

Imago Relationship Therapy and Accurate Empathy Development

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Fourteen individuals participated in Imago relationship therapy (IRT) group training and intervention. The sessions were carried out at a public institution of higher education in the southwest and facilitated by a certified Imago therapist. The study followed an experimental–control group design. Findings indicate that while accurate empathy responding remained low, as well as constant, across time in the control group, participation in the IRT sessions strongly increased one's ability to accurately empathize with their partner/spouse. This study provides strong evidence for a theoretical goal of IRT, namely that it improves accurate empathic responding for individuals who have received the intervention.

KEYWORDS couples counseling, empathy, Imago therapy

INTRODUCTION

The development of empathy within the individual is heavily influenced by early and significant, socializing relationships. As noted by Swick and Freeman (2004), caring societies begin with peaceful and loving interactions between the parent–infant, the parent/caretaker–child, and family members. These relationships remain the most powerful influence of caring potential (Swick, 2005). Although developmental psychologists and attachment scholars have long observed foundational roots of empathy in infancy, as well

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as the significance of early relationships (Goleman, 1995; Hoffman, 2000), far too often positive and nurturing relations are disrupted, inconsistent, or in some cases, nonexistent. During early, formative years and critical developmental periods, threats to emotional security and consistent, nurturing relational bonds can heavily and negatively impact the developing child (Booth & Amato, 2001; Brazleton & Greenspan, 2000; Harold, Shelton, Goeke-Morey, & Cummings, 2004). Children whose emotional needs are significantly frustrated or neglected and who lack a sense of security in love, protection, or value are more likely to demonstrate emotional insensitivity to others. In many instances, empathy development and caring potential is thwarted and replaced by self-destructive or anti-social behavior (Karr-Morse & Wiley, 1997), emotional issues (Swick, 2005), low academic achievement (Harold, Aitken, & Shelton, 2007), and even physical illness (Cherlin, Furstenberg, & Chase-Lansdale, 1991).

In the therapeutic professions, Carl Rogers is credited as the most influential contributor of the empathy construct within a helping relationship (Bohart & Greenberg, 1998; Teich, 1992; Wispe, 1987). As a result of his work, the examination and establishment of empathy as a core condition to therapeutic progress emerged during the 1960s (Berenson & Carkhuff, 1967; Carkhuff, 1969a, 1969b; Truax & Carkhuff, 1967) and remains an essential and foundational component of counseling relationships, mental health intervention, clinical progress, and psychological adjustment (Adams & Juhnke, 2001; Barak, Engle, Katzir, & Fisher, 1987). Rogers' definitions reflected several key ideas: (a) empathy involves an accurate cognitive and emotional understanding of the internal frame of reference of another. The helper does not lose one's self through identification but rather empathizes through an "as if" position (Rogers, 1957, p. 210), and (b) the judge of empathy accuracy is the helpee who also guides the helper in the relationship (Rogers, 1975).

This construct is equally important and foundational to Imago relationship therapy (IRT). As part of the couples' dialogue process, each partner is asked to imagine the cognitive and emotional experience of the other, to feel what their partner feels, and to communicate this understanding to their partner. Similarly, each partner checks in with the other to ensure that their understanding is accurate. Without expressions empathy, self-protection, reactivity, and self-absorption tend to increase during couple conflict. Accurate expressions of empathy help to dissolve emotional symbiosis, restore emotional safety, and relax defensive responding in each individual (Clinical Instructor's Manual, 2003; Hendrix, 1988).

EMPATHY AND IMAGO RELATIONSHIP THERAPY

Johnson and Greenberg (2010) have documented the habitual patterns through which adults interact that mirror early response patterns to

separation distress. When counseling couples, they conclude that the foundational needs of emotional security must be addressed before addressing more practical conflicts and issues (Johnson, 2008). IRT is congruent with this concept and works to establish connection and safety between the couple before problem solving. Emotional safety is essential for empathy between individuals.

