Advancing Empathy Skills in Doctoral Training: A Comprehensive Literature Review

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Abstract

Empathy is an interpersonal skill that allows people to interact, communicate, and develop meaningful relationships. The foundation of psychological interventions lies in the relationships built between psychologists and their clients. Psychologists' abilities to provide empathy and understanding to their clients play a significant role in the results of therapeutic interventions. Despite the importance of teaching empathy skills to developing psychologists, there is a lack of training available in doctoral-level psychology programs that specifically focuses on actively fostering these skills. The present study's focus was on identifying how to increase empathy skills in students enrolled in doctoral-level psychology programs.

Relationships are a foundation for psychology practice, and a psychologist's abilities to form effective interpersonal relationships are significant in demonstrating professional competency (American Psychological Association [APA], 2012a; National Council of Schools and Programs in Professional Psychology [NCSPP], 2007). Competent psychologists develop positive and effective relationships in order to provide the highest standards of care to their clients. The collaboration between psychologist and client—the therapeutic alliance—is one of the most important aspects of therapeutic intervention. The nature of the therapeutic alliance is a reliable predictor of the efficacy of treatment interventions (Cottone & Tarvydas, 2016; Hook, Davis, Owen, & DeBlaere, 2017; Nezu, Nezu, & Colosimo, 2015; Weck, Grickscheit, Jakob, Hofling, & Stangier, 2015).

Empathy is an interpersonal skill that plays a significant role in establishing, developing, and maintaining effective interpersonal relationships with others and factors into better service delivery, greater client satisfaction, and increased client compliance with treatment plans and goals (Berger, 2014; Sultmann & Burton, 2003). A psychologist's ability to be empathic in therapeutic interventions promotes positive change and strengthens therapeutic relationships and the working alliance (Bean, Davis, & Davey, 2014; Decety & Michalska, 2010; Gair, 2013; Kitron, 2011). Psychologists with strong empathy skills have been shown to achieve better outcomes than psychologists with limited empathy skills, regardless of treatment modality (APA, 2017; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Bean et al., 2014; Davidson, 2015; Decety & Michalska, 2010; Feller & Cottone, 2003; Gair, 2013; Hook et al., 2017; Nezu et al., 2015; Patterson, Anderson, & Wei, 2014; Sackett & Lawson, 2015; Teding van Berkhout & Malouff, 2016; Wampold, 2011; Weck et al., 2015).

Positive and effective interpersonal skills facilitate understanding others' perspectives, their desires, how they experience and explore their world, and how they meet their needs and achieve goals. Empathy is an important element of interpersonal relationships that facilitates the sharing and understanding of the experiences of others and increases an individual's abilities to relate to others in a meaningful way (Bean et al.,

2014; Carkhuff, Berenson, & Tamagini, 2009; Decety & Michalska, 2010; Gair, 2013; Hook et al., 2017; Kitron, 2011). How a psychologist communicates and interacts with a client initially and throughout therapy directly impacts how the client perceives, experiences, engages in, and benefits from therapy, which is significant in the development of effective therapeutic relationships (Cottone & Tarvydas, 2016; Hook et al., 2017; Wampold, 2011; Weiner, 2016; Weck et al., 2015).

Professional Competence

To help doctoral students become competent psychologists, doctoral psychology programs aim to provide education and training that meet competency standards conceptualized and established by the NCSPP and APA. To ensure that doctoral psychology programs provide the highest standard of education and training that will ultimately produce well-trained and competent psychologists, the APA has based their accreditation standards on these established competencies and guidelines. The APA's Commission of Accreditation (CoA) rigorously evaluates and reviews doctoral programs based on these standards in order to award professional accreditation. (APA, 2017). The goals of accreditation are to evaluate, enhance, and recognize the quality of psychology programs with the intentions of improving the quality of teaching, learning, research, and practice (APA, 2017). The APA and NCSPP both identify interpersonal relationships in all professional roles as a core competency expectation for professional psychologists, and empathy is identified as a skill necessary for developing effective relationships.

The NCSPP outlines standardized competency guidelines for professional psychologists in the *Competency Developmental Achievement Levels* (NCSPP, 2007). The NCSPP competency model of education and training describes seven competency expectations for practicing psychologists: relationship, assessment, intervention, diversity, research/evaluation, management/supervision, and consultation/education (NCSPP, 2007). The NCSPP (2007) suggests that education and training that enhance relationship competency should include a focus on developing interpersonal relationship skills, including empathy. The knowledge, skills, and attitudes associated with relationships include: (a) theories of individual systems functioning and change, (b) knowledge of the self, (c) knowledge of others, (d) intellectual curiosity and flexibility, (e) open mindedness, (f) belief in the capacity for change in human attitudes and behavior, (g) appreciation for individual and cultural diversity, (h) personal integrity and honesty, and (i) a value of self-awareness (NCSPP, 2007).

In the *Standards of Accreditation for Health Service Psychology* (SoA; APA, 2017), the APA identifies competency benchmarks that doctoral-level psychology students are expected to develop during their training. Psychologists are expected to demonstrate competence in research; ethical and legal standards; individual and cultural diversity; professional values, attitudes, and behaviors; communication and interpersonal skills; assessment; intervention; supervision; and consultation and interprofessional/disciplinary skills (APA, 2017). The SoA competencies are identified and evaluated to ensure quality education for psychologists and that psychologists possess the necessary knowledge, skills, attitudes, and values that contribute to competent and safe practice. Knowledge refers to discipline-specific knowledge an individual must have to achieve profession-wide competencies. Doctoral psychology programs must

provide students with the ability to demonstrate competencies through coursework and other didactic training. Programs must also provide activities that promote opportunities to demonstrate skills that meet profession-wide competencies such as delivering psychological services, teaching classes, or supervising others. Professional psychology attitudes and values include demonstrating concern for the welfare of others, accountability, integrity, professional identity, deportment, and lifelong learning. Students should be able to show competency in professional and personal self-reflection and engage in activities that enhance well-being, professional effectiveness, and performance; actively seek and demonstrate responsiveness and openness to supervision and feedback; and progressively increase abilities to independently respond to complex situations (APA, 2017).

The APA (n.a.) identifies interpersonal professional relationships as an important factor for evaluating professional competency and states that psychologists should also demonstrate communication and interpersonal skills competencies related to developing and maintaining effective interpersonal skills and professional relationships and providing and understanding written, verbal, and nonverbal communication. The APA's Interpersonal Professional Relationship Competency Rating Form identifies important aspects of relationships as follows: (a) empathy, compassion, and desire to help; (b), experience and use of affect; (c) affect tolerance; (d), effective boundary management; (e) recognizing effects on self and others; (f) respectful interactions with others; (g) demonstrating effective interpersonal skills in challenging situations; (h) openness to providing and receiving feedback; (i) cooperation and collaboration; (j) expressive skills; and (k) awareness of and commitment to interpersonal competence (APA, 2012c).

Furthermore, professionally licensed psychologists receive comprehensive doctoral-level education and training in both foundational knowledge and skills essential for the practice of psychology. Licensed psychologists demonstrate competency through rigorous examinations, postgraduate training, and by successfully passing national and state licensing examinations. In addition, it is an ethical obligation that licensed psychologists act in accordance with the APA's *Ethical Principles of Psychologists and Code of Conduct*, relevant laws and regulations governing health service psychology, and relevant professional standards and guidelines (Cottone & Tarvydas, 2016). The APA provides ethical codes and guidelines psychologists should follow to provide and maintain the utmost respect for the welfare and protection of the individuals with whom they work. Professional psychologists are to hold a personal commitment and lifelong effort to conduct themselves ethically and to encourage ethical behavior in others, including students, supervisees, and employees (APA, 2010).

The APA outlines ethical standards related to competency in the *Ethical Principles of Psychologists and Code of Conduct* (2010). Ethical standards related to competence are identified in Section 2 and include (2.01) Boundaries of Competence, (2.02) Providing Services in Emergencies, (2.03) Maintaining Competence, (2.04) Bases for Scientific and Professional Judgments, (2.05) Delegation of Work to Others, and (2.06) Personal Problems and Conflicts. Maintaining one's professional competence is therefore an important element of the ethical practice of psychology as reflected in these standards. Such maintenance requires psychologists to make substantive efforts throughout their training and their careers to develop and maintain competencies related

not only to knowledge of applied practice and research but also skills essential to interpersonal effectiveness.

Maintaining competence is therefore an important obligation, and psychologists are expected to undertake ongoing efforts to develop and maintain their knowledge, skills, and attitudes essential to the practice of psychology (APA, 2010). As such, the emphasis on competency is foundational in one's education, training, licensure processing, and ethical practice. Because these competencies are at the center of the practice of psychology and are essential for licensure, doctoral-level programs are expected to provide students and trainees the appropriate knowledge and experiences for developing them.

Implications of Poor Interpersonal Skills

Empathy can be one of the most difficult skills for psychologists to teach, apply, and retain. Training in graduate psychology programs for increasing positive and effective interpersonal relationship skills is lacking. Methods that can increase these skills are not explicitly integrated into clinical psychology training program curricula (Feller & Cottone, 2003; Hojat et al., 2002).

Interactions between therapists and clients can affect clients' feelings about themselves and their therapists (Pavord & Donnelly, 2015). In fact, clients have reported poor relationships with providers as a more significant treatment barrier than the provider's expertise and skill set (Pavord & Donnelly, 2015). Psychology students should develop, practice, and enhance interpersonal relationship skills throughout their training and career because it directly affects treatment effectiveness and success (Pavord & Donnelly, 2015).

A lack of positive responses from a psychologist can send clients negative messages, create stress, and lead to feelings of rejection, worthlessness, and devaluation (Pavord & Donnelly, 2015; Sultmann & Burton, 2003; Wright, 2007). Positive interactions with psychologists allow individuals to feel valuable and important to others. A psychologist's ability to show interest in clients' perceptions and experiences without judgment or bias facilitates trust and rapport and is important in building positive therapeutic relationships. Strong therapeutic alliances are important and necessary in therapy, and trust in mental health service providers is essential for successful treatment outcomes (Decety & Michalska, 2010; Hook et al., 2017; Kitron, 2011; Weiner, 2016).

In its guidance on competency benchmarks, the APA (2012a) states that "Trainees with competence difficulties are often reported to have particular problems with relationships" (p. 14). Because of the difficulties graduate psychology students appear to have with relationships, the APA developed the Interpersonal Professional Relationships Rating Form (2012c). This form includes a more comprehensive outline and evaluation of relational skills and competencies than is included in the competency benchmarks evaluation system (APA, 2012b). Acknowledging the significant problems students appear to have in developing relationship competencies is an important step toward identifying a greater need to develop these skills; however, it would be beneficial to take further steps that provide guidance on how to teach interpersonal skills and empathy in doctoral psychology programs. Integrating methods for fostering interpersonal relationships into doctoral programs could help to address students' relational strengths

and weaknesses. More robust training should be available and implemented in psychology training programs because these skills can significantly affect therapeutic alliances and treatment outcomes (Bean et al., 2014; Casas et al., 2017; Decety & Michalska, 2010; Edwards, 2013; Fernandez-Olano, Montoya-Fernandez, & Salinas-Sanchez, 2008; Gair, 2013; Ogle, Bushnell, & Caputi, 2013; Teding van Berkhout & Malouff, 2016).

Decreased empathy due to stress associated with educational and training demands, experiences of vicarious trauma, and other personal experiences that may cause distress can lead to compassion fatigue and burnout, can have significant negative effects on interpersonal relationships, and may lead to poor treatment alliances and outcomes (Rosenfield & Jones, 2004). In addition to increasing empathy and relationship skills to help build stronger therapeutic alliances, empathy training may decrease the effects of burnout and compassion fatigue and increase students' understanding and awareness of the harm that can be caused when empathy-enhancing skills are not practiced. Specific training on these issues may be beneficial for enhancing professional competency among students and trainees.

Inclusion in Doctoral Curriculums

Empathy is a significant factor in the ethical and effective practice of psychology and should be built into doctoral psychology education and training programs with equal importance as other competencies. Understanding the importance of empathy and its influence on relationships can also facilitate more client-centered conceptualizations about their experiences and perspectives. Increasing psychologists' abilities to understand and appreciate clients' perceptions, beliefs, and values that shape their experiences and views of the world around them is crucial in therapeutic intervention. Greater awareness and understanding of the importance of various aspects of empathy and how empathy can impact the therapeutic alliance may increase students' interpersonal relationship competencies.

Competent psychologists are motivated to make efforts to enhance and maintain professionalism and will pursue opportunities for professional growth throughout their careers (Caspar, 2017). Because empathy skills can be applied to all areas of one's life, practicing and applying effective empathy skills will likely become a part of who psychologists are in both clinical and personal environments. Learning to meaningfully incorporate empathy skills into professional relationships can also develop into an internal process that is used throughout all situations and experiences. Empathy skills can strengthen interpersonal interactions and contribute to positive and effective relationships with clients as well as others; for example, supervisors, interdisciplinary professionals, and other colleagues.

The research included in this study reflects the NCSPP's (2007) relationship and the APA's (2017) interpersonal skills domains. However, all domains of expected competencies are in some way integrated with these specific domains. For example, having strong interpersonal skills contributes to the APA's professionalism benchmark because this benchmark requires an understanding, communication, and demonstration of professional values, cultural diversity, ethics, and self-awareness and self-care. Additionally, the APA research and application benchmarks necessitate evaluating

effectiveness of professional activities and evidence-based methods (APA, 2012b) which fundamentally include the foundational working alliance. These APA benchmarks are congruent with NCSPP's development achievement levels of research and evaluation, intervention, and assessment.

What is Empathy?

Empathy is generally described as the ability to see things from another's point of view, both cognitively and emotionally, and is a significant aspect of interpersonal relationships (Dethier & Blairy, 2012; Ferrari, Smeraldi, Bottero, & Politi, 2012; Gair, 2013; Khanjani et al., 2015; Meneses & Larkin, 2012; Van der Graaf, Branje, De Wied, & Meeus, 2012). Empathy involves insight into another individual's emotional state and requires a motivation to understand the other's experience as it is for that individual (Decety & Michalska, 2010). The ability to understand one's own behavior and the behaviors of others in terms of feelings, thoughts, wishes, and desires is a process referred to as mentalization (Feenstra, Luyten, & Bales, 2017). A psychologist's ability to mentalize in therapeutic relationships increases empathy skills as it provides greater appreciation for the experiences of others. Mentalization is the capacity to differentiate between one's internal world and external environment based on the understanding that people have different perspectives and views of the world (Yusof & Carpenter, 2015).

Further examination of empathy, its components, and how these components affect interpersonal relationships is important. It is also important to not only examine how clients understand, experience, and express empathy but also how the therapist does the same while simultaneously understanding and responding to the client's expression of empathy. These processes are valuable in bringing to light the possible features related to good or poor empathic abilities (Marshall & Marshall, 2011).

Understanding emotion is an extremely complex process that requires the ability to comprehend various aspects of emotional experiences through cognitive and affective processes (Belacchi & Farina, 2012; Khanjani et al., 2015). The ability to share another's emotional state while simultaneously knowing and understanding the differences between one's emotional state and that of another is an important skill in relationship building (Dethier & Blairy, Ferrari et al., 2012; Gair, 2013; Khanjani et al., 2015; Meneses & Larkin, 2012; Van der Graaf et al., 2012). Cognitive and affective processes, or thinking and feeling, are two separate but interrelated processes that contribute to the various qualities of empathy previously mentioned. Empathy can be better understood when broken down into these two important elements. Defining the differences between cognitive and affective empathy is important in understanding how individuals' empathy skills may differ and why or how they may differ (Dethier & Blairy, 2012; Cassels, Chang, Chung, & Birch, 2010; Ferrari et al., 2014; Marshall & Marshall, 2011; Munoz, Qualter, & Padgett, 2011; Smits, Doumen, Luyckx, Duriez, & Goossens, 2011; Van der Graaf et al., 2012).

Cognitive Empathy

Cognitive empathy refers to knowing why and how others have certain feelings and emotions (Munoz et al., 2011; A. Smith, 2009). It requires perspective taking or the ability to recognize and identify someone else's feelings and emotions. Perspective taking is a component of cognitive empathy that denotes the inclination to spontaneously

understand the mental state of another (Dethier & Blairy, 2012; Ferrari et al., 2014; A. Smith, 2009; Smits et al., 2011).

