An Interpretive Review of Psychoanalytic Literature on Empathy in the Therapeutic Relationship

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ABSTRACT

This dissertation is an interpretive review of psychoanalytic literature on empathy within the therapeutic relationship. The creative science of hermeneutics is used to explore the history of empathy and its function within the therapeutic relationship. A critical analysis of the literature provides the platform for assessing present arguments for the importance of empathy in the therapy relationship. This analysis identified three important areas neglected in the research. These are the wider context of the evolution of empathy, the role of culture and consideration of the client's experience. A discussion of these areas concludes this dissertation.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any degree or diploma of a university or other institution of higher learning.

Signed:

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CHAPTER 1: INTRODUCTION

Empathy has been explored across many disciplines over the years. In psychotherapy, it has been identified as a necessary component for affecting change in a clinical setting. While empathy is accepted as a natural human ability, it is a complex notion to understand within a therapeutic setting. A lack of consensus in relation to the definition of empathy stems back to the original translation of the word from German to English. This interpretive literature review explores the psychoanalytic understanding of empathy within a therapeutic relationship. It includes recent research in psychoanalysis, developmental psychology and neuroscience that suggests the importance of redefining empathy so that it is understood as bodily based and inclusive of the mind and body of both therapist and client.

Empathy is a familiar word to most people and is taken for granted in day-to-day life. It was not until my professional training and practice that I became curious about it. For humans to navigate their social environment successfully, they need to be able to experience and understand the emotional states of others, a process typically known as empathy (Bohart & Greenberg, 1997).

In the early mother and infant relationship, empathy is a necessary function of connection and communication. Through the process of attunement, a mother understands non-verbal communication from the infant and responds to that, with empathy developing through this interaction (Stern, 1985). It has been argued that this is similar to what occurs in the therapist/client relationship (Meissner, 2010).

In the counselling and psychotherapy professions, empathy has been linked to positive outcomes and is considered a necessary attribute for a therapist to possess (Rogers, 1957). Empathy from the therapist allows the client to make meaning of

their inner experience and is therefore an integral component of therapeutic practice. Through an empathic relationship, capacities central to psychological relating are strengthened (Corsini & Wedding, 2014). Empathy provides a foundation for therapeutic change and is a fundamental component of the healing process. Bohart and Greenberg (1997) argue that the therapeutic process is significantly reliant on empathy as a core ingredient, as it facilitates change and generates an experience of recognition within the receiver (Corsini & Wedding, 2014).

There are many schools of thought and models of practice, but empathy is one component common to all therapeutic modalities. It is an aspect of practice that requires more focus, especially since there is no agreed definition to date, in order to bring clarity to our understanding of empathy and therefore increase our efficacy in clinical practice. Understanding empathy becomes particularly important when we try to make sense of how and why some clients don't engage with therapy, or when therapy has failed.

In my opinion, the concept of empathy cuts across all barriers and allows us to reach and connect with others because it is an innate human quality, except when there are medical or biological reasons for its absence, for example, with autism. Despite the problems in defining empathy, a common definition of it is the ability to understand another's emotional experience while at the same time remaining separate from their experience.

Although my training is in psychodynamic psychotherapy, I have chosen to focus on psychoanalytic views of empathy for this dissertation. There are many more studies available in the psychoanalytic literature than in the psychodynamic, and there exists enough commonality between the traditions to further explore empathy within

the therapeutic context using this approach (Jones-Smith, 2016). Many psychoanalytic theorists and scholars disagree about the definition and aspects of empathy within the therapeutic encounter. Research from other disciplines such as developmental psychology and neuroscience have clarified and expanded on some areas of empathy. Therefore, a deeper understanding of empathy within the therapeutic relationship will be drawn from a literature review of psychoanalytic studies of empathy, neuroscience research and developmental psychology research into attunement. My research employs the paradigms of interpretivism and hermeneutics to interpret this literature.

The remainder of this chapter provides a brief overview of the research topic, outlines the aims of the study and discusses my position as a researcher. In chapter 2, I explain the selection of methodology and methods for this research, and discuss the development of the question and the chosen epistemological and theoretical framework. Chapter 3 begins with an historical outline of empathy in the psychoanalytic tradition, followed by a critical review of the research and an interpretation of the findings. Chapter 4 focuses on empathy in the therapeutic relationship drawing on attunement and neuroscience research. Chapter 5 discusses three areas neglected in the research: context, culture and clients. The final chapter includes the conclusion and future recommendations, as well as a critical reflection and evaluation of the conclusions and the implications of research for psychotherapy practice.

The topic

The study of empathy became important to me during my psychotherapy training, leading me to want to research this topic for two reasons. First, as empathy has been identified as a core part of therapy and associated with therapeutic healing, it is important to me as a psychotherapist that I have a clearer understanding of this concept. Secondly, my curiosity about the variations in the sense of empathy I witnessed between myself and other training therapists concerned and confused me. I am sure that I am not alone in this quest and as much as empathy heals, a lack of empathy can also hurt. And therapists have a moral obligation to heal and not hurt.

My training was in psychodynamic psychotherapy. However, a literature search produced few non-specific studies relevant to my topic, as they did not specifically focus on the aspects of empathy in the therapeutic relationship. Therefore, I decided to focus on psychoanalytic literature, which had substantially more articles on the topic. Psychodynamic therapy shares the same roots as psychoanalytic therapy (Jones-Smith, 2016).

The psychoanalytic view of therapy has a unique and specific type of engagement that focuses on the conscious and unconscious processes according to Freudian drive theory. Psychodynamic psychotherapy in contrast focuses on attachment and relationship dynamics, and the mental health issues that arise from one's needs not being met. Therefore, while these two traditions have similar roots, they differ in their approach and focus. Nevertheless, they are similar in their understanding of the unconscious aspects of the therapist and client interaction. The review of the literature displayed an overlap between the traditions, with authors identifying their research as psychoanalytic and also discussing psychodynamic

elements of therapy. My decision to use the term psychoanalytic in my dissertation title and database searches was to ensure consistency in the research process.

This interpretive literature review of empathy begins with an historical overview. I have chosen to review contextual material on empathy, by which I mean the descriptions and definitions of empathy within the context of the therapeutic relationship, in order to gain a clearer understanding of how empathy is conceptualised within the therapeutic relationship. Initially, I focused my search on the most recent journal articles in keeping with the academic requirements of "expectations of recency in research" (Smythe & Spence, 2012, p. 22).

After the initial review, I decided that I needed to widen my research to include books and book chapters to gain a broader understanding of the historical background of empathy. As my reading progressed, I became interested in neuroscience and attunement and their influence on the understanding of empathy. Inclusion of these came as a consequence of preliminary reading for my research, which made it evident that these were key areas that had a significant contribution to understanding interpersonal relating, and specifically, empathy.

My position as researcher

The importance of empathy was brought to the fore during my psychotherapy training. I realised that my effectiveness as a psychotherapist depended on my ability to be empathic. As I engaged more and more in the subtle process of psychotherapy, both as giver and receiver, I was intrigued and alarmed by my varying levels of empathy. I discovered that empathy was not a fixed attribute but had considerable nuances and variation. At times empathy came naturally, and at other times it was difficult to feel with different clients.

The combination of my observations of other practitioners and my own experience as a training psychotherapist led me to believe that empathy existed at different levels. At times it appears naturally, and other times it is conscious work. Sometimes it is difficult to access depending on the situation and underlying issues. This realisation spurred me to seek a deeper understanding of this phenomenon.

My view of empathy is influenced by my gender, race, ethnicity and the present day world and social environment I live in. I was born and raised in South Africa during the apartheid era. I am of Indian/Hindu descent, a mother of two adult daughters, and I returned to study as a mature woman. All these aspects of myself and my experiences within these contexts influence my interpretation of the literature and the topic of empathy. Therefore, culture is an important influence in my interpretation.

The choice of an interpretive methodology was fitting for this research because interpretivism asserts that all research is shaped and influenced by pre-existing world views of the researcher (Willis, 2007). Therefore, it is important that I acknowledge and am aware of the ways in which my views relate to what will be researched.

CHAPTER 2: METHODOLOGY AND METHOD

This chapter outlines the research approach to the study of empathy within the therapeutic relationship. It outlines the epistemology and theoretical framework underpinning the literature review. Hermeneutics lies at the core of the interpretive methodology will be expanded on, the method, and process by which the literature was brought together by which to study empathy within this context.

Methodology

My methodology draws on the paradigms of epistemology, interpretivism and hermeneutics.

Epistemology

Epistemology refers to the theory of knowledge about itself, and thus relates to ways of knowing (Savin-Baden & Howell, 2013). In qualitative and quantitative research, it is important that the researcher acknowledges and is aware of the ways in which their stance is directly related to what will be researched. The epistemology underpinning this research project is that reality is socially constructed and all research is influenced by pre-existing worldviews (Willis, 2007). It acknowledges the relationship between the research participant and the researcher (Ponterotto, 2005). Conversely, quantitative research is based on a positivist paradigm, which suggests there is one true reality. The assumption is that the researcher and participant are independent of each other.

Researchers always bring a set of beliefs and assumptions to their research, and meaning making is a group process. Therefore, the research that is conducted and disseminated is most understood by members of the group who share the same

version of what has been researched (Willis, 2007). As a trained psychotherapist working with clients, I am closely positioned to the topic under investigation and will therefore interpret the literature through a psychotherapist's lens. Meanings that I construct come from the knowledge I gain from my experience as a psychotherapist, as well as from being a mother, my culture and my gender. Thus, my meanings will be different to others and emerge from engagement with the realities in that world. Willis (2007) argues that interpretivists accept that standards and rules of science are subjective and therefore imperfect, rather that universal and objective.

