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College of Social and Behavioral Sciences

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Heather Chapman

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Walden University
2015

Abstract

Using Character Analysis Techniques to Teach Cognitive Empathy

by

Heather A. Chapman

MA, Pepperdine University, 1997

AB, Smith College, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

May 2015

Abstract

Individuals who report better relationships with their mental health providers have better treatment outcomes. One element of the relationship is therapist empathy, or the therapist's ability to see the world from the client's point-of-view. Researchers have struggled to define, measure, and teach empathy. The purpose of this study was to investigate whether instruction in character analysis techniques, such as those used by actors, had an effect on cognitive empathy. A convenience sample of 20 adults enrolled in undergraduate or graduate-level coursework was recruited for participation in this study. Each individual provided demographic information and completed the Interpersonal Reactivity Index (IRI) and the Literature Empathy Test (LET). The intervention group (n = 10) participated in a 45-minute character analysis training prior to completing the LET. The control group (n = 10) completed both assessments in a separate meeting with no intervention. A univariate analysis of covariance was used to discover the effect of character analysis training on LET scores in light of IRI scores. The data analysis revealed no significant relationship between the intervention and LET scores, but the findings provided several insights. Future research would benefit from modifications to the LET, inclusion of an additional empathy measure, and revisions to the sample size and inclusion criteria. Although the results of the present study were not significant, this area of research remains a promising means by which to promote social change by informing the pursuit of positive interpersonal relationships and prosocial behaviors.

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Dedication

This study is dedicated to my mom, Karen Lee Hyatt. She is possibly the only person outside of my committee who will read this cover-to-cover. I hope now that she has my dissertation she will recycle all of my embarrassing college papers that she has held on to. Dear Mom, thank you for the purple tambourine, and thank you for your endless enthusiasm for all of my projects.

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Thank you to E for being a baby who enjoyed hearing psychology journals read aloud. Thank you to ZachyBean for never treating me like a grown-up. Thank you to Kari for our sister bonding days where I could read and edit while you slept. Thank you to Mom Herde, Roy Wirtz, and John Wirtz for teaching me everything I know about theatre. Thank you to everyone else who helped me finally figure out how to relax, enjoy life, Live Dangerously and Embrace the YES.

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Chapter 1: Introduction to the Study

Introduction

Actor Joseph Jefferson reflected, "For myself, I know that I act best when the heart is warm and the head is cool" (as cited in Cole & Chinoy, 1970, p. 554). In his comments on acting and character preparation, Jefferson described the balance between an actor's ability to feel, listen, and react while applying the skills of intellect and analysis to the events on stage. And for more than 2500 years, actors have tried to find the balance between feeling and thinking. They wrestled with the question of whether to present a character or become the character (Brestoff, 1995). According to Brestoff, it has been suggested that acting can bring on distress or even mental illness in actors who portray troubled individuals. Jefferson's balance of warm heart and cool head has been revealed to be an effective strategy for imagining the world of a character without becoming lost in it. Actors and directors have applied psychological principles to their work, but only recently have psychologists begun to look at how acting might contribute to the field of psychology (Goldstein, 2009; Goldstein & Bloom, 2011; Goldstein & Winner, 2010) and cognitive science (Noice & Noice, 2006). Great acting is a rare and innate art (Goldstein & Winner, 2010), but the cited researchers also noted that actors possess a teachable skill set, including vocal flexibility, memory, imagination, and character analysis. Acting is both an art and a science.

The same might be true for the delivery of mental health services. While there are seemingly intangible therapist qualities that contribute to therapeutic outcomes, there are also identified, teachable skills, such as empathy (Crits-Christoph, Gibbons, Crits-

Christoph, Narducci, Schamberger, & Gallop, 2006; Goldstein & Goedhart, 1973; Hatcher & Nadeau, 1994; Meffert, et al., 2013). To *act* best as a mental health professional, it would seem that the science of evidence-based therapies and advancements in neuropsychology ought to be combined with the art of creating a positive therapeutic relationship. I propose that the skills actors use to analyze and ultimately portray characters quite different from themselves can also be used by mental health providers to better understand the perspectives of diverse clientele.

Researchers in the medical and mental health care fields have explored the use of perspective-taking exercises to enhance clinician empathy. In one study, medical students participated in empathy training that used character analysis strategies, such as writing the patient's life story, examining the patient's many roles, and performing a monologue as the patient (Reilly, Trial, Piver, & Schaff, 2012). Although the student participants reported mixed reactions to the training, the medical school faculty—who also participated—recognized the educational potential of acting and narrative exercises for medical students. In a second, similar study, medical students reported that a course requiring them to write narratives from the perspectives of fictional patients helped them learn to empathize with patients (Dhurandhar, 2009). Psychology has been slower to adopt specific strategies for developing empathy in students and trainees. But two studies in multicultural competence included discussions of creating case conceptualizations for fictional clients (Jones, Sander, & Booker, 2013; Sehgal et al., 2011).

As psychology has advanced, the study of the therapeutic relationship—and empathy in particular—has come in and out of fashion (Norcross, 2002). When

behaviorists dominated the field, the concept of empathy was rejected because it was subjective and was associated with the mind rather than anatomy or observable behaviors (Edwards, 2013). Dymond (1949) described empathy as a personality trait that could be studied. After only three mentions of empathy in psychology research between 1909 and 1948, its new operational definition led to more than 40 articles published between 1950 and 1959 (Edwards, 2013). Rogers' person-centered therapy brought empathy to the forefront, but the psychoanalytic school also recognized empathy as an important component in the therapeutic process (Kohut, 1959, 1981). By the early 1980s, the legitimacy of empathy research was again questioned, and for a period of roughly 20 years, empathy was all but ignored (Bohart, Elliott, Greenberg, & Watson, 2002). Yet, in common factors research, the therapeutic relationship has been established as a significant component of therapeutic outcomes (Lampropoulos, 2000). Within the therapeutic relationship, therapist empathy has shown promise as a means to help individuals be receptive to interventions and progress through the stage of change (Prochaska, 2000). One question not fully answered in the literature is how empathy can be taught to or increased in mental health professionals. If empathy can be taught or increased, the potential for social change might include improved therapeutic outcomes for underserved and underrepresented individuals. Advances in the understanding of empathy may also benefit the growing number of individuals diagnosed with an autism spectrum disorder (Baron-Cohen & Wheelwright, 2004; Lawrence, Shaw, Baker, & Baron-Cohen, 2004). In Chapter 1, I describe the study's purpose, problem statement, nature, research questions, theoretical foundation, generalizability, and significance.

Problem Statement

The quality of the therapeutic relationship has been associated with treatment outcomes and therapist empathy has been identified as a common factor related to positive outcomes (Lampropoulos, 2000; Moyers & Miller, 2013; Norcross & Wampold, 2011; Watson, Steckley, & McMullen, 2013). Investigations have also found that the study of acting can increase empathy in research participants (Dow, Leong, Anderson, & Wenzel, 2007; Goldstein & Winner, 2012; Goodwin & Deady, 2013). Despite these findings, many formal training programs for mental health professionals neglect the teaching of empathy as a discrete skill (Boswell & Castonguay, 2007; Crits-Christoph, Gibbons, Crits-Christoph et al., 2006; Stein & Lambert, 1995). Thus, although therapist empathy has been identified as a factor influencing therapeutic outcomes, training programs for mental health professionals lack an effective method for teaching cognitive empathy.

Nature of the Study

In this quantitative study, I investigated the relationship between (a) training in character analysis and (b) cognitive empathy in mental health professionals. I examined the scores of an experimental group and a control group on the Literature Empathy Test (LET, Mahoney, 1960) and the Interpersonal Reactivity Index (IRI, Davis, 1980). Participants in the treatment group received instruction in basic character analysis strategies while the control group did not. The independent variables in the study were (a) assignment to the experimental or control group and (b) gender. The dependent variable was the score on the LET. Scores on the IRI's Perspective-Taking Scale was used as a

covariate. I used an ANCOVA to analyze the data, which provided insight into whether the character analysis workshop was an effective intervention.

Research Question and Hypotheses

The study's purpose was to investigate the use of character analysis strategies as a means to increase cognitive empathy scores among the participants. The research question for the study was as follows: Do individual Literature Empathy Test scores differ between individuals who received character analysis training and those who did not, after controlling for IRI scores? This question generated the following hypotheses:

$H_0$1: There will be no statistically significant relationship between training in character analysis techniques and cognitive empathy as measured by scores on the LET, in the study participants when IRI scores are removed.

H_a1: There will be a statistically significant relationship between training in character analysis techniques and cognitive empathy as measured by scores on the LET in the study participants when IRI scores are removed.