Perspective taking is significant in that it gives rise to empathic and sympathetic responses and involves sharing emotions and emotional meanings (Decety & Michalska, 2010; A. Smith, 2009; Smits et al., 2011; Teymoori & Shahrazad, 2012). Cognitive empathy uses a process called theory of mind (ToM), a necessary component of perspective taking (Cassels et al., 2010). ToM is the ability to not only understand that people have different beliefs, motivations, knowledge, and moods but also understand how these factors affect the actions and behaviors of the individual as well as the observer (Smits et al., 2011).

Cognitive empathy includes the ability to knowingly separate one's own reactions from how the other may be feeling at that time (Meneses & Larkin, 2012; A. Smith, 2009). It requires the ability to acquire knowledge about others' experiences without allowing one's own response or reaction to these experiences interfere with the understanding of what these individuals are experiencing (Meneses & Larkin, 2012). The ability to know and understand what an individual is feeling while at the same time identifying it as the individual's emotional state, which is separate, is a part of the cognitive empathic process (Meneses & Larkin, 2012). Recognizing emotions is an important part of empathy and allows an observer to respond empathically in different situations (Belacchi & Farina, 2012).

Affective Empathy

Affective empathy, sometimes referred to as emotional empathy, is characterized by feeling the emotions of others and is thought to be learned through mimicry and simulation (Khanjani et al., 2015; Munoz et al., 2011). Mimicry is a reaction to another's emotional expression in which an individual observes the expression of emotion of another, and that emotion is then mimicked by the observer in a spontaneous and contagious manner (Hofelich & Preston, 2012). Affective empathy facilitates the ability to share emotions and feel one's own emotional responses to the emotional experiences of others. The empathizers' emotions do not have to be the same as the people they are empathizing with, but these feelings should match with the other's circumstances (Cassels et al., 2010; A. Smith, 2009; Ze, Thoma, & Suchan, 2014). For example, one might feel anger as an empathic response to seeing a child physically hurt. The child may be experiencing fear, but the observer's affective empathic emotion is anger (Cassels et al., 2010). The ability to integrate cognitive and affective empathy experiences allows individuals to increase overall awareness of others' perspectives and factors like feelings, intentions, desires, and beliefs that contribute to their perspectives. Having a good understanding of the affective states of others is an important component of socialization and interpersonal relationships (Belacchi & Farina, 2012).

A. Smith (2009) defined two types of affective empathy: direct and indirect. Direct affective empathy is defined as responding to overt cues such as others' facial expressions and emotional vocalizations. Indirect affective empathy is understanding the mental states of others and requires the ability to share inferred emotional states, not observed states (A. Smith, 2009). A. Smith further explained that individuals with direct affective empathy may not be fully aware that they are sharing others' emotions.

Within the affective empathy domain are *emotional contagion* (A. Smith, 2009) and *personal distress and empathic concern* (Meneses & Larkin, 2012). These two components are considered to always be involved in the empathic process on some level (Meneses & Larkin, 2012). Emotional contagion is believed to be a process in which an individual observes the expression of emotion of another, and that emotion is then mimicked by the observer in a spontaneous and contagious manner (Hofelich & Preston, 2012). For example, most people connect with the emotions and feelings of a character in a movie or book and take on as their own the feelings and emotions displayed in the character's experiences (Hofelich & Preston, 2012). Emotional contagion should not be confused with empathy because emotional contagion is a sort of motor response whereas empathy involves insight into another individual's emotional state and requires a motivation to understand that other's experience as it is for that individual (Decety & Michalska, 2010). Personal distress is an emotional response to feelings that arise in the empathizer that leads to the empathizer turning his or her focus inward regarding how these feelings and emotions are experienced. Empathic concern is feeling concern for another's well-being or needs and the desire to relieve the other's distress (Cassels et al., 2010; Meneses & Larkin, 2012; A. Smith, 2009; Smits et al., 2011). Being able to feel and recognize another person's distress is necessary for responding to a person or situation but does not require the ability to comprehend feelings in a cognitive way or use ToM or perspective taking (Belacchi & Farina, 2012).

Emotional contagion and personal distress may be influential in activating the empathic process, but these two factors are not experienced by the person being observed. Instead, they are the observer's own personal responses to the other's experience (Meneses & Larkin, 2012). In other words,

> When observing another's state, we activate our own neural feeling substrates (i.e., "neural resonance"), we quickly and intuitively comprehend their specific state (i.e., "conceptual understanding"), and we may mimic their expression (i.e., "mimicry") or feel their affect as their own (i.e., "emotional resonance"). (Hofelich & Preston, 2012, pp. 119–120).

Empathy vs. Sympathy and Compassion

It is important to identify the differences between empathy, sympathy, and compassion because these terms are often used interchangeably but denote different processes. Clarifying these processes facilitates a better understanding of how they affect interpersonal relationships and their role in burnout and compassion fatigue. This clarification also facilitates understanding of how to best operationalize the construct of empathy in order to develop a program to advance the skill in doctoral students.

Sympathy

Sympathy is a response to another's experiences or circumstances that evokes feelings of concern or sorrow for that person. Sympathy is conceptualized as the perceiver's motivation, intentions, and self-regulation that influence the experience of empathy (Decety & Michalska, 2010; Edwards, 2013). Sympathy is a feeling of concern for the well-being of others. Sympathetic responses are thought of as subjective experiences that are emotional reactions to a situation (Meneses & Larkin, 2012).

Sympathetic feelings that are a response to another's situation can be associated

with and lead to empathic concern (Cassels et al., 2010; Meneses & Larkin, 2012; A. Smith, 2009; Smits et al., 2011). Unlike empathy, sympathy does not necessitate understanding another's perspective or feelings and does not require the sympathizer to feel others' feelings in order to be sympathetic (Decety & Michalska, 2010; Krznaric, 2014).

Compassion

Compassion involves feeling sympathetic as well as feeling or having a desire to alleviate the distress of the person one is feeling sympathy for and the desire to find and apply ways to alleviate the person's suffering (Choi, Lee, No, & Kim, 2016; Godlaski, 2015; Jazaieri et al., 2013). It can be expressed through verbal support, listening, and/or providing something to respond to those in need (Choi et al., 2016; Godlaski, 2015). Compassion is associated with increased positive and decreased negative feelings and contributes to positive behaviors toward oneself and others. It is also a unique positive emotion as it leads to altruistic behaviors, which in turn result in greater social connectedness and appreciation for others' experiences (Choi et al., 2016; Godlaski, 2015; Jazaieri et al., 2013).

Compassion is distinct from empathy because empathy rests on the capacity to put oneself in the position of another. Empathy does not necessitate the act of doing anything to alleviate an individual's suffering (Godlaski, 2015). Compassion is also a way for people to provide their own resources to replenish the resources of others. As one experiences more instances of giving and receiving compassion, positive emotions and feelings increase and contribute to effective self-regulation. Compassion is valuable for regulatory processes and is important in recovering and maintaining emotions, behaviors, and thoughts (Choi et al., 2016; Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014; Jazaieri et al., 2013).

Therapeutic Alliances and Treatment Outcomes

As previously mentioned, the nature of the therapeutic alliance plays a significant role in therapeutic outcomes. The stronger the therapeutic alliance, the more likely treatment interventions will lead to positive and effective outcomes (APA, 2017; Anderson et al., 2009; Bean et al., 2014; Davidson, 2015; Decety & Michalska, 2010; Feller & Cottone, 2003; Gair, 2013; Hook et al., 2017; Nezu et al., 2015; Patterson et al., 2014; Sackett & Lawson, 2015; Teding van Berkhout & Malouff, 2016; Wampold, 2011; Weck et al., 2015). Furthermore, if the alliance lacks cohesiveness and the client–therapist relationship is weak, interventions will likely lead to poorer outcomes (Anderson et al., 2009; Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014; Weck et al., 2015). To explore the emotional connection between the therapist and client and its impact on the therapeutic alliance, Sackett and Lawson (2015) researched the strength of the alliance as it relates to greater meaningful experiences in the client–therapist relationship. A mixed methods approach that included quantitative and phenomenological techniques was used in this study. The authors defined meaningfulness as whatever a client and counselors-in-training felt was a touching or impressive happening during the counseling process that did not rely on knowledge and focus on theory, interventions, or conventional in-session changes.

Study participants included 24 clients and counselors-in-training working in and receiving services from a public university education training clinic (Sackett & Lawson, 2015). Counselors were 12 master's-level counseling students receiving their first experiences training with actual clients. The 12 client participants were students from a nearby community college. To evaluate the strength of the working alliance, Sackett and Lawson (2015) used the Working Alliance Inventory (WAI), which has client and counselor versions. The WAI is a 36-item self-report measure that uses a 7-point Likert-type scale ranging from 1 (*never*) to 7 *(always*). There are three subscales—Bond, Goal, and Task—each consisting of 12 items. The Bond scale assesses the connection between the counselor and client, the Goal scale indicates agreement between the client and counselor about treatment goals, and the Task scale refers to the focus and direction the counseling will take (Sackett & Lawson, 2015).

Clients were interviewed after their second session with their counselor. Sackett and Lawson (2015) selected the second session to collect data about possible factors and dynamics contributing to alliances early in treatment that may not be apparent later. Interviewers asked both clients and counselors questions associated with meaningfulness as it related to that particular session. Questions included "What things felt most meaningful to you in today's session?" "Which of those things felt the most meaningful?" "What things seemed most important to you?" "What of those seemed most important?" "What stood out for you in today's session?" and "Which of those things stood out the most for you?" There were some variations between the client and counselor interviews; for example, clients were asked about why they sought counseling and about their treatment expectations. Some of the counselor-specific questions included asking them to describe their relationship with their client and if and how they believed counseling has been effective with their client. Interview protocols were consistent but varied in length due to content provided by the client or counselor (Sackett & Lawson, 2015).

After all information was gathered, the interviews were compared with WAI scores and separated into four groups (Sackett & Lawson, 2015). Group 1 contained the highest WAI scores and strongest alliances; Group 4 included the lowest WAI scores and weakest alliances. Evaluating the depth of meaningful experiences was established by rating the amount of hope clients apparently gained from the experience, the amount of emotion displayed coupled with cognitive learning, and the amount of apparent new learning experienced (Sackett & Lawson, 2015). Fourteen of the 24 participants indicated that the depth of the meaningful experiences clients and counselors had in treatment was directly connected to the strength of the therapeutic alliance. In 11 of the 14 cases (six clients and five counselors), the participants reported a strong alliance and depth at some level, while the remaining three participants (two clients and one counselor) reported that their alliance lacked depth, which was consistent with their low WAI scores (Sackett & Lawson, 2015).

Results from nine (four clients and five counselors) cases indicated that while it is possible to have meaningful experiences even when the alliance is not strong overall, the meaningful connection between the client and therapist has a significant impact on the therapeutic alliance (Sackett & Lawson, 2015). On the WAI, all 24 participants rated the bond as more important than tasks and goals. The study results supported the postulation

that stronger therapeutic alliances are directly associated with the depth of meaningful experiences (Sackett & Lawson, 2015).

Sackett and Lawson's 2015 study has various strengths and weaknesses. Using mixed methods is a strength because the congruent results between the application of quantitative and qualitative procedures gave more power to the results. The WAI results were consistent with interviewing responses, which supported the positive influence of the overall therapeutic relationship on alliances and outcomes. The sample size was somewhat small, which is a weakness. The results may have been more significant if from a larger sample, although it seems enough to assume results with a larger sample may produce similar results. Another weakness is the therapists' limited experience as these sessions were their first with actual clients. Results may have been different if they were experienced therapists.

Additional research also supports the link between alliances and outcomes. For example, Weck et al. (2015) investigated the relationship between treatment outcomes and therapeutic alliance, therapist adherence, and therapist competence. The study results supported a relationship between strong alliances and positive outcomes. Weck et al. defined the therapeutic alliance as the emotional connection and collaboration between the therapist and client. Therapist adherence referred to the degree to which a therapist followed the treatment procedures provided in specific treatment manuals. The therapist's ability and skill to apply treatment procedures reflected therapist competence. Treatment success was identified by a decrease or elimination of symptoms. Treatment failure referred to a client's premature termination due to dissatisfaction about the treatment process, lack of response to interventions, deterioration in mental status during treatment, and increases in symptoms after treatment was complete (Weck et al., 2015).

Weck et al. (2015) conducted three randomized control trials with 61 clients participating in individual therapy for social anxiety, hypochondriasis, and major depression. Thirty-two therapist participants were trained in and provided specific cognitive behavioral therapy (CBT) interventions. Sessions were videotaped and rated by two independent judges. Weck et al. chose the client's first three therapy sessions to evaluate adherence, competence, and alliance. However, some videotapes of the first three sessions were not available due to various reasons like technical issues; as such, evaluations of subsequent sessions were sometimes necessary (Weck et al., 2015).

Weck et al. (2015) evaluated therapeutic alliances with the Helping Alliance Questionnaire (HAQ). The HAQ includes 11 items that clients rate on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). For this study, a revised version, the HAQ-R, was used for independent ratings of the therapist–client relationship. Therapist adherence was measured using the Cognitive-Behavioural Therapy Adherence Scale (CBT-AS), a 23-item scale that uses a 3-point rating scale (*not adherent*, *partly adherent*, and *adherent*) to assess therapists' adherence to various CBT components. Example items include time management, identification of automatic thoughts, and reviewing homework. To assess therapist competence, the Cognitive Therapy Scale (CTS) was used. The CTS is a 14-item measure that uses a 7-point scale (*poor*, *barely adequate*, *mediocre*, *satisfactory*, *good*, *very good*, and *excellent*). Example items include dealing with problems/questions/objections, clarity of communication, and interpersonal effectiveness (Weck et al., 2015).

Weck et al. (2015) found that the therapeutic alliance is an important factor in predicting treatment outcomes as it mediates the effects of adherence and competence on outcomes. The study authors also found that without a strong alliance, adherence and/or competence alone were not predictive of successful outcomes. Additionally, the study results suggested that the therapeutic alliance in the first session influenced the therapist's competence and adherence in successive sessions but competence and adherence in the first session did not influence alliance in the subsequent sessions. Weck et al.'s findings indicated that stronger therapeutic alliances contribute to more successful outcomes.

One strength of the Weck et al. (1995) study is the large number of client (61) and therapist (32) participants. This moderately high sample size likely made results more significantly valid and reliable. Another strength is using CBT as a uniform intervention as opposed to allowing the therapists to conduct sessions using their own preferred interventions. On the other hand, this could also be seen as a weakness because the results cannot be generalized for alliances in which the therapist uses other theoretically based interventions. A third strength is the inclusion of three different client presentations/diagnoses. Including three client diagnoses likely prevented bias that could have impacted results due to unique client characteristics associated with a certain diagnosis. A weakness of the Weck et al. study is that the study authors had to improvise if there were any issues collecting the first three sessions. This may have impacted overall results because some therapists may have achieved stronger alliances or had more practice using CBT techniques by their fourth, fifth, or sixth session.

Further support of the relationship between strong alliances and positive outcomes was found by Schmidt et al. (2014) in a study on the role of the therapeutic alliance in treatment outcomes in child therapy. Study participants included 117 families (children and parents) with a child between ages 3 and 15 years who presented with externalizing behavioral difficulties. Group sessions were co-led by 16 practitioners. Schmidt et al. (2014) used the WAI Short Form (WAI-S) and the Treatment Evaluation Inventory (TEI) and Parent Evaluation Inventory (PEI) to evaluate alliances and outcomes. The WAI-S is a 12-item short version of the WAI. The TEI (therapist version) and PEI (parent version) assess the amount of change achieved as a result of parenting intervention. The PEI is a 19-item self-report measure with items rated on a 5-point Likert-type scale. The PEI has two subscales: Acceptability (eight items) and Progress (11 items). Acceptability refers to how well the parent receives treatment, and progress reflects how much is learned and changes in parenting style as a result of the parenting intervention. The TEI is similar to the PEI but includes only 15 items, and the two subscales are Progress (six items) and Improvement (nine items). The Progress scale is comparable to the PEI Progress scale, whereas the Improvement scale refers to the therapist's evaluation of parent improvement such as using the skills taught and the ability to maintain the changes achieved (Schmidt et al., 2014).

Participants attending Triple P family groups at a community-based children's mental health center were evaluated over a 4-year period for this study. The Triple P groups included four face-to-face sessions with parents and child, three individual phone sessions (15 min with each parent), and a final face-to-face group session. Because of the complexity of the cases (i.e., high levels of need, involved in protective services), 75% of

the families had three face-to-face sessions instead of the three phone sessions (Schmidt et al., 2014).

