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Empathy from the client's perspective: A grounded theory analysis

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Abstract

Although empathy is one of most robust predictors of client outcome, there is little consensus about how best to conceptualize this construct. **Objective:** The aim of the present research was to investigate clients' perceptions and in-session experiences of empathy. **Method:** Semi-structured, video-assisted interpersonal process recall interviews were used to collect data from nine clients receiving individual psychotherapy at a university psychology clinic. **Results:** Grounded theory analysis yielded a model consisting of three clusters: (1) *relational context of empathy* (i.e., personal relationship and professional relationship), (2) *types of empathy* (i.e., psychotherapists' cognitive empathy, psychotherapists' emotional empathy, and client attunement to psychotherapist), and (3) *utility of empathy* (i.e., process-related benefits and client-related benefits). **Conclusions:** These results suggest that empathy is a multi-dimensional, interactional process that affects—and is affected by—the broader relationship between client and psychotherapist.

Keywords: empathy; qualitative; grounded theory; interpersonal process recall

Empathy is more strongly correlated with outcome than perhaps any other variable studied in psychotherapy research (Wampold & Imel, 2015). Nevertheless, empirical attention has shifted away from empathy over the last 30 years and has moved increasingly toward other psychotherapy constructs, like the therapeutic alliance. This decline in empathy research has been attributed to the ambiguity that remains about the empathy construct (Bohart, Elliott, Greenberg, & Watson, 2002; Duan & Hill, 1996). A plethora of definitions have been advanced (e.g., see Barrett-Lennard, 1981; Buie, 1981; Greenberg, Watson, Elliot, & Bohart, 2001; Rogers, 1980; Truax & Carkhuff, 1967; Watson, 2001); yet, there appears to be no consensual definition of empathy in psychotherapy (see Bohart & Greenberg, 1997; Elliott, Bohart, Greenberg, & Watson, 2011; Gibbons, 2011).

Client's Perspective

To elucidate the empathy construct, it would make sense to initiate an approach from the client's perspective because, as noted by Duan and Hill (1996), what

ultimately matters in psychotherapy is the client's experience. Clients seem to understand empathy differently than psychotherapists and researchers, as evidenced by relatively weak correlations between client-rated empathy and psychotherapist—and observer-rated empathy (Greenberg et al., 2001). Moreover, there is some evidence that client-perceived empathy is a better predictor of outcome than psychotherapist—and observer-rated empathy (Barrett-Lennard, 1981; Elliott et al., 2011). These findings underscore the importance of systematically studying the empathy construct from the client's point of view (see also Olivera, Braun, Penedo, & Roussos, 2013).

Qualitative Research

A powerful, yet underutilized approach for illuminating clients' perceptions of empathy is qualitative study (Duan & Hill, 1996; Hill, Chui, & Baumann, 2013; Roussos, 2013). Qualitative methods are capable of accessing the richness of the client's phenomenological experiences (Morrow, 2005; Ponterotto, 2005; Rennie, 2002) and are especially

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valuable when the construct of interest is poorly understood or ill-defined, as is the case for the empathy construct. Despite the promise of this approach, there are only a few qualitative studies (Bachelor, 1988; Brodley, 2002; Myers, 2000; Wynn & Wynn, 2006) that have explored clients' perceptions of empathy.

By analyzing exchanges between clients and psychotherapists, both Brodley (2002) and Wynn and Wynn (2006) determined that empathy might be interactionally constructed. Their results indicated that empathic engagement entailed at least a two-turn exchange, with the psychotherapist's expression of empathy and the client's reception of it (Brodley, 2002; Wynn & Wynn, 2006). The clients' receipts of empathy took different forms, including nonverbal behaviors (e.g., nods of acceptance), brief utterances (e.g., "uh huh," "yeah," and "right!"), and more elaborate utterances to verify the empathic understanding (Brodley, 2002; Wynn & Wynn, 2006). Brodley (2002) noted that after such receipts of empathy, clients frequently returned to their narratives or engaged in additional self-disclosure. Wynn and Wynn (2006) highlighted the conversational failures that resulted when the client did not acknowledge the psychotherapist's expressed empathy. Findings from these two qualitative studies dovetail with Barrett-Lennard's (1981) theory that empathy is a multi-phased, interactional process.

Although investigations by Brodley (2002) and Wynn and Wynn (2006) have clarified the client's role in the empathic process, studying client–psychotherapist exchanges may have limited their access to the client's point of view and internal experiences. Other data collection methods, like free-response questionnaires and interviews, would likely have yielded a richer understanding about the client's perceptions of empathy (see Olivera et al., 2013).

