Empathy from the Psychotherapy Client's Perspective; A Qualitative Examination

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Abstract

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Empathy from Psychotherapy Clients' Perspective; A Qualitative Examination

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Empathy has been one of the best and most consistent predictors of outcome in quantitative research. Yet a basic understanding of the definition and uses of this common therapeutic factor has been hindered by theoretical difficulties. This study aimed to reexamine existing theoretical considerations of empathy through a qualitative analysis of clients' phenomenological experience of empathy, the clients' understanding of the therapists' empathic communications, and the clients' understanding of the utility of empathy.

Participants consisted of nine clients seeking individual psychotherapy at a training clinic for doctoral students in clinical psychology. Semi-structured video-assisted interpersonal process recall (IPR) interviews lasting approximately 120 minutes each, were used for data-collection. The video-replay of the respondents' latest therapy session during interviews facilitated access to the clients' thoughts and feelings experienced during the session without undue interference. Subsequent transcription of the interviews was further enhanced through a multi-channel video-recording of the interviews.

Grounded theory was used for the analysis of the transcripts, and analysis was furthered by access to the video-recordings of the interviews by four co-researchers. The use of a problem formulation to guide the interviewer during interviews and initial exploration of respondents' definitions of empathy at the beginning of each interview,

allowed the respondent and interviewer to quickly focus in on the subject matter under investigation while leaving the client free to explore their actual experiences as prompted by the video-replay of the sessions. An iterative process of interviewing and data-analysis as indicated by grounded coding led to a saturation point after the sixth interview, ending data-collection after three additional interviews. Final categories were contributed to by most participants, and contributions from all nine participants were utilized in the final model.

The analysis of the interviews yielded a model consisting of three clusters: (a) client-perceived types of empathy (the first two problem formulations gave rise to the first cluster); (b) client-perceived relational context of empathy (the second problem formulation); (c) client-perceived utility of therapist (the third problem formulation). The first cluster explored existing theoretical considerations related to typology including a discussion of cognitive versus affective types of empathy and a focus on client contributions to the process of empathy. The second cluster further elaborated on client impact on empathy engagement through client descriptions of their relationships with their therapists. The third and final cluster explored client experience and level of understanding of the usefulness of empathy in the therapeutic endeavor with an emphasis on the clients' contribution to the empathic engagement. The final hierarchical model consisted of a total of eight lowest-level categories. Results included exploration of linkages between types of empathy and utility of empathy. Results were discussed in the context of existing theory and research.

Keywords: empathy, client perspective, grounded theory, interpersonal process recall, utility of empathy, empathy theory, psychotherapy outcome.

Dedication

To my son, Lars Søren Bommarito MacFarlane.

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Introduction

Empathy has been studied from a number of different perspectives. In developmental psychology, "Theory of mind" research and theory is nearly synonymous with empathy and is defined by the basic ability of humans to understand that others have minds as well (Baron-Cohen, 1991). Goldman (1993) suggested an alternative called "Simulation Theory" which theorizes that we, in interpreting other's actions and motives, simulate them in our own minds, and hence come to understand them in a way that promotes empathy and sympathy. In neuro-science the concept of mirror-neurons addresses the notion that humans (and at least some primates) have motor-neural pathways that are triggered when we merely see someone else having experiences (Keysers, Kaas, & Gazzola, 2010), leading some to speculate that these neuronal pathways play an important role in complex social behavioral patterns, including empathy.

The original surge of interest in empathy in clinical psychology was fueled by Roger's (1959) hypothesis that empathy was one of the most emphasized of six therapeutic conditions that were necessary and sufficient for therapeutic change (Bohart & Greenberg, 1997). When asked about his most important contribution to the field during a public lecture in 1977, Carl Rogers responded that in his view, the single most important contribution he had made to the lives of others was his observations and writings about empathy (Clark, 2007). Similarly, Strupp and Binder (1984) wrote that "…empathy is the single most important human and technical tool at the therapist's disposal" (p. 47).

Nine to 10 percent (mean weighted $r = .31$) of the variance in psychotherapy outcome has been attributed to empathy (Elliott, Bohart, Greenberg, Watson, 2011). Yet during the last 25 years, there has been a relative dearth of research about empathy within psychotherapy research. According to Duan & Hill (1996), the reason for this decrease in empathy research during the past two decades is because there has been confusion about the meaning of empathy. Furthermore, research on empathy has been criticized due to questionable validity of measures, lack of appropriate and sensitive outcome measures, and a restricted range of predictor variables (Watson, 2001). Others have suggested confounds due to variation in time of assessments, experience of raters, and questionable sampling methods (Greenberg, Watson, Elliott, & Bohart, 2001). Finally, though empathy in a clinical context has widely been theorized to be a multi-modal and multi-stage process (e.g., Barrett-Lennard, 1981; Bohart & Greenberg, 1997; Feshbach, 1975; Jordan, 1991; Schafer, 1983; Strayer, 1987), there has been little emphasis in the research literature on exploring or testing hypotheses that include the complexities of these theoretically defined properties.

The present study is one of only a handful that has examined empathy both qualitatively and from the client's point of view. The clients' perspective is believed to be particularly valuable in this context, as research has repeatedly shown that client ratings of several psychotherapy processes (including empathy) correlate with outcome measures (Duan & Hill, 1996; Greenberg, Watson, Elliott, and Bohart, 2001). The advantage of client ratings of empathy has remained strong even when both predictor and

outcome variables were rated by the same rater (Greenberg, Watson, Elliott, Bohart, 2001).

Few studies have attempted to elaborate on the construct of empathy using qualitative methods, and most of these have been recent investigations (e.g., Bachelor, 1988; Brodley, 2002; Kerem, Fishman and Josselson, 2001; Myers, 2000; Wynn & Wynn, 2006). Brodley (2002) developed a taxonomy of therapist responses, while Wynn and Wynn (2006) have begun unraveling the complex cyclical nature of empathy through applied conversational analysis. Myers (2000) explored client's phenomenological experience of being listened to, and has begun to uncover client experiences related to empathic failure or breakdown. Addressing another key theoretical concern related to empathy, Kerem, Fishman and Josselson (2001) explored the issue of cognition versus affect in empathy. Finally, Bachelor (1988) used qualitative methods to derive a taxonomy of received empathy and explored client experiences of how empathy was seen to relate to both therapist activity and therapy outcome. Bachelor identified four distinct styles of perceived empathy: (a) perceived cognitive empathy, (b) perceived affective empathy, (c) perceived sharing empathy, and (d) perceived nurturant empathy. (These qualitative studies are described in greater detail in Appendix A.)

Methodological and conceptual limitations have somewhat restricted the usefulness and range of the findings of the above- mentioned qualitative studies. The utility of Brodley's (2002) findings were narrowed by an incomplete description of the therapy samples used as well as a limited description of the organization of verbal expressions into the taxonomy she created. Both Wynn and Wynn (2006) and Bachelor

(1988) failed to provide their participants with a clearly defined working definition or understanding of the construct of empathic attunement; a step that is paramount in exploring the clients' experiences of empathy. Bachelor's methodology further limited client exploration of the concept of empathy because her study relied on written responses, gathered without the possibility of further clarifying questions. Yet other qualitative studies were problematic because responses were possibly affected by the potential biases of complex relationships, which was the case when Myers (2000) studied therapist-interviewers of their client-participants. It is arguably unlikely that clients' would be unbiased in their reported empathy to their own therapists, especially in regard to their relationships or that therapists would be unbiased in extracting their clients' reported empathy.

These limitations of previous studies were addressed in the present study through the use of grounded coding which stipulates an iterative process including both data-gathering and data-analysis; a process that addresses concerns related to validity and anticipates several of the concerns outlined above. To further address validity, a video-assisted interpersonal process recall (IPR) methodology was used for data collection. IPR is particularly useful in exploring processes that develop over time (Elliott, 1986). Finally, the present study used these methods of data collection and data analysis in order to more readily account for the complexity of the contexts in which empathy takes place and grounding these descriptions of empathy to the numerous processes theorized to be involved in the expression, receipt and confirmation of empathy as it develops in psychotherapy (Stiles, 1993).

Problem Formulation

The goal of the present study was to shed light on empathy processes as they take place in a psychotherapeutic context and from the clients' perspective. The focus was to investigate empathy as a multimodal, multistage, moment-to-moment process. Three areas of inquiry were formulated, which lay the theoretical foundation for the present study. Following the methodology of grounded coding (Strauss and Corbin, 1998), these areas of inquiry were not considered the final scope of possible findings (as occurs with formal hypotheses in traditional experiments), but served as an organizing framework from which the specific inquiry during interviewing and data analysis took place. Areas of inquiry aided in developing the initial interviews, and subsequent interviews were developed as the iterative process of data analysis and data collection unfolded within the grounded theory qualitative methodology.

Area of inquiry #1: Clients' immediate experience of empathy. The goal of the initial inquiry of client experience of empathy was made in an attempt to be experience-near, allowing the respondent to begin to think about their experiences of empathy in the session. Furthermore, this aim attempted to minimize interference of the client's ability to discuss their phenomenological experience of received empathy, while also allowing the client to develop a deeper understanding of the topic under investigation. This aim was based on findings (e.g., Bachelor, 1988) that clients' immediate experience of empathic attunement was complex and took several forms, including cognitive, affective, sharing, and less frequently, nurturant empathy. Focusing on the client's immediate experience of empathy allowed this project to take into account the breadth of the empathic moment in

therapy. Some (e.g. Barrett-Lennard, 1981; Greenberg & Elliott, 1997) have indeed described empathy as circumscribed or limited periods of therapy, while others (e.g., Bachelor, 1988; Myers, 2000) have found empathy to be perceived as a broader ambience or background across multiple sessions and throughout a therapeutic relationship. The reasons for this disagreement are varied and complex, including defining pressures of theoretical perspectives and modes of investigation such as the point of view of the targeted respondent. The addition of a video-assisted recall methodology in the present study made it possible to explore these aspects more deeply because inquiry started with specific video-recorded moments but also encouraged clients to describe if, and how, those moments were part of a broader background.

Area of inquiry #2: Client understanding of the therapists' empathic communication. A second aim was to explore client interpretation of therapist empathic intentions and intrapersonal activities related to expressed empathy. Inquiry in the present study began with Greenberg and Elliott's (1997) useful categorization of therapist empathic communication: (a) understanding, (b) evocation, (c) exploration, (d) conjecture, and (e) interpretation. Therapist activities may include those suggested by Greenberg and Elliott (1997) in their discussion of empathic attunement. Though these components may not be directly obvious to the client, it was hypothesized that clients understand them in ways similar to Greenberg and Elliott's definitions. It was also assumed that these five forms of empathy may vary depending on frame of reference (client or therapist) as well as the degree to which new information has been added. In addition, this area of inquiry began with the assumptions that client momentary

experiences of therapist empathy was grounded in a complex context of nuanced interpersonal behavior. Past research, for example, has shown that clients tend to react most favorably to responses that contain some, but not much new information (Bohart, Elliott, Greenberg & Watson, 2001). It was expected that the manner of the therapist's communicating empathy included features such as facial gestures and vocal intonations, which could best be described verbally by the client. Intention of the therapist's communication was also explored from the client's perspective.

Area of inquiry #3: Client understanding of the utility of empathy. Client understanding of the utility of empathy in therapy made up the third area of investigation. Bachelor (1988), discussing the client self-related benefits of empathy, suggested a classification into three sub-groups: (a) specific therapeutic effects, (b) client distress-reduction, and (c) client narcissistic gains. Bachelor further identified a second category of effects, therapist-related effects of empathy, which covered items that were not directly therapeutic but were related to their relationship with the therapist. These were effects such as feelings of closeness and attachment to the therapist, as well as increased trust and gratitude toward the therapist. These previous findings formed the initial groundwork for inquiry of this third area of inquiry.

Method

Participants

Interviewees. Nine psychotherapy clients were interviewed for the present study (the rationale for that number is explored in the grounded theory analysis section below). Clients ranged in age from 21 to 54 (mean age = 36.4). The sample consisted of six female and three male clients. One of the clients identified as Hispanic and eight as Caucasian. Five of the clients were adult community members (not college students), three were undergraduate students and one was a graduate student. At the time of interviews, the respondents had completed an average of 29 sessions (range: 8 – 107 sessions; median = 12). A thick description of interviewees often included in reports of qualitative research (Holloway, 1997) is excluded as clients would be identifiable by their therapists and would therefore violate confidentiality (see Appendix B regarding institutional review board documents including confidentiality forms).

Therapists. All clients were seen by clinical psychology doctoral students in their 3rd through 5th years of the program and were practicing at an in-house training facility. All therapists started their practical experience (seeing individual clients) at the beginning of their second year. One participating therapist was male, one (female) therapist saw more than one participant, and thus eight therapists participated.

Researchers. The first author, a 6th year doctoral student in clinical psychology, conducted all interviews. All data-analysis was performed by a research team consisting of the first author, two clinical psychology doctoral students, and the first author's advisor. Meetings were held nearly weekly with the advisor and periodic group meetings

were held with all four members prior to, during and following the initial analysis and data-collection process. The first author had experience with the clinical use of empathy as a clinician through his training program, practica and internship, and had been influenced by theorists such as Greenson, Kohut and Rogers. His theoretical orientation was client-centered (CC) /interpersonal process (IPT)/emotion-focused (EFT) orientations and he had further been trained in motivational interviewing (MI) and cognitive behavioral techniques (CBT). A second researcher was a doctoral-level psychotherapy researcher with a strong affinity for and belief in the efficacy of common factors and was further informed by dynamic and humanistic theoretical perspectives. One male and one female graduate student researchers were also part of the team. The male had, at time of interviewing and initial data-analysis, completed less than one year of clinical training and described his orientation as eclectic with a primary allegiance to CBT and additional interest and training in interpersonal psychotherapy, client centered psychotherapy, and motivational interviewing. The female had more than three years of clinical training and experience. She identified her theoretical orientation as eclectic with interests in emotionally focused therapy and interpersonal psychotherapy.

Procedures

As this study sought to elaborate on theory regarding psychotherapy process, a video-assisted interpersonal process recall methodology of interviewing was chosen (Elliott, 1986; Kagan, 1975). Grounded theory analysis (Glaser & Strauss, 1967; Rennie, 2006) was used to explore the subjective phenomenological experiences of the client and to develop an empirically grounded theory of empathy from the clients' perspective.

Recruitment. Recruitment was initiated by contacting the director of a psychotherapy training clinic and asking for a list of supervisors in a clinical psychology doctoral program. These supervisors were contacted and asked for their permission to contact student-clinicians under their supervision. Full disclosure of research topic and methodology was given to supervisors to allow them to make an educated decision about inclusion of their students and clients into the study. All three supervisors who had supervisees actively seeing clients in the training clinic agreed to participate and offered names of potential supervisees.

Twelve supervisees were asked to participate in the study. Of these 12, one supervisee, initially asking for additional information prior to a meeting, did not wish to participate, two supervisees reported having no active clients in the training clinic, and one supervisee attempted participation but the client denied it. The remaining eight participated, of whom one female participated with two clients. All participating clinicians were initially asked to meet with the lead author to explore their participation and ask questions. Therapists were not given details about the research topic as it was feared therapists would change their mode of interaction, potentially influencing the data (video-recording of given session), but were informed that their supervisors were well aware of the nature of the research and had given their approval. We anticipated some nervousness from therapists regarding being examined by one of their peers, as well as allowing their clients to take part in the study. These concerns were discussed during the initial meetings. As the training therapists were accustomed to ongoing examination and disclosures through individual and group supervision, only one clinician had further

concerns about participation and voiced trepidation about being evaluated by fellow students. This clinician decided to participate after further discussion. Furthermore, the clinicians' supervisors voiced support of the study to their supervisees which likely helped the clinicians feel comfortable allowing access to their clients.

