Empathy

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Psychotherapist empathy has had a long and sometimes stormy 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; Duan & Hill, 1996).

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), particularly because empathy came to be seen as a major part of "emotional intelligence" (Goleman, 1985). We believe the time is ripe for the reexamination and rehabilitation of therapist empathy as a key change process in psychotherapy (Bohart & Greenberg, 1997). Indeed, the meta-analytic results we will present clearly support such a conclusion. The most important development in the past 10 years, however, is the emergence of active scientific research on the biological basis of empathy, as part of the new field of social neuroscience (Decety & Ickes, 2009), which we will address briefly in the next section.

Definitions and Measures

Defining Empathy

The first problem with researching empathy in psychotherapy is that there is no consensual definition (Bohart & Greenberg, 1997; Duan & Hill, 1996; Batson, 2009). Recent neuroscience research on empathy begins to clarify some of the conceptual confusion, as a result of the concerted efforts of researchers using a variety of methods ranging from performance tasks, self-report, and neuropsychological assessment to fMRI and transcranial stimulation. Research examining the brain correlates of different component subprocesses of empathy (Decety & Ickes, 2009) has extended the initial discovery of "mirror neurons" in the motor

cortex of macaque monkeys (e.g., Gallese, Fadiga, Fogassi & Rizzolatti, 1996) to a broader range of affective and perspective-taking components of empathy in humans (Decety & Lamm, 2009). The result of this research has been to deepen and clarify our understanding of therapist empathic processes (Watson & Greenberg, 2009), resulting in a growing consensus (e.g., Eisenberg & Eggum, 2009) that it consists of three major subprocesses, each with specific sets of neuroanatomical correlates. First, there is an *emotional simulation* process that mirrors the emotional elements of the other's bodily experience with brain activation centering in the limbic system (amygdala, insula, anterior cingulate cortex) and elsewhere (Decety & Lamm, 2009; Goubert, Craig, & Buysse, 2009). Second, a conceptual, *perspective-taking* process operates, particularly localized in medial and ventromedial areas of prefrontal cortex as well as the temporal cortex (Shamay-Tsoory, 2009). Third, there is an *emotion-regulation* process that people use to reappraise or soothe their personal distress at the other person's pain or discomfort, allowing them to mobilize compassion and helping behavior for the other (probably based in orbitofrontal cortex, as well as in the prefrontal and right inferior parietal cortex; Decety & Lamm, 2009; Eisenberg & Eggum, 2009).

Interestingly, 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, as well as its feeling aspects. That is, they have focused on empathy as *connected knowing* (Belenky et al., 1986), 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; Hayes & Goldfried, 1996; Tausch, 1988). However, understanding clients' frames of reference does include understanding their affective experiences. 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 this tradition 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, expressions, and modes can be nested. There are different ways one can put oneself into the shoes of the other: emotionally, cognitively, on a moment-to-moment basis, or by trying to grasp an overall sense of what it is like to be that person. Within these subtypes different aspects of the client's experience can become the focus of empathy (Bohart & Greenberg, 1997). Similarly, there are many different ways of expressing empathy, including empathic reflections, empathic questions, experience-near interpretations, empathic conjectures, as well as the responsive use of other therapeutic procedures. Accordingly, empathy is best understood as a complex construct consisting of a variety of different acts used in different ways.

We distinguish between three main modes of therapeutic empathy: empathic rapport, communicative attunement, and person empathy. First, for some therapists empathy is primarily the establishment of empathic rapport and support. 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. A second mode of empathy 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, empathic rapport, communicative attunement, and person empathy 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 (Egan, 1982; 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).

Measuring 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; client-rated empathy; therapists rating their own empathy; 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) and Carkhuff and Berenson (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. Samples are usually drawn from the beginning, middle, and/or the end of therapy. Scales such as these do not adequately reflect the client-centered conception of empathy as an attitude, because they focus narrowly on a particular kind of response, often empathic reflections. Furthermore, the equation of a particular response with empathy has also made these scales less appropriate for measuring empathy in approaches other than client-centered (Lambert, De Julio, & Stein, 1978).

