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# Affective Orientation, Alexithymia, and Multidimensional Empathy in Counselors-in-Training

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# AFFECTIVE ORIENTATION, ALEXITHYMIA, AND MULTIDIMENSIONAL EMPATHY IN COUNSELORS-IN-TRAINING

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# AFFECTIVE ORIENTATION, ALEXITHYMIA, AND MULTIDIMENSIONAL EMPATHY IN COUNSELORS-IN-TRAINING

Terrilyn J. Krueger, Ed.D.

Western Michigan University, 1997

The purpose of this study was to investigate the predictive relationship between two affective measures, affective orientation and alexithymia, and five empathy measures in 67 master's degree level counselor trainees. It was hypothesized that affective orientation would be predictive and alexithymia inversely predictive of five distinct dimensions of empathy: communicated, observed, emotional, cognitive, and relational. Communicated empathy was measured by trainees' audio-taped responses to a client stimulus which were assessed by "blind" raters. Observed empathy was measured by practicum supervisors based on their observations of trainees with clients. Emotional, cognitive, and relational empathy were assessed by trainees' self-reported responses about emotional and cognitive empathic dispositions and experiences of empathy in relationship(s) with clients.

Data were analyzed through 10 simple linear regression equations examining the relationship between two independent variables, affective orientation and alexithymia, and five dependent variables, communicated, observed, emotional, cognitive, and relational empathy. Results yielded six statistically significant predictive relationships at the $p \leq .01$. Affective orientation was predictive and alexithymia inversely predictive of three measures of empathy: emotional, cognitive, and relational empathy. Scores of females and males were significantly different for both affective orientation and alexithymia.

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To Mother for her resolute and prayerful support

and to Father who must surely have a pleased twinkle in his eye!

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The doctoral process has been an incredibly challenging and fascinating learning experience for me. I have learned that it takes a "village" to write a dissertation. While for many months, the dissertation seemed to be "the enemy," through the magnanimous offerings of friendship, encouragement, proofreading, and prayer—whatever I needed, my committee and community of supporters bolstered me and helped transform my nemesis into a unique symbol of growth. I am now the fortuitous owner of a "debt" of gratitude.

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ii

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This has been a time of special remembrance of my father, whose passion for life, and his pride in and love for me have motivated me to do my best. My mother, a terrific supporter, has taught me persistence in spite of adversity. Her belief in my abilities has been unwavering and her prayers unceasing. She is truly an inspirational and spiritual model to whom I dedicate this work.

Terrilyn J. Krueger

iii

# TABLE OF CONTENTS

CHAPTER

CHAPTER

APPENDICES

# LIST OF TABLES

ix

CHAPTER I

INTRODUCTION

Since the 1980s, interest and research in human emotion has greatly expanded throughout the social sciences (Omdahl, 1995). Studies of affect[1] have increased in a variety of contexts, including counseling psychology (Robertson & Freeman, 1995), developmental psychology (Eisenberg & Okun, 1996), social psychology (Omdahl, 1995), marital therapy (Johnson & Greenberg, 1994), personality psychology (Pervin, 1993), psychoanalysis (Taylor, Bagby, & Parker, 1997), education (Salovey & Sluyter, 1997), and the communication sciences (Buck, 1994; Yelsma, 1996). The surge of interest in emotion has occurred after decades of emphasis on cognition and behavior (Safran & Segal, 1990). In the last two decades emotion regulation has come to be viewed by many as integral to relationships, intimacy, attachment, problem-solving, communication, and providing feedback on the personal significance of events (Bowlby, 1988; Plutchik, 1984; Saarni, 1997).

Counseling and psychotherapy occur within the therapeutic relationship and as such, this study attempted to research aspects of affect which are relevant to this form of human communication. Berscheid (1987) expressed the connection between communication and emotion:

> the association between interpersonal communication and the experience of emotion are so strong that problems of emotion and of communication are

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[1] Terms in the following four clusters are used interchangeably: (1) "affect" and "emotion"; (2) "counselor," "psychotherapist," and "therapist"; (3) "counseling," "psychotherapy," and "therapy"; and (4) "client" and "patient."

1

inextricable, intertwined, and integral to one another; any information about one is likely to benefit understanding of the other. (pp. 86–87)

Two recently introduced constructs which pertain to affect regulation, emotional expression and affect dysregulation are: (1) *affective orientation* (Booth-Butterfield & Booth-Butterfield, 1990); and (2) *alexithymia* (Krystal, 1993; Taylor, 1995). A third construct, empathy, has experienced renewed research interest in the field of counseling in the last decade (e.g., Duan, 1992; Duan & Hill, 1996; Emiston, 1990; Murphy, 1988; Poff, 1991), developmental psychology (Hoffman, 1984; Saarni, 1997), and social psychology (Omdahl, 1995). Taylor et al. (1997) indicated that these constructs represent important aspects of affect regulation (or lack of): awareness, appraisal, and utilization of emotions as important signals to oneself and as guides in social behavior. A history of affect and how it has been described further provides the context for the present study.

## History and Significance of Affect

Only in the last two decades have theorists and researchers directly focused on the role of affect in counseling (Safran & Greenberg, 1991). In psychology, traditionally conceived research involving emotion has centered on the interaction of cognition and affect as seen in memory and judgment (e.g., Blaney, 1986; Clark & Fiske, 1982). In traditional cognitive-behavioral theory, emotions have been regarded as a postcognitive phenomenon with a focus on negative affective states like anxiety and depression and on techniques to control emotions (Beck, 1967; Krantz, 1985). Little attempt has been made to understand emotion as an integrated aspect of the human biological system with a particular role to play in adaptive human functioning and communication (Greenberg & Safran, 1987).

Focus on therapist use and regulation of emotion has been sparse (Izard, 1991). The client-centered tradition has studied therapist provided "core facilitative conditions" as formulated by Carl Rogers (1957, 1975), but these have been interpreted largely as attitudes (Goldstein & Michaels, 1985), with little direct reference to emotions (Luepnitz, 1988) and no development of affect theory (Pervin, 1993). The psychoanalytic field traditionally has studied emotion of the therapist in difficult to operationalize and complex terminology of "countertransference" in which therapist emotion has been "seen as a neurotic disturbance in the psychoanalyst, preventing him from getting a clear and objective view of the patient . . . and should be eliminated" (Segal, 1993, pp. 13–14).

A dramatic shift in attitudes has occurred, from regarding emotions as disruptive and disorganizing (e.g., Young, 1943) and not suitable as scientific data (Skinner, 1953), to considering them an essential factor in human information processing, communication, and psychotherapy (Safran & Greenberg, 1991). One indication of this change in emphasis is research investigating the role of emotion in empathy (Ekman, 1993; Feshbach, 1976; Hoffman, 1984; Omdahl, 1995), levels of affective development (Lane & Schwartz, 1987; Lewis & Haviland, 1993), affective orientation and communication (Booth-Butterfield & Booth-Butterfield, 1990; Bradbury & Fincham, 1987), expressed emotion in psychotherapy (Johnson & Greenberg, 1994), and in the therapeutic relationship (Horvath & Greenberg, 1994).

Affect

### Affective Orientation

Therapist emotional qualities which appear to be essential in the provision of effective, emotionally sensitive communication are contained in a construct labeled "affective orientation" (Booth-Butterfield & Booth-Butterfield, 1990). Affective orientation (AO) is the degree to which people are aware of emotions, perceive them as important, and actively consider their affective responses in making judgments and interacting with others (Booth-Butterfield & Booth-Butterfield, 1994). On the other hand, people low in AO, when aware of their feelings, are likely to interpret them as bothersome or as an interfering factor in daily life.

Affective orientation has been found to be an important variable in interpersonal relationships, guiding one's behavior and communication. AO refers to a condition in which there is susceptibility to and perception of one's emotions such that one can identify and describe feelings. Interpersonal pulls to certain actions and impulses to execute various behaviors are communicated to oneself through affect (Greenberg & Safran, 1987). People with high AO are more aware of their impulse tendencies than those low in AO, and utilize them as signals to themselves.

### Alexithymia

At the low end of the continuum measuring AO is a condition known as *alexithymia* (Bagby & Taylor, 1997; Salovey & Mayer, 1990). The alexithymia construct was formulated by Sifneos (1972) to classify a cluster of affective and cognitive characteristics observed in patients with psychosomatic diseases. Literally translated, *alexithymia* means "no words for feelings" and connotes a lack of ability

to identify and verbalize an awareness of affect (Taylor, Bagby, & Parker, 1991). It is based on the theoretical view that alexithymia reflects a deficit in one's personality such that one has an inability to regulate affect—to cognitively process, monitor, and modulate emotions (Parker, Taylor, & Bagby, 1993; Sifneos, 1988). This condition has been associated with a lack of psychological mindedness (Taylor, 1995) and has been implicated as responsible for poor outcome in psychotherapy (Krystal, 1982, 1988).

## Empathy

### Importance of Empathy

Few hypotheses about psychotherapy have prompted more research than Carl Rogers' (1957) premise that therapist provision of empathy, unconditional positive regard and genuineness are "necessary and sufficient" conditions facilitating positive client outcome in therapy. Most schools of psychotherapy are part of the consensus that empathy is integral to effective psychotherapy (Perry, 1993). The level of empathy extended by the counselor and its effects on the client has been the object of extensive theory and research (Goldstein & Michaels, 1985; Rogers, 1951, 1957, 1975; Rogers & Truax, 1967; Wilson & Lindy, 1994). This research has consistently demonstrated that a therapist's empathy with the client's feelings strongly influences the quality of the helper-client relationship. Subsequently, the degree of client change, at least with a substantial proportion of psychotherapy clients, is influenced by therapist empathy (Greenberg, Rice, & Elliott, 1993; Kanfer & Goldstein, 1991; Truax & Mitchell, 1971).

Construct of Empathy

Empathy has proven to be an elusive and complex construct, difficult to operationalize (Duan & Hill, 1996). After a thorough review of the literature, Goldstein and Michaels (1985) stated, "Empathy has been diversely defined, hard to measure, often resistant to change, yet emerges as a singularly important influence in human interaction" (p. ix). The confusion regarding empathy is due, in part, to its multidimensionality and complexity (Barrett-Lennard, 1986; Davis, 1980; Duan & Hill, 1996; Gladstein, 1983). Different theorists and researchers define empathy differently (Carkhuff, 1969, Greenson, 1960). Two distinct lines of thought have characterized empathy, based on two different definitions of the empathic process (Goldstein & Michaels, 1985; Mehrabian & Epstein, 1972). These are: (1) an affective experiencing model which has historical roots in the way empathy was first introduced in the early 1900s (Lipps, 1903); and (2) a cognitive, role-taking approach, first submitted by sociologist Mead (1934) and pursued in psychology by Dymond (1949). The construct of empathy has been viewed as a dispositional personality trait, a context-specific state, and/or a process comprised of various phases (Duan & Hill, 1996). The biggest debate still seems to be over the nature of empathy, whether it is primarily an affective or a cognitive phenomenon (Gladstein, 1987). Many empathy theorists and researchers have agreed that emotion and cognition influence each other and have moved toward integration and measurement of both aspects (Davis, 1983; Feshbach, 1982; Omdahl, 1995). Davis (1983) demonstrated that emotional and cognitive empathy can be measured separately as dispositional traits. Considering that cognition and emotion affect each other, he expected and found low correlations between emotional and cognitive empathy. After

much empathy research, Barrett-Lennard (1962, 1978, 1986) divided empathy into three phases—"empathic resonation," "empathic communication," and "received empathy." He asserted (1993) that instruments which measure different phases of empathy are not likely to correlate highly with each other.

Empathy has proven to be a somewhat complicated multidimensional construct. Because of its importance that researchers continue to try to measure it (Duan & Hill, 1996; Watson & Greenberg, 1994). Using a number of measurement instruments, this study attempted to measure affective variables and explore their relationship to several dimensions of empathy: (a) communicated (Truax & Carkhuff, 1967); (b) observed (Carkhuff, 1969); (c) emotional (Davis, 1983); (d) cognitive (Davis, 1983; Gladstein, 1983); and (e) relational empathy in the therapeutic relationship (Barrett-Lennard, 1978).

In the present study, following the lead of numerous investigators, empathy will be defined as a process with several stages which are primarily oriented toward (a) shared emotion, (b) cognitive analysis or perspective-taking, and (c) communication or external expression of empathy (Barrett-Lennard, 1978, 1986; Carkhuff, 1969; Davis, 1983; Goldstein & Michaels, 1985, Jordan, 1991; Macarov, 1978). Using five measures of empathy, including perspectives from objective raters, supervisors, and counselors-in-training, this study will attempt to add to the knowledge base of empathy and emotion.

## Counselor Affect, Empathy, and the Therapeutic Relationship

The client and therapist are part of a two-person emotional system, and both members of that system, as Sullivan (1953) stated, play an inextricable role in all change that occurs. Izard (1991) indicated that both therapists' and clients' emotional

expression and regulation are integral to the process of psychotherapeutic change. Safran and Greenberg (1991) in their book, *Emotion, Psychotherapy and Change*, state the importance of therapist emotions: "The therapist will have an impossible time relating to the client with appropriate emotional responses if he or she is unaware of them and does not have access to his or her emotions" (p. 356).

There are also times when counselors may need to involve their genuine feelings and share them with a client, especially one who questions authenticity of the counselor. A number of case presentations illustrate times when clients need therapists to appropriately communicate their true emotions to show clients that the relationship is real to them (Guidanno, 1991; Maroda, 1991).

Whether or not clients develop safe and trusting attachment to the therapist and the therapeutic process usually depends on the therapist's ability to provide a "therapeutic holding environment" (Winnicott, 1965) to facilitate the "therapist's attempt to relate to the client through the client's personality" (Trembley, 1996, p. 73). McCann and Coletti (1994) found that traumatized clients need therapists to be trustworthy, able to genuinely listen, and be continuously present emotionally.

Researchers have identified empathy as an essential counselor characteristic in the creation of a secure therapeutic relationship (Safran & Segal, 1990; Watson & Greenberg, 1994; Wilson & Lindy, 1994). The major feature of the counselor/client therapeutic relationship is development of a relational bond, the context in which the tasks and goals of therapy can be integrated and which combine synergistically to produce a positive outcome (Bordin, 1979; Greenberg & Pinsof, 1986).

## Statement of the Problem

The present study was designed in order to identify how selected counselor-trainee affective characteristics were related to empathy—a therapeutic performance measure associated with the therapeutic relationship and with outcome (Watson & Greenberg, 1994). Specifically, this study was designed to investigate the relationship between two independent variables—affective orientation and alexithymia—and five dependent variables comprised of five types of counselor trainee empathy (communicated, observed, emotional, cognitive, and relational). Trainees' observed levels of empathy were evaluated by practicum supervisors; communicated levels of empathy were assessed by a team of independent raters; and subjects self-reported their emotional, cognitive, and relational levels of empathy.

## Purpose of the Study

Despite the increased focus on empathy and the new attitude toward emotion, no known studies have focused on counselor emotion, affective orientation, alexithymia, or the relationship of emotion to empathy in counselor-trainees. It appears that knowledge of the interaction between empathy and affect in counselors is of considerable value in understanding empathy as well as shedding light on the therapeutic relationship.

Therefore, this study was designed to examine relationships between levels of affective orientation, alexithymia, and five types of empathy in counselors-in-training. Empathic understanding has been linked with counselor facilitativeness (Gelso & Carter, 1985), the therapeutic relationship, and positive outcomes in psychotherapy (Watson & Greenberg, 1994). This study measured selected variables of affect

through several self-report measures, to find whether they may be predictive of various forms or phases of empathy, including communicated, observed, emotional, cognitive and relational empathy in counselors-in-training.

## Significance of the Study

This research is important to the field of counselor training because it provides some clarification as to whether and how counselor personality characteristics and processes pertaining to affect regulation are related to various measures of empathy. The results provide data explicating the nature and relationship between and among personal affective characteristics of participants.

The therapeutic relationship has gained much attention from theorists and researchers who associate the relational conditions with the bond of therapy (Greenberg & Pinsof, 1986). The therapeutic relationship has been shown to be important in its contribution to positive outcome in therapy (Horvath & Greenberg, 1994; Strupp, 1960). However, researchers have not as yet, fully demonstrated what in the therapeutic alliance has produced these positive results but many believe that empathy is one essential factor (Kaplan, 1991). This study posits that counselors' affect is important to empathy.

These data potentially provide information which can be utilized to improve the admissions and selection process of training programs contributing to the training of sensitive, emotionally intelligent counselors. The results may also be used by counselor educators as they revise curricula of professional counseling programs and provide information about the use and utility of specific instruments to measure characteristics, skills, and behaviors in individuals who have not yet entered professional practice.

Literature on counselor training suggests that training include a focus on personality development as well as the teaching of technical skills (Carlozzi & Hurlburt, 1982; Greenberg & Goldman, 1988; Roy, 1980; Wegner & Lehr, 1981). Research indicated the ability to share in another's affective state enhanced the interventions of the designated helper (Barnett & Thompson, 1985; Grzegorek & Kagan, 1974). The examples referenced here direct attention to the contributions that affective orientation, a major aspect of the personality of the designated helper, can provide in counseling.

Because empathy plays a central role in therapeutic effectiveness (Jordan, 1991; Patterson, 1984; Truax & Carkhuff, 1967), regardless of the therapist's theoretical orientation or modality used (Perry, 1993), it would be valuable to know if affect regulation is predictive of empathy, that is, if measures of affective orientation and alexithymia are predictive of multiple measures of empathy. This study provides information about the statistical association between counselor-trainee affective orientation, alexithymia, and empathy.

## Research Questions

The focus of the present study was to examine relationships of selected affective variables, affective orientation and alexithymia, upon counselors-in-training measures of various types and components of empathy. Consistent with this examination, the following research questions were studied:

1. Is affective orientation of subjects, measured by the Affective Orientation Scale (AOS), predictive of (a) communicated empathy on Carkhuff's *Communication Assessment Index* (CAI), (b) observed empathy via supervisor-rated empathy items on Carkhuff's *Empathic Understanding in Interpersonal Processes* (EUIP) scale,

(c) emotional empathy via counselor-trainee self-report on the Empathic Concern

Scale of the *Interpersonal Reactivity Index* (EC-IRI), (d) cognitive empathy via

counselor-trainee self-report on the Perspective-Taking Scale of the IRI (PT-IRI),

and (e) relational empathy on the therapist's version of the Empathy Scale of Barrett-

Lennard's *Relationship Inventory* (RI)?

2. Is alexithymia, measured by the Toronto Alexithymia Scale (TAS),

predictive of (a) communicated empathy on Carkhuff's *Communication Assessment*

*Index* (CAI), (b) observed empathy via supervisor-rated empathy items on Carkhuff's

*Empathic Understanding in Interpersonal Processes* (EUIP) scale, (c) emotional

empathy via counselor-trainee self-report on the Empathic Concern Scale of the

*Interpersonal Reactivity Index* (EC-IRI), (d) cognitive empathy via counselor-trainee

self-report on the Perspective-Taking Scale of the IRI (PT-IRI), and (e) relational

empathy on the therapist's version of the Empathy Scale of Barrett-Lennard's

*Relationship Inventory* (RI)?

## Definition of Terms

For purposes of this study certain terms are defined in both theoretical and

operational terms.

*Affect/Emotion.* Following common practice, these terms will be used

interchangeably unless otherwise denoted (Jones, 1995). While there is no consensus

in definition, there is agreement that affect is an innate biological phenomena

comprised of three spheres of response: (1) neurophysiological (largely autonomic

nervous system and neuroendocrine); (2) behavioral-expressive (e.g., facial

expressions, crying, tone of voice); and (3) cognitive-experiential (subjective

awareness and verbal reporting of feeling states). These are integrated systems such

that activation in one domain produces changes in the other two (Dodge & Garber, 1991).

*Affective Orientation.* Affective orientation (AO) is defined as (a) awareness, (b) implementation, (c) importance, and (d) intensity of one's emotions. For the purpose of this study, subjects' levels of AO are operationalized in terms of their responses to the Affective Orientation Scale (AOS) (Booth-Butterfield & Booth-Butterfield, 1990). Higher scores on the AOS reflect higher AO.

*Affective/Emotional Regulation.* Affective or emotional regulation refers to the process of handling responses that originate within physiological-biochemical, cognitive-experiential, and behavioral-expressive components which will facilitate a person's monitoring, evaluating, and changing her or his emotional reactions to maximize her or his intrapersonal and interpersonal competence (Dodge, 1989; Saarni, 1997; Taylor, 1994).

*Alexithymia.* Alexithymia is defined as the inability to be aware of, to differentiate, or to verbalize feelings. It also includes external thinking, approaching people and things as objects vs. personally. For the purpose of this study, alexithymia is operationally defined as subjects' scores on the Toronto Alexithymia Scale (TAS) (Taylor, 1991). The higher one's score, the lower the level of affect awareness and the higher the level of alexithymic characteristics.

*Client.* For the purpose of this study, *client* is used interchangeably with *patient.* Client is defined as any person seen by a counselor-trainee, counselor, or psychotherapist for the purpose of psychological counseling or psychotherapy. It will be made clear when reference is made to the particular clients of the counselor-trainees used in this study.