This was the approach taken by Bachelor (1988), who administered a free-response questionnaire asking clients to describe "... a situation in which your therapist was empathic toward you." Bachelor (1988) reported that of the 27 participating clients, 44% perceived their psychotherapist's empathy as *cognitive* (i.e., psychotherapist recognizes the client's experience, state, or motivation), 30% as *affective* (i.e., psychotherapist feels what the client is feeling), 18% as *sharing* (i.e., psychotherapist discloses personal opinions or experiences relevant to client's communication), and 7% as *nurturant* (i.e., psychotherapist's supportive, security-providing, or totally attentive, presence). Evidence for distinct cognitive and affective styles was also obtained in the aforementioned Wynn and Wynn (2006) study,

although a qualitative investigation with non-client participants (Kerem, Fishman, & Josselson, 2001) indicated that affective empathy almost always involves cognitive empathy (but not vice versa). The degree of overlap between cognitive empathy and affective empathy remains unclear and warrants additional research.

Bachelor (1988) also created three categories to represent clients' perceptions about the utility of empathy: *client-related* (e.g., increased self-understanding, self-confidence, and relief from distress), *psychotherapist-related* (e.g., deepening of the therapeutic bond), and *global effects* (e.g., increased appreciation about empathy generally). This categorization scheme should be regarded as preliminary, however, because clients were not specifically asked about the utility of empathy. Rather, clients spontaneously described the benefits of empathy when writing about a situation in which their psychotherapist was empathic (see Bachelor, 1988). In this way, Bachelor's (1988) use of questionnaire data, gathered without the possibility of further clarification, limited the scope and depth of findings.

In contrast, Myers's (2000) open-ended phenomenological interviews (see Seidman, 1991) provided opportunities to immediately elaborate on relevant information and thus her work represents the most thorough and incisive investigation of clients' perceptions of empathy. In this study, two psychotherapists conducted interviews with clients whom they had previously seen for at least 20 psychotherapy sessions. Data from these interviews and from client-prepared written narratives were coded for content by two independent raters. As discussed by Myers (2000), all five participating clients felt empathically understood when their psychotherapist demonstrated attentive listening. The psychotherapist's nonverbal behaviors (e.g., eye contact) were deemed by clients to be critical to the empathic process, which is in accord with quantitative (Dowell & Berman, 2013) and qualitative (e.g., Bachelor, 1988) findings. Clients in Myers's (2000) study also identified instances of misunderstanding, although these misunderstandings were evidently "worked through and subsumed" within a safe and supportive therapeutic relationship (p. 159). In fact, each of the participating clients cited their feelings of safety and trust as contributing factors in their experiences of being heard and empathically understood (Myers, 2000), corroborating Bachelor's (1988) finding of a *nurturant* style of perceived empathy. This notion that empathy can manifest as a "general relationship ambience" (Bachelor, 1988, p. 235) has implications for clinical theory, research, and practice and highlights the importance of exploring the phenomenological experiences of clients.

Present Research

The present research attempted to improve upon past methodologies. A shortcoming of the Myers (2000) study is that psychotherapists interviewed their clients, which likely biased the resulting data. The interviewer in the current research, by comparison, had no previous affiliation with participating clients. Moreover, because previous research employed data collection strategies that were largely static (e.g., questionnaires; see Bachelor, 1988; Brodley, 2002; Wynn & Wynn, 2006), we used a grounded theory design (see Glaser & Strauss, 1967) that entailed cycles of data collection and analysis, where analysis informed the next cycle of data collection. This approach allowed for deeper investigation of the emerging data. Finally, to draw the client's attention to in-session experiences of empathy, a video-assisted interpersonal process recall (IPR; Kagan, 1975, 1984) methodology was employed. IPR is particularly useful when exploring processes like empathy that develop over time (Elliott, 1986).

Areas of inquiry

The goal of the present study was to illuminate how clients perceive the empathy process in a psychotherapeutic context. Three areas of inquiry were formulated: (i) *clients' phenomenological experiences of empathy*, (ii) *clients' interpretations of the psychotherapists' empathic communication*, and (iii) *clients' perceptions of the utility (e.g., benefits and consequences) of empathy*. Following the methodology of grounded coding (Strauss & Corbin, 1998), these areas of inquiry were not considered the final scope of possible findings but served as an organizing framework for data collection and data analysis (see also Knox & Burkard, 2009).

Method

Participants

Clients/interviewees. Nine psychotherapy clients were interviewed for the present study. Clients ranged in age from 21 to 54 years (mean age = 36.4 years). The sample consisted of six female and three male clients. Eight clients identified as Caucasian, and one identified as Hispanic. Three of the clients were undergraduate students, one was a graduate student, and the remaining five were members of the local community. At the time of interviews, the respondents had completed an average of 29 sessions (range: 8–107 sessions; median = 12 sessions).