More recent observer empathy measures are based on broader understandings of forms of empathic responding. Elliott and colleagues's (1982) measure breaks empathy down into component elements and has shown good psychometric properties, but has not been widely used. Watson and Prosser (2002) developed a promising new observer-rated measure of empathy that assesses therapists' verbal and non-verbal behavior and shows convergence validity with client ratings on the Barrett-Lennard Relationship Inventory.

In addition, the therapist's general empathy can also be rated by others who know or have supervised the therapist. For instance, therapists' empathic capacities can be rated by their supervisors (Gelso, Latts, Gomez, & Fassinger, 2002). For purposes of our meta-analysis, we lumped together all observer perspective measures of empathy.

Client ratings. The most widely used client-rated measure of empathy is the empathy scale of the Barrett-Lennard Relationship Inventory (BLRI). Other client rating measures have been developed (e.g., Hamilton, 2000; Lorr, 1965; Persons & Burns, 1985: Truax & Carkhuff, 1967). 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; Gurman, 1977; Bohart, Elliott, Greenberg & Watson, 2002; Orlinsky, Grawe, & Parks, 1994; Orlinsky & Howard, 1978, 1987).

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 Acccuracy. Several studies use 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. For instance, one study compared how therapists rated clients on Kelly's REP grid with how clients rated themselves (Landfield, 1971). The measure of empathy is the degree of congruence between therapist and client ratings. This can be referred to as predictive empathy, because the therapist is trying to predict how clients will rate themselves. This is closer to a measure of the therapist's ability to form a global understanding of what it is like to be the client (person empathy) than it is to a process measure of ongoing communicative attunement.

Recent work on empathic accuracy, however, does provide a predictive measure of communicative attunement (Ickes, 1997, 2003). This line of research typically employs a tape-assisted recall procedure in which therapists or observers' moment-to-moment empathy is measured by comparing their perceptions of client experiences 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 different empathy measures. Intercorrelations of different empathy measures have generally been weak. Low correlations have been reported between cognitive and affective measures (Gladstein et al., 1987) and between predictive 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. Trying to predict how a client will fill out a symptom check list is very different from responding sensitively and tentatively in a way that demonstrates subtle understanding of what the client is trying to communicate, while checking and adjusting one's emerging understanding with that of the client. Similarly, client ratings of therapist understanding may be based on many other things than the

therapists' particular skill in empathic reflection. Accordingly, we should not expect different measures of this complex construct to correlate (Gladstein et al., 1987).

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). Others have reported that the empathy scale loaded .93 on a global BLRI factor, with Positive Regard loading .87 and Congruence loading .92 (Blatt et al., 1996). Such results suggest that clients' perceptions of empathy are not clearly differentiated from their perceptions of other relationship factors.

On the other hand reviews of several factor analytic studies where, instead of using scale scores, specific items were used have found empathy emerging as a separate factor (Gurman, 1977). In addition, empathy tends to correlate more highly with the bond component of the therapeutic alliance than with the task and goal components (Horvath & Greenberg, 1986). Thus, there is evidence both for and against the hypothesis that the Rogerian triad of empathy, unconditional positive regard, and congruence are separate and distinct variables. 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. He had previously called and had sounded desperate over the phone. The therapist initially was concerned that Mark might be in a state of crisis.

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, using his attunement to the client's experience to identify effective interventions, and to stay responsively attuned so that therapeutic procedures could be adjusted to maximize learning. The following are two examples of therapist's utilization of empathic responding during the first session:

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 on the verge of a psychotic break. I'm actually afraid of completely falling apart. Nothing like this has ever happened to me before. I always felt in charge of myself before, but now I can't seem to get any control over myself at all.

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. The anxiety feels 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.

Later, the client role-played a dialogue between two sides of himself. One side, his critic or "should" side, said that he should get a stable job and get married, and criticized him for not being married. The other side was the "want" side -- or in this case, the "don't want" side — which said "I don't want to live an ordinary life; I want to live a creative life." This side came out in the form of defensive rebellion. Empathic sensitivity was used to help the therapist tune into the client's point of view and to focus the client's exploratory activities during the the role-play. What emerged from this role-play was that there was a longing for a "normal" life style underlying Mark's defensive rebellion, in conflict with a desire to do something creative.

