Institute for Clinical Social Work

How Do Psychodynamic Social Workers Understand Empathy?

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By

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Abstract

This study examines how psychodynamic social workers understand empathy. Using a constructivist, grounded theory approach, the researcher interviewed 20 psychodynamic social workers with over five years of clinical experience. Each audio-recorded interview was an hour to an hour and a half and took place in the clinician's or researcher's professional office. The researcher maintained all interviewees' confidentiality and closely studied, coded, and collated the data.

As a result of the clinician interviews, the researcher found that empathy can be innate and empathy can be learned. She also had several sub-findings. Clinicians stated that they deepen their understanding of empathy through what their clients teach them, that they look for client meaning as part of understanding empathy, and that empathy is a choice. Clinicians interviewed also emphasized the importance of suspending judgment and considering clients' cultural contexts as part of their understanding of empathy. All clinicians interviewed stressed the importance of understanding countertransference as it informs psychotherapeutic work.

The researcher analyzed the data in this study through a self psychology lens. She conducted a thorough literature search and then looked at the data through that lens as part of her analysis of how clinicians understand empathy.

For Lee, Adam, Aaron, Ana, my parents, and Lee's parents

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To all in my village, thank you. You have made my world a better place.

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Chapter I

Introduction

This study examines how social workers at the master's and doctoral level understand empathy. DeGeorge and Constantino (2012) stated, "Patient-perceived therapist empathy is an important clinical variable common to many psychotherapies (Bohart, Elliott, Greenberg, & Watson, 2002; Rogers, 1957). . . . Therapist empathy has been associated with positive outcomes" (p. 52). Numerous other psychotherapists and authors have discussed their views of empathy. Carlton (2010) expressed,

> Empathy, a single word embodying multiple ideas, has continuously been a controversial concept within psychoanalysis. A listening stance; a mode of observation; an intuitive, feeling resonance with another; a compassionate feeling for or response to another; a data-gathering tool; and most recently, a physiological capacity located in our "mirror neurons"—each of these diverse descriptions has been understood as empathy. It is a mode of observation intrinsic to psychoanalysis itself, regardless of theory (p. 117).

When the researcher entered "empathy" as the search term, the academic search engine on Pep Archive turned up 19,206 psychology articles and books. The search terms "empathy" and "psychotherapy" resulted in 2,965 articles and books. When the

researcher entered “psychotherapists,” “understand,” and “empathy,” the search engine found 1,025 articles and books.

Spiro, Peschel, Cumen, and St. James (1993) posed some interesting questions with regard to empathy in their studies of physicians-in-training. These questions can be relevant when studying empathy and psychotherapy:

- Where does empathy begin?
- Is it a quality of the physician only?
- Does it need to reside in the patient?
- Can it be learned or is it innate?
- Is it only countertransference as psychiatrists might wager?
- Is empathy possible for everyone, are everyone’s receptors “down regulated” or, to use modern parlance, must the right neural connections be formed early in life when the brain is still plastic?
- Are some patients more “empathogenic” than others?
- Are there truly hateful patients or physicians who cannot love and whom no one can love? (p. 4)

They also ask:

- Is empathy a gift or a skill?
- Is it verbal or visual?
- How can you express it?
- How can we make ourselves more empathic? (p. 11)

Though numerous practicing psychoanalysts have studied empathy (Basch, 1988; Goldberg, 1995; Kohut, 1984), the meaning of this concept for psychodynamic therapists must be further understood. Goldberg (2012) claimed that:

> One of the great arguments in Self Psychology is waged over the status of empathy. Is it a process of data gathering or a therapeutic tool in its own right? When a patient is understood by a therapist according to the therapist, is that fact helpful in its own right or must the patient feel understood in order to benefit? (p. 162)

In the psychotherapy world, practitioners consider empathy in two ways. From the therapist's perspective, empathy can be a means of data gathering. From another perspective, the patient feels or does not feel the therapist as empathic. The researcher considers both views in this study.

Though understanding of empathy varies, as Goldberg suggested, numerous authors agree that empathy plays a key role in the therapeutic relationship. Rogers (1975) believed,

> We should re-examine and re-evaluate that very special way of being with another person which has been called empathic. I believe we tend to give too little consideration to an element which is extremely important both for the understanding of personality dynamics and for effecting changes in personality and behavior. It is one of the most delicate and powerful ways we have of using ourselves. In spite of all that has been said and written on this topic, it is a way of being which is rarely seen in full bloom in a relationship. . . . Over the years, however, the research evidence keeps piling up, and it points strongly to the conclusion that a high degree

> of empathy in a relationship is certainly one of the most potent factors in bringing about change and learning (p. 137).

Kohut (1977) stated that understanding patients is "unthinkable" without empathy (p. 306), and Wolf (1988) said that "the empathic vantage point becomes the organizer for all observations made" (p. 20). Tolmacz (2008) described how Kohut's theory of self psychology and his thoughts on empathy evolved over time:

> In self psychology (Levy, 1985), empathy is linked with information-gathering and an analytical understanding of patients; it is an integral part of interpretation and an aspect of development. . . . Kohut describes empathy as a "mode of observation attuned to the inner life of man" (p. 396), an investigatory stance that he believes constitutes the "quintessence of psychoanalysis" (p. 398). In [Kohut's second book, published in 1977], he describes empathy as a "powerful emotional bond between people" (p. 397) and claims that "empathy per se, the mere presence of empathy, has a beneficial, in a broad sense, a therapeutic effect—both in the clinical setting and in human life in general" (p. 397). "Thus, empathy is used to denote both a means of psychological inquiry and a form of emotional relating" (p. 263).

This project analyzes how psychodynamic social workers understand empathy in the therapeutic relationship. The researcher intentionally used the word "understand" in the research question to encourage clinicians to consider meaning. By this thoughtful consideration, each clinician interviewed traveled inward to think about empathy in a new and deeper way.

This study contributes to the significance of social work in that clinicians interviewed described their understanding of empathy and its impact on their practices

and clients. Elson (1986) claimed, "What has been generic to social work practice has been the experience of the universal human need on the part of the individual to be confirmed, to be mirrored as worthwhile" (p. 137). Social work education universally emphasizes finding the strength in every client. Clients come from all socioeconomic and psychological backgrounds. Elson stated, "The social worker has only one tool, and that tool is she" (p. 3). Cooper and Lesser (2005) stated,

> Empathy in therapy is essential for the patient's emotional growth and development. It is a quality that is learned within the context of the therapeutic relationship that further develops over the course of time as new relational experiences are internalized (p. 117).

Therefore, we can look at empathy as a process that develops over time, throughout the relationship between the psychotherapist and the client. Cooper and Lesser (2005) summarized Kohut's original findings this way: "Empathy is more than the therapist feeling for the patient—it is listening in such a way that the therapist hears the patient's story and is able to comment on the patient's life" (p. 117).

According to Green and Christensen (2006), Harwood and Safren (2008), and Springer and Wang (2008), empathy has been significant in the social work setting. Clearly, the social work profession values empathy as an important component of the relationship social workers have with their clients.

DeGeorge and Constantino (2012) found that patients' perception of empathy is an essential clinical variable. (Bohart, Elliott, Greenberg, & Watson, 2002; Rogers, 1957). They also claimed that "Therapist empathy has been associated with positive outcomes" (p. 52).

However, the definition of empathy has been unclear, and no previous researchers actually interviewed psychodynamic social workers to find out how they understand empathy in the psychotherapeutic setting. In planning this project, this researcher conjectured that conducting and studying interviews with clinicians would lead to a new understanding of empathy in the social work profession.

Chapter II

Literature Review

Pigman (1995) traced the history of the concept of empathy back to 1588, when Montaigne claimed that he often saw and felt attributes of his friends "more precisely than they can themselves." Pigman credited Visher with coining the term *Einfühlung* (empathy) in 1873 and using it "to designate the projection of human feeling on the natural world" (p. 236). "For a quarter of a century," Pigman went on, "*Einfühlung* and the related concept of 'inner imitation' were central, endlessly debated questions in psychological aesthetics" (p. 236). Shortly thereafter, he said, Theodor Lipps, a philosopher whom Freud admired for many years, transferred the term to psychology "in an attempt to explain how we discover that other people have selves" (p. 237). Freud, Pigman continued, viewed empathy through an intellectual lens, "as the process that allows us to understand others by putting ourselves in their place" (p. 237). He also said, "Although the Standard Edition never translates '*Einfühlung*' as empathy, in a clinical context, Freud regards it as essential for establishing the rapport between patient and analyst that makes interpretation possible" (p. 101).

Kohut (1959) described empathy as a new way of gathering information about patients that would help therapists to further understand their experience. As the founder

of self psychology, Kohut (1982) explained how empathy and introspection are essential parts of psychological observation:

> We may thus repeat the earlier definition in the form of an explicit statement: we designate phenomena as mental, psychic or psychological if our mode of observation includes introspection and empathy as an *essential constituent.* The term "essential" in this context expresses the fact that introspection or empathy can never be absent from psychological assessment (p. 462).

Kohut believed in Freud's psychoanalytic model and then expanded upon Freud's original idea as he began to see additional ways to work with his patients effectively. According to Siegel (1996), Kohut's theory evolved when a patient did not respond to Kohut's interpretations during psychoanalytic psychotherapy. When Kohut began to listen to this patient in a more empathic way, Siegel said, "Self Psychology was born" (p. 16). Siegel pointed out that Kohut defined empathy as follows:

> The way one can learn about the inner experiences of another. Empathy is *the* data gathering tool in psychoanalysis and, Kohut argues, an experience or an act may be considered to be psychological *only* when it is observed via introspection and empathy (p. 49).

Moses (1988) summarized Kohut's view when he stated, "Only when we 'think ourselves into the patient's place' through vicarious introspection can we revive inner experiences that were previously unknown" (p. 579). Goldberg (1983) viewed empathy as "a method of observation . . . guided by a theory that directs it" (p. 160). Through this method of observation, Goldberg (2010) saw that Kohut did not "merely listen to or

observe a patient; rather he connected to the patient by way of a temporary identification or sharing of beliefs or feelings" (p. 290).

Kohut believed that as patients described experiences of loss, psychotherapists could access their own emotional experiences with loss, therefore empathizing with the patients' emotions. During this process, the clinician must remain objective so that the patient's emotion, not the clinician's, is at the forefront of the psychotherapeutic work. Rieveschl and Cowan (2003) described the essential shift that Kohut made from the framework of psychoanalytic psychology to his view of the self-object.

Rieveschl and Cowan (2003) said Kohut defined the subjective experience of another person as follows:

> Supplying or sustaining essential functions within the self. . . . [T]he proud gleam in his or her parent's eye initially supplies the small child with self-esteem before it has become internally structured as a function within the child's self. After it has become progressively internalized, he or she can experience such proud looks as sustaining, rather than solely supplying, feelings of self-esteem and is more able to tolerate their absence. Kohut described an identifiable developmental sequence of self object strivings in normal development or self object transferences in the psychotherapeutic restoration of self: from mirroring to idealizing to twinship. He conceived the healthy self as developing through this sequence of self/self object relations, pursuing its unique trajectory from cradle to grave (p. 126).

Other psychotherapists and authors expanded on Kohut's views of empathy and self psychology. Geist (2007) quoted Kohut's 1984 definition of the first mode of empathy as vicarious introspection:

> From this perspective we sense in ourselves the feeling states of the analysand and therefore come to know some of the hopes, motivations, fears, self-states and expectations that she is feeling. The second mode of empathy, empathic resonance, experientially feels more immediate in our understanding of the patient and often occurs without awareness of our associations. We react unselfconsciously to the patient's associations and do not recognize the rationale for our responses until we look back and analyze their context (p. 78).

The third mode is somatic empathy, which connected analyst and patient through the experience of physical feelings that reflected a visceral communication, often tapping into what Orange (1995) referred to as an emotional memory that occurred before the capacity for symbolization and outside the realm of verbal expression (p. 7). Geist (2007) illustrated his definition of somatic empathy as follows:

> During the first six months of treatment, I learned to differentiate between a sinking feeling in the pit of my stomach, which always communicated a suicidal feeling without intended action, and a percussive drumming in my chest when she actually intended to harm herself (p. 7).

Geist believed that it was important for him to remain in the empathic stance throughout the treatment process in order to facilitate an optimal connection with his client.

Miriam Elson (1986) considered it important to apply the self psychology perspective in clinical work:

> Self Psychology now adds to our understanding of the manner in which the self of the social worker becomes a key element in the repair and restoration of psychic

> structure building in the individual or individuals with whom we work. Kohut's theory of self psychology, with its concept of the self object, becomes the key to our understanding of why it is and how it is that the self of the social worker exerts a force in restoring an individual's self-esteem and enables him to regulate that self-esteem as he seeks to realize cherished goals (p. 4).

Rieveschl and Cowan (2003) summarized Kohut's view that empathy is the bridge between a clinician and a patient:

> Kohut became convinced that a key difference between developmentally enhancing and developmentally thwarting relational events rests in the self's subjective experience of the quality of the significant other's empathy. Even in instances when a particular need cannot be gratified, the experience of being understood empathically can make the difference between a manageable frustration that still supports, and, indeed, may further growth versus a traumatic one that derails it (p. 126).

