Final version published as: Elliott, R., Bohart, A.C., Watson, J.C., & Greenberg, L.S. (2011). Empathy. *Psychotherapy: Theory, Research, Practice & Training, 48,* 43-49. DOI: 10.1037/a0022187 .

Empathy

Robert Elliott, University of Strathclyde
Arthur C. Bohart, California State University Dominguez Hills and Saybrook University
Jeanne C. Watson, University of Toronto
Leslie S. Greenberg, York University

Author's Note: This article is adapted, by special permission of Oxford University Press, from a chapter of the same title by the same authors in J. C. Norcross (Ed.), 2011, *Psychotherapy relationships that work* (2nd edition). New York: Oxford University Press. The book project was co-sponsored by the APA Division of Psychotherapy.

Contact information for corresponding author: Robert Elliott, Counselling Unit, School of Psychological Sciences and Health, University of Strathclyde, 76 Southbrae Drive, Glasgow G13 1PP, UK. Email: fac0029@gmail.com.

Abstract

After defining empathy, discussing its measurement, and offering an example of empathy in practice, we present the results of an updated meta-analysis of the relation between empathy and psychotherapy outcome. Results indicated that empathy is a moderately strong predictor of therapy outcome: mean weighted r = .31 (95% confidence interval: .28 - .34), for 59 independent samples and 3599 clients. Although the empathy-outcome relation held equally for different theoretical orientations, there was considerable nonrandom variability. Client and observer perceptions of therapist empathy predicted outcomes better than therapist perceptions of empathic accuracy measures, and the relation was strongest for less experienced therapists. We conclude with practice recommendations, including endorsing the different forms that empathy may take in therapy.

Keywords: empathy, psychotherapy, therapy relationship, Carl Rogers, meta-analysis

Psychotherapist empathy has had a long and sometimes controversial history in psychotherapy. Proposed and codified by Rogers and his followers in the 1940's and 1950's, it was put forward as the foundation of helping skills training popularized in the 1960's and early 1970's. Claims concerning its universal effectiveness were treated with skepticism and came under intense scrutiny by psychotherapy researchers in the late 1970's and early 1980's. After that, research on empathy went into relative eclipse, resulting in a dearth of research between 1975 and 1995 (Watson, 2001).

Since the mid-1990's, however, empathy has once again become a topic of scientific interest in developmental and social psychology (e.g., Bohart & Greenberg, 1997; Ickes 1997). In addition, the past 10 years has seen the emergence of active scientific research on the biological basis of empathy, as part of the new field of social neuroscience (Decety & Ickes, 2009). We believe the time is ripe for the reexamination and rehabilitation of therapist empathy as a key change process in psychotherapy. Indeed, the meta-analytic results that we update here clearly support such a conclusion.

Definitions and Measures

There is no consensual definition of empathy in psychotherapy (Bohart & Greenberg, 1997; Batson, 2009). Research examining the brain correlates of different component subprocesses of empathy (Decety & Ickes, 2009) has extended the initial discovery of so-called "mirror neurons" in the motor cortex of macaque monkeys to a broader understanding of human empathy (Decety & Lamm, 2009). The result is a growing consensus that it consists of three major neuroanatomically-based subprocesses (e.g., Eisenberg & Eggum, 2009): (a) an *emotional simulation* process that mirrors the emotional elements of the others' bodily experience with brain activation centering in the limbic system and elsewhere (Decety & Lamm, 2009); (b) a conceptual, *perspective-taking* process, localized in parts of prefrontal and temporal cortex (Shamay-Tsoory, 2009); (c) an *emotion-regulation* process used to soothe personal distress at the others' pain or discomfort, making it possible to mobilize compassion and helping behavior for the other (probably based in parts of the orbitofrontal, prefrontal and right parietal cortex, Decety & Lamm, 2009).

The two therapeutic approaches that have most focused on empathy -- client-centered therapy and psychoanalytic – have emphasized its cognitive or perspective-taking (Selman, 1980) aspects, focusing mainly on understanding the client's frame of reference or way of experiencing the world. By some accounts, 70% or more of Carl Rogers' responses were to meaning rather than to feeling, despite the fact that his mode of responding is typically called "reflection of feeling" (Brodley & Brody, 1990). In addition, empathy and sympathy have typically been sharply differentiated, with therapists such as Rogers disdaining sympathy but prizing empathy (Shlien, 1997). In affective neuroscience terms, this means that therapists in these traditions have often emphasized conscious perspective-taking processes over the more automatic, bodily-based emotional simulation processes.

