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Empathic Listening Processes in Couple Therapy: A Task Analysis of Effective Interventions by Therapists in Training

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Doctor of Philosophy

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ABSTRACT

**Empathic Listening Processes in Couple Therapy: A Task Analysis of
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Listening is a fundamental and deceptively complicated component of talk therapy that has received very little specific research attention. The work of Carl Rogers and others promotes the importance of empathic listening to create safety and process client experiences, and several models identify its importance in processing and regulating client emotions (especially in couple therapy, where empathic listening can disrupt rigid conflict cycles and model coregulation skills). Much of the dysregulation and resistance we see in therapy may be related to a perceived lack of safety caused by persistent conflict or previous trauma, explained by the unconscious processes of the autonomic nervous system and polyvagal theory. Polyvagal research also supports the relationship between empathic listening and emotional safety: demonstration of genuine interest, care, acceptance, and validation are perceived as evidence of safety that encourage emotional connection. These behaviors are accessible to novice therapists who are still learning specific models and interventions. This study seeks to illustrate this relationship by conducting a task analysis on empathic listening behaviors by therapists in training in a therapy-as-usual environment. Observation of emotional inquiries in therapy leading to increased perceptions of safety demonstrate that empathic listening requires a sustained balancing of safety-promoting and exploratory behaviors. Therapist directiveness, possibly rooted in anxiety, was a common observation across segments where client safety was not achieved. Our observations also highlight the importance of therapist attunement, or neuroception, to determine whether to use safety-promoting behaviors or exploratory questioning. It is my hope that this

research can lend illustration and clarity to the theoretical underpinnings of empathic listening to guide therapist interventions and training.

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Many studies have demonstrated that talk therapy is effective in addressing a variety of

mental health and relationship problems (Snyder & Halford, 2012; Wampold, 2007). As theories

and philosophies of therapy evolved into specific models and manualized interventions, research

further analyzed the effectiveness of these models compared against each other or control groups

(Shedler, 2018). Not all models in general practice have been proven effective by research, and

evidence-based models often rely on findings that are technically significant but account for only

a small amount of difference against control groups (Shedler, 2018). In any case, these studies

rely on controlled, manualized applications of the model in specific contexts, reducing

generalizability of the findings for therapists in diverse contexts, most of whom practice within

an integrative framework (Gold & Stricker, 2012; Lebow, 1997).

In recent history, increased recognition of the common factors of therapy (Duncan et al.,

2010), integrative frameworks of practice (Gold & Stricker, 2012), and deliberate practice

training (Rousmaniere et al., 2017) has emphasized the fundamental processes and techniques of

therapy that are shared across models. These processes – asking questions, reflecting, reframing,

challenging – are generally derived from philosophy and theory and heuristically intuited by

practicing therapists (Geller, 2005). The lack of focused research on the efficacy and application

of fundamental therapy processes represents a wealth of opportunities to further understand,

refine and enhance the practical skills of providing therapy.

Process research allows us to identify and carefully analyze the core processes that lead

to successful change in talk therapy (Greenberg, 1986). These processes are conceptualized and

perceived in the context of theory, and as such their derivation will reflect the assumptions of

that theory, and may describe small, discrete processes or broader groups of behaviors that combine towards the same therapeutic goal.

Empathic listening, a concept arising from person-centered and emotion-focused theory, describes an array of behaviors that communicate the therapist's genuine interest in, and facilitate the evocation of, the client's emotional experience (Rogers, 1975). These behaviors include presence, questioning, reflection, empathic conjecture, heightening and validation (Cain, 2010; Greenberg, 2015). Empathic listening as a core process is designed to increase the client's perception of safety, strengthen the therapeutic alliance, and arrive at the core emotional experiences related to the client's presenting problems (Rogers, 1975).

Many clients arrive at therapy resistant to sharing or processing their emotional experience, particularly primary emotions related to insecurities or perceived vulnerabilities (Paulson et al., 2001; Tursi, 2016). Polyvagal theory, which helps us understand the role of the nervous system in our behavioral choices and reactions, suggests that many clients may be in a 'fight or flight' pattern when confronted with core issues related to security and self-worth, especially in the context of relationships with others (Dana, 2018; Porges & Buczynski, 2011). In this state, clients are defensive and resistant to connecting with others, fearing a personal attack or confirmation of their fears of rejection or abandonment. Empathic listening is critically important in demonstrating that the therapist is genuinely interested in the client's emotional experience and will provide a nonjudgmental, validating response.

This is especially true for couple therapy settings, where clients are often experiencing conflict, criticism, defensiveness or accumulated resentment. The therapist's use of empathic listening behaviors is not only important for processing emotional experiences, but for modelling and facilitating the development of empathic listening processes within the client relationship.

A more detailed understanding of how empathic listening works in therapy has important implications for clients and therapists. If we can identify the behaviors and sequencing related to empathic listening that are most successful in creating safety and engagement with clients, therapists will be able to replicate them in their own practice, and clients will benefit from a stronger therapeutic alliance and deeper engagement with therapy. These implications are particularly relevant to therapist training programs: supervisors could promote the importance of empathic listening behaviors, which may be more immediately accessible to novice therapists than manualized models and specified interventions. Studying these behaviors in a couple therapy context provides additional opportunities to identify indirect effects of empathic listening on partners also present in therapy. The purpose of this research is to use task analysis (a form of process research) to identify and describe in detail the successful application of empathic listening behaviors leading to increased client safety in couple therapy.

Literature Review

Polyvagal Theory

New developments in neuroscience research offer deeper understanding of the physiological and emotional features of couple conflict. Polyvagal theory describes how the nervous system defensively activates in response to perceived threats, or downregulates these defenses to encourage openness and connection (Porges, 2011). According to polyvagal theory, we employ a hierarchy of three autonomic states to assess environmental threats and mediate our behavior (Porges, 2001, 2003, 2011). The primary state, related to the dorsal vagal complex, responds to the perception of extreme threat by shutting down or feigning death – often referred to as 'freezing'. The next state is popularly known as 'fight or flight'; this state is related to activation of the sympathetic nervous system which mobilizes physical resources and adrenaline

in response to perceived threats. A third state – most recently developed in the evolutionary timeline and associated with mammalian behaviors – relates to activation of the ventral vagus, part of the parasympathetic nervous system. This autonomic stance has also been referred to as the 'rest and digest' state, where social engagement and relationship interaction is more likely to occur (Gilbert, 2017; Porges, 2011).

According to polyvagal theory, the nervous system combines with neurological sensors to perceive external threats on a subcortical, subconscious level, a process that has been termed 'neuroception' (Porges, 2009). As these systems operate on subcortical levels and are informed by past experiences, polyvagal theory offers important insights into the otherwise confusing activation of anxiety, stress and other 'fight or flight' reactions to seemingly safe environments and events. A therapist may pay careful attention to create a safe therapeutic environment, but any miscellaneous cues that relate to a traumatic memory may create unconscious perceptions of danger and threat, and lead to activation of a more primitive state of emotion regulation with its associated resistance to connection (Dana, 2018; Geller & Porges, 2014).

While polyvagal theory explains how relationship connection can be disrupted due to these uncontrolled internal factors, it also offers insight into how safety and connection can be fostered via cultivation of the social engagement system. The social engagement system relates to the projection and reception of cues of safety between humans (and other mammals) that signal a lack of threat and presence of safety (Porges, 2011). This is accomplished in a complicated interaction between the heart and facial muscles that coordinates the expression of calm-indicating behaviors related to our own state of functioning. In other words, "how we look, listen, and vocalize conveys information about whether we are safe to approach" (Porges, 2017, p. 8). These cues are also interpreted subconsciously via neuroception, but subtle eye

movements, posturing, breathing and other factors combine to indicate downregulation of the self and provide safety cues to others, which can then be reciprocated in a process of coregulation. This coregulation can be promoted further via more specific behaviors related to connection and safety (Dana, 2018; Geller & Porges, 2014). A practical example of this is a simple hug, or the act of lying on another person: this behavior, unique to mammals and described in polyvagal theory as 'immobilization without fear', is seen as an indicator of vulnerability; an unspoken, implicit suggestion of trust in willingly allowing oneself to be placed in a vulnerable position (Porges, 1998).

It takes little imagination to consider the implications of polyvagal theory in couple therapy settings. The well-established concepts of therapeutic presence, empathic listening behaviors, and the therapy alliance are highly related to the perception of safety in the relationship via activation of the parasympathetic nervous system. Polyvagal theory and the subconscious process of neuroception explain the difficulty of consolidating the specific behaviors related to establishing safety, and support the philosophy that self-work, genuine interest and positive regard are most critical in maintaining the therapeutic alliance and encouraging connection and expression of primary emotional experiences with clients.