Potential client-participants were told the research would focus on their experience of an hour of psychotherapy, and would be paid $20 for their participation. They were informed that the most recent videotape of their session would be used during a two-hour interview to help the client's recall what transpired during the session. The potential participants were informed that the research was about their experience of an hour of psychotherapy, but were not given further details related to the focus of the study as full disclosure could affect both client and therapist behaviors during the session. Clients and therapists were advised that full participation included video-recording of a full therapy session, followed by a two hour interview within two days of the therapy session. Clients were informed they could deny consent at any time during the process, and that therapists would not have access to any information shared during the interviews. Therapists were given scripts to facilitate their discussion of the study with potential participant-clients. The script included instructions to tell clients that their relationships with their therapists would not be influenced by whether the client participated. Clients eligible for this study were adults receiving individual therapy, were not exhibiting any psychotic symptoms, and were judged to not be at a high risk of suicide. Additionally, therapists and supervisors were asked to nominate clients with insight and verbal abilities; supervisors were in a particularly good situation to nominate

such clients as they were given full details about the focus of the study, yet few nominated specific clients, leaving that up to their student supervisees. All research contact and interviews were performed by the first author.

Interpersonal process recall interviews. Qualitative research on client-therapist interactions often solicits client recollections of care by retrospectively exploring clients' memories (e.g., Levitt, Butler & Hill, 2006). Such approaches bring to the fore concerns related to client recall due to the delay between situation and interview and that intrapersonal processes may be especially difficult to remember. Interpersonal process recall (IPR) consists of interviews where participant and interviewer are aided by reviewing recent and recorded experiences together (Elliot, 1986; Kagan, 1975), and seeks to access conscious intrapersonal processes as close in time to the event as possible.

IPR originally grew out of health-skills training programs (Kagan, 1980, 1984). IPR's strengths – including aiding in recall and fostering a reflexive stance during the interview – drew the attention of psychotherapy process researchers (e.g., Rennie, 1990; McCloud, 2001). IPR further has the advantage of reminding participants of the specific momentary experience being described and exploring interpersonal processes, including therapy processes such as when a client and therapist works toward a shared understanding and meaning-making (Spence, 1982). A number of other strengths specific to IPR are important to consider: (a) the viewing of recordings cue client memory; (b) memories are influenced by the passing of time (memory decay curve; Brown, 1958); (c) the IPR process slows down the interview, allowing clients to sort through and express more clearly their experiences and recollections; (d) the interviewer is given a unique tool

to help focus portions of the interview on subjects of particular interest (focusing on client reactions to specific experiences during the session, and limiting generalizations and broad reactions to the therapy or the therapist as a whole). IPR has repeatedly been found to be powerful at accessing psychotherapy clients' thoughts and feelings (Elliott, 1986; Hill, et.al., 1994; Levitt, 2001; Henretty, et al., 2008; Frankel and Levitt, 2009).

The interviews were conducted in a quiet, comfortable and private room within the same building as the training clinic. The remote control for the videotape player was shared between the interviewer and respondent to allow access to pause the video playback. The style of the IPR interview also followed recommendations of prior research, including techniques for ease of communication and even placement and communication about the video remote (Larsen, Edey & Lemay, 2007).

Content of the IPR interviews was structured around the particular research areas of inquiry since it has been found to facilitate completion of the IPR interview process within the allotted time (Rennie, 1990). All interviews lasted at least 90 minutes, and none lasted more than 135 minutes, with the majority lasting just under the two hour time-frame proposed. In order to increase immediacy of experiential recall, the IPR interviews were conducted in close temporal proximity to the recorded therapy sessions. Eight interviews were performed within 24 hours of the video-recorded session, and all interviews were completed within 48 hours of the session. The interviewer introduced the study to the given participant and informed him or her of the focus of the study through engaging in a conversation with the respondent. A script which outlined the interview's scope and focus was used to help orient the interviewer and client during the first

interview (see Appendix C for a sample script). Subsequent interviews were modeled on the initial script but included information from the previous interview(s) as well; no script was utilized following the first interview.

The interviews were video-recorded using a four-channel digital video-recording device of which three channels were utilized: one channel for each of the participants (interviewer and interviewee), and one channel to record the replayed video from the therapy session. These video-recordings allowed for deeper engagement of the data during the grounded theory coding and analysis process.

Grounded theory data analysis. An adapted grounded theory approach was used (Rennie, 2002) to analyze the qualitative data collected through the process of video-assisted IPR interviews. To be a grounded theory approach, a basic social (psychosocial) process must be investigated (Strauss & Corbin, 1998) making this method ideal for delving into the lived experience of clients as they engaged in the work of therapy with the clinician. The primary goal of the grounded coding approach was to generate theory, and as such was discriminated clearly from the hypotheses-testing goal of quantitative research. Consequently, the indicators of trustworthiness were also different. The use of grounded theory analysis within clinical psychology (i.e. Levitt, Butler & Hill, 2006; Morrow, 2005; Miller, 2005; Lilliengren & Werbart, 2005; Huband & Tantam, 2004; Rennie, 2002) implied a set of methods to enhance trustworthiness.

The coding procedures were designed to maximize trustworthiness (see Appendix D for a detailed discussion regarding trustworthiness in qualitative research) through adherence to state-of-the-art procedures, utilizing co-researchers, keeping detailed

records and memos, and balancing sensitivity with objectivity. The interviewer explored existing empathy theory prior to performing the interviews to develop the focus of research including formulation of the areas of inquiry. The engagement of existing theory further allowed for exploration and identification of own assumptions, in turn allowing for bracketing of these assumptions during the interviews Bowers, 1988; Hutchinson, 1993).

For this study, NVivo (NVivo, 2006) – a computer program for qualitative analysis – was used. The first aspect of the grounded theory approach involved open coding which consisted of a number of steps, many of which occurred in an iterative pattern. The steps are as follows.

The initial contact with the data included deep engagement with the transcribed interviews. The qualitative researcher sought to be "engaged but still distinct from our subjects" (Fine, 1992), to allow the researcher as broad a surface of contact with the subject as possible, while maintaining a critical and self-conscious approach. These competing components were maximized through the following procedures. The researcher, in addition to having done the interviews, read through the interview transcripts several times until familiar enough with the responses that he could instantly locate a remembered section. The researchers worked with difficult sections by actively engaging in the interpretation of their meaning through exploring the context in which the specific responses were given and re-watching video-recorded interview segments.

The critical and self-reflective stance so necessary to maximize objectivity and reduce the influences of the researchers' biases on the interpretation was maintained

throughout the coding process. The researcher kept notes throughout the investigation (Morrow, 2005). These notes helped the researcher keep track of discussions, reactions and emerging awareness of biases and assumptions as they appeared. Additional researchers were included in the coding process. This allowed the researchers to reflect upon the coding process with each other, and as "devil's advocates," suggesting other possible interpretations (Hill et al., 2005; Morrow, 2005). Finally, knowledgeable colleagues with which the researcher had contact were engaged in critical discussions to broaden the perspective of the theoretical approach and allow for differing yet informed perspectives (Rossman & Rallis, 2003). Toward this end, frequent meetings between the researcher and the author's advisor were scheduled.

The actual coding of the qualitative data was processed through the following steps. The data was transcribed into NVivo and the transcripts were then divided into meaning units (Bachelor, 1995; see also Appendix E for additional note about meaning units). Meaning units in NVivo are created by assigning "free nodes" to the sections of text. This, in effect, "tells" NVivo that this section of text is a unit. Assigning "free nodes" comprises the first step of the coding process. These nodes were then systematically sorted into descriptive categories based on the meaning(s) embedded in each segment. In NVivo, the "free nodes" are organized into "tree nodes." The labels for the "tree nodes" selected in this way consisted of a short sentence, fragment, or word, based on the unifying meaning in the meaning units (see Appendix F., Tables 2a-4c). We adhered to the constant comparative method as described by Glaser & Strauss (1967), engaging in an iterative process each time more data became available following another

interview. This process was repeated until the model was saturated. The interviews yielded infrequent and superfluous additional coding after the first six interviews. The practice of interviewing three more participants was followed (Levitt, 2001), and as no further substantial information added to the complexity of the developed model, the interviewing process was ended following the ninth interview (see Appendix G for additional discussion about saturation and sample size). Data from all nine interviews were included in the final model.

Findings

The transcripts from the nine video-assisted interpersonal process recall (IPR) interviews yielded 541 meaning units, 450 of which were used for the present examination of empathy. The remaining meaning units initially culled from the transcripts focused on relational and therapy process constructs not directly relatable to empathy as defined in the problem formulation. The final hierarchy consisted of three clusters: (a) client-perceived types of empathy (problem formulations I and II), (b) client-perceived relational context of empathy (problem formulation II), and (c) client-perceived utility of therapist (problem formulation III). The final hierarchy consisted of a total of eight lowest-level categories (see Table 1). All categories were explored by at least seven of the nine respondents, and most of the eight categories included all nine respondents. The following description of results was organized according to this hierarchy, first describing each cluster followed by descriptions of categories.

Table 1.
Coding results: Clusters and categories of meaning units (N=9)

Cluster	Categories	n	MU[1]	Exanples (session #)
1. Client-perceived types of empathy	1a. Cognitive empathy	9	61	Yeah, because if I say something about how I feel, then she will say it back to me and word it in like a simpler way, maybe just in a different word choice, and then that can click with me and I can realize what I said. (43).
	1b. Emotional empathy	9	80	…I was talking about something really intense and I could tell she was teary eyed and she started to cry and I started to cry and I think, that from that, that was really early on, and so I felt she was really empathetic the entire time, and maybe some people misconstrue that, but I feel like she is just human, really human, and she makes herself really human to her clients. (43).
	1c. Client attunement	7	30	She wants to get to that point because she wants to know why something upset me so badly. I don't even understand a lot of it, you know, she has to get to that core, but the more I get upset, I can see her backing off, and part of her, I think is taking it in: "ok, this really upset you, how am I gonna deal with that?" That's just the way I envision it, you know. (107).
2. Client-perceived relational context of empathy	2a. Therapist private persona	8	42	It's almost like she's a friend but not a friend; I know I am going in there for specific reasons, but yet she treats me like a person which a lot of them don't do. (16).
	2b. Therapist professional persona	9	33	I think it would be nice [if therapist self-disclosed] but I also understand that, you know, this is her job basically. You know, I don't know why she has never told me anything about herself; I never really knew about [previous therapist] either. (107).

Table 1: Continued

3. Client-perceived utility of empathy	3a. Client ego-support	9	127	Her mind doesn't wander, when she is in a conversation with you she's in a conversation with you. That's why I say, I trust [therapist's name], she is very professional. When she has a conversation with you she is in the session. (9).
	3b. Enhancing therapy process	9	55	She is questioning me and questioning me; then I got to a point where she pulled her chair over and held my hand. I think that's when the empathy really kicks in because she gets to a point where she knows she can't keep questioning me because I am so upset now that she uses a more gentle approach. (107).
	3c. Client self-attunement	8	22	It's the relationship [with the therapist] that I'm starting to value. I found that interesting. I never even saw that until [the therapist] is like:" I can understand that perfectly". And I was like: "how?" But she plays it back to me, and I was like: "yeah, it does, that perfectly makes sense. (8).
	Total meaning units:		450	

[1.] Meaning Units.

Cluster 1: Client-perceived Types of Empathy

Clients' immediate experience of empathic attunement and their understanding of their therapists' empathic communications with them was explored, yielding information both about client's perception of their therapists, as well as clients' own attunement to their therapists (see problem formulations 1 and 2). Clients' descriptions of their engagement in the empathic relationship were categorized into three types of attunement: (a) Cognitive empathy (n=9), (b) Emotional empathy (n=9), and (c) Client attunement

(n=7). It should be mentioned that cognitive and emotional empathy were found to be on a continuum (see descriptions below).

1a. Cognitive empathy. All clients explored the therapist cognitive empathic attunement (n=9) (see Appendix F, Table 2a. for meaning units). Clients' experience of therapists' cognitive engagement denotes this type of empathy, and the clients explored several aspects of the process including the interaction itself (asking questions, remembering content from previous sessions, therapist apparent effort in grappling with content), as well as the emotional impact these attempts had on the client.

From the client's perspective, there was a continuum of empathic experiences. The cognitive category captures client understanding of therapist communications as an apparently purely intellectual engagement, where the therapist is experienced as not taking part in the client's emotions (see Appendix H., Table 6., ex. 1). Here emotion was only verbally expressed by the client and the therapist followed suit, engaging in the emotion verbally without direct evidence of own emotional involvement. Instead the therapist behavior mostly yielded intellectual processing of the emotional material.

In other interactions, clients indirectly implied some sign of shared emotion, for instance when the therapist was described as "not using a monotone" (see Appendix H., Table 6., ex. 2). The therapist behavior suggested to the client that not only did the therapist understand the client in an intellectual way (which was important to the client), but also shared the emotional experience by displaying an emotional reaction to the material, which in turn felt validating. Example 3 (see Appendix H., Table 6.) suggested a potential third level of cognitive empathy that approached emotional empathy, as the

client described how she experienced the therapist as capable of feeling her feelings, yet did not discuss an actual situation where this took place.

Example 3 indicated a pattern in which respondents described their therapist as appearing to follow them so closely in discussions of client situations that the client experienced the therapist as being with them both cognitively and emotionally, even though the therapist was not directly evidencing their own emotional experience. Two examples (see Appendix H., Table 6., ex. 4 and 5) described the closeness involved in the process of shared understanding. Although the clients are talking strictly about the cognitive or intellectual attunement between therapist and client, the respondents voiced how important this closeness was to them, indicating the concomitant emotional connection between client and therapist.

Several examples contained expressions of client appreciation of therapist, as well as expressions of how unique the experience was to have someone else empathically attuned to their thoughts and feelings (see especially Appendix H., Table 6., ex. 2). Conversely, when the connection was disrupted by therapist difficulties attuning to the client (see Appendix H., Table 6., ex. 6), the work appeared to suffer. In this case the client described needing to switch to a more logical or intellectual engagement of material, away from expecting the much younger therapist to engage with emotional depth around experiences the therapist had not yet had. However, such therapist shortcomings may leave the therapeutic relationship and the client's appreciation of the therapist relatively intact. But in the case of one client-therapist dyad, when the therapist expressed little to no signs of being attuned (either cognitively or emotionally) the client

was left confused and blaming herself for the lack of a relationship with the therapist (see Appendix H., Table 6., ex. 7).

1b. Emotional empathy. Subjects often focused on the emotional content of the empathy interaction and their experience of the therapist sharing their emotional experience (n=9) (see Appendix F., Table 2b). In doing so, they discussed specific situations as evidence for their therapist's emotional attunement. Several therapists were described as engaging in self-disclosure, either through direct emotional disclosure or through disclosure of similar emotional experiences. This allowed the client to perceive the therapist's understanding of the emotional situation.