Based on a synthesis of attachment theory, object relations, developmental psychology, transactional analysis, and behavioral change techniques, IRT was developed by Hendrix and Hunt as an integrative, relational approach for couples (Hendrix, 1988, 1992). The Imago view of human nature is that we are born connected, relational, and preempathic. Through the process of parenting and socialization, secure, relational bonds are ruptured in varying degrees and during key developmental stages, resulting in emotional symbiosis, defense adaptations, and unconscious, internalized self-rejection. No one escapes childhood unaffected, undefended, and blocked in varying degrees; thus, this is the human condition. Compensatory behaviors, while offering relief, cannot heal relational wounds or reset human development; therefore, the greatest potential for healing and progressing comes through relationship. In the Imago view, it is ultimately the practice of receiving and offering the caring and love that was needed during critical periods that connection and wholeness is restored (Clinical Instructor's Manual, 2003; Hannah, Luquet, & McCormick, 1997; Hendrix, Hunt, Hannah, & Luquet, 2005; Luquet, 1996).

While substantial evidence supports the importance of empathy on the part of the helper, IRT asserts that healing and growth opportunities in committed, romantic partnership outweigh opportunities afforded through an objective helper. Essentially, IRT places partners in the role of one another's helper as the true therapeutic agent, with interventions that resemble core conditions and skills used by counselors and therapists within the therapeutic context. Given these conditions, a corrective experience can occur when partners' body responses are regulated, they are attuned to each other's needs, fear responses are modulated, and empathy is present (Siegel, 2007).

IRT has long posited that calming of the brain during dialogue processes through visualization and breathing processes allows deep connection and empathy to emerge (Hendrix, 1988; Luquet, 1996). Conditions that foster safety and connection may also have long-term effects on the brain's ability to maintain conditions for empathy. In a study by Rousseau and Beeton (2014), the brains of nine couples were scanned using quantitative electroencephalography (QEEG) before, during, and after 12 weeks of IRT. Individuals showed sustained significant effect in right brain systems involved with a sense of others, as well as in left brain systems involved in language processing, areas associated with a sense of others and empathy. These sort of sustained changes in interactions allows the brain to rewire itself for empathy rather than reactivity (Fishbane, 2013).

In *Getting the Love You Want: A Guide for Couples* (1988), Hendrix introduced the skill of couple's dialogue, which remains the cornerstone of IRT (Hendrix, 1992; Hendrix et al., 2005; Luquet, 1996). According to IRT, conflict and dynamics in the couple relationship create a close facsimile of early, wounding experiences associated with critical, relational, and developmental needs. These conflicts create opportunity for resolution through restored emotional connection (Hendrix, 1988, 1992). Through structured dialogue, each partner takes turns listening, mirroring back what they hear, and offering responses that demonstrate cognitive understanding, or validation, and emotional understanding, or empathy. These responses serve to restore an empathic connection in the relationship and to develop differentiation, or a sense of awareness and respect for each other's separateness, unique needs, and differences.

Hendrix describes communicating empathy as the most critical variable of the dialogue process. The use of empathy is foundational to couples' abilities to strengthen relational bonds; however, in addition to restored trust and intimacy in the relationship, individuation, personal development, and transformation are simultaneously developed in each individual partner (Clinical Instructor's Manual, 2003; Hannah et al., 1997; Luquet, 1996).

METHODOLOGY

The purpose of this study was to investigate the efficacy of IRT on accurate empathy development as defined by Truax & Carkhuff (1967). *Accurate empathy* is defined as a therapist's ability to understand and to accurately communicate this understanding to a client (Truax & Carkhuff). Through the couples' dialogue process, IRT places partners in a therapist-like role for each other; therefore, the researchers sought to assess accurate empathy response levels for each participant in a couple relationship.

A total of 14 adults—seven couples—were randomly assigned to one of two treatment groups in a pretest–posttest control group design. The experimental group received 4 hours of IRT training and intervention for 2 consecutive weeks. The control group received the training after the posttest was completed. The researcher examined whether adults who participated in 8 hours of IRT training and intervention scored a statistically significant higher mean difference on the *Empathic Understanding in Interpersonal Process* 5-level discrimination scale (Carkhuff, 1969b) between pretest and posttest compared with adults on a wait-list control group.