However, applying the principles of polyvagal theory requires more than a simple replication of listening behaviors. The implications of neuroception demand genuine curiosity and compassion from the therapist to create the perception of safety (Rogers, 1995). Empathic listening also requires a sustained process of multiple listening behaviors; the downregulation of physiology can take some time to occur within the client, and the arrival at a primary emotional experience via various tertiary layers requires a diverse set of approaches to process. At the same time, the therapist must take care not to assert too much pressure in the form of exploratory

questions, as this can increase resistance and stall downregulation. The complicated and intricate nature of this process again reinforces the importance of genuine compassion and curiosity, which will subliminally activate external cues of safety and accurate interpretation of the client's autonomic state (Dana, 2018; Geller & Porges, 2014).

The behaviors related to couple conflict are the typical behaviors related to activation of the sympathetic nervous system (SNS). Polyvagal theory explains how underlying beliefs and fears regarding acceptance and inclusion from others relate to the activation of the sympathetic nervous system (Porges & Buczynski, 2011). Furthermore, polyvagal theory identifies how reciprocal connecting behaviors can activate the parasympathetic nervous system to foster safety and security in a process of coregulation (Dana, 2018; Geller & Porges, 2014; Porges, 1998). Here, couple therapy could be conceptualized simply as a deeper awareness of the SNS, followed by conscious attempts to facilitate PNS-activating behaviors.

In this process, the role of the therapist is crucial to help clients recognize the features of the SNS by perceiving and responding to these features as they arise. In the SNS state, clients need remote objective feedback to enhance their awareness, especially as self-awareness is impaired while the SNS is activated. Though the therapist may feel drawn in to the negative features of these client states and tempted to engage their own SNS, they should ideally stay in a supportive and connecting stance to help foster client awareness of their state and simultaneously engage in connecting behaviors that support regulation (Geller & Porges, 2014). Polyvagal theory adds new dimensions of understanding for the role of the therapist by describing the approach and orientations that support and model coregulation. A primary therapeutic concept that encompasses the supportive, safety-promoting behaviors identified in polyvagal theory is empathic listening.

Empathic Listening

Empathic listening can be defined as a set of verbal and non-verbal listening behaviors that emanate from the listener's genuine interest and compassion; the concept is often associated with Rogers' person-centered theory (Rogers, 1975), and has been further developed by emotion-focused theorists (Greenberg, 2015; Johnson, 2012). Empathic listening is supported in these theories as a necessary skill for helping clients feel safe and accepted as a precursor to emotion processing, and is therefore closely aligned with the polyvagal concepts of coregulation and activation of the social engagement system (Dana, 2018). This relationship is supported by research demonstrating that empathy and empathic listening are indicators of healthy relationships, and empathic listening is a sign of interpersonal affection (Floyd, 2014). Empathy training for couples has been shown to increase empathy in relationships, which contributes to relationship satisfaction (Long et al., 1999). Gottman (1999) found that couples who demonstrated active listening skills (derived from person-centered theory) with each other maintained healthy relationships.

In couple therapy, empathic listening is a precursor to perceptions of safety and empathic responding, not only towards the therapist, but towards others in the therapy setting (Block-Lerner et al., 2007). Jordan (2000) recommends an approach that emphasizes empathy not only in the client-therapist relationship, but one that assesses for and aims to develop other empathic relationships in the client's social network. In other words, the therapist's support for mutual empathy in the therapeutic alliance can encourage and model coregulation and social engagement in other relationships; especially in couple therapy where relationship processes are present and directly involved.

In support of process-oriented couple therapy, Fishbane (1998) recommends a reorientation away from structural change and towards relational dialogue— based on the I-thou philosophy of Buber (2004)—as the primary focus of relationship therapy. Fishbane suggests that couples—feeling unsafe, unheard, and unable to listen to each other—are often stuck in transactional perspectives, holding back their own feelings and unable to see the 'whole' of the other. Using empathic listening skills, the therapist can support and model an atmosphere of safety and acceptance, and then encourage clients to see the wholeness of their partner instead of objectifying them. Couple therapy is seen primarily as supporting a safe and open dialogue between living persons, supported by empathic listening, which identifies the roots of conflict and encourages supportive, validating responses (Lysack, 2008; Rober, 2005). However, while these arguments promote the importance of empathic listening within dialogical, process-oriented therapy, the myriad benefits that empathic listening contributes to the common factors of the therapeutic alliance (in promoting safety and openness) denote its generalized value in other models that may prioritize structural or individual change.

Definitions

The terms empathy and listening are open to diverse definitions within different contexts, even within the field of psychotherapy. Specification of the context is a primary task of process research; here I will define empathic listening within the context of emotion-focused theories. In defining empathic listening within this context, I do not refer to any specific theory or model, but rather the larger body of clinical research and practice that focuses primarily on emotions (Greenberg, 2011).

Early therapeutic definitions identified empathy as a personality trait, or a particular state of being (Truax & Carkhuff, 2017). Carl Rogers, the creator of person-centered theory, originally

defined empathy as a state in which one were to "perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto" (1959, pp. 210–211). Later, he redefined empathy as a process encompassing several facets of a way of being with another person, including entering their private world, sensing meanings, and nonjudgmentally communicating with them your 'sensings' and perceptions (Rogers, 1975). Rogers asserted that genuine, compassionate curiosity was an essential ingredient of empathic listening (Rogers, 1975).

Rogers' reframing of empathy as a set of active processes rather than a state of being is reflected in more recent conceptualizations. Elliott et al. (2011) identified a growing consensus that empathy consists of three sub-processes: emotional simulation (or mirroring of another's emotional experience), a conceptual perspective-taking process, and an emotion-regulation process that helps soothe another's distress.

Emotion-focused theory also specifies empathy as an active process in psychotherapy to increase safety and willingness to process primary emotions (Bohart et al., 2002; Elliott et al., 2011). Through the active use of skills including empathic exploration and conjecture, reflection of feeling, heightening and validation, the therapist is able to mirror and perceive the client's emotional state and enhance emotion regulation (Elliott et al., 2011; Greenberg, 2015).

If we consider empathy as an active process comprising a set of behaviors that stem from the therapists' genuine compassion and curiosity, then empathic listening is simply the application of genuine empathy in a listening stance. This definition transcends simplistic descriptions of listening behaviors, such as using simple and complex reflections, asking questions, maintaining eye contact, etc. These processes may exist in empathic listening, but

only as a natural byproduct of the congruence, care, exploration, perspective-taking and emotional mirroring described by empathy (Rogers, 1975).

Principles of Empathic Listening

Framing empathic listening as an active process arising from the therapist's genuine interest and curiosity, in this section I will examine research regarding the necessary preconditions and skills required to listen empathically.

Therapist Stance. Most therapeutic interventions are described in terms of specifically defined processes with prescribed scripts; the internal frame of reference of the therapist often goes unacknowledged. Empathic listening, as an extension of person-centered theory, pays careful attention to the therapist's fundamental assumptions about therapy, and their 'way of being' with the client (Rogers, 1995).

Therapists of this orientation often refer to the I-thou philosophy of Martin Buber to describe the therapeutic relationship. Buber (2004) identified two ways of relating to others: I-it, where the other is seen in a utilitarian frame towards achieving personal objectives, and I-thou, where the other is seen as a whole, complete being full of mysterious potential, and capable of intimacy.

Buber's philosophy informed Rogers' theory of Client-Centered Therapy, later renamed Person-Centered Therapy (PCT), which prescribes that the therapist maintains three necessary conditions: congruence, care, and empathic listening (Rogers, 1959). Rogers described these conditions as mutually supportive processes: a therapist could not listen empathically without genuine care for the client, and empathic listening was also compromised if the therapist were disingenuous.

Listening Skills. The primary skill espoused by person-centered theory is active listening: the use of reflective questions and summary statements of the client's thoughts and expressed feelings to establish and indicate shared understanding and empathy (Rogers & Farson, 2015). While some have criticized this skill as over-simplistic (Arnold, 2014), it derives its power from the therapist's engaged stance and genuine interest, which lend power to the simple exchanges. Rogers' stated intention was to avoid the narrowness and inflexibility of prescribed models and interventions (Rogers, 1986). The common behaviors of empathic listening may be derived from his prescribed conditions: validation emerging from unconditional positive regard, immediacy and presence from congruence, and active listening skills emerging from genuine care for the client.

