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Empathy in Psychosocial Intervention: a theoretical overview

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Abstract

Empathy is a concept that is found in the lexicon of many of the 'helping professions' be it medicine, nursing, education or social work to name a few. It is a key element that determines professional competence and considered necessary for effective relationship based practice. Almost all training programs within the helping professions strive to incorporate this ability within the skills repertoire of budding professionals.

Empathy is not a new concept in practice and reference to it can be traced to the writings of early case workers. It has been considered to be vital in building trust and developing a relationship that will foster growth and change (Pinderhughes, 1979). Carl Roger's person centred approach envisages empathy to be one of the core conditions of the positive, purposeful and professional relationship that practitioners strive to establish with clients.

Empathy enables one to see external events through the client's eye lens and thus provides a near accurate subjective perception of distressful environmental stressors and the realities of the client's life situation. This is important to understand how oppression is experienced by the 'other' if one wants to help alleviate distress. Key tasks of capacity building, resource mobilisation and conscientization would only be possible if the practitioner has a near-accurate perception of the client's life scenario. While empathy is certainly a virtue in helping, there are also dangers associated with boundary cross over, an issue that practitioners need to be cautious about.

This paper looks at the nature, structure and types of empathy and examines its importance in psychosocial intervention. It explores its links with establishing rapport with clients, to resilience, social justice and empowerment; concepts which are of central concern to a psychosocial approach. Finally it discusses barriers in the manifestation of empathy and its relationship to compassion fatigue and burnout.

Key words: Psychosocial intervention, Social Justice, Resilience, Empowerment, Self, Professional Boundaries, Professional Relationships, Burnout, Compassion

Empathy in Psychosocial Intervention: a theoretical overview

"*No one cares how much you know, until they know how much you care*" — Theodore Roosevelt

Introduction:

Psychosocial interventions are non-pharmacological therapeutic interventions which address the psychological, social, personal, relational and vocational problems of people. These interventions draw techniques from cognitive behavioural therapies (CBT) and educational theories and are used for instance with people having mental health problems, substance misuse issues, HIV/AIDS, interpersonal adjustment difficulties and a host of other such issues. Empathy is a key ingredient in approaches that seek to understand people and their life situation. It refers to the ability to understand others by imagining what it might feel like to be them; how it might feel to experience the world by being in their shoes or from within their skin. Dymond (1949), one of the earliest writers to define empathy, refers to it as the 'imaginative transposing of oneself into the thinking, feeling, and acting of another and so structuring the world as he does.' Empathy toward others enhances emotional well-being, interpersonal relationships, and life success (Mehrabian, 1996). Empathy is also claimed to be central in promoting pro-social behaviour through increasing positive, helping and thoughtful actions (Natale & Sora, 2010). In fact, it is seen as the glue that holds society together, the capacity without which humans would not have evolved (Fuchsman, 2015).

