Towards Elucidating the Operationalization and Measurement of Empathy in

Clinical Outcome Research

By

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## Abstract

Although the study of empathy within the helping professions has a long history, it is a complex, multifaceted phenomenon, whose precise definition remains elusive. Despite the ambiguous nature of empathy, it has been theorized to be an important relationship variable that positively affects client outcomes in medicine and psychotherapy. However, since numerous problems exist in the measurement of empathy, the importance of this prominent relationship variable in medical and psychotherapeutic outcomes cannot be corroborated. The current study was designed to address the problems plaguing empathy research and has several aims. First, the study provides a proposal for the operationalization of empathy as comprising both a cognitive and behavioral component along with evidence supporting this conceptualization. Additionally, solutions are provided for improving the measurement of clinical empathy using the revised Response Empathy Scale (Elliott, 1982). Finally, a study is proposed whereby the revised Response Empathy Scale is tested in clinical practice and client outcomes associated with therapist empathy are examined.

# Contents

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Empathy is one of the most frequently cited and studied relationship

variables of patient care in both psychotherapy and medicine (Elliott et al., 1982;

Linn, DiMatteo, Cope, & Robbins, 1987), and few question its importance to the

helping relationship (Hojat, 2007). Although the study of empathy's significance in

these professions has a long history, it is a complex, multifaceted phenomenon,

whose precise definition remains elusive. In fact, a review of the literature dating

back to the 1940's reveals that there is more disagreement than agreement on its

definition (Hojat, 2007). Thus, "empathy" has been described as a "slippery concept"

(Eisenberg & Strayer, 1987, p. 3), and one researcher even asserted that empathy

has grown to mean so many different things that it really means nothing (Pigman,

1995).

Given the plethora of conceptualizations that exist, there is reasonable

skepticism over the validity of empathy outcome research (Wispe, 1986). Thus, the

current study was designed to move the field towards creating a more reliable and

valid way of quantifying clinician empathy in order to elucidate empathy's role in

patient outcomes. Before introducing the nature of the study, it is prudent to review

empathy research by covering three important domains: Thus, the major historical

definitions and conceptualizations of empathy, the theoretical importance of

empathy in the clinical setting, and the current problems in the measurement of

empathy will be examined.

## A Myriad of Definitions

The word "empathy" stems from the German word *Einfühlung*, a term first coined in 1873 to describe feelings that were elicited by works of art (Hunsdahl, 1967; Jackson, 1992). *Einfühlung* was later used by Sigmund Freud in 1905 to describe the psychodynamics of putting oneself in the position of another (Pigman, 1995). In 1909, Edward Bradner Titchener first coined the term "empathy," which he derived from the Greek word *empatheia*, defined as the appreciation of another's feelings (Di Lillo, Cicchetti, Scalzo, Taroni, & Hojat, 2009). Subsequently, Southard (1918) asserted the importance of empathy for facilitating outcomes in the clinical setting (Carkhuff, 1969; Hojat, 2007). However, Rogers (1957) is often given credit for presenting the first popularized definition of empathy, which jumpstarted the use of the term and its study within the helping relationship. By 1968, twenty-one definitions of empathy had been proposed within the counseling literature alone (Hackney, 1978).

Carl Rogers, the founder of client-centered therapy, refined his definition of empathy over the years. He initially viewed empathy as the ability "to perceive the internal frame of reference of another with accuracy as if one were the other person but without ever losing the 'as if' condition" (1959, p. 210). Rogers (1995) later defined it as "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). Another way he phrased this definition is, "[Empathy is] being sensitive, moment by moment, to the changing felt meanings which flow in this

other person…" (p. 142). Rogers' definitions have been considered the most insightful and thorough in empathy research (Eisenberg & Strayer, 1987). His early attempts to describe empathy in terms that were "clearly definable and measurable" (Rogers, 1957, p. 3) were the catalyst that stimulated a large volume of research and debate on the topic.

Although Rogers' attempted to define empathy in measurable ways, he fell short in that he described an internal and unobservable state—for instance, by describing those processes of empathy of which only the clinician is aware. This is true despite the fact that Rogers (1957) asserted that if the counselor's empathy was going to be effective, it had to be communicated to the client. Recognizing this dilemma, Truax, one of the earliest empathy researchers, modified Rogers' definition to allow for the possibility of identifying observable and measurable phenomenon associated with the communication of empathy. Truax (1963) definition incorporated both the state of empathy as well as its process by proposing that empathy was "…the sensitivity to current feelings and the verbal facility to communicate this understanding in a language attuned to the client's current feelings" (p. 46). In 1965, Truax and his colleague, Carkhuff, modified this definition slightly, defining *accurate empathy* as "…the skill with which the therapist is able to know and communicate the client's inner being" (p. 5). Thus, over time, Rogers' original definition was shifted from an internal perception to an externally observable skill (Hackney, 1978).

Barrett-Lennard (1981) also drew from Rogers' ideas about empathy by expanding the concept into a three-phased cyclical model that taps various

components of empathy, and his model is most closely aligned with Roger's definition of empathy (Gurman, 1977). He purported that Phase 1 empathy consists of the clinician's experience of *empathic resonation* with the client's experience. Phase 2 empathy consists of *expressed empathy*, or the clinician's communication to the client that he or she understands the client's experience. Finally, Phase 3 empathy is *received empathy*, or the client's perception of the clinician's understanding and attunement to his or her immediate experience. Barrett-Lennard's model is also unique in that rather than assessing empathy broadly, as has generally been the case, he measured it as a process consisting of specific therapeutic interactions within a single counseling session.

According to Elliott, Bohart, Watson, and Greenberg (2011), Rogers' definitions of empathy imply that it is a higher-order phenomenon comprising several subtypes. Specifically, Elliott et al. (2011) derived three modes of empathic expression stemming from Rogers' definitions. These include (1) *empathic rapport*, in which the therapist approaches the client with compassion and attempts to demonstrate understanding of the client's experience; (2) *communicative attunement*, which is a constant attempt to stay mindfully attuned to the client's ongoing experience; and (3) *person empathy* (Elliott, Watson, Goldman, & Greenberg, 2004), which is experiencing a close understanding of the client's world, achieved through familiarizing oneself with how the client's background of experiences has led him or her to currently interpret the world. Thus, Elliott et al. (2011) views empathy as comprising multiple elements.

Psychodynamic investigators have often emphasized affective and subjective processes in their conceptualizations of empathy. For example, Basch (1983) defined empathy as an affective state within the therapist in response to the patient, and Book (1988) asserts that empathy is "a spontaneous, intrapsychic, preconscious experience...within the therapist" (p. 421). Furthermore, Frayn (1990) states that "The patient compels the therapist to experience the patient's inner world by inspiring in the therapist a feeling, thought, or self-state that previously had only remained within himself" (p. 194). Although a therapist's own emotional reactions to a client could provide insightful information to the conceptualization of the patient, emotional responses to another are generally idiosyncratic and reveal more about the therapists' perceptions and beliefs than the clients' (Burns & Auerbach, 1996).

A review of the definitions indicates that empathy has been conceptualized as a cognitive or an emotional (affective) attribute, or some combination of both. Definitions that emphasize cognitive components of empathy include processes such as perspective taking and stress understanding rather than emotional involvement (Rogers, 1975). Those definitions that stress the emotional components of empathy, however, emphasize processes such as shared emotional experience (e.g., Batson & Coke, 1981). Still, many definitions emphasize both cognitive and affective processes (Baron-Cohen & Wheelwright, 2004; Davis, 1983). Whether empathy is viewed primarily as a cognitive process or an emotional one is important because cognition and emotion are actually two separate systems. Although these systems work together to process incoming information, distinct

brain mechanisms seem to be involved in their processing (Tomkins, 1962, 1963).

Cognitive processing involves higher-order mental processes such as social

perception, reasoning, analyzing, and synthesizing information for responding.

Emotional processing, on the other hand, is a more primitive process and largely

automatic. A person responding emotionally is operating through a process of

contagion, in which the person responds in an emotionally similar way to others

present in the interaction. According to Hojat (2007), an emotional response leads

to more inaccurate interpretations than a cognitive one because it is more

dependent on subjective judgments. Nevertheless, the argument over whether to

conceptualize empathy as a cognitive and/or emotional process has been one of the

biggest disagreements over its definition since its early history and has contributed

to some of the major problems in the study of empathy.

### The Theoretical Importance of Empathy within the Clinical Setting

Nonspecific elements in psychotherapy are components of therapy that are

shared across nearly all psychotherapeutic interventions, regardless of their

theoretical origins (e.g., healing setting, treatment rationale, and the therapeutic

relationship; DeRubeis, Brotman, & Gibbons, 2005). Alternatively, specific elements

of psychotherapy are the techniques employed by a therapist that are unique to a

particular school of thought or theoretical orientation (e.g., hypnotism, meditation,

and exposure exercises; Butler & Strupp, 1986). Empathy is considered a

nonspecific element of psychotherapy and a pivotal feature of the therapeutic

alliance. Thus, before delving into the research supporting the importance of

empathy within the clinical setting, it is prudent to briefly review outcome research involving the therapeutic relationship (i.e., therapeutic alliance).

Bordin (1979) proposed a definition of the therapeutic alliance that is applicable to a variety of therapeutic approaches. Bordin's conceptualization highlights the collaborative relationship between the patient and the therapist as they work towards the common goal of reducing the patient's suffering. According to Bordin (1979) the therapeutic alliance consists of three essential elements: agreement on the goals of the treatment, agreement on the tasks required to meet these goals, and the development of a personal relationship made up of reciprocal positive feelings. He asserts that the first two components of the alliance can only develop if there is a relationship of confidence and regard, since an agreement on therapeutic goals and tasks requires the patient to place trust in the therapist's abilities, and the therapist in turn must be confident in the patient's resources. Bordin views the alliance as an essential ingredient that enables the patient to accept, follow, and believe in the treatment. Rather than separating therapeutic processes and intervention techniques, Bordin argues that they are interdependent components affecting outcome (Ardito & Rabellino, 2011).

An expanding body of evidence supports the idea that the quality of the therapeutic alliance is linked to the success of treatment across a wide range of clients, treatment modalities, and identified problems (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). Although alliance accounts for only 7% of the variance in outcome (Flückiger et al., 2012), the relationship between the therapeutic relationship and outcome has remained steadfast across meta-analyses that have

been conducted since the 1990's (Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011, Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The correlations between alliance and outcome have remained even when disorder-specific treatment manuals are used or when studied in the context of randomized clinical trials (Flückiger et al., 2012). Additionally, within the field of medicine, a large body of research has demonstrated the beneficial effects of positive clinician-patient relationships on patients' adherence to treatment regimens, the comprehension and recall of medical information, the ability to cope with diseases, quality of life, and overall well-being (Hojat, 2007).

Despite the extensive research documenting the importance of the therapeutic alliance to outcome, it is important to note that there have been criticisms in the methodology of some studies. For example, some meta-analyses have included studies whose therapists utilized techniques from more than one theoretical orientation (e.g., Horvath & Symonds 1991; Martin et al., 2000). Thus, the relationship between alliance and outcome within a specific form of psychotherapy was not addressed. Additionally, the results of studies investigating the role of alliance within a specific therapeutic tradition have been somewhat inconsistent.  For example, although some studies have found that therapeutic alliance leads to symptom improvement (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Krupnick et al., 1996; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Raue, Goldfried, & Barkham, 1997), others have been unable to demonstrate this relationship (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Safran & Wallner, 1991). Based on these results, some researchers

have suggested that the therapeutic alliance may have different effects across treatment modalities (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998).

Criticisms of the alliance/outcome literature also stem from the failure of some studies to account for the possibility that a positive treatment outcome positively affects therapeutic alliance rather than vice versa. In fact, in two studies evaluating the therapeutic alliance during the course of cognitive therapy, researchers found that although there was no relationship between alliance and symptom change early in therapy, alliance scores late in therapy could be predicted by the degree of client improvement (DeRubeis & Feeley, 1990; Feeley et al., 1999). Furthermore, Tang and DeRubeis (1999) found that although alliance was higher following sudden symptom improvement in cognitive therapy (i.e., "sudden gains"), it did not predict such improvement. Thus, in these studies, the alliance appeared to be the result of—not the cause of—a positive treatment response.

Some studies have examined the therapeutic alliance in relation to outcome and have taken into account potential temporal confounds. For example, in a study employing brief dynamic therapy, Barber et al.(2000) found a significant relationship between alliance and outcome controlling for prior symptom improvement. Furthermore, in a study of cognitive-behavioral analysis system of psychotherapy (CBASP), Klein et al. (2003) found that alliance early in treatment predicted subsequent symptom improvement, but improvement did not predict alliance.  Thus, despite the criticisms, evidence exists for the positive associations between a strong working alliance and positive outcomes. Given that empathy has been heavily theorized to be one of the active components of the therapeutic

relationship (Rogers, 1959), it is not surprising that researchers have hailed empathy as a clinically important outcome variable.

**Empathy and Outcome in Medicine**

Although empathy has been considered a basic component of all helping relationships, meaningful empathy research is lacking in the primary care setting (Mercer & Reynolds, 2002). Researchers have concluded that patients' own conceptualizations of quality care in primary practice include empathy as a key component (Lewis, 1994), however, more research on the role of empathy in terms of clinical outcomes is needed. The work that has been done suggests that empathy is key in a positive doctor-patient relationship and improves satisfaction for both treatment providers and patients (Levinson, Gorawara-Bhat, & Lamb, 2000; Marvel, Epstein, Flowers, & Beckman, 1999; Suchman, Roter, Green, & Lipkin Jr, 1993). Empathy may also be an important part of positive treatment outcomes. For example, in one study, researchers examined the relationship between physician empathy and outcome in diabetic patients (Hojat et al., 2011). This study revealed a positive relationship between physician's empathy and patients' ability to gain control over their symptoms and underscored the importance of clinician empathy in even highly regimented interventions.

**Empathy and Outcome in Psychotherapy**

A vast array of literature supports the notion that empathy plays a key role in outcome with some asserting that the empathic process is inherently curative (Bohart & Greenberg, 1997). One meta-analysis revealed that empathy accounted for 9% of the variance in psychotherapy outcome (Elliott et al., 2011). Additionally,

Burns and Nolen-Hoeksema (1992) treated a sample of 185 individuals with depression using cognitive-behavioral therapy (CBT) and demonstrated that therapist empathy had a moderate-to-large effect on treatment outcome, even when controlling for homework compliance.  In another study, Miller, Taylor, and West (1980) randomly assigned clients presenting with problematic drinking habits to nine counselors, who varied in levels of accurate empathy. The researchers found that after six months, the correlation between therapists' level of empathy and outcome (number of drinks consumed per week) was $r = .82$, which accounted for two-thirds of the variance. Similarly, Ritter et al. (2002) treated patients for alcohol addiction using standardized cognitive-behavioral therapy and then examined the relationship between therapist characteristics and client outcomes 3 months later. They found that therapist empathy was associated with improvements across multiple domains (e.g., number of negative consequences because of drinking and the degree of physical dependence). Additionally, in a treatment study for pregnant and post-partum cocaine users, Pantalon, Chawarski, Falcioni, Pakes, and Schottenfeld (2004) found that client ratings of their therapist's empathy correlated significantly with abstinence rates and engagement in therapy six months after treatment.

Not only is therapist empathy considered necessary for client change, but low therapist empathy may even be considered toxic (Moyers & Miller, 2012). For example, Valle (1981) compared relapse rates of clients seeing therapists scoring high, medium, or low in Rogerian skills (e.g., empathy, warmth, and genuineness). Valle (1981) found that at each follow-up point, the risk for relapse was two to four

times higher for clients treated by therapists scoring low in Rogerian skills. The clients of these therapists also had four times the number of drinking days.

One major outcome variable for which therapist empathy has been shown to play a role is attrition from therapy. Premature termination of therapy services is a widespread problem that limits the effectiveness of applied interventions and leads to poorer outcomes (e.g., Klein, Stone, Hicks, & Pritchard, 2003; Wierzbicki & Pekarik, 1993). The impacts of client attrition also extend to the larger society, given the increased burden of mental illness experienced by those who are not receiving services (Barrett, Chua, Crits-Critstoph, Gibbons, & Thompson 2008). The most recent meta-analysis by Swift and Greenberg (2012) revealed a psychotherapy dropout rate of nearly 20%, but a previous meta-analysis reported a dropout rate of 47% across 125 studies (Wierzbicki & Pekarik, 1993). In attempts to examine therapist factors involved in client attrition, several studies have examined empathy in relationship to dropout. For example, Kolb, Beutler, Davis, Crago, and Shanfield (1985) examined the relationship between patient process variables and a variety of outcomes. They found that patients who perceived their therapist as having a high degree of facilitative skills (for which empathy was a component) were significantly less likely to drop out of treatment than those who perceived their therapist as having low facilitative skills. They also found that there was little relationship between remaining in treatment and either symptomatic or global improvements. In a similar study, Saarnio (2002) demonstrated that therapists with low levels of Rogerian skills had more clients drop out of treatment than therapists with high levels. In a different study, Beckham (1992) found that therapist empathy, as

measured by administration of the client-rated BLRI after the initial session,

predicted the clients who would and would not end therapy services prematurely.

Although far from comprehensive, the research presented here supports the

importance of empathy in patient outcomes. Thus, it is no surprise that in a review

of reviews of therapist variables in regard to therapy outcome Patterson (1984)

concluded that the evidence is supportive for the necessity—and perhaps the

sufficiency—of empathy, warmth, and genuineness on the part of the therapist.