Interpretivism

The theoretical framework structuring this critical review of the literature is interpretivism. Birks (2014) argues that interpretivism views the world as essentially relative, meaning that pre-existing notions and world views held by the researcher influence research. As these theories and world views are socially constructed, research is better understood by others who share the same socially constructed reality (Willis, 2007). Interpretivism acknowledges that meaning making is subjective, as opposed to more objective observations indicative of quantitative research.

The interpretivists paradigm is well suited to psychotherapy research and is appropriate for this project. This review aims to explore the interpersonal relationship between therapist and client and allows for the co-construction of meaning within the research process. This parallels with the interpretive approach and has much in common with the "reflective practitioner" model of professional practice (Willis, 2007, p.108). Orange (2011) asserts that Freud's emphasis on interpretation in psychoanalysis would have been viewed as a hermeneutic study. By approaching the

literature review from this stance I am acknowledging my impact on the meanings I draw from the literature.

Qualitative researchers thus seek perspective from a range of perspectives, while recognising that their own personal, historical and cultural experiences and backgrounds shape their interpretation (Creswell, 2009). Rather than starting with a theory, as in positivism, interpretive researchers endeavour to make sense of the meanings others have about the world. In this review, the process of interpretivism promotes a deeper understanding about the notion of empathy and its importance in the therapeutic relationship.

By using an interpretive research framework, I acknowledge that given my personal perspective only some meanings and perspectives will be highlighted about the topic. I will be more aware of my choice of literature and use a reasonable approach to the findings. Aligning closely with interpretivism is to acknowledge a degree of subjectivity in the research process and therefore the first person will be used throughout this review.

Hermeneutics

The methodology chosen for this dissertation is hermeneutics. Hermeneutics is the "art and science of interpretation" (Ezzy, 2002, p.24). The term is used to describe a process of understanding through interpretation. The term hermeneutics comes from the Greek god Hermes. Hermes carried messages from the gods to humans, bridging the gap between the thinking of the gods and that of humans (Orange, 2011). Theologians originally used hermeneutics to describe the process of interpreting biblical texts (McLeod, 2011). Hereafter hermeneutics evolved and permeated the field of humanities and social sciences.

The underlying assumption of hermeneutics is that the reader is displaced in time and place from the author. As a result, the reader will have a different perspective of the text to that of the author. This view highlights that an individual's ideas are located in culture, history and language (McLeod, 2011), thereby acknowledging that ideas are formed in context of the time during which the writing occurred and the conditions present at that time.

Willis (2007) identifies the two main elements of hermeneutics as understanding the limitations of language and that context is a frame for understanding, that is, human behaviour cannot be understood in isolation. Smythe & Spence (2012) argue that researchers in health practice recognise the dynamic and contextual nature of understanding. Hence, the study of empathy examined in both the past and present contexts fits well within this research paradigm.

In a research situation, both the enquirer and the reader of the hermeneutic tradition approach the text with previous knowledge of the material (McLeod, 2011). Interpretation is multifaceted. As Gadamer (1975) argued, hermeneutics appreciates that successful interpretation arises from a position within history, requires a sensitivity to the use of language and leads to a shift in the interpreter. Text is therefore created in a cultural-historical context and our understanding of anything is created from cultural constructs embedded in language (McLeod, 2011).

McLeod (2011) argues that central to the work of hermeneuticists is the use of empathy when engaging with the work of authors. Interpretation requires gaining a personal "sense of understanding of the emotional and interpersonal worlds, and cultural-historical situation of the person(s) who generated the text" (McLeod, 2011,

p. 33). Therefore, the use of hermeneutics for the study of empathy from a psychoanalytic perspective seems to be the ideal fit.

Frank (1987) argues that psychotherapy is a practice that seeks to interpret and transform clients' communication and that resembles hermeneutics. In contrast, a phenomenological approach states that human experience can be understood within the context of that experience. The researcher has to be able to remove their preconceptions and conduct research with an open mind, 'bracket' such assumptions (McLeod, 2011).

Method

The method used in this research is a hermeneutic literature review. Hermeneutics is concerned with the process and creation of interpretive understanding (Boell & Cecez-Kecmanovic, 2010). The whole body of relevant literature on a topic is made up of individual texts, and these texts are in turn part of the whole. In order to understand the whole, one has to understand the parts. This circular process is referred to as the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010). Through interpretation comes understanding that is derived from previous experiences.

The choice of an interpretive literature review aligns with my perspective on the subject being researched. As a psychotherapist I cannot distance myself from the subject of empathy. Firstly, it is a human quality, and secondly, I need to make meaning of empathy in every client interaction. This means that I cannot maintain the neutral observer stance and separate my understanding of empathy from my interpretation. Our understandings about the world we live in and the phenomenon we encounter cannot be separated from us, they are embedded in our understanding derived from previous experiences. Understanding arises from the back and forth of

experience and interpretation and re-interpretation of it; it is dialectical (Smythe & Spence, 2012).

In contrast, a systematic literature review follows a structured approach to a literature review with clearly defined criteria making it possible for other researchers to reproduce. Systematic reviews are extensive and time consuming and are widely used in medicine for evidence-based practices that ensure priority to effective treatment outcomes. They are based on quantitative research designs and randomised control trials (RCTs). Ponterotto (2005) argues that although RCTs provide the gold standard for evidence in many areas of medicine, they are difficult to replicate in psychotherapy research. The synthesis of qualitative research is difficult, hence results are indicative rather than definitive (Petticrew & Roberts, 2006). Systematic reviews have been critiqued for being positivist and reductionist, suggesting that evidence has less statistical value when systematic reviews extend to the wider social world with higher levels of ambiguity (Silverman Dixon-Woods, 2011).

A hermeneutic literature review is not based on a logical linear process as in the systematic review, but instead is a circular process of reading, thinking and writing. Understanding arises from the back and forth reading and conversation between the text and the reader.

Literature search

I began my research by restricting my review to the past ten years of journal articles. My process of reviewing the literature took the form of reading and digesting the material before moving onto the next article. As new insights arose I noted them for further research.

I utilised Clark (2007) for the historical overview as this text was succinct, and Akhtar (2009) for psychoanalytic definitions of terms. During the supervision process, I was asked why I chose Ahktar and whether it was to provide an additional cultural perspective. At the time I replied that it was because of the psychoanalytic definitions. On reflection, however, I realised that culture was an area not explored in the psychoanalytic research into empathy, and I may have unconsciously chosen Ahktar to add a cultural dimension to the study.

I have chosen to review articles that explicitly describe and analyse the components of empathy in order to gain a clearer understanding of this concept within the therapeutic relationship. Initial searches of empathy produced a plethora of studies on the topic. Narrowing my search to 10 years was therefore practical.

I began my search for literature using the Auckland University of Technology (AUT) library website, using PsychInfo, PEP and Psyche Articles databases and a library search. The keywords for searches were 'empathy', 'psychoanalytic psychotherapy', 'attunement' and 'neuroscience'. The searches produced many articles but not many of them were contextual studies. Grant & Harari (2014) assert that the lack of psychoanalytic studies of empathy is due to most psychoanalysts failing to name empathy for what it is. This was a possible reason for the thin scope of articles available in database searches.

The most relevant articles were selected from the headings and the abstracts. Many of these did not fit the required context of the study, so I referred to reference lists of suitable articles to identify relevant material. This process of snowballing is where researchers refer to reference lists in order to identify key researchers on that particular topic (Boell & Cecez-Kecmanovic, 2010). However, a hermeneutic study is

more about depth than the narrow isolation of keyword searches. Guided keyword searches risk creating a false sense of security about the known thinking on a topic and adequacy of the review for the researcher and reader (Smythe & Spence, 2012).

The initial phase of the reviewing process involved skimming through the literature and identifying the appropriate matches for the research. Once the relevant material was selected I started by reading, re-reading and highlighting key points. I needed to be mindful throughout the process that my experience, prior knowledge and understanding already coloured my thinking and how I read the material.

Application of methodology

The first stage was to read the literature and understand the author's perspective. Once the articles were read through, I digested the material by taking time away from the literature to allow the ideas and concepts to merge with my own experience and knowledge of empathy. Then I read the articles again, this time highlighting key points. The decision about how to write the review was a difficult one, as I considered that if I wrote it at this stage, it would be only a partial interpretive process. I knew that it was important to convey the key ideas and definition of terms in order to get a clear perspective of empathy, and also that as this was a 60-point dissertation I was limited in how much depth my research could involve.

After summarising and highlighting key points in each article, the content was critically analysed. This process allowed me to formulate an interpretation of the material from the material and not from what was known and unknown to me. The process of reading, re-reading and finally writing many times over allowed the meaning of the literature to emerge. Staying closely aligned with the material enabled me to remain contained within the research process and keep focused on the research

as opposed to my personal influence on the material. Engaging with literature hermeneutically is distinctive in that there are few rules to follow, but rather involves a way of being attuned (Smythe & Spence). It took several attempts at writing and standing back from what I had written before the meanings began to arise and finally arriving at an understanding that was woven between the lines.

As I began to understand more of the psychoanalytic view of empathy, I became increasingly aware of the difference between this view and others, particularly the humanistic tradition. The difference spurred me to broaden my reading to include these views, which I explore in the overall discussion. Smythe & Spence (2012) argue that engaging with difference is vital for a deeper understanding of something as it raises questions and is a way to thinking more deeply.

Inclusion and exclusion criteria
As I was interested in the underlying aspects of empathy, I limited my study to conceptual studies of empathy. My search was limited to psychoanalytic psychotherapy literature for the main body of research. For the discussion section, I explored other views, namely humanistic, to expand my understanding.