Schmidt et al. (2014) found that the parents' ratings of alliance were positively correlated with treatment outcomes. Stronger alliances appeared to contribute to more change and improvement and better treatment outcomes. In contrast, therapist-rated alliances were not indicative of outcome. This discrepancy suggested that the therapist's perception of the alliance is less important than the client's view of the alliance (Schmidt et al., 2014).

Schmidt et al.'s 2014 study has some important strengths. The sample size was large (117), which increased the significance of the results. In addition, both mothers and fathers were included and produced similar results on alliance and outcome assessment measures. Including a relatively high number of practitioners over the course of 4 years also likely strengthened overall results. A weakness of this study is that there were no evaluations of the child's perceptions and experiences. Schmidt et al. also did not identify if and how the children's behaviors changed and for what reasons. It may have been of value to understand the role of the alliance with the child and if such an alliance is significant.

Empathy and the Therapeutic Alliance

The results from Sackett and Lawson's 2015 study showed that positive and meaningful relationships are significant in developing effective working alliances, and results from Weck et al. (1995) and Schmidt et al. (2014) suggested that strong therapeutic relationships contribute to positive and effective outcomes. Therefore, it is important to investigate which interpersonal relationship skills contribute to the development of meaningful relationships. Results from a 2009 study by Anderson et al. (2009) indicated that empathy is an interpersonal quality that influences outcomes.

Anderson et al. (2009) examined how therapists' interpersonal characteristics may affect outcomes. The study authors used archival data from 1,141 clients who participated in treatment at a university counseling center and who were included in two previous studies. Twenty-five therapists participated and included 17 licensed doctoral-level therapists, two postdoctoral but not fully licensed therapists, three predoctoral interns, and three graduate trainees (mean years of experience = 11.5). The client sample had completed anywhere from three to 72 therapy sessions with the therapists included in this study. All clients had completed the Outcome Questionnaire-45 (OQ-45), a measure that was routinely administered prior to each therapy session at the counseling center (Anderson et al., 2009).

Therapists completed the Social Skills Inventory (SSI) and a performance task that measured their facilitative interpersonal skills (FIS) upon termination of each client's treatment (Anderson et al., 2009). The SSI is a 90-item self-report measure that assesses self-reported social skills. For this study, therapists completed the SSI after client treatment termination. The SSI measures skills in expressivity, sensitivity, and control in verbal (social) and nonverbal (emotional) domains. The performance task measured the therapists' abilities to perceive, understand, and communicate a wide range of interpersonal messages (Anderson et al., 2009). In addition, the task assessed an individual's ability to persuade others with personal problems to apply suggested

solutions to their problems and abandon maladaptive patterns. Licensed clinicians rated the therapists on verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus (Anderson et al., 2009).

The FIS performance task included four videotaped therapy process segments that displayed a range of problematic patient personality styles, including (a) a confrontational patient ("You can't help me"); (b) a passive, silent, and withdrawn patient ("I don't know what to talk about"); (c) a confused and yielding patient (only the therapist's opinion matters); and (d) a controlling and blaming patient (implies that others, including the therapist, are not worthy of him/her). Two of the patient personality styles were intended to represent highly self-focused, negative, and self-effacing patients; the other two were intended to be highly other-focused and friendly but dependent patients. Each of the eight segments was shown for 2 min. Therapists then responded to the videos as if they were providing actual therapy to the videotaped client. Two licensed clinicians observed therapist responses and rated them on a 5-point Likert-type scale (1–2 reflected skill deficiencies, 3 was a neutral score, and 4–5 indicated proficiencies; Anderson et al., 2009).

Study results suggested that therapists' facilitative interpersonal skills (verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus) had a significant positive affect on outcomes (Anderson et al., 2009). The study authors found that clients working with therapists with higher FIS ratings reported experiencing more improvement than therapists with lower FIS ratings. Analysis of OQ-45 data suggested that the average number of sessions necessary for a client to make reliable change was 14. Anderson et al. (2009) noted that one specific therapist included in the study had significantly poorer outcomes and suggested that it would be of importance to not only study interpersonal qualities that lead to positive outcomes but also what particular types of interpersonal qualities may contribute to poorer outcomes (Anderson et al., 2009).

A strength of the Anderson et al.'s 2009 study is the large client size (n =1,141) which strengthened the validity of the results. Another study strength is the use of OQ-45 archival data. Also, the average number of sessions needed to make positive change were analyzed and identified, which can be useful in understanding at what point one might surmise probable treatment outcomes. A weakness is that there was no control group to compare results to and therefore no way to assess if these changes happened due to the study's methods or if the results would have been similar in a control sample.

Research supports the association between therapeutic alliances and treatment outcomes. It is apparent that the quality of the therapeutic alliance plays a significant role in treatment outcomes. Without a strong alliance, treatment outcomes will likely be poor. Research further supports empathy as an interpersonal skill that affects therapeutic alliances and therefore may predict outcomes. It is important to understand and identify which therapist attributes contribute to developing positive and effective alliances. To achieve positive and effective alliances, therapists must know and be aware of the influence empathy can have on the therapist–client relationship because it appears to be a common factor in studies focused on identifying specific interpersonal skills that attribute to therapeutic alliances. Other qualities that influence empathy skills, like good

communication, acceptance, acceptance, and validation, were also indicated to positively affect alliances.

Importance of Validation and Acceptance

Expressing validation and acceptance to others is a means of communicating empathy and strengthens the capacity to connect with others. Empathy, validation, and acceptance have significantly positive effects on overall mental health, well-being, and quality of life and increase the strength of therapeutic relationships (Bean et al., 2014; Hook et al., 2017). Validation and acceptance allows for trust and rapport building because it decreases clients' feelings of being negatively judged or uncomfortable in disclosing important information. On the other hand, invalidation and judgment can lead to negative views about mental health services and to poor outcomes (Bean et al., 2014). Negative judgments about individuals with mental health needs are often related to stigma. Stigma refers to an individual's unawareness (ignorance), attitudes (prejudice), and behavior (discrimination) about another individual (Friedrich et al., 2013).

Limited expression of empathy skills toward clients can negatively impact trust and rapport and compromise overall treatment efficacy, leading to poorer outcomes (Bean et al., 2014; Decety & Michalska, 2010; Gair, 2013; Kitron, 2011). Inadequate trust between therapist and client makes it more difficult for developing a therapeutic alliance and establishing a secure relationship. Clients who have had negative experiences with stigma and mental health services are often guarded and mistrustful toward mental health professionals, which can prevent them from seeking help and engaging in effective treatment (Xu et al., 2016).

Greville-Harris, Hempel, Karl, Dieppe, and Lynch (2016) demonstrated the negative impact invalidation can have on therapeutic alliances; specifically, how validation, acceptance, and invalidation affect interpersonal relationships. The researchers examined physiological arousal, mood state, perceived safety levels, willingness to take part in the experiment again, and social engagement behaviors after providing validating and invalidating feedback. Ninety participants were separated into three groups: a control group (n = 49), a validating group (n = 23), and an invalidating group (n = 19). Each subject completed a Difficulties in Emotion Regulation Scale (DERS) to measure self-reported levels of emotion regulation skills. After completing the DERS, electrodes for measuring heart rate and skin conductance were placed on each subject, who then completed the Positive and Negative Affect Schedule (PANAS), a self-report measure of positive and negative affective states (Greville-Harris et al., 2016). The participants then completed a task that was designed to create mental stress. After completing the task, control group participants provided feedback on an online form describing their feelings about the task (Greville-Harris et al., 2016). The remaining subjects were asked to describe their feelings about the task to an experimenter who either provided validating or invalidating feedback.

Greville-Harris et al. (2016) videotaped the feedback sessions to assess nonverbal social engagement behaviors. Validating feedback included normalizing feedback: "Lots of people have said that they felt that way" or matched disclosures: "I felt exactly the same way when I did the task." Invalidating feedback included pathologizing statements: "I'm not sure why you are stressed; nobody else has said that they felt that way" or

insisting feedback: “You shouldn’t be as stressed/frustrated as this” (Greville-Harris et al., 2016). After receiving feedback, the participants completed a second PANAS.

Greville-Harris et al. repeated the process of doing the stressful task, receiving feedback, and filling out the PANAS a total of three times to examine the cumulative effects of repeated exposure to validation and invalidation. The participants then completed an online questionnaire that measured perceived experimenter validation levels, perceived levels of safety, and willingness to take part in the study again (Greville-Harris et al., 2016).

Nonverbal social engagement behaviors were assessed by a researcher who watched the videos of participants receiving feedback (Greville-Harris et al., 2016). Nonverbal behaviors included eye gazing, smiling, frowning, and laughing and were rated on a 5-point Likert-type scale (1=*not at all* to 5= *frequently*). Additionally, head positioning was assessed by observing if the participants head was (a) toward the researcher, (b) away from the researcher, (c) up toward the ceiling, or (d) down toward the floor. Head position was rated on a 5-point Likert-type scale with 1 reflecting the participant’s head straight ahead. Engagement referred to smiling, laughing, and frowning while disengagement was looking away and turning the head away, up, or down (Greville-Harris et al., 2016).

Findings supported Greville-Harris et al.’s (2016) hypothesis that invalidation negatively affects and validation positively affects interpersonal relationships. Subjects in the invalidation group experienced adverse emotional and physiological responses that negatively impacted their social engagement behaviors. Greville-Harris et al. also found that invalidation produced decreases in emotional expression, feelings of safety, and overall social interactions. Invalidated participants also showed significantly higher negative affect, significantly lower perceived safety ratings, decreased willingness to repeat the experiment, and significantly less social engagement behaviors than validated participants. Greville-Harris et al. also noted that a lack of invalidation rather than a presence of validation appeared to reduce negative emotional and physiological arousal.

Strengths of Greville-Harris et al.’s 2016 study include the size of the sample groups and comparison to a control group, which likely contributed to significant reliability and validity. Repeating the procedure also appeared to strengthen overall results (Greville-Harris et al., 2016). The study authors also noted that using physiological, subjective, and objective assessments reinforced the study findings as the results from each element were congruent. A study weakness is that the control group did not have the social interaction with an experimenter but rather only responded to their experience on an online form. This prevented comparing how one may interact socially after such a task if given neutral or no feedback.

Findings from Greville-Harris et al. (2016) illustrate the significance of providing clients with empathy and acceptance and support the importance of providing empathy training in doctoral psychology programs. The lack of positive communication toward the subjects in this study had significantly negative effects on the subjects’ relational connection to the experimenters. When psychologists engage in empathic behaviors with clients, clients will likely feel safe and willing to engage in their treatment. It is important for psychology students to be aware of and gain a greater understanding about the harm that can be caused when the therapeutic relationship lacks empathy.

Stigmatization and the Therapeutic Alliance

Researchers have found that stigmatization of individuals with mental illness has significant negative effects on the ability to develop interpersonal relationships. Therapists' assumptions about symptoms associated with certain disorders can impede their ability to provide effective treatment because they may not fully understand clients' actual experiences and perceptions. If clients feel that their experiences and perceptions are not fully understood or are being ignored, there is an increased risk that the therapeutic relationship will be negatively impacted, which increases the likelihood of poor outcomes.

Peer, Warnecke, Baum, and Goreczny (2015) examined stigmatization of people with schizophrenia by health care professionals. The study participants were 91 graduate students in psychology, occupational therapy, and physical therapy programs. Each participant completed questionnaires that assessed stress and coping skills for stress, including the Depression Anxiety Stress Scale (DASS), the General Self-Efficacy Scale (GSES), the Satisfaction with Life Scale (SWLS), and a narrative about a person with schizophrenia (Peer et al., 2015). The DASS is a 42-item self-report measure that assesses three interrelated emotional scales of depression, anxiety, and tension/stress. Each item is rated on a 4-point Likert-type scale indicating how often the individual has experienced a certain behavior or emotion in the last week. The GSES is a 10-item scale that measures self-efficacy. Each item assesses coping abilities for daily struggles and how the individual views success. The SWLS is a 5-item measure that assesses overall satisfaction with life. Items are rated on a 7-point Likert-type scale from 1 (*strongly disagree*) to 7 (*strongly agree*). This scale has also shown to be predictive of future behaviors, including suicide attempts (Peer et al., 2015). The schizophrenia narrative was a short description of a person diagnosed with schizophrenia detailing some common symptoms such as paranoid delusions, auditory hallucinations, and associated life stressors. The narrative was developed specifically for this study. Study participants filled out the questionnaires for themselves and completed a second questionnaire as if they were the person with schizophrenia in the narrative provided (Peer et al., 2015).

Peer et al. (2015) found that the students perceived more depression, anxiety, and stress and less satisfaction with life and self-efficacy in individuals with schizophrenia compared to themselves. Peer et al. noted that while depression and anxiety can be comorbid with schizophrenia, participants significantly exaggerated the actual rates of comorbid depression and anxiety in people with schizophrenia. Peer et al. concluded that health care professionals hold stigmatizing beliefs and judgments about individuals with mental illness (Peer et al., 2015).

A strength in Peer et al.'s 2015 study is the large sample size, which increased the significance of the findings. Having the subjects answer questions as themselves and then as if they were an individual with schizophrenia showed obvious differences in their perception of themselves versus those with mental illness and appeared to be a valuable and effective method for this study. A possible weakness is that health professionals tend to work with people with schizophrenia who are actually experiencing marked symptoms of depression and anxiety rather than those who are not, although this could still be seen

as bias. Another weakness is that the sample lacked diversity as most participants were White women.

Xu et al. (2016) researched treatment-seeking attitudes of people at risk for psychosis. Subjects in this study were 67 individuals between ages 13 and 35 years assessed as being at high risk for psychosis on the adult or children–youth version of the Schizophrenia Proneness Interview, at extremely high risk for psychosis on the Structured Interview for Prodromal Syndromes, or at risk for bipolar disorder according to the Hypomania Checklist. Data regarding risk for psychosis were collected at baseline and at 1-year follow-up (Xu et al., 2016).

Xu et al. (2016) also evaluated stigma's effects on attitudes about seeking professional help. Help-seeking attitudes were measured by one item on psychiatric medication ("If I become mentally ill, I would be willing to take psychiatric medication") and one item on psychotherapy ("If I become mentally ill, I would be willing to go to counseling/psychotherapy"), both rated on a 9-point Likert-type scale (1 = *not at all* to 9 = *definitely*). Self-labeling as mentally ill was measured as how participants perceived their mental health on a 9-point Likert-type scale (1 = *I am perfectly mentally healthy* to 9 = *I am severely mentally ill*). Xu et al. used the Perceived Devaluation-Discrimination Questionnaire to measure perceived public stigma. Cognitive appraisal of mental illness stigma as a stressor was assessed using the Stigma Stress Scale, an eight-item measure that includes four items for the primary appraisal of mental illness stigma as harmful and four items for the secondary appraisal of perceived resources to cope with stigma. Positive and negative psychotic symptoms were assessed using the Positive and Negative Syndrome Scale (Xu et al., 2016).

Xu et al. (2016) found that perceived stigma and stress caused by stigma prevented individuals at risk for psychosis from seeking professional assistance. Xu et al. noted that the fear of being labeled and identified as mentally ill perpetuates self-stigmatization and negative effects on self-esteem. These factors also appeared to prevent study participants from disclosing symptoms and diagnoses and could contribute to an individual's denial and avoidance of problems, which could be harmful to the individual or others (Xu et al., 2016).

A strength of Xu et al.'s 2016 study is that the researchers discriminated between self-stigma and perceived public stigma. Xu et al. concluded that perceived public stigma directly affects how individuals think and feel about themselves, which can negatively impact engagement in help-seeking behaviors. Xu et al. further noted that the study results shed light on how mental illness continues to be seen as a negative and therefore shameful attribute. A study weakness is the limited measurement of help-seeking attitudes.

Zeligman, Hagedorn, and Barden (2017) investigated stigma's effects on people living with HIV. Participants were 124 people with HIV from agencies that provide services to people living with HIV/AIDS. Participants completed an assessment packet that included the Berger HIV Stigma Scale and the Impact of Event Scale–Revised (IES-R). The Berger HIV stigma scale is a 40-item self-report measure that assesses perceived stigma for people living with HIV/AIDS (Zeligman et al., 2017). Items are rated in a range from *strongly disagree* to *strongly agree*. Four factors are measured: (a) disclosure concerns, (b) personalized stigma, (c) concern with public attitudes, and (d) negative self-

image. Personalized stigma represents internalized stigma, public attitudes refer to the how the public creates stigma about individuals with HIV, and negative self-image is the awareness and shame found in perceived stigma (Zeligman et al., 2017). The IES-R is a 22-item measure that assesses the emotional impact of living with HIV. Items are rated on a range from *not at all* to *extremely*. Items are designed to measure event impacts that are congruent with posttraumatic stress disorder (PTSD) symptoms. Responses are measured in terms of avoidance, intrusion, and hyperarousal (Zeligman, 2017).

