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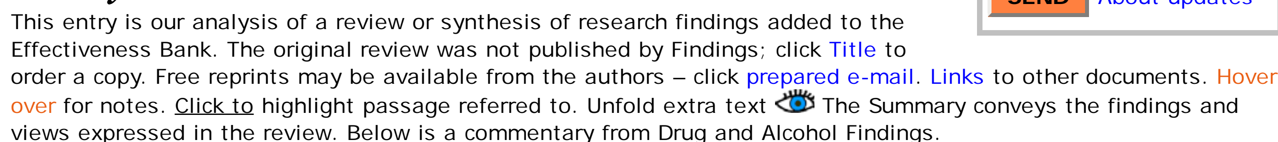

analysis

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This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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▶ Therapist empathy and client outcome: an updated meta-analysis.

Elliott R., Bohart A.C., Watson J.C. et al.

Psychotherapy: 2018, 55(4), p. 399–410.

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Review commissioned by the American Psychological Association finds that the more therapists empathically communicate their understanding of and compassion for clients, the better the outcomes. Recommendations will help counsellors, therapists, trainers and supervisors foster this important foundation for therapist–client relationships.

SUMMARY [Though not specific to clients with drug and alcohol problems, the principles derived from this review of psychotherapy studies are likely to be applicable, partly because severe substance use problems generally form part of a complex of broader psychosocial problems. This review updates an earlier version also in the Effectiveness Bank.]

The featured review is one of several in a special issue of the journal *Psychotherapy* devoted to features of the therapist-client relationship related to effectiveness, based on the work of a task force established by the American Psychological Association. This particular review's aim was to investigate the links between outcomes of therapy and how empathic the therapist is seen or felt to be by themselves, patients or observers.

Key points
From summary and commentary

Commissioned by a task force of the American Psychological Association, this review evaluated the influence of the links between how empathic the therapist seems to be (to themselves, patients or observers) and the outcomes of therapy.

The empathy–outcomes link has been investigated among 82 samples of patients. Across these the link was of medium strength and statistically significant, indicating that the more the therapist communicates their understanding of and compassion for the client, the better the outcomes tend to be.

Though the link is not necessarily causal, it is recommended that within the context of an overall positive therapeutic relationship, to improve outcomes therapists should seek to develop their ability to empathise with clients.

The reviewers distinguished three main modes of therapeutic empathy:
• empathy as the establishment of empathic rapport and support – in practice, the therapist exhibits a benevolent, compassionate attitude toward the client and tries to demonstrate that they understands the client's experience;
• empathy may instead/also be conceptualised as an active effort to stay attuned on a moment-to-moment basis with the client's communications and unfolding experience during a therapy session, an attunement which may be expressed in many ways, but most often in empathic responses;
• lastly, empathy may be seen as a sustained effort to understand the historical and present context of the client's current experiencing, asking: How have the client's experiences led him or her to see/feel/think/act as he or she now does?

These three forms of empathy are not mutually exclusive, and the differences are a matter of emphasis. Empathy itself is not distinct from other facets of a relationship, and is best seen as a

Measuring therapist empathy

component of a higher order therapeutic relationship. For example, empathy correlates strongly with 'congruence' (being real and/or genuine, open, integrated and authentic with the client) and 'positive regard' (acceptance of and respect for the patient). At a conceptual level, empathy can be distinguished from other relationship dimensions, but in practice this turns out to be a reductionist fiction.

The featured review incorporated a meta-analysis amalgamating results from relevant studies to provide estimates of the overall strength of the link between outcomes and the quality of the therapist's empathy, and to be able to probe for influences on the strength of that link. Included were English-language studies of samples of five or more clients whose clinical problems were being addressed by therapies averaging at least three sessions, and which related therapist empathy to outcomes including symptom change, improvement or post-session progress ratings, or client satisfaction. The resulting 80 studies involved 6,138 clients in 82 different samples.

The the empathy scale of the Barrett-Lennard Relationship Inventory is the most widely used measure of the empathy as perceived by the client. Its questions operationalise the conceptualisation advanced by the seminal therapist, Carl Rogers (1 2). Some of the statements which clients rate from true to untrue are reproduced below:
"My counsellor usually senses or realizes what I am feeling."
"My counsellor looks at what I do from his/her own point of view." (reverse scored)
"My counsellor may understand my words but he/she does not see the way I feel." (reverse scored)
"My counsellor wants to understand how I see things."
"My counsellor nearly always knows exactly what I mean."

The strength of the empathy–outcomes link was calculated as a correlation coefficient, an expression of the degree to which outcomes co-varied with empathy. The chosen metric ranges from -1 (perfect negative co-variation meaning that as one side of the link gets larger the other diminishes) to +1 (perfect positive co-variation meaning that as one side of the link gets larger so does the other). These coefficients were also converted to effect sizes. Effectively these metrics indicate how influential perceptions of empathy had been if causally linked to outcomes. In amalgamating findings, the assumption was made that there is no single, true strength of the link between empathy and outcomes which appears to vary only because of methodological differences, but that instead strength really did vary across the studies included in the analysis.

Main findings

Overall the correlation between therapist empathy and therapy outcomes was 0.28, equating to an effect size of 0.58 – a statistically significant, medium-strength relationship which accounts for about 8% of the difference in outcomes, similar to the difference accounted for by the relationship between outcomes and the alliance between therapist and patient, and greater than that accounted for by the specific therapeutic method. In other words, the more the therapist communicates their understanding of and compassion for the client, the better the outcomes tend to be.