> Nevertheless, it is easy to see both processes in Rogers' (1980) definition of empathy: "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference..." (p. 85)….. "It means entering the private perceptual world of the other...being sensitive, moment by moment, to the changing felt meanings which flow in this other person... It means sensing meanings of which he or she is scarcely aware...." (p. 142)

Defined this way, empathy is a higher-order category, under which different subtypes, aspects, and modes can be nested. For example, we find it useful to distinguish between three main modes of expressing therapeutic empathy. First, for some therapists empathy is primarily the establishment of *empathic rapport*. The therapist exhibits a compassionate attitude towards the client and tries to demonstrate that he or she understands the client's experience, often in order to set the context for effective treatment. Second, c*ommunicative attunement*, consists of an active, ongoing effort to stay attuned on a moment-to-moment basis with the client's communications and unfolding experience. Client-centered and experiential therapists are most likely to emphasize this form of empathy. The therapist's attunement may be expressed in many different ways, but most likely in empathic responses. The third mode, *person empathy* (Elliott, Watson, Goldman & Greenberg, 2003) or experience-near understanding of the client's world, consists of a sustained effort to understand the kinds of experiences the client has had, both historically and presently, that form the background of the client's current experiencing. The question is: How have the client's experiences led him or her to see/feel/think and act as he or she does? This is the type of empathic understanding emphasized by psychodynamic therapists. However, these three modes of empathic expression are not mutually exclusive, and the differences are a matter of emphasis.

Many other definitions for empathy have been advanced: as a trait or response skill (Truax & Carkhuff, 1967), as an identification process of "becoming" the experience of the client (Mahrer, 1997), and as a hermeneutic interpretive process (Watson, 2001). Perhaps the most practical conception, and one that we will draw on in our meta-analysis, is Barrett-Lennard's (1981) operational definition of empathy in terms of three different perspectives: that of the therapist (empathic resonance), the observer (expressed empathy), and the client (received empathy).

Reflecting the complex, multidimensional nature of empathy, a confusing welter of measures have been developed. Within psychotherapy, the measures of therapist empathy fall into four categories: empathy rated by nonparticipant raters (expressed empathy); client-rated empathy (received empathy); therapists rating their own empathy (empathic resonance); and empathic accuracy (congruence between therapist and client perceptions of the client).

Observer-rated empathy. Some of the earliest observer measures of empathy were those of Truax and Carkhuff (1967). These scales asked raters to decide if the content of the therapist's response detracts from the client's response, is interchangeable with it, or adds to or carries it forward. Typically, trained raters listened to two-to-five minute samples from session tapes. In spite of later criticism (Lambert, De Julio, & Stein, 1978), these scales have been widely used. More recent observer empathy measures are based on broader understandings of forms of empathic responding and measure multiple component elements of empathy (Elliott et al., 1982; Watson and Prosser, 2002). In addition, therapist general empathy can be rated by others who know or have supervised the therapist, such as supervisors (Gelso, Latts, Gomez, & Fassinger, 2002).

Client ratings. The most widely used client-rated measure of empathy is the empathy scale of the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962), although other client rating measures have also been developed (e.g., Persons & Burns, 1985). Rogers (1957) hypothesized that clients' *perceptions* of therapists' facilitative conditions (positive regard, empathy, and congruence) predict therapeutic outcome. Accordingly, the BLRI, which measures clients' perceptions, is an operational definition of Rogers' hypothesis. In several earlier reviews, including our meta-analysis in the previous edition of this book, client-perceived

empathy predicted outcome better than observer- or therapist-rated empathy (Barrett-Lennard, 1981; Bohart, Elliott, Greenberg & Watson, 2002; Gurman, 1977; Orlinsky, Grawe, & Parks, 1994).

Therapist Ratings. Therapist empathy self-rating scales are not so common, but the BLRI does have one. Earlier reviews (Barrett-Lennard, 1981; Gurman, 1977) found that therapist-rated empathy neither predicted outcome nor correlated with client-rated or observer-rated empathy. However, we previously found that therapist-rated empathy did predict outcome, but at a lower level than client or observer ratings (Bohart et al., 2002).

Empathic Accuracy. Several studies have used measures of therapist-client perceptual congruence, commonly referred to as "empathic accuracy" (Ickes, 1997, 2003). These typically consist of therapists rating clients as they think the clients would rate themselves on various measures, such as personality scales or lists of symptoms, and then comparing these ratings to how clients actually rated themselves. The measure of empathy is the degree of congruence between therapist and client ratings, thus providing a measure of therapist global person empathy. Recent work on empathic accuracy, however, does assess communicative attunement (Ickes, 1997, 2003) by using a tape-assisted recall procedure in which therapists or observers' perceptions are compared to clients' reports of those experiences. Unfortunately, no process-outcome studies using this promising but time-consuming method have yet been carried out.