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. Initially, the therapist had not taken this too seriously, since progress was apparently being made through the collaborative use of other procedures. Because the therapist was not psychogenetic and past-oriented, she had not tuned into this. The therapist's lack of person empathy (i.e., grasping of how figural this was for the client within the client's frame of reference) 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. It also illustrates how sensitive empathic understanding of the *client's* way of seeing the problem is sometimes crucial for therapeutic progress (Hubble, Duncan & Miller, 1999). This led to a breakthrough moment. In reviewing his childhood, Mark became emotionally aware of how neglected he had felt as a child by his high-achieving parents, who were not mean and cruel, but who were not themselves highly empathic. As a child, the client had always been unusually interested in fantasy activities, and was a rather "inner" person, in contrast to his siblings, who were more conventional and high-achievers at school. The parents had not known what to make of their unique child and were unable to respond in an empathic and supportive way to his emerging uniqueness.

The result was that he had had to adopt a defensive "I have a right to be different" attitude. He was rarely able to genuinely consider whether he wanted to be conventional or not. Underlying this was a longing for conventionality. Accessing this in the context of his family life helped him accept that he was different and to mourn the fact that he was not conventional (and, in effect, mourn that he might never be what his family wanted him to be). Over the course of this work, Mark's anxiety decreased. Eventually he made a decision to continue to pursue an acting career, for a while at least; and his crisis abated.

Meta-Analytic Review

In this section we report the results of an original meta-analysis conducted on 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 (i.e., sample size, treatment setting, therapy format and length, level of client severity, therapist experience, type of outcome measure, unit of process)?

Search strategy

Articles were culled from previous reviews (Beutler, Crago, & Arizmendi, 1986; Gurman, 1977; Lambert, DeJulio & Stein, 1978; Mitchell, Bozarth, & Krauft, 1977; Orlinsky & Howard, 1986; Orlinsky, Grawe, & Parks, 1994; Parloff et al., 1978; Truax and Mitchell, 1971; N. Watson, 1984). We also searched PsycInfo and PsycLit forward from 1992 (two years before the publication of the last major review of empathy research in Orlinsky et al., 1994), using the search terms, "empathy" or "empathic" and "psychotherapy", "counseling" or "counseling". Additionally, we consulted the tables of contents of relevant journals such as: *Psychotherapy, Person-Centered Journal, Psychotherapy Research, Journal of Counseling Psychology,* and *Person-Centered and Experiential Psychotherapies.*

Inclusion Criteria

Our inclusion criteria were as follows: (a) a specific measure of empathy was used; (b) empathy was related to some measure of therapy outcome; (c) the client sample involved genuine clinical problems; (d) the average number of sessions was three or more; (e) the study was available in English; (f) the study included at least five clients; (g) the study was available in published form; and (h) the study contained sufficient information to calculate a weighted effect size.

Characteristics of the Studies

To examine variables that might moderate the empathy-outcome association, we evaluated the studies on a wide range of sample and methodological features. For measures of outcome, we included a study as long as there was some assessment of the effects of therapy, even if only at the session level (immediate outcome). For example, we included abstinence from drinking (Miller et al., 1980), level of depression (Burns & Nolen-Hoeksema, 1992), MMPI scores (Kiesler et al., 1967), client satisfaction (Lorr, 1965), supervisors' ratings of client improvement (Gelso et al., 2002), client and therapist post-therapy ratings of amount of change (Hamilton, 2000), and post-session ratings of progress (Orlinsky & Howard, 1967). There is some conceptual overlap between feeling understood and client satisfaction, but this one outcome measure represented only 6% of effects; we subsequently examined type of outcome measure as a moderator variable. 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. Table 1 summarizes relevant study characteristics.

Estimation of Effect Size

For effect sizes, we used Pearson correlations if available. Our strategy was to extract all possible effects. Therefore, we used the following conventions (extensions of those used in Smith, Glass & Miller, 1980) to estimate r: First, if we had a significance level, converted it to r. If the result was nonsignificant, but we had enough information to calculate a t and then convert, we did so. If we had no other information than that the effect was nonsignificant, we set r at 0. If the authors indicated a "nonsignificant trend," but did not report a correlation (for instance, a key study, Kiesler et al., 1967, indicated several trends on MMPI scales), we estimated the trend by assigning an ES of half the size of a significant r.