Psychotherapists. The nine clients were seen by one of eight psychotherapists (one psychotherapist saw two clients) at a psychology department training clinic. All psychotherapists were graduate students in their third, fourth, or fifth year of a clinical psychology Ph.D. program and had at least one year of clinical experience. One participating psychotherapist was male, and the rest identified as female.

Researchers. The first author, a sixth-year doctoral student in clinical psychology, conducted all interviews. A research team was formed to analyze the resulting data. This research team consisted of the first author (Caucasian male), the first author's research advisor (Caucasian male), and two second-year clinical psychology doctoral students (Caucasian male and Asian female).

The first author had experience with the clinical use of empathy through his training program, practica, and internship. His theoretical orientation was mostly informed by client-centered, interpersonal process, and emotion-focused approaches. The first author's advisor was a doctoral-level psychotherapy researcher with a strong allegiance toward common factors theory. The two second-year male graduate students reported an eclectic theoretical orientation.

Procedures

IRB approval was obtained and all ethical standards were followed. This study was conducted in the psychology department of a large Midwestern University.

Recruitment. We first contacted clinical supervisors in the psychology department's training clinic and requested their permission to contact student-psychotherapists under their supervision regarding this study. Three supervisors agreed and provided the names of 12 psychotherapists.

Of these 12 psychotherapists, 2 were not actively seeing clients, 1 declined participation, and another attempted to participate but his/her client declined. The remaining eight psychotherapists participated. These psychotherapists met with the lead author to discuss the study further. Psychotherapists were not given details about the research topic because of concerns that psychotherapists would alter their interaction styles and thus influence the resulting data. Psychotherapists and supervisors were asked to nominate clients with relatively good insight and verbal fluency and who were not exhibiting symptoms of psychosis or suicidality.

Potential client-participants were told that the research would focus on their experience of a psychotherapy session, and that they would receive \$20 for their participation. Potential participants were informed that the most recent videotape of their session would be used during a 2-hr interview to help the clients recall what transpired during the session. Clients were also informed that their psychotherapists would not have access to any information shared during the interviews. In total, nine clients provided informed consent and agreed to participate.

IPR interviews. As this study sought to elaborate on theory regarding psychotherapy process, a video-assisted IPR methodology of interviewing was chosen (Elliott, 1986; Kagan, 1975). In IPR interviews, the interviewer and participant review recorded events together (Elliott, 1986; Kagan, 1975). In this way, IPR interviews have the advantage of reminding participants of specific momentary experiences, thus fostering deeper reflection and discussion. There is considerable evidence that IPR is a powerful approach for accessing the client's thoughts and feelings (Elliott, 1986; Levitt, 2001; Henretty, Levitt, & Mathews, 2008).

In order to increase immediacy of experiential recall, the IPR interviews were conducted in close temporal proximity to the recorded psychotherapy sessions. Eight interviews were performed within 24 hr of the video-recorded session, and all interviews were completed within 48 h of the session.

The first author performed all interviews. The interviews were conducted in person, in a quiet, comfortable, and private room within the same building as the training clinic. The interviews adhered to a semi-structured format and followed recommendations of existing literature (e.g., Knox & Burkard, 2009; Larsen, Edey, & LeMay, 2007). In accordance with Knox and Burkard's (2009) recommendations, the first author constructed an interview outline (**Table I**) that contained primary areas of inquiry and open-ended questions. This outline served as a guide, yet the interviewer remained open and flexible so as to probe the interviewee's responses in more detail (Knox & Burkard, 2009). The interviewer thus encouraged discussion of each area of inquiry of each respondent but also pursued in more depth particular areas that arose for each interviewee (Hill et al., 2005; Knox & Burkard, 2009). While the first interview closely tracked the outline, subsequent interviews were modeled after the outline but included information from the previous interview(s) as well. That is, interviews were based on an iterative process of data analysis and data collection (see

Glaser & Strauss, 1967; Rennie, 2006). All interviews ranged from 90 to 135 min in duration, with the majority lasting about 120 min.

The interviews were video-recorded using a four-channel digital video-recording device, of which three channels were utilized: one channel recorded the interviewer, one channel recorded the interviewee/client, and one channel recorded the replayed video of the psychotherapy session. These video recordings allowed for deeper engagement with the data during the grounded theory coding and analysis process.