Zeligman et al. (2017) found that stigma related to an HIV diagnosis had a significant negative impact on how individuals with HIV perceived themselves, could make having an HIV diagnosis a more traumatic experience, and could increase depression symptoms. The study authors also noted that stigmatization by self and others can increase social isolation and feelings of deserving judgment and poor treatment from others. Findings from Zeligman et al. demonstrated the negative impact of biases on overall mental health, well-being, and quality of life and supported the importance of validation and acceptance in therapeutic relationships.

A strength of the Zeligman et al. 2017 study is the acknowledgment and assessment of how stigma can lead to symptoms associated with PTSD. Not only can the experience of being diagnosed with HIV be traumatic, the stigma associated with this diagnosis can lead to heightened or additional posttraumatic symptoms. Zeligman et al.'s evaluation of multiple factors such as shame, self-stigma, and persistence of symptoms allowed for identifying stigma's various influences and how they may impact therapeutic alliances, treatment, and outcomes. A study weakness is that Zeligman et al. only used self-report measures, which may have skewed results because participants may minimize their symptoms to appear more socially desirable.

The Peer et al. (2015), Xu et al. (2016), and Zeligman et al. (2017) studies are relevant to therapist alliance and treatment outcomes as they reflect the negative effects on therapeutic relationships that can be caused by therapists having negative feelings toward certain clients. A lack of awareness about one's own negative feelings, judgments, or assumptions can greatly affect the therapeutic alliance and treatment outcomes. It is important to identify and address negative thoughts and feelings about clients in order to increase empathy and understanding for their experiences.

It is evident that stigma and invalidation can negatively impact interpersonal relationships, including the therapeutic relationship. Findings from studies on stigmatization support the significance of empathy training for doctoral psychology students. Providing information about individuals' experiences with psychologists can facilitate increased awareness and understanding of client perspectives. Awareness of differing perspectives and experiences associated with specific disorders clients present with can be utilized across all situations when conceptualizing and working with clients.

Stigma is strongly associated with feelings of shame and fear of being labeled as having a mental disorder. Empathy and shame are believed to be related and intercorrelated (Marshall & Marshall, 2011). Shame is a self-conscious emotion that differs from basic emotions such as anger, anxiety, or sadness because it necessitates a sense of self-identity and self-awareness. Shame is characterized by a desire to hide from others or to be "unseen" due to feelings of being incapable, undesirable, and/or flawed in some way. Individuals who feel shame tend to perceive others as rejecting observers

who hold feelings of ridicule, disgust, and contempt toward them. Shame can be a typical emotion when it promotes healthy moral and social development; however, it can contribute to significant psychological distress when felt chronically and intensely (Black, Curran, & Dyer, 2013).

Pervasive feelings and experiences of shame can impact the ability to form and maintain meaningful relationships. As such, shame will likely interfere with developing a positive and effective therapeutic alliance. When clients feel shame in the therapeutic relationship, they may also worry about rejection and their inability to cope with situations and experiences, which may result in their not disclosing important information.

Black et al. (2013) examined how client shame can affect the therapeutic alliance and intimate relationships. The study authors investigated the effects of state shame and shame coping styles on the therapeutic alliance and relationship functioning in a general clinical population. Study participants included 50 adults ages 21 to 67 years who were participating in primary care mental health services. Participants were experiencing mild to moderate mental health symptoms and were given informal diagnoses based on clinical judgment by 14 therapists, including nine clinical psychologists, four cognitive-behavioral therapists, and one counseling psychologist.

Black et al. (2013) administered four assessment measures: the Compass of Shame Scale (CSS), the State Guilt and Shame Scale (SGSS), the WAI-S, and the Multidimensional Relationship Questionnaire (MRQ). The CSS is a self-report trait questionnaire that assesses four coping styles identified by Nathanson's compass of shame model. It uses a 5-point Likert-type scale indicating frequency of four coping styles—withdrawal, attack self, attack other, and avoidance—in response to descriptions of 12 potentially shame-inducing situations. Withdrawal is defined as a conscious attempt to reduce shame-induced discomfort by pulling away from others. Avoidance involves the individual's denial or rejection of shame to distract the self from painful feelings. Attack self refers to the individual feeling flawed and negatively criticized by others. Attack other is the externalization of affective shame by attacking someone or something else (Black et al., 2013). The SGSS is a 15-item self-report questionnaire that measures state shame, guilt, and pride using a 5-point Likert-type scale. The MRQ is a 60-item questionnaire that assesses 12 aspects of intimate relationship functioning. Black et al. used three subscales of this measure: Relationship Depression (e.g., feeling unhappy about the relationship), Relationship Satisfaction, and Internal Relationship Control (e.g., feeling in control and in charge of the relationship).

Black et al. (2013) found that experiences of shame associated with stigma can have a significantly negative impact on therapeutic alliances. The study authors also found that individuals who most often engaged in withdrawal as a shame coping style had more difficulty forming relationships with their therapists than those who used avoidance, attack self, or attack other. Black et al. concluded that this finding was not surprising as this coping style significantly affects the initiation of the therapeutic relationship. With this style, the client prefers to remain detached from intense and uncomfortable feelings and can keep the therapist at a distance. Black et al. also found that withdrawal coping had the greatest influence on relationship depression and satisfaction. Individuals who coped by withdrawing in intimate relationships had higher levels of relationship

depression and lower levels of relationship satisfaction. In addition, those who coped with distressing feelings associated with shame appeared to experience greater difficulties forming intimate relationships than in therapeutic relationships (Black et al., 2013).

A strength in Black et al.'s 2013 study is the discrimination between the four shame coping styles that facilitated understanding different ways clients cope with shame. Knowing about these shame coping styles can be important for understanding client experiences and perspectives. Another strength is the number of participants and therapists included in the study as the sample size increased the validity of results and made them more generalizable across populations. A study weakness is that data were only collected at one point and did not identify length of time participants were in treatment. This information would be beneficial as some participants may have only been in therapy for a short time, which could possibly produce different results and inferences about the development of the therapeutic alliance.

Although Black et al. (2013) focused on client shame, it can be assumed that therapists may also experience these feelings as a result of developing their own interpersonal relationship styles. Feelings of shame can also manifest in psychologists who experience their own mental health issues during their education, training, or professional careers. Therefore, it is important that psychologists have a good awareness of how these feelings may arise and how they may affect empathy and therapeutic relationships.

Increasing empathy through identifying and exploring others' experiences is important for building positive and effective therapeutic relationships. Communicating understanding and acceptance to clients can facilitate developing a strong alliance and therefore lead to better treatment outcomes. This information is significant as it supports the need for further training about the importance of awareness of self and others. Increasing one's awareness of assumptions and biases can also be valuable for developing knowledge that can contribute to overall self-care and maintenance.

Factors That Impact Therapists' Empathy Skills

It is obvious that the stigmatization of mental illness can significantly impact individuals experiencing psychological distress. This knowledge is important when considering the mental health of psychology students and professionals. Doctoral psychology students may encounter situations and circumstances that negatively impact their own mental health, which can then affect the relationships they build with clients and others. Providing adequate empathy to clients may become impaired if this distress is not dealt with in appropriate ways. Unidentified stress in psychologists can also lead to burnout and decrease the quality and effectiveness of therapy they provide (Lambie, Smith, & Ieva, 2009).

The inability to cope with stressors can lead to psychological symptoms that significantly affect relationships and overall functioning. It is important for psychologists to understand how psychological distress can affect empathy and interpersonal skills. This knowledge is necessary for understanding the many aspects and dynamics associated with therapeutic relationships, outcomes, professional relationships, and overall functioning and well-being.

Some psychological symptoms can diminish the ability to accurately assess others' emotional states and perspectives and can increase distress (A. Smith, 2009). Some individuals experiencing significant distress may feel responsible for the pain felt by others, and these perceptions of guilt and blame can become unrealistic or exaggerated (O'Connor, Berry, Lewis, Mulherin, & Crisostomo, 2007). As distress increases due to misinterpretations, guilty feelings and blame toward the self or others can also increase due to the belief that the individual caused pain in someone else (O'Connor et al., 2007; Thoma et al., 2011). It is also possible that a distressed individual may interpret neutral, ambiguous, or positive expressions and demeanor as negative (Thoma et al., 2011). These interpretations may be associated with impaired ToM and executive functioning and can contribute to an overall lack of positive interpersonal relationships (Thoma et al., 2011). Incorrect perceptions and interpretations of others' cognitive and affective states often contribute to impairments in decoding and responding to social signals (American Psychiatric Association, 2013; Thoma et al., 2011). Stress can create impairments in emotion regulation that can contribute to significant relationship conflicts and impede the ability to make accurate judgments of others and their intentions (Dethier & Blairy, 2012). Distress may also lead to diminished emotional expression and may create aversion to attending to other's facial expressions, which reduces and interferes with the ability to recognize feelings in others. Facial and body cues may be ignored and avoided, which then reduces the capability to learn about and interact with others appropriately (K.-H. Lee, 2007). It is also possible that emotional states and facial expressions may be perceived as threatening and angry even when these negative emotional states are not being felt or expressed by another individual (Dethier & Blairy, 2012; Ferrari et al., 2014; Thoma et al., 2011). These difficulties in decoding other's feelings and intentions exacerbate difficulties in relationships and can lead to negative confrontations and threatening situations (Dethier & Blairy, 2012).

It is possible that a therapists' own experiences can influence a desire to pursue a career in mental health (Parpottas & Draghi-Lorenz, 2015). As such, an individual's history of adverse experiences is another factor that can impact empathy skills. Adverse experiences relate to trauma and abuse; can involve psychological, verbal, physical, and sexual abuse and neglect; and are often related to family dysfunction (Skarupski, Parisi, Thorpe, Tanner, & Gross, 2016). It is important to consider how a therapist's adverse experiences can hinder interpersonal and empathic skills and how these experiences can affect interactions with clients (Dethier & Blairy, 2012).

Experiential trauma can greatly affect how individuals experience and interact with the world (Lim & DeSteno, 2016). Adverse life experiences or complex trauma negatively impacts social functioning (Lim & DeSteno, 2016). Complex trauma is typically defined as continuous and prolonged emotional abuse that is often characterized by psychological, physical, and sexual abuse or neglect (Schore, 2001). Repeated abuse has been shown to impact cognitive and affective abilities and compromise empathic ability (Schore, 2001). Pervasive emotional abuse by a caregiver negatively affects an infant's abilities to regulate emotions and cope with stress, thus impairing self-regulation (Schore, 2001). Affect regulation is associated with right-brain functioning. With a secure attachment between caregiver and infant, right-brain development fosters effective emotion regulation and the infant's overall psychopathology (Schore, 2001). Prolonged

negative emotional states create an inability to regulate emotions effectively, alter the infant's or child's physiological development, and specifically impact coping abilities (Schore, 2001). Poor attachment with caregivers and lack of appropriate interpersonal development are associated with anxiety and depression and can increase risks of alcohol dependence (Dethier & Blairy, 2012; Ferrari et al., 2014).

When a developing infant or child experiences prolonged and repeated trauma, the body responds with significant stress, which decreases the capacity to recover to a baseline state (Heller & LaPierre, 2012). Experiencing prolonged and repeated trauma can impede the ability to effectively deal with stress, and coping strategies generally remain primitive (Heller & LaPierre, 2012). Exhaustion from being in a constant state of stress causes significant changes in brain development and increases vulnerability to illness. The individual may become detached and lack the energy to interact with others in any meaningful way (Heller & LaPierre, 2012).

Significant maladaptive and dissociative behaviors and the inability to manage stress are characteristic of individuals who experience complex trauma and, if not addressed, can persist into adulthood (Schore, 2001). When an infant or child experiences extreme neglect or abuse, the lack of soothing and comforting of negative emotional states can lead to severe emotional dysregulation (Schore, 2001).

Parenting style is believed to be significantly associated with empathy development as the parent or caregiver is assumed to regulate the child's emotional responses to situations, thoughts, and feelings. Because adverse experiences are often linked to family dysfunction, attachment styles are therefore relevant to empathy development. Attachment styles consist of conscious and unconscious strategies a person uses to organize attachment-related information and contribute to establishing internal expectations of the self and others. Attachment styles are important to therapeutic relationships and alliances because both the therapist's and client's personal experiences of relationship development work in conjunction and directly affect how their alliance develops. Because of these relational styles, therapists should be aware of how the constructs impact their clients' experiences as well as their own (Strauss & Petrowski, 2017).

How parents or caregivers teach and model coping skills to their children contributes to how the children develop relationship skills and behaviors (Strauss & Petrowski, 2017). Early attachment experiences with a parent or caregiver significantly influence how one interacts with and relates to others as well as one's affective behaviors and self-regulation. Attachment styles are established as parents model behavior in their interactions that their children can then duplicate (Cassels et al., 2010; Strauss & Petrowski, 2017; Teymoori & Shahrazad, 2012).

Secure attachments with caregivers are characterized by adequate and effective interpersonal skills that generally protect individuals from significant difficulties relating to others. In contrast, insecure attachments increase vulnerability to environmental stressors and can negatively affect the ability and capacity to develop positive and effective coping and relational sills (Strauss & Petrowski, 2017).

Findings from studies on attachment styles in therapists are varied; however, there is strong indication of a significant number of therapists who themselves have insecure attachments (Parpottas & Draghi-Lorenz, 2015). A lack of positive parental and

caregiver support can significantly impact psychologists' abilities to develop relationships with their clients. Psychologists who have had limited experiences with role relationships and a nonegalitarian power structure may have more difficulty understanding the perspectives of others because they are taught that people are not equal and some deserve more than others. As such, gaining awareness of how these experiences can affect their empathic abilities in the therapeutic alliance is important (Teymoori & Shahrazad, 2012). Some research has shown that people with poor caregiver attachment and who lack appropriate interpersonal development have an increased risk of becoming alcohol dependent as well as developing anxiety and depression (Ferrari et al., 2014; Dethier & Blairy, 2012).

Parpottas and Draghi-Lorenz (2015) reviewed 14 studies on the influence of therapists' attachment styles on therapeutic alliances and outcomes. Results from 13 of the 14 studies indicated that therapist's attachment style may play a significant role in alliances and outcomes; results from the remaining study showed no effect. Therapists with secure attachments appeared to develop stronger emotional relationships, had greater empathic abilities, were able to maintain positive alliances over time, and achieved better outcomes than those with poor or insecure attachment styles (Parpottas & Draghi-Lorenz, 2015). Therapists with insecure attachment styles had difficulties understanding and responding effectively to some clients, which appeared to contribute to overall poorer alliances and outcomes.

Results from Parpottas and Draghi-Lorenz's 2015 review of previous studies indicate the significant effects of therapists' attachment styles on therapeutic alliances. Therapists with histories of insecure attachments could benefit from empathy training as such training may lower the negative impacts of insecure attachments and increase the therapists' awareness of how their personal experiences and attachment styles can be harmful to clients.

Self-Compassion

Empathy has a positive effect on overall mental health, well-being, and quality of life and facilitates the cultivation of self-compassion (Beaumont, Durkin, Hollins Martin, & Carson, 2016; Hook et al., 2017). Self-compassion can be understood as a means for providing empathy toward the self. Individuals who are self-compassionate are less likely to engage in self-judging thoughts about themselves and are more resilient to emotional exhaustion. Having self-compassion increases positive feelings, well-being, and self-esteem (Beaumont et al., 2016).

Choi et al. (2016) investigated how compassion can reduce the negative emotions, thoughts, and behaviors of nurses from three hospitals that contained over 400 beds each. Study participants in the study included 284 nurses, and data were collected over the course of 1 week. The majority of the participants were female, permanent employees, and registered nurses. Variables measured included experiencing compassion, self-esteem and self-efficacy, anxiety, burnout, workplace deviance, and intention to quit (Choi et al., 2016). Choi et al. defined compassion as altruistic behavior and a desire to alleviate the suffering of others and can be expressed through things like offering support or providing relief in some way. Self-esteem is influenced by positive and negative experiences and can affect a person's desire for things like social status and acceptance,

affiliation, love, and sympathy. Self-efficacy referred to an individual's performance accomplishments, vicarious experiences, verbal persuasion, and physiological states. Verbal persuasion was described as a resistance to perseverate on one's own inadequacies when confronted by difficult situations. Anxiety was defined as fear and uneasiness about the future and discomfort caused by high arousal. Burnout referred to fatigue and breakdown resulting from an exceedingly demanding environment. Workplace deviance was defined as being characterized by the expression of suppressed anger and negative emotions in the workplace (Choi et al., 2016).