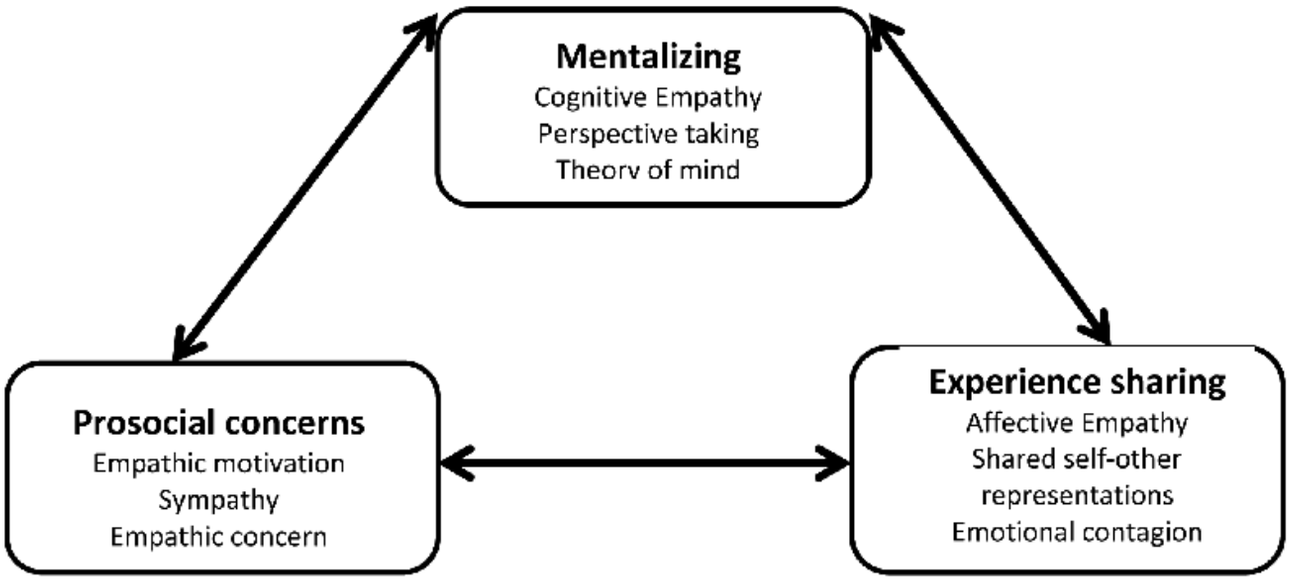
Empathy: its nature and structure

Empathy is the act of perceiving, understanding, experiencing and responding to the emotional state and ideas of another person (Barker, 2003). While it is possible to understand another person without feeling with him, true empathic skill includes the capacity for an emotional response (Shantz, 1975). Rogers explains empathy as sensing 'the client's private world as if it were your own, but without ever losing the 'as if' quality (Rogers, 1957). This implies that though the practitioner strives for a near accurate perception of the client's inner world, he does so without losing his own objectivity and in this sense brings to his perception a degree of detachment. Truax (1967) states 'it is not necessary- indeed it would seem undesirable-for the therapist to share the client's feelings in any sense that would require the therapist to feel the same emotions that the client feels.' According to Cooper (1970) the practitioner 'temporarily feels at one with the object while maintaining his individuality.'

Empathy has been described as vicarious introspection (Kohut, 1959). This implies that the practitioner penetrates the inner world of the client while simultaneously reflecting on the feelings that this transposition evokes in him.

Empathy has been conceived variously by different authors; to be a dispositional trait or personality attribute (Martin & Clark, 1982), a situation-specific cognitive-affective state (Duan & Hill, 1996), as a 'facilitative communication skill' (Carkhuff, 1969) and as a interpersonal and experiential process (Barrett-Lennard, 1981).

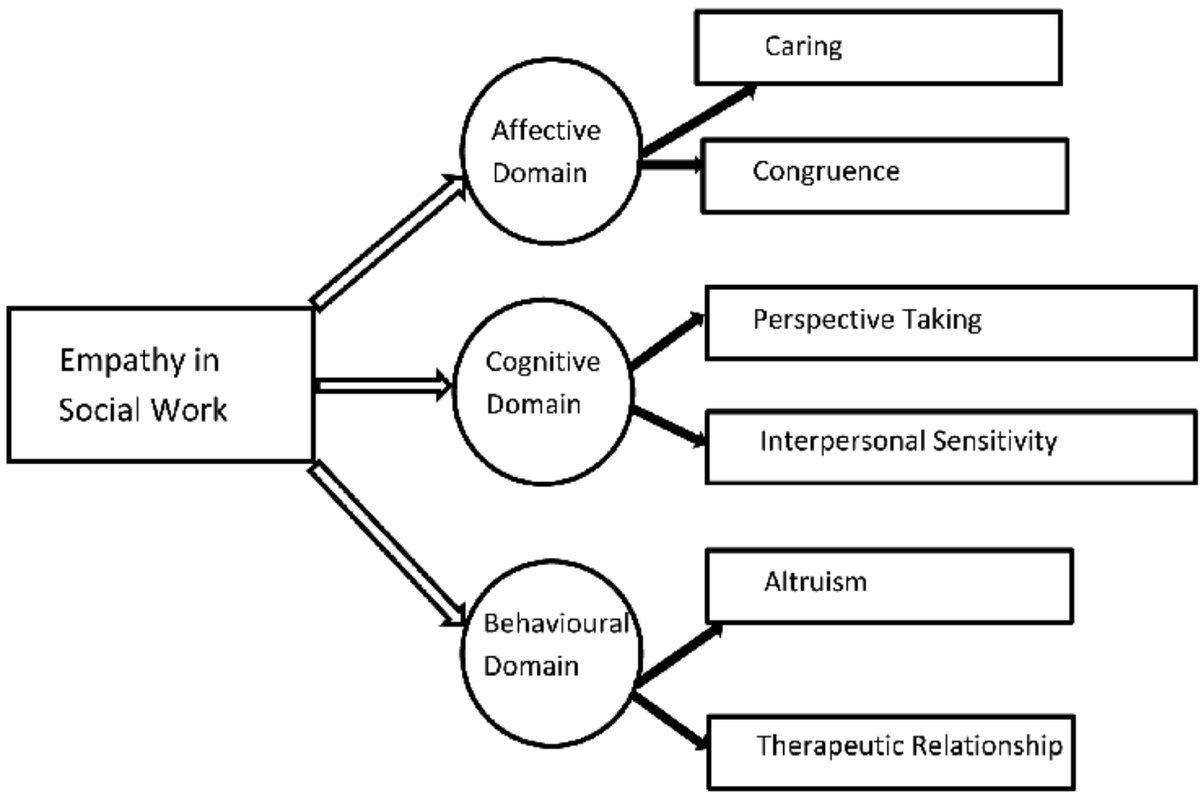
Figure 1: The process of empathy: from Zaki & Ochsner (2012)