Grounded theory data analysis. A grounded theory approach (Rennie, 2002, 2006) was used to analyze the qualitative data collected through the video-assisted IPR interviews. The primary goal of the grounded coding approach is to generate theory, which contrasts with the hypothesis-testing goal of quantitative research. The use of grounded theory analysis within clinical psychology (e.g., Huband & Tantam, 2004; Levitt, Butler, & Hill, 2006; Lilliengren & Werbart, 2005; Morrow, 2005; Rennie, 2002) entails a set of methods to enhance trustworthiness (see Morrow, 2005; Williams & Morrow, 2009). Many steps were taken in the current research to maximize trustworthiness, including adherence to state-of-the-art procedures, utilizing co-researchers, keeping detailed records and memos, and balancing sensitivity with objectivity (see Morrow, 2005; Williams & Morrow, 2009). These are discussed in greater detail below.

Prior to conducting the interviews, the interviewer engaged with existing empathy theory to formulate areas of inquiry and to identify personal assumptions. This in turn allowed the interviewer to bracket his assumptions during the interview process (Fischer, 2009; Hutchinson, 1993). The interviewer encouraged participant elaboration (Seidman, 1991) but attempted to refrain from therapeutic responses (Knox & Burkard, 2009) and opinions that might bias resulting data.

Collected interview data were transcribed into NVivo (2006), a computer program designed for qualitative analysis. Following the recommendations of Fine (1992), the initial phase of the coding process involved deep engagement with the interview data by the first author. This was achieved by reading through the transcripts a sufficient number of times, so that a remembered piece of dialogue could be located instantly (Hsieh & Shannon, 2005; Strauss & Corbin, 1990).

Transcripts were then divided into meaning units (Bachelor, 1995). A meaning unit was created in NVivo by assigning a *free node* to a section of text.

Table I. Outline of initial interview.

1. Introduction
• This study focuses on your empathic experiences in therapy
• We hope you will help us better understand client's inner experience regarding empathy
2. Conceptual framework
• What does empathy mean to you?
• Prompt (as necessary): Empathy can mean that you feel what another person feels. 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.
• More discussion
3. Session Review
• Did you, during this last session, experience that your therapist was really getting you or really understanding you (use respondent's words when possible)?
• Discussion
• Video review
• When empathy identified, stop video for discussion
• Primary areas of inquiry:
(I) Client's phenomenological experiences of empathy
(II) Client's interpretations of the psychotherapist's empathic communication
(III) Client's perceptions of the utility (e.g., benefits and consequences) of empathy

These nodes were then systematically sorted into descriptive categories. The first author used note taking and analytic memos to track themes and to identify biases and assumptions as they emerged (Morrow, 2005).

Credibility and confirmability were further enhanced through interactions with research team members (Morrow, 2005). The first author held weekly meetings with the second author, and several meetings were held with the entire research team. At these meetings, interview transcripts, as well as the first author's interpretations of those transcripts, were discussed. The other researchers assumed a critical stance to challenge and elaborate the emerging theory (Rossman & Rallis, 2003). Following the Ward method (1987), the first author cycled between individual work and group work in order to reach accurate interpretation of the data (Schielke, Fishman, Osatuke, & Stiles, 2009).

We adhered to the constant comparative method as described by Glaser and 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 (Rennie, 2006; Strauss & Corbin, 1998). 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 ceased following the ninth interview. A sample of nine participants is consistent with research using similar methodologies (e.g., Henretty et al., 2008; Levitt, 2001; Levitt et al., 2006; Watson & Rennie, 1994).

Results

The transcripts from the nine video-assisted IPR interviews yielded 541 meaning units. Ninety-one meaning units were deemed unrelated to the empathy construct and thus were excluded from analysis. The remaining 450 meaning units were analyzed and organized into three clusters: (i) *relational context of empathy* (as derived from areas of inquiry i and ii), (ii) *types of empathy* (as derived from areas of inquiry i and ii), and (iii) *utility of empathy* (as derived from area of inquiry iii). The three clusters contained seven lower level categories. Seven participants discussed material from all seven categories, eight participants discussed material from six categories, and nine participants discussed material from five categories. See Table II for a summary of the results.

Cluster 1: Relational Context of Empathy

When asked about the empathic process, clients frequently discussed the broader relationship between client and psychotherapist. Clients described two elements of this therapeutic relationship: a personal relationship (referenced by eight participants; $n = 8$) and a professional relationship ($n = 9$).

Personal relationship. This category pertains to the personal connection or bond between psychotherapist and client. Clients generally spoke well of their psychotherapists and labeled them as genuine, caring, honest, and trustworthy. One client commented that her psychotherapist is "really human" and "doesn't pretend." This client reported feeling "cared about" because her psychotherapist

Table II. Coding results: clusters and categories of meaning units.