*Counselor.* Counselor, *therapist,* and *psychotherapist* are used interchangeably, unless otherwise noted, to designate practitioners of psychological counseling/psychotherapy.

*Counselor-trainee.* Counselor-trainee and *counselor-in-training* are used interchangeably, and unless otherwise indicated, are used to designate the subjects of this study who were enrolled in master's degree level counseling practicums.

*Counseling Practicum.* Counseling practicum is a structured experience designed to achieve counselor-trainee proficiency under supervision while working with actual clients. Counselor-trainees met in a group of 5–7 students and practicum supervisor, to discuss their interviews, review audio and videotapes of their sessions, and receive instruction from the professor-supervisor. They met individually with the supervisor weekly for group and individual supervision.

*Emotional Intelligence* (EI). EI, a concept introduced by Salovey and Mayer, (1990), was identified as being similar to AO (Bagby & Taylor, 1997). EI is defined as the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotions and to empathize. As such, the construct of EI encompasses the concepts measured in this study, AO, alexithymia, and empathy. Bagby and Taylor (1997) suggested that the AOS be used to measure EI. They stated that AO (and empathy) are at the high end of EI and alexithymia at the low end.

*Empathy.* Empathy is defined as a "dynamic cognitive-affective process of joining with and understanding another's subjective experience" (Jordan, 1984, p. 2). It is an act of emotionally "feeling with" the client, cognitive comprehension of his/her situation and communication of one's understanding.

1. *Communicated Empathy.* Communicated empathy is verbally expressed empathy which demonstrates that the counselor understands the client intellectually and experientially, approximating the intensity, feeling tone, and responsive activity level of the client in language that the client can understand (Carkhuff, 1969). Communicated empathy is the second stage in Roger's (1975) and Kohut's (1984) models of empathy and the third or fourth stages in the empathy models of Barrett-Lennard (1986), Goldstein and Michaels (1985), Keefe (1976), and Macarov (1978). Operationally defined, communicated empathy was measured by "blind" raters of trainees' verbal responses to client stimulus statements using Carkhuff's (1969) *Communication Assessment Index* (CAI) and scale of *Empathic Understanding in Interpersonal Processes* (EUIP).

2. *Observed Empathy.* Observed empathy is a global empathy, representing empathy which is manifest externally. It is comprised of all aspects of empathy observable to one not in an empathic relationship, but who observes the interaction between counselor and client. Primarily a measure of communicated empathy, it was unlike the CAI, in that supervisors could observe nonverbal cues for example, demeanor, gestures, proxemics, and voice quality. A potential aspect of observed empathy was client response to trainee empathy. In this study, observed empathy was operationalized by practicum supervisors' ratings on the *Empathic Understanding of Interpersonal Processes* scale by Carkhuff (1969).

3. *Emotional Empathy.* Emotional or affective empathy is the affective or subjective responsiveness of the counselor to the client, demonstrating the ability to "feel with," or to "feel at one with" the client at that moment. In this study, emotional empathy was measured as a dispositional trait. Counselor-trainees' levels of

emotional empathy were operationalized with the Empathic Concern subscale of Davis' *Interpersonal Reactivity Index* (IRI).

4. *Cognitive Empathy.* Used synonymously with intellectual empathy, cognitive empathy is the counselor trainees' intellectual understanding or comprehension of the content, issues, and feelings of the client from her or his internal frame of reference. In this study, cognitive empathy was quantified as a dispositional trait. It was measured by counselor-trainees' self-report on the Perspective-Taking subscale of the *Interpersonal Reactivity Index* (IRI).

5. *Relational Empathy.* Relational empathy is empathy which is experienced for another in the context of the therapeutic relationship. In this study, relational empathy was operationalized as a state specific, relationship specific, emotional and cognitive experience of the counselor trainee. This comprised the first phase of Barrett-Lennard's empathy model, "empathic resonation." It refers to the self-reported experience of empathy by counselor-trainees with their clients. Relational empathy was measured by the Empathy Scale of Barrett-Lennard's *Relationship Inventory* (RI).

*Personal Therapy.* The demographic form asked subjects whether they had sought personal psychotherapy on their own behalf. They were given five multiple-choice answers from which to choose including "never been" and ranging from 3 months in length to +2 years.

*Practicum Supervisors.* There were 12 practicum supervisors in this study (some were duplicated from one semester to another). Each supervisor had between five and seven counselor-trainees in each class. Supervisors gave instruction, conducted group and individual supervisions using two-way mirrors, audiotapes, and

videotapes. In this study, individual supervisors rated only their own counselor-trainees.

*Therapeutic Relationship.* The therapeutic relationship refers to the relational conditions, the bond, alliance, or union formed between client and therapist which is characterized as being trusting and safe for the client. The therapeutic relationship is in contradistinction to the working conditions characterized by the tasks and goals of therapy.

## Assumptions of the Study

Certain assumptions were made in this research project. It was assumed that individuals who volunteered as subjects for this study were not substantially different from counselors-in-training in this setting who did not volunteer. Similarly, it was assumed that volunteer subjects at the research site, Western Michigan University, did not differ in any substantial way from counselors-in-training at Council on Accreditation for Counseling and Related Educational Programs (CACREP) of a similar size and character throughout North America.

It was further assumed that volunteer student subjects provided honest, truthful responses on the affective self-report instruments, and provided empathic responses representative of their levels of skill on Carkhuff's *Communication Assessment Index*. Also, it was assumed that the expert raters involved provided honest ratings of subjects' responses and that supervisors prepared unbiased evaluations of their students' empathy as counselors.

It was assumed that the time period when the study was being conducted was not significantly different in any way from other semesters at this counselor training program. Further, it was assumed that the students enrolled in practicum classes were

a representative sample of those traditionally enrolled in this program. It was assumed that no local, national, or worldwide events occurred which substantially impacted subjects' levels of empathy and affect during the conduct of the study. It was further assumed that the ratings of others involved in the project were not influenced by similar events or circumstances of which the researcher had no knowledge or control.

## Limitations of the Study

One limitation of the study is that the subject population could not be randomly assigned to counseling practicum class sections. A second limitation is that the instructor-supervisors for the counseling practicum classes could not be randomly chosen considering the small number of sections that were needed for the study. Concomitantly, the study was restricted to one Midwestern university and data collected during winter and fall semesters.

Since participation was purely voluntary, some students did not participate in this study. It was considered a limitation of the study that all counselors-in-training enrolled in the practicum classes (or a randomly selected group) did not participate and thus may have affected the study in some unknown way. Another limitation is that it is possible that some subjects may have misinterpreted questions used to obtain self-reported responses.

## Organization of the Remaining Chapters

This study is organized into five chapters. Chapter I has presented the problem to be investigated, the significance of the problem, the purpose of the study, the research questions, definitions of terms, assumptions and limitations of the study,

and organization of the remaining chapters. Chapter II of this document provides a review of the pertinent literature related to empathy, affective orientation and alexithymia. Chapter III describes the methodology which was employed in this effort, including selection of subjects, hypotheses tested, research design used, instrumentation issues, statistical procedures employed, methods used, and limitations of the study. Chapter IV contains the results of the study, including reliability estimates for Carkhuff's *Communication Assessment Index*. Results referring to each hypothesis and subhypotheses are presented along with data appropriate to it. Post hoc analyses are included also. Chapter V includes conclusions, findings and implications based on the findings, and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

A pivotal change in attitudes toward emotion and emotional expression has occurred during the last two decades (Safran & Greenberg, 1991). Whereas emotions were generally considered to play little causal role in normal social behavior, "emotions are now viewed as both a product of and process in social interaction" (Eisenberg, Fabes, & Losoya, 1997, p. 130). Research is now clear that affect, whether one is aware or not, is a pervasive influence in one's life (Krystal, 1993; Taylor et al., 1997). Researchers currently view affect regulation as an essential factor in appraisal of the significance and meaning of communication (Buck, 1994), in attachment and intimacy (Bowlby, 1988; Stern, 1985), and in empathy (Mayer & Geher, 1996). Affect awareness and empathic attunement are important capabilities in psychotherapists (Johnson & Greenberg, 1994; Safran & Segal, 1990). There is scant research on therapist emotions, despite the fact that therapists' emotional experiences play equally important roles as those of clients' (Jordan, 1991; Sullivan, 1953). In reviewing current empathy research, Duan and Hill (1996) stated:

> . . . the possible role of counselors' affect in therapeutic empathy has not drawn research attention. Considering that the counselor has a role in all levels of the therapeutic relationship, it makes logical and practical sense to examine counselor affect as one predictor of therapist empathy. (p. 268)

The purpose of this study was to examine possible predictive relationships between multiple measures of affect and multiple measures of empathy in counselors-in-training. A major question for exploration was, "Does high affective orientation or

20

low alexithymia predict empathy in counselor-trainees?" No known study has investigated how various types of empathy may be related to constructs of affect regulation in counselors. Thus, this chapter reviews both theoretical and empirical literature pertaining to levels of affective awareness and empathy. It is organized into three main parts: (1) affective orientation, (2) alexithymia, and (3) empathy. Review of affect and empathy includes history, definition and description, importance, and measurement.

## Affect

The growth of interest in the study of emotion is illustrated by research on *affective orientation* (AO) and *alexithymia*, new constructs representing aspects of affect regulation and dysregulation, respectively (Taylor et al., 1997). These constructs, along with empathy, comprise the cognitive and affective capabilities contained in Salovey and Mayer's (1990) proposed framework of *emotional intelligence* (Goleman, 1995; Mayer & Salovey, 1997).

Such skills include an ability to accurately appraise one's emotions and use them in adaptive ways, and an ability to comprehend feelings of other people and make empathic responses (Salovey & Mayer, 1990; Taylor et al., 1997, p. 15). People who display deficits in these capabilities have been described by clinicians as alexithymic (Krystal, 1982, 1993; Taylor, 1984). Based on the body of research literature which already exits on alexithymia, and on Yelsma's (1992, 1996) findings that affective orientation and alexithymia are highly correlated, Taylor et al. (1997) concluded that Salovey and Mayer (1990) correctly placed affective orientation and alexithymia at opposite ends of the continuum of emotional regulation. Currently,

there is no known research which has explored the relationship between affective orientation, alexithymia and empathy.

A new level of acceptance of affect and its functions has occurred in the research literature and field of psychology (Safran & Greenberg, 1991). A brief history of affect may provide context to better understand the dramatic changes which have taken place in the investigation of affect.

## History of Affect

Both Plato in the 4th century B.C. and Descartes in the 17th century separated "mind and body," "reason and emotion," producing a mechanistic, rationalistic bias and devaluation of emotional and somatic processes (Mahoney, 1991; Payne, 1983). Passions were to be ruled by the will and mind (Payne, 1983).

Emotional responses held a central role in psychoanalysis in its earliest days (Butler & Strupp, 1991). At the core of neurosis were hysterical symptoms, intense "strangulated" emotions that needed to be directly expressed, *abreacted*, resulting in the cure or *catharsis*, the draining of emotional energies (Freud, 1898/1962). When catharsis and abreaction became controversial, *interpretation* took over the central position and the role of affect waned (Butler & Strupp, 1991).

Therapist emotion has been discussed in the psychoanalytic tradition most frequently in terms of "countertransference" (CT), a complex and difficult construct to measure (Hill & Corbett, 1993). Freud (1910), who introduced the term, stated countertransference (therapist's unresolved tranference to client) had adverse effects on the ability of therapists to understand and function effectively with patients. As Segal (1981) recounted, ". . . countertransference was first seen as a neurotic disturbance in the psychoanalyst, preventing him from getting a clear, objective view

of the patient. . . . *It is still often contended that ideally, CT should be eliminated*" (p. 14). More recently, countertranference has been recognized as an important source of information about clients (Maroda, 1991).

Early psychology texts included definitions of emotion and are illustrative of the inferior status of affect. Emotion caused "a complete loss of cerebral control" and contained no "trace of conscious purpose" (Shaffer, Gilmer, & Schoen, 1940, pp. 457–458), as well as Young's (1943) definition of emotions as "acute disturbance(s) of the individual as a whole" (p. 263).

Safran and Greenberg (1991) recounted that the behavioral school, which dominated academic psychology from the 1930s to the mid-1960s, and cognitive psychology, which followed, avoided dealing with emotions, by declaring them inadmissable as scientific data. "In the therapeutic domain, cognitive therapy has viewed rationality and objectivity as the *sine qua non* of mental health" (p. 2).

While humanistic-experiential therapeutic approaches have historically valued emotion and bodily felt experience (e.g., Bioenergetics, Psychodrama, Gestalt, Communication, a là Satir), most authors in these traditions have not pursued empirical research to validate practice (e.g., Moreno, 1946; Perls, Hefferlin, & Goodman, 1951; Satir, 1972). One exception was Carl Rogers (1951, 1957, 1959, 1975), and associates (Barrett-Lennard, 1962, 1981; Gendlin & Berlin, 1961; Truax & Carkhuff, 1967), who published numerous articles emphasizing therapist-provided "core conditions." However, acceptance, genuineness and empathy were presented as attitudes, not as emotional artifacts per se, nor did Rogers provide a theory of affect (Pervin, 1993), possibly due to the predominance of rationalistic language and paradigms (Luepnitz, 1988).

Zajonc's 1980 article sparked interest and debate in the field of psychology (Lazarus, 1982, 1984, 1991; Zajonc, 1989). Stating that "affect dominates social interaction and is the major currency in which social intercourse is transacted," Zajonc (1980, p. 155) encouraged researchers to study affect as more than a mere byproduct of cognition. This article seemed to mark a change of perspective on emotion in the field of psychology (Greenberg & Safran, 1987).

It is now clear that the 1960s and 1970s were a "cognitive revolution" in academic psychology, and that the 1980s and 1990s are experiencing an "affective revolution" (Safran & Greenberg, 1991). The Cartesian, dualistic world view is being challenged by a holistic paradigm that recognizes emotion, cognition, biology, and behavior as vital, interactive processes in human functioning (Grotstein, 1997). As Taylor (1997) pointed out, "Over the past two decades, there has been an expanding scientific interest both in the development and regulation of affects, and in the impact of dysregulated affects on mental and physical health" (p. 1). Taylor attributes interest in emotion to development of new technologies to study brain functions and by "fascinating findings from observational studies of the infant-caregiver relationship" that have prompted new conceptions regarding development and function of affects, which have significant clinical ramifications. In addition, new tools have been developed to measure dispositional differences in affect regulation.

<u>Affect Regulation</u>

Affect regulation includes awareness, appraisal, and utilization of emotions as important signals to oneself and as guides in social behavior (Taylor, 1994). Models of affect regulation have replaced Freud's "drive theory" (1898/1962) and have been widely applied to the study and understanding of emotion (Krystal, 1993).

Taylor et al. (1997) describes affect regulation as organizing affect, while allowing affect to coordinate thinking and behavior. Since primary emotions are adaptive, regulation of emotion does not necessarily imply "control" of emotions, although one with normal affect regulative abilities is able to modulate expression of emotion (Izard & Kobak, 1991). To Dodge and Garber (1991), regulation is an integrative interactional process among the three domains of emotion response systems and with the environment: "the process of managing responses that originate within cognitive-experiential, behavioral-expressive, and physiological-biochemical components" (Brenner & Salovey, 1997, p. 170). Affect regulation involves reciprocal interactions such that when one system is activated, the other two are altered (Izard & Kobak, 1991). Saarni (1997) suggested that affect regulation describes the ability to manage one's feelings in adaptive, flexible ways. Further, she described optimal affect-regulation as contributing to self-efficacy, well-being, and relatedness to others. When failures in affect development occur, one is predisposed to affect dysregulations seen in personality traits or psychopathology and poor physical health (Taylor, 1995).

## Description and Functions of Emotions

While there is no commonly accepted definition of emotion in the field at this time, theorists and researchers are arriving at a consensus as to some aspects of emotional functioning (Safran & Greenberg, 1991). Emotions provide important information to oneself, often as "rapid, direct responses to situations" (Greenberg & Johnson, 1988, p. 5). The essential functions of emotion, according to Johnson and Greenberg (1994), are (a) attentional, influencing the salience of information; (b) motivational, influencing goal setting; and (c) communicational, regulating

interaction with others. Primary emotions are considered biologically adaptive, oriented to growth, motivational in nature, and serve important communicative functions (Buck, 1994; Izard, 1993). Emotions comprise "action tendencies" that are initially based on one's instantaneous assessments of a circumstance and how it fits with one's basic concerns (Lazarus, 1991).

Due to the centrality of emotional functions, Frijda (1986) stated that emotion was beginning to be judged as pivotal in understanding interpersonal interaction and cognition. Emotions provide key information about one's reactions to others and readiness to act, which can be heeded or disregarded. For instance, love as intense positive arousal provides information about one's readiness to act in an affiliative manner (Isen, 1987). Thus, emotions play a potentially adaptive role in human relationships (Frijda, 1986; Izard, 1977). Emotions involve the whole body and can be observed directly by others without the necessity of verbal communication, even before an individual is aware of her or his own subjective feelings (Buck, 1994; Schwartz, 1987). Omdahl (1995) studied empathy based on cognitive appraisal, stating that it seems likely that we "use cues about the cognitive appraisals of others to share their emotional states" (p. 6).

Epigenesis of Affect Development

Most developmental psychologists (Izard, 1977; Zajonc, 1980, 1989) and psychoanalytic theorists (Krystal, 1993; Taylor et al., 1997) posit an epigenetic sequence of affect development whereby emotion structure and function develop in the organism gradually as it matures and develops in complexity. Other factors are personality and temperament, neurobiological structures, and reciprocal interactions between inherited aspects and early social environment (Watson & Clark, 1994).

Spitz (1963) posited two lines of affect development: affect differentiation and verbalization with concomitant desomatization. He demonstrated that as early as 6–9 months old, infants are capable of developing a link between a felt emotion and mode of communication that becomes progressively less somatic, more verbal and related to finer and finer distinctions of meaning and facial expression. Based on observations like these, Lane and Schwartz (1987) elaborated a five-stage model of affect development corresponding to Piaget's levels of cognitive maturation. The model is based on one's level of awareness ranging from experience of emotion as bodily sensation only (observed in facial expression) to awareness and communication of "blends of blends" of feelings in self and others (including self and other empathy). The more precise one's awareness of emotions is, the greater is their usefulness as signals to oneself. As language develops, symbolic representations of emotions can be communicated verbally (Taylor et al., 1997). Krystal (1978) pointed out that normal development relies on a "good enough" (Winnicott, 1965) caretaker who mirrors and responds to children's subtle communications, reinforcing expressions of increasingly specificity.

The caretaker's pattern of responses generates attitudes about affect which become important influences in a child's character traits (Taylor et al., 1997). For example, with nonempathic parenting, when only intense or positive emotional communications are acknowledged by parents, the child associates emotions with control of others, eventual manipulation, versus as signals to oneself. Dysfunctional attention to the young child's growing ability to differentiate emotions results in arrested development or regression to a more primitive level of functioning in which emotional experiences are not entirely encoded in words (Khantzian, 1990, 1993).

Parental soothing is critical to normal development of affect, containment of feelings, holding the infant and small child when they feel threatened by primitive affects that scare them (Winnicott, 1965). The ability to self-soothe, an invaluable psychic tool, is developed through the process of parental soothing. Bowlby (1988) and Winnicott (1965) believed that self-soothing is learned during early development, through parents' empathic attunement to children's emotional signals—mirroring their expressions and verbal tones, physically holding them. At later stages of development, containment is through eye contact and verbal soothing. Krystal (1993) pointed out that possibly the most crucial and difficult aspect of parenting

> . . . consists in permitting the child to bear increasingly intense affective tension, but stepping in and comforting the child before his [or her]emotions overwhelm him [or her]. [Parents'] empathy with [their]child is [their]only guide. If the . . . parent fails to prevent the infant's affect from reaching an unbearable intensity that overwhelms him [or her], a state of psychic trauma may develop . . . competent parents assist their children in practicing affect tolerance. . . . When the child does lose control, the parent steps in, offers support . . . (pp. 30–31)

When a parent empathically attunes to the child, she or he is giving the child permission to learn self-empathy and self-soothing and is modeling how to do it (Bowlby, 1988). Over time, the affective system becomes self-regulating and children learn to identify, distinguish, endure, label, and contain their own feelings (Parker & Taylor, 1997). Bagby and Taylor (1997) inferred that one's level of affect regulation was closely associated with one's level of affective orientation.

<center>Affective Orientation</center>

Affective orientation (AO), defined by Booth-Butterfield and Booth-Butterfield (1990), is "the degree to which individuals are aware of and use affect cues to guide communication" (p. 451). They describe AO as a stable personality

trait. This section covers origin of AO in personality, the AO construct, role of AO in communication, and AO measurement.

## Affective Orientation and Personality

A major function of emotions and the emotional system is the organization of personality traits and dimensions (Izard, 1991; Malatesta, 1990). Recent work in the field of emotion and personality has identified a number of dispositional precursors which impact the experience and expression of emotion (Emmons & Colby, 1995). The modern idea that individuals can be characterized by fundamental personality traits that are believed to be determined by constitutional factors has persisted since the 4th century B.C. when Hippocrates categorized and described four fundamental emotional orientations (sanguine, choleric, melancholic, and phlegmatic). The importance of personality dimensions and their impact on behavior (Cattell, Eber, & Tatsuoka, 1980; Eysenck, 1959; 1982) and counselor function (Barrett-Lennard, 1962, 1981) remains a vital area of inquiry.