The reason for choosing to focus on psychoanalytic material was because a search using the key word 'psychodynamic' did not produce as many contextual studies of empathy as was when the keyword 'psychoanalytic' was used. As mentioned before, this is due to the overlap of psychoanalytic and psychodynamic theories. Only journal articles with 'empathy' in the title were selected. I refined my search to a ten-year period between 2004 and 2014. This decision was made because of the vast amount of literature on empathy. I chose to restrict my literature review of empathy in the psychoanalytic tradition to journal articles because I wanted to focus

my research on peer-reviewed published material. Aveyard (2010) suggests that primary research provides the best quality and most relevant evidence for addressing a research question.

Most psychoanalytic literature includes case study material. These studies were excluded on the grounds that only some components of empathy were explored, which proved too narrow for this research as they would not provide sufficient data for analysis. Other exclusions were studies not written in English, not relevant to my topic and ones that did not have 'empathy' in the title or were not specific to the therapy relationship. All books, conference papers and newspaper or magazine articles were excluded from the initial review.

However, once I had collated sufficient articles on psychoanalytic views of empathy and reviewed them, I identified areas that needed further exploration, such as neuroscience and attunement. I then decided to broaden my search to include books and book chapters across a greater period of time. This forms the basis of chapter four of exploration of empathy in the therapeutic relationship.

Ethics

This research did not involve human or animal participants. It will not affect the privacy, rights and freedom of anyone and therefore will not require an ethics application or approval (AUT website).

Conclusion

The underpinning epistemology and theoretical framework require that I acknowledge my own perspective and the potential influence I have as an observer on the literature. This approach acknowledges subjectivity, but places some objective

constraints such as helping ensure the review results are meaningful to others who have differing worldviews and experiences from myself. My experience in my training highlighted that my view of empathy differed from others and that I was beginning to experience other forms of empathy, which spiked my curiosity of psychodynamic/psychoanalytic views.

CHAPTER 3: EMPATHY

Introduction

In this chapter I will critically analyse and interpret the findings of the literature. A historical outline will provide the framework and context for a broader understanding of empathy. However, it remains a notion still debated with no clear consensus as to its definition.

Empathy has been identified as an important factor in the therapist/client relationship. The purpose of providing a historical context is to view the development of empathy over time, which in turn sets the context for the present.

Historical context

Exploring the origins of the word empathy and its definition provides an important frame of reference. It also gives insight to some of the discrepancies and debate surrounding this notion.

Empathy has been identified as an important factor for healing and behaviour change across many professional areas. Therefore, it is important to achieve some common understanding of this concept. Although this review focuses on psychoanalytic research, it is important to acknowledge that there are other views of empathy equally valuable.

A psychoanalytic definition of empathy taken from Akhtar (2009) states that,

> derived from the German Einfuhlung, the term 'empathy' refers to the ego's capacity to transiently identify with someone else in order to grasp his or her subjective experience. An altruistic elimination of one's personal agenda – to the extent this is possible – and an attunement to the other's affect and fantasy are hallmarks of 'empathy' (Akhtar, 2009, p. 93).

Akhtar (2009) suggests that attunement allows the giver of empathy to understand the other's subjective experience without the interference of their own psychic contents (memory stores). A possible limitation of this definition is that there is no mention of unconscious processes, which I will explore later in this chapter. Another definition of empathy is the ability of one to "take the perspective of the other person" via our imagination (Decety & Jackson, 2006, p. 55).

A historical perspective of the origins of the word empathy highlights discrepancies in definition across the literature. Despite psychoanalytic researchers not always agreeing on definitions of empathy, they do agree that empathy extends beyond "emotional synchrony or attunement" (Arizmendi, 2011, p.409).

The word empathy was translated from the German word *einfuhlung*. In 1873, Robert Vischer used *einfuhlung* to explain the appreciation of art, where one projects one's feelings into an art form. It described what he believed people felt when viewing art and the feelings that art work evoked within them.

According to Clark, *einfuhlung* translates as "feeling oneself into" (Clark, 2007, p. 4). This suggests that one's own feelings are thus projected onto the object, in this case art, which will be unidirectional. However, when two people are involved there is a bi-directional flow of feeling states.

It seems to suggest that the process of evoking a feeling state arises in a person while in contact with an inanimate object. Hence, the feeling state is evoked within the person from the artwork. This feeling state arises from their own experiences and then gets projected onto the object giving the object meaning. The artwork then takes on meaning that has been projected onto it.

This interpretation may present a problem when the word empathy is then applied to a situation between two people, each with their own experiences and feeling states. Being able to differentiate between each other's feelings and deciphering what feeling belongs to whom may be problematic.

In 1897, psychologist Theodor Lipps developed a theory that extended this term into the area of interpersonal functioning. This concept broadened the meaning of empathy into the psychological area of understanding others through a process of projection and imitation (Clark, 2007). At this point, unconscious processes are included into the definition, adding another dimension to understanding empathy.

In the twentieth century, Edward Titchener translated *einfuhlung* into empathy and emphasised the aesthetic aspects of the term. He argued that empathy is an imaginative aspect of feeling oneself into situations that individuals experience (Palombo, Bendicsen, & Koch, 2009). In other words, through visual perception one is able to imagine what it may feel like for the other person.

Freud (1920/1955) said, "A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by which we are enabled to take up any attitude at all towards another's mental life" (cited in Clark, 2007, p. 91).

Freud is suggesting that identification with the other allows one to imitate what their felt experience is and this mechanism of identification and imitation is what enables us to have an understanding of them. However, he does not go on to elaborate on the ego characteristics, countertransference or unconscious introjects of each person involved. The relevance of these are evident in present arguments on

empathy, which recognise these aspects as being part of empathy, or empathy as such.

Another leading figure in the psychoanalytic tradition, Sandor Ferenczi, recognised in the early 1930s the integration of empathy into a therapeutic relationship.

Ferenczi practiced face-to-face therapy, believing non-verbal gestures from the patient were meaningful observations for interpretation. He provided technical recommendations for therapy and drew on another important dynamic of empathy, that is, the observation of the other's facial expression. This shift in thinking acknowledges the position of the other and a two-person interaction. This idea links with attunement and the mirror neuron debates, which are discussed in Chapter 4.

The introduction of a two-person psychology and intersubjectivity was a shift from the traditional blank screen approach, as in Freud's view of the therapist as the objective neutral observer (Corsini & Wedding, 2014). The Freudian practice of remaining still in therapy fits with the idea of a unidirectional 'feeling into the other'. Ferenczi differed from this view and saw value in having direct face-to-face contact with clients because non- verbal cues provided valuable information for interpretation (Clark, 2007).

Heinz Kohut (1959) introduced new ways of thinking about the therapeutic function of empathy. He argued that it was important to understand the client in an experienced near way and that empathic responsiveness created a corrective emotional experience (Palombo, 2009). Empathic understanding provided a non-threatening environment for interpretations. It allowed empathic failures on the part

of the analyst to be an opportunity for the client to learn more about their self-structure (Bohart and Greenberg, 1997).

During the Kleinian and post-Kleinian period, unconscious processes of projective identification, the mother-infant relationship and the development of mentalisation were introduced into the understanding of empathy (Bolognini, 2007). The analytic encounter is between two people struggling to make meaning of the client's life, into which the therapist is inevitably drawn (Mitchell& Black, 1995).

To conclude, the term empathy was originally coined to describe a process of evoking in oneself a feeling state towards art. The original word was used in the context of art appreciation, between art and a person. In this instance, there is only one person involved in the process of empathy and a feeling state is evoked from the individual's own experiential memory stores, through which then the artwork takes on meaning for the observer.

Later on, this term was applied to a particular feeling state between two people. The term was adopted by the talking therapies and applied to a particular feeling state between two people that enabled therapists to understand how their clients felt. Freud's stance on empathy retained some of the unidirectional focus in his blank screen approach to therapy. The shift from this view occurred later to a more interpersonal meaning, with a bidirectional approach, recognising that one person is able to tune into the other's emotional state, and then, through a process of identification and differentiation between self and other, is able to imagine the other person's perspective.

Literature review

Empathy is a huge topic spread across disciplines. In order to achieve an understanding of the concept of empathy within the therapeutic relationship, I needed to study literature that examined the elements of empathy. The literature for this research included journal articles, books and book chapters. Relevance was determined by whether the literature encapsulated a detailed psychoanalytic understanding of the concept.

In this section I will critically analyse and interpret the literature on psychoanalytic empathy. The literature discussed empathy from a historical view, it highlighted problem areas in psychoanalytic empathy and offered possible solutions for the problems identified. This literature review is structured accordingly.

The view I brought with me into my psychodynamic psychotherapy training was that empathy is the ability to stand in another's shoes and feel what it is to be in their situation, with warmth, love and compassion. So, was I wrong or was I right? Is there an empathy that we can all agree on in the therapeutic setting? These were the questions I began this research with. In order for me to be an effective and empathic therapist, I needed to have a deeper and clearer understanding of empathy in the therapeutic relationship.

In the context of the therapeutic relationship, empathy has taken on a meaning of its own, different to the everyday understanding of empathy. Various authors have different explanations of what psychoanalytic empathy is, and the controversy of clinical empathy has divided the field (Poland, 2007, Aragno, 2008, Zepf & Hartmann, 2008, Meissner, 2010, Krause, 2010). This parallels the experience I had in my training.

There was a common theme throughout the literature that psychoanalytic understanding and use of empathy posed problems. Some authors identified similar problems while others differed in their view of where the issues with empathy resided. Authors agree that problems with defining empathy stem from the original translation from German to English. Psychoanalytic empathy formalised by Freud for a specific goal of investigating and interpreting the unconscious morphed empathy into that of an instrument (Aragno, 2008).