Coding Procedure

The following variables were coded: therapy format (individual or group); theoretical orientation; experience level of therapists; treatment setting (inpatient, outpatient); number of sessions (typically the mean); type of problems (mixed neurotic, depression, anxiety, severe problems such as psychosis); source of outcome measure (therapist rating, client rating, objective, and other measures); when outcome was measured (e.g., postsession, posttherapy, followup); type of outcome measured (symptom change, improvement, global); source of empathy measure (objective ratings, therapist, client, therapist/client congruence, trait measure); and unit of measure (2-5 minute samples, session, therapy to date).

We conducted two sets of analyses: 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 client samples using Fisher r-to-z conversions to correct for distributional biases before further analysis, thus avoiding problems of nonindependence and eliminating bias due to variable numbers of effects reported in different studies (Lipsey & Wilson, 2001) ; e.g., one study, Kurtz & Grummon, 1972, contributed 42 effects). For analyses across studies, we weighted studies by inverse error and analyzed for heterogeneity of effects using Cochrane's Q (following the Hunter-Schmidt method, using the program in Diener, Hilsenroth & Weinberger, 2009), and also I^2, an estimate of the proportion of variation due to true variability as opposed to random error (Higgins, Thompson, Deeks & Altman, 2003). Finally, where necessary in the correlational analyses of moderator variables to correct for nonindependence, we used weighted effects by the inverse of number of analyses per study.

Results

The single best summary value, as shown in Table 2, is the study-level, weighted *r* of .30, a medium effect size. Average effects were .22 for analyses of the 224 nonindependent separate effects, probably an underestimate due to smaller effects found in one study (Kurtz & Grummon, 1972). These 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). Overall, empathy typically accounts for more outcome variance than does specific treatment methods (compare Wampold's, 2001, estimate of 1 to 8% for intervention effects). However, the .30 figure conceals statistically significant variability in effects, as indicated by a study-level Cochrane's Q of 205.8 (*p* < .001); in addition, I^2 was 67%, considered to be a large value. This means that a further examination of possible moderators of the empathy-outcome association is not only justified but is in fact necessary (Lipsey & Wilson, 2001).

Moderators and Mediators

We divide this section on moderators and mediators into two parts: meta-analytic analyses of moderator variables and therapist mediating factors.

Meta-analytic Moderator Analyses

The significant Q and large I^2 statistics point to the existence of important moderator variables or 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. For example, one might expect the association to be larger in those therapies for which empathy is held to be a key change process, such as person-centered

therapies. However, our analyses, summarized in Table 3, turned up little evidence of such a trend, but significant, large amounts nonchance heterogeneity within the CBT and Other/Unspecified therapy samples. 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 conjecture, but points to important sources of variability that need to be explored

In Table 4 we chart 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; Parloff, Waskow & Wolfe, 1978), 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, empathy accuracy measures were unrelated to outcome (.08; n = 5, ns). Although the overall Q value for between group heterogeneity was not significant, comparison of confidence intervals indicated that client-perceived empathy significantly predicted outcome better than accuracy measures ($p < .05$).   A word of caution: All perspectives except empathic accuracy are characterized by large (> 50%), statistically significant amounts of nonchance heterogeneity. Clarification of the source of this heterogeneity, awaits further research; however, for now it seems fair to say that clients' feelings of being understood and observer ratings (and to a lesser extent, therapist impressions) appear to carry significant weight as far as outcome goes, but that empathic accuracy measures do not, in spite of their intuitive appeal.

Finally, in Table 5, we examine several other variables that might account for some of the heterogeneity of the effect sizes: year of publication, sample size, outpatient vs. inpatient treatment, treatment format (individual vs. group), length of therapy, client severity, therapist experience level, globalness of outcome measures (invidualized to satisfaction ratings), and size of empathy unit (5 min segment to whole therapy). Using ordinary (that is, unweighted correlations), none of these were statistically significant. On the other hand, analyses using weighting for inverse error (i.e., sample size minus 3) were significant for all variables except outcome globality and size of empathy unit; however, these suffer from nonindependence within studies, and will require a substantially larger set of studies or more sophisticated, multi-level meta-analytic methods to verify. Briefly, these analyses point to the possibility that empathy is 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).

