), borderline personality disorder, and post-traumatic stress disorder (Fowler et al., 2014) are some examples of situations involving difficulties in emotion regulation. A study directed by Whelton and Greenberg (2001) found lower resistance to self-

criticism in more subjects who were vulnerable to depression than in the less vulnerable population, which showed a greater ability to use positive emotional resources against the negative experiences. Some authors have argued that depression can be seen as a result of successive dysfunctional attempts to regulate emotions and of excessive use of maladaptive strategies like rumination (Campbell-Sills & Barlow, 2007; Kring & Werner, 2004). In fact, depressed people have difficulty in accepting negative emotions and a lower perception of the meaning of their own emotions (Rude & McCarthy, 2003). Thus, promoting adaptive ways and skills of emotion regulation as acceptance of negative emotions seems to be very relevant to the process of change and therefore to the success of psychotherapy (Barlow, Allen, & Choate, 2004). For Watson and colleagues (2011), emotion regulation should be a target of change in psychotherapy.

Berking and colleagues (2008) argued that therapeutic success may be related to the development and training of emotion regulation strategies, since many of the problematic issues that lead individuals to seek therapy are in fact based on uncertainties about the meaning of their emotions and a lack of abilities to regulate them. Psychotherapy can then provide the client with adaptive ways of controlling unregulated emotions (Ochsner & Gross, 2005). As mentioned before, emotion regulation involves consciousness, symbolization, and adaptive use of emotions to deal with possibly difficult situations (Greenberg, 2002). Every emotion has its own purpose, so therapists should guide their interventions based on the individual situation and the ongoing emotional process. Indeed, Watson (2007) stated that it is important to identify the key aspects to be used with clients to adapt the different ways of working better to solve the problems brought to the therapeutic process. Therapists should lead clients to understand their problems, goals, and objectives, demonstrating that they are involved and interested in solving their problems based on pillars such as the congruence and openness of both parties. Leading clients to develop their acceptance, modification, and tolerance of negative emotions is the largest and most consistent gain that can be achieved through therapeutic intervention.

Thus, several forms of psychotherapy, sometimes with different theoretical conceptions, seem to share the idea that emotional work, including emotion regulation, is a critical requirement for a good therapy outcome (Elliot, Watson, Goldman, & Greenberg, 2004b; Greenberg & Pascual-Leone, 2006; Whelton, 2004). Providing the exploration and identification of clients' emotions in the therapeutic process certainly appears to be a core issue for change (Greenberg, 2008). Subsequently, the assessment of emotion regulation through the therapeutic process can help in gaining an understanding of the development of the same.

In recent years some measures have been developed with good psychometric features and with different methodologies (e.g., self-report; observational and psychophysiology) (Sloan & Kring, 2007). Actually, a considerable number of measures can be used in psychotherapy research and practice. Sloan and Kring (2007) asserted that it is important to include these measures as an indicator of the effectiveness of the therapy. However, they stressed that therapists should use these measures as an indicator of psychotherapy progress to provide a form of monitoring of the process.

In the field of psychotherapy research and practice, we should be aware that these several measures assess different aspects of the emotional process, like emotional experience, emotional expression, and emotion regulation (Sloan & Kring, 2007). Another consideration that should be taken into account is the fact that different measures have different conceptions of these processes, as is the case of emotion regulation. Sloan and Kring (2007) reviewed these measures and made suggestions regarding the appropriate selection of them. Based on a literature review, we will present below some of the most used measures of emotion regulation in psychotherapy research and practice.

### **1.1.1. Self-report measures**

#### ***The Emotion Regulation Questionnaire (ERQ; Gross & John, 2003)***

The ERQ (Gross & John, 2003) is based on the process model of emotion regulation pioneered by Gross (1998), which contemplates different emotion regulation strategies. The perspective of the model is that emotion regulation strategies can be classified into two categories: antecedent focused and response focused. The ERQ was designed to assess the individual differences in two of them: cognitive reappraisal and expressive suppression (Sloan & Kring, 2007).

Cognitive reappraisal is defined as an antecedent cognitive strategy, since it occurs before a person faces the situation and looks for a change in its emotional impact. On the other hand, expressive suppression is a response-focused strategy because it occurs when the person is already engaged in the situation and feeling the emotion and is seeking the inhibition of the ongoing emotion-expressive behavior (Sloan & Kring, 2007).

The ERQ is composed of a 10-item scale, each item of which measures respondents' tendency of emotion regulation in terms of cognitive reappraisal and expressive suppression on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree), with higher

scores reflecting a better emotion regulation tendency. Earlier research by Gross and John (2003) conducted with a sample of 1483 undergraduate students showed an adequate factor structure and Cronbach's alpha (on average .79 for cognitive reappraisal and .73 for expressive suppression).

The ERQ was translated into Portuguese and validated for the Portuguese population by Vaz and Martins (Questionário de Regulação Emocional – QRE; 2009). To evaluate the replication of the two factors of the original model, the authors conducted a principal component analysis followed by varimax rotation that confirmed the existence of two explanatory factors accounting for 49.64% of the variance in a sample of 851 participants. The first factor was assigned to cognitive reappraisal and explained 32.77% of the variance, and the second factor was emotion suppression and explained 16.78% of the variance. In the Portuguese version, 1 item is not part of the same scale as in the original version, corresponding to item 5 (“When I’m faced with a stressful situation, I force myself to think about that situation in a way to help me stay calm”). In the original version, this item belongs to the scale of cognitive reappraisal, and in the Portuguese version it is integrated into emotion suppression. Vaz and Martins (2009) considered that the difference in psychometric behavior of this item may be related to the cultural differences between Portugal and the United States of America. In the Portuguese sample, the change of thought associated with the experienced emotion can be interpreted as a way to suppress the enthusiasm that the individual intends to express, taking control of emotion activation and then greater discomfort (Vaz & Martins, 2009). Test-retest analysis with a 6-week interval revealed acceptable time stability for both scales (Vaz & Martins, 2009).

### ***Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)***

Gratz and Roemer (2004) developed this self-report measure to assess the complexities and clinical difficulties of emotion regulation in adults. The DERS contains 36 items for which clients are asked to indicate how often each applies to themselves on a 5-point Likert-type scale that ranges from 1 (almost never) to 5 (almost always). The specific emotion regulation difficulties assessed are: a) non-acceptance of emotional responses (non-acceptance); b) difficulties in engaging in goal direction when experiencing unpleasant emotion (goals); c) impulse control difficulties (impulse); d) lack of emotional awareness (awareness); e) limited access to emotion regulation strategies (strategies); and f) lack of emotional clarity (clarity)

(Sloan & Kring, 2007). In the DERS higher scores indicate more difficulties in regulating emotions.

The initial validity study of the scale reported that the six factors are significantly correlated and that the total DERS has a high degree of internal consistency ( $\alpha = .93$ ), as each of the six subscales has a Cronbach's  $\alpha > .80$ . Good test–retest reliability for a period between four and eight weeks (.80) was also found. In the case of the subscales, the results indicated a modest to good test–retest reliability: non-acceptance (.69); goals (.69); impulse (.57); awareness (.68); strategies (.89); and clarity (.80).

The DERS was translated into Portuguese and adapted to the Portuguese population by Vaz, Vasco, and Greenberg (Escala de Dificuldades de Regulação Emocional – EDRE; 2009, cit. Coutinho, Ribeiro, Ferreirinha, & Dias, 2010). In the Portuguese version, high to moderate internal consistency values were found for the six subscales, with the non-acceptance (.87), impulse (.84), and strategies (.83) subscales showing higher alpha values. The results showed a very similar factor structure to the original version, very good test–retest reliability ( $r = .82$ ), and very good internal consistency (Cronbach's  $\alpha = .93$ ).

This study provided an important starting point that could fill a gap experienced by Portuguese clinicians in terms of emotion regulation assessment. The authors found statistically significant differences between clinical and non-clinical subjects in terms of difficulties in emotion regulation that represent empirical support for the idea that these difficulties are in some way related to clinical problems.

### ***Emotion Regulation Skills Questionnaire (ERSQ; Berking & Znoj, 2008)***

The ERSQ is a 27-item self-report measure that was developed to assess the adaptive emotion regulation skills taking into account the Adaptive Coping with Emotions Model (ACE; Berking, 2010, cit. Berking et al., 2011). The model contemplates 9 dimensions/abilities in the process of emotion regulation: (a) be aware of emotions, (b) identify and label emotions, (c) correctly interpret emotion-related body sensations, (d) understand the prompts of emotions, (e) actively modify negative emotions to feel better, (f) accept negative emotions when necessary, (g) tolerate negative emotions when they cannot be changed, (h) confront (vs. avoid) distressing situations to attain important goals, and (i) compassionately support oneself in emotionally distressing situations (Berking et al., 2011).

Each ability is assessed on a five-point Likert-type scale (0 = not at all to 4 = almost always) and with a subscale of three items preceded by the stem, “Last week ...”: “I paid

attention to my feelings” (awareness); “my physical sensations were a good indication of how I was feeling” (sensations); “I was clear about what emotions I was experiencing” (clarity); “I was aware of why I felt the way I felt” (understanding); “I accepted my emotions” (acceptance); “I felt I could cope with even intense negative feelings” (tolerance); “I did what I had planned, even if it made me feel uncomfortable or anxious” (readiness to confront distressing situations); and “I was able to influence my negative feelings” (modification). The ERSQ total score is computed as the average of all the items (Berking, Orth, Wupperman, Meier, & Caspar, 2008).

Berking and colleagues (2011) stated that the ERSQ total score showed adequate-to-good internal consistency (Cronbach’s  $\alpha = .90$ ) and adequate retest stability ( $rtt = .75$ ; 2-week interval). The support for the dimensionality of the measure was provided by the exploratory and confirmatory factor analyses, and the sensitivity to change has been demonstrated in multiple samples of clients in psychotherapeutic treatment. All the scales have shown negative associations with measures of ill-being, psychopathology, and emotion regulation difficulties and positive associations with measures of well-being and mental health (Berking & Znoj, 2008).

In our review we did not find a Portuguese version of the ERSQ.

***Cognitive Emotion Regulation Questionnaire (CERQ; Garnefsky, Kraaij, & Spinhoven, 2001)***

The CERQ is a multidimensional self-report measure consisting of 36 items in a 5-point Likert response format ranging from 1 (almost never) to 5 (almost always), which have been used to assess the conscious cognitive components of emotion regulation (Garnefski & Kraaij, 2007). Specifically, 9 cognitive emotion regulation strategies are distinguished, each of them referring to a person’s thoughts after experiencing a negative or traumatic event. They are: acceptance, positive refocusing, refocusing on planning, positive reappraisal, putting into perspective, self-blame, rumination, catastrophizing, and blaming others.

The CERQ has shown good psychometric properties with alpha coefficients ranging between .70 and .80 and can be applied to people over the age of 12 years. Lately a short version has been developed, containing 18 items that could be used as a fast-screening instrument that is useful, for instance, for psychiatric patients (Garnefski & Kraaij, 2006).

The CERQ was translated into Portuguese and validated for the Portuguese population by Castro, Soares Pereira, Chaves, and Macedo (Questionário da Regulação Emocional Cognitiva – QREC; 2013) with a sample of 344 university students. The Portuguese version of

the CERQ revealed good psychometric properties, like a Cronbach's alpha of "very good" (.89) and a high, positive, and significant test-retest correlation coefficient ( $r = .58$ ;  $p < .001$ ). The factorial structure of the Portuguese version also significantly overlaps with the original version.

***Emotion Regulation Profile – Revised (ERP-R; Nelis, Quoidbach, Hansenne, & Mikolajczak, 2011)***

The ERP-R is a revision of the Emotional Regulation Profile Questionnaire, an unpublished measure (ERP-Q; Quodiach, Nelis, Mikolajczak, & Hansenne, 2007, cit. Nelis et al., 2011). The ERP-R includes the regulation of positive emotions, which was not included in the original ERP.

The ERQ-R is a vignette-based measure that includes 15 scenarios with different situations in terms of the types of emotion elicited (e.g. fear, shame, anger, sadness, among others), which are followed by 8 possible reactions. For each scenario people are asked to choose the strategy(ies) (4 adaptive and another 4 maladaptive) that best illustrates their most likely reaction in that situation. In the original study, the reliability of the global ERP-R score was good ( $\alpha = .84$ ), and the 2-factor analysis showed satisfactory internal consistency (down-regulation of negative emotions  $\alpha = .83$  and up-regulation of positive emotions  $\alpha = .79$ ). In terms of convergent and discriminant validity, the ERP-R demonstrated evidence with a large number of other variables (Nelis et al., 2011).

There is a short version of these measures that was adapted to and validated for the Brazilian population by Gondim and colleagues (cit. Rocha, 2015). In this version only 6 scenarios are presented. It is also composed of the 2 dimensions corresponding to the 2 types of emotion regulation strategies: up-regulation of positive emotions – joy, admiration, and pride (3 items,  $\alpha = .60$ ) – and down-regulation of negative emotions – sadness, jealousy, and fear (3 items,  $\alpha = 0.60$ ) (Gondim et al., cit. Rocha, 2015). The measurement of the 2 factors is performed by the score in each scenario. Each scenario provides 8 response options and the individual receives 1 point for each functional strategy activated and -1 point for each dysfunctional strategy chosen. Thus, the individual scores between -4 and 4 points.

### **1.1.1.1. Observational measures**

In our review of the literature, we found just one observational measure of emotion regulation processes, namely the Observer Measure of Affect Regulation.

#### ***Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006)***

The O-MAR is an observational measure that allows the assessment of clients' affect regulation in terms of multiple domains and emotion regulation strategies. This scale was developed based on the theoretical and empirical literature related to emotion regulation and emotional processes and allows the rating of clients' level of emotion regulation at the moment when they are evaluated (Watson, McMullen, Prosser, & Bedard, 2011). Clients' affect regulation is assessed based on five subscales of emotional processing: 1) Level of Awareness; (2) Modulation and Arousal; (3) Modulation and Expression; (4) Acceptance of Affective Experience; and (5) Reflection on Experience. Each of the subscales is rated on a seven-point Likert scale with lower scores reflecting lower levels of functioning. The average of the five ratings gives an overall score of affect regulation.

Watson and colleagues (2011) reported that the preliminary findings showed that the O-MAR has high internal consistency (early O-MAR = .86; late O-MAR = .93). The O-MAR's scores also demonstrate evidence of construct and predictive validity.

Usually, data collection for emotional processes' research is carried out with self-report measures. These measures could be retrospective (relative to the emotional experience of individuals in the past) or in the present by the analysis of the individual emotional responses at the moment. However, in addition to the use of self-report measures to assess the emotional processes, we can apply observational measures (Watson et al., 2011). In the case of randomized control trials, this could be a particularly important or the only way to study these processes when they were not contemplated at the beginning of the research.

### **1.1.1.2. The aim of this study**

The manual of application of the O-MAR is available from the authors (Watson & Prosser, 2006). Nevertheless, the original manual lacks specific examples of the different levels of emotion regulation. Therefore, besides translating the manual into the Portuguese language,

our main goal was to expand the manual with specific useful clinical illustrations of the different coding possibilities. Based on the consensual discussion of four different cases, we will present each domain and the level of the O-MAR with those clinical vignettes in the remainder of this article. Our goal is to support the future training of judges and to increase the reliability of the application of this scale.

## **1.2. Method**

### **1.2.1. Judges and auditor**

The procedure was carried out by two judges and an auditor. The two judges were master's students in clinical and health psychology and the auditor was a doctoral student in psychology with previous training in empathy and emotion-focused therapy. It is important to mention that the judges and the auditor were not aware of the therapeutic outcome of each case.

### **1.2.2. Clinical material**

The clinical sample for this work consisted of four clients who participated in the ISMAI Depression Study (Salgado, 2014), a randomized clinical trial (RCT) for the treatment of depression, which compared the efficacy of two empirically supported therapeutic models for the treatment of this disorder – cognitive-behavioral therapy (CBT) and emotion-focused therapy (EFT). All the clients in this RCT were initially evaluated and diagnosed with a mild or moderate major depressive disorder, and they completed sixteen sessions of psychotherapy with trained therapists. The inclusion criteria for the ISMAI Depression Study were being diagnosed with a major depressive disorder ( $AGF > 50$ ) and not being medicated. The exclusion criteria were: currently taking medication or following another form of treatment; currently or previously being diagnosed with one of the following DSM-IV Axis I disorders: substance abuse, panic, bipolar, psychosis, or eating disorder; having one of the following DSM-IV Axis II disorders: antisocial, narcissistic, borderline, or schizotypal; or being at high risk of suicide. All the four clients who made up part of this sample met the criteria for inclusion in the study after being assessed with the Structural Clinical Interview for the DSM-IV-TR (First, Spitzer, Gibbon, & Williams, 2002). They were all equally randomly assigned to the CBT group treatment or to the EFT group treatment. Three of the selected cases were part of the CBT group

and the other case belonged to the EFT group. The sessions were recorded with the consent of the client to allow their further study. The cases used for the manual elaboration were randomly selected among those who had completed the sixteen sessions of psychotherapy at the time and were available with tapes. We present below a brief description of the cases selected.

#### ***Case A***

The depressive symptoms were particularly related to being unemployed and overweight, difficulties in terms of body image, and relationship difficulties with the individual's mother.

#### ***Case B***

The depression symptoms were associated with difficulties in the relationship with the individual's husband and difficulty in dealing with her mother's illness. There was also some performance anxiety and complaints about occupational lack of self-actualization.

#### ***Case C***

The depression symptoms were related to difficulties in personal relationships, difficulties in being alone and trusting people, and problems with systematic engagement in new relationships. The individual's unstable relationship with her father and some conflicts within the family were also a problem.

#### ***Case D***

The depressive symptoms were associated with relationship problems with the individual's ex-husband and difficulties in her relationship with her father. At the same time, some anxiety and easy irritability were particularly related to not being able to keep her family together.

### **1.2.3. Measure**

***Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006) – Unpublished measure developed in the Department of Adult Education and Counseling Psychology, OISE, University of Toronto***

As referred to earlier in the literature review, the O-MAR is an observational measure used to assess clients' level of emotion regulation in the therapy process. The scale includes five domains (subscales) in terms of emotion regulation, each rated with a score ranging from one to seven points from a series of instructions, with one being the value associated with the lowest level of functioning and seven the value associated with the highest level of functioning. The final score of the client's emotional level is the average of the ratings. Watson and Prosser (2006) mentioned in the scale that the domain "awareness/labeling" refers to the emotion experience and to its level of arousal. Regarding the domain "modulation of arousal/experience," it assesses the capacity to vary and adjust the intensity, duration, and/or state as well as the ability to generate and sustain emotional experiencing. "Modulation of expression" is related to a visible outward expression/display of emotions, while "acceptance of experience" involves the inner relationship that the person has with his or her own feelings (if they are accepted, suppressed, neglected, avoided, annihilated, controlled, nurtured, etc.). Finally, "reflective of feelings/experience" refers to the level of reflection of the client. The domains (subscales) of emotion regulation assessed are presented below but not in as much detail as in the original scale.

Table 1

*O-MAR subscales*

Awareness/Labeling
1. Very low awareness;
2. Labeling of behaviors and action tendencies or somatic sensations, with little awareness of emotional experience;
3. Labeling of some emotions without awareness or awareness without labeling;
4. Some awareness; undifferentiated description of feelings using simple terms; few emotion words;
5. Some differentiated labeling of feelings with restriction in range; increased awareness of arousal and emotions;
6. Differentiated description of feelings using a range of feeling terms;
7. Highly differentiated description of feelings – finely attuned to nuances. Aware of momentary flow and tracking it.
Modulation of Arousal/Experience
1. Excessively under- or over-modulated;
2. Modulation somewhat impairs functioning in a number of different areas or significantly impairs functioning in one or two areas;
3. Some modulation but strategies usually don't enhance functioning;
4. Some modulation and use of strategies that enhance functioning;
5. Increased modulation that enhances functioning;
6. Modulation frequently enhances functioning; frequently functioning well;
7. Modulation enhances functioning in most areas of life.

Table 1 (cont.)  
*O-MAR subscales*

<p><b>Modulation of Expression</b></p> <ol style="list-style-type: none"> <li>1. Excessively under- or over-modulated expression of emotions;</li> <li>2. Expression/response impairs functioning;</li> <li>3. Expression/response sometimes appropriate but still significant over/under-modulation of expression evident;</li> <li>4. Increased modulation of expression;</li> <li>5. Expression somewhat enhances functioning;</li> <li>6. Expression/response frequently enhances functioning; frequently functioning well;</li> <li>7. Expression/response enhances functioning in most areas of life. Not over- or under-modulated.</li> </ol>
<p><b>Acceptance of Experience</b></p> <ol style="list-style-type: none"> <li>1. Denial/disavowal of experience (repression, annihilation). Emotion is cut off;</li> <li>2. Very negative evaluation of experience. Rigid standards about experience and expression;</li> <li>3. Negative evaluation of experience but standards around experience and expression are not as rigid. Feelings often not owned;</li> <li>4. Some negative evaluation of certain aspects of experience but acceptance of other aspects;</li> <li>5. Moderate acceptance of experience. Recognition of experience with some attempts to use it to guide actions;</li> <li>6. Approaching 7 but not quite as high (accepting but may not be as nurturing as at level 7);</li> <li>7. High acceptance of experience (nurturing). Emotions fairly to fully integrated.</li> </ol>
<p><b>Reflective of Feelings/Experience</b></p> <ol style="list-style-type: none"> <li>1. No reflection. Simple presentation of a problem with no reflection;</li> <li>2. Primarily ruminative;</li> <li>3. Some rumination. Some reflection;</li> <li>4. Little rumination. A little reflection but not posing questions;</li> <li>6. Fairly high reflection. Beginning to solve questions; entertaining new perspectives;</li> <li>7. High reflection. Questions posed are solved or being solved at the moment. Resolution.</li> </ol>

#### 1.2.4. Procedures

The first phase of this work involved the translation of the scale into the Portuguese language. Consent for the translation of the scale and its adaptation to the Portuguese population was obtained through personal contact with one of the scale authors (Jeanne Watson).