Zaki & Ochsner (2012) hold that empathy comprises of two related but distinct processes through which 'perceivers' (individuals focusing on another person's internal states) relate to 'targets' (individuals who are the focus of perceivers' attention). They have grouped the processes that underlie empathy into three broad classes depicted in Figure 1 alongside some allied terms from the literature. The three classes include (i) experience sharing: vicarious sharing of targets' internal states (Gallese, Keysers & Rizzolatti, 2004). (ii) mentalizing: explicitly considering (and perhaps understanding) targets' mental states and their sources (Leslie, Friedman & German, 2004) and (iii) prosocial concern: expressing motivation to improve targets' experiences (for example, by reducing their suffering) (Batson, 2011).

Empathy has been considered to include two basic components: the affective component or the matching of affective experience between a participant and a target individual; and the cognitive component, which is concerned with the ability to take the perspective of others (Lian & Lieberman, 2009).

Figure 2: Conceptual framework of empathy in social work practice (Adapted from King, 2011)



Empathy: a framework

A framework to understand empathy in social work practice envisages two primary domains viz. affective and cognitive and together lead to behavioural expressions (King, 2011). These three dimensions are broken down into six underlying constructs drawn from the extant literature (Figure 1). The affective dimension includes the constructs of caring and congruence. Professional caring is a form of interpersonal communication whereby one applies the content and principles of a specified knowledge area (e.g., counselling) within the context of a professional relationship for the purpose of rendering a service designed to improve the human condition (Knowlden, 1998). Congruence was proposed as a core condition by Rogers and refers to being open, non-judgemental and honest within the helping relationship (King, 2011). The cognitive dimension of empathy involves IS, intellectual flexibility, and openness to understanding the experiences and taking the perspectives of another. The second construct of cognition, perspective taking, is the ability to accurately perceive another's point of view (Davis, 1980). This involves the internal and cognitive interpretation and understanding of another's mental and emotional state. Behavioural manifestations of empathy involve interpersonal motivations and actions and they demonstrate functional aspects of empathy and its concrete applications within helping relationships. Altruism and the therapeutic relationship are the two constructs within the behavioural dimension. Altruism has been defined as a "motivation to benefit others" by Batson (2002) and as an action where the goal is to benefit others without any expectation of reward or benefit in return (Monroe, 2002).