Initial research has demonstrated that affect orientation is a stable, enduring, identifiable "trait" phenomenon that has implications for information-processing and information production (Booth-Butterfield & Booth-Butterfield, 1990, 1994). It is not equated with mood states.

## Affective Orientation Construct

Affect orientation (AO) represents a new way of considering the interface of emotional and cognitive information-processing (e.g., Buck, 1984; Hall, 1984). AO comprises the degree to which individuals competently audit and self-regulate affect, including awareness, appraisal, and adaptive use of one's emotions (Salovey &

Mayer, 1990). The Booth-Butterfields' (1990) approach includes the perception of emotional cues as one type of information which is differently implemented depending on the individual's orientation. Affective orientation is comprised of two major components. The first is awareness of emotions in one's self. Recognition and awareness of one's emotions, an intrapersonal event, is a prerequisite to deciding how to employ affect to consciously guide behavior.

The second element of affective orientation involves taking action upon the affect cues one receives, the process of using affect as signals to guide one's behavior (Greenberg & Safran, 1987; Taylor et al., 1997). Not all information available to communicators is equally weighted or scrutinized. People who are low in AO (Booth-Butterfield & Booth-Butterfield, 1990), seem to weigh logic and facts more heavily than affects in guiding their behavior; they tend to believe that emotions guide behavior only when they are unusually intense, as in life or death, for example. They seem to believe that emotions interfere with effective communication and interaction, rather than enhance it or provide information.

In comparison, individuals who are high in AO find affect cues to be "valid sources of information to guide interaction and judgments" (Booth-Butterfield & Booth-Butterfield, 1990, p. 453). High AO individuals are conscious of a range of emotional responses and attend to their emotions, using affect as information to direct information-processing, interactions, and decisions. A general emotional sensitivity dimension seems to underlie affective orientation; for example, individuals high in AO tend to be more conversationally sensitive. Those who are highly affectively oriented appear to be more self-aware, experience their emotions more intensely, and are more privately self-conscious and aware of internal states than

those who are low in AO (Booth-Butterfield & Booth-Butterfield, 1990). They believe that certain situations need a response based on emotions.

Although the concept of AO is similar to self-awareness, emotionality, and patterns of information-seeking, Booth-Butterfield and Booth-Butterfield (1990) found it to be a unique process. They examined the relationships of the AO construct with basic dimensions of personality, as suggested by Costa and McCrae (1987). They compared the AO construct with reliable and valid measures of other personality dimensions.

Several studies by Booth-Butterfield and Booth-Butterfield (1990) found the AO construct seemed to entertain a different area not completely measured by other constructs. In one study, over a dozen conceptually related indices were compared to the Affective Orientation Scale (AOS) used to measure AO and were found to have relatively low correlations. Underlying dimensions that were significant were affect intensity and private self-consciousness. While AO is positively and significantly correlated with related constructs, it seems to cover a different conceptual area.

In a second study reported by Booth-Butterfield and Booth-Butterfield (1990), the researchers assessed the stability of AO responses. Across a 4-week time period, AO remained highly consistent and thus was apparently not a function of mood state at the time of responding (Booth-Butterfield & Booth-Butterfield, 1990, 1994). AO appears to be a predispositional pattern of responding to affective information. According to the epigenetic sequence of emotional development proposed by Lane and Schwartz (1987), AO represents the mature end of the scale, where one is aware of nuances between feelings. Bagby and Taylor (1997) placed AO at the upper end of EI.

The Role of Communication in Development of Affective Orientation

Affective orientation, manifested most often through communication is typically developed in the family, where patterns of earliest communication are formed and thought to affect all subsequent relationships (Vangelisti, 1993). Family systems and communication researchers have identified a number of links between family communication and development of affect in individual functioning (Demo, Small, & Savin-Williams, 1987). Functional families tend to have more open and frequent exchanges of emotional information (Hauser, Powers, & Noam, 1991). In dysfunctional families, members tend to withhold verbalization of their wants, likes, dislikes, and feelings (Ferreira & Winter, 1968). Panksepp (1989) found that even communication of negative thoughts and emotions within relationships of secure attachment has resulted in beneficial effects. How family members communicate with the child determine the kind, intensity, and order of emotional schema that are cultivated and quality of relationships (Bornstein, Fitzgerald, Briones, Pieniadz, & D'Ari, 1993). Thus, affect patterns are important influences on character traits, communication and quality of relationships.

*Affective Orientation Scale*

The *Affective Orientation Scale* (AOS), developed by Booth-Butterfield and Booth-Butterfield (1990), measures the extent to which individuals are aware of affect and use emotional cues as information to guide behavior. Although AO is conceptualized and measured as a single factor, the AOS has four scales, measuring (1) awareness, (2) use, (3) intensity, and (4) implementation of affect. Validity and reliability are reported in Chapter III.

In a study of subjects' report of their behavior with distressed friends, subjects with high AO on the AOS reported both a higher number of comforting strategies and greater diversity of responses in contrast with those who reported low comforting (Dolin & Booth-Butterfield, 1993). Emotional distancing was negatively related to AO. Dolin and Booth-Butterfield concluded that because affectively oriented respondents use emotions as information, when faced with other's emotional distress, they may empathize more readily, believing distress is worthy of attention, and be both motivated and capable of doing something to alleviate it.

Yelsma (1996), using the AOS, discriminated between nonabusive and abusive couples. Couples who reported being verbally and physically abusive with each other also reported low affective orientation, while those who were not abusive scored higher in AO.

In a study of Japanese and American students' affective orientations, Japanese students scored significantly lower on AO than did American students (Frymier, Ishi, & Klopf, 1990). American females scored the highest, followed by American males. Japanese females and males scored lower than both American females and males, but there was no difference between Japanese females and males scores.

## Alexithymia

### Introduction

Alexithymia has become an increasingly researched topic across a wide variety of disciplines including personality psychology (Zuckerman, 1992), psychoanalysis (Krystal, 1993; Taylor et al., 1991, 1997), psychosomatic medicine (Zerbe, 1992), and communication (Yelsma, 1992, 1996). Operationalized as a

personality trait normally distributed in the general population (Taylor et al., 1991), alexithymia is described as a fundamental difficulty of affective and cognitive regulation (Taylor, Ryan, & Bagby, 1985; Taylor, 994).

Alexithymia is conceived of as a continuous variable which overlaps diagnostic categories. Since no known research focuses on the alexithymic orientations of therapists, this review covers areas thought to be pertinent to a deeper understanding of the construct of alexithymia and how it may relate to counselor empathy. The section covers the alexithymia construct, history, affect regulation, relationships, empathy, measurement, and therapeutic considerations.

## The Alexithymia Construct

Alexithymia is a multidimensional construct operationalized as a cognitive and affective personality trait involving difficulty in experience and expression of emotions. Derivation of the term "alexithymia" from the Greek, literally translated is "no words [for] feelings" and denotes lack of awareness of affect (Sifneos, 1973).

The construct is identified by four standard criteria: (1) difficulty identifying and describing feelings; (2) trouble distinguishing between feelings and the bodily sensations of emotional arousal; (3) constricted imaginal processes, as evidenced by low level of fantasy or daydreaming experience; and (4) presence of externally oriented thinking style (Taylor et al., 1991). Taylor (1994) reports that there is consensus in the literature regarding the definition of the alexithymia construct (Acklin & Alexander, 1988; Nemiah, 1977; Sifneos, 1973, 1987; Taylor, 1994).

## History of Alexithymia Construct

Psychoanalysts and psychodynamic psychotherapists first noted relevant characteristics of clients who had difficulty communicating feelings. They showed little interest in their subjective lives, reported few dreams and fantasies, and exhibited an externally oriented style of thinking (Horney, 1952). These characteristics were noted first among patients with classical psychosomatic diseases (Ruesch, 1948) and later were reported among patients with an assortment of disorders including substance abuse, post-traumatic stress disorders, eating disorders, panic disorder, and somatization disorders (Bruch, 1982/1983; Flannery, 1978; Krystal, 1968; Krystal & Raskin, 1970; Nemiah, 1984). A number of labels were applied to these clients: "immature or infantile personalities" (Ruesch, 1948); "emotional illiterates" (Freedman & Sweet, 1954); and "normopaths" (McDougall, 1980). Marty and de M'Uzan (1963) referred to the lack of drive-related fantasies and externally oriented cognitive style as "pensee operatoire" (i.e., thinking operationally).

## Affect Regulation in Alexithymia

Alexithymia is a major disturbance of affect regulation in four essential functions: (1) desomatization, (2) differentiation, (3) affect tolerance, and (4) communication (Krystal, 1993; Taylor, 1994). Deficits in these functions have been associated with severe disturbances in affective functioning and are often present after trauma (Krystal, 1978, 1993).

### Desomatization

Alexithymics have difficulty differentiating emotions from bodily sensations. Krystal (1993) pointed out that emotions in a regressed form manifest in a predominantly physical way and are so vague and undifferentiated that they only call attention to the emotions or physical sensations themselves rather than that which they are signaling. He gave an example, typical of alexithymics, "Like the patient with a bellyache, this patient only wants the pain stopped—rather than paying attention to the pain as a sign of danger" (p. 264). A sign of emotional maturation is being able to verbalize feelings with an accompanying diminishing of physical, uncontrollable, and random affect expressions.

### Differentiation

Differentiation refers to recognizing one's emotions and distinguishing one emotion from another. Initial recognition distinguishes between pleasurable and distressing and becomes more successively more specific. With affect maturity, differentiation extends to distinguishing "blends of blends" of feelings (Lane & Schwartz, 1987). Every mental event, whether a perception, impulse, or memory, has an "affective charge" associated with it (Gardner, 1985; Krystal & Krystal, 1994). Lane and Schwartz (1987) indicated that alexithymic individuals are distressed when exposed to feelings of undifferentiated emotional arousal and so they must block their perceptions or become insensitive to the signals of affect.

## Affect Tolerance

Krystal (1993) defined affect tolerance as the "ability to take our reaction off the signal and put it on to the meaning, the import, of that signal" (p. 69). He further describes it as the ability to tolerate frustration and delay of gratification without "snowballing" the affective reactions to it (p. 36). It includes bearing and containing one's feelings without acting them out dysfunctionally (Krystal, 1993). Whether persons increase or decrease their range of conscious perceptions depends on their ability to tolerate the affective responses elicited by the perception (Krystal & Krystal, 1994). Low tolerance leads to restriction of consciousness by becoming less sensitive to subliminal "affective charges" which are contained in all events, thoughts, and memories (Krystal & Krystal, 1994).

Individuals who demonstrate deficient affect tolerance have a lessened capacity to maintain emotions in a range that is endurable. Furthermore, lack of affect tolerance can produce behaviors not conducive to the individual's relationships and long-term interest.

## Communication

In normal verbal skill development, the precision and effectiveness of verbal expression demonstrates the preferred way of handling affects (Krystal, 1993). However, alexithymics display "a specific disturbance in an individual's psychic functioning that is manifest primarily in his/her communicative style" (Taylor, 1984, p. 726). Their ineffective communication is manifest by affective experiences which are either limited or are not expressed at all (Taylor, 1994). Alexithymic individuals have been identified as having difficulty in recognizing and verbalizing their own

feelings, or being preoccupied with details and minutiae pertaining to the external environment.

Alexithymics lack mental symbolization and have an impoverished fantasy life, resulting in a utilitarian, pragmatic mode of thinking and verbalizing (Sifneos, 1973). Alexithymics recognize few of their affective stimuli, blocking their barely conscious perceptions until emotional energy builds. Then, they explode or display "knee-jerk" reactions instead of effectively expressing their emotions in ways that will enhance long-range goals (Hadley, 1983; Krystal, 1978, 1990). They approach situations analytically rather than holistically, tend to be fact-oriented, process information in strict sequence rather than doing parallel-processing on several levels, and are intolerant of cognitive incongruence such as illogical dreams and ambivalence (Giora, 1981).

Studies assessing associations between alexithymia and related characteristics of communication indicate that alexithymic individuals in clinical samples have restricted gestures and near expressionless faces (Nemiah, Freyberger, & Sifneos, 1976), reduced recognition of posed facial expressions of emotion (Parker et al., 1993), and difficulty expressing feelings in words.

Hoppe and Bogen (1977) studied eight commissurotomized patients who were highly alexithymic. They had flat, dull, uninvolved speech lacking in color and expression; they were less apt to fantasize about or imagine symbols. Passive, indirect, and unresponsive to symbols, alexithymics described circumstances surrounding events rather than feelings about events.

McDougall (1974) understood alexithymics' speech or "primitive communication," usually to be ingenuous. She felt a strong "pull" from them to do something which they themselves could not name or become aware of—to

understand and relieve their distress. Only through awareness of her own feelings which the client stirred in her, her "countertransference affect" was she able to know their inner experience and what they were signaling (p. 180). Katan (1961) illustrated the communication style of alexithymic parents:

> If such parents speak about their feelings which they are unable to show, or speak about the child's feelings, it is clear that their words are used not to further expression of emotions but to ward off these emotions. If this is the case, the words are not a bridge . . . but are a defense against the emotions. The child may now take over the example set by the parents and also use words defensively. (p. 187)

Since Krystal (1993) indicated that children typically acquire affect tolerance through learning and identification, children whose parents have difficulty handling affect also have difficulty with their own emotions. There is danger of therapists setting up similar circumstances for their clients. As Krystal described it:

> . . . a similar self-defeating situation is set up by the analyst who verbally encourages the patient to experience his emotions consciously, while he himself sits like a wooden Indian. For the patient who suffers an impairment of affect tolerance, the analysis must provide an opportunity to gain greater comfort in bearing his emotions. Otherwise, he receives his interpretations on an intellectual level, in a state of isolation of affects, and converts the interpretation to a cliche.

The implication is that if the therapist acts alexithymic, without appropriate affect expression, the client will act a part vs. experiencing genuine feelings. In summary, alexithymic individuals appear to have difficulties expressing a full range of positive and negative emotions with others which may account for their tendency toward impoverished interpersonal relationships (Krystal, 1982; Martin & Pihl, 1986).

Alexithymia and Interpersonal Relationships

Alexithymics are socially ineffective. Considering the problems that alexithymics have in communication, it is not surprising that they have disrupted

interpersonal relationships. Yelsma (1992) found that low self-esteem is associated with alexithymia. Major emotional problems affect their relationships. Krystal (1978, 1993) discovered their impairment in the capacity for self-care and anhedonia, the inability to enjoy oneself. While he found that they had a prohibition against experiencing pleasure which frequently included all forms of play, they allowed themselves to get relief from their physically-felt, often generalized distress by using external "other" sources, for example, people, substances, drugs, medicine, risk-taking (Krystal, 1993).

Krystal (1982) found that alexithymics are dependent on external sources to meet their needs, express their emotions, and think their thoughts. Their dependence on external sources for relief predisposes them to overconformity in interpersonal relationships (Krystal, 1993). Often another person becomes part of the alexithymic, doing their thinking and feeling such that the alexithymic feels incomplete when away from that person.

## Alexithymia, Self Care, and Empathy

From a clinical perspective, Danieli (1981) and Krystal (1978) found that traumatized adults cannot utilize their affects for self-caring purposes, and therefore have extreme difficulty being empathic toward others. Since they follow an inner prohibition against self-care, they cannot bear emotion which may signal their needs. Thus, emotion cues become a fearful experience and jars them into defensive manuevers to avoid feeling and to avoid comforting themselves (Taylor et al., 1997). This process renders alexithymic individuals unable to recognize affect as information about themselves, others and their circumstances.

When alexithymics continually ignore their affect cues, they have an absence of fantasy and lack creativity (Krystal & Krystal, 1994). Thus, capacity for creative self-care is highly dependent on developing and maintaining a mature self-representation that allows the use of affects, symbols, and fantasy for self-caring purposes. Krystal (1993) recounted a clinical example of a patient he initially believed did not have the ability to do cognitive processing necessary for verbalization until he realized her verbalization represented self-care. Her lack of verbalization related to her need to see herself as unable to take care of herself.

Krystal's (1993) clinical observations indicated that alexithymics have a seriously diminished level of emotional involvement with their objects and "little or no capacity for empathy" (p. 251). However, while it is intuitively plausible and validated by counselors clinically, that alexithymia is associated with lessened capacity to be empathic, few empirical studies have verified this. Parker et al. (1993), doing clinical observations, found that alexithymia interferes with both emotional processing and interpersonal behavior. Mayer, DiPaolo, and Salovey (1990) and McDonald and Prkachin (1990) found that the inability to accurately interpret emotion-relevant information is associated with alexithymia and that accuracy in emotional perception was related to empathy. In summary, alexithymics' poor affect regulation contributes to low self-caring potential, poor communication skills, poor social relationships, and a hypothesized low level of empathy.

<div align="center">Measurement of Alexithymia</div>

There are a number of scales that measure alexithymia. These include the *Schalling Sifneos Personality Scale*, the *Revised Schalling Sifneos Personality Scale*,

the *Minnesota Multiphasic Personality Inventory Alexithymia Scale*, and the *Toronto Alexithymia Scale*, 26-item and revised 20-item versions.

The *Twenty-Item Toronto Alexithymia Scale* (TAS-20), used in the present study, eliminated items on the 26-item TAS which assessed daydreaming and other imaginal activity because of low correlation with the other items on the scale, or because they correlated highly with a measure of social desirability. As a result, the TAS-20, used in this study, has a three-factor structure. These are: (1) difficulty identifying feelings, (2) difficulty describing feelings to others, and (3) externally oriented thinking. Taylor (1995) pointed out that the stability and replicabililty of this three-factor structure has been demonstrated with both clinical and nonclinical populations. In spite of the elimination of items that deal directly with daydreaming, the scale still correlates significantly and negatively with a measure of fantasy (Bagby, Parker, & Taylor, 1994).

Therapeutic Considerations Regarding Alexithymia

Blocked from making needs known, from verbalizing and listening, and from observing their mental processes, the alexithymic is a difficult person and client (Krystal, 1982). Krystal (1993) stated that because because the role of emotions in psychotherapy is so central and essential the field did not at first notice alexithymic problems. "The psychotherapy field adherred to conventional 'wisdom' that everyone is capable of responding emotionally in an adult fashion but may be obstinately defending against it" (Krystal, 1993, p. 254). As Sifneos (1973) reported, "Most of all, these patients simply do not respond to insight derived from psychotherapy or to any form of treatment which emphasized verbal expression and requires a capacity

for emotional interaction" (p. 261). Berger (1987) noted alexithymic incapacity for self-awareness and reflectiveness.

Therapy which calls on the client to utilize reflective self-awareness is not possible for the alexithymic (Taylor et al., 1997). The inability for reflective self-awareness wherein one identifies their feelings, experiences them, and determines appropriate self-fulfilling behavior necessitates a distinctive phase or type of therapy to get the alexithymic client ready for insight or experiential therapy (Krystal, 1993).

Certainly these observations from clinical work and the cited studies compel study of counselor emotions. A question that presents itself is, "How empathic and how effective are alexithymic counselors, considering that therapy they conduct would be devoid of genuine emotional interaction on the part of the counselor?"

Empathy

Introduction

Empathy is a construct of "great and enduring interest" (Goldstein & Michaels, 1985, p. x). Psychologists from many theoretical orientations agree that empathy is an integral part of therapy (Gold, 1996; Perry, 1993). Empathy has been widely accepted as a valuable, if not "sufficient," component in therapist efficacy and formation of the therapeutic relationship (Lambert, Shapiro, & Bergin, 1986). Empathy fosters the emotional climate of the therapeutic relationship and the bonds within it (Gold, 1996).

And yet, empathy research in counseling has declined. Upon concluding a substantial review of empathy literature, Duan and Hill (1996), while noting a drastic decrease in research studies on empathy in counseling psychology in the last decade,

encouraged research on empathy, especially on counselor empathic emotions to better understand empathy and its role in the therapeutic relationship. After their extensive literature review, Goldstein and Michaels (1985) concluded, "Empathy has been diversely defined, hard to measure, often resistant to change, yet emerges as a singularly important influence in human interaction" (p. ix). History of empathy offers a context from which to understand its importance and diversity.

History of Empathy

The term "empathy" was first used in a literary context in 1903 by German psychologist Lipps, as the English equivalent of the German "einfuhlung" (Wispe, 1986). "Einfuhlung" literally translated is "to feel [oneself] into" or "to feel within," termed "empathy" by Titchener in 1910. Empathy, a psychological process, involved *understanding through shared feelings* (Goldstein & Michaels, 1985).

It is little known that Freud mentioned empathy 15 times in his work (Basche, 1983). Basch (1983) asserted that Freud's view of the importance of empathy was overlooked and lost through mistranslation. Ferenczi (1928), Freud's colleague, wanting to make the emotional atmosphere of psychoanalysis more compassionate and less "austere" and "authoritarian," was the first to introduce empathy into psychoanalysis with this statement (Rachman, 1988): "I have come to the conclusion that it is above all a question of psychological tact whether one should tell the patient some particular thing. But what is 'tact?' It is the capacity for empathy" (p. 89).