In this first phase, to achieve conceptual definitions, it was necessary to clarify the concepts that are part of the original O-MAR to ensure that they will be equivalent in the Portuguese language/culture. Some concepts were not recognized or were meaningless, so work was undertaken to accommodate the cultural values. The initial translation was subsequently reviewed by experts in the field via a spoken reflection process. The final phase was a backward

translation carried out by a bilingual person to check that the translated version actually reflects the contents of the original version.

The second phase was the application of the scale to psychotherapy sessions following the instructions of the authors, coding the middle 20 minutes of the sessions (Watson et al., 2011). To gain a perspective of the cases' progress throughout the sessions and simultaneously to allow the collection of data for future works, 5 sessions were evaluated by case (S1/S4/S8/S12/S16). In total 20 sessions of the 4 randomly selected cases (Case A, Case B, Case C, and Case D) were observed and rated. The initial procedure was rating, followed by a discussion and an attempt to reach inter-judge agreement (consensual discussion; Hill, Thompson, & Williams, 1997). Thus, the middle 20 minutes of each session were viewed and then each judge rated the 5 subscales. At the end of this process, each rating of each subscale of the O-MAR was discussed until consensus was reached. At the end of each case, the judges selected extracts that could represent good examples of each level and domain, and later on these were subjected to a consensual discussion with the auditor. After assessing the 20 sessions, the excerpts that best exemplify each level were selected. Thus, the manual provides a total of 70 excerpts, specifically 2 excerpts for each level of each domain of the scale. In this article, however, we will present only 1 clinical vignette per level.

### 1.3. Results

In this section we present some excerpts from the manual that illustrate each level of emotion regulation of each subscale, followed by a brief justification for the selection of that passage.

#### 1.3.1. Domain: Awareness/Labeling

For this domain the selected clinical vignettes are as follows:

*Level 1: Very low awareness*

T: ... but do you feel sad?

C: I don't know how to describe ... I think the right word is tired ... (Case C/s4/13.30 sec.)

The client shows very little awareness of feelings and emotions, and the labeling is mainly somatic.

*Level 2: Labeling of behaviors and action tendencies or somatic sensations, with little awareness of emotional experience*

C: ... I take everything very seriously, everything, and I'm always there "hammering" the same ... I don't know what for, because it doesn't take me anywhere ... (Case B/s1/14.22 sec.)

The client labels behaviors and action trends but has little awareness of the emotional experience.

*Level 3: Labeling of some emotions without awareness or awareness without labeling*

C: ... I will seriously think a little more about me ... I feel very, very, very stuck in a hole ...

T: Mm-hmm.

C: Really a lot ... (Case B/s1/58.20 sec.)

The client is aware that something does not feel right ("stuck in a hole") but cannot label the emotion.

*Level 4: Some awareness; undifferentiated description of feelings using simple terms; few emotion words*

C: ... I don't know what you do to me here but I am much better ... I go with ideas a little more organized ... I go with another spirit and I face problems in another way ... Maybe I feel safest now ... I don't know ... (Case B/s12/2.06 sec.)

The client reveals some awareness and describes feelings using simple terms. However, few words translate into an emotional state.

*Level 5: Some differentiated labeling of feelings with restriction in range; increased awareness of arousal and emotions*

C: ... The problem is that I don't have an obvious reason for this ... do you realize? Whatever ...

T: I don't want to look for the reason ... I just want to know how it is ... how is it inside ... what is happening?

C: How am I? First of all I feel like an idiot ...

T: Mm-hmm.

C: And then is like ... furthermore ... I feel lost, frightened, alone ... (Case D/s4/1.58 sec.)

The client shows some differentiation in identifying feelings but with a restricted range and little experience of consciousness. There is increased awareness of arousal and of emotion.

*Level 6: Differentiated description of feelings using a range of feeling terms*

C: ... I'm feeling as someone else ... no doubt ... by the way I don't need to feel ... people around me say that I'm not the same person I was ... I'm much better, much more positive ... I'm not very playful ... I am not ... But I like some jokes sometimes. I am more extroverted than I was ... I was much shrunken, very shy. This project changed me ... (Case B/s16/50.52 sec.)

The client reveals awareness and a wide range of terms about feelings. She also uses metaphorical language.

*Level 7: Highly differentiated description of feelings – finely attuned to nuances. Aware of momentary flow and tracking it*

C: I don't know ... I speak for me ... I am a bit insecure. In fact, I am very insecure, I know I am ... It costs me to take the first step, I do not throw myself easily and lately I venture a little more ... I venture.

T: And when you take the risk, how do you feel?

C: It is something new, a good feeling, some of these risks are not always calculated ... Then I regret it, but it is done, and I really have to be that way ... If I don't take the risk, I won't know what the flavor is ...

T: Mm-hmm, in other words, what you tell me is that when we don't take risks we avoid the bad things but also avoid the good things ...

C: Because ... How do I know the result if I did not get there?

T: Therefore, you are taking risks, a little bit more ...

C: A little more ... let's not think I've changed completely, which is not true ... I'm still insecure and shy ...

T: Did you want to change completely?

C: I don't know ... I am used to the person I am ... This is my character, my way of being and I don't believe that people change radically from day to night ... but I was a little more retiring ... not now ... I'm a little bit untied ... (Case B/s8/7.28 sec.)

The client shows herself to be very aware of the arousal and experience and reveals a differentiated description of feelings.

### **1.3.2. Domain: Modulation of Arousal/Experience**

For this domain the selected clinical vignettes are the following:

*Level 1: Excessively under- or over-modulated*

(Talking about the client's difficulty in maintaining her personal relationships)

C: (with a very monochord voice) ... I am beginning to fall into disbelief of myself, and ...

T: And that means what? That you will probably never be able to develop a loving relationship?

C: I don't know ... I don't know what does it mean ... Honestly I don't know what it means, you know, I don't miss games, but I miss seeing myself excited about something, with someone ...

T: Mm-hmm.

C: And I can't, is that ... (Case C/s16/23.15 sec.)

In this case over-modulation significantly impairs functioning. The affect is very low, the voice is monotonic, and there is numbness, as if the client is not feeling what she is saying.

*Level 2: Modulation somewhat impairs functioning in a number of different areas or significantly impairs functioning in one or two areas*

C: ... In these days I was so depressed for being upset with my mother that I didn't feel like doing anything ... So I stayed stuck at home and I still felt even more depressed, and then I eat what I shouldn't eat and I become even more depressed because I eat and I should not ... So, when I have this type of conflict or so is when I feel worse ... (Case A/s1/57.23 sec.)

In this example, the client is relating an example of how she has been under-modulating her feelings and how that leads her to episodes in which she breaks her diet (she is fasting, because she needs to lose weight). The client's modulation significantly impairs her functioning: she still takes refuge in food when feeling depressed. There is also significant rumination, discomfort, and depression.

*Level 3: Some modulation but strategies usually don't enhance functioning*

C: ... We had a snack at my house, and of course it always has bread with something, and other things, and I ate a little bit of everything ... it was not correct but it wasn't overkill.

T: It was an exception to our system but ...

C: It was not exaggerated ...

T: It was not exaggerated ...

C: And that's why I get frustrated, I could understand if I had not lost weight, if I had kept, but my frustration is "Gee! I make so much effort to achieve weight loss, I pass all the week making enough effort and then I leave off the normal just for one day and instead of keeping the weight, which is what happens to ordinary mortals, my weight just increases, why?" That causes me a lot of confusion ... (Case A/s4/6.29 sec.)

There are some modulation strategies but they do not improve the global functioning. Thus, she was able to express her frustration and not let herself immediately engage in a binge episode. However, this does not make a real change to her global well-being.

*Level 4: Some modulation and use of strategies that enhance functioning*

C: After I arrived there at the weekend, because of a handful of little things, it looks like it will all just go downhill, all the effort that I went downhill, and I was a bit down because of that ... I was sad ... but then I think that I have to have the courage not to give up. (Case A/s4/1.45 sec.)

In this passage activation is apparent and intense feelings are acknowledged, but there is also some indication that the client uses adaptive coping strategies to modulate her emotions.

*Level 5: Increased modulation that enhances functioning*

(Talking about her emotional change)

C: ... Before, I had no time to think right or wrong, and most of the time I thought wrong, because everything that is done in a rush and impulsive most of the time is bad, and I had many troubles for being like that, and my mother said “don’t do that ... count to ten,” but when I had arrived at three I had lost count, “one, three, ten ...” and now ...

T: Is it calmer?

C: I’m more thoughtful, you see Dr?

T: Mm-hmm.

C: Of course that doesn’t mean to have times that I’m not 100% right?

T: It feels that somehow that person, who felt so down, so depreciated, looks like she was growing, right?

C: Exactly, it was really ... not in size but in strength, in ability ...

T: Security.

C: Autonomy, security, and I think that I’m much more ...

T: Much higher ...

C: Exactly, I’m big! I am tiny in size but big ... in depth, I’m big ... (Case D/s12/34.58 sec.)

The client’s modulation improves her functioning despite occasional difficulties. She expresses her feelings in an embodied way.

*Level 6: Modulation frequently enhances functioning, and the client is frequently functioning well*

(Talking about therapeutic change observed by the client)

T: And looking at you today, what do you see?

C: Hum ... I’m much more pleased with myself, I am much more satisfied with others ... I feel much stronger, more able to make decisions regardless of their impact.

T: Mm-hmm.

C: I feel more quiet, I can soothe myself ... I take a breath ... Doesn’t mean I go free of my explosive state sometimes because it is already part of my way of being ... (Case D/s16/57.11sec.)

The client is able to soothe herself, distract herself, and solve her problems. Modulation often improves her functioning.

*Level 7: Modulation enhances functioning in most areas of life*

(Talking about the improvement in the relationship with her ex-husband)

C: ... Alone with him ... of course I won't go out, that's unquestionable, right? Especially because I have ...

T: A person ...

C: And my mind tells me that this should not be done, right? But when I go for a stroll with the kids, of course, they are two kids and they are selfish, and he says, "you could also come." Why don't I go? There is no problem, to everywhere I go, I know very well what I should do, there is no problem, and I think that this is how it should be ...

T: Feels safer, more determined ...

C: I feel ... I feel ...

T: And this, gives us power ...

C: And there is no longer any doubt if I would do well or not ... What happened, happened, the decisions that were taken, were taken, I already said that there are decisions that I don't know if I made well ...

T: You are quieter, calmer.

C: Completely, it gives me more peace and quiet and I appreciate myself more ... (Case D/s12/53.42 sec.)

The client's modulation improves her functioning and her emotions are well modulated. She retrieves the experience in a way that allows her to have a friendly relationship again with her ex-husband.

### **1.3.3. Domain: Modulation of Expression**

For this domain the selected clinical vignettes are as follows:

*Level 1: Excessively under- or over-modulated expression of emotion*

(Talking about her ex-boyfriend)

C: ... I first did not find him very funny ... I noticed him later ... and then we started talking and we started going out, and he is also like me ... fantastic ... because I have this aim to hit always on those who are the wrong ones ... (Case C/s1/58 sec.)

The response significantly impairs functioning in a number of different areas. She expresses no feelings or needs in the way in which she related to her ex-boyfriend.

*Level 2: Expression/response impairs functioning*

(Talking about her possibility of going back to the gym, something that would be very good for her and that she would like to do)

C: ... But I don't do it because I can't leave my husband to work alone and it would be only me enjoying that pleasure.

T: Mm-hmm.

C: Because I would have to tell him ... To feel less pressured ... (Case B/s1/54.15 sec.)

The expression/response impairs functioning. The client wants and feels that it would be beneficial to return to physical activity, but by over-modulating her experience she refuses to do so exclusively due to not wanting to leave her husband to work alone and due to being afraid of what he might say. Needs are expressed but with some embarrassment and little liveliness.

*Level 3: Expression or response sometimes appropriate but still significant over/under-modulation of expression evident*

(Talking about her difficulty in telling people that she is unemployed)

C: ... I find it ridiculous, ridiculous ... I'm so irritated with myself for not being able to tell people openly, because it is like that ... I try to explain why this has happened and sometimes I think like this "ok ... At that time I wasn't ok, I didn't feel right," so I was not feeling comfortable to justify ... because I was really very, very down.

T: Mm-hmm ...

C: Then, to lie is like a snowball, right? Going, growing, growing and we're in such a way that we don't even know where we should turn ... (Case A/s4/52.47 sec.)

In this passage there is some expression of feelings but with a high level of complaints mixed with some withdrawal and anger.

*Level 4: Increased modulation of expression*

(Talking about a course)

C: Oh yes, more, I won in terms of contact, trust, in contact with the unknown ... both with colleagues and with trainers ...

T: Of the institution.

C: Yeah ... I am in the training and I feel perfectly at ease to put questions that are sometimes even a bit nonsensical or ridiculous ... I don't think about it ...

T: Mm-hmm.

C: Before I thought thirty times, "and now I ask you this? But is this nonsense? Will it look bad?" Now I don't feel this so much ... I feel better in that sense, I won a lot in terms of confidence, I won so much ... I express myself better ... (Case A/s12/23.35 sec.)

There is an expression of feelings but still without identifying needs. Something that was previously seen as negative (out of the comfort zone, contact with strangers) is now faced with some security.

*Level 5: Expression somewhat enhances functioning*

(Talking about the help that the therapy has been giving)

C: ... I don't believe in miracles, they don't even exist, I have to look inside of me, I have to make an effort, have to stop being lazy, in the good sense ... Mm-hmm... But really, yes ... I think this effort is really worth it.

T: Mm-hmm.

C: I'm feeling a little bit of courage.

T: What is this courage?

C: Mm-hmm ... Valuing me a little bit more ... (Case B/s4/7.28 sec.)

Somehow, expression promotes functioning. The client expresses feelings and needs with some strangeness and caution, which can be seen in the constant hesitations in her speech.

*Level 6: Expression/response frequently enhances functioning; frequently functioning well*  
(The client talks about a job interview)

C: ... I forced myself to take the first step and schedule the interview ... Mm-hmm ... Also because at that time I was feeling capable of doing it, I didn't feel so down, so insecure, I already felt a greater ability to be with the unknown, and then it was also that push from our talks, isn't it? Okay, now we have to go, we are already at a stage where we need to progress, isn't it ... (Case A/s12/12.26 sec.)

In this passage there is an expression of feelings and needs that promote functioning.

*Level 7: Expression/response enhances functioning in most areas of life. Not over- or under-modulated*

(The client talks about her feelings)

C: ... I feel more confident ... like this ... as you had told me several times, I don't have to be accepted by all because we don't accept all of ...

T: Mm-hmm ...

C: Each of us is as one is ... I do not have to be accepted by everyone, I know I do not like everyone else, no doubt, but in my way I try to do my best and I don't get down my head so much.

T: Mm-hmm ...

C: I don't walk with my head in the sand, I face things differently, in another way, more positive ... (Case B/s12/24.15 sec.)

The expression/response promotes functioning in most areas of life. She understands needs and action tendencies and clearly expresses herself in a way that promotes her functioning. The expression/answer meets the implicit need of the feelings. The way in which the client expresses her feelings promotes herself and her relationship with others.

### **1.3.4. Domain: Acceptance of Experience**

For this domain the selected clinical vignettes are the following:

*Level 1: Denial/disavowal of experience (repression, annihilation). Emotion is cut off*  
(Talking about men who have passed through her life)

C: ... I don't feel what people expect me to feel ...

T: Mm-hmm ... And what do you feel for them now?

C: I don't even stop to think, to analyze, or to find out.

T: Mm-hmm ...

C: Perhaps I could like it, but since I don't give it time, I don't understand, and if the person leaves the circle, I don't miss that person ... (Case C/s1/13.18 sec.)

In this passage there is an annihilation or disavowal of the experience and the emotion is cut off. The client does not feel anything for other people.

*Level 2: Very negative evaluation of experience. Rigid standards about experience and expression*

(The client talks about the absence of her ex-husband and how that affects her children)

C: I know that my kids need to feel that their father loves them ... and I know they need it, they even say “oh I don’t need my father for anything” but suddenly I realize that there is something missing ...

T: That they feel something missing ...

C: And it is like this ... Sometimes I like to snoop in my daughters’ things because ... even to be aware because at certain ages they often don’t feel at ease ...

T: Do not tell things ...

C: And I got to catch some small clippings wherein the older one talked about her father, and of course I know she feels hurt ... I know ... I know ... she feels hurt.

T: Sad ...

C: Because she misses her father, she even said “I miss you and you abandoned me when I needed you most” ... (Case D/s8/20.13 sec.)

The client is externally focused (on her children lacking the presence of their father): too focused on her children’s feelings without focusing on herself.

*Level 3: Negative evaluation of experience but standards around experience and expression are not as rigid. Feelings are often not owned*

C: ... I can’t explain why, it is something that perhaps we can also work on ... I was ashamed to tell people that I’m unemployed. I didn’t say ... even today many people don’t know that I’m unemployed ... at that time I didn’t feel good and therefore I couldn’t even talk, I couldn’t say ... (Case A/s1/10.57 sec.)

In this passage there is a negative evaluation of experience with some focus on herself. She expresses needs but is negligent in terms of feelings.

*Level 4: Some negative evaluation of certain aspects of experience but acceptance of other aspects*

(The client talks about a discussion she had with a boyfriend)

C: ... I felt embarrassed by the things he said ... I think my thought was “I have to leave here, I want to be out of here, get me out of here” ... hmm ... he told me the truest things, right?

T: Mm-hmm ...

C: And the truth sometimes is hard to listen to ...

T: Mm-hmm ...

C: And I did not even oppose him, because I thought I shouldn’t even try to argue, because he was right ...

T: Mm-hmm.

C: And arguing would have been creating more stories and more fantasies and feeding things that made no sense, so I did not even defend myself ... (Case C/s4/5.05 sec.)

Although the client did not like to hear some critical remarks, ultimately, she recognized and accepted the criticisms and did not avoid the feeling of embarrassment.

*Level 5: Moderate acceptance of experience. Recognition of experiences with some attempts to use them to guide actions*

T: In relation to weight issues, how are we? Have you gone for your walks?

C: The weight issue is always like that, it goes up and down, up and down, but I do not let myself go down ...

T: Because you have already created other habits, haven't you?

C: Exactly, and I'm starting raising up ... (Case A/s16/19.06 sec.)

There is a moderate acceptance of experience.

*Level 6: Approaching 7 but not quite as high (accepting but may not be as nurturing as at level 7)*

C: I was at 181.5 lbs, I never got out from there, but okay ... It's to say that was not too bad, I understand that even failing ...

T: You don't explode ...

C: Right ... it doesn't mean that everything goes back behind, so I am a little more used to, I realize that I will go slowly but at the end of the week I didn't stay so stressed and so nervous ... (Case A/s8/2.23 sec.)

The acceptance is approaching level 7 but still not that high. The client accepts the experience and no longer deregulates emotionally but it is not at its maximum. Emotion is tightly integrated and awareness is evident about what her emotions/feelings really are.

*Level 7: High acceptance of experience (nurturing). Emotions fairly to fully integrated*

C: ... When I started the treatment, everything that was expected are all my little big trophies ... and it is for all those changes that have occurred that I feel great, I feel more capable, stronger, more relaxed, more confident.

T: Mm-hmm.

C: I don't need others to respect me because I respect myself and that's enough, is not it? But I demand that they respect me ...

T: Mm-hmm, and you are feeling that?

C: And I'm feeling it ... (Case D/s16/67.35 sec.)

The client shows a high level of acceptance and is connected with the experience. There is emotional congruence and valuation of feelings.

### **1.3.5. Domain: Reflective of Feelings/Experience**

For this domain the selected clinical vignettes are as follows:

*Level 1: No reflection. Simple presentation of a problem with no reflection*

C: I don't feel capable to manage anything alone, anything, anything at all ... (Case B/s1/16.12 sec.)

There is no reflection, only a very simple and general presentation of a problem.

*Level 2: Primarily ruminative*

C: I have a huge amount of shame because I think people should look at me and say: "she's so fat, she's misshapen." I can't say that I felt it from friends ... That, I don't feel ... but one thing was, if I was so fat throughout all life, but as I was before and how I am now, it is a very big change in physical terms, and not only but particularly in physical terms ... (Case A/s1/9.57 sec.)