Purpose of the Study

The intent of this study was to investigate whether instruction in character analysis techniques, such as those used by actors, had an effect on cognitive empathy, as measured by LET and IRI scores. The LET scores of the intervention group were compared to those of the control group. The participants' IRI Perspective-Taking Scale scores were used as a covariate.

Theoretical Foundation

Humanistic psychology, or the client-centered approach, was the primary guiding theory for the study. Psychoanalytic and psychodynamic psychologists, such as Freud and Kohut, recognized empathy, but Rogers (1946, 1949, 1957) defined the concept's role in therapeutic outcomes. Rogers asserted that individuals who felt valued and understood had the power to change and grow. The study was also founded in the transtheoretical model of change and common factors theory. The transtheoretical approach views all change, in or out of therapy, as a process that progresses through common stages that rely heavily upon the individual's readiness and desire to change (Prochaska & Di Clemente, 1982). Common factors theory states that the myriad theoretical orientations and therapeutic techniques have more similarities than differences and that those similarities, or common factors, are responsible for significant portions of therapeutic outcomes (Rosenzweig, 1982).

Definition of Terms

Character analysis techniques: These are the strategies actors use to create realistic characters based upon information provided in a script (Abel, 1999). The information comes from the author, the character's words, other characters, and the actor's imagination (Abel, 1999; Grote, 1999).

Cognitive empathy: Cognitive empathy is the deliberate effort to understand another's perspective, feelings, and actions without vicariously experiencing their emotions or losing sight of one's self (Gilin, Maddux, Carpenter, & Galinsky, 2013; Shamay-Tsoory, 2011). Alternately referred to as perspective taking (Van der Graaff et

al., 2013; Zhang, Fung, Stanley, Isaacowitz, & Ho, 2013) and theory of mind (Goldstein & Winner, 2010) in some literature.

Empathy: Empathy is a broad term for experiencing the world as another does (Dymond, 1950). Also referred to as affective empathy to emphasize the role or mirror neurons and the sharing of feelings expressed by another (Gilin et al., 2013; Van der Graaff et al., 2013).

Mental health professionals: Mental health professionals include individuals working independently or as part of a non-profit or for-profit organization that provide services related to the mental health and well being of individuals, couples, families, and communities. Mental health professionals is a broad term encompassing a variety of educational and licensing backgrounds including psychiatrists, psychologists, social workers, psychiatric/mental health nurses, and licensed professional counselors (National Alliance on Mental Illness, 1996).

Assumptions, Scope, and Limitations

I joined with past researchers and assumed empathy was a teachable and measurable construct. I also assumed empathy could be divided into separate, although likely related skills, of cognitive and affective empathy. My interpretation of the study's results assumed that the selected instruments, the LET and IRI, measured what they purported to measure. It was further assumed that participants (a) had no fear of penalty or coercion, (b) attended appropriately to the intervention and (c) responded to all instruments and demographic questionnaires honestly.

The results of the study could be generalized to adults enrolled in undergraduate or graduate-level courses. The focus of the study was cognitive empathy. The study might be limited by the study participants' receptiveness to the character analysis training. LET scores could be influenced by the participants' perception of the researcher/presenter and preexisting impressions of the fictional characters used as illustrations in the training. For example, a participant who has a strong dislike for the stepmother in the story of Cinderella might not be fully engaged in the training exercises. The social desirability of empathy could limit the accuracy of participant responses to the self-reported IRI.

Significance of Study

The development of strategies to teach cognitive empathy could benefit mental health professionals and their clients. They could also benefit medical students and practicing physicians, given the medical field's renewed interest in developing empathy (Dow et al., 2007; Shapiro, Morrison, & Baker, 2004). The aim of the research was to effect positive change in therapeutic outcomes for all individuals, which in turn, could (a) decrease time in therapy, (b) provide an effective alternative or complementary therapy vis-à-vis psychopharmaceutical interventions, (c) lead to improved delivery of services and health outcomes.

The research has multiple implications for positive social change. Just as actors often portray characters quite different from themselves, so must mental health professionals serve individuals with experiences quite different from their own. Effective training in cognitive empathy for mental health professionals has the potential to enhance

the dignity and efficacy of the interventions for individuals seeking mental health services. It was proposed that if individuals feel more valued, accepted, and understood, they will be more likely to remain in treatment, adhere to recommendations, and feel better. The discovery of new means with which to enhance cognitive empathy may give mental health professionals the confidence to work with more diverse clientele and to bring services to areas where they are lacking. Moreover, the development of a strategy to improve empathy training for mental health professionals has the potential to create social change by extending quality mental healthcare to traditionally underserved and underrepresented populations. The research might encourage the use of character analysis training in the education of physicians, nurses, and other health service providers. It is possible that cognitive empathy skills could bring about a greater awareness of diverse populations' treatment needs and unique experiences.

Summary

Therapist empathy is an important component of the therapeutic relationship, but current training models for mental health professionals often neglect the conditions for change advocated by Rogers in favor of cursory reviews of basic attending skills, such as body language. The field of psychology has struggled to define empathy, and that struggle has carried over into confusion about how to develop it. A few pilot studies investigating the use of acting techniques to develop cognitive empathy have yielded promising results. While much of the current empathy research focuses on individuals with diagnoses on the autism spectrum or meeting the diagnostic criteria for psychopathy, this study could fill a gap in the literature on professional preparation. The study sought

to determine whether character analysis skills could increase cognitive empathy in mental health professionals. Adults were recruited via community bulletin boards on a university campus. All research participants completed two empathy measures and those randomized into the intervention group received character analysis training in a classroom setting.

In Chapter 2, I present a comprehensive review of the literature on empathy and acting technique. In Chapter 3, the research design, procedures, measurement tools, data collection, and data analysis are discussed. The study's results are presented in Chapter 4 and the results are discussed in Chapter 5.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative study was to investigate whether instruction in character analysis techniques, such as those used by actors, had an effect on cognitive empathy. The purpose of this chapter was to review the relevant research and identify the gap in the literature.

This literature review used the following databases: PsycARTICLES, PsycINFO, PsycBOOKS, MEDLINE®, Sage, Academic Search Premiere, and Academic Search Complete. The initial parameter was 2008–2014. But because there were limited resources pertaining to the search terms (see below), I reran the searches with no limits on the date of publication. This yielded the resources necessary to trace the evolution of the topic and identify the current state of the research. The review of the literature on acting methodology and character analysis extended beyond peer-reviewed journals to theatre textbooks, memoirs, and biographies. The following keywords were used: *empathy*, *cognitive*, *Rogers*, *therapeutic outcome*, *alliance*, *therapist*, *psychologist*, *common factors*, *perspective-taking*, *theory of mind*, *measurement*, *training/teaching*, *ANCOVA*, *literature*, *fiction*, *theatre*, *drama*, and *acting*.

I begin the literature review with a description of empathy and its role in the delivery of mental health services. Next, I describe the tools developed to measure empathy and the methodologies for developing empathy in mental health and medical professionals. In the final section, I discuss acting techniques.

Empathy

Empathy is difficult to study primarily because of the range of operational definitions assigned to the term. In addition, it is often bundled with similarly nebulous or loaded terms, such as *relationship, alliance,* and *warmth*. Thus, it is no surprise that different researchers use different definitions. One segment of the mental health field describes empathy as one part of the therapeutic alliance that is often overlooked by training programs (Bohart & Greenberg, 1997; Duan & Hill, 1996; Goldfried & Davila, 2005). Another segment focuses on the physiological and cognitive processes that underlie empathy (Blair, 2005; Levenson & Reuf, 1992; Shamay-Tsoory, Aharon-Peretz, & Perry, 2009). Still other researchers continue to investigate whether empathy is a skill to be developed (Crits-Christoph, Gibbons, & Hearon, 2006) or a stable trait (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003; Hickson, 1985).

While Freud included empathy as a component of his psychoanalytic approach, the term is most often associated with the person-centered work of Rogers, who proposed that feeling understood was a necessary condition of the client's therapeutic process (Bohart, 1991). According to the literature, empathy has rarely been investigated on its own and has was more often been included as one component of the therapeutic alliance (Jorgensen, 2004; Kirschenbaum & Jourdan, 2005; Safran & Muran, 2006). Furthermore, disagreement has continued to focus on whether empathy was curative on its own or whether it provided the foundation for the therapist's interventions (Crits-Christoph, Gibbons, & Hearon, 2006; Watson, 2007).

Defining Empathy

Scholars continue to struggle with a common definition for empathy. The origin of the word itself is somewhat convoluted. Aestheticist Theodor Vischer was the first to use *Einfühlung,* the German word for "projecting," in 1873 (Hassenstab, Dziobeck, Rogers, Wolf, & Convit, 2007). Titchener attempted to translate the German to English and proposed *empathy*. Coulehan et al. (2001) worked from the same primary source and further explained the English term empathy comes from the Greek roots *em* and *pathos*, meaning to *feel into*.