Borrowing from person-centered and emotion-based theories, emotion-focused therapy models (Greenberg, 2015; Johnson, 2012) have further described and illustrated the skills emerging from person-centered therapy, adding more emotion-specific skills to encourage the processing of client emotions. For example, empathic exploration (Goldman & Greenberg, 2019; Greenberg, 2015; Johnson, 2012) describes the processes of evocative questioning: identifying the emerging edges of the client's emotional experiences and asking questions about them. Empathic conjecture (Goldman & Greenberg, 2019; Greenberg, 2015; Johnson, 2012) describes the skill of using the therapist's empathic experience to identify and gently explore potentially unspoken emotions. Heightening (Goldman & Greenberg, 2019; Greenberg, 2015; Johnson, 2012) involves reflecting the client's expressed experience using more intense words and descriptions, to invite further illustration or clarification of the client's emotional experiencing. Emotion-focused therapy also offers further illustration and detail around the skills emerging

from person-centered theory to provide therapists with an array of possible behaviors and interventions that support the process of empathic listening.

Non-verbal Communication. The idea that our non-verbal behaviors are critical to communication and listening is well-established (Phutela, 2016). In a therapeutic setting, research shows that nonverbal behaviors are a major facilitator of attachment and emotion regulation in relationships, and powerfully communicate safety and acceptance (or the opposite) to those we are interacting with (Pally, 2001). In one study, nonverbal messages were found to account for twice as much variance as verbal messages on client perceptions of empathy (Haase & Tepper, 1972). Polyvagal theory, which I will discuss in more detail, further illustrates the critical importance of non-verbal behaviors in the development of the therapeutic alliance (Dana, 2018).

Models Incorporating Empathic Listening

Although empathic listening may be seen as a fundamental process utilized across almost all forms of therapy, some models have specified some general techniques and interventions to support and facilitate empathic listening behaviors.

Emotion Focused Therapy (EFT) was developed to emphasize the emotional content and processes of therapy (Johnson et al., 1999). Greenberg (2015) situates 'empathic exploration' as the core process of EFT, and describes it as "sensitively attending, moment by moment, to what is most poignant in clients' spoken and non-spoken (nonverbal) narrative" (p. 95). Therapists balance a process of 'leading' and 'following' the client's emotional experience, prioritizing the latter.

Greenberg and Goldman (2008) further elaborate on EFT interventions for couples, emphasizing the need to establish an alliance with both partners by attuning to and validating

their experience with empathy, genuineness and positive regard. The therapist uses empathic exploration to access primary emotions, connect them to the relationship context, and directs partners to engage in empathic listening and sharing with each other. These techniques are also evident in the attachment-related EFT model further developed by Johnson (2012).

Building on the foundations of person-centered therapy and EFT, Emotional Schema Therapy (EST) incorporates a meta-emotional frame that explores the client's feelings and thoughts about their emotions and about emotions in general (Leahy, 2015). A therapist utilizing EST will actively pursue not only the client's primary emotions, but how they interpret and make sense of those emotions, using a reflecting empathic style and gentle empathic confrontations (Leahy, 2015).

Motivational Interviewing (MI) is not an emotion-based therapy, but it does emphasize the importance of non-judgmental exploration of the client's perspective (Miller & Rollnick, 2013). MI describes reflective, or active listening as non-judgmental, explorative, and engaged. MI also emphasizes the importance of non-verbal behaviors that exemplify empathic listening (Miller & Rollnick, 2013).

As mindfulness has become more popular in therapeutic practice, we see empathic listening themes emerge. Shafir (2008) describes the mindful listener as one who is able to 'sustain their attention over time, hear and see the whole message, make the speaker feel valued and respected, and listen to themselves" (p. 219). Bien (2008) illustrates how mindfulness can help a therapist accept what is happening with a client in the moment and remain flexibly responsive to their presentation.

Benefits of Empathic Listening

Empathic listening is strongly linked to many of the core processes of therapy and has been associated with successful therapeutic outcomes. In this section I will identify and discuss research on how empathic listening facilitates emotion processing, supports ethical practice, satisfies clients' expectations for a positive therapy experience, and leads to successful client outcomes.

Emotion Processing. Exploring intense, primary emotions is one of the core tasks of therapy, creating opportunities for resolution, acceptance and reframing that reduce distress for the client (Greenberg & Pascual-Leone, 2006). This helps clients learn new emotional insights and regulation techniques to increase their own emotional intelligence (Greenberg, 2015). In recent years, models promoting the primacy of emotion have grown in popularity, including Emotion-Focused Therapy (Greenberg, 2015; Johnson, 2012) and Emotional Schema Therapy (Leahy, 2015).

Because primary emotions are often individually perceived as vulnerabilities, clients (and therapists) may have difficulty making contact with them. The autonomic nervous system defaults to protection against threats; it is only when the system detects markers of safety that this system can downregulate physiology to allow clients to engage emotionally (Geller & Porges, 2014). While the use of empathic listening directly addresses and assesses the client's emotional experience, it is the process of empathic listening – encompassing curiosity, care, non-judgment, and acceptance – that fosters an atmosphere in which clients feel safer to process primary emotions.

Client Expectations of Empathic Listening. Client expectations preceding therapy might also serve as a reminder for the importance of empathic listening. Before commencing

therapy, clients expect the therapist to be listening and supportive, and that the relationship should be close and personal. Clients expect that they will be asked to disclose their experiences (Hill et al., 2012).

A qualitative research study described the experiences of clients who felt 'heard' in therapy (Myers, 2000). Participants receiving therapy that emphasized empathy described positive reactions compared to previous therapeutic experiences, and observers noted that the therapist was more engaged, and more painful material was processed in sessions.

Successful Outcomes. There is a clear relationship between empathy and positive therapeutic outcomes. Empathy and empathic listening are a common factor related to successful outcomes across established and emerging models and theories of treatment (Feller & Cottone, 2003). In a meta-analytic review, Elliott et al. (2011) found that therapist empathy had a positive effect size of .31, explaining 9% of variance in therapy outcomes across a range of models and theoretical orientations - a finding replicated in other studies (Greenberg et al., 2001; Soto, 2017). This effect size holds across different models and practice approaches. Bohart et al. (2002) also found that empathy explains at least as much, if not more, outcome variance than therapeutic interventions.

Research on the effectiveness of empathic listening in systemic therapy is less clear. Graff et al. (2009) found that therapist empathy did not predict the rate of dropout in a couple therapy outpatient alcoholism treatment program. However, studies in SNS synchrony among therapists and couples in relationship therapy demonstrated that therapist empathy decreased clients' emotional arousal related to distress (Voutilainen et al., 2018) and that the therapist's autonomic state predicted the client's autonomic state (Karvonen et al., 2016). While these

synchrony studies suggest correlation, they do not illustrate the particular behaviors or processes that encourage activation of the PNS in couple therapy settings.

Therapist Training. Anxiety is common amongst therapists in training programs, who are required to learn and practice complicated theories, models and interventions (Brown et al., 2013; Shamoon et al., 2017). In contrast to manualized, specified models, the main principles of empathic listening rely on humanistic concepts of genuine care and concern for the client, authentically communicated via congruent verbal and non-verbal behaviors (Rogers, 1975). As these concepts are derived from therapist attributes and life experiences, they may be more immediately accessible to novice therapists, increasing their personal confidence, efficacy, and sense of agency (Mutchler & Anderson, 2010; Rogers, 1986). Empathic listening is also recognized as a therapeutic common factor (Duncan et al., 2010); research suggests that the incorporation of common factors into systemic training programs is highly beneficial (D'Aniello & Fife, 2017).

The importance of empathic listening is commonly recognized across a range of models, philosophies and fields of practice, yet there is a lack of research on the specific patterns and applications of empathic listening in talk therapy. Much of what has been written about empathic listening is heuristic and theoretical. Research focusing on the process of empathic listening in therapy settings will help us better understand how this common factor works in therapy, and how we might adapt and apply it in specific contexts.

Process Research

Research in talk therapy has generally followed in the vein of traditional medical research methods: that is, randomized control trials, data modelling and other research based on surveys and quantitative data collection (Heatherington et al., 2005; Miller & Johnson, 2014; Pinsof &

Wynne, 2000). Whilst this research has been valuable in demonstrating the efficacy of therapy in general and links between particular models and desirable outcomes, it has been less beneficial in understanding how the actual processes of therapy function withing unique therapeutic contexts and relationships to create change (Heatherington et al., 2005; Pinsof & Wynne, 2000; Rohrbaugh, 2014). Process research analyzes the processes, interventions and behaviors that occur in therapy and predict desirable outcomes. In this regard, process research is a natural extension of the therapist's efforts to study and learn from their own clients.

Process research on therapeutic interventions usually consists of audio, video and physiological data collected in clinical environments, and lends some flexibility in approach and interpretation based on research interests. For example, a researcher might be interested in illustrating the behaviors that bridge predictors and outcomes already established by outcome research and may qualitatively study and describe the common processes that explain this relationship. Another researcher may be interested in a particular significant change event in therapy and will compare occasions where the change occurs against occasions where it does not occur to determine differentiating features. Another researcher might simply use outcome research to identify above-average clinicians and study their unique behaviors and characteristics (Greenberg, 1986; Heatherington et al., 2005; Woolley et al., 2000).

