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Conceptualizing Empathy in Cognitive Behaviour Therapy: Making the Implicit Explicit

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Abstract. Although empathy has been shown to play an important role in therapeutic outcomes for cognitive-behaviour therapy (CBT) as for other therapies, there has been remarkably little discussion or research on empathy in the CBT literature. This paper seeks to make the implicit explicit: to conceptualize the nature and function of therapeutic empathy within CBT. It proposes a model of therapeutic empathy with four key elements: Empathic attunement, Empathic attitude/stance, Empathic communication, and Empathy knowledge. The model points to the importance of the "person of the therapist" and self-reflection in the development of therapeutic empathy; and describes how the specific contribution of CBT knowledge and skills can help therapists understand clients' moment-to-moment experiences and, if used sensitively, can enhance the empathic process. The paper indicates how therapists may use different modes of empathic processing to process experience under different circumstances, and how empathy fulfils a variety of functions within CBT. This conceptualization has considerable implications for therapists, trainers, supervisors and researchers including: more accurate identification and targeted strategies to address therapeutic empathy problems; recognition of the value of personal experiential work and self-reflection in empathy training; increased understanding of the functions of empathy; and development of finer-grained clinical and research measures.

Keywords: Cognitive-behaviour therapy, empathy, interpersonal, therapeutic relationship, cognitive-behaviour therapy training.

Introduction

Many writers have identified empathy as one of the key ingredients in promoting psychotherapeutic change (Beck, Rush, Shaw and Emery, 1979; Bohart and Greenberg, 1997a; Rogers, 1967). Its significance can be gauged from a recent meta-analytic review that concluded that empathy accounts for between 7–10% of the variance in therapy outcome studies (Bohart, Elliott, Greenberg and Watson, 2002). Rogers (1967) suggested that a warm, empathic relationship was one of the necessary *and* sufficient conditions for therapeutic

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change. In contrast, most cognitive therapists have argued that empathy is a necessary, but not sufficient, condition for change to occur (Beck et al., 1979).

This paper seeks to conceptualize the nature and function of therapeutic empathy within cognitive-behavioural therapy (CBT). Following Burns and Auerbach (1996), we use the term "therapeutic empathy" throughout much of the article to distinguish the sophisticated set of skills that advanced therapists might use in the therapy context from a naturally occurring empathic experience that lay people might have in everyday life. While there is considerable overlap between empathy skills in therapy and everyday life, there are also differences in both form and content.

We have decided to develop a CBT-specific conceptualization of therapeutic empathy for four reasons. First, while empathy is commonly mentioned in CBT books and articles (e.g. Beck, 1995; Guidano and Liotti, 1983; Young, Klosko and Weishaar, 2003), there is a paucity of empirical research or theoretical literature on the topic (for exceptions, see Burns and Auerbach, 1996; Gilbert, 2005; Leahy, 2005). This can be contrasted with abundant writings about empathy within the person-centred (e.g. Patterson, 1984; Schmid, 2001) and psychoanalytic literatures (e.g. Book, 1988). Given the centrality of empathy to the therapeutic process in CBT (Beck et al., 1979), a clearer conception of empathy seems a worthwhile endeavour to facilitate theoretical and empirical development.

Second, a major problem with previous discussions of empathy is that there is currently no agreed definition or accepted understanding (Bohart et al., 2002). For instance, empathy has been defined as a personality trait, a state and an experiential process (Trusty, Ng and Watts, 2005), and has been variously used to describe an attitude or stance, a perceptual skill, and a type of communication. A tighter understanding of the nature and types of empathy should assist clinicians and researchers.

Third, with occasional exceptions (Gilbert, 2000, 2007), there have been few attempts to develop a specific understanding of empathy within the CBT context. Discussions of empathy from a CBT perspective have tended to implicitly utilize conceptualizations of empathy from other theoretical traditions (e.g. Burns and Auerbach, 1996; Hoffart, Versland and Sexton, 2002). For example, although a key paper on empathy from a CBT perspective (Burns and Auerbach, 1996) is quite explicit in rejecting certain elements of psychoanalytic definitions of empathy, the measures of empathy developed were not specific to CBT. A CBT understanding of empathy is likely to draw on understandings from other psychotherapeutic traditions. However, there may be some aspects or functions of empathy within CBT that are relatively specific and contextual, since CBT has a different theoretical underpinning from either psychoanalytic approaches or person-centred approaches. Of particular interest in this regard is the meta-analytic study of empathy undertaken by Bohart et al. (2002). The authors found higher effects sizes for empathy in the CBT studies than in studies of other theoretical orientations (e.g. psychodynamic, experiential). To explain the finding, Bohart et al. (2002) speculated that perhaps empathy is even more essential in intervention-based therapies than in those that place greater emphasis on the therapeutic relationship as the primary mechanism of change. As will be discussed later, the paradoxical implication may be that when cognitive therapists ask patients to engage in difficult and emotionally challenging tasks, therapeutic empathy becomes even more important.

Fourth, an agreed conceptualization of empathy within CBT should be helpful in the training and supervision of therapists. It is probably true to say that most CBT training programmes tend to focus more on conceptual and technical skills than interpersonal. Lack of clarity

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about exactly what we should be training, and how, may be part of the problem. We need to understand better what exactly we should be training and what methods would be effective. It is, therefore, the aim of this article to:

1. To clarify our understanding of the terms "empathy" and "empathic";
2. To identify the different components of therapeutic empathy, and how they relate to one another within the therapeutic process;
3. To discuss empathic processing within an information processing framework;
4. To identify the functions of empathy in CBT;
5. To discuss implications for the training and supervision of empathy in CBT therapists.

The paper is divided into two sections. In Section 1, we review previous literature on empathy, drawing selectively on a range of sources. These include a rich literature on empathy from a variety of other therapeutic traditions; writing and research on empathy within CBT; and developmental research on empathy. In Section 2, a new model of Therapeutic Empathy is presented, together with its four key components (Empathic attunement, Empathic stance/attitude; Empathic communication; Empathy knowledge). We identify different ways in which therapists may process and communicate empathy; examine the functions of empathy in CBT; derive implications for the training and supervision of CBT therapists; and draw conclusions for future research and clinical practice.

Section 1: Conceptualizations of empathy from previous literature

Our aim in this section is not to undertake an exhaustive review of a voluminous literature on empathy; rather it is to draw out key themes and elements that should be incorporated into a CBT conceptualization of empathy. At the outset, it should be noted that empathy is not a unitary concept. Different writers have emphasized different elements from a variety of theoretical perspectives, and there is no consensual definition (Bohart et al., 2002). Conceptions of empathy also show considerable overlap with closely related concepts such as sympathy, validation and compassion.