Harmful intent

I will begin this review by drawing on an aspect of empathy highlighted in the literature and rarely discussed, which is how empathy can be also used for harmful intent.

Empathy is generally thought of as a positive quality that most humans possess. However, this assumption detracts from how it can also be used for harmful intent (Poland, 2007). The use of a warm and caring attitude can be used to lure people into an abusive situation. There are also individuals in society who have low or no empathy as a consequence of biological, social and medical conditions such as autism and Attention Deficit Hyperactivity Disorder (ADHD) (Howe, 2013). Bolognini (2004) argues that in the therapeutic context, being sentimental with empathy risks having the analyst fail to empathise with the negative aspects of the client.

The psychological and emotional makeup of each individual is unique to that person and the therapist is no exception. Individual differences between people, including between client and therapist, means empathy is not consistent and stable in any relationship. Individual differences between people create 'blind spots' and

therefore interfere with assessment accuracy (Zepf & Hartmann, 2008). This seems to suggest that from the onset there are obstacles to forming an empathic connection with the client (Meissner, 2010).

The psychoanalytic view of empathy as method for inquiry by application into the world of the client will no doubt have problems related to its specific use within its particular context. The problems identified in the literature will be discussed.

Problems with empathy in psychoanalytic context

Authors draw on specific areas of psychoanalytic theory to discuss problems related to empathy in the therapeutic encounter. Empathy is described as a cognitive-affective form of experiencing. The subject attunes to communications from the other person and makes intimations of their state of mind. In this way, through identification, the therapist temporarily becomes the patient. However, mechanisms underlying empathy remain ambiguous because of the mediating factors of unconscious communication (Meissner, 2010). This suggests that problems that arise with empathy between therapist and client are related to unconscious aspects of individual difference. This view does not take into account the cultural and religious factors that may influence the individual's perception of themselves and in turn their empathy for another.

Identification

The term trial identification is used in relation to empathy within the context of the therapeutic relationship. Akhtar (2009) defines this as a process by which the therapist identifies with the patient to understand their state of mind. However, identification is critiqued as being unable to adequately explain empathy (Aragno, 2008; Krause, 2010; Meissner, 2010; Zepf & Hartmann, 2008). The reason resides

with each person's own internalised object relations, which form part of their mental contents. These contents become entangled with those of the client and thus impact on empathic attunement. Analytic understanding is dependent on the therapist's awareness of their own unconscious conflicts (Zepf & Hartmann, 2008). It cannot be assumed that the therapist is aware of their countertransference reactions and their unconscious roots all of the time.

The identification process is theoretically an unconscious process that occurs for defensive reasons (Zepf and Hartmann, 2008). However, movement between unconscious, preconscious and conscious states in the process of identifying with someone is problematic and not clear. This means that in order for something to be identified with and known, it has to be conscious or preconscious. If it is unknown and/or unconscious can it still be called identification?

Krause (2010) argues that when explaining empathy through primary identification, the problem is with object cathexis. Object cathexis refers to the process of a child psychologically detaching from their primary caregiver. So, in relation to the identification process, the primary object of identification has to be cathected first. If this cathexis has not occurred in the therapist, identification becomes problematic. In other words, there will be a possible overlap between the therapist's psychic material and the patient's. When this occurs unconsciously, the therapist's unresolved psychic material would have a harmful effect on the client.

The concept of projective identification (Meissner, 2010; Zepf & Hartmann, 2008) is closely related to identification. Projective identification occurs when parts of the self are split off and projected into an external object. The object becomes identified with the split off part and also controlled by it (Akhtar, 2009). It is argued

that empathy requires the ability of one to separate one's self from another. However, with projective identification it is difficult to assess whether what is felt is from one's own introjective make-up or the other's. In the experience of projective identification, it is very difficult in the moment to ascertain what feeling belongs to whom. Working with projective identification is often difficult and unpredictable, and empathy would be difficult if the projection is a negative/hostile one. It takes some working through and enough self- awareness to establish whose is what.

Introjections

Within the definition of empathy, the emphasis is on the separation between self and other. Identification as a process of empathy can be problematic because of introjections (Krause, 2010; Meissner, 2010). Introjection is a term used in psychoanalysis to describe a cluster of memory traces of self and object representation. More importantly, it is the affective tone of their connection that resides in memory (Akhtar, 2009).

With empathy and countertransference, introjective make-up becomes an important concept, because pathogenic distortions originate from the self-concept and that provides the basis for projection (Meissner, 2010). Introjections are less assimilated into a person's self-representation than identification and exist only in parts of the psychic structure. In order for identification to occur, parts of the self-need to change under the influence of the other who is perceived as separate to the self. Hence, in order for an object (person) to be identified with, that object has to first be cathected and the self-representation remain the central organising agency (Krause, 2010).

Krause (2010) argues that the question is not "how we understand the other? but how does one know what belongs to whom? A 'false self' emerges when there is little overlap between self and other" (p. 142). The degrees of overlap between the self and object representation determines whether internalisation of the object follows the identification or introjective model. The identification process occurs only if the self is capable of assimilating attributes of the object without giving up essential features of the core self.

Empathic experience is open to uncertainty because of such mechanisms that mediate unconscious communication and affect resonance. Affect states link interactions between subject and object through motoric interaction. When inferences of affect occur before there can be an interpretation of one's own affective state, this causes a problem with empathy (Krause, 2010).

Countertransference

Countertransference refers to a psychotherapist's feelings and reactions to a client's transference. The transference is a function of unresolved conflicts of the client (Saffron and Kriss, 2014). There are two distinct aspects to gaining knowledge through countertransference, countertransference reaction and empathic understanding (Zepf & Hartmann, 2008; Meissner, 2010). Countertransference can provide conscious knowledge to the therapist within the analytic context if used from an empathic perspective. Therefore, empathy is an approach to gaining knowledge of the client's inner world through the theoretical stance from which the therapist is working.

Attunement

Attunement is considered to have a fundamental role in empathy (Aragno, 2008; Arizmendi, 2011; Ginot, 2009; Meissner, 2010; Zepf & Hartmann, 2008). Stern (1985) asserts that attunement is a shared affect state between two people with the imitation of the precise behavioural expression of that inner state. The human nervous system is pre-wired to react to affect signals from others, and is the biological roots of empathy (Aragno, 2008). The emergence of empathy begins through attunement and imitation within the mother and infant relational dyad (Arizmendi, 2011), and the capacity for empathy is dependent on this early attunement and the consequent stages of development. In other words, this means that the ability to feel empathy is dependent on one's nurturing.

Zepf and Hartmann (2008) critique this view by arguing that it is questionable as to how a child can develop the capacity for empathy from the experience of being empathically understood. They argue that it is not clear how the one leads to the other. Sensorimotor actions and mimetic (imitative) expressions are signs, but mental contents that lie beneath them can never fully be known. Therefore, empathy is based merely on perception and inferences of manifest cues (Zepf & Hartmann, 2008).

Ginot (2009) asserts that early infant/caregiver interactions have lasting imprints on the brain and ultimately influence the capacity for affect integration and regulation. In the therapy relationship, attunement is not conscious but "mediated by automatic mechanisms of perception" (Meissner, 2010, p. 458). While attunement seems vital for empathic experience there are reservations from some authors about the extent of its function. The literature did not provide much depth of analysis in relation to empathy and attunement, so I will explore this aspect further in Chapter 4,

because developmental research provides valuable findings for interpersonal relating and understanding empathy in the context of the therapeutic relationship.

Neuroscience

Neuroscience findings and the discovery of mirror neurons provide evidence for underlying physiological and neurobiological mechanisms in empathy (Aragno, 2008; Arizmendi, 2011; Ginot, 2009; Krause, 2010; Meissner, 2010; Zepf & Hartmann, 2008). Mirror neurons show how we understand actions or the intentions of an action in others via observation. This is the first phase of empathic resonance (Ginot, 2009), which enables us to recognise others as being like us in a shared intersubjective experience (Aragno, 2008).

However, it is also argued that hidden intentions and mental contents may lead to inaccurate interpretations (Ginot, 2009; Meissner, 2010; Zepf & Hartmann, 2008). Mirror neuron research provides substantial evidence for a mirroring of affect in empathic experience; however, it does not provide a complete understanding of empathic relating. Cross-cultural studies of affect are not conclusive and show that the more someone from non-western culture is exposed to western culture the closer the interpretation of affect is to the western interpreters (Zepf & Hartmann, 2008). The study cited tested the assumption of genetically prewired relationship between specific affect and the corresponding behaviours. Participants were asked to identify facial expressions and attribute the related feeling states attached to the specific expression. The results were not conclusive and the study's methodology was critiqued on the grounds that the choices offered were given with no other options (six expressions of feeling were assigned to six pre-determined feeling related words) (Zepf & Hartmann, 2008).

Intersubjectivity

Intersubjectivity is the term used to describe the interpersonal psychic matrix of two individuals where mental occurrences are dialectically created experiences, specific to that interaction (Akhtar, 2009). Intersubjectivity focuses on the interaction between individual subjectivities that have a reciprocal, mutual influence on each other.

Poland (2007) states that empathy cannot be discussed without implying Intersubjectivity, because empathy requires one person's understanding of another and thus implies separateness between the two people.

The client and therapist are a unified couple interacting as separate individuals, therefore empathy can only be an attempt at knowing but cannot lead to complete knowledge (Poland, 2007). In the early stages of therapy when the therapist and client are building a relationship there would be more separateness between them and less of a unified dynamic until a strong working alliance has been established. This early stage is when empathy needs to be at its peak in order to establish a sense of safety for clients to be themselves and thus allow a trusting relationship to be forged.