Indeed, many prominent models or therapeutic approaches of philosophy were developed under the auspices of a process research approach, where therapists and researchers identified and studied therapy processes that resulted in successful outcomes (Greenman & Johnson, 2013; Rogers, 1986). But while this research can lead to the development of models and manualized interventions, its ability to focus on isolated interventions and processes in therapy-as-usual

settings is especially conducive to clinicians in practice, most of whom practice from an integrative, eclectic framework (Lebow, 1997).

Process research can claim other unique benefits: as a primarily observational method, it adds new and detailed perspectives to the body of data regarding the internal experiences of clients and clinicians in therapy. It may be argued that observational data, often collected and interpreted by multiple observers, is more objective and accurate than self-reports that are subject to internal biases and singular perspectives (Heyman, 2001). This is especially important in relational research; individuals located in one point of a dyadic or systemic relationship network are less capable of seeing the whole system with objectivity (Heatherington et al., 2005). While some have argued that observational coding may be unreliable, subject to observer bias and misperception (Haro et al., 2006), many studies support the reliability of inter-rater coding processes, and have shown that even untrained observers can accurately code subjective human experiences and interactional processes (Baucom et al., 2012).

Task Analysis

One specific form of process research is task analysis, developed by Greenberg (2007), to identify and map out sequences related to specific significant changes in therapy. Task analysis is conducted by identifying a therapeutic task of interest, using relevant research and experience to explicate a conceptual map and construct a proposed model, and then using recorded data to analyze and compare successful and unsuccessful task completions against the proposed model. The researcher uses these observations to synthesize a rational-empirical model and explore the theoretical underpinnings that may explain how the observed processes contribute to successful completion of the task in therapy (Greenberg, 2007).

Bradley and Furrow (2004) used task analysis to explore and describe how a successful blamer-softening event occurs in couple therapy. The researchers hypothesized a rational model based on EFT theory and then created an appropriate coding scheme. They then coded and performed content analysis on four therapy session transcripts, each session was conducted by the same therapist. The same session recordings were later examined using different emotional experiencing coding schemes to identify the positive impact of therapeutic emotional presence on blamer-softening processes and client emotional engagement, finding that therapist emotional experiencing and vocal quality predicted client emotional experiencing in softening events (Furrow et al., 2012). Task analysis has also been used to study withdrawer re-engagement (Lee, 2015) enactments in couple therapy (Woolley et al., 2012), and de-escalation of high-conflict co-parents (Anderson et al., 2020). While most of this research was conducted within the specific context of emotion-focused therapy, each task analysis related to a specific intervention or therapy process generalizable to other modalities and therapeutic styles.

The Current Study

The present study applies polyvagal theory towards understanding the therapist behaviors that support the client's perception of emotional safety in a therapist training environment. A client's perception of safety is critical to their progress and alliance (Friedlander et al., 2006), and so my primary purpose is to discover and better understand the specific therapeutic behaviors that encourage activation of the PNS in the context of emotional exploration. I also refer to person-centered and emotion-focused theory to delineate and describe therapist behaviors that promote safety and encourage emotional responsiveness, or in other words, activation of the PNS. Studying these behaviors in a training environment will help us more specifically identify common interventions accessible to novice therapists. I propose that a task

analysis of the activation of the PNS in couple therapy in the context of emotional inquiry will show that empathic listening behaviors predict activation of the PNS, especially when applied in an extended sequence using multiple behaviors.

Methods

Participants

Data for this study comes from the Changing Hearts and Minds in relationshiPS (CHAMPS) project conducted at Brigham Young University (BYU). Client participants were recruited from couples seeking relationship counseling at a university-based clinic. To be eligible for the study, participants had to be English-speaking, married for at least a year, experiencing clinically significant distress as determined by either partner having a score <13.5 on the Couple Satisfaction Index (CSI-4) (Funk & Rogge, 2007), and free from a substance abuse problem, addiction or a severe mental disorder.

Client participants included 22 couples, all of whom were married for the duration of the study. Half of participants (n=22) were male and half (n=22) were female. The average age of participants was 29.45 (*SD*=4.4; range=22-38) with the sample being 85.71% White (n=36), 2.38% Black (n=1), 7.14% Asian/Pacific Islander (n=3), and 4.76% Hispanic (n=2). Couples had an average of 1.85 children (*SD*=1.53; range:0-5) and average family income was between $45,000 and $55,000. Education levels of client participants varied; for 9.52% (n=4) the highest level of education was a GED or high school, for 7.14% (n=3) an Associate degree, 26.19 (n=11) a Bachelor's degree, for 4.76 (n=2) vocational or technical school, for 38.10% (n=16) some college, and for 14.29% (n=6) a Masters or Professional degree. Therapist participants were drawn from a pool of second-year MFT masters-level or PhD interns at the BYU Comprehensive clinic. They were assigned to client-participants based on availability. Video and audio of the

first four sessions of therapy were recorded, along with physiological measures of heart rate variability, cardiac impedance, and electrodermal activity. Standard therapy methods/techniques were used in a Treatment-As-Usual (TAU) format.

In the data selected for analysis, 25 therapy segments were used: fifteen related to successful task resolution and ten related to unsuccessful task resolution. The fifteen successful segments involved eight separate couples and seven different therapists. The ten unsuccessful segments involved seven separate couples and six different therapists. Two of the couples were participants in both successful and unsuccessful segments, and two therapists were also participants in both successful and unsuccessful segments. No therapist or couple was represented more than three times in either successful or unsuccessful segments.

Measures

Experiential Therapy Adherence Measure - Empathic Listening (ETAM-EL)

To conceptualize and identify empathic listening behaviors, a coding scheme was adapted from empathic listening behaviors described in two previously developed coding schemes: the draft Experiential Therapy Adherence Measure (ETAM) (Goldman & Greenberg, 2019) and the Emotionally-Focused Therapy Coding Scheme (EFT-CS) developed by Bradley and Furrow (2004). The ETAM and the EFT-CS both offer detailed descriptions of empathic listening behaviors and are compatible with process research methods; the EFT-CS has been applied to previous task analysis research (Bradley & Furrow, 2004; Bradley & Johnson, 2005; Furrow et al., 2012; Lee, 2015). While the ETAM describes six important empathic listening behaviors: 'presence and immediacy', 'exploratory question', 'reflection of feeling', 'empathic exploration', 'empathic conjecture', and 'heightening experience', the EFT-CS offers additional detail describing these behaviors and also identifies 'validation' as an important empathic listening

process. From the ETAM and EFT-CS, I selected and compiled these described behaviors into a

new coding scheme I called the Experiential Therapy Adherence Measure - Empathic Listening

(ETAM-EL, see Table 1).

Researchers were oriented to the ETAM-EL to provide them with a shared language and

understanding of the critical processes of empathic listening as they were observed and

discussed. The coding scheme was not designed to be used for quantitative analysis, neither was

there an expectation that the coding scheme would be used outside of the scope of this project, or

that it would remain unchanged. Task analysis allows for the evolution of coding schemes and

other analysis tools as necessary in supporting model evolution (Pascual-Leone et al., 2009).

Table 1

Experiential Therapy Adherence Measure - Empathic Listening (ETAM-EL)

Code	Item	Description
P	Presence/immediacy	Note observations about the client experience, asking what the client is currently feeling, describing the therapist's current experience.
Q	Exploratory question	Inquiring into what the client is/was experiencing, asking questions that encourage the client to explore their experience.
R	Reflection of feeling	Reflect the client's expressed feelings.
E	Empathic exploration	Empathically attend to the emerging edges of feelings.
C	Empathic conjecture	Speculating with clients about what might be beyond the client's described emotion, attempting to identify and process hidden/primary emotions.
H	Heightening experience	Intensifying described emotions or experiences, asking clients to repeat their emotional expressions.
V	Validation	Communicating to the client that they are entitled to their thoughts and feelings.

Respiratory Sinus Arrhythmia (RSA)

Substantial positive changes in RSA have been identified as related to activation of the PNS (Austin et al., 2007; Brooker & Buss, 2010; Cui et al., 2015; Grossman & Taylor, 2007; Porges, 2009); research has also shown that RSA levels significantly increase when compassion is elicited (Stellar et al., 2015). In the CHAMPS sample used for this study, RSA data was collected in-session from all clients and therapists. I processed and exported the RSA data relevant to the selected segments in Mindware in a continuous format (second by second, using a sliding window with a fixed buffer size of 30 seconds to calculate). The calculation of RSA controlled for respiration, as it has been found that respiration may affect the relationship between RSA and PNS activation (Berntson et al., 2007).