A range of emotionally empathic experiences were described by clients. At the more emotionally engaged end of the category, for example, a client had described to his therapist an experience of a loss in his life. This client had described how meaningful it was that his therapist disclosed the facts related to her own loss (see Appendix H., Table 7., ex. 1 and 2). This client went on to explore the necessity that the therapist had similar experiences to fully grasp the client's emotional reactions to his situation. The same therapist had managed to engage in a similar way with a different client (see Appendix H., Table 7., ex. 3), but in this case the therapist displayed emotion (tearing up) during the session. The respondents expressed significant appreciation for their therapist's ability and willingness to engage with them in a personal and emotionally transparent way. The second client went on to describe how this experience had been a turning point for her, finally allowing the client to trust the therapist in spite of the therapist's different background. These two examples further highlight an important distinction between

client-focused and therapist-focused definitions of empathy. The clients expressed similar reactions to the two different types of therapist behaviors (in example 1, the therapist described only the context of her own similar loss; in example 2, the therapist openly displayed her own distress in session). In both cases, the clients appeared to infer the therapist's close attunement to their (the clients') emotions.

In example 4 (see Appendix H., Table 7) the client interpreted the behavior of the therapist, and through this interpretation realized the level of therapist attunement. As the therapist expressed discomfort around the client's emotional display, the client in turn inferred that the therapist understood the intensity of that emotion. Although the therapist was perceived as having had an emotional reaction in this case, it is unclear how congruent this emotion was, and the therapist was perceived to have emotionally distanced herself from the client's emotion (client stated that she had "lightened the mood").

Another client described her therapist's apparently less attuned or expressed emotional engagement (see Appendix H., Table 7., ex. 5). The client voiced appreciation of the therapist's willingness to share the client's emotions in the moment, and yet indicated there was an emotional distance in their relationship. The client apparently picked up on the therapist's difficulty in openly engaging in an emotional way, as the client later discussed how the therapist had difficulty being open with people.

Finally, the noted absence of emotional empathy was also an example of this meaningful sub-cluster. For example, a client (see Appendix H., Table 7., ex. 6) who did not know much about her therapist and had difficulty understanding the therapist's

intentions, felt lost and unable to connect in a meaningful and trusting way. When asked, the client could not describe her therapist's intentions, thoughts, motivations, or read the therapist's emotional state during the session we watched together (this was her 8th session with this therapist). In this case there appeared to be no communication of therapist attunement, if in fact there was any.

The above examples indicate emotionally empathic attunement on a continuum: from an apparently effortless, natural and smooth emotional engagement on the part of the therapist (including significant therapist self-disclosures and emotional transparency, and through effortful shared emotion, first by the client, then by the therapist) to--as in the last example--an apparent absence of therapist transparency. The above cases further highlight the importance of client insights about their therapists (the therapists' similar experiences and emotions, for example), as well as additional client understanding of the therapists' interpersonal styles. These additional client insights are explored in the third category below.

1c. Client attunement. The client attunement category focused on client's understanding of therapist behaviors, intent, and motives throughout the interviews (n=8). Attunement focused on a wide range of therapist behaviors (see Appendix F., Table 2c. for meaning units). Examples in the other clusters highlight how client experience of therapist empathic attunement influenced their broader experience of the therapist. The client's understanding of the therapist's empathic attunement was further based on how clients drew conclusions related to the therapist's professional interests (see Appendix H., Table 8., ex. 1).

The same client described the professional role of the therapist (see Appendix H., Table 8., ex. 2), and in doing so, suggested an understanding of the therapist's struggle with client emotions. That the therapist understood or at least registered the client's emotional experience was comforting to the client. Furthermore, the client's understanding of the therapist's internal struggles and professional concerns allowed for a consistent and intelligible whole to the client.

The therapist's empathic activity was dependent on the client's attunement to the behavior, interpreted motives, personality and level of transparency of the therapist. Client descriptions of empathy indicated a complex and interwoven construct that did not easily lend itself to discrete categories, because the client's interpretations of the therapist's empathic activities were significantly interwoven with additional material.

Cluster 2: Client-perceived Relational Context of Empathy

All respondents were readily able to discuss the second aim of this study, which was to understand the clients' interpretations of therapists' intentions and intrapersonal

activities related to expressed empathy. In fact, clients spent considerable time during the interviews exploring their therapist's attuning activities, and how these activities impacted the client-therapist relationship. Client interpretations of therapist intentions and motives yielded coding into two categories: 2a. Therapist private persona (n=8), and 2b. Therapist professional persona (n=9).

2a. Therapist private persona. This category included client statements about interpretations of therapists' private persona (that is, as non-professionals). Clients often wondered about the therapist's level of genuineness (see Appendix F., Table 3a. for meaning units), often through perceived and imagined therapist efforts (see Appendix H., Table 9., ex. 1). Some respondents expressed the client-therapist relationship in terms of "normal" relationships, expressing confusion as they were not "real friendships," yet also not experienced as strictly professional "doctor/patient" relationships (Appendix H., Table 9., examples 2 & 3). In doing so, clients often discussed perceived therapist motives (see Appendix H., Table 9., ex. 4).

Respondents spoke mostly well of their therapists, and were always mindful of the therapist's real persona behind the façade of their professional role. Their apparent struggle, as evidenced by the frequency with which this topic spontaneously arose during the interviews, was primarily around genuineness, trust, and therapist motives; these are topics of importance to the clients and their therapeutic relationships. Eight of nine respondents discussed these concerns, spending considerable time during the interviews processing these aspects of their relationships.

2b. Therapist professional persona. This category explored clients' (n=9) interpretations of therapists' motivations and intentions as related to their professional roles (see Appendix F., Table 3b. for meaning units). Clients reported struggling with their relationship with their therapists to the extent that this relationship was different from normal relationships outside of therapy. In this context, some clients voiced a wish for something more, while also appreciating the therapist's professional limitations (see Appendix H., Table 10., ex. 1). Within this type of relationship, small gestures appear to make a big impression on many of the clients (see Appendix H., Table 10., ex. 2).

Both clients and therapists engaged actively in the therapeutic process which allowed clients to attune or resonate well enough with the therapists to interpret therapist intent and motive through their attuning (and other) activities. Through this understanding, the client could begin to trust the therapist. A client (see Appendix H., Table 10., ex. 3) gained an understanding through the myriad signals during therapy and interpreted the therapist's "true nature" underneath the professional role. She knew the therapist was in graduate school to become a therapist and assumed values and ethics defined by the profession. This assumption allowed her to trust the therapist further. A particularly insightful client explored how the limits of self-disclosure on the part of the therapist allowed the client to invent the person of the therapist she needed (see Appendix H., Table 10., ex. 4).

Some clients spoke more eloquently than others about their relationships with their therapists, yet all indicated interpreting their therapists' motives and intentions through conjectures and information gathered in session, often focusing on therapist roles

in session. The relational context of the therapist personas appeared to be of considerable interest to the clients and played an important role in the client's understanding of therapist attuning behaviors.

Cluster 3: Client Perceived Utility of Empathy

Clients' understanding of the usefulness of empathy, the third area of inquiry, yielded three sub-categories: 3a. client ego-support, 3b. therapy process, and 3c. client self-attunement. However, it is important to note that examples often fit into more than one category. For instance, it was not always clear whether a client expression belonged in the client ego-support category or the enhancing therapy process category, as each of the ego-support items mentioned also may further the process of therapy. The following classification is therefore an imperfect description of a complex construct, yet offers the simplest categorization scheme of the existing data. Each will be described in turn in the following section.

3a. Client ego-support. The client ego-support category (n = 9; meaning units = 127) focused on client responses that tied empathy to ego-supports through the enhanced relationship they felt with their therapists due to the empathic attunement (see Appendix F., Table 4a. for meaning units). All respondents discussed a close association between therapists' attunement and the quality of the relationship, as related to how they felt about their therapist and their beliefs about how the therapist felt about them. For example, a therapist allowing herself to cry in response to the client's description of her traumatic experiences indicated something very meaningful to that client (see Appendix H., Table 11., ex. 1). This client went on to describe how the therapist's emotional transparency

allowed her to feel close and safe with this therapist (see Appendix H., Table 11., ex. 2), allowing for greater client transparency and validation.

Others explored specific reactions. One client (Appendix H., Table 11., ex. 3) expressed finding someone she could trust and assumed the therapist's motivation behind her actions: that her therapist cared about her. This in turn allowed the client to "open up," moving the therapy forward. The client further hinted at the importance of the effort the therapist brought to bear through the therapist's empathic behaviors.

Another client, although commonly terse regarding emotional expression, managed to smile warmly when talking about the therapist (Appendix H., Table 11., ex. 4). This client, as the previous one, assigned significant importance to the effort and assumed motives of the therapist, which in turn allowed the client to trust the therapist. Clients' interpretation of therapists' personal emotional investment in the client--as evidenced through the process of engaging in the empathic communication—is very important in allowing clients to feel trusting enough for the therapeutic process and the therapeutic relationship to develop. The developing relationship, in part through the empathic attunement of the therapist, is heavily reliant on the client's attunement to the therapist, as they read the therapist's personal investment, level of genuineness, and motive. The therapy relationship was therefore enhanced by all three types of client-therapist attunement (emotional and cognitive empathy as well as client attunement to therapist).

3b. Enhancing therapy process. The utility of enhancing the therapy process (n=9; meaning units=45) centered on how the client experienced the influence of the

therapist's empathy on the therapy process. This included the therapist's accurate understanding of the client situation and its importance, in-the-moment emotional guidance, meeting client processing "pace" and client interpretation of therapy outcome (see Appendix F., Table 4b. for meaning units).

Empathy allowed for therapist accurate understanding, allowing the therapist to gauge the situation from the client's perspective (see Appendix H., Table G., ex. 1). Another client, in describing the moment-to-moment exchange with his therapist, described both frustration and shared momentum (see Appendix H., Table G., ex. 2). However slow the process might have been for this client, he described how the therapist met his pace. In describing the moment-to-moment development, a client (see Appendix H., Table G., ex. 3) discussed how the therapist changed her behavior due to picking up on client emotional responses. No words were uttered by the therapist at that moment, but her behavior ("pulled her chair over and held my hand") indicated to the client that the therapist had noticed a shift in the client's emotions and adjusted her behavior accordingly.

Client understanding of empathy's effect on the within-session process relied heavily on client attunement to the therapist, especially regarding the client's understanding of the therapist's attunements to the client (cognitive and emotional). The client's understanding of empathy's effect on the therapy process was commonly described as an in-the-moment process. Clients appeared to understand the process well, expressing how the therapist's attunement to them allowed them to move forward together while being mindful of the client's emotional state.

3c. Client self-attunement. Most clients (n=8; Meaning units=22) mentioned increased cognitive, emotional or interpersonal understanding as benefits of the empathic engagement with their therapists (see Appendix F., Table 4c., for meaning units). For several clients, the development of their narrative through therapist-client empathic attunement was important (see example in Appendix H., Table H., ex. 1). Another client described how she understood the therapist's engagement in the empathic relationship as a way for her to better understand a specific situation (Appendix H., Table H., ex. 2).

For other clients, the development of self-understanding appeared to be an ongoing interplay between relationship, meaningful interpretations, and movement toward a better and shared understanding (Appendix H., Table H., ex. 3).

Few managed to express the more complex interplay of emotional and cognitive exploration and understanding within the empathic relationship as this last client did. Nearly all respondents (8) understood empathy as a process of deepening self-understanding. Most respondents (Appendix H., Table H., ex. 2) grasped the relationship between empathy and self-understanding at the cognitive level only, and expressed appreciation for how the moment-to-moment interplay between therapist and client understanding developed. As before, this area of empathy utility relied on a combination of empathy types, with client attunement to the therapist again being important for client understanding, and each of the other types (emotional and cognitive) being factors in the type of understanding gained. However, most were aware of the more transparent cognitive processes and gains via their discussions with their therapists, while fewer

discussed the perhaps less obvious increase in emotional self-awareness potentially gained through the empathic process with their therapists.

Discussion

Three main areas of client experience of empathy in the psychotherapy dyad were explored: (a) client immediate experience of empathy; (b) client interpretation of therapist empathic behaviors, and (c) client experience of the utility of empathy. The results yielded the three clusters discussed in the results section above. The first two areas of inquiry produced the first cluster (types of empathy) and the second area of inquiry produced the second cluster (relational context of empathy). The third area of inquiry, utility of empathy, gave rise to the third cluster. Additionally, it was found that each of the categories in the present classification of empathy types and utility (and described here as discrete categories for clarity) were intertwined, each working together with the others. These linkages are described in the sections below. Finally, recent discussions in the theoretical and research literatures related to client experiences of empathy – either as a diffuse background variable or as specific and time-circumscribed activities – was explored. These findings are discussed in the following sections. Consistent with a constructivist-hermeneutic approach, the research findings of this study were not meant to be the only possible way of interpreting the data, but as a contribution to theory development of an established, clinically-meaningful, phenomenon.

Types of Empathy

Existing literature (i.e. Bachelor, 1988; Duan & Hill, 1996; Bohart & Greenberg, 1997) has focused on the categorization of empathy, especially into classifications of cognitive and emotional empathy. The present results appeared consistent with the utility of such a classification, yet also indicated potential difficulties and inaccuracies such a

classification might offer. Bohart and Greenberg further suggested using understanding and experiencing as names for the two types of empathy instead, highlighting the complexity of empathic interaction, as nearly all such interactions appear to be an amalgam of cognition and affect. The present results suggested that most clients conceptualized the broader potential of including both affective and cognitive components of empathic attunement. The results further indicated a complex interplay of affect and cognition, confirming Bohart and Greenberg's contention, and also suggested the possibility of a continuum of affective content. Examples in the results section highlighted the complexity involved in exploring the client's perspective as they engaged in ongoing interpretations of the therapist activities and suggested that empathic attunement was a process dependent upon interplay of the experiences, emotions, and empathic attunements of both people as suggested by Jordan (1997).

Empathy has been considered a universal human capacity (Baron-Cohen 1991, 2011), which may be a reason why the clients in the present study had a well-developed understanding of the construct. Jordan (1997), in discussing empathy in therapeutic dyads as a mutual and bidirectional activity, lends further explanation to the present respondents' ability to understand their therapists' attempts at empathic attunement through their *own* empathic attunement to their therapists. The clients also offered conjectures about the therapists' motives and emotional reactions to their relationships. These client conjectures laid the foundation for the clients' developing sense of trust, both in their therapists and in the therapy process. In his discussion of the qualitative research paradigm, Stiles (1993) explored how experiences occur in a "polydimensional

meaning context" (p. 597), and that causal relationships are infinitely complex and seldom -- if ever -- follow a mathematical format. Furthermore, though existing research is unclear on client contributions to empathy in session, as Truax & Carkhuff's (1967) findings indicated that therapists' level of empathy is stable across clients, and Gladstein et al. (1987) indicated some variability in therapist empathy across clients, the present research indicated that even circumscribed empathic interactions between client and therapist contain a multitude of experiences, both cognitive and emotional, and are actively contributed to and interpreted by both the therapist and the client. The client, then, may be usefully seen as an active contributor to the empathic process, and not a simple receiver of the therapist-administered treatment efforts.

