By Adam Gerace MAPS

The power of empathy

Empathy is generally considered indispensable to the therapist-client relationship. In his 1957 highly influential paper, 'The necessary and sufficient conditions of therapeutic personality change', Carl Rogers discussed the role of empathy in bringing about positive client change:

To sense the client's private world as if it were your own, but without ever losing the 'as if' quality – this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavouring to describe (p. 99).

In this article, I discuss why empathy is important in the therapeutic encounter regardless of specific techniques, the ways in which it emerges and is used in therapy, and finally how psychologists can build – their empathy skills.
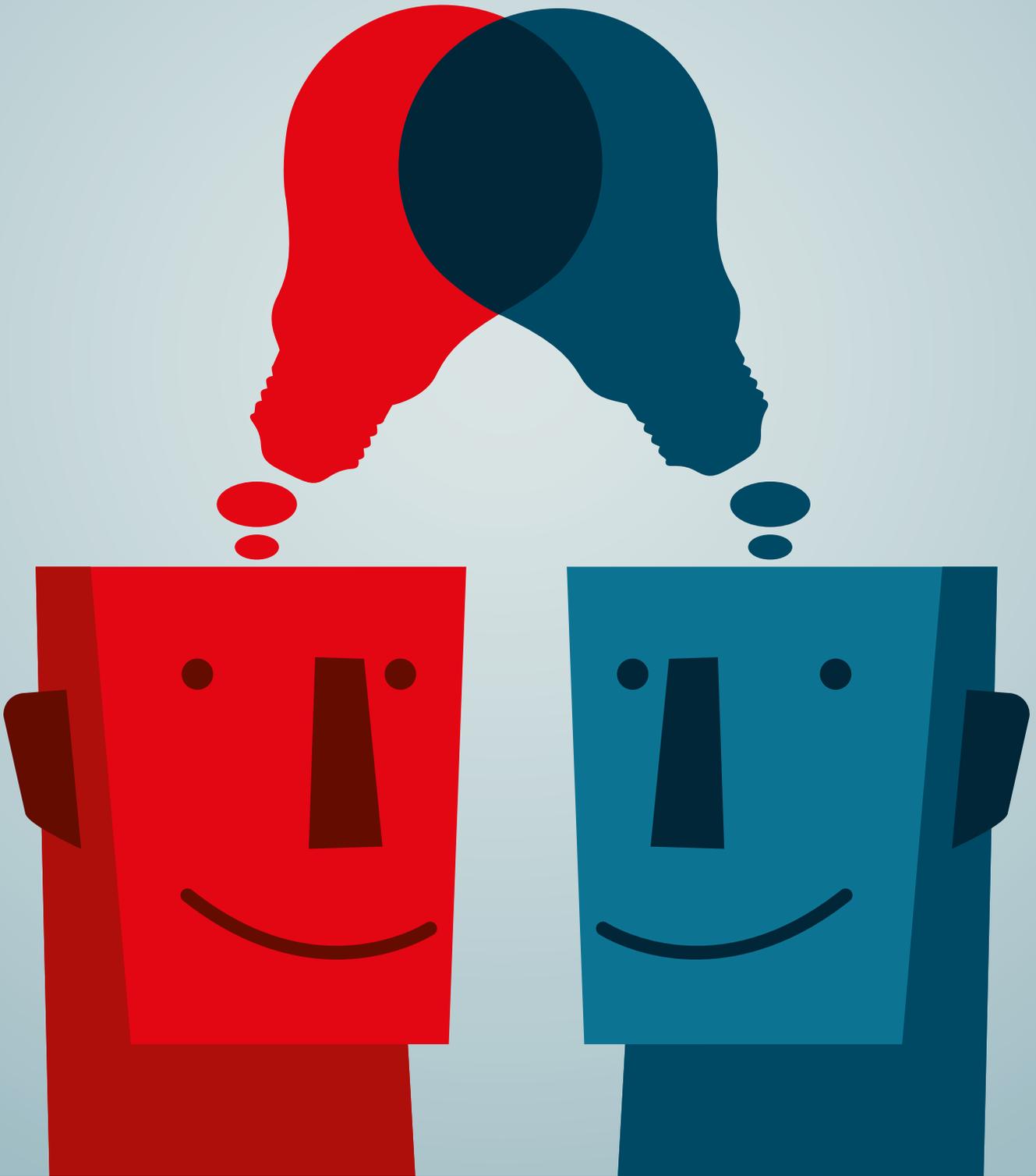
"In some ways, across psychology, empathy has been put in the 'too-hard basket' to understand, with it "frequently underestimated or misunderstood in terms of its therapeutic potential and range of application in a treatment situation" (Clark, 2013, p. xii).