Selection of Therapy Segments

The principal data of a task analysis are selected therapy segments; primarily segments where the task is accomplished, and a smaller number of segments where the task is not accomplished for comparison. Task analysis procedures recommend analyzing three successful and three unsuccessful segments to synthesize a discovery-oriented model, followed by 2-3 additional analysis sessions with three successful segments each to synthesize the rational-empirical model (Greenberg, 2007). Noting that previous task analyses generally had much smaller pools of data to draw from, I decided to increase the number of successful segments in each analysis to five. I also decided to analyze an additional three unsuccessful segments in the second wave of analysis to increase our confidence in isolating the processes related to successful resolution. This necessitated identifying 20 successful segments and six unsuccessful segments.

To identify successful segments, I created a table listing RSA (Respiratory Sinus Arrhythmia) changes for each one-minute period for all clients across all sessions, and then sorted the table in descending order to identify the largest positive changes of RSA within a one-minute period. Starting from the largest change, I assessed each entry for inclusion. I eliminated an entry if it occurred in the first 10 minutes of the session, reasoning that events prior to the session may have affected RSA levels. I then reviewed the session transcript to identify a specified marker (an emotional inquiry) in the ten minutes preceding successful resolution (RSA change), as recommended by Greenberg (2007). When a segment with the appropriate task was identified, it was marked for inclusion, and the process was repeated until 20 successful segments were identified. The included segment with the largest change in RSA presented a 65% increase over one minute, while the smallest change for an included successful segment presented a 57% increase in RSA over one minute. These increases compare favorably to another study which found that eliciting compassion in participants produced an average 17% increase in RSA over a 90 second period (Stellar et al., 2015). To identify six unsuccessful segments for comparative analysis, I reviewed a list of randomly sorted transcripts against RSA data to identify segments where an inquiry was made into the client's internal experience and the PNS was not activated until I found six eligible segments. Segment timecodes and transcripts (separated into talk-turns) were collected for audio/video review.

Steps of Task Analysis

As I have previously described, task analysis is a form of process research that identifies and maps out the processes of therapy that lead to successful resolution of therapeutic tasks (Greenberg, 2007). In the initial discovery-oriented phase, researchers specify the task of interest, their cognitive map and theoretical assumptions, and describe the research environment.

They then construct a rational model based on theory and clinical experience and compare this against an initial set of observed segments (the empirical task analysis) to create a discovery-oriented model. This is followed by the validation phase, where researchers compare the discovery-oriented model against additional segments until no further refinements are identified, which indicates the synthesis of a rational-empirical model (Greenberg, 2007).

Specifying the Task

The task is specified by defining an initial event marker and a successful resolution. In this study I defined the event marker as the therapist asking a question about the client's emotional experience; in other words, the thoughts or emotions they experienced at the present moment or in an important event being described. The resolution was defined as activation of the PNS using the physiological measure of RSA. To incorporate the systemic nature of couple therapy and potential reciprocity of the predicted effects, it was not specified that the client who experienced PNS activation needed to be the same client towards whom the event marker (emotional inquiry) was directed.

Explicating the Clinician-Investigator's Cognitive Map

As a form of research that aims to evolve our understanding of existing theories and models, task analysis requires a prior explication of the theoretical assumptions related to the processes being investigated. As I undertake to study the processes of empathic listening and emotional safety, I propose that individuals experience emotions on a deeper level that helps explain their behaviors, and that relationship conflict patterns are generally reflective of secondary or tertiary reactions and behaviors extending from these primary emotional experiences. I further propose that the expression and processing of deeper emotional states can invite empathic responses from others that moderate negative interactions, and that therapy can

facilitate expression and processing of deeper emotions and supportive responses. In couple therapy, I believe that empathic listening can create a perception of safety in both participating clients via alternating attention from the therapist, or by witnessing one's partner expressing vulnerability and disclosing primary emotional experiences. I believe that the preconditions for empathic listening are therapist attunement, genuine interest and positive regard. As task analysis is designed to discover and illustrate ideal or "pure gold" interventions (Greenberg, 2007), my rational and rational-empirical models will identify the ideal therapist as attuned to and interested in the client's experience.

Specifying the Task Environment

A specification of the task environment describes the parameters of my research setting to identify the generalizability of my findings. The task environment described in the sample is a therapist training setting with no mandated interventions. The specified marker of inquiry into emotional experience might be framed as emotion-focused therapy – not the model specified by Johnson (2012), but the broader, integrative framework and approach described by Greenberg (2015). I am using the ETAM-EL to account for and code the basic and universally recognized processes involved in empathic listening in therapy. I believe this generalized task environment enhances the generalizability and usability of any findings.

Construct the Rational Model

A rational model is constructed by the primary researcher using theory and clinical experience to act as a comparative baseline for task analysis observations (Greenberg, 2007). Owing to the therapy-as-usual, non-manualized task environment, the construction of a rational model presents some difficulties. Task analysis usually derives concrete steps and processes from a manualized intervention which is consciously applied by therapists. Therapy-as-usual in a

broader integrative style is subject to the therapist's personal style and decision-making in the moment, and integrative theory proposes that there can be multiple effective approaches that lead to the same outcome of positive change (Lambert & Ogles, 2004). To preserve the benefits of generalizability, the rational model will be less specific in defining sequences of behaviors but will attempt to predict key descriptors of the process.

Referring to person-centered theory, polyvagal theory, and clinical experience, the activation of the PNS and experience of emotional safety in therapy is more likely to occur when empathic listening behaviors are carefully sustained in a repeated sequence, allowing time and space for the client to respond (Dana, 2018; Geller & Porges, 2014). In the rational model, I predict that the sequence of achieving safety while processing emotional experiences begins with an inquiry from the therapist into the client's experience, followed by a sequence of validating behaviors and exploratory interventions, with a duration of at least two minutes of sustained empathic exploration (see Figure 1). In a couple therapy setting, I believe that the application of empathic listening behaviors to either partner in a sustained process has the potential to increase perceptions of safety for both partners – whether they are engaging in or observing the process.

Figure 1

Rational Model
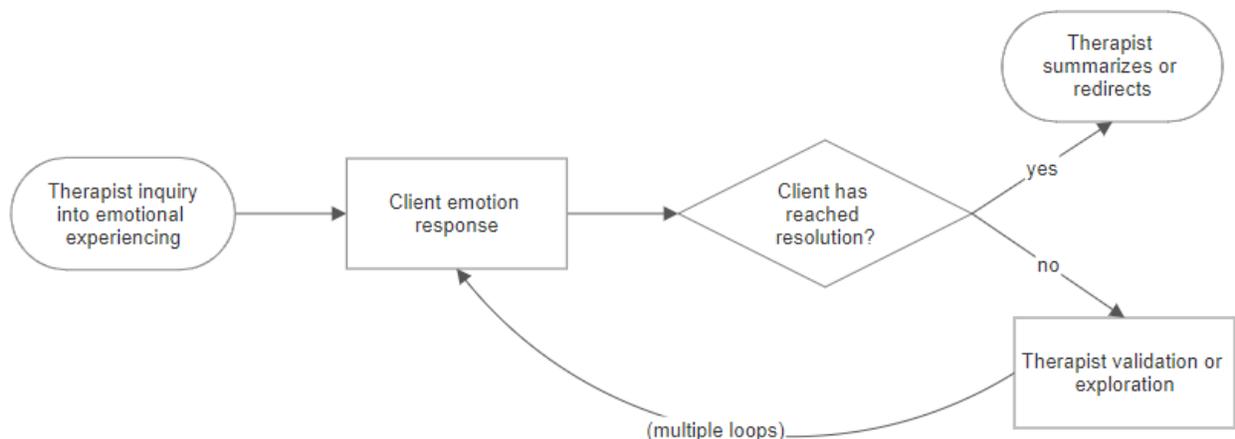
Conduct the Empirical Task Analysis

The empirical task analysis represents the core of the discovery-oriented phase. In this phase, the researchers review an initial round of successful and unsuccessful segments and compare them against the rational model; they use their observations to develop the discovery-oriented model. Item 1 in Table 2 identifies the steps undertaken in this analysis.

The coding, analysis and iterative model development processes of task analysis are conducted by two or more researcher-clinicians (researchers with clinical expertise related to the processes studied) to gain the benefit of clinical expertise and insight whilst minimizing perception bias (Greenberg, 2007). For this study, the primary author participated as a researcher-clinician, and recruited two additional researcher-clinicians with emotion-focused therapy training and professional experience. These participants were a Marriage and Family Therapy PhD candidate and a student from a Marriage and Family Therapy master's program. Participants were recommended by program supervisors as well-qualified to engage in a task analysis study.