Choi et al. (2016) also included the following control variables: gender, age, occupational rank, pay level, agreeableness (as defined as the tendency to empathize and assist others), and negative emotions. Responses to all variables were rated on a 5-point Likert-type scale (1=*strongly disagree* to 5=*strongly agree*). The items included in the experiencing compassion variable asked how often participants experienced compassion on the job, compassion from their supervisors, and compassion from their coworkers. The self-esteem variable assessed self-appraisal, self-efficacy items evaluated feelings about one's actual abilities, anxiety evaluated statements about temporary or state anxiety such as ambivalence and fear, burnout items targeted feelings of emotional exhaustion, workplace deviance measured interpersonal deviance and organizational deviance, and intention to quit assessed participants thoughts about quitting their job (Choi et al., 2016).

Results from Choi et al. (2016) indicated that compassion was negatively correlated with anxiety, burnout, workplace deviance, and intentions to quit. However, the study authors also investigated possible mediating factors that may have influenced these results and found that compassion appeared to increase self-esteem and self-efficacy, which may mediate and increase positive relationships between anxiety, burnout, and workplace. When including self-esteem and self-efficacy as additional variables, Choi et al. found that self-esteem and self-efficacy can mediate effects on anxiety. Furthermore, self-efficacy appeared to not only influence anxiety but also burnout and deviant interpersonal and organizational behaviors (Choi et al., 2016).

Beaumont et al. (2016) investigated associations between self-compassion, compassion fatigue, well-being, and burnout in student counselors and student cognitive behavioral psychotherapists. Self-compassion was identified as an ability to cope with symptoms related to stress, failure, and distress that inhibits compassion fatigue and burnout and increases overall feelings of well-being. Compassion fatigue and burnout generally occur when a counselor lacks the ability to apply effective self-care strategies for coping with knowledge about clients' personal experiences of suffering related to trauma. Self-care denotes the ability to engage in activities that prevent or decrease compassion fatigue and burnout (Beaumont et al., 2016).

Participants in Beaumont et al. (2016) were 54 students in their final year of counselor studies with cognitive behavioral and person-centered theoretical orientations. Students were assessed using the Professional Quality of Life (ProQOL), the long version of the Self-Compassion Scale, the short Warwick and Edinburgh Mental Well-Being Scale (sWEMWBS), and the Compassion for Others Scale (CFO). The ProQOL is a 30-item self-report scale for counselors that assesses thoughts and feelings experienced over the past 30 days related to compassion satisfaction, compassion fatigue, secondary traumatic stress, and burnout (Beaumont et al., 2016). Items are scored on a 5-point

Likert-type scale (1= *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, 5 = *very often*). The Self-Compassion Scale is a 26-item scale that measures self-kindness, self-judgment, mindfulness, common humanity, isolation, and overidentification. Items are rated on a 5-point Likert-type scale (1 = *almost never* to 5 = *almost always*). The sWEMWBS includes seven items rated on a 5-point Likert-type scale ranging from 1 (*none of the time*) to 5 (*all of the time*). The sWEMWBS evaluate feelings of well-being in the previous 2 weeks identified on a 5-point Likert-type scale (1 = *almost never* to 5 = *almost always*). The CFO is a 24-item scale divided into 6 subscales: kindness, indifference, common humanity, separation, mindfulness, and disengagement (Beaumont et al., 2016)

Beaumont et al. (2016) found that individuals who scored high on compassion satisfaction had low scores of compassion fatigue and burnout. Higher scores on self-kindness were associated with increased well-being. Self-judgment scores were correlated with decreased well-being and higher levels of compassion and burnout. There appeared to be no correlation between self-compassion and compassion for others (Beaumont et al., 2016).

Self-Awareness

As psychologists gain more awareness about who they are, developing an internal process that uses this awareness in all situations and experiences can be beneficial in developing and maintaining positive and effective alliances with clients. Acknowledging one's own subjectivity and working to achieve objectivity is important and facilitates the ability to comprehend others' perspectives, feelings, and experiences (Bean et al., 2014; Edwards, 2013). Good empathy skills facilitate psychologists' abilities to observe their clients and themselves from different points of view and to be aware of how actions and responses shape the therapeutic alliance (Cassels et al., 2010).

Developing a good capacity to empathize is beneficial for therapists and clients. It is important to explore one's own judgments and assumptions about others as well as oneself. Not exploring judgments and assumptions about the self and others may negatively impact therapeutic relationships and outcomes (Bean et al., 2014; Decety & Michalska, 2010; Gair, 2013; Greville-Harris et al., 2016; Kitron, 2011; Peer et al., 2015). Continuously gaining knowledge and awareness about one's own and others' experiences is important throughout a psychologist's career as perceptions and awareness evolve through work and personal experiences. Gaining these perceptions and improving awareness of personal experiences helps to increase professional competency over time (Bean et al., 2014; Casas et al., 2017; Ogle et al., 2013).

Psychologists who engage in practices that foster and increase self-awareness tend to be better able to uphold professional boundaries and are more likely to avoid enmeshment with clients (Bean et al., 2014). Enmeshment can be characterized as a relationship between two people who develop blurred personal boundaries and dependency on each other, creating a lack of autonomy. Enmeshment can be very damaging to the client because the relationship with the therapist will mimic past relationship and attachment patterns and behaviors and perpetuate problems for the client (Walzer & Nottis, 2013). Other dilemmas include inhibition of empathy and loss of control of empathy. Inhibition of empathy refers to the fear of getting too involved with a patient whereas loss of control is when one becomes too intensely involved with the

patient, which impedes the ability to observe and evaluate the patient (Rosenfield & Jones, 2004).

Burnout and Compassion Fatigue

Developing self-compassion can be a preventative measure for avoiding burnout and compassion fatigue. As previously noted, lack of engagement in activities that promote self-care can lead to burnout and compassion fatigue (Beaumont et al., 2016). Burnout is characterized as a response to chronic occupational stress. Burnout involves the experiences of emotional exhaustion and depersonalization that decrease a therapist's sense of personal achievements in the context of work. Burnout can exhaust emotional resources and create negative attitudes towards clients and others (Salmi & Ajitoni, 2016). Compassion fatigue is developed as a response to the awareness of others' suffering associated with traumatic experiences (Beaumont et al., 2016). Having a great deal of empathy for the suffering others experience can be a significant challenge and may cause therapists a great deal of anxiety, which can lead to burnout and compassion fatigue. These experiences can lead to maladaptive reactions in therapeutic and other interpersonal relationships that can significantly impact the therapeutic alliance (Rosenfield & Jones, 2004).

A limited awareness of one's personal triggers increases the likelihood that the therapist's interventions and interactions will lack effectiveness due to habitual and unevaluated responses and reactions (Bean et al., 2014). Having a positive disposition about an individual has a significant impact on how one may empathize with that person (Marshall & Marshall, 2011). It may become very challenging for a psychologist to work with an individual when there are negative feelings about the client's presentation and behavior. Being able to emphasize and remain objective is important for overcoming these feelings.

A common therapist response to learning about traumatic stress in children is a strong desire to resolve and fix the children's problems. The children's experiences may be so painful that the therapist responds with premature wishes to solve problems, which can hinder their ability to observe, listen, or appropriately apply therapeutic interventions (Osofsky, 2009). These responses can lead to compassion fatigue related to empathic feelings and emotional investment. At times, therapists may experience emotional numbing, terminate treatment prematurely, or even abandon their field altogether (Osofsky, 2009).

Cultural Competence

In the 18th century, during Herder and Kant's theorizing about the concept of empathy, Herder identified culture as an important and fundamental part of developing accurate interpretations of empathy (Edwards, 2013). He argued that empathy involves conscientious investigation into the culture and features of the person being observed; for example, an individual's age when historical events occur (i.e., World War II) or when specific political attitudes are prominent (Edwards, 2013). Herder spoke to the significance of scholars' and practitioners' abilities to achieve objectivity by recognizing their own embeddedness and naturally occurring epistemology (Edwards, 2013). Herder (as cited in Edwards, 2013, p. 272) further stated, "Because categories and concepts

people used to organize and express knowledge were part of a continuum, scholars must try to grasp others' meaning through authorial experience and not assume their personal concepts were universally applicable." Being aware of one's own cultural differences and how they affect perceptions and feelings about others can positively affect the quality of treatment and treatment outcomes. Cultural sensitivity increases psychologists' abilities to understand themselves and others and the interaction of cultural similarities and differences. Being aware of these factors can increase client engagement and treatment adherence because they facilitate meaningful relationships between psychologists and clients (Bean et al., 2014).

Psychologists need to be aware of cultural differences that can affect empathy in the therapeutic relationship. Clients and therapists both bring their cultural experiences and values into the therapeutic relationship. How these factors affect initial interactions between clients and therapists should be explored so therapists can gain insights into how clients perceive and process their experiences. Assessing clients' cultural values can increase therapists' awareness of differing perspectives and how they conceptualize clients and their presenting problems. Therapists with a greater awareness of cultural dynamics will take more purposeful steps to understand their clients' cultural values as well as their own.

The expression of empathy and empathic ability vary as do other characterological factors such as temperament and ability to regulate emotions. Cultural factors and belief systems can influence how a group displays empathy for others and how dynamics that influence development such as experiences and interpersonal relationships contribute to the nature of empathic processes (Hojat et al., 2002). For example, Park, Haslam, Kashima, and Norasakunkit (2016) studied empathy's effects on cultural bias and found differences associated with regional expressions of empathy. Park et al. used the term self-humanizing to refer to the tendency to attribute greater humanness to oneself over others or the belief that one has more traits typical of humans, such as empathy, than others. The study authors postulated that greater empathic ability decreased perceived differences between the self and others.

Participants in Park et al. (2016) were 80 Japanese undergraduate students from a university in Japan and 80 European Australian undergraduate students from a university in Australia. Participants were administered questionnaires with items from the IRI and 20 items identifying various personality traits. Prior to taking the questionnaire, the students were randomly assigned to either an empathy group or a control group. Students in the empathy group were asked to recall a situation in which they observed someone who appeared sad and felt empathy for them before filling out the questionnaire. Park et al. assumed that the task required of the empathy group would decrease self-humanizing in the subjects.

Park et al. (2016) found greater changes in Japanese students than in European Australian students, indicating that eliciting empathy increased attribution of self-humanizing in Japanese students. The authors concluded that differences may have reflected cultural influences on how empathy is expressed. Park et al. noted that Australians appear to have a tendency to perceive the self as more independent of others whereas Eastern Asians appear to perceive the self to be more interconnected with others and less as an independent entity.

Psychologists need to be aware of their own cultural values and similarities between clients and family members or significant others (Bean et al., 2014). When psychologists lack awareness of cultural factors, they may revert to previously learned ways of interacting, which may not be conducive to therapy (Bean et al., 2014). Awareness of these important factors while providing therapy and in consultation and supervision may increase positive outcomes and overall effectiveness (Bean et al., 2014).

Soheilian and Inman (2013) investigated the possible effects of trainee race on cultural competence, empathy, and multicultural counseling self-efficacy when working with Middle Eastern American clients. Participants were 256 trainees (68.4% White) recruited through contact with training and program directors associated with Lehigh University's master's- and doctoral-level counseling psychology, clinical psychology, marriage and family therapy, counseling education, and school psychology programs.

Participants in Soheilian and Inman (2013) provided demographic information and were administered the IRI, the Cross-Cultural Counseling Inventory-Revised (CCCI-R), and the Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD). The CCCI-R is a 20-item measure that uses a 6-point Likert-type scale (1 = *strongly disagree* to 6 = s*trongly agree*) to assess multicultural competence. The MCSE-RD is a 37-item measure that uses a 10-point Likert-type scale to assess perceived ability to remain flexible and accepting in resolving clients' cross-cultural issues and perceived ability to implement culturally appropriate assessment tools. Soheilian and Inman used vignettes describing three Middle Eastern American clients to investigate differences between White subjects and subjects of color. Study results indicated no significant differences in multicultural competence, empathy, or multicultural counseling self-efficacy between subjects (Soheilian & Inman 2013).

Research has indicated that therapist gender has little affect on empathy levels. Hojat et al. (2002) examined medical students' empathy related to clinical competence and gender. Study participants were 371 third-year medical students who had completed six core clerkships during their third year of school (family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and surgery) and who took the Jefferson Scale of Physician Empathy (JSPE). After each clerkship, faculty assessed student performance competency using a 4-point scale ranging from *High Honours* (superior) through *Excellent* and *Good to Marginal Competence* (barely passing). These ratings were then compared to JSPE scores. Student scores from the Medical College Admission Test grades earned on exams during the first and second year of medical school and scores on Steps 1 and 2 of the U.S. Medical Licensing Exam were also collected and used as indicators of performance in objective examinations of medical knowledge (Hojat et al., 2002). The study authors hypothesized that students with higher empathy scores would receive higher competency performance ratings and that women would achieve higher empathy scores than men.

After comparing the JSPE scores and clerkship ratings, Hojat et al. (2002) found that students who received three or more High Honours ratings had the highest mean scores on the JSPE. Students who did not receive any High Honours ratings in the six clerkships had the lowest mean JSPE scores. Students who received three or more Good or Marginal ratings had the lowest mean empathy scores. Overall, students who had at least one High Honours rating had significantly higher mean empathy scores than

students who had no High Honours ratings (Hojat et al., 2002). Results indicated a significant relationship between empathy scores and clerkship performance competency ratings. Consistent with previous research, the study authors found no significant correlations between empathy scores and examinations of medical knowledge.

On the JSPE, female subjects achieved significantly higher scores than males (Hojat et al., 2002). Hojat et al. (2002) conducted further analyses to investigate possible gender differences associated with performance competency ratings; however, no significant differences were found. Hojat et al. (2002) concluded that gender did not affect clinical competence.

A strength of Hojat et al. (2002) is the large sample size, which strongly supports the results that gender had no significant effect on medical students' professional competence. However, there were obvious differences in empathy scores on the JSPE, indicating that women may have higher empathy levels. A study weakness is the lack of information about which factors related to competency were assessed. It would be beneficial to assess information provided by clients about their experiences of empathy in the clinical setting. Although there are some differences between medical and psychological interventions and relationships, it is probable that such an inquiry would produce similar results.

Ivtzan, Redman, and Gardner (2012) examined relationships between gender, empathy, and theoretical orientation. Study participants were enrolled in postgraduate courses in person-centered therapy (PCT) and CBT. PCT requires therapists to provide unconditional positive regard to be congruent with and accepting and empathetic toward clients. CBT focuses on identifying and changing thinking patterns and their effects on behavior by questioning clients systematically and analytically. PCT differs from CBT in that it focuses on interpersonal and emotional needs whereas CBT focuses on purpose-driven methods and rationality (Ivtzan et al., 2012). The sample of 70 subjects in Ivtzan et al.'s study consisted of 48 women and 22 men. Participants were divided into three groups: PCT students (n = 31), CBT students (n = 21), and a control group (n = 18). The control group included participants enrolled in various social science courses, excluding psychology.

Ivtzan et al. (2012) used the IRI's Empathic Concern and Perspective-Taking subscales and the Bern Sex-Role Inventory (BSRI) to measure empathy and masculine and feminine qualities. The BSRI consists of 20 masculine, 20 feminine, and 20 neutral adjectives rated on a 7-point Likert-type scale (1 = *never*, 7 = *always true*). Participant demographics were collected on gender, age, highest previous qualifications, and postgraduate course enrolled in (Ivtzan et al., 2012).

Results from Ivtzan et al. (2012) indicated higher empathy levels in students enrolled in the PCT course; however, there were no gender differences in empathy scores. In the CBT and control groups, women had slightly higher empathic concern scores than men, but these results were not statistically significant. Ivtzan et al. also found that femininity was related to higher empathy scores, independent of gender. These results indicated associations between PCT, empathy, and femininity.