On the other hand, it may be that the empathy relationship is slightly less predictive of positive outcome in inpatient settings, and with more experienced therapists (study level mean r = -.19; effect level = -.29); the latter is the largest of this set of correlations, and is consistent with our 2002 meta-analysis. As we previously speculated, there are at least two possible reasons for this: To begin with, inexperienced therapists may vary more in empathy, while smaller correlations for experienced therapists may reflect a restriction of range or ceiling effect. Alternatively, experienced therapists may have developed additional skills such as effective problem-solving, so that clients are more likely to forgive empathic misattunements.

Therapist Mediating Factors

As noted earlier, affective neuroscience researchers have proposed that empathy involves three interlinked skills or processes: affective simulation, perspective taking, and regulation of

one's own emotions (Decety & Jackson, 2004). Supporting this, research has found a relationship between various measures of cognitive complexity, such as those of perspective-taking or abstract ability, and empathy in both developmental psychology and in psychotherapy (Eisenberg & Fabes, 1990; Henschel & Bohart, 1981; 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. Similarity and familiarity between the target of empathy and the empathizer have been found to be important modulators of empathy in neuroscientific 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 the relative infrequency of talking too much, giving advice, and interrupting (Duan & Hill, 1996; Watson, 2001). Other research has shown that responses that are just ahead of the client seem to be more effective than responses which are either at the same level as the client, or at a more global level (Sachse, 1990a, b; Tallman et al., 1994; Truax & Carkhuff, 1967). An a qualitative study of clients' experience of empathy, interrupting, failing to maintain eye contact, and dismissing the client's position while imposing the therapist's own position were all perceived as unempathic (Myers, 2000). 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 amount of therapist empathy varies as a function of the client. Early studies (Kiesler et al.,1967), for example, found that levels of empathy were higher with clients who had less pathology, who were brighter, but yet were lower in self-esteem. Therefore, the client him or herself almost certainly influences therapist empathy. As Barrett-Lennard (1980) 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., 2004).

On the other hand, not all clients respond favorably to explicit empathic expressions. In their review, Beutler, Crago, and 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." Another study (Mohr & Woodhouse, 2000) found that some clients prefer business-like rather than warm, empathic therapists. 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.

More broadly, Duan and Hill (1996) speculated that different types of empathy may be hindering or helpful to clients at different times. Hill and her colleagues (Hill et al., 1992; Thompson & Hill, 1991) found that when clients had negative in-session reactions to their therapists, the therapist's awareness or understanding of the reaction "led to interventions that were perceived as less helpful than when the awareness was absent" (p. 269). In such relational ruptures, it is probably useful for therapist empathy to be accompanied and deepened by genuine warmth, openness, and concern for the clients' feelings, rather than defending oneself and blaming the client (also see Safran & Muran, this volume).

Keeping in mind the notion of empathy as not only getting inside the skin of the client, but getting inside the skin of the relationship (O'Hara, 1984), it may be that in some cases the therapist is more empathic by not expressing empathy. Martin (2000, pp. 184-185) notes: "Think of the insensitive irony of a therapist who says, 'I sense the sadness you want to hide. It seems like you don't want to be alone right now but you also don't want somebody talking to you about your sadness....' "This response might technically seem empathic, but in fact at a higher level, it is unempathic, controlling and intrusive, because it violates the client's need for interpersonal distance. Variations among clients in desire for and receptivity to different expressions of empathy need further research.

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. 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, most of the therapists scored below the minimum considered to be effective, and outcome was only modest to moderate in the study. It is not surprising that no significant correlations were found. Furthermore, in a few cases, results were reported as either significant in the positive direction or nonsignificant, possibly disguising weak negative effects. This is particularly a problem for calculating effect sizes based on limited information, thus introducing error into the process.