Correlations among empathy measures. Intercorrelations of different empathy measures have generally been weak. Low correlations have been reported between cognitive and affective empathy measures (Gladstein et al., 1987) and between accuracy measures and the BLRI (Kurtz & Grummon, 1972). Other research has found that tape-rated measures correlate only moderately with client-perceived empathy (Gurman, 1977). These weak correlations are not surprising when one considers what the different instruments are supposed to be measuring.

Confounding between empathy and other relationship variables. A related concern is the distinctiveness of empathy from other relationship constructs. One early review of more than 20 studies primarily using the BLRI found that, on average, empathy correlated .62 with congruence and .53 with positive regard, and .28 with unconditionality (Gurman, 1977). Factor analysis of scale scores found that one global factor typically emerged, with empathy loading on it along with congruence and positive regard (Gurman, 1977). Such results suggest that perceptions of empathy are difficult to differentiate from perceptions of other relationship factors. On the other hand, factor analytic studies at the item level sometimes identify empathy as a separate factor (Gurman, 1977). We view empathy as a relationship component that is both conceptually distinct and part of a higher-order relationship construct.

Clinical Example

Mark presented to psychotherapy complaining of pervasive anxiety. He was a 30-year-old unmarried man who had been struggling since his early 20's to break into the movie business. When he entered therapy he was working as a waiter. He came from a traditional family, living in the southern United States. His brothers and sisters all had successful careers, and were married, with children. His parents were constantly pestering him about his not being married and not having a stable career. His anxiety attacks had begun a few weeks after a visit home for the Christmas holidays. When Mark came to his first appointment he was clearly agitated. The therapist's orientation was integrative experiential/humanistic, based in the principles of person-centered therapy. The therapist tried to understand the client's point of view actively and empathically and to share that understanding, and to stay responsively attuned so that therapeutic procedures could be adjusted to maximize learning:

C1: I'm really in a panic (anxious, looking plaintively at the therapist). I feel anxious all the time. Sometimes it seems so bad I really worry that I'm completely falling apart. Nothing like this has ever happened to me before.
T1: So a real sense of vulnerability—kind of like you don't even know yourself anymore.
C2: Yes! That's it. I don't know myself anymore. I feel totally lost, like a big cloud that just takes me over, and I can't even find myself in it anymore. I don't even know what I want, what I trust….I'm lost.
T2: Totally lost, like, "Where did Mark go? I can't find myself anymore."
C3: No, I can't (sadly, and thoughtfully).

The dialogue continued like this and soon the therapist's empathic recognition provided the client with a sense of being understood. This fostered a sense of safety, and gradually the client moved from agitation into reflective sadness. The client then began to reflect on his experience in a more productive, exploratory manner. He talked about the basic conflict in his life: over whether to continue to pursue an acting career or to find a "real job" and life partner, given that he was now 30 and had shown no signs of making a breakthrough in acting.

During the first few sessions the client had repeatedly expressed the suspicion that something about his early relationships with his parents played an important role in his current problems. The therapist at first missed this, because she was not psychogenetic and past-oriented. The therapist's lack of person empathy for the larger meaning of the client's interest in this topic had effectively shut off this avenue of exploration. Eventually, the therapist listened, responded in an invitational way to the client, and the client began to explore his childhood. This illustrates how empathy not only gives permission, but also provides active support for exploration. This led to a breakthrough moment, in which Mark became emotionally aware of how neglected he had felt as a child by his high-achieving parents, who had not known what to make of their imaginative, inwardly-focused child. The result was that he had adopted a rebellious "I have a right to be different" attitude. Underlying this, however, was a longing for conventionality. Accessing this helped him accept that he was different and to mourn that he might never be what his family wanted him to be. Over the following sessions, Mark's anxiety decreased and he made a decision to continue to try pursuing an acting career, for a while at least.

Meta-Analytic Review

In this section, we report the results of an original meta-analysis of available research relating empathy to psychotherapy outcome. We addressed the following questions: (a) What is the overall association between therapist empathy and client outcome? (b) Do different forms of psychotherapy yield different levels of association between empathy and outcome? (c) Does the type of empathy measure predict the level of association between empathy and outcome? (d) What other study and sample characteristics predict an association between empathy and outcome? (See Elliott, Bohart, Watson & Greenberg, 2011, for more details, including list of studies included, relevant study characteristics, and specifics of analysis procedures.)