A strength in Ivtzan et al. (2012) is the distinction between gender and femininity and masculinity, which was an interesting method for reducing gender stereotypes. Ivtzan et al. noted the importance of considering social changes associated with

femininity and masculinity since the BSRI's development in 1974, although results from a 1988 study indicated comparable internal consistency to the original study. Results associated with theoretical orientation are of interest as whether individuals with higher levels of empathy are drawn to PCT or if levels of empathy changed as a result of training in PCT could not be reliably determined. If Ivtzan et al. had determined that the changes occurred due to PCT techniques, these findings would support the efficacy of certain techniques used in the empathy training proposed in the current study. A study weakness is the lack of information identifying the number of women and men included in each group. Ivtzan et al. only indicated this information in the total sample size but not within groups. As is apparent in other studies, the sole use of self-report measures may obscure actual empathy skills as participants may attribute more positive attributes and skew actual empathy levels.

Although some study results indicated differences in empathy between groups, the aforementioned studies also support the idea that competence is more important than empathy differences themselves. It appears that the ability to empathize when developing and maintaining relationships is important for competency; however, the distinct manner in which someone empathizes (i.e., according to race, gender, etc.) does not necessarily impact overall professional competence. Therefore, focusing on fostering empathy in general in doctoral psychology training is more important than identifying specific cultural characteristics explaining why or how an individual provides empathy.

Assessing Empathy Skills

The following assessment measures are commonly used, valid, and reliable tools that can provide important information about the efficacy of empathy skills training in doctoral psychology programs. These measures were incorporated into the proposed empathy skills training detailed in this study. Data from these measures can provide educators and training supervisors with valuable information for evaluating students' progress toward competency and the areas that might need additional focus to enhance abilities necessary for providing the highest levels of care.

Interpersonal Reactivity Index

The IRI is a 28-item self-report that assesses cognitive and affective empathy (Davis, 1980). The IRI shows good reliability and validity and is one of the most commonly used tools for measuring empathy (Leppma & Young, 2016). Items are rated on a 4-point Likert-type scale from 0 (*does not describe me well*) to 4 (*describes me very well*). The IRI includes four subscales with seven items in each subscale: Fantasy (FR), Perspective-Taking (PT), Empathic Concern (EC), and Personal Distress (PD). The FR subscale assesses individuals' abilities to imagine themselves in the shoes of a fictional character, PT assesses the ability to take another's point of view, EC measures feelings of sympathy and concern for others, and PD measures anxiety and discomfort in stressful interpersonal situations (Leppma & Young, 2016). Alpha coefficients have ranged from .70 to .78, and test–retest reliabilities have ranged from .62 to .71 (Beitel, Feerer, & Cecero, 2005; Berthoz, Wess, Kedia, Wicker, & Grezes, 2008; Cassels et al., 2010; Greason & Cashwell, 2009; Hopkins & Proeve, 2013; Leppma & Young, 2016; Poorman, 2002; Smits et al., 2011; Teymoori & Shahrazad, 2012; Yeh, Lo, Tsai, & Tsai, 2015).

Jefferson Scale of Physician Empathy

The JSPE and JSPE–Student Version are 20-item self-reports that assess a health care professional's empathy. Items are rated on a 7-point Likert-type scale (1 = *strongly disagree*, 7 = *strongly agree*; Hojat et al., 2001). Psychometric data supporting the JSPE's validity, reliability, and internal consistency were determined by Cronbach's coefficient ($\alpha \sim .80$). Significant correlations have been found between the JSPE and the IRI (Casas et al., 2017; Fernandez-Olano et al., 2008; Friedrich et al., 2013; Hojat et al., 2001; Nasr Esfahani, Behzadipour, Jalili Nadoushan, & Shariat, 2014; Ogle et al., 2013).

Empathy Quotient

The Empathy Quotient (EQ) was developed for clinical application and to be sensitive to a lack of empathy. The EQ is a 60-item questionnaire, 40 of which tap empathy, and 20 filler questions. Responses are rated on a 4-point Likert-type scale. The test has a forced-choice format, and scores do not depend on interpretation (Baron-Cohen & Wheelwright, 2004).

The EQ can be self-administered. This measure has good internal consistency, concurrent and convergent validity, and good test–retest reliability (Baron-Cohen & Wheelwright, 2004; Berthoz et al., 2008; Lawrence, Shaw, Baker, Baron-Cohen, & David, 2004).

Balanced Emotional Empathy Scale

The Balanced Emotional Empathy Scale (BEES) is a 30-item measure of affective empathy designed to differentiate between individuals who experience more of others' feelings and individuals who seem less responsive to others' experiences (Mehrabian & Epstein, 1972; Williams & Wood, 2010). Questions are rated on a 9-point Likert-type scale ranging from *very strong agreement* to *very strong disagreement*. Internal consistency is .87.

Questionnaire Measure of Emotional Empathy

The Questionnaire Measure of Emotional Empathy (QMEE) is a widely used, valid, and reliable measure designed to assess an individual's tendency to react strongly to the experiences of others (Mehrabian & Epstein, 1972). It contains seven subscales: (a) Susceptibility to Emotional Contagion, (b) Appreciation for the Feelings of Unfamiliar and Distant Others, (c) Extreme Emotional Responsiveness, (d) Tendency To Be Moved by Others' Positive Emotional Experiences, (e) Tendency To Be Moved by Others' Negative Emotional Experiences, (f) Sympathetic Tendency, and (g) Willingness To Be in Contact With Others Who Have Problems. Reliability is approximately .73 (Baron-Cohen & Wheelwright, 2004; Lawrence et al., 2004; Mehrabian & Epstein, 1972; Pecukonis, 1990).

Working Alliance Inventory

The Working Alliance Inventory (WAI) is a 36-item self-report that uses a 7-point Likert-type scale ranging from 1 (*never*) to 7 (*always*; Horvath & Greenberg, 1989). Three subscales—Bond, Goal, and Task—each consist of 12 items. The Bond scale

assesses the connection between the counselor and client, the Goal scale indicates agreement between the client and counselor about treatment goals, and the Task scale refers to the focus and direction the counseling will take. Both the client and counselor versions of the WAI have shown good validity and reliability (Sackett & Lawson, 2015).

Empathy Training

Research findings support the efficacy of training that increases empathy and have shown positive effects of such training on interpersonal relationships and therapeutic alliances. Researchers have studied a variety of methods for increasing empathy through training. Of these methods, mindfulness, role-play, and sharing stories are most often used to foster empathy. There is little evidence that any other method, aside from lectures, has been used to increase empathy. Lectures appeared to have little if any affect on empathic ability but were sometimes used in conjunction with other methods.

Mindfulness includes focusing on the present moment; nonjudgmental awareness; and acceptance of thoughts, emotions, and sensations as they are felt. Core concepts of mindfulness practice are focusing on what is presently occurring; being aware of one's own physical sensations, thoughts, and emotions; and accepting them without further analysis and evaluation (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Campbell & Christopher, 2012; Winning & Boag, 2015). Mindfulness's attitudinal foundations include acceptance, curiosity, letting go, loving-kindness, nonattachment, nonjudging, nonreactivity, nonstriving, openness, playfulness, and trust (Shapiro & Carlson, 2009).

The core concepts of mindfulness are strongly associated with empathy and have been found to increase empathic abilities. As previously discussed, providing validation and acceptance communicates therapists' empathy for clients and their experiences and strengthens therapeutic relationships.

Csaszar and Curry (2010) identified concentrative meditation, mindfulness meditation, and directed meditation as three types of mindfulness practice. Concentrative meditation requires focusing on something specific like breath, an object, words, or mantras. Mindfulness meditation is the act of being in the present and concentrating and focusing on anything that enters the individual's awareness. Directed meditation uses any content that engages the awareness of one's personal aspects. These methods can be used alone or in combination (Csaszar & Curry, 2010).

The key components of mindfulness practice include breathing, mantras, relaxation, attention and focus, and spirituality and belief systems. Some mindfulness exercises focus specifically on breathing and being consciously aware of and in control of how one breathes; for example, breathing through the mouth or nose and focusing on breath rate and depth. Breathing can also be used as an anchor for other types of mindfulness exercises that do not directly focus on breathing (Csaszar & Curry, 2010). Mantra is the repetition of a sound, word, or phrase of any kind. Relaxation is a major element of mindfulness practice and is the component most often associated with mindfulness (Csaszar & Curry, 2010). Attention and focus is being purposefully attentive to an object, mantra, or body part. Spirituality and belief systems can be

incorporated into mindfulness as a foundation for how different mindfulness activities are performed and may include a focus on transcendence (Csaszar & Curry, 2010).

As mindfulness skills are learned and practiced, they are incorporated in both professional and personal experiences and become a way of life rather than skills that are used selectively (Campbell & Christopher, 2012). With increased understanding and practice of mindfulness, behaviors, attitudes, and manner of thinking change and evolve. Psychologists' abilities to be present and aware of their own feelings and sensations and to communicate them can be an important element of therapy (Campbell & Christopher, 2012).

Role-play can foster empathy as it requires the ability to accurately embody a character's motivations, feelings, desires, and beliefs. Cognitive empathy and perspective taking, defined earlier, are significant elements associated with role-play. Role-play requires the cognitive ability to recognize and identify others' feelings and emotions (Dethier & Blairy, 2012; Ferrari et al., 2014; A. Smith, 2009; Smits et al., 2011). Perspective taking is significant in that it gives rise to empathic and sympathetic responses and involves sharing emotions and emotional meanings, which is vital in role-playing (Decety & Michalska, 2010; A. Smith, 2009; Smits et al., 2011; Teymoori & Shahrazad, 2012). ToM is the ability to understand that people have different beliefs, motivations, knowledge, and moods and that these factors affect the actions and behaviors of individuals engaged in role-playing (Smits et al., 2011). Finally, sharing stories involves reading and/or sharing the experiences of others, which have been shown to increase empathy and self-awareness (Banyard, 2000; Davidson, 2015; Eklund, Andersson-Straberg, & Hansen, 2009; Heliker & Nguyen, 2010).

Teding van Berkhout and Malouff (2016) conducted a meta-analysis of 18 randomized and controlled trials of empathy training that included 1,018 subjects and found that, overall, the various empathy trainings were efficacious. Common factors associated with higher effect sizes included type of trainee (i.e., health professionals in training and students) and using objective measures that focused on accurately understanding others' feelings and emotions rather than self-report measures.

Teding van Berkhout and Malouff (2016) investigated the efficacy of types of empathy training (cognitive, affective, and behavioral) and length of training. Behavioral skills included modeling, instructions, rehearsal, and feedback. Studies that included all four behavioral skills were compared to those that did not. Teding van Berkhout and Malouff also examined length of training and found that the number of hours spent in training had no significant relationship with the training's effectiveness.

Results showed that training methods that included behavioral methods of teaching empathy were more effective than those that did not (Teding van Berkhout & Malouff, 2016). Cognitive training appears more prominently in research than affective training, likely because cognitive skills require conscious processes whereas affective skills are unconscious processes and are therefore more difficult to identify and measure. Teding van Berkhout and Malouff (2016) suggested that including behavioral skills in trainings is efficacious because behavior is a response to both cognitive and affective processes and therefore can encompass more aspects of empathy.

A strength of Teding van Berkhout and Malouff (2016) is that it is a meta-analysis of a relatively large number of studies and included a significant number of subjects,

which greatly increased the significance of the findings. The differentiation between cognitive, affective, and behavioral techniques is also helpful as it brings to light how teaching behavioral empathy techniques can influence both cognitive and affective aspects of empathy and that active techniques may play a more important role in increasing empathy. A weakness in this study is that the training length was based on various populations. For example, some of the population samples included health professionals whereas others included individuals with intellectual disabilities and therefore may have produced insignificant results where significant results may have otherwise been found. Another weakness in this study is that the meta-analysis may not have brought to light nonsignificant trends. Including more studies may have been necessary to do so.

Andersson, King, and Lalande (2010) investigated the efficacy of using mindfulness-based role-play (MBRP) supervision to foster empathy in therapists. MBRP includes mindful awareness of cognitive, affective, visual, auditory, olfactory, kinesthetic, and gustatory elements while engaging in dialogues with other people. Supervision sessions involved three stages: acquainting, theme, and sharing. In the acquainting stage, supervisees role-play themselves and their clients engaging in a general therapy conversation without focusing on any particular themes or difficulties in the therapy. The theme stage focuses on an area of difficulty in therapy. The sharing stage is when the role-play interaction is guided toward the client and therapist sharing how it was for each of them to be with one another and how they felt about each other. During the supervision process, the theme and sharing stage may be revisited (Andersson et al., 2010).

The sample in Andersson et al. (2010) included 13 individuals who had between 2 and 26 years of professional experience in the mental health field. Subjects participated in an MBRP workshop followed by one session on MBRP supervision guidelines facilitated by the study's principal researcher. Participants were then interviewed, and responses were analyzed qualitatively. Data collection indicated the presence of five domains: emotional responses to the supervision, cognitive reflections on the supervision, supervision outcomes related to client, supervision outcomes related to self, and supervision outcomes related to the therapy process (Andersson et al., 2010).

Andersson et al. (2010) found that using MBRP as part of clinical supervision had a positive effect on therapists' abilities to more accurately empathize with clients. Following the MBRP activities, participants indicated that they felt less judged and safer than in supervision experiences prior to participating in this study. Participants also reported that the supervision sessions were more experiential than other supervision experiences, which supports the idea that empathy requires more than just intellectual understanding. The participants also reported increased feelings of empathy for clients' emotional and physical experiences. Study results indicated that empathy can be enhanced when mindfulness and role-play are included in training (Andersson et al., 2010).

A strength of the Anderson et al. (2010) study is the use of both mindfulness and role-playing methods. Using more than one method appeared to be more beneficial in increasing empathy skills. Another strength is the qualitative method used to break down significant themes and domains indicated in the post-session interviews. This

information is helpful in understanding the participants' experiences and which factors, like safety and nonjudgment, are affected the most. A study weakness is using only one supervision session instead of multiple sessions as it is difficult to ascertain the long-lasting effects of this training method. It would also have been helpful to know how the participants interacted with their clients after the MBRP session and if the clients noticed differences.

Hopkins and Proeve (2013) studied the effects of an 8-week mindfulness-based cognitive therapy (MBCT) program on psychologists' stress and career development. The Perceived Stress Scale, the Five Facet Mindfulness Questionnaire, and the IRI were used to assess aspects of empathy and stress at the beginning and end of the training and at 2 months after the course ended. Hopkins and Proeve found differences in some aspects of empathy and stress after training was completed. Over time, trainees continued to develop mindfulness skills, which Hopkins and Proeve attributed to continued practice of core mindfulness skills after program completion. Hopkins and Proeve suggested that the willingness to learn mindfulness practices may depend on the individual's personal motivation and that such practice contributes to positive change.

Leppma and Young (2016) examined the effects of loving-kindness meditation (LKM) on counseling students' empathy levels. LKM is a compassion-based mindfulness meditation that incorporates cognitive and emotional aspects. This meditation approach increases care for oneself and others by initially directing loving-kindness, or compassion, toward oneself (Leppma & Young, 2016). LKM does not aim to change cognitive or behavioral factors; rather, the purpose is to use an affective technique to cultivate positive emotions. LKM facilitators in Leppma and Young's study were five doctoral students and one postdoctoral instructor who participated in a 1-hr training and were given manuals for the intervention, meditation scripts, session outlines, and handouts.

Participants in Leppma and Young (2016) were 103 students in a master's-level counseling program. Fifty-four students were included in the intervention group; the rest were in a control group. LKM intervention included psychoeducation, an LKM exercise, and processing participants' experiences through meditation. Each weekly 60-min session included a 30-min check-in, processing, and psychoeducation related to counselor wellness. The association between meditation and counselor self-care was made explicit (Leppma & Young, 2016).

For Weeks 2 through 6 of the LKM intervention, students completed weekly meditation logs documenting time spent daily practicing formal meditation between group sessions and whether they used a meditation CD provided to the group (Leppma & Young, 2016). In the logs, participants also rated how well they were able to bring the attitudes, intentions, and principles discussed in the group into their daily lives on a 5-point Likert-type scale (1= *strongly disagree* to 5 = *strongly agree*). The IRI was administered at the first and final sessions (Leppma & Young, 2016).

Leppma and Young (2016) found that the LKM intervention had a positive effect on cognitive empathy. The study authors suggested that increasing cognitive empathy may be significant in that it appears to be a protective factor from vulnerability and burnout. Cognitive empathy allows counselors to maintain connection without becoming affectively overwhelmed (Leppma & Young, 2016).

The number of participants and use of a control group are significant in the Leppma and Young (2016) study as they strengthened the significance of findings. Another strength is using psychoeducation and LKM simultaneously as two methods for increasing empathy rather than only one or the other. One study weakness is that the actual use of meditation practices outside of the class could not be confidently assessed.