Ferenczi strove to be emotionally attuned to the impact of his interpretations on the analyzand and urged analysts to follow the "rule of empathy," for patients who act out their feelings of rejection by being "bad patients," suggesting that when they had an "excessive degree of antipathy," to strive for empathic understanding of such

patients (Rachman, 1988). Integration of empathy into practice was a "significant technical advance for that time, but still requires special emotional and intellectual capacities in practice today" (Rachman, 1988, p. 2).

Interestingly, 29 years later, Strupp (1957) found that therapists tended to be hostile and ineffective with hostile clients. Writing as a "master-therapist," Strupp (1996) indicated that based on his 40+ years of research, empathy was critical. He exhorted therapists to be empathic, avoiding "pejorative comments" to clients.

In the psychodynamic schools, as Berger (1987) indicated, writing on empathy greatly increased in the early 1970s and has continued through the present. Clinically-based writers have intricate descriptions of empathy, an intrapsychic capacity that includes brief partial identifications with others, difficult processes to operationalize (Langs, 1978/1979). Descriptions of empathy continue to emphasize affect, the capacity to know emotionally what another is experiencing (Berger, 1987).

In 1934, sociologist Mead made a major change in the definition of empathy as a conscious, deliberate role-taking response, instigated when one puts oneself in the place of the other. Deutsch and Madle observed that post-Mead, "empathy was no longer viewed as . . . sharing of feeling . . ." but included empathizers' intellectual abilities "to put themselves in the other's place" (Deutsch & Madle, 1975, p. 270).

Not until Carl Rogers' client-centered writing (1951, 1957), in which he identified "core conditions" of genuineness, unconditional positive regard, and empathy as "necessary" and "sufficient" to facilitate client change, was empathy a subject of empirical studies (Gladstein, 1983). His definitions emphasized the role-taking "as if" dimension of empathy within a warm, accepting therapeutic relationship (1957; 1975). Rogers' work initiated a period of voluminous theory, research, and operationalization of the empathy construct (e.g., Barrett-Lennard, 1962, 1978;

Carkhuff, 1969; Danish & Kagan, 1971; Davis, 1980; Hogan, 1969; Rogers, Gendlin,

Keisler, & Truax, 1967; etc.). His work was further developed by researchers such as

Truax and Carkhuff (1967), Carkhuff and Berenson (1967), and Carkhuff (1969,

1972), who became interested in empathy training, and by writers of training texts

(Egan, 1994; Ivey, Ivey, & Simek-Downing, 1987). Research into these conditions

constitutes "a body of research which is among the largest for any topic of similar

size in the field of psychology" (Patterson, 1984, p. 431). Rogers' work has had an

impact on virtually every approach to counseling and therapy (Beutler, Engle, Oro'-

Beutler, Daldrup, & Meredith, 1986).

Empathy has seen a dramatic decrease in empirical research in the field of

counseling psychology. Patterson (1984) indicated there were 439 references listed in

the extensive 1967 review of Truax and Carkhuff. Sexton and Whiston (1994)

counted only 11 empathy-related studies published in major counseling psychology

journals since 1985. Duan and Hill (1996) noted after Gladstein's (1983) critical

review that researchers may have despaired at the complexity of researching empathy

and turned to other issues, such as the therapeutic relationship. Ironically, during

much of the same period, in the last 25 years, writing on empathy burgeoned in

psychodynamic literature, possibly a result of increased interest in the analysts'

emotions (Berger, 1987; Maroda, 1991).

Researchers at the Stone Center have focused on the mutual, relational, and

emotionally rich aspects of empathy (Jordan, 1997; Jordan, Kaplan, Miller, & Stiver,

1991). Interested in women's development, they identified and reframed what had

been viewed culturally as weaknesses in women—their relational orientations—as

strengths (Jordan, Surrey, & Kaplan, 1991). They found that "empathic relating is at

the heart of this new understanding of women" (Jordan, 1991, p. 6). Empathy is

considered central to psychotherapy from a relational perspective (Jordan et al., 1981). Work at the Stone Center provided a new model for innovative investigation, using collaborative discussion groups, to stimulate their "works in progress" (Jordan, 1991).

The 1960s was a period of global outcome investigation in psychotherapy research including empathy-outcome studies, in which uniformity premises prevailed such that operationally, all therapists and clients were treated as more or less equivalent (Mahoney, 1991). In the late 1970s and 1980s, psychotherapy research was shifting toward becoming more prescriptive, for example, seeking to identify therapist, patient, and treatment characteristics that combine to enhance therapeutic outcome (Goldstein & Michaels, 1985). Several types of research questions now being asked are: "To the extent that therapist empathy is not only client specific, but also a reliable therapist characteristic, are there other therapist qualities predictive of or associated with it?" (Goldstein & Michaels, 1985, pp. 137–138). They note that research questions are taking form around the therapist-client relationship (e.g., Horvath & Greenberg, 1994; Rennie, 1992). This study focused on therapist affective qualities hypothesized to be predictive of empathy.

## Definitions of Empathy

There is lack of consensus in the field on the definition of empathy (Duan & Hill, 1996). Because of interest in empathy in therapy across theoretical orientations, its meaning has grown, shifted, and been adapted by researchers from differing schools of counseling (Jordan, 1991; Kohut, 1977; Rogers, 1957; Truax & Carkhuff, 1967). The following definitions demonstrate some of the controversy which exists in the field:

Empathy is the capacity to take the role of the other and to adopt alternative perspectives via oneself. (Mead, 1934, p. 27)

[Empathy is] emotional knowing, the experiencing of another's feelings. (Greenson, 1960, p. 418)

. . . the state of empathy or being empathic is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the other person, but without ever losing the "as if" condition. (Rogers, 1975, p.4)

When we fill in the concept of empathy, part of what we imply is that the empathizer has himself had some things happen to him right then; it is not just that he has thought hard, or tried to figure something out. (Sawyier, 1975, p. 39)

Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings. It is not necessary—indeed it would seem undesirable—for the therapist to share the client's feelings in any sense that would require him to feel the same emotions. (Truax & Carkhuff, 1967, p. 46)

Experientially, empathy begins with the basic capacity and motivation for human relatedness that allows perception of the other's affective cues . . . followed by a surrender to affective arousal in oneself—as if the perceived affective cues were one's own—thus producing a temporary identification with the other's emotional state. Finally, there occurs a resolution period in which one regains a sense of separate self that understands what has just happened. (Jordan, 1991, p. 29)

As observed, essential differences exist between writers in their definitions of empathy. The diversity of empathy is revealed in the definitions. While empathy is specified in this study as communicated, observed, emotional, cognitive, and relational, overall, a holistic definition of empathy is used: "a dynamic cognitive-affective process of joining with and understanding another's subjective experience" (Jordan, 1984, p. 2).

Empathy Construct

Since the earliest uses of the construct, empathy has undergone so many redefinitions that it no longer has a precise meaning (Duan, 1992). Writers have agreed that the construct of empathy is complex and eludes simple description (Berger, 1987; Gelso & Carter, 1985). The construct of empathy has been construed in primarily three ways: (1) personality trait; and/or (2) state-specific state; and (3) a process, comprised of several stages including experiencing empathy and communicating it (Barrett-Lennard, 1993; Goldstein & Michaels, 1985). Whether a trait, state or process, the nature of empathy has been identified as possessing two main dimensions or components: (1) emotional, and/or (2) cognitive (Gladstein, 1983, 1987). A discussion of the construct and nature of empathy follows.

Empathy as a Dispositional Trait

Those who have been most interested in the trait aspects of empathy are developmental researchers who conceive of empathy as primarily an internal capacity resulting from growth and socialization (Hoffman, 1984). Experts believe the dispositional capacity for empathy is established in childhood and increases in empathic functioning occur with cognitive and affective maturation and the completion of developmetal tasks (Erikson, 1959; Kazdin & Johnson, 1994, Piaget, 1965). Lane and Schwartz (1987) enumerated six stages of emotional development based on the cognitive developmental stages of Piaget. In the most mature stage, in which one is able to distinguish "blends of blends" of feelings in self and other, mature empathy, involving both affective and cognitive processes is possible.

Davis (1983) employed the term "dispositional empathy," which refers to cognitive and affective role-taking tendencies. In exploration of the notion that therapists differ in "facilitativeness," empathy and core conditions were depicted as being offered nonselectively to clients by virtue of "basic abilities" or "interpersonal orientations" (Rogers, 1957). Empathy was conceived then, as an invariable trait, existing in high (facilitative) or low (nonfacilitative) degrees.

## Empathy as a State

Empathy is also referred to as a state-specific phenomenon. Greenson (1960) viewed empathy as "emotional knowing," involving a state in which one experienced another's feelings. In Rogers' early work, (1951, 1957, 1959), he treated empathy as a state of knowing another that progresses, moment to moment. Other researchers who emphasized state-specific aspects provided empathy training materials to remedy deficits in empathic communication responses (e.g., Bullmer, 1975; Carlozzi & Hurlburt, 1982; Truax & Carkhuff, 1967).

## Empathy as a Communication Process

Communicated empathy is understood to be the transmission of what the counselor has understood about the client through observable communication (Barrett-Lennard, 1986). The first researchers to identify, measure, and teach this aspect of empathy were Rogers (1959, 1975), and Truax and Carkhuff (1967). Rogers made a shift from referring to empathy as a "state" (1959) to referring to stages of empathic process which emphasized "temporarily living" in the client's life and "communicating one's empathic understandings" to the client (1975). Rogers believed that an assortment of channels exist for accurate expression of empathy, one

of which is reflection of feelings. Carkhuff (1969) stated, "Empathy is perhaps the most critical skill of all helping dimensions . . . without empathy, there is no basis for helping" (p. 82). He went on to describe the interactive communication process, stating that "accurate empathy" has occurred only if the "helper's communications enable the helpee to continue to understand himself at even deeper levels" (p. 83).

The model of empathy used by Truax and Carkhuff (1967) hinged on communication of empathy through reflection of feelings and meanings to clients. This model was used in a host of research studies, most of which found that empathy was associated with effectiveness (Truax & Carkhuff, 1967).

Likewise, Barrett-Lennard (1978) presented a model of empathy as a cyclical, multistage, multidimensional process in which communication plays an important part: (a) empathic set, (b) empathic resonation, (c) communicated empathy, and (d) received empathy. His model provides a structure to conceptually order elements of the empathic process described by several theorists (Danish & Kagan, 1971; Feshbach, 1982; Greenson, 1960; Katz, 1963; Rogers, 1957, 1975; Truax & Carkhuff, 1967).

## Communication of Empathy in Counselor-Training

Numerous studies of counselor training programs have demonstrated that communication of empathic responses, primarily as reflections of feelings, can be taught and learned (Greenberg & Goldman, 1988; Hovestadt, 1973; Lawson & Gaushell, 1988; Poff, 1991; Truax, Carkhuff, & Douds, 1964). Communication processes help the client or observer to note empathy through aspects of "tone," "expression," and accurate meanings (Carkhuff, 1969).

Barrett-Lennard (1962) further substantiated the importance of empathy training in the counseling process when he reported that in addition to empathy level being associated with positive counseling outcome, "experts evidently communicate their empathic understanding much more unambiguously than non-experts" (p. 31). This implies that through instruction or experience, counselor-trainees may improve communication of empathy.

In operationalizing this implication, Carkhuff (1969) proposed that effective helping skills and more particularly empathy, can be systematically taught and learned. In his training model, often specified as didactic-experiential in format (Goldstein & Michaels, 1985), two primary elements of empathic functioning are advanced: (1) the ability to discriminate between empathic and unempathic responses, and (2) the ability to effectively communicate empathic responses.

Research supporting (didactic-experiential) training as an effective means for enhancing empathy is extensive (Bath, 1976; Becker & Zerit, 1978; Berenson, 1971; Bierman, Carkhuff, & Santilli, 1972; Hovestadt, 1973; etc). In addition, the textbook training systems of Egan (1994) and Ivey and Authier (1978) have purported to effectively raise communicated empathy levels in trainees.

## Nature of Empathy as a Multidimensional Construct

To solve the dilemma of definition of empathy, a number of reviewers including Barrett-Lennard (1986), Goldstein and Michaels (1985), Duan and Hill (1996), and Gladstein (1983) have concluded that empathy should be viewed and measured as a complex multidimensional and multistage phenomenon, including cognitive, affective, and communication domains. Many theorists and researchers support a process model of empathy, occurring in stages. Rogers (1975) and Kohut

(1977) describe a two-stage process: (1) experience, and (2) communication of empathy. Others break it down further into an emotional stage, followed by conscious cognitive activity, which is then communicated from therapist to client (Barrett-Lennard, 1981; Goldstein & Michaels, 1985; Katz, 1963; Stewart, 1956).

## Affective and Cognitive Components

Seeking to refine and clarify the construct, Gladstein (1983) examined social and developmental psychology literature and the counseling-based body of knowledge on empathy. He identified two types of empathy common to these three disciplines: (1) emotional or affective empathy (taking on the feelings of another); and (2) cognitive or intellectual empathy (role-taking, perspective-taking, "I understand what you feel")—or some combination of the two (in which either or both are activated).

Duan and Hill (1996) assert that studies of empathy which do not identify it as a cognitive or affective process have created an unclear and sometimes confusing situation.

> Continuous effort is needed in understanding how these two processes may exist separately, coexist, or influence each other. . . . There is very limited material about the part that empathic emotions or the relationship between intellectual empathy and empathic emotions play in the psychotherapy or counseling literature. (Duan & Hill, 1996, pp. 263–264)

Other researchers agree that to deepen understanding of empathy, both its affective and cognitive elements must be explicitly recognized (Deutsch & Madel, 1975; Duan & Hill, 1996; Feshbach, 1976; Hoffman, 1977).

A number of researchers contend that the cognitive and affective components of empathy are inseparable (Greenberg, Rice, & Elliott, 1993; Greenson, 1960; Isen, 1984; Piaget, 1965; Safran, 1990). The work of Coke, Batson, and McDavis (1978)

supports this model, finding that helping behavior of subjects who learned of another's need and were given the opportunity to help was greatest from subjects who experienced the most empathic emotion. Perspective-taking alone did not influence helping behavior but was influential through its effect on empathic emotion. Davis (1983) also found a significant, moderate, positive correlation between two of his scales measuring affective and cognitive empathy.

## Summary of Construct

In summary, empathy researchers have expressed different perspectives in defining the construct of empathy. Those who focus on empathy as a general human ability, a disposition or personality trait, tend to be those who are most interested in inter-individual differences or in empathy development in children (Eisenberg, 1989; Feshbach, 1979). A certain degree of innateness of empathic ability is posited, and it is inferred that some are more empathic than others by nature or through development (Piaget, 1965).

Other investigators who emphasize the situationally-determined psychological state of empathy tend to be most interested in the role of cognitive appraisal and stimulus-induced empathy in social processes (Omdahl, 1995). It is assumed that given people's development, their empathic experiences may vary as situations vary (Duan & Hill, 1992).

Empathy and Affect in the Therapeutic Relationship

## Empathy and Emotion in the Personality of the Counselor

There have been continuing efforts to identify counselor personality variables and behaviors associated with successful counseling outcomes (Orlinsky & Howard, 1967, 1975, 1980; Scott, 1985; Strupp, 1996). Some examples include the following: Goldstein and Michaels (1985) found that therapists and counselors and counselor trainees differ in the amount, range, and intensity of empathy they demonstrate; counselor-trainees' ability to process their own experiences was positively correlated to their level of empathic functioning in counseling relationships (Rennie, Brewster, & Toukmanian, 1985).

There is some evidence that awareness of emotions is related to ability to be empathic. For instance, Krystal (1988) has found that clients with low awareness of emotions also have low amounts of empathy. Developmental researchers Feshbach (1975) and Hoffman (1984) found emotional responsiveness is related to affective empathy in children. The relationship between empathy and emotion in counselors and psychotherapists has rarely been explored empirically.

In a study of clients 1 to 2 years after completing psychoanalytical or behavior therapy, researchers found that 70% of successful patients in both therapies rated the following as "very important" or "extremely important": personality of the therapist, being helped by therapist to understand their problems, being able to talk to an understanding person, having someone help them to understand themselves (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). This seemed to demonstrate that affective and personality factors of the therapist were more important than technique, regardless of theoretical orientation.

Functions of Empathy in the Therapeutic Relationship

In this section, several therapeutic functions which have been associated with counselor empathy in therapeutic relationship will be reviewed. Understanding the quality and function of the therapeutic relationship has been a topic of interest since Freud's first attempts to describe the treatment relationship (1912). Greenberg and Pinsof (1986) reported that the therapeutic alliance is becoming a major variable utilized by psychotherapy researchers around which other variables can be organized: it is the vessel, relational context, and part of the "holding environment" (Winnicott, 1965) in which therapy transpires.

Research on therapeutic alliance has been facilitated by the formulations of Bordin (1979), who explicated three highly integrated dimensions relevant to establishing a working alliance, common to all theoretical orientations: (1) creating a bond, (2) agreement on tasks, and (3) goals.

Affective Orientation in the Therapeutic Relationship

While differentially emphasized, the majority of schools of psychotherapy agree that the therapeutic relationship is essential to effective therapy and positive outcome (Horvath & Greenberg, 1994). Since therapist and client are both part of a two-person system, as Sullivan (1953) indicated, emotional experiences of therapists as well as clients play an equally important part in the change process. The therapeutic relationship can provide a safe context in which a client can change emotions connected with early experiences and associations (emotional schemata) that may be counterproductive in the present (Johnson & Greenberg, 1994). In studies of the characteristics of good therapy hours, Orlinsky and Howard (1967,

1975) examined therapists' and clients' immediate postsession ratings on the Session

Therapy Report. They discovered that good therapy hours focused on intimate

personal relationships and self-exploration with insight. The manner of the session

was warm, collaborative, and expressive. Successful therapy was characterized as an

intense affective experience, with client and therapist sharing a dominant mood or

affect. This kind of emotional matching and mirroring (Winnicott, 1965) requires

counselors to be affectively flexible to adapt to various client affects and personality

styles in order to interact (Trembley, 1996). Several aspects of the therapeutic

relationship that are affected by emotion are discussed below.

### Emotional Climate

Empathy assists in establishment of an emotional climate in therapy (Gold,

1996), helps to create therapeutic relationships (Watson & Greenberg, 1994), aids in

formation of a relational bond (Safran & Segal, 1990), facilitates emotional

exploration in clients (Greenberg et al., 1993), and facilitates counselor-client

collaboration (Hackney & Cormier, 1988; Raue & Goldfried, 1994). "The emotional

climate refers to the quality and quantity of affective engagement and involvement

between patient and therapist that are thought to be helpful, necessary, or

ameliorative" (Gold, 1996, p. 90).

Many theorists believe that for change to occur, it is necessary for the client

to form a safe and trusting relationship which is a function of the counselor's ability

to accurately listen, be emotionally available, and communicate understanding of the

client's phenomenological world (Kahn, 1991; Rogers, 1951, 1957). Research has

demonstrated that empathy with clients' feelings strongly influences the quality of the

helper-client relationship, and, subsequently, the degree of client change in a

substantial proportion of psychotherapy clients (Kanfer & Goldstein, 1991; Patterson, 1984; Truax & Carkhuff, 1967).

Many cognitive-behavior therapists view the therapeutic bond between themselves and clients as a necessary prerequisite to specific techniques (e.g., Beck, Rush, Shaw, & Emery, 1979; Goldfried & Davison, 1976; Raue & Goldfried, 1994). Safran (1990) asserted that empathy is simultaneously a cognitive and affective process and "should involve the therapist's continuing attempt to understand patients' inner experiences" (p. 98).

Hackney and Cormier (1988, p. 89) commented that although empathy is not a panacea, it is an effective way to create an atmosphere of closeness and warmth; and it contributes to a sense of self-acceptance because when a person feels understood they feel less confused and more acceptable. The emotional climate of empathy and acceptance provides clients with fresh perceptions of self-worth and profound disconfirmations of old and dysfunctional thoughts, opinions, and feelings about self and others (Rogers, 1975).

The importance of emotional and relationship factors, including empathy, to promote change in dynamic psychotherapies has been clear for decades (Strachey, 1934). Kohut (1977) and Winnicott (1971), among others, agree that the therapist provides corrective emotional experiences for the client, such as empathy, soothing, and encouragement, which would ideally be internalized by the client.

DeVoogd (1987), Gold and Wachtel (1993) and Greenberg et al. (1993) have pointed out the need for empathic attunement, safety, closeness, and confirmation of the client in the therapeutic relationship before effective, change-producing confrontation can transpire. The need for empathy was exemplified in Becker's work (1990) with organically impaired patients, Cummings (1993) with substance abusers,

and Grzesiak (1993) with chronic pain patients. Most therapists would agree that "empathic engagement is indeed necessary but is not sufficient to produce much meaningful change in and of itself" (Gold, 1996).

### Communication of Authentic Feelings

Communicating one's authentic feelings to a client has two major positive results. One is that the client can more readily trust the therapist and that the relationship is a real one to the therapist. Secondly, the therapist is modeling affective awareness and affective communication to the client. Counselors need to be aware of their own emotions in order to respond genuinely, from an experiential base. Safran and Greenberg (1991) echoed this notion: "The therapist will have an impossible time relating to the client with appropriate emotional responses if he or she is unaware of them and does not have access to his or her emotions" (p. 356).