A useful place to start is with Carl Rogers who, more than any other writer, has been responsible for highlighting the role of empathy in the psychotherapeutic process. Rogers (1967) defines empathy as when "the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from 'inside', as they seem to the client, and when he can successfully communicate something of that understanding to his client " (p. 62). A similar definition is provided by Kohut (1984, p. 82): "It is the capacity to think and feel oneself into the inner life of another person."

Rogers' and Kohut's definitions emphasize two important aspects of empathy. First, empathy has both emotional and cognitive aspects; it involves the ability to tune into the emotions experienced, and to derive meanings associated with the emotions. Most definitions of empathy within psychotherapy have emphasized the cognitive or perspective-taking component of empathy – understanding the client's frame of reference (Bohart et al., 2002). In contrast, writers from a developmental perspective have tended to see empathy largely as an emotional response. For example, Hoffman (2000) describes empathy as "an affective response more appropriate to another's situation than one's own" (p. 4). Eisenberg and Fabes (1998, p. 702) similarly suggest that empathy is "an affective response that stems from the apprehension or comprehension of another's emotional state or condition, and that is identical or very similar

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to what the other person is feeling or would be expected to feel." One of the features that may distinguish "therapeutic empathy" from "natural empathy" is the addition of the cognitive perspective-taking component to the emotional one; the cognitive component helps the therapist to conceptualize the client's distress in cognitive terms. Inasmuch as CBT formulations of client experiences differ from formulations in other psychotherapeutic traditions, this may be one way in which CBT-oriented empathy differs from empathy in other therapies.

A second aspect of empathy suggested by Rogers' and Kohut's definitions is that therapists engage in a particular mode of processing when being empathic: "feeling oneself into the inner life of another person" (Kohut, 1984), "perceive these [feelings] from 'inside'" (Rogers, 1967). Shamasundar (1999) and Jacobs (1991) have made similar points. Shamasundar (1999) suggested that empathy involves "the ability to be affected by the other's affective state, as well as the ability to 'read' in oneself what the effect has been" (p. 234). Jacobs (1991) advocated that to gain empathic understanding, therapists should reflect on personal memories, emotions, and shifting self-states that are evoked by, and resonate with, the client's internal struggles. For instance, therapists might reflect on the finer nuances of the client's experience (e.g. guilt) by tuning into similar experiences of their own. The implication of these writings is that the empathic mode of processing involves use of "the self", and reflection on the self, to process and understand the experience of the client. This mode of processing may be contrasted, for instance, with the more "external", rationalistic mode of processing that a cognitive therapist might adopt when formally mapping a cognitive formulation with a client.

A third aspect of empathy commonly found in the literature is the distinction between "perceptual" aspects of empathy, in which the therapist is "empathically attuned" to the subtle nuances and nonverbal behaviours of the client; and "response or communicative" aspects of empathy, in which therapists "actively communicate" their understanding and appreciation of the client's emotional experience and frame of reference (Barrett-Lennard, 1993; Bohart et al., 2002). Empathy can be communicated in many ways: for instance, not only through empathic reflections, but also through empathic questions, empathic conjectures, and the sensitive use of therapeutic techniques. Importantly, although CBT has a tendency to de-emphasize the non-verbal skills involved in a therapeutic encounter, empathy can be communicated as much by non-verbal behaviour and tone of voice as the content of the speech itself, providing a sense of safety, warmth, understanding and acceptance (Gilbert, 2007; Greenberg, 2007).

A further important element in therapeutic empathy is an "empathic stance or attitude". As various authors have noted (Gilbert, 1997; Wispé, 1986), skills in empathic attunement and empathic communication do not necessarily lead to caring or a therapeutic act. Gilbert (1997, p. 139) has pointed out that "a torturer may put a gun to your head; the empathic torturer puts it to your child's head", and Wispé (1986) has observed how certain actions by the Nazis designed to create increased fear among civilians required the ability to understand how this would affect the attacked individuals. One could imagine an empathic yet psychopathic therapist who might misuse his skills to take sexual advantage of vulnerable clients. For empathy to become therapeutic empathy there has to be a particular attitude or stance on the part of the therapist (Greenberg, 2007).

How therapeutic empathy develops in therapists is a topic that has received relatively little attention. A key question is to what extent empathic stance, and capacities to empathically attune and communicate predate therapist training, and to what extent these skills can be developed during training. The available evidence suggests that developmental factors exert a marked effect, and that specific training strategies can facilitate certain aspects of therapeutic empathy.

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Authors frequently remark that therapists come into training with different levels of empathy (Dobson and Shaw, 1993), suggesting the importance of developmental factors. The developmental literature suggests that there are likely to be childhood experiences and personality factors such as attachment style (Trusty, Ng and Watts, 2005) that impact on the ability of therapists to experience empathy; genetic factors and parenting styles may also play major roles in children's abilities to respond empathically (Valiente et al., 2004).

Baron-Cohen's work on Theory of Mind (e.g. Baron-Cohen, 1994), and his more recent neurocognitive model of empathy (Baron-Cohen, 2005) identify key mechanisms through which empathy appears to develop. Principal amongst these are the "Emotion Detector", which allows individuals to recognize and represent affective states in others, and our own affective reactions in response (e.g. "I am sad – that you are distressed"); and the "Empathizing System", which allows individuals to mentally represent epistemic mental states (e.g. "my patient *thinks* that she is worthless").

While developmental factors clearly play a major part in adults' capacity to attune and respond empathically, there is also evidence to suggest that therapists can develop some aspects of empathy skills through training programmes (Lyons and Hazler, 2002; Nerdrum and Ronnestad, 2003) and, more specifically, that they can be trained to attend to, and respond to, non-verbal communication by clients (Grace, Kivlighan and Kunce, 1995). In the CBT context, self-experiential work coupled with self-reflection also appears to enhance empathy (Bennett-Levy, Lee, Travers, Pohlman and Hamernik, 2003). Thus, the available evidence suggests that therapeutic empathy is a product of long-standing aspects of the personality, and may also incorporate more specific empathy knowledge and skills learned during therapist training.

Writers have described empathy as serving various functions. Perhaps the most frequently described is that empathy furthers the development of the therapeutic alliance (Book, 1988; Bohart et al., 2002). Empathy may also promote access to the inner world of the patient (Book, 1988), enhance exploration and meaning creation (Bohart et al., 2002), and provide a "corrective emotional experience", where clients learn that they are worthy of respect and that their feelings and emotions make sense (Bohart and Greenberg, 1997b; Jordan, 1997).