Participants

The sample was moderately skewed among racial/ethnic identity, educational attainment, and gender representation. The sample consisted primarily

of Caucasian participants, with 93% identifying as Caucasian and 7% identifying as Caucasian/Hispanic. Participants who indicated their educational level as “postcollege” comprised 71% of participants, while 29% attained vocational or associate’s degrees or attended some college. Regarding gender, 64% identified as female while 36% identified as male, 29% were engaged in a committed, same-sex relationship while 71% were engaged in a committed, opposite-sex relationship, indicating that the sample did provide some diversity in terms of sexual identity. All partners lived together regardless of marital status. It is important to note that same sex partners cannot be married in the state where the study was conducted.

The sample also provided diversity among participants’ ages and duration of relationship. Ages varied from 30 to 59, with 29% at ages 30 to 39, 43% at ages 40 to 49, and 29% at ages 50 to 59. The duration of relationship ranged from 6 months to 25 years, with 14% of participants together less than 1 year, 29% together between 1 and 4 years, 29% together between 5 and 10 years, 14% together between 10 and 15 years, and 14% together between 20 and 25 years.

Both the experimental and control groups consisted primarily of Caucasian participants with post college education. The average length of relationship for both groups was 8 years. Overall, the majority of participants were in their relationship for less than 10 years, while one-third of participants in the control group were in their relationship for over 10 years and one-fourth of participants in the experimental group were in their relationship for over 10 years. Half of the participants in the control group were in their 30s, while the other half were in their 40s. A small percentage of participants in the experimental group were in their 30s, a larger percentage in their 40s, while half were in their 50s.

More specifically, the control group was composed of three heterosexual, Caucasian couples; 83% indicated their education level as postcollege. The average length of relationship in the control group was 8 years, with 67% in their relationship from 0 to 9 years and 33% for 10+ years. Ages ranged from 30 to 46 years, with an average age of 37. In addition, 50% of individuals were in the age bracket of 30 to 39 and 50% were in the age bracket of 40 to 49.

The experimental group was composed of four couples; 87% of participants identified as Caucasian and 13% identified as Hispanic, and 75% indicated their education level as postcollege, with 25% indicating an associate’s degree or vocational school. Half of the participants were in a same-sex relationship, while the other half were in opposite-sex relationships. The average length of the relationship for the experimental group was also 8 years, with 75% in their relationship between 0 to 9 years and 25% for 10+ years. Ages ranged from 35 to 59 with an average age of 49 years. In addition, 13% of individuals were in the age range of 30 to 39, 38% were 40 to 49, and 50% were 50 to 59.

Instrument

Developed for research, the *Truax Accurate Empathy Scale* is a measure of empathy based on Carl Rogers' definitions. It was designed to be used with recorded or live observations of sessions to assess a counselor's ability to demonstrate accurate empathy. A 9-point scale is used to assess low to advanced levels for each condition. Based on the Truax measure, the researcher used Carkhuff's modified *Empathic Understanding in Interpersonal Process* five-level discrimination scale to assess partners' empathy levels pre-IRT and post-IRT (Carkhuff, 1969b):

- Level 1—Partner's verbal/behavioral responses do not attend or detract significantly.
- Level 2—Partner verbal/behavioral responses attend but detract noticeably.
- Level 3—Partner responses express essentially the same affect and meaning.
- Level 4—Partner responses add noticeably to express feelings deeper than the partner was able to express.
- Level 5—Partner responses add significantly to accurately express feeling and meaning beyond what the partner was able to express or to be fully with their partner in the partner's deepest moments.