In this passage the discourse is mainly ruminative, telling the same story and not adding anything new.

*Level 3: Some rumination. Some reflection*

C: ... But I place the weight as the big factor ... it is not the only one, of course, but I place it as the major factor of feeling less ...

T: Lively?

C: Exactly ... maybe I talk less and feel less comfortable than when I felt good ... (Case A/s1/62.45 sec.)

In this passage there is some reflection but also some rumination. The client was reflective enough to conjecture a possible connection between her depression and her weight. Nevertheless, she was still ruminating about her weight.

*Level 4: Little rumination. A little reflection but not posing questions*

C: ... I would like to have more confidence in myself and say what I think at the time ... when I think that is not right ... if I decided at the time I wouldn't stay with that ... massacring me ... (Case B/s4/11:50 sec.)

There is little rumination and some reflection but without questions. The client is aware of what she does and of the consequence but does not look at the experience in a new way.

*Level 5: Moderate reflection. Posing questions. Working with/looking at experiences in a new way*

C: I think I don't put so much pressure on me to be perfect ... I face the error in a different way, perhaps more as learning, isn't it?

T: Mm-hmm.

C: Everyone makes mistakes and I will also make mistakes ... (Case A/s16/26.51 sec.)

In this excerpt the client is starting to engage in moderate reflection and in questioning her experience by tentatively arguing that maybe she is dealing with mistakes in a different way. She also views the experience in a new way, trying to gain clarification of the meaning.

*Level 6: Fairly high reflection. Beginning to solve questions; entertaining new perspectives*

T: In what do you feel more confident?

C: I am able to make decisions.

T: Mm-hmm ...

C: Without being worried about what will or may happen, I assume my responsibilities, and before, I didn't even assume anything.

T: Mm-hmm.

C: Now if I have to do it, I will do it, and I will endure the consequences, I'm an adult, bigger, but I also think that I lose more if I do not try ... (Case B/s16/22.26 sec.)

The client is showing a high level of reflection. She is beginning to solve her issues and create new perspectives, showing that she knows what she needs and what actions she should take.

*Level 7: High reflection. Questions posed are solved or being solved in the moment. Resolution*

C: ... I don't get out of here and get into my car with my problems solved. What I have to do is to get out of here and face them in another way.

T: Mm-hmm.

C. Because they are not solved, and I know that with another stance I could lead this in another way ...

T: Mm-hmm ...

C: I also accommodate myself to everything and I can't change all these things from one day to another. It is necessary to change a little inside here, in myself, but it's not from one day to another, you know ... (Case B/s4/25.01 sec.)

Questions are being solved at the moment and there is a high degree of reflection in the way in which the client talks about her experience.

#### **1.4. Final Remarks**

Currently, in the field of emotion regulation research, there are some measures with good psychometric features, and some of them have been validated for the Portuguese population. However, all of the measures validated for the Portuguese population are self-report measures. As mentioned before, in some cases the only way to collect data implies the use of observational measures. Moreover, from a clinical point of view, it is important to develop these kinds of measures as guidelines for the training of future professionals. In our review we did not find any observational measure to assess emotion regulation in the clinical context adapted to the Portuguese population. Consequently, this work represents an important step in filling a gap that currently exists.

In addition, the current work stemmed from the need to support the training of judges – and for training psychotherapists or other professionals interested in assessing emotion

regulation – in the application of this measure, expanding the original manual with clinical vignettes. As an innovative measure in Portugal, this measure could be an important resource to facilitate the growth of understanding of the functioning of emotion regulation in different populations and with different symptomatology.

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## Study 2\*

### From empathy to emotion regulation: An intensive case study of Emotion-Focused Therapy for depression

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**Abstract:** *The aim of this exploratory and idiographic study was to explore the evolution of therapist's expressed empathy, client's emotional regulation and clinical symptoms during the therapeutic process in a good outcome case that was part of a randomized clinical trial for the treatment of depression. A further aim was to explore the longitudinal session-by-session association between: (a) the level of therapist expressed empathy and the intensity of clinical symptoms (b) the level of client emotion regulation and the intensity of clinical symptoms (c) the level of therapist expressed empathy and the level of client emotion regulation. Data on empathy and emotion regulation were collected by visualizing and coding the middle 20 minutes of sessions from two observational measures: Measure of Expressed Empathy (MEE; Watson & Prosser, 1999, 2002) and Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006). To examine the possible longitudinal association between the variables, a time series analysis was conducted using the simulation modelling analysis software (SMA; Borckardt & Nash, 2014). The results suggest a moderate positive association between the therapist's level of empathy and the client's level of emotional regulation in the same session  $r = .55$ ,  $p = .015$ , but a non-significant association between the therapist's level of empathy and the client's level of emotional regulation and the intensity of clinical symptoms. Finally, an additional qualitative exploratory description is provided to develop potential explanatory hypotheses for the observed findings. Our findings suggest that high levels of therapist empathy contribute to improvements in clients' emotion regulation, but as an explanatory study the results should be interpreted with caution.*

**Keywords:** Depression, emotion regulation, empathy, psychotherapy, therapeutic outcome.

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## 2.1. Introduction

There is no doubt that psychotherapy is fundamentally a relational process and thus, the quality, evolution, and outcome are intrinsically linked to the quality of the relationship between therapist and client. According to Norcross and Wampold (2011), and Wampold (2015), an authentic therapeutic relationship is one way in which psychotherapy can lead to positive outcomes, and this association is independent of the therapeutic model (Vitinius et al., 2018). In fact, research has shown that approximately 30 per cent of the outcome can be attributed to the relationship variables (Norcross & Lambert, 2011). One that has received much research interest is empathy.

Empathy has been considered by Rogers (1957) as an effective, essential, and necessary helping skill for therapeutic change. As a research topic, empathy had a period of fading but currently it's considered a central theme for psychotherapy research (Elliott et al., 2018; Norcross & Lambert, 2018; Vitinius et al., 2018; Watson et al., 2020). Due to the growing interest in psychotherapy research, but also in various fields (e.g., social psychology, development psychology), and even other disciplines (e.g., medicine, neuroscience), several definitions of empathy have emerged. Rogers (1957, p. 143) defined empathy as "*the therapist's capacity to enter the private perceptual world of the client, to become sensitive to it, and to communicate this understanding to the client.*".

Empathy is an interpersonal process of *being with* the client in a way which reflects an accurate and attuned understanding of what they are experiencing, thinking, and feeling, and communicated in a way which validates, respects, and supports. As noted by Elliott and colleagues (2018), regardless of definitional differences, empathy involves the ability to understand and communicate a client's personal experience in an accurate, accepting, and nonjudgmental manner. This involves actively listening and engaging with clients in a way that demonstrates compassion and a desire to understand their perspective and creating a safe and supportive setting for them to explore and express their feelings.

According to Cuff and colleagues (2016), there are three interlinked components in empathic process: the ability to *understand* and take other's perspective, to *feel* what the other is feeling, and to *regulate* the felt emotions. This perspective is in line with what has been suggested by neuroscience research, which argues that that empathy involves a *simulation process* (based on the other's body experience), a more *conceptual process* (taking another's perspective), and a *process of emotional regulation* that mobilizes compassion and helps to comfort the pain/discomfort of others (Decety & Lamm, 2006; Eisenberg & Eggum, 2009).

Then empathy involves cognitive and emotional aspects in constant attunement to the experience of the other.

But why is empathy so important to the therapeutic process? An empathic therapist can help clients to feel comfortable and secure enough to be an active participant in the therapeutic process. By creating an atmosphere of safety and support, the therapist can encourage clients to explore their thoughts and feelings freely, without fearing judgement or rejection (Elliott et al., 2004; Greenberg, 2014; Kim, 2018; Malin & Pos, 2015; Watson, 2016). For Rogers (1975), when clients feel, they're being listened to with empathy, they're more likely to gain insight into what they're thinking and feeling, which can promote self-acceptance and improve their ability to care for themselves. Empathy can help therapists to help clients expand their understanding of themselves and challenge existing perspectives. This can lead to greater personal growth and enable them to choose from a wider range of options for their lives.

And how is this possible? To help clients access and symbolize their experience in words, and to deepen and reflect on their values and goals, empathic therapists should focus on what is said and what is not said, what is in the focus of consciousness and what is not in that focus (Elliott et al., 2011). Thus, empathy can be expressed verbally and non-verbally through different types of responses: understanding, affirmation, evocation, exploration, and conjecture (Elliott et al., 2011; Goldman et al., 2021).

According to Berger (2013, cit. Vitinius et al., 2018) empathic compassion is fundamental to successful therapy. Indeed, research has empirically demonstrated the importance of this variable in the therapeutic process. As noted by Watson and colleagues (2014), the research is clear on the role of empathy in establishing and maintaining a positive therapeutic relationship, but also on the predictive power of empathy for outcome. Examples are studies conducted by Barnicot et al. (2014), Burns and Nolen-Hoeksema (1992), Malin and Pos (2015), McClintock et al. (2018), Prosser (2007), Watson and Geller (2005), Watson et al. (2020), Watson et al. (2014), Vitinius et al. (2018) which showed significant associations between therapist-expressed empathy and reduced intensity of depressive symptoms during the therapeutic process.

According to Watson (2016), the positive effect of empathy on outcome is one of the largest and strongest of the relationship variables, accounting for more of the variance in outcome than, for example (Watson et al., 2014), specific interventions, therapeutic approach, or other therapist qualities. In fact, according to the latest meta-analysis by Elliott et al. (2018), empathy is a moderately strong predictor of outcome ( $r = .28$ ), with the client perspective being

the most effective evaluator, followed by the observer perspective, and the therapist perspective being the least effective.

Empathy is therefore seen as a powerful ingredient for change in psychotherapy. An empathic therapist has a soothing and compassionate effect on the client's experience, but it also facilitates other processes that may be important for therapeutic change. According to Watson (2007a), empathic therapists resonate with clients' inner worlds and reflect on their understanding, becoming a model for regulating experience. Thus, one of the functions of empathy is to facilitate emotional regulation.

Research has shown that difficulties in emotion regulation are at the root of the development and/or maintenance of various psychopathological disorders (Fehlinger et al., 2013; Grant et al., 2018; Gratz et al., 2015; Iwakabe et al., 2023; Werner & Gross, 2010), such as Major Depressive Disorder (Campbell-Sills & Barlow, 2007; Fehlinger et al., 2013; Visted et al., 2018), and that emotion regulation also contributes to therapeutic outcome (Berking et al., 2014; Berking et al., 2008; Daros et al., 2021; Fehlinger et al., 2013; Greenberg & Pascual-Leone, 2006; Watson et al., 2011). According to Berking and colleagues (2014), cross-sectional studies have shown that people with depressive disorders have difficulties in identifying, accepting, tolerating, and modifying their negative emotions. Furthermore, longitudinal studies have shown that difficulties in emotion regulation are probably the greatest risk factor for the development and maintenance of major depressive disorder (Berking et al., 2013; Grant et al., 2018). In a study by Watson and colleagues (2011), emotion regulation at the end of therapy was predictive of treatment outcome, independent of the contribution of other factors. Experimental studies in this area have shown that people with depressive disorder are more likely to use maladaptive emotion regulation strategies that hinder their recovery.

Emotion regulation is also a concept that lacks an agreed-upon definition due to different models. However, in the psychotherapeutic context the integrative model proposed by Watson and colleagues (Elliot et al., 2004; Watson et al., 2011) suggests that for adaptive affect regulation to occur, people need to be *aware* of their emotional arousal, then be able to *label* their emotional experience, view the emotional experience as *valued* and *acceptable*, then *modulate* its arousal and expression according to their needs and goals, and finally *reflect on* and integrate it with other dimensions of the self and environment. That's the perspective we've taken in the study.

According with several authors taking emotional regulation into account when conceptualizing clinical disorders may help to identify common mechanisms underlying different disorders (emotional regulation difficulties as a transdiagnosis in psychopathology)

(Fehlinger et al., 2013; Gratz et al., 2015; Muñoz-Navarro et al., 2022; Werner & Gross, 2010) and guide more effective interventions (Muñoz-Navarro et al., 2022; Werner & Gross, 2010).

Peluso and Freund (2018) affirms that enhancing emotional expression is essential to helping clients with emotional problems, but this can only be achieved within the context of a validating and authentic therapeutic relationship. The therapeutic relationship is crucial for clients to experience and express their emotions, and it is often through this relationship that clients can vicariously learn effective emotional regulation (Greenberg, 2014). Only with an empathic and present therapist is it possible to achieve a validating relationship in which the client feels safe and in which emotion regulation can be achieved. According to Greenberg (2021) the way in which the therapist engages with clients and connects with them emotionally is the first experience in therapy that has an impact on emotion regulation. So, providing a safe, validating, and empathic environment is the first step in helping clients to develop emotion regulation.

It is not difficult to understand the importance of empathy for emotional regulation. Empathy promotes a safe environment in which emotional experiences can be addressed and tolerated (Greenberg 2021; Greenberg, 2014; Malin & Pos, 2015; Paivio & Laurent, 2001; Watson, 2016; Watson, 2002), understood and accepted, and unknown needs revealed (Malin, 2016). As mentioned by Watson and colleagues (2014), the way in which individuals interact with significant others can either promote self-care and protection or contribute to psychological distress by overwhelming and ignoring what is being experienced. By empathizing with the client's affect, the therapist promotes self-exploration, self-acceptance, and self-empathy (Greenberg, 2014), and the internalization of a model of emotion regulation throughout therapy (Greenberg, 2014; Malin, 2016). As a result, a process of co-regulation of affect can occur, leading to the possibility of change.

Paivio and Laurent (2001) identify the main functions of the empathic response that assist the client in regulating emotions. By focusing the client's attention on their emotional experience, empathic responses increase the client's awareness and understanding of affective experiences. By validating the client's experience as important, empathic responses contrast with the often-learned sense of worthlessness/insignificance. At the same time, through empathic responses, the client learns to label and then understand experiences (Paivio & Laurent, 2001). An empathic therapist provides understanding and support that helps to soothe the client's distress and feelings of isolation when painful/intense feelings are expressed. In these circumstances, and a significant other (as the therapist) shows compassion and understanding, clients are better able to tolerate these experiences. Internalization of the

therapist's empathic acceptance and responsiveness increases the client's ability to cope with strong emotions. The arousal of repressed emotions can also be increased through evocative empathic responses. Empathy implicitly teaches how to communicate emotions, thereby reducing feelings of isolation and helping the client to re-establish interpersonal connections, initially in the therapeutic setting but later beyond.

Some studies have examined the relationship between therapists' empathy and clients' emotional regulation. Prosser's study of PET and CBT for depression (Prosser, 2007), found that the predictive power of the therapist empathy on outcome was mediated by changes in the client emotion regulation, i.e., client-rated therapist empathy facilitated emotion regulation, and this led to a positive outcome in several measures. Watson and colleagues (2014) suggested that in order to better understand the role of empathy as mechanism of change, and the relationship between this variable, and the development of emotional regulation in depressive disorder, further research was needed. The most recent study conducted by Watson and colleagues (2020) found that the relationship between therapist empathy and outcome in depression was mediated by changes in emotional regulation. The authors suggested that dimensions that would be important to investigate are symptom severity, the impact of specific types of response, the extent to which the therapists focus was on affect and which therapist behaviors at what point in the session are related to the client's experience of empathy.

As mentioned above, several studies have demonstrated the predictive/facilitating role of these variables in relation to treatment outcome/success. However, these studies have been conducted on a sample basis and provide little information on potential idiographic patterns between these variables that could be relevant to clinicians/clinical practice. To the best of our knowledge, there are no studies that have examined the relationship between these variables longitudinally, session-by-session. The purpose of this study is to address this gap in the literature by examining the development of therapist-expressed empathy and client emotion regulation in a good outcome case of Emotion-Focused Therapy (EFT) for depression. We expect to find high levels of expressed empathy, but its evolution may be stable, progressive, or irregular. We also anticipate positive developments in terms of emotional regulation, but we do not advance any specific hypothesis regarding its longitudinal pattern that can range from sudden positive development to irregular or progressive.

Another purpose of this study is to explore if empathy and emotion regulation are longitudinally associated with the decrease of intensity of clinical symptoms in depression. So, the second specific aim is to explore the session-by-session associations between: the levels of therapist's expressed empathy and the intensity of clinical symptoms; the client's level of

emotion regulation and the intensity of clinical symptoms; the therapist's expressed empathy and client's emotion regulation throughout therapy. In addition, a secondary qualitative description is presented, highlighting some of the therapist's empathic verbal/non-verbal behaviors that may help to provide possible explanations for the patterns observed during the viewing and discussion of the videotaped therapy sessions.

## **2.2. Method**

### **2.2.1. Participants**

#### **2.2.1.1. Client**

Claudia (fictional name) was a Portuguese 57-year-old single women, employed and with a college degree. Claudia integrated the ISMAI Depression Study (Salgado, 2014), a clinical trial that compared the efficacy of EFT and CBT in the treatment of major depressive disorder. In this clinical trial the inclusion criteria were a diagnosis of major depressive disorder, no medication, and Global Assessment of Functioning above 50. As exclusion criteria there were: 1) current use of medication for depression; 2) a current or previous diagnosis with the following DSM-IV Axis I disorders: bipolar, panic, psychosis, eating disorder, or substance abuse; 3) diagnosis of one of the following DSM-IV Axis II disorders: antisocial, borderline, schizotypal, or narcissistic; 4) a high risk of suicide.

At baseline assessment, Claudia received the diagnosis of severe major depression and it was randomly assigned to the EFT condition. Her sessions of psychotherapy were conducted in the psychotherapeutic lab at ISMAI during 16 sessions. Following a thorough explanation of the aims and procedures of the clinical trial, as well as the intended use of the data, Claudia provided consent to have her therapy sessions recorded. Throughout the clinical trial, both the ethical principles outlined by the Order of Portuguese Psychologists and the American Psychological Association were strictly adhered to.

When Claudia started her therapy, she shared that she was experiencing sadness due to the recent loss of her mother, with whom she had lived most of her life. Additionally, she was struggling with a long-term unsatisfying relationship with a man who had repeatedly been unfaithful. She had also great difficulties in getting in touch with her feelings, disregarding them as signs of weakness. At intake her Beck Depression Inventory score (BDI-II, Beck, Steer,

& Brow, 1996) was 25, but in the pre-session assessment in the first session increased to 31 (severe depression). Claudia's case was randomly chosen from EFT good outcome cases (N=18) according to the Beck Depression Inventory-II (BDI-II; translated and validated to the Portuguese population from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002). It was considered a recovered and reliably changed case since (1) in the last session the total score was below the cutoff point of 13 (BDI-II scores = 25), and (2) the change from pre-test to post-test was higher than the reliable change index (RCI; Christensen & Mendoza, 1986; Jacobson & Truax, 1991) of 7.75 ( $\Delta$  BDI-II scores = 25).

### **2.2.1.2. Therapist**

Claudia's therapist was a PhD Portuguese male therapist with 20 years of clinical experience and 3 years as an EFT therapist, that received weekly supervision.

### **2.2.2. Therapy**

Emotion-Focused Therapy is an integrative process-experiential therapy, empirically validated (Elliott et al., 2004; Greenberg, 2017; Greenberg & Watson, 2006) that consider emotions as a nuclear element in human functioning. EFT considers that emotions provide a source of information to signal important needs, orienting adaptive action tendencies and so promote survival and well-being (Greenberg, 2017; Greenberg & Pascual-Leone, 2006). According to EFT<sub>2</sub>, psychological problems result from maladaptive emotional processing and therapeutic change is achieved through changing maladaptive emotions with adaptive emotions by developing the ability to experience, tolerate, symbolize, and express emotions (Greenberg, 2017; Pos & Greenberg, 2007). In the case of depressive disorder EFT proposes to solve the difficulties of emotional processing through specific emotion-evocative therapeutic tasks (Watson & Bedard, 2006) to promote access to the depressive scheme and to increase client's emotional processing to a new and more adaptive one (Greenberg & Pascual-Leone, 2006).

### **2.2.3. Measures**

#### **2.2.3.1. Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006)**

The O-MAR is an observational measure that allows the assessment of clients' affect regulation in terms of multiple domains and emotion regulation strategies. This scale was developed based on the theoretical and empirical literature related to emotion regulation and emotional processes and allows the rating of clients' level of emotion regulation (Watson et al., 2011). Clients' affect regulation is assessed based on five subscales of emotional processing: 1) Level of Awareness; (2) Modulation and Arousal; (3) Modulation and Expression; (4) Acceptance of Affective Experience; and (5) Reflection on Experience. Each of the subscales is rated on a seven-point Likert scale with lower scores reflecting lower levels of functioning. The average of the five ratings gives an overall score of affect regulation. Watson and colleagues (2011) reported that the preliminary findings showed that the O-MAR has high internal consistency (early O-MAR = .86; late O-MAR = .93). The O-MAR's scores also demonstrate evidence of construct and predictive validity.