Dymond (1950), an empathy researcher, proposed that empathy involved using one's imagination to understand the perspective of another person. More importantly perhaps, Dymond asserted empathy's unique meaning was separate from projection, insight, sympathy, and identification. Kohut (1959), a psychoanalytic therapist, described empathy as vicarious introspection, but asserted empathy was but a means to an end, not a treatment on its own. In the days before his death, Kohut addressed the psychological community (Lifespan Learning, 2010). He reflected on his previous statements about empathy and clarified empathy was a way of gaining knowledge of another person in order to help or harm. Wispé differentiated between empathy and sympathy stating sympathy is a way of relating while empathy is a way of knowing (1986). Empathy is defined in the *APA College Dictionary of Psychology* (APA, 2009) as imaginatively adopting another's "frame of reference" (p. 126) in order to understand that person.

The sampling of definitions found above demonstrates the conflicts in the ongoing discussion of what empathy is and how it is applied to a range of theoretical

orientations. A definition of empathy remained difficult to operationalize for research purposes as well. A search of the literature revealed researchers sought a more specific definition of empathy than was previously available by investigating whether empathy could be broken into stages or subtypes. Kurtz and Grummon (1972) compared six separate measures of therapist empathy and found little no significant correlation between the scores. Moreover, they observed negative correlations between some of the measures of empathy. The authors echoed concerns that empathy could not be measured if it could not be defined. Barrett-Lennard (1981) took a different approach and attempted to define empathy's stages. He described a process of interactions between two parties marked by three phases: empathic resonation, responsive understanding, and reception or awareness. In other words, one individual relates to the reported experience of another, attempts to demonstrate their understanding, and in turn, the second individual perceives the support. Within this model, multiple opportunities for misunderstanding or rupture of the alliance were possible. Inaccurate empathy was found to be a result of limited disclosure on the part of clients, limited life experiences or references on the part of the empathizer, or the pursuit of a wrong hunch (Buie, 1981).

Despite a large volume of studies and an on-going, robust discussion of empathy, Gladstein's (1983) review of empathy research demonstrated little had been resolved and additional questions developed. With a lack of a common definition, for instance, researchers across multiple theoretical perspectives were often comparing apples to oranges. Gladstein found substantial agreement in the field about empathy as an either affective or cognitive, multistage process developed in individuals across the lifespan

which could produce a positive outcome in therapy. Finally, Gladstein concluded the state of the literature showed empathy research had become too broad and nonspecific, particularly in the area of outcomes; and the author suggested a sharper focus for future research to be useful.

In an attempt to understand the role of empathy in therapist effectiveness, Duan and Hill (1996) proposed empathy could be described as either dispositional or experiential. Dispositional empathy referred to a stable trait possessed at varying levels by individuals while experiential empathy was that which developed as a result of the therapeutic process. Hall, Davis, and Connelly (2000) continued this line of research by seeking to understand how dispositional empathy was related to psychologists' self-reports of effectiveness. Although the division in empathy was established, the literature reflected an on-going focus on experiential or process empathy.

Blair (2005) took yet another approach and asserted empathy was divided into three subsets: motor empathy, emotional empathy, and cognitive empathy. Motor empathy referred to taking on the posture, movement, or facial expressions as a response to another. In therapeutic settings, this skill was described as mirroring, one of several attending behaviors. Emotional empathy referred to one's affective response to the state or experience of another. Emotional empathy responses followed displays of emotions from others or emotionally charged stimuli. Finally, cognitive empathy referred to the ability to understand, anticipate, or *read* how others are feeling. Bachelor (1988) examined how empathy was received by therapy clients and identified four styles: affective, sharing, cognitive, and nurturant. The study concluded that therapy was most

effective when the therapist's empathy style matched the client's preferred mode of receiving support. For instance, 44% of the study participants reported their preference to receive cognitive empathy. The participants stated therapists demonstrated cognitive empathy by listening, asking clarifying questions, limiting self-disclosure, and refraining from advice giving. Cognitive empathy was synonymous with Theory of Mind in most current literature although there were researchers who proposed Theory of Mind and empathy were two separate constructs (Goldstein, 2009; Goldstein & Winner, 2012; Goldstein, Wu, & Winner, 2009-2010). Similarly, reenactive empathy was described as the process by which we experience, or imitate the thoughts of others in order to understand his or her motivations to act (Stueber, 2006).

Finally, some researchers proposed empathy is a trait. Barrett-Lennard (1993) introduced a multiphase model of empathy wherein one person actively attends to another. Phase I of the model was described as empathic resonation, or identification with the other. The next phase was marked by the expression of empathy followed by the final phase, received empathy. According to Barrett-Lennard, the cycle could repeat itself many times and was not necessarily linear. Hakansson and Montgomery (2003) proposed empathy was a series of interactions between the empathizer and target. In the study of 56 individuals who reported on 21 dimensions of their experience as the empathizer or target, the authors determined empathy was an interpersonal process comprised of the empathizer's understanding the situation, the target's experiencing emotion, both parties' perception of similarity between the two, and the empathizer's development of concern for the target. The model then supported the notion of both cognitive and emotional

elements of empathy. In addition to the identified stages, the literature supported the presence of antecedents of empathic concern namely being aware of another in need and valuing the welfare of the other (Batson et al., 2007; Hakansson & Montgomery, 2003).

The current state of the literature is that multiple theories of empathy remain, but researchers who investigate its cognitive and affective attributes reflect the predominant perspective. Shamay-Tsoory, Aharon-Peretz, and Perry (2009) supported the theory of two types of empathy, cognitive and emotional, in a study of individuals with lesions in the ventromedial prefrontal or inferior frontal gyrus. The researchers discovered lesions in the brains of the thirty neurological participants corresponded to deficits in either emotional or cognitive empathy when compared to the study's thirty control participants. After neurological examinations, the study participants were evaluated using the Individual Reactivity Index (Davis, 1983), a Theory of Mind task, and a computer-based emotional recognition task. Emotional empathy was found to be impaired in individuals with lesions on the inferior frontal gyrus area of the brain while damage to the ventromedial prefrontal cortex was associated with difficulty with cognitive empathy. Along with the work of Seitz, Nickel, and Azari (2006) and Shamay-Tsoory, Shur, Harari, & Levkovitz (2007), a follow-up study provided evidence that while there were independent neural bases for the two types of empathy, the systems likely interacted depending on the stimulus and characteristics specific to the individual (e.g., gender, valence of emotion). Current research also has investigated empathy in individuals meeting the diagnostic criteria for psychopathy and found they have deficits in both affective and cognitive empathy (Brook & Kosson, 2013).

Regardless of its definitions and subsets, empathy's role in psychotherapy practice was cemented by the writings of Rogers who described it as the process of taking on another's perspective in order to understand the individual's thoughts, experiences, and emotions (1975). Rogers' client-centered therapy (later known as person-centered therapy) was most in vogue in the 1950s and 1960s and then fell out of favor as directive therapies such as Cognitive Behavioral Therapy rose in popularity. Rogers' ideas have enjoyed a revival as attention has turned towards common factors, or those elements of therapy that apply to all interventions regardless of the mental health professional's theoretical orientation.

Client-Centered Practice

While empathy entered the vocabulary of psychology much earlier, it was through the work of Rogers that its importance came into sharper focus. Rogers (1940) emphasized the fact that clients had the power to change when conditions were right. It was also Rogers' view that the therapist's job was not to do things to the client, but rather allow the client to drive the sessions and pursue self-discovery in an environment wherein the individual felt heard, not evaluated (Rogers, 1946). According to Rogers' description of client-centered therapy, training in therapeutic skills was of primary importance and superseded diagnostic skills, because of client-centered therapy's non-directive nature. Rogers' approach came to be defined, not by a specific set of strategies but by an attitude that allowed the therapist to understand the client's perspective (1949). Rogers further developed his theory of psychotherapy by naming the necessary and sufficient conditions for personality change in 1957. The best known of these conditions

were traits of the therapist: congruence, unconditional positive regard for the client, and empathy for the client. He defined empathy as the ability to understand another's frame of reference accurately without losing sight of one's own identity (1959).

In 1975, Rogers argued empathy could be the most important element for creating change. His paper called for a return to an empathic attitude rather than the distorted technique of empathic listening often described as the repeating of the client's last words. Rogers reviewed the work of multiple authors and combined with his own experiences, concluded empathy was related to positive therapeutic outcomes. He proposed that empathy could be learned from empathic role models or developed over time, with maturity and increased self-awareness. He wrote passionately of the powerful effect of feeling understood and accepted. Empathic therapists, he explained, could facilitate positive therapeutic outcomes and help the client to experience events and feelings more accurately. Rogers thus proposed, "the ideal therapist is first of all empathic" (p. 5).