Winning and Boag (2015) investigated if brief mindfulness training can increase empathy. The study included 102 subjects; 91 first-year psychology students and 11 individuals recruited from the general population. Study subjects were divided into an experimental group (n = 50) and a control group (n = 52). The experimental group listened to a 15-min audio recording featuring a guided mindfulness meditation. The control group listened to a 15-min audio recording of the same voice; however, this recording was not guided and asked participants to follow their own thoughts. Following the exercise, subjects were assessed using the Manipulation Check, a 4-item measurement that uses a 5-point Likert-type scale. Scores on the Manipulation Check indicated the subject's mindfulness state level during the mindfulness exercise. Participants then completed the Mindfulness Empathy Test and the PANAS. The Mindfulness Empathy Test measures cognitive and affective empathy through responses to photos of people experiencing a range of emotions. Results indicated that short-term mindfulness training effected changes in cognitive empathy (Winning & Boag, 2015).

A strength in Winning and Boag (2015) is the use of assessment measures that were not self-reports. Self-reports may significantly affect results in that they reflect individuals' perceptions rather than what may be realistic. A weakness of this study is the inclusion of the general public participants. Winning and Boag only required these participants to acknowledge that they were in a quiet environment, but this information could not be confirmed. In addition, the number of student participants far exceeded the number of general public participants. Having an unevenly distributed population may have biased the study results. It is possible that using a sample with 91 general public participants and 11 students may have produced different results.

Kipper and Ben-Ely (1979) compared and evaluated the efficacy of three empathy training methods: the psychodramatic double method, the reflection method, and lecture methods. The psychodramatic double method requires two people, an actor and a double. The person playing the double repeats and mirrors the actor's words, expressions, and behaviors as if they are working together as one person. The double can also inquire about the meaning of the actor's words, expressions, and behaviors to clarify and amplify feelings. It is not the role of the double to interpret but instead to act as one with the actor in a way similar to a person having an internal debate or dialogue (Kipper & Ben-Ely, 1979). In response to the double's inquiries, the actor is encouraged to confirm, rebut, or clarify information. In the reflection method, two people face each other, and one person is required to reflect back what he or she perceives are the thoughts and feelings of the other. The two face each other, and the partner acts an observer or interviewer. Unlike the double method, the reflection method involves the two people talking as opposed to pretending to be one person. The lecture method included six short lectures (Kipper & Ben-Ely, 1979).

Kipper and Ben-Ely (1979) administered the Accurate Empathic Scale to 120 high school students to determine if they qualified for the study. Students who showed

moderate but not high empathic ability were included in the final sample, which consisted of 32 male and 32 female high school students. Sixteen subjects were included in each method; the remaining 16 were used as controls. Role-plays included 12 predetermined situations based on their relevance to the students' actual experiences. The sessions were held for 40 min once every 10 days (Kipper & Ben-Ely, 1979). The lectures were six 40-min sessions every 10 days. Each session consisted of 25 min of lecture, 10 min of discussion, and 5 min for writing down answers to three questions. Results indicated that the double method produced the most significant changes in empathy, followed by the reflection method. The lecture method was the least effective method (Kipper & Ben-Ely, 1979).

Comparing role-play use to only using lectures is a strength in Kipper and Ben-Ely (1979). This comparison supports using active methods to teach empathy and shows that lecture methods are insufficient. Session length is also a significant strength in this study as using six separate sessions over the period of 60 days for a long period of time (40 min) increased the validity of study results. Although this study is dated, the results are congruent with other studies that indicate role-play as a valuable method to teach empathy. One weakness in this study is the use of high-school students. Older participants may have produced different results as teenagers' empathy levels change due to brain development and maturation.

Friedrich et al. (2013) investigated using the Education Not Discrimination (END) intervention in medical school. END focuses on reducing mental health stigmatization in professional training. The program includes education about stigma and discrimination, testimonies of personal experiences with stigma (personal or professional), and role-play. Students engage in role-play followed by feedback from fellow peers and actors.

Study participants were 1,452 third-year medical school students (Friedrich et al., 2013). The students were assessed before, following, and 6 months after program completion using the Mental Health Knowledge Schedule, the Community Attitudes Towards the Mentally Ill, the Reported and Intended Behaviour Scale, and the JSPE. The assessment measures focused on establishing differences in knowledge, attitudes, behavior, and empathy. Study results indicated significant increases in all areas in the intervention group (n = 1,066) compared to the control group (n = 386) immediately following the END program (Friedrich et al., 2013).

Friedrich et al. (2013) did not find significant differences in knowledge, behavior, and empathy at 6-month follow-up. However, attitudes of students in the intervention group both immediately and 6 months after the program were significantly better than in the control group. Study participants indicated that hearing about clients' perspectives and experiences, which contributed to attitudes, was particularly beneficial in that they provided insights into issues that were not included during the participants' formal training. Friedrich et al. hypothesized that there may have been no significant difference between groups at 6 months post training due to being enrolled in formal education that may have had similar foci to the END program, nullifying the program's effects. The authors concluded that teaching and exploring biases and stigma can be effective but that interventions should be more integrated and applied for longer periods of time.

Friedrich et al.'s 2013 study illustrates the effectiveness of role-play and perspective taking, which supports the use of this method in training empathy skills. The sample size is significant because it includes the involvement of a large participant pool. A limitation to this study is that the training showed more effectiveness short term than long term, but findings did suggest that training may be more effective if applied for longer periods of time. As they relate to the present study, these findings support that empathy training would be more effective if it is available and used throughout the training and education offered in doctoral graduate programs.

E. O. Lee, Goforth, and Blythe (2009) conducted a case study on using role-play to increase social work students' understanding of diversity issues and how to approach these issues sensitively when working with and interacting with others. Students gave feedback about the experience and provided their perspectives on the value and effect of this intervention on their understanding of diversity and social justice issues. The study authors also evaluated the students through direct observation and participation to assess the significance of this intervention.

The role-play intervention in E. O. Lee et al. (2009) was a scenario based on an incident that took place in a human rights center in Chiapas, a Mexican state where more than 90% of the population are Mayan. Students were given descriptions and information about a character to play and goals and points to make when role-playing a meeting between the characters. Character descriptions also included information about the character that the student would not share with the other meeting members. The reason given for the meeting was a conflict about salary inequity that appeared to reflect racism (E. O. Lee et al., 2009).

Following the role-play meeting, students were asked to provide feedback and reflections about their experiences. Questions asked included (a) What was your experience of the meeting? (b) What was most helpful about participating in the role play? What was least helpful? (c) Do you think this is a racist situation? If you think it is, what is the source of the racism? How could the racism be changed? (d) Do you find it easy or difficult to talk about race issues that occurred in a foreign country? (e) What other factors besides race and culture are at play here? and (f) What should the center do to solve its problem? Would you like to propose a solution? (E. O. Lee et al., 2009).

Students generally described the role-playing as a good experience and indicated that the intervention's interactive nature was helpful in understanding others' experiences (E. O. Lee et al., 2009). The students also reflected on the benefit of talking about their experiences and reactions after the role-play was completed. Another aspect that students identified as valuable was the difficulty in developing an adequate understanding of the complete experiences of their character's experiences regarding race and cultural factors. Although the students were not fully able to encompass the racial and cultural factors, they stated that this difficulty was important as it made them aware of topics that could be beneficial in future interactions (E. O. Lee et al., 2009).

E. O. Lee et al. (2009 noted the value of allowing and encouraging students to talk about guilt and self-censorship regarding their own cultural and racial roles. The role-play intervention also appeared to foster empathy for the characters, group dynamics, power structure in the human rights center, and the vulnerability of oppressed populations (E. O. Lee et al., 2009).

Results from E. O. Lee et al. (2009) illustrate the significance of role-play in fostering empathy and cultural competence. Students experiences of the role-play were largely positive and effective in increasing knowledge and understanding of differing perspectives. A strength of this study is that role-play was used in a large group, which required the whole class to participate rather than only a few students while the rest of their classmates observed. It may have been of value for E. O. Lee et al. to acknowledge the social worker students' race and ethnicity and perhaps even provide descriptions of the students' own experiences with culture and privilege. Overall, this study seems to show that role-play can foster empathy for and awareness of others' experiences when working with clients of different cultures.

Hutchinson et al. (2014) designed and developed a brief training and assessed its efficacy in increasing empathy. The program, Who's Challenging Who (WCW), was developed to increase empathy in staff who work with individuals with intellectual disabilities displaying challenging behaviors. WCW's theory is that positive attitude change can be made when individuals have contact with the stigmatized group (Hutchinson et al., 2014). The WCW training was co-led by an individual with an intellectual disability, and exercises provided contact with and exposure to individuals with intellectual disabilities, who shared their experiences and perspectives on how services could be improved (Hutchinson et al., 2014).

Participants in Hutchinson et al. (2014) included 76 staff from a variety of programs and organizations that serve people with intellectual disabilities. Prior to the start of the WCW training, staff members provided information about their empathy for and attitudes toward people with challenging behaviors. At the end of the training, subjects completed a questionnaire so that the study authors could compare differences between pre- and posttest results and determine the efficacy of the WCW training. Hutchinson et al. suggested that empathy and positive attitudes toward people with challenging behaviors increased staff's confidence in working with people with intellectual disabilities. The results indicated immediate and positive changes in pre- and posttest empathy.

A strength in Hutchinson et al. (2014) is the relevantly large number of participants and that the participants came from varying programs and organizations. These factors probably made the results more generalizable across all staff working with individuals with intellectual disabilities. Although staff members were tested before and after training, it may have been of more value to test the participants 6 months after training. It is possible that participants may have experienced burnout and that the training may have only produced a short-term effect. The results could be stronger if factors such as burnout were taken into account. It could also be possible that participants responded more positively because of concerns about job performance and evaluation.

Heliker and Nguyen (2010) investigated the efficacy of story sharing in nursing homes. Subjects included 84 nursing assistants and 45 residents working and living in nursing homes. The participants were asked to share information about relationships between staff and residents, how they connected, and how sharing personal experiences changed or affected their relationships. The study authors compared story sharing and communication skills interventions to assess their effects on empathic meaningful

relationships. The Emotional Empathy Tendency Scale and the Mutuality Scale were used to assess relationship characteristics. The Mutuality Scale measures interpersonal skills including reciprocity, shared values, shared pleasurable activities, and affective closeness (Heliker & Nguyen, 2010).

Study results indicated that story sharing was an effective intervention for increasing and fostering empathy in therapeutic relationships (Heliker & Nguyen, 2010). Empathy and empathic traits were assessed after the intervention; Heliker and Nguyen (2010) found that the intervention's effects were still significant after 6 months. Heliker and Nguyen (2010) also noted that the quality of the relationship and feeling cared for were more important than the nursing assistants' skills and general professional duties.

A strength of Heliker and Nguyen's 2010 study is that the participants could report not only if but also how sharing stories actually changed or affected their relationships. Evaluating various interpersonal skills with the Mutuality Scale was beneficial in understanding which aspects of relationships were affected. More detail on the effects of age on the results would have been helpful. Because of the nature of an older population, there was a higher likelihood of participants with cognitive impairments, which could have impacted the findings.

Banyard (2000) studied the efficacy of including autobiographical writings in an undergraduate abnormal psychology class. The writings were first-person accounts of people with various mental illnesses and included descriptions of positive and negative views of oneself and interactions with others. Students were given a written assignment that asked the following questions: (a) What symptoms, cause, or treatments of the disorder did the individuals describe? (b) What were the individual's thoughts, feelings, and experiences? (c) How did the autobiographical experiences match the symptoms descriptions portrayed in text and lecture? (d) Which theories and research on etiology and treatment did this first-person account exemplify? and (e) What did you learn about this disorder from the first-person account that was not in your textbook? First-person accounts were supplemented with additional information during class discussions about the account and questions asked for the written assignment. Banyard encouraged the students to think about societal stigmatization of mental disorders. Two-thirds of the way through the semester, students wrote about an encounter with another individual with mental illness outside of class. The students then wrote papers describing that person's symptoms, etiology, and treatment. They also compared the second case to the first case and what they learned from their textbooks and explored what these individuals' experiences suggested about society's treatment of people with mental disorders. The purpose of comparing cases was to provide practice comparing and contrasting information on mental disorders from different sources. Sharing other accounts also provided students more examples and perspectives of people experiencing mental illness (Banyard, 2000).

Forty-one students in Banyard (2000) responded to closed- and open-ended questions about the perceived quality of using the textbooks and autobiographies to increase knowledge. Eight questions related to the textbook and autobiographies were rated on a 5-point Likert-type scale (1= *not at all* to 5= *very much*). Two open-ended questions were also asked about reactions to textbook and autobiographical information. Study participants reported greater appreciation and understanding of the experiences of

individuals with mental illness when autobiographical reading and writing were included in class (Banyard, 2000). Responses on questions about empathy indicated that autobiographies facilitated better understanding of the thoughts, feelings, and experiences people with mental illness have. The students also reported an increased understanding of different diagnoses and what it feels like to have certain symptoms (Banyard, 2000).

Banyard (2000) incorporated different methods to teach empathy, which is a study strength. Using textbooks, first-person accounts provided as well as ones the students found, and writing assignments enveloped various aspects of empathizing. The sample size was likely large enough to assume that these methods are useful in teaching empathy. A weakness is that the study was conducted in a graded class. The students may have answered more positively due to the nature of the setting, and questions did not specifically ascertain if students actually experienced increased empathy or just reported that they did.

Livingston, Milne, Fang, and Amari (2011) conducted a meta-analysis on 13 studies on the efficacy of substance use-related stigma interventions. The studies were divided into three categories based on the type of stigma: self-stigma, social stigma, and structural stigma. Findings suggested that self-stigma could be reduced through therapeutic interventions such as group-based acceptance and commitment therapy (Livingston et al., 2011). Effective strategies for addressing social stigma included communicating positive stories of people with substance use disorders. Training and education programs targeting medical students and professionals were also found effective (Livingston et al., 2011). Livingston et al. concluded that substance use-related stigma interventions significantly decreased negative attitudes toward alcohol and heroin users and significantly decreased anxiety and discomfort about working with alcohol users.

It is evident that listening to the experiences of others increases empathy and the ability to understand others' perspectives. Story sharing is also helpful as it can lead to identifying similar experiences with others. Identifying the important aspects of others' experiences and reflecting on these stories can facilitate better understanding of why and how individuals perceive their worlds.

The literature reviewed in this section supports the effectiveness of various methods that can increase empathy, including mindfulness, role-play, and sharing stories. The literature also supports using these methods to help increase empathy in psychology students. Enhancing doctoral psychology students' empathic abilities can positively affect communication and interpersonal relationships, which are necessary for achieving positive and effective therapeutic alliances and outcomes.

Maintaining Interpersonal Skills Competencies

Practicing and maintaining good empathy skills throughout one's career is important for psychologists as well as others they may teach and train. Modeling and applying behaviors that foster empathy can also be essential components in helping students and supervisees expand interpersonal effectiveness in their practice and increase their awareness of how empathy influences the therapeutic relationship and clinical outcomes.

Ongoing mentoring and supervision are important in facilitating doctoral psychology students' growth as brief trainings do not create lasting change (Bean et al., 2014). Effective supervision includes creating a trusting environment with room for exploring the supervisees' knowledge, skills, and attitudes related to their developing practice and identity as psychotherapists (Osofsky, 2009). Open communication between supervisor and supervisee can also act as a model for communication between the client and therapist, colleagues, and others who may be involved in client treatment (Osofsky, 2009). Principles of reflective supervision include the intentional practice of reflection as well as mutual collaboration and consistency throughout the supervisory relationship. Reflective supervision provides supervisees the tools for increasing capacities, resilience, and resourcefulness and also increases awareness about the value and significance of the supervisee's feelings and emotions (Osofsky, 2009).

In a qualitative study, V. J. Smith (2011) investigated the importance of relationships and their influence on treatment outcomes by studying the quality and features of student–tutor relationships in a college counseling program. The qualities and features identified were similar if not the same as one would see in a typical client–therapist relationship. Study participants were 15 female students from a 2-year part-time postgraduate counseling training course (eight first-year and seven second-year students). Students were interviewed during one 30-min and one 50-min focus group. The group discussions focused on the positive and negative features of relationships in general and with tutors, the extent to which positive relationships with tutors are important for learning, how relationships with tutors affect learning, and aspects of the course where positive relationships might be particularly important (V J. Smith, 2011).