There are also times when counselors may need to involve their genuine feelings and share them with a client, especially one who questions the authenticity of the counselor as if she or he were only playing a role. A number of case presentations illustrate times when clients need therapists to appropriately communicate their true emotions to show clients that the relationship is real to them (Guidanno, 1991; Hammer, 1990).

> . . . A primary purpose of the therapeutic context is the provision of an actual *relational experience* that does not replicate the relational experiences which have been pathogenic in the client's life. . . . All of therapy is about the provision of a good relationship with a good enough adult other, the therapist. (Trembley, 1996, p. 74)

> The therapist must "break through the barrier to human relatedness . . . and allow an authentic I-Thou encounter to take place." (Safran & Greenberg, 1991, p. 357)

The client cannot achieve intimacy in a vacuum; the therapist needs to know how to be an integral part of a real relationship. (Strupp, 1996, p. 135)

Emotional contact is the touchstone of intimate relationships. (Johnson & Greenberg, 1994, p. 11)

## Modeling of Emotional Process

One of the major ways that clients make progress is by learning novel ways of coping through therapist-modeling (Gold & Wachtel, 1993). Clients with defective early development, especially, need therapists to model healthy, mature emotional processing of feelings and conflicts; they need a coping model (Meichenbaum, 1977). Often, when therapists cannot identify a patient emotion, it is because they are defending against their own similar feelings (Krystal, 1988).

## Affective Orientation, Intimacy and Attachment

Affective awareness and expressions promote attachment and intimate relationships (Bowlby, 1988). As Johnson and Greenberg (1994) state, "The emotions that organize an intimate relationship are best evoked, aroused, and reprocessed in the session, that is, they are best experienced rather than discussed or viewed from a distance" (p. 17). Being emotionally available requires that one know how to process one's feelings, especially when a primary process is operating and controlling much of a person's energy (Frijda, 1988).

Guidanno (1991) suggested that therapists must provide clients with new emotional experiences to change their core emotional themes and the idiosyncratic and possibly maladaptive attributions inherent in them. Research has found that intimate relationships, in which one shares confidentially, buffer individuals against stress and promote mental and physical well-being (Pennebaker & Roberts, 1992).

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One of the major ways that clients make progress is by learning novel ways of coping through therapist-modeling (Gold & Wachtel, 1993). Clients with defective early development, especially, need therapists to model healthy, mature emotional processing of feelings and conflicts; they need a coping model (Meichenbaum, 1977). Often, when therapists cannot identify a patient emotion, it is because they are defending against their own similar feelings (Krystal, 1988).

### Affective Orientation, Intimacy and Attachment

Affective awareness and expressions promote attachment and intimate relationships (Bowlby, 1988). As Johnson and Greenberg (1994) state, "The emotions that organize an intimate relationship are best evoked, aroused, and reprocessed in the session, that is, they are best experienced rather than discussed or viewed from a distance" (p. 17). Being emotionally available requires that one know how to process one's feelings, especially when a primary process is operating and controlling much of a person's energy (Frijda, 1988).

Guidanno (1991) suggested that therapists must provide clients with new emotional experiences to change their core emotional themes and the idiosyncratic and possibly maladaptive attributions inherent in them. Research has found that intimate relationships, in which one shares confidentially, buffer individuals against stress and promote mental and physical well-being (Pennebaker & Roberts, 1992).

Recognition of the crucial role of affect in intimate relationships has been growing (Dandeneau & Johnson, 1994; Denton, 1991).

Therapists who want to help individuals and couples with intimacy may need to be able to model intimacy themselves. Intimacy involves connection with one's own affective experience and acceptance and connection with the another's affective experiencing (Cusinato & L'Abate, 1994). Intimacy is trusting self-disclosure followed by empathic responding (Wynne & Wynne, 1986). As they pointed out, the more dissociated individuals are from their affect, the more the therapist must intervene as an "active partner" to help them connect with and express affect. The empathic attunement that Johnson and Greenberg (1994) recommended, a "process of imaginatively entering the inner world of the other, affectively resonating with it, and then exploring the emerging edges of that experience" (p. 307), requires intimacy skills on the part of the counselor.

Because the majority of clients identified good therapy hours as intimate with intense emotional experience (Orlinsky & Howard, 1967, 1975), the therapist must have the capacity to allow clients to securely "attach" to or bond with them. Attachment is a way clients invest in the therapeutic relationship and the therapy process Trembley, 1996). Attachment theory views adult love as an emotional bond addressing innate needs for security and contact with significant others. Johnson and Greenberg (1994) explicated the role of affect in attachment theory.

> Attachment theory, as well as focusing on internal representations, sees
> emotion as the primary signal of the success and failure of attachment and as
> motivating attachment-seeking behaviors.... The emotional accessibility and
> responsiveness of the partners form the basis of the bond between them and
> facilitate emotional engagement and contact. (p. 4)

In this context, therapists who want clients to attach to them must display some level of emotional accessibility; counselors can coordinate adaptive attachments and aid

empathy, and genuineness to increase attachment, helping clients to experience affirming relationships in which they may learn new, more functional patterns of communication and affective regulation (Taylor et al., 1997; Watson & Greenberg, 1994).

The affective presence of the therapist is continually identified by clients as essential to their positive experiences in therapy. In a study by Visher (1996), hundreds of clients were questioned post-therapy regarding their perspectives on what comprised successful stepfamily therapy. Of 12 possible reasons, the majority of clients (22%) identified affective support as the most helpful aspect of therapy, while the clarification of issues and insights was second.

## Counselor Affect Tolerance

The ability to help and to understand whatever that individual is feeling, requires a high degree of "affect tolerance" (Krystal, 1988). Affect tolerance is the ability to recognize an intense feeling in oneself without resorting to defensive maneuvers to eliminate it (e.g., distancing). Krystal (1988) viewed affect tolerance as integral to healthy affect regulation and affective orientation.

In work with traumatized clients, McCann and Coletti (1994) found that therapists must be trustworthy, able to genuinely listen, be affectively present moment to moment, and understand clients' conflicted inner experiences and hostile outer realities. To accomplish this affective presence, the therapist must be able to "contain" or "tolerate" unbearable affects (Parson, 1988). The more traumatized the client is, the more the therapist is required to be empathic and tolerant of intense affect, which is necessary to provide a safe environment for the client (McCann &

Pearlman, 1990; van der Kolk, Boyd, Krystal, & Greenberg, 1984). Krystal (1993)

described affect tolerance as:

> Pain and the painful affects can be lived only under protest and demand for
> relief, for they are signals of protest. However, it is advantageous to be able
> to utilize such affects as signals, to recognize them as part of one's own
> living, to heed them and live them lovingly—in other words, to develop to the
> maximum one's affect tolerance. (p. 80)

The affective containment function has been described as the caregiver's

capacity to absorb, contain, process, and interpret the client's affect states. The

counselor's ability to be consciously aware of and tolerate certain painful affective

states can enhance therapeutic possibilities.

### Empathic Attunement

Empathy involves a process of affect attunement in that the therapist must not

only grasp the "idea" of the client's internal experiences, but also the "feel" for subtle

nuances of the experiences of which the client may not be fully aware (Safran &

Segal, 1990). Attunement always involves feelings. "[Attunement] is like

communion, where one shares another's experience without attempting to change

that person" (Hammer, 1990, p. 115). The concept of empathic attunement has been

explored by infant and child researcher, Stern (1985), who stated that affect

attunement involves three steps: (1) parent reads infant's feeling state from infant's

overt behavior, (2) parent performs some "corresponding" behavior, and (3) infant

reads this corresponding behavior as a reflection of the infant's experience.

A wide range of theorists, from psychodynamic to cognitive-behavioral, have

hypothesized that internalized schemas are major correlates of emotional experience

and interpersonal behavior (Henry, Schacht, & Strupp, 1990). Henry and Strupp

(1994) concluded that because of the central role of internalized prior relational

experiences in maintaining "problematic affective/interpersonal cycles, it would stand to reason that any successful therapy would likely alter a patient's introject state by some means" (p. 70). Thus, client exploration requires trust in a good therapeutic relationship (Watson & Greenberg, 1994).

Greenberg et al. (1993) discussed the use of counselor empathy to: (a) evoke, (b) explore, and (c) deepen client affect when appropriate. They also pointed out that therapists can use empathy to selectively focus on client material, thereby actively directing the therapeutic effort. Rogers (1959) found that the confirmatory experience of feeling understood seemed to give substance and power to the client's expanding self-concept and in itself effected growthful change (p. 191). Rogers (1975) and Carkhuff (1969) identified advanced empathy, a form of "midwifery," as Barrett-Lennard (1986) termed it, which facilitates deeper exploration. Carkhuff's Level V, the most empathic level on his *Empathic Understanding in Interpersonal Processes* scale (see Appendix D) is a type of advanced empathy.

## Empathy and Effectiveness

The level of communicated empathy extended by the counselor and its effects on the client has been the object of substantial theory and research (Goldstein & Michaels, 1985; Rogers, 1951, 1957; Rogers & Truax, 1967). Tausch (1988) found (a) there are differences in the extent to which psychotherapists of different schools attend to their client's emotions and/or cognitions, and (b) therapists have a definite influence on their client's attention to emotions or cognitions. More than 28 confirmatory studies were done in the 10 years following Roger's claim that empathy was an important factor in therapeutic change (Truax & Carkhuff, 1967). Research has consistently demonstrated that a therapist's empathy with a client's feelings

strongly influences the quality of the helper-client relationship and, subsequently, the degree of positive change in a substantial proportion of psychotherapy clients (Kanfer & Goldstein, 1991; Patterson, 1984; Truax & Carkhuff, 1967).

Comparing contributions of technique and relationship variables in cognitive therapy with depressed clients, Persons and Burns (1985) found that both within-session changes of belief in an "automatic thought" (the technique) and the client's assessment of the quality of the relationship (e.g., counselor warmth, empathy, and trustworthiness) made independent and additive contributions that accounted for significant amounts of outcome variance. Burns and Nolen-Hoeksema (1992) investigated the causal effect of therapist empathy on depression in cognitive-behavior therapy. They found that client perception of empathy had a moderate to large effect on recovery, whereas severity of depression had only a very small effect on perception of empathy.

## Empathy and Negative Outcome

Some fruitful research in affirming the importance of empathy and rapport in therapy has come from negative outcome research. A number of studies have shown poor outcome and clients who do not stay in therapy when empathy and warmth are not present. Using the Barrett-Lennard *Relationship Inventory* measuring clients' perceptions of their therapists, it was found that those who dropped out of therapy saw their therapists more negatively (i.e., less warm, empathic, and genuine) following intake than nondropouts; education, therapist-client congruence, and practical problems did not predict dropout (Beckham, 1992). In studying ruptures in the therapeutic relationship, Safran, Crocker, McMain, and Munay (1990) found that failures in empathy can give rise to or exacerbate breaks in the relationship and result

in clients negative outcome. Safran et al. (1990) suggested that therapists' self-awareness and willingness to accept their contributions to ruptures can facilitate healing them. In a review of negative outcome research, Mohr (1995) found that lack of empathy and negative countertransference, among other therapist variables accounted for negative outcome.

### Affective Orientation and Countertransference

While it is a term most often used in psychodynamic circles, countertransference refers to the affect of the therapist and is therefore pertinent to the present review. The term "countertransference" (C-T), first coined by Freud (1910), traditionally has referred to the transference reactions, or unresolved issues and feelings with others which one transfers to another person. Writers have distinguished between the inevitable existence of C-T feelings and the need to control one's reactions to the feelings (Segal, 1994). Current writers recognize C-T as inevitable and often useful to the therapist to better understand the client, as well as the therapist's own emotional and interpersonal dynamics (Maroda, 1995; Wolstein, 1996).

Recently, C-T has been described most often as any emotional response of the therapist that interferes with the necessary understanding of the client and manifests itself in interfering behavior. Countertransference has been linked with impediments to provision of empathy (Greenson, 1960). Most frequently noted C-T reactions are becoming enmeshed or withdrawing personal involvement from client concerns, and inability to accurately perceive client issues and dynamics due to one's internal reactions to the client (Emiston, 1990; Maroda, 1995).

Awareness and subsequent affect tolerance is especially important when therapists experience negative, internal reactions to clients. Research has demonstrated that therapist self-disclosure of negative countertransference and feelings to clients had deleterious effects (Henry, Schacht, & Strupp, 1986; Mohr, 1995). One factor in not allowing C-T reactions to negatively impact therapy is affect tolerance. The counselor who is sensitively attuned to self will be more likely to note the affect cues of countertransference (Book, 1991).

The pitfalls of either significant fluctuations in empathy or empathic failures have been well documented in the clinically-based psychoanalytic literature (e.g., Kohut, 1984) and more recently by cognitive-behavioral researchers (Safran et al., 1990). If ruptures in empathy are not attended to and monitored within the emotional life of the therapist, the resulting reactions may increase the empathic breach and undermine and threaten the therapeutic relationship as a whole (Safran et al., 1990; Wilson & Lindy, 1994).

When therapists are able and willing to monitor their internal reactions and remain aware of their feelings, they are more likely to control their external behavior so it does not interfere with therapy (Cerney, 1985). Therapists who have difficulty processing the full range of emotional experience themselves will have difficulties in unhooking from certain types of maladaptive transactional cycles (Safran & Segal, 1990). The foremost approach in the resolution of C-T reactions is to expand the therapist's internal awareness of reactions toward clients (Herron & Rouslin, 1990). Self-monitoring of affective reactions can sometimes lead to adequate self-control (Greenson, 1974). Robbins and Jolkovski (1987) found that therapists' awareness of countertransference feelings was inversely related to countertransference behavior. Another study demonstrated an interaction effect between awareness of feelings and

theoretical framework suggesting that high awareness of countertransference feelings

and subsequent employment of a theoretical framework to understand these feelings

resulted in less avoidance with clients than for those therapists who had less

awareness of their feelings even when they had a high theoretical framework (Latts &

Gelso, 1995).

> Associations, as every mental content, come with their own subliminal
> affective charge. This is a consciously unnoted affective signal that may
> mobilize the individual's typical predominant characterological defenses. That
> is why the most important roles of emotions are not those that we become
> aware of, but those minimal signals which are the "switches" in all of our
> information processing. (Krystal & Krystal, 1994, p. 189)

Highly developed self-awareness makes it possible to be conscious of the nearly

imperceptible emotional "switches" which potentially may throw one into a C-T

reaction and disrupt good information processing.

When aware of their emotions, counselors find they provide useful

information about their own reactions evoked by particular clients. Clients

dysfunctional communication and interpersonal patterns tend to evoke certain

emotional and behavioral reactions in others. The therapist can become aware of

these patterns and the responses they elicit in others by tuning in to his or her own

reactions (Butler & Strupp, 1991).

Safran and Greenberg (1991) assert that therapists need to be familiar with

their own affective processing to be effective with clients who need to do emotional

self-exploration in therapy. Self-awareness is the therapists best protection against

being drawn into dysfunctional transactional patterns. As Kiesler (1988) stated:

> Since the therapist cannot be pulled in by the patient, the therapist of
> necessity experiences feelings and other engagements with the patient before
> he or she ever notices or labels them. The first essential step in the
> disengagement process, then, is that the therapist notice, pay attention to, and
> subsequently label the engagements being pulled from him or her from a given

patient. Until the therapist notices what is happening internally, he or she is caught in the patient's transactional game. (p. 38)

Safran and Greenberg (1991) asserted that there is a strong relationship between the degree of difficulty counselors experience in fully processing and experiencing certain aspects of their own emotional experience and their difficulties attuning to related aspects of the client's experience.

## Measurement of Empathy

Misunderstandings about empathy are most clearly manifested in the many instruments which have been developed to measure the construct (Duan & Hill, 1996). The controversy that surrounds the conceptualization of empathy is reflected in the numerous instruments purported to measure it.

Kurtz and Grummon (1972), in a study of empathic skills of 31 counselors, used four empathy instruments: situational, predictive, tape-judged, and subjective measures. While Carkhuff's (1969) *Empathic Understanding in Interpersonal Processes* scale (the tape-judged measure of empathy) correlated with client-perceived empathy, Kurtz and Grummon found no correlation between any of the four measures. Barrett-Lennard (1986, 1993) and Gladstein (1983) pointed out that this lack of correlations is to be expected, due to the measurement of differing stages of the empathy process.

Barrett-Lennard (1978), using the model of a three-stage "empathy cycle," developed the *Relationship Inventory* (RI) in two formats: MO (Myself to Others), a subjective, self-rated assessment of therapists' empathic abilities; and OS (Others to Self), a client-rated assessment of their therapist's provision of empathy. The Empathic Understanding scale of the MO version represents the first stage of his

empathy cycle, "empathic resonation." Stage Two is "expressed empathy," communication of the therapist's understanding of the client's experience (Barrett-Lennard, 1986, p. 446). Stage Three, "client received empathy," is measured by the OS version of the RI. Barrett-Lennard believed that any stage in the empathy cycle could be measured from participant ratings and/or observer-judge ratings. However, different methods of measuring empathy would likely yield different results, unless the underlying theory was highly developed, and the focus was on the same elements or stages of empathy.

Davis (1980, 1983), drawing upon research by Coke et al., (1978), operationalized the concept of empathy as a multidimensional construct in his *Interpersonal Reactivity Index* (IRI) . The dispositional assumption of empathy's nature is reflected in two scales of his index: Perspective-Taking (PT), and Empathic Concern (EC). The EC scale assesses potential for affective empathy (responding with the same emotion to another person's emotion) and the PT scale measures potential for cognitive empathy (intellectually taking the role or perspective of another person). He concluded that moderate correlations of the PT and EC scales were indications that while having some distinct functions, empathy involves both cognitive and affective functioning which are difficult to measure separately. Thus, measurement of empathy remains a difficult prospect. But, as Duan and Hill (1996) suggested, the continued importance of empathy compels further research.

## Chapter Summary

Empathy is a process which is seen to be an essential ingredient in counselor behavior within the therapeutic relationship (Barrett-Lennard, 1993; Goldstein & Michaels, 1985; Safran & Greenberg, 1994; Strupp, 1996). It plays at least four vital

functions in therapy, such as: (1) building an emotionally safe relationship and climate; (2) empathic attunement with vulnerable clients, especially those who have been abused or traumatized; (3) information gathering about client's inner conflicts and feelings; and (4) evoking and exploring feelings, etc (Bowlby, 1988; McCann & Coletti, 1994; Watson & Greenberg, 1994).

Empathy is a complex construct and not simple to define or operationalize. Empathy has been defined in numerous ways and measured by many instruments which reviewers have indicated may account for inconsistent findings (Duan & Hill, 1996; Patterson, 1984). Reviewers are exhorting empathy researchers to clearly define empathy and utilize tools to match their theoretical definitions of empathy, especially regarding the nature of empathy, affective or cognitive (Duan & Hill, 1996; Goldstein & Michaels, 1985).

Two new constructs, *affective orientation* (Booth-Butterfield & Booth-Butterfield, 1990) and low *alexithymia*, identify the tendency for one to be in tune with her or his own feelings and to use them to guide behavior. These qualities can effect important outcomes in the therapist-client relationship. Therapy goals are limited not only by client characteristics, but by the person of the therapist. "Therapists who are not themselves comfortable with emotions may find it too difficult to connect people with their emotions, or to use emotions therapeutically (Johnson & Greenberg, 1994, p. 322).

Considering the intimate nature of therapist's work, several capacities are requisite for therapeutic relationship building and maintenance with clients: ease of intimacy and attachment behaviors built on empathic attunement, personal awareness of one's internal affective reactions to clients, sensitivity to client's minimal responses, expression of genuine feelings to the client when therapeutically useful,

and avoidance of inappropriate countertransference reactions. Johnson and

Greenberg (1994) asserted that researchers and clinicians are just beginning to

grapple with "that most fundamental dimension of intimate relationships, emotion.

They will continue to do so because . . . the hope for the future lies . . . in the

struggle to understand and improve the fundamental quality of human relationships"

(p. 322).

# CHAPTER III

# METHODOLOGY

## Introduction

This study was designed to examine the relationships between two affective variables: affective orientation and alexithymia; and five empathy variables including (1) communicated, (2) observed, (3) emotional, (4) cognitive, and (5) relational empathy in counselors-in-training. Subjects completed self-report inventories which measured their levels of affective orientation and alexithymia. Three "blind" and independent raters assessed subjects' audiotaped responses of communicated empathy; practicum supervisors rated their individual counselor-trainees' levels of empathy from their clinical observations. Self-report questionnaires measuring emotional, cognitive, and relational empathy were completed by counselor-trainees. A review of literature indicated more research is needed to explore the relationship of counselor emotion with various types of empathy.

Thus, the present methodology was employed within an existing counseling setting. The results provide foundational knowledge to the counseling profession, particularly to educators in the field, about how personal characteristics related to emotional awareness and affect regulation are related to empathy in counselor trainees.

73

## Population

The population for this study was comprised of 67 graduate students in a counselor education or counseling psychology program at Western Michigan University, a large Midwestern university. Forty-nine (73%) females and 18 (27%) males participated in the study.