Harrison and Westwood (2009) echoed Rogers' confidence in the power of empathy. They found that therapists who accurately understood the client's point-of-view without becoming lost in it contributed to positive therapeutic outcomes. Therapists who practiced empathy rather than sympathy reported less distress when working with traumatized clients than their sympathetic peers. This study demonstrated clients and therapists benefited from the therapists' understanding the clients' pain, not feeling it.

Rogers was not without his critics. Lambert, DeJulio, and Stein (1978) questioned the role of the therapeutic relationship in client outcomes and argued against the emphasis on interpersonal skills in training programs. The authors' review of the

literature pertaining to empathy and outcome appeared to find minimal support for Rogers' hypotheses as well as numerous shortcomings in assessment tools used to measure empathy and its effects.

Batson et al. (1995) noted therapist congruence, unconditional positive regard, and empathy were difficult to study separately. The authors explained empathy directly affected one's regard for the other and likewise the regard, or value placed on the other's welfare affected empathy. Thus, according to this study, empathy and unconditional positive regard were bound to one another. Bozarth (1997) advanced this connection between empathy and unconditional positive regard by theorizing the two were, in fact, the same and not two separate conditions. Positive regard, like empathy, proved difficult to define and measure, and was subsequently challenging to validate as an agent of change (Farber & Lane, 2001). Farber and Lane's review of the literature noted a modest, but nonetheless positive relationship between positive regard and therapeutic success, thereby establishing positive regard as at least necessary, if not sufficient condition for change. Watson (2007) refuted these claims and argued empathy was necessary, but was not curative on its own. Kirschenbaum and Jourdan (2005) found a middle ground between these two perspectives. The authors hypothesized empathy, unconditional positive regard, and congruence were common support factors leading to positive therapeutic outcomes, but argued many other common factors existed.

Psychotherapy Integration and Transtheoretical Therapy

Rosenzweig (1936/2002) noted the number of theoretical approaches to psychotherapy was constantly growing and proposed the many schools of thought might

have more commonalities than differences. The author also argued his review of the literature at the time demonstrated any well-trained, consistent therapist with an effective personality could have success with a patient regardless of specific techniques employed. Rosenzweig's introduction of common factors was credited with laying the foundation for the transtheoretical and integrationist movement in psychology (Weinberger, 1995). Weinberger argued common factors while recognized by the major schools of thought, were virtually ignored in favor of adhering to strict orthodoxies. The author listed attribution of outcome, mastery, confronting of problems, expectations, and relationship as the five most common factors. He diverged from those who advocated for technical eclecticism wherein one or a few common factors were emphasized for individual clients or diagnoses at the expense of other factors. Instead, Weinberger proposed a system of theoretical integration in which all the strengths of all therapies were synthesized and applied at the stage of change for which they were most effective.

Feixas and Botella (2004) also called for psychology's major schools to bring forth common terms for the change process. Moreover, the authors discussed concerns about the growing number of therapists identifying themselves as eclectics because they did not adhere to any one school of thought. They argued eclecticism often meant employing therapeutic techniques and practices that were incompatible perhaps out of convenience instead of deliberate choices aimed at developing one's own coherent individual style. The integrationist approach was concerned with moving the divergent theories of psychotherapy back to a convergent path based on empirically supported common factors and techniques.

Common factors. With the growing integration of psychological theoretical orientations, researchers endeavored to identify those factors that transcended any one theoretical approach or specific technique. Shapiro, Krauss, and Truax (1969) found empathy was the influential factor in determining the level of self-disclosure in their study's 95 participants. In fact, the researchers discovered individuals' openness, both in and out of psychotherapy, increased as they perceived empathy from the listener/therapist. Early research comparing therapists representing the Psychodynamic, Behaviorist, and Humanist schools discovered little difference in empathy among participants (Fischer, Paveza, Kickertz, Hubbard, & Grayston, 1975). Fischer et al. noted although each school defined and usused the therapeutic relationship differently, theoretical orientation had no bearing on the participants' observed use of empathy. In recognition of the blurring of the boundaries separating theoretical orientations and the growing eclecticism in the field, the National Institute for Mental Health developed recommendations for interventions and therapist training devoted to identifiable common factors (Wolfe & Goldfried, 1988).

Greencavage and Norcross (1990) conducted a meta-analysis of 50 studies that each investigated therapeutic common factors and therapeutic outcomes. Fifty-six percent of the studies named the therapeutic alliance as a common factor. This finding was significant given a total of eighty-nine factors were identified. The authors further proposed psychotherapy integration occurred on three levels, one of those being recognition of common factors. Stein and Lambert's (1995) meta-analysis of literature on graduate training in psychotherapy also suggested common factors be emphasized in

training protocols. Moreover, as compared to other common factors, the authors concluded the literature provided the most support for relationship skills and attitudes from the client-centered school. The findings of Carroll, Nich, and Rounsaville (1997) provided additional support for the relationship between common factors and therapeutic outcome, but the authors also remained concerned that specific treatments or other mediating factors might influence the overall outcome.

Once common factors were identified, several researchers attempted to estimate how much of therapeutic outcomes could be attributed to common factors and which of those common factors was most powerful. Lampropoulos (2000) concluded only 15% of client change was due to the specific technique or intervention strategy used. The relationship, the placebo effect, and other client factors were credited with producing the remaining 85% of client change. While there was some disagreement as to the degree of influence common factors exerted upon therapeutic outcome, in a research summary compiling multiple meta-analyses, Lambert's and Barley's (2001) research summary found it was reasonable to attribute approximately 30% of outcome to common factors.

In a meta-analysis of 47 empathy and outcome studies conducted between 1961 and 2000, theoretical orientation was not found to be a mediating variable while up to 10% of outcome variance could be attributed to therapist empathy (Greenberg, Watson, Elliot, & Bohart, 2001). A more extensive meta-analysis of 190 studies similarly concluded therapist empathy accounted for between 7% and 10% of variance in outcome, which was noted as equal to or greater than the outcome variance that could be attributed to the form of intervention employed by the therapist (Bohart et al., 2002). Moreover, in

their meta-analysis of 14 studies of therapist characteristics and techniques negatively impacting therapy, Ackerman and Hilsenroth (2001, 2003) concluded a negative alliance created by therapists' negative personal traits was detrimental to treatment outcome regardless of the therapist's theoretical orientation, and positive traits, such as warmth and openness contributed to the outcome across all treatment modalities.

Boswell, Castonguay, and Wasserman (2010) were also interested in how training and types of interventions chosen effected therapeutic outcome. The clients' ratings of session outcomes were not significantly correlated to any one theoretical orientation and clients perceived Cognitive Behavioral Therapy (CBT) as less effective if previous sessions relied heavily on common factors. A key finding of their work was that regardless of therapists' theoretical orientation, or training, therapists reported more common factors used than any other strategies listed on Multitheoretical List of Therapeutic Interventions.

The review of the literature supported therapist empathy as a common factor contributing to positive therapeutic outcomes, yet training and supervision practices did not readily reflect its significance (Boswell & Castonguay, 2007). Researchers, such as Goldfried and Davila (2005), suggested psychology should cease the debate over whether or not the technique or the relationship were curative and instead shift to a focus on general principals of change. It might be reasonable to conclude each time psychology began to agree on the definition and importance of empathy, the zeitgeist shifted, and empathy was left unresolved once again. The pursuit of empathy's role in therapeutic outcome may never reach a conclusion if Orlinsky, Ronnestad, and Willutzki (2004) were

correct. The authors remarked no current Institutional Review Board would approve a study wherein patients received treatment from mental health professionals pre-identified as good and bad empathizers; it was the authors' opinion this method was the only way to be certain of empathy's effect on the outcome.

Transtheoretical stages of change. At the same time that some researchers were debating the definition or empathy or which common factors most influences therapeutic outcomes, an additional perspective emerged. Influenced by the common factors movement and alarmed by the growing number of therapies, Prochaska and Di Clemente (1982) proposed all psychotherapy shared common stages of the change process. Although the review of the literature revealed the Transtheoretical Model was most often investigated in the treatment of addictive behaviors, as it gained popularity, its application was broadened (Aten, Strain, & Gillespie, 2008; Evers et al., 2006). Prochaska and Di Clemente (1982) sought to understand how people changed and which theoretical approaches and treatment techniques were most appropriate at each step. The Transtheoretical approach proposed individuals, whether in formal treatment or not, transitioned through five stages of change in their thinking and behavior. According to the model, individuals were first in precontemplation wherein they did not recognize any need to change their thinking or behaviors (Prochaska, Di Clemente, & Norcross, 1992). Next, the individual acknowledged the concern, but had no plan or intent to make changes. Third, the individual prepared to make a change. If the desire were to cease smoking tobacco, purchasing gum or nicotine patches might mark the preparation stage. Next, the individual was ready for action according to the authors. Finally, the individual

endeavored to maintain the changes in thinking and behaviors. Therapists had to be able to assess the individual's stage of change accurately and tailor therapeutic interventions to that stage. In trade literature, this was often referred to as meeting the client where he or she is.