The key question of whether empathy is causally related to therapeutic outcome -- as opposed being merely a correlate of it -- cannot be answered definitively from our meta-analysis. This is the central limitation of the process-outcome research reviewed here. However, data from several studies shed light on the question. First, Burns and Nolen-Hoeksema (1992) and Cramer and Takens (1992) have used causal modeling (structural equation modeling, path analysis) to explore the relationship between empathy and outcome. Second, in another study (Miller et al., 1980), ratings of therapist empathy were made by supervisors before and independent of knowing about outcome data. Yet empathy showed a strong ($r = .82$) relationship to outcome in a cognitive-behavioral program for drinking. Third, Anderson (1999) measured therapists' facilitative interpersonal skills, including accurate empathy, before therapy, by having them respond to videotapes of clients who presented in difficult interpersonal ways. Anderson found statistically significant relationships between this prior measure of therapist interpersonal skills and client outcome in subsequent psychotherapy, a finding recently replicated with a larger, practice-based sample of therapists and clients (Anderson, Ogles, Patterson, Lambert & Vermeersch, 2009).

On the other hand, Burns and Nolen-Hoeksema (1992) note that structural equation modeling cannot definitely show causality but only explore and elaborate particular causal models. Miller et al (1980) had supervisors rate supervisee's levels of empathy, but it is possible that these ratings were influenced by supervisee's reports of how well therapy was going with their clients. In Anderson et al.'s (2009) study in which empathy was measured independently of therapy, empathy is confounded with other facilitative interpersonal skills. Even though

empathy is the predominant process in client-centered and related therapy, it is not the only process.

The evidence we have presented is clearly compatible with a causal model implicating therapist empathy as a mediating process leading to client change. It is true that correlational studies can only probe into or lend support for or against causal models of therapeutic change. As is the case for much of the social sciences, establishing conclusive evidence for particular hypothesized causal processes is notoriously difficult and may ultimately prove elusive. Insofar as codes of professional ethics stipulate a caring, transparent empathic stance in all professional contacts, it is therefore both impractical and unethical to randomize clients to demonstrably empathic vs. unempathic therapists. In such cases, meta-analyses can provide a valid alternative to randomized clinical trials (Berman & Parker, 2002), providing that the identification and analysis of observational studies has been done carefully and systematically.

Therapeutic Practices

The most consistent and robust evidence is that clients' perceptions of feeling understood by their therapists relate to outcome. As we have shown, empathy is a medium-sized predictor of outcome in psychotherapy. It also appears to be a general predictor across theoretical orientation, treatment formats, and client severity levels. This repeated finding, in both dozens of individual studies and now in multiple meta-analyses, leads to a series of clinical recommendations.

• It is important for psychotherapists to make efforts to understand their clients, and to demonstrate this understanding through responses that address the needs of the client as the client perceives them on an ongoing basis. 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, both explicit and implicit. Empathy entails capturing the nuances and implications of what people say, and reflecting this back to them for their consideration.

• Empathic responses continue to coordinate with the "moving point" of the focus of the client's concerns as therapy progresses.

• Our meta-analytic findings that observer ratings of accurate empathy predict outcome suggest that therapist responses that accurately respond to and carry forward the meaning in the client's communication are useful.

• Research has identified a range of useful types of empathic responses, several of which we illustrate here with a running example. *Empathic understanding responses* convey understanding of client experience. For example:

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, so last night was another night without sleep… and work has been so busy and I have been so tired and P needs my attention. I have been going around in circles 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 I have been doing other things, and then my Dad was here. Things are just swirling around me. I don't know how to keep my stuff together enough for me even to survive.
> 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 explorations are attempts by therapists to get at that which is implicit in clients' narratives and focus on information that has been in the background but not yet articulated

> C: I keep responding to him, like it's against what I want to do.
> T: Somehow you can't let go. It is just so hard to walk away

Empathic conjectures go beyond explorations in that they are guesses at what the client feels. They are similar to interpretations but do not attempt to provide the client with new information, rather they are presented as hunches grounded in what the client has presented:

> C: Yeah, yeah that is it exactly, and P is not helping. One of his friends has needed to use the computer. So he has been over every night this week. 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. We are not eating regularly, we are not sleeping.   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. Therapists need to help clients access as much internal information as possible. To this end they need to attend to that which is not said, or that which is at the periphery of awareness as well as that which is said and is in focal awareness (Watson, 2001).