Articles were culled from previous reviews (e.g., Gurman, 1977; Orlinsky, Grawe, & Parks, 1994), by searching PsycINFO and PsycLIT using the search terms "empathy" or "empathic" and "psychotherapy," "counseling" or "counseling." Additionally, we consulted the tables of contents of relevant journals.

Our inclusion criteria were: (a) use of a specific measure of empathy; (b) empathy related to some measure of therapy outcome (including pre-post symptom change, improvement ratings, client satisfaction, post-session progress ratings); (c) clients had genuine clinical problems; (d) average number of sessions = 3+; (e) English text or abstract; (f) n = 5+ clients; (g) published;

and (h) sufficient information to calculate or estimate a Pearson correlation. Our strategy was to extract all possible effects, in order to avoid selection bias. The resulting sample consisted of 224 separate tests of the empathy-outcome association, aggregated into 59 different samples of clients (from 57 studies) and encompassing a total of 3,599 clients.

We coded therapy format, theoretical orientation; experience level of therapists; treatment setting, number of sessions, type of problems, source of outcome measure, when outcome was measured, type of outcome measured, source of empathy measure, and unit of measure.

For effect sizes, all analyses used Fisher r-to-z conversions to correct for distributional biases before further analysis. We analyzed by effects and by studies: First, we analyzed the 224 separate effects in order to examine the impact of perspective of empathy measurement and type of outcome. Second, study level analyses used averaged individual effects within study samples, thus avoiding problems of nonindependence and eliminating bias due to variable numbers of effects reported in different studies (Lipsey & Wilson, 2001). For summarizing analyses across studies, we weighting studies by inverse error (which gives larger samples greater weight) and employed Hedges and Olkin's (1985) the simpler fixed effects model to assess statistical significance and heterogeneity of effects (with Cochrane's Q, using the program in Diener, Hilsenroth & Weinberger, 2009). We also applied a newer statistic, I^2, to estimate the proportion of variation due to true variability as opposed to random error (Higgins, Thompson, Deeks & Altman, 2003).

The single best summary value of our results, as shown in Table 1, is the study-level, weighted *r* of .31 ($p < .001$; 95% confidence interval: r = .28 - .34), a medium effect size. (Average effects were .24 for analyses of the 224 nonindependent separate effects, probably an underestimate due to smaller effects found in one study with 42 analyses; Kurtz & Grummon, 1972). Both values were very similar to our previous review (Bohart et al., 2002), and mean that in general empathy accounts for about 9% of the variance in therapy outcome. This effect size is on the same order of magnitude as, or slightly larger than, previous analyses of the relationship between the alliance in individual therapy and treatment outcome (i.e., Horvath et al., this volume: .275; Martin, Garske & Davis, 2000: .22). However, the .31 figure conceals statistically significant, nonrandom heterogeneity of effects, as indicated by a study-level Cochrane's Q of 212.3 ($p < .001$) and I^2 of 72.7%, a large value.

Moderators and Mediators

Meta-analytic Moderator Analyses

The significant Q and large I^2 statistics point to the existence of important moderator variables (sources of heterogeneity), but do not specify what those are. We began our search by testing the hypothesis that different empathy-outcome correlations might be obtained for different theoretical orientations. However, our analyses turned up little evidence of such a trend. This finding contrasts with our previous meta-analysis (Bohart et al., 2002), where we found tantalizing evidence that empathy might be more important to outcome in cognitive-behavioral therapies than in others. However, our present analysis failed to confirm that earlier possibility.

We next charted relations between specific types of empathy measures and outcome, using effect level analyses aggregated within studies ($n = 82$). As we expected, and has been noted by previous reviewers (e.g., Barrett Lennard, 1981), the perspective of the empathy rater made a difference for empathy-outcome correlations. Specifically, client measures predicted outcome the best (mean corrected $r = .32$; $n = 38$), slightly but not significantly better than

observer rated measures (.25; $n = 27$) and therapist measures (.20; $n = 11$); each of these mean effects was significantly greatly than zero ($p < .001$). In contrast, empathic accuracy measures were unrelated to outcome (.08; n = 5, ns). Comparison of confidence intervals indicated that client-perceived empathy significantly predicted outcome better than accuracy measures ($p < .05$). (All perspectives except empathic accuracy are characterized by large, statistically significant amounts of nonchance heterogeneity).