Prochaska (2000) noted psychology could improve outcomes by getting individuals into therapy and then keeping them in therapy. The author further stated individuals in precontemplation had difficulty forming a good therapeutic alliance and would benefit most from person-centered or humanistic strategies to move them to the contemplation stage. The Transtheoretical approach emphasized the importance of understanding in which stage of change the individual was and creating a strong therapeutic alliance to help facilitate progress from precontemplation to action. Norcross and Wampold (2011) and Renninger (2013) reaffirmed evidence-based interventions are most effective when they are deliberately chosen with the individual's current stage of change in mind.

Measurement of Empathy

Researchers could not agree upon a common definition of empathy, nor could they conclusively establish its role in therapeutic outcomes. However, many endeavored to measure the elusive concept. A review of the literature revealed as many measures of empathy as there were definitions. Early attempts at the measurement of empathy included Dymond's (1948, 1949) exploration of the ability to see things from another's point of view. Dymond (1949) also questioned what accounted for individual differences in empathy and whether or not it was a teachable skill. The Accurate Empathy (AE) Scale

(Truax, 1961), also purported to measure therapist empathy, but the scale drew criticism due to the small number of therapists and raters used in its development (Chinsky & Rappaport, 1970). Chinsky and Rapport also asserted Truax's scales assessed vocal qualities or other unknown characteristics of the participating therapists rather than the accuracy of their empathic responses (1970, 1972). Hogan (1969) developed the Hogan Empathy Scale, which identified individuals with high empathy by way of responses to 64 self-report items. The Hogan Empathy Scale was found to be a valid measurement of empathy, yet the accuracy of the individual's perceptions was not tested (Johnson, Cheek, & Smither, 1983). Johnson et al. further discovered while the Hogan Scale purported to measure cognitive empathy, factor analyses showed personality traits such as self-confidence and social skills were being measured instead.

Greif and Hogan's (1973) earlier efforts to establish the Hogan Scale's validity using 359 male and female undergraduate students at Johns Hopkins University led to similar conclusions. A factor analysis comparing Hogan Scale scores with scores from the California Psychological Inventory demonstrated individuals who were identified as empathic by the scale were also deemed to be even-tempered, liberal and humanistic in their thinking and politics, outgoing, and social. Moreover, Hogan (1975) described trait and state empathy and concluded while trait empathy was genetic and reliant upon early childhood experiences, state empathy was fluid. The Hogan Scale was likely a measure of social intelligence (Wispé, 1986). Nonetheless, the Hogan Empathy Scale and the Questionnaire Measure of Emotional Empathy (QMEE) (Mehrabian & Epstein, 1972) became the standard for empathy measurement as the tools provided complementary

data. The Hogan measured cognitive factors indicative of social intelligence and role taking while the QMEE's focus was personality and emotional responses to the experience of others (Chlopan, McCain, Carbonell, & Hagen, 1985).

Between 1980 and 1986, the La Monica Empathy Profile (LEP) was developed to measure the therapist's ability to empathize with clients. The tool was comprised of 30 self-report items regarding interpersonal characteristics. La Monica identified five modes of empathy: Nonverbal Behavior; Perceptive Feelings and Listening; Responding Verbally; Respect of Self and Others; and Openness, Honesty, and Flexibility. Both McCammon (1989) and Phelps (1989) reported extensive concerns about the LEP's validity and reliability due in part to the lack of data provided in the manual. McCammon noted while the five subscales may have indeed loaded on empathy, there were no data to support the scales as discreet components of empathy.

During the same period, Davis (1980) developed another brief self-report instrument, the IRI. Davis also ascribed to a multidimensional theory of empathy, which he divided into four categories: Perspective Taking, Fantasy, Empathic Concern, and Personal Distress (Davis, 1983). Davis noted a significant positive correlation between the Perspective Taking subscale and the Hogan Empathy Scale; a negative correlation was found between Perspective Taking and all scales within the Mehrabian and Epstein Emotional Scale. Thus, Davis (1983) asserted the IRI identified and measured the multiple dimensions of empathy, rather than focusing on purely cognitive or purely emotional constructs. The IRI was developed using factor analyses that revealed the instrument's internal reliability and determined the four components of empathy were

independent of one another. Davis (1980) reported the final version of the IRI, developed using a sample of 579 male and 582 female college students, and an additional sample of 109 additional undergraduates, demonstrated significant test-retest reliability. The review of the literature revealed a recent trend of employing the IRI in studies of clinical and/or correctional populations. The IRI purported to combine the cognitive, or role-taking, component of empathy with the emotional aspects, such as vicarious arousal and was thus deemed appropriate for investigations of dysfunction in neuroanatomy and neurotransmitters (Harari, Shamay-Tsoory, Ravid, & Levkovitz, 2010).

Concerns about the reliability and validity of the IRI in diverse populations were addressed by studies conducted in varied settings and cultures. For instance, the IRI was translated into additional languages, notably German and Spanish. The Chilean adaptation of the Spanish version of the IRI was found to have good test-retest reliability and internal validity (Fernandez, Dufey, & Kramp, 2011). Notably, the study of 435 Chilean college students demonstrated sex differences and relationships among the four subscales similar to investigations of the English version's psychometric properties. The IRI was also adapted to assess individuals with lower reading comprehension skills better. Lauterbach and Hosser (2007) eliminated negatively-worded IRI items in their study of 839 incarcerated males aged 15-28 years to address the individuals' lower intelligence scores and verbal skill scores. The authors discovered the Perspective Taking Scale scores of the shortened IRI were good predictors of recidivism and scores on the Fantasy, Perspective Taking, and Empathic Concern Scales highlighted the differences between violent and non-violent offenders. Although the IRI demonstrated acceptable

reliability and validity for the measurement of empathy as additional operational definitions of empathy arose, so did additional tools to measure the construct.

The next generation of empathy measures took two distinct paths. One group of researchers continued to attempt to tease out the components of empathy for measurement. Such efforts were seen in the Balanced Emotional Empathy Scale (BEES), a descendant of Mehrabian's earlier Emotional Empathic Tendency Scale (EETS), which sought to measure interpersonal positivity and the ability to experience other's feelings vicariously (Mehrabian, 1995). The BEES was criticized for its perceived confusion between empathy and projection (Urbina, 1998) as well as the normative data's shortcomings related to differences of gender and social conditioning (Johnson, 1998). Instruments designed to measure empathy in clinical populations also separated cognitive and affective empathy in order to further illuminate the neurological bases of empathy as well as to understand deficits related to specific disorders better. For example, Baron-Cohen and Wheelwright (2004) introduced the Empathy Quotient (EQ), a 60-question self-report measure of empathy. This tool was found to tap both cognitive empathy and emotional reactivity while controlling for individuals' tendency towards socially desirable responses (Lawrence, Shaw, Baker, Baron-Cohen, & David, 2004). The EQ proved useful in describing how individuals with Asperger Syndrome experience difficulty in social situations due to low cognitive empathy skills while the participants' affective empathy did not differ significantly from the general population (Baron-Cohen & Wheelwright). The review of the literature produced multiple results related to measures developed to explore empathy in individuals on the autism spectrum further,

such as the Movie Assessment of Social Cognition and the Multifaceted Empathy Test (Dziobek et al., 2006, 2008). Tools specific to individuals on the autism spectrum were beyond the scope of this research.

A second group of tools broadened the measurement of empathy with attention to the alliance between therapist and client. For instance, The Psychotherapy Process Q-Set (PQS) and the California Psychotherapy Alliance Scales (CALPAS) emerged as tools of choice for observers to analyze therapeutic interactions (Price & Jones, 1998). The Working Alliance Inventory, Vanderbilt Therapeutic Alliance Scale, and Penn Helping Alliance Rating Scale added to the canon, yet also revealed limitations in the measurement of the alliance. Notably, test developers failed to arrive at a common definition of the alliance and discovered little correlation among the alliance ratings of therapists, clients, and observers (Cecero, Fenton, Frankforter, Nich, & Carroll, 2001). The importance of perceived empathy was also illustrated in the development of the Consultation and Relational Empathy (CARE) measure, a patient report tool designed to rate the quality of interaction between patients and medical doctors (Mercer, Maxwell, Heaney, & Watt, 2004).