The primary researcher prepared segment transcripts for each researcher-clinician that detailed the text of the segment, continuous RSA data for each client and the therapist, and space for note-taking and relevant ETAM coding for each talk-turn. The primary researcher then oriented the two additional researchers to the ETAM-EL and the rational model, and to the task analysis process. The three researchers then reviewed video and audio of five successful segments to identify specific tasks and sequences leading to successful task resolution. Initially, the video was paused between each talk-turn to allow time for notation, coding discussions, and other observations. As the researchers expressed more familiarity and congruence in their coding, the video was paused less frequently; however, each participant was permitted and

encouraged to pause the video at any stage to take notes and discuss their observations. To support balanced discussions and reduce the influence of preliminary hypotheses, the primary researcher refrained from discussing any observation until both additional researchers had responded. At the conclusion of each segment, the researchers referred to their notes and shared their observations, comparing them to the rational model. After reviewing five successful segments, three unsuccessful segments were analyzed using the same processes to identify the behaviors unique to the successful segments. After reviewing all segments, the researchers engaged in reflective discussion to compare their observations against the rational model and develop the discovery-oriented model (Figure 2). The researchers also identified potential improvements for the ETAM-EL.

Synthesize a Rational-Empirical Model

In the final, validation phase, researchers analyze additional segments until significant model improvements cannot be identified (Greenberg, 2007). For this study, the same group of researchers combined for two additional analysis sessions. The first additional session analyzed five successful and three unsuccessful segments using the same processes outlined above and identified further model improvements. An additional session analyzed five successful segments and was unable to identify any meaningful improvements, indicating model validation and identification of the rational-empirical model. Table 2, items 2 and 3 present an overview of the steps undertaken in this phase. The results of these analyses are detailed below.

Table 2

Procedures for Conducting the Empirical Task Analysis and Synthesizing the Rational Model

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1. 1st Analysis Session (Empirical Task Analysis):

   a. Researchers simultaneously analyze video and RSA data of five successful cases and identify common behaviors and sequences.

   b. Researchers analyze video and RSA data of three unsuccessful cases and identify common behaviors and sequences.

   c. Researchers identify common behaviors and patterns relative only to successful segments.

   d. Researchers compare observations against the rational model and use these findings to develop a discovery-oriented model.

2. 2nd Analysis Session (Synthesizing a Rational-Empirical Model):

   a. The same researchers analyze five successful and three unsuccessful segments, comparing them against the discovery-oriented model.

   b. Researchers identify improvements to be made to the discovery-oriented model.

3. 3rd Analysis Session: (Synthesizing a Rational-Empirical Model)

   a. The same researchers analyze five successful segments, comparing them against the improved discovery-oriented model.

   b. No meaningful improvements are evident, resulting in identification of the rational-empirical model.

Results

Phase 1: Discovery-Oriented Model

Our observations of emotional exploration segments leading to PNS activation confirmed some initial predictions and increased our understanding of how empathic listening encourages emotional safety in therapy. We observed that therapists utilized a variety of behaviors, including exploratory questions, reflections of content, reflections of feeling, validation, and empathic conjecture. Heightening was not identified in any of the observed segments; it is possible that this was explained by the therapists' general lack of experience or competence using a more specified skill. The most frequently observed behaviors related to validation and

presence/immediacy. Therapists observed in successful segments seemed to prioritize the client's

sense of safety and helping the client perceive permission to be vulnerable. In some cases,

therapists increased their physical proximity to the client and used affirming physical touches

(for example, gently touching the client's knee) when the client seemed hesitant to disclose a

difficult emotion. We also noted that these therapists made frequent use of encouragers, in the

form of non-verbal cues (head nods), simple reflections, or verbal cues ("mm-hms", "right", "I

see", etc.). These appeared to sustain the clients process of emotional disclosure and demonstrate

the therapist's interest.

  We also observed that the pacing of successful interventions was slow; the therapist

allowed more chronological space for the client and only intervened when the client seemed

stuck, or when they started to stray from their emotional disclosure. The balance of time also

skewed heavily towards the client – the therapist's responses were careful and minimal.

Primarily, we observed therapists balancing their interventions between fostering a sense of

safety and helping clients discover and process underlying emotions. Behaviors that seemed to

promote safety were most frequently used, while behaviors that explored emotions were used

occasionally to help clients who appeared stuck or who were straying from the emotional content

of their experience.

  The following transcript from a successful segment exemplifies the sustained process

described above, utilizing a balance of safety-promoting and exploratory behaviors:

  Therapist: What about you, for you? *(referring to the question, "what kind of marriage*

      do you want to create")

  Client: I want all the members of my family to know that they are important to me.

  Therapist: Mmm

Client: I don't, I don't want it to be a situation of, you know … Dad is more worried

            about this than me.

Therapist: Yeah. So you want people to know how much you care.

Client: Mhmm.

Therapist: You want them to like, yeah. Sorry, I don't want to speak for you, but that

            makes sense to me. Can you keep explaining that a little more?

Client: Um…so I don't mean to blame my parents, but they had to struggle a lot with

            a lot of things. And so, a lot of times as a kid, I felt like, you know, Mom

            doesn't care or Dad doesn't care.

Therapist: Mmm

Client: But, it's because it was out of their control to be able to care. They didn't

            have an option. It was either: (client name) eats or (client name) is cared for

Therapist: Sure

Client: Right, and so, I don't want anything like that to be an issue. I don't want, I

            don't want uh, bowling night, or work-

Therapist: Yeah yeah yeah

Client: -or even the church, I don't want my kids to be like, Dad cares more about,

            you know, home teaching than me.

Therapist: Yeah. Does it, does it hurt you when (partner name) says that, like, when she

            brings up things like I want to feel important to him?

Client: That, when, when you said it like that it didn't, but maybe it's cause she says

            it differently.

Therapist: But, but other, maybe not from me, but when she says it?

Client: Yeah.

Therapist: Why?

Client: Because I do try to show her that she's important and then we go like this and then I worry about my cords on my arm.

Therapist: So what does it say about you that she worries about that?

Client: That I don't.

Therapist: And that means, what? Like…

Client: That I don't? It, it either means that I don't or that I do and I haven't done good enough. It means one of the two.

For segments where PSA was not activated, the primary observation also related to pacing: the therapist seemed to divert from the disclosure process quickly towards directive statements or other lines of inquiry. Therapists in these segments had more closed postures and were more corrective and directive in their responses to the client. My initial prediction that successful segments would last at least two minutes proved somewhat accurate: unsuccessful segments were distinct in their brevity, averaging two minutes and three seconds long, whilst successful segments were four minutes and 38 seconds in average length. The following example transcript is typical of an unsuccessful segment, where the therapist initially engages in exploration but quickly redirects, and PNS is not activated:

Therapist: Yeah. Okay. I noticed you kind of have like a nervous smile in saying that. Is there... do you have any hesitations about bringing that up?

Client: No.

Therapist: Okay. So I guess, what do you feel like has made it stay the same this week? I know we worked pretty hard last session and it was pretty emotional, but what has it been like for you since?

Client: I feel like we forget to do the things that we should, like talk about our emotions and feelings instead of fighting.

Therapist: Uh huh. Right.

Client: Getting impatient. Yeah.

Therapist: Okay. So for you, it's kind of been the same because you haven't been changing the way you do things very much.

Client: Yeah.

Therapist: Okay. That makes sense. Alright, so I'm going to push these nightly check-ins again. I know it's really hard with your schedules because they're really crazy, but even if it's not at night, whenever you see each other, to just make that a real priority. Just because, the more you're able to do that, the more positive contact you're going to have with each other. Right? More good interactions. So when's a time that you could consistently be able to do that? Or something we could do to make sure that that happens every day?
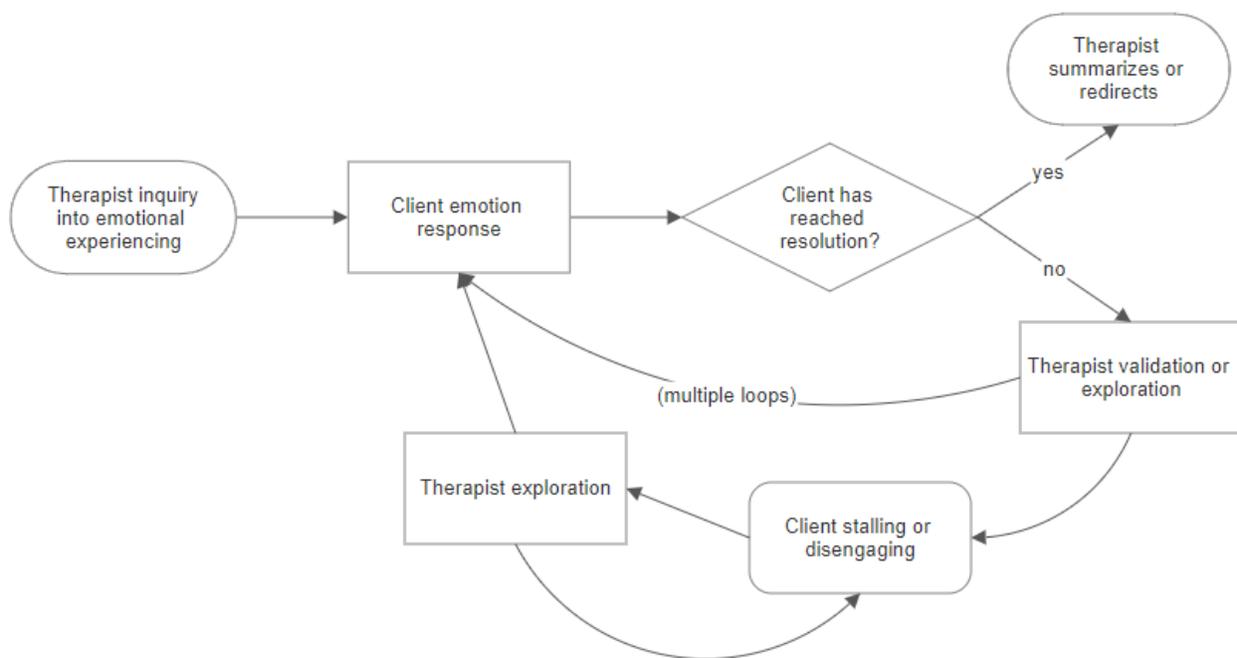
Discovery-Oriented Model