Shaughnessy (1995) inferred that the working alliance (sometimes referred to as the therapeutic alliance) and empathy are both necessary in order to have a strong therapeutic relationship (p. 221). Rogers (1980) stated, "We think we listen, but very rarely do we listen with real understanding through empathy" (p. 116). Many patients come into therapy to report that they have not been listened to or understood outside of the therapy setting. Often they feel that their outside listeners have applied the lens of their own experiences, agendas, or biases. Rogers proceeded to explain that true listening requires a unique type of attention beyond restating what one has heard. As other authors stated, this

unique listening requires listeners to put aside their own perspectives and attempt to identify with patients' emotional experiences in order to understand in an empathic way.

Michael Basch (1983) expanded Kohut's view of empathy by wondering if empathy was related to a clinician's intuition and explored whether empathy was a listening stance or a type of clinical introspection (p. 146). Later, Basch (1988) continued to ponder the meaning and definition of empathy:

> For lack of a better definition, empathy has often been spoken about as if it were a quality or talent inherent in the therapist; one is either "empathic" or "unempathic" as one may be "musical" or "not musical." I do not think this is the case. I believe that coming to an empathic understanding is a process that can be dissected, described, taught and learned (p. 146).

Basch's description of empathy illustrated a process between clinician and patient that evolves over time. This evolution includes many mutually shared clinical moments in which trust is built as empathy is experienced. This process is quite individual and depends upon the unique relationship between each clinician and patient, as well as on the patient's use of the therapeutic process.

Tolmacz (2008) discussed his view of the difference between concern and empathy.

> In my opinion, whereas empathy is a matter of how incisively we see into the depths of the Other's Soul, concern is the emotional filter through which we look. We can look at others favorably or apathetically, angrily or lustfully. Therefore, when we hear that a particular therapist is very empathic, it is still valuable, in my opinion, to ask whether the therapist is caring (p. 266).

Tuch (1997) looked at empathic failures as a strong possibility in treatment, saying that when we work with someone who has a very different background from our own, we may feel like strangers in a foreign land. He also said some psychotherapists may feel hesitant about leaving the "isolation of the position of the uninvolved observer," which is necessary to embrace the empathic position (p. 262). He quoted Greenson (1960) who claimed that "some patients are terrified at the thought of being understood, as a deeper understanding could hold meaning for these patients of being "destroyed, devoured or unmasked" (p. 422). These patients had a great need to keep their inner lives guarded, with strong boundaries particularly as close relationships become more possible.

Currently, more research is being done in the field of neuroscience regarding empathy. Schore (2012), Watt, D. (2007), and Biven and Panksepp (2007) are among the neuroscientists who have studied emotional life and brain development, including the concept of empathy. Watt stated,

> Schore's work perhaps has been the most paradigmatic here, in terms of his consistent emphasis on the critical role of empathy both in parenting and psychotherapy . . . finding evidence that empathic failures in early parenting may drive the brain into maladaptive neurodevelopmental pathways, whereas more empathic connections may foster more optimal brain development (p. 132).

Theoretical and Conceptual Framework

I analyzed and interpreted the data for this research study through a self psychology lens. Kohut, who developed self psychology, began his career as a psychoanalyst. Through his work with patients, he discovered that for many people, the drive model did not seem to address emotional life in the most comprehensive way. The premise of self psychology is that self-cohesion is needed for individuals to feel at peace with themselves. This premise differs from drive theory's underlying principle, which stresses the centrality of the resolution of inner conflicts.

A turning point came when a patient of Kohut's confronted him, dissatisfied with her treatment and stating that Kohut did not understand her feelings or needs (Kohut, 1971). By attempting to focus on the nature of his patient's experience without applying the classical explanations that had informed his interpretations, Kohut became more in tune with and responsive to a different level of experience in his patient.

Berzoff, Melano, Flanagan, and Hertz (1996) viewed self psychology theory as a deficit model, stating that psychological issues occur "when the legitimate developmental needs of the three poles (mirroring, idealizing, and twinship needs) have not been met with optimal empathy and optimal frustration" (p. 491). The person whose psychological developmental needs have not been met may have a hard time with self-soothing, self-regulation, and self-cohesion. In addition, these clients will have self-esteem issues that may be revealed through poor relationship choices, limitations in confidence, and other aspects of decision making. Self psychology is concerned with an individual's early environment and the capacity of self-objects to provide an environment that is optimal for

emotional growth. However, a lack of inner balance and self-cohesion "due to biological and social causes can also contribute to a lack of significant self cohesion" (Berzoff, Melano, Flanagan, & Hertz, 1996, p. 191). Therefore, other factors in addition to environment can contribute to the lack of a strong sense of self.

Mitchell and Black (1995) described Kohut's view of the optimal emotional environment as follows:

> Human beings must be designed to flourish in a certain type of human environment. That environment must in some way provide necessary experiences that allow a child to grow up not only being human but feeling human, an energized, connected member of the human community (p. 149).

Good self-regulation enables people to manage their moods effectively most of the time and make healthy relationship choices, and it strengthens their decision making ability. Kohut (1984) defined the experience of a self-object responding to a child's greatness and achievements as mirroring. These reactions by the self-object will help to expand the child's ability to be creative and will strengthen self-esteem (p. 159).

Mitchell and Black (1995) offered a vivid description of a young child running through the house with a Superman cape on, stating that this child needs to be enjoyed and celebrated, not quieted, criticized, or dismissed (p. 159). The child who is appropriately celebrated has the opportunity to develop self-esteem and in turn will have a better ability to self-regulate.

The child who is dismissed or criticized may have difficulty internalizing self-approval. Kohut and Wolf (1978) stated that the second type of necessary developmental experience "requires the child's involvement with powerful others to whom the child can

look up and with whom he can merge with as an image of calmness, infallibility and omnipotence" (p. 414). Kohut (1984) defined this as idealizing, and he described a third type of self-object experience that is important for a child: twinship. Twinship is a process in which the child has self-objects whom the child experiences as being similar to himself. This brings us back to his summary of psychological development and the nature of psychopathology:

> Self psychology holds that, with regard to a large number of patients . . . the essence of psychopathology is the defective self (i.e., the self prone to states of fragmentation, weakness, or disharmony). A healthy self, it should be added, is a structure that—except perhaps as an outcome of the most severe forms of traumatization such as prolonged confinement in concentration camps and other protracted dehumanizing experiences—is not prone to become fragmented, weakened, or disharmonious during maturity, at least not severely and/or for long periods (p. 70).

In cases where a patient has difficulty with self-regulation, Kohut (1982) believed that the patient's developmental needs of mirroring, idealizing, and twinship may not have been comprehensively met. Siegel (1996) described Kohut's major contributions to emotional understanding, including Kohut's belief that narcissism is normal, with its own developmental course. Kohut's theory, Siegel explained that unconscious configurations form during the development of narcissism, and within these configurations lie certain human needs, including the needs for consistent love, nurturing, admiration, affirmation, and ongoing emotional support. Kohut believed that the development of a healthy self requires ongoing responsiveness to those needs. When there is a deficit or interruption in

that caring, the self may suffer injuries which can appear as symptoms such as fragmentation.

Palombo, Bendicsen, and Koch (2009) stated that in Kohut's view of the development of the self, the milieu that parents or caretakers provide during childhood is crucial. Kohut refers to caregivers as "objects" providing "self object" functions through their responses to a child's needs. Kohut defined the interaction of the self with self-objects as "the bipolar self" in his original writings. Palombo, Bendicsen, and Koch summarized Kohut's views this way:

> Self object functions are psychological functions with which people are not born. Initially, they are mental states that have not acquired the stability, autonomy, and continuity to be considered psychic structures within the self that permit the person to function effectively. . . . Eventually children internalize these experiences into the matrix of their sense of self as psychological structures, at which point they represent enduring functions that accrue to the self. . . . Self objects may be defined as the set of experiences that, when present, lead to feelings of cohesion and stability; but which, when absent, lead to feelings of disruption and fragmentation (p. 264).

Kohut's theory of self psychology evolved over time. In 1984, he described particular psychic structures that are part of the self-object process, including the grandiose self, the idealized parent imago, and the alter ego. He stated,

> The essential therapeutic conclusion of all my contributions to the understanding of the self and its development can be formulated as follows: it is the defect in the self that brings about and maintains a patient's self object (narcissistic) transference, and it is the working through of this transference which, via transmuting internalization,

> that is, via a wholesome psychic activity which has been thwarted in childhood, lays down the structure needed to fill the defect in the self. Indeed, I take the emergence of this process, and especially its persistent engagement, as evidence that the treatment situation has reactivated the developmental potential of the defective self (p. 4).

Kohut believed that by his use of empathy he could deepen his understanding of his patient's experiences and their inner worlds. This understanding includes his consideration of their self-esteem development as well as their ability or inability to self-regulate their emotional lives.

Berzoff, Melano, Flanagan, and Hertz (1996) stated that Kohut believed that the development and strength of a cohesive self was at the center of psychological development and therefore, a crucial focus of self psychology theory.

Kohut's view of empathy began with his belief that empathy is a way of knowing. In his final paper, he stated his changed view: "The mere presence of empathy has also a beneficial, in a broad sense, a therapeutic effect, both in the clinical setting and in human life in general" (1981, p. 398).

Before the researcher presents excerpts from interviews in which psychodynamic social workers define empathy, let's review some definitions of empathy that have been used over time. Kohut (1984) said, "The analogue to the terse scientific definition of empathy as 'vicarious introspection' is that it is the capacity to feel oneself into the inner life of another person" (p. 84).

Basch (1988) said,

> Practically speaking, empathy means that the therapist does not simply take a patient's words at face value but looks for the deeper meaning of what the patient is saying, or not saying, in the affective signals that the patient is, often unwittingly, transmitting (p. 145).

Goldberg (1995) described empathy this way:

> Understanding connects us to one another. Its subcategory, self-understanding, connects us to ourselves. It is this that underscores all the understanding of meanings, interpretations and explanations that we achieve. Self-understanding is a form of separating off a part of us, contemplating it, and integrating it into the whole. To understand someone else is an aspect and a result of communication; to understand oneself comes from self reflection. We understand someone by reading that person, usually by way of empathy (p. 186).

Empathic connection occurs when clinicians explore their own experiences that are similar in nature to the client's experiences. For example, a clinician who has experienced loss travels back to that feeling state as a way to understand a client's description of loss. By understanding similar experiences, clinicians can establish an empathic connection. However, the client's experience may be very different than the clinician's, and clinicians should be mindful not to interject their own expectations.

This study defines empathy as the process by which clinicians attempt to understand another person's emotional experience.

Chapter III

Methodology

This study examines how psychodynamic social workers understand empathy in the psychotherapeutic setting. It takes a qualitative approach using grounded theory, as Strauss and Corbin (1998) and Charmaz (2006) outlined. The qualitative data comes from interviews with 20 psychodynamic clinical social workers, referred to here as clinicians, who have five or more years' experience. The researcher recruited these clinicians from the North Carolina chapter of the National Association of Social Workers. She did an initial assessment by phone with clinicians who expressed interest in the study to make sure that they had sufficient clinical experience and that they were psychodynamic in theory and practice. The researcher then conducted full interviews in the therapists' offices, a neutral location such as a library meeting room, or her own office. She asked clinicians the research question, "How do you understand empathy?"

All clinician identities remain confidential. Each clinician signed a consent form (Appendix A) giving permission to be audiotaped for the purpose of this study. After the first interview, the researcher began coding. Charmaz (2006) described initial coding as studying each word, line, or segment of data with the goal of remaining open to potential theoretical directions (p. 46). The researcher took this approach to organize and represent

the information the interviewees provided. The researcher based her analysis on the coding as well as on memos she took during the interviews.

Grounded theory is a constructivist approach, explained Mills, Bonner, and Francis (2006):

> Charmaz has emerged as the leading proponent of constructivist grounded theory. For constructivist grounded theorists Charmaz's (2001) work provides guidelines in making meaning from the data, and rendering participants' experiences with "readable theoretical interpretives" with an emphasis on keeping the researcher close to the participants, by keeping their words intact. In the process of analysis, Charmaz has striven to maintain the participants' presence throughout (p. 7).

Data Collection Methods and Instruments

The researcher collected data by conducting interviews of one and one-half hours in length with 20 psychodynamic adult clinicians, audiotaping the interviews with the clinicians' permission. Using the grounded theory methods of Charmaz (2012), the researcher then transcribed, coded, and categorized the audiotapes for themes and commonalities. Charmaz expanded her original definition of grounded theory, calling it,

> a comparative, iterative and interactive method. The emphasis in grounded theory is on analysis of data; however, early data analysis informs data collection. . . . Grounded theory has certain distinctive features that distinguish it from other forms of qualitative analysis (see Wertz et al. 2011).

This method:

- provides explicit tools for studying processes;
- promotes an openness to all possible theoretical understandings;
- fosters developing tentative interpretations about the data through coding and categorizing; and
- builds systematic checks and refinements of the researcher's major theoretical findings.

Plan for Data Analysis

Using grounded theory, as outlined by Charmaz (2006), the researcher gathered data from the interviews with social workers who are psychodynamically oriented. Grounded theory has specific steps to follow that guided the analysis of the data from the interviews. The process of analyzing the data began with initial coding of each transcribed interview. Initial coding is a process in which each word, line, and piece of data has the potential to provide the direction for theoretical expansion. In initial coding, the researcher documents words, lines, segments, and incidents. Grounded theory uses coded data from interviews to construct theory. Grounded theory does not use an initial hypothesis as the basis for research. The next step was focused coding, which was the first attempt at combining and categorizing the data. Following the initial coding, axial coding began. Axial coding links data findings with subfindings; it is an organizational technique within grounded theory. Charmaz (2006) refers to axial coding as a frame or structure for researchers. The next step in the analysis was theoretical coding, which

identified relationships between the findings that emerged in focused coding. As a result of coding and analysis, themes began to emerge from the data. Therefore it was essential to approach the interviews without preconceived notions or themes. Because grounded theory is an emergent process, memo-writing enabled the researcher to capture each interviewee's words, meanings, and themes. Memo-writing is the step between collecting data, coding, and writing. It is an organizing process that happens early in the research endeavor and continues throughout the process as appropriate. The researcher also used member checking to establish the accuracy of her coding. She contacted respondents by phone or e-mail to assess whether the coding truly represented their experience.