One difficulty with the concept of empathy, which repeatedly emerges in the literature, is the problem of distinguishing it from other closely related concepts such as sympathy, validation and compassion (Book, 1988; Gilbert, 2005; Leahy, 2005; Linehan, 1997; Wispé, 1986). The empathy-sympathy distinction is perhaps the most straightforward. Whereas the focus in empathy is on *understanding* the experiences of the other, the focus in sympathy lies in reaching out to the other in an attempt to *alleviate suffering* (Gilbert, 2005, Wispé, 1986). Empathy may lead to sympathy but is formally distinct.

Interestingly, cognitive therapists have often focused not upon empathy but on the overlapping concept of validation (Leahy, 2005; Linehan, 1997). Leahy has described validation as "finding the truth in what we feel and think" and has suggested that it "stands as the fulcrum between *empathy* (where we recognize the feeling that another person has) and *compassion* (where we feel *with* and *for* another person and care about the suffering of that person" (Leahy, 2005, p. 196). The same author describes a variety of ways in which the therapist can validate a patient's experiences, encourage expression, make sense of their emotions and help develop emotional tolerance, thus preventing CBT becoming experienced as a detached, mechanistic process. In almost all of these therapeutic strategies, empathy is a prerequisite step. Empathy has also been closely linked with the concept of compassion. For

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instance, Gilbert (2005) identifies empathy as a component of compassion along with other elements such as sympathy, non-judgment, and care for the well-being of others. In practice, therapists' use of effective interpersonal skills (e.g. empathy, positive regard, genuineness) are so highly correlated that they repeatedly co-occur (Bohart et al., 2002), and it may be difficult to distinguish the effects of empathy, validation or compassion within empirical studies. Nevertheless, there is enough of a conceptual distinction, as well as a considerable literature on empathy, to suggest the value of conceptualizing empathy in cognitive therapy.

In summary, the literature reveals empathy to be a multi-dimensional concept. A cognitive conceptualization of empathy should encompass the following:

1. Therapeutic empathy has both emotional and cognitive aspects;
2. Empathy involves a specific mode of information processing, where therapists can observe and reflect on their own emotional reactions in order to understand the client;
3. Empathy can be differentiated into four distinct components:
   a) Empathic attunement as a perceptual skill;
   b) Empathy as a therapeutic stance;
   c) Empathic communication as a relational or communication skill;
   d) Declarative knowledge about empathy, which is acquired as part of therapist training and may influence pre-existing empathic stance, attunement and communication skills;
4. Empathy serves a number of functions in the therapeutic process;
5. Therapeutic empathy is likely to be a product both of long-standing aspects of "the person of the therapist" and of knowledge and skills learned as a result of training;
6. Training strategies can be identified to promote therapeutic empathy;
7. Empathy is highly related to, but distinct from, sympathy, validation and compassion.

Section 2: Towards a cognitive-behavioural conceptualization of therapeutic empathy

In this section, we present a cognitive-behavioural conceptualization of therapeutic empathy. Parts are applicable to empathy in the context of any psychotherapeutic orientation; parts are more specific to CBT.

The model of therapeutic empathy is derived from our recent model of therapist skill development, the Declarative-Procedural-Reflective (DPR) model (Bennett-Levy, 2006; Bennett-Levy and Thwaites, 2007),which was developed to specify the core elements of psychotherapy skill, and the relationship between them. Bennett-Levy (2006) gives a detailed presentation of the general model; Bennett-Levy and Thwaites (2007) focus more specifically on the acquisition and refinement of interpersonal skills. In this paper, we focus the model further to provide a specific model of therapeutic empathy.

Figure 1 illustrates the Therapeutic Empathy Model. In the next section, the four main components (Empathic attitude/stance, Empathic attunement, Empathic communication skills, Empathy knowledge) of therapeutic empathy are described. We indicate which elements in this conceptualization of therapeutic empathy may be general across therapeutic orientations and which may be relatively specific to CBT. We illustrate how this conceptualization appears to capture many of the key features of therapeutic empathy identified in Section 1 (e.g. different components, emotional and cognitive aspects, importance of self and self-reflection), and how it may be useful in identifying therapeutic empathy problems with different causes. Examples of empathic responses via various pathways are provided to illustrate the model.

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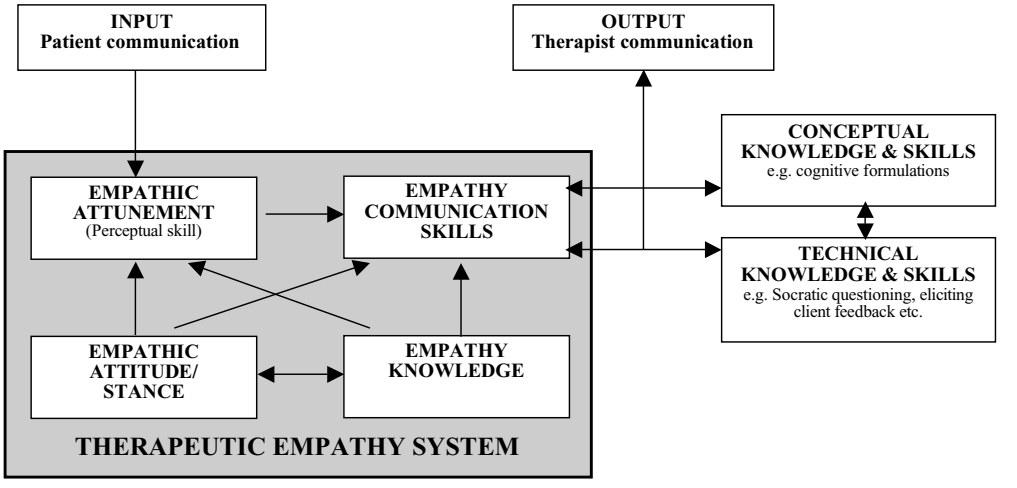


Figure 1. The Therapeutic Empathy System.

Key components of therapeutic empathy

Empathic attitude/stance. Greenberg (2007) in particular has emphasized the importance of therapist stance in setting the tone of therapy. An empathic stance infuses other aspects of empathic skill (attunement, communication skills) with a sense of benevolence, curiosity and interest. Many therapists will have chosen the profession because of a basic "helping" orientation, and therefore their stance will have pre-dated entry into the profession. Other aspects of stance may be learned during therapist training. For instance, therapists who have experienced cognitive therapy for themselves frequently remark on their renewed empathy for clients struggling with the process of change (Bennett-Levy et al., 2003).

Problems with empathic stance can be at the level of character (in which case the choice of profession is questionable) or be more situational. For instance, some therapists have beliefs or reactions that make it difficult for them to empathize with depressed patients. A second, and more specific, example could be that of a therapist who has been in a controlling relationship and finds it difficult to empathize with the distress of controlling patients, especially when it is manifested as attempts to control the therapy relationship. Furthermore, as human beings with their own life events and problems, most therapists will experience times when their empathic attitude is affected by feeling worried about their own problems, feeling ill or perhaps overworked. Implications for supervision have been addressed elsewhere (Bennett-Levy and Thwaites, 2007).