Relational Context of Empathy

Therapist professional and personal roles were of interest to the respondents as they discussed their interpretations of therapist intentions and behaviors related to empathy (see problem formulation 2). In the existing literature there appears to be a significant intersection of therapist expressed empathy and therapist self-disclosures. For example, in exploring the client's interpretation of therapist intent behind self-disclosures, Knox et al. (1997) found that the client sometimes feels understood by their therapist through emotional self-disclosure. To the client, a therapist's display of own emotional reactions may likely both be therapist expressed empathy and therapist self-disclosure. Similarly, in defining therapist self-disclosure, Cherbosque (1987) included therapist expressed feelings about client behaviors and statements. In the present research, qualities and behaviors related to therapist private and professional roles

included professional closeness, the therapists' personal efforts and motivations, and trust that was based on trappings of the therapists' professional role. These were communicated to the client through therapist empathy, often as therapist self-disclosures such as emotional reactions or indications of being able to understand the client through having had similar experiences in the past. For example, one respondent expressed with great awareness of the process, that therapist empathically attuned self-disclosures were appropriate and welcomed and enhanced the felt closeness and trust with her therapist. This respondent went on to discuss that the specific therapist self-disclosure was a positive experience for her, but had the disclosure come earlier in their relationship, or had there been more of such emotionally empathic expressions, the client might have lost respect for the therapist, experiencing the therapist as someone who could not help her because the therapist would be judged to have problems of their own. The findings from the present study are also consistent with Hill et al.'s (1988) suggestion that therapist self-disclosures are best received by clients when they are infrequent. In general, respondents expressed appreciation for empathically attuned therapist self-disclosures, and given their enthusiasm for knowledge about their therapists' private and professional personas, such empathic disclosures may serve the additional purpose of allowing client's to develop cohesive and meaningful stories about therapist motives and intentions. Thus, this and above mentioned studies suggest that empathy may likely be dynamically interdependent with numerous variables, such as self-disclosure and time in therapy. Furthermore, more simple, categorical conclusions about its presence or absence or

simple linear associations with single variables might well be at the risk of missing much of what empathy actually is (and does) within psychotherapy.

Utility of Empathy

Clients' understanding of the utility of empathy yielded three sub-categories: client ego-support, therapy process, and client self-attunement. The third sub-category of the utility cluster, "client self-attunement" was often described by clients while discussing empathic experiences at the cognitive end of the continuum. Consistent with Bohart and Greenberg's (1997) classifications of therapist empathic utterances, client self-understanding was improved through the process of cognitive attunement where the therapist responded with varying degrees of additional information, organization, and deepening of the exploration. These efforts appeared transparent and intelligible to the clients as they described them willingly and with significant understanding, again contrary to previous suggestions of client experience of empathy as a vague background variable (i.e. Myers, 2000).

The first sub-category of the utility cluster, "client ego-support", consisted of empathic activities by both the client and therapist, as previously discussed, and enhanced the clients' feelings of trust, safety, and closeness with the therapist (which in turn appeared to allowed for better therapeutic process). The clients indicated an increase in feeling understood and met by their therapists, which they described as intensely positive. The clients spoke frequently of their appreciation for the work of the therapist. Linehan (1997), in describing her concept of validation, captured the broader relational context in which empathy appeared to play a significant role for the respondents of the present

study. Clients pointed out that empathy was how they experienced the effort and hard work the therapist brought to the sessions, and that these aspects were proof that they really did matter to their therapist. In turn, these aspects influenced the in-session utility of empathy through relationship building and a broad enhancement of the working alliance (Bordin, 1979). Jordan (1999) described the complex therapeutic relationship through discussing the connection between empathy and relational development, exploring the universal psychological necessity for human beings to engage with others in meaningful ways through empathic attunement. In the present study, respondents repeatedly and emphatically offered indications of their need and appreciation for this closer contact during the interviews, for instance through statements like the ones in Appendix H, Table 9, that focus on the therapist's private persona. Similar expressions by respondents are found throughout the interviews, where clients voiced their appreciation and at times surprise, over the therapist willingness and ability to engage with them in meaningful ways. Empathy, then, may be seen in the complex context of psychotherapy, whether in relation to other curative factors or directly in the context of therapeutic outcomes, as it appears to play an integral role in the therapeutic relationship.

Empathy as Background Ambiance or Specific and Temporally Circumscribed Activity

Research by Bachelor (1988) and Myers (2000) found that clients think of empathy as background ambiance and that they have little understanding of the construct or its process in therapy. However, others have suggested that empathy occurs in circumscribed or limited periods of time during therapy (e.g. Barrett-Lennard, 1981;

Greenberg & Elliott, 1997). The respondents in the present study were capable of identifying and exploring instances of empathy activities and situations during the video-playback interviews, and were also capable of engaging in further in-depth discussions of empathy as a part of a background ambience, offering insights about how the ongoing empathic relationship was developed over time through the accumulation of specific empathic interactions. It therefore seems likely that clients' are aware of and are able to describe both the specific activities and general atmosphere of empathy. This finding of confirming both aspects of client experience of empathy, was likely influenced by the use of the specific methodologies of video assisted interpersonal process recall. video-recordings of therapy sessions that had occurred in the last 24 to 48 hours allowed clients to recall the specific activities and experiences. The interviews focused on those specific incidents, but also allowed for building that focus to broader relational aspects of empathy. In contrast, Bachelor (1988) utilized written open-ended responses to a single question in developing her classifications, potentially leading clients to remember an instance of empathy, and when describing it, likely drawing on other memories that confirmed the initial one and thereby falling prey to confirmation biases in emotional memory (e.g., Baron, 2000).

Strengths and Limitations

Focusing on the client's experience offers new and potentially fruitful classifications and measurements, especially as client report of empathy has proven itself particularly good at predicting outcome (Elliott, Bohart, Watson, & Greenberg, 2011). Utilizing IPR to explore empathy in the therapy situation allowed for a closer

examination of the complex interpersonal processes from the client's perspective. It appeared that clients are capable of thinking about empathy both as a circumscribed in-session activity as well as a background variable. The clients further gave an indication of the complex interactive nature of empathy where both parties are engaged in "reading into" the words, mannerisms, and behaviors of the other person. IPR was uniquely equipped to delve into intra-personal experiences and processes as it captured reactions to in-the-moment experiences subsequent to the experiences, and causing minimal interference with the experiences (Kagan, 1975).

Previous psychotherapy process research has benefitted from utilizing video-assisted interpersonal process recall (e.g., Elliott, 1986; Frankel & Levitt, 2009; Henretty, Levitt, & Mathews, 2008; Hill et al., 1994; Levitt, 2001; McLeod, 2001; Rennie, 1990). In the present study, video playback of the recent session allowed client and researcher to focus on specific empathic engagements between client and therapist. This allowed for a close examination of relevant client processes in response to these in-the-moment experiences, dissuading clients from resorting to broad generalizations, while broader client reactions were attained during interview segments during times when the tape was paused. In this way the IPR was a tool for the interviewer to move from specific to general explorations of clients' experiences.

Reviewing IPR methodology and previous research using the methodology for suggestions regarding interview process allowed for the incorporation of several procedures (see especially Larsen, Flesaker, & Stege, 2008). Not all respondents easily assumed the role as co-researchers, the utility of which has been discussed as gaining

reflexivity and hence increased objectivity (Kagan, 1984). Clients were engaged in an exploration of these difficulties and solutions were found in collaboration. For example, a few respondents appeared to be uncomfortable at the beginning of the interviews and when asked, described discomfort watching themselves and displaying their private experiences with their therapist to a stranger (the interviewer). The processing of these thoughts and feelings with the interviewer apparently assisted the respondents in settling into the interview with greater comfort. Similarly, the often used process of enlisting the respondent as a co-researcher was commonly met with some trepidation. Lighthearted joking about remembering to use the remote and sharing own difficulties with technology appeared to help the clients engage in actively exploring their reactions and memories to the video material.

Sensitivity to client material, client emotional reactions, and client privacy was similarly important in helping client's engage reflexively. Clients often shared sensitive and personal material both in the video-recorded session and during the interview. Kagan (1975) suggested that viewing therapy sessions during IPR causes a flashback allowing clients to relive the session during the interviews. Furthermore, as both IPR interviews and therapy often focus on process more than other types of interactions, the clients may experience IPR interviews as similar to therapy sessions. In response, frank and sensitive discussions often occurred about the interviewer's role as researcher and not therapist. This is not to say that the researcher should avoid being transparently warm and supportive throughout the interviews. Such relational qualities were found to be

important in the creation of a useful and productive research alliance (see for instance Rubin & Rubin, 2005).

Though IPR allowed for a close examination of the topic under scrutiny, it offered some difficulties related to therapist comfort with some therapists likely either refusing participation or indicating significant concerns. The method further focused attention on the video-recording that takes place in most therapy sessions in the utilized training-clinic and was difficult for some of the respondents to watch. Several respondents voiced discomfort with the process of watching themselves and watching something as private as a therapy session with a stranger. As such, this methodology, though obviously less invasive than interrupting the session in real time whenever empathy was witnessed by a third person, it was also far more invasive than asking the client to complete a questionnaire subsequent to the session. It is unclear how much the client discomfort in this regard influenced their ability to report their thoughts and feelings related to empathy. Considering the depth of many of the responses, client discomfort was assessed to not have been overly restrictive, but had a small impact.

This study relied heavily on existing theory to establish a jumping-off point for the beginning interviews. As such, we assumed a balance between focusing clients on the topic versus biasing the clients that was tipped in favor of staying close to the topic under investigation. Furthermore, we believe the first author's in-depth familiarization with the existing theory prior to interviewing clients allowed for greater bracketing of preconceived notions, or biases, regarding the concept of empathy.

The present research, in relying on client interpretations, excludes the input of therapists and other outside resources of information. A follow-up including therapist responses to the material, perhaps covering the same interactions from the same video-tape would have likely added significantly to the study of empathy. Furthermore, this research focused only on a single therapy session, and as such may be limited in capturing the therapists' use of empathy across the therapy experience.

Empathy is a construct that has been difficult to research due to its complexity (Duan & Hill, 1996; Elliott, et al., 2011). Further, it is a construct that attempts to simultaneously capture activities between and within two people. Finally, the study of empathy has traditionally been approached from a top-down approach with a focus on therapist activities and client receipt of such activities. In doing so, the client's active contribution to the process may have been neglected. It is our hope that the present study will help to more fully realize the client contribution to the theoretical construct of empathy.

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Appendix A: Review of Qualitative Research of Empathy

In spite of its apparent usefulness in generating theory and examining complex interactions of context and interpersonal activities, only a few have approached the empirical study of empathy through qualitative methodologies (e.g., Bachelor, 1988; Myers, 2000, 2003; Kerem, et al., 2001; Brodley, 2002; Wynn and Wynn, 2006). A complete review of these approaches follows below, which sheds light on several empathy components and indicates some of their interactions. Brodley (2002) developed a taxonomy of therapist responses, while Wynn & Wynn (2006) have begun unraveling the complex cyclical nature of empathy through applied conversational analysis. Myers (2000) explored client's phenomenological experience of being listened to, and has begun to uncover client experiences related to empathic failure or breakdown. Bachelor (1988), in an oft quoted article, uncovered a taxonomy of received empathy and explored client experiences of how empathy was seen to relate to both therapist activity and therapy outcome. Finally, taking up yet another key theoretical concern related to empathy, Kerem, Fishman and Josselson (2001) explored the issue of cognition versus affect in empathy. These articles are described in substantial detail in part due to their scarcity, but more importantly, because they offer insight both for specific methodological considerations as described in the method section, but also as a basis for an initial understanding of clients' perspectives on empathy which will assist the interviewer in orienting to the respondents.

Therapist Empathic Responses

Brodley (2002) compared 86 samples of therapist responses culled from 20 therapy sessions where she herself had been the therapist, with 131 samples of therapist utterances selected unsystematically from 22 sessions with Carl Rogers as the therapist; the exchanges from sessions with the author as therapist included only the ones eliciting the strongest explicit confirmations that the therapist had heard them correctly. Common client responses to therapist accurate empathic understanding included slight nods of acceptance, utterances such as “ah haw”, “uh huh”, “uhm hm”, as well as “yes”, “right!”, and “yeah”. Such expressions were commonly followed by clients returning to their narratives. Occasionally clients also repeated the point made by the therapist as a way to indicate their confirmation. Responses where categorized into meaningful clusters, including words or phrases that express emotions or feelings, words of phrases with vivid or evocative qualities, phrases without feeling words or evocative qualities, and words for specific cognitive processes, as well as some therapist stylistic forms of therapist utterances. Reliability ratings were in the 85%-98% range, and all disagreements where resolved by the author.

Brodley’s (2002) dissemination of types of therapist expressions of empathic understanding, laid the groundwork for further examinations and understanding of such therapist empathic communication and lended themselves as guidelines for the present study’s interviewing process as they assisted the interviewer in anticipating common verbal responses to underlying processes of interest. Brodley’s findings are summarized below.

The first category, words and phrases expressing feelings such as “tense”, “calm”, “afraid”, and “rage”, were found in less than 1/3 of all the interaction units examined. The second category consisted of words or phrases that allude to feelings. Within the combined sample, she found such expressions of empathy to take place in 52% of the interaction units, and commonly expressed dispositions, evaluations and volitional states. They were made up of such words or phrases as “ignored”, “pleading”, “very careful”, “worried”, “intimate aspect”, “closeness”, “merged”, “ and “confusing”.

That Brodley found these more complex and nuanced expressions of emotional empathic understanding more frequently than simple “words-for-emotion”, was likely due to the nature of empathic attunement where, what the therapist is attempting to understand was more nuanced and complex than client’s simple feeling states. Most often, the “alluding to emotions” statements also contained cognitive elements, which highlighted the complexity of empathic attunement, and may have been contradictory to the suggestion of Duan and Hill (1996) for the field to study empathy separately as either cognitive or emotional in an attempt to clarify the construct. Finally, when combining the two classifications, Brodley found that, across the two therapists, 67% of all interaction units contained either simple words for feelings, or words and phrases alluding to feelings, or both.

Words or phrases with and without vivid or evocative qualities made up the third classification identified by Brodley, and captured short metaphors that contribute to the vividness and liveliness of the therapist’s communicated empathy. Figures of speech often referred to what was happening to the person or what the person was doing in their

life. Cited examples included “drain on your life”, “part of you is torn away”, “in a black hole”, and “clam up”. Both therapists were seen to pick up on a client’s own metaphors, and carried it or an element of it into future discussions. However, most such figures of speech were not picked up from the client, but instead were spontaneous expressions of their empathic understanding of the client. Such expressions may elaborate for the client the therapist’s perception of their situation or emotional context in a vivid and present way – the therapist thus appears present in the relationship in an emotionally alive fashion.

Specific words for cognitive processes, such as “think”, “interest”, “consider”, “means”, or “implies”, were found in approximately 1/3 of the responses, across both samples. Many of the empathic responses contained both feeling experiences and evocative experiences along with cognitive words. When comparing the frequencies of empathic responses containing feeling references with specific words for cognitive processes, Brodley found that feeling references were found in approximately twice as many empathic response units as were specific words for cognitive processes.

Brodley (2002) also disseminated the responses into stylistic aspects. For instance, Brodley discussed the frequencies of the therapists’ use of first-person in their empathic response units, stating that such use took place in 29% of Carl Rogers’ empathic responses, while Brodley only used the first person reference in 14%. Brodley goes on to discuss in more detail, her assumptions regarding such first-person statements (such as “how am I going to deal with it within myself”, “Where am I going?”, “I must be empty”, and “God damn it!”), characterizing them as communicating to the client a sense

of the therapist's close participation in the client's world. She further states that such expressions may also be seen as partially directive. Such suggestions are of particular interest to researchers looking at client interpretations of therapist responses as they focus attention on the variability of possible client-interpretations of therapist utterances.