Chapter IV

Findings

The experience of interviewing 20 clinicians for this study was an uncharted journey into the privacy of their clinical practices. Though there have been multiple studies on empathy, these studies have been written from a theoretical perspective without the depth that comes from interviewing actual clinicians about their clinical practices.

Most clinicians stated that they had never been asked to think about their understanding of empathy. As the interviews proceeded, clinicians paused when the interviewer repeated the research question, particularly when she used the word "understand." Interviewees would ask, "Understand?" with some inquisitiveness around the use of that particular word. They would comment on how complex the concept of empathy was, how they hadn't quite thought about it in such a deep way, and how it was interesting to stop and analyze something that felt so natural yet had such depth. As they began to reflect on what the research question meant to them, many feelings, thoughts, and experiences began to emerge.

Clinicians' Understanding of Empathy

This study's overarching finding (Charmaz, 2006) is clinicians' understanding of empathy. Additional findings include:

1. Empathy is innate.
2. Empathy is learned.
3. The process of empathy
4. Components of empathy

Within each of these major findings, the study explores the following additional findings:

1. Empathy is innate.
    - It's like breathing.
    - Feeling empathy
    - Empathy and compassion
    - Empathy through experience
2. Empathy is learned.
    - What our clients teach us
    - Looking for client meaning as part of understanding empathy
    - Using empathy is a choice.
    - Suspending judgments and expectations
    - Cultural empathy
    - Teaching empathy to other clinicians
3. The process of empathy
    - Empathy by example (Bettleheim)
    - Clinicians as clients

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4. Components of empathy
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Empathy Is Innate

It's like breathing.

The clinicians interviewed had various points of view as to whether the ability to be empathic is innate or whether it can be taught and learned. The clinicians provided a variety of perspectives regarding this question.

One clinician responded to the research question—"How do you understand empathy?"—by saying that after forty years of practice, she believed that the process of empathy was like breathing. It was so natural to her that she had never stopped to consider the concept through the lens of understanding.

She saw empathy as innate, as if it were the air that breathes life into the therapeutic relationship. Another interviewee who believed that empathy is innate shared a story from her experience at her husband's funeral: "All of my family was in couples and I was alone, and this little eight-year-old girl (my granddaughter) came over to me and took my hand—isn't that empathy?"

One might consider whether this clinician's granddaughter was innately empathic. Many clinicians mentioned in the interviews that they knew early in their lives that they

would do some type of work with people, given their innate empathic skills. One clinician stated, "I've always been this way," referring to her empathic nature as far back in time as she could remember.

For the purpose of this study, initial findings indicated that some clinicians believed that they were, in fact, "hard-wired" as empathic. One said,

> Empathy is a hard-wired feature—it's like a trait. I think that if you are going to do social work, if you're going to be a clinician, you're going to be a psychotherapist—there has to be a starting point.

A clinician interviewed shared the following story as a way to illustrate her understanding of empathy:

> I live in an assisted living facility. One day I saw a man changing a light bulb. I asked him, "Have I met you—are you new here? Have you worked in an old folks' home before?"
>
> He said, "No."
>
> Then I asked, "What makes you come here?"
>
> He said, "My grandmother just went into a place like this, and I figured that if I could help somebody here, then maybe someone is helping my grandmother." Isn't that empathy?

This clinician felt that some people demonstrate a unique "tuning in" that illustrated her understanding of empathy. Other clinicians described this "tuning in" as well as an intuitiveness that lends itself to an empathic approach. One said, "When I think of my empathy muscles being overdeveloped, I also think of intuition and a way that I tune in to the world—there's empathy and awareness and vigilance about human beings."

Regardless of whether clinicians felt that empathy was innate, most stated that the use of empathy can be tailored to individual client needs and varied clinical situations. Clinicians also expressed that there is always room to learn and grow as a clinician, including an expansion of empathy skills. One said,

> For some people (clients), they've literally never had people in their lives who just sat with them and witnessed what they were saying and feeling, and reflected it back, and for young clinicians it is like the hardest lesson to learn. It's not something you do, it's something that you are, and some people are and some people aren't.

Feeling empathy.

Within the framework of believing that empathy may be innate, clinicians gave various descriptions of how they "felt" empathy with and for their clients. Clinicians interviewed gave examples of "feeling oneself into the inner life of another person" as they discussed their understanding of empathy. One said,

> Empathy is not only the experience of the other person but also what their emotions are and their associated feelings. Somebody may be having an experience I've never been through—for example though I've never had a heart attack, I can imagine, I can empathize with someone who has had a heart attack, what they might have experienced, what they might have gone through, or what the feelings attached to that might be.

Clinicians working with their clients paid close attention in their practices to their clients' body language. Through their clients' feeling states, body language, and

narratives, clinicians were able to begin to feel closer to their clients' experiences. A clinician interviewed shared her experience as her client talked about grief:

> It's an emotional state . . . .I feel grief but it's not because I've lived that person's grief, it's because I've lived my own grief. The feeling is the same, but the story is different.

Other clinicians described feeling empathy through a "type of resonance" with their clients. One said,

> You never understand what someone else is feeling, but I'm feeling some type of resonance. It's all like my own experiences. It's all filtered through my past history and everything I've been through, so you can't ever know what they are feeling exactly. And the other side is we are all humans, we are all here together, and we're all in this almost like spiritual way. If someone is having a deep feeling and I'm feeling it too, then this is this human thing that happens . . . and I feel like it's a deep level, like this is the feeling and we have it, and this is how we are connected.

Although clinicians said that one can never know what clients feel exactly, resonance was universally seen as part of empathic understanding. Several clinicians shared phrases their clients used to communicate feeling understood. Clients replied that they were "feeling felt" and said, "exactly" when their clinicians communicated their understanding of the clients' feelings. When clients used these types of words, clinicians reported feeling that they had made an empathic connection, that their clients felt "resonance." One clinician said,

> I think of empathy as experiencing or being in touch on a feeling level with someone else's feeling. Not identifying with them in terms of "I felt that way too," but

> understanding. You may see that what's going on right now is that they are very anxious, or they feel frightened, or the situation is obviously overwhelming. . . . [Empathy is] being able to tap into them, to understand what they are feeling.

Another said,

> If someone is feeling sad, maybe [empathy is] not defining sadness by your own experiences, [but] simply allowing that appreciation of sad. Sitting there and having that other person inform [you of] the details of their experiences of sadness. When people are in a moment or a space of grief or sadness or frustration or anxiety and they are having these intense emotions, we all know jumping in and fixing it doesn't help.

This clinician's recommendation that one "sit with" a client's affect without trying to problem-solve or fix is a hard practice to learn, particularly for newer clinicians.

Another clinician described empathic space as a place he needed to be in, in order to be fully present for his clients:

> The empathic space is sort of available, receptive, tuned in, and not much else going on in my mind. Not thinking per se at that moment. I'm just very present, very much in the same time-space with the other person. Being receptive . . . and connected and in tune, and nothing else is interfering at that moment. For instance, someone is talking about feeling distress over their son's illness, . . . how their son's illness keeps them from focusing on their own stuff, so I might just say something like, "You're afraid that your time is slipping away," and that feels empathic to that client.

This is an example of how clinicians reflected upon clients' feelings and then chose their own words carefully when providing feedback and interpretations to their clients.

Clinicians reported that clients commented that this type of feedback was helpful and they felt supported and heard.

Empathy and compassion.

Clinicians explained that they often viewed the terms empathy and compassion as intermingled. Clinicians interviewed who saw empathy as innate also felt that compassion was innate as well. One said,

> Compassion, empathy—part of me thinks they are the same, part of me thinks they are different. I think compassion is to feel the passion, feel coming alongside with someone, but I think that's what empathy means—to feel alongside someone.

Some clinicians expressed a difference between compassion and empathy, emphasizing the necessity of clear clinical boundaries as part of the process. Boundaries were necessary, clinicians felt, and they needed to be clear about their own emotions as well as those of their clients. One said,

> Someone said to me that there is a big difference between empathy and compassion, that in empathy you really feel it, and in compassion you're holding love and energy and your heart is open toward the other person, but you are not taking on the pain.

Clinicians discussed feeling it was essential to allow their clients the space and time to feel their own emotions. This required that clinicians pause when clients were speaking to allow clients to feel their emotions and pain. Clinicians described needing to resist the urge to rush in and speak or attempt to solve their client's presenting issues or dilemmas. One said,

> I think empathizing along is about recognizing where one person ends and the other begins and having compassion but also being able to realize that we're separate entities. We can't sort of move into somebody else's space—or allow somebody else's stuff to become our own.

Clinicians who felt empathy and compassion thought carefully about the empathic therapeutic environment, while keeping professional boundaries in mind. One clinician described the approach as "being careful not to swim in my clients' stories." Another said,

> For me, I have been able to move between empathy and compassion by not taking responsibility to fix the other person. When I want to fix and want to help, I really feel their pain and it bogs me down and weighs me down. When I'm in a space where all I am is a container and vessel for spirit, then I'm not taking that on. I can feel some pain, but it doesn't stay in me. It kind of moves through.

Another clinician stated,

> When somebody is crying and feeling pain, when I'm really in that space of compassion, I have a faith and a trust that they have what's needed inside of them, that there is a healing capacity within them. I don't get anxious about needing to help them fix their pain or get out of their pain.

Being present and available for clients without "swimming in their stories" is a way that some clinicians described their understanding of empathy.

Empathy through experience.

One clinician described how he believed his client experienced empathy in the therapeutic relationship:

> You know, it feels like being seen and heard and understood, I think, especially if there is a slight element of surprise. Seen and heard, and a little surprised that they are seen and heard . . . because we never expect anyone to really get us, right? That's why we go to therapists!

Clinicians shared that many clients come to them who feel they haven't been understood or truly seen in their lives. When truly understood in therapy, the clients sometimes feel an element of surprise. Another clinician shared a vivid example when he described how his understanding of empathy evolved from trying to connect with his clients' experiences. He said that if he hadn't experienced the actual situation that the client had experienced, he would need to listen to his own emotions in order to identify with his client's emotional experience:

> I have a client who is haunted by having killed somebody in Vietnam. I never killed anybody. I killed a woodchuck and felt really bad. How much can I extrapolate from killing a woodchuck to killing a person? . . . I may not be empathic, or be able to empathize having shot someone in Vietnam, but I can empathize in needing to look away, . . . a shame connection. . . . I can empathize with or I can sense the connection between what's happening in his body and what's happening in my body.

Clinicians describe the process of empathy unfolding in terms of looking at one's own emotions in a deep way as well as paying close attention to physical internal cues. Another interviewee said, "It doesn't so much have to be a shared experience, as much as

it is having to imagine what the emotions are like, the feelings, what it would be like to go through something like that."

At times, clinicians needed to stretch their paradigm or worldview in order to look through the lens that their clients were experiencing. This was particularly important when one had not had the intensity and depth of experience that the client described. A clinician said,

> I could simply try to hear what the patient was saying and listen to them and so forth, and I think increasingly it's my sense that to be empathic one has to try to see if one can find in oneself either a similar conflict that maybe had been faced or surmounted and then try to see that from a person's worldview. Whatever they are doing, however they are trying to deal with things from their worldview, it is likely almost always—I can't even think of an exception—logically coherent. And it's that that I have to tap into.

Many clinicians interviewed described the complexity of trying to understand a client through the client's experience and worldview. In doing so, clinicians could then begin to understand and empathize with their clients.

Empathy is Learned

What our clients teach us.

Another clinician also spoke about having to stretch his perspective in order to see the client's view or reality. This clinician works as a social worker in an ob–gyn unit of a hospital. A physician approached him who wanted him to respond to the client in a

certain way; however the clinician, through his understanding of empathy, was able to see his client through the lens of her experience. This new perspective enabled him to embrace his client empathically in a unique way. Had he stayed in the frame of his own experiences, he stated, his empathy would have been limited. His empathy expanded his ability to connect with his client:

> In the obstetrics clinic, I was asked to come and speak to a 17-year-old girl who said that she really wanted to become pregnant. The doctor tried to talk her out of it. He asked if I would talk with her about not getting pregnant. . . . I was going to give her a little lecture. . . . I thought about being a clinician. I asked her to tell me more about her desire to become pregnant, and she wound up telling me . . . that within the last year or two, she had lost . . . to gang violence . . . two contemporaries. And that since she really had no guarantee how long she would live, she decided she wanted motherhood to be part of her life experience. This required me to see that from her worldview. Being a middle-class white male, . . . for me the empathy at that moment meant to think about what it means to live in a world that's violence ridden, where one's safety is challenged from day to day. If I could have taken a step back before I had gone back in the room and used that way of thinking and said something like, "Under what circumstances would I want to have a child if I was low income and unmarried, etc.," then maybe I could have gone in with more of an open mind. But she did open my mind. . . . Suddenly what she was saying made perfect sense to me. Instead of me giving her a lecture and getting her channeled into my point of view, I became channeled into hers. I still said I thought there could be other possibilities for her. I thought that when a young person who is single becomes pregnant that it often

> puts one on a path to poverty, . . . there is yet another child, and so forth, and that I hoped that she would really think this through. But I still got where she was coming from.