Although numerous inventories currently exist to measure empathy, reflecting both a diversity and lack of consensus regarding its definition (Chlopan, McCain, Carbonell, & Hagen, 1985; Duan & Hill, 1996; Gladstein, 1983), the researcher selected the instrument for the following reasons: (a) it is historically relevant and appropriate to professional counseling, (b) it was designed to be used with recordings or live observations of sessions by objective, observer raters versus self-report, and (c) it measures the ability to accurately understand both the internal cognitive and emotional experience of another through an interpersonal relationship, such as the couple. The scales (Carkhuff, 1969a, 1969b; Truax & Carkhuff, 1967) remain a basis for more recent investigations into the measurement of empathy (Barone et al., 2005) and have also been adapted to facilitate and measure deeper meaning response skills in play therapy training (Garza, Falls, & Bruhn, 2009).

Many studies have been conducted documenting the reliability of the accurate empathy rating scale (Truax, 1961, 1962; Truax & Carkhuff, 1963). The intraclass reliability for the aforementioned studies ranged from 0.69 to 0.89. According to Nunnally and Bernstein, reliabilities of 0.80 indicate expected levels of reliability when conducting between group research, and 0.70 indicates moderate levels of reliability. Thus, the reliability levels achieved in this study appear to demonstrate acceptable levels for between-group research.

Shapiro (1968) measured ratings of therapy samples using the accurate empathy rating scale and a 7-point semantic differential rating of understanding/not understanding, and achieved a significant correlation of 0.67. Furthermore, Lister and Truax (1970) conducted a study to measure ratings of accurate empathy with the Porter (1943) scale. The scale found no significant correlation between the accurate empathy rating scale and the interpretative or evaluative scales. Both of these scales pairings are nonrelated concepts, and as such, the results provide supporting evidence for divergent validity of the instrument. Furthermore, a study by Truax et al. (1966) indicated that the instrument had divergent validity with nonpossessive warmth, and a study by Truax, Carkhuff, and Kodman (1965) indicated divergent validity with genuineness, indicating that the instrument can vary significantly from these divergent concepts and strengthens the evidence for the construct validity of the instrument.

Without knowledge of group membership or pretest/posttest status, three raters individually scored 10% of the sample to establish a baseline of interrater reliability. On completion, the raters achieved a perfect agreement for 87.5% of ratings. The raters proceeded to score half of the sample individually. On completion, another interrater perfect agreement percentage was calculated at 83.3% agreement.

Hallgren (2012) states that simple percentages of agreement between raters are frequently not sufficient for interrater agreement. To provide a more full exploration of the reliability and agreement of raters, intraclass correlation coefficients (ICCs) were correlated for the three raters. As all raters completed ratings of every participant, a two-model of ICC was conducted using SPSS. Of primary interest is the ICC for the average measure as the analysis took the mean of the three raters for statistical analysis, but both individual and mean ICCs will be reported. The ICC for the individual raters measure is 0.79, and the ICC for the average measure is 0.92, indicating excellent interrater reliability.

Procedures

Before the intervention, participants were instructed to participate in a 10-minute recorded conversation with their partner/spouse pertaining to a relationship conflict or issue. No other instruction was provided in order to obtain a sample of conversation representative of natural communication for both participants. Both members of the couple were assigned an individual accurate empathy rating based on their responses throughout the conversation.

On completion of recordings, couples were randomly assigned to one of the two groups. The experimental group consisted of participants who

received 8 hours of IRT during the first 2-week period. The control group consisted of participants who were placed on a waiting list and received no treatment intervention until the second 2-week period. All participants were instructed to participate in a final 10-minute recorded conversation with their partner/spouse pertaining to a relationship conflict or issue. For the control group, this occurred before treatment intervention, and for the experimental group, this occurred on completion of treatment intervention. The first 10-minute conversation was the pretest, and the second 10-minute conversation was the posttest.

Participants completed two 4-hour IRT sessions in a group format. Sessions were facilitated by a certified Imago relationship therapist. Sessions consisted of educational training followed by practice and intervention assisted by the facilitator. All training and intervention practices followed protocol outlined by Hendrix (Clinical Instructor's Manual, 2003; Luquet, 1996).