Finally, we examined several other variables that might account for some of the heterogeneity of the effect sizes: Consistent with our 2002 meta-analysis, the strongest moderator variable in this set of correlations indicated larger effects for less experienced therapists (weighted effect level $r = -.29$, $p < .001$; study level mean $r = -.19$, n.s.). In addition, empathy was slightly more predictive of positive outcome in group therapy, with more severely distressed clients, in more recent studies, and with more global outcome measures (i.e., satisfaction ratings, which begin to overlap conceptually with empathy), and in outpatient settings.

Therapist Mediating Factors

Although our meta-analysis did not examine mediators of empathy; however, the available literature points to some interesting possibilities. Consistent with recent affective neuroscience research, research in both developmental psychology and in psychotherapy has found relations between various measures of cognitive complexity, such as those of perspective-taking or abstract ability, and empathy (Eisenberg & Fabes, 1990; Watson, 2001). With respect to affective simulation and emotion regulation, therapists who were open to conflictual, countertransferential feelings were perceived as more empathic by clients (Peabody & Gelso, 1982).

The degree of similarity between therapist and client (Duan & Hill, 1996; Gladstein & associates, 1987; Watson, 2001) also influences the level of empathy, as does similarity and familiarity between the target of empathy and the empathizer in neuroscience studies of mirror neurons (Watson & Greenberg, 2009). Another important factor is therapist nonlinguistic and paralinguistic behavior. This encompasses therapists' posture, vocal quality, ability to encourage exploration using emotion words, and not talking too much, giving advice, or interrupting (Duan & Hill, 1996; Watson, 2001). In a qualitative study of clients' experience of empathy (Myers, 2000), interrupting, failing to maintain eye contact, and dismissing the client's position while imposing the therapist's own position were all perceived as unempathic; conversely, being nonjudgmental, attentive, open to discussing any topic, and paying attention to details were perceived as empathic.

Client Contributions

Clinical and research experience suggest that the client him or herself clearly influences level of therapist empathy. Early studies (Kiesler et al., 1967), for example, found that levels of empathy were higher with clients who had less clinical dysfunction, who were brighter, but yet were lower in self-esteem. As Barrett-Lennard (1981) pointed out, the client's revealing of their experiencing is an essential link in the cycle of empathy. Clients who are more open to and able to communicate their inner experiencing will be easier to empathize with. Empathy truly appears to be a mutual process of shared communicative attunement (Orlinsky et al., 1994).

On the other hand, not all clients respond favorably to explicit empathic expressions. One set of reviewers (Beutler, Crago, & Arizmendi, 1986, p. 279) cite evidence that suggests that "patients who are highly sensitive, suspicious, poorly motivated, and reactive against authority perform relatively poorly with therapists who are particularly empathic, involved, and

accepting." It is worth noting, however, that when therapists are truly empathic they attune to their clients' needs and accordingly adjust how and how much they *express* empathy, especially, when clients are experiencing negative in-session reactions to their therapists or shame-ridden vulnerability (Duan & Hill, 1996; Martin, 2000).

Limitations of the Research

Many reviewers (e.g., Watson, 2001; Patterson, 1984) have discussed problems with the research on empathy. In addition to the well-known difficulty of inferring causality from correlational data, these entail: (a) the questionable validity of some outcome measures (e.g., client satisfaction); (b) lack of appropriate, sensitive outcome measures; (c) restricted range of predictor and criterion variables; (d) confounds among variations in time of assessment, experience of raters, and sampling methods; (e) reliance on obsolete diagnostic categories; and (f) incomplete reporting of methods and results. To these issues, we can add the heterogeneity of effects within and across studies, which leads us to urge caution in generalizing our results. In fact, these and other problems are not restricted to empathy research but are common to all process-outcome research (Elliott, 2010).

The restricted range of predictor and criterion variables is particularly a problem. In the Mitchell, Truax, Bozarth, and Krauft (1973) study, for instance, no significant correlations were found, but most of the therapists scored below the minimum considered to be effective, and overall outcome was only modest. Using only highly empathic therapists or good outcome cases in a study would similarly hide the therapeutic effects of empathy.

The key question of whether empathy is causally related to therapeutic outcome -- as opposed being merely a correlate of it -- cannot be answered unequivocally from a meta-analysis of process-outcome studies. Several studies have employed causal modeling to explore the directional relation between empathy and outcome (e.g., Burns & Nolen-Hoeksema, 1992; Cramer & Takens, 1992), while others (e.g., Miller et al., 1980; Anderson, Ogles, Patterson, Lambert & Vermeersch, 2009) have tried to measure empathy or comparable variables separately from therapy. The evidence we have presented is clearly compatible with a causal model implicating therapist empathy as a mediating process leading to client change, but establishing conclusive evidence for particular hypothesized causal processes is notoriously difficult. Insofar as codes of professional ethics stipulate a caring, empathic stance in all professional contacts, it is both impractical and unethical to randomize clients to demonstrably empathic vs. unempathic therapists. In such cases, many researchers have argued that meta-analyses can provide a valid alternative to randomized clinical trials (Berman & Parker, 2002).