Nonetheless, as is outline below, many researchers would find fault with this

statement

## A Comment on Specific Factors

Although the therapeutic relationship and other nonspecific factors (i.e.,

elements in psychotherapy treatment that are shared across nearly all therapeutic

interventions) such as empathy have been demonstrated to be important to

psychotherapy outcome, some researchers suggest that the specific effects of

psychotherapy (i.e., the technical maneuvers therapists utilize based upon their

theoretical orientation) may be markedly stronger than is commonly believed.

Proponents of specific factors research have offered alternative explanations to

research that supporters of the nonspecific factors hypothesis offer to support their

claims.

There are two major arguments that have been used to support the notion that

therapies exert their effects via nonspecific means (Ahn & Wampold, 2001;

Castonguay et al., 1996; Ilardi & Craighead, 1994; Luborsky, Singer, & Luborsky,

1975; Strupp & Hadley, 1979). First, when psychotherapies are compared, they all

appear to be equally effective. Thus, proponents of the nonspecific factors hypothesis conclude that this equivalence must stem from components of psychotherapies that are shared amongst the various schools of thought. Second, a large body of evidence demonstrates that the therapeutic alliance plays a major role in determining treatment success. Given that all psychotherapists—regardless of their theoretical orientation—seek to establish an alliance, treatment outcome must be largely determined by such nonspecific factors (DeRubeis, Brotman, & Gibbons, 2005). These two major lines of research have led many to believe that specific therapeutic technique exert little or even no influence in psychotherapy outcome.

Although the therapeutic relationship and other nonspecific factors such as empathy have been demonstrated to be important to psychotherapy outcome, some researchers suggest that the specific effects of psychotherapy may be markedly stronger than is commonly believed. This line of thinking stems from problems in the way psychotherapies have been commonly compared. For instance, global meta-analyses (e.g., Shapiro & Shapiro, 1983) from which proponents of the nonspecific factors hypothesis draw much of their evidence, pose broad questions that preclude meaningful interpretation. Meta-analyses, for example, may examine the effectiveness of one therapy against the effectiveness of a different therapy across patient populations and/or disorders. Answering these broad questions informs the practice of psychotherapy very little because it is possible for a therapy to be beneficial for one problem and potentially harmful for a different problem or for a different person. In light of such criticisms, researchers have begun untangling the question regarding the effectiveness of certain psychotherapies for particular

disorders, presenting problems, populations, etc. (DeRubeis, Brotman, & Gibbons, 2005).

Based on the results of numerous comparative outcome studies, researchers have identified four disorders for which "efficacious and specific" treatments haven been identified (DeRubeis & Crits-Christoph, 1998). For example, researchers have discovered that the best outcomes for individuals with obsessive-compulsive disorder (OCD) are achieved when therapists utilize exposure and response prevention (e.g., Fals-Stewart, Marks, & Schafer, 1993). Other empirically-supported treatments for specific disorders include cognitive therapy for panic disorder, exposure therapy for post-traumatic stress disorder (PTSD), and cognitive-behavioral group therapy for social phobia. Thus, at least for some disorders, evidence suggests that specific therapeutic techniques proffer the most efficacious outcomes. Notably, however, research is lacking in the examination of the importance of therapeutic empathy for client outcome within the context of empirically-supported treatments.

## Problems in the Measurement of Empathy

A review of clinical empathy would not be complete without describing the problems plaguing empathy measurement within the helping professions. In these fields, empathy is theoretically vital for the achievement of accurate case-conceptualization and the development and maintenance of a positive working alliance, both of which are associated with improved client/patient outcomes. Although the ability to express empathy varies across individuals, empathy can be taught as a skill and developed over time (Alligood, 1992; Spiro, 1992). However,

valid and reliable measurement tools are necessary in order to assess the effectiveness of empathy training programs and conduct methodologically sound empathy outcome studies, and these are currently lacking. Given the theoretical importance of empathy within the clinical setting, the lack of sound measuring tools is surprising and deserves attention. Optimally measuring empathy in the future relies on drawing from the strengths and weakness of existing assessment measures.

Empathy measures have become as diverse and varied as the definitions they arose from. Table 1 (see Appendix A) lists some of the more common empathy instruments, but it is far from exhaustive. The measures included in the table are those that have been used to measure clinician empathy quantitatively in psychotherapy and/or medicine in at least two empirical studies. Also included are the more contemporary empathy scales (those developed since 1980), since these have attempted to address previous measurement issues. Instruments were excluded if they were used to measure empathy exclusively within certain therapy protocols (e.g., Motivational Interviewing). As can be seen from the table, the measures generally fall into one of three categories based on whose perspective is being used to assess clinician empathy. The categories include self-rated measures, client-rated measures, and observer-rated measures. Some empathy instruments use a combination of perspectives, but these are relatively rarer. Additionally, the measures in the table differ by the type of empathy being assessed (e.g., cognitive or emotional empathy). However, a large proportion of the measures do not specify

this information.  Specific items from the measures are pulled to illustrate the problems discussed below, however, the lists of examples are not all-inclusive.

**Validity Issues**

Empathy scales that have been commonly used in outcome studies have been highly criticized for their lack of validity. Johnson, Cheek, and Smither (1983) cautioned researchers attempting to measure empathy:

Psychometrics, like any form of mathematics, is an arbitrary convention designed to give coherence to one's empirical observations. When one forces one's research into an inappropriate mathematical mold, the purpose of mathematics is defeated. When psychometrics becomes an end in itself, the growth of substantive psychological knowledge suffers (p. 1308-1309).

Thus, although empathy scales' numbers in relation to factor-loading, variance, and reliability can be quite impressive, examination of individual items reveals that these scales lack validity.

**Confounding empathy with other relationship variables.** Although it is nearly impossible to treat emotion and cognition as completely separate factors because they cannot exist in isolation, it is practical to view these as distinct processes. Researchers have nonetheless used the two concepts of empathy and sympathy interchangeably despite evidence demonstrating that they describe different qualities that differently influence clinicians' professional behavior, use of resources, and clinical outcomes (Nightingale, Yarnold, & Greenberg, 1991; Yarnold, Greenberg, & Nightingale, 1991). For instance, there is some evidence suggesting that what some might refer to as emotional empathy, or sympathy, is actually

detrimental within the helping relationship. Neuroscientific evidence suggests that goal-directed behavior is dependent on executive processes such as working memory. A clinician might depend on his or her working memory to retain client information while drawing inferences about the client's experience. Emotional stimuli are strong distracters that can impair cognitive performance by capturing attention from goal-directed behavior and reallocating processing resources (Ellis & Ashbrook, 1988).

Evidence for the potential detrimental effects of emotional arousal on the part of the clinician has been previously documented. For example, one study found that physicians who sympathetically expressed a worried affect had patients who recalled less information, perceived their condition to be more severe, had more anxiety, and had faster heart rates than the patients of those physicians who did not express this sympathy response (Shapiro, Larsen, & Jacokes, 1991). Furthermore, evidence suggests that feelings of personal distress evoke self-centered motivation to turn one's attention to reducing self-arousal (Batson, Fultz, & Schoenrade, 1987), which would limit allocated attentional resources to another (e.g., the client or patient).

According to a review of the empathy literature, few would argue with the notion that empathy is an important relationship variable with positive effects on patient outcome. Furthermore, evidence suggests that emotional activation on the part of the clinician could have detrimental effects on the quality of services delivered. Thus, if sympathy (i.e., emotional empathy) were confounded with cognitive empathy and included on empathy measures, positive effects of empathy

on outcome could be attenuated. One proposal for lifting the definitional fog and clarifying outcome research would be to operationalize empathy as a primarily cognitive process rather than an emotional one. Previous authors have distinguished empathy from sympathy in this way, suggesting that the pivotal feature of empathy is the primarily cognitive processing that distinguishes it from the primarily emotional processing associated with sympathy (Brock & Salinsky, 1993; Streit-Forest, 1982; Wolf, 1980). In other words, they describe empathy as an intellectual attribute rather than an emotional experience (Gruen & Mendelsohn, 1986)—the difference between *knowing* and *feeling*. However, it would also be important to keep in mind that an understanding of patients would be ineffective if this understanding were never communicated to them in some way. According to those who adopt a cognitive understanding of empathy, an example of a sympathetic response is, "I feel worried for you," while an empathetic response might be, "I understand you might feel worried because the test results won't come back until next week."

In addition to sympathy, other scholars have used empathy interchangeably with other relationship variables. Rogers (1957) stressed that empathy was not the same as unconditional positive regard (i.e., liking and valuing the client) or compassion. Although perhaps part of a higher-order relationship construct, it is also conceptually distinct from such relationship variables as warmth and genuineness (Elliott et al., 2011). Examining the items on various empathy measures, however, reveals that empathy is defined as many different things. For example, the Empathy Scale (Persons & Burns, 1985) includes several examples of

items confounding empathy for other relationship variables and is actually an instrument that captures the quality of the helping relationship generally rather than empathy specifically. Only two of the ten items on the instrument appeared potentially valid in measuring empathy through their focus on the cognitive processing that delineates empathy from other relationship variables: *My therapist understood what I said during today's session*, and *My therapist did not always understand the way I felt inside* (Persons & Burns, 1985).

Items from many other "empathy" measures also reveal the lack of clarity between empathy and other relationship variables. As can be seen from Table 2, empathy is has been used as a term that describes sympathy, care/concern, compassion, a positive attitude, etc. These qualities may indeed be profound in a highly empathetic clinician; however, in order to study the effects of empathy on a variety of outcomes, it needs to be successfully isolated as a distinct relationship variable. The list of examples in the table is far from exhaustive, but they illustrate the lack of discriminant validity present in many empathy measures.

Table 2

*Examples of Empathy Confounded with other Relationship Variables*

| Measure | Examples |
|---|---|
| Interpersonal Reactivity Index (Davis, 1983) | *Sometimes I don't feel very sorry for other people when they are having problems* (reversed scored). *I often have tender, concerned feelings for people less fortunate than me. When I see someone being taken advantage of, I feel kind of protective towards them.* |

| The Consultation and Relational Empathy (CARE) Measure (Mercer, Maxwell, Heaney, & Watt, 2004) | *How was the doctor at showing care and compassion? How was the doctor at being positive?* |
|---|---|
| Hogan's Empathy Scale (Hogan, 1969) | *I have seen some things so sad that I almost felt like crying.* |
| The Empathy Scale (Burns, 1994) | *My therapist was friendly and warm toward me. My therapist pretended to like me more than he or she really does. Sometimes my therapist did not seem to be completely genuine* (reverse scored). |
| Questionnaire of Emotional Empathy (QMEE; Mehrabian & Epstein, 1972) | *I become more irritated than sympathetic when I see someone's tears* (reverse scored). |
| Measure of Expressed Empathy (MEE; Watson & Prosser, 2002) | *Does the therapist look concerned?* |
| Therapist Empathy Scale (Decker, Nich, Carroll, & Martino, 2013) | *A therapist demonstrates warmth by speaking in a friendly, cordial, and sincere manner…In some way, the therapist seems kindly disposed toward or fond of the client.* |

**"Empathy" items irrelevant to the clinical encounter.** There are many measures that include items purporting to measure empathy that are either irrelevant in that their content does not appear related to the construct of empathy or irrelevant in that they do not ask about empathy within an actual clinical interaction. Items for which the former is true are listed in Table 3. As demonstrated in the table, content of several of these items asks about one's imagination or fantasy and one's appreciation for the literature or the arts, including Davis' (1983) Interpersonal Reactivity Index (IRI). Ironically, however, Davis (1983) asserts that, "It is not apparent that a tendency to become deeply involved in the fictitious world

of books, movies, and plays will systematically affect one's social relationships" (p.

115). Thus, even though these items are not apparently related to empathy and may

have no value in predicting outcomes, they are still being included in measures of

empathy.

Some items containing content that is more related to the construct of

empathy, however, are irrelevant to the measurement of empathy within the clinical

setting. For example, the following item appears on a scale asking responders to

formulate an appropriate response: *I just can't communicate with my parents.*

*Whenever I try to explain how I feel about things they get all upset and call me a fool*

(A Pencil-and-Paper Empathy Rating Test; Winefield, 1982). Although a response to

this item may tap someone's empathic abilities, answers to this item may be entirely

irrelevant to the interactions a clinician might have with his or her patients/clients

within the work setting. Another example of an item that may be irrelevant to

empathy expressed within the clinical encounter comes from the empathy scale of

the Princess Margaret Hospital Patient Satisfaction with Doctor Questionnaire

(PMH/PSQ-MD; Loblaw, Bezjak, & Bunston, 1999): *There were some things about my*

*visit with the doctor that could have been better* (reverse scored). A positive

endorsement to this item may have little to nothing to do with the clinician's

empathic abilities, but could reflect a responder's dissatisfaction with the time it

took to get in to see the doctor, the diagnosis and/or prognosis received, or the cost

of the visit amongst other things.

According to Pedersen (2009), the endorsement of some items contained in

various self-report empathy measures may even be counterproductive to the

clinician's role within the helping professions and do not appear to be measuring empathy. For example, endorsing the following items on the Questionnaire of Emotional Empathy (QMEE; Mehrabian & Epstein, 1972) will reduce one's empathy score: *I am able to remain calm even though those around me worry*; *I tend to lose control when I am bringing bad news to people* (reverse scored). Similarly, when endorsing the following items on the IRI one's empathy score will increase: *When I see someone who badly needs help in an emergency, I go to pieces; I am usually pretty effective in dealing with emergencies* (reverse scored); and *I sometimes feel helpless when I am in the middle of a very emotional situation* (Davis, 1983)[1]. Most would agree that "empathy" as reflected in these items would be associated with poorer clinical outcomes and reflect poor emotion regulation abilities on the part of the clinician.

Table 3

*Examples of Items Irrelevant to the Construct of Empathy*

| Name of Measure | Examples |
| --- | --- |
| Hogan's Empathy Scale (Hogan, 1969) | *I enjoy the company of strong-willed people.* *I frequently undertake more than I can accomplish.* *Disobedience to the government is never justified.* *It is the duty of a citizen to support his country, right or wrong.* |
| Jefferson Scale of Physician Empathy (JSPE; Hojat, 2007) | *I have a good sense of humor, which I think contributes to a better clinical outcome.* *I do not enjoy reading nonmedical literature and the arts* (reverse scored). |

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[1] Although these items are from the *Personal Distress* subscale of the IRI, Davis (1983) reports that this subscale measures emotional empathy.

| General Empathy Scale<br>(GES; Linn, DiMatteo, Cope, & Robbins, 1987) | *People have often told me that I am very imaginative* |
|---|---|
| Interpersonal Reactivity Index<br>(IRI; Davis, 1983) | *I really get involved with the feelings of the characters in a novel*<br>*Becoming extremely involved in a good book or movie is somewhat rare for me* (reverse scored)<br>*I daydream and fantasize, with some regularity, about things that might happen to me.* |

**Measuring empathy too globally.** A related problem to measuring empathy with irrelevant items is measuring empathy outside of the clinical encounter (i.e., not including items asking about actual clinician-patient interactions). Self-report and client-rated measures are particularly apt to probe about clinicians' general personal inclinations removed from clinical practice (Elliott et al., 2011; Pederson, 2009). In particular, self-report measures rarely ask about direct clinical encounters and instead include general items that may have little to do with behavior in clinical practice (e.g., *It makes me sad to see a lonely stranger in a group*; Hojat, 2007)*.* Even when patients are used as informants after an interaction with their clinician, self-report items inquire about the general characteristics of the clinician (e.g., asking if the doctor was generally understanding) instead of asking about specific experiences within patients' interactions with their clinician (e.g., *Did you feel understood when you explained your presenting concern to the doctor?*).

One problem with measuring empathy too globally is that evidence suggests that the expression of clinician empathy can vary across patients. In other words, the level of empathy provided may not be primarily a function of the therapist. For

example, Gladstein and Brennan (1987) found that client behaviors affected the

amount of empathy offered by the counselor. In particular, clinicians offered more

empathy with clients who were more compliant. Henry, Schacht, and Strupp (1990)

also found that therapist empathy varied across clients. Given that the empathy

expressed within a clinical interaction is theoretically what will affect client

outcomes, an optimal measure of clinician empathy would include items directly

relevant to the clinical encounter(s) of interest.

**Low Correlations Within and Among Empathy Measures**

Given the conceptual disagreement and confusion surrounding empathy, it is

not surprising that correlations among various empathy measures have been low. At

least 38 measures of empathy have been used in medicine alone (Pederson, 2009),

but they may be tapping different components of empathy or even measuring

different constructs altogether (e.g., sympathy). Kurtz and Grummon (1972)

examined correlations among six commonly used empathy scales such as the

Barrett Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1976), Empathic

Understanding Scale (Carkhuff, 1969), Affective Sensitivity Scale (Campbell, Kagan,

& Krathwohl, 1971), and Interpersonal Checklist (LaForge & Suczek, 1955), but

found no statistically significant relationships among them. Similarly, Ham (1981)

found no significant relationships between the Affective Sensitivity Scale and

Hogan's Empathy Scale (Hogan, 1969). Since the individual reliability of scores is

high for the measures used in these studies, the authors concluded that the validity

of these measures is questionable. In another study, Jarski, Gjerde, Bratton, Brown,

and Matthes (1985) compared four empathy instruments consisting of one self-

report measure—Hogan's Empathy Scale and three observer-rated measures—

Empathic Understanding Scale, the BLRI, and Hornblow's General Empathy Rating

Scale (Hornblow, Kidson, & Jones, 1977). Although statistically significant

correlations were found among the three observer-rated scales, Hogan's Empathy

Scale and the other measures did not significantly correlate. Additionally,

correlations between cognitive and affective empathy measures have been

especially low (Gladstein & Brennan, 1987).