Empathy versus sympathy and compassion

The terms compassion, empathy, altruism, and other similar terms (connectedness, compassionate love, agape) have sometimes been used interchangeably, but refer to somewhat different but possibly over lapping phenomena (Monroe, 2002). Sympathy is important in human relationships as an expression of concern or sorrow about distressful events in a person's life (Monroe, 2002). Through the consideration of four comparative dimensions in the

counselling experience--aim, appraisal, apprehension, and agreement, empathy has been distinguished from sympathy (Meier & Davis, 2008). In terms of aim, the primary intent in employing empathy is to express understanding of a client (Clark, 2010), whereas a sympathetic response has the more circumscribed function of expressing compassion for an individual's distressful condition or situation (Eisenberg, 2000). From the point of appraisal, empathy entails attunement with a client's feelings and meanings (Pearson, 1999) while sympathy is a reaction to a client's distress that becomes manifest in mild to intense expressions of feelings of sorrow for an individual's plight (Gribble & Oliver, 1973). In terms of apprehension, a deeper way of knowing an individual is more likely to occur when a practitioner attempts to empathically understand a client from multiple perspectives (Switankowsky, 2000). For instance, through their identification and imaginative capacities practitioners can subjectively apprehend what clients are experiencing. In contrast, when expressing sympathy it is not necessary to "enter into" a client's experiencing or to have a deeper knowledge of the person and it is possible only to have a general understanding of a client's plight and still be able to be sympathetic (Clark, 2010). Finally in terms of agreement, accurate and appropriate use of empathy involves expressing an empathic understanding without implying agreement with the client. In contrast, in expressing compassion and commiseration, it is possible to sympathetically convey agreement with the views and perspectives of a client (Gribble & Oliver, 1973). Sympathy may carry connotations of 'looking down' on somebody and pitying them for the plight they are in and may distort the egalitarian nature of the relationship which practitioners strive to establish.

Compassion is considered to be more active than empathy in the sense that it involves a tendency for action. Lilius et al. identify three elements of compassion, 'noticing another person's suffering, empathically feeling that person's pain, and acting in a manner intended to ease their suffering' (Egan, 2010). The connection to suffering is seen in theoretical and empirical analyses of compassion and this is also common to empathy as well as altruism (Lilius, et al., 2008).

Common to the concepts of empathy, altruism and compassion is the importance placed on the replacing of self-concern with concern for others and expressing empathy, as opposed to sympathy, is more objective and accurate, intellectual rather than emotional, altruistic, requires more effort but conserves energy, has more positive effects on the clinician (such as personal growth and career satisfaction), and leads to better patient health outcomes (Martins et al., 2013).

Relationship in psychosocial intervention

The therapeutic relationship is the medium which facilitates exploration of issues, provides hope and nurturance and is the channel through which strategies for intervention are introduced. The nature and quality of the therapeutic relationship has been established as an important variable in determining outcome (Ardito & Rabellino, 2011). It has been acknowledged that client growth depends on the qualities of the helping alliance, and this is a defining variable of the profession (Biestek, 1957). A productive helping alliance is one in which a helper is accepting, non-judgmental, supportive, and empathic (Lambert & Barley, 2002). Empathy is envisaged to be essential in building trust and developing a relationship that will foster growth and change (Pinderhughes, 1979). Effective practice depends on the interpersonal and empathic skills of the practitioner (Turner, 2009). Empathy is central with regard to the personality of the therapist as well as being important for skilful therapeutic communication (Duan & Hill, 1996).

Empathic responses in the helping process bring benefit to both actors in the relationship. It conveys to the client that the professional is 'there' not only listening to him but 'with' him in terms of understanding his perceptions of distress. Empathy may, in itself, have a therapeutic effect, may contribute to relieving patients' distress, and may contribute to the deepening of the therapeutic bond (Jurkovitch, Pananen & Rivara, 2000). It has been found to have strong positive therapeutic effects on service users' physical, mental and social well-being (Morrison, 2007). It also conveys to the client a sense that he is not alone in dealing with his difficult circumstances and that there is a concerned 'other' who is keen to enable him deal with his situation. Empathic responses strengthen relationship with the client, breaking down defensive behaviours and enlisting client participation in the process. It provides a medium

for the practitioner to demonstrate concern, offer reassurance and to sustain client engagement. It thus also becomes an important tool with which to collect accurate information from the client which would then enable the formulation of a holistic assessment and potentially lead to effective strategies of intervention. Empirical evidence points to empathy being an important tool for positive therapeutic intervention (Watson, 2002). Empathy has been identified as the single most consistent condition of a productive therapeutic relationship in outcome research (Sinclair & Monk, 2005).