We imagine that most aspects of empathic stance are general across psychotherapeutic orientations. However, there may be some elements of CBT that have specific impacts on empathic stance. For example, CBT's particular emphasis on the collaborative relationship may enhance empathy for the challenges of therapeutic change, though we know of no data that specifically address this question.

Empathic attunement. Empathic attunement is a therapist perceptual skill (Bennett-Levy, 2006), which Bohart et al. (2002, p. 90) have referred to as "an active ongoing effort to

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stay attuned on a moment-to-moment basis with the client's communications and unfolding process". The attunement system is emotion-led. It enables the therapist to "operate within the internal frame of reference of the client . . . listening from the inside as if 'I am the other' . . . being attuned to the nuances of feeling and meaning, as well as the essence of another's current experience" (Greenberg and Elliott, 1997, p. 167–168). The process of empathic attunement overlaps with the notion of mindfulness within sessions, allowing the therapist to direct his or her attention appropriately whilst remaining open to whatever is occurring through non-judgmental awareness (Safran and Muran, 2000).

For example, imagine a distressed young woman with borderline personality-type problems of affect regulation, experiencing an uncertain sense of self during a particular stage of a therapy session. A combination of moment-to-moment attunement to what she was saying (and also not saying) and conceptual knowledge about emotion regulation problems might allow the therapist to notice that she was dissociating, feeling emotionally overwhelmed, confused, hollow and empty. The therapist could then use his empathic communication skills to communicate an awareness of the client's state, helping her to label it, modelling acceptance, and validating her difficulties in the context of her learning history. This, of course, is very different from, but no less genuine or human than, the natural response of a caring non-therapist.

Judging from the absence of literature on perceptual skills in cognitive therapy (Bennett-Levy, 2006), cognitive therapists appear to place rather less emphasis on perceptual skills compared with exponents of some other therapies (e.g. experiential therapy, psychodynamic therapy). Furthermore, compared with many therapies, cognitive therapy has a strong technical and conceptual emphasis, which may get in the way of attunement to the moment-to-moment process, particularly in therapists-in-training who are trying to learn the technical elements of the therapy (Bennett-Levy and Beedie, 2007). However, videotape recordings of advanced therapists (e.g. Padesky, 2004) would suggest that the best therapists are able to combine a hypothesis-testing approach with a keen awareness of the "moment-to-moment state" of the client.

While empathic attunement in CBT may be broadly similar in form to empathic attunement in other psychotherapies, it may sometimes differ in focus and context. For instance, while attunement in psychodynamic therapies may be largely focused on the dynamics of the therapeutic relationship, attunement in CBT is more likely to be focused on problem description, formulation and intervention strategies (unless there is a therapeutic rupture, or the relationship exemplifies aspects of the formulation). The active nature of CBT may also provide different contexts for attunement; for example, focusing on the moment-to-moment state of the client is *particularly* important when undertaking a therapist-guided behavioural experiment (Bennett-Levy et al., 2004).

Empathic communication skills. Whereas empathic attunement is a perceptual skill, empathic communication skills result in active communications directed back to the client. CBT theorists have placed most emphasis on this component of empathy. For example, the Empathy Scale (Burns and Auerbach, 1996) concentrates on measuring both therapist's and client's perception of the communication of empathy by the therapist. Whilst this is undoubtedly an important aspect of the therapeutic process, concentration on the communication of empathy has been at the neglect of earlier stages and has perhaps limited a full conceptualization of the wider process of empathic communication in CBT. Indeed, it is questionable whether an accurate communication of empathy can actually occur without the involvement of other components such as empathic stance or empathic attunement.

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As Section 1 indicated, good empathic communication reflects both clients' emotional experience (articulated and unarticulated) and their frame of reference; there are cognitive and emotional aspects to accurate empathy. The model addresses this issue by positing input into empathic communication skills from other emotion-based elements of the therapeutic empathy system (e.g. empathic attunement and stance) and from the cognition-based conceptual knowledge/skills system. Indeed, it is wholly consistent with the CBT model that empathic communication should seek to relate thoughts, emotions and behaviour at every appropriate opportunity. To the extent that clients accept the rationale for CBT formulation, and the therapist combines emotional and cognitive aspects of empathy, then CBT appears to provide a strong foundation for promoting empathic communication.

In discussing validation in Dialectical Behaviour Therapy (DBT), Linehan (1997) provides an example of the integration of cognitive and emotional aspects of empathy. She describes five levels of "validation". Level 1 is "the listening to and observing of what the client is saying, feeling and doing" (p. 360) (empathic attunement in the present model). Level 3 captures the communication of therapist empathy, by an articulation of the client's experience and responses to events that has not been verbalized by the client. Level 4 involves validating behaviour in terms of its causes, in other words, helping the client to realize that their behaviour makes sense in the context of their current experience and life to date. Whilst aimed at individuals with borderline personality difficulties, these various levels could easily be applied to individuals with other types of enduring personality problems or indeed common Axis 1 problems.

Another input to the empathic communication skills comes from *technical* knowledge/skills, since some technical aspects of CBT may actively promote empathic communication. For instance, careful Socratic questioning can both promote a sense of being heard, and help uncover useful information to assist understanding beyond the immediate awareness of the client (Padesky, 1993). Regular client feedback is another CBT strategy that can promote empathy, and assist the therapeutic relationship. However, the technical emphasis of CBT also carries dangers. If poorly managed, CBT techniques can hinder therapeutic empathy; Bennett-Levy and Thwaites (2007) provide an example of a female depressed client who felt invalidated when her therapist repeatedly moved into problem-solving mode without acknowledging the extent of her distress.

In summary, the communication of empathy in CBT is liable to take a slightly different form from the communication of empathy in other psychotherapies due to differences in formulation and in some technical skills. Indeed, it would be helpful to identify what elements of CBT formulations and which technical skills contribute most positively to therapeutic empathy, and which may not.

Empathy knowledge. A significant contribution of the present model is to highlight the importance of empathy knowledge in the therapeutic empathy system. Other writers about empathy have usually focused on attitude and skills, to the exclusion of empathy knowledge – even though, ironically, this is what they are creating.

Empathy knowledge is what therapists learn from teachers or from reading during training and professional development. Importantly, empathy knowledge acquired through therapist training is one of the key factors that differentiates therapeutic empathy from "natural empathy". For instance, therapists may be didactically taught that showing clients that they understand how they are thinking and feeling enhances the therapeutic relationship; or they may read about more complex uses of empathy, such as how to work with the therapeutic

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process, and possible interfering factors such as security operations (Safran and Segal, 1996) and resistance (Leahy, 2001).