In addition to low correlations among empathy measures, low correlations

among types of empathy within individual measures have also been reported. For

example, in Barrett-Lennard's cyclical model of empathy, expressed empathy (Phase

2) and client-received empathy (Phase 3) have been inconsistently related. In his

review, Gurman (1977) found that correlations between these two types of empathy

ranged from .0 to .88, and the mean value was only .24. Low correlations between

expressed empathy and client-perceived empathy may indicate the possible

inaccuracies in measuring the components of empathy that predict client

perceptions and outcomes (Elliott et al., 1982). Alternatively, low correlations

among the various components of empathy may indicate that they uniquely predict

outcome and should be measured separately.

One of the reasons low correlations have been found among empathy

measures could be that different individuals have been used as the judges. Therapist

and client assessments of the quality of empathy often differ within the same

session and also differ from ratings of trained observers (Gladstein, 1987; Moyers &

Miller, 2013). Thus, observer ratings, therapist ratings, and client ratings of clinician

empathy may all be capturing different aspects of empathy or even measuring different constructs all together (Moyers & Miller, 2013). It is not surprising then that intercorrelations among different empathy measures have been weak overall (Elliott et al., 2011).

**Problems in Types of Empathy Measures**

Although overarching problems exist in empathy measurement, specific drawbacks are also noted in the various types of empathy measures (i.e., self-report, observer-rated, and client-rated). According to a meta-analysis by Elliott et al. (2011), client-rated empathy measures in psychotherapy best predict outcome ($r =$ .32), followed by observer-rated ($r = .25$) and therapist-rated measures ($r = .20$). However, the usefulness of these types of measures should not be determined by this information alone, as all types of measures have distinct advantages and disadvantages.

**Client-rated measures.** It would be tempting to conclude that client-rated empathy measures, or those in which the patient is used as the rater, are the *sine qua non* of empathy measurement because they have the strongest association with outcome, at least within psychotherapy (Elliott et al., 2011). However, caution should be used in reaching this conclusion. It is quite likely that clients who are more motivated and engaged in therapy are more likely to perceive their therapist in a positive light (Wallach & Strupp, 1960). Client-rated measures in particular are vulnerable to the "halo effect" (Thorndike, 1920), in which the perception of one positive personality trait influences the positive perception of other traits. Thus, it is probable that clients who "like" their clinician will rate him or her as more

empathetic. For example, a charismatic doctor or therapist might receive higher

empathy ratings than an equally empathetic but less charismatic individual.

Additionally, when patients are used as informants, they may be confounding

empathy with unrelated factors such as a positive treatment outcome. For example,

Silvester, Patterson, Koczwara, and Ferguson (2007) found that client-rated

physician empathy was more influenced by perceived reassurance such as hopeful

statements about outcome of their diagnosis when compared to observer-rated

physician empathy. Thus, while client-rated measures are most predictive of

outcome, it may be because they are measuring confounding variables such as

positive perceptions of physicians, prognosis, reassurance from the physician, or

motivation and engagement in treatment.

**Self-report measures.** Self-report measures are those in which the clinician

is the responder or informant. Notably, however, clinicians are often inaccurate in

interpreting their clients' perceptions of them. For example, Free, Green, Grace,

Chernus, and Whitman (1985) found that even when using the same rating scale for

the same session, there was no significant agreement among patients, therapists,

and clinical supervisors in how they rated level of therapist empathy. The BLRI self-

rating scales in particular do not predict outcome or correlate with the client or

observer-rated scales. According to Squier (1990) in order for empathy to influence

psychotherapy outcome, it must be perceived by the patient.

Additionally, self-reports have been found to be inconsistent with behavior in

clinical practice. For example, researchers have demonstrated that low correlations

exist between responders' self-reports of empathic concern and their subsequent

willingness to discuss their patients' personal matters (Hammond & Kern, 1959). Low correlations have also been found between measures of empathic responding and subsequent interview behaviors (Elliott et al., 1982; Engler, Saltzman, Walker, & Wolf, 1981; Robbins et al., 1979). One possibility that might explain the disconnect between physician's self-reports and actual behavior concerns the social desirability bias, or the tendency to answer items in a way that will be viewed favorably by others (Crowne & Marlowe, 1960). It may be apparent to responders what responses a competent clinician "should" give to certain items, which in turn may reduce honest self-reflection. Given the concerns with self-report measures, it may not be surprising that they predict outcomes the least well when compared to client-rated and observer-rated measures (Elliott et al., 2011).

   **Observer-rated measures.** Observer rated measures are those that depend on trained observers to assess physician or therapist empathy. Although these measures may be appealing because of their objective nature, they often presuppose that observers know the patient's feelings or experiences (Pedersen, 2009), which can lead to inaccurate conclusions. Two commonly used and heavily criticized observer-rated scales include Truax and Carkhuff's Accurate Empathy Scale (Truax & Carkhuff, 1967) and Carkhuff's Empathic Understanding Scale, which is a revision of the former. In both scales, an observer listens to recordings of clinical interactions and assigns the segments to one of several stages of empathy. Writers have highlighted problems with these measures concerning the material being rated, the training of the raters, and inconsistencies between the operationalization of

empathy and what is actually being measured (e.g., Fridman & Stone, 1978;

Gladstein, 1977; Gormally & Hill, 1974; Hill & King, 1976).

Shapiro (1969) criticizes the Accurate Empathy Scale in particular on the

lack of clarity in how the different levels of empathy are measured by raters. For

example, he criticizes the complexity through which objective raters might decide

the accuracy of a therapist's interpretation of the client's feelings. One of his

arguments highlights that the accuracy of a therapist's interpretation may not be

determined until a later time in therapy, outside of the brief segment coded by the

trained raters. Furthermore, he states that nonverbal expressions of empathy would

be missed by relying on recordings of clinician-patient interactions. The complexity

of interpretation of empathy based on Truax and Carkhuff's (1967)

conceptualization of accurate empathy is reflected in the wide range of reported

reliabilities for the scale (.43 to .95). In spite of these criticisms, the Accurate

Empathy Scale and the Empathic Understanding Scale have been widely used

(Elliott et al., 2011). More recently developed observer-rated scales such as the

Revised Response Empathy Rating Scale (Elliott, 1982), the Measure of Expressed

Empathy (MEE; Watson & Prosser, 2002), and the Therapist Empathy Scale (TES;

Decker, Nich, Carroll, & Martino, 2013) were created with a thorough understanding

that empathic responding comprises multiple elements. Subsequently, these scales

measure multiple components of empathy, but have been relatively untested and

unused in clinical research and practice (Elliott, Greenberg, Watson, Timulak, &

Freire, 2013).

Although observer-rated measures have been faulted on numerous grounds, they do have an important advantage over self- or client-rated measures. With the exception of the Pencil-and-Paper Empathy Rating Test (Danish & Hauer, 1973), these measures assess clinician empathy within actual clinician-patient interactions. In other words, rather than asking about how one generally responds in given scenarios, ratings are based on actual clinical interactions. This is an important consideration given that it is the empathy expressed by the clinician and received by the patient in practice that has been theorized to predict outcome. In fact, one study reported that while the IRI (a self-report measure) did not reflect relevant and positive changes in medical students' interpersonal skills after training, these changes were detected when observers used rating scales to assess video recordings of clinical interactions. The observer measures, but not the self-report measure, were able to detect increased ability to elicit patient concern, increased depth and accurate communication of responding, and increased clinical interviewing skills (Evans, Stanley, & Burrows, 1993). When it comes to measuring the type of empathy most relevant to outcomes within the helping professions (i.e., empathy actually expressed within the clinical interaction), observer-rated measures seem to be the most promising.

**Summary and Research Questions**

Several conclusions can be drawn from the foregoing review. First, there is no general consensus on the meaning of empathy within the clinical setting. Second, even though the nature of empathy has remained ambiguous, it has been theorized to be an important relationship variable for outcomes in medicine and

psychotherapy, even when the treatments are highly manualized (e.g., CBT). Third, perhaps primarily stemming from the myriad of definitions that exist, numerous problems exist in the measurement of empathy, muddling the results of outcome research. Thus, the importance of clinician empathy in medical and psychotherapeutic outcomes cannot be corroborated until better assessment instruments are available and tested in actual clinical encounters.

Based on the problems outlined from the preceding review, several solutions can be proffered for the refinement of empathy measurement. The measurement of empathy is complicated because of the plethora of definitions that exist. Although a single exact definition of empathy is unlikely to be adequate to cover all components for every clinical situation, one proposal introduced earlier for attenuating the conceptual confusion surrounding empathy was to view empathy as a primarily cognitive process, and indeed, this view of empathy has been supported by numerous others (Brock & Salinsky, 1993; Streit-Forest, 1982; Wolf, 1980). However, it is also important to keep in mind that understanding a patient would likely be ineffective if this understanding were never communicated to the patient and/or accurately acted upon (Mercer & Reynolds, 2002). Thus, when looking at outcomes in the clinical setting, it is proposed that empathy be viewed as comprising both a cognitive and behavioral component (i.e., the understanding/conceptualization of a client as well its communication). The definition of clinical empathy offered by Coulehan et al. (2001) is particularly endorsed, which incorporates both of these aspects: "the ability to understand the

patient's situation, perspective and feelings, and to communicate that understanding to the patient."

The current problems within empathy measurement in the clinical setting also stem from the various ways empathy is being assessed. For example, many measures include items that are irrelevant to empathy, not directly related to the clinical encounter, or confounded with other relationship variables. Additionally, empathy may be inaccurately captured based on who is doing the rating. For example, client-report measures are subject to the "halo effect" and the confounding of empathy with unrelated factors such as a positive treatment outcome. Self-report measures are also subject to extensive biases such as the social desirability bias (Crowne & Marlowe, 1960) and do not correlate well with outcome. In addition, some observer-rated measures have been heavily criticized in the training of the raters and in the lack of specification of how ratings are to be made. However, evidence suggests that observer-rated measures used in actual clinician-patient interactions may provide the most useful and accurate measure of empathy's effect on clinical outcomes (Hojat, 2007). Thus, it is proposed that these types of measures be refined and further tested, particularly, the revised Response Empathy Scale (Elliott et al., 1982). Although Elliott et al. (1982) did not provide an explicit definition of empathy, the scale's items fit with the operationalization of empathy as comprising both cognitive (understanding the client) and communicative (responding to the client based on this understanding) components. In addition, this scale is used for rating real-time clinical interactions. However, it has not yet been tested in clinical practice, and no published training manual exists for use of the

scale, which decreases the likelihood that it can be used reliably in the future. Thus, in compiling the knowledge gathered from a review of the current problems in empathy measurement within the clinical setting and the proposals set forth for attenuating these concerns, the present study had several aims.

The first aim of this study was to develop a training manual for the RES in order to achieve adequate interrater reliability. Because many of the criticisms of observer-rated scales involve inadequate training of raters and the material being rated is complex (Shapiro, 1969), it seemed prudent for the scale to be supplemented with precise training instructions for its reliable use in clinical practice. With the development of a rating manual, it was expected that interrater reliabilities would be adequate for all of the components. The second aim of the study was to demonstrate convergent and divergent validity of the RES. It was predicted that the scale would show a significant relationship with client-rated empathy and the therapeutic alliance, of which empathy has been considered a key component (Rogers, 1959). It was also predicted that the scale would not be related to other variables in the study that were theoretically different from empathy.

The final aim of the study was to test the hypothesis that therapeutic empathy is associated with clinical outcomes, particularly client attrition. A recent meta-analysis by Swift and Greenberg (2012) revealed that psychotherapy dropout was higher for studies in which trainees were used as the therapists. In particular, clients of experienced therapists dropped out of therapy at a rate of 17.2%, while clients of those in training dropped out of therapy at a rate of 26.6%. It is feasible that relationship variables such as empathy play even a greater role in drop-out

rates for therapists who are still in training and who may not have acquired developed skills in the application of specific therapeutic techniques. Thus, it was expected that therapists in training with higher levels of empathy would have fewer clients drop out of treatment.

**Method**

**Participants**

**Clients***.* Clients seeking treatment at the University of Kansas Psychological Clinic (KUPC) were recruited to participate. Inclusion criteria for participating clients included the following: (a) clients were being seen for therapy exclusively at the KUPC and were new clients; (b) they were over the age of 18 and under the age of 65; and (c) they were being treated by a therapist participating in the study. Clients who participated in the study ranged in age from 19 – 65 with a mean age of 31.24. The most common complaint was depression (53%). Other presenting concerns included anxiety, alcoholism, school-related stressors, ADHD, sleep problems, bipolar disorder relationship difficulties (both with family and significant others), bulimia, and adjustment issues. Client scores on a brief measure used to assess overall distress (Outcome Questionnaire—45.2) at the first session ranged from 19 – 109 with a mean of 76.75. Notably, a score of 63 or higher indicates symptoms of clinical significance. Criteria for defining client dropout were based upon a similarly designed study by Beckham (1992):

1. Following one or more missed sessions, the client communicated to the therapist that he or she did not wish to be seen by him or her any further.

Alternatively, following the missed sessions, the therapist was unable to contact the client.

2. The client attended fewer than six sessions. No more than six sessions was chosen for the cut off because previous studies have found the median number of sessions to be between six and eight (Garfield, 1986). It also seemed reasonable to conclude that it would be unlikely for significant insight or behavioral change to occur prior to the sixth session.

**Therapists**. The therapists were volunteer clinical psychology doctoral students at the University of Kansas, who were seeing clients at the KUPC as a part of program requirements. A total of 13 therapists volunteered, although only 10~~9~~ therapists were assigned new clients also participating in the study throughout the study's duration. There were ~~six~~ seven participating female therapists and three participating male therapists consisting of four third-year students, and ~~five~~ six second-year students ranging in age from 23 to 34 with a mean age of 27.

**Raters**. Two female undergraduate psychology students from the University of Kansas served as the raters for the study. They independently rated therapist empathy for each recorded session.

**Measures[2]**

**Outcome Questionnaire-45.2 (OQ-45.2).** The Outcome Questionnaire-45.2 (OQ-45.2) is a 45-item questionnaire designed to measure important areas of functioning (symptoms, interpersonal problems, social role functioning, and quality

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[2] All measures are included in the Appendixes at the end of this document.

of life) and track client progress in psychotherapy over time. Scale items inquire about common symptoms and problems that occur most frequently in psychiatric disorders. Respondents are asks to fill out the questionnaire based on the previous two weeks. Each item is rated on a 5-point Likert scale from 0 (*Never*) to 4 (*Always*). One overall and three subscale scores are yielded based on major domains of functioning (*Social Role, Symptom Distress*, and *Interpersonal Relationships*). (Lambert et al., 1996) reported high internal consistency values for the scale ($\alpha=$ .93), and moderate to high correlations between the OQ-45.2 total score and other widely used measures of psychological functioning have also been found (Beckstead et al., 2003).

**Therapist Background Questionnaire.** The Therapist Background questionnaire consisted of 15 items designed specifically for use in this study to collect demographic and self-report information from therapist participants. Items tapped general background information such as year in the program, gender, and age as well as therapists own views on their empathic abilities and expressions.

**Client Background form (KUPC).** As part of admittance to the KUPC for treatment, all new clients are required to fill out a background form that inquires about general demographic information. For purposes of this study, the only information that was collected from this form was age and gender.

**Visual Analog Scale (VAS).** The VAS is a quasi-dimensional ordinal scale (Feinstein, 1987) that will be used in this study to measure client perceptions of how well they felt understood in a particular session. A nine-centimeter visual line will be used to represent a continuum of therapist understanding. Clients were

asked to mark with a writing utensil a point on the 9cm line that best represented the degree to which they believed their therapist understood them in the previous session. At one end of the line was be the phrase, *My therapist understood me none of the time,* and at the other end of the line was the phrase, *My therapist understood me all the time.* The responses were recorded in number of centimeters from the far left of the line and rounded to the nearest tenth.

**Working Alliance Inventory-short version (WAI-S).** The WAI-S is a 12-item self-report measure of the strength of the therapeutic relationship (Horvath, 1981) and consists of both a client-rated and therapist-rated version. The WAI-S is comprised of three subscales: *Goals, Tasks, and Bond*. The *Goals* subscale measures the extent to which a client and clinician agree on the goals/outcomes of therapy (Adam O Horvath & Greenberg, 1989). The *Tasks* subscale measures the degree of client/therapist agreement on the behaviors and cognitions that substantiate the therapy process (Horvath & Greenberg, 1989). Finally, the Bond subscale measures "mutual trust, acceptance, and confidence" between the therapist and the client (Horvath & Greenberg, 1989, p. 224). Four items make up each subscale, which is scored on a 7-point Likert scale ranging from 1 (*Never*) to 7 (*Always*). Higher scores are indicative of a more positive alliance. Internal consistency has been reported to range from .90 to .92 for the client version and .83 to .91 for the therapist version. Internal consistency estimates for the total scores have been reported to be .98 for the client version and .95 for the therapist version (Tracey & Kokotovic, 1989).