Looking for client meaning as part of understanding empathy.

Clinicians reported that part of understanding empathy was looking for meaning behind clients' words, behaviors, choices, and actions. The more experienced clinicians that the researcher interviewed appeared to have the most comfort with this concept. They spoke of realizing that behavior was often a signal to them that there were deeper emotional issues going on for their clients. A clinician who works with an incarcerated population offered the following example:

> Feeling empathy provides meaning to behavior. Empathy gives understanding to the behavior, . . . and in some ways it gives clearer understanding of this behavior that is maladaptive and so socially maladjusted. It would give a starting place as well as [an indication of] how to intervene with the change process. . . . It might provide hope for a clinician to say, "Maybe there is a way to speak into this," . . . but apart from that understanding and knowledge, I think the clinician may be left with, "There is just that behavior and there is just this person." It almost makes them not human. But as the teacher might say, "This child just keeps doing these things," but if I had the story, it gives them this meaning and significance. It gives them their whole life story. Then it really says, "OK, I can actually connect with the person a little bit better or try to connect." I can't guarantee a connection ever. I can try to think about creative ways to connect with this person, try new things. The point of that

> therapeutic relationship is to help this person function more aptly in society—I would say that's a very important thing.

It became apparent through the interviews that many of the more experienced clinicians were also in roles as supervisors, consultants, and teachers. In those roles, these clinicians felt it was important to teach more about their understanding of empathy. Part of this teaching included helping new clinicians become more experienced in looking for and understanding meaning behind client behaviors.

Using empathy is a choice.

Clinicians described how they make a choice about whether to use empathy in an interaction with a client. This was particularly important when one was dealing with a person who might be combative or difficult. One clinician said,

> You make a choice about how you are going to engage with that person. It's like a feedback thing, . . . but the way that I see relationships in general is that you have to commit to a relationship in some capacity for that relationship to have any potential.

Some clinicians stated that they had to thoughtfully approach certain clients, as they didn't feel naturally empathic. This often happened with clients who had committed a crime or displayed significant antisocial behavior. One clinician said,

> Empathy is a choice. You choose. "How am I going to act with this person? How am I going to engage with this person?" Then you can proceed in engaging with that person. . . . The relationship happens. It can deepen, it cannot, it could click, it could not click.

Supervisees were taught to examine their feelings regarding their clients (countertransference) so that they could make choices prior to sessions as to how they wanted to interact and respond. Most clinicians interviewed discussed that being in a centered, mindful place allowed them to feel more present when working with their clients.

Suspending judgments and expectations.

Clinicians interviewed for this study practiced in a wide variety of settings, including prisons and psychiatric hospitals. Clinicians described how many of their clients initially were difficult to empathize with because of the clients' trust and attachment issues and their deviant behaviors. Many of the clinicians interviewed stated that their understanding of empathy included the ability to recognize their own expectations and judgments and to work on suspending them in their therapy relationships. One said,

> Yes I think [empathy is] open-mindedness, the ability to understand a person's situation or circumstances and essentially suspend judgment in a sense. Really tune in to what is going on for this person.

Clinicians interviewed felt strongly that without suspending judgment and expectations, it would be very difficult to establish and maintain empathy in the treatment setting. This required that clinicians understand their countertransference issues within the treatment relationship. One commented,

> For empathy there has to be a willingness to not judge and to have compassion. . . . When you tell me your story about these terrible things that you are going through—what do I do with that? That's the part [when] I can take an empathic stance or

> not . . . . How do I interpret what you are saying about the information you are giving me? And how do I use this to be in a place of compassion and empathy? You are making decisions from this place that I can't really understand—what history you come from, how you were raised as a child, what options you come from. And I can say to myself, "I can't really understand, regardless of what judgments are easy to grab."

Other clinicians described the emotions that they went through when they began to work with clients who might have different values or make different life choices than they would. One explained,

> It's hard to feel empathic if I am with someone who is cruel. It's easier to be empathic when with a patient who is "good intentioned" or "noble," . . . harder to empathize with a patient who "pushes my buttons" in some ways. If I feel personally threatened, it is harder for me to empathize. Somehow it's easier to excuse when it's a person from a different culture—easier to forgive than an American who is being difficult or nasty.

Clinicians discussed that a premise of empathy is that a nonjudgmental, encouraging approach will help the client to thrive. For those clients who had not had consistently nurturing parenting, clinicians reported that creating a nonjudgmental milieu was a particularly key part of empathy. One said,

> Maybe empathy is a lack of judgment. I look at that place of "I'm hearing what you are saying and I will hold on to a place of compassion with that." When I think about empathy, I think about labels. Labels are good, bad, right, or wrong. When I think

> about empathy, the labels fall away. Empathy is absent of those things. That, for me, is empathy.

Another said, “Empathy is that holding piece, . . . a place of not judging, understanding, trying to gain a more in-depth, intimate understanding of what that might be like.”

Clinicians felt clearly that if there was judgment in the psychotherapy space, it would interfere with the therapeutic process. One hope for therapy is that clients will experience and internalize caring. This may lead, sometimes for the first time, to clients learning to value and care about themselves. As a result of this process, a stronger sense of self can develop. One clinician said,

> You have to find something to love in every patient. And almost above anything else, this work is about love. And if somebody comes to me and I can’t find anything to love, I have to send them to somebody else. . . . A woman called me with a very heavy accent. She had been sent by her psychiatrist and she said, “How do you feel about treating a German patient?” She grew up in Germany during the war. I said, “I think I can handle it. How do you feel about having a Jewish therapist?” And she said, “I think it could be a good thing.” We worked together for many years, . . . very successfully, very positively. . . . Her mother had been so judgmental. She had been made to feel by her mother—who didn’t want her—like the worst thing on the earth . . . I had to teach my client how to empathize with herself. You know she couldn’t empathize with herself at all.

One clinician stated, “Judgment is going to get in the way of [empathically] showing up.” Other clinicians described their experiences and views of judgment and

expectations, and how continuing to work with themselves increases their availability to their clients. The following clinicians realized their judgments might prevent them from "showing up" in an empathic, clinical way. One told this story:

> [My family and I] see this person walking down the street, and the person has very vibrant tattoos on their body. . . . I ask, . . . "How will they get a job?"
>
> My brother-in-law says, . . . "Maybe they work as a tattoo artist."
>
> And in that moment I thought, 'Wow—maybe these tattoos are a gift.'

Another clinician recommended "letting go of expectations and old ideas about what you think about certain populations of people or what you think you know about poverty or unplanned pregnancy or disability . . . Just trying to keep an open mind." Yet another clinician reflected,

> I had a very interesting experience for myself. People would come to see me who were badly disfigured with few capabilities. At that point they could no longer return to their employment that they had started with initially. When I first started working with them, I found I was reluctant to ask questions that might make them shy or uncomfortable in some way, but as I grew in the job I found that I was much more able to relate and discuss. . . . Empathy for me is not something you always need to work with. Sometimes you have to understand what's wrong—it's necessary as well to be direct and to not show a feeling for the negative.

Clinicians discussed the importance of considering a client's story, culture, and context. Without this consideration, they might make incorrect assumptions and judgments that would interfere with empathy. They felt it was important to consider their clients' cultures and contexts in order to understand what their actual struggles were.

Several clinicians who worked with women and men who had been abused discussed how suspending judgment was essential in working with this population. One said,

> If I'm helping somebody who is in an abusive relationship, I can have empathy for them in that I can use my experiences in relationships and hear about the things they are going through and have compassion for that as opposed to coming from a place of judgment. . . . I think that's a huge indicator—if I am coming from a place of judging, it's going to be a lot harder to have empathy. If I can come from a place of compassion and understanding, that's how I'm able to meet you in finding whatever support you feel you need, because you can tell me you are in this terrible situation—and you are going home to that person tonight. So that's your choice.

Because the clinicians in this study were psychodynamic social workers, several offered a perspective within which to consider a client's presentation, especially when that presentation was difficult or disturbing. One clinician explained his perspective:

> You have to believe people are well-intentioned, and if they exhibit tough behavior, this represents a "failed adaptation." . . . Empathy involves seeing beyond the surface and understanding the reasons beyond a client's behavior. Empathy can be a tool to see what's inside a client, behind the screen. . . . For example, in narcissism someone may come across as arrogant or entitled. Those are hard qualities to relate to in some positive way unless you understand them as defense against feeling worthless.

This clinician explained that considering a client's behavior as a "failed adaptation" created a way to look at clients through a psychodynamic lens. The behavior informs the clinician of the psychodynamic context. He continued,

> Understanding empathy is not based on a book or article or a class, you know. [To empathize, you] really kind of tune in to the person, the energy, and their experiences or what you know about them. And imagine what it would be like to see and experience life though their eyes to some extent.

Clinicians made clear that "empathic presence" with a client does not mean that one will always agree with a client's choices or presentation. However, the client must feel that presence on some level in order for the therapeutic relationship to develop. One clinician noted,

> You know when it's there—to me it's not a matter of just being present, it's presence with a client. And understanding and feeling where they are—and understanding and connecting with them, I would say almost on an intuitive level, to what their feelings are. That's how I think about it—and just because I have empathy for them doesn't mean you agree with them or that you can support where they are, but you understand what they are experiencing.

Clinicians particularly noted this concept of "presence" with a client when they discussed working with clients presenting varied issues, and/or coming from a variety of cultural backgrounds.

Cultural empathy.

Many clinicians stated the need to learn about their clients' cultural backgrounds as part of the empathy. Often clinicians would ask their clients to teach them about their backgrounds and cultures as part of the initial joining process in therapy. Clinicians emphasized the importance of realizing that clients come from a macro culture (their

community, religion, traditions) but also the micro culture of the family of origin and extended family and friends. Clients' cultures had a direct effect on their beliefs, value systems, and decisions. The scenario one interviewee described reflects this:

> My first internship in graduate school was with an affordable housing agency. We had a child abuse/child neglect call. One of the relatively new mothers, who were from Africa, had left her two-year-old child in the crib. We knew this because one of the maintenance men knocked on the door, and when no one answered they went in the house. They found the two-year-old in his crib. . . . The maintenance man waited five, 10, 15 minutes. No one showed up. They called us and we did have to call child protective services. Mom came to our office, she spoke very little English, and she had to work with child protective and the police. Luckily, someone on staff was able to communicate with Mom, and we needed to help her to understand that leaving a child to go to visit a neighbor was common in other countries . . . but not allowed here. . . . We had to follow this case, the interpreter explaining to her that this is something she cannot do in the United States.

By having an understanding of the culture that this client came from, the clinician was able to develop a better sense of empathy. Clearly this client had to learn and follow new cultural rules.

In other cases, some clinicians explained that some of their clients struggled with shame when they made different life choices than their families may had made. These clients welcomed a nonjudgmental approach that their clinicians provided.

Teaching empathy to other clinicians.

Clinicians reported that some of their trainees were very strong academically and yet needed coaching to connect with their clients in a more empathic way. Clinicians often referred to therapists they were supervising who sometimes found empathy challenging. One clinician who supervised other clinicians described how she was trying to teach empathy to a supervisee:

> And so we [the clinician/supervisor and the clinician/supervisee] started to think about where [the client's] language could be coming from, where his ideology could be coming from, what his experiences could have been like to lead to his thinking. And we moved away from [the supervisee's] reaction and her anger to whatever it was he was saying or doing and to trying to understand who he is and what his backstory is to get him to where he is.

This clinician/supervisor demonstrated her belief that guiding her supervisee to look at the "backstory" was part of understanding empathy.

A clinician described looking behind the client's presenting behavior:

> I do in fact feel people need boundaries in order to develop their own internal sense of "boundaryness," but I would have to say it's about understanding the origin of a behavior or a difficulty so that we can appropriately respond, not just in this sort of one-size-fits-all punitive fashion. We can give the response, we can give the consequence that fits the actual need through the way that we react.

This clinician alluded to body language, phrases, and interpretations as ways clinicians can communicate empathy to clients:

> [The clinician/supervisee] was sitting with a client. She was really mad at him because he had been kind of a shit, in her opinion, a schmuck to his wife, and had not been thoughtful or respectful. And so [the supervisee] was saying, "I'm just so angry . . . I hear him being sexist. It makes me mad." And I hear all these things . . . and I said, "Let's try to understand why he is the way he is. Let's not be mad at him because of how he is. Let's try to understand what brought him to this point because you know, being mad at him all day isn't going to make him connect with you more or you connect with him or you understand. . . . It's not going to do anything. Trying to understand where he's coming from might deepen your ability to connect with him."

In all of these examples, clinicians in supervisory positions felt that a comprehensive, sensitive, psychodynamic understanding of clients is essential in order to provide good care.

Another clinician described working with a client by asking him to describe his feeling state. By working in this way, empathy for her client increased. She asked her client, "What's it like when you get angry? What does it feel like afterward? What happens if someone sees you—what do you feel like?"

Her client said, "Yeah, that's horrible, that's terrible. . . ."

When her client is able to get in touch with his feelings and disclose, to let his guard down, to be less defensive, this clinician reported, "I feel more empathy toward him."

Many clinicians explained that understanding a client's development will enrich the possibility of an empathic connection. One supported this by stating, "When things are

particularly difficult with clients, I recognize where the behaviors come from in a developmental context, and that helps me be more patient and have compassion."