Poland (2007) argues that empathy is a valuable concept that cannot be reduced to a singular factor, and is valid only when there is respect and individual authenticity. The idea that empathy is for knowledge gathering in a sense contradicts the general understanding of empathy as a way of understanding how another person may feel. One has to have some knowledge of the other to imagine how they feel, but empathy is much more, in that the other has to feel understood. Knowledge gathering is important when trying to understand the client and their history, but empathy is about acceptance and acknowledgement rather than enquiry.

Solutions to psychoanalytic empathy issues

Recommendations offered by authors to counteract the issues arising with analytic empathy are outlined below. The suggestions follow the same approach as their conceptualising of empathy does, in that solutions are also methods/instruments of inquiry. These solutions come with problems, although authors argue that solutions offered are less problematic than the issues they aim to address.

Communication involving semiotic processes

Aragno (2008) argues that within the specialised field of psychodynamic psychotherapy there exist two types of empathy, immature and mature. The earliest form, immature empathy, is identifiable by the merger with another. Mature empathy is notably different, in that separation and complex forms of communication exist. This communication involves semiotic processes. Semiotic means a system of signs in language. "A singularly human trait that enables us to make use of signs and symbols as designators and signifiers of things—to point to, refer to, represent, stand for, and depict complex meanings as no other species can" (Aragno, 2008, p. 726).

This suggests a specific human predisposition for empathy through an aspect of language that allows humans to communicate with meaning to each other (Aragno, 2008; Zepf & Hartmann, 2008; Ginot, 2009; Meissner, 2010; Arizmendi, 2011). Semiotic processes involved in human communication are different from other species, because we are able to communicate complex meanings to each other through signs and symbols via various brain structures (Aragno, 2008). The formation of signs and symbols are programmed in a developmental sequence from conception. This model illustrates how empathy originates in humans and is

instinctual and occurs through a range of basic emotional expressions that are facilitated by semantic and/or verbalising processes.

Within the therapeutic relationship, communication through signs and symbols assumes that the therapist has to be knowledgeable about the form of response that arises within them i.e. a bodily based sense. The therapist stance must integrate auditory, perceptual and emotional stimuli (Aragno, 2008). Through language, an awareness of unconscious meanings is conveyed and interpreted in a logical way, so empathy is an interpretive technique whereby the therapist acts as an interpreter. The therapist uses all the information gathered from these senses when responding to the client. Like an instrument to the client, the therapist conveys an understanding rather than participating in their emotional world. Through this process, knowledge travels via experience by witnessing and understanding (Aragno, 2008). Ginot (2009) argues similarly that in the same way enactments present both participants with an authentic opportunity to symbolise and create what cannot yet be verbalised.

Perspective taking

Taking the perspective of the other is the basis of empathy and is grounded in three different processes, "motoric affect contagion", "taking the perspective of another" and "prosocial activities" (Krause, 2010, p. 140). Krause argues that although identification is based on imitation it does not imply empathy because of the emphasis on separation between subjects' experience.

Piaget identified in his experiments with children that perspective taking was not possible in children younger than 17 months of age (Krause, 2010). To be able to take the perspective of another, the child has to first perceive themselves as separate

to the other. Bischof-Kohler (1991) noted that secure attachment was an "important moderating variable" in the process of perspective taking (cited in Krause, 2010, p.140).

Mirror neurons are the physiological mechanism for perception coupled with action, and are the prerequisite for empathy. Motoric affect contagion is based on mimicry, and therefore separation between self and other is not needed and identification is not an important element of affect contagion (Krause, 2010). Finally, prosocial behaviour such as helping others in need is a necessary component for this model. As was highlighted in previous arguments, the problem of distinguishing between each person's feelings is still an issue in this view.

In contrast to the previous views, this model of empathy does not place emphasis on affect resonance and attunement. Ginot (2009) argues that there is no causal relationship between mirror neurons and the felt experience of empathy.

Neurophysiological and psychological mechanisms
According to Meissner (2010) "hard-wired and automatic neurological, neurophysiological, neuromuscular and autonomie" mechanisms play a vital role in affective experience and communication in both parties (p.460).

In the first instance, the client experiences emotion, and their neurophysiological processes are set in motion. There is a psychological affect related to sense of self, where subjective conscious or unconscious self-object representations are stimulated. The therapist perceives cues that cause a neurological (mirror neuron) response, that is the same as the client's. Mirror neuron emotional activation leads to the therapist responding emotionally to the client. Affective neural activation resonates with some aspect of the client's introjective organisation that informs

his/her sense of self (self-object). An unconscious empathy response from neural activation in the therapist is activated. Self- syntonic or self-dystonic states lead to defensive responses of splitting and projection. Transference will be onto the object of the therapist. Projective identification is the activation of introjective configurations in the client that stimulates a defensive response, which in turn impacts on the therapist's empathic response (Meissner, 2010, p. 455-460).

According to this model, affects automatically resonate psychologically with the introjective organisation of both parties. There is no question of projection or trial identification. Projection is a term used to describe the disownment of an unacceptable impulse to the external object (Akhtar, 2009). Affective resonance of the client's usually unconscious self-experience is unconsciously communicated to the therapist in whom it is received and registered. If elements of both party's introjective parts align, the more in tune they will be. This is crucial for empathic response. Although complex processes remain unconscious, their affects are registered and become conscious. Only at the latter stages of the advanced development of the responses, and when the neurological processing involved in the inferential process has reached a certain point of elaboration, can these become conscious (Meissner, 2010). Before that, through projection or not, the affective component will remain unconscious.

This model is closely aligned with the concept of attunement and provides some resolutions to the problem of certainty about 'what mental contents belong to whom'. This is expressed as affective responses of the therapist being more in tune with the self- experience of the client. Meissner (2010) asserts that there is no transmission or projection nor any unmediated unconscious communication, but

rather is simply what already exists in each participant's introjective organisation. For example, the client's enactment of a masochistic stance will resonate with the therapist's own masochistic aspects from his/her victim introject. In this instance, the therapist's response would take the form of countertransference instead of empathy.

Imagery

Imagery is a form of nonverbal communication that flows from the client and forms part of an interactive process in treatment, an important element in the transition from attunement to empathy (Arizmendi, 2011). There is a reciprocal relationship between the emotional feel co-created by two people and image formation, and it is the emotional experience that lies at the core of the therapeutic relationship. This model attempts to deconstruct the process of empathic states from a neurobiological perspective with an emphasis on imagery. This means that the therapist has to achieve an empathic stance by imagining the perspective of the client via three mechanisms. These are, in order of sequence, automatic processes of mimicry, emotional states and physiological states (Arizmendi, 2011).

Through the process of mimicry, when attuned to each other, the therapist and client are able to sense their own as well as the other's emotional and physical state. This process is mediated through physiological and behavioural domains in the brain. Imagery represents a cognitive linking mechanism to help in the transition from emotional sharing to empathy. One is able to imagine the feeling state of the other and in turn feel empathy for them. Images represent feelings the therapist has that are communicated back to the patient symbolically or explicitly.
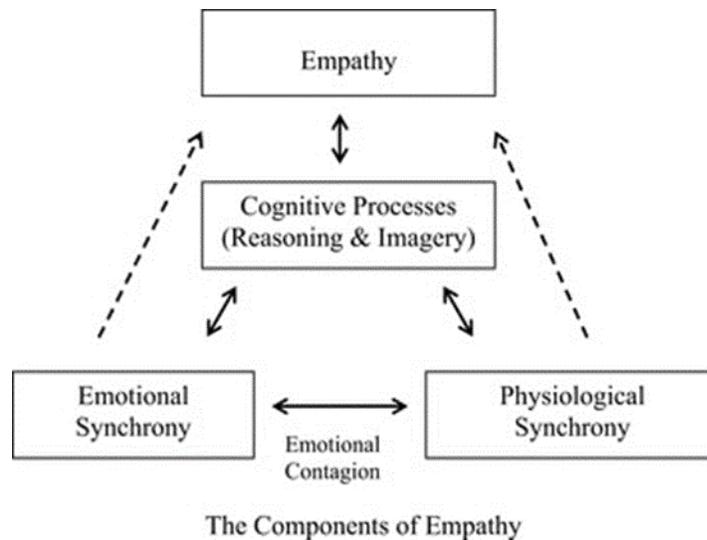
The Components of Empathy

Figure 1. From Arizmendi, 2011, p.417.

Arizmendi (2011) proposes that physiological synchrony is achieved when mental images via neural mapping of our own body states reach the other, creating the perception of another. Figure 1 shows the components of empathy and the interaction between them. A feedback loop between external and internal events is created between two people through physiological and emotional synchrony between them. The brain's dispositional records are directed through echoing body signals, with attention being to those images that are more or less congruent with the affective state that currently exists while ignoring others.

Discussion

Psychoanalytic empathy is a construct of many elements. Identification, projection, countertransference, attunement and intersubjectivity are some commonly discussed when describing empathy. However, it appears that these concepts are not without limitations. So, when trying to stand in another's shoes it is difficult to ascertain if the feelings of empathy that arise in the therapist belong to conscious or unconscious material of the client or therapist.

Empathy in psychoanalysis is the therapist's tool for the task of acquiring knowledge and gaining an understanding of the client. Knowledge of the client provides the therapist with information that can be used for the purpose of interpretation. Empathy in this context is used for "understanding and explaining" (Tudor, 2011, p.39). The literature suggests that during the process of empathy, unconscious mental contents of the therapist and client create barriers to complete knowledge, making it difficult to know what feelings belong to whom. Unconscious processes of either party are thus problematic for empathy.