Another dramatic form of empathic responding is a statement representing a third person, presented as a quote to the client. Examples given include speaking for client's parents: "I don't like this, so you mustn't, because you are part of me", and the therapist picking up on a client's third-person dramatic form about herself; client: "she'll have a career and have great children and all of that, but she'll be alone (laughs)." Therapist: "and she'll celebrate for ten years". A similar example includes a variant of this form as the therapist picks up on the client's discussion regarding when he was a little boy: "the little boy feels, 'this feels good to me, it's satisfying to me to do this'." Much as the figures of speech examples given above, these appear to add vitality and variety to the empathic responses, and may help the client experience the therapist's engagement and presence, in particular when the therapist utilizes the same forms of speech (first person, third person, figures of speech) as the client.

Brodley suggested 'therapist references to self' as another category of interest when examining and disseminating therapist empathic responses. However, the type of self-references she discussed were only ones where the therapist refers to own uncertainty or tentativeness about their understanding of client material. These include "I guess the impression I get is…", "what I hear you saying is…", "I guess you're saying there…", "but there too, I guess I get the feeling that…" and were found in approximately 1/5 of

Rogers' expressions and 9% of Brodley's units. Such statements, she maintained, are not aimed at producing an effect, though she suggested that there could be a serendipitous effect as the clients sense the therapists' presence as a personal participant when owning their imperfections to the listener. Others (Bachelor, 1988) have suggested that, not only are client's tolerant of the therapists' imperfections, they are also particularly grateful of the therapist's genuine attempts at understanding, which in turn may add to the bond between client and therapist.

Cyclical and Dyadic Process of Empathy

Wynn and Wynn (2006) took up the topic regarding the cyclical nature of the empathic engagement between client and therapist as they applied conversational analysis (Ten Have, 1999) to videotaped recordings of twenty therapy consultations between 15 outpatients and 4 therapists (all described as eclectic). In describing previous empathy research as primarily either purely theoretical or based on scoring therapist actions directly or through use of questionnaires, they suggested that little work had been carried out which focused on the details of actual sequences of the conversational exchanges through which empathy is achieved. Previous research had, they argued, focused on empathy rendered out of context, while much current theoretical work described empathy as an ongoing conversational process between client and therapist. Conversational analysis, they argued, would be useful in disseminating this theorized process of empathy. They argued that empathy is interactionally constructed, and that the development of empathy relies on the client's signaling receipt of the therapist's empathic utterances, thus demonstrating to the therapist that the therapist's utterance was

accepted by the client. They suggested that such a receipt commonly takes the form of, for instance, answering the therapist's questions, agreeing with the therapist's assertions, demonstrating understanding of the therapist's utterances, and/or an appropriate showing of emotion. In fact, the authors suggested that such acknowledgment of receipt of empathy is so ingrained in our patterns of verbal interaction that it's non-occurrence is most often noted and oriented to by the interactants.

The authors only found evidence for the first (and larger) three of Bachelor's (1988) styles of empathy (description of Bachelor's study can be found below). In other words, they found no evidence for a nurturant category. As this category was only endorsed by two clients in Bachelor's study, it is no surprise that others have had difficulty locating evidence for such a construct. However, this category, perhaps more so than the other three, may rely heavily on the client's interpretation of the therapist activities. In fact, that the therapist creates a comfortable, safe and encouraging environment for the client, may not be evident in empathy when measured using quantitative methods, but there is a strong theoretical background suggesting such an effect (e.g., Greenson, 1960; Rogers, 1975; Kohut, Goldberg and Stepansky, 1984), and only through exploring the internal meanings of the client could such activity come to be understood as empathic. Furthermore, an as yet unpublished qualitative analysis of client responses to therapist activities carried out by the present authors suggest that clients interpret the therapist activities vis-à-vis creating a nurturant, safe and welcoming environment, as understanding their needs and unspoken concerns.

A concern regarding Wynn & Wynn's (2006) article should be raised. Though Wynn and Wynn quote Bachelor's categories of client received empathy, the examples given as evidence for affective empathy, do not directly match affective empathy as defined by Bachelor (1988). It appears that Wynn and Wynn define affective empathy more broadly, as a situation where the therapist understands that the client is experiencing emotion, while Bachelor defined it very specifically as a situation where the therapist experiences some part of the emotion experienced by the client. This relates to a possible shortcoming of both studies. Wynn and Wynn's analysis is based strictly on transcribed videos of therapy exchanges, and without specific therapist statements indicating their emotional state, they do not have access to such information. Similarly for the Bachelor study. Unless the clients have specific information regarding the therapist's emotional state, they too may not be good reporters of such situations. However, Bachelor does report clients stating that they interpreted therapist actions and behavior (ex., therapist had tears in her eyes) as evidence that the therapist indeed did experience similar emotions. This allows for some confirming evidence of therapist emotional state through interviews with clients.

Client Phenomenological Experiences of Therapist Expressed Empathy

Myers (2000) and a colleague interviewed 5 female clients (all above the age of 25), who had been therapy clients of each of them, successively, at a university counseling center. Client responses regarding one of the interviewers/therapists was collected by the other interviewer/therapist. In addition to the interviews, the respondents also turned in written material that was included in the qualitative analysis and was an

expansion on questions emerging from the interview transcripts. The interviews were done as open-ended phenomenological interviews according to the guidelines of Seidman (1991), with the aim of identifying specific dimensions of the empathic process as experienced by the clients. Participants were asked to elaborate on their experiences of being understood or listened to, and were asked to also elaborate on situations where they had been misunderstood or not heard in hopes that it would further clarify what it meant to the clients to be heard and understood. The respondents chosen were those who were deemed to have demonstrated a capacity to reflect on their experiences and to articulate their journey through the therapeutic process. Only clients above the age of 25 were used, as these were expected to be able to bring more life experience to their therapeutic relationships than traditional undergraduates.

All five of the respondents identified listening as an essential aspect of the therapeutic relationship, and all five linked being heard with the experience of being empathically understood. Three categories of responses were identified as: 1) experiences of being misunderstood/not being listened to, 2) feedback, and 3) safety. Respondents identified a number of specific behaviors which indicated to them that the other person was not paying attention or not listening to them. These included: 1) the listener drawing on their own interpretations (too quick to comment), 2) the listener dismissing the respondents position, 3) the listener moving the focus away from the respondent's expression, 4) lack of eye contact, 5) yawning, 6) interrupting, 7) monotone answers, 8) inaccurate feedback, 9) the listener speaking the instant the respondent stopped speaking (as if waiting for their turn regardless of what had just been said), 10)

the listener shifting around, 11) the way it made the target feel ("I feel good when I'm being listened to because I know the person cares about me and what I am saying." (p. 158)). Clients responded to such breaches in a number of ways: 1) sensing the other's disinterest the target loses focus, 2) the target no longer feels comfortable exploring and, 3) the target feels devalued.

Respondents' remarks also suggest tolerance for misunderstanding. One respondent suggested the helpfulness of such misunderstanding as it would sometimes help her to look closer at her own meanings. It was only when misunderstanding happened repeatedly that the respondent remarked that it breeched her confidence in the other person. The client's high tolerance for therapist misreading of meaning and emotion was borne out by Bachelor 's (1988) study, where she reported similar remarks by clients.

Regarding being understood, clients' responses included comments about the usefulness of empathy, such as producing: 1) an opportunity for self-expression, 2) a sense of working together, 3) a sense of making a journey together ("I knew he was there, you know, with me.") 4) a feeling that the other person was really working at it and working with the respondent, 5) being validated. All five respondents also identified feedback as central to their experience of knowing that the therapist was listening and understanding. Therapist behaviors categorized as feedback included paraphrasing, clarifying, questioning, and attending to detail. This appreciation of therapist activity of attending to the client's in-session struggles to communicate their situation further speaks to the importance of respecting the client's concerns. Finally, a respondent highlighted

the importance of being given the space to hear herself. In other words, being silently understood appears to have promoted self-understanding by this respondent.

Feelings of safety and trust were cited by all respondents as contributing factors in their experiences of being heard and understood (Myers, 2000). In highlighting the interactive nature of empathic attunement, one respondent suggested that it takes time to get to a point where she could not only discuss some very private and painful situations, but also to allow the therapist to truly be involved in them through the client's experience of the emotions involved. It was easy enough for this client to discuss what had happened, but being given the permission to explore and experience the events and situations with another person was very moving to her. Furthermore, as highlighted by another client, the therapist's willingness to explore the patient's experiences, no matter what the client presented, was a modeling experience. The client became better able to look at herself and her own difficult experiences. The therapist's acceptance was seen to be translated into the client's acceptance of herself.

Through the interviews and client narratives, Myers (2000) casts light on the clients' experience of the therapist's expressed empathy. The interpretation of the respondents' materials may at times wander into other territory than purely empathy, however. This is likely in part due to the complexity of the term, and to the concern voiced above regarding the likely overlap of the construct of empathy with other, and similar, constructs, such as alliance. The respondents do identify a number of very important aspects, however. Myers highlights both direct therapeutic effects of empathy, as well as the environmental effect of empathic attunement within the therapeutic

situation. Through the safety and trust engendered by the empathic attunement as it is understood by clients, these client's feel both more willing, but also more able to explore their narratives. This exploration is furthered through the ongoing feedback offered by the therapist, which serves both the immediate goal of furthering the exploration, but also signals to the client that the therapist is attuned. Such attunement, in turn, is also understood by the clients as a behavior that demands effort, and the effort in turn is interpreted, at least by some, as an indication of care and concern.

Client Perceptions of Received Empathy and Utility of Empathy

Bachelor (1988), in a qualitative analysis of 52 (of which 25 were non-therapy) participants, asked respondents to describe "… a situation in which your therapist was empathic toward you…" (non-therapy respondents were asked a similar question without the therapy association. These single-question open-ended response sheets were distributed to respondents (in-therapy group) prior to their fourth or greater therapy session with one of 17 therapists (graduate students with a variety of theoretical orientations). Clients were free to take the questionnaire with them and return it later. The majority of responses were returned after one week, and all were returned within two weeks. Non-therapy subjects had the questionnaire sent to them. The majority of the non-therapy responses were returned within 2 weeks, and all used responses were returned within one month.

Bachelor identified 4 distinct styles of perceived empathy. The largest category consisted of "perceived cognitive empathy". For these respondents, the helper was seen as empathic when accurately communicating back the client's ongoing innermost

experience, state, or motivation. This communication was done primarily through reformulation, questioning, interpretation, confrontation and advisement. These differing modes of verbal communication by the therapist may be seen to fall at various levels in the continua formulated by Greenberg and Elliott (1997), as they appear to offer differing amounts of new information as well as whether they are in the "frame of reference" of the client, therapist, or a shared frame of reference. In this regard, it is important to highlight that Bachelor also found respondents stating that they felt thoroughly understood by their therapist, but that the therapist communication of empathy was entirely non-verbal, such as "At that moment we were looking each other in the eyes. And I felt she understood what had just happened." (Bachelor, 1988, p. 231). Such a non-verbal shared understanding is not uncommon in the literature, but makes coding of specific behaviors more complicated. Yet, Bachelor, through exploring the client's experiences, was able to identify such instances within their context through a qualitative approach.

The second largest response group was coded as perceived affective empathy and covers the client's perception that the therapist is experiencing some of the same feeling as the client, in the moment (not to be confused with a therapist who merely grasps that the client is experiencing an emotion). The respondents' typical characterization of this type of empathic perception was that they felt that the therapist was feeling what they were feeling. Most frequently there was no other indication of modality of how the client knew the therapist was empathic. Though, one example is given in Bachelor's (1988) article of an entirely non-verbal communication of such empathy by the therapist: "I felt a great intimacy (complicité) at that instant. I thought I saw her eyes water and I had the

impression that she truly understood and felt entirely what I was experiencing… A total comprehension of what I had experienced and talked about" (p.232.)

The third category of empathy described by Bachelor as "perceived sharing empathy," covered the therapist disclosing personal opinions or experiences related to the client's ongoing communication. Bachelor described this category from the client's point of view as if the therapeutic relationship assumed the form of an exchange or dialogue, or even friendship. This was highlighted because characteristics of the therapist disclosures were unsolicited and spontaneous, and the therapists did so with ease and naturalness.

Bachelor's (1988) fourth and final category of client empathic experiences was identified as perceived nurturant empathy, and was suggested by 7% (n=2) of the client sample and 24% of the non-clinical sample. This empathic style denotes the helper's supportive, security-providing, or totally attentive, presence. In the context of Greenberg and Elliott's (1997) model, it is surprising that only two client cases highlight the type of empathy that primarily has the effect of helping the client feel comfortable, safe, and supported. As we saw earlier, Greenberg highlighted two major therapist intents in selecting the form of empathic communication to the client. One of these was to create a supportive and accepting environment. Yet, the effects of the four classifications defined by Bachelor's research do not seem to break down into such categories. Each of the four classifications, in fact, appeared to impact across Greenberg and Elliott's classification of intent. This should not come as a surprise, as Bachelor's categories intend to classify "types" of clients. Yet, it is noteworthy that all four types of clients manage to reflect on both types of empathic effects; the immediate ambience of therapy (Feeling understood,

and the safe, trusting, encouraging nature of the therapeutic situation as it is highlighted through the different forms of empathy) as well as long-term effects of the empathic approaches (increased self-knowledge and self-exploration) used by their respective therapists.

Bachelor's (1988) 4 types of clients relate to Barrett-Lennard's (1981) fourth stage in his multistage model. However, Bachelor reported finding no evidence of the fifth stage, namely the feedback from client to therapist that was hypothesized as central for the therapist's adjustment of empathic accuracy, as well as being central to the cyclical aspect of Barrett-Lennard's model; the fifth step in the model yields material for the therapist to "resonate" to, in effect starting the chain again. Bachelor suggests the omission on the part of the respondents of not indicating any ongoing, or cyclical, feedback-loop, may indeed be due to the limits of the particular research methodology used for her study. Additional questions attempting to elucidate such aspects as ongoing, cyclical engagement over a period of time, might have helped elucidate any such possible mechanisms, indicating a weakness in her particular approach of asking a single question on a sheet of paper. In fact, the very wording of the question may well have indicated to participants that the researchers were interested only in a single instance of empathic connection, and not to describe a process (cyclical or otherwise).

A final comment must be made regarding Bachelor's (1988) findings that the four categories (cognitive, affective, sharing, and nurturant) were likely client "styles"; she suggests they may be attributable to individual clients' perceptual styles. As respondents were instructed to describe "… a situation in which your therapist was empathic toward

you…", it appears just as likely that a given instance of empathic connection was primarily one or the other of the four identified classifications, and not at all related to client perceptual styles. If the lack of respondent description of a cyclical pattern of an empathy process could be due to the limitations of the used methodology, then, indeed it seems equally likely that the instance of empathy described would not necessarily encompass several types of empathy simultaneously, but instead be described as primarily one or the other of the types identified. In other words, it is unclear whether the types of empathy Bachelor found are what they are due to client "style" or simply due to the fact that client identified empathy comes in different forms. Perhaps, certain common activities of therapists are seen as empathically attuned moments to the client, and these activities lend themselves to be categorized into these four (or more) types.

Bachelor (1988) found that clients' spontaneous responses that related to the effects of empathy could be classified into those that were 1) client-related, 2) therapist-related, and 3) global effects. The third group encompassed general statements reflecting the importance of empathy, the helpfulness of therapy, and the utility of therapy in the client's life. This group will not be discussed further as it lends little to no new information towards deepening the understanding of how empathy is seen to be therapeutic, either directly or indirectly. In discussing the client self-related benefits of empathy, Bachelor (1988) suggests further classification into 3 sub-groups: 1) specific therapeutic effects, 2) client distress-reduction, and 3) client "narcissistic" gains. Effects that are seen as directly therapeutic were therapist empathic activities promoting self-understanding, self-disclosure, and self-reflection, but also as leading to helpful counsel,

and contributing to better functioning and progress in therapy. Effects that were seen as falling into the "distress-reduction" category spanned client statements about alleviation of problems, as well as relief and consoling effects. Finally, the category of "narcissistic" gains covered gains related to self-acceptance, self-confidence, self-esteem, and self-respect. This category further covered statements related to empathy as proof that the therapist was considered, cared about them, was warm and supportive, and where the client could feel totally understood.