Other clinicians discussed their views of the relationship between clients and their past issues with attachment with primary figures. One said,

> I began to see the origins of so much pathology and dysfunction and failures of attachment basically and to see the developmental trajectory that follows. And [to see] people that don't have healthy attachments and recognize that those disruptions may result in adult behaviors that some may see as disruptive or oppositional or difficult. Whereas I try to understand that this is actually a person asking for some help. They don't have the language to ask for help, they don't even have the way to conceptualize this, but it's potentially a way of a person looking to have a need met that they didn't have met in their earlier development.

The Process of Empathy

Empathy by example (Bettleheim).

How do clinicians approach the understanding of empathy? What does this process look like if put on a screen to visually observe? One clinician interviewed spoke of the well-known psychiatrist Dr. Bruno Bettleheim, who used a particular technique to develop an empathic perspective in his psychiatrists-in-training:

> [Bettleheim] just wanted a description of what the kid was doing—John is kicking a chair, Sally is mushing food against a wall. He would say to his students, "Now that you've told me what your student has done, under what circumstances would you do

> this? Under what circumstances would you push a chair? Under what circumstances would you push food against a wall?" It's that kind of empathy that's really about trying to find a piece of that person in yourself.

Another said,

> When I'm "in empathy," what I do now is notice the sadness or anger in my own body, and I'll use that as a tool to say, "Wow, you are feeling sad." But then I'll come out of it, and I'll remind myself to ground, to breathe, that it's not my responsibility to fix it—and then I can actually be a lot more supportive of that person.

Clinicians described that at times empathy is about visualizing oneself in the life of another and trying to connect to the feeling that could be behind a particular behavior like mushing food against a wall or pushing a chair. Though often client behavior is alien to the clinician's experiences, some clinicians felt that the closer they could get to imagining that state, the stronger their ability to be empathic would be. Clinicians also described feeling bodily sensations as their clients were talking. These sensations sometimes acted as cues for clinicians to look inward to try to understand the meaning behind the sensations.

Clinicians described another part of the process, determining when to listen to a client and when to provide feedback or interpretations about what the clinician has heard. One stated,

> You know, if I am in a building-rapport stage with someone, I'm more likely to primarily rely on empathy until someone really knows what I am really talking

about, and then I'm more likely to say things that are more challenging. I'll go more toward experience distance communication.

Therefore, part of clinicians' understanding of the process of empathy is determining the best timing for interacting with clients in particular ways.

Clinicians as clients.

Most clinicians in this study stated that it would be much more difficult for them to understand the process of empathy if they hadn't had their own positive therapeutic experience. Those clinicians who had negative empathy experiences felt that they strengthened them in their own practices and made them particularly sensitive to tuning in to their client's needs. Many clinicians interviewed described their own therapy experiences as being essential in helping them to understand the process of empathy. They said that being on the client side and experiencing empathy was essential for them to understand empathy. One clinician described her therapist this way:

> She still looks at me and smiles and has these kind eyes even though I'm saying these things that really look scary. Or I think someone's going to say, "Those are such horrible thoughts." . . . It took a while of doing that before it sunk in that [my therapist] was going to remain.

Another clinician said,

> [My therapist] holds me in warm regard. It took a while for that to sink in—then I knew she was really deeply compassionate, and even when I come in and say, "I am a mess here" or "I'm messing up," she's like, "All right—let's look at that. Bring that here. . . . It's OK."

These clinicians stated that when they began therapy they were hesitant and concerned as to whether they would be accepted and understood. There was comfort in discovering that their therapists welcomed them with whatever issues and emotions they wanted to share. Another clinician said, "I've felt it's very comfortable and familiar to go visit her—something about just going—I feel like I sit down and it feels like there's this kind space that happens." Another stated,

> Therapy should be part of graduate education. This allows an expansion of our level of awareness, . . . helps us know what our own issues are. Being in the role of the patient helps us to understand that the work is very hard, . . . helps us to experience the process of "stockiness" and feeling blocked, mentally bound up, intellectualizing, or resistant.

Most clinicians interviewed discussed their own therapy experiences and the influence on their understanding of empathy.

Empathy and self-care.

Some clinicians shared that high levels of empathy and intuition could contribute to a feeling of burnout. These clinicians emphasized the need for self-care as they keenly felt the world around them, sometimes feeling overwhelmed by their own levels of sensitivity. One clinician stated,

> High levels of empathy and intuition can cause burnout and [make one] tired emotionally. These traits can cause someone to be too taken in; they can't even watch the news as their empathy is off the chart. When planes are lost in Malaysia, when the news shows a woman [passenger] for a split second, it actually shows her

face—some people can watch that story, listen to the information, digest it, and continue to watch the show.

I can walk in the room, look at the face of the mother, and walk back in the kitchen. I could work with her if she was my patient, but if I can't do something about it, why would I want to expose myself to it?

Several clinicians spoke of going on meditation retreats in order to practice self-care at particularly difficult stages of their careers and/or their lives. One clinician spoke of feeling that she knew when she needed to retire because she started to feel less empathic for her clients. She noted, "If I am not taking care of myself enough—I'm too deregulated or something—then I can't have empathy." Another said,

When I'm meditating regularly, I have a great capacity for empathy. When I have a hard time with my clients, I would want to fix their problems and send them away. I'd think, "Just do this and the other thing and be on your way." I wasn't emotionally available. I probably wasn't as attuned or empathic as I normally am.

Another clinician said, "It's easier to be empathic when I am rested and good, harder when I am exhausted or depleted." All clinicians agreed that psychotherapy is a field where self-care is imperative. It is only when clinicians can model and take care of themselves that they can be present in the most therapeutic sense for their clients.

Empathic rupture and repair or empathic failure.

One clinician described a clinical supervisor who she felt was unempathic and, in turn, unreachable and unhelpful. She envisioned that if this supervisor worked with

clients, the clients might also experience a lack of empathy and understanding, and therefore, empathic failure. She said,

> When the phone rang, my supervisor would answer it in the middle of our supervision. She would say, "Oh, I'm thinking of something. . . . I have to send this e-mail before I forget." Then she'd come back and say, "What were we talking about?" Then if I was talking about a client and something I felt was emotional or difficult or meaningful, . . . she would ask this question that showed that she wasn't really deeply listening. . . .
>
> I remember one of my co-workers saying they had gone to visit this family, . . . and something happened that was pretty traumatic, . . . and my co-worker was saying, "Oh my God, this horrible thing happened and I was so upset."
>
> And the supervisor asked, "Oh, well, did you write your incident report yet?" instead of actually first attending to the feelings and what was going on. . . .
>
> She was also so anxious it was like she couldn't be present. . . . And then I don't know if it was because of the anxiety, but I felt like she couldn't go to a feelings level, which is where I think empathy resides. She stayed on the superficial—like, "Do your incident reports, organize your consultations, and case manage, and do this." It didn't ever feel like she was with me.

Other clinicians gave a variety of perspectives for empathic failure or empathic rupture and repair. Some clinicians felt that any therapy relationship that didn't work out was a failure, though the treatment could have been with a client who went through multiple clinicians. Other clinicians pointed to specific clinical examples where they felt that an empathic failure occurred due to a disruption of some kind in the relationship

between client and clinician. Some clinicians appeared to be hard on themselves when the therapeutic relationship didn't go in the direction they hoped for. One clinician explained a clinical situation that she saw as empathic failure:

> There's a couple that comes to mind—one of the partners had an onset of mania. He was angry and banging on the door and trying to get into the session. He was very angry with me for not siding with him. His wife was trying to set limits, so he became really angry with me, and I really and truly tried to keep him engaged and give him adequate treatment. I needed to be able to tell him he needed med changes. . . . He was just livid. He also threatened divorce. I felt my empathy was interrupted. I felt much more empathy for her at that moment and was concerned about her safety.

This clinician saw this experience as empathic failure as she couldn't connect with this husband in the way that she hoped. On the other hand, another clinician said,

> [Empathic failure is] not so charged. I don't think it's such a bad thing. It's diagnostic. If I as a clinician feel like I can't connect with somebody and I'm lacking empathy for them, for me it tells me more about their dynamics. I know myself as such a high empathy person. That's my baseline. I'm more empathic than I want to be.

Another expressed, "It's common to have empathic failure with people who have not addressed the fact that they are in denial—I've seen folks who have a lack of empathy for clients who have addiction issues."

Clinicians reported that the ability to offer their clients the comfort of discussing relationship dynamics represented an empathic bond. Often clients said they had not had

that opportunity previously in other relationships outside of the therapy setting. Clinicians reported that clients were often afraid to be assertive or forthright outside of the therapeutic relationship for fear of criticism, rejection, or abandonment. Therefore, a clinician's ability to work through an empathic rupture could be a positive part of the therapeutic work, representing an empathic rupture and repair. A key factor in empathic rupture and repair is the ability of the clinician and client to talk through what has happened and then to move on in a healthy way. Clinicians said that attending to rupture and repair may represent the first time that a client was able to express feelings fully in a significant relationship where feelings were encouraged and held respectfully in the therapeutic space.

Components of Empathy

The use of silence.

Clinicians believed that silence was a very important part of the therapy process; some said that perhaps it was a skill that they needed to talk about and develop in their own clinical supervision. They said they believed some clinicians were often uncomfortable with silence because they felt they weren't being helpful to their clients when they didn't speak. Often these clinicians used talking in therapy to fulfill their own needs or manage their own anxiety. Some clinicians described silence as an essential part of empathy, demonstrating to clients that the clients' feelings, thoughts, and words were worthy of being listened to. One said,

> If you're silent sometimes, sometimes in the unspoken their worth is returned to them, even in the act of listening. It's a unique opportunity for us to give people

> worth and place and presence, to say, "Your thoughts matter. Your feelings matter." It's this undivided attention we are paying you—it is not just understanding intellectually but emotionally as well—saying you are not alone.

Another said, "I think there is something powerful about a therapist being silent—people feel like there's room for them to emerge. So that empathy that we have in that place, that's stronger than words."

Overempathizing and countertransference.

Many clinicians expressed the belief that countertransference informed them of many aspects of treatment, including where their empathy was for their clients. If they were feeling that they were drawn to overempathize, they looked at what that meant for them. Clinicians talked about overempathizing as getting overinvolved with their client's emotions to the point where the clinicians couldn't be objective. These clinicians asked themselves: "What is this client bringing up for me?"; "What emotions are they triggering and why?"; "What is it about this particular client that brings me to feel how I am feeling?"; "What meaning is behind these feelings?"; "Why do I feel a stronger need to be the helper with this client?"; and "Why do I want to save them in a different way than other clients?"

Clinicians said that understanding countertransference was a way that they could stay centered with their clients' best interest in mind. One said, "My conditioning since I was very young was to be the responsible, strong one. That mode kicks in easily. I've done a lot of work around not taking responsibility and not fixing." A clinician who worked with a client who had an experience similar to her own noted,

> I would definitely say I was triggered because I always had that experience alive in me when she was talking about it. The thing that was alive in me got really activated.
>
> I would say I was maybe not overempathic. I would say it wasn't just empathy.
>
> Maybe there was some empathy, but even more it was just her stuff kicking up mine.

A third clinician said, "When I think about being overempathic, I think about somebody who can't maintain a boundary and then might break a frame because they are too invested in a client."

Clinicians discussed how they kept themselves centered (and not "swimming in their clients' stories") so that their boundaries were clear and their clients' needs were the focus of treatment. Some clinicians felt that being in too overempathic a place could cause them to feel burnt out and tired. Countertransference is a very powerful and necessary tool that informs clinicians to work on staying grounded and centered in the therapeutic frame. One clinician interviewed stated,

> One of the things I learned in supervision is that if I have negative feelings . . . to identify my negative feelings and not let them get in the way of my work.
>
> Understanding countertransference was the greatest professional growth that I had.

Clinicians spoke of the importance of this perspective in order to maintain therapeutic objectivity and keep the work in the service of the clients. Countertransference can be stirring in powerful and unexpected ways, as Spiro, Peschel, Cumen, and St. James (1993) explained: "We can also get emotionally and existentially wounded by patients who arouse anxieties or through transference and countertransference force us to reappraise powerful episodes in our own lives or to face unresolved ongoing conflicts" (p. 158).

Understanding and working with the countertransference process is an important part of understanding empathy according to the clinicians interviewed. One stated,

> When you are working through your own countertransference as an early, young clinician, I think you are forced to look at your own process and see where you get under-involved and have empathic failure for some reason, or overinvolved (having rescue fantasies about certain patients) and why it is that you find yourself spending more time with a patient.

Another recounted listening to what she called "a horrific trauma story":

> And I thought [about my client], 'You should surely feel horrible about what just happened.' And it was more a matter-of-fact statement for this person, and what was actually horrible was a lot of other things that had happened. I couldn't understand how a lot of other things could be more horrible than this thing. What might be absolutely horrific for you might be the norm for someone else.

Most of the clinicians interviewed stated that countertransference was an essential part of the psychotherapy process. One clinician said, "We bring a lens based on our countertransference issues" to work with clients. Zepf and Hartmann stated (2008), "The analyst's emotional response to his patient within the analytic situation represents one of the most important tools of his work. The analyst's counter-transference is an instrument of research into the unconscious" (p. 81). Unlike Freud, Zepf and Hartmann found themselves confronted with the problem of explaining how empathy and countertransference—both essential means of acquiring knowledge about the contents of other people's egos—differed from each other (p. 743).