#### **2.2.3.2. Measure of Expressed Empathy (MEE; Watson, 1999)**

The MEE is an observer-rated measure of therapist expressed empathy that evaluates therapists' verbal and non-verbal behaviors, speech characteristics, and response modes. Based on the percentage of time that one behavior is present during the rated segment, it consists of 10 dimensions that are rated on a 9-point Likert scale (from 0 = 'never' to 8 = 'all the time'). A global empathy score is calculated as the average of the 10 subscale ratings. Scale developers referred a high Internal consistency for the scale ( $\alpha = .88$ ). Construct validity is provided by a large and significant correlation ( $r = 0.66, p < 0.01$ ) with client ratings of empathy in the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). The 10 therapist expressive dimensions assessed are: 1) vocal concern; 2) vocal expressiveness; 3) vocal matching; 4) warmth and interpersonal safety; 5) responsive attunement; 6) look of concern; 7) responsiveness/following; 8) understanding experience; 9) understanding cognitive meaning; 10) therapist genuineness/acceptance (Watson, 1999; Watson & Prosser, 2002, cit. Decker et al., 2014).

### **2.2.3.3. Outcome Questionnaire-10.2 (OQ-10.2; Lambert, Finch, Okiishi, & Burlingame, 2005)**

The OQ-10.2 (Lambert et al., 2005) is a self-report inventory that assesses a client's general clinical symptoms. The 10 items (e.g., "I am satisfied with my life", "I feel blue") are scored on a scale ranging from 0 to 4 with the total score ranging from 0 to 40. Higher scores indicate more intense level of symptomatic distress. In the ISMAI Depression Study's sample (Salgado, 2014; N = 64), the Portuguese version presented an adequate internal consistency (Cronbach's Alpha = .77) and test-retest reliability over a 1-week interval (Pearson's  $r = .74$ ). The instrument presented a moderate concurrent validity with the BDI-II (Pearson's  $r = .51$ ).

### **2.2.4. Procedures**

#### **2.2.4.1. MEE Judges' training**

MEE Judges' training. There were three judges who were part of the training. Two, one female and one male, were Clinical and Health Psychology Master's students and the other was a female PhD student with previous training in EFT. 30 segments, of the 33 presented at the MEE manual based on Three Approaches to Psychotherapy I, II, II & IV videos (Watson et al., 2003), of 5 minutes each, were coded. The scores were then compared with the ratings presented by the experts in the manual and discussed between judges. For the present study, and because one of the aims was to investigate a possible association between therapist expressed empathy and client's emotional regulation, the three judges independently coded the 20 middle minutes of each sessions of Claudia's case with MEE. Then, a total of empathy score was calculated as average of the 9 dimensions scores for each session. *Reliability*. Reliability was determined through *Intraclass Coefficient Correlation (ICC)* with a moderate reliability (ICC = .711,  $p < .000$ ) between the 3 judges by comparing their independent codification. The disagreements were discussed, and final scores were achieved by mutual consensus.

#### **2.2.4.2. O-MAR Judges' training**

Before this study, and in order to train and to use this measure adequately, it was elaborated an adaptation manual where the 20 middle minutes of 44 sessions were coded in the five domains (subscales) by two judges (Clinical and Health Master Students) and one auditor (PhD student), totalizing 220 evaluations (cf. Almeida et al., 2016). The reliability between judges was calculated using the *Intraclass Coefficient Correlation (ICC)* with an excellent score ( $ICC = .976, p < .000$ ). For this study, after reading, training and discuss the sessions coded from the above-mentioned manual, the same three judges mentioned in MEE training, coded independently the 20 middle minutes of the 16 sessions of Claudia's case. *Reliability.* Reliability between the 3 judges was determined by comparing their independent codification through *Intraclass Coefficient Correlation (ICC)* with an excellent reliability score ( $ICC = .950, p < .000$ ). The disagreements were discussed, and final scores were achieved by mutual consensus.

#### **2.2.4.3. Symptoms measurement**

The OQ-10.2 was administered immediately before the beginning of each session. It was used in this study as session-by-session measure of the intensity of the clinical symptoms.

### **2.3 Results**

#### **2.3.1. Statistical analysis**

The longitudinal association between the therapist's expressed empathy, emotional regulation, and intensity of clinical symptoms was computed based on bootstrapping methods using the *Simulation Modeling Analysis* software (SMA; Borckardt & Nash, 2014). This statistical software was designed to account for autocorrelated time-series data streams in single-case designs (i.e., the same variable is observed several times throughout the therapy). Pearson rho tests were computed based on SMA cross correlation models to explore multiple temporal associations between variables. Since this is an exploratory study, we compared the strength of the association between the level of therapist expressed empathy and client's emotional regulation in one session and clinical symptoms' intensity in the same session (lag 0) and with subsequent session (lag +1). It was not considered the same analysis with prior

session since the data of clinical symptoms` intensity were collected at the beginning of the session, and data from therapist`s expressed empathy and client`s emotion regulation were collected in a middle phase. For that reason, it used the Bonferroni-adjusted alpha level of .025 (.05/2). To fulfill the third aim of this study we compared the strength of the association between the level of therapist expressed empathy in one session and client`s emotional regulation in the same session (lag 0), and with the subsequent session (lag +1) and the preceding session (lag - 1). In this case the Bonferroni-adjusted alpha level of .016 (.05/3).

### 2.3.1.1. Empathy and outcome throughout therapy

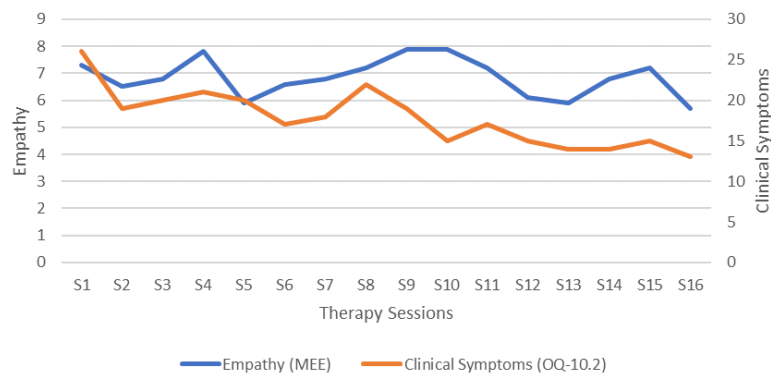
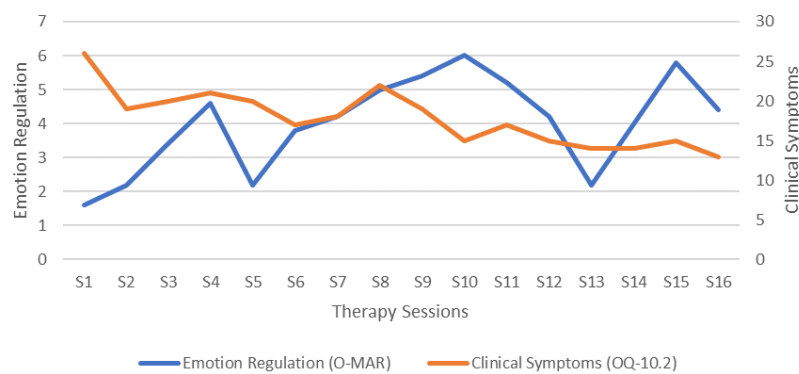


Figure 1. Averages of empathy and intensity of clinical symptoms throughout therapy

The evolution of the therapist`s expressed empathy (MEE average levels per session) and the intensity of clinical symptoms (OQ-10.2 scores) throughout therapy are presented in Figure 1. As it is possible to see, despite the observed variation, therapist`s expressed empathy level is high since first session (MEE average = 7.3). The higher score is observed at sessions 4, 9 and 10 (MEE average = 7.8, 7.9 and 7.9, respectively) and the lower scores are observed in session 5, 13 and 16 (MEE average = 5.9, 5.9 and 5.7, respectively). The intensity of the clinical symptoms varies from the highest level in session 1 (score =26) to the lower level in session 16 (score = 13). Looking at this variation in more detail there is a decreased tendency of clinical symptoms throughout therapy with some moments of setbacks (e.g., sessions 4, 8 and 11). Finally at a final phase there is a decrease and stability of the intensity of clinical symptoms. In this case Pearson`s correlation coefficient indicated there are nonsignificant

associations between the MEE levels and the OQ-10.2 scores in the same session (lag 0),  $r = .38$ ,  $p = .079$  and in the subsequent session (lag +1),  $r = .15$ ,  $p = .285$ .

### 2.3.1.2. Emotion regulation and outcome throughout therapy



*Figure 2. Averages of emotion regulation and intensity of clinical symptoms throughout therapy*

In Figure 2. are presented the evolution of the client's emotion regulation (O-MAR average levels per session) and the intensity of clinical symptoms (OQ-10.2 scores per session) throughout therapy. Client's level of emotion regulation tended to increase over the course of therapy with the lower score observed in the first session (O-MAR average = 1.6) and the higher score at session 10 (O-MAR average = 6). However, there is a marked decrease at session 5 and session 13. As mentioned before, regarding the intensity of clinical symptoms there is a decreased tendency of clinical symptoms throughout therapy with some moments of setbacks and a stability at the final phase of therapy. In this case Pearson's correlation coefficient indicated there are nonsignificant associations between the O-MAR levels and the OQ-10.2 scores in the same session (lag 0),  $r = -.037$ ,  $p = .117$ , and in the subsequent session (lag +1),  $r = -.26$ ,  $p = .196$ .

### 2.3.1.3. Empathy and emotion regulation throughout therapy

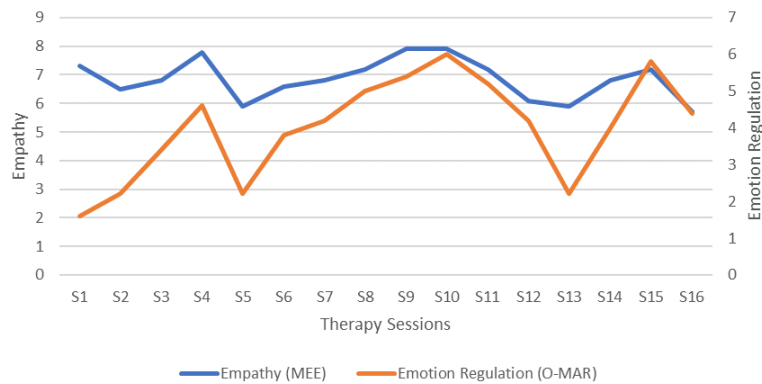


Figure 3. *Averages of empathy and emotion regulation throughout therapy*

In Figure 3. are presented the evolution of the therapist's expressed empathy (MEE average levels per session) and the client's emotion regulation (O-MAR average levels per session) throughout therapy. As noted above, the levels of therapist's expressed empathy do not vary much except in session 4 (there is an increase, MEE average=7.8) and in sessions 5, 13 and 16 there is a decrease (MEE average=5.9; 5.9 and 5.7 respectively) and although the emotion regulation tended to increase over the course of therapy there were some setbacks especially in session 5 and session 13. Looking in more detail it is possible to see that in some moments an increase in the therapist's expressed empathy is followed by an increase in the client's emotional regulation levels (sessions 4, 10 and 15) and moments of setbacks in emotion regulation such as in sessions 5 and 13 were two of the sessions where therapist's expressed empathy level was lower. In this case Pearson's correlation coefficient indicated there is a moderate, significant, positive association between the MEE level and the O-MAR scores in the same session (lag 0),  $r = .55$ ,  $p = .015$ . We found nonsignificant associations between MEE levels and O-MAR scores in the subsequent session (lag +1),  $r = .003$ ,  $p = .453$ .

## 2.4. Qualitative Description

Since we found a significant association between expressed empathy and emotion regulation within the same session (lag 0) a secondary qualitative exploratory description is presented that could provide potential explanatory hypotheses for the observed patterns that emerged during the viewing and discussion of the therapy session videos

EFT considers depression as resulting from affect regulation problems due to blocked, maladaptive, and unprocessed emotional experiences (Greenberg & Watson, 2006; Watson,

Goldman, & Greenberg, 2007). So, helping clients access and process their emotional experiences is an initial goal of EFT therapists. It is important for the client and therapist to understand together what client is doing and experiencing that makes him/her feels depressed (Watson, Goldman, & Greenberg, 2011). Thus, in an initial phase, EFT therapists listen clients' narratives to help to identify the difficult aspects of what they're experiencing. On an early stage of therapy, therapist's concern was to establish an empathic and therapeutic relationship with Claudia. This was particularly important as Claudia started therapy feeling very distressed and struggling to access her emotional experience typical of depressed clients. Given Claudia's difficulties in getting in touch with her emotional experience, an intensive empathic exploration work was made.

Claudia's therapist looked to promote her awareness of her emotional experience and specially to tolerate her distressful emotions. If we look at Figure 1, effectively in this first phase of therapy, therapist's scores of expressed empathy were high (particularly in session 4). Therapist sought that Claudia got in touch with her painful emotions, express this experience and gradually tolerate her. During session 2, Claudia talked about the past and about constant comparisons that were made between her and her brother. To explore this situation therapist permanently maintained eye contact, demonstrated a concerned expression and a warm vocal tone with a constant sense of interest.

Therapist: When you remember these things, what is it like? (*Soft resonance.*)

Client: I'm sad...

Therapist: Hmm-mm... Hmm-mm... very sad... (*Conveying warmth and attuned to the client's inner world.*)

Client: (cries)...

Therapist: It's like a feeling of... they forgot about you? Not looking at you? Not valuing you? To not be esteemed? (*Maintaining eye contact, warm vocal tone, conveying softness and receptiveness.*)

Client: Yes... That... (sighs) [Session 2]

This empathic exploration and conjectures allowed Claudia to progressively feel more secure on accessing and accept her painful emotions, and simultaneously to tolerate them, deepening her emotional experience in subsequent sessions. At session 3, while Claudia talks about her mother's last times, and how difficult it was, she cries and shows great discomfort.

In that moment it was possible to see that therapist responsively attuned to the Claudia's inner world, showed concern and engagement, conveying an emotional understanding of her grief.

Client: (cry)...

Therapist: Hmm-mm... Hmm-mm... Ok... So there's a big sadness (pointing to the heart) in the loss that this constitutes for you... **(Deep, warm tone of voice, conveying softness, emotional understanding and concern.)**

Client: (still cries)

Therapist: It's a huge loss for you... And it's such a pain, isn't it? **(Emotional involvement and mirroring the client's grief.)**

Client: (deep crying) Because I think that she was the only person who liked me...

Therapist: Hmm-mm... Hmm-mm... [Session 3]

In this case, therapist ability to “become the client experience”, to “feel what the client felt”, assisted Claudia to symbolize her emotional experience. In the early phase of therapy, the intensity of client's clinical symptoms has mobilized compassion in the therapist allowing Claudia to feel safe to access, express and symbolize her pain and sadness with which therapist have remained attuned, moment-by-moment, validating the experience of being Claudia. This in-depth empathic exploration made it possible that in session 4 a clinical experiential co-formulation of her dependence on an unsatisfactory relationship and of her submissive pattern were related with her pervasive fear of rejection and abandonment.

Client: I feel fear, fear, fear. Fear of asserting myself, fear of everything, fear to say anything. I am always in touch with this fear, it's always here... This fear limits me... Fear of express myself because if I do so, others will abandon me, and I will be alone. [Session 4]

EFT therapists first listen to clients' narratives to identify problematic aspects. It is important to reach a shared understanding of what clients do and experience that may contribute to their depression (Watson, Goldman, & Greenberg, 2011) in a co-constructed and experiential formulation.

As mentioned earlier, at a middle therapy phase there was a slight increase in the intensity of client's clinical symptoms. In this clinical case, this matches with the deepening of therapeutic work, where different tasks were performed. For instance, at session 8, Claudia's clinical symptoms at the beginning of the session were higher than in previous sessions. Spontaneously during a two-chair dialogue task with her coercive critic, Claudia acknowledged that her critical voice sounded like her mother's voice. When assuming this critical voice Claudia got in touch and deepened her pain and sadness. Therapist compassionate behavior toward her suffering allowed to deepen her emotional experience and to reflect on her during the task. Therapist helped Claudia to experience her core vulnerabilities, maintaining eye contact, with an open quality voice, being receptive Claudia's concerns, providing moment-to-moment acknowledgements, and adjusting his responses to follow Claudia's experience.

Client: (talking to the self-chair, while in the critical chair): You've got no personality, you don't know how to affirm yourself ... (looking to the therapist) this was left here, it is stuck.

Therapist: Left by whom? **(Tone of voice matching her level of emotional experience intensity.)**

Client: By my mother (laughs). (resuming the critical voice and looking to the other chair) you don't have personality, you don't know how to affirm yourself, other people make fun of you.

Therapist: Hmm-mm. OK, OK. So, let's give a voice to your mother. Be that voice. **(Vocal tone that shows high energy, attuned with client facial expression.)**

Client: (as her mother): you don't have any personality: you don't know how to affirm yourself.

Therapist: Come here (inviting to change chairs to the experiential self-chair). Hmm-mm, ok. What can you tell her?

Client: I was really sad, oh, and I rebelled myself, rebelled and always told to myself that the truth was that she was wrong . . . but then deep down I . . .

Therapist: Hmm, what is it? Can you stay with that sadness? [the therapist focuses on her sadness to help Claudia access her core pain.] **(Worried and warm vocal tone. Therapist pick up the live edges of Claudia's experience showing a sensitive appreciation and gentle caring for her feelings.)**

Client: Ah I'm . . . it's too strong. it's painful to be in here. [session 8]

The experience of empathic listening helps clients to develop more positive, nurturing introjects and more soothing, validating, and protective ways of reacting to themselves (Watson, 2002). This could lead to a change in their sense of self and make them less self-critical. This is particularly important for clients who have been neglected, abused or who have experienced distressing events. Their attachment experiences did not allow for a nurturing and affirming attitude towards themselves. Given her discomfort and pain, therapist empathic behaviors, like the permanent eye contact, his concerned expression and vocal tone, have demonstrated compassion for her hurting, creating a level of emotional involvement that generate a sense of safety in Claudia and allowed to get in touch with her unmet needs.

Therapist: Painful. How is that feeling? Can you tell me about that feeling? (**Warm and soft vocal tone. Therapist demonstrates an equal level of emotional involvement.**) Client: It's tightness. (Therapist: A tightness . . .) Tightness. I don't know, something that's here, inside. I need to take a deep breath to get it out.

Therapist: To get it out. . . Stay with that for a moment. So, it's almost like you are being . . . constrained. (**Therapist adjust his responses to follow Claudia's emotional experience, providing moment-by-moment acknowledge of that experience and showing his understanding of Claudia's inner emotional experience.**)

Client: Squeezed.

Therapist: Squeezed, hurt? (**Being gentle, careful, attentive, concerned.**)

Client: That's it.

Therapist: Almost trampled. (**Therapist is attentive to nuances of meaning and feeling and pick up the live edges of Claudia's experience.**)

Client: I felt many times like that, completely trampled.

Therapist: Hmm-mm, so that's the feeling of tightness, anguish. That has to do with that expression of . . . criticism from your mother? (**Therapist shows engagement, maintaining eye contact and conveying an emotional understanding of the client's inner experience, validating that experience.**)

Client: Always my mother!

Therapist: Of some depreciation.

Client: Always, always.

Therapist: Yes, if we give it a voice . . . what does it say?

Client: Angry, I'm angry for those criticisms.

Therapist: Hmm-mm. **(Gentle.)**

Client: For discrimination.

Therapist: Hurt, rejected? **(Having a concerned expression.)**

Client: I think that the word would be "rejection."

Therapist: I'm not having . . . what is it that you're missing? **(Exploratory response, accepting Claudia's experience and being non-judgement.)**

Client (cries): It's difficult.

Therapist: It's difficult to tell. **(Validating Claudia's feelings with warm and soft vocal tone.)**

Client: But I won't cry. I don't want to.

Therapist: Hmm-mm, but . . .

Client: It's care, attention.

Therapist: Hmm-mm, support.

Client: Yes, that's it.

Therapist: Are you able to tell her that? **(Maintaining the focus on the unexpressed need.)**

Client: (7 seconds of pause and the client starts crying)

Therapist: Because it's hard, it's painful, and because of that it's hard for you to stay in touch with that. **(Therapist show compassionate behavior toward Claudia's suffering, being providing moment-to-moment acknowledgement and conveying an emotional understanding her inner feelings.)**

Client: I know . . . what I miss . . .

Therapist: What is it?

Client: Love. [Session 8]

After session 11, the intensity of Claudia's clinical symptoms tended to stabilize, except for the session 15 in which there was a slight increase. During this session, Claudia talked again about her mother and about one part of herself that continued to feel the need of being estimated and loved by her. When talking about this need, she got emotional. Therapist's empathic behaviors of exploration, and moment-by-moment attunement with that feeling allowed to easily engage on an empty-chair work. During the task therapist's empathic behaviors were determinant to Claudia "let go" her unmet needs towards a dismissive mother that emerged during the exercise.

Client: I have to live like this. I have to know how to live.

Therapist: So, what can you say to her? **(Soft resonance and verbal expression of concern, calmness, showing comfort, receptiveness, validating Claudia's experience.)**

Client: I will live without your support and I won't let that affect me. It's like that, I have to accept.