From a client perspective, empathy in therapeutic settings is seen to involve the client feeling "understood, accepted, and prized in a way that is meaningful to that particular client" (Lambert & Barley, 2001, p. 359). However, for a concept as prevalent in therapeutic, as well as everyday discourse, there remain fundamental questions regarding its nature, development, and practice in therapist-client interaction. Rogers, himself, later felt that his methods and approach, in particular the idea of nondirective therapy and the importance of the therapist's reflection on the client's emotions, were misunderstood and caricatured as an approach where therapists merely "repeat the last words the client has said" (1975, p. 3). In some ways, across psychology, empathy has been put in the 'too-hard basket' to understand, with it "frequently underestimated or misunderstood in terms of its therapeutic potential and range of application in a treatment situation" (Clark, 2013, p. xii).

What is empathy?

The concept of empathy has a long history in psychology, with Edward Titchener generally believed to have been the first (or one of the first) within the discipline to have substituted the German term *einfühlung* for the English-language *empathy* in the early 20th century. However, for much of its systematic investigation in our discipline over the ensuring century, definitional clarity has alluded what we mean when we talk about empathy.

The term generally, though sometimes controversially, refers to two constructs. The first involves the process of placing oneself into another person's shoes, referred to as perspective-taking or role-taking. This is the closest to Rogers' (1957) definition of empathy. The second construct involves the experiencing of emotional reactions to the other person's situation, often referred to as emotional empathy or empathic concern, with related concepts such as compassion and sympathy included (depending on the theorist) under the emotional empathy umbrella.

However, there are questions as to whether empathy is a trait or state; how perspective-taking relates to empathic emotion; how we actually engage in perspective-taking; and whether the nature of the emotion influences our behaviours and the experiences of the recipient of empathy.

Refining the construct

In an effort to bring clarity to this definitional ambiguity, Mark Davis (1994/2018) developed a model that organises an empathy episode into *four interrelated constructs*, with each construct in the liner model influencing later constructs, as well as adjacent constructs having the strongest relationship to one another.

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First in the model are *antecedents*, which include the empathiser's dispositional perspective-taking ability and tendency to experience emotional responses, the types of emotions the situation involves, and similarity between the empathiser and recipient of empathy. Based on my own research, I would also suggest that an important antecedent is the tendency for the empathiser to being able to self-reflect on their own previous experiences (Gerace, Day, Casey, & Mohr, 2017), as well as values and biases that will influence their taking of the other person's perspective (Gerace, Oster, O'Kane, Hayman, & Muir-Cochrane, 2018).

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The second construct within the model addresses the *processes* in which an empathiser might engage. These processes include unconscious behaviours (e.g., motor mimicry), those that are based on conditioned responses and, most important to the present discussion, the more voluntary and cognitively complex process of perspective-taking. We actually use a number of strategies to take another person's perspective, including imagining ourselves in their situation; utilising our own perspective, but adjusting our inferences to consider the other person's unique situation; reflecting on times we have experienced a similar situation to that of the other person; and making use of stereotypes or heuristics (rules of thumb) regarding how certain types of people feel in certain types of situations (Gerace, Day, Casey, & Mohr, 2013). As a result of empathic processes, the empathiser may experience both intrapersonal and interpersonal outcomes.

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The third construct, *intrapersonal outcomes* include empathiser affective responses, including where the empathiser experiences the same or similar affect to the other person (parallel outcome), or where the empathiser experiences affect that is a response to the other's situation, but is not necessarily the same or similar to that of the other person (reactive outcome). The latter include empathic concern, compassion, and sympathy to the other person, and even personal distress, where the emotion felt is aversive and more self- than other-focused. Reactive outcomes, mainly sensitive, concerned, and compassionate responses are denotative of the therapist's emotional reaction, rather than the experiencing of the same parallel emotions as their client (Greenberg & Elliott, 1997; Truax & Carkuff, 1967/2017).