Empathizing with clients' experiences is a very complex process, but countertransference can be an essential and guiding tool. One clinician interviewed stated, "Sometimes it's good to have strong feelings about things. Countertransference may even point you to relational dynamics or some things you may not have been aware of had you not listened to it."

One of the clinicians interviewed understood empathy as "walking alongside." This thought seems to encompass the many perspectives expressed during the research interviews.

Chapter V

Implications

Theoretical Implications

The 20 psychodynamic clinical social workers interviewed for this study had more than five years of clinical practice experience and had worked in a variety of clinical settings, including private practices, agencies, governmental departments, schools, prison settings, and medical and psychiatric hospitals. These clinicians worked with clients who presented with a multitude of clinical diagnoses and presentations, who ranged in age from early childhood through the upper nineties, and who came for individual, couple, family, and group therapies.

Though all clinicians interviewed self-identified as psychodynamic, none of them were proponents of any particular psychodynamic theory. Interviewees focused on the research question, which asked how they understood empathy. The word "understand" in the research question lent itself to clinicians thinking deeply about the psychodynamic therapy process.

The following themes arose from the data:

- Empathy is essential for a successful psychotherapy.
- Empathy can be innate or learned.
- Countertransference informs our understanding of empathy.
- Clinicians need to understand meaning behind clients' presenting behaviors.

- Empathic rupture and repair and empathic failure are important components of empathy.
- It is possible to teach empathy to others.
- One can learn about empathy through having an empathic experience, for instance by being in a successful psychotherapy.
- Clinicians had to suspend judgments and expectations to empathize with their clients.
- Clinicians had to understand their clients' cultures in order to empathize with them.
- Empathy includes using silence in the psychotherapy relationship.

What follows is an in-depth review of some of these findings.

Empathy is essential for a successful psychotherapy.

Much of the data from the interviews is consistent with self psychology theory. The first theme above—"Empathy is essential for a successful psychotherapy"—is a major premise of self psychology. Rowe and Mac Isaac (1989) described Kohut's conception of the role of empathy in self psychology as follows:

> He clearly stated that the primary function of empathy was to make possible the painstaking unfolding of a patient's inner experiences and the emergence of specific developmental needs (selfobject transferences). It is this process that leads to in-depth understanding and interpretation, and to reliable psychological change. This in-depth empathic process led also to Kohut's theoretical formulations, . . . the door for further advancements in theory (p. 21).

A clinician interviewed for this study described empathy in a way that is consistent with self psychology:

> It's definitely tracking—experience near vs. experience far, and there is a process of staying aligned with the client very tightly which allows a different experience for that client. And it's really forming a self-object relationship, and you need to have empathy to be able to have that stay present. And if there's not an empathic relationship, then the client cannot use the self-object. He can't use me in a way that will allow him or her to deal with what may be going on that's not conscious. . . . Empathy is sort of the thread and can build that basic trust, and if I can't acknowledge that, I make a mistake. I'm misaligned. . . . I will cut my usefulness as a self-object because there is no way for them to stay connected with me. The empathy is sort of a thread, the alliance that keeps us.

Elson (1986) explained how self psychology and social work have always had a natural connection:

> I have found a special congruence between the practice of Social Work and Self Psychology. . . . Self Psychology enhances our understanding of the manner in which the Social Worker, as new selfobject in the present, provides and promotes the conditions for healing deficits in self structure (p. 7).

All clinicians in this study supported this statement with their descriptions of how they were present through empathy for their clients. Though they did not use the term "self-object" in the interviews, they described being present for their clients in a way very much in line with Elson's description.

Elson (1986) also stated,

> Social workers may now avoid a repetition of past injury to the individual that has resulted in maladaptive behavior and failure by understanding the needs for mirroring, idealizing, or partnering selfobject functions. Most importantly, self psychology enables social workers to develop a more effective understanding of the manner in which their selfobject functions may facilitate an individual's capacity to transmute missing functions into self functions, to transmute missing structure into psychic structure which can reliably regulate self-esteem (p. 6).

Clinicians described facilitating this process through their use of empathy. It was interesting to note that even though clinicians did not describe practicing through a particular psychodynamic theory, much of the data in this study is consistent with a self psychological approach.

Empathy can be innate or learned.

Some clinicians felt that empathy was innate, and some felt it was learned. Those who believed it was learned appeared to have varying definitions. One clinician described meeting with a client and claimed he felt the power of empathy through what he learned from his client. Other clinicians also reported this experience during the interviews. Clinicians also described empathic learning in a way that reflected Nathanson's (1997) concept of the "empathic wall." Nathanson described his belief that people are born with empathy but through experiences may develop an empathic wall to protect themselves from hurt or pain others might inflict. He stated,

> It seemed only reasonable, therefore, to suggest that free-floating affective resonance is the norm for early childhood, blocked at some point in normal development, and

> reestablished by those adults to whom it seems either interesting or unavoidable. . . . this block to primitive empathy was learned (Nathanson, 1986, 1989), offered as its label the "empathic wall", and demonstrated that it was essential for the formation of the adult personality. An adult who walked through life always vulnerable with their affect being broadcast into the local environment would be unable to maintain personal boundaries, just as an adult who admits no information from the affect broadcast by others is truly isolated. The empathic wall must be strong when necessary but possess doors and windows that can be opened when necessary and optimal (p. 133).

Many clinicians in this study described how their clients discussed their background stories, often including a need to self-protect and defend against fully feeling their emotions. Clinicians interviewed shared some of their theories regarding how their clients' needs to self-protect came about. Nathanson (1989) explored his concept of the empathic wall:

> How might this learned mechanism be constructed? Is it automatic that every culture on the planet requires that children mute their display of affect by the time they are three years old. We teach this every time we "shush" a child and every time we value verbal over affective communication. To socialize a child is to teach it how to modulate the display of innate affect; socialization demands that a child yield its ability to take over interpersonal space broadcast of each affect at the maximal end of its range. Shaming labels like "immaturity," "childish" and "infantile" drive home this message about affective broadcast (p. 133).

This is supported by the findings as clinicians described numerous clients who had to "relearn" empathy through the therapy process after being dismissed, ignored, or misunderstood earlier in life. These clinicians explained that it was not that their clients never learned empathy, but that they developed defenses over time that clouded their access as a way of self-protection.

Nathanson (1997) summarized beliefs from a self psychology perspective regarding the empathic wall:

> Adult life as we know it would be impossible were we unable to achieve optimal and flexible immunity to the affect experienced by and therefore broadcast by others in our environment, much that goes wrong in our shared world may be traced to maladaptive development of the empathic wall in individuals and families. . . . Some feel a fine line connecting Kohut's (1971) concept of selfobject function to Basch's (1976, 1981) work on empathy to Nathanson's (1986, 1992) concept of the empathic wall, to Kelly's (1996) work on the capacity for intimacy and the repair of problems of intimacy. But now the line has grown longer to include new work on the importance of selfobject function and the empathic wall in the larger, public group that we call "society" or "culture." (pp. 136–137)

This view of the empathic wall may be connected to self psychology's view of self-object failure or empathic failure in that clinicians and clients must connect and be able to work through empathic ruptures in order for empathy to flourish. According to Tuch (1997),

> When a caregiver fails to satisfy the child's need to idealize or to be mirrored, we call these selfobject failures (Stolorow, Brandchaft, & Atwood, 1987, p. 17). When

> that person fails to understand how and why a child feels a certain way, we call these empathic failures. While empathic failures may contribute to selfobject failures, it is essential that the two terms may not be considered synonymous. A failure to differentiate the two has led to murky thinking, especially with regard to the concept of optimal frustration. . . . Not all empathic failures entail a selfobject failure. This is true because the need to feel understood or empathized with is not one of the bipolar needs that originally defined a selfobject. Sometimes the need for empathy has been elevated to the status of basic need, on a par with the needs of a bipolar self, to be idealized and to be mirrored. Some feel that if analysis could be free of empathic failures (an admittedly impossible task) analysands would undergo sufficient change, just by having their needs for emotional attunement met, and the venture could be regarded as truly psychoanalytic (p. 261).

The findings for this study consistently supported the notion that there is no perfect empathy (described above as "an impossible task"), and the idea that empathic failure is a necessary and rich part of the therapeutic process. Tuch (1997) said, "A failure to understand accurately either how or why individuals feel as they do, . . . empathic failures are usually not detected until the analyst's actions demonstrate to the patient whether she or he has been well understood" (p. 264). Zepf and Hartmann (2008) reflected upon this complex question of how clinicians understand empathy:

> Among the unanswered questions, are, for instance, how the child can develop its own capacity for empathy out of the experience of being empathically understood as Greenson (1960) postulates, and how in later life the umbilical cord can be restored in sublimated form of empathy, as Ferreira (1961; see also Kohut 1966)

> maintains. . . . .What most authors describe are very general mother-infant interactions which are substrates for all later interactional patterns. . . . It remains far from clear how one phenomenon leads to the other (p. 744).

The interviews were consistent with self psychology theory in that clinicians felt strongly that part of the empathy process is working with empathic failure as a necessary part of psychodynamic treatment. The reason is that often empathic failures represented a gap in a client's earlier life where self-object failures and empathic failures occurred without repair, potentially affecting the client's abilities to self-soothe and self-regulate.

Tuch (1997) explored causes of empathic failures when he stated,

> While empathic failures are most often thought to result from the analyst's failure to properly understand the patient, empathic failures may occur for other reasons as well. What follows is a discussion of the various factors which may contribute to empathic failure: 1. The analyst's contributions to empathic failures; 2. The patient's contributions to his or her failure to be understood by the analyst; and 3. Instances when empathy cannot be achieved simply because it's impossible to empathize with different aspects of another's experience when those aspects are in conflict with one another (p. 266).

This study's findings illustrate the complex nature of empathy and show that empathic rupture and failure are part of how clinicians understand empathy. Some clinicians referred to therapists who displayed an inability to truly empathize. Similarly, Tuch (1997) referenced Greenson (1960) who discussed,

> How some analysts may be "unconsciously unwilling to leave the isolation of the position of the uninvolved observer" because they feel threatened by the temporary

> decathexis of their self-image which is necessary in order for them to feel another's feelings or put themselves in another's place (p. 267).

In other words, a clinician could put up an empathic wall, whether conscious or unconscious of doing so. Clearly this could prevent the therapeutic relationship from thriving and lasting.

Countertransference informs our understanding of empathy.

One of the findings that is consistent with self psychology is the clinicians' commitment to self-reflection and understanding countertransference. This process involves sitting quietly with thoughts, contemplating the question, and reflecting upon it for a while before answering. When asked how they understood empathy, several clinicians stated they had "never thought about it" and that being empathic was a natural part of their self-identities. This response was consistent throughout the interviews, whether the clinicians saw empathy as innate or learned.

The fact that countertransference informs the therapeutic process was another key finding of this study. Wagoner and Gelso (1991) stated similar views on the importance of countertransference:

> The therapist's internal reactions need to be attended to, understood, and in one way or another, managed. An imperative for the therapist, therefore, is to bring these reactions into awareness, examine them, and use them in the service of the work, rather than permitting them to impeded effective treatment (Fromm Reichmann, 1950; Gelso & Carter, 1985; Heimann, 1950; Reich, 1960) (p. 412).

Clinicians interviewed described the process of looking inward to reflect upon their understanding of empathy. In addition, many clinicians said that empathy included using countertransference as an informing tool throughout the life of therapeutic relationships with their clients. One clinician interviewed claimed the following about countertransference:

> You have 10 people you have to see through the day and will spend two hours with one and 10 seconds with another—and you have to wonder—what's going on there? For me, having done this work for a long time, I know what my trigger points are. When I overidentify with somebody, I can tell when that is, and I have to articulate this, . . . so that's how I know. I have to teach what I'm practicing. . . . I have to teach residents, social work students. . . . I have to come out there and process what I did, what I didn't do, . . . and I ask learners, . . . "Why did you do what you did? Why did you say what you said?"

Countertransference as an informer is an ongoing theme in self psychology, and the interviews in this study consistently referred to it. Many of the clinicians interviewed supported the notion that attention to countertransference is important in any therapy relationship. Rowe and Mac Isaac (1989) stated, "Being aware of what we are experiencing is important in alerting us to interferences in maintaining empathy. However it does not necessarily follow that simply being conscious of an experience means that there are no unconscious disturbing influences" (p. 266). Many clinicians interviewed described how countertransference is a very complex process that needs continuous attention and consideration. Zepf and Hartmann (2008) shared,

> Countertransference reactions are always a joint creation of the patient and the analyst, and it is the status of the analyst's conflicts and self and object representations that decides as to the conscious and hence usable forms of countertransference. If important parts of the analyst's life history are inaccessible to him because of a blind spot, it is very likely that countertransferences capable of entering consciousness will also be molded by what is concealed from him, thus leading to reactive transferences onto the patient. In the evaluation of his countertransference, his insights into the darkness of the other's psychic life will then also be distorted in the same proportion as his preconscious countertransference reactions are distorted by his reactive transferences and his own residual unconscious conflicts (p. 183).

Continual attention to countertransference is an essential part of understanding the psychotherapy process as well as empathy.

Clinicians need to understand meaning behind clients' presenting behaviors.

Kohut's theory of self psychology evolved over time; his original premise was that it required listening closely to a client's presentation and meaning behind that presentation. Clinicians in this study supported this premise through many of their examples. Kohut's second definition included his theory that giving clients feedback was also essential. Though clinicians mentioned feedback throughout the interviews, they didn't refer to it often.