**Revised Response Empathy Scale.** The revised Response Empathy Scale was designed to measure empathy based on the quality of certain counselor

behaviors (Elliott et al., 1982). The Lister Empathy Scale (Hargrove, 1973, 1974) served as the basis for scale, which consists of nine components: *Intention to Enter the Client's Frame of Reference, Perceptual Inference and Clarification, Accuracy-Plausibility, Here and Now, Topic Centrality, Choice of Words, Voice Quality, Exploratory Manner,* and *Impact (Facilitation vs. Blocking, Distraction).* The researchers found strong interrater reliabilities ranging from .75-.91 (Cronbach's alpha; Nunnally, 1978) for all but two components (*Voice* and *Manner*), and interrater reliability for total empathy was .91. When averaged across three episodes sampled per session, client ratings of feeling understood by their therapist showed strong correlations resulting in large-sized effects for total empathy ($r$ = .53; Elliott et al., 1982).

**Procedure**

  **Manual development and training of raters.** In the article describing the development of the scale, Elliott et al (1982) reported reliability results from five trained undergraduate students as the raters. The counselors were internship-level graduate students and faculty and the "clients" were volunteer undergraduate students who were instructed to discuss "a genuine personal concern" (p. 381) with the counselor. Elliott et al. (1982) achieved adequate interrater reliabilities for all but two components (*Voice* and *Manner*). Thus, the purpose of the manual was to provide extensive guidance to raters in how ratings were to be made so that adequate inter-rater reliabilities would be achieved across components. The training manual was developed before raters were trained, but the final product evolved throughout the course of training, based upon noted discrepancies between

raters. The manual consisted of descriptions for each of the nine components of the scale based on Elliott et al.'s (1982) work and based on the definition of empathy by Coulehan et al., (2001). Examples of more and less empathetic responses were given for each of the nine components of the scale (See Appendix G for the training manual used in the present study).

Before the start of the study, volunteer raters received extensive training with the use of the scale over a period of three months. Raters met with the PI on five separate occasions for 1-2 hours each day. The first of these meetings was designed to familiarize the raters with the scale and develop a plan for training. Over the following couple of months, the raters participated in a number of training activities. During the second and third meeting, a licensed psychologist, who was conducting his own empathy research using Elliott et al.'s (1982) scale, was invited to participate. During the first training session with this individual, each of the nine items of the scale were explained in detail. The licensed psychologist provided examples of more and less empathetic responses for each of the scale's items. Following a thorough explanation of the manual, the raters practiced devising examples of both high and low empathy responses for each of the scale's items.

During the second training session, the PI and the licensed psychologist participated in and recorded two mock therapy sessions. The raters took notes throughout each mock session and wrote down examples of responses that helped inform their ratings for each of the scale's nine items. Following each role-play, the raters finalized their ratings. The PI, licensed psychologist, and raters then discussed the ratings and addressed discrepancies. The manual was modified during

these first few meetings to clarify points of confusion or add illustrative examples that arose during training.

The raters then independently watched examples of online psychotherapy videos and practiced rating therapist empathy with the RES. Sample sessions were chosen by the PI and raters to represent a range of expressed therapeutic empathy within sample sessions. Between video viewings, meetings were held in order to discuss ratings on items and address any discrepancies.

Towards the end of the training period, the licensed psychologist met with the raters for a final training session before they began watching study videos, and the PI was available by phone. During this meeting, final questions were addressed about the nine empathy components. Raters also re-watched the mock therapy videos that were recorded earlier in the training process and rated the therapist on empathy. At the end of the video, they discussed their ratings and addressed any remaining discrepancies.

When the raters were nearly halfway finished rating the audio files for the study, another training session was held. The purpose of this meeting was to review the manual and prevent drifts in adherence. During this meeting, components of the empathy scale were reviewed, particularly those for which the raters had the lowest agreement. We discussed the ways in which the raters were reaching their conclusions on ratings for these items and identified any discrepancies. For example, on item 4 (*Here and Now*), it was discovered that one of the raters was including niceties such as, "How are you doing today" in her ratings while the other rater was not. Thus, it was clarified that these questions did not meet *Here and Now*

criteria, and the rater was allowed to re-review the audio files to amend her ratings on this item. For two audio files, errors in transcription were discovered and corrected. For additional training, raters agreed to review and discuss an audio file from the study that could not be used for data analysis due to its having been recorded during the wrong session.

No audio files were rated for over one month during Winter Break, as the graduate student who allowed access to the recordings was unavailable. Following this hiatus, one rater then embarked on a series of graduate school interviews and was unable to come in to rate videos. Shortly thereafter, however, ratings resumed and were made over the time span of another six weeks until raters had finished. Notably, there were large discrepancies between raters in a few videos rated during this time. Thus, raters were alerted to this fact and were encouraged to re-check their notes for errors and revisit the audio files if necessary. They were allowed to amend their ratings if, after re-checking their notes or revisiting the files, they believed that they had made mistakes or were not adhering to the manual. One rater admitted to having not thoroughly listened to several recordings and was encouraged to review these recordings and revise her ratings where necessary. Ratings were subsequently finalized.

**Therapist Recruitment.** Therapists at the KUPC were recruited via email announcement of the study, in-person contact with the researcher, and announcements about the study during team supervision meetings. They were informed that their participation was strictly voluntary and that their participation or lack thereof would not affect their standing in the program or any evaluations

from supervisors. Interested therapists filled out a consent form followed by a background questionnaire before participating in the study.

**Client Recruitment.** As part of routine procedure at the KUPC, clients who are interested in receiving services fill out an intake form with a student therapist on duty. For purposes of this study, all potential clients were informed of the study during the intake process and asked if they were willing to speak with a researcher prior to their first therapy session in order to discuss their participation. Clients who agreed to meet with a researcher were flagged as "interested in the study" using a colored sheet of paper with their intake form. Office members assigned 3-digit study numbers to all clients that were flagged.

The clinic coordinator was notified about which therapists were participating in the study so that she could alert the principal investigator (PI) when a participating therapist was assigned a new client that also expressed interest in the study. The PI then contacted the therapists to determine when the first session was scheduled and assigned a research assistant to meet with the client briefly before their appointment in an available therapy room. At this time, the study was explained in more detail, and those who wished to participate signed a consent form. The research assistant then led the client back to the waiting room in the clinic so they could meet with their therapist.

As part of routine procedure in the KUPC, therapists are required to have their new clients to complete an OQ-45.2 and a background questionnaire prior to session. These forms are then turned over to clinic staff for filing and scoring. For purposes of this study, one staff member was responsible for de-identifying this

data and making it available to the researcher by placing this information in the assigned folder of the PI located in the KUPC. The first session was audio-recorded by the therapist so that it could be rated for empathy. The director of the KUPC was responsible for transferring all recordings to the secure drive of the first-year clinical psychology graduate student volunteer for the study so that this individual could allow the raters to access them.

Immediately following the first therapy session, a researcher met with the participating clients back in the waiting room of the clinic and administered the VAS so that clients could rate their therapist on levels of empathy for the prior session. The VAS was then placed in the primary researcher's folder in the clinic along with other study materials. All study questionnaires were labeled with the clients' assigned study numbers.

Data was again collected during the first therapy session after the diagnostic interview and the administration of a routine clinical assessment battery was complete (This was usually the 4th session with the first three sessions being devoted to the diagnostic interview and psychological testing). Therapists administered the OQ-45.2 and WAI before the session. Once again, a staff member was responsible for de-identifying this data and making it available to the researcher by placing this information in the assigned folder of the PI located in the KUPC.  Therapists also audio-recorded this session so that raters could again assess therapist empathy. Following this session, clients also completed the VAS to assess the degree of their therapist's empathy. The WAI was again administered two sessions following the second recorded session.

**Results**

Descriptive statistics were first computed, and the relationships among variables was explored. Regarding participants, there were 21 clients in the study, which were seen by one of ~~nine~~ 10 participating therapists. Therapists were assigned anywhere from one to four participating clients each during the course of the study. The average number of clients that were seen by each therapist throughout the duration of the study was 2.1. There were a total of three male and s~~ix~~even female therapists. Ten clients in the study were assigned male therapists, and eleven clients were assigned female therapists. A chi-square test revealed that male and female clients were not assigned differently across male and female therapists, $X^2$ (1, n = 21) = 1.17, $p$ = .279. The distribution of clients across therapists by gender is presented in Table 4.

| Table 4 | | | | |
|---|---|---|---|---|
| Distribution of Clients Across Therapists by Gender | | | | |
| | | Client | | |
| | | Female | Male | Total |
| Therapists | Female | 7 | 4 | 11 |
| | Male | 4 | 6 | 10 |
| Total | | 11 | 10 | 21 |

Therapists ranged from age 23 to 34 and clients ranged from age 19 to 65, indicating a high degree of variability ($M$ = 31.24, $SD$ = 13.21). A total of 14 clients remained in therapy, six clients dropped out prematurely, and one client transferred therapists, so was not classified either way. Independent samples $t$-tests revealed no significant age differences between clients who remained in therapy ($M$ = 31.42, $SD$

=15.02) and those who terminated prematurely ($M$ = 30.86, $SD$ =9.55); $t$(19) = .019,

$p$ = .928. There were also no significant differences in scores on the OQ.45 at the

start of therapy between clients who remained in therapy ($M$ = 84.08, $SD$ = 24.77)

and those who dropped out ($M$ = 63.14, $SD$ = 28.50); $t$(18) = 1.71, $p$ = .104.

Additionally, chi-square tests revealed that male clients were no more likely to drop

out than females, $X^2$ (1, $n$ = 21) = .10, $p$ = .757; dropouts were no more likely to have

been assigned a male therapist than a female therapist, $X^2$ (1, $n$ = 21) = .38, $p$ = .537;

and dropouts were no more likely to be assigned a second-year therapist than a

third-year therapist, $X^2$ (1, $n$ = 21) = .53, $p$ = .469.

Descriptive statistics for the combined administrations of the VAS, WAI, and

OQ.45-2 as well as for total empathy (the sum of the nine items) from each rater and

the average of the raters are shown in Table 5.  Notably, there was a high degree of

variability in observer-rated empathy ratings. For example, possible empathy scores

ranged from zero to 36, and the observed average empathy ranged from 5.5 to 35

($M$ = 21.88, $SD$ = 8.38). However, there was little variability in scores on client rated

empathy, as measured by the VAS, and scores were skewed in the positive direction.

For instance, possible scores on the VAS, ranged from 0 – 9, but observed scores

ranged from 4.90 to 9 ($M$ = 7.26, $SD$ = .89).

Table 5

Descriptive Statistics for Measured Variables

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Average Empathy | 30 | 5.50 | 35 | 21.88 | 8.38 |
| Rater 1 Empathy | 30 | 4 | 35 | 21.30 | 8.94 |

| | | | | | |
|---|---|---|---|---|---|
| Rater 2 Empathy | 30 | 3 | 36 | 22.47 | 8.39 |
| VAS | 27 | 4.90 | 9 | 7.26 | .89 |
| WAI | 22 | 30 | 60 | 44.23 | 8.69 |
| OQ-45.2 | 28 | 19 | 127 | 81 | 27.37 |

Pearson product-moment correlation coefficients and point-biserial correlation coefficients were calculated to examine the relationships among the variables in the study. Pearson's *r* was used for comparisons of pairs of continuous variables, and point-biserial correlations were used for comparison of one continuous variable and one dichotomous variable. These correlations are shown in Table 6. Scores on the OQ.45 were significantly correlated with therapist gender, such that clients with higher levels of distress were significantly more likely to be paired with a female therapist, $r_{pb}(18) = -.61$, $p = .005$. Empathy was significantly correlated with therapist gender, such that female therapists were more likely to receive higher empathy ratings than male therapists, $r_{pb}(19) = -.50$, $p = .022$. Therapist age was significantly correlated with year in the program, $r_{pb}(19) = -.49$, $p = .23$, so that younger therapists were more likely to be in their third year in the program rather than their second year. Notably, these latter relationships were likely driven by therapist effects. For example, although there were only three male therapists in the study, one of these male therapists saw four clients. Additionally, this therapist's empathy ratings ranged from 5.5 to 14.5 with a mean of 11 across clients. This highlighted the importance of controlling for therapist effects in future analyses.

| | T. Gender | C. Gender | Drop | T. Year | Empathy | C. Age | T. Age | VAS | WAI | OQ.45 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Table 6** | | | | | | | | | | |
| **Correlations Among Variables** | | | | | | | | | | |
| Empathy | -.50497* | -.091 | -.2547 | .3545 | 1 | | | | | |
| C. Age | .3215 | .123 | -.021 | -.340 | -.3105 | 1 | | | | |
| T. Age | -.112 | -.23.25 | .060 | -.494* | -.343 | .040 | 1 | | | |
| VAS | -.1545 | -.043 | -.0765 | .434 | .063 | .30298 | -.423 | 1 | | |
| WAI | -.2546 | -.10096 | -.212 | -.0218 | -.1548 | -.014 | .300 | -.3658 | 1 | |
| OQ.45 | -.6106** | -.123 | -.374 | .434 | .4107 | -.3987 | -.121 | .1545 .061 | | 1 |

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

## Interrater reliability

A total of 30 audiotapes were rated for empathy independently by the two trained undergraduate raters. Weighted Cohen's kappa was calculated for each item on the RES as well as for total empathy using VasserStats online software (Lowry, 2015). Ratings for each item were first organized in contingency tables in Excel, which showed the frequencies of ratings amongst the two raters across the nine categories. These tables were then entered individually into the program, which calculated the weighted Cohen's kappa, standard error, and 95% confidence intervals. This information is represented in Table 7 below.

| | Kappa w/ Linear Weighting | Std. Error | 95% CI |
|---|---|---|---|
| **Table 7** | | | |
| **Kappa Values for Items Comprising the RES** | | | |
| Intention | .55 | .09 | .37 - .72 |
| Inference | .60 | .10 | .41 - .78 |
| Accuracy | .72 | .09 | .56 - .89 |
| Here/Now | .74 | .08 | .59 - .89 |

| | | | |
|---|---|---|---|
| Centrality | .69 | .08 | .53 - .85 |
| Words | .60 | .10 | .41 - .78 |
| Voice | .56 | .10 | .37 - .76 |
| Manner | .57 | .09 | .40 - .74 |
| Impact | .61 | .09 | .44 - .78 |
| Total | .67 | .03 | .61 - .73 |

As you can see from the table, kappa values ranged from a low of .55 (Intention) to .74 (Here/Now). Although "no one value of kappa can be regarded as universally acceptable," (Bakeman, Quera, McArthur, & Robinson, 1997, p. 357), general guidelines have been proffered. One commonly cited standard put forth by Landis and Koch (1977) characterized kappa values from 0 – .20 as slight agreement, .21 – .40 as fair agreement, .41 – .60 as moderate, .61 – .80 as substantial, and .81 – 1.00 as almost perfect agreement. Based on these interpretations, estimates of interrater reliability among items range from moderate to substantial agreement, with total empathy falling within the substantial range.

Confidence intervals were large, and in the case with several items, they contained low values. The items whose confidence intervals included a value less than .41 were then removed from the scale, as any kappa value less than .41 would indicate only fair agreement. The abbreviated scale was re-examined after the removal of item 1 (*Intention*), item 7 (*Voice*), and item 8 (*Manner*). Descriptive statistics for total empathy after these items were removed are shown in Table 8. Possible total empathy (The sum of the six remaining items) ranged from 0 - 24. The kappa value for total empathy after removal of the three items with the lowest

interrater reliabilities was .70 with a standard error of .03. The associated .95% confidence interval was .63 - .77.

| Table 8 | | | | |
|---|---|---|---|---|
| Descriptive Statistics for RES without Items 1, 7 & 8 | | | | |
| | Minimum | Maximum | Mean | Std. Deviation |
| Average Empathy | 3 | 23 | 12.83 | 5.39 |
| Rater 1 Empathy | 2 | 23 | 13.27 | 5.93 |
| Rater 2 Empathy | 2 | 24 | 14.07 | 5.57 |

## Internal Consistency for the RES

Cronbach's alpha was calculated in SPSS to provide a measure of internal consistency. Alpha values were calculated for the RES ~~as well as each of its nine items~~ as measured by each rater individually and as measured by taking the average of both raters. For the first rater (Rater 1), internal consistency among items was excellent ($\alpha = .95$). Inter-item correlations were lowest overall for item 4 (See Table 9), and a slight increase in internal consistency would have been achieved if this item were removed from the scale ($\alpha = .96$). However, this item's score correlated adequately with the composite scores from the other items ($r = .60$).

| Table 9 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Inter-item Correlations: Rater 1 | | | | | | | | | |
| | Intention | Inference | Accuracy | Here/Now | Centrality | Words | Voice | Manner | Impact |
| Intention | 1.00 | | | | | | | | |
| Inference | .66 | 1.00 | | | | | | | |
| Accuracy | .77 | .83 | 1.00 | | | | | | |
| Here/Now | .47 | .69 | .60 | 1.00 | | | | | |
| Centrality | .63 | .66 | .70 | .42 | 1.00 | | | | |
| Words | .75 | .74 | .69 | .55 | .73 | 1.00 | | | |
| Voice | .72 | .77 | .73 | .56 | .80 | .78 | 1.00 | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Manner | .60 | .72 | .80 | .49 | .75 | .69 | .69 | 1.00 |
| Impact | .67 | .80 | .79 | .51 | .86 | .76 | .81 | .88 | 1.00 |

For the second rater (Rater 2), internal consistency among items was also excellent ($\alpha = .94$). Inter-item correlations were again lowest overall for item 4 (See Table 10), and a slight increase in internal consistency would have been achieved if this item were removed from the scale ($\alpha = .95$). Notably, however, this item correlated adequately with the composite scores from the other items ($r = .56$).