Therapeutic Practices

As we have shown, empathy is a medium-sized but variable predictor of outcome in psychotherapy. The most robust evidence is that clients' perceptions of feeling understood by their therapists relate to outcome. This repeated finding, in both dozens of individual studies and now in multiple meta-analyses, leads to a series of clinical recommendations.

- An emphatic stance on the part of the therapist is an essential goal of all psychotherapists, regardless of theoretical orientation, treatment format, and severity of patient psychopathology.
- It is important for psychotherapists to make efforts to understand their clients, and to demonstrate this understanding through responses that address the perceived needs of the client. The empathic therapist's primary task is to understand experiences rather than words. Empathic therapists do not parrot clients' words back or reflect only the content of those words; instead, they understand overall goals as well as moment-to-moment experiences.
- Therapist responses that accurately respond to and carry forward the meaning in the client's

communication are useful. These responses can take various forms, illustrated in the following by a running example. *Empathic understanding responses* convey understanding of client experience:

> Client: I have been trying to push things away, but every time I sit down to do something it is like I forget what I am doing.
>
> Therapist: Somehow you are not in a space to work, it's hard for you to concentrate.

Empathic affirmations are attempts by the therapist to validate the client's perspective:

> C: And my cat is still lost, so we have been staying up at night in case he returns, and work has been so busy and I have been so tired and P needs my attention, and, oh, everything is just a big mess, you know?
>
> T: Yeah, really hard, being pulled in a million different directions and there hasn't been time for you, no wonder it feels like things are a mess.

Empathic evocations try to bring the clients' experience alive using rich, evocative, concrete, connotative language and often have a probing, tentative quality:

> C: I don't know what I'm going to do. I have two hundred dollars this month, everything's behind, there isn't enough work, and then my Dad was here. Things are just swirling around me.
>
> T: It's like being caught in a whirlpool as if it is hard to keep your boat from being sucked in or capsizing.

Empathic conjectures attempts to get at what is implicit in clients' narratives but not yet articulated. They are similar to interpretations but do not attempt to provide the client with new information; rather they are guesses grounded in what the client has presented:

> C: And one of P's friends has been over every night this week using our computer. I did not want him over Wednesday because I had friends coming over. So he agreed not to come over, but then P brought him over anyway at around midnight and it was difficult for me to get to sleep. Our lives just seem so chaotic right now. P and I had Friday alone but then R was over again all day Saturday.
>
> T: Just a continual sense of being intruded on. I guess this leaves you feeling so feeling so invaded?

• Empathic therapists assist clients to symbolize their experience in words, and track their emotional responses, so that clients can deepen their experience and reflexively examine their feelings, values, and goals. To this end, therapists attend to what is not said, or what is at the periphery of awareness as well as that which is said and is in focal awareness.

• Empathy entails individualizing responses to particular patients. For example, certain fragile clients may find the usual expressions of empathy too intrusive, while hostile clients may find empathy too directive; still other clients may find an empathic focus on feelings too foreign (Kennedy-Moore &Watson, 1999). Therapists therefore need to know when--and when not-- to respond empathically. When clients do not want therapists to be explicitly empathic, truly empathic therapists will use their perspective-taking skills to provide an optimal therapeutic distance (Leitner, 1995) in order to respect their clients' boundaries.

• There is no evidence that accurately predicting clients' own views of their problems or self-perceptions is effective. Therapists should assume neither that they are mind readers nor that their experience of understanding the client will be matched by the client feeling understood. Empathy should always be offered with humility and held lightly, ready to be corrected.

• Finally, because research has shown empathy to be inseparable from the other relational conditions, therapists should seek to offer empathy in the context of positive regard and

genuineness. Empathy will not be effective unless if it is grounded in authentic caring for the client. We encourage psychotherapists to value empathy is both an "ingredient" of a healthy therapeutic relationship as well as a specific, effective response that promotes strengthening of the self and deeper exploration.

References

Anderson, T., Ogles, B.M., Patterson, C.L., Lambert, M.J., & Vermeersch, D.V. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*, 755-768.

Barrett-Lennard, G. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs, 76*, 43, Whole Number 562.

Barrett-Lennard, G. T. (1981). The empathy cycle: Refinement of a nuclear concept. *Journal of Counseling Psychology, 28*, 91-100.