According to Bolognini (2004), the increased interest in empathy as the therapist's goal and key to effective clinical engagement occurred as a consequence of the success of self-psychology and Kohut's model of empathy (1959). This widely accepted stance in self- psychology shows the psychoanalytic instrument as impoverished, and places empathy in its "realistic character as a goal rather than a method within the therapeutic process" (Bolognini, 2004, p. 119).

However, Tudor (2011) argues that while almost all psychotherapy approaches, including neuroscience, view the therapist's empathy as central to its effectiveness, the work of Carl Rogers and his person-centered therapy is rarely mentioned. Tudor argues that this is because person-centered practise is considered too simple, it has been associated more with counselling than psychotherapy, there have been misunderstandings between the person-centered approach and client-centered therapy, and practitioners and theorists develop within their own traditions to the exclusion of other fields (2011). I will elaborate on the work of Rogers in the final discussion as it relates to the overall discussion of empathy within the therapeutic relationship.

There has been increased reference to neuroscience research in psychoanalytic literature over the past decade. The discovery of mirror neurons and affect in interpersonal relating adds valuable information to the experience of empathy, particularly in the therapeutic relationship. Therefore, neuroscience findings and the concept of attunement within the context of the therapeutic relationship will be explored in the following section.

Conclusion

The literature suggests that there are several problems with the psychoanalytic construction of empathy. The predominant issue identified was with the unconscious psychic material of the client and therapist, casting doubt as to whether the understanding arrived at via empathy is accurate. In order to overcome some of these issues, authors suggest possible alternative models of empathy. The solutions to the problems of empathy are inclined toward affect, attunement and sensing of the client through neurophysiological processes. In the light of these findings, attunement and neuroscience research in relation to empathy in the therapeutic context will be explored further.

The overall conclusion is that psychoanalytic empathy is significantly different to the humanistic view of empathy (Rogers, 1957) and the empathy I am most accustomed to. I draw on Carl Rogers because his view on empathy in person-centered therapy has had a significant influence within the helping professions, and I would be dishonoring my stance and world view if I did not include it in my interpretations.

According to Rogers (1957) empathy is the therapist's ability to "sense the client's private world as if it were your own, but without ever losing the "as if"

quality … When someone understands how it feels and seems to be me, without wanting to analyse me or judge me, then I can blossom and grow in that climate" (cited in, Rogers, 1965, p. 99).

The question I have is, what are the possible solutions to bridging the gap between these two forms of empathy?

CHAPTER 4: THE THERAPEUTIC RELATIONSHIP

In this chapter I explore empathy in the context of the therapeutic relationship with a focus on neuroscience and attunement. The previous chapter and literature review on psychoanalytic empathy highlighted interesting solutions to some of the problems with psychoanalytic empathy. I explore those areas further with a specific focus on context, i.e. the therapeutic relationship, as this is a place where clients feel understood through empathic experience (Greenberg, Watson, Elliot, & Bohart, 2001).

Research shows empathy and the quality of the relationship between the client and therapist to be important factors in therapy outcomes. A meta-analysis of the effects of empathy on psychotherapy outcome, found that of the four mediators between empathy and outcome, three processes were of a relationship nature. These were a "relationship condition, a corrective emotional experience and a cognitive-affective processing condition, and the fourth was to do with the role of client as self-healer" (Greenberg et al., 2001, p. 382). The authors acknowledge that these are theoretically identified mediators and that their study had several limitations.

Throughout the research on empathy, the areas of neuroscience and attunement were most frequently referenced. The therapeutic relationship is an intersubjective relationship that has been explored via the concept of attunement in early developmental psychology and neurological studies.

Attunement

Inferences have been made about the therapeutic relationship based on the early developmental view of attunement in social relationships. Empathic attunement experienced in the psychotherapy setting appears as the single critical variable for successful outcome (Spiegel, Severino, & Morrison, 2000). Within the client and therapist relationship, attunement conveys a sense of respect for the client. By providing the safety to explore difficult emotional experiences with validation, the therapist provides a different response to what the client originally felt, resulting in a different and healing experience. Tudor (2011) argues that the term empathic attunement when used alongside empathy is confusing because attunement is the therapist's experience of attunement and differs from the communication that stems from that attunement.

Erskine et al. (1999) argue that "attunement goes beyond empathy" and is a two-part process whereby the attuned therapist must first be aware of the client's sensations and needs (p. 236). Attunement allows the therapist to be aligned with the emotional state of the client and an awareness of when this changes, thus allowing them to respond appropriately. The authors list different types of attunement as cognitive (understanding the client's cognition), affective (sensing of the client's affect with a reciprocal affect, i.e. the therapist feels what the client is feeling), rhythmic (tuning in to the client's physiological rhythms) and developmental (responding to the client's regressed stage of development). As we have seen, these types of attunement appear to overlap with elements of empathy. Empathy is both a cognitive and affective state that includes resonance at a bodily level with the other.

Stern (1985) has been widely quoted in the literature on the early development of the infant, the mother-infant relationship and the development of empathy through attunement. Therefore, I have drawn on his view to discuss attunement in the therapeutic relationship. Attunement has been called different names, such as emotional attunement, affect attunement and empathic attunement. In this research I refer to the notion as attunement. Stern (1985) uses the term affect attunement and argues that although several other terms exist to encompass it, they fail to adequately capture the underlying phenomena. "Affect attunement, then, is the performance of behaviors that expresses the quality of a feeling of a shared affect state without imitating the exact behavioral expression of the inner state" (Stern, 1985, p. 142).

Stern argues that attunement is not close enough to what is generally meant by empathy, because attunement occurs mostly out of awareness and automatically. Empathy, on the other hand, involves the mediation of cognitive processes. Attunement and imitation are not separate but occupy two ends of a spectrum (Stern, 1985). Affect is a distinct form of affective exchange. It starts with emotional resonance like empathy, but casts the experience into another form of expression. Attunement is the predominant way of sharing internal states; it allows a shift of focus from external behaviours to the quality of feeling behind the behaviour being shared.

The very first relationship in human life between infant and mother/parent is characterised by communication through attunement and affect resonance. This intimate engagement allows the infant to convey to the parent their needs, while through this process, the attuned parent assesses what those needs are. Therefore, attunement enables the nervous systems of the child and caregiver to synchronise,

each affecting the other's nervous system (Hart, 2006). This is essential for us to feel and be felt, and facilitates the development of attachment and the ability to relate to others throughout the lifespan. Cozolino (2002) asserts that there is a unique level of communication in the early relationship, and understanding between individuals goes beyond imitation behaviour and includes proto-conversations. Proto-conversations are complex, shared interaction and communication through sound, movement and touch. This "shared biochemical environment informs the child about his mother's state of arousal and sense of safety" (Cozolino, 2002, p. 177).

Secure attachment is achieved through the mother's "sensitive psychobiological attunement to the infant's internal states of arousal" (Schore, 2012, p. 56). This regulatory mechanism between the mother and infant dyad optimises the communication of emotional states. Schore (2012) argues that this is the psychobiological underpinning of empathy. The wiring of the brain requires attunement to others (Fishbane, 2007).

Neuroscience research shows that the human body and nervous system are uniquely designed for the brain of one person to interact with the brain of another (Balbernie, 2007). This interaction of brain connection is evident in the first year of human life. In this stage of development, the essential task is the creation of a secure attachment bond with the caregiver.

It appears from this that the building blocks of empathy begin at this stage (Hart, 2006). This first relationship through attunement and attachment helps guide and regulate thoughts and emotions. This early relationship forms the foundation for the establishment of the self. Cozolino (2002) argues that the self is a socially

constructed way of feeling about oneself within a group and develops through learning and memory. One's sense of self is an important aspect of empathy.

Lamagna (2011) argues that who we are and how we react is dependent on our capacity to attune and respond adaptively to our thoughts, perceptions and impulses. Self-regulation develops within the child and attachment figure dyad. The mind adopts these regulatory abilities across the lifespan through a similar dyad (Lamagna, 2011). Internal working models are not formed only by attachment but by the impact within the intersubjective matrix set up by attachment; they are essential to brain design and efficient interpersonal navigation (Balbernie, 2007).

From the very first relationship between infant and caregiver an attachment bond is developed through the process of attunement. Attunement enables the caregiver to understand the needs of the infant and the infant is able to communicate their needs via attunement. Through being able to understand the function of attunement in this early stage of life, it is possible to apply this to the therapeutic relationship. Siegel (1999) argues that "interpersonal relationships can provide attachment experiences that can allow similar neurophysiological changes to occur throughout life" (p. 285). Therefore, attunement between the therapist and client in the context of the therapeutic relationship offers the opportunity for healing of emotional and psychological wounds that occurred early in life, as well as those occurring throughout it.

Neuroscience

Empathy in the therapeutic relationship is mediated by affect resonance between the therapist and client. Studies of affect resonance in relation to empathy show that the human brain and its interconnected parts house the intricate neural connections that

allow us to feel, think and learn (Siegal, 1999). Siegal asserts that the brain is shaped by interactions with the environment and interpersonal relationships, and from this the mind emerges.

Neuroscience research is particularly important for psychotherapy because understanding the functions of mirror neurons enables us to understand the actions of others (Watson & Greenberg, 2009). There is now scientific evidence for some of the neurophysiological processes and mechanisms previously identified in psychoanalysis (Reiss, 2011). This is of particular interest in relation to empathy. The therapist and client relationship reflects an underlying biology characterised by markers that can be used to improve treatment outcomes (Reiss, 2011). It is important to make the distinction between affect resonance (unconscious, biological and socially encoded) and mirror neurons, as some authors have argued that affect resonance occurs prior to motoric contagion resulting from mirror neuron activation (Aragno, 2008; Ginot, 2008; Meissner, 2010).