Clusters	Categories	n ^a	MUs ^b	Examples (session number)
1. Relational context of empathy	1a. Personal relationship	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. (16)
	1b. Professional relationship	9	33	I think it would be nice if [psychotherapist name] 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 psychotherapist] either. (107)
2. Types of empathy	2a. Psychotherapists' 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)
	2b. Psychotherapists' 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)
	2c. Client attunement to psychotherapist	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 she backed 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. (107)
3. Utility of empathy	3a. Process-related benefits	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)
	3b. Client-related benefits	9	149	I never even saw that until she [psychotherapist] 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)

^aNumber of participants contributing to category (total participants = 9).^bNumber of meaning units contributing to category (total meaning units = 450).

demonstrated that "she thinks about me after we have our session." Another client stated that her psychotherapist "really cares" and "is not just going to school to be somebody to make money ... she wants to help." Yet another discussed the "true nature" of her psychotherapist. Some expressed the client–psychotherapist relationship in terms of "friendships" and "normal" relationships. In other words, clients evidently recognized and felt connected with the *person* who assumed the psychotherapist role.

Professional relationship. Clients also referenced the component of the client–psychotherapist relationship that existed solely for the purpose of the psychotherapeutic work. That is, the client referenced the goals and tasks of psychotherapy and, in this light, described the relationship as more business-like and professional. One client indicated that his psychotherapist engaged in little self-disclosure, which he attributed to the psychotherapist's professional role: "I think it would be nice [if psychotherapist self-disclosed] but I also understand that, you know, this is her job basically." One particularly insightful client explained how the confines of

the professional relationship allowed her to "make up" the psychotherapist she needed in each session. Another client reported trusting the psychotherapist because of the expectation that her psychotherapist would adhere to the values and ethics of the profession. This sentiment was raised by another client, who stated that psychotherapists have a professional responsibility to "care" and "help people." Thus, clients seemed to view the professional relationship as playing an important role in feeling understood and cared for.

Cluster 2: Types of Empathy

Three types of empathy were derived from the interview data. The first two pertain to the psychotherapist's attunement to the client (psychotherapists' cognitive empathy, $n = 9$; psychotherapists' emotional empathy, $n = 9$), whereas the third pertains to the client's attunement to the psychotherapist (client attunement to the psychotherapist, $n = 7$).

Psychotherapists' cognitive empathy. According to client reports, some variants of empathy are

almost exclusively cognitive or intellectual. That is, psychotherapists may, at times, engage with and process the client's experience without becoming emotionally aroused themselves. Clients indicated that this cognitive empathy manifested in a wide variety of psychotherapist behaviors, including "asking questions," recalling content from previous sessions, and simple reflections. One client indicated that after sharing an experience, his psychotherapist echoed that experience back to the client using "a different word choice." Other clients reported that their psychotherapist "followed" and "walked with" their narratives. For another client, this cognitive engagement was akin to an attentive presence: "Her mind doesn't wander, when she is in a conversation with you, she's in a conversation with you." Although perhaps lacking in emotional depth, these efforts were appreciated and were seen to be critical for tracking the client's moment-to-moment experiences.

Psychotherapists' emotional empathy. As discussed, some forms of cognitive empathy did not involve emotional resonance. Yet, from the client's point of view, emotional resonance necessarily implicated cognitive empathy. Put differently, emotional empathy suggested to the client that the psychotherapist also cognitively understood their experience. Many clients inferred emotional attunement via the psychotherapist's nonverbal behaviors (e.g., "[the way] she looks at me" and "she pulled her chair over and held my hand"). One client perceived emotional engagement when the psychotherapist became "teary-eyed" in response to the client's disclosure about a traumatic event. In another case, a client presenting with bereavement issues reported feeling emotionally understood when his psychotherapist disclosed her own recent loss. In fact, clients frequently linked emotional attunement to psychotherapist self-disclosures, including the disclosure of both present-moment emotions and personal narratives. These disclosures evidently communicated that the psychotherapist was emotionally resonating with the client's difficulties. Interestingly, one client characterized emotional empathy as the psychotherapist's willingness to "feel a little bad too."