Empathy knowledge may be both explicit/declarative (e.g. our knowledge about the importance of empathy in cognitive therapy) and implicit/procedural (e.g. often we have no conscious awareness of the plans, rules and procedures that guide us when we are being empathic). Over time, explicit empathy knowledge may become implicit as it embeds within the procedural system (Bennett-Levy, 2006). The relationship between declarative and procedural knowledge has been discussed at length within the cognitive science literature (e.g. Anderson, 1987), and has featured in our previous writing (Bennett-Levy and Thwaites, 2007). While, for the present purposes, we deemed it parsimonious to place them under one heading (empathy knowledge), it should be noted that declarative knowledge plays a key role in pattern recognition and matching, which then allows the procedural mechanisms to implement the appropriate rules (Anderson et al., 2004).

Empathy knowledge can shape and inform our practice of therapeutic empathy, and provide a platform for further development. Reading this paper may provide some useful concepts with which to distinguish different aspects of empathy; it may influence the reader's stance on therapeutic empathy, and provide some ideas for developing attunement skills and communication skills. However, empathy knowledge will not on its own create a more empathic therapist. Therapists need to turn explicit knowledge into procedural skills through practice, feedback and reflection before empathic knowledge becomes skilled action.

The four components of therapeutic empathy: specific types of empathy-related problems? It is hoped that clearly distinguishing the four components of the therapeutic empathy system from one another, and indicating their links, will assist in the conceptualization of empathy in cognitive therapy, with benefits for clinical practice, training and research. One of the practical consequences of these distinctions is that it may be possible to identify different types of empathy problem in therapists, depending on which of the components are deficient. Table 1 provides hypothetical examples of types of empathy problems that may be seen when different components are functioning well, or not so well. For example, at one extreme is the potentially psychopathic therapist with exemplary empathy knowledge, attunement and communication skills but an absence of empathic stance; while at the other extreme is the well-meaning potentially infuriating amateur with empathic stance, but none of the other skills. If this model enhances the capacity of supervisors to identify types of empathy skill deficit, this opens the way for more specific and targeted training and supervision strategies (Bennett-Levy and Thwaites, 2007; and see later discussion).

Information processing in therapeutic empathy

As indicated in Section 1, empathy does not arise *de novo* when we become therapists. Empathy skills are part of the fabric of everyday social interaction. Basic empathy skills are learned in childhood. To a greater or lesser extent, we already had an empathic stance/attitude towards the suffering of others, could attune emotionally, and communicate empathically, and had some largely implicit empathy knowledge before our therapy training. When we became therapists, we brought these "person of the therapist" attributes with us, and they continued to exert a strong influence on our therapeutic empathy skills (Jennings and Skovholt, 1999; Machado, Beutler and Greenberg, 1999). However, we also developed some new declarative (and, later,

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Table 1. Possible behavioural manifestations of therapeutic empathy difficulties according to which components are deficient

Empathic stance	Empathic attunement	Empathic communication skills	Empathy knowledge	Behavioural manifestation
+	+	+	+	• Excellent empathy skills – attunement and communication • Authentic, warm, genuine
−	+	+	+	• Appears empathic, but other elements of behaviour may suggest dangerously using the relationship for own ends (perhaps seeing clients as objects) • At worst, psychopathic
+	-	+	+	• Authentic and warm, fine with simple emotions, but can struggle with more complex/mixed emotions (e.g. guilt, shame) • Better at Axis I than Axis II problems
+	+	−	−	• Well-tuned in and authentic • May lack skills to communicate empathic understanding as well as emotion, or to frame difficulties within a cognitive conceptualisation • Perhaps a novice therapist who assumes that empathy experienced by the therapist is automatically felt by the client (needs to learn the importance of explicitly communicating empathy and how to do this)
+	−	−	−	• Well-meaning "amateur" • Doesn't listen well, will tend to gloss over, change subject or relate personal stories, rather than focus on issues of concern
+	−	−	+	• Understands empathy intellectually and is well-meaning • Has little ability to tune into emotional content and respond appropriately • Perhaps may also find it difficult to tune into own emotions and reflect appropriately

procedural) empathy knowledge as a result of training, which translated into additional "self as therapist" attitudes and skills.

This conceptual distinction between the "person of the therapist" and "self as therapist" derived from the DPR model (Bennett-Levy, 2006; Bennett-Levy and Thwaites, 2007), is important in distinguishing "natural" empathy from therapeutic empathy, and can assist our

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understanding of the variety of modes of information processing involved in therapeutic empathy. Our model suggests that there are several information processing routes from empathic attunement to empathic communication. Some responses have a near-automatic quality, such as when the therapist responds "naturally" to a client's distress, or can anticipate a phobic client's terror. Other responses are potentially much more complex and require the therapist to internally represent and reflect on the client's emotional experience, and then to frame an empathic response that encompasses the nature and extent of the client's emotional distress, and a cognitive understanding based on the formulation of the client's problems.

Here we describe three possible pathways for empathic responding, and illustrate these in Figure 2, while acknowledging that skilful therapist responses during the course of a session may contain hybrid elements of all three. Pathways 1 and 2 are relatively simple; Pathway 3 is rather more complex.

Pathway 1 (as illustrated on the left of Figure 2) is essentially "natural" empathy, experienced by therapists and non-therapists alike. For instance, a client (or a friend) may have just received some bad news about his health. We momentarily experience his sadness and almost immediately respond to this news without reflection ("What a shock, I'm so sorry"). Here we process and respond to the client's experience through the "person of the therapist", registering the emotion in part as if we had had the experience ourselves. We do not necessarily try to add a cognitive formulation.

Evolutionary theories of empathy describe why we have the ability or tendency (that might at times appear bizarre or unhelpful) to experience the emotions of another individual around us (Gilbert, 2005). Animals (including humans) need to be highly sensitive to, for example, anxiety in others. A threat to others often means a threat to us, and an immediately evoked emotion provides a rapid acting alarm system that may protect us from danger (Gilbert, 2005). This fast acting system explains why we experience rapid empathic responses to distress in others (Decety and Jackson, 2004) – not just to humans, but also to animals and even to robots that we have never met (supported by the number of people crying in the cinema whilst watching the young robot boy being abandoned in the film AI by Stephen Spielberg!).