Before conducting the analysis, the data were screened for assumptions of normality, skewness, and kurtosis. The researchers conducted the Shapiro-Wilk test of normality as well as visual analysis of Q-Q plots and histograms, which indicated that the normality assumption was met. Skew and kurtosis values were within normal limits indicating the data were appropriate to analyze. After normality, skewness, and kurtosis were investigated, the results of the accurate empathy rating scales were analyzed using a split-plot ANOVA (SPANOVA), to assess the impact of the intervention across two time periods (pretest and posttest).

RESULTS

Results of the SPANOVA indicated that there was a statistically significant interaction between group and time, Wilks $\lambda = .029$, $F(2,12) = 402.94$, $p < .005$, partial $\eta^2 = .971$. This indicates that the degree of accurate empathy across time differed between the control group and the experimental group. The interaction graph (Figure 1) suggests that both groups were similar at pretest in their ability to demonstrate accurate empathy but that the control group showed little change across time when not receiving treatment, whereas there was a significant increase among the experimental group in the ability to demonstrate accurate empathy. This indicates that while accurate empathy tends to stay the same across time, when individuals participated in IRT sessions, their ability to accurately empathize with their partner was greatly increased.

A post-hoc power analysis was conducted to determine the power of this individual-level analysis. The analysis was conducted using the power-analysis software G*Power with the formulas for a repeated-measures ANOVA with between and within interactions. For the calculation, an effect size of 0.971 was used, a statistical significance of .05, and a total sample

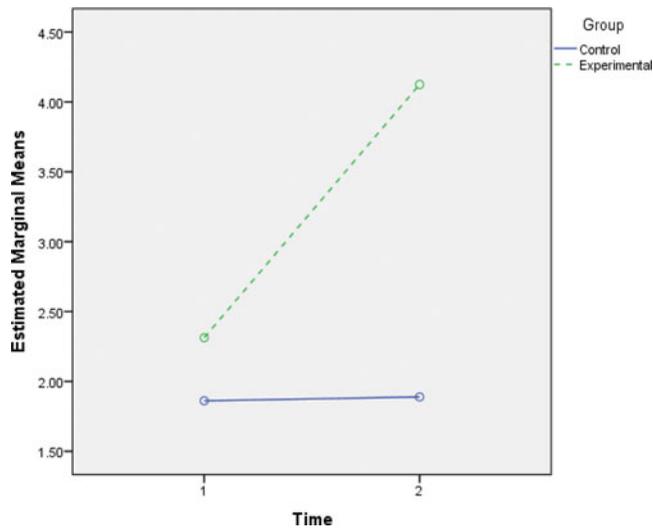


FIGURE 1 Accurate empathy measures for couples participating in the control group and Imago therapy session.

size of 14. This yielded a power of 0.85, which would indicate a sufficient amount of power to interpret the data.

When asked to discuss a conflict or issue at pretest, no individual exceeded level 3 responding on the Empathic Understanding in Interpersonal Process scale. All participants' accurate empathy responding levels were assessed on a range of levels 1 to 3, with a statistical mean and mode of level 2. According to Carkhuff (1969b), a level 3, where an individual is able to demonstrate essentially the same affect and meaning as their partner, is the *minimum* level for facilitative, interpersonal communication. At posttest, participants in the control group responded at the same levels as their pretest, with some continuing to respond at level 1 or 2. In contrast, participants in the experimental group increased their accurate empathy responding by an average of two levels, resulting in an accurate empathy level of 4 or 5, indicating empathy, which not only accurately captured the meaning of their partner's message but also provided additive empathy. These findings reflect significant gains in participants' abilities to convey understanding and meaning beyond what their partner had shared.

Furthermore, not only was the change statistically significant, but it yielded a large effect size, with a partial η^2 of .97. This large effect size was found in the interaction effect between time and group membership. There are two important interpretations of this result: first, the change in the groups could not be attributed to the passage of time alone, and second, as Figure 1 shows, it was participation in IRT that generated a large change in accurate

empathy among the experimental group, as opposed to the control group, which demonstrated almost no change.