Table 10

Inter-item Correlations: Rater 2

| | Intention | Inference | Accuracy | Here/Now | Centrality | Words | Voice | Manner | Impact |
|---|---|---|---|---|---|---|---|---|---|
| Intention | 1.00 | | | | | | | | |
| Inference | .75 | 1.00 | | | | | | | |
| Accuracy | .57 | .59 | 1.00 | | | | | | |
| Here/Now | .37 | .55 | .57 | 1.00 | | | | | |
| Centrality | .53 | .62 | .59 | .42 | 1.00 | | | | |
| Words | .71 | .85 | .58 | .50 | .55 | 1.00 | | | |
| Voice | .68 | .75 | .62 | .53 | .68 | .77 | 1.00 | | |
| Manner | .66 | .76 | .71 | .43 | .75 | .70 | .68 | 1.00 | |
| Impact | .73 | .88 | .74 | .49 | .79 | .75 | .73 | .88 | 1.00 |

Finally, internal consistency was excellent ($\alpha = .96$) for the RES as measured by taking the average ratings between the two raters. Not surprisingly, correlations were lowest for item 4, but removal of this item would have resulted in a negligible increase in the value of alpha by .004, and this item's score correlated adequately with the composite scores from the other items ($r = .60$). Thus, this item was left in the scale. Table 11 shows inter-item correlations for the scale using the average ratings between raters.

Table 11

Inter-item Correlations: Average Ratings

|  | Intention | Inference | Accuracy | Here/Now | Centrality | Words | Voice | Manner | Impact |
|---|---|---|---|---|---|---|---|---|---|
| Intention | 1.00 | | | | | | | | |
| Inference | .73 | 1.00 | | | | | | | |
| Accuracy | .69 | .77 | 1.00 | | | | | | |
| Here/Now | .42 | .68 | .63 | 1.00 | | | | | |
| Centrality | .58 | .70 | .66 | .41 | 1.00 | | | | |
| Words | .81 | .89 | .68 | .57 | .69 | 1.00 | | | |
| Voice | .78 | .84 | .72 | .60 | .78 | .82 | 1.00 | | |
| Manner | .67 | .78 | .79 | .46 | .78 | .73 | .74 | 1.00 | |
| Impact | .72 | .85 | .79 | .52 | .87 | .79 | .81 | .92 | 1.00 |

## Internal Consistency for the RES (Abbreviated Scale)

Cronbach's alpha was calculated in SPSS to provide a measure of internal consistency for the RES with the items that achieved the lowest interrater reliability values removed (i.e., without items 1, 7 and 8). Alpha values were calculated for the RES as well as each of its nine items as measured by each rater individually and as measured by taking the average of both raters. For the first rater, internal consistency among items was excellent ($\alpha$ = .93), and a slight increase in internal consistency would have been achieved if item 4 were removed from the scale ($\alpha$ = .94). However, this item's score correlates adequately with the composite scores from the other items ($r$ = .61). For the second rater, internal consistency among items was also excellent ($\alpha$ = .91) for the abbreviated scale. Again, a slight increase in internal consistency would have been achieved if item 4 were removed from the scale ($\alpha$ = .92), but this item correlated adequately with the composite scores from the other items ($r$ = .57). Finally, internal consistency was excellent ($\alpha$ = .93) when looking at the average ratings of the two raters for the abbreviated scale. Not

surprisingly, removal of item 4 would have resulted in a slight increase in the total alpha value ($\alpha$ = .94). However, this difference was negligible, and this item's score correlated adequately with the composite scores from the other items ($r$ = .61), so this item was left in the scale. Inter-rater reliability was improved after the removal of items 1, 7, and 8. Removal of these items did not affect internal consistency for the RES, as it remained excellent. Thus, for all subsequent analyses, observer-rated empathy was measured using the average of ratings across raters for the abbreviated scale.

**Validity of the RES**

Both convergent and divergent validity were examined for the abbreviated RES using hierarchical regression analyses in SPSS. Therapist effects were controlled for by creating effect codes for the variable "Therapist." There were ~~nine~~ ten therapists, so ~~eight~~ nine new effect coded variables were created in SPSS, with a weight assigned to each (-1, 0, or 1) such that the constant was equal to the unweighted grand mean of all of the observations. For subsequent analyses, therapist effect coded variables were entered into the model in the first step. Predictor variables were then entered into the model in the second step, which allowed for the examination of the effect of the predictor variable on the outcome variable when therapist effects were held constant. A 95% confidence level was used to assess outcomes.

Regarding convergent validity, it was predicted that observer-rated empathy, as measured by the RES in the first session, would show a significant relationship to client-rated empathy and the working alliance. In order to examine these

relationships while controlling for therapist effects, two separate hierarchical regression analyses were utilized with the therapist effect coded variables entered in the first step and empathy in the second step. Scores on the VAS and WAI were the outcome variables of interest respectively in each analysis. Results revealed that observer-rated empathy did not significantly predict client-rated empathy when controlling for therapist effects, $\beta$ = -.00<u>0</u>~~3~~, $p$ = .94<u>3</u>~~8~~, and the overall model was not significant, $F(10$<u>9</u>, 26) = 1.83<u>9</u>~~1~~, $p$ = .13<u>5</u>~~2~~. Observer-rated empathy also did not significantly predict working alliance when controlling for therapist effects, $\beta$ = -.01<u>4</u>~~02~~, $p$ = .83<u>9</u>~~9~~, and the overall model did not approach significance, $F(10$<u>9</u>, 21) = .74<u>8</u>~~3~~, $p$ = .68<u>0</u>~~5~~.

Importantly, hierarchical regression analyses were also utilized to examine divergent validity with theoretically dissimilar constructs that were measured in the present study. The constructs that were examined in relationship to observer-rated empathy included client distress (i.e., OQ-45.2), client age, and client gender. First, client distress at the time empathy was measured did not predict observer-rated empathy when controlling for therapist effects, $\beta$ = -.01<u>4</u>~~0~~, $p$ =.85. Although the overall model was significant, client distress did not account for a significant amount of the variance over and above therapist effects, $F(10$<u>9</u>, 27) = 3.39~~9~~, $p$ = .01<u>3</u>~~06~~. Client gender also did not predict observer-rated empathy when controlling for therapist effects, $\beta$ = -~~.~~1.31<u>1</u>~~4~~, $p$ =.57<u>2</u>~~5~~. Although the overall model was significant, client gender did not account for a significant amount of the variance over and above therapist effects, $F(10$<u>9</u>, 18) = <u>3.36</u>~~4.04~~, $p$ = .049<u>2</u>~~5~~. Finally, client age did not predict observer-rated empathy when controlling for therapist effects, $\beta$

= .08~~24~~, *p* =.1~~9~~5. Again, the overall model was significant, but client age did not account for a significant amount of the variance over and above therapist effects, *F*(10~~9~~, 18) = 4~~5~~.21~~15~~, *p* = .026~~11~~.

**Empathy and Drop-out**

A logistic regression analysis controlling for therapist effects was conducted to predict whether a not a client would drop out of therapy using therapist empathy expressed in session one, as measured by the RES (average ratings from abbreviated scale), as the predictor. A total of 19 therapist and client pairs were included in the analysis out of a total of 21 therapist and client pairs that were in the study. One client transferred therapists and could not be classified as a drop-out or not, and one audio-recording was missing from the first session, so empathy could not be rated. The logistic regression model showed that observer-rated therapist empathy did not predict who would and would not drop out of therapy when controlling for therapist effects, β = .21~~39~~, *p* = .652~~37~~, and the overall model was not significant, $\chi^2$(10~~9~~) = 11.02~~7.87~~, *p* = .356~~55~~.

<div align="center">

**Discussion**

</div>

This study sought to reliably and validly measure therapist empathy expressed within actual clinical interactions, and to do so using a theoretically sound observer-rated measure that had never been tested in a professional setting. The RES was utilized and its reliability and validity assessed. Empathy's relationship to client attrition in a University-based psychological clinic was subsequently examined. Findings, limitations, and future recommendations regarding the

reliability and validity of this measure as well as the use of this measure in predicting drop-out are presented below.

**Reliability of the RES**

Substantial interrater reliability can be achieved on this scale of empathy, with moderate to substantial agreement on each of its nine components. Because of the low number of empathy ratings (30) from each of the raters, however, the confidence intervals were somewhat large. Much larger samples are mathematically most likely to produce very small confidence intervals, which would result in a much more precise estimates of agreement. For three of the items (1, 7, & 8), the confidence intervals included values that would be associated with only fair interrater reliability. Thus, these items were dropped from the scale, which corresponded with an increase in the kappa value for the whole scale (with the remaining six items) from .67 to .70. Additional ratings from a larger sample may have narrowed the confidence interval for these items such that all values included within the scale would be associated with at least moderate interrater reliability. Interestingly, however, item 7 (*Voice*) and item 8 (*Manner*) also did not achieve adequate interrater reliability in Elliot et al.'s (1987) study.

It was ultimately decided to drop items 1, 7, and 8 from the scale not only because of poorer interrater reliability in comparison to the other items, but also because after further examination of these items, it was not clear that they were essential to the construct of empathy. In the case of item 1 (*Intention*), it could be argued that trying to understand a client's experiences and feelings by asking questions does not relate to one's actual ability to understand a client. Item 7 (*Voice*

*Quality*) asks raters to judge the expressiveness of the therapist's voice as well as its appropriateness based on what the client is expressing in the moment. It seems reasonable to conclude that the drawback of this item is that it relies on subjective judgments of when the content of the client's speech demands a particular voice tone and volume, which may lead to inaccurate and inconsistent conclusions. Finally, item 8 (*Exploratory Manner*) measures the degree to which the therapist communicates to the client that they are working together as a team, and seemed only peripherally related to the construct of empathy.

Internal consistency was excellent both for the total scale for each rater ($\alpha$ = .95 and $\alpha$ = .95) as well as for the average of both sets of ratings ($\alpha$ = .96). Internal consistency was also excellent for the abbreviated scale (without items 1, 7, and 8) for each rater ($\alpha$ = .93 and $\alpha$ = .91) as well as the average of both sets of ratings ($\alpha$ = .93). It was ultimately decided to retain item 4 (*Here/Now*) despite the fact that its deletion would have resulted in an increase in alpha values for both the full and abbreviated scale for each rater individually as well as for the average of both sets of ratings. There were several reasons for retaining this item. Notably, the resulting increase in alpha values if this item were deleted would have been negligible, and the item's score correlated adequately with the composite scores from the other items in all cases. Additionally, there is evidence to support the notion that present-moment awareness may enhance empathy (e.g., Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007). It is feasible that paying attention to another's moment-by-moment experiences is essential for understanding what that individual might be thinking and feeling. Indeed, one of Roger's definitions of empathy was "…being

sensitive, moment by moment, to the changing felt meanings which flow in this

other person…" (Rogers, 1995, p. 142). Thus, item 4 contained content that was

theoretically important to the construct of empathy.

A few reasons that item 4 correlated the least well with other items may have

had to do with the sample of therapists used in this study. Notably, scores were

consistently low for this item, and there was only one rating of "4" for this item

across all raters. It is possible that comments about present-moment observations

(e.g., subtle shifts in affect and client behaviors within the therapy room) is a

learned therapy skill that beginner therapists have not yet fully developed. It is also

possible that the small number of therapists that volunteered for this study differed

from the larger population of therapists on this element. Finally, it is also

conceivable that the manual's descriptions of the higher ratings on this item were

too rigorous regarding how and how often a highly empathetic therapist may utilize

comments and inquiries about the present-moment experiences of the client.

Finally, one potential drawback to the scale was that it excluded any

observations of empathetic body language. The results of several early studies

involving systematic manipulations of behavior suggest that certain behavioral cues

on the part of the therapist can play an important role in perceptions of empathy

(Hall, Harrigan, & Rosenthal, 1996). For example, researchers have found that a

forward trunk lean, close distance, and eye contact were important cues in

expressing empathy, genuineness, and respect (Haase & Tepper, 1972; Hermansson,

Webster, & McFarland, 1988; Tepper & Hesse, 1978). Positive relationships have

also been reported between empathic qualities and postural congruence between

client and therapist (Charny, 1966; Maurer & Tindall, 1983; Trout & Rosenfield, 1980). Researchers of one study (Haase & Tepper, 1972) found that nonverbal components of communicated empathy accounted for more than twice the variance of perceived empathy than the verbal message. The researchers went on to conclude that relying solely on verbal communication of empathy can reduce the accuracy of one's judgment by 66%.

**Validity**

Observer-rated therapist empathy, did not predict client-rated empathy or the working alliance as assessed by the client, and thus convergent validity for the RES was unable to be established. It is possible that the RES is not a valid measure of therapist empathy. However, it is also possible that no relationships among these variables were established because the sample was too small.

Drawbacks in the methodology could have limited the ability to find a relationship between the working alliance and observer-rated empathy. For instance, because the WAI can only be administered after a therapeutic relationship has been established, it was given several sessions after empathy was first assessed. It would have been more methodologically sound to compile an average of empathy within all sessions preceding the administration of the WAI. Therapist empathy can vary from session to session, and in the present study empathy was only consistently measured within the first session. Empathy was again assessed in the fourth session and the WAI assessed in the final session, which opened up the possibility of using an average of the two empathy ratings to predict the average of the two working alliance scores. However, there were far too few clients who had

completed the study, had completed both WAI's at the appropriate time, and for whom raters had completed a second set of empathy ratings. Thus, this analysis would have been inappropriate.

It was perhaps not surprising that observer-rated empathy did not predict client-rated empathy for several reasons. First, there was little variability in scores on the VAS. Clients appeared to overwhelmingly rate their therapist highly on empathy. This could be because the VAS was not a good measure of client-rated empathy. In support of this, the VAS and the WAI did not significantly correlate, and the relationship of empathy and the working alliance has been previously documented (Greenberg & Watson, 1998). Second, this measure—similarly to other client-rated measures—may have been subject to the "halo effect," in which the perception of one positive personality trait influences the perception of other traits (Thorndike, 1920). Thus, clients who liked his or her therapist or found him or her physically attractive may have given him or her higher ratings. Finally, it is possible that client-rated empathy and observer-rated empathy are unique constructs that predict outcomes differently. In support of this, in Barrett-Lennard's (1976) cyclical model of empathy, therapist expressed empathy and client-received empathy have been inconsistently related. For example, correlations have ranged from .00 to .88 with a mean value of .24 (Gurman, 1977).

Observer-rated empathy was not predicted by theoretically dissimilar constructs, which supported its discriminant validity from other variables in this study. However, this study had a small sample size, which may have precluded the detection of an effect if one existed. Thus, discriminant validity of the RES should be

established with a larger sample. Additionally, it may be wise to establish discriminant validity with additional variables such as theoretically unrelated therapist personality variables (e.g., extraversion/introversion).

**Empathy and Client AttritionOutcome**

Although it was predicted that therapists with higher levels of empathy would have fewer clients drop out of treatment, this was not supported. It is possible that therapist empathy does not play a significant role in client attrition. However, there are several other reasons that could have accounted for the lack of relationship found between therapist empathy and client dropout in the present study. First, the small number of therapists and clients that were able to be recruited may have precluded the detection of a significant effect. Second, numerous other factors have been hypothesized to play a role in psychotherapy dropout rates and that may have played a more significant role for the clients in this study. For example, in a recent meta-analysis on premature discontinuation in psychotherapy, client age and diagnosis (i.e., personality disorder and eating disorder) were consistently found to predict drop-out (Swift & Greenberg, 2012). Other factors have been implicated, although less consistently. For example, therapist factors such as experience level (McNair, Lorr, and Callahan, 1963), degree (Kulish, 1985), and theoretical orientation (Blatt, Sanislow, Zuroff, & Pilkonis, 1996) as well as therapist and client match (Beck & Jones, 1973; Maramba & Nagayama Hall, 2002) have been demonstrated to affect client attrition. Additionally, treatment factors such as dissatisfaction with services (Hunsley, Aubry, Verstervelt, & Vito, 1999), disagreement over the nature of the presenting problem (Lake & Levinger, 1960),

being placed on a waiting list (Festinger, Lamb, Marlowe, & Kirby, 2002; Stasiewicz & Stalker, 1999) and having a long wait from intake to first treatment session (Rodolfa, Rapaport, & Lee, 1983) have been cited as reasons clients have disengaged early from treatment. These factors were not accounted for in the present study, although they may have influenced premature termination.

## Conclusions and Future Directions

Based upon the preceding results, several suggestions are offered for the ongoing measurement and study of empathy.  For example, it is proposed that modifications be made to the RES for future study. First, items 1 (*Intention*), 7 (*Voice*), and 8 (*Manner*) should be dropped, as these items failed to achieve adequate interrater reliability. Additionally, in the case of items 1 and 8, it was not apparent that they were essential to the construct of empathy, and in the case of item 7, ratings were based on judgments seemed too subjective to be precise. Notably, items 7 and 8 also failed to achieve adequate inter-rater reliability in the initial validation study that utilized a larger sample (Elliot et al., 1982). Furthermore, in the present study, ratings for item 4 (*Here and Now*) were consistently lower than the other items across raters. Thus, future studies could compare ratings from beginner and advanced therapists to determine 1) whether or not comments about clients' present-moment experiences differ significantly between beginning and advanced therapists and/or 2) based upon empathy ratings from a larger sample of therapists, whether or not the manual's description of ratings for this item should be adjusted. Researchers should also consider adding items assessing empathetic body language such as eye contact, posture, and distance

from client. Finally, this scale should be retested in a clinical setting with a larger population.