We hypothesized a discovery-oriented model based on these observations (refer to Figure 2). The process starts with some form of emotional inquiry from the therapist, followed by an emotional disclosure of some kind from the client. An attuned therapist will resist the urge to move to resolution or become directive, and instead utilize safety-promoting and emotional exploration behaviors with the client. If the client continues to express emotional content, the

cycle repeats again, primarily with safety-promoting behaviors from the therapist. If the client

diverts from emotional expression or stalls in the process, an attuned therapist will use

exploration behaviors to encourage continued emotional processing. When the client again

reverts to emotional expression, the cycle restarts. Finally, when the therapist perceives that the

exchange has reached a natural resolution, they may summarize, respond, and/or redirect to a

new topic.

Figure 2

Discovery-Oriented Model

We also decided to modify the ETAM-EL to better reflect our observations and the

discovery-oriented model. Seeing no obvious examples of heightening, we removed this from the

coding scheme. Confusion between empathic exploration and conjecture revealed minimal

benefit from their differentiation, so we also removed 'empathic exploration'. We added

'encouragers' and 'reflection of content', as these behaviors were frequently present in

successful segments; we inferred their definitions from observed behaviors. Recognizing the dual

importance of alternating safety and exploration behaviors in successful segments, we grouped

coded behaviors into either (or both) of these dimensions: for safety; 'validation', 'encouragers',

'reflection of content', 'reflection of feeling', for exploration; 'exploratory questions', 'empathic

conjecture'. We reasoned that 'presence/immediacy' behaviors (for example, "it feels like you

are holding something back right now") could apply to both dimensions, as they modelled

openness but also identified potential avenues for exploration (refer to Table 3).

Table 3

Experiential Therapy Adherence Measure - Empathic Listening v. 2 (ETAM-EL v. 2)

| Code	Item	Description
		Safety behaviors
V	Validation	Communicating to the client that they are entitled to their thoughts and feelings.
EN	Encouragers	Verbal and nonverbal cues demonstrating interest, e.g. head nods, "mm-hm", etc.
RC	Reflection of content	Reflecting the salient points within what the client is discussing.
RF	Reflection of feeling	Reflect the client's expressed feelings.
		Exploration behaviors
Q	Exploratory question	Inquiring into what the client is/was experiencing, asking questions that encourage the client to explore their experience.
C	Empathic conjecture	Speculating with clients about what might be beyond the client's described emotion, attempting to identify and process hidden/primary emotions.
		Safety and exploration behaviors
P	Presence/immediacy	Note observations about the client experience, asking what the client is currently feeling, describing the therapist's current experience.

Phase 2: Model Refinement

A second review session where researchers analyzed additional successful and unsuccessful segments in the same review format confirmed many of our previous observations and identified improvements in mapping the empathic listening process. We had hoped to identify common behavior-response relationships, but across successful sessions there were no readily identifiable associations. We intuited the client's perception of safety and emotional engagement and the attuned responses of the therapist, but it was difficult to explain in objective or descriptive terms why the successful therapist made certain choices. Ultimately, we saw this as an acknowledgement of the polyvagal concept of neuroception: our intuition as human beings and additional training as emotion-focused therapists were able to intuit the client's experience of safety and emotional engagement without being able to dissect and describe all the behaviors and signals that broadcast this, and we saw resonance and efficacy in the therapist's attuned response without being able to calculate precisely what they were responding to. Parallel to this, we noted the inherent lack of detail provided by the transcripts we referred to alongside the video observation: much of the information that conveyed client and therapist engagement was conveyed via tone, body language, and other neuroceptive factors that are difficult to quantify.

We also noted the systemic implications of empathic listening in a couple therapy context. In some segments, the therapist would redirect to the partner with use of an exploratory behavior and continue the empathic listening process with them. In one instance we saw the therapist return again to the original partner, continuing the empathic listening process even when one partner had reached a point of resolution or activation of the PNS. While we were unable to observe enough instances of this to draw clear inferences or decision points, we decided to update the model to illustrate this systemic behavior.

In observing segments where the PNS was not activated, we saw confirmation of our previous observations; these segments were brief, and therapists were directive and seemingly agenda-driven. We also identified a shared perception, supported by RSA data, that therapists in these segments exhibited some markers of anxiety or nervousness in their body language (fidgeting, high energy) and tone, which may have contributed to their directiveness and impaired responsiveness to the client's emotional presentation.

Refined Discovery-Oriented Model

In this adapted model, which is more reflective of the intuitive, dynamic and cyclical reciprocity of empathic listening, the attuned therapist enquires into the client's emotional experience, and the client's response communicates their (a) perception of safety and (b) contact with their primary emotion/s. The attuned therapist perceives this and responds with safety-promoting interventions or emotion-exploring behaviors as necessary. This process continues until the attuned therapist perceives that both safety and contact with the primary emotion are high and that the intervention has reached a natural point of resolution, and then summarizes or redirects to another intervention (refer to Figure 3).

Figure 3

Rational-Empirical Model
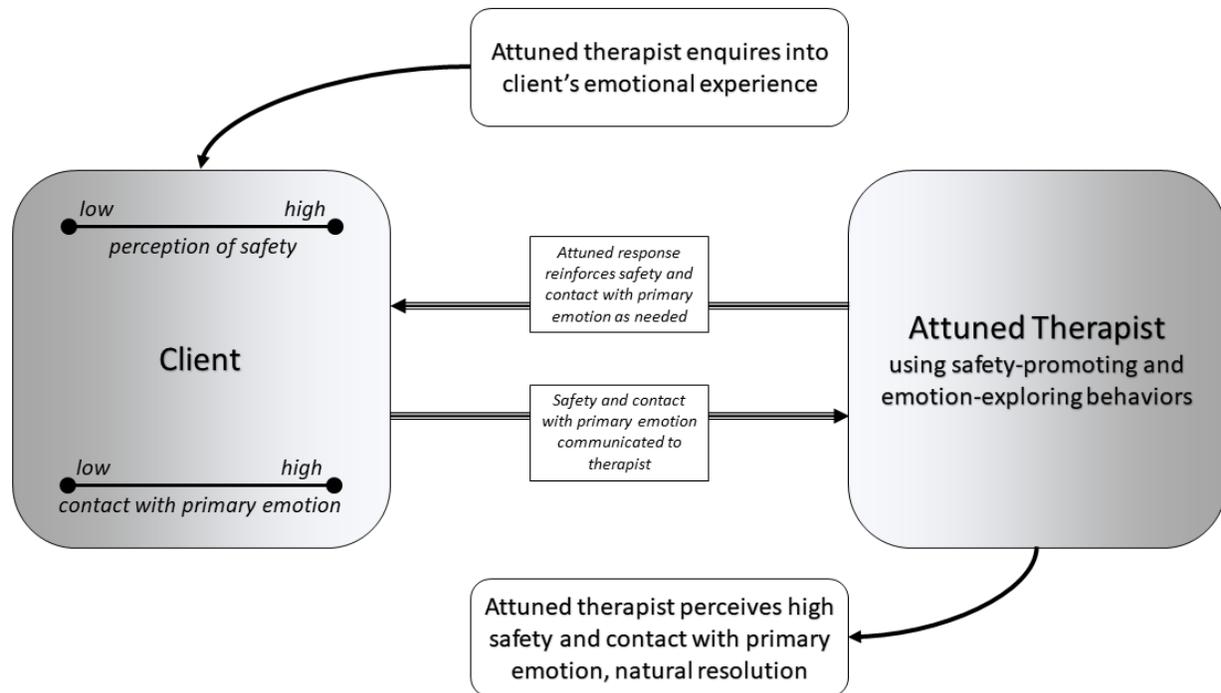
Rational-Empirical Model, Phase 3

A third round of observation indicated that we had reached saturation in that all our observations were confirmed, and we were unable to identify observations that could not be explained by the previous model.