However, the closeness of the empathy–outcomes link varied across the studies much more than would be expected by chance. It was strongest when measured from the client's point of view, but still moderate and statistically significant when assessed by observers or therapists. Possible reasons for this variation were explored.

The more clients sampled in a study and the greater the range of outcome measures, the less strong the links between empathy and outcomes tended to be. Using global outcome variables like client satisfaction resulted in a stronger link, possibly because of the overlap between client perceptions of empathy and client ratings of post-therapy satisfaction. There was some evidence that empathy-outcome associations were stronger for clients treated in outpatient rather than inpatient settings.

One possible influence *not* significantly related to variation in the empathy–outcomes link was the therapist's theoretical orientation. Unlike other ways of measuring empathy, it was virtually unrelated to outcomes when measured as the degree to which client and therapist shared the same perceptions of what the client was feeling or thinking ('empathic accuracy'). Among the seven studies on "self-damaging activities" (which included substance misuse), at 0.19 the correlation between outcomes and empathy was smaller than average, but still statistically significant and not significantly different from

that registered among other types of patients/problems.

Though these could not be assessed in the meta-analysis, there is also evidence that more similar (eg, in values) therapists and clients generate greater empathy. Also important is the therapist's 'body language' and way of communicating, including their posture, vocal quality, ability to encourage exploration using emotion words, being nonjudgmental, attentive, open to discussing any topic, and paying attention to details. On the negative side, perceptions of empathy suffered when therapists too often did the talking, gave advice, interrupted, avoided eye contact, or dismissed the client's position while imposing their own. There is, however, no particular set of therapist behaviours or techniques which clients universally identify as empathic; it is, it seems, not so much how the therapist behaves, but how the client *interprets* their behaviour that matters.

The client also clearly influences therapist empathy. For example, clients who are more open to their inner experiences and able to communicate these are easier to empathise with. On the other hand, not all clients respond well to explicit empathic expressions, in particular clients who are highly sensitive, suspicious, poorly motivated, or who react against authority. However, when therapists are truly empathic they will be attuned to these clients, and adjust how and how much they express empathy.

It is important to acknowledge that the sorts of studies included in the analyses of the empathy–outcomes link mean the resulting links may or may not be causal. Possibly, for example, what causes clients to generate or feel greater empathy also causes them to do better in therapy, rather than empathy as such being the active ingredient. Also, some outcome measures included in the analysis (eg, 15% of the studies used client-rated benefit or satisfaction with therapy as their main outcome measure) were of questionable validity.

Practice implications

Empathy is a robust, medium-sized predictor of psychotherapy outcomes, an association evident across theoretical orientations, treatment formats, and client problems. This repeated finding emerging from now over 80 studies and multiple meta-analyses supports a series of clinical recommendations:
• Psychotherapists should continuously try to understand their clients and to demonstrate this understanding through responses that address the perceived needs of the client. The empathic therapist's primary task is to understand the import or impact of clients' experiences rather than the words. Empathic therapists do not parrot clients' words back or reflect only the content of those words. Instead they understand overall goals and tasks, moment-to-moment experiences in therapy, and unspoken nuances and implications.
• Empathic responses require therapists to continually adjust their assumptions and understandings, attending to the 'leading edge' of client experience – those yet to be fully expressed – to facilitate awareness of emerging feelings and perspectives.
• Rather than the perspectives of therapists or observers, clients' reports of therapist empathy best predict treatment outcome. Instead of trying to intuit whether therapist behaviour is empathic, prioritise and regularly assess the client's experience of empathy.
• Empathy is shown as much in how well the therapist receives, listens, respects, and attends to the client, as in what they do or say.
• There is no evidence that being accurate about the clients' own views of their problems or self-perceptions promotes better outcomes. Therapists should assume neither that they are mind readers nor that their experience of understanding the client will be matched by the client feeling understood. Empathy should always be offered with humility and held lightly, ready to be corrected.
• Empathy entails individualising responses to particular patients. For example, some fragile clients may find the usual expressions of empathy intrusive, while hostile clients may find empathy too directive, and others may find an empathic focus on feelings alien. Effective empathic therapists know when – and when not – to respond with more or less empathically oriented responses.
• Finally, because research has shown empathy to be inseparable from the other relational dimensions, therapists should seek to offer empathy in the context of positive regard and genuineness. Empathy will probably not be effective unless it is

grounded in authentic caring for the client. Empathy should be valued as both an 'ingredient' in a healthy therapeutic relationship and a specific, effective response which strengthens the client's sense of self and promotes deeper exploration.

FINDINGS **COMMENTARY** The practice recommendations advanced by the reviewers are based on the possibility of a causal link – that within the context of an overall positive relationship, the degree to which patients experience their therapist as empathic makes a contribution to how well they are able to deal with or overcome the problems which brought them to therapy. However, the reviewers are clear that the limitations of the evidence mean a causal link has not been proven, but also not disproven. Missing in particular are studies which can rule out alternative explanations of the association between empathy and outcomes. On the other hand, the link is relatively strong, found across a variety of contexts, a degree of causality is a plausible explanation, and if therapists attend to the warning that really empathic therapists will know when *not* to be explicitly empathic, then being empathic should not be capable of being counterproductive. Indeed, among the 82 samples of patients included in the analysis, in just two was the relationship between empathy and outcomes on average negative. All this means that it should be safe to hire and develop empathic therapists, and that not doing so is likely to damage patients' chances of improvement: the probable cost-benefit balance argues in favour of acting as if empathy is indeed a causal influence.

As they are added to the Effectiveness Bank, listed below will be analyses of the remaining reviews commissioned by the American Psychological Association task force.
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