Notably, client-rated empathy did not significantly correlate with observer-rated empathy in the present study. Future studies, however, may want to reassess this relationship in a more methodologically sound way (i.e., by obtaining an average of observer-rated empathy across numerous sessions and relating this value to the working alliance after these sessions). It may be unreasonable, for example, to expect the working alliance at session four to relate to empathy in session one. Notably, however, client-rated empathy and observer-rated empathy have been reported to be inconsistently related in others studies (e.g., Gurman, 1977). Because of discrepancies in ratings of therapist empathy between trained observers and clients, future research should examine the extent to which observer-rated empathy and client-rated empathy may agree or differ based upon various client characteristics such as diagnosis and personality traits. Researchers should also assess the degree to which observer-rated and client-rated empathy may agree or differ based upon factors such as congruency among the client, therapist, and raters in domains such as age, ethnicity, gender, SES, etc., in order to begin to tease apart the specific factors that may be accounting for discrepancies in ratings of therapist empathy between observers and clients.

Numerous factors have been demonstrated to play a role in attrition from psychotherapy, and in this study, empathy was not implicated in dropout within the small sample utilized. Because of the vast inconsistencies in studies for factors that do and do not predict client attrition, it is possible that the factors that have been

found to play a role in client attrition depend on mediating variables such as treatment setting and/or disorder. It may be, for example, that therapist empathy plays more of a significant role in outcome for clients with particular psychological disorders or personality profiles. It is also possible that therapist empathy plays a greater role in outcome for non-manualized treatments. Thus, studies should begin to tease apart which variables contribute to attrition from psychotherapy for particular groups of people or within particular forms of psychotherapy.

In conclusion, numerous problems exist in in the way empathy has historically been measured and defined within the helping relationships. This study attempted to address these problems and elucidate empathy's role in an important outcome variable—namely, client attrition. It was the first study to utilize the RES, which is based upon a cognitive operationalization of empathy (versus an affective one), to asses therapist empathy within actual client-patient interactions. Choosing the RES for use in this pursuit was based upon strong theoretical reasoning. First, in regards to research related to client outcomes within the helping relationships, the importance of measuring empathy expressed within an actual therapeutic interactions has been underemphasized. Previous studies have drawn unsubstantiated conclusions about the role of empathy as it relates to outcome based on measures that do not include items related to the clinical encounter(s) of interest. Many outcome studies also draw conclusions about empathy's role in outcome based upon measures that include items confounded with other relationship variables (e.g., warmth and sympathy) or seem to be entirely unrelated to the construct of empathy (e.g., measuring one's interest in art) altogether. Finally,

many studies utilize judgments about empathy based upon viewpoints that are arguably biased (i.e., from the perspective of the therapist or client involved in the interaction). While bias in human research can never be avoided entirely, using objective observers as informants may mitigate the problem.

Although it was demonstrated that the RES is a reliable measure, this study failed to validate the instrument or find a significant effect in the relationship between therapist empathy and dropout within a university-based psychological clinic. However, one overarching drawback that could account for this was the small sample size utilized. With small revisions to the RES, it would be of immense value to repeat the present study with a larger sample and within other helping relationships (e.g., doctor-patient relationship) for the reasons outlined above. Researchers would be remiss to ignore the problems currently plaguing empathy research. Unfortunately, researchers are still utilizing empathy instruments that have been argued to be invalid or devising new empathy measures without consideration of the flaws in existing measures. This study utilized available reliability and validity data to scrutinize existing empathy measures and thus could be of great benefit to researchers hoping to accurately operationalize and measure this important relationship variable in the future. Researchers are urged to consider current methodological flaws in the empathy literature as it relates to the helping relationship and utilize this information to move towards the adoption of a common conceptualization and method of measurement of this important relationship variable. Sound conclusions cannot be made about empathy's role in a variety of outcomes until better assessment measures are routinely implemented in its study.

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Appendix A

| Table 1 | | | |
|---|---|---|---|
| *Commonly Used Empathy Measures* | | | |
| Name of Measures | Brief Description | Sample Items | Type of Empathy Measured |
| *Client-rated measures* | | | |
| The Consultation and Relational Empathy (CARE) Measure (Mercer et al., 2004) | Patient responds to ten statements on a 5-point Likert scale ranging from "poor" to "excellent." An option of "does not apply" is also given. | *How was the doctor at:*<br>*...making you feel at ease?*<br>*...being positive?*<br>*...being interested in you as a whole person?*<br>*...showing care and compassion?* | Not explicitly stated |
| Reynolds Empathy Scale (Reynolds, 1999) | 12-item scale with responses given on a 7-point Likert scale from 1 (Always like) to 7 (Never like). | *Ignores verbal and nonverbal communication*<br>*Explores personal meanings of feelings*<br>*Provides the client with direction* | Empathy described as cognitive, but definition used contains emotional content |
| Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPE; Kane, Gotto, West, Hojat, & Mangione, 2007) | Patients respond to five items rated on a 5 point Likert scale from 1 (strongly disagree) to 5 (strongly agree). | *My doctor:*<br>*...understands my emotions, feelings, and concerns.*<br>*...seems concerned about me and my family.*<br>*...can view things from my perspective (see things as I see them).*<br>*...asks about what is happening in my daily life.*<br>*...is an understanding doctor.* | Cognitive |
| Empathy Scale (Burns, 1994) | 10-item questionnaire with responses rated on a 4-point Likert scale with responses ranging from, "I do not feel this statement is valid" to "I feel this statement is completely valid." | *My therapist understands what I say to him or her*<br>*My therapist understands my words, but not the way I feel inside* (reverse coded)<br>*My therapist felt I was worthwhile* | Not explicitly stated |
| *Self-report measures* | | | |
| Interpersonal Reactivity Index (IRI; Davis, 1983) | Four subscales of 7 items: Perspective Taking (PT), Fantasy (FS), Empathic Concern (EC), and Personal Distress (PD). Answers given on a scale from A (Does not describe me well) to D (Describes me very well). | PT: *I sometimes find it difficult to see things from the "other guy's" point of view* (reverse scored).<br>FS: *I daydream and fantasize, with some regularity, about things that might happen to me.*<br>PD: *I sometimes feel helpless when I am in the middle of a very emotional situation.*<br>EC: *I am often quite touched by things that I see happen.* | Both |
| Jefferson Scale of Physician Empathy (JSPE; Hojat, 2007) | Twenty items total with three factors: perspective taking, compassionate care, and standing in the patient's shoes. Items rated on a 7-point Likert Scale from 1 (strongly disagree) to 7 (strongly agree). Scale revised from JSPPPE. | *Patients' illness can be cured only by medical treatment; therefore, affectional ties to my patients cannot have a significant place in this endeavor* (reverse coded).<br>*An important component of the relationship with my patients is my understanding of the emotional* | Cognitive |

| | | | |
|---|---|---|---|
| | | *status of themselves and their families.* | |
| Questionnaire of Emotional Empathy (QMEE; Mehrabian & Epstein, 1972) | 33-item measure that contains 7 subscales (*Susceptibility to Emotional Contagion, Appreciation of the Feelings of Unfamiliar and Distant Others, Extreme Emotional Responsiveness, Tendency to be Moved by Others' Positive Emotional Experiences, Tendency to be Moved by Others' Negative Emotional Experiences, Sympathetic Tendency,* and *Willingness to Be in Contact with Others Who Have Problems*) with scale answers varying from +4 (very strong agreement) to -4 (very strong disagreement). The QMEE was further advanced into the Balanced Emotional Empathy Scale (BEES; (Mehrabian, 1996) which has 30 items rated that are rated on a similar 9-point Likert scale. | *When a friend starts to talk about his problems, I try to steer the conversation to something else* (reverse scored). *Becoming involved in books and movies is a little silly* *I often find public displays of affection annoying* (reverse scored) *I tend to get emotionally involved with a friend's problems.* | Emotional |
| Hogan's Empathy Scale (Hogan, 1969) | Individuals respond either "true" or "false" to 64 items selected from existing psychological assessments. Hogan defines empathy as ''the intellectual or imaginative apprehension of another's condition or state of mind." | Empathic answers are given in parentheses: *As a rule I have little difficulty in "putting myself into other people's shoes.* (T) *I am usually rather short-tempered with people who come around and bother me with foolish questions.* (F) *I enjoy the company of strong-willed people.* (T) | Not explicitly stated; emotions not referred to in definition |
| Empathy Construct Rating Scale (ECRS; La Monica, 1981) | 84 items rated on a 6-point scale from -3 (extremely unlike) to +3 (extremely like). | *Seems to understand another person's state of being.* *Does not listen to what the other person is saying.* *Is arrogant and consumed with feelings of pride and self-importance.* | Both |
| *Observer-rated measures* | | | |
| Accurate Empathy Scale (Truax & Carkhuff, 1967) | An observer listens to recordings of a clinical interaction and assigns the segments to one of nine stages of empathy. Truax and Carkhuff conceptualize "accurate empathy" as encompassing both the therapist's sensitivity to the current feelings of the client as well the therapist's ability to verbally | Stage 1: *Therapist seems completely unaware of even the most conspicuous of the client's feelings: his responses are not appropriate to the mood and content of the client's statements.* Stage 5: *Therapist accurately responds to all of the client's more readily discernible feelings. He also shows* | Cognitive (The researchers stress that the therapist's sensitivity to the client's feelings should not involve the therapist feeling the same emotions |

| | communicate his or her understanding of the client. | awareness of many less evident feelings and experiences but he tends to be somewhat inaccurate in his understanding of these. Stage 9: The therapist in this stage unerringly responds to the client's full range of feelings in their exact intensity. Without hesitation, he recognizes each emotional nuance and communicates an understanding of every deepest feeling. | as the client, but rather should involve an awareness of those feelings) |
|---|---|---|---|
| Carkhuff's Empathic Understanding in Interpersonal Process Scale (A Revision of the Accurate Empathy Scale; Carkhuff, 1969) | Empathic understanding on the part of the therapist is rated by an observer on one of five levels with increasing levels indicating greater empathy. | Excerpts from the Levels' descriptions: Level 1: The verbal behavioral expressions of the helper either do not attend to or detract significantly from the verbal behavioral expressions of the helpee(s)... Level 3: The expressions of the helper in response to the expressions of the helpee(s) are essentially interchangeable... Level 5: The helper's responses add significantly to the feeling and meaning of the expressions of the helpee(s) | Not explicitly stated, but focuses on cognitive components |
| The Roter Interaction Analysis System (RIAS; (Roter & Larson, 2002) | Developed to code video or audio-recorded interactions between patient and doctor. Each complete thought by physician or patient is coded into one of 38 categories. There are two main types of categories: Socioemotional Exchange (these categories include empathy statements) and Task-Focused Exchange. Raters also assign "Global Affect Ratings" (rating various affects) on a scale of 1 (low) to 6 (high) to the dialogue for both doctor and patient. Empathy is one of 13 affects included. | Examples of coded phrases: "I understand that this might be distressing for you." "You seem a little confused." "I understand why you are feeling anxious." | Not explicitly stated, but focused on emotions |
| A Pencil-and-Paper Empathy Rating Test (Danish & Hauer, 1973) | Individuals write short responses to 10 different statements. Responses are then coded for empathic content on a 5-point Likert scale: 0 = aggressive or derogatory response, 2 = partially acceptable: open-ended question, or response that acknowledges both feeling and content of statement 4 = facilitative: reflects but also adds deeper feeling and meaning to the statement in a way that encourages self-exploration. | Examples of trigger statements: *My children tell me I'm old-fashioned. After all I've done for them! However, hard I try they just don't appreciate me.* *If my exam marks don't improve I'm going to fail and lose my government allowance. I don't know what to do.* *Whenever I try to get close to someone of the opposite sex I always mess it up. Am I so physically unattractive? How do I turn them off?* | Not explicitly stated |

| | | | |
|---|---|---|---|
| Revised Response Empathy Rating Scale (Elliott, 1982) | Objective raters rate counselors' responses on a 5-point Likert Scale (0 = No, definitely; 4 = Yes, definitely) for 9 separate components: the therapist's intention to enter the client's frame of reference, the degree to which the counselor makes inferences about and elucidates the client's frame of reference, the plausibility of the therapist's inference, reference to the client's present-moment experience(s), the degree to which the therapist refers to the main topic, the types of words the counselor uses (e.g., richness), the counselor's quality of voice, the degree to which the therapist is exploratory, and the impact of the practitioner on the client. | Examples of descriptions for three components:<br>1. *Intention to enter client's frame of reference.* Does the counselor try to perceive the world as it appears to the client (e.g., by gathering information about the client's experiences and feelings)?<br>2. *Here and now.* Does the counselor refer to what the client is experiencing at the current moment?<br>3. *Exploratory manner.* Does the counselor communicate a sense that the counselor and client are working together in a process of exploration? | Attempts to measure different components of response empathy |
| Measure of Expressed Empathy (MEE; Watson & Prosser, 2002) | This is a revision of the first version of the instrument (Watson & Prosser, 2002). The MEE is based on behavioral correlates of empathy: therapist verbal/non-verbal behaviors, speech characteristics, and response modes. Items inquiring about a 5-minute therapist/client interaction are rated on a 9-point Likert scale from 0 (*Never*) to 8 (*All the time*) | *Do the therapist's responses convey an understanding of the client's cognitive framework and meanings? Is the therapist responsive to the client?*<br>*Does the therapist look concerned?* | Expressed empathy |
| Therapist Empathy Scale (Decker et al., 2013) | The TES is 9-item observer-rated scale based on (Watson, 1999) work and adapted from the MEE. Responses are given on a 7-point Likert Scale to reflect frequency of the behavior in question from 1 (*not at all*) to 7 (*extensively*). Items were re-written to refer only to behaviors that could be assessed from an audio recording. | *A therapist's voice demonstrates expressiveness when the therapist speaks with energy and varies the pitch of his or her voice to accommodate the mood or disposition of the client.*<br>*A therapist demonstrates warmth by speaking in a friendly, cordial, and sincere manner…* | Cognitive, affective, attitudinal, and attunement aspects of empathy are all assessed |
| *Miscellaneous* | | | |
| Barrett-Lennard's Relationship Inventory (BLRI; Barrett-Lennard, 1976) | Client, clinician, or observer versions all exist. The RI consists of four scales of 16 items measuring four therapist attitudes: Empathic Understanding (E), Level of Regard (R), Unconditionality of Regard (U), and Congruence (C). Patients rate each item describing their therapist based on a 6-point Likert Scale from +3 (I strongly feel that it is true) to -3 (I strongly feel that it is not true). Positive and negative items for each dimension are counterbalanced between the two halves of the test such that each item can either add to or subtract from the total scale score. | An example of both a positive and negative item from the client version measuring empathic understanding respectively:<br>*He realizes what I mean even when I have difficulty in saying it and*<br>*He may understand my words but he does not see the way I feel.* | Not explicitly stated |

| Hornblow's Empathy Rating (Hornblow, 1977) | Clinicians are rated on a 7-point Likert Scale from -3 to 3 on degree of empathy. Raters are given Hogan's definition of empathy as well as descriptions of an empathetic and non-empathetic person to make their judgments. Raters can be peers, observers, simulated patients, or one's self. | Empathy is defined as the intellectual or imaginative apprehension of another's condition or state of mind without actually experiencing that person's feelings (Hogan, 1969) | Not explicitly stated; definition of empathy is focused on cognitive components |
|---|---|---|---|
| The Group Assessment of Interpersonal Traits (GAIT; Schag, Loo, & Levin, 1978) | Eight interpersonal qualities including empathy are rated on this assessment. Empathy is rated on a 6-point Likert scale from 1 to 6, with "6" being highly empathic. The judge can be either a peer or other observer. | Descriptions of a rating of "1": *Ignores the feelings of the other, gives much advice regardless of what the other says, completely uninterested in understanding the other person and shows obvious lack of interest.* Descriptions of a rating of "6": *Attempts to verbally label the other's feelings and is accurate. The conversation remains mostly on this level of feeling discussion.* | Not explicitly stated |
| The Affect Reading Scale (ARS; Holm, 1996) | Ratings are based on four clinical interviews. Responders record the feelings that were invoked in them by the patient, and the responses are evaluated by a rater in seven categories on a 5-point scale. | The worst responses are those in which the responder is unable to identify one's own feelings (*I'm not sure what I felt*), and complex feelings are best (*I felt compassion for her, but I also felt somewhat irritated by her anger*). | Emotional |

Appendix B

# Therapist Background Questionnaire

Please complete each of the following questions.