Two additional measures of empathy helped to illustrate the diversity of tools that grew out of the many definitions of empathy. The LET (Mahoney, 1960) was a little known tool developed in the spirit of Dymond's and Davis's emphasis on perspective taking to distinguish between good and bad empathizers. The test was comprised of four brief literary selections providing detailed character sketches. After reading each selection, participants were asked to answer a series of questions as they surmised the

character they just read about would respond to the items. The tool was well validated as a standardized measure of empathy within the undergraduate population used during the LET's development. Participants also completed the College Ability Test, Nelson-Denny Reading Test, and selected subtests of the Wechsler Adult Intelligence Scale in order to ascertain the presence of confounding variables impacting empathy ratings. No significant correlation was found between LET scores and reading ability, scholastic aptitude, or intelligence. Mahoney established the instrument's concurrent validity with Kerr and Strupp's Empathy Test, yielding correlation scores at the .05 significance level for both men and women. Moreover, the correlation between the Empathy Test and LET score was found to be significant at the .01 level for all combined participants. The author noted the test's limitations included the reliance upon subjects' lack of prior exposure to the literary selections and attainment of college-level reading skills.

Although described as a Theory of Mind task, Happé's (1994) Strange Stories test also measured participants' abilities to understand motivations, emotions, and figurative language. The instrument was developed using 24 autistic children who were compared to control groups of mentally handicapped and non-handicapped children and adults. The test was comprised of 24 vignettes depicting naturalistic, non-fictionalized interactions between characters. Each story ended with a "strange" statement or lie. Participants were asked first, "Is that true what he/she said?" And then, "Why?" The children with autism scored significantly lower than all control groups on the "Why?" questions. Happé hypothesized the results demonstrated a deficit in Theory of Mind related to autism that lead to impaired social interactions. As previously stated, a review of the literature

revealed tools intended to measure empathy appear to be increasing as world-wide interest in diagnosing and treating autism spectrum, disorders grew.

The measurement of empathy remained elusive, as did a common definition of the term. Some researchers narrowed empathy into emotional and cognitive components while integrationists moved beyond Rogers' notions of necessary conditions to bring attention to the wider concept of alliance, or working alliance. The working alliance included therapist characteristics, such as empathy, as well as the client's perception of the therapist's ability to hear and understand. Perhaps, Hatcher and Barends (2006) summed-up the state of alliance research best when the authors concluded "the relationship" became a catchall for instruments measuring specific, purposeful techniques, personality traits such as empathy, and client participation. The current state of the literature indicates there is no definitive measurement of empathy because there is no common definition.

Teaching Empathy

As the overarching question "What is empathy?" remained, researchers entered into conversations about how empathy could be taught. Dymond (1949) defined empathy as "the imaginative transposing of oneself into the thinking, feeling, and acting of another and so structuring the world as he does" (p. 127). Dymond's work was significant because it offered the first operational definition of empathy. Before 1948, empathy was viewed as too subjective to study and was loosely associated with sympathy and intuition. Dymond's definition did not differentiate between the cognitive and affective

components of empathy, but it was the impetus for research that investigated empathy as a trait (Edwards, 2013).

Dymond's (1950) exploratory study of 80 undergraduate social psychology students found individuals identified as possessing high empathy also tended to be outgoing, optimistic, warm, emotional, secure, and interested in others while not surprisingly perhaps, those with low empathy were described as rigid, introverted, inclined towards emotional outbursts, and inwardly focused. The question of whether or not empathy could be taught remained unanswered. However, Dymond's work identified key characteristics of empathic individuals. If a reader were to rely upon *The Encyclopedia of Psychology* (Eisenberg, 2000), a likely conclusion would be empathy is more a trait than a state and thus, difficult to teach explicitly. The entry's author only made use of research supporting the view that empathy is learned in infancy and early childhood through classical conditioning during interactions with caregivers. On the other hand, Campbell, Kagan and Krathwohl (1971) developed a measure of empathy focused on the ability to understand the affective state of another and concluded individuals could improve this ability with practice as evidenced by their pretest-posttest design employing videotaped sessions and multiple choice scale. Fish (1970) also found highly empathic therapists were able to describe their own emotional experiences with rich detail and were better able to distinguish between the 10 emotions used in the study. The review of the literature once again demonstrated psychology continued to struggle with the disagreement about defining and ultimately, teaching empathy.

The medical and mental health fields concurrently explored ways in which to develop empathy in practitioners. As noted previously, this research took place in the absence of one commonly agreed upon definition or conceptualization of empathy and its role in therapeutic outcome. Goldstein and Goedhart (1973) used modeling, role-playing, and reinforcing desired ways of being to develop empathy in student nurses. The researchers found humanizing the patients by way of structured academic and *in vivo* learning experiences was most effective when participants received feedback as skills were transferred to interactions with real patients. While Goldstein and Goedhart represented the effort to develop empathy as a skill, researchers such as Hart (1973) investigated how counselor attitudes could be developed. Hart identified open-mindedness as a key characteristic of "good" counselors, in part because of its assumed role in experiencing empathy for clients. The authors found attitudes indeed could be taught and enhanced via structured learning experiences and reinforcing or corrective feedback. Marangoni, Garcia, Ickes, and Teng (1995) also noted marked improvement in accurate empathy of the 80 undergraduate participants when they were given feedback.

Rogers' necessary and sufficient conditions for therapeutic change additionally inspired training programs used to develop interpersonal skills in therapists. While it was difficult to identify, measure, and change attitudes or emotional conditions, these programs focused on developing what are now referred to as attending behaviors. Ivey and Ivey's (2007) system of intentional interviewing described attending behaviors as foundational microskills such as appropriate eye contact, verbal and non-verbal indications of presence and focus, and appropriate body language. Quite a bit earlier,

Lambert et al. (1978) criticized this focus on superficial skills, questioned the effectiveness of such training approaches, and bemoaned the departure from Rogers' theoretical beliefs. On the other hand, in a study employing the Truax Carkhuff Scales for Accurate Empathy, Non-possessive Warmth and Genuineness, Peebles (1980) discovered personal therapy was an effective tool for developing the ability to show empathy and be genuine, but did not necessarily make the participating graduate students warm. Fernald (1995) also found psychology interns could learn to listen empathically through modeling, practice, and reading assignments that explicitly defined and taught the skills needed to engage in person-centered counseling as Rogers proposed it. Geller (2005) reached a similar conclusion in a commentary on the need to bring relational awareness into the manualized practice of psychotherapy. To that end, Geller called for psychotherapy training that included as much emphasis on listening, restructuring, and *being with* as it did the interventions specific to a particular theoretical orientation.

In their commentary on the alliance and outcome, Crits-Christoph, Gibbons, and Hearon (2006) more cautiously proposed if the alliance had a causal relationship to therapeutic outcome, then bibliotherapy, self-help exercises, and empathy training should be further researched to improve client care. Whether they were defined as Rogerian conditions or common factors, the importance of the therapeutic skills, which transcended any one school of thought or specific intervention was key to Geller's conclusions. Lampropoulos and Dixon (2007) echoed the recommendation that common factors should be key components of training programs as their survey of APA-accredited

internships and counseling psychology programs reported one-half to one-third of psychologists surveyed described their theoretical orientation as eclectic or integrative.

In the midst of the debate about how to teach empathy, the Division 29 Task Force of the American Psychological Association (2001) brought their conclusions and recommendations forth regarding therapeutic relationships. Tasked with investigating which components of the therapeutic relationship affected therapy outcomes, the group concluded empathy was among four elements supported by the literature as effective. Rogers' other conditions, positive regard and congruence/genuineness, were also deemed "promising and probably effective" through the task force's review of the literature. The international psychological community also expressed interest in the need for systematic empathy training. One such study conducted by Nerdrum and Ronnestad (2003) provided fifty-six hours of training dedicated to the importance of empathy in practice as well as role plays, feedback, and clinical practice with real clients. The skill-building component of the training included decentering, another term for the ability to set one's self aside to better hear and understand the client's affective experience. Both qualitative and quantitative analyses of Nerdrum's and Ronnestad's data provided evidence that not only could empathy be effectively taught, but it also led to measurable changes in therapist attitudes and interactions with clients.

In addition to perspective taking and decentering, the ability to use common experiences or reference points to empathize with clients was identified as a key therapeutic skill. Hatcher et al. (2005) described the cognitive and affective processes by which therapists in their study were able to empathize with clients who were different

from them. Highly empathic therapists, identified by the IRI (Davis, 1980), also tended to be more able to draw from their own personal experiences in order to find a connection to the clients' thoughts and feelings. Hassenstab, Dziobek, Rogers, Wolf, and Convit (2007) arrived at similar conclusions in a comparison of 19 therapists and 19 control participants. The researchers found the therapists possessed superior cognitive empathy skills that allowed them to gain understanding through client language and word choice. Additionally, while the therapists and controls reported equal levels of empathic concern, therapists were better able to distance themselves from others' experiences to avoid personal distress.