DISCUSSION

This study yields several results that are of importance for the couples counseling field. First, the study is one of the few between-groups experimental studies that has been conducted for IRT. Although IRT has some degree of research (Hannah & Luquet, 1997; Hannah et al., 1997; Hogan, Hunt, Emerson, Hays, & Ketterer, 1996; Luquet & Hannah, 1996; Schmidt, Luquet, & Gehlert, *in press*), there is a need for randomized, between-group studies or large time-series design studies for an intervention to be truly viewed as an empirically supported therapy. Second, the study provides strong evidence for a theoretical goal of IRT; namely, that it does, in fact, improve accurate empathic responding for individuals who have received the intervention. At pretest, most participants did not express empathy adequate to facilitative communication with their partner, yet after training and practice in IRT, participants in the experimental group increased their accurate empathy levels during discussion of a conflict or an issue. This observation is important in that the natural tendency between partners in conflict is toward negative escalation or withdrawal (Gottman & Schwartz-Gottman, 2008). When empathic responding is needed most, self-protective or defensive responding is usually heightened; a tendency that was observed in the pretests of both groups. Some examples include:

1. I don't know what else to say. I mean that's a disagreement. It's not like we're going to resolve it sitting in here.
2. You get upset regardless of what I say.
3. You're basically walking me into a two-way damned if I do, damned if I don't, situation.
4. I'm not justifying my behavior by all means, but that's just me, you know. When things are too hard I just cut and run.
5. I don't understand how one little bitty item makes that big of a difference. You should be glad I'm with you, not because I'm wearing a ring.
6. I hear you say you can't use the sink. I guess from my point of view I'm over here going, well, yeah, you can.
7. Your facts. Not mine.
8. The things you say to me hurt me just as much. I just bombard you all at one time. You give me a little bit at a time.

In contrast, the experimental group participants' responses observed in the post-test reflected a demonstration of empathic responding. Some examples include:

1. For you there's a big sense of being hopeless.
2. You have a big fear about getting back on a medication and that it might be an issue because of the abuse history. And that's pretty scary for you. You're also feeling that it might potentially cause an issue with us.
3. You just wanted to know that your parents were engaged or interested in what you were about as a child. You wanted time spent together and you wanted it to be meaningful and to not feel dismissed.
4. You're concerned about how I interact with him when he has something he wants to show me or tell me. And what the long-term effects of that are going to be if he feels dismissed or like he's not important.
5. I can understand why that would make you afraid and scared and probably pretty anxious. And I would imagine it makes you probably nervous. It all makes tremendous sense to me.
6. I just want you to know that it makes sense to me that when I get upset that you can think we're over. Every sense of safety was threatened for you, because in reality you really had no idea what was causing your mother to leave you or to hand you over to your grandparents. So it makes perfect sense—you wouldn't have any idea what will be the thing that breaks me and makes me say, 'I'm out of here.'

In addition, some moved toward a resolution to the problem in a mutually supportive manner. Some examples from experimental group posttest observations include:

1. I can understand where you're coming from, which makes it easier, you know, at least to even talk about it. And I think we've come to some common ground that we weren't able to come to before.
2. That makes sense. I understand that. It's something that I do struggle with. And I think there's a few things we could incorporate to make that go smoother.
3. If I'm hearing this correctly from you it doesn't mean there is a loss of connection. You are trying to formulate and say things because you are not wanting to wound. So for me, to also maybe again recognize that I assume a wound is intended.
4. And as we've talked about before, giving me the space to formulate something internally before I speak it, whereas you do all your formulating verbally.
5. Even though I don't have depression and anxiety issues they do make sense to me. I can definitely empathize with that. With that said, we still have to find a solution to that because nobody needs to live with that.