Client attunement to psychotherapist. As detailed by the previous two categories, clients evinced a moment-to-moment awareness of their psychotherapist's cognitive/emotional empathy. We can therefore conclude that, at least to some extent, clients were attuning to their psychotherapists. Clients demonstrated this empathy in other ways as well. At least three clients explicitly speculated

about the motives underlying their psychotherapist's behaviors. For instance, one client drew conclusions about the psychotherapist's professional interests based on in-session helping behavior. Another client observed that the psychotherapist was uncomfortable in the psychotherapy context and inferred that this might be a problem in others areas of the psychotherapist's life. In one particularly illustrative example, a client described a progression of empathic events that unfolded when the client became acutely "upset." The psychotherapist first detected the client's distress and "backed off" her line of inquiry. The client, in turn, imagined what the psychotherapist might be thinking in that moment (i.e., "ok, this really upsets you, how am I gonna deal with that?"). However, not all clients demonstrated this capacity to intuit their psychotherapist's mental states. One client stated that he could not "read" his psychotherapist, although it is unclear whether this was due to a lack of client empathy or deficits in the psychotherapist's communications. In any event, the present results perhaps imply that the impact of the psychotherapist's empathy might be dependent on the client's attunement to the psychotherapist.

Cluster 3: Utility of Empathy

A third and final area of investigation was the clients' perceptions of the benefits and consequences of empathy. Client responses to this topic were organized into two categories: process-related benefits ($n = 9$) and client-related benefits ($n = 9$).

Process-related benefits. From the client's perspective, the psychotherapist's empathy serves to facilitate and enhance the process of psychotherapy. At least two clients articulated how the psychotherapist's attunement permitted better pacing of the psychotherapy session (e.g., "backing off" a line of inquiry). Another client stated that the empathic process allowed him to "open up" and engage in deeper levels of self-disclosure. One client, who identified demographic differences between she and her psychotherapist, asserted that her psychotherapist's attempts to "understand" were instrumental in overcoming these differences and establishing trust in their relationship. Likewise, one client reported feelings of trust and intimacy when the psychotherapist became tearful and emotionally transparent in session. Empathy, for another client, signified that her therapist "cared" about her. Therefore, while empathy emerges in the context of a caring and trustful therapeutic relationship (see Cluster 1), empathy—from the client's perspective—can help

to reshape that very relationship. To further illustrate this point, one client upon noticing that her psychotherapist was not attuning to her (neither cognitively nor emotionally) became confused and blamed herself for problems in the client–psychotherapist relationship. This underscores the potentially reciprocal influence between the therapeutic relationship and psychotherapists' use (or underuse) of empathy.

Client-related benefits. Clients also reported that the empathic process between client and psychotherapist had an effect on their well-being. Nearly all respondents reported that their self-understanding improved as a result of the empathy process, and many attributed this improvement specifically to the cognitive variants of empathy. In this regard, one client suggested that a simple reframe allowed him to reexamine his thoughts and feelings. Two clients remarked that having the psychotherapist's undivided attention was unique and special, with one client exclaiming, "I've never had that before, and it's just amazing." This might imply that the psychotherapist's empathy can serve as a corrective experience. Others spoke more broadly about the empathic relationship between client and psychotherapist and noted how this lead to feeling "good," and having "more security" and "more happiness." Despite prompts from the interviewer, no adverse effects of empathy were noted.

Discussion

The current study employed video-assisted, IPR interviews (Elliott, 1986; Kagan, 1975) and grounded theory analysis (Rennie, 2002) to understand clients' perceptions of empathy. Our results imply that the client's experience of empathy is couched in the broader relationship between client and psychotherapist. This relationship, according to clients, entails both a personal/human component as well as a professional/working component. From the client's reports, two types of psychotherapist empathy (i.e., cognitive and emotional empathy) and one type of client empathy (i.e., client attunement to psychotherapist) were identified. As consistent with previous work (Barrett-Lennard, 1981; Brodley, 2002; Wynn & Wynn, 2006), these types of empathy implicate *at least* a two-turn empathy exchange, with the psychotherapist's expression of empathy and the client's attunement to that empathy. Clients also reported numerous benefits associated with empathy, particularly benefits to psychotherapy process and to their well-being. These

findings are elaborated and discussed in the context of existing theory and research below.

One of the most significant findings to emerge from this study is that clients actively contribute to the empathy process; not only does the client supply the material that invites empathy from the psychotherapist, but the client then fulfills the exchange by attuning to the psychotherapist's empathic gestures. Based on this evidence, we would reject the notion that clients merely receive empathy and instead would favor models conceptualizing empathy as a dynamic, "temporal sequence" between client and psychotherapist (see also Barrett-Lennard, 1981; Duan & Hill, 1996). This conceptualization has implications for psychotherapy practice, as psychotherapists should assess how attuned and responsive different clients are to expressions of empathy.