The medical field also contributed a great deal to the debate about the teaching of empathy. Spiro (1992) recognized medical students and residents lost empathy as they were hardened by training and the realities of clinical settings. The author proposed by reconnecting the doctor and patient through history taking, such detachment could be mitigated. Platt and Keller (1994) developed training workshops for physicians wherein cognitive empathy was honed via history taking and interview vignettes. Physicians were particularly aided in empathizing with patients who were perceived as emotional or engaging in self-destructive behavior. Although no empirical data supported the supposition, Platt and Keller made a strong case for empathy being a teachable and learnable skill for those lacking the innate ability to connect with others unlike themselves. Coulehan et al. (2001) further proposed physicians could demonstrate empathy through a combination of basic attending skills and perspective taking. The authors hypothesized, patients would feel understood when their doctor attempted to

connect with their physical and emotional experiences. An examination of nursing education yielded similar results, finding because empathy was difficult to define and measure it was equally challenging to teach (Reynolds, Scott, & Jessiman, 1999).

Research teams led by Hojat added numerous studies and an empathy assessment tool to the literature. Hojat et al. (2001) developed the Jefferson Scale of Physician Empathy to measure how important empathy was to the practice of experienced physicians, residents, and third-year medical students. The twenty-item scale contained statements, scored on a Likert-scale, such as "A physician who is able to view things from another person's perspective can render better care." Hojat et al. (2004) continued to study empathy in medical school students, finding statistically significant declines on several items of the Jefferson Scale between commencing medical school and the end of the third year of study. In an earlier study of empathy and clinical competence, Hojat et al. (2002) found a significant relationship between empathy scores and clinical competence, but no relationship to objective examinations. The authors concluded the medical students with higher empathic abilities were also rated as highly competent although no clear causation could be found. For example, Hojat et al. (2002) posited the ratings of competency could be related to the individuals being more likeable in the eyes of their clinical supervisors or delivering better care through their abilities to take thorough histories, understand patient symptoms and experiences, or develop treatment plans to which patients were likely to adhere. Hojat et al. (2002) illuminated the issue the field of psychology continued to wrestle with: We know empathy is important, but why exactly is that the case?

Stepien and Baernstein (2006) reviewed thirteen qualitative and quantitative peer-reviewed studies of empathy in medical students and discovered the lack of an operational definition for empathy and the wide range of tools used to assess empathy, hindered teaching of empathy. Despite these flaws, Stepien and Baernstein found twelve of the thirteen studies demonstrated some pretest/posttest gains in empathy, an indication some empathic skills may indeed be teachable.

Hojat (2009), a leading researcher in the area of teaching empathy, proposed ten means, based upon his previous research, by which empathy could be taught to health and human services professionals. The study of arts and literature and viewing theatrical performances were among the strategies suggested. Hojat contended empathy might be enhanced when participants added new insights, experiences, and perspectives via the thoughts, feelings, actions, and stories of fictional characters. His synthesis of the available literature also led the author to propose the study of arts and literature and the attendance of theatrical performances as meaningful ways in which to strengthen empathy and develop the imagination. In short, the study of arts and literature and viewing of performances, according to Hojat, provided fuel for health and human services professionals' imaginations and helped them to understand circumstances beyond those which they had personally experienced.

In 2006, Crits-Christoph et al. asked whether therapists could be trained to improve their alliances. The researchers engaged five therapists in alliance fostering training composed of an intensive workshop followed by weekly individual supervision. They found training improved overall alliance and some of its components, including

empathy. Crits-Cristoph et al. (2006) subsequently advocated for training in alliance-fostering therapy as a means to improve therapeutic outcomes. The researchers' conclusion relied, in part, on the extensive body of literature demonstrating the alliance was a common factor to which therapeutic outcome can be correlated when other elements were controlled.

Despite a rich foundation of work illustrating both the need for and potential success of explicit training in therapeutic skills, Boswell and Castonguay (2007) noted much remained unknown about how to train therapists in basic skills such as empathy and rapport building effectively. The authors further suggested the field's drive towards evidence-based interventions ought to inform its investigation and implementation of training models, as well. Angus and Kagan (2007) described such a program implemented in both the master's and doctoral practica and internships at York University. Empathy and empathic bonds were explicitly modeled and developed in parallel experiences, in supervision and work with clients. Angus and Kagan asserted the promotion of the personal development of trainees was primarily for the benefit of clients. However, it may be reasonable to assume students would also realize secondary benefits of empathy training in their personal interactions, as well.

A parallel conversation about the role of empathy and how to teach it emerged in the medical field. Larson and Yao (2005) proposed medical doctors would improve physician and patient outcomes through acting. Using literature from the fields of psychology, medicine, and business management, the authors posited doctors could use surface acting and deep acting to communicate empathy and better understand patients'

experiences. Surface acting was described as displaying appropriate facial expressions and body language and responding verbally to indicate empathy even if the clinician does not feel what the patient feels or understand the patient's perspective. Deep acting, on the other hand, was described as role taking wherein the physician attempted to imagine the patient's motivations and feelings in order to respond accurately. Larson and Yao argued deep acting could help physicians tap into the cognitive and affective world of the patient.

Acting technique was similarly purported to promote better healing relationships by Andres-Hyman, Strauss, and Davidson (2007). The authors proposed method acting and related character analysis skills could be used to train clinicians. Andres-Hyman et al. acknowledged continuing questions as to whether the common factors, in this case the relationship, were cures themselves or preconditions for interventions, but asserted improving training beyond basic attending skills would serve clients no matter the answer. The article was aspirational rather than empirical, but provided guidance for which activities might develop the ability of therapists to enter the client's world. For instance, conducting script analysis, writing narratives or monologues, playing the person, and imagining the individual's life beyond the script were exercises identified as appropriate for therapists. The aforementioned interventions are the therapist's work outside of therapy sessions as opposed to the expressions of understanding and empathy that occur within the session. In the next section, I will explain foundational acting techniques such as those used in the exploratory studies of acting and empathy and

explain how those techniques can be applied to the understanding of individuals' thoughts and behaviors.

Acting Technique

An unnamed comedian once said, "Acting is a game of psychology. All an actor does is but to reveal to the minds and souls of observers the workings and experiences of the mind and soul of an assumed personality" (as cited in Belasco, 1970, p. 582). Psychology may in turn be a game of acting wherein the therapist seeks to understand the client through careful observation of the personality and history presented in sessions. As stated in Hakansson and Montgomery's (2003) model of empathy as an interpersonal process, acting might be viewed as interpersonal interactions between the actor and the character.

From the earliest actors taking the stage in the great Greek amphitheaters until the mid twentieth century, to act meant to present a character (Brestoff, 1995). The actor's foci were the voice, stance, and physical appearance of the character. Greek actors concentrated on projecting their voices in order to be heard in large outdoor spaces. Delsarte codified a system of facial expressions, poses, and hand gestures meant to convey emotion, and in some cases, create emotion in the actor (Brestoff, 1995). Costumes were often the current style rather than true to the character or time period and blocking, or stage movement, was dictated by what would show off the actor's finery best. In short, world theatre lacked realism for approximately 2500 years (Brestoff, 1995). All of this would change with the introduction of Stanislavski's system for acting.

Stanislavski is credited with breaking from the tradition of presentational acting by calling upon actors to explore the motivations and emotions of characters. Stanislavski's multivolume memoirs and reflections of acting and directing detailed his desire to create realistic characters. In *An Actor Prepares* (1936/1989) Stanislavski described *the magic if*. Acting as if or the magic if, means the actor thinks, responds, and feels as if her or she is in the character's circumstance. Once this work of imagination was addressed, Stanislavski's lessons delved more deeply into discovering the character's motivation and super-objective. What Stanislavski called his system, became known as method acting when it reached the United States through the teachings of Adler, Strasberg, Meisner, and to a lesser extent Hagen (Brestoff, 1995).

Method Acting

Actors are asked to play characters quite unlike themselves, yet modern audiences expect authenticity and nuance rather than stereotypical, obvious portrayals of these individuals. In the performances of lauded actors such as Marlon Brando and Robert De Niro, American audiences observed the power of characters on stage and screen that had an inner life. "Method" actors, as they came to be known, were trained by Strasberg with techniques adapted from the early work of Stanislavski or Adler, who drew upon Stanislavski's revisions of his theories later in life wherein he deemphasized the use of affective memory (Adler, 2000; Brestoff, 1995). Strasberg's students were asked to draw upon their own emotional experiences and memories in order to connect with the state of the character. Adler, on the other hand, emphasized imagination. For instance, Adler taught that an actor could understand the character by finding the secrets within the

script. Students used the text to gain a sense of the character's world and circumstances to decode what the character did and felt. Adler further advised actors who spent time on this type of study, would be able to believably inhabit the world of the character. Meisner worked in a similar vein as he rejected Strasberg's focus on harnessing affective memory in favor of developing the imagination in order to realistically portray characters (Meisner & Longwell, 1978).