## Description of Subjects

The subjects who participated in the study were master's level counselor trainees who were enrolled in a counseling practicum in the Department of Counselor Education and Counseling Psychology at Western Michigan University, in Kalamazoo, Michigan. Western Michigan University is a Carnegie Level I doctoral institution with approximately 26,000 students enrolled annually. The counseling program provides both master's and doctoral level training in the field, with some 90 students graduating annually. Subjects were enrolled in one of five concentrations or majors, which included Community Agency Counseling, School Counseling, Student Affairs in Higher Education, Rehabilitation Counseling, or Counseling Psychology. From an original pool of 91 subjects, 67 (73%) participated in the research. Because all of the subjects were volunteers, many characteristics of the sample were not under the control of the researcher. All individuals included in the sample, met the following criteria: (a) enrollment in the counseling practicum class at the master's level in the Counselor Education and Counseling Psychology program during the spring or fall semester of 1994; and (b) completion of all prerequisite classes—Tests and Measurements, Counseling Techniques, Professional Issues and Ethics, and Theories

of Counseling (those in all but the Counseling Psychology option also needed Career Development.

## Description of Study Variables

The variables that were examined in this study included affective orientation, alexithymia, and five types of empathy. Six other demographic variables related to subjects such as work experience, area of academic concentration, and number of client and supervisory sessions were collected, but these were used for descriptive rather than analytical purposes.

Affective orientation and alexithymia were the independent variables. Communicated, observed, emotional, cognitive, and relational empathy were the dependent variables. Each of these variables were considered interval in nature, with levels measured on one or more standardized scales or by standardized procedures which yield interval scores.

## Design of the Study

The study was designed to secure a measure of independent affective variables and dependent empathy variables at a single point in time in a single setting. The researcher was aware of no intervention impacting these variables; therefore, a single measure of each variable for the sample as a whole provided sufficient information to answer the study questions and test the study hypotheses. The principle feature of the design was to measure each variable and describe its characteristics and its relationship to other variables.

Instrumentation

Seven instruments were utilized in this study to measure two hypotheses, each with five subhypotheses. The two independent variables, affective orientation and alexithymia, measured counselor-trainees' affective awareness through self-report on the *Affective Orientation Scale* (AOS) (Booth-Butterfield & Booth-Butterfield, 1990), and the *Twenty-Item Toronto Alexithymia Scale* (TAS-20) (Bagby et al., 1994).

The five dependent variables were assessed with five empathy instruments, two for observers and three self-report questionnaires as follows: (1) the *Communication Assessment Index* (CAI) (Carkhuff, 1969); (2) the scale of *Empathic Understanding in Interpersonal Processes* (EUIP) (Carkhuff, 1969); (3) the Empathic Concern Scale (EC-IRI); and (4) the Perspective-Taking Scale (PT-IRI), both from the *Interpersonal Reactivity Index* (IRI) (Davis, 1980); and (5) the Empathy Scale from the *Relationship Inventory* (RI) (Barrett-Lennard, 1962, 1978, 1986). In this study, "communicated" empathy was measured by three "blind" and independent raters who assessed subjects' empathic levels of communication using the CAI procedure, which consisted of trainees' audiotaped responses to client stimulus expressions; the raters used the EUIP to quantify their ratings. "Observed" empathy was operationalized by practicum supervisors who rated their own group of counselor-trainees on the EUIP, based on their clinical observations of counselor-trainees' levels of empathy. The IRI questioned trainees' about their typical behaviors that were a measure of their "emotional" empathy (EC-IRI) and "cognitive" empathy (PT-IRI). "Relational" empathy was operationalized by the RI which asked counselor-trainees about levels of empathy they experienced in therapeutic

relationship with their client(s). All of the instruments and procedures chosen for use in this study have been used in previous research efforts and reported in research literature.

### The *Affective Orientation Scale*

The AOS is a questionnaire developed by Booth-Butterfield and Booth-Butterfield (1990) to assess individual's awareness and use of affect cues in guiding their communication with others. The instrument "identifies respondents who are either sensitive to their emotions and remain aware of what they are feeling, or who pay little attention to emotional states" (Booth-Butterfield & Booth-Butterfield, 1990, p. 451).

Although the AOS is comprised of four subscales: (a) awareness of emotion; (b) implementation of emotion; (c) importance of emotion; and (d) intensity of emotion; only the summation of the four subscores, creating a one-factor total score, was used in this study. The 20 items of the measure consist of a 5-point Likert scale, resulting in a possible range of scores from 20 (least awareness of affect) to 100 (most awareness).

#### Reliability and Validity

Booth-Butterfield and Booth-Butterfield (1990) report alpha reliability for the total score at .86. A principal component factor analysis resulted in one major, unrotated factor employing 18 of the 20 items.

Utilizing two groups of subjects (college students and adults), the authors have provided normative scores for college student males of 71 and for college student females of 78. Adult females are reported to have significantly higher

awareness of affect than college subjects or male adults. Students who scored high on the AOS were able to remember significantly more details about a recent emotional event in their lives than students who scored low on the assessment. AOS scores also correlated significantly with awareness, recall, and production of emotional words at times when emotions were salient (Booth-Butterfield & Booth-Butterfield, 1994, p. 452).

### Twenty-Item Toronto Alexithymia Scale

The *Twenty-Item Toronto Alexithymia Scale* (TAS-20) (Bagby et al., 1994) is composed of 20 items on a 5-point Likert scale ranging from 1–5 (strongly disagree to strongly agree). The higher the score, the more alexithymic. The TAS-20 has three psychometric factors to assess alexithymia. Three subscores of this instrument are (1) difficulty identifying feelings, (2) difficulty describing feelings, and (3) externally-oriented thinking. All three subscores are combined to produce a global assessment of alexithymia.

#### Reliability and Validity

Comparisons of the TAS-20 with additional measures of personality have demonstrated that it is a reliable and valid measure of alexithymia (Taylor, 1994). Bagby, Taylor, & Ryan, (1986) and Taylor et al. (1991) demonstrated a moderate positive correlation between the hypochondriasis subscale of the Beck Depression Inventory and the TAS, and moderate negative correlation between the Need for Cognition Scale and Psychological Mindedness subscale of the Personality Inventory. Coefficient alphas for three samples on the scale are reported to be $r = .82$ (Bagby et al., 1994), and mean interitem correlation coefficients for all three samples is reported

to be somewhat low, $r = .16$. Bagby et al. also reported that the TAS discriminated between alexithymia and nonalexithymic individuals, as determined by the judgments of experienced clinicians, noting that results from the newly revised TAS-20 correlate significantly ($r = .05$ or greater) with several of the NEO Personality Inventory subscales.

These correlations support the conclusion that the TAS-20 is a valid measure of three features of individual's experience and expression of their emotions, the inability to distinguish between feelings and bodily sensations, as well as the inability to describe feelings, and externally-oriented thinking.

## Communication Assessment Index

The Carkhuff *Communication Assessment Index* (CAI) is a procedure whereby "blind," independent raters listen to audio-taped counselor-trainee responses to an audio-taped client's brief (approximately 10–30 seconds) presentation of an issue. This procedure is used to rate subjects on the facilitative core dimension, communication of empathic understanding. The CAI instrument was designed to require approximately 10–15 minutes for completion. It is comprised of five tape-recorded, simulated client stimulus excerpts, each no more than 2 minutes in length. Subjects listen to these taped stimuli and then respond verbally onto another tape recorder, providing what they judge to be their most appropriate, empathic responses to each stimuli excerpt.

The standardized stimuli segments of the CAI portray client statements across three dominant affective and four dominant content areas. The affective areas are depression-distress, anger-hostility, and elation-excitement. The content areas are

social-interpersonal, educational-vocational, sexual-marital, and confrontation with the counselor. Each excerpt represents a single affective and a single content area.

Following the protocols developed by Carkhuff (1969), subject responses to the five excerpts are then judged by independent "blind" raters utilizing Carkhuff's (1969) *Empathic Understanding in Interpersonal Processes*, a standardized scale divided into five levels which are descriptive of the quality, depth, and degree of empathic understanding.

### Reliability and Validity

Reliability alpha coefficient estimates from 28 previous studies range from .43 to .95. This indicates a moderately low to high degree of reliability (Truax & Carkhuff, 1967). The content validity of the scale has been supported by authority, while its concurrent validity has been verified by its positive relationship to a wide range of client therapeutic outcomes (Truax & Carkhuff, 1967).

### *Empathic Understanding in Interpersonal Processes*

The *Empathic Understanding in Interpersonal Processes* (EUIP) assessment scale is comprised of five graded descriptions of increasingly empathic therapeutic behavior. This scale has also served as the definitional anchor for independent raters who evaluated subjects' responses using the CAI procedure. In the CAI, subjects record their verbal responses to client stems and these are evaluated by raters who using the EUIP definitions. Carkhuff revised this measurement tool from two versions of scales validated in extensive process and outcome research on counseling and psychotherapy. These included *A Scale for the Measurement of Accurate*

*Empathy* by C. B. Truax, a nine-level tool, reviewed by Truax and Carkhuff (1967), and an earlier version summarized in Carkhuff and Berenson (1967).

Carkhuff reduced the scale, from nine descriptors of empathy to five, to increase reliability and reduce ambiguity (Carkhuff, 1969). Responses rated at Level One are considered nonempathic feedback and related to negative therapeutic outcomes; responses rated at Level Five are considered feedback maximally related to positive outcomes in therapy (Carkhuff, 1969). Level Three verbal responses of subjects are considered to be essentially interchangeable with those of the client in that they verbalize the same affect and meaning as the client (Carkhuff, 1969). Subjects' ratings on this scale are considered representative of their levels of communicated empathy.

### Reliability and Validity

Carkhuff (1969) indicated that factor analysis of communication responses demonstrated a principal factor accounted for approximately two thirds of the variability such that all excerpts were measuring the same variable regardless of affects or problem areas. In one of the first studies using the EUIP as the definitional scale with the CAI taping procedure with 16 different client stimulus statements, the scale was able to discriminate between inexperienced communicators, experienced counselors, and counselors who were experienced and systematically trained in empathic communication. The latter demonstrated a significant increase in response: repertoire, frequency, and empathy level from those who were experienced counselors but not systematically trained, and even more dramatically so versus inexperienced respondents. The mean rating of respondent groups who were not experienced counselors was 1.5–1.6; of experienced counselors, it was 2.2 (both

these means are considered to be dramatically below a "facilitative" level of empathic

response; and of experienced counselors with systematic training, it was 3.0.

Carkhuff (1969) indicated:

> . . . it is noteworthy that the levels of communication established here
> are essentially replications of previous data obtained in standard interviews
> (see Carkhuff & Berenson, 1967, p. 9). Thus, the data establish not only the
> construct validity of the instrument but also the stability of the findings.
> (p. 104)

The levels of empathy communicated by the subjects in these studies was rated

similarly across items regardless of client affect expressed and regardless of specific

content.

## *Interpersonal Reactivity Index*

Created by Davis (1980), the Interpersonal Reactivity Index (IRI) is a 28-item

self-report questionnaire that consists of four seven-item subscales, each of which

assesses a specific aspect of empathic disposition. Two of the subscales were of

interest in this investigation: the Perspective-Taking and Empathic Concern Scales,

comprised of seven items each. The Perspective-Taking Scale provides an assessment

of the subject's tendency to adopt the point of view of other people, in ordinary

situations. It is designed to measure a person's propensity to utilize cognitive

empathy. A sample item is, "I sometimes try to understand my friends better by

imagining how things look from their perspective."

The Empathic Concern Scale measures the respondent's tendency to

experience feelings of compassion and nurture for others. As such, it is explicitly a

measure of emotional responsiveness or emotional empathy. An example of an item

on this scale is, "I often have tender, concerned feelings for people less fortunate than

me."

Reliability and Validity

Evidence regarding the validity of these two subscales was initially reported from studies done by its author, Davis (1980), in which he tested the questionnaire with over 500 subjects of each sex. Separate factor analyses were conducted on the data collected from male and female respondents. Factor analyses were performed resulting in a four-factor solution specified for the analyses of each sex. The results of the factor analyses provided strong support for the utilization of the two empathy scales. The internal reliability coefficients (standardized alpha) were computed for each of the four subscales separately in each sex. These ranged from .70 to .78.

Several more recent investigations indicated that scores on the Perspective-Taking Scale have been associated with several qualities and behaviors that theoretically appear to be related to perspective-taking capacity. Davis (1983) found Perspective-Taking Scale scores correlated with a constellation of personal characteristics indicative of social competence and satisfaction (i.e., higher social self-esteem and a lack of shyness, loneliness, and social anxiety.) It has also been reported that scores on the Perspective-Taking Scales are also a significant predictor of accuracy in perceiving others (Berstein & Davis, 1982).

Davis (1983) reported that the Empathic Concern Scale has received support as a measure of individual differences in emotionality. Davis (1983) reported that scale scores on the Empathic Concern Scale were correlated with an existing measure of general emotional responsivity: the Mehrabian and Epstein Emotional Empathy Scale ($r$ = .63 and .56, for male and female respondents, respectively). Consonant with this, Davis (1983) found that high Empathic Concern scores were associated

with stronger emotional reactions, than were low scores, to an appeal for help from a needy student.

## *Relationship Inventory*

The *Relationship Inventory* (RI), written by Barrett-Lennard in 1962 and revised in 1978 and 1986, is a 64-item questionnaire is comprised of four scales measuring empathy, unconditionality of regard, level of regard and congruence. There are two forms of the questionnaire. The inventory, or system, as he referred to it (Barrett-Lennard, 1986), used was "myself to the other" (MO) which frames questions to the counselor about the levels of empathy he or she offered in a specific therapeutic relationship(s). In this study, a revision of the Empathy Scale from Barrett-Lennard's (1986) chapter, "The Relationship Inventory Now: Issues and Advances in Theory, Method, and Use," was used. This version contains 10 items, 6 worded positively and 4 negatively. He noted that one could adapt the empathy questions to fit various perspectives, for example, client perceptions about counselor's empathy, counselor about his or her experienced empathy. Each item was answered on a 6-step anchored scale, with numerically coded answers ranging from +3 (yes, as strongly felt agreement) to –3 (no, as strongly felt disagreement).

### Reliability and Validity

Barrett-Lennard (1962) reported reliability to exceed $r = .80$ in split-half analysis applied to client and therapist RI data and test-retest correlations for a sample of friend and family relationships. In each sample, mean reliabilities across the four component scales were $r = .85$ or above. A review by Gurman (1977) includes

the principle published cumulation of internal and test-retest reliability of RI scales, based on data from a substantial range of contexts and investigators, that is, 15 respondent samples from the work of 12 researchers including naturalistic and analogue studies. Using split-half and alpha coefficients from the 15 samples, Gurman found a mean alpha coefficient for empathy of $r = .84$.

As Barrett-Lennard (1986) indicated, the RI was theoretically founded and designed to measure subtle and complex relational-attitudinal qualities. Direct checks on the content validity of the scales included appraisal of the items by five judges. The judges were asked to classify each statement of empathy as a positive or negative formulation, with the option of identifying it as neutral or nonrelevant. All items retained met the criterion of being classified in the same way by all judges. Three experienced colleagues reviewed the draft revision and gave feedback "to qualitative use in finalizing the exact sampling and form of the items" (Barrett-Lennard, 1978, p. 14).

The positive results of a range of independent predictive studies concerned with association between the RI-assessed relationship conditions and outcome in actual therapy have accumulated, forming strong and extensive evidence of predictive construct validation (Barrett-Lennard, 1986). He further reported that a variety of careful studies with groups of couples using the RI as a measure of change provided evidence that the empathy scale is "sensitive to effects that are carefully expected, or assessed in alternate ways, in the sphere of attitude and relationship quality (Epstein & Jackson, 1978; VanSteenwegen, 1979, 1982; Wampler & Sprenkle, 1980; Wells, Figurel, & McNamee, 1975; see also Wampler & Powell, 1982, pp. 141–142)" (Barrett-Lennard, 1986, p. 459).

Barrett-Lennard (1986) reported that factor-analytic studies by Cramer (1986), using the varimax rotation, ascertained that the postulated constructs did support construct validity. Gurman (1977) noted that factor-analytic studies he reviewed demonstrated that the RI was tapping dimensions consistent with its claims.

## Hypotheses

Two hypotheses, each with five subhypotheses, are presented to examine relationships between the independent variables, affective orientation and alexithymia, and the dependent variables, which were five types of empathy.

H1: Subjects' self-reported affective orientation, as measured by the *Affective Orientation Scale* (AOS), will be predictive of several types of empathy: (a) communicated empathy, as assessed by "blind" raters on the *Communication Assessment Index* (CAI); (b) observed empathy, as assessed by practicum supervisors on the *Empathic Understanding in Interpersonal Processes* (EUIP) scale; (c) emotional empathy, self-reported on the Empathic Concern Scale of the *Interpersonal Reactivity Index* (EC-IRI); (d) cognitive empathy, self-reported on the Perspective-Taking Scale of the IRI; and (e) relational empathy, self-reported on the Empathy Scale of the *Relationship Inventory* (RI).

H2: Subjects' self-reported alexithymia, as measured by the *Twenty-Item Toronto Alexithymia Scale* (TAS-20), will be inversely predictive of (a) communicated empathy on the CAI, (b) observed empathy on the EUIP, (c) emotional empathy on the EC-IRI, (d) cognitive empathy on PT-IRI, and (e) relational empathy on the RI.

Procedures

## Selection of Subjects

In the spring and fall semesters, students from 12 of the 13 (92%) of the practica sections in the counseling department were involved in this study. Upon obtaining prior permission of the practicum supervisor for each of the sections, the investigator, or an associate, presented a verbal and written description of the study to students in practicum classes during the designated semesters. The time commitment and task requirements for participation were explained and volunteers were requested. The goal was to select approximately 60–70 individuals as potential subjects.

Since participation was strictly voluntary and subjects could discontinue involvement in the study at any time, a larger number of individuals than was actually needed was sought in the selection process. A majority of the students from each practicum section volunteered to take part. Of the approximate 100 practica students, 67 subjects completed all procedures.

Demographic data were collected from subjects at the time of testing using a demographic form (see Appendix A). Forty-nine (73%) females and 18 (27%) males participated. Subjects were enrolled in one of five concentrations in counseling: Counseling Psychology (38), Community Agency (13), School Counseling (9), Rehabilitation Counseling (4), and Student Affairs (3). Regarding job-related training, or other human services work, 12 subjects reported none, 15 were or had been teachers, 11 worked with community mental health organizations, six had crisis intervention training, four had done academic advising or career counseling, three worked at a psychiatric hospital, and the others had miscellaneous entries. Regarding

personal therapy, 16 subjects reported no involvement in personal therapy, 25 reported having 12 or less sessions, 12 reported between 32 and 90 sessions, and 14 reported 100 sessions or more.

The majority of subjects (51) had no supervisory sessions with additional supervisory professionals; 12 reported 1 to 3 sessions, and 4 reported 8 to 14 sessions with persons other than their practica supervisors. Data collection from subjects occurred in weeks 6 to 11; 6 subjects in weeks 6 and 7, the majority (49) collected in weeks 9 and 10, and 3 in week 11. Number of client sessions at the time of data collection ranged from 0 to 16 sessions; 3 subjects had 0 sessions, 9 subjects had between 2 and 5 sessions each, 21 subjects had between 6 and 9 sessions, 32 subjects had between 10 and 14 sessions, and 2 subjects had 16 sessions each. Number of supervisory sessions ranged from 0 to 16 sessions also; 3 subjects had 0 sessions, 10 subjects had 2 to 4 sessions each, 42 subjects had between 5 and 8 sessions, 7 subjects had 9 sessions, 4 subjects had 10 sessions each, and 1 subject had 16 sessions. These demographic data revealed that these were practica students typical of other practica students in other years. Nothing of note or unusual emerged from the demographic data.

Collection, Selection, and Rating of *Communication Assessment Index*

After getting signatures of prospective subjects on the consent form (Appendix B), times were arranged to return to the classes to collect data. On the second visit, the researcher or associate collected data, which included each subjects' audiotaped verbal responses to the simulated client stimulus excerpts (the *Communication Assessment Index* [CAI] procedure); a packet of self-report questionnaires including the *Affective Orientation Scale, Toronto Alexithymia Scale,*

Empathic Concern and Perspective-Taking Scales from the *Interpersonal Reactivity Index*, and a demographic form (Appendix A). In addition, practicum supervisors were given the *Empathic Understanding in Interpersonal Processes* (EUIP) scale for the individual counselors-in-training who had volunteered to be subjects in their particular sections. All of these data were collected approximately midway through the practicum course.

Up to 7 subjects per class met in their classroom for instructions, demonstration, and practice. All subjects received their own blank cassette audiotape to record their empathic responses, marked with an individualized, randomized, numbered code. Subjects went into their own private counseling lab-rooms in the Center for Counseling and Psychological Services, where two tape recorders had been set up. One contained a master tape with directions and client excerpts, including intervals of silence to allow subjects' responses to be recorded on the blank tape. Subjects were instructed to start both tapes at the same time and to leave them running throughout the taping procedure. After each excerpt, subjects received 45 seconds in which to record their verbal responses on the blank tapes. When they had responded to all five excerpts, they returned to the classroom and received the packet of questionnaires with the same number as their blank tape.