Therapist: Accept that . . . **(Soft resonance.)**

Client: Accept that you are just like that.

Therapist: So what do you do about your need? What was her support about? **(Attentive to nuances of meaning and feeling and pick up Claudia's live edges.)**

Client: To feel safety. (Therapist: OK.) I needed to feel safe.

Therapist: So, I will find that security and safety. **(Tone of voice with high energy, emphasis, that matches with the intensity of Claudia's need.)**

Client: Ah yes, even without you I will achieve that safety.

Therapist: I will become a secure person, even without you.

Client: Yeah, yeah.

Therapist: Even without your support. **(Expressive voice.)**

Client: Even without your support I will become a secure person, less fearful of others' criticisms.

Therapist: I will be me. **(Therapist provide moment-to-moment acknowledgement, and fine-tune his responses to fit with Claudia's.)**

Client: I will accept me. [Session 15.]

## 2.5. Discussion

Empathy is seen as an integral part of any psychotherapeutic approach. Process-experiential approaches, like EFT consider empathy to be a core essential ingredient or condition for psychotherapy and the client's intra- and interpersonal change (Watson, 2007a). According to Watson (2007b) in EFT, relational conditions are an integral part of identifying relevant interventions, establishing different ways of working and resolving specific cognitive affective difficulties. In EFT, much of the therapeutic work involves empathically following the client's moment-by-moment experience. Empathy helps clients to establish an attachment bond with their therapist, which is important throughout therapy, but especially in the early sessions (Mlotek, 2013).

In this EFT case, as expected, the therapist's level of expressed empathy was high from the first session. According with some research therapist's empathy in the first session has been associated with a decrease of clinical symptoms during therapy (e.g., Hoffart et al., 2002) and with outcome (Malin & Pos, 2015). Our findings suggest that the therapist's expressed empathy was consistently high throughout therapy. However, its evolution was irregular, with some moments of increase and decrease. There were moments on therapy process that therapist had more difficulties to empathize so well with client. As Norcross and Wampold (2011) claimed psychotherapy is fundamentally a human relationship, an inherently human encounter. Empathy requires ongoing attunement to the client's experience and careful attention to the nuances of that experience. We can't ignore that many times clients and therapists come from different backgrounds, have different experiences, or view the world differently from themselves.

Both participants bring themselves (their backgrounds, cultures, personalities, psychopathologies, expectations, biases, defenses, and strengths) into the human relationship. This could lead to difficulties in maintaining high levels of empathy throughout therapy. In some therapy moments, maintaining a high level of empathy can be challenging. Clients may

sometimes be resistant/unresponsive to therapist empathy. This also can lead to the therapist becoming frustrated or disillusioned, which in turn can lead to setbacks in empathy. It is important to note that irregular levels of empathy throughout therapy are a normal and expected part of the therapeutic process. They do not necessarily indicate that the therapist is providing poor care or that the therapy is failing. However, in order to provide the best possible care for their clients, it may be helpful for therapists to reflect on and address any factors that may be contributing to difficulties in being fully empathic.

In addition, as would be expected in a good outcome case, despite the variation observed, the level of emotional regulation increased over the course of therapy and the intensity of clinical symptoms decreased. In other words, over the course of therapy, Claudia improved her ability to be more aware of her emotional experience, to tolerate and modulate her arousal and expression, to accept her emotions and to reflect on them. The increase in the client's emotion regulation over the course of therapy is also consistent with previous research showing the effectiveness of EFT in improving emotion regulation skills (Greenberg, 2021).

However, there were some setbacks in some sessions. These moments of setback suggest that emotion regulation is not a linear process and that there may be specific situations or contexts in which clients find it difficult to regulate their emotions, such as in moments of crisis or when the client is experiencing intense emotions. Therapy is designed to help the individual to work through difficult emotions and experiences from the past, which can be challenging and emotionally draining. Therefore, it is not uncommon for people to experience setbacks or heightened emotions during therapy. It is important to remember that setbacks and challenges are a natural part of the therapeutic process and do not necessarily mean that one is not progressing or growing. These can be seen as a natural part of healing and an opportunity to grow and develop. In therapy, the trajectory of emotion regulation may be affected because different situations or topics may elicit different emotional responses. Even people who have developed strong emotional regulation skills may experience setbacks or struggle to regulate their emotions at particularly challenging times.

In EFT, these setbacks are extremely common during tasks/exercises such as the Empty Chair Work or the Two Chair Work. These are often the moments in therapy when the client has access to their core pain and it becomes difficult to tolerate or modulate the emotional experience.

In this clinical case we found no statistically significant associations between emotional regulation and the intensity of clinical symptoms, nor between empathy and clinical symptoms, when these variables are considered session by session.

These findings indicate that at an idiographical level, we cannot assume a linear effect of empathy or emotional regulation in the clinical symptoms. Nevertheless, the values of the association between emotional regulation and clinical symptoms in the next session, and especially between empathy and clinical symptoms in the same session (lag 0,  $r = .38$ ,  $p = .079$ ), even if not statistically significant, have a magnitude that deserve further research, with larger samples and other statistical methods.

We found a moderate, significant, and positive association between the therapist's empathy and the client's emotion regulation in the same session [(lag 0),  $r = .55$ ,  $p = .015$ ], which is an interesting finding. As mentioned before, according to Greenberg (2021) the way in which the therapist engages and connects emotionally with the client is the first experience in therapy that influences emotion regulation. This finding of a positive association between empathy and emotion regulation in the same therapy session is particularly noteworthy. It suggests that these processes may be dynamically interconnected.

This association highlights the importance of empathy in promoting emotion regulation in therapy. Accordingly with literature (Greenberg, 2021; Watson, 2016; Malin & Pos, 2015; Paivio & Laurent, 2001) when therapists express empathy towards their clients, they create a safe and supportive environment that allows clients to explore and regulate their emotions more effectively. Feeling heard and understood in an empathic way helps people to feel secure in an interpersonal context, which in turn allows them to focus on themselves and to explore their inner worlds. Our finding supports the theoretical and empirical assumption that client's emotion regulation skills are enhanced in the presence of empathic therapist.

The positive association in this study is consistent with previous research that has shown the positive impact of therapist empathy on client emotion regulation (Prosser, 2007; Watson et al., 2020). This pattern of association highlights the importance of empathy in promoting emotion regulation in therapy. According to Watson (2016) the way in which client's experiences are treated by others is internalized and create (or not) conditions of worth. So, it is especially in the interaction with others that the course of attending and accepting our subjective experience develops. An empathic therapist could support self-acceptance and self-empathy (Greenberg, 2014) as we could see in this clinical case.

Contrary to what was expected, in this clinical case no statistically significant associations were found between emotional regulation and the intensity of clinical symptoms, nor between empathy and clinical symptoms, when these variables are considered session by session. It is possible that the numbers of sessions (16) were insufficient to detect significant

associations. To find significant associations between these variables, a larger sample size may be needed.

The finding of a positive association between therapist expressed empathy and client emotion regulation in the same session is important for psychotherapy research and to clinical practice. This supports that therapist empathy is key to helping clients regulate their emotions, providing therapists with specific information about how to enhance therapeutic processes. For example, therapists could be encouraged to focus on building a strong empathic relationship with their clients. Empathy is an essential component of the therapeutic relationship, and the quality of the therapeutic relationship has been shown to be a critical factor in successful therapy outcomes. Thus, this study emphasizes the importance of developing and maintaining a strong empathic therapeutic relationship for effective emotion regulation and successful therapy outcomes.

In this way, therapists may be able to promote the emotional regulation of their clients and, ultimately, have an impact on their clients' outcomes. This is particularly important for clients with depression, as emotion dysregulation is a core symptom of this disorder, and emotion regulation is an essential skill that enables individuals to manage their emotions effectively.

Given that this is an exploratory case study, the results may be due to the client's idiosyncrasies which do not allow for generalization. Another weakness of our results is that they are inevitably influenced by the theoretical orientation of the therapist. Further research with larger samples of sessions and clients in different therapy approaches is needed to explore the relationship between these variables. However, it seems that it would be important to assess these variables at several points in the therapy process and not just in few sessions.

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### **Study 3**

**Empathy and emotion regulation in depression: Examining the role of therapists' empathy and clients' emotion regulation on psychotherapy outcome in depression**



## Abstract

The aim of this study was to investigate whether clients' emotion regulation serves as a mediator in the relationship between therapist empathy and the outcomes related to depressive symptoms and overall distress. Specifically, the study addressed if: (a) therapists' expressed empathy is a predictor of clients' outcomes, in terms of depressive symptoms and overall distress at the end of therapy; (b) therapists' expressed empathy predicts improvements in clients' emotion regulation capacity, as assessed by an observer measure; (c) the association between therapists' expressed empathy and clients' outcomes is mediated by clients' capacity to regulate emotions. Statistical analyses were performed using R (version 4.1.1), using a linear mixed models (LMM) approach due to the availability of multiple data points for both outcomes and explanatory variables. The sample was composed of 49 clients selected from the 50 clients who successfully completed the assigned treatment in a larger randomized clinical trial, aimed to investigate and compare the efficacy of Emotion-Focused Therapy and Cognitive Behavioral Therapy in treating Major Depressive Disorder (Salgado, 2014). Data from expressed therapist empathy, client emotion regulation, general clinical symptoms, and depressive symptoms were collected at sessions 1, 4, 8, 12, and 16. The results indicate a mediation effect of emotion regulation on the relationship between expressed empathy and depressive symptoms, with marginal significance and a negative effect ( $\beta=-5.124$ ,  $p=.093$ ). Additionally, a significant mediation effect of emotion regulation on the relationship between empathy and general clinical symptoms was observed, with a negative effect ( $\beta=-12.885$ ,  $p=.047$ ). These findings suggest an indirect effect of therapist empathy on treatment outcomes, mediated by clients' ability to regulate their emotions. This offers empirical support for the conceptualization that therapists' ability to exhibit empathy contributes to the development of clients' affect regulation abilities, influencing treatment efficacy. Further discussion explores the practical and theoretical implications of these results.

**Keywords:** Depression; Emotion regulation; Empathy; Psychotherapy Outcome



### 3.1. Introduction

Therapist empathy has been underscored as main common mechanism of change in psychotherapy. Various empirical studies (e.g., Abargil & Tishby, 2022; Hara et al., 2017; Hoffart et al., 2016; Malin & Pos, 2015; McClintock et al., 2018; Mlotek, 2013; Moyers et al., 2016; Vitinius et al., 2018; Watson & Geller, 2005; Watson et al., 2014, 2020; Wing, 2010), and comprehensive meta-analyses (Elliott et al., 2011, 2018; Greenberg et al., 2001) have shown that empathy is a predictor of positive outcomes across different therapeutic modalities. Accordingly, the work of Norcross and Lambert (2018) work for the *Third Interdivisional APA Task Force on Evidence-Based Relationships* reaffirmed the relevance of empathy in psychotherapy.

The concept of empathy has evolved significantly over time, with contemporary definitions (Batson, 2009; Decety & Holvoet, 2021) recognizing its multifaceted nature, extending beyond mere active listening to encompass deeper emotional connection and understanding. As a pioneer in this area, Rogers described empathy as "(...) *the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view.*" (1975, p. 85), and as "(...) *being sensitive, moment by moment, to the changing felt meanings which flow in this other person.*" (1975, p. 142). In psychotherapy, empathy is often described as the therapist's capacity to "*step into the client's shoes*" (e.g., Abargil & Tishby, 2022; Prosser, 2007).

In response to the presence of numerous potential definitions for the construct, and the need to organize the field, Batson (cit. Bošnjaković & Radionov, 2018; Nienhuis et al., 2018; Soto, 2017) identified and categorized eight, although, distinct phenomena that have been called empathy: a) the process of gaining knowledge about another person's thoughts and emotional state; b) adopting the other person's posture or aligning with their neuronal responses; c) feeling how the other person feels; d) projecting ourselves into the situation of the other; e) imagining how the other feels or thinks; f) imagining how we would act, think and feel in the place of the other; g) experiencing distress when witnessing the suffering of another; h) feeling empathy for the other person who is suffering. So, there is a diverse of possibilities to define empathy.

Regardless of the adopted definition, therapist empathy goes beyond active listening, involving emotional connection and understanding (Singer & Lamm, 2009). It is characterized by dynamic, fluid, and complex processes that involve continuous interactions between the therapist and the client. This complex nature of empathy is underscored by its multi-faceted structure, leading numerous authors, to conceptualize it as a complex construct composed of

various interconnected components (e.g., Decety & Holvoet, 2021; Elliott et al., 2018; Gibbons, 2011), as it is conceived in this study.

The original studies on this area were devoted to assess the impact of empathy on outcome. Therefore, explicitly or implicitly, they revolved around the notion that empathy has a direct effect on the client. However, as the research gradually evolved, the question that emerged was to detect *how* an interpersonal event (empathy) can have an intrapsychological stable effect. Therefore, some researchers started to look for intrapsychological processes that may positively be affected by empathy.

Aligned with the perspective that empathy indirectly influences psychotherapy outcomes, research findings suggest that its impact is mediated by changes in clients' internal psychological processes (e.g., Malin & Pos, 2015; Mlotek, 2013; Watson et al., 2014). Recent empirical work (e.g., Watson et al., 2020) suggests that the effect of therapist empathy on treatment outcomes may be mediated by changes in clients' internal psychological processes, particularly in the domain of emotion regulation (ER).

Within this domain, numerous authors emphasize the essential role of effective ER in clients for achieving positive outcomes (e.g., Daros et al., 2021; Greenberg & Pascual-Leone, 2006; Igra et al., 2023; Peluso & Freund, 2018; Prosser, 2007; Sønderland et al., 2023; Whelton, 2004). ER has emerged as a critical component in the maintenance and treatment of psychological disorders, particularly Major Depressive Disorder (MDD). The literature emphasizes the link between ER deficits and various psychopathologies, including MDD (e.g., Aldao & Nolen-Hoeksema, 2010; Berking et al., 2019; Daros et al., 2021; Visted et al., 2018). For example, empirical research has shown that individuals with depression frequently struggle in implementing adaptive ER strategies (Berking et al., 2014).

Central to this discussion is the integrative model proposed by Watson and colleagues' model (cit. Elliot et al., 2004; Rodrigues, 2010), which posits that effective ER involves the awareness of emotional arousal, accurate labeling of experiences, modulating arousal to meet personal needs. Consequently, in this study, ER is conceived as the process of "*how people process, modulate, and express their emotional experience*" (Watson et al., 2011, p. 86). In depression, where individuals commonly struggle with emotional identification, acceptance, self-compassion, and emotional modification (Angell, 2017), this model holds significant relevance.

Authors highlight the transformative potential of emotional experience and its regulation in psychotherapy (e.g., Fosha, 2001; Grecucci et al., 2017), emphasizing that therapeutic changes are most impactful when emotions are adequately regulated, facilitating

the processing of their meaning (Whelton, 2004). Collaborative efforts by therapists involve guiding clients to confront and explore their painful emotions (Peluso & Freund, 2018). Therefore, establishing an authentic therapeutic relationship is essential for enabling clients to fully engage with and express their emotions. This dynamic relationship plays a pivotal role in shaping clients' emotional experiences, emphasizing its fundamental importance in the process ER and overall therapeutic progress. Hence, when evaluating the influence of therapist empathy on change in the client's internal processes, Watson (2016) suggests that one of the functions of therapist empathy is the regulation of emotions.

Expanding on Rogers's Process Model, Watson (2011) suggests that clients internalize how others perceive and treat their emotional experiences, influencing their self-worth and emotional self-regulation. Creating an environment where individuals can openly share and validate their emotions is crucial for regulating internal emotional states (e.g., Greenberg & Watson, 2006; Paivio & Laurent, 2001). Therapist empathy establishes a secure space, enabling clients to engage with their emotions and enhancing emotional approach and tolerance (Greenberg, 2014, 2021; Malin & Pos, 2015; Watson, 2016, 2018) fundamental to emotional awareness, symbolic representation, deep exploration, needs recognition, and consequently, more effective ER (Watson et al., 2014).

Only a limited body of research has explored the intricate association between therapist empathy and client ER. In a study in the context of Process-Experiential Therapy (PET) and Cognitive Behavioral Therapy (CBT) for depression, conducted by Prosser (2007), the path analysis revealed that the predictive effect of therapist empathy on therapeutic outcomes was mediated by changes in clients' ER. In Watson and colleagues' study (2020), the primary aim was to examine whether changes in clients' ER ability mediated the influence of therapists' empathy on therapeutic outcomes. Therapist empathy emerged as a robust predictor of positive changes across various outcome measures, and of client ER. Particularly noteworthy was the mediation effect of changes in clients' ER, involving their ability to be aware, accept, modulate emotional arousal and expression, and reduce emotional suppression and reactivity. Watson and colleagues (2020) recommend that research should continue to investigate empathy's role as a mechanism of change, aiming to advance our understanding of its relationship with the development of ER.

This study seeks to continue exploring these two essential elements and examine how they jointly contribute to complex psychotherapy outcomes. Within the framework of a randomized clinical trial (RCT) for depression treatment, employing both Emotion-Focused Therapy (EFT) and CBT, the primary objectives are to investigate whether clients' ER serves

as a mediator in the relationship between therapist empathy and the outcomes related to depressive symptoms and overall distress. By testing this model, this study aims to address the following hypotheses: (a) therapists' expressed empathy is a predictor of clients' outcomes, specifically in terms of depressive symptoms and overall distress at the end of therapy; (b) therapists' expressed empathy predicts improvements in clients' ER capacity, as assessed by an observer measure; (c) the association between therapists' expressed empathy and clients' outcomes is mediated by clients' capacity to regulate emotions.

Unlike previous investigations with limited time-point assessments, this study takes the advantage of longitudinal data collected throughout therapy sessions. Additionally, it was used a Linear Mixed Models (LMM) approach, chosen for its suitability in analyzing data collected over multiple time points and its ability to accommodate the correlated nature of repeated measurements on the same subjects. This methodological approach enhances our capacity to explore the dynamic interplay between therapist empathy, clients' emotion regulation, and psychotherapy outcomes.

## **3.2. Method**

### **3.2.1. Clients**

The study sample comprises 49 clients selected from the 50 clients who successfully completed the assigned treatment in the larger RCT (N=64), designated as the ISMAI Depression Study (Salgado, 2014). This study aimed to investigate and compare the efficacy of EFT and CBT in treating MDD. One client was excluded from the current study due to missing data regarding outcome measures in two of the analyzed sessions.

Inclusion criteria for the clinical trial involved a confirmed diagnosis of MDD, absence of concurrent medication for depression, and a Global Assessment of Functioning score above 50. Exclusion were as follow: 1) current usage of medication for depression; 2) a current or prior diagnosis of specified DSM-IV Axis I disorders, including bipolar disorder, panic disorder, psychosis, eating disorders, or substance abuse; 3) diagnosis of one of the specified DSM-IV Axis II disorders, such as antisocial personality disorder, borderline personality disorder, schizotypal personality disorder, or narcissistic personality disorder; 4) a high risk of suicide. Diagnostic assessments were performed using the Structural Clinical Interview for the DSM-IV-TR (First et al., 1997, 2002).

After being selected to the clinical trial, clients were randomly assigned to CBT or EFT treatment modalities, and to a therapist. All clients provided informed consent for the videotape of their therapy sessions and the use of their data to scientific research purposes. They were briefed on the clinical trial's aims and procedures, as well as the intended use of their data. To ensure anonymity and protect personal information, the data were de-identified. Throughout the clinical trial, ethical guidelines followed the principles established by both the Order of Portuguese Psychologists and the American Psychological Association.

Table 2 provides an overview of the sample's characteristics. All participants were of Portuguese nationality, from the northern region of the country. Their ages ranged between 19 and 57 years ( $M = 36.18$ ,  $SD = 9.7$ ), with the majority comprising 41 females (84%). In terms of civil status, 21 clients were single, 20 were either married or in a common-law relationship, and 8 were divorced or separated. A substantial proportion had attained a higher education level (65%), while 16 possessed a secondary education, and a sole client held only a primary education qualification. Employment statuses varied, with 24 clients being employed, 17 unemployed, and 8 were students or student workers. In terms of treatment modality, 26 clients received CBT, and 23 go through EFT, with the majority (61%) demonstrated to be good outcome cases.