The second group, therapist-related effects of empathy, covered items that were not directly therapeutic but where related to their relationship with the therapist. These were effects such as feelings of closeness, attachment and friendship with the therapist, as well as increased trust and gratitude toward the therapist. The effects, then, as seen from the clients' point of view, are primarily person or process related. The clients appear to focus on the utility of therapy (what they are there for), and the effects of empathy that can further the process of therapy. In this sense, Bachelor's (1988) categories, as outlined above, can be seen from Greenberg and Elliott's (1997) point of view. In discussing the quality of empathic communication – the range of communication performed by the therapist which has a goal of communicating to the client that the therapist is attuned – Greenberg suggests the type of empathic communication is determined by the therapist intentions of which he suggests two broad categories: 1) intent is to create an accepting, supportive environment, and 2) intent to promote exploration and growth. As these two categories are quite broad, they capture all of Bachelor's suggested examples. Similarly, Barrett-Lennard (1981) has suggested that

received empathy has a healing and growth-enhancing effect, as described in this and previous sections. A number of researchers have been involved in an ongoing debate of the utility of empathy and client-centered approaches. From the clients' point of view, high empathy attunement periods in therapy have been found to fall into the following three categories: 1) insight into oneself, 2) having the opportunity to and risking talking about personal issues, and 3) searching together (Vanaerschot, 1997).

Cognitive and Affective Components of Empathy

Kerem, Fishman and Josselson (2001) examined the empathy related responses of 14 undergraduate students who had been given a semi-structured interview by one of seven psychology graduate student interviewers. They asked respondents about relationships in which they had either felt they really understood the other person, or in which the other person really understood them. They report using "understand" as it is an experience-near word which encompasses empathy's complex meanings. Additional foci of the interview included aspects of what was understood, how it was understood, and how the person knew or felt they either understood the other person, or how they knew or felt the other person understood them. Within the process of empathizing, they also pulled for responses related to what the other person felt, thought, and the content of the given situation that was being understood, as they were in part interested in both affective and emotional aspects of the empathic material and empathic process. Data was analyzed utilizing a qualitative approach within the phenomenological framework as they attempted to return to experience to obtain comprehensive descriptions that could subsequently provide the basis for an analysis that portrays the essence of experience.

Regarding the discussion of whether empathy can be examined as two distinct processes, affective and cognitive (Duan & Hill, 1996), Kerem et al.'s (2001) findings suggest that the picture appears more complex than that. They suggest that some respondents distinguish between affective and cognitive empathic experiences, while others integrate both the cognitive and affective components integrated into the same empathic experiences. They found some descriptions where both aspects, emotional and cognitive, were intertwined and may have been experienced simultaneously, while at least one description suggested a situation where the process went from one to the other. This combined type included containing the distress of the other, and then going on to organizing the emotional experience in a cognitive way. Regarding the types of empathic experience where only one aspect was experienced, there were numerous examples of descriptions that included only cognitive aspects with no affective component. When a description included affect, however, there was usually some cognitive aspect described as well, and was often part of a complex experience. These findings are consistent with Eisenberg and Strayer's (1987) suggestion that, although there are many purely cognitive empathic experiences, there have rarely been any purely affective experiences.

There are numerous reasons why Kerem et al. (2001) may have failed to find affective empathic experiences as prevalent as the cognitive ones. There may be greater difficulty in verbally describing affective experiences due to the emphasis western culture places on logic and rational thinking, and the language itself may also limit the expression of descriptions of affective experiences, due to inherent limitations. Jordan (1991) suggested that affective arousal is also more temporary than cognitive

understanding; the emotion is short lasting, followed by a return to a cognitive understanding. Finally, Kerem et al., suggest that the use of "understand" may carry with it a cognitive bias, priming the respondents to focus more often on cognitive events.

Appendix B: Internal Review Board Documents

Initial IRB Approval

OHIO UNIVERSITY

Office of the Vice President for Research

10F040

Office of Research Compliance
Research and Technology
Center 117
Athens OH 45701-2979

T: 740.593.0664
F: 740.593.0638
www.research.ohiou.edu

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below.

Project: Empathy from Psychotherapy Clients' Perspective; A Qualitative Examination

Researcher(s): Peter Douglas-Soeren MacFarlane
Timothy Anderson

Advisor: (if applicable) Timothy Anderson

Department: Psychology

Jeff Vancouver, Ph.D., Chair
Institutional Review Board

11/18/10
Approval Date

11/7/11
Expiration Date

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

Client Consent Form

OHIO UNIVERSITY
INSTITUTIONAL REVIEW BOARD

NOV 18 2010

APPROVED

Appendix A-1: Ohio University Consent Form; Client Form

Title of Research: Empathy from Psychotherapy Clients' Perspective: A Qualitative Examination

Researchers: Peter MacFarlane, Tim Anderson, Andrew McClintock, Xiaoxia Song.

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

The purpose of this study is to explore psychotherapy clients' beliefs and thoughts about the use of empathy within psychotherapy. If you choose to participate, you will take part in an interview. Completion of the interview will take approximately two hours and will involve viewing a video recording of your most recent therapy hour. Viewing the video tape while being interviewed will allow you to better remember what happened during your therapy session. The interview itself will also be video-taped and this video-tape will later be transcribed and used to explore your responses.

Following the completion of this interview we may decide to invite you back for a second interview that will continue to focus on the same therapy session recording. To contact you we will utilize the same contact information used to contact you for the first session, unless you specifically instruct the interviewer to do otherwise. This second interview would be scheduled within one week of the completion of this interview.

Risks and Discomforts

During this study, you will be asked for your thoughts and opinions about your experiences in your current psychotherapy. Please consider your comfort level with questions about your relationship with your therapist before agreeing to participate in the study. This study involves no physical risks for participants. However, some individuals might experience some discomfort in discussing their therapy experiences. Participation is voluntary, and you may stop responding and withdraw from the study at any point without penalty.

Benefits

Your participation will provide you the opportunity to learn, first-hand, the process of data collection for a qualitative psychological experiment. The data from this study could also be helpful to mental health service providers through the improvement of such services.

Confidentiality and Records

Your identity will be protected. All of your data will be kept confidential. Confidentiality will be protected by keeping all materials containing identifying information secure. A copy of the video recording of your most recent session will be made and will be transported to the interview room in a locked container, and will, immediately after the completion of the interviewing phase, be locked in a secure storage room when not in use. The video-recording of your session will be kept for purposes of coding and destroyed upon completion of this study (November, 2011.) The video-tape of the interview will be transcribed for use in the current study. The video recording of the interview will

Clinician Consent Form

OHIO UNIVERSITY
INSTITUTIONAL REVIEW BOARD

APPROVED

NOV 18 2010

Appendix A-1: Ohio University Consent Form; Clinician Form

Title of Research: Empathy from Psychotherapy Clients' Perspective; A Qualitative Examination

Researchers: Peter MacFarlane, Tim Anderson.

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

The purpose of this study is to explore psychotherapy clients' beliefs and thoughts about psychotherapy. If you choose to participate, one or more clients of yours will take part in an interview that will be video-recorded. The interview will explore the clients' personal relationship with their therapist (you). During the interview with the client, a video tape of the most recent therapy session will be used to help the client remember interpersonal processes and illuminate specific behaviors such as verbal exchanges.

Risks and Discomforts

Please consider your comfort level with having a video recording of your therapy session being utilized in this way before agreeing to participate in the study. This study involves no physical risks for clients or therapists. However, some clients might experience some discomfort in discussing their therapy experiences, and may be interested in further discussion between you and your client in subsequent sessions. Participation is voluntary, and you may withdraw from the study at any point without penalty.

Benefits

Though your participation can be considered incidental, some benefits are possible. These include that your client may develop a greater appreciation for aspects of your therapy that involve your interpersonal processes. Furthermore, at the end of the research project, Peter MacFarlane will invite you to a feedback session where he will share the findings of the study with participating student-clinicians and supervisors. The feedback will not identify you or your client, and all data presented will be aggregated and de-identified. Finally, the data from this study may also be helpful to mental health service providers through the improvement of such services.

Confidentiality and Records

Your identity will be protected. All of your data will be kept confidential. Confidentiality will be protected by keeping all materials containing identifying information secure. A copy of the video recording of your most recent session will be made and will be transported to the interview room in a locked container, and will, immediately after the completion of the interviewing phase, be locked in a secure storage room when not in use. The video-recording of your session will be kept for purposes of coding and destroyed upon completion of this study (November, 2011.) The video-tape of the interview with your client(s) will be transcribed for use in the current study. The video tape of the interview will also be stored in a locked storage room, and only removed when needed for coding. Information gathered in this study will be used by investigators for research purposes only and no

Appendix C: Script for Initial Interview

Initial interview script: “this study focuses on your empathic experiences in therapy. We hope you will help us better understand clients’ inner experiences regarding your therapist’s empathy. First, let’s talk a little about what empathy means. Empathy means you feel what they feel. For example, hearing a friend’s dog died, allows me to feel some of what the friend is feeling. In the context of therapy, empathy may mean that your therapist understands you really well, and that you feel that [he/she} gets you, or is attuned to you, or that your connection with [him/her] is deeper and more meaningful to you. The word “understanding” comes close, both intellectually but also emotionally. What do you think it means?” (At this point a brief conversation about the meaning was encouraged.) “OK, I’d like to ask you a question. Did you, during this last session, experience that your therapist was really getting you, really understanding you (use respondent’s words when possible); did [he/she] seem to understand where you were coming from at certain times during the session?” We then proceeded to watch the video from the beginning of the session, and the interviewer stopped the tape when he saw what looked like empathic communications taking place by the first therapist.

Appendix D: Trustworthiness in Qualitative Methodologies

Several criteria can be seen to loosely parallel the measures of internal and external validity, reliability and objectivity in quantitative research (Morrow, 2005). Internal validity is paralleled by credibility, and covers rigor in the research process. There are a number of activities the researcher engages in to enhance credibility. Using peer researchers during coding decreases the effect the single researcher might otherwise have on data interpretation, as the dialogue between researchers keeps each researcher accountable for the decisions they make. Researcher reflexivity similarly allows for accountability. Reflexivity in this context refers to how well the researchers can reflect on their own understanding of the topic under investigation and how this understanding may color their interpretations of the data. Finally, deep engagement with the data enhances the contact between the instrument (the coders) and that which is being measured (the data).

External validity in quantitative methodology is similar to transferability or generalizability in qualitative research, and refers to how far the reader can generalize the findings of the study to their own context (Morrow, 2005). Results of qualitative research, due to the commonly smaller sample sizes and lack of statistical procedures, are not generalizable in the same way that quantitative findings may be. It is in part due to this limitation that a thorough description of context, participants and processes be included in the final report. In qualitative research it is also important to include detailed information about the researcher(s) as they are used as primary instruments of measurement and interpretation. Related to the concept of reflexivity described above,

the researcher comes to the project with a number of ideas regarding the topic of investigation. A description of these beliefs and experiences, including any personal orientations that may be seen to influence the objectivity of the researcher vis-à-vis the theory being generated or elaborated, increases transparency (Levitt, Butler, Hill, 2006, Morrow, 2005).

It is important to keep a record of the process that can be examined by peer researchers. This record should include details about the research activities such as data-collection and analysis, but also the process of emerging themes and categories through the use of a detailed chronology and analytic memos (Morrow, 2005; Stiles 1993; Strauss & Corbin 1990). These methodologies focus on increasing transferability and consistency (consistency parallels reliability and deals with the problem of consistency across time, researchers, and analysis techniques).

Keeping a record of the research process is also important for the level of confirmability (parallel to objectivity in quantitative methods) (Morrow, 2005). Confirmability addresses the issue that research is never completely absent of outside influences, but that we can address this problem and maximize the data's influence on our findings through strict adherence to methodologies and record keeping of these methodologies. Furthermore, confirmability also deals with the reader's ability to confirm the adequacy of the methods and findings through the reporting of possible outside influences.

Since the researcher can usefully be thought of as the instrument in qualitative research, bracketing researcher bias to minimize its influence on the process of analyzing

the data is additionally a method to increase trustworthiness (Creswell, 1998, Morrow, 2005). This bracketing is commonly done through a disclosure section which includes the researchers' experiences and understanding of the phenomenon under study (Morrow, 2005; Levitt et al. 2006). The primary author, Peter MacFarlane, has had experience with empathy in the therapeutic context through five years of graduate training experiences. As he considers empathy to be a key predictor of outcome, the primary author has put emphasis on further understanding and utilizing this aspect in his experiences as a training therapist. The primary author's theoretical knowledge of empathy in a therapeutic context has been significantly influenced by the writings of Rogers (1975), Kohut et al. (1984), Greenson (1960), Barrett-Lennard (1981), Bohart and Greenberg, (1997), Clark (2007) and Ickes (1997), but Rogers and Kohut are particular favorites due to their rich contributions in thinking about application, while Barrett-Lennard and Greenberg and Elliott have contributed in important ways to the author's sense of empathy as a multi-modal process. The author is oriented towards empathy as a complex, moment-by-moment, multimodal process, as well as the idea that empathy can be understood as a structure of constructs and intra- and inter-personal processes. He further is of the belief that empathy likely is seen quite differently by clients than by extant theory as suggested by the work of a few qualitative researchers (e.g. Bachelor, 1988; Myers, 2000, 2003; Brodley, 2002).

Another key role of the researcher in qualitative research is to maintain both sensitivity and objectivity (Strauss & Corbin, 1998). Objectivity refers to the researcher's ability to remain open to what the participants say. Strauss and Corbin

suggest a number of approaches to maximizing objectivity, including stepping back and understanding what the participants are really saying, obtaining multiple perspectives of the phenomenon under scrutiny, and maintaining an attitude of skepticism. These positive properties are attained, in large part, through adherence to the methods described below in the "coding process" section. Maintaining sensitivity, on the other hand, can be seen as an addition to utilizing methods to increase objectivity. Strauss and Corbin suggest doing this by using literature as well as the professional and personal experiences of the researcher. These sources add context and can stimulate thinking about relationships between concepts when thinking about the patterns that evolve from the data. However, it should also be remembered that one should not include these sources of sensitivity as parts of the data. These sources of understanding can be kept separate by comparing what the researcher thinks he sees in the data, with what the data shows at the property and dimensional level (Strauss & Corbin, 1998). Maximizing sensitivity while maintaining objectivity, is one useful way of thinking about qualitative research that adheres to the grounded coding approach. As the researcher is the measuring instrument, the researcher should be as sensitive and objective as possible since we strive for both complete and accurate information to more fully understand the phenomenon under scrutiny.

Appendix E: Meaning Units

Meaning units are sentences, paragraphs, or fragments of paragraphs, that constitute a unit of meaning, i.e., “content shifts such as different situations, thoughts, and feelings” (Bachelor, 1995). Levitt and colleagues (2006) found that two raters had an agreement rate of 84 % (Cohen’s Kappa = .71) across 111 units and concluded that.meaning units can reliably be identified.