The five excerpts used in this study—numbers 1, 4, 5, 6, and 10 from Carkhuff's CAI—were chosen because they represented at least one of each type of affect and content contained in the scale. For purposes of this study, the excerpts, representative of the following affects, were selected: two depression-distress, two anger-hostility, and one elation-excitement. Content areas of the excerpts included one social-interpersonal, one educational-vocational, one marital, and one

confrontational with the counselor. For this study, all excerpts were read by the same individual—a white, 30-year-old female drama student.

The researcher used a randomized number table to choose three responses from each subject. Each of these were separately recorded, in randomized order, onto the respective master tape, excerpts 1–5, which were used by the "blind" raters. The two remaining responses, per subject, were randomly ordered and used for rater training and computation of the interrater reliability of the raters. Two responses were also randomly chosen to be repeated with each excerpt group for the computation of intrarater reliability.

The team of raters consisted of one male counseling professor, one female doctoral level psychologist, and one female doctoral candidate in counseling psychology. The raters were trained conjointly according to the research protocols of the instrument (Carkhuff, 1969), including a theoretical description and copy of the EUIP scale they used to assess subjects' empathy, according to Carkhuff (1969). Discussion of the scale was continued until it was believed that a consensus of understanding among the raters was achieved.

The CAI procedure recommended by Carkhuff (1969) was utilized to enhance the raters' skill in the use of the three scales. Raters were presented with a sample of actual counselor-trainee responses; however, none of the sample responses appeared as responses to be rated in the study. The training audiotape consisted of several client stimulus expressions used in the CAI followed by a number of counselor-trainee responses not used in the study. Counselor-trainee responses to the client stimulus expressions communicated varying degrees of empathic understanding. During the training, after each excerpt was rated, incongruities were discussed until all raters could agree on the ratings. When an acceptable level of

consistency among raters was achieved, they received the subjects' randomized tapes to rate their communicated empathy, independently and "blindly." Rater reliabilities on the *Communication Assessment Index* will be reported in Chapter IV.

<u>Collection of Practicum Supervisor Ratings</u>

Practicum supervisors as well as the independent "blind" raters used the EUIP scale to rate each of their counselor-trainees who volunteered for the study. Practicum supervisors based their ratings on their contact with each of their own individual counselor-trainees assessing subjects' observed empathy. These contacts included live observation of actual counseling sessions from behind a one-way mirror, and individual and group supervision utilizing video and audiotaped sessions. Using the EUIP scale, practicum supervisors rated counselor-trainees' levels (1–5) on their observed empathy.

Analyses of Hypotheses

Scoring of the three "blind" raters' assessments, part of the *Communication Assessment Index* procedure randomized subject numbers and randomized choice of excerpts, was completed as prescribed by Carkhuff (1969). To test Hypotheses 1 and 2 of this study, each with five subhypotheses, a linear regression design was used to understand the predictive relationship between two independent variables: (1) affective orientation, and (2) alexithymia; and five dependent variables: (1) communicated, (2) observed, (3) emotional, (4) cognitive, and (5) relational empathy. AOS and TAS scores, which comprised the predictor variables, were collated and coded for computer processing and statistical analysis, along with the criterion variables, five types of empathy, as measured by the CAI, EUIP, EC-IRI,

PT-IRI, and RI. A linear regression analysis was used to test Hypotheses 1a, 1b, 1c, 1d, 1e, and 2a, 2b, 2c, 2d, 2e, with .05 being the designated level of statistical significance.

# CHAPTER IV

## ANALYSES OF THE DATA

The present study was designed to identify selected affective variables, affective orientation and alexithymia, which would significantly predict subjects' five types of empathy. The analyses of these data addressed research questions and hypotheses presented in Chapters I and III. This chapter presents analyses of the data through the use of linear regression. Probability of all analyses in this study was set at .05. Several post hoc analyses results will be included.

## Linear Regression Analyses for All Subjects

The predictor variables were two forms of affect, affective orientation measured by the *Affective Orientation Scale* (AOS) (Booth-Butterfield & Booth-Butterfield, 1990) and alexithymia measured by the *Twenty-Item Toronto Alexithymia Scale* (TAS-20) (Taylor et al., 1991). The criterion variables for each hypothesis were five types of empathy, as measured by five instruments: (1) communicated empathy on the *Communication Assessment Index* (CAI) (Carkhuff, 1969); (2) observed empathy on the *Empathic Understanding in Interpersonal Processes* scale (EUIP) (Carkhuff, 1969); (3) emotional empathy on the Empathic Concern scale of the *Interpersonal Reactivity Index* (EC-IRI) (Davis, 1980); (4) cognitive empathy on the Perspective-Taking Scale of the IRI (PT-IRI); and, (5) relational empathy on the Empathy Scale of the *Relationship Inventory (RI)* (Barrett-Lennard, 1986).

93

Five linear regression equations, one for each dependent variable, were predicted by two independent variables, affective orientation and alexithymia. Research questions for investigation were formulated as follows:

1. Is affective orientation of subjects, as measured by the *Affective Orientation Scale* (AOS), predictive of (a) communicated empathy on Carkhuff's *Communication Assessment Index* (CAI), (b) observed empathy on Carkhuff's *Empathic Understanding in Interpersonal Processes* (EUIP) scale, (c) emotional empathy on the Empathic Concern Scale of the *Interpersonal Reactivity Index* (EC-IRI), (d) cognitive empathy on the Perspective-Taking Scale of the IRI (PT-IRI), and (e) relational empathy on the Empathy Scale of Barrett-Lennard's *Relationship Inventory* (RI)?

2. Is alexithymia of subjects, as measured by the *Twenty-Item Toronto Alexithymia Scale* (TAS-20), inversely predictive of (a) communicated empathy on the CAI, (b) observed empathy the EUIP, (c) emotional empathy on the EC-IRI, (d) cognitive empathy on the PT-IRI, and (e) relational empathy on the Empathy Scale of the RI?

## Hypothesis 1

The predictive value of the independent variable affective orientation, as measured by subjects' *Affective Orientation Scale* (AOS) scores, was investigated by Hypothesis 1 with five subhypotheses. Hypothesis 1 is as follows:

H1: Subjects' self-reported affective orientation, as measured by the *Affective Orientation Scale* (AOS), will be predictive of five types of empathy: (1) communicated empathy, as assessed by "blind" raters on the *Communication Assessment Index* (CAI); (2) observed empathy, as assessed by practicum supervisors

on the *Empathic Understanding in Interpersonal Processes* (EUIP) scale;

(3) emotional empathy, self-reported on the Empathic Concern Scale of the

*Interpersonal Reactivity Index* (EC-IRI); (4) cognitive empathy, self-reported on the

Perspective-Taking Scale of the IRI; and (5) relational empathy, self-reported on the

Empathy Scale of the *Relationship Inventory* (RI).

The linear regression equations for affective orientation revealed three

criterion variables to be statistically significant: relational, cognitive, and emotional

empathy. Relational empathy contributed 12% of the variance ($F = 9.09$, $df = 65$, 1;

$p = .004$) (see Table 1 for results). The second significant criterion variable was

cognitive empathy which contributed 10% of the variance ($F = 8.51$, $df = 65$, 1,

$p = .01$). The third significant criterion variable was emotional empathy which

contributed 10% of the variance ($F = 7.69$, $df = 65$, 1, $p = .0005$). Since criterion

variables predicted by AO, emotional, cognitive, and relational empathy, were found

to be significant, Subhypotheses 1c, 1d, and 1e were accepted.

Table 1

Linear Regression Analysis for All Subjects: Significant Independent Variable,
Affective Orientation, Predicting Empathy Scores for the Total Sample

| Variable Entered | Beta | Multiple R | $R^2$ | F | df |
|---|---|---|---|---|---|
| Relationship Inventory | .14 | .35 | .12 | 9.09* | 65, 1 |
| Perspective-Taking, Interpersonal Reactivity Index | .16 | .34 | .12 | 8.51* | 65, 1 |
| Empathic Concern, Interpersonal Reactivity Index | .14 | .32 | .10 | 7.69* | 65, 1 |

*$p < .01$

The independent variable affective orientation failed to predict the following dependent variables: communicated empathy and observed empathy. Therefore, affective orientation, as measured by the AOS, was not considered to be significantly predictive of counselor-trainees' communicated empathy assessed by "blind" raters on the CAI, or observed empathy ratings as measured by practicum supervisors on the EUIP. In view of these findings, subhypotheses 1a and 1b were rejected.

## Hypothesis 2

A second independent variable selected for inclusion in linear regression equations for all counselor-trainees was alexithymia. The predictive value of alexithymia, as measured by subjects' *Twenty-Item Toronto Alexithymia Scale* (TAS-20) scores, was investigated on Hypothesis 2 with five subhypotheses. Hypothesis 2 is as follows:

H2: Subjects' self-reported alexithymia, as measured by the *Twenty-Item Toronto Alexithymia Scale* (TAS-20), will be inversely predictive of five types of empathy: (1) communicated empathy, as assessed by "blind" raters on the *Communication Assessment Index* (CAI); (2) observed empathy, as assessed by practicum supervisors on the *Empathic Understanding in Interpersonal Processes* (EUIP) scale; (3) emotional empathy, self-reported on the Empathic Concern Scale of the *Interpersonal Reactivity Index* (EC-IRI); (4) cognitive empathy, self-reported on the Perspective-Taking Scale of the IRI; and (5) relational empathy, self-reported on the Empathy Scale of the *Relationship Inventory* (RI).

The linear regression equations for alexithymia revealed three criterion variables to be statistically significant: emotional, cognitive, and relational empathy. Relational empathy, as measured by the RI, contributed 17% of the variance

($F = -13.26$, $df = 65$, 1, $p = .0005$) (see Table 2 for results). A second variable,

emotional empathy, as measured by the EC-IRI, contributed 9% of the variance

($F = -6.36$, $df = 65$, 1, $p = .014$). The third criterion variable, cognitive empathy,

as measured by the PT-IRI, generated 8% of the variance ($F = -5.87$, $df = 65$, 1,

$p = .01$). Subhypotheses 2c, 2d, and 2e were accepted.

Table 2

Linear Regression Analysis for All Subjects: Significant Independent Variable,
Alexithymia, Predicting Empathy Scores for the Total Sample

| Variable Entered | Beta | Multiple R | $R^2$ | F | df |
|---|---|---|---|---|---|
| Relationship Inventory | −.20 | .41 | .17 | −13.26* | 65, 1 |
| Empathic Concern, Interpersonal Reactivity Index | −.16 | .30 | .09 | −6.36* | 65, 1 |
| Perspective-Taking, Interpersonal Reactivity Index | −.17 | .29 | .08 | −5.87* | 65, 1 |

*$p < .01$

The independent variable alexithymia failed to achieve significance with the

following dependent variables: communicated and observed empathy. Therefore,

alexithymia, as measured by the TAS-20, was not considered to be significantly

predictive of counselor-trainees' communicated empathy assessed by "blind" raters

on the CAI, or observed empathy ratings as measured by practicum supervisors on

the EUIP. In view of these findings, Subhypotheses 2a and 2b were rejected.

Post Hoc Analyses

<u>Reliability</u>

Chronbach alpha reliabilities for the scales measuring independent and dependent variables were within acceptable ranges. The alpha for affective orientation on the *Affective Orientation Scale* was .91, and the alpha for alexithymia on the *Twenty-Item Toronto Alexithymia Scale* was .79. Chronbach alphas for the scales measuring the dependent variables are as follows: for observed empathy on the *Empathic Understanding Scale in Interpersonal Processes* scale, .93; emotional empathy on the Empathic Concern Scale of the *Interpersonal Reactivity Scale*, .84; Perspective-Taking on the IRI, .85; relational empathy on the Empathy Scale of the *Relationship Inventory*, .53. These alpha coefficients are normative with comparative samples of subjects.

<u>Rater Reliability of *Communication Assessment Index*</u>

Due to the restricted range of possible scores on the criterion measures, the usual Pearson or Spearman coefficients for estimating intrarater reliability were considered inappropriate. The measure of rater consistency which was used in this study was the same as that developed by Edwards (1971) and used by him, as well as by Norton (1972) and Hovestadt (1973). This formula for the Index of Rater Consistency (IRC) is based upon the concepts presented by Ferguson (1971) in his discussion of measures of disarray. This conceptualization of reliability as consistency identifies the complement of the ratio between unaccounted and total variance. The specific formula to compute the IRC is as follows:

$$\text{IRC} = 1 - \frac{\text{Sum of observed differences}}{\text{Maximum of possible sum of differences}}$$

The resulting statistic has a possible range from 0–1, where values approaching "1" indicate a high degree of rate-rerate agreement. As the sum of observed differences approaches the maximum possible sum of differences, the resulting statistic nears "0" and indicates a low degree of rate-rerate agreement. The estimate of intrarater reliability was computed to be .86 using the IRC based on ratings from five communication excerpts during rater training, before raters received responses from trainees to rate. Using the same formula to assess raters after they completed their ratings, intrarater reliability was also .86.

Interrater reliability among the three sets of ratings on each of the criterion measures used an "Analysis of Variance to Estimate the Reliability of Measurements" (Winer, 1962). Since subsequent analysis of the ratings relied on the mean rating to which all of the raters contributed, and since the zero point on the scales which were used was meaningless, the next formula was employed in figuring interrater reliability:

$$r_k = \frac{^{MS}\text{ between people (excerpts)} - ^{MS}\text{ residual (error)}}{^{MS}\text{ between people (excerpts)}}$$

The interrater reliability coefficient for "blind" raters during the CAI training procedure was .86, which was considered acceptable. After raters completed their assessments of trainees, they submitted ratings of the same responses used during the training session. Using the same formula, the interrater reliability coefficient after

ratings were completed was .83. These levels of reliability were considered acceptable.

## Comparison of Mean Scores Between Studies

Several studies have been done using the AOS and TAS-20. Booth-Butterfield and Booth-Butterfield (1990), authors of the AOS, reported four studies using the AOS. AOS means in three studies with undergraduate college students were: 74.7, 73.8, 79.0, and 75.3 in a fourth sample with an adult population, most of whom were school teachers. Yelsma (1996) reported AOS means of three groups, "normal" adult subjects (76.6), victims of spousal abuse (74.6), and perpetrators of spousal abuse (70.4). In the current study, the AOS performed consistently with previous studies resulting in an overall mean score of 78.5. Similar to several studies reported in Booth-Butterfield and Booth-Butterfield (1990), significant differences were found between female and male AOS scores in the present study. Using a two-tailed test, the mean score for females was 80.5 and for males was 72.8 ($p < .009$).

Alexithymia mean scores varied somewhat among different studies. Parker, Taylor, and Bagby (1993) using the 20-item TAS reported a mean of 42.9 for "normal" college students and a mean of 64.9 for alexithymic college students. Yelsma (1996), who used the TAS-20 with abusing and nonabusing couples, found the following mean scores of three groups, "normal" subjects (48.1), victims of spousal abuse (55.3), and perpetrators of spousal abuse (57.6).

In the current study, the TAS-20 scores were suprisingly lower than the mean scores for "normal" subjects in the prior studies. Counselors-in-training were found to have the lowest alexithymic mean score of 38.6 for any group reported in the literature. Unlike other studies reported in the literature, the present study found

significant differences between female and male TAS-20 scores. Using a two-tailed test, the mean score for females was 37.3 and for males was 42.0 ($p < .037$).

Post hoc analysis revealed an association between the two affect variables, affect orientation and alexithymia. Pearson product moment correlations produced a statistically significant inverse relationship ($r = -.51, p < .000$). This means that as alexithymia scores increased, affective orientation scores decreased. This result is consistent with the association ($r = -.50$) found in the Yelsma (1992) study that analyzed affective orientation and alexithymia of college students.

An additional post hoc analysis in the current study found that the Empathic Concern Scale of the IRI measuring emotional empathy and the Perspective-Taking Scale of the IRI measuring cognitive empathy were significantly correlated (.66) at the .01 level. This correlation is substantially higher than that found by Davis (1983) (.33). The Empathy Scale of the *Relationship Inventory* which measured relational empathy correlated with both the Empathic Concern Scale of the IRI (.33) ($p = .003$) and the Perspective-Taking Scale (.36) ($p = .001$). These results will be discussed in Chapter V.

# CHAPTER V

## SUMMARY, FINDINGS, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

### Summary

The present study was undertaken in order to investigate the predictive association between selected affective variables and multiple measures of empathy. The two independent affective variables, affective orientation and alexithymia, were measured by counselor-trainees' self-reported scores on the *Affective Orientation Scale* (AOS) (Booth-Butterfield & Booth-Butterfield, 1990) and the *Twenty-Item Toronto Alexithymia Scale* (TAS-20) (Bagby, Parker, & Taylor, 1994). The five dependent empathy constructs were assessed with five instruments. On the first instrument, three "blind" raters assessed trainees' empathic communication using the *Communication Assessment Index* (CAI) (Carkhuff, 1969) procedure, which consisted of trainees' audiotaped responses to client stimulus expressions. The "blind" raters then used the *Empathic Understanding in Interpersonal Processes* scale (EUIP) (Carkhuff, 1969) to rate counselor-trainees' responses. On the second empathy instrument, practicum supervisors used the *Empathic Understanding in Interpersonal Processes* scale (EUIP) (Carkhuff, 1969) to assess trainees' observed performances of empathy. The last three empathy inventories consisted of counselor trainee self-reports of: emotional empathy on the Empathic Concern Scale of Davis' *Interpersonal Reactivity Index* (IRI); cognitive empathy on the Perspective-Taking Scale of the IRI (1980); and relational empathy on the Empathy Scale of Barrett-

102

Lennard's *Relationship Inventory* (1962), in which trainees reported on their empathic experiences in a therapeutic relationship(s) with a current client(s).

The sample included 67 subjects who were volunteer counselors-in-training enrolled in the practicum course for their master's degree, in one of five areas of counseling concentration at Western Michigan University. Subjects also completed a "Demographic Form." A summary of demographic characteristics of the population was presented in Chapter III.

## Findings

Two hypotheses, each with five subhypotheses, were formulated and tested. The author theorized that affective orientation would be a positive and alexithymia would be a negative predictor of five types of empathy: communicated, observed, emotional, cognitive, and relational empathy. Five linear regression equations, one for each empathy criterion variable, were calculated to determine the predictive association with affective orientation and alexithymia, and five measures of empathy. Results revealed six statistically significant predictive relationships at the $p \leq .01$ level of probability. Affective orientation, as measured by the AOS, predicted three self-reported empathy variables: emotional, cognitive, and relational empathy on the EC-IRI, PT-IRI, and RI. These results validated Subhypotheses 1c, 1d, and 1e, respectively.

The second independent variable, alexithymia, inversely predicted emotional, cognitive, and relational empathy, as measured by the empathy instruments. These results validated Subhypotheses 2c, 2d, and 2e, respectively. Scores for males and females were significantly different for both the AOS and TAS-20.

Linear regression analyses indicated that neither affective orientation or alexithymia was significantly predictive of counselor trainees' communicated or observed empathy. Communicated empathy was assessed by "blind" raters on the CAI and observed empathy was rated by practicum supervisors on the EUIP.

Post hoc analyses indicated a number of noteworthy findings. Mean scores for females and males were significantly different on both the AOS and the TAS-20 ($p \leq .05$). Mean scores for counselor-trainees on the TAS-20 are the lowest currently found in the literature. In addition, the AOS and TAS-20 were highly inversely correlated ($r = -.51$). The Empathic Concern Scale of the IRI and the Perspective-Taking Scale of the IRI also were significantly correlated ($r = .66$).

## Conclusions and Implications

The findings of the present study appear to provide support for several positions noted in the professional literature regarding affective awareness and empathy, essential components of the therapeutic relationship. This research provided information about the predictive association between counselor trainees' intrapersonal affective experiencing (AO) and multiple dimensions of empathy. Research methods which have been employed in assessing empathy in prior studies seem to suggest a gap between how empathy was defined and what was actually measured (Duan & Hill, 1996). Limitations of measurement instruments and methodologies have often led to confusing results (Gladstein, 1987). In the present study, empathy was intentionally measured from a multidimensional perspective with instruments that reflected more precise definitions of empathy than some of those reported by Duan and Hill (1996) and Gladstein (1987).

Analyses of results of empathy are as follows. Both dispositional emotional and cognitive empathy (on the EC-IRI and PT-IRI) were predicted by dispositional affective orientation (on AOS and TAS-20). Further, dispositional affective orientation (on AOS and TAS-20) was predictive of state-specific relational empathy (on the RI) which measured trainees' experiences in their relationships with particular clients. These results would seem to imply that measurement of trait affective characteristics helps to predict how trainees report their empathic experiences with clients. It appears that trainees who reported that they were capable of emotional awareness, differentiation, and expression (on the AOS and TAS-20) were also more likely to indicate that they often experience the feelings and take the perspective of others (on the EC-IRI and PT-IRI). In addition, those who reported more characterological disposition to emotional awareness, labeling and expressing of their feelings (on the AOS and TAS-20) also reported more empathic behavior in the counseling setting (on the RI).