Discussion

Clinical Implications

The clearest implication from these results is that empathic listening requires patient, genuine engagement from the therapist, who is attuned to the client's sense of safety and contact with their underlying emotional experience. In segments where the PNS was activated, the process unfolded over several minutes, and the client spoke far more than the therapist did. In segments where the PNS was not activated, the therapist was more directive, often resulting in a

minor emotional disclosure followed by redirection to another intervention. Therapists in training should consider their engagement with the process and allow time for the client to process their underlying emotions, whilst supervisors could highlight the importance of pacing and allowing space for the client. The results also suggest that therapist training programs could emphasize the importance of validating behaviors, as these were prominent in successful segments.

We were unable to observe or infer common behavior-response relationships in successful segments; instead, therapists appeared to use intuition and attunement to infer the client's state and respond accordingly. We would not recommend that therapists try to delineate or model specific pathways or decision points – the complicated processes of attunement implied by polyvagal theory renders this ambition both unrealistic and potentially distracting from the process, potentially increasing anxiety and distraction in novice therapists. Instead, polyvagal theory encourages us to incorporate our neuroceptive assessment of the client's emotional state, and then dynamically adjust our empathic listening responses accordingly. Reflecting on and practicing skills related to empathic listening behaviors outside of therapy sessions will increase the efficacy of dynamic responses within sessions.

Our observations suggested that the effects of therapist anxiety were related to increased directiveness and decreased emotional engagement/attunement. Therapists in training should attend to their anxiety and reflect on how it inhibits their neuroceptive processes and decreases the client's perception of safety in session. Management of therapist anxiety should be a core component of therapist training programs (Shamoon et al., 2017). Rogers suggests that therapist anxiety may be relieved as the therapist cultivates a genuine interest in the client's experience and well-being (1961).

We also observed that in some successful segments, the partner who experienced activation of the PNS was not the partner to whom the initial emotional inquiry was directed, and that therapists intuitively redirected exploratory behaviors between partners. While specification of systemic processes between the therapist and both partners is beyond the scope of this project, it was clear that empathic listening processes were frequently applied to both partners in successful segments (an adapted model, Figure 4, represents this dynamic process). In relational settings, therapists should attune to both partners and monitor each partner's emotional state, redirecting their interventions as necessary. Therapists can also be aware that empathic listening directed at one partner can potentially increase perceptions of safety and emotional engagement for both partners in therapy.

Figure 4

Rational-Empirical Model, Partner Included
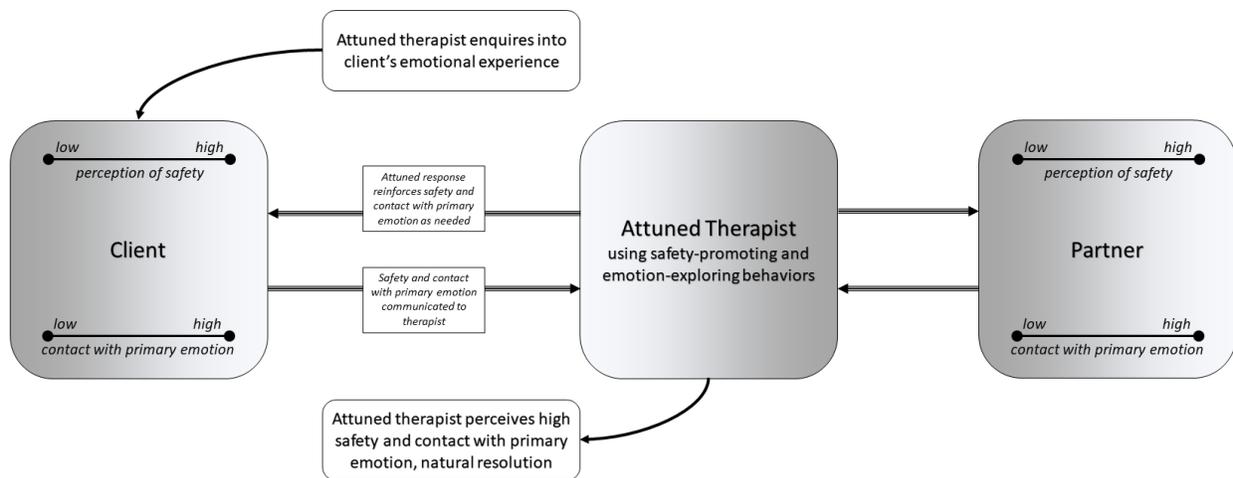
Limitations

Although this study was conducted in a couple therapy environment, the focal point of the research relates to individual clients' perceptions of safety and emotional engagement. While we witnessed various types of interactions from and between both partners in observed segments, the complexity of these processes transcended the parameters of the research environment and

we are therefore unable to specify how systemic processes related to both partner's perceptions of safety and emotional engagement. For example, Figure 4 represents our observations in successful segments of the therapist dynamically applying empathic listening behaviors to both partners, but as we did not specify this systemic pattern in the rational model or identify it in all successful segments, I only offer this as a potential finding highlighting future research opportunities. Other inter-partner effects may also affect our findings; for example, client perceptions of safety may relate to whether they are observing or participating in empathic listening processes, or to the type of content being discussed. The complexity of systemic therapy provides numerous opportunities for further process research and task analysis projects.

I am also mindful of other potential limitations related to the research. The sample comes from a single university clinic, and all recorded therapy sessions were conducted by student therapists. Whilst these findings are particularly relevant to therapist training programs, caution should be applied in making inferences about their relevance to more experienced therapists or other treatment settings. The specific procedures and equipment required to record sessions and client physiology may have also impacted clients' (and therapists') safety and comfort levels.

During our segment review, we identified the benefit of reviewing multiple segments to distill and reinforce our findings. Although we had more segments to utilize than previous landmark task analyses (Aspland et al., 2008; Bradley & Furrow, 2004; Furrow et al., 2012; Swank & Wittenborn, 2013), I would stress the importance in future research to acquire and utilize numerous successful interventions across multiple settings and therapists to identify and increase the generalizability of key therapeutic tasks.

We also noted in our observations that we could not perfectly delineate 'good' vs 'bad' examples – as empathic listening is a complex and multi-faceted process and we vary in our

engagement with it, we could identify instances of safety-promoting behaviors in 'unsuccessful' segments, and vice-versa. As physiological measures mature, I believe it would be interesting to analyze entire sessions to identify instances of safety-promoting and disengaging behavior from the same therapist within the same session to isolate effective behaviors.

Finally, in traditional task analysis studies, behaviors and choice points are often clearly delineated. After protracted discussion and reflection, we found it impossible to describe and model clearly delineated pathway of behaviors and responses due to the dynamic and intuitive nature of empathic listening. While the concept of neuroception is theoretically sound and heuristic to practicing clinicians who rely on intuition and subliminal perceptions to guide therapeutic interventions, it also explains the difficulty of quantifying and defining common patterns and responses. As researchers in this study, we ultimately found ourselves relying on neuroceptive processes to observe and assess empathic listening processes, finding that our neuroceptive assessments consistently aligned with each other and with clients' perceptions of safety and engagement demonstrated via RSA in recorded segments. We identified neuroception as an important therapeutic tool comprised of mechanisms and sensors that were beyond our ability to consciously recognize and describe.

Indeed, one might say that these findings support the view of therapy as an art form, incorporating elements that are often beyond our conscious awareness. It is also possible that research on therapist decision-making based on attunement and neuroceptive processes has been limited due to measurement constraints and a historical emphasis on clearly delineated relationships in behavioral research. With this view, I hope that this study may register as an initial step towards future research efforts to investigate and describe these hidden, critical elements of the therapeutic process.

Conclusion

It is difficult to identify any therapeutic component that is more important than the client's perception of safety in the relationship; it is critical to the alliance and supports the client's ability to process emotional experiences. Empathic listening behaviors promote safety and emotional engagement, and are accessible even to therapists in training. A lack of research focusing on these behaviors may be explained by the difficulty of delineating and describing dynamic processes, yet task analysis has afforded us a more comprehensive understanding of empathic listening whilst also acknowledging its reliance on intuition and neuroception. Future observational research on the core processes of psychotherapy could help us further recognize their value and illustrate their best practices.

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