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Finally, intrapersonal outcomes include a range of *interpersonal behaviours*; the most often investigated being altruism and helping (Batson, 2011). Research by Daniel Batson and his team over several decades has demonstrated that empathic concern motivates the empathiser to want to help the other person, while personal distress tends to inhibit such helping behaviours (Batson, 2011).

Davis' (1994/2018) model focuses on the empathiser's cognitions and feelings, but it is also important to consider how the empathiser (in the case of present discussion, the therapist) demonstrates their empathy to the client. When considering the client's experience, we can use the model in a similar way by considering whether the client believes that the therapist has attempted to take their perspective (process), is being compassionate (intrapersonal outcome), and is attempting to help them (interpersonal outcome). We can also examine the types of processes in which the client engages, such as therapist empathy leading to the client exploring their experiences. Outcomes for the client may then include development of self-awareness, understanding, and insight, and the ability to assimilate problematic experiences and feelings (Bohart, 2004; Greenberg & Elliott, 1997). While the therapist and client have their own separate and unique perspectives, therapist-client empathic processes also involve the therapist and client developing a shared understanding of the client's perspective and experience (Greenberg, & Elliott, 1997).

Why is empathy important?

According to Lambert and Barley (2001), we can attribute 30 per cent of client outcomes in psychotherapy to factors apparent across therapeutic approaches. These 'common factors' involve things about the therapist, the therapeutic alliance, and facilitative conditions, such as empathy, warmth, and congruence.

In a meta-analysis utilising studies from 59 samples and 3599 clients, the mean weighted effect size of the relation of empathy to psychotherapy outcome was .31, which indicates that empathy accounts for approximately nine per cent of variance in therapeutic outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). This relationship was strongest when therapist empathy was rated by the client (.32), followed by an outside observer (.25), and finally, the therapist themselves (.20). This means that a stronger predictor of therapeutic outcome is whether the client felt understood by the therapist, rather than whether the therapist felt they had acted in an empathic way.

While empathy is a facilitative condition of therapy, it is also an important part of the therapeutic alliance. A therapeutic alliance involves the therapist and client agreeing on the goals of therapy, collaborating on the specific tasks to be achieved, and sharing an affective bond (Bordin, 1979; Zuroff & Blatt, 2006). Empathy allows the therapist to build a therapeutic alliance by apprehending the client's perspective and goals, understanding their unique personality style and preferences, and communicating with them in an appropriate way. It also allows the therapist to respond in a way that builds client trust, non-defensiveness, experiences of less isolation in their experiences, and willingness to disclose during the working part of the therapeutic relationship (Forchuk et al., 1998; Greenberg & Elliott, 1997; Horvath, 2001; Lambert & Barley, 2001; Lemmens et al., 2017).

While empathy is important throughout therapy, it is a necessity in the early stages of a therapeutic relationship (Horvath, 2001). This is likely because of the importance of early connection and rapport when disclosing problematic issues or being acutely unwell. In a study by Zuroff and Blatt (2006), decreases in indices of maladjustment for clients with major depressive disorder were predicted by the clients' early ratings (during the second session) of the therapeutic relationship. In one of my own studies, which involved nurses (Gerace et al., 2018), one mental health nurse explained the buffering effect of empathy formed early in the relationship:

I'm not always going to be fabulously empathetic, but if I've buggered up the first few interactions with the person then not being completely empathic in that next situation is going to make things worse. If I've started well with my first interactions with the person, and I've developed that rapport, there may be some interactions where I'm not as empathic as I should be, it will still be okay (p. 100).

Empathy is not only important to the recipient of help. A recent systematic review supported the relationship between higher empathy in mental health professionals (nurses and medical professionals) and lower reported occupational burnout (Wilkinson, Whittington, Perry, & Eames, 2017). There are fewer recent studies examining empathy and burnout in psychologists. However, a study of psychologists and social workers (n = 532) reported that higher compassion satisfaction (positive appraisals of working with clients) was related to lower levels of compassion fatigue and burnout (Craig & Sprang, 2010).

How do psychologists use empathy?

Empathy emerges within the therapeutic encounter and involves both therapist-client interaction and internal processes in both the therapist and client. In an early influential approach to understanding therapist empathy, Truax and Carkuff (1967/2017) presented a nine-point scale that can be used to rate a therapist's degree and complexity of empathic response to their client. At lower levels, therapist responses are often an inaccurate interpretation of the client's feelings and there are few attempts to be in the moment with their client. At higher levels, the therapist demonstrates in the moment understanding of the client's perspective, attempts to adjust communication and voice accordingly, and responds in ways that help the client to explore, clarify, and explain their feelings and experiences.