Recent findings in neuroscience research and technological advances substantiate the findings that have led to increased knowledge of brain function and empathy. In the late 1990s and early 2000s, empathy became strongly linked to neurobiology. This occurrence was made possible by neuroscience research, and in particular the discovery of mirror neurons (Gallese, Eagle, & Migone, 2007).

Empirical studies show that "unconscious automatic mimicry" mechanisms are at work between people when observing each other (Decety & Jackson, 2006, p. 55). There are "autonomic response associated with those bodily states and facial expressions of the person being observed" (Decety& Jackson, 2006, p. 55). This suggests that this system automatically prompts the observer to resonate with the

emotional state of the other person. Studies using functional magnetic resonance imaging (fMRI) showed neural activity in the same regions of the brain for facial expression mimicry and physiological states in the observer as in the person being observed. Similarly, other studies showed that the same occurs for the expression and perception of emotions such as disgust (Decety & Jackson, 2006).

Decety and Jackson (2006) identify the three major components of empathy as an affective response to another person or sharing of that person's emotional state, the cognitive capacity to take the perspective of another person, and emotion regulation (p. 54). Depending on how empathy is triggered, whether involuntarily or intentionally, these triggers are differentially involved and both aspects touch similar neural mechanisms that underpin emotion processing. In other words, irrespective of how empathy arises within the person it involves the same emotional processing centres in the brain.

An important function of empathy is the ability to distance oneself from the other in order to distinguish what feelings belong to whom. Specific areas in the brain have been identified for the function of self-agency and self-awareness. Decety and Jackson (2006) argue that this neurocognitive mechanism plays a central role in this important factor in empathy, and that a lack of self and other differentiating can consequently lead to personal distress. To prevent any confusion, the inability to move between self and other experience is overcome by self-regulatory processes. The ability to regulate one's own responses helps to separate what belongs to whom.

Developmental studies with infants and caregivers have shown motor and affective mimicry. Decety and Jackson (2006) assert that this direct link between perception and action is the basic mechanism for social interaction. They argue

humans are pre-wired to resonate with others' emotional states through autonomic and somatic responses (Preston & de Waal, 2002, cited in Decety & Jackson, 2006).

Through the process of imitation, we can understand the context of another's experience. The clinician is able to project future actions and anticipate possible outcomes. "Observing and watching others in a particular emotional state automatically activates a representation of that state in the observer with its associated autonomic and somatic responses" (Ginot, 2009, p. 127).

Neuroscience research emphasises early attachment and brain development, and findings highlight the brain's ability to be restored (neuroplasticity). A therapist's encounter with a client is therefore powerful, in that it is capable of changing a client's brain for better or worse (Jones-Smith, 2016). The therapist-client relationship is a fundamentally life-altering encounter and needs to be embarked on with great sincerity and commitment to the welfare of the client. The relationship thus transcends expertise, theoretical framework or technique. It is the human-to-human relationship of "unconditional positive regard" and empathy (Rogers, 1957) that sits at the core of emotional healing.

CHAPTER 5: DISCUSSION

In this chapter I highlight the areas of empathy in therapeutic practice that are important for further discussion: context, culture and the client. My interpretation of the research on empathy arises from a non-western practitioner's perspective. From this perspective, I have identified gaps in the research not adequately explored within the studies utilised for this dissertation or the literature in general. Furthermore, it is vital for present theories and practice to be evaluated within the current environment of rapidly advancing technology and global multiculturalism, and, in New Zealand, biculturalism. The clinical implications of this research and the research gaps will follow on from this discussion.

Context

Understanding the wider historical context of empathy provides some insight into possible reasons as to how and why it remains a contentious notion. The word empathy has been used over time in ways that depict the era and purpose of its use. Hence, the meaning of empathy has also changed along with its movement across disciplines.

Romantic empathy (Bolognini, 2004) predates the first introduction into English of the word translated from the German term, *einfuhlung*. During this period there was a rediscovery of the emotional element of human life by intellectuals, poets and philosophers. It was a culture characterised by intense relationships and communication among scholars. During this time of great creativity and grandiosity, empathy became characterised by projective functions that resembled this. Artwork came to life via the feelings of the artist. Romantic empathy did not reflect the

separation between object and subject; it was a mental style that privileged "feeling over thinking" (Bolognini, 2004, p. 27).

The aesthetic stance set the stage for a shift in the way people were understood "not from the outside looking in, but from the inside looking out" (Howe, 2013, p. 9). Social scientists recognised the potential of empathy to help understand the human experience from the subject's point of view (Howe, 2013). Theorists and clinicians from various schools of psychology and psychotherapy also developed and used empathy for ,understanding and explanation", diagnosis and treatment (Tudor, 2011, p.39). There has also been a longstanding tradition of conflict in the mental health profession beginning with Freud and colleagues, and continuing among competing schools and practices. Gergen (2006) argues that competition between the biomedical model of mental health and the traditional talking therapies means there are now two opposing camps in mental health, and that more is at stake than privileging one tradition over the other.

Empathy is presently undergoing yet another transformation with recent developments in neuroscience research (Decety & Jackson, 2006; Gallese, et al, 2007). There is now a move toward providing scientific evidence for the presence or absence of empathic relating, among other neurological processes. The literature shows a noticeable rise in neuroscience research on empathy in recent years. The question is, how will this impact on empathy in practice? Neuroscience research merges with the biomedical model of health and the medicalisation of mental health in particular. Healing is closely intertwined with diagnosis and drug treatments aimed

at "curing mental illness", which poses a danger to traditional therapies "concerned with the cultural constitution of human action" (Gergen, p. 139).

The helping profession runs the risk of veering away from the origins and treatment of the individual and their unique circumstances surrounding emotional and psychological distress. Rather than professionals viewing the client's world from the outside in, they need to narrow the divide by attuning to the experience of the client, to understand rather than evaluate. Neuroscience should inform our present knowledge base and practice, not guide treatment at the expense of the client.

The psychoanalytic perspective of empathy as a method for understanding a client differs from client-centred views of empathy as a therapeutic stance toward the client. Psychoanalytic empathy is viewed as an instrument of enquiry into the world of the client, whereas the client-centred view of empathy as an approach is free of evaluation (Tudor, 2011). This is where the debate lies: is empathy a therapeutic tool, attitude or both?

Although the use of empathy was adopted from aesthetics and art, its basic understanding within that context still relates to present day discussions on the definition within the therapy relationship. Attunement and neuroscience findings suggest that it is a feeling (affect) component in empathy that brings us closer to understanding other's emotional experience. When empathy was adopted into the fields of counselling, psychology and psychotherapy, the emphasis was placed on thinking (imagining) how the other may feel. Current definitions of empathy place separation between therapist and client as an essential component of empathy.

The psychoanalytic understandings of empathy emphasise that when one understands another via identification and imagination there has to be a separation

between self and other. This is an important aspect of empathy, because it allows differentiation between experiences of the client and therapist. Where possible it allows the therapist to be a 'neutral' observer and not to be overwhelmed by the difficult emotions of the client. By standing apart from the client's emotions, the therapist is able to convey what it must feel like without actually feeling the same emotional response. This separation, however, also creates a sense of detachment from the client's experience.

The essential distinction between self and other in relationship creates a world of distances, where I am here and you are there (Gergen, 2006). Gergen argues that this view of individual minds stems from the western emphasis on independence and individuality, which creates alienation and mistrust (2006). The desire for connectedness in relationship is a universal human need that does not belong to one group or another. The therapy relationship is no exception to this. Clients come to therapy vulnerable and with some kind of emotional pain. As therapists we are in a privileged position because we are entrusted with stories that clients have probably not shared with anyone else. Clients entrust the therapist with the most vulnerable parts of themselves and their experiences. The therapist therefore, sits in a 'sacred' space with and alongside the client, and has to value this accordingly, with reverence. The therapeutic relationship is a place that needs to provide safety, trust, acceptance and most importantly, respect, so that clients feel they can be heard without judgment.

The therapeutic relationship is unique in its purpose and intent, where the relationship between therapist and client provides a place for understanding, development and healing. When empathy in the therapeutic context is used as a skill

or tool for interpretation, it loses the very essence of caring and acceptance and being with the other in their experience. Both of these are vital elements of empathy, but without the trust of a client who feels valued and acknowledged, the tool loses its effect.

Culture

New Zealand, along with many other countries, has rapidly become a multicultural society. However, New Zealand stands apart from other countries in that we are a bicultural country based on the Treaty of Waitangi. Biculturalism means that all people residing in New Zealand have an obligation to tangata whenua (people with customary rights to the land) to uphold and engage with their cultural values and principles (Durie, 2003).

Biculturalism is an official government policy recognising the historical interaction of two people, Maori (indigenous people of New Zealand) and Pakeha (European/British New Zealanders). Ruwhiu (2001) argues that helping others requires a comprehensive understanding of the Treaty of Waitangi and the historical path of biculturalism, and non- Maori need to participate fully as Treaty partners. Maori conceptual, theoretical and practical wisdom needs to be incorporated into helping profession frameworks. Whanau (family), hapu (clan) and iwi (tribe) are core to Maori decision making and are important to value when working with Maori clients.

The increased migration of people between countries over recent years has meant that society continues to evolve and change as different world views converge on each other. Therefore, old views and methods of practice need to be evaluated accordingly. In the data gathered in this research there was no mention of culture.