Study participants identified acceptance, support, encouragement, and affirmation as important aspects of their relationships with tutors (V. J. Smith, 2011). They also identified empathy, openness, genuineness, self-disclosure, sense of equality, tutor modeling (demonstrating a positive attitude), giving and receiving feedback, and providing a safe, supportive learning environment significant in developing and maintaining positive relationships. It appeared that providing a safe and supportive environment appeared to be the most influential aspect of the relationship (V. J. Smith, 2011). V. J. Smith (2011) concluded that the students who had positive relationships with tutors found it easier to accept feedback, ask questions, and be open and vulnerable in learning processes.

A strength of V. J. Smith (2011) is the student participants' abilities to express their feelings and thoughts in their own words rather than words provided by V. J. Smith or on assessment measures. Also valuable is that V. J. Smith identified factors that influence relationships in general and how they compare to important aspects of the therapeutic alliance. Study weaknesses include the small sample size and that it only included women. Also, the study was only conducted with one group in one course; as such, its findings may not be applicable to other groups.

It is important that reflective supervision is available to students and trainees. The ability to reflect on intense emotions that arise from hearing clients' traumas allows therapists to provide effective therapeutic interventions and facilitates positive self-care (Osofsky, 2009). Students and supervisors do not necessarily have to analyze their feelings but rather just acknowledge feelings that exist and find ways to cope with these

feelings so they can maintain professional boundaries with their clients (Slesnick, Glassman, Katafiasz, & Collins, 2012).

In addition to reflecting on intense experiences in therapy, being able to anticipate strong emotional reactions to clients' experiences is vital. Knowing that certain client experiences may induce uncomfortable feelings increases a therapist's understanding of the significance of seeking support from supervisors to share and reflect on these feelings. As therapists learn and grow from these experiences, they can learn and maintain the necessary tools for supporting others who work with similar clients. In supervisory roles, it is important for supervisors to not only be aware of their own emotional feelings and reactions but to also gain insight into supervisees' emotional responses. These insights can help supervisors encourage supervisees to process uncomfortable feelings and engage in self-care behaviors to alleviate these feelings and allow better focus on providing effective treatment (Osofsky, 2009).

Brockhouse, Msetfi, Cohen, and Joseph (2011) examined factors such as a sense of cohesion, organizational support, and empathy that may contribute to positive vicarious posttraumatic growth. Vicarious posttraumatic growth refers to a therapist's psychological growth that results from exposure to traumas their clients have experienced. Sense of cohesion was described as the degree to which a person perceives the world as meaningful, manageable, and comprehensible. Organizational support referred to the therapists' perceptions of support provided by their associations that was associated with their value and well-being as an employee (Brockhouse et al., 2011).

Participants in Brockhouse et al. (2011) were 118 registered therapists who had experience working with trauma clients full or part time in private practice, clinics, or both. On average, participants spent approximately 14 hr a week with clients. Demographic information included age, gender, ethnicity, and current relationship status. Information was also collected regarding qualifications, training experience, practice orientation, years working as a therapist, hours per week working face-to-face with clients, use of personal therapy, frequency of receiving supervision, and personal trauma history. Therapist exposure to vicarious trauma was assessed by years of practice, weekly face-to-face hours with clients, percentage of vicarious exposure to trauma in the previous month, and exposure to clients deemed to have PTSD (Brockhouse et al., 2011).

Brockhouse et al. (2011) administered the JSPE, the short form of the Sense of Coherence scale, the short form of the Perceived Organisational Support Scale, and the Posttraumatic Growth Inventory. The JSPE was previously described. The Sense of Coherence scale short form is a 13-item measure of coherence scored on a 7-point Likert-type scale. The short form of the Perceived Organisational Support Scale is an 8-item measure that assesses employees' perceptions of the extent to which an organization values their personal contributions and cares about their well-being and is scored on a 7-point Likert-type scale. The Posttraumatic Growth Inventory is a 21-item questionnaire scored on a 5-point Likert-type scale that measures experience of psychological growth.

Results from Brockhouse et al. (2011) indicated that empathy and sense of coherence predicted psychological growth levels and that greater amounts of vicarious exposure contributed to greater overall psychological growth. Therapists with higher empathy levels had more beneficial experiences than those with lower empathy, and empathy had a significant moderating effect between relating to others and vicarious

exposure to trauma. Individuals with lower empathy scores who experienced higher vicarious trauma levels reported higher levels of relating to others, and individuals with higher empathy appeared to have lower levels of relating to others. Brockhouse et al. suggested that this finding may have resulted from highly empathic therapists' abilities to establish more relational distance between themselves and the client, thus allowing them to more effectively adapt to various perspectives. Closer relational distance appeared to create more challenges and great efforts to explore and change various perspectives. Therapists with higher senses of coherence appeared to experience lower levels of growth (Brockhouse et al., 2011).

Results from Brockhouse et al. (2011) shed light on how higher empathy levels can contribute to more effective self-preservation. Experiencing vicarious trauma when working with clients with trauma histories can lead to burnout and compassion fatigue. Increased empathy may hinder these issues, allowing therapists to provide interventions more effectively and competently.

A strength of the Brockhouse et al. (2011) study is the examination of the relationship of various factors to psychological growth. Few researchers have explored these relationships, and Brockhouse et al.'s findings can increase understanding of empathy's effects on therapeutic interventions and professional growth. Findings from this study support the efficacy of training for doctoral psychology students that enhances empathic abilities, especially for therapists working with clients who have experienced trauma. Including multiple variables such as demographics and experience may have strengthened the overall results of Brockhouse et al.'s research. However, the study authors provided little information about the relationship between personal experiences of trauma and empathy, although there was some indication that personal experiences of trauma decreased relational distance with clients and presented therapists with greater challenges in adapting their relational schemas, which may limit psychological growth. In addition, using self-report measures may not have accurately represented empathic abilities because the responses were based on study participants' own perceptions of their experiences.

Slesnick et al. (2012) investigated treatment barriers for homeless clients and therapists' experiences of working with this population. Fifteen families from a homeless shelter participated in the study. All mothers met criteria for alcohol and/or other substance use disorders and had custody of at least one biological child between ages 2 to 6 years. Three White female doctoral students provided therapeutic interventions over a 6-month period. The therapists' experiences included managing the chaotic nature of the clients' lives, wanting to manage their lives, and frustration related to trajectories of the clients' lives (Slesnick et al., 2012).

The therapists participated in weekly supervision to talk about their experiences, during which they described frequent feelings of worry and concern for their clients and feeling bad for them. When the therapists spent a significant time assisting with client problems, such as gaining employment, and their clients did not follow through with the task, they expressed increased feelings of frustration and decreased self-efficacy. At times, they felt unappreciated and that they were wasting their time with the client. Supervision that addressed these feelings facilitated changes in perspective and depersonalization of clients' behaviors toward the therapists (Slesnick et al., 2012).

It is important to understand the positive effects that practicing and applying empathy skills can have on others because the effects can be wide ranging. In addition to client and supervisory relationships, positive and effective interpersonal interactions can significantly impact other professional relationships and personal relationships. As a sense of compassion develops in oneself, it can expand to others (Leppma & Young, 2016).

Resilience is the ability to adapt and improvise when unexpected adverse conditions are encountered as a result of significant disturbances or buildup of several minor disturbances. Team resilience is the ability for employees to achieve positive outcomes by collectively overcoming disturbances. When individuals are part of a team, they tend to internalize the group's norms and values and exemplify similar attitudes and behaviors the group displays as a whole (Meneghel, Salanova, & Martinez, 2016). Affective events are events that have personal significance and can be experienced through interpersonal interactions as well as the demands of work tasks and duties. Negative interactions with others can significantly affect employees and lead to increased anger and stress (Totterdell, Hershcovis, Niven, Reich, & Stride, 2012). For example, Totterdell et al. (2012) examined the psychological effects that witnessing others' unpleasant interactions may have on the observer. Thirty-seven subjects working at a hospital emergency department participated in the study. Participants were asked to identify positive (pleasant) and negative (unpleasant) interactions between coworkers that they witnessed over the course of 15 work days and respond in writing to a series of questions about the incident. Interactions referred to comments, gestures, or behaviors made directly to or indirectly about another coworker and excluded any interaction that involved the participant themselves (Totterdell et al., 2012).

Totterdell et al. (2012) measured emotional exhaustion with four items from the Emotional Exhaustion subscale of the Maslach Burnout Inventory. Each item was scored on a 5-point Likert-type scale that indicated levels of various feelings felt during the past week. Emotion regulation behaviors were assessed using a 5-point Likert-type scale to rate six items about the extent to which the person used certain behaviors to regulate emotions. Participants also rated their feelings on three 5-point scales (1 = *gloomy* to 5 = *happy*, 1 = *anxious* to 5 = *calm*, and 1 = *tired* to 5 = *energetic*; Totterdell et al., 2012). The study participants were asked to respond to a question about the type of interaction they witnessed (direct or indirect), to what degree they had taken the perspective of the individual being targeted, to what degree they felt a need to control their feelings about the situation, and to what degree the situation felt emotionally draining. Totterdell et al. identified and evaluated over 100 interactions for the study.

Results from Totterdell et al. (2012) indicated that witnessing an unpleasant interaction leads to emotional exhaustion. Totterdell et al. also found that mood at the time of the incident and degree of emotion regulation had mediating effects on the observer's emotional exhaustion level. The greatest feelings of emotional exhaustion were seen when observers witnessed direct interactions in which they took the target's perspective. Totterdell et al. concluded that interactions between coworkers are affective situations that provoke emotional reactions from others. The study authors also suggested that the emotional exhaustion caused by witnessing unpleasant interactions

increases vulnerability and fatigue and can lead to situations in which employees become more compliant and vulnerable to persuasion due to decreased emotional resources.

A strength in Totterdell et al. (2012) is the nature of the workplace environment investigated as the study was conducted in a health service environment. However, the effects of witnessing unpleasant interactions would likely be similar in any environment, although health service workers may be particularly vulnerable to the effects of witnessing unpleasant interactions due to the nature of their work. It may have been significant to assess to what degree personal experiences outside of work affected emotional exhaustion. It also would have been beneficial for Totterdell et al. to gain more insights into the empathy skills of each participant and why and how the participants took on their coworkers' perspectives. In addition, the relationships between coworkers would have been interesting to evaluate as well as if the nature of their relationship to the target made a difference.

In further support of this concept, Campos, Schoebi, Gonzaga, Gable, and Keltner (2015) investigated the effects of observing others' positive emotions on developing new relationships. Ninety-one female participants were randomly assigned to watch six video clips designed to elicit positive and negative emotional responses either alone, with a stranger, or with a roommate. Video clips were intended to elicit specific emotions that included amusement, awe, interest, love, fear, and sadness (Campos et al., 2015). Following each clip, participants rated 21 emotions on a 7-point Likert-type scale indicating to what degree they experienced each emotion while watching the clip (1 = *never* to 7 = *intense emotion*).

After viewing all clips, Campos et al. (2015) administered a self-report measure to subjects in the stranger and roommate conditions that assessed the closeness they felt toward the stranger or roommate. Subjects were also videotaped while watching the videos, and research assistants coded nonverbal facial expressions of emotion based on the Facial Action Coding System. To rate closeness between the subject and stranger or roommate, the Inclusion-of-Other-in-the-Self was used. This assessment consists of seven pairs of circles. The first pair of circles do not overlap, and pairs progressively overlap, with the seventh pair almost completely overlapping. Subjects identified which pair of circle overlaps best indicated their relationship with the other person (Campos et al., 2015). Subjects were additionally administered the Big Five Inventory (BFI), a 44-item self-report measuring personality traits of extraversion, agreeableness, conscientiousness, neuroticism, and openness characteristics on a 5-point Likert-type scale.

Results from Campos et al. (2015) indicated that when people observe others expressing positive emotions, they are more motivated to engage in social interactions with the others and to take advantage of new relationship opportunities. Study subjects also reported greater closeness to strangers and roommates when positive emotions were shown in the video clips and when the other was perceived to be expressing positive emotions. Campos et al. also found that personality characteristics were not associated with displays of emotion and did not affect the degree of expression or feelings of closeness.

It is of interest that the sample for Campos et al. (2015) was only female. Campos et al. provided no explanation or reasoning for this population. However, the sample size

is large enough to demonstrate that results were significant. It is a strength that the study included three conditions (alone, with stranger, and with roommate) and that Campos et al. noted a possible discrepancy between known individual and a stranger.

Meneghel et al. (2016) investigated the association between employee team resilience and collective positive emotions and effects on team outcomes. The sample group consisted of 1,076 from 40 companies. There was a total of 216 teams ranging between two and 38 members. Assessment measures were used to evaluate positive emotions, team resilience, and team performance.

To assess positive emotions, Meneghel et al. (2016) selected five emotions to measure how the team collectively felt during the previous year: enthusiasm, optimism, satisfaction, comfort, and relaxation. Team members rated these emotions on a 7-point bipolar scale representing degree of satisfaction (0 = *frowning* to 6 = *smiling*). Team resilience was assessed using a seven-item scale developed to evaluate organizational team resilience. Statements indicating resilience were rated on a 7-point Likert-type scale (0 = *never* to 6 = *always*). An example statement was "In difficult situations, my team tries to look on the positive side." Team performance was assessed using modified versions of the Job Performance Scale, a 25-item instrument for measuring altruism, conscientiousness, and task performance (Meneghel et al., 2016).

Results from Meneghel et al. (2016) indicated that collective positive emotions experienced in teams were strongly correlated with team resilience. The findings suggested that the relationship between job performance and collective positive emotions fully accounted for the degree of team resilience.

Strengths of Meneghel et al. (2016) are the large sample size and number of different company teams included. It would have been helpful for the authors to evaluate or describe the type of difficult or distressing situations teams encountered. Other factors such as play/salary or better working conditions (i.e., cleaner, safer) may also have played a role.

It can be inferred that collective positive emotions are characteristic of strong interpersonal relationships, and therefore empathy can play a key role in the organizational team satisfaction and performance. Because empathy has a significant effect on relationships, empathy training will likely have a strong influence on psychologists' productivity and their abilities to develop professional relationships.

Summary and Conclusions

Clarifying the definition and characteristics of empathy as well as the role it plays in therapeutic alliances and outcomes lays a foundation for graduate psychology students' understanding of how empathy relates to competency standards identified by the APA and the NCSPP. Results from the current literature review reflect methods that have been successfully and effectively used to enhance empathy skills. Integrating education about empathy and competency and methods for increasing empathy skills into graduate psychology programs would enhance the training provided in these programs and contribute to professional psychologists' overall competency.

Providing empathy training during education and training can facilitate growth throughout a psychologist's career. Requiring doctoral psychology students to practice empathy enhancing techniques can foster awareness of the importance of continued

dedication to practice and applying these skills to achieve positive outcomes by providing the best possible care to clients. Knowledge of these effects will likely continue as a driving force in establishing therapeutic relationships after completing licensure requirements.

Extending the training to other mental health professionals in a variety of environments may lead to increased cohesiveness in agencies and organizations that provide mental health services. If psychologists consistently practice and model good empathy skills when interacting with clients, supervisees, colleagues, and others, they will likely foster an environment of positive collaborative relationships through displaying positive emotions and cooperative relationships. Not only would this be beneficial for professional relationships, but clients may internalize observations of positive emotions and relationships modeled in an agency. This may in turn motivate clients to be more engaged in treatment and thus increase treatment efficacy and overall treatment outcomes.

Gaining awareness about one's own characteristics and behaviors can be difficult for some, and more support may be needed for students having difficulties understanding and observing themselves and how their behaviors affect others. Gaining awareness may prove to be one of the more difficult aspects of empathy training, and additional time may be needed to focus on this specific aspect of professional development.

To increase graduate psychology trainees' competency, their training should reflect the interpersonal relationship competencies outlined by the APA and the NCSPP. Evidence-based tools and methods for increasing empathy skills need to be included in graduate psychology courses and training. Combining psychoeducation and practices that foster empathy may significantly increase psychology trainees' professional competencies and improve the overall effectiveness of therapeutic interventions.

Individuals seeking help for psychological distress depend on psychologists to provide validation and understanding of their experiences. If clients feel judged or stigmatized by psychologists, they will likely lose motivation to engage in the therapeutic process, which may hinder or prevent them from achieving their desired goals. The lack of interpersonal skills training impedes graduate psychology trainees' abilities to meet professional competency expectations. Not providing adequate and effective interpersonal skills training creates a void in overall professional competency. The literature reviewed strongly supports the importance of including empathy skills training in doctoral psychology programs.

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