The complexity of this process might at least partly explain why a consensual definition of empathy has remained elusive (Bohart & Greenberg, 1997; Elliott et al., 2011; Gibbons, 2011). Conceivably, the construct of "empathy" could encompass the client's disclosure, the psychotherapist's experiential attunement, the psychotherapist's verbal/nonverbal empathy, the client's attunement to the psychotherapist, the client's experience of receiving empathy, the client's verbal/nonverbal response to empathy, or the entire sequence (see Duan & Hill, 1996; Gibbons, 2011). This, of course, poses challenges for assessing empathy and could potentially lead to a plethora of empathy measures that assess empathy at any point (s) along this sequence (see Duan & Hill, 1996). We agree with Duan and Hill (1996), who advocated for a coalescence of research on client-experienced empathy, and would further suggest that it is the client's *construal* of empathy—rather than observable, "objective" behavior—that has the greatest implications for psychotherapy process and outcome (see also Horvath, 2006).

Dovetailing with extant literature (e.g., Bachelor, 1988; Bohart & Greenberg, 1997; Duan & Hill, 1996; Kerem et al., 2001; Wynn & Wynn, 2006), clients perceived that their psychotherapists engaged in two types of empathy: cognitive empathy and emotional empathy. The difference between these empathy types was intelligible to clients, contrary to previous reports that empathy cannot be divided into cognitive and emotional components (Baron-Cohen & Wheelwright, 2004). In accord with Kerem et al.'s (2001) qualitative study, affective empathy was seen to necessarily implicate cognitive empathy (but not vice versa). Therefore, empathic behaviors could be mapped on a gradient from no affective arousal (i.e., purely cognitive) to high levels of affective arousal.

Surprisingly, clients frequently attributed empathy to their psychotherapist's self-disclosures. The literature on psychotherapist self-disclosure is relatively sparse, yet there is some evidence for its beneficial effects (Audet & Everall, 2010; Hill, Mahalik, & Thompson, 1989; Knox & Hill, 2003; Knox, Hess, Petersen, & Hill, 1997; Yalom & Leszcz, 2005). Yalom and Leszcz (2005) reported that in post-psychotherapy debriefing sessions, "the great majority" of clients expressed the wish that the psychotherapists had been more open and transparent (p. 224). Although not an explicit focus of the current study, two clients shared this wish that their psychotherapist engage in more self-disclosure. Knox et al. (1997) found that psychotherapist's self-disclosures helped clients to feel understood. In contrast, Curtis (1982) and Peca-Baker and Friedlander (1987) determined that greater therapist self-disclosure was related to poorer evaluations of psychotherapist empathy. Given these mixed results, we would suggest, based on the current results and previous recommendations (Gibbons, 2011; Knox & Hill, 2003), that psychotherapists are likely to be viewed as more empathic when their self-disclosure is judicious and provided at moderate levels.

Clients also attributed empathy to their psychotherapist's nonverbal behaviors. For example, clients cited handholding, eye contact, and tearfulness as mechanisms for their psychotherapist's empathy. In a recent study, Dowell and Berman (2013) found that high eye contact and forward trunk lean enhanced perceived psychotherapist empathy. Similarly, clients may infer psychotherapist empathy via facial expression (Duff & Bedi, 2010) and postural shifts (Hermansson, Webster, & McFarland, 1988). This knowledge is useful for training psychotherapists to be more empathic (Duan & Hill, 1996).

Clients in the current study viewed empathy as integral to the personal and professional relationship they had with their psychotherapist, perhaps suggesting that clients were capable of conceptualizing empathy both as a circumscribed in-session activity (e.g., cognitive/emotional empathy) and as a "general relationship ambience" (Bachelor, 1988, p. 235; see also Myers, 2000). The personal relationship, identified by clients, is roughly akin to Gelso's *real relationship* (e.g., see Gelso & Hayes, 1998), and the client-identified professional relationship is roughly akin to Bordin's *working alliance* (e.g., see Bordin, 1979), and so these terms will be used interchangeably here. Previous research indicates that clients' ratings of psychotherapist empathy are strongly correlated with their ratings of the real relationship (e.g., $r = 0.61$; Fuertes et al., 2007) and

their ratings of the working alliance (e.g., $r = 0.64$; Evans-Jones, Peters, & Barker, 2009). Of course, these associations do not imply a direction of influence. Many have suggested that psychotherapist's empathy facilitates relationship development (Bohart et al., 2002; Feller & Cottone, 2003; Gelso & Hayes, 1998; MacFarlane, Anderson, & McClintock, 2015), although the reverse may be true as well (Myers, 2000). Our qualitative data imply that empathy may influence—and be influenced by—the broader therapeutic relationship and moves us closer toward a "conceptual map" of the therapeutic relationship and how the pieces on the map dynamically relate to each other (Horvath, 2006, p. 261).