Lachmann (2010) described some valuable insight from Kohut's final speech:

> Therefore, Kohut (1981) used his last talk, used his last breath, to clarify, once more, what he meant by empathy. He reiterated and illustrated how he has always thought of and written about empathy. . . . He had referred to astronauts to differentiate between vicarious extrospection and vicarious introspection. To illustrate vicarious extrospection, Kohut asked us to imagine ourselves into outer space, based on the reports of the astronauts. This, he said, is vicarious extrospection. It enables us to imagine to be in places we have not been. He then drew a parallel to his own explorations of inner space, using vicarious introspection whereby you "put yourself in the shoes" of the patient. Kohut established a link between the astronauts and himself, the difference being in the different worlds that each explored (p. 144).

The clinicians interviewed described experiences similar to traveling to outer space and imagining one is in places one has not been. Clinicians described sitting with many of their clients needing to stretch their own paradigms and experiences of the world. As their clients described their own unique and varied experiences, clinicians traveled with them to new places. Clinicians interviewed expressed that being willing and open to traveling to these places with their clients was a key part of empathy.

Elson (1992) stated an additional perspective on "traveling" with our clients:

> With the lens of self psychology the therapist responds to the affective state which lies under driven behavior and thought, the longing for mirroring, the opportunity for idealizing, the experiences of the likeness—the alter ego or twinship experience. Kohut was fond of saying that without theory we can see nothing, but with theory alone we block the discovery of new knowledge. "Theories must be the helpmates of the observer, not his masters" (Kohut, 1984, p. 67) (p. 376).

Findings in this study are consistent with this self psychology premise as clinician/supervisors described teaching newer clinicians to travel beyond clients' presenting issues in order to understanding deeper meanings.

The clinician who stated that empathy was "like breathing" supported Wolf's (1988) description of empathy through a self psychology lens. Wolf said,

> Knowing that one is understood by another makes one feel better. A person's sense of self is enhanced by the knowledge that another person understands his inner experience. . . . [The other person is] aware of that inner experience and is responding to it with warmly colored positive affects. This phenomenon can easily be observed by paying close attention to one's inner state introspectively or by empathically getting in touch with another's inner experience. These empirical observations are so fundamental and universal that usually they are taken for granted (p. 36).

Many of the clinicians consistently expressed the importance of responding to clients and providing feedback and interpretations when necessary; they echoed Wolf's observation that a person feels better when "another person understands his inner experience, . . . is aware of that inner experience and is responding to it." Though one can never understand another's experience completely, several clinicians described how their clients would say "Exactly" when they felt their clinicians understood what they meant. Some clients were surprised and comforted that their therapists understood them and shared that understanding, an experience they stated they had not had previously. Siegel (1996) described how Kohut's definition of self psychology shifted over time from an emphasis on knowing what a client feels (referred to as a lower form of empathy) to an

emphasis on the clinician giving interpretations to clients (referred to as an upper form of empathy) (p. 189).

Clinicians described the experience of teaching other clinicians about empathy. They stated that empathy includes considering what is behind the presenting words and behavior of clients. In doing so, clinicians began to develop an understanding and to communicate this understanding to their clients. Newer clinicians were sometimes intimidated by clients presenting issues such as intense anger and felt unsure about how to empathize and connect. Self psychology supports the clinician's observations in that a key premise of self psychology theory is carefully understanding and communicating that understanding to clients. Goldberg (1988) described how Kohut, by embracing this process, realized clients were speaking two languages, the language initially heard and the language behind the words:

> Behind Miss F's nagging, complaining, insistent demanding whine . . . [Kohut] heard the voice of a misunderstood child trying to hold herself together, and when he taught himself to speak to that child, he started to feel much better and so did the patient (p. 55).

This is consistent with many of the findings in this study. Supervising clinicians discussed teaching newer clinicians to look at these two voices and to consider the true emotions the client was experiencing. This process helped newer clinicians to develop empathy for their clients, therefore gaining a deeper psychodynamic understanding. Again, this illustrates how this study's findings are consistent with self psychology.

Ornstein (2011) stated,

> I claim that empathy clearly belongs (and has always belonged) to a two-person psychology. . . . The data gained through any of the other usual channels of perception should be harnessed for the enhancement of our empathy-based entry into our patients' inner world. But this still leaves the question of how empathy-based understanding is to be communicated to the patient in the two steps of the interpretive process; understanding and explaining (Ornstein & Ornstein, 1980, 1985). . . . And what is the function of theory in analytic communications? The answer, in one word, is to *guide* the analyst in his or her understanding and responsiveness (p. 441).

"Understanding" is a large part of what clinicians in this study described. "Explaining understanding" to clients, as Ornstein referred to above, is an area of the role of empathy in psychotherapy that merits further research.

Empathic rupture and repair and empathic failure are important components of understanding empathy.

Many clinicians talked about empathic rupture, repair and empathic failure as important concepts within their understanding of empathy. Their definitions of these processes are also consistent with self psychology.

Self psychologists believe that early in life self-objects (primary caretakers) either provide an optimal emotional environment, a moderately healthy environment, or a faulty one. If the environment is faulty, Kohut and Wolf (1978) stated,

> Faulty interaction between the child and his selfobjects result in a damaged self. . . . [When this person enters psychotherapy,] he reactivates the specific needs that had

> remained unresponded to by the specific faulty interactions between the nascent self and the selfobjects of early life. . . . a selfobject transference [to the psychotherapist] is established. . . . Depending on the quality of the interactions between the self and its selfobjects in childhood, the self will emerge either as a firm and healthy structure or as a more or less seriously damaged one. The adult self may thus exist in states of varying degrees of cohesion, from cohesion to fragmentation; in states of varying degrees of vitality, from vigor to enfeeblement; in states of varying degrees of functional harmony, from order to chaos. Significant failure to achieve cohesion, vigor, or harmony, or a significant loss of these qualities after they had been tentatively established, may be said to constitute a state of self disorder. The psychoanalytic situation creates conditions in which the damaged self begins to strive to achieve or to re-establish a state of cohesion, vigor, and inner harmony (p. 414).

Clinicians described that their understanding of empathy included how they navigate the therapeutic process of client needs being "reactivated," what this looks like in the psychotherapy, and how the client tolerates this process. Many clinicians believed that the ability to work through empathic rupture and repair with their clients was a sign of having a deep understanding of empathy.

Self-object failures and empathic failures are different. Though the interviewees did not describe the difference, self psychology offers a clear delineation between these two principles. Clinicians in this study did not discuss self-object failures, but did refer to empathic failures throughout the interviews. This is a function of clinicians having identified themselves as psychodynamic without referring to a more specific theory.

Referring to Goldberg (2012), Agosta (2014) pointed out,

> One might not like Goldberg's suggestion that failure is a fact of life in the profession; but it does create possibility where possibility was not previously visible. In short, the possibility of failure provides access to an opening for success. Thus, Goldberg's latest raid on the inarticulate pushes back the boundaries of that which psychoanalysts and analytically-oriented therapists are reluctant to engage and question: What can we learn from failed psychoanalysis outcomes; how have we contributed to our less optimal outcomes; and how can we improve our future results? (p. 167)

The data in this study is consistent with this perspective in that several clinicians discussed what they saw as empathic failures and explored ways that they learned and grew from those experiences. A clinician interviewed stated the following with regard to empathic rupture:

> I had a client a few months ago, first time coming in, psychologically minded, and he had made some very self-critical comment about himself—and I just put it out there, and I said, "You seem to be self-critical." Suddenly I could feel my back coming up, and it was clearly a rupture for him and he kind of stumbled through it. We continued on. . . . I was left wondering what I had done to not connect with him empathically, and the following week that was the first thing he started with.
>
> He said, "You know I was thinking about what you said, that I was self-critical, and I'm not self-critical." I then . . . acknowledged that rupture.

Later on in the treatment process, this particular client did tell his clinician that he was self-critical, commenting that the empathic rupture and repair was an important part of the treatment.

This acknowledgement of rupture and attempt at rupture repair are both consistent with self psychology theory, with recognition and feedback being essential parts of Kohut's theoretical discovery.

Goldberg (2012) emphasized the complexity of the definition of empathy, which he sees as often being simplified or misunderstood:

> Rather, empathy is better thought of as a particular form of data gathering or investigation of others that, although it may be positive or negative in its intention, affects people differently. . . . people may feel better or may feel worse in being understood. Some feel better having shared their feelings, whereas some require that they have their feelings and beliefs shared, acknowledged and agreed with. This last is most important because it often delineates the extent of our capacity to be empathic . . . .Empathy must be seen in two perspectives: the capacity and limitations of the person who is the target of the empathy, and the impact on the person who is the target of the empathy. Just as we are all not capable of understanding everyone, so, too, are we all affected differently by attempts to understand us (p. 190).

Here, Goldberg emphasized the importance of approaching each client as an individual with unique experiences, needs, and responses. The clinicians also discussed this approach, and it would be worthwhile to study further.

The findings make clear that clinicians' descriptions were not consistent with all the tenets of self psychology theory:

- Self psychologists believe empathy can be used for good or evil purposes. The findings do not reflect empathy being used for evil purposes.
- Though destructive use of empathy is terrifying, Kohut felt "empathylessness" in an environment was worse. Siegel (1996) refers to the Nazis and other terrorists using empathy to lure their victims. The clinicians did not address these ideas.
- Clinicians did not elaborate on the importance of giving feedback, which was a key part of Kohut's definition of empathy at the end of his career. Some mentioned this, but most focused on initial empathic understanding.
- Clinicians did not expand upon the difference between self-object failure and empathic failures in psychotherapy.
- Clinicians did not expand on their thoughts about empathic rupture and how this process could further inform effectiveness in therapy.

In summary, clinicians interviewed for this study expressed consistently that empathy is an essential part of the psychodynamic psychotherapy process. Though these clinicians self-identified as psychodynamic, they did not express a particular connection to any particular theory. This study suggests that the interviewees' social work training may have included many of the principles central to the descriptions of empathy in self psychology. However, areas within the scope of empathy could continue to be explored.

Clinical Implications

Many clinicians in this study described how their clients discussed their background stories, often including a need to self-protect and defend against fully feeling their emotions. Nathanson (1989) offered an explanation of how this pattern might have evolved as a result of childhood experiences.

The clinicians interviewed for this study universally indicated that empathy is an essential part of the therapy experience. When answering the research question, clinicians thoughtfully expressed their feelings about empathy and about how they saw possibilities for it throughout the therapeutic experience.

These possibilities appear to be dependent upon the ability of the clinician and client to navigate the rich complexity of their therapeutic journeys. For the clinicians, these journeys included understanding countertransference, as well as looking for meaning behind the words, behaviors, actions, and decisions of clients. Clinicians also emphasized the importance of understanding empathic rupture, repair and empathic failure. They indicated the importance of allowing silence, appreciating cultural differences, being open to learning from clients, and suspending judgment as part of their understanding of empathy.

This study has many clinical implications. Learning more about what happens inside the therapeutic space can help to sharpen the awareness of practicing clinicians. It can also help to train new therapists to be thoughtful and contemplative about the work they do with their clients.

All of these findings and essential concepts merit continued study. The more that clinicians study and consider and understand the therapy process and their contributions

to it, the stronger they will be as clinicians. Continuing to look inside the realities of the work will help clinicians evaluate themselves honestly and critically, therefore serving their clients clinically in the best way that they can.

Previously, this study listed some questions regarding empathy that Spiro, Peschel, Cumen, and St. James (1993) used in a study of physicians. The adapted list of questions below could be very useful for expanding clinical knowledge and introspection:

- Where does empathy begin?
- Is empathy possible for everyone, are everyone's receptors "down regulated" or to use modern parlance, or must the right neural connections be formed early in life when the brain is still plastic?
- Are some patients more "empathogenic" than others?
- Are there truly hateful patients who cannot love and whom no one can love? (p. 4)

The adapted list of questions continues:

- Is empathy a gift or a skill?
- How can we make ourselves more empathic? (p. 11)

The clinicians' responses in terms of looking inward were quite consistent with self psychology. The interviewees raised such questions as: How can clinicians' understanding of empathy bring us closer to looking at ourselves as clinicians? What do we see that we don't like, and why? What blind spots have kept us from seeing our true work? What does our countertransference tell us?

Goldberg (1999) took a close look at psychotherapists and judgment, and he explained that judgment is part of the normal course of a psychotherapeutic experience:

> At any given moment in analysis we seem to be making some judgment of the way things ought to be, and we tend to direct the process according to that judgment. It is a judgment based on what we claim to be correct and real and true. But just as biology seems to help at certain times, so at others cultural factors seem to weigh in. There can be little doubt that people can go more than one way in more than one domain. It seems a bit naïve to say either that we let the patient decide, or that we allow normal development to unfold. We are not merely watching. However, once we relinquish our neutral stance as untenable, we are committed to standing somewhere. Lest we too quickly claim allegiance to a newly popular embrace of "authenticity," we should probably recognize that one can be an authentic scoundrel as well as a saint, as well. Sometimes the two stances seem to be at odds, in need of some principle of unity (p. 353).

Goldberg eloquently described the necessity of looking inward in an ongoing way, in order to fully embrace what is happening in the psychotherapeutic process. Clinicians need to truly look inside themselves and their work, sometimes seeing things that they may not be proud of. This difficult process may be necessary in order for clinicians and their clinical work to deepen and grow.