Empathy and the 'self'

Self-awareness plays a key role in empathic experience as one becomes aware of the feelings and emotional state of others in relation to one's own emotional disposition. There are two view points within the literature on this relational perspective. The first considers empathy as being a result of identification that blurs the distinction between the self and the other (Lerner, 1980). Empathy does not simply entail the matching of feelings, but the adoption of feelings that are more congruent with the other's situation than with one's own (Hoffman, 2000). The second view point considers empathy to result from a 'self-other distinctness' as it allows one to recognise the particularity and uniqueness of the other (Batson, et al., 1997). It would appear that while both experiences relating to the 'self' are different vis-à-vis the manifestation of empathy, they are both important in the context of professional relationships. The astute practitioner would attempt to get as close to the client's inner world as possible while at the same time maintaining an emotional distance. The latter is important to preserve one's own well-being and to prevent compassion fatigue and burn out.

Four empathic behaviours characterise the expression of empathy (Keefe, 1976). The first requires perceiving accurately the client's gestalt. The second involves allowing a direct feeling response to arise. Third the practitioner needs to keep distorting cognitive processes in abeyance, and finally an ability to separate one's own feelings from those shared with the client. Accurate and appropriate feedback needs to complement these processes and the professional needs to convey his understanding of the client's state back to him with sensitivity and in a non-hurtful manner. Empathic behaviour requires the worker to be receptive and to transmit accurately to the client his awareness of the client's state of being. Empathy in students has been found to have a positive correlation with self-awareness (Stanley & Bhuvaneswari, 2016a)

Resilience

Resilience refers to positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity (Wald et al., 2006). The nature of psychosocial intervention requires practitioners to be high on resilience in order to be able to often deal with elevated levels of distress that is often manifest in their clients, which is likely to have adverse implications for their own mental health and well-being. Resilience has the potential to buffer the negative impact of work stress, especially in challenging working environments (Howard, 2008). In this sense resilience is a particularly important quality for practitioners, as it may help them adapt positively to stressful situations and enhance their professional growth (Howe, 2008). A study of trainee student social workers found that empathetic concern (feelings of warmth, compassion and sympathy) enhanced stress resilience and that empathetic distress (anxiety and discomfort that result from observing another's negative experience) may diminish it (Kinman & Grant, 2011). A study from India shows that entrants to the social work degree and those in the final year of their course experience more stress and anxiety when compared to students in the second year (Stanley & Bhuvaneswari, 2016b). These studies emphasise the importance of building resilience in students training to serve the helping professions. It is thus important that practitioners develop clear emotional boundaries to ensure that healthy empathetic concern does not spill over into empathetic distress, which is likely to have negative implications for clients as well as themselves.

Compassion fatigue and Burnout

Compassion fatigue refers to the negative consequences of working with traumatized clients and vicariously experiencing the effects of their traumatic life events (Harr & Moore, 2011). It tends to occur as a result of exposure

to client suffering and can be complicated by a lack of support at work or at home (Figley, 1995). It may also be caused by the moral stress or distress caused by the need to resolve ethical and value conflicts in practice that are often encountered when dealing with clients (Forster, 2009). Empathy for clients may contribute to the risk of compassion fatigue among experienced professionals and it may pose an even greater threat to inexperienced students who initiate their practice during field placement without the benefit of the mediating factors of practice wisdom and experience (Harr & Moore, 2011). Compassion fatigue can result in the caregiver experiencing a reduced capacity for or interest in being empathic (Adams, Boscarino & Figley, 2006). The use of self/other-awareness, emotion regulation, and perspective-taking skills maximize resiliency and allow for empathic engagement with clients that minimizes aversive responses such as compassion fatigue or secondary trauma (Thomas & Otis, 2010).