1) Full name (first and last) _____

2) Year in program:
  ☐ Second
  ☐ Third
  ☐ Fourth
  ☐ Fifth
3) Age _____

4) Gender
  ☐ Female
  ☐ Male

5) Relationship status (please check the box that most closely describes your relationship status)
  ☐ Single, not dating
  ☐ Single, casual dating
  ☐ Single, in a steady relationship
  ☐ Engaged to be married
  ☐ Married

6) When taking care of your patients, to what extent do you try to see the world "through their eyes"?
  ☐ Not at all
  ☐ A little
  ☐ Sometimes
  ☐ Often
  ☐ All the time

7) When taking care of patients do you intentionally provide them with new ways of looking at things (a
new perspective)?
  ☐ Not at all
  ☐ A little
  ☐ Sometimes
  ☐ Often
  ☐ All the time

8) When you do offer new perspectives are they generally accurate/plausible?
  ☐ Not at all
  ☐ A little
  ☐ Sometimes
  ☐ Often
  ☐ All the time

9) When you take care of patients do you get them to focus on the present moment while they're with you
(rather than past or future)? For example, do you ever ask for their reactions to diagnosis or

treatment right in the exam room?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

10) Are you able to focus on what's most important to patients (versus focusing on your agenda as the therapist)?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

11) Do you use rich, vivid, metaphorical language, consistent with your patient's concerns?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

12) Is your voice expressive, empathetic, and appropriate to the situation?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

13) Do you communicate in ways that expresses your desire to explore and understand patients (vs. lecturing to them?)
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

14) Do you believe that your responses to patients make an impact on them?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

15) To what extent do you see yourself as empathetic?
- ☐ Not at all
- ☐ A little
- ☐ Sometimes
- ☐ Often
- ☐ All the time

Appendix C

# **Visual Analog Scale**

**<u>Directions:</u>** Please use a writing utensil to place a mark on the line below that best

represents how well you felt as though your therapist understood you (e.g., how

well he/she understood your thoughts, emotions, and situation) in the previous

session.

←------------------------------------------------------------------→
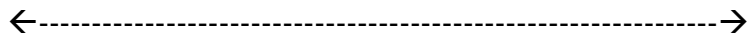
"My therapist understood
me none of the time."

"My therapist understood
me all the time."

Appendix D

# Working Alliance Inventory Short-Form Revised (WAI)

**Instructions**: Below is a series of statements about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. For each statement, please take your time to consider your own experience and then fill in the appropriate bubble.

Name: _____

Date_____/_____/_____ Client #_____

*Important:* The rating scale is not the same for all the statements. **Please read carefully!**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | As a result of these sessions I am clearer on how I might be able to change. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 2. | What I am doing in therapy gives me new ways of looking at my problem. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 3. | I believe that _____ likes me. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |
| 4. | _____ and I collaborate on setting goals for my therapy. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 5. | _____ and I respect each other. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |
| 6. | _____ and I are working toward mutually agreed upon goals. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |
| 7. | I feel that _____ appreciates me. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |
| 8. | _____ and I agree on what is important for me to work on. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 9. | I feel _____ cares about me even when I do things that he/she does not approve of. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |
| 10. | I feel that the things I do in therapy will help me accomplish the changes that I want. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 11. | _____ and I have established a good understanding of the kind of changes that would be good for me. | Seldom ○ | Sometimes ○ | Fairly Often ○ | Very Often ○ | Always ○ |
| 12. | I believe the way we are working with my problem is correct. | Always ○ | Very Often ○ | Fairly Often ○ | Sometimes ○ | Seldom ○ |

APPENDIX E

# Outcome Questionnaire (OQ®- 45.2)

**Instructions**: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Name:_____ Age:_____Yrs

Date____/____/_____ Client #_____

| | | Never | Rarely | Sometimes | Frequently | Almost Always |
|---|---|---|---|---|---|---|
| 1. | I get along well with others. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 2. | I tire quickly. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 3. | I feel no interest in things. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 4. | I feel stressed at work / school | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 5. | I blame myself for things. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 6. | I feel irritated. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 7. | I feel unhappy in my marriage / significant relationship. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 8. | I have thoughts of ending my life. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 9. | I feel weak. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 10. | I feel fearful. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 11. | After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never") | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 12. | I find my work / school satisfying. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 13. | I am a happy person. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 14. | I work / study too much. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 15. | I feel worthless. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 16. | I am concerned about family troubles. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 17. | I have an unfulfilling sex life. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 18. | I feel lonely. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 19. | I have frequent arguments. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 20. | I feel loved and wanted. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 21. | I enjoy my spare time. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 22. | I have difficulty concentrating. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 23. | I feel hopeless about the future. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 24. | I like myself. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 25. | Disturbing thoughts come into my mind that I cannot get rid of. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 26. | I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never") | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 27. | I have an upset stomach. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 28. | I am not working /studying as well as I used to. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 29. | My heart pounds too much. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 30. | I have trouble getting along with friends and close acquaintances. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 31. | I am satisfied with my life. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 32. | I have trouble at work / school because of drinking or drug use. (If not applicable, mark "never") | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 33. | I feel that something bad is going to happen. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 34. | I have sore muscles. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 35. | I feel afraid of open spaces, of driving, or being on buses, subways, and so forth. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 36. | I feel nervous. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 37. | I feel my love relationships are full and complete. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 38. | I feel that I am not doing well at work / school | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 39. | I have too many disagreements at work / school. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 40. | I feel something is wrong with my mind. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 41. | I have trouble falling asleep or staying asleep. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 42. | I feel blue. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 43. | I am satisfied with my relationships with others. | ○ 4 | ○ 3 | ○ 2 | ○ 1 | ○ 0 |
| 44. | I feel angry enough at work / school to do something I might regret. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |
| 45. | I have headaches. | ○ 0 | ○ 1 | ○ 2 | ○ 3 | ○ 4 |

Appendix F

## Revised Response Empathy Rating Scale

**Items**
___

1. *Intention to enter client's frame of reference.* Does the counselor try to perceive the world as it appears to the client (e.g., by gathering information about the client's experiences and feelings)?

2. *Perceptual inference and clarification.* Does the counselor make inferences to tell the client something the client hasn't said yet, in order to add to the client's frame of reference or to bring out implications?

3. *Accuracy-plausibility.* To the extent that inference or clarification is present, how likely to be true is what the counselor said, given what the client has said so far?

4. *Here and now.* Does the counselor refer to what the client is experiencing at the current moment?

5. Topic *centrality.* Does the counselor refer to what is most important to the client? Does the counselor's response relate to the client's basic complaint or problem?

6. *Choice of words.* Does the counselor use rich, vivid, metaphorical language in a way consistent with the client's discourse?

7. *Voice quality.* Is the counselor's voice expressive or empathic and appropriate to what the client is expressing?

8. *Exploratory manner.* Does the counselor communicate a sense that the counselor and client are working together in a process of exploration?

9. *Impact (facilitation vs. blocking, distraction).* Does the response facilitate the client's exploring further or bringing up new material, or does it block or distract the client?
___

All components were rated on 5-point behaviorally anchored rating scales. For example, the anchors that applied to the client frame scale (i.e., "Does the counselor try to perceive the world as it appears to the client?") were as follows:
4: Yes, definitely. (Raters should look for questions intended to gather information about client's experiences and feelings; reflections, except "quote" reflections; "inside" interpretations.)
2: Perhaps, not sure. (Raters should look for "uhhuhs"; questions intended to gather information about facts of situation.)
0: No, definitely. (Raters should look for pure advisement; social talk; opening, closing, or structuring session; process advisements or reassurance.)

Appendix G

The *Response Empathy Scale* Training Manual

It is universally understood that empathy is important, despite the fact that there is little consensus as to its definition. Some experts in the field have viewed empathy as a cognitive process while others have seen it as an affective (i.e., emotional) process. Regardless of how you define it, empathy is well known to facilitate the process of psychotherapy. As you learn to use this *Response Empathy Rating Scale* (RERS; Elliott, Filipovich, Harrigan, Gaynor, Reimscheussel, & Zapadka, 1982) to rate psychotherapist empathy, we recommend that you keep in mind the definition proposed by Coulehan et al. (2001): "the ability to understand the patient's situation, perspective and feelings, and to communicate that understanding to the patient."

Not only has empathy been defined in many different ways, it has also been measured using three major approaches: client-report, self-ratings, and trained expert ratings. Each of these approaches has limitations. For example, client-report measures are subject to the "halo effect" and the confounding of empathy with unrelated factors such as therapist warmth, genuineness, and expertise. Self-report measures of empathy are subject to extensive biases such as the social desirability bias (Crowne & Marlowe, 1960) and do not correlate well with psychotherapy outcome. Evidence suggests that trained expert ratings used in actual clinician-patient interactions may provide the most useful and accurate measure of empathy's effect on clinical outcomes (Hojat, 2007). The challenge with trained

expert ratings is in the process of training experts to reliably make ratings that minimize individual differences in perceptions of empathy.

The RERS is an observer-rated measure of empathy, whose items reflect the cognitive and behavioral definition of empathy stated above. This training manual lists items in the RES (Table 1) and is followed by detailed descriptions of each of the nine items with accompanied examples/illustrations. The manual concludes with vignettes and responses that represent differing levels of empathy on these nine items, as well as explanations of how ratings might be assigned.

Practice makes perfect!  In addition to studying this manual, you will be rating tapes of therapy sessions in order to practice what you have learned from this manual. The real test will come as we compare your ratings to those of other experts trained to use this scale.

**The Revised Response Empathy Rating Scale**

*Format: All 9 components of the Response Empathy Rating Scale are rated on 5-point behaviorally anchored rating scales.*

| Items |
|---|
| 1. *Intention to enter client's frame of reference.* Does the counselor try to perceive the world as it appears to the client (e.g., by gathering information about the client's experiences and feelings)? |
| 2. *Perceptual inference and clarification.* Does the counselor make inferences to tell the client something the client hasn't said yet, in order to add to the client's frame of reference or to bring out implications? |
| 3. *Accuracy-plausibility.* To the extent that inference or clarification is present, how likely to be true is what the counselor said, given what the client has said so far? |
| 4. *Here and now.* Does the counselor refer to what the client is experiencing at the current moment? |
| 5. Topic *centrality.* Does the counselor refer to what is most important to the client? Does the counselor's response relate to the client's basic complaint or problem? |
| 6. *Choice of words.* Does the counselor use rich, vivid, metaphorical language in a way consistent with the client's discourse? |
| 7. *Voice quality.* Is the counselor's voice expressive or empathic and appropriate to what the client is expressing? |
| 8. *Exploratory manner.* Does the counselor communicate a sense that the counselor and client are working together in a process of exploration? |
| 9. *Impact (facilitation vs. blocking, distraction).* Does the response facilitate the client's exploring further or bringing up new material, or does it block or distract the client? |

Elliott, R., Filipovich, H., Harrigan, L., Gaynor, J., Reimschuessel, C., & Zapadka, J. K. (1982). Revised Response Empathy Rating Scale [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t01287-000

**Description of Ratings**

Table 1 contains the nine items on the RERS, along with brief descriptions. In this

section we provide instructions regarding the ratings of each of these items. Again

the ratings of each item may be rated from "0" (lower levels of empathy) to "4"

(higher levels of empathy).

**Item 1 - Intention to enter client's frame of reference.** Does the counselor try to
perceive the world as it appears to the client (e.g., by gathering information about
the client's experiences and feelings)?

> *4: Yes, definitely.* The counselor regularly tries to understand the experiences
> and feelings of the client. Rather than asking about details of a situation (factual
> information), the therapist poses questions about what certain experiences
> were like for the client and how he or she felt about them. Questions are posed
> in a way that are intended to elicit information with the intention of
> understanding the client's frame of reference. The following questions are
> provided as examples of attempts to perceive the world as the client does:
> "What do you think about that?"
> "How do you feel about that?"
> "What are you worried about?)

> *2: Perhaps, not sure.* The therapist asks questions for understanding, but rather
> than attempting to understand the client's feelings and experiences, the
> questions are intended to gather factual information (e.g., information outside
> of the client's subjective experiences).

> *0: No, definitely.* The therapist may have his or her own agenda for the session,
> so instead of clarifying the client's experiences, the therapist regularly asks
> tangential questions. The therapist may offer the client advice or reassurance
> about a situation rather than trying to understand it. The following are
> provided as examples of questions that do not necessarily relate to the client's
> subjective experience:
> "What does your dad do for a living? "
> "How old is your sister? "
> "How was your drive into the office this morning?"

**Item 2 - Perceptual inference and clarification.** Does the counselor make
inferences to tell the client something the client hasn't said yet, in order to add to
the client's frame of reference or to bring out implications?

> *4: Yes, definitely.* The counselor repeatedly makes attempts to elaborate on the

client's words or actions in a way that reflects the therapist's receptivity and understanding of the situation the client is trying to communicate or experiencing. While the therapist may paraphrase what the client is communicating, the counselor does so in a way that adds to the client's descriptions. The therapist often goes above and beyond the client's basic description of a situation to bring out implications of the experience. The following questions are provided as examples of attempts to perceive the world as the client does:

"Perhaps you felt... "

"It sounds like you were worried about..."

*2: Perhaps, not sure.* The counselor makes some attempts at making inferences, but the statements mostly do not clarify the client's explanation or add much to the client's own words and statements. The inferences may have to do with factual information rather than the client's own experiences/feelings and interpretations of events. Many of the inferences do not get at underlying implications.

*0: No, definitely.* The therapist does not attempt to make inferences or attempt to clarify the client's statements. The counselor may ask the client to expand on a topic but adds nothing of value to the client's statements and may seem to just parrot the client's words or phrases. The following are provided as examples of responses that do not necessarily relate to the client's subjective experience:

"I see."

"Uh huh."

"Go on."

**Item 3 - Accuracy-plausibility.** To the extent that inference or clarification is present, how likely to be true is what the counselor said, given what the client has said so far?

*4: Very likely.* The inferences or attempts at clarification pertain to the client's dialogue or the therapeutic interaction. Rather than distracting the client, the inference/clarification flows from the conversation or atmosphere of the therapy room. The inference/clarification may stimulate further conversation and exploration about the topic at hand or the client may confirm that the therapist's inferences/clarifications are correct or might be correct.

*2: Neither likely nor unlikely.* The inferences or attempts at clarification may have relevance to the client's statements or conversation but the connection is unclear or vague. Alternatively, the inferences simply restate what the client has already said. Therefore, therapist's attempts at drawing inferences or clarifying information may not stimulate further conversation or lead to client insight. Alternatively, the client may disagree with the therapist's inferences or clarifications without it stimulating further therapeutic conversation.

*0: Not at all likely.* The inferences are either not present at all or do not pertain at all to what the client is discussing or does not match the client's portrayal of a situation or associated feelings/emotions. The client may express frequent surprise or frustration in response to the therapist's inferences or clarifications.

**Item 4 - Here and now.** Does the counselor refer to what the client is experiencing at the current moment?

*4: Yes, definitely.* The counselor often inquires about or comments on the client's present-moment feelings and experiences. The therapist may refer to things such as the client's current posture, emotional expressions, thought processes, appearance, tone of voice, energy level, etc. The following statements are provided as examples of attempts to keep the client in the here and now:
"You appear to be fidgeting nervously right now."
"You look tired."
"You just smiled when I mentioned Jon's name."
"Something just triggered your anxiety."

*2: Perhaps, sometimes.* The therapist may occasionally inquire about or comment on a client's present-moment experience. If the therapeutic conversation is about the current moment, the client may have initiated it. When the therapist does comment on the present, it is usually because the client is obviously escalated.

*0: No, definitely.* The therapist does not comment on the client's current experience even if the client is obviously distressed. Similarly, when discussions are about the client's experiences, they are usually focused on past experiences.

**Item 5 - Topic centrality.** Does the counselor refer to what is most important to the client? Does the counselor's response relate to the client's basic complaint or problem?

*4: Yes, definitely.* The therapist discusses the topic that is most pertinent to the client and his or her chief complaint. If reflections or inferences are made, the therapist makes a point to refer to the most relevant and meaningful material to the client. If the client begins to discuss tangential information, the therapist skillfully brings the conversation back to relevant material. The following statements are provided as examples of attempts to perceive the world as the client does:
"The most important thing on your mind today is..."
"Let's prioritize your concerns."
"Let's get back to what is bothering you the most."

*2: Perhaps, not sure.* The counselor occasionally focuses solely on the most

pertinent material to the client. If the therapist uses reflections or makes inferences, they may sometimes miss the most important point or relate to somewhat tangential information. The therapist may occasionally engage the client in periods of non-therapeutic conversation ("chit-chat").

*0: No, definitely.* The counselor clearly misses or does not understand the most pertinent material of the client's discussions. The therapist's reflections or inferences are tangential or unrelated to the client's main complaint. He or she may regularly engage the client in non-therapeutic conversation either by his or her own initiative or by failing to redirect the client back to therapeutic topics.

**Item 6 - Choice of words.** Does the counselor use rich, vivid, metaphorical language in a way consistent with the client's discourse?

*4: Yes, definitely.* The therapist's descriptions are clear and illustrative. The counselor uses lucid examples and perhaps metaphorical language in order to illustrate points so that one can visualize or get a felt sense of the counselor's portrayals. However, the counselor is attuned to the client's level of verbal skills/understanding and adjusts his or her language and communication style accordingly. The following phrases are provided as examples of attempts to vivid understanding of the client's experience:
"Red with anger"
"Enraged"
"Sloth-like movements"
"Sick with fear"
"Jumping with joy"

*2: Perhaps, not sure.* The counselor uses some descriptive language to illustrate points, but it might be unclear, vague, or confusing to the client at times. One is sometimes left with a lack of confidence in what the therapist is portraying. The therapist might struggle at times to present information in a way that matches the client's verbal comprehension skills. Vague adjectives such as "upset," "good," or "okay" are frequently used over more precise and descriptive words.

*0: No, definitely.* The therapist does not use vivid or metaphorical language to illustrate or clarify points. Alternatively, if attempts are made, they are confusing to the client and detract from the flow of the conversation or client's thought processes. The therapist does not seem attuned to client's verbal capacities by either using over simplistic and unnecessary explanations or using language far above the client's skill level.

**Item 7 - Voice quality.** Is the counselor's voice expressive or empathic and appropriate to what the client is expressing?