Batson, C.D. (2009). These things called empathy: Eight related but distinct phenomena. In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 3-15). Cambridge, MA: MIT Press.

Berman, N.G., & Parker, R. (2002). Meta-analysis: Neither quick nor easy. BMC Medical Research Methodology 2002, 2:10. Accessed on-line on 19 June 2010 at http://www.biomedcentral.com/1471-2288/2/10

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 257-310). New York: Wiley.

Bohart, A.C., Elliott, R., Greenberg, L.S., Watson, J.C. (2002). Empathy. In J. Norcross (ed.), *Psychotherapy relationships that work* (pp. 89-108). New York: Oxford University Press.

Bohart, A. C., & Greenberg, L. S. (1997). Empathy: Where are we and where do we go from here? In in A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 419-450). Washington, DC: American Psychological Association.

Brodley, B. T., & Brody, A. F. (1990, August). *Understanding client-centered therapy through interviews conducted by Carl Rogers*. Paper presented at the annual convention of the American Psychological Association, Boston, MA.

Burns, D. D., & Nolen-Hoeksma, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology, 60*, 441-449.

Cramer, D., & Takens, R. (1992). Therapeutic relationship and progress in the first six sessions of individual psychotherapy: A panel analysis. *Counselling Psychology Quarterly, 5*, 25-36.

Decety, J., & Ickes, W. (Eds.) (2009). *The Social Neuroscience of Empathy*. Cambridge, MA: MIT Press.

Decety, J., & Lamm, C. (2009). Empathy versus Personal Distress: Recent evidence from social neuroscience. In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 199-213). Cambridge, MA: MIT Press.

Diener, M.J., Hilsenroth, M.J. & Weinberger, J. (2009). A primer on meta-analysis of correlation coefficients: The relationship between patient-reported therapeutic alliance and adult attachment style as an illustration, *Psychotherapy Research, 19*, 519 - 526.

Duan, C., & Hill, C. E. (1996). A critical review of empathy research. *Journal of*

Counseling Psychology, 43, 261-274.

Eisenberg, N., & Eggum, N.D. (2009). Empathic responding: Sympathy and personal distress. In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 71-83). Cambridge, MA: MIT Press.

Eisenberg, N., & Fabes, R. A. (1990). Empathy: Conceptualization, assessment, and relations to prosocial behavior. *Motivation and Emotion, 14*, 131-149.

Elliott, R. (2010). Psychotherapy Change Process Research: Realizing the Promise. *Psychotherapy Research, 20*, 123-135.

Elliott, R., Bohart, A.C., Watson, J.C., & Greenberg, L.S. (2011). Empathy. In J. Norcross (ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Elliott, R., Filipovich, H., Harrigan, L., Gaynor, J., Reimschuessel, C., & Zapadka, J.K. (1982). Measuring response empathy: The development of a multi-component rating scale. *Journal of Counseling Psychology, 29*, 379-387.

Elliott, R., Watson, J., Goldman, R.. Greenberg, L.S. (2003). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: APA.

Gelso, C.J.; Latts, M.G., Gomez, M.J., Fassinger, R.E. (2002). Countertransference management and therapy outcome: An initial evaluation. *Journal of Clinical Psychology, 58*, 861-867.

Gladstein, G., A., & Associates (1987). *Empathy and counseling: Explorations in theory and research*. New York: Springer-Verlag.

Goubert, L., Craig, K.D., & Buysee, A. (2009). Perceiving others in pain: Experimental and clinical evidence of the role of empathy. In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 153-165). Cambridge, MA: MIT Press.

Gurman, A.S. (1977). The patient's perception of the therapeutic relationship. In A.S. Gurman & A.M. Razin (Eds.), *Effective Psychotherapy: A handbook of research* (pp. 503-543). New York: Pergamon.

Higgins, J.P.T., Thompson, S.G., Deeks, J.J., & Altman, D.G. (2003). Measuring inconsistency in meta-analyses, *British Journal of Medicine, 327*, 557–560.

Hedges, L. V., & Olkin, I. (1985). *Statistical methods for meta-analysis*. San Diego, CA: Academic Press

Ickes, W. (Ed.). (1997). *Empathic accuracy*. New York: Guilford.

Ickes, W. (2003). *Everyday Mind Reading: Understanding What Other People Think and Feel*. Amherst, NY: Prometheus Books

Kennedy-Moore, E., & Watson, J. C. (1999). *Expressing emotion: Myths, realities, and therapeutic strategies*. New York: Guilford.