Clients linked psychotherapist empathy specifically, and the therapeutic relationship more broadly, to a number of client-related benefits. Convergent with Bachelor's (1988) qualitative data, cognitive empathy was seen as promoting self-understanding. Together, these results imply that cognitive empathy should not be overlooked in the context of psychotherapy and that cognitive empathy and emotional empathy might achieve different ends. Based on our results, cognitive empathy may be useful for tracking the client's experience and for improving self-understanding, while emotional empathy might bond the client and psychotherapist. Clients also reported that the empathic relationship between client and psychotherapist led to feelings of security, well-being, and happiness, consistent with research by Myers (2000; Myers & White, 2010). In a comprehensive meta-analysis (client $N = 3599$), Elliott et al. (2011) found that empathy accounted for nearly 10% of the variance in client outcome. Our results substantiate this positive impact of psychotherapist empathy.

Strengths and Limitations

There are a number of strengths and weaknesses associated with the current research. Focusing on the client's experience offers a new and potentially fruitful classification of empathy, especially given that client reports of empathy robustly predict psychotherapy success (Elliott, Bohart, Watson, & Greenberg, 2011). Yet, we concede that the current classification is an imperfect representation of a highly complex construct.

Another strength is that we utilized existing theory to establish a *jumping-off point* for the initial interviews and then used the resulting data to inform subsequent rounds of data collection (see Glaser & Strauss, 1967; Rennie, 2006). In this way, we attempted to orient clients to the topic without biasing the results. It should be noted that the first

author's familiarization with extant theory prior to interviewing clients likely permitted greater bracketing of preconceived notions and biases when collecting and analyzing that data (Fischer, 2009; Hutchinson, 1993). As discussed, we also took many steps to maximize trustworthiness (see Morrow, 2005; Williams & Morrow, 2009).

Our interview methodology was sound. First, interviews allowed the first author to explore the emerging data with greater depth and immediacy than was likely possible in prior research (e.g., Bachelor, 1988; Brodley, 2002; Wynn & Wynn, 2006). Second, we reasoned that a dual relationship with clients (i.e., as psychotherapist and interviewer; see Myers, 2000) might bias the data, and so we used an interviewer who had no previous affiliation with the clients. Third, because qualitative research on client–psychotherapist interactions is often conducted long after those interactions occur (e.g., Bedi, 2006), all interviews were conducted within 48 h of the video-recorded session to minimize memory decay. Fourth and finally, the video-assisted IPR methodology was uniquely useful for drawing the client's attention to specific in-session experiences of empathy.

Although IPR methodology was advantageous for developing a comprehensive understanding of clients' perceptions of empathy, interviewing clients about these powerful, affect-laden moment in psychotherapy could have increased their feelings of vulnerability (Birch & Miller, 2000). These feelings of vulnerability could have been magnified by the fact that we conducted only one interview per client (see Knox & Burkard, 2009). Several respondents voiced discomfort with the process of watching themselves and watching something as private as a psychotherapy session with a stranger (i.e., the interviewer). Extant literature (Hutchinson & Wilson, 1992; Knox & Burkard, 2009) suggests that interviewees who are experiencing discomfort and vulnerability may respond minimally, offering vague or unclear responses, or may change the focus of the interview (Hutchinson & Wilson, 1992; Knox & Burkard, 2009). However, considering the scope and depth of responses, client discomfort likely only had a minimal impact.

One of the most salient limitations of the current research is the relatively small sample size. This is a weakness of most qualitative research samples, which need to be small to enable a thorough and incisive analysis (Olivera et al., 2013). In addition, this research primarily focused on single psychotherapy sessions, limiting our understanding about clients' experience of empathy over the full duration of treatment.

Future Research

Because clients are evidently active participants in the empathy process, future research should test if the effect of the psychotherapist's empathic behaviors is moderated by the client's attunement to the psychotherapist. Other avenues for future research include the role of empathy in the therapeutic relationship, the intersection between psychotherapist's self-disclosure and perceived empathy, as well as the distinction between cognitive and emotional empathy and their implications for psychotherapy process and outcome. In particular, researchers could use a mixed-methods approach to investigate if different types of empathy (e.g., cognitive vs. emotional) are differentially related to quantitative alliance ratings. Such research might improve psychotherapist training and ultimately client care.

Conclusion

Empathy is difficult to study because it is a construct that exists between and within two (or more) people. Most attempts to understand empathy have followed a "top-down" approach, in that much of the definitional work on empathy has emerged from theoreticians, psychotherapists, and researchers. As such, the client's active contribution to the empathy process may have been neglected. It is our hope that the present study will help us to more fully understand clients' perceptions and contributions to psychotherapeutic empathy.

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