*4: Yes, definitely.* The counselor's tone of voice matches the mood of the

conversation. If the client is expressing affect that is inappropriate to the topic (laughing when talking about abuse), the counselor does not match the client's tone, but rather the content of the speech. For example, the counselor's voice may become softer and rate of speech may slow when discussing difficult issues with the client. Alternatively, voice volume and pitch may increase when the client discusses an exciting accomplishment or event.

*2: Perhaps, not sure.* The counselor's voice may not fluctuate in response to the client's discourse. Alternatively, the counselor may occasionally express an inappropriate tone of voice (ex., talking very quickly or loudly when the client is discussing difficult material or laughing along with a client who is discussing painful events).

*0: No, definitely.* The counselor does not seem mindful of the mood of the conversation. The counselor's voice is not at all expressive and often inappropriate to what the client is expressing.

**Item 8 - Exploratory manner.** Does the counselor communicate a sense that the counselor and client are working together in a process of exploration?

*4: Yes, definitely.* The therapist and client appear to be working as a team. The counselor clearly communicates to the client that he or she is working with the client and that the client's concerns are important. Although the therapist is the "expert," he or she does not use forceful or overly directive language. At the same time, the therapist makes it clear that he or she is supporting the client in the process of therapy and that the client is not alone. The therapist regularly elicits feedback from the client throughout the session. It is clear that the therapist and the client are working towards mutually agreed-upon goals. The following phrases are provided as examples of attempts to set a collaborative atmosphere:
    "Let's try to figure this out together."
    "How has this session been helpful to you so far?"
    "Are we working towards your goal?"

*2: Perhaps, not sure.* It is not clear that the therapist and client are working together as a team. There may be times when they seem to have a collaborative relationship, but at other times the therapist seems closed off to the client either by presupposing knowledge and offering too much direction or not offering much input to the session. The therapist and client may or may not be working towards mutually agreed-upon goals.

*0: No, definitely.* The therapist and client do not at all appear to be working as a team. The counselor is either overly controlling or overly-passive. The therapist might assume knowledge of the client's concerns. Alternatively, he or she may lack input to the session, leaving the client "stranded" in conversation.

**Item 9 - Impact (facilitation vs. blocking, distraction).** Does the response facilitate the client's exploring further or bringing up new material, or does it block or distract the client?

> *4: Yes, definitely.* The therapist's responses facilitate the flow of the therapeutic conversation. The therapist does not appear to have a strict agenda and allows the client to explore relevant topics or bring up new topics. If the therapist frequently needs to redirect a tangential client back to his/her main complaint, he or she does so in a way that facilitates the therapeutic conversation. Rather than "blocking" the client, the therapist's redirections are facilitative to the therapeutic atmosphere. The client might say something like, Wow, I've never thought of it that way…, That was a helpful insight and explains why I behave…, or *Yes, that reminds me of another time…*

> *2: Perhaps, not sure.* At times, the therapist's responses seem to facilitate the client's therapeutic explorations, but at other times the therapist's responses are disruptive or distractive to the client. The therapist may occasionally interrupt the client or cut him/her off unnecessarily. The responses may disrupt the flow of conversation at times.

> *0: No, definitely.* The therapist's responses are frequently disruptive to the flow of the therapeutic interaction. The responses might be confusing, causing the client to become distracted or frustrated. Additionally, the counselor may be overly directive and controlling, eliminating the client's freedom to explore topics more deeply or move on to different topics.

**Vignettes**

  The vignettes depicted in this section are based on mock sessions used in the training of raters during the development of this manual. An expert therapist with extensive knowledge of empathy played the part of a more or less empathetic therapist. An advanced doctoral graduate student in clinical psychology played the part of the client. The vignettes below are followed by ratings of therapist empathy along with explanations of how those ratings were derived.

**Vignette 1 Background**

  The client is a 27 year-old female doctoral student in clinical psychology diagnosed with general anxiety disorder. She is currently seeking services because her anxiety about getting an internship, which is the final step of her doctoral program before graduating, is interfering with her ability to carry out her daily functions. This is her second session with her therapist. Although the script does not allow one to judge voice quality, it is important to note that in this session, the therapist spoke in a monotone voice throughout.

**Ther**: What would you like to discuss today?

**Client**: Well, as I mentioned over the phone, I have just submitted my internship applications, and I'm terrified I won't get an internship. My thoughts have been just spinning about how terrible it would be if I didn't match to an internship site. I can't focus on other things I'm supposed to be doing.

**Ther**: What are these other things you are supposed to be doing?

**Client**: Well, I have to teach my class, and I'm a student therapist, so I see clients as well.

**Ther**: Oh, so you do therapy?

**Client**: Yes.

**Ther**: [Appearing surprised] I would think doing therapy you would have a lot of experience helping people with problems.

**Client**: Well, I guess I'm embarrassed now because since I'm a therapist I should be able to help myself.

**Ther**: So, you believe you need to be perfectly mentally healthy to help people?

**Client**: Well, not perfectly healthy…but I should be able to help myself if I help others.

**Ther**: Well, you're helping yourself by coming here.

**Client**: True. I guess I didn't think of it that way.

**Ther**: So, let's see if I can help you with your fear of not matching. Tell me, how likely is it that you wouldn't match?

**Client**: There is an 85% match rate, meaning I have a 15% chance of not matching.

**Ther**: That's a pretty small percentage, don't you think? Maybe you should be focusing on the fact that you have an 85% chance of matching.

**Client**: Well, that doesn't help because there's still a significant chance of not matching. And, it's such a big deal if I don't match—not only emotionally and academically, but financially too. I mean, every application costs money, and then there's all the airfare and other travel expenses for the interviews. The whole process of trying to get an internship costs thousands!

**Ther**: If you don't match this year, can you try again next year?

**Client**: [Exasperated] Yes, but I don't want to have to go through all this again. And, I hate interviewing! I'm terrible at it. I get all nervous and flustered.

**Ther**: Maybe you're being too judgmental of yourself.

**Client**: Maybe, but I do know I get anxious during interviews.

**Ther**: Has anyone ever told you this?

**Client**: [sighs impatiently] Of course not. That's not something people typically do in an interview.

## Ratings and Explanations

**Item 1 - Intention to enter client's frame of reference.** Does the counselor try to perceive the world as it appears to the client (e.g., by gathering information about the client's experiences and feelings)?

Rating = 2

The therapist in this vignette would receive a rating of a "2" for this item. He asks a lot of questions, but little about the client's subjective experiences. He particularly

fails to try and understand the client's emotional experiences, favoring instead attempts to understand the facts of the client's situation (e.g., How likely is it that you won't match and If you don't match this year, can you match next year?).

**Item 2 - Perceptual inference and clarification.** Does the counselor make inferences to tell the client something the client hasn't said yet, in order to add to the client's frame of reference or to bring out implications?

**Rating = 2**

The therapist would receive a rating of a "2" on this item. The therapist did use occasional inferences, but missed opportunities to get at underlying implications of the client's statements. There was one strong inference (*So, you believe you need to be perfectly mentally healthy to help people?*) that subsequently led to the client and therapist to a deeper understanding of the client's expectations and beliefs about herself. However, this was in contrast to weaker inferences that did not lead to deeper understanding of the client (ex: *Maybe you are being too judgmental of yourself*).

**Item 3 - Accuracy-plausibility.** To the extent that inference or clarification is present, how likely to be true is what the counselor said, given what the client has said so far?

**Rating = 2**

On this item, the therapist would receive a rating of a "2." The therapist's inference about how the client is helping herself by coming into therapy seems to hit home with the client based on her response (*True, I guess I never thought of it that way*). However this is the only inference that seems accurate and leads to client insight.

**Item 4 - Here and now.** Does the counselor refer to what the client is experiencing at the current moment?

**Rating = 0**

On this item, the therapist would receive a "0." He simply never comments on the client's present-moment experiences in the therapy room, despite the fact that the client appears to become frustrated and sighs in response to his comments.

**Item 5 - Topic centrality**. Does the counselor refer to what is most important to the client? Does the counselor's response relate to the client's basic complaint or problem?

**Rating = 2**

On this item, the therapist would receive a rating of a "2." The client clearly expresses her anxiety and concern over obtaining an internship. Although they certainly discuss this fear, the conversation frequently gets derailed by the therapist who focuses on nonessential matters. For example, when the client is distressed that her anxiety is interfering with other things she is supposed to be doing, the therapist refocuses the conversation away from her anxious concerns and asks, *What are these other things you are supposed to be doing*? Additionally, his comment, *Oh, so you do therapy?* derails the conversation further away from the client's main concerns.

**Item 6 - Choice of words.** Does the counselor use rich, vivid, metaphorical language in a way consistent with the client's discourse?

**Rating = 1**

On this item, the therapist would receive a rating of a "1." The only somewhat-descriptive phrase he used was *perfectly mentally healthy*. The rest of his dialogue lacked vividness. The use of illustrative phrases such as *shaking with fear* or *like a juggler trying to keep so many balls in the air* would have improved his score.

**Item 7 - Voice quality.** Is the counselor's voice expressive or empathic and appropriate to what the client is expressing?

**Rating = 1**

Because his tone was never inappropriate (e.g., laughing at a description of a painful event), the therapist would receive a rating of a "1" for this item. As mentioned in the background information, this therapist spoke in a monotone voice throughout the session, and based on his responses lacked sensitivity to the client's emotional distress in the therapy room.

**Item 8 - Exploratory manner.** Does the counselor communicate a sense that the counselor and client are working together in a process of exploration?

**Rating = 1**

On this item, the therapist would receive a rating of a "1.". Overall, this session does not appear to be collaborative. The client becomes frustrated at times in response to the therapist's dismissiveness of the client's concerns. There was no use of the words *us* or *we*, which would indicate a collaborative exploration into the problem. However, the therapist did not over- or under-control the session.

**Item 9 - Impact (facilitation vs. blocking, distraction).** Does the response facilitate the client's exploring further or bringing up new material, or does it block or distract the client?

**Rating = 0**

The therapist would receive a rating of "0" for this item. The therapist seems to lead the client away from the client's concerns, causing frustration and disruptions in the client's explorations of her concerns. The client seems to not be able to openly discuss her anxiety, leaving her concerns unaddressed.

**Vignette 2 Background**

The client is a 28 year-old female who recently became engaged to her partner of one year. She had just accepted a job in a differ fiancé to live apart for one year. She is seeking services because she reports significant worry about the relationship and the possibility that her fiancé will leave her. This is her first session with her therapist. Although the script does not allow one to judge voice quality, it is important to note that in this session, the therapist spoke in a tone of voice that matched the client's emotional state (e.g., quiet, slow tone when the client was discussing difficulties).

**Ther**: I know we talked briefly over the phone about some of your concerns, and I'm wondering what's most pressing for you today?

**Client**: Well, as I mentioned earlier, I just accepted a job offer in Iowa, and my fiancé won't be able to move up to be with me for another year. You know, I'm just nervous that things are going to go downhill for us. A lot of relationships end this way.

**Ther**: I can hear the worry in your voice as you speak. What is your biggest fear about all of this?

**Client**: That we will break-up somehow, and maybe even he will be unfaithful. I mean, I don't think he would ever do that, but you just never know. I'm mostly afraid that one way or another, he will leave me.

**Ther**: Do you have any reason at all to believe that this might be the case?

**Client**: Not substantially. I mean, we fight sometimes, and I can be moody which bothers him, but our relationship is pretty solid right now.

**Ther**: If you could rate your relationship on a scale from 0-100 on quality, what rating would you give it?

**Client**: I would say it's in the 90's. I mean, we're close. That's what scares me. I have something good. I don't want to lose it.

**Ther**: What makes it a good relationship to you?

**Client**: Well, we share a lot of the same interests and hobbies. We work out together and play on soccer leagues together. Also, we are so open with each other. There are no secrets, and I feel like I can talk to him about anything without being judged. We are best friends, and we laugh a lot when we're together.

**Ther**: So a definite strength of the relationship is that you share hobbies, and it sounds like you enjoy each other a lot. The way you were talking and smiling just now almost seems as if you believe you were made for each other in a sense.

**Client**: Yes, I think I'd agree with that. He has all the qualities I want in a partner.

**Ther**: So, despite the current health of the relationship, you still have fears about it ending. Can we talk little more about what kind of specific fears you have?

**Client**: Sure, well one of the things that could create problems for us is that I don't like talking on the phone. I get impatient being on the phone—I always have. I'm worried he will want to talk more than me and I'll upset him.

**Ther**: Have you considered alternatives like Skype?

**Client**: (smiles and chuckles)

**Ther**: Your face just lit up right now. What are you thinking?

**Client**: Well, just the other day I was talking to him about doing Skype workout days since we both will have workout equipment in our apartments. We were also discussing other things we could do over Skype together that we normally do together. I know it sounds silly and we were joking around when we were talking about it, but I guess we should really do these things.

**Ther**: I think that sounds like a fantastic idea—a way to stay connected and keep doing the things that you enjoy in the relationship. Now I know we only discussed one of your fears, but I wanted to check in with you to see if your anxiety about the move was any less than when you first came in today.

**Client**: Definitely. Now that we are coming up with practical solutions to some of my fears, I feel a little more in control of the situation—like I have more confidence that I can influence things to work out for the better.

**Ther**: So it sounds like you are solution-oriented, and we can definitely come up with concrete things for you to do to feel more confident moving forward.

**Client**: That would be great!

## Ratings and Explanations

**Item 1 - Intention to enter client's frame of reference.** Does the counselor try to perceive the world as it appears to the client (e.g., by gathering information about the client's experiences and feelings)?

Rating = 4

The therapist in this vignette would receive a rating of a "4" for this item. The questions he ask get at understanding the client's cognitive and emotional experiences that shape her interpretation of the events in her life (e.g*., What is your biggest fear about all of this… Your face just lit up right now. What are you thinking?)*

**Item 2 - Perceptual inference and clarification.** Does the counselor make inferences to tell the client something the client hasn't said yet, in order to add to the client's frame of reference or to bring out implications?

**Rating = 4**

The therapist would receive a rating of a "4" on this item. While the therapist did reflect what the client was saying, he did so in a way that added substantially to the client's discourse, which led to deeper understanding of the client's experiences. (e.g., *So a definite strength of the relationship is that you share hobbies, and it sounds like you enjoy each other a lot…The way you were talking and smiling just now almost seems as if you believe you were made for each other in a sense…So it sounds like you are solution-oriented…)*

**Item 3 - Accuracy-plausibility.** To the extent that inference or clarification is present, how likely to be true is what the counselor said, given what the client has said so far?

**Rating = 4**

On this item, the therapist would receive a rating of a "4." The therapist's inferences are all confirmed and/or reflected on by the client (e.g., *Yes, I think I'd agree with that…*).

**Item 4 - Here and now.** Does the counselor refer to what the client is experiencing at the current moment?

**Rating = 4**

On this item, the therapist would receive a "4." He frequently made comments about what the client was experiencing in the therapy room (e.g*., I can hear the worry in*

*your voice as you speak… The way you were talking and smiling just now almost seems…Your face just lit up right now.*)

**Item 5 - Topic centrality**. Does the counselor refer to what is most important to the client? Does the counselor's response relate to the client's basic complaint or problem?

**Rating = 4**

On this item, the therapist would receive a rating of a "4." The client came into the session with anxiety about her relationship ending. The therapist stayed with the client's concerns the entire session, asking pertinent questions without getting off topic. For example, he didn't engage the client in nontherapeutic "chit-chat" or inquire about things with no therapeutic value (e.g., *What does your fiancé do for a living?*)

**Item 6 - Choice of words.** Does the counselor use rich, vivid, metaphorical language in a way consistent with the client's discourse?

**Rating = 3**

On this item, the therapist would receive a rating of a "3." Overall, the therapist used language consistent with the client's verbal capacities and was clear in what he was trying to portray, although he could have used more vivid language. More uses of phrases like, *Your face just lit up…* would have earned him a "4" (Note that this was just a small portion of a longer therapy session, so this therapist would have likely exhibited more descriptive words and phrases in the therapy hour that would give him a rating of a "4").

**Item 7 - Voice quality.** Is the counselor's voice expressive or empathic and appropriate to what the client is expressing?

**Rating = 4**

On this item, the therapist would receive a rating of a "4." As mentioned in the background information, the therapist spoke a tone of voice that matched the client's emotional state (e.q., quiet, slow tone when the client was discussing difficulties).

**Item 8 - Exploratory manner.** Does the counselor communicate a sense that the counselor and client are working together in a process of exploration?

**Rating = 4**

On this item, the therapist would receive a rating of a "4." In several ways, the

therapist made it seem as if he and the client were working together. For example, he starts the session by asking the client what concern is most pressing for her. Additionally, he used language that indicated a "team effort" (e.g., *Now that **we** are*…). Finally, he took the time to check in with the client to see if what they were discussing was helpful to her (e.g., *I wanted to check in with you to see if your anxiety about the move was any less than when you first came in today)*.

**Item 9 - Impact (facilitation vs. blocking, distraction).** Does the response facilitate the client's exploring further or bringing up new material, or does it block or distract the client?

**Rating = 4**

The therapist would receive a rating of "4" for this item. The therapist's remarks and questions stimulate new ideas and thoughts for the client. The session flows well without distractions or significant detours from therapeutic conversation. Based on the client's responses, she indicates that she is benefitting from the session (e.g., *Now that we are coming up with practical solutions to some of my fears, I feel a little more in control of the situation—like I have more confidence that I can influence things to work out for the better*).