Appendix F: Meaning Units by Category (Tables 2a through 4c)

Table 2a.
Client perceived types of empathy: Cognitive attunement (n=9, 61 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Cognitive attunement	3	4
Utility specific to cognitive attunement	1	1
Utility of dialoguing back and forth	3	5
Description of empathy in the moment	5	13
Tuning In	2	2
Being seen	3	4
Client experiences therapist as with him	2	4
Not being seen	1	1
Therapist in client's shoes	1	1
Established rapport masking empathy process	2	5
Meeting pace of client	4	4
Therapist elaboration on Client's utterance	1	1
Clarifying through tuning in	3	3
Empathy as tuning in	1	1
Therapist matching Client's speed	2	2
Therapist gently pushing own agenda, lack of direct connection	1	1
Therapist moving client toward further exploration	3	3
Walking with in intimacy	2	2
Lack of reasonable interaction may lead client to self-doubt	1	1
Not being understood	2	2
Only behavioral learning without relationship	1	1

Table 2b.
Client perceived types of empathy: Emotional attunement or focus (n=9, 80 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Description of empathy in the moment	2	3
Client identifies empathic connection	1	2
Client describes how therapist need not have same experience to offer help	1	1
Definition of emotional empathy - possible shared experience	1	1
Definition or understanding of emotional empathy	1	2
Emotional attunement moment to moment	2	2
Intensity of emotion expressed by therapist	4	6
Limited shared experience no hindrance	1	1
Shared experience	3	9
Therapist analogue emotional experience	1	1
Therapist emotional understanding of client	5	10
Therapist sharing own experience	2	2
Therapist tears up regarding client material	1	1
Therapist tuning into Client in the moment	3	3
Therapist tuning into Client's feeling in the moment	4	5
Therapist using own experiences to tune into client's	1	1
Lack of emotional connection to therapist	1	1
Lack of emotional connection, meaning	3	13
Lack of emotional empathy leaves client alone and bewildered	1	1
Limits of therapist actions in being empathic	5	8
Therapist just acting as if listening - leaves client unsafe	1	1
Therapist limited emotional awareness or engagement	1	4
Therapist making listening noises. Rupture	1	1
Therapist unemotional hinders client's process	1	1

Table 2c.
Client perceived types of empathy: Reverse empathy (n=7, 30 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Biderectional emotional attunement	2	4
Client empathetic with therapist	1	1
Client attuned to therapist emotional need	3	5
Empathy is relational	3	3
Therapist apparent investment furthers process	3	8
Therapist listening means therapist cares	2	4
Therapist crying	1	1
Therapist likes me, maybe	2	3
Client identifies therapist struggle with relationship	1	1

Table 3a.
Client perceived relationship with therapist: Therapist private persona (n=8, 42 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Client-therapist similarities or differences	2	5
Crush on therapist	1	2
Difficulty enhances relationship	1	1
Relational aspects	1	3
Therapist willingness	3	12
Therapist effort	3	5
Therapist remembers it all	3	3
Therapist likes me – maybe	2	3
Therapist seen as sincere due to remembering	1	1
Therapist self-disclosure	5	7

Table 3b.
Client perceived relationship with therapist: Therapist professional persona (n=9, 33 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Can I trust relationship since it is a therapist	3	3
Client explores peculiar relationship	2	2
Distraction is comforting because normal	1	1
Professional closeness	1	1
Quality of relationship due to therapist trappings	2	2
Therapist good will through professional role	1	3
Therapist professionalism assumed	1	1
Therapist self-disclosure and privacy	2	2
Therapist values valued	1	3
Therapists lack of experience hinders empathy	1	1
Therapist's pressure to perform	1	1
Trappings of therapy	6	8
Trust based on trappings of prof role	2	3
Would we be friends	2	2

Table 4a.
Client perceived utility of empathy: Client ego-support (n=9, 127 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Awesome to be seen	1	1
Client feels confirmed	2	2
Client feels understood	1	1
Comfort in disclosing	4	9
Empathy process seen as lack of trust	1	1
Empathy suggests support and sincerity to client	1	1
Internalized voice of therapist related to empathy	1	1
Loss of attunement during ego-support feel better	1	1
Nurturant attunement, attentive, supportive, secure	3	4
Shared emotion shows client she is understood	1	1
Therapist aloofness hinders client risking emotionally	1	1
Therapist empathic verbalization adds to clients confidence	1	1
Therapist empathy allows for in-session soothing	1	1
Therapist filling needs, reassurance, friend, self-image	3	3
Therapist is with you and on your side	1	1
Therapist responsive to client needs	3	18
Trust and empathy	4	11
Clients Interpersonal insecurities	2	2
Close attunement leads to trust	3	3
Empathy furthers trust	1	1
Empathy is how you demonstrate you care	1	1
Empathy is how you show you care	4	11
Empathy shows that Therapist cares about client	1	1
Empathy-based help improves relationship	4	11
Empathy-based relationship tied to treatment process or utility	3	5
Empathy-based trust begets openness in therapy	1	2
Lack of empathy leads to unhelpful focus	1	1
Process of attunement seen as caring leading to appreciation, trust, openness, better process	1	1
Shared emotion brings them closer	1	1
Shared emotion increasing in session atmosphere	3	6
Shared laughter	2	3
Therapist crying	1	1
Therapist genuine	2	4
Therapist genuineness	1	5
Therapist listening means Therapist cares	2	4
Therapist personal involvement through empathic process improves relationship	4	6

Table 4b.
Client perceived utility of empathy: Therapy process (n=9, 55 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Attunement allows for accurate understanding	1	1
Attunement allows for better process	1	1
Clear utility of therapy little effect on relationship without connection	1	1
Close attunement allows for emotional guidance	1	2
Empathic attunement allows for good process	1	1
Empathic connection likened to a mirror	2	2
Empathy (understanding) is prerequisite for accurate therapy process	2	8
Empathy allows for checking in	1	1
Mood management by therapist	3	5
Previous therapist genuineness	1	1
Relationship between empathy and therapeutic effect	5	14
Therapist apparent investment furthers process	3	8
Therapist asking many questions is part of healing	3	5
Therapist skill allows for greater utility which in turn leads to a better relationship	4	4
Transparency vs. emotional connectedness vs. orientation	1	1

Table 4c.
Client perceived utility of empathy: Client self-understanding (n=8, 22 M.U.s)

Meaning Unit Descriptor	n	M.U.s
Empathic exchange helps clients understanding	4	4
Empathy as holding hands, walking with	1	1
Empathy furthers narrative development	4	10
Empathy furthers narrative process	2	2
Enhancing narrative, other	1	1
Relationship strengthened through meaningful interpretation	1	1
Teach a man to fish	1	1
Therapist empathy furthers client understanding	1	1
Therapist leading client	1	1

Appendix G: Sample-size Estimation

Size estimation of nonprobabilistic and purposive samples is complex (Guest, Bunce & Johnson, 2006). Few authors have given recommendations for sample size, yet to be able to estimate a final sample size is of importance to researchers who need to seek funding and establish firm time-lines for completion of the study. It is of similar importance for dissertation writing graduate students who are time-delimited by funding and are under personal and professional pressures to complete within a certain timeframe.

The number of participants to be included in the present study was determined through the established process (Glaser and Strauss, 1967) of continuing data-collection until the developing model became theoretically saturated. The term "saturation" refers to whether the model has become well-defined and whether each new portion of data adds further to the model (Rennie, 2006). Saturation of the model is a key deciding factor of sample size and indicates when to stop further interviewing. Saturation occurs when no new and relevant data in establishing categories emerges, the categories are well developed in terms of properties and dimensions that demonstrate variation, and the relationships among categories are well established and validated (Strauss and Corbin, 1998). At the point when further data no longer adds to the complexity and depth of the model, three more interviews were completed to reduce the likelihood of premature termination.

Estimates of sample size can be established based on recent research literature utilizing similar methodology and complexity of the constructs under investigation. Levitt (2001), in examining silences during psychotherapy, and utilizing both video-

assisted process recall and grounded coding methodologies, included 7 participants. More recently, Levitt, et al. (2004) included 9 participants in their qualitative research of transformational experiences in psychotherapy; they also utilized a grounded theory approach. Henretty, Levitt and Mathews (2008), utilizing audio assisted recall and grounded coding methodologies included 10 participants. Table 5 indicates an estimated sample size for the research project through summarizing pertinent information from the Journal of Psychotherapy Research and the Journal of Counseling Psychology. A search for "grounded theory" was performed within these journals, and all articles utilizing grounded theory and focusing on therapy process research are included in the table.

Table 5.
Sample size estimation based on extant literature

Author	**Jour-nal**	**Construct studied**	**Interview**	**Data Analysis**	**Sample size**
Frontman and Kunkel (1994)	JCP	Psychotherapists' construals of success in the initial therapy session	Mailed open-ended questionnaires	Grounded Theory (Strauss, 1987; Rennie, Phillips, & Quartaro, 1988)	N=69
Rennie (1994)	JCP	Clients' deference to the psychotherapist	IPR using video or audio recordings of sessions	Grounded theory (Glaser & Strauss, 1967; Rennie, 1994)	N=14 (saturation at 14)
Watson and Rennie (1994)	JCP	Client's experience of exploring problematic reactions in therapy	IPR1 using video-recording of session	Grounded theory (Glaser & Strauss, 1967; Rennie, 1994)	N=8

Table 5: continued.

Levitt (2001)	PR	Categorization of clients' pauses/silence in session	IPR using video-recording of session	Grounded Theory Analysis (Glaser & Strauss, 1967, Rennie et al., 1988)	N=7 (ended when dense)
Ward (2005)	JCP	African Am. clients' assessment. of safety and efficacy in therapy	Unstructured interviews	Grounded theory (Glaser & Strauss, 1967; Charmaz, 2000)	N=13 (saturation at 13)
Levitt, Butler and Hill (2006)	JCP	What clients find helpful in psychotherapy	Semi-structured exploratory interviews after therapy termination	Grounded theory (Fassinger, 2005, Glaser & Strauss, 1967, Rennie, 2000)	N=26 (saturation at 21)
Abba, Chadwick and Steven-son (2008)	PR	Client experience of the application of mindfulness to disturbing psychotic experiences	Qualitative interviewing, both in groups and individually	Grounded theory (Glaser & Strauss, 1967)	N=16 (Saturation at 13)
Willliams and Levitt (2007)	PR	Expert therapists' conceptualization of enhancing agency in session	Interviews using open-ended and non-directional questions	Grounded theory (Glaser & Strauss, 1967; Rennie, 2000)	N=14 (saturation at 10)
Henretty, Levitt, Mathews (2008)	PR	Clients' experiences of moments of sadness in psychotherapy	IPR1 using audio-recording of session	Grounded Theory analysis, (Glaser & Strauss, 1967, Rennie et al., 1986)	N=10 (ended at saturation)
Van Vliet (2008)	JCP	Client process of bouncing back from shame experiences	Open-ended qualitative interviews	Grounded Theory (Glaser & Strauss, 1967; McLeod, 2001)	N=13 (ended at saturation)

Table 5: continued.

Williams and Levitt (2007)	PR	Client's experiences of differences with their therapist	IPR1 using audio-recording of session	Grounded Theory analysis, (Glaser & Strauss, 1967; Rennie et al., 1986)	N=12 (saturation at 8)
Daly and Mallinckrodt (2009)	JCP	Therapists' approach to *therapeutic distance* with attachment avoidant clients	Interviews following stimulus vignettes	Grounded theory (Strauss and Corbin 1998; Fassinger, 2005)	N=12 (Saturation at 10)

All research projects included in the above table have sample sizes between 7 and 26 (when excluding Frontman and Kunkel's (1994) article which relied on mailed, open-ended questionnaires and did not utilize standard procedures to limit the sample-size). Furthermore, when the construct under investigation is specific and limited, as in Levitt's (2001) article focusing on silences during sessions, the sample size is similarly smaller. Conversely, when the construct is broad and diffuse, as in the Levitt, et. al.'s (2006) study focusing on what clients find helpful in therapy, the sample-size increases.

In locating the present study's likely sample size within this continuum of complexity, it was important to draw attention to two aspects influencing this matter. The first one was that the concept of empathy is complex, the concepts within the construct are varied and many, and their qualities and interrelatedness was not well understood. This state of affairs indicated a sample size equivalent to the upper end of the spectrum, perhaps as high as twenty or thirty.

A second consideration, which reduced the estimated sample-size, should similarly be discussed. In further examining the articles mentioned in the above table, the differences in the constructs under investigation, was also dependent upon apparent

clarity of the topic. The present study strived to clarify the specific areas it wished to explore, and more importantly, the limits of these explorations. Relying on extant theory and research has allowed us to substantially limit the focus of the investigation, which reduced the number of subjects needed to reach saturation.

A recent Sage publication addressed the issue of establishing guidelines for researchers regarding expected sample sizes (Guest, Bunce and Johnson, 2006) and supported the notion that, in many cases, anywhere from six to twelve respondents would likely uncover nearly all the themes that would otherwise appear if the sample was increased substantially. Such numbers, they warned, are guidelines, and depend on a number of qualities of the research, most notably the complexity of the construct under investigation, as well as the model of research undertaken. For instance, they suggested, if the sample is heterogeneous, the data quality is poor, or the domain of inquiry is diffuse or vague, then the numbers needed to validly capture the construct in question would grow.

The purpose of data collection was to generate enough data to identify and establish patterns, concepts, categories, properties, and dimensions of the phenomena under investigation (Glaser & Strauss, 1967). When this goal is achieved, there is no reason to continue data collection. As mentioned, the point at which data-collection is terminated is often determined by the fact that little or no new meaningful data appears during three interviews. Additionally, the point of data-collection termination is established when a) the constructs under investigation have been developed in terms of dimensions and properties and demonstrates variation, and b) the relationships between

categories are well established and validated (Strauss and Corbin, 1998). To elaborate on this point, the specific constructs discussed in the problem formulation will act as a guide for when the model has become dense as they are expected to be elaborated on according to the above mentioned guidelines. Finally, it is anticipated that the construct will be described as being connected in different ways to other constructs under scrutiny. As an example, do clients consider being understood as directly curative, was it useful in allowing them to further develop their understanding of themselves, was it important in establishing a safe environment for development in other ways, are all areas that were elaborated upon. For a developing model to be considered dense, similar connections between constructs, as well as the elaboration of qualities of such constructs, would need to be established.

However, one of the aspects on which sample size rests, is the scope of the research question (Morse, 2000). Strauss and Corbin (1998) recommend narrowing the focus of research questions after three or four interviews, if indeed the scope proves to be well beyond time and financial limits of the research project. Similar solutions have been proffered in response to a number of other aspects influencing sample size. Hence, concerns related to an increased sample size due to the nature or sensitivity of the phenomena under investigation, can be alleviated through a focus on the expertise and training level of the interviewers (Morse, 2000). As an example, if the topic under investigation is of a particularly sensitive nature, the interviewer needs to be well versed in creating a safe and trusting atmosphere at the outset of the interview.

The expertise of the interviewer will further influence the sample size and length of interviews (Strauss & Corbin, 1998). Researchers with greater expertise in the area under investigation and strong interviewing skills gained through practice, will be able to focus on the topic under investigation while motivating the respondent to continue to explore their personal phenomenological experiences that are relevant. The expertise brought to the interviewing process by the interviewer offers a risk of determining the data collected, hence the preconceived knowledge of the material under investigation must act only as a guide and not a hindrance.