Table 2  
*Sample characteristics*

	N	%
Civil status		
Married	20	40,8%
Divorced	8	16,3%
Single	21	42,9%
Education		
Primary education	1	2,0%
Secondary education	16	32,7%
College education	32	65,3%
Socio-economic status		
1	11	22,4%
2	30	61,2%
≥ 3	8	16,3%

Table 2 (cont.)  
*Sample characteristics*

	N	%
Profession		
Unemployed	17	34,7%
Employed	24	49%
Student/Student Worker	8	17,3%
Therapeutic model		
EFT	23	46,9%
CBT	26	53,1%
Client's sex		
Female	41	83,7%
Male	8	16,3%
Therapeutic result		
Unsuccess	19	38,8%
Success	30	61,2%

### 3.2.2. Therapists

The clinical trial involved a total of 11 therapists, comprising 2 males and 9 females, all Portuguese, and all possessed prior clinical experience. Within this group, 7 therapists held professional titles as clinical psychologists, while 4 were doctoral students in counseling or clinical psychology graduate programs. In the EFT group, there were 6 therapists, 2 males and 4 females, aged between 31 to 45 years, ( $M = 35.4$ ,  $SD = 4.5$ ). They had accumulated clinical experience ranging from 3 to 22 years, with 1 to 6 years of experience in the EFT model ( $M = 3.8$ ,  $SD = 1.6$  years). The CBT group consisted of five female therapists, aged between 28 to 37 years ( $M = 32.4$ ,  $SD = 3.6$ ), with clinical experience ranging from 4 to 14 years, and 3 to 14 years of experience in the CBT model ( $M = 7.8$ ,  $SD = 4.5$  years). Both groups received an extensive six-month training (80 hours) in the specific protocol of their respective therapeutic modalities and received weekly group supervision for their clinical practice, with each supervision session lasting 2 hours per week.

### 3.2.3. Therapies

As previously mentioned, EFT and CBT were the therapeutic approaches employed in the treatment of depression, with interventions adhering to specific protocols developed within the ISMAI Depression Study (Salgado et al., 2014).

**EFT.** The EFT intervention protocol was based on the previous work developed by Elliott and colleagues (2004) and Greenberg and Watson (2006), for the treatment of depression. EFT is an empirically validated integrative process-experiential therapy approach (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006) that places emotions at the core of human functioning. According to EFT, emotions are vital sources of information, signaling important needs, guiding adaptative action tendencies, and promoting survival and overall well-being (Greenberg, 2008; Greenberg & Pascual-Leone, 2006). Psychological problems, within the EFT approach, are viewed as resulting from maladaptive emotional processing, and therapeutic change is achieved through the transformation of maladaptive emotions into adaptive ones. This transformation involves developing the ability to experience, tolerate, symbolize, and express emotions (Greenberg, 2002; Pos & Greenberg, 2007). In the context of treating depressive disorder, EFT addresses emotional processing difficulties through specific emotion-evocative therapeutic tasks (Watson & Bedard, 2006). These tasks aim to facilitate access to the depressive scheme and enhance the client's emotional processing, guiding them towards a new, more adaptative form aligned with their needs (Greenberg & Pascual-Leone, 2006).

**CBT.** The CBT treatment used an adapted protocol based on the ISMAI depression study (Salgado, 2014), derived from the original protocol for depression developed by Beck and colleagues (1997). CBT is a semi-structured, directive therapeutic approach that conceptualizes clinical problems as outputs from of cognitive processing errors in interpreting reality. These errors interfere with the way individuals think, behave, and feel (Beck 2011; Beck et al., 1997). In the context of psychotherapy, the central goal is cognitive restructuring, involving the challenging and changing dysfunctional beliefs and schemas to more adaptive ones. This process aims to foster positive emotional states and promote more adaptive thoughts and behaviors.

### 3.2.4. Measures

#### 3.2.4.1. Outcome Measures

**Beck Depression Inventory (BDI-II).** The BDI-II (Beck et al., 1996, translated by Coelho et al., 2002) is a 21-item self-report inventory that assesses cognitive, affective, and somatic symptoms of depression. Each item is scored on a scale from 0 to 3, resulting in a total score ranging from 0 to 63. In the Portuguese version of the BDI-II (Coelho et al., 2002), a score of 13 is the cutoff for clinical depression. Scores below 13 falls within the normal range (non-clinical), while scores between 14 and 19 indicate mild to moderate depression, scores between 20 and 28 signify moderate to severe depression, and a total score of 29 or higher indicates a severe level of depression. This Portuguese version of the BDI-II has demonstrated good internal consistency, with a Chronbach`s alpha of .89.

**The Outcome Questionnaire (OQ-45).** The OQ-45 (Portuguese version from Machado & Fassnacht, 2014) is among the most widely used self-report measure for monitoring psychotherapy outcomes, especially in assessing change during psychotherapy treatments. It consists of three subscales: Symptom Distress (SD), typically evaluating symptom reduction; Interpersonal Relation (IR); and Social Role (SR). The OQ-45 assesses overall well-being, including functioning with a partner, family, and friends (IR scale), as well as performance in different settings, such work, school, and leisure (SR scale). The Portuguese version of the OQ-45 (Machado & Fassnacht, 2014) has demonstrated adequate reliabilities in terms of internal consistency and test-retest. For the total score, a cutoff score of 62 is applied, while cutoffs of 36, 14, and 13 apply to the SD, IR, and SR subscales, respectively. Reliable Change Index (RCI) values were calculated as 15 points for the total score and 12, 8, and 7 for the SD, IR, and SR subscales, respectively.

#### 3.2.4.2. Process Measures

**Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006).** The Observer Measure of Affect Regulation (O-MAR) is an observational tool designed for evaluating clients` affect regulation, encompassing various domains and emotion regulation strategies. Developed by integrating insights from theoretical and empirical literature on emotion regulation and emotional processes, the O-MAR allows for the assessment of clients`

emotion regulation levels during the evaluation (Watson et al., 2011). The O-MAR assesses clients' emotion regulation through five subscales of emotional processing: 1) Level of Awareness; 2) Modulation and Arousal; 3) Modulation and Expression; 4) Acceptance of Affective Experience; 5) Reflection on Experience. Each of these subscales is rated on a seven-point Likert scale, where lower scores indicate lower levels of functioning. The average of these five ratings provides an overall score for emotion regulation. Watson and colleagues (2011) have reported that the O-MAR demonstrates high internal consistency, with early O-MAR reliability at .86 and late O-MAR reliability at .93. Moreover, the scores obtained from the O-MAR exhibit evidence of construct and predictive validity.

**Measure of Expressed Empathy (MEE; Watson, 1999).** The Measure of Expressed Empathy (MEE) is an observer-rated measure used for the assessment of therapist-expressed empathy. It evaluates therapists' verbal and non-verbal behaviors, speech characteristics, and response modes. Comprising 10 dimensions rated on a 9-point Likert scale (ranging from 0 for "never" to 8 for "all the time"), each dimension's score is determined based on the percentage of time the behavior is observed during the rated segment. A global empathy score is computed by averaging the ratings across these 10 subscales. The MEE demonstrates a high level of internal consistency, with a reported Cronbach's alpha ( $\alpha$ ) of 0.88. Construct validity is affirmed by a significant correlation ( $r = 0.66$ ,  $p < 0.01$ ) between MEE scores and client ratings of therapist empathy, as assessed by the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). The 10 therapist expressive dimensions evaluated by the MEE include: 1) Vocal concern; 2) Vocal expressiveness; 3) Vocal matching; 4) Warmth and interpersonal safety; 5) Responsive attunement; 6) Look of concern; 7) Responsiveness/following; 8) Understanding experience; 9) Understanding cognitive meaning; 10) Therapist genuineness/acceptance (Watson, 1999; Watson & Prosser, 2002).

### **3.2.5. Procedures**

#### **3.2.5.1. Treatment Procedures**

As mentioned earlier, following the initial assessment phase where each client was deemed eligible for the clinical trial, they were randomly assigned to either the CBT or EFT treatment condition and then further randomized to one of the therapists within their respective

condition. Subsequently, each client goes through a total of 16 individual psychotherapy sessions. However, due to variations in individual needs, idiosyncrasies, or progress, two clients completed the therapy process before the 16th session (at session 12), while two others required an additional session (for a total of 17 sessions). These deviations from the original 16-session protocol were thoroughly discussed, analyzed, and assessed during supervision group sessions.

Except for the four cases that completed the psychotherapy process either earlier or later than the 16th session, the remaining cases had sessions 1, 4, 8, 12, and 16 analyzed to explore therapist empathy, client emotion regulation, and depressive and distress symptoms throughout therapy. These specific sessions were chosen because they represent different phases of the therapeutic process, providing an overview of how the variables of interest evolved over the course of therapy (Hill et al., 1997). Simultaneously, these sessions coincided with the moments when clients completed the outcome measures as outlined in the clinical trial protocol, allowing for an investigation into the associations between process and outcome measures. In cases where therapy was completed by the 12th session, this session was regarded as the final one. For the two clients who concluded their therapy at the 17th session, the 17th session was considered the last session for analysis due to the availability of outcome measure data.

All clients completed both the BDI-II and OQ-45 at the beginning of sessions 1, 4, 8, 12, and 16. In situations where clients completed their therapeutic process before the 16th session, data from both measures were collected during the same sessions, and in the case of the final session (Session 17).

### **3.2.5.2. Process Measurement**

A total of 245 therapy sessions were coded for this study. The collection of data from observational measures involved training judges over several sessions. In the training and coding of therapy sessions, three judges were involved, including two Clinical and Health Psychology Master's students and one PhD student with prior training EFT, who was also the first author of this study. The following sections outline the general data collection procedures and specific details for each measure.

### **3.2.5.2.1 General Procedures**

1) Judge Training: The judges who participated in the coding process received training on the use of the observational measures. This training included detailed explanations of the measures, coding criteria, and how to use the rating scales effectively. Judges were familiarized with the key concepts related to therapist empathy and client emotion regulation.

2) Practice Sessions: Before beginning the coding of actual therapy sessions, the judges participated in practice sessions to ensure that they were proficient in using the observational measures. These practice sessions involved coding training videos or recorded therapy sessions to refine their coding skills.

3) Reliability Checks: To ensure inter-rater reliability, judges independently coded the same therapy sessions. Discrepancies and differences in coding were discussed, and consensus was reached on how to code specific behaviors and dimensions. This process continued until a satisfactory level of agreement was achieved among the judges.

4) Coding of Therapy Sessions: Once the judges demonstrated a high level of inter-rater reliability, they began coding the actual therapy sessions included in the study. They independently rated therapist empathy, client emotion regulation, and other relevant variables during each session.

The use of multiple judges and training procedures aimed to enhance the reliability and accuracy of the observational data collected for the study. This systematic approach ensured that the coding of therapy sessions was consistent and valid for subsequent analyses.

### **3.2.5.2.2. MEE Judges` Training**

The training phase involved independently coding 30 segments from the 33 provided in the MEE manual. These segments were derived from the Three Approaches to Psychotherapy I, II, III & IV videos (Watson et al., 2003), each lasting 5 minutes. After coding, the scores assigned by the judges were compared to the ratings provided by experts in the manual, and any discrepancies were discussed among the judges.

Following this phase, each judge was assigned 20 therapy sessions, which had been previously rated and used in the development of the O-MAR Application Manual (Almeida et al., 2016). They independently rated these sessions to assess interrater reliability. Any doubts

or discrepancies that arose at the end of each session were discussed among the judges. The interrater reliability of these 20 sessions was determined using the Intraclass Coefficient Correlation (ICC), which showed a moderate reliability ( $ICC = .711, p < .000$ ) between the three judges based on their independent codification. Disagreements were solved through discussion, and final scores were achieved through mutual consensus. This training and reliability assessment procedure was carried out for all sessions ( $N=245$ ).

### **3.2.5.2.3. O-MAR Judges' Training**

Prior to conducting this study, an adaptation manual for the O-MAR was developed to ensure consistent and accurate coding. The adaptation manual included the coding of the 20 middle minutes of 44 therapy sessions across five domains (subscales) by two judges who were Clinical and Health Master's students and one auditor (the first author of this study). In total, 220 evaluations were conducted as part of this manual's development (cf. Almeida et al., 2016). The reliability between judges in the adaptation manual was calculated using the Intraclass Coefficient Correlation (ICC), and it established excellent reliability ( $ICC = .976, p < .000$ )

For the present study, after training and discussion of the sessions coded in the adaptation manual, two judges (the same individuals involved in the Measure of Empathy - MEE - training) and the same auditor independently coded the 20 middle minutes of the 16 sessions of the only excluded case from this study. The same procedures used during the MEE training phase were followed, including independent codification, presentation of scores from each judge, and reflection/discussion. After coding these 16 sessions, the reliability between the three judges was determined through ICC, showing excellent reliability ( $ICC = .950, p < .000$ ). Subsequently, all cases of this study were coded using the same procedures established during MEE.

## **3.3. Results**

### **3.3.1. Statistical analysis**

Statistical analyses were performed with R (version 4.1.1). Continuous variables were described with means (M) and standard deviations (SD). Categorical variables were described as frequencies (n) and proportions (%). Data of MEE, O-MAR, OQ-45 and BDI-II were

collected at sessions 1, 4, 8, 12 and 16. Because multiple data points were available for both outcomes and explanatory variables a linear mixed models (LMM) approach was used, instead of focusing on single vectors of summarized information.

LMM approach has the advantage of using all data points and therefore cannot assume independence of explanatory variables. LMM are an extension of simple linear models in the way they allow fixed and random effects. Fixed effects are estimated from the included fixed variables. These variables are assumed to be measured “without error” and are expected to be the same if the values were to be retrieved from another study. Random effects are estimated from the included random variables. These are components that attempt to represent a random sample of all possible values of that variable (Lu et al., 2009) and thus account for this degree of uncertainty.

Shapiro-Wilk test, Kolmogorov-Smirnov tests and histograms were used to assess variables normality, confirming this assumption. We estimated fixed effects for MEE and O-MAR considering the outcomes BDI-II and OQ-45. Clients were considered as random effects. Baron and Kenny (1986) causal steps approach were used to assess OMAR mediation effect on MEE's association with symptoms outcomes BDI-II and OQ-45. All models were adjusted to type of therapy (CBT vs EFT). BDI-II and OQ-45 evolution was also assessed and compared by MEE and OMAR scores. For that, three groups were created considering MEE and O-MAR division into tertiles. Significance threshold was set at  $p < .05$ .

### **3.3.1.1. Outcome (BDI-II) – Testing Direct and Indirect Effects of Therapist Empathy on Outcome (BDI-II)**

Table 3 shows results of LMM assessing direct and indirect fixed effects of MEE and OMAR across sessions 1, 4, 8, 12 and 16 to predict BDI. Model was adjusted for type of therapy. Coefficients were calculated for CBT, considering EFT as reference. MEE effect on BDI was negative ( $\beta = -2.438$ ) and statistically significant ( $p < .001$ ) suggesting that higher values of MEE were associated with lower values of BDI-II (model 1). MEE interaction with therapy had positive ( $\beta = 1.820$ ) and statistically significant ( $p = .004$ ) effect on BDI suggesting that in CBT the effect of reducing BDI attributed to MEE is higher than in EFT.

MEE was significantly associated with the mediator OMAR ( $\beta = 0.598$ ,  $p < .001$ ), suggesting that higher scores of MEE are associated with higher scores of O-MAR. MEE

interaction with model of therapy was not statistically significant ( $p=.650$ ), suggesting that the therapeutic model has no effect in the association of MEE with O-MAR.

When including both MEE and O-MAR (model 3), the last one showed marginal significance, with a negative effect on BDI ( $\beta=-5.124$ ,  $p=.093$ ). MEE lost significance ( $p=.460$ ) and no significance was found for interaction of MEE x O-MAR ( $p=.814$ ). These results suggest a mediation effect of O-MAR on the relation of MEE with BDI-II. When including the therapeutic model effect in the interaction of MEE and O-MAR there was no significant association,  $p=.869$ , allowing to conclude that the mediation effect happens, regardless of the type of therapy (Table 3).

**Table 3**  
*Results of LMM assessing direct and indirect fixed effects of MEE and O-MAR across sessions 1, 4, 8, 12 and 16 to predict BDI-II*

	<b>B</b>	<b>SE</b>	<b>t</b>	<b>P</b>	<b>AIC</b>	<b>BIC</b>	<b>logLik</b>
Model 1: Outcome BDI-II					1795.718	1816.725	-891.859
IV: MEE	-2.438	0.627	-3.886	<b>p&lt;.001</b>			
MEE x TT (CBT)	1.820	0.627	2.902	<b>p=.004</b>			
Model 2: Outcome O-MAR					632.410	653.418	-310.205
IV: MEE	0.598	0.058	10.289	<b>p&lt;.001</b>			
MEE x TT (CBT)	-0.026	0.058	-0.455	$p=.650$			
Model 3: Outcome BDI-II					1737.65	1783.168	-855.826
IVs							
MEE	1.000	1.349	0.741	$p=.460$			
O-MAR	-5.124	3.029	-1.692	$p=.093$			
MEE x O-MAR	-0.111	0.470	-0.236	$p=.814$			
MEE x O-MAR x TT (CBT)	0.077	0.470	0.165	$p=.869$			

All models adjusted for type of therapy (TT) and results presented as CBT compared to EFT as reference.

Next, we analysed BDI-II evolution along the therapy sessions for MEE tertiles low (1.8-5.2), medium (5.2-6.4), and high (6.4-8.0) (Figure 4). MEE were divided into tertiles so that the effect of BDI could be observed in its three strata groups. Therefore, one can assess if the trends of BDI-II are different according to different scores of MEE. Symptoms (BDI) showed a significant linear negative trend along the therapy sessions ( $p<.001$ ). These results suggest that BDI-II score decreased along therapy. Moreover, there was no effect of MEE tertiles, suggesting that BDI-II symptoms are reduced regardless of the MEE scores (Table 4). Despite no statistical difference was found for this trend considering the three different tertiles of MEE, the MEE lowest tertile group showed increased BDI in the last session (Figure 4).

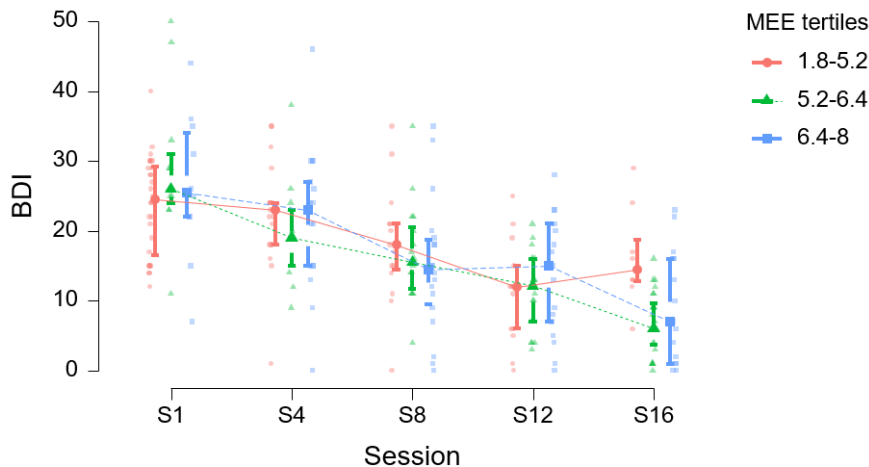


Figure 4 - Depressive symptoms (BDI-II) evolution stratified by tertiles of MEE

Table 4  
Linear trend of BDI-II along sessions and effect of MEE tertiles (stratified)

	<b>B</b>	<b>SE</b>	<b>T</b>	<b>p-value</b>
Intercept	27.087	3.024	8.956	p<.001
Session 4	-4.050	1.278	-3.170	p<.001
Session 8	-8.812	1.282	-6.875	p<.001
Session 12	-13.112	1.309	-10.019	p<.001
Session 16	-16.099	1.313	-12.258	p<.001
MEE (tertiles)	-0.306	0.528	-0.579	Ns

ns= non-significant

We did the same analysis to analyse BDI-II evolution along the therapy sessions for O-MAR tertiles low (1.0-2.6), medium (2.6-3.4), and high (3.4-6.8) (Figure 5). O-MAR were divided into tertiles so that the effect of BDI could be observed in its three groups of low, medium, and high score.

Depressive symptoms (BDI-II) showed a significant linear negative trend along the therapy sessions. All baseline comparisons were statistically significant (p<.001) (Table 5). These results suggest that BDI-II score decreased along therapy. BDI-II linear trends were significantly different according to O-MAR tertile groups (p<.001). There was a significant effect of O-MAR tertiles ( $\beta=-2.091$ , p<.001) in BDI-II (Table 5). These results suggest that BDI-II varies differently across different levels of O-MAR. Clients with higher levels of O-MAR tend to have lower levels of BDI-II along therapy and clients with lower levels of O-MAR tend to have higher levels of BDI-II along therapy. Figure 5 shows that clients classified

in the first tertile of O-MAR end therapy (session 16) with a BDI-II score close to baseline (session 1).