Pathway 2 represents another kind of simple empathic response, but relies much more on an understanding of the client's difficulties derived from the cognitive formulation (see middle illustration in Figure 2). While for Pathway 1, there was minimal involvement of the "self as therapist" (empathy was "natural", "person of the therapist" based), for Pathway 2 the emphasis is on "self as therapist" processing – incorporating conceptual understanding of the client's problems – with sometimes rather little involvement of the personal self. The therapist attunes to the client's communication, and, with minimal reflection, responds to the patient using self as therapist empathic communication skills. For example, an experienced cognitive therapist, well used to working with clients with panic disorder, may not need to process their client's experience through their own personal experiences or emotional system (or necessarily need to experience a strong emotional resonance with the client) in order to reflect empathically that the client naturally felt terrified when he had thoughts like "I'm going to have a heart attack" and "I'm going to die". Pathway 2 is likely to work best for simple emotions in predictable circumstances.

Pathway 3 combines the "person of the therapist" and "self as therapist" elements of Pathways 1 and 2, and may involve rather greater use of reflective processes (Bennett-Levy and Thwaites, 2007). Therapists may use Pathway 3 where more complex emotions are involved (e.g. shame, guilt, envy), and/or where it is particularly important that they respond

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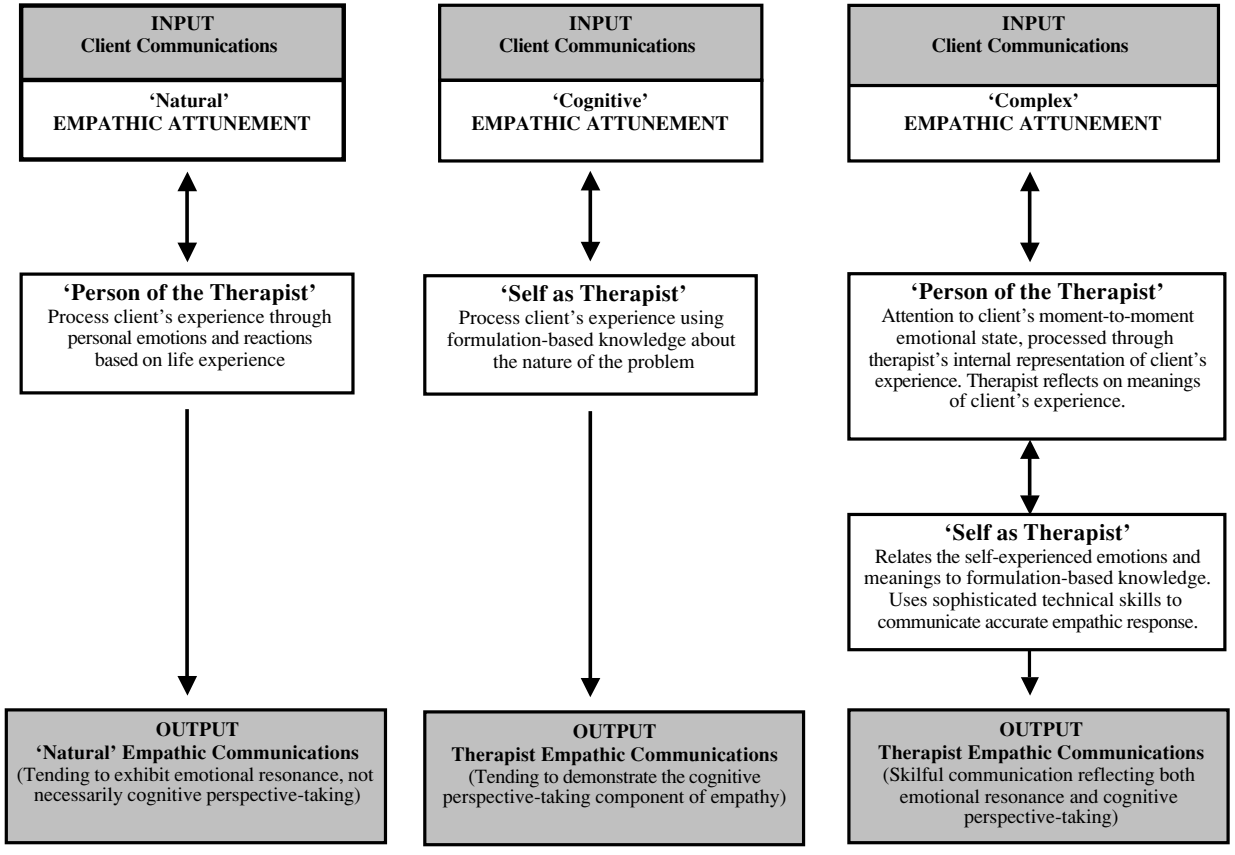


Figure 2. Three possible pathways for the empathic process: Pathway 1 (left): A 'natural' human empathic response (in or out of therapist role). Pathway 2 (centre): A 'simple' formulation-based empathic response in the therapeutic context (may lack emotional accuracy and personal engagement). Pathway 3 (right); A more sophisticated empathic response engaging both the 'person of the therapist' and 'self as therapist' – for instance in response to a complex emotion such as shame, or to a situation demanding a high level of therapist empathy.

empathically to the gravity of a situation and degree of distress that this has caused. Under these circumstances, therapists need to understand the client's experience "from the inside" in order to empathize fully and conceptualize the complexity and extent of the emotions in cognitive terms. Here, the therapist processes the client's experience through the "person of the therapist" as if the experience had happened to them; reflects on the emotional content and client's understanding of the situation; and uses declarative knowledge and procedural skills to address the client's experience in the context of the formulation. These are a highly sophisticated set of skills, engaging all aspects of the Therapeutic Empathy system, including conceptual knowledge and technical skills, in the production of a skilful empathic response.

In practice, skilful empathic responding is likely to be a combination of all three (and possibly other) pathways to empathy. For example, when discussing the neutralizing rituals of a male client with OCD, whose life had become governed by the problem, a female therapist noted his tone of voice and body language (e.g. lowered head, slumped posture, tearfulness). Imagining how she would feel in his situation, she experienced a sense of entrapment and defeat. Putting this experience in the context of her conceptual knowledge about OCD and an idiographic formulation of the client's problem (a long history of deteriorating OCD, reduced engagement with the world, a fear of emotions including anxiety and sadness), she reflected: "Right now, it feels to me as if you're feeling sad at just how much these obsessions are ruling your life – and maybe you're thinking that this is how it's always going to be? Can *you* put into words how you are feeling?" The aim of empathic statements at this point might be to help the patient to become more aware of his feelings, and for them to feel more understandable and manageable; or to help him feel understood and accepted, whilst introducing further doubt about the reality of his anxiogenic beliefs.

The benefit of the CBT approach for empathic processing is that diagnosis-specific formulations allow CBT therapists to predict with some accuracy the kind of emotions clients are likely to experience, and typical thoughts, beliefs and behaviours that might be associated with them. However, the benefit is also a potential danger. The perceptual filter created by "off the shelf" formulations (e.g. Pathway 2) may blind the therapist to the idiosyncratic elements of the client's experience, and lead to blinkered or inaccurate reflections. Furthermore, if the CBT therapist has not learned to use his/her own emotions to internally represent and reflect on the client's experience, then the empathic processing of more complex emotions may be deficient.