There are, however, large amounts of research on the subject, but according to (Howe, 2013), no firm conclusions. Culture is defined as a combination of behaviour patterns, shared values, beliefs and customs that are passed down from generation to generation, through family and community (Jones-Smith, 2016). From early development, enculturation becomes an internal mode of regulating behaviour, action and emotion (Tseng & Streltzer, 2001). The term culture needs to be differentiated from terms such as race, ethnicity and minority, which are used incorrectly or interchangeably. Culture is an abstract concept and difficult to define.

All individual members of a group or society have their own cultural mode, regardless of race, ethnicity, minority or majority status (Tseng & Streltzer, 2001). The difficulty with defining culture exactly is partly because aspects of culture are fluid and there are many grey areas resulting from the process of acculturation. Individuals, who re-evaluate their own cultural norms against others, may differ in their perspectives from others, in the same culture as themselves. Therapists need to have an astute awareness of cultural difference and how that intersects with their cultural identity, always respecting and valuing the client's cultural heritage.

Psychoanalytic formulations of a client are centred on object relations, and conscious and unconscious processes. When culture is excluded from this understanding, a very important pivotal object is removed from the formulation of the individual. Even though it may be safe to assume that most cultures have been to some degree successfully westernised, it does not eliminate their cultural identity, however minimally visible. Jones- Smith (2016) asserts that counselling interventions that are Eurocentric may not work with eastern, Asian and African clients. It is widely noted in research that people from group cultures think and act differently to

those from individualistic cultures, by emphasising the group over the individual. Individuals from group cultures view themselves in relation to their family and community. In contrast, people from individualistic cultures place value on independence and individual ideals. Therefore, clients' beliefs and behaviours treated out of context may be misinterpreted, disregarded or even considered maladaptive (Chi-Ying & Bemak, 2002).

In an example from my own cultural (Hindu) perspective, family ties and the notion of karma are cultural beliefs ingrained in my view of self in relation to my behaviour and actions. The notion of karma underpins the Hindu way of life, and everyday thoughts and actions are governed by this belief. When working with non-Hindu clients, a lack of understanding that this view is not universal can lead to misinterpretation of the client's view, which can result in a breakdown of the therapeutic relationship, as well as enactments that damage established bonds of trust. This is just one example of cultural nuances and values that make up the individual.

As a Hindu psychotherapist, I am aware that my cultural views are held outside of the relationship with non-Hindu clients. My experiences growing up in a western culture and living alongside other cultures have been advantageous to me in my work. This is because being forced to assimilate into the dominant culture requires one to consciously study the other in order to blend in by taking on some aspects of the other culture and adapting oneself to that. However, this assimilation does not fully and completely erase the original culture; one just learns to live in both. It has become an automatic process for me to be curious about their culture when I encounter a person from another culture. As a consequence, I have learned about the values, beliefs and customs of many cultures. This experience of being of a culture

that is different from the dominant one means that I feel and view empathy differently.

Therapeutic notions of empathy are largely based on western Euro-American values and rarely take into consideration cross-cultural effects (Chi-Ying Chung & Bemak, 2002). To know that you are acknowledged for who you are regardless of difference is what brings understanding, even if there are errors in judgment and interpretation. The therapist has to be able to see the world through the eyes of the client and attune to the client's emotional experience, while keeping his/her own cultural identity separate (Chi-Yang & Bemak, 2002). During the research for this dissertation I felt a disconnect between the psychoanalytic theories of empathy and the client experience of empathy. Putting myself in the client's shoes, empathy, in my view, means to be understood with patience and warmth that acknowledges my experience and the emotional response related to that experience. Psychoanalytic use of empathy leaves me feeling like an object of investigation and my experience minimised for the sake of understanding through enquiry.

Client

The psychoanalytic use of empathy serves to understand in order to explain and interpret. The separation between client and therapist in this context is obvious and the therapeutic interaction feels clinical and cold. The client thus becomes the 'object' of scrutiny. It is difficult to determine how healing occurs from this approach.

Empathy is defined as a way of understanding others and how they feel by imagining what it must feel like to be in their situation. The research on empathy and psychoanalysis suggests ways of achieving this understanding through various psychoanalytic processes, with the aim of empathy ultimately being for the role of

interpretation. In my view, understanding alone does not convey to the client that they are understood. Instead this comes from the felt sense that the therapist experiences through aligning with the client's feelings about a specific concern and from this to demonstrate a genuine acknowledgement and concern for the client and validation of their feelings (which does not require agreeing with the client).

This feeling of the therapist for the client is associated with warmth and caring, much like a parent's love. A parent's love (in most cases) arises from how the parent views the needs of a child, as though the child becomes embodied in the parent. The parent digests what is received from the child and then offers back to the child a visceral resonance of feeling, permeating that feeling back into the child endowed with acceptance, tolerance, compassion and understanding – this is love, this is empathy. In collectivist cultures there is no individual, everything is perceived and experienced through the eyes of the greater family, clan and community. Therefore, empathy is the foundation of parental love and collectivist culture.

Rogers (1965) stated that personality change in a client does not occur as a result of the therapist's skills or qualifications, but solely as a result of the "attitudinal characteristics in the relationship" (p. 96). Six essential attitudes identified by Rogers were 1) psychological contact, whereby the client and therapist see their experience as a relationship, 2) an incongruent client unsuccessfully tries to cope with a problem, 3) genuineness and congruence of the therapist, 4) a warm acceptance and valuing of the client, i.e. unconditional positive regard, 5) therapist empathy, and 6) a sensitive empathic understanding of the client's feelings that are conveyed to the client (Jones-Smith, year). The Rogers' work resonated strongly with me when I was first introduced to the concept of professional empathy in my undergraduate year. I

experienced a warm, compassionate sense of understanding just from hearing about his work. My sense of Rogers is that a sense of unconditional love and acceptance of all people is at the heart of his theories, and that his philosophy of the human condition and suffering is truly embodied in his work, and his understanding comes from the people he worked with and observed.

Rogers (1980) emphasised that a consequence of empathic interaction was that it dissolved alienation. This non-judgmental, sensitive understanding allows the recipient to feel cared for, accepted and valued for the person they are, as they are. According to Rogers, the difference between client-centred therapy and other therapies is that "true empathy is always free of any evaluative or diagnostic quality" (p. 154).

The most quoted theorist on empathy in the psychoanalytic tradition is Hans Kohut (1923–1981). Kohut (1959) argued that the only way to understand another is through introspection of oneself, and empathy, which he defined as "vicarious introspection", was a process of coming to an understanding of another through introspection of one's own experience (p. 459). In his work with narcissistic clients, Kohut re-evaluated previous classical psychoanalysis by metaphorically putting himself in the client's shoes so that he could understand the experience from their point of view. As a result, "empathic immersion and vicarious introspection became defining features of psychoanalytic methodology" (Mitchel & Black, 1995, p. 157). Hence, empathy in the therapeutic relationship became a tool by which to gain an understanding of the client.

CHAPTER 6: CONCLUSION AND IMPLICATIONS

This dissertation began with an inquiry into psychoanalytic empathy as a consequence of the confusion of approaches to empathy I experienced during my training. The aim of the research was to find a clearer understanding of empathy within the therapeutic relationship.

Outcomes of the review highlighted that empathy is an important key factor in positive therapy outcomes. However, the concept of empathy remains plagued with different understandings and debate across disciplines. Research findings into psychoanalytic empathy distinctly identify empathy as an interpretive tool for the purposes of understanding the client's inner world.

Based on this view, authors identified problem areas of empathy and offered potential solutions to those problems. Problems were associated with unconscious ego processes and unknown psychic contents of each individual, which could not clearly be differentiated one from the other. This in turn shed doubt on whether empathy from therapist to client was accurate and/or effective.

The solutions to these problems centred on neurophysiological processes and affect resonance between therapist and client, which were deemed more accurate for empathy. This focus coincides with recent developments in neuroscience research and empathy.

The therapeutic relationship was explored from developmental (attunement) and neurological (neuroscience) perspectives with a focus on intersubjectivity in the therapeutic dyad. The findings from the review showed that there was a strong link between affect resonance and empathic accuracy, based on mirror neurons and emotional/psychological development from early infant/mother interaction.

Based on the research review of psychoanalytic empathy, neuroscience and attunement, the following gaps were identified. There was a concerning lack of reference and discussion of socio-political context, culture and the experience of the client. These areas were only able to be briefly explored in the discussion as a consequence of the requirements limiting this project, including exploring culture and psychotherapy within the context of our bicultural country. This issue is deserving of far more depth, and my recommendation is that it needs more research and is an entire dissertation on its own.

My experience as a non-Maori and a non-western therapist/person, positions me in a point of difference and partnership from which I explore the environment I engage with. Smythe & Spence (2012) experienced in their study of birthing that exploring different literature exposed them to different views, which added to their insight and understanding of what they were researching. I also was inevitably drawn in a different direction based on my position within this process. I drew on Carl Rogers and his person-centred view of empathy in order to deepen my understanding of empathy.

It is from this juncture that I present the implications for practice and suggestions for future research. I consider it is time that scholars and theorists removed their egos from the precious and sacred work of healing. In order to improve our practice for the sake of our clients, practitioners and theorists need to attune to each other and find what works *for the client*. Interpretation and understanding is a vital part of therapy. However, without the compassion and warmth of acceptance, all else fails. More research on empathy is needed from the client's perspective.

Perhaps my initial confusion lay in that what was labelled empathy did not feel like empathy to me. Empathy is not only important for everyday person-to-person relating everywhere, it has added importance in the New Zealand context because it is only through empathy that we can relate biculturally with our clients and each other in our daily lives.

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