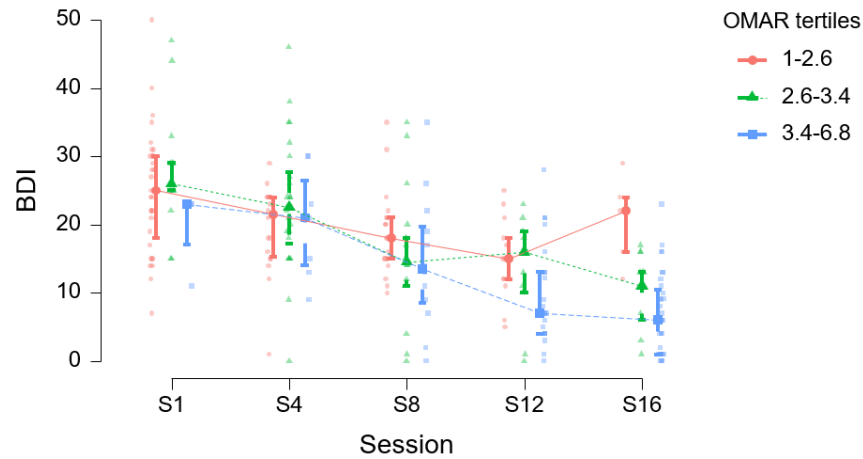


Figure 5 - Depressive symptoms (BDI-II) evolution stratified by tertiles of O-MAR

Table 5  
Linear trend of BDI-II along sessions and effect of O-MAR tertiles (stratified)

	<b>B</b>	<b>SE</b>	<b>T</b>	<b>p-value</b>
Intercept	30.640	1.841	16.644	p<.001
Session 4	-3.330	1.245	-2.676	p<.001
Session 8	-7.799	1.264	-6.170	p<.001
Session 12	-11.212	1.357	-8.262	p<.001
Session 16	-12.951	1.543	-8.391	p<.001
OMAR (stratified)	-2.091	0.585	-3.571	p<.001

ns= non-significant

### 3.3.1.2. Outcome OQ-45 – Testing Direct and Indirect Effects of Therapist Empathy on Outcome (OQ-45)

As in BDI-I, MEE effect on OQ-45 was negative ( $\beta=-5.196$ ) and statistically significant ( $p<.001$ ) suggesting that higher values of MEE were associated with lower values of OQ-45 (model 1) (Table 6). MEE interaction with model of therapy had positive ( $\beta=4.641$ ) and statistically significant ( $p=.002$ ) effect on OQ-45 suggesting that the effect of reducing OQ-45

attributed to MEE is higher in CBT. As already studied in the BDI-II model, MEE was significantly associated with the mediator O-MAR ( $\beta=0.598$ ,  $p<.001$ ), suggesting that higher scores of MEE are associated with higher scores of O-MAR. MEE interaction with model of therapy was not statistically significant ( $p=.650$ ), suggesting that the therapeutic model has no effect in the association of MEE with O-MAR.

When including both MEE and O-MAR (model 3), only O-MAR showed statistical significance, with a negative effect on OQ-45 ( $\beta=-12.885$ ,  $p=.047$ ). MEE lost significance ( $p=.290$ ) and no significance was found for interaction of MEE x O-MAR ( $p=.922$ ). These results suggest a mediation effect of O-MAR on the relation of MEE with OQ45. Including therapy effect in the interaction of MEE and O-MAR,  $p=.869$ , showed no significant association, allowing to conclude that the mediation effect happens, regardless of the type of therapy (Table 6).

Table 6

*Results of LMM assessing direct and indirect fixed effects of MEE and O-MAR across sessions 1, 4, 8, 12 and 16 to predict OQ-45*

	<b>B</b>	<b>SE</b>	<b>T</b>	<b>P</b>	<b>AIC</b>	<b>BIC</b>	<b>logLik</b>
Model 1: Outcome OQ-45					2145.116	2166.025	-1066.558
IV: MEE	-5.196	1.463	-3.552	<b>p&lt;.001</b>			
MEE x TT (CBT)	4.641	1.463	3.172	<b>p=.002</b>			
Model 2: Outcome O-MAR							
IV: MEE	0.598	0.058	10.289	<b>p&lt;.001</b>	632.410	653.418	-310.205
MEE x TT (CBT)	-0.026	0.058	-0.455	$p=.650$			
Model 3: Outcome OQ-45					2060.970	2095.818	-1020.485
IVs							
MEE	3.046	2.874	1.060	$p=.290$			
OMAR	-12.885	6.446	-1.999	<b>p=.047</b>			
MEE x O-MAR	-0.097	0.996	-0.098	$p=.922$			
MEE x O-MAR x TT (CBT)	-0.286	0.996	-0.287	$p=.774$			

All models adjusted for type of therapy (CBT vs EFT)

Figure 6 shows OQ-45 evolution along the therapy sessions for MEE tertiles low (1.8-5.2), medium (5.2-6.4), and high (6.4-8.0). The stratification of MEE into tertiles allowed to observe and assess the effect of OQ-45 along the three strata (Figure 6). General clinical symptoms (OQ-45) showed a significant linear negative trend along the therapy sessions ( $p<.001$ ). No difference was found for this trend considering the three different MEE tertiles (Table 7), suggesting that OQ-45 do not vary differently across different levels of MEE. Hence, OQ-45 score reduces along therapy for all levels of MEE.

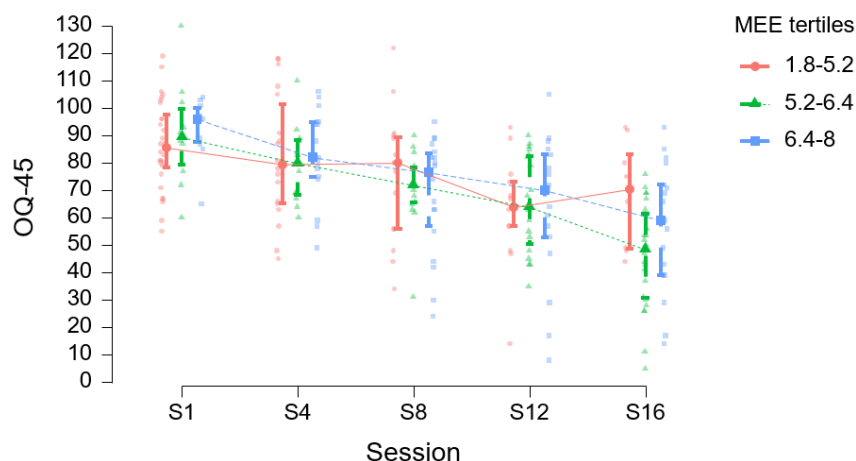


Figure 6 - General clinical symptoms (OQ-45) evolution stratified by tertiles of MEE

Table 7  
Linear trend of OQ-45 along sessions and effect of MEE tertiles (stratified)

	<b>B</b>	<b>SE</b>	<b>T</b>	<b>p-value</b>
Intercept	88.080	7.167	12.289	p<.001
Session 4	-6.060	2.814	-2.153	p<.001
Session 8	-16.864	2.799	-6.026	p<.001
Session 12	-24.418	2.857	-8.548	p<.001
Session 16	-34.951	2.869	-12.183	p<.001
MEE (stratified)	0.056	1.243	0.045	ns

ns= non-significant

Figure 7 shows OQ-45 evolution along the therapy sessions for O-MAR tertiles low (1.0-2.6), medium (2.6-3.4), and high (3.4-6.8). O-MAR stratification into tertiles allows the effect of OQ-45 to be observed in its three groups of low, medium, and high score. Symptoms (OQ-45) showed a significant linear negative trend along the therapy sessions, with significant comparisons to baseline ( $p<.001$ ). OQ-45 linear trends were significantly different according to OMAR tertile groups ( $p<.001$ ) (Table 8). Higher levels of OMAR are associated with lower levels of OQ-45 ( $\beta=-5.096$ ,  $p<.001$ ) (Table 8). These results suggest that OQ-45 varies differently across different levels of O-MAR. Clients with higher levels of O-MAR tend to have lower levels of OQ-45 along therapy and clients with lower levels of O-MAR tend to have higher levels of OQ-45 along therapy. Figure 7 shows that clients classified in the first tertile of O-MAR end therapy (session 16) with an OQ-45 score close to baseline (session 1).

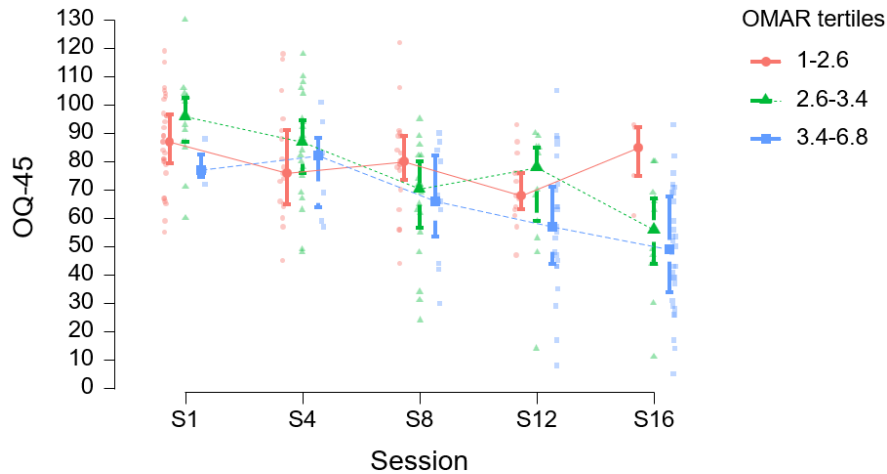


Figure 7 - General clinical symptoms (OQ-45) evolution stratified by tertiles of O-MAR

Table 8

Linear trend of OQ-45 along sessions and effect of O-MAR tertiles (stratified)

	<b>B</b>	<b>SE</b>	<b>T</b>	<b>p-value</b>
Intercept	101.005	4.306	23.458	p<.001
Session 4	-4.065	2.727	-1.491	p<.001
Session 8	-14.165	2.751	-5.148	p<.001
Session 12	-19.253	2.965	-6.494	p<.001
Session 16	-26.718	3.403	-7.850	p<.001
OMAR (stratified)	-5.096	1.333	-3.824	p<.001

### 3.4. Discussion

Recognized as a fundamental and influential factor in psychotherapy outcomes, therapist empathy has gathered substantial attention (Norcross & Lambert, 2018). The impact of therapist empathy on the efficacy of psychotherapeutic interventions has been well-documented, with recent comprehensive meta-analyses revealing a medium effect size of .28 across diverse therapeutic modalities and patient populations (Elliott et al., 2018). Despite the established significance of therapist empathy in predicting treatment outcomes, the intricate mechanisms through which it drives therapeutic change remain a subject of ongoing inquiry.

In this study, which explores the intricate relationship between therapist empathy and treatment outcomes, our findings illuminate a significant and relevant pattern. Results suggest that therapist empathy exerts a clear influence on both outcome measures, since they reveal a

robust and statistically significant negative effect (BDI-II:  $\beta = -2.438$ ,  $p < .001$ ; OQ-45:  $\beta = -5.196$ ,  $p < .001$ ). This outcome indicates that higher levels of therapist empathy are linked to reduced depressive symptoms and overall distress, corroborating earlier research findings (e.g., Abargil & Tishby, 2022; Elliott et al., 2018; Vitinius et al., 2018; Watson et al., 2020).

Interestingly, our study's observation of an interaction effect between therapist-expressed empathy and CBT on both outcome measures (BDI-II:  $\beta=1.820$ ,  $p=.004$ ; OQ-45:  $\beta=4.641$ ;  $p=.002$ ) seems to diverge from the predominant trend identified in the literature. Existing studies, as reviewed, generally suggest a lack of significant differences in the impact of therapist empathy outcomes among various therapeutic approaches. This finding suggests that the impact of MEE on reducing BDI and OQ-45 scores are higher in the context of CBT. In other words, higher levels of empathy in CBT appear to amplify the positive effect of MEE in alleviating depressive symptoms.

Our study moves beyond the direct association between therapist empathy and outcome to investigate the role of empathy in a more distinctive way. When we incorporate ER as a mediating variable into our analysis, the picture becomes more complex. As anticipated, therapist empathy exhibits a statistically significant association with clients' capacity to regulate their emotions ( $\beta = 0.598$ ,  $p < .001$ ). However, what is particularly relevant is the subsequent loss of its direct impact on both outcome measures (BDI-II:  $\beta = -0.111$ ,  $p = .814$ ; OQ-45:  $\beta = -0.097$ ,  $p = .922$ ).

This finding suggests an indirect effect of therapist empathy on treatment outcomes, mediated by clients' ability to regulate their emotions, a finding that aligns with previous studies (e.g., Prosser, 2007; Watson et al., 2020). It is important to underscore the relevance of this result. Our study clearly supports that empathy is a catalyst for the development of other crucial variables, such as emotion regulation (e.g., Watson, 2020). Thus, this study offers empirical support for the conceptualization that therapists' ability to exhibit empathy contributes to the development of clients' ER abilities, which, in turn, influence treatment efficacy.

Our results build upon the findings of previous studies that have established a positive association between therapist empathy and emotion regulation, contributing to the outcomes of psychotherapy for depression (Prosser, 2007; Watson et al., 2020). A notable strength of our study lies in the methodological approach we employed, specifically the use of Linear Mixed Models (LMM). Unlike previous research that often relied on cross-sectional designs or limited time point assessments, our study harnessed the full potential of longitudinal data collected at multiple therapy sessions. This approach allows for a more comprehensive analysis by considering the entire dataset instead of relying on summarized information from isolated data

points. Crucially, LMM is well-suited to handle the intercorrelated nature of the data in our study. Given that we collected repeated measures from the same clients, it is essential to acknowledge the potential lack of independence among data points. By incorporating random effects into the LMM, we effectively account for the inherent correlation between observations from the same individuals. This approach mitigates the issue of interdependence and ensures the reliability of fixed effect estimates. Consequently, the utilization of LMM enhances the robustness and precision of our analysis, providing a more accurate estimation of the relationship between the variables under investigation.

Our analysis was adjusted for the type of therapy (CBT vs. EFT) and revealed consistent mediation effects in both therapeutic approaches. This suggests that the mediation of OMAR on the relationship between MEE and clinical outcomes is not limited to a specific therapeutic modality but holds across different treatment approaches. This enhances the generalizability of the mediating effect in different therapeutic settings, which could have implications for clinical practice and the training of therapists across diverse therapeutic orientations.

As mentioned before, this study shows that therapist empathy is positively and significantly associated with clients' emotion regulation. This result supports the perspective that, when clients have an empathic therapist, they perceive a growth-facilitating environment that enables them to access and explore their painful emotions and, in each moment, to accept and tolerate their experiences. Clients' perception of their therapists' empathic understanding and acceptance helps them remain with intense negative emotions, thus paving the way for a deeper understanding of their difficulties. Furthermore, the experience of compassionate empathy from their therapists serves as a model for relational soothing, which clients can internalize and apply to their self-relationship, thereby regulating the arousal and expression of their emotions. This capacity is pivotal for acquiring new emotional skills, enabling clients to manage their emotional experiences without becoming overwhelmed. This process, involving the co-regulation of affect, can reveal previously unidentified needs and stimulate client transformation. These findings substantiate both theoretical and empirical assertions that an empathic therapist plays a pivotal role in enhancing a client's awareness, acceptance, expression, and modulation of their emotional experiences.

These results have practical implications for clinicians and mental health practitioners. Therapists who focus on enhancing their empathy skills may indirectly contribute to improvements in clients' emotional regulation and, consequently, more favorable treatment outcomes. Additionally, our results emphasize the importance of assessing and targeting clients' emotional regulation capacities during therapy to optimize treatment effectiveness.

### **3.4.1. Limitations and Future Directions**

Despite the valuable insights gained from this study, some limitations should be acknowledged. First, the study's design was based on a randomized clinical trial, which may not fully replicate the complexities of real-world therapeutic settings. Further research in naturalistic clinical contexts is needed to confirm these findings. Second, sessions were systematically chosen at regular intervals throughout the therapeutic process to represent the progression of therapists' expressed empathy and clients' ER. The intentional selection might not fully capture the overall progress of the client, and crucial moments may have been overlooked (Crits-Christoph et al., 2013). Third, although the mediation model presented here demonstrates that OMAR mediates the relationship between MEE and clinical outcomes, there may be other unexplored factors influencing this relationship. Future research can investigate additional mediators and moderators to gain a more comprehensive understanding of the processes involved.

In contrast to the general notion of a uniform impact, our study revealed a significant interaction effect with CBT. This apparent contradiction prompts further consideration and exploration of factors that may contribute to divergent findings, such as variations in study methodologies, participant characteristics, or specific aspects of therapist empathy assessed.

In sum, this study provides empirical evidence for the mediation of clients' affect regulation capacity in the relationship between therapist empathy and treatment outcomes in the context of depression therapy. These findings underscore the importance of therapist empathy and the enhancement of clients' emotional regulation as targets for improving the effectiveness of psychotherapeutic interventions.

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## **Conclusion**

In this dissertation, three empirical studies were conducted. The initial study centred on adapting an observational measure of emotion regulation (ER). The subsequent following two studies, undertook longitudinal investigations into the dynamics between therapist-expressed empathy and client ER, examining their impact on therapeutic change and outcomes. To simplify the conclusion, an integrated presentation and discussion of the results has been adopted. Additionally, the inherent limitations in these empirical studies have been acknowledged, while also discussing their implications for clinical practice and suggesting possibilities for future research.

### **Integrated Discussion of Empirical Study Outcomes**

#### **The adaptation and elaboration of an application manual of the Observer Measure of Affect Regulation (O-MAR, Watson & Prosser, 2006)**

The growing recognition of emotions and clients' ER in psychotherapy has led to the development of various measures, crucial for research and clinical practice. Traditionally, psychotherapy research has heavily relied on standardized self-report measures. While these measures are fundamental to different purposes, they also have inherent limitations. Specifically, they depend on subjective client/therapist self-reports, making them susceptible to response tendencies, retrospective cognitive biases, and constrained self-representations (Girard & Cohn, 2016; Schwartz et al., 2023). Moreover, they do not allow adequate assessments of previously recorded sessions. Considering these limitations, observational measures emerge as a crucial alternative, offering distinct advantages.

Schwartz and colleagues (2023) emphasize a key advantage of observational measures, highlighting their unique ability to yield insights and data that are otherwise inaccessible through alternative methods. This is particularly evident when observational measures serve as the only viable approach for collecting data on a specific topic of interest, as is the case in this dissertation.

Furthermore, these measures, play a critical role in evaluating therapeutic processes and outcomes, especially in the exploration of the relationship between therapeutic processes and

change (Llewelyn et al., 2016). Observer measures, such as O-MAR (Watson & Prosser, 2006), provide valuable insights that surpass the limitations associated with self-report measures. Their focus on assessing factors like ER, believed to be integral to change process, aligns with the broader paradigm shift toward adopting multiple measures (Schwartz et al., 2023). This shift aims to foster a more precise understanding of the complexities underlying an individual's emotional experiences and behaviors.

Observational measurement surpasses the capturing of behavior in real-time, understanding both verbal and nonverbal exchanges, thereby offering a more nuanced exploration (Girard & Cohn, 2016; Schwartz et al., 2023). In this dissertation, O-MAR was applied to video recordings, allowing to use varied sources of information, such as verbal exchanges, behaviors, and non-verbal cues (e.g., movement, gestures, and facial expressions). This depth was especially critical, as these diverse channels of communication played an integral role (Schwartz et al., 2023) in understanding the unfolding of clients' ER, especially when evaluating the degree/level of client's ER in the various domains of the measure (e.g., awareness, modulation of emotional experience).

While this thesis was under development, the field of ER research had established several measures with strong psychometric properties, and a number of these had been validated for use in the Portuguese context. However, all the measures validated for the Portuguese population were self-report measures. The adaptation of O-MAR for the Portuguese population addressed a gap in available measures, contributing to a more objective assessment of psychotherapeutic processes.

Many criticisms directed at observer-rated measures rely around concerns of insufficient or inadequate raters training (e.g., Sharp, 2016). Addressing this issue, clinical vignettes/excerpts were introduced, something that was absent in the original manual. These vignettes serve to exemplify different levels within each domain of emotional regulation (ER) assessed by the measure. This expansion of the original manual not only facilitates the training of judges but also proves instrumental in the training/education of psychotherapists and students.

As mentioned earlier, only a limited number of studies have examined the relationship between therapists' empathy and clients' ER (Prosser, 2007; Watson et al., 2020). These studies found that the predictive power of the therapist empathy on outcome was mediated by changes in the client's ER. Watson and colleagues (2020) suggested that, to a better understanding of empathy as a mechanism of change and its relationship with the development of emotional regulation in depressive disorder (Watson et al., 2020), further research was needed.

In the scope of the second and third empirical studies of this dissertation, the longitudinal contribution of therapists' expressed empathy to the clients' ER and symptoms' severity/ outcomes was explored.

### **The evolution of therapist-expressed empathy, client's ER and symptoms throughout therapy**

Studies demonstrating the predictive/facilitating role of therapist empathy in clients' ER and psychotherapy outcome have employed a sample-based approach, providing limited information into potential idiographic patterns between these variables relevant to clinicians and clinical practice. The second study purpose aimed to address this gap in the literature by examining the session-by-session development of therapist-expressed empathy, client emotion regulation and symptomatology in a good outcome case of EFT for depression.

#### **Therapist-expressed empathy throughout therapy process**

Consistent with the literature, high levels of expressed empathy were anticipated over the therapy course. In the context of EFT, empathy is recognized as a crucial facilitator for clients in establishing and nurturing an attachment bond with their therapist – a factor of particular significance throughout the psychotherapy process (e.g., Greenberg et al., 2001; Watson, 2016), especially in the initial sessions of therapy (Mlotek, 2013). In this EFT case, the expected high levels of expressed empathy from the beginning and over the course of therapy sessions were confirmed.