Many of Truax and Carkuff's (1967/2017) points regarding therapist empathy are reflected in the later work of Greenberg and Elliott (1997). However, there are also notable differences. Greenberg and Elliott suggest that rather than levels, we can identify five forms of empathic responding, which are undertaken by the therapist at different times in their work with the client. These are understanding, evocation, exploration, conjecture, and interpretation.

Understanding involves the therapist attempting to take or apprehend their client's perspectives and to communicate this understanding. *Evocation* involves the therapist helping the client to bring forth and vividly experience their emotions and situation. *Exploration* involves the therapist facilitating the client to consider and focus on aspects of their situation that may have been hitherto less explored and considered. Finally, the therapist provides potential tentative analysis of the client's experience (*conjecture*) or new information to the client based on the therapist using his or her own perspective on what the client has experienced (*interpretation*).

Interestingly, Bohart (2004) contends that a rethinking of the dominant model of the therapist-client relationship is required. In traditional conceptions, Bohart believes, "the therapist's interventions operate on the client to produce change" (p. 103). In contrast, he believes that rather than the therapist's actions leading to client self-reflection, exploration, and processing of experiences, empathy allows "clients operating on therapists' interventions to produce change" (p. 106). For example, by a therapist discussing a deep thought, this stimulates the client to engage in deeper thinking of their situation. Similarly, repeating the client's words and thoughts back to them, while also bringing attention to the implications of these statements, allows the client to see their situation "from a different angle from before" (p. 111).

Exploring the model

While the clinical literature is replete with examinations of the empathic responses of therapists and clients' perceptions of therapist empathy (or lack thereof), it is largely silent on *how* exactly therapists experience empathy for their clients. My study with mental health nurses and patients in acute psychiatric units (Gerace et al, 2018) addressed this question. In this study, nurses and patients discussed a time when they experienced a conflict with their patient or nurse, respectively, such as a patient not wanting to take their medication or having self-harmed, or a patient feeling that the nurse was dismissive of their concerns.

Using the model by Davis (1994/2018) to interpret the findings, the overarching theme was the idea that the nurse's role involves a balance between maintaining patient safety or reducing risk and using empathy in the therapeutic encounter. Antecedents to the empathy experience included the nurse's ability to be empathic and self-reflect on their biases and values Empathy involved the nurse trying to understand the patient's perspective, which both groups acknowledged could be quite different to the nurse's or difficult to comprehend. One patient used the example of their auditory hallucinations to explain an empathic response: "She [the nurse] actually acknowledged that, although she couldn't hear the voices...for me they were a real experience at that point in time" (pp. 97-98).

Nurses found it useful to maintain clear awareness and differentiation of their own and their patient's perspective. This was apparent in their discussion of the internal perspective-taking strategies they used, such as imagining themselves in the patient's place and using their past experiences. Nurses enacted these strategies at a distance or used general past experiences, rather than looking for highly similar experiences that they had in common with the patient. Similar findings regarding lesser perceptions of similarity to clients were reported in an earlier study with psychologists (Hatcher et al., 2005).

Maintaining distinct perspectives was particularly important to regulating emotion. Nurses discussed feeling a range of emotions *for* the patient, such as feeling apprehensive, fearful, angry, and frustrated. However, if nurses felt that they were starting to feel the same emotions as the patient (so fearful instead of fearful *for*), they found it useful to remind themselves that this was the patient's experience and emotion and the nurse's task was to *help* them with these emotions and experiences.

Not surprisingly, patients did not focus on the internal experiences of their nurses. Instead, they described empathy as being demonstrated by the nurse "being there", which involved many of the skills that a psychologist would use in their day-to-day practice: spending time with the patient and letting them discuss experiences in their own time, listening, questioning, negotiation, providing choice, not being patronising, and the appropriate use of tone of voice and body language.

Overall, empathy was a way to resolve nurse-client conflict, but also to move patient's towards recovery and taking control of their lives again. These findings share much in common

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with a counselling model (Bayne & Hays, 2017), where empathy involves the practitioner's qualities (e.g., personality), internal (e.g., emotional distancing, exhaustion) and external (e.g., care restrictions, high numbers of patients) barriers, initial (e.g., listening) and genuine (e.g., understanding) empathic processes, the patient's experiences of empathy (e.g., receptivity), and results (e.g., patient engagement, success).