The finding of this study, that relational empathy (on RI) is predicted by AO, indicates that the AO of the counselor could be important in the prediction of empathy in the therapeutic relationship. Omdahl (1995) stated that Barrett-Lennard's *Relationship Inventory* measures both emotional experiencing and cognitive role-taking. The trainees in this study, who indicated that they believed that emotions are important and useful also stated that they attended to, understood and experienced emotions of their client(s). Thus, emotional awareness and affect regulation may be predictive of counselor empathic behavior.

The finding that two kinds of empathy, emotional and cognitive, are predicted by affect regulation, is similar to Davis' finding of a correlation between emotional and cognitive empathy. These results may provide additional support to the body of

research which recognizes an essential connection between affect and cognition. In observation of empathic mediation of helping behavior Coke, Batson, and McDavis (1978) found perspective-taking was necessary for empathic emotion to occur; empathic emotion in turn could increase helping behavior. They suggested that while empathy is affective, cognitive activity is necessary for it to occur. Considering the high correlation $(r = .66)$ of emotional and cognitive empathy in this study, these two types of empathy seem to be integrally related such that if one is emotionally empathic, one is also likely to be cognitively empathic and vice versa.

Similarly, Eisenberg and Lennon (1983) pointed out that affective role-taking (imagining the feelings of another) could provide a basis for empathic responding. Although a type of empathic arousal may occur spontaneously, without affective role-taking (Hoffman, 1982), the ability to identify the emotions of others has been considered to be an important component of most empathic responding (Eisenberg & Lennon, 1983; Feshbach, 1979; Lane & Schwartz, 1987).

Booth-Butterfield and Booth-Butterfield (1990) speculated that when faced with another's emotional distress, high AO individuals may empathize more readily than those low in AO. Predictions of emotional, cognitive, and relational empathy of high AO counselor trainees in the current study would seem to support their conjecture.

Psychodynamic researchers have given substantial attention to therapist behaviors injurious to the therapeutic relationship (Strupp, 1996; Wilson & Lindy, 1994). These behaviors are usually considered to be the result of feelings which are acted out rather than brought to full awareness, tolerated and processed (Fiedler, 1958; Greenson, 1967; McCann & Coletti, 1994). Interfering behaviors most often identified include withdrawal, emotional distancing, and becoming hostile or

seductive with clients (Emiston, 1990; Yulis & Kiesler, 1968). Acting out such feelings has been associated with low empathy, ruptures in the therapeutic relationship, and negative outcome (Mohr, 1995; Safran et al., 1990; Wilson & Lindy, 1994). A safe emotional climate is necessary to create trust, intimacy, deep exploration and eventual interdependence (Gold, 1996; Rogers, 1957). As van der Kolk (1994) indicated, "Clinicians have long noticed that before autonomy can occur, the safety of the relationship needs to be internalized" (p. xi). The current study suggests that trainees reporting high AO predictably describe themselves high in three kinds of self-reported empathy, which in turn may be associated with less injurious behavior and more emotionally safe therapeutic relationships.

Alexithymia also was predictive of low emotional, cognitive, and relational empathy at statistically significant levels, as measured by the Empathic Concern Scale on the *Interpersonal Reactivity Index,* the Perspective-Taking Scale of the *Interpersonal Reactivity Index,* and the Empathy Scale of the *Relationship Inventory,* respectively. Alexithymia was not predictive of communicated or observed empathy on the *Communication Assessment Index* and *Empathic Understanding in Interpersonal Processes* scale. Counselor trainees who scored lower in alexithymia tended to perceive themselves as more empathic in their therapeutic relationships than those who scored higher in alexithymia.

The present study seems to suggest that trainees who scored higher on alexithymia and concomitantly lower on empathy bolsters Krystal's (1993) clinical observations that alexithymics tend to be less empathic than nonalexithymics. While this study involved a "normal" sample, counselor trainees, it lends support to Krystal's assertions of alexithymics' low empathy, in that even subclinical levels of alexithymia were predictive of low emotional, cognitive, and relational empathy. In

addition, Krystal (1993), Taylor (1995), and others have noted that alexithymics are poor communicators, especially regarding expression of emotions, and lack intimate interpersonal relationships. Alexithymics not only ignore others' affect cues but their own as well and seem to lack a basic level of permission to take care of themselves (lack self-soothing and self-empathy) (Krystal, 1993). In the current study, trainees who scored high in alexithymia concurrently reported lower levels of relational empathy. Therefore, it may be hypothesized that those trainees high in alexithymia may have more negative feelings toward clients and provide a less empathic emotional climate in therapy.

Taylor, Bagby, and Parker (1997) reported on developmental issues involving alexithymic individuals who were unable to identify and describe their own or others' emotional states. This inability has been linked to failure to elevate emotions from a preconceptual level of organization to the conceptual level of mental representations in Lane and Schwartz's (1987) model of affect development. Therefore, trainees high in alexithymia may need further affective development to become more empathic. Whereas Krystal (1993) and Danieli (1981) found people with clinical levels of alexithymia difficult to treat psychodynamically, they recommended alexithymics be trained in affective awareness, discrimination, vocabulary, expression, and regulation.

Training programs may find several of the instruments used in this study helpful in assessing levels of affective orientation or alexithymia of prospective students, or students currently in their programs. For instance, counselor training programs which prefer more emotionally attuned counselors could use the AOS or TAS-20 in selection of prospective counselors who are high in affective orientation and low in alexithymia. As Carkhuff (1969) pointed out nearly three decades earlier, counselor training programs have a responsibility to select people who will be "good

helpers." He recommended that training programs utilize methods and indices which would select appropriate types of people as candidates to become professional counselors and therapists, "persons who exhibit a sincere regard for others, tolerance and ability to accept people with values different from one's own, a healthy regard for the self, a warmth and sensitivity in dealing with others, and a capacity for empathy" (Carkhuff, 1969, p. 49). He de-emphasized grade point factors in lieu of personal factors, believing the type of person who can help others must be self-reflective and self-aware. The *Affective Orientation Scale* and *Twenty-Item Toronto Alexithymia Scale* could be useful in identifying people likely to be emotionally sensitive, empathic counselors.

Knowing that affective scales predict particular measures of empathy, it may be possible to organize training around the deficits and needs of counselors-in-training. Programs may develop curricula and seminars involving particular types of affective awareness, communication, and empathy training for those who score low in affect awareness. Test and retest procedures could be employed to guide development and refinement of effective training methods. Supervisors may want to assess supervisees' levels of affective awareness to better pinpoint areas of challenge and strength. Dispositional affect and empathy, while enduring, may be alterable with provision of appropriate empathic models, training opportunities, or psychotherapy.

Carkhuff (1969) stated, "Those who communicate [accurate empathy] at high levels are best equipped to help persons in need" (p. 93). Carkhuff further suggested that trainees' levels of empathy be measured throughout the process of training. While it might be optimal to use experiential testing such as the CAI to measure counselor trainees' entry levels of empathic communication, as well as improvement levels, this would be both a cost- and time-intensive project. Assessment using the

*Affective Orientation Scale* and *Twenty-Item Toronto Alexithymia Scale* would likely be much more cost- and time-efficient.

In this study, the associations between affect and empathy self-report measures were found to be significant. Both the *Affective Orientation Scale* and the *Twenty-Item Toronto Alexithymia Scale* predicted three types of self-reported empathy on the Empathic Concern Scale of the *Interpersonal Reactivity Index*, the Perspective-Taking Scale on the *Interpersonal Reactivity Index*, and the Empathy Scale on the *Relational Inventory*. On the other hand, the AOS and TAS-20 did not significantly predict empathy on the *Communication Assessment Index* and the *Empathic Understanding in Interpersonal Processes* scale, both "objective" methods. The CAI and EUIP purport to measure a different stage of empathy, one which must be perceived by objective, external observers, while the IRI scales and the RI measure the first stage "empathic resonation" (Barrett-Lennard, 1986).

Barrett-Lennard (1993) suggested that the CAI and the EUIP measure communicated or "expressed empathy." The two separate stages—(1) "empathic resonation," experience of empathy; and (2) successful interpersonal communication of one's empathy—have proven to correlate at low levels, if at all, in prior studies (Barrett-Lennard, 1993; Gurman, 1977). Barrett-Lennard (1993) pointed out that the CAI and EUIP represented the second phase of empathy and, as such, should demonstrate very little correlation with instruments that measure different phases of empathy (Barrett-Lennard, 1993).

The CAI and EUIP are limited in that they provided only audible cues to both the trainees and to the "blind" raters. Trainees responded to audio-taped client stimulus expressions, read by an actress. As such, they did not have benefit of the wide array of nonverbal communication cues that are normally available in the

therapeutic context, for example, gestural, proxemic, postural, and paralinguistic, which, as Goldstein and Michaels (1985) pointed out, "all play a role in this affective decoding effort, but a role clearly subsidiary to that provided by facial expressiveness . . ." (p. 109) (e.g., Emde, 1991; Izard, 1971). Similarly, the "blind" raters had only verbal data—the audio-tapes of trainees. These limitations may explain, in part, this study's failure to predict empathy on the CAI and EUIP. In many studies, reported by Truax and Carkhuff (1967), communication levels of empathy, even for experienced therapists, tended to be barely at or below "minimally facilitative levels"; inexperienced counselor-trainees often demonstrated less than facilitative levels.

Another limitation of the CAI and the EUIP scale is the small range of possible responses available to raters of communicated and observed empathy. Whereas the other empathy self-report measures used in this study had minimum scores ranging from seven to 28 on the EC-IRI and PT-IRI and –30 to +30 on the RI, "blind" raters and practicum supervisors had a range of only 1–5 to rate trainees on the CAI and EUIP.

<center>Post Hoc Analyses</center>

Several post hoc analyses are worthy of discussion. Statistically significant differences were found in this study between females and males on both the AOS and the TAS-20, consistent with other studies using the AOS (Booth-Butterfield & Booth-Butterfield, 1990; Osani & Frymier, 1990) and the TAS-20 (Yelsma, 1992). Several explanations could account for this difference. Feminist psychologists have stated that women in Euro-American culture tend to be more relationally oriented and are taught and expected to be more affectively attuned to the needs of others

than are males (Gilligan, 1982; Jordan et al., 1991; Miller, 1976, 1986). In a study of

therapy outcome, Orlinsky and Howard (1980) found that experience was unrelated

to outcome for female therapists, but highly related to outcome for male therapists.

The highly experienced male therapists were as good as any female therapist, but less

experienced male therapists had at least twice the others' rate of worse and

unimproved patients. Kaplan (1991) concluded that women's greater effectiveness

could be attributable to cultural expectations such that they have already become

skilled at emotionally sensitive and empathic behaviors, which they perform in many

of their relationships.

The social construction perspective of gender recognizes that individuals are

embedded in social contexts which are stratified by levels of advantage, privilege, and

power (Reid & Whitehead, 1992). From this viewpoint, gender differences can reflect

power relationships. Lakoff (1990), who recognized the political implications in

language, suggested that feminine and masculine ways of communicating are based

on power. As Thompson (1993) stated, "There are consistent, though mostly small

gender differences in communication, but it is a matter of interpretation whether

women's communication style . . . indicates powerlessness—appeasement and

submissiveness—or care—attentiveness and responsiveness (Aries, 1987; Hall,

1987)" (p. 562). In many relationships, due to differences in power, women may be

expected to be caring, empathic, emotionally supportive and sensitive. Therefore,

female counselor trainees may have scored higher in AO and lower in alexithymia

than males due to social conditioning within the context of power relationships in

Euro-American culture.

Another post hoc finding was that counselor trainees' mean scores for

alexithymia, on the TAS-20, were lower than for any other group currently reported

in the literature. Various career theories and assessment methodologies are based on the idea that people self-select themselves into careers based on salient personality characteristics (Campbell, 1988). From this framework, it could be expected that people who are attracted to becoming counselors and psychologists could tend to value identification and description of feelings, emotional expression, relational connection with others, greater affect tolerance and emotional sharing.

Since Carl Roger's (1957) pioneering work on therapist provision of "core conditions," the field of counseling and psychotherapy has embraced the perspective that therapist provision of warmth, genuineness, acceptance, empathic understanding, and reflection of feelings are essential ingredients in affecting therapeutic change in clients. The aforementioned core conditions are inconsistent with the personality characteristics of individuals who score high in alexithymia. Thus, it may be speculated that highly alexithymic individuals would be less inclined to choose counseling as a profession than those who are low in alexithymia.

### Limitations

Two limitations of this study are noted. One limitation is inherent in the attempt to operationalize a subjective, internal process, that is, sharing another's feelings—emotional empathy, or sharing another's perspective cognitively. This internal, subjective state is the first stage of empathy in most multistage empathy models, for example, Barrett-Lennard's "empathic resonation" (Barrett-Lennard, 1978; Goldstein & Michaels, 1985; Keefe, 1976). Watson and Greenberg (1994) pointed out that while validation and measurement of the subjective, intrapersonal, aspect of empathy are very difficult, the field needs this kind of data, most appropriately accomplished through self-report.

A second limitation was the use of self-report questionnaires. Self-report is susceptible to social desirability bias. Counselor trainees may have tended to present themselves as they wanted to be perceived. Therefore, as with all self-report measurement, some degree of caution must be exercised in interpreting assessment results. Authors of the self-report assessment instruments used in this study included both positive and negative scale items to moderate the social desirability bias.

## Recommendations for Future Research

The current study may stimulate further research in a number of directions.

1. An area for further study is development of instruments and methodologies which measure the various stages of empathy and the nature of empathy, emotional and cognitive. Considering the complexity of empathy, it would be useful to have a wide array of scales to measure empathy. Improvement of tools and methods which measure subjective experiencing are needed to further our understanding of Barrett-Lennard's and others' first stage of inner empathic experiencing.

2. Qualitative methods may be appropriately suited to capture the complexity of internal experiencing of the therapist, and the client in the therapeutic relationship. Some evidence exists that a combination of quantitative and qualitative measurement "triangulation" may be most effective (Frey, Botan, Friedman, & Kreps, 1991). Since qualitative measurement allows subjects more description about their intrapersonal experiences than some of the instruments used in this study, it would be valuable to get more extensive feedback from trainees about their experiences of empathy. For instance, practicum supervisors could be interviewed to get more specific information about their perceptions of trainees' empathy and experiences with each trainee. Interview data would likely include peculiarities that may have been caused by factors

other than trainee empathy, such as particularly difficult clients, sickness, fewer sessions, or cultural barriers. In addition, qualitative interview methodology may be more likely to detect any prejudice on the part of supervisors regarding their beliefs about affect, empathy, or particular trainees.

3. Another method of data collection which might facilitate knowledge about empathic interaction is having raters observe the same trainee and client (live or through video-tape), comparing ratings of 15–50 minute segments of actual full-length counseling sessions. Mintz and Luborsky (1971) suggested that if the researcher is interested in the relationship or interactive qualitites of empathic communication, that actual whole counseling sessions should be evaluated. Content analysis of video-taped sessions in addition to counselor and client interview data could be combined. Because of unique empathic qualities which are communicated through nonverbal cues, including facial expression and subtle voice qualities (Emde, 1991), researchers measuring empathic interaction should ensure the use of equipment which can adequately capture these data.

4. Client experience of empathy is has been closely associated with client positive outcome (Greenberg & Pinsof, 1986; Gurman, 1977). It is recommended that future studies which attempt to capture the stages of "communication of empathy" and "received empathy" (Barrett-Lennard, 1993) include client report data. In the current study, in which only "subjective" measures (versus objective measures) were found to be statistically significant, it would have been helpful to know how another observer would have rated trainee empathy. If client report had been used, would clients perceptions have been more closely associated with objective observers or with counselor perceptions? Instruments like the *Working Alliance Inventory* (Horvath, 1982), which reveal both counselors' and clients' inner experiencing,

would seem to be most appropriate for a study like the present one which attempted to measure the first stage of empathy, "empathic resonation" (Barrett-Lennard, 1986).

 5. The issue of different levels of dispositional affect awareness and empathy is relevant to selection and training issues. Can counselors be trained to be more empathic? As Surrey (1991) stated, "The development of the capacity for empathy needs to be studied and elaborated carefully" (p. 53). Henry and Strupp (1994) noted that many therapists have been found to misread crucial underlying interpersonal processes in the therapeutic relationship. The researchers suggested that "fundamental training in the perception of moment-by-moment interpersonal process should be an initial foundation for later training in different theory-based therapies" (1994, p. 68). What counselor training, if any, can promote growth toward more affectively-oriented, empathic counselors? Might the AOS or TAS-20 be used to measure progress?

 6. It would be of interest to know to what degree family of origin experiences influence clients' and therapists' ability to be empathic and to bond in the therapeutic relationship. Possible questions for study are the following: What is the relationship of AO and alexithymia with family of origin measures? How do different levels of AO and alexithymia impact therapists' therapeutic relationships? Are affectively-oriented individuals more capable of empathic attunement and provision of a close, emotional bond in therapy? Are individuals high in alexithymia incapable of interpersonal modes of counseling? If so, at what levels?

Appendix A

Demographic Form

117

## DEMOGRAPHIC FORM

Please answer the following questions to the best of your ability. Please feel free to clarify or embellish any of your answers. All answers and forms will be handled with strict confidentiality.

1. Gender        Male ___        Female ___

2. Your Counseling Specialty or Major _____

3. Please indicate any previous training in counseling, helping, or human services skills that you have had, including job-related training.

   _____

   _____

4. Usually, being a client in counseling and therapy has a positive impact on one. If you have ever been a client, to the best of your knowledge how long did your counseling or therapy experience last? (If you are currently in therapy, please circle the answer that best indicates the length of your therapy experiences.)

   3 months        1 year        2 years        Over 2 years        Never been

   Other: _____
   　　　　(list specifically, if you like)

5. Total number of weeks you have been involved in your present practicum training. (This class began the first week of May).

   _____

6. Total number of one-to-one supervisory sessions you have had with your Practicum Instructor/Supervisor.

   _____

7. Total number of one-to-one supervisory-type sessions you have had with other professionals for this class.

   _____

8. Total number of client sessions you have had. (Include total number, even if you saw more than one client.)

   _____

Appendix B

Consent Form

119

College of Education
Counselor Education and Counseling Psychology

Kalamazoo, Michigan 49008-5195
616 387-5100

# WESTERN MICHIGAN UNIVERSITY
## CONSENT FORM

Principal Investigator: Dr. Al Hovestadt, Research Associate: Teri Krueger

I have been invited to participate in a research project entitled "Empathy, Affect, and Supervisor Ratings of Counselors-in-Training". I understand that this research is intended to study the relationship between several counselor-trainee characteristics and some of their helping behaviors. I further understand this is Teri Krueger's dissertation project.

My consent to participate in this project indicates that I will attend one, one-half hour session, with other counselor-trainees in the CECP Department at WMU and Teri Krueger, in the Center for Counseling and Psychological Services (CCPS). In CCPS, I will privately tape-record my spontaneous verbal responses to an audio-taped set of five simulated client excerpts. Then I will complete several questionnaires of a psychological nature commonly used in the therapy and counseling fields. I will also provide general information about myself such as my sex and training. I need not answer any question with which I am uncomfortable. I understand that my practicum instructor will fill out a rating form on my counseling skills based on my general skills. I further understand that data collected from my instructor will be compared with my empathy and questionnaire responses.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise stated in this consent form. I understand that I may be uneasy about answering some of the questions or about the taping. Should I become significantly upset, I understand that Teri Krueger, a Licensed Professional Counselor, is prepared to provide crisis and stress reduction counseling and that she will make a referral if I need further counseling. I understand that I will be responsible for the cost of any further counseling if I choose to pursue it.

One way I may benefit from this activity is by having the opportunity to better understand the process of research and data collection. In hearing about the results of the study, I may learn about the counseling variables under study, as well as gain in self-awareness by doing the questionnaires. In addition, others in the counseling field may benefit from the knowledge that is gained from this research.

I understand that all information collected from me is strictly confidential. While my instructor of CECP 612 will complete a rating form for me, he or she will not know my code number or see my questionnaires or tapes. My name will not appear on questionnaires or cassette tape. These will be coded with a number. Ms. Krueger will keep a separate list with the names of participants and the corresponding code numbers which will be destroyed once the data are collected and analyzed. All other forms will be retained for up to two years in a locked filing cabinet in Dr. Hovestadt's office.

I understand that I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact either Teri Krueger at 965-4124, or Dr. Alan Hovestadt at 387-5117. I may also contact the Chair of Human Subjects Institutional Review Board at 387-8293 or the Vice President for Research at 387-8270 if questions or problems arise during the course of the study. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

Name _____ Date _____

Appendix C

Approval Letter From the Human Subjects
Institutional Review Board

121

Human Subjects Institutional Review Board

Kalamazoo, Michigan 49008-3899
616 387-8293

# WESTERN MICHIGAN UNIVERSITY

Date:   July 15, 1994

To:     Terrilyn Krueger

From:   Kevin Hollenbeck, Chair      *jr. for K. Hollenbeck*

Re:     HSIRB Project Number 94-05-17

This letter will serve as confirmation that your research project entitled "Empathy, affective sensitivity and supervisor ratings of counselors-in training" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

Approval Termination:        July 15, 1995

xc:     Hovestadt, CECP

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123

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