Appendix H: Interview Excerpts (Tables 6 through 13)

Table 6.
Examples of cognitive empathy

ex.	Transcript excerpt
ex. 1	Yeah, because if I say something about how I feel, then she will say it back to me and word it in like a simpler way, maybe just in a different word choice, and then that can click with me and I can realize what I said.
ex. 2	She doesn't use a monotone which a lot of them can do. She looks at me and she makes me feel like she is actually listening to me, that she understands what I went through, that she understands how difficult it is for me to actually talk about this situation. I've never had that before and it's just amazing.
ex. 3	That she would have felt the same thing [if the therapist had experienced what the client had]. As opposed to just being someone on the outside looking in she really makes me feel like she, even though she never did experience something like it, she can really empathize with how I feel.
ex. 4	When I use that [describing why he used "holding hands" with therapist] I meant assisted, not even guided, but walking *with*, getting to the solution *together*. Yeah, I think there is an intimacy between a patient and a therapist.
ex. 5	It's like we are like this (folds hands together) I can talk to her.
ex. 6	They are trying to learn -- they do have supervisors who are older and have probably gone through things. That doesn't bother me at all, that they are not old enough, that they haven't experienced so many things. Because then I try to switch my experience to scientific, you know. [...] But for her to totally understand what I am experiencing, I just don't think she does.
ex. 7	I think on the top of it is, it's getting feedback, we are used to getting feedback, like being able to read when people are thinking, and so when you're not given anything to read, it just gets to be uncomfortable. And it's almost, and I start wondering am I wrong, did I do something wrong, like, uhm, is this a response to me, or like what is going on.

Table 7.
Examples of emotional empathy

ex.	Transcript excerpt
ex. 1	Well, she knows a lot about what I am feeling because of her own similar experiences, she had the same feelings, you know. Anybody, parents, grandparents, anybody gets down like this, you feel helpless. I think she felt the same way with her situation, she's got a pretty good feeling about where I am at right there.
ex. 2	I did tell her that it upset me that there is nothing I can do. You hate to see someone there and you can't help 'em. Some people say, yeah, I know exactly how you fell, but if you haven't been in a certain situation, you don't know. You might think you know, but, it not being your relatives lying there, you don't know.
ex. 3	She, uhm, she in one of our very first sessions I was talking about something really intense, and I could tell she was teary eyed and she started to cry and I started to cry and I think, that from that, that was really early on, and so I felt she was really empathetic the entire time, and maybe some people misconstrue that, but I feel like she is just human, really human, and she makes herself really human to her clients.
ex. 4	Interviewer: She is picking up on the feeling of frustration, and I like how you put it, that she giggled a little bit, or laughed about it a bit, but it wasn't ridiculing laughter, it was not as if she was laughing *at* you, she was laughing a little at, perhaps, the discomfort of having a strong emotion. Respondent: yeah. Interviewer: ... like having had the experience herself. Respondent: Yeah. Like I do that myself sometimes.
ex. 5	Her saying it that way, that is definitely comforting. It's just that like, you know, [paraphrasing the therapist:] "I am going to, you know, I am obviously not in a bad mood, you are obviously feeling horrible, you know, so I am going to sit down here with you, and I am going to feel a little bit bad too."
ex. 6	Interviewer: You've never been late for an appointment or she has been peculiar in a session taking place (no) or shown much of herself, say about the way that she thinks, to give you any kind of insight about her character, her personality? Respondent: And that's why I didn't think I could describe her to you… I don't have anything…

Table 8.
Examples of client attunement

ex.	Transcript excerpt
ex. 1	Obviously she wants to help people, otherwise she wouldn't be doing this in the first place. Yeah, I don't think it's particularly my individual problem with this. She is interested in learning how to teach people, how to deal with their problem, that's what she is doing with me.
ex. 2	…she wants to get to that point because she wants to know why something upset me so badly. I don't even understand a lot of it, you know, she has to get to that core, but the more I get upset, I can see her backing off, and part of her, I think is taking it in: "ok, this really upset you, how am I gonna deal with that?" That's just the way I envision it, you know.

Table 9.
Examples of the relational context of empathy: Therapist private persona

ex.	Transcript excerpt
ex. 1	She is real, she knows I have a good bullshit detector in me, she doesn't pretend, you know. And I think she does, you know, put in a lot of effort, and it demonstrates to me that she, the fact that she thinks about me after we have our session, or like expresses having a similar experience to mine, or just the things that she recalls, it seems she does care about me.
ex. 2	Well it [therapist attuning efforts] automatically makes you feel, uhm, you know, connected with them, it's like they're your friend, kinda, you know what I mean?
ex. 3	It's almost like she's a friend but not a friend; I know I am going in there for specific reasons, but yet she treats me like a person which a lot of them don't do.
ex. 4	She really cares. She is not just going to school to be somebody to make money. She wants to help you. And it feels like when we are in there, it's just her and me, and there is nobody else in there. In the back of her mind she is thinking about how we can handle things and what we can do.

Table 10.
Examples of the relational context of empathy: Therapist professional persona

ex.	Transcript excerpt
ex. 1	I think it would be nice [if therapist self-disclosed] but I also understand that, you know, this is her job basically. You know, I don't know why she has never told me anything about herself; I never really knew about [previous therapist] either.
ex. 2	I mean, there are sessions where I ask her for a hug and she gives me one.
ex. 3	Because I think the nature of the business is, like I said, you do care about people, you want to look after their well-being, and you're willing to do this personally. I mean, why would you be a doctor if you don't want to help people. You know. So it's in your nature as a psychiatrist or psychologist, because that's what you want to do.
ex. 4	Maybe part of it is me making up the [therapist] I want within an hour. You know, because she doesn't give a lot of herself. There is a little part she gives, and I think that I catch that.

Table 11.
Examples of client perceived utility: Client ego-support

ex.	Transcript excerpt
ex. 1	I think I just felt like, uhm, I felt like she had no, she had let down the facade of objectivity. I felt like she felt like there is no such thing as objectivity, and I felt she was really human and things make us cry, no matter how hard we try to swallow that, you know, the physical reaction of being alive, you know.
Ex. 2	…but sometimes she does talk about herself to help me relate to her, and I think that has really made me feel like I have more trust in her.
ex. 3	Yeah, I trust her. I was able to open up with her in a way I could never do with other people, and that makes you feel good. that makes you feel like, hey she is listening to me, she is trying things to actually help me get through this so that I can approach the rest of my life with more security, with more happiness, where I didn't have any before. She actually cares.
ex. 4	Her mind doesn't wander, when she is in a conversation with you she's in a conversation with you. That's why I say, I trust [therapist's name], she is very professional. When she has a conversation with you she is in the session.

Table 12.
Examples of client perceived utility: Enhancing therapy process

ex.	Transcript excerpt
ex. 1	She doesn't make it small. This is a large part of my life. It has affected my life, my whole life, and she wants to be able to get as much closure as possible, while also realizing that it will never go away. And we are working on the tools to help me accept it -- to not think about it as much – and to not have it depress me as much, so she is really onboard with what I need.
ex. 2	As far as, was she helping me, moving us along, asking the right questions, she was. You know -- her job there compared to my job there -- you know -- we were both in similar situations, and just one of us couldn't start moving quicker, and so she was moving at my same pace, you know, and I am still, you know, we are slowly back and forth, moving forward.
ex. 3	She is questioning me and questioning me; then I got to a point where she pulled her chair over and held my hand. I think that's when the empathy really kicks in because she gets to a point where she knows she can't keep questioning me because I am so upset now that she uses a more gentle approach.

Table 13.
Examples of client perceived utility: Client self-attunement

ex. (ID)	Transcript excerpt
ex. 1	If I say something about how I feel, then she will say it back to me and word it in like a simpler way, maybe just in a different word choice, and then that can kinda click with me and I can realize what I said… And she will then wait for my response to that and then maybe I'll then move from there… It's just somehow tweaked or different and it somehow strikes a chord, a little bit.
ex. 2	I feel that's because I don't understand why I feel this way. I don't feel she is questioning herself, she is questioning me. So I think she understands the things that I don't understand. […] Like when she said that I am saying contradicting things, I think she stops me there not because she is confused, but because I am confused.
ex. 3	It's the relationship [with the therapist] that I'm starting to value. I found that interesting. I never even saw that until [the therapist] is like:" I can understand that perfectly". And I was like: "how?" But she plays it back to me, and I was like: "yeah, it does, that perfectly makes sense."

Appendix I: Literature Review of Empathy Research and Previous Taxonomies

Researchers have attempted to understand and measure the construct. Barrett-Lennard (1962), using a 7-point scale (Barrett-Lennard Relationship Inventory; the BLRI) included assessments of the extent to which the therapist is seen as empathic, congruent, prizing, and accepting of the client (following Rogers, 1957). Truax's Accurate Empathy Scale (AES; Truax & Carkhuff, 1967), also designed to measure Rogers' (1957) conception of accurate therapist empathy, measures whether responses from the therapist detract from the client's verbal expression, are interchangeable with it, or add to it in a way that reflects emotion. More recently, Lister's scale (Hargrove, 1974) attempted to measure eight aspects: internal frame of reference, perceptual inference, accurate perceptual inference, immediacy, emphasis on personal perceptions, use of fresh words, appropriate voice, and pointing to exploration. Elliott and colleagues (1982), expanded on Cochrane's (1974) scale, measuring 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 equality, exploratory manner and impact facilitation versus blocking, and distraction. In doing so they have addressed a number of the shortcomings of the previous scales, and have come closer to measuring the multi-modality of empathy as theoretically suggested (e.g. Barrett-Lennard, 1981.) Finally, a recently developed scale, the Measure of Expressed Empathy (MEE; Watson, 1999) measures expressivity, concern, warmth, moment-to-moment attunement, appearance (e.g. eye contact, looking bored), and responsivity, as well as the extent to

which these additional aspects of communication are congruent with the verbal content and apparent emotional content of the client communications.

Theorists and researchers have lamented the complexity of the empathy construct (e.g., Duan and Hill, 1996; Bohart and Greenberg, 1997; Watson, 2001; Bohart, et al., 2002; Bachelor, 1988; Kerem, et al., 2001; Wynn and Wynn, 2006). Greenson (1960) emphasized the importance of the emotional aspects of the empathic experience, Batson and Shaw (1991) indicated that the vicarious emotion of the therapist is only congruent with the emotion of the client, and Davis (1994) spoke about both "parallel" and "reactive" affective outcomes in further detailing the inaccuracy of the therapist's affective experience. Furthermore, Schafer (1959) suggested that the inner experience of sharing and comprehending the momentary psychological state of another person is a process with equally important cognitive and affective aspects.

Qualitative research has begun exploring empathy from the clients' perspective, and have found differing categorization schemes (see addendum A). Bachelor (1988) identified four areas or types of empathy: a. that the clients experience feeling understood (cognitive), b. that they experience the therapist as partaking of the same feeling as them (affective), c. that the therapist discloses personal experiences relevant to the clients' experiences (sharing), and d. that the therapist provides an attentive, supportive and secure presence (nurturant). She went on to suggest that, since the 52 respondents indicated only one of each of these categories, it was reasonable to suggest that empathy should not be conceived of as a global, unidimensional construct, instead suggesting client types as a potential explanation for the findings. Eight out of the 9 respondents in

the present study confirmed experiencing all 4 types of empathy identified in this study (two of these were not coded as discreet types of empathy in the present study; one was coded within the core category of utility instead (nurturing) and one was included within the existing emotional empathy type (therapist sharing own experiences), and as such suggested variations in individual client's experience of empathy. Furthermore, though Bachelor (1988) described having a small number of clients in her study (2 of 52) verbalize the experience of the nurturant style of empathy (helping client feel safe, supported, comfortable), this was a commonly expressed reaction to client-therapist work in the present study; for instance, all clients (N=9) in the present study expressed appreciation for therapist efforts in establishing a secure and safe environment for them to work in. When clients are asked specific questions about their reactions to the utility of empathy, nurturance was a common construct for clients to discuss.

Appendix J: Literature Review Regarding Utility of Empathy

Early in psychotherapy's history, Freud (1924) discussed the utility of maintaining a suspended and even-hovering attentional and listening attitude in therapy, allowing the clinician to understand the client through what he termed identification. Greenson (1960) took up the topic of empathy which he considered critical to a successful implementation of psychoanalysis, describing therapist insight, organization, and direction in the client's therapeutic process, as areas of empathic utility. Rogers (1959) explored empathy as a key factor of a therapy intended to offer an atmosphere of acceptance, and through this acceptance allow the clients to more readily be open to new ways of thinking and behaving. Rogers (1980) further suggested that empathy allows for the best window into the client's psyche, "in all its complex mystery" (p.50). Kohut (1959), made an even stronger argument for the information gathering utility of empathy as he suggested it stands alone with introspection in making psychological material available to the observer.

Besides being significantly one-sided in their attention to the therapist intrapersonal processes, these theorists elaborated on a number of important aspects of the use of empathy in the therapy setting. To them, empathy took place within a dyadic relationship, was dependent on both parties (at least partially), and was important for the ongoing uncovering of new ways of thinking about the client. Furthermore, empathy allowed for closer contact between client and therapist and this contact was either directly curative or necessary for the curative process to take place.

Bachelor (1988), in a qualitative examination of open-ended responses by 52 participants, suggested that effects of empathy could be classified into those that were 1) client-related, 2) therapist-related, and 3) global effects. The third group encompassed general statements reflecting the importance of empathy, the helpfulness of therapy, and the utility of therapy in the client's life. In discussing the client self-related benefits of empathy, Bachelor (1988) suggested further classification into 3 sub-groups: 1) specific therapeutic effects, 2) client distress-reduction, and 3) client "narcissistic" gains. Effects that are seen as directly therapeutic were therapist empathic activities promoting client self-understanding, self-disclosure, and self-reflection, but also as leading to helpful counsel, and contributing to better functioning and progress in therapy. Effects that were seen as falling into the "distress-reduction" category spanned client statements about alleviation of problems, as well as relief and consoling effects. Finally, the category of "narcissistic" gains covered gains related to self-acceptance, self-confidence, self-esteem, and self-respect. This category further covered statements related to empathy as proof that the therapist was considerate, cared about them, was warm and supportive, and created a space where the client could feel understood.

The second group, therapist-related effects of empathy, covered items that were estimated to not be directly therapeutic but where related to their relationship with the therapist. These were effects such as feelings of closeness, attachment and friendship with the therapist, as well as increased trust and gratitude toward the therapist. The effects, then, as seen from the clients' point of view and according to Bachelor's study, may be primarily person or process related. The clients appeared to focus on the utility

of therapy (what they are there for), and the effects of empathy that can further the process of therapy. In this sense, Bachelor's (1988) categories, as outlined above, can be seen from Greenberg and Elliott's (1997) point of view. In discussing the quality of empathic communication – the range of communication performed by the therapist which has a goal of communicating to the client that the therapist is attuned – Greenberg suggests the type of empathic communication is determined by the therapist intentions of which he suggests two broad categories: 1) intent to create an accepting, supportive environment, and 2) intent to promote exploration and growth. As these two categories were quite broad, they captured all of Bachelor's suggested examples. Similarly, Barrett-Lennard (1981) suggested that received empathy has a healing and growth-enhancing effect, as described in this and previous sections. A number of researchers have been involved in an ongoing debate of the utility of empathy and client-centered approaches. From the clients' point of view, high empathy attunement periods in therapy have been found to fall into the following three categories: 1) insight into oneself, 2) having the opportunity to and risking talking about personal issues, and 3) searching together (Vanaerschot, 1997). These typologies offered a jumping off point for the present discussion of the classification of empathic utility.

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