Functions of therapeutic empathy

Therapeutic empathy in CBT appears to serve various functions. A brief examination of these is provided below.

Empathy in establishing a therapeutic relationship. There is good evidence to suggest that empathy is central to the establishment of effective therapeutic relationships within CBT (Hardy, Cahill and Barkham, 2007). Indeed, it is hard, but not impossible, to imagine an effective therapeutic relationship without the presence of empathy by the therapist. However, in the vast majority of cases, feeling understood, accepted and to some extent safe, is essential to the development of a relationship in which the client is able to engage in the process of facing painful thoughts and feelings, the discussion of them with a stranger and the difficult process

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of trying to make changes (Hardy et al., 2007). From a DBT perspective, Linehan (1997) has suggested that one of the functions of validation and empathy is to "create a positive, attached, therapeutic relationship" (p. 391).

Empathy in assessment and data gathering. Clients often show significant embarrassment or discomfort in discussing painful feelings, or thoughts and behaviours that they view as inappropriate. With respect to the display or discussion of emotions, patients often describe parents who criticized, ridiculed or shamed them for expressing emotions, and as such find it difficult to experience, remain in contact with and discuss feelings. Significant empathy and validation may be required to enable the assessment and understanding of emotions within the formulation. For example, male clients often have very rigid and explicit rules about the experience and display of emotions that are activated within therapy when discussing emotional subjects and may lead to unhelpful interpersonal safety behaviours or "protective" secondary emotions that mask the primary emotion, such as anger (Greenberg, 2002).

Again, with the discussion of potentially shameful thoughts (e.g. intrusive thoughts about harming a child in OCD), behaviours (e.g. self-harming) or previous life experiences (e.g. sexual abuse), implicit and explicit empathy is likely to enhance the first stage of the therapeutic process – the assessment. Bohart et al. (2002) have reviewed a number of qualitative studies on the therapeutic relationship and suggest that feeling understood enhances feelings of safety within the therapy relationship and facilitates self-disclosure.

Empathy as a facilitative factor in formulation. Cognitive formulation does not end following the initial information-gathering stage. As therapy proceeds, empathic attunement allows the therapist to notice clients' subtle communications, which provide information regarding their feelings and underlying belief systems. Examples could include their unspoken reticence to take part in certain behavioural experiments, their feelings about the therapeutic process, and any possible resistance to changing thoughts, feelings and behaviours (Leahy, 2001). Such information can inform the developing formulation. A clinical example could be an individual with relatively straightforward OCD who appears to be progressing in therapy until a particular session when the therapist discusses performing a behavioural experiment involving dropping neutralization strategies the following week. It is at this point that the empathic attunement, empathic stance and declarative knowledge about empathy and OCD combine to help the therapist notice the non-verbal communication that is saying anything other than the actual verbal agreement that is coming out of the client's mouth. This feeds directly into both the implicit and explicit formulation by the therapist, enhances her understanding of the patient, and allows a possible rupture to be addressed (e.g. by seeking feedback, probing and enquiring in a genuine fashion into the worries and concerns of the client, recognizing, reflecting and validating the emotional state of the client given their beliefs).

Empathy to enable "traditional" CBT techniques. It is difficult to imagine a CBT technique that is not enhanced by the experience of, and communication of empathy to the client. For example, whilst it is possible that a non-empathic therapist could work with a client to drop safety behaviours that are maintaining anxiogenic beliefs and subsequent problems (Thwaites and Freeston, 2005), it is likely to be far more effective if the therapist can communicate an awareness of how frightening this might be for the client, yet how ultimately worthwhile an experiment this might be. Imagine a client with panic disorder, terrified to enter a busy shop without carrying a bottle of water in case they start to choke. Showing

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no awareness of the client's thoughts and feelings, and encouraging them to leave the water at home, is less likely to be effective than explicitly communicating an understanding of the client's anxiety and beliefs about what might happen, but still encouraging them to test out the beliefs (Bennett-Levy et al., 2004). Other CBT techniques (e.g. automatic thought records, activity schedules, schema change strategies) may similarly benefit from empathic understanding and enhanced trust. In fact, some CBT techniques (e.g. agenda setting, seeking client feedback), if used correctly, may in themselves be tools to promote empathy.

Empathy in the maintenance of the therapeutic relationship. At some point, therapeutic relationships with patients with complex problems may experience a rupture or an impasse. Currently, there exist a number of models to work through such problems (e.g. Bennett-Levy and Thwaites, 2007; Safran and Muran, 2000; Safran and Segal, 1996), each of these requiring empathic skills to negotiate an effective resolution of the problem. For example, responding to a patient who feels dissatisfied that his needs are not met in therapy, despite them not being communicated directly as needs but as "neediness" (Safran and Muran, 2000) involves several empathic elements. Initially, empathic attunement is required to notice the perhaps subtle interpersonal markers of dissatisfaction, such as body language indicating emotional withdrawal or resignation, shame at feelings of neediness or anger at his needs not being met. With both an empathic attitude towards this patient, and empathic knowledge, (e.g. regarding the role of empathy in working through ruptures and conceptual knowledge), the therapist would be in a position to reflect on her own feelings and role in the situation before utilizing empathic communication skills to show a genuine understanding of the emotional state, cognitions and behaviours of the patient, thus validating this patient's response in the context of his developmental history and the therapy situation.

Empathy as a therapeutic agent. Whilst there is significant agreement that empathy is necessary for the "real business" of CBT to take place, there is also a growing recognition that empathy, validation and compassion can, in themselves, be therapeutic agents of change (Gilbert, 2005). All three elements appear to share an emphasis on helping patients change how they relate to themselves and their own experiences via a new experience or relationship with the therapist. In standard CBT terms, the relationship can be a way of people developing new beliefs about themselves, others and the relationship between them (Gilbert and Leahy, 2007).

It is likely that the requirement for empathy, validation, warmth and compassion, and how these need to be displayed, differs from patient to patient and are inextricably linked to the formulation of the patient's problems. In summary, however, these aspects of the relationship have been suggested to be therapeutic in themselves by reducing a sense of threat and, even more importantly, providing a sense of social safeness – both having conditioning implications and developing the patient's ability to represent the self as an object for introspection and as an individual accepted by others and with intrinsic value (Gilbert, 2007).