• Empathy entails individualizing responses to particular patients. We found significant heterogeneity across studies in the size of the empathy-outcome association, pointing to the need for caution. 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 neither assume 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.

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Table 1
Study Characteristics

Parametric Characteristics:	M	SD	Range
Sample size:	61	59.6	6 - 320
Length of therapy (sessions)	24	42.4	3 - 228
Effects per study	3.8	5.7	1 - 42
Categorical Characteristics:	Typical Categories		%
Time period (range: 1961 – 2008)	Before 1980		49
Theoretical orientation	Mixed, eclectic or unknown		40
Modality	Individual		74
Client presenting problem	Mixed neurotic (mixed anxiety/depression)		40
Therapist experience level	Recent Ph.D or M.D.		36
Outcome assessment time point	Posttreatment		60
Empathy perspective	Client (mostly Barrett-Lennard) Observer (mostly Truax-Carkhuff 34%)		39
Empathy measurement unit	Therapy to date		60

Table 2
Empathy-Outcome Correlations: Overall Summary Statistics

	Effect Level ($N = 224$)		Study level ($N = 59$)	
N	M	Sd	M	Sd
Weighted Mean r	.22*	.33	.30*	.13
Cochrane's Q		646.22*		174.65*
I^2		65.49		66.79

 * $p < .001$

Note. Fisher's r-to-z transformation used to calculate means and sds. Weighted *r*s use inverse variance (i.e., n-3) as weights and are tested against mean $r = 0$ following the Hunter-Schmidt method using Deiner's (2010) program.

Table 3
Mean Effects Across Theoretical Orientation

Theoretical Orientation	n	Mean Weighted r	Within Group Q	I^2
Experiential/ Humanistic	8	0.26**	7.68	8.91
Cognitive-Behavioral	10	0.31**	24.55*	63.34
Psychodynamic	4	0.19**	2.01	0
Other/Unspecified	37	0.31**	138.01**	74.64
Between groups Q	2.39 (df = 3, 55, ns)			

*p < .01; **p<.001

Note. Mean correlations calculated using Fisher's z scores. Significance tests for mean correlations are against the null hypothesis of mean *r = 0.* Q tests for heterogeneity are evaluated as a Chi-square test, using Diener et al.'s (2009) program using the Hunter-Schmidt (ref) method. Within groups Q is analogous to a one-way ANOVA with study samples as levels; between groups Q calculated as difference between total sample Q and within group Q, following Lipsey and Wilson (2001).

Table 4
Mean Effects Across Empathy Measurement Perspectives

Measurement Perspective	n	Mean weighted r	Within Group Q	I^2
Observer	27	.25**	93.14**	72.09
Client	38	.32**	119.35**	69.00
Therapist	11	.20**	21.05*	52.50
Empathic Accuracy	5	.08	5.91	32.35
Total	82	.27	258.08**	68.61
Between groups Q		2.39 (df = 3, 78, ns)		

*p < .05; **p < .001
Note. See note for Table 3.

Table 5

Correlations between Empathy-Outcome Effect Size and Selected Moderator Variables

Predictor	Unweighted		Weighted	
	r	*n*	*r*	*n*
Year of publication	.14	59	.12*	3422
No. of clients in study	.06	59	.15*	3422
Setting (1 = outpatient; 2 = inpatient)	-.13	58	-.08*	3305
Format (1 = individual; 2 = group)	.12	54	.15*	2807
Length of therapy (in sessions)	.04	41	-.08*	2074
Client severity (3-point scale)	.10	41	.14*	2320
Therapist experience level (6-point scale)	-.19	51	-.29*	2820
Outcome globality (6-point scale: individualized to satisfaction ratings)	.17	59	.00	3360
Size of empathy unit (4-point scale)	-.06	59	-.02	3443

p < .001

Note. Weighted analyses used inverse error (i.e., degrees of freedom) but are not corrected for nonindependence of participants within studies; analyses of outcome globality and size of empathy unit analyses were also inverse-weighted by number of effects per study to correct for nonindependence of effects within studies.