Goldberg also stated:

> To be sure, the complex role of empathy in psychotherapy and psychoanalysis is not diminished by a recognition of its inherent limitations. But we need to add a crucial component to the data obtained by empathy. A component that belongs to the observer, it may be thought of as consisting of preconceptions or perspectives or theories, but it is essentially derived from the eye of the other. It is a judgment. The

> balance to the purely subjective experience of the patient is offered by the judgments brought by the observer. These are the observer's theories, preconceptions, morality. If the observer believes in the unconscious, it is added to the mix. To gain access to another, we carry ourselves and our beliefs along, and so every first-person perspective, every study of individual meaning, is seen and then changed by the onlooker. (And it needs perhaps to be said that every third-person perspective also carries with it the subjective coloration of the observer.) The psychoanalytic observer, the empathic student of a patient, carried convictions and judgments not only about the patient's reported experiences but also about what is known at first only to the analyst; the content of the patient's unconscious. Initially this is felt by the patient as foreign and separate. The unconscious is experienced not as first-person phenomena but as something alien and apart (p. 356).

Clinicians need to embrace that judgment comes into the clinical treatment space. The more open clinicians are to the possibilities, the greater chance empathy has to thrive. Psychotherapy is not, and will never be, a stagnant field. Clinicians should grow with their clients, continuing to look honestly into the mirror of their work.

In another article, Goldberg (1999) stated,

> As much as I'd like everyone to agree with me, the real pleasure comes from getting someone to feel some of that unsettled state that sometimes succeeds in pulling us away from what we know for sure (p. 395).

This statement supports the beauty of "unknowing," a state clinicians often find themselves in during the journey of clinical work. Goldberg (1999) encourages them to embrace that state as part of the clinical process. "Not knowing" is not only acceptable

but part of the process of a clinician who is open to the possibilities and willing to suspend a set template or idea. Goldberg also says, "We must live in the tension," which elaborates on this idea. Isn't this what clinicians encourage clients to do as part of their inward journeys?

Casement (2002) also encouraged clinicians to look inward, having posed several important questions for them to consider. Goldberg and Casement also believed that clinicians often do not look inward as much as they need to, which can affect how they engage in the psychotherapy process. Might this also affect their understanding of empathy? Casement asked,

> When a patient opposes the analyst, is this always to be regarded as resistance or an attack on the analysis or might it be an attempt to be understood better? . . . Are we in danger of using patients to give credence to our theories rather than remaining sufficiently open to the individuality of each patient? . . . Are analysts ready to accept those times when they are mistaken? Or do they continue to assume that error belongs mostly to others rather than to themselves? . . . When there are opposing ways of seeing clinical material, does one way have to be seen as right and any other as wrong? Could there be valuable elements in each? . . . Are we finding ways that truly free the mind and creativity of those who come to us for analysis or therapy? . . . Do we adequately guard against the danger of turning others into some version of our own selves, so that they then come to see themselves as we see them? (pp. 126–128)

These questions can serve to continue to keep clinicians' minds open, which in turn may deepen their understanding of empathy. What these authors may infer, and what this

researcher has found, is that in order to understand empathy, clinicians first need to commit to the ongoing journey of looking inward and understanding themselves. This includes a willingness to embrace uncertainty, to learn from mistakes, and to accept their own (and their clients') imperfections.

Further Research

The interviews for this study revealed that clinicians' understanding of empathy is complex and extensive. Findings that emerged as a result of the interviews included:

1. Empathy is innate.
    - It's like breathing.
    - Feeling empathy
    - Empathy and compassion
    - Empathy through experience
2. Empathy is learned.
    - What our clients teach us
    - Looking for client meaning as part of understanding empathy
    - Using empathy is a choice.
    - Suspending judgments and expectations
    - Cultural empathy
    - Teaching empathy to other clinicians
3. The process of empathy
    - Empathy by example (Bettleheim)
    - Clinicians as clients

- Empathy and self-care

4. Components of empathy

- Empathic rupture and repair or empathic failure
- The use of silence
- Overempathizing and countertransference

Any one of these findings could be studied in and of itself, due to its complexity and depth. Each finding represents a meaningful part of the therapeutic experience, warranting closer attention, focus, and contemplation.

Clinicians in this study repeatedly mentioned and emphasized several findings, including countertransference, whether empathy is innate or learned, looking for client meaning, and empathic rupture, repair and failure.

Many clinicians discussed the importance of understanding countertransference as part of their understanding of empathy overall, and further research could be done in this area. A possible research project interviewing clinicians about how they experience and work with their own countertransference could lead to valuable insight about this essential concept in the therapy relationship. This part of the psychotherapeutic process warrants greater expansion and further study.

Clinicians also consistently mentioned looking for client meaning in the interviews, particularly in cases where clients presented as difficult, combative, or angry. Clinicians had to work harder to understand the psychodynamics behind clients' presentations as part of the empathy process. Some clinicians reported that it was much harder to empathize with some types of clients than others.

The interviewees discussed at length the question of whether empathy is innate or learned. When some clinicians mentioned that empathy is learned, they then discussed how many clients needed to "relearn" empathy to get past what Nathanson (1986) theorized as the empathic wall.

Further research could look more deeply into the concept of the empathic wall. Nathanson (1986) begins to describe Emde's studies into infant attachment, detachment, attunement, and misattunement. These theories could be expanded upon in terms of individuals' abilities to give and receive empathy in adult relationships, based on their experiences earlier in life.

As most clinicians for this study worked with adults, more specific studies on understanding empathy through work with children could be enlightening for those in the field. In addition, empathy with couples and families could be explored. Clinicians mentioned that when working with more than one person, they often needed to work with themselves to avoid empathizing more with some clients than with others.

This particular study focused on how psychodynamic social workers understand empathy. One could wonder if the results would differ if psychologists and/or psychiatrists were interviewed regarding their views.

In looking at empathic rupture, repair, and failed empathy, looking at Goldberg's research (2012) from "failed cases" could continue to expand the knowledge base. Looking inward appears to be a very powerful way to expand knowledge on a variety of levels. Goldberg pointed out that looking at "failure" could in fact, be "opportunity." There is always room to grow and to learn; psychotherapy is a field that should never be stagnant, nor should clinicians' skills or perspectives.

Psychotherapy is an ongoing process, and looking at our understanding of empathy and countertransference throughout the process could be helpful to the social work field. In the interviews, one therapist described how he made some interpretive comments to his client in a first session, resulting in an empathic rupture. A closer look at the timing of sharing interpretations could be useful. In that example, it appeared that an interpretation shared early in treatment could have been received by the client differently had the clinician and client had a longer-term, more established relationship.

Further study could be done to deepen and widen the understanding and usage of empathy, with close consideration to all clients as individuals with their own histories, needs, and internal structures. Goldberg (2012) said,

> The most common misconception in the world of therapy is its concern and emphasis on being empathic with others, assuming everyone reacts similarly and that the reaction is a positive one. Persons who wish to take advantage of others and/or to hurt them may well be exquisitely empathic. So, too, may some whom we may wish to help but who will not allow us entry into their inner world. The two-way street of empathy demands our continued resistance to reductionism or over implication (p. 191).

In essence, Goldberg refers to the initial social work premise of starting (and being) where the client is. This principle appears to be the place to start, and to remain, throughout the course of psychodynamic work. In addition to being where the client is, clinicians have to continue to evaluate where they are as clinicians, continually paying close attention to how they can grow from an empathic standpoint, in the service of their clients.

In conclusion, this study has addressed multiple aspects of how psychodynamic psychotherapists understand empathy. One area for further study is how other psychodynamic theorists and practitioners—aside from those who believe in and practice self psychology—understand empathy. These findings are consistent with broad areas of psychodynamic theory.

Another possible area for further research is expanding our understanding of the empathic wall. This complex concept, originated by Nathanson, includes the belief that people who have been emotionally injured in some way create an empathic wall that they believe may protect them from further emotional injury. Clinicians need to understand and work with this concept when joining with a client and developing an ongoing relationship.

The notion of sustained empathy also warrants further study, including developing an expanded view of how a therapist's suspending judgment is related to empathy. In addition, we can deepen our understanding of how psychotherapists establish and operationalize clear boundaries.

This research has enriched the researcher's clinical practice. In listening to the interviewees, analyzing the data, and studying the theorists, the researcher has learned a variety of deeper ways to listen and to be empathic.

Appendix A

Consent Form for Participants

Consent Form

I, _____, agree to participate in a research project titled "How Do Psychodynamic Social Workers Understand Empathy?" conducted by Lisa Baron as part of her requirements for fulfilling the PhD program at the Institute for the Clinical Social Work. I understand that the purpose of the research is to gain a better understanding of the subjective experience of clinical social workers and their understanding of empathy.

As a participant in this study, I am aware that I will be asked to comment on my experience as a clinical social worker. I understand that my participation in this study is voluntary, and I can decide to not answer any particular question and/or stop the interview at any time and that this will be accepted without question. If I wish to withdraw from the study, I only have to verbally inform Lisa Baron with the right to have any recordings made of me returned to me.

I understand that the research will involve one interview which may last up to an hour and a half. I understand that the interview will be recorded, and that a transcription of the tape will be made.

These interviews will be audio-recorded, but I understand that anything I say will be treated as confidential information. The recordings will be transcribed, and the recordings and transcriptions will be identified by a code and not by the name of the participant. The coding data will be kept privately by the researcher and not shared with others. All the information used will be summarized in a manner in which no individual participant can be identified.

With my signature below, I indicate that I have read and agreed to the conditions of participation. If at any time I have questions about the research, I may contact Lisa Baron at 847-501-0371 or LisaDBaron@gmail.com.

_____

Signature

_____

Date

Appendix B

Individual Consent for Participation in Research

Individual Consent for Participation in Research

INSTITUTE FOR CLINICAL SOCIAL WORK

I,_____, acting for myself agree to take part in the research entitled: How Do Psychodynamic Social Workers Understand Empathy?

This work will be carried out by Lisa Baron, LCSW (Principal Researcher) under the supervision of Joan DiLeonardi, PhD, Dissertation Chair.

This work will be conducted under the auspices of the Institute for Clinical Social Work, 401 South State Street., Suite 822; Chicago, IL 60605, (312) 726-8480, as part of the requirements for fulfilling the PhD degree.

Purpose.

The purpose of this study is to closely study and gain a clearer picture of how psychodynamic social workers understand empathy in the context of the psychotherapy process. This study will involve interviewing 20 psychodynamic social workers who have five or more years of clinical experience. Results may be used to expand the knowledge base on the subject of empathy, which could help experienced clinicians as well as clinicians in training. These research findings could also contribute to the existing body of literature on empathy.

Procedures used in the study and the duration.

After potential interviewees are identified, the researcher will explain the purpose of the research and each interviewee will explain what their understanding is of the research. After this, the researcher and interviewee will agree on a meeting time and location. Once they meet, the interviewee will sign a consent form, with the understanding that they can

remove themselves from the interview process at any time if they need to. Participation in this study will include being interviewed for a one and one-half hour session.

Benefits.

There are no direct benefits for participation in this research project. It is possible that as a result of this research, a deeper understand of the process of empathy in the clinical setting could be gained. This could benefit experienced clinicians as well as clinicians in training.

Costs.

There will be no costs involved with this study.

Possible risks and/or side effects.

There is no physical risk associated with this study. It is possible (though unlikely) that interviewees may have an adverse reaction to any of the interview questions asked. All interviewees have the right to not respond to any particular question or to withdraw from the interview process at any time.

Privacy and confidentiality.

Participant's privacy and confidentiality will be maintained at all times. All recorded interviews will be erased after transcripts are typed. All data obtained from transcripts of interviews will be kept in the researcher's private files. This data will be destroyed after five years.

Subject assurances.

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Lisa Baron, LCSW, 847-501-0371 (Principal Researcher) or Joan DiLeonardi, PhD (Dissertation Chair) at this phone number (312) 726-8480 , day and evening.

If I have any questions about my rights as a research subject, I may contact John Ridings, PhD, Institutional Review Board; ICSW; 401 South State, Suite 822, Chicago, IL 60605; (312) 726-8480.

Signatures.

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____

Signature of Participant

_____

Date

I certify that I have explained the research to _____ (Name of subject) and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____
Signature of Researcher

_____
Date

Appendix C

Phone Explanation about Research to Potential Participants

Phone Explanation about Research to Potential Participants

My name is Lisa Baron, and I am a doctoral student at the Institute for Clinical Social Work in Chicago, IL. I earned my master's degree in social work at the University of Connecticut in 1983. Since that time, I have been a psychotherapist for adults and children in various clinical settings. I have a particular interest in studying the concept of empathy. I will be conducting a research study for my doctoral dissertation regarding psychodynamic social workers' understanding of the concept of empathy in the therapeutic setting. The process will include an interview that will last between an hour and an hour and a half, at your office, my office, or a neutral location. All names and other information will be kept confidential. You will sign a consent form before participating in the interview. I will also be audiotaping the interview, so that when I begin to assess the data I can accurately capture each interviewee's words, thoughts, and feelings regarding the concept of empathy in the psychotherapeutic setting. All information will be kept confidential. If you are interested in participating in the study, you will be asked to explain your understanding of the study to me and to sign a consent form. Participation in this study is voluntary, and no compensation is offered. Also, if at any time you are uncomfortable or wish to stop participation in the study, you can withdraw from the study with no penalty. After all the interviews have been completed, the data will be gathered, studied, and analyzed based on common themes. The dissertation will discuss the analysis of my findings after all interviews are completed. This information will be beneficial for social workers in the field as well as social workers in training.

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