As mentioned by several authors, the establishment of this early attachment bond sets the stage for a secure and collaborative therapeutic relationship (e.g., Castonguay & Beutler, 2006; McClintock et al., 2018; Nienhuis et al., 2018; Watson & Geller, 2005), providing a safe space for clients to explore and process their emotional experiences (e.g., Angus & Kagan, 2007; Lynch, 2012; Watson, 2002, 2016, 2018).

As asserted by Norcross and Wampold (2011), psychotherapy is based on a human relationship, it is inherently a human encounter. Empathy, a vital component, requires ongoing attunement to the client's experience and careful attention to the nuances of that experience. In the presented case study, the pattern of therapist-expressed empathy was irregular, marked by moments of both increase and decrease. There were moments during therapy process that

therapist faced challenges in empathizing effectively with the client. While this result was not surprising, it is important to acknowledge and consider its importance.

In the complex field of psychotherapy process, sustaining a consistently high level of empathy, as observed in this case, can present challenges. It is crucial to recognize that variations in empathy levels are not only normal but expected. Therefore, this result aligns with the inherent complexities of the therapist-client relationship. Indeed, the therapist-client relationship, like therapist empathy, is a dynamic process (Bohart & Greenberg, 1997; Decety & Holvoet, 2021; Elliott et al., 2018; Gibbons, 2011; Prosser, 2007), influenced by a myriad of factors. There are moments in therapy, when maintaining a high level of empathy proves challenging. Irregularities in empathy levels should not be automatically interpreted as indicators of poor care or therapy failure. On the contrary, these variations should be viewed as opportunities for exploration and growth within the therapeutic relationship.

### **Client ER throughout therapy process**

Given that the longitudinal analysis was conducted within the context of a good outcome case, a positive development in the client's emotional regulation ability was anticipated throughout the therapy process. However, the study deliberately refrained from formulating specific hypotheses about longitudinal pattern.

In this study, the client's level of ER had a tendency to increase over the course of therapy, with the lowest score observed in the first session and the highest score at session 10. Consistent with expectations for a positive outcome case, the client's ER exhibited improvement over therapy, demonstrating enhanced awareness, tolerance, modulation of arousal and expression, and reflection on emotions. This increased trajectory in the client's ER aligns with previous literature on EFT arguing its effectiveness in improving emotion regulation skills (e.g., Fosha, 2001; Greenberg, 2010, 2021).

However, the pattern of ER was not stable. In this case, there were moments (sessions) where a marked decrease in ER ability was observed. Such variations are not uncommon in the therapeutic process, and they may signify periods of heightened emotional exploration (e.g., during a task or exercise) or temporary setbacks, which are inherent components of the dynamic nature of therapy.

## **Clinical symptoms throughout therapy process**

In this study a decrease in the intensity of clinical symptoms was observed, aligning with the expected trajectory of therapy. Similar to the pattern observed in ER, variations in the intensity of clinical symptoms, were observed, reflecting the expected trajectory of the therapy process, where occasional setbacks may occur.

## **The association between therapist-expressed empathy, client ER and clinical symptoms/outcomes**

### **Session-by-session analysis**

Both literature reviews and sample-based research have suggested a predictive effect of therapist empathy on outcomes (e.g., Abargil & Tishby, 2022; Hara et al., 2017; Norcross & Lambert, 2018; Vitinius et al., 2018; Watson et al., 2020) and highlighted associations between ER and outcomes in depression (e.g., Berking et al., 2014; Mehrabi et al., 2014; Watson et al., 2011). However, the clinical case study did not find significant associations between therapist empathy and symptoms or between client ER and symptoms, either in the same or subsequent sessions. These results suggest that, in the specific context of this study, the immediate and short-term impact of therapist empathy, and client's ER, on symptoms intensity was not statistically significant.

The nature of this study, with its session-by-session and in-depth focus on a single client, may yield distinctive findings due to the idiosyncrasies of individual therapeutic processes, which may not always correspond to generalizable patterns observed in larger sample studies. Furthermore, the limited number of sessions and the singular focus on one client may restrict the ability to discern statistically significant associations. It is important to highlight that the lack of statistically significant associations does not diminish the clinical significance of therapist empathy or client's ER in relation to symptomatology.

In this study, a moderate significant positive association was found between therapist empathy and client ER in the same session. This finding aligns with existing literature and research on the relationship between therapist empathy and ER (e.g., Greenberg, 2021; Greenberg & Watson, 2006; Malin & Pos, 2015; Prosser, 2007; Watson et al., 2020). It particularly supports the notion that empathic attunement and responsiveness from the therapist

facilitate continuous, moment-to-moment emotional communication, enhancing the client's ability for emotional communication (Fosha, 2001; Paivio & Laurent, 2001). The identification of a positive association between therapist-expressed empathy and client ER within the same session holds significant implications for both psychotherapy research and clinical practice. It illustrates one possible way of *how* therapist empathy operates during psychotherapy process, contributing to the clarification of its role in clients' change. This result supports the pivotal role of therapist empathy in facilitating clients' ER, providing therapists with specific insights into improving therapeutic processes. It offers therapists information on how to enhance the therapeutic experience, potentially empowering them to actively foster the ER of their clients. Additionally, it underscores the importance of integrating empathic strategies into therapeutic interventions for more effective treatment.

Acknowledging the inherent constraints of the second study, particularly the challenges of generalizing from a single case study, the third study adopted a sample-based approach. This study extended the exploration of the fundamental elements of therapist empathy and client ER, examining their joint contributions to complex psychotherapy outcomes through the testing of a mediational model.

### **Mediational analysis**

The primary objective of this study was to investigate whether clients' ER serves as a mediator in the relationship between therapist empathy and outcomes related to depressive symptoms and general clinical symptoms. In contrast to previous investigations (Prosser, 2007; Watson et al., 2020) with limited time-point assessments, this study takes the advantage of longitudinal data collected throughout therapy sessions. Data were collected from 49 clients at sessions 1, 4, 8, 12, and 16, about both EFT and CBT for depression.

In testing the mediation model, and according with previous research, it was hypothesized that: (1) therapists' expressed empathy would predict clients' outcomes, specifically in terms of depressive and general clinical symptoms at the end of therapy; (2) therapists' expressed empathy would predict improvements in clients' ER capacity; and (3) the association between therapists' expressed empathy and clients' outcomes would be mediated by clients' capacity to regulate emotions.

The results revealed a statistically significant negative effect of therapist empathy on both depressive and general clinical symptoms, suggesting that higher levels of expressed empathy were associated with lower levels in depressive and general clinical symptoms. This

aligns with existing literature and research supporting the predictive effect of therapist empathy on outcomes (e.g., Abargil & Tishby, 2022; Elliott et al., 2011, 2018; Greenberg et al., 2001; Hara et al., 2017; Lambert & Barley, 2001; Norcross & Lambert, 2018; Vitinius et al., 2018; Wampold & Imel, 2015).

Furthermore, consistent with expectations, it was confirmed that levels of therapist-expressed empathy were significantly and positively associated with clients' ER, mirroring the findings in the case study. Higher scores of therapists' empathy were associated with higher scores of clients' ER. This result also aligns with existing literature and research (e.g., Greenberg, 2021; Greenberg & Watson, 2006; Malin & Pos, 2015; Watson et al., 2020).

However, when considering how therapist empathy operates during the psychotherapy process (e.g., Watson et al., 2020) and its potential direct or indirect effects on treatment outcomes, when including all variables in the equation, the analysis revealed that only ER showed statistical significance. In its role as a mediator between therapist empathy and therapy outcomes, ER exhibited a marginal negative impact on depressive symptoms and a more substantial moderate negative effect on overall clinical symptoms. These findings were further substantiated during the analysis of the evolution of depressive and general clinical symptoms across therapy sessions, categorized by empathy and ER tertiles (low, medium, and high).

Depressive and general clinical symptoms exhibited a significant linear negative trend throughout the therapy sessions, consistent with the clinical case study. However, no effect was observed from the different tertiles of therapist-expressed empathy on symptoms reduction, indicating that symptoms decreased regardless of empathy scores. Nevertheless, the same analysis revealed significant differences in linear trends based on ER tertile groups. ER tertiles demonstrated a significant effect on depressive and clinical symptoms, suggesting that symptoms varied distinctly across different ER levels. Clients with higher levels of ER tended to exhibit lower symptom levels throughout therapy, while clients with lower ER levels tended to experience higher symptom levels over the course of therapy.

These findings align with previous research supporting an indirect effect of therapist empathy on treatment outcomes (e.g., Hoffart et al., 2012; Malin & Pos, 2015; McClintock et al., 2018; Mlotek, 2013; Watson & Geller, 2005; Watson et al., 2014; Wing, 2010). Particularly, they corroborate previous findings of the mediation role of clients' ability to regulate emotions in the predictive effect of therapist empathy on treatment outcomes (Prosser, 2007; Watson et al., 2022). This study clearly supports Watson and colleagues' notion (2020) that empathy serves as a catalyst for the development of other crucial variables, such as ER.

The mediation effect of ER on the relationship between therapist empathy and depressive symptoms was only marginal significant, in contrast to the observed significant mediation effect in general symptoms. Depressive symptoms are inherently more complex, often involving multifaceted cognitive, emotional, and behavioral components. The marginal mediating effect observed for these symptoms might indicate the complex nature of these symptoms, suggesting that the influence of therapist empathy and emotion regulation on depressive symptomatology operates through multifactorial paths. Conversely, general clinical symptoms may hold a broader demonstration of psychological distress, including anxiety, stress, and other non-specific symptoms. The significant mediating effect for general clinical symptoms may suggest that the impact of therapist empathy on overall clinical distress is more easily mediated by the client's ability to regulate their emotions. The expansive scope of general clinical symptoms may allow for a more visible influence of emotion regulation.

Furthermore, the measurement instruments used to assess depressive symptoms (BDI-II) and general clinical symptoms (OQ-45) may have different sensitivities to change. The OQ-45 comprise a wider range of distress, potentially leading to a more pronounced mediational effect. Additionally, it is important to recognize that the temporal dynamics of the therapeutic process differ for depressive symptoms and general clinical symptoms. General clinical symptoms are likely to respond more rapidly to changes in treatment progress compared to the core symptoms of depression, which typically require a more extended therapeutic trajectory for observable effects. Understanding these temporal dynamics is crucial for interpreting the varying mediational effects observed in the study, shedding light on the differential impact of therapist empathy and ER on distinct facets of psychological distress.

The conducted analysis in this study, adjusted for the type of therapy (CBT vs. EFT) revealed consistent mediation effects in both therapeutic approaches. This suggests that the mediation of ER on the relationship between therapist empathy and psychotherapy outcomes is not limited to a specific therapeutic modality but maintains across different treatment approaches, aligning with previous research (Watson et al., 2020; Prosser, 2007). However, in testing the mediational analysis, an unexpected interaction effect between therapist-expressed empathy and CBT on both outcome measures introduced a noteworthy dimension to the findings.

This effect suggests that the impact of therapist empathy on outcomes is higher in the context of CBT. More specifically, it suggests that the impact of therapist empathy on reducing depressive and general clinical symptoms is more pronounced in the context of CBT. The observed interaction effect with CBT appears to diverge from the predominant trend identified

in the existing literature and process-outcome research, which usually suggests a lack of significant differences in the impact of therapist empathy on outcomes among various therapeutic approaches (Abargil & Tishby, 2022; Watson, 2020; Elliott et al., 2018; Norcross & Lambert, 2018; Watson, 2018; Soto, 2017; Hara et al., 2017). This discrepancy is noteworthy and deviates from usual findings in the literature of process-outcome research (e.g., Abargil & Tishby, 2022; Watson, 2020; Elliott et al., 2018; Norcross & Lambert, 2018; Watson, 2018; Soto, 2017; Hara et al., 2017). Existing studies, as reviewed, generally suggest a lack of significant differences in the impact of therapist empathy outcomes among various therapeutic approaches. It is important to acknowledge and briefly consider this discrepancy in the context of the current study's results.

Given that CBT operates on a different theoretical foundation compared to person-centered approaches, where empathy is a foundational element of the therapy, it can be hypothesized that certain aspects or functions of empathy within CBT might be more specific. Interestingly, Bohart and colleagues' (2002) meta-analysis on therapist empathy revealed higher effect sizes for empathy in CBT studies compared to those of other theoretical orientations. The authors speculated to explain this finding, suggesting that empathy may be even more crucial in therapies focused on therapeutic tasks, like CBT, compared to those placing greater emphasis on the therapeutic relationship as the primary basis of change. This paradoxical implication suggests that, especially when cognitive-behavioral therapists' guide clients through challenging and demanding tasks, therapeutic empathy assumes an even greater significance.

In summary, these studies collectively contribute to psychotherapy research, offering insights into dynamic impact of therapist empathy on outcomes and the mediating role of clients' ER. The nuanced understanding gained holds implications for improving therapeutic interventions and expanding the field's comprehension of intricate psychotherapy processes. However, like any research, it has limitations that will be presented shortly.

## **Limitations**

Several factors should be considered as limitations in the three studies.

In the first study, the adaptation aimed to align the O-MAR manual with the cultural and linguistic context of the Portuguese population. Despite meticulous translation efforts for linguistic equivalence, capturing all linguistic nuances and cultural details might not have been fully achieved, potentially impacting the precision and reliability of the adapted manual.

Throughout the adaptation and extension procedures, two judges and an auditor followed a consensual discussion procedure based on the guidelines outlined by Hill and colleagues (1997). The selection of clinical vignettes/excerpts, to exemplify each level of every domain within the scale resulted from mutual consensus. While this approach adhered to a rigorous and systematic procedure, it is essential to acknowledge that clinical decision-making is inevitably influenced by subjectivity and potential rater bias. Despite the commitment to maintaining objectivity, the inherent interpretive nature of clinical judgments introduces an element of variability that may influence the outcomes of the adapted manual.

Applied to video recordings, O-MAR is designed not only to comprehensively capture verbal information but also to allow for the observation of non-verbal cues. This comprehensive approach enables a holistic understanding of how clients regulate their emotions. However, a notable limitation in the first study is the absence of access to video recordings, which hinders the ability to fully appreciate the context and nuances that might influence the selection of excerpts/clinical vignettes from the manual. This limitation underscores the importance of incorporating video-based observations for a more nuanced and accurate interpretation of therapeutic interactions and the assessment of ER.

The successful application of observer measures, such as O-MAR, relies heavily on the reliability and consistency of raters. Challenges may arise due to differences in interpretation, biases, and subjective judgments among raters, impacting the achievement of high level of agreement. Despite demonstrating moderate inter-rater reliability in MEE and excellent inter-rater reliability in O-MAR, estimating inter-rater reliability is not always straightforward.

Moreover, the collection of data from observational measurements, as undertaken in this dissertation, requires a substantial amount of time. This temporal constraint places limitations on the number of participants involved in the studies, consequently diminishing statistical power and generalizability (Schwartz et al., 2023). In the second study, while all sessions were analyzed, the third study's analysis was limited to a selected number of sessions, potentially introducing bias into the results.

The findings from the single-case study offer clinical relevance but possess limited generalizability to broader populations. The idiosyncrasies of the client may not fully represent the experiences of other depressive clients undergoing EFT or other intervention approaches. It is crucial to interpret the results within the context of this specific case, acknowledging that the intricacies of individual experiences and therapeutic dynamics may vary across diverse populations and treatment modalities.

In the third study, sessions were systematically chosen at regular intervals throughout the therapeutic process to represent the progression of therapists' expressed empathy and clients' ER. While the LMM approach offers the advantage of utilizing all data points and incorporating fixed and random effects, the results could be influenced by the sessions chosen for detailed analysis. The intentional selection might not fully capture the overall progress of the client, and crucial moments may have been overlooked (Crits-Christoph et al., 2013).

The study's design was based on a randomized clinical trial, which may not fully replicate the complexities of real-world therapeutic settings. Further research in naturalistic clinical contexts is needed to confirm these findings. The mediational model proposed in the third study simplifies the complex interplay between therapist empathy, emotion regulation, and clinical outcomes. Undoubtedly, the actual mechanisms underlying these relationships involve additional variables not considered in the current model (e.g., symptoms severity, specific dimensions of therapist-expressed empathy, specific dimensions of ER).

Recognizing these limitations is crucial for achieving a comprehensive understanding of psychotherapy change process and guiding future research in refining methodologies and addressing potential biases.

### **Implications for clinical practice and research**

One of the primary goals of researching the psychotherapeutic change process is to contribute to understanding how therapy operates. With this knowledge as a foundation, the aim is to improve therapist training and enhance the overall effectiveness of clinical practice (Gelo et al., 2015; Goldman, 2019; Pascual-Leone & Yeryomenko, 2017; Wampold, 2001). In this context, the adaptation of O-MAR manual not only provides a rich tool for future research to deepen our understanding of the complex interplay between ER and psychotherapeutic processes but also offers practical benefits for students and therapists.

The O-MAR manual provides a structured support for assessing ER in psychotherapy sessions. The manual has the potential to provide researchers with a more comprehensive and objective tool for assessing clients' ER abilities and challenges, thereby improving the accuracy of clinical assessments, and informing more targeted and effective therapeutic interventions. Moreover, the manual's application extends to clinical practice, and could contribute to improve psychotherapy outcomes. Therapists can use this tool to systematically evaluate and understand how clients manage their emotions during therapeutic interactions. Observing and monitoring

clients' ER could assist in more effective clinical decision-making, improved case conceptualization, and adaptive adjustments in therapeutic strategies throughout the therapeutic process. By identifying specific patterns of ER, therapists can tailor interventions to address clients' unique needs. This, in turn, can lead to a more in-depth understanding that facilitates a more holistic understanding of ER processes, refining existing theories and generating novel insights in the field. Additionally, it contributes to the training and supervision of therapists and students, enhancing their understanding of emotional regulation dynamics.

Future research endeavors can focus on further validating the O-MAR manual across diverse populations and therapeutic modalities, exploring its predictive value in relation to therapy outcomes. Cultural adaptation studies may ensure its applicability across different cultural contexts. Researchers could investigate how observations from the O-MAR manual align with self-reported measures and other assessment tools, fostering a comprehensive understanding of affect regulation that integrates multiple perspectives.

The absence of video recordings corresponding to the manual excerpts poses a limitation worthy of consideration. Future research efforts could involve integrating video recordings with the excerpts to facilitate a more nuanced and precise interpretation of the different levels of emotional regulation. To address ethical concerns, one feasible approach is to apply the O-MAR measure to freely accessible or commercially available videos within the field of psychotherapy research. Undertaking this additional effort not only serves to overcome the current limitation but also holds the potential to enhance alignment and consensus among judges. This work would significantly contribute to enhancing the inter-rater reliability and validity of the O-MAR.

Building on previous research and the findings of the second and third studies, it is suggested that therapists should be encouraged to establish a robust empathic relationship with their clients, cultivating an empathic attitude moment by moment, irrespective of their therapeutic approach. Expressed empathy should be considered when monitoring therapeutic progress or in supervision contexts. As observed in the clinical case study, high levels of expressed empathy are not always constant throughout therapy. In the event of a decline in empathy levels, therapists are recommended to approach this with curiosity and self-reflection rather than judgment. Reflecting on the factors influencing empathy levels can provide valuable insights into the therapist's internal state, potential setbacks, or external stressors affecting the therapeutic relationship. Through this reflective practice, therapists can deepen their awareness of their own responses and enhance their empathic ability.

Findings from the second and third studies support the idea that establishing a therapeutic relationship characterized by empathy, validation, and support is essential for helping clients develop their emotion regulation (ER) capacity. This type of relationship is often internalized by the patient and can play a crucial role in altering schemas that are believed to be at the root of emotional dysregulation. Given that most people seeking psychotherapy have difficulties regulating emotions, facilitating effective ER should be a common goal across psychotherapies (Leahy et al., 2011).

Therapists should actively promote clients' ability to regulate emotions, particularly in cases of depression where emotional regulation is crucial. Difficulties in regulating emotions can perpetuate the disorder, contribute to therapy failure, and sustain the client's suffering. Therapists should consistently assess the development of clients' emotional regulation as part of the therapeutic process.

Considering that previous research and the studies presented in this dissertation were based on samples of depressive clients, it is important to clarify whether similar results are observed in other psychopathological disorders. This question is crucial for exploring whether this is a mediational effect associated with client change in psychotherapy, regardless of the specific problems and/or therapeutic approach.

The longitudinal design and methodological approach of the third study were advantageous. However, the restricted number of sessions assessed for each case may not fully capture the complete trajectory of therapeutic change. Analyzing a broader array of sessions could offer a more detailed understanding of the processes over time.

The unexpected finding in the third study, indicating that in the specific context of CBT, therapist-expressed empathy exerts a more pronounced influence on reducing both depressive and general clinical symptoms, highlights the complex nature of therapeutic processes and the potential variability in the impact of therapist empathy across different therapeutic modalities. It prompts further exploration into the specific mechanisms at play within the framework of CBT that enhance the efficacy of therapist-expressed empathy. Understanding these nuances can inform tailored interventions and potentially optimize treatment outcomes in CBT settings.



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