Kiesler, D. J., Klein, M. H., Mathieu, P. L., & Schoeninger, D. (1967). Constructive personality change for therapy and control patients. In C. R. Rogers et al. (Eds.), *The therapeutic relationship and its impact* (pp. 251-294), Madison: University of Wisconsin Press. (Combined with Barrington, 1967, and Van Der Veen, 1967)

Kurtz, R. R., & Grummon, D. L. (1972). Different approaches to the measurement of therapist empathy and their relationship to therapy outcomes. *Journal of Consulting and Clinical Psychology, 39*, 106-115.

Lambert, M.J., DeJulio, S.J. & Stein, D.M. (1978). Therapist interpersonal skills: Process, outcome, methodological considerations, and recommendations for future research. *Psychological Bulletin, 85*, 467-489.

Leitner, L. M. (1995). Optimal therapeutic distance: A therapist's experience of personal

construct psychotherapy. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 357370). Washington, DC: American Psychological Association.

Lipsey, M.W., & Wilson, D.B. (2001). *Practical meta-analysis*. Sage: Thousand Oaks, CA.

Mahrer, A. R. (1997). Empathy as therapist-client alignment. in A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 187-216). Washington, DC: American Psychological Association.

Martin, D. G. (2000). *Counseling and therapy skills* (2nd ed.). Prospect Heights, Illinois: Waveland Press.

Martin, D. J., Garske, J. P., & Davis, M. D. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Miller, W., Taylor, C., & West, J. (1980). Focused versus broad spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology, 48*, 590-601.

Mitchell, K. M., Truax, C. B., Bozarth, J. D., & Krauft, C. C. (1973, March). *Antecedents to psychotherapeutic outcome*. NIMH grant Report (12306). Arkansas Rehabilitation Research and Training Center, Arkansas Rehabilitation Services, Hot Springs, Arkansas.

Myers, S. (2000). Empathic listening: Reports on the experience of being heard. *Journal of Humanistic Psychology, 40*, 148-173.

O'Hara, M. M. (1984). Person-centered gestalt: Towards a holistic synthesis. In R.F. Levant & J. M. Shlien (Eds.), *Client-centered therapy and the person-centered approach: New directions in theory, research and practice* (pp. 203-221). New York: Praeger.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-378). New York: Wiley.

Patterson, C. H. (1984). Empathy, warmth, and genuineness: A review of reviews. Psychotherapy, 21, 431-438.

Peabody, S. A., & Gelso, C. J. (1982). Countertransference and empathy: The complex relationship between two divergent concepts in counseling. *Journal of Counseling Psychology, 29*, 240-245.

Persons, J. B., & Burns, D. D. (1985). Mechanisms of action of cognitive therapy: Relative contribution of technical and interpersonal intervention. *Cognitive Therapy and Research, 9*, 539-551.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

Selman, R. I. (1980). *The growth of interpersonal understanding*. Orlando, FL: Academic Press.

Shamay-Tsoory, S. (2009). Empathic processing: Its cognitive and affective dimensions and neuroanatomical basis. In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 215-232). Cambridge, MA: MIT Press.

Shlien, J. (1997). Empathy in psychotherapy: A vital mechanism? Yes. Therapist's conceit? All too often. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy* (pp. 63-80). Washington, DC: American Psychological Association.

Truax, C.B., & Carkhuff, R.R. (1967). *Toward effective counseling and psychotherapy: Training and practice*. Chicago: Aldine.

Watson, J. C. (2001). Re-visioning empathy. In D. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 445-471). Washington: APA.

Watson, J.C., & Greenberg, L.S. (2009). Empathic resonance: A neuroscience perspective. In In J. Decety & W. Ickes (Eds.) (2009). *The Social Neuroscience of Empathy* (pp. 125-138). Cambridge, MA: MIT Press.

Watson, J.C., & Prosser, M. (2002). Development of an observer rated measure of therapist empathy. In J. C. Watson, R. Goldman, & M Warner (Eds.), *Client-centered and experiential psychotherapy in the 21st century: Advances in theory, research and practice* (pp.303-314). Ross on Wye: PCCS Books.

Table 1

Empathy-Outcome Correlations: Overall Summary Statistics

	Effect Level		Study level	
	M	Sd	M	Sd
Weighted Mean r	.24*	.33	.31*	.13
N	224 effects		59 samples; 3599 clients	
Cochrane's Q	765.2*		212.3*	
I^2	70.9%		72.7%	

* $p < .001$

Note. Fisher's r-to-z transformation used to calculate means and sds. Weighted *r*s used inverse variance (i.e., n-3) as weights and were tested against mean $r = 0$ following the Hedges & Olkin (1985) fixed effects model.