These statements are indicative of the beginnings of deeper neurological processes occurring in the limbic system and prefrontal cortex. Recent advances in neurosciences have described how mirror neurons in the brain

are triggered when witnessing emotions in the other. Mirror neurons stimulate the Insula, located in the middle prefrontal cortex, and the observer begins to feel a similar emotion as the sender of the message through a process called interoception. The prefrontal cortex then begins to interpret that the emotional experience is not centered within the observer and attributes the emotion to the other. When given a dialogical structure, the observer is able to feel the feelings of the other without getting lost in their internal state (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003; Siegel, 2012).

Limitations and Recommendations

While this study yields promising data in support of the development of empathy within members of a couple relationship, there are several study limitations that include sample size, sample diversity, and duration of treatment. Larger studies will be necessary to generalize results to populations that include broader racial/ethnic, educational level, and gender diversity. Such studies will require the involvement of multiple certified Imago therapists, who tend to be scarce in certain regions, as was the case in this study. In addition, the duration of treatment in the study was limited to 2 weeks. Studies that target IRT intervention over time, in a therapy, group, or a workshop format, can aid further investigation into short- and long-term effects on accurate empathy development for members in a couple relationship in addition to exploration of IRT as an evidence-based model.

Of most concern is the dissipation of effect that occurs in most therapeutic and skills-based couples interventions post treatment (Synder & Halford, 2012; Snyder, Wills, & Grady-Fletcher, 1991). While a meta-analysis of MFT interventions found that the average individual receiving treatment for couple distress was better off at termination than were 80% of those in the no-treatment control group (Shadish & Baldwin, 2003), there is typically some noticeable loss of therapeutic gains made during therapy. This calls into question whether learning skills in a short-term model are sufficient or if there is a need for consistent contact with, and use of, the skills until they become habit. Those using skills-based models such as IRT may want to consider booster programs (Christensen & Heavey, 1999) to help integrate gains. Overall, short-term skills-based couples interventions have been found to be effective for couples communication and relationship satisfaction (Halford & Snyder, 2012).

In addition, these findings do not reflect accurate empathy responding across all situations and are limited to empathy responding with one's partner/spouse, therefore, inclusion of widely-used, self-report measures such as the Interpersonal Reactivity Index (Davis, 1980) or Hogan's Empathy Scale (HES) (Hogan, 1969) can bolster psychometric support and enhance the data with multidimensional or generalized constructs of empathy versus the singular, quality of accurate empathy within an interpersonal relationship.

Last, due to the small numbers of participants, findings are preliminary; however, with 29% of participants engaged in same-sex relationships and diverse representation across participant age (30 to 59 years) and duration of relationship (6 months to 25 years), there are indicators that individuals in same-sex couple relationships, in both newly formed and long-term relationships, as well as from various ages and life stages can develop empathic responding through participation in IRT.

One area of future research would be to investigate neurological changes derived from dialogue and empathy using more sophisticated functional magnetic resonance imaging technology. Recent research at Princeton University on two individual in conversation in two functional magnetic resonance imaging scanners shows a brain coupling occurring when the receiver understands the message of the sender, as opposed to a disconnection of brain activity when the sender speaks in a language unknown by the receiver (Hasson, Ghazanfar, Galantucci, Garrod, & Keysers, 2012). Similar studies using couples in dialogue could be conducted in an effort to understand empathy between couples and the short- and long-term neurological effect of empathic connection.

Finally, future researchers ought to consider inclusion of the couple as a unit of analysis. This will provide a systemic examination of participants' interactions along with data regarding how participants' scores relate to each other; for example, if one's partner's ability to empathize increases, does the other partner's ability also increase? If one's partner's empathy does not increase, does the other partner's empathy also tend not to increase?

Implications

As IRT has become one of the well-established contemporary models of couples therapy (Helmeke, Prouty, & Bischof, 2015), it is important that a variety of research studies testing its theory and practices are conducted to show its efficacy in working with couples. The results of the present research are promising and imply that the methods of the model work to increase accurate empathy responses for participants in the short term. Skills taught to both members of the couple allowed empathy to emerge in a safe and regulated space and to be interpreted and responded to accurately by the partners. Future research should be conducted with a larger sample and over a longer period of time to see if the changes are sustained.

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