Implications for supervision and training of therapeutic empathy

While a full discussion of the implications for training and supervision of empathy is beyond the scope of the present paper, here we make two points. First, different components of empathy are likely to require specific training strategies for maximum effectiveness (Bennett-Levy and Thwaites, 2007; Burns and Auerbach, 1996). For instance, while reading and didactic teaching may be useful strategies to facilitate *Empathic knowledge*, in isolation

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they are poor strategies for enhancing *Empathic communication skills* or *Empathic stance*. *Empathic attunement* may benefit from specific strategies such as emotion and non-verbal communication recognition training; role-playing is particularly beneficial for the development of *Empathic communication skills*; and therapists beliefs and assumptions about empathy (*Empathic stance*) may be uncovered through use of therapist questionnaires (Leahy, 2001) and CBT techniques to identify cognitions.

Second, as indicated above, the development of empathy skills cannot be divorced from the development of the "person of the therapist". Whereas the acquisition of technical and conceptual skills in cognitive therapy do not need to make great demands on the "person of the therapist", personal development appears to be central to therapists' acquisition and refinement of empathy skills. Indeed, such is the impact of the "person of the therapist" on therapist interpersonal skills that cognitive therapists Dobson and Shaw (1993) have suggested that "the ability to build sound therapeutic relationships, based on our experiences, is an aspect of therapists' functioning that is relatively immutable over the course of training" (p. 575).

While this conclusion may be unduly pessimistic, as some forms of training may make a difference to elements of therapeutic empathy (Bennett-Levy et al., 2003; Shapiro, Morrison and Boker, 2004), the available data suggest that the best strategies to develop empathy skills in therapists have a direct impact on the person of the therapist (Bennett-Levy et al., 2003; Laireiter and Willutski, 2005; Macran and Shapiro, 1998). Other therapies (e.g. psychodynamic, gestalt) have long recognized the importance of personal development by making personal therapy a requirement (Geller, Norcross and Orlinsky, 2005). Despite occasional observations in the cognitive therapy literature about the importance of personal experiential work for therapist development (Beck, 1995; Padesky, 1996; Sanders and Wills, 2005), personal therapy or experiential training using cognitive therapy strategies on oneself is a formal requirement in only a few countries.

For CBT, the implication is that to the extent that training courses fail to incorporate self-experiential work or personal therapy into training, CBT trainers may be failing to develop empathy skills in trainees to the optimum extent.

Conclusion

The aim of this paper has been to pull together a somewhat disparate literature on empathy into a coherent theoretical framework that can provide a basis for clinicians, supervisors and trainers to think constructively about their clinical practice (e.g. empathy strengths and weaknesses and areas for development), and for researchers to develop measures of empathy that are more appropriate for CBT research. To date, the discussion of the role of empathy within CBT has tended towards a generic psychotherapy definition of empathy. Whilst our conceptualization of empathy overlaps with ideas from other therapeutic schools, it has specific implications for CBT, which can contribute to the refinement of clinical practice, supervision, training and research.

The present conceptualization contributes to our understanding of empathy in various ways. First, it makes a distinction between four elements of empathy – Empathic attunement, Empathic attitude/stance, Empathic communication, Empathy knowledge – which previous CBT (and non-CBT) literature has not adequately differentiated. Second, it highlights the role of the person of the therapist, and self-reflection, in empathic responding. Third, it suggests that, due to the nature of CBT formulations and intervention strategies, there are some unique features to empathy in CBT, which may account for the relatively stronger relationship between

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empathy and outcome in CBT compared with other psychotherapeutic orientations (Bohart et al., 2002). Fourth, it suggests that therapists may use different modes of processing to experience and communicate empathy, dependent on such variables as the complexity and strength of the client's emotion, the skill and experience of the therapist, and the problem formulation. Fifth, empathy has various functions in CBT, some shared with other therapies, and some more specific to CBT.

There are a number of potential benefits for therapists, trainers, supervisors and researchers resulting from this new conceptualization. The distinction between the four elements of empathy allows us more precisely to identify the locus of any deficits and target specific remediation strategies. For instance, difficulties with empathic attunement have quite different training and supervision implications from difficulties with empathic communication, or lack of knowledge about empathy (see Bennett-Levy and Thwaites, 2007).

The suggestion that empathic processing occurs at different levels (e.g. "natural" person of the therapist empathy, formulation-based empathy, combined person of the therapist/formulation-based empathy for complex emotions) may enable therapists to determine which levels they customarily use, and whether their use is appropriate. The role of the personal self and self-reflection in empathic processing and responding is critical. Difficulties or unwillingness to self-reflect may present major obstacles for the development of empathy (Bennett-Levy and Thwaites, 2007), while personal experiential work and self-reflection should enhance it (Bennett-Levy et al., 2003; Laireiter and Willutski, 2005).

The present conceptualization should help researchers to refine their measures. Current measures of empathy in CBT are either undifferentiated (e.g. the Cognitive Therapy Scale, Young and Beck, 1988), or relatively non-specific (Burns and Auerbach, 1996). This new model requires empirical testing in line with the emphasis within CBT on empirically-validated models. Although there is already initial support for aspects of the model such as the role of self-practice and self-reflection in the development of therapeutic empathy skills (Thwaites, Chaddock and Bennett-Levy, 2006), each of the key elements proposed and the relationship between them needs to be examined. The distinction between the four elements of empathy, and between different modes of processing may assist researchers to achieve greater specificity.

Knowledge of the functions of empathy can also help us to specify more precisely the focus of our interventions, and especially the role of the interpersonal process. The type of empathic communication, and the level of therapist skill required, will differ depending on the function of the communication. For instance, there is a considerable difference in both the level and type of skill required between empathic communication to enable CBT techniques, and empathy in the context of repairing a therapeutic rupture.

This paper has inevitably raised more questions than it has answered. For instance, we still do not know if there are some therapists' skills or abilities that cannot be developed. Whilst it seems that clinicians can be trained to communicate empathy at a basic level relatively easily, what about the individuals lacking in the ability to experience empathy for their clients – the individuals who are unable either to have a felt sense of the anxiety or sadness of their clients and/or to cognitively take the perspective of their clients? Dobson and Shaw (1993) suggest that there are some clinicians who lack empathy skills and will not attain maximal competence regardless of the amount of specific training. They advocate that relationship building ability should be a selection factor for training courses, but we are a long way from specifying either criteria or measures. A wide variety of individuals, with vastly differing experiences, are currently being trained in CBT, in much greater numbers than for any

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other formal psychotherapy approach previously. Empathic ability cannot be assumed to be a given.

The conceptual and technique-oriented focus of the CBT literature and of many training courses leaves the impression that CBT therapists only pay specific attention to the empathic process when there is negative feedback from the client. This new model provides CBT therapists with a framework for conceptualizing therapeutic empathy, and raises important questions about how it may be researched, trained and developed in clinicians.

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