It is important to distinguish between burnout and compassion fatigue while recognizing that they may share similar symptoms (Harr & Moore, 2011). Burnout is defined as a psychological syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occurs among individuals who work with other people, particularly in conflicting or otherwise critical situations (Maslach & Schaufeli, 1993). Affective sharing is crucial in all the helping professions, but as documented in the literature, can also lead to emotional and physical burnout (Eisenberg, 2000). Burnout is not limited to those who work with the traumatized and tends to occur over a prolonged period of time and can be caused by conflict between individual and organizational demands, an overload of responsibilities, a sense of being denied decision-making input, little financial reward and positive recognition, lack of status or respect in the workplace, lack of job fulfilment, or reduced sense of accomplishment and achievement (Harr & Moore, 2011). Compassion fatigue may be treatable, while burnout may result in the necessity of a job or career change (Sabin-Farrell, & Turpin, 2003). A practitioner who cannot turn off the empathic awareness of a client's despair or anxiety after the workday, may experience emotional burnout (Gerdes & Segal, 2011). The high levels of stress and burnout experienced by social workers have been found to contribute to the growing retention problems within the profession (Kinman & Grant (2011).

Social empathy: links to social justice and empowerment

Psychosocial approaches often focus on the alleviation of needs and mobilisation of resources for marginalised and vulnerable individuals and groups and this requires an empathic understanding of their life situation, needs and priorities. Social empathy is the ability to understand people by perceiving or experiencing their life situations and as a result gain insight into structural inequalities and disparities (Segal, 2011). It is thus an extension of empathy to larger social groups which are vulnerable and exposed to oppressive experiences owing to structural inequities or negative attitudes directed towards them by the majority. An appreciation of difference and diversity and minority experiences would be facilitated through the promotion of social empathy. This then is a prerequisite if practitioners have to engage with advocacy, rights campaigns and social action on behalf of these groups to initiate social change. Empathy is an important contributor in strengthening social interaction through its ability to motivate individuals to cooperate, to share resources and to help others (Van Lange, 2008).

Social empathy has been conceived to be a combination of self-reflection and an accurate perspective or understanding of the underlying causes of social problems that can potentially lead to empathic action to improve societal well-being (Segal, 2011). Social empathy promotes not only a tolerance of people and their diverse cultures but also a more deep seated acceptance and non-judgemental attitude towards their uniqueness, all of which are values cherished by the helping professions. Thus stigma towards particular social groups, their behaviour and other associated atypical features and the social alienation experienced by them can be reduced to a large extent. A social empathic perspective from a macro-context can enable the development of services and policies that are socially and economically just, sensitive to people's needs, and based on the realities of actual situations (Gerdes, 2011) and can thus enable a non-discriminatory approach to promote the welfare of the marginalised.

Barriers to empathy

Cognitive distortion includes stereotyping, making value judgments, or analysing perceptions according to a fixed theoretical schema can interfere with a practitioner's ability to empathise with others (Keefe, 1976). A belief in the superiority of the 'professional self' and the 'I am the expert' complex and a fear of letting go some degree of power could be a barrier that prevents practitioners from entering into honest, open and egalitarian relationships with clients. The fear of over identification and the caution exercised in maintaining rigid professional boundaries could also interfere with the establishment of spontaneous and genuine relationships and limit the experience of empathy. A moralistic perspective on social issues about what is right and appropriate could limit acceptance of the other and curtail the expression of genuine empathy. Other external barriers such as high case loads and the pressure of time, resource constraints, work place frustrations and an increasingly bureaucratic ethos are some external factors that could undermine practitioners' ability to empathise. Cultural, racial, ethnic and socio-economic differences can also contribute to the gulf between the professional and the client. In the context of medical education, some barriers to empathic practice are owing to lack of appropriate role models, failing to teach empathy as a cognitive skill, negative experiences, time pressures and an overreliance on technology (Hojat et al., 2009).

Conclusion

Empathy clearly is perhaps one of the most important skills that psychosocial workers bring to their relationship with clients. Judicious use of empathy is mutually beneficial to both client and practitioner and quintessential in furthering the helping process. Education programs need to ensure that training goes beyond theoretical orientation to empathy, to ensure that skill inculcation activities are used to incorporate this vital aspect in the repertoire of budding professionals. The importance of helping students to develop their emotion management and social skills in order to enhance well-being and protect them against professional burnout has been highlighted. In conclusion, it is appropriate to quote Pink (2006) who says that 'sometimes we need detachment (objectivity); many other times we need attunement (receptivity) and the people who will thrive will be those who can toggle between the two.'

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