While psychologists would likely agree on the need to maintain clarity over therapist and client perspectives, some intriguing research has examined synchronicity in therapists and clients' verbal and even physiological responses. For example, studies have demonstrated that greater consistency in physiological responses in the therapist and client, measured using skin conductance, are related to client ratings of higher therapist empathy and an observer's perceptions of more positive therapist-client interactions (Marci, Ham, Moran, & Orr, 2007). In another study investigating motivational interviewing sessions, language style synchronicity, defined as "how the client and therapist match the stylistic words they use to talk about the topic at hand" (Lord et al., 2014, p. 301) was greater in sessions considered high-empathy sessions than in low-empathy sessions.

How can psychologists improve their empathy?

As Rogers (1975) described over 40 years ago, therapists can often identify what empathy is through experiencing times in therapy when it seems to fail. That is, those times when the therapist's response "caused a fruitful flow of significant expression to become superficial and unprofitable", rather than when it "turned a client's dull and desultory talk into a focused self-exploration" (p. 3).

Most psychologists who research or work in the area believe that while empathy is to some degree an innate disposition, empathic processes and (particularly) empathic responses are skills that we can all learn and strengthen through training. In particular, I would suggest that self-reflection and insight are core skills for therapists to develop for their practice. This involves examination of one's own values, goals, biases, as well as overall schemas and construals, and how they influence the ways in which one can take another's perspective and experience (or not) emotional empathy.

Therapists should also be mindful of their emotional reactions to see whether their responses are compassionate and motivate them to help, or involve high levels of personal distress, which results in more surface-level interaction, decreased desire to engage with the other person's experiences, and decreased motivation to help them (Batson, 2011). Indeed, in research by Rubino, Barker, Roth, and Fearon (2000) both therapist and client attachment styles interacted to determine therapist empathy. As these researchers concluded, "therapists, like other human beings, are susceptible to repeating their usual patterns of relating in the therapy room, unless they are able to recognize their expectations in close relationships and to

reflect on them, thus ultimately controlling their influence when interacting with patients" (p. 418).

I would also argue that self-reflection should involve close examination of one's own problematic past experiences and perspectives on situations. Therapists are sometimes reluctant to examine the ways in which their experiences may be similar to those of their clients. However, using similar past experiences to understand another person increases the ease with which we can understand that person (Gerace, Day, Casey, & Mohr, 2015), as well as resulting in higher empathic concern (Batson et al., 1996), which, as mentioned, predicts increased motivation to help others. It is important, however, that therapists who use their past experiences to understand others have developed some understanding of these experiences that moves beyond rumination towards self-awareness and insight (Gerace et al. 2017). There are many ways to do this, such as trying to reflect on one's experiences from a self-distanced perspective, which is what Ayduk and Kross (2010) refer to as a 'fly on the wall' perspective. Also, developing self-compassion, which involves examination and understanding of one's experiences and past failings from a wider perspective, is related to increased perspective-taking and empathic concern, decreased personal distress, and increased helping behaviour (Neff & Pommier, 2013). Such self-reflection can likely be undertaken by the therapist themselves and in modes such as clinical supervision or watching video of sessions.

The role of self-care

There is, however, a difference between utilising experiences to understand a client and disclosing these experiences to the client. Hill and Knox (2001) believe that such disclosure should be used sparingly, but can normalise and validate client experiences, increase perceptions of similarity, and allow modelling of behaviour. Indeed, research outside of the clinical setting by Hodges, Kiel, Kramer, Veach, and Villanueva (2010) found that empathy recipients rated those empathisers who disclosed similar experiences as more understanding than those who had such an experience but did not disclose the experience.

Finally, while important to focus on increasing empathy and compassion for clients, it is equally important that therapists build their abilities to empathise by engaging in self-care. Studies have indicated that mindfulness and other practices such as loving-kindness meditations can foster both self-compassion and concern for others, which are important to decreasing burnout and engendering emotions when working with clients that are not driven by personal anxiety and distress, but by compassion and wanting to help (Asuero et al., 2014; Boellinghaus, Jones, Hutton 2014). It is at the point when therapists know themselves and their clients and feel they have the resources to delve into the other's perspective, while maintaining their own, that the power of empathy is unleashed.

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References available online: psychology.org.au/inpsych