Character Analysis

Grote (1989) advised student actors must find out or create everything they could about the character. This information could come from the character's words and actions as well as from what the author or other characters said about the character. Basic acting courses instruct students to analyze the script to determine the character's intention, objective, and goal. What is not explicit in the text is to be deduced and imagined. To understand the intention, the objective, and the goal is to understand what the character wants from others immediately, in the near future, and in the long run. Of course, characters, like clients, do not always know what they want. Method acting techniques provide the means by which actors delve into the background of a character and develop an interior monologue. By developing an inner life for the character, the actor is able to act *as if* (Grote, 1989).

If acting is to be understood as a game of psychology, understanding motivated behavior requires an exploration of what needs are being expressed or satisfied (Maslow, 1943). According to Maslow, humans act in order to get their needs met. These needs are arranged in a hierarchy beginning with basic physiological needs to safety, then love and

esteem, and ultimately self-actualization. Maslow further asserted although the most pressing needs dominate human behavior, acts are often multi-motivated. Rotter's (1966) theory of locus of control also offered clues about individuals' reasons for acting. According to social learning theory, Rotter proposed individuals' interpretation and response to events depends on how much influence they believe they have on rewards and reinforcements. In other words, individuals with an internal locus of control see reinforcements and rewards as direct results their actions while those with an external locus of control view outcomes as independent, unpredictable events.

The actor considers motivation similarly when analyzing the character. Abel (1999) detailed one process by which novice actors can develop an understanding of character. Motivation speaks to why the character is doing what he or she is doing or saying what he or she is saying. "Why am I doing what I am doing?" then leads to the character's objective: "What do I want to do? "What are my goals or intentions?" Next, the actor considers the obstacles standing in the way of the character achieving the identified goals: "Who or what is preventing me from doing it?" Subsequently, either through the written text or imaginative inference, the actor comes to understand the character's strategy to address the conflict. Lastly, the actor's analysis of the scene leads to an awareness of what is at stake for the character: "What do I stand to gain or lose?"

The process outlined above is the standard by which many young actors are trained in middle school and high school theatre arts programs. Although textbooks at these levels often do not connect the exercises and theories presented to Stanislavski, Meisner, Adler, or Strasberg, it is their work that informs the instruction. In their

textbook, Schanker and Ommaney (1999) summarized all the great lessons of acting into sixteen steps for creating believable characters. The authors called upon young actors to use such skills as concentration, observation, projection, props/objects, focus, and energy. Emotional memory was also listed as one approach to portraying realistic characters on the stage. The remaining steps required the actor to understand the character's objectives, obstacles, and motivation in order to uncover all the character's thoughts and feelings (Schanker & Ommaney, 1999). The evolution of theatre textbooks and acting theory was also observed in a recent update to Cohen's *Acting Power* (2013). The book does not purport to teach Method Acting, but Cohen's GOTE system of script analysis is similar to the strategies outlined above. Cohen's approach to understanding the character includes (a) goal of the character, (b) other people who present obstacles to the character; (c) tactics the character uses to reach the goal; and (d) expectations the character has about outcomes and other people.

All of the aforementioned strategies – text analysis, observation, and exploring motivation- were classified by Bandelj (2003) as identification of character. In a study of how method actors' creation of roles was influenced by social learning and established social roles, Bandelj observed acting classes, viewed archival interviews with well-known actors, and surveyed the literature. The author discovered character identification, or character analysis, was an imaginative, creative process informed by education and observation within acting classes as well as by work with other actors and directors. Therapists similarly are asked to identify the character of individuals seeking treatment. Ickes's (1993) writings on empathic accuracy also created a bridge between the worlds of

acting and psychology. Ickes proposed empathic individual aim to understand others' current states and personality traits that motivate behavior. He described accurate empathy as the ability to infer the other's thoughts, feelings, and immediate goals in the moment correctly. Actors strive for this same understanding.

Verducci (2000) explored the ethics of caring for others and concluded Method Acting techniques could be used to teach children both morals and ethics. While not an empirical piece, Verducci's writing proposed Method Acting develops empathy through honing the individual's ability to observe situational and behavioral cues, understand the motivations of others, and analyze text. The curiosity regarding actors' ability to develop empathy led to Nettle's (2006) research conducted with a sample of 191 actors. Nettle found as compared to the general population, actors in the study scored higher on the Baron-Cohen Empathy Quotient as well as on measures of openness, extraversion, and agreeableness. While actors scored higher in empathy than non-actors, Nettle discovered actors had no deficits in other areas. The finding was considered significant because in clinical populations, such as individuals on the Autism spectrum, low empathy is often correlated with higher levels of introversion or systematization. Nettle's preliminary results revealed actors tended to be higher in empathy than the general population, but the question of whether acting makes one empathic or empathic individuals gravitate towards the acting profession remained unanswered.

Although Meffert et al. (2013) did not directly investigate acting as a means to teach empathy, the authors' findings reinforce the notion that empathy can be taught. Eighteen individuals diagnosed with psychopathy and twenty-six control participants

viewed brief video segments of two hands interacting in an emotional or neutral fashion. The researchers found the experimental group showed less activity in the areas of the brain associated with empathy than the control participants. When the experimental group was instructed to think about the feelings of one of the actors in each scene, the difference between brain activity in the two groups was significantly reduced. Meffert et al. (2013) demonstrated that deliberate effort to empathize might be an effective method to compensate for deficits. The authors did not provide further direction to the participants, but the review of the literature demonstrated acting techniques might one way to improve empathy. Johnson, Cushman, Borden, and McCune (2013) studied reading fiction's effectiveness as a method for the development of empathy. They found reading fiction generates rich imagery that assists the reader in experiencing the emotions of the character. Research participants who focused on sensory details in the assigned reading reported the most empathy for the character, when they were compared to groups assigned to attend to semantics only or read as if for leisure.

Some of the most current research explicitly tying acting to the teaching of empathy comes from Yale University's renowned Theatre and Psychology programs. Psychologist Goldstein, along with various collaborators, continues to conduct studies of empathy and Theory of Mind in children, adolescents, and adults. Although Goldstein (2009) agreed Method actors draw upon Theory of Mind, empathy, and emotional regulation to understand and portray characters, the author failed to determine how actors develop these abilities. However, Goldstein, Wu, and Winner (2009-2010) continued to question the roles of empathy and Theory of Mind in actors and found actors possessed

more Theory of Mind skills than the controls, but not higher empathy levels. The authors conducted one study of high school students identified as actors and a control group of non-actor peers. A second study compared young adult actors and a control group of psychology majors. The result of the second study revealed the psychology students reported higher levels of empathy than the actors and the levels of empathy were positively correlated with the psychology students' ages. Goldstein et al. (2009-2010) proposed actors relied more heavily upon Theory of Mind skills because experiencing empathy, defined by the authors as experiencing the character's feelings, would be exhausting. The question of whether of Theory of Mind is different from cognitive empathy remained. Winner and Goldstein (2012) continued the inquiry and found participation in an acting class also increased empathy scores in elementary school-aged children and adolescents. Students enrolled in other arts courses did not show the same growth, nor did control subjects.

Goodwin and Deady (2013) proposed Stanislavski's and Strasberg's method acting techniques could be used to develop empathy in mental health professionals. They explained the need for psychiatric nurses to be able to relax, cope with stress, and understand patients' perspectives. Although they did not perform any original research or implement an intervention, the article broke new ground by suggesting that psychiatric nurses could be trained to improve their ability to relate to patients by using the strategies actors use to understand their assigned character. The recommendations are notable because they went beyond the use of role-playing to create affective memories and acting warm-up exercises to develop focus and self-awareness. Goodwin and Deady began a

new discussion about how character analysis techniques and imagination could be used to improve cognitive empathy.

Summary

The purpose of the study was to explore character analysis strategies' utility for enhancing cognitive empathy in mental health professionals. The study built upon previous research that used instruction in acting skills to teach empathy (Andres-Hyman, Strauss, & Davidson, 2007; Dow et al., 2007). In this chapter, I reviewed the relevant literature pertaining to empathy, client-centered therapy, and acting technique. Just as psychology has generally moved away from fixed theoretical orientations and leaned towards a transtheoretical model (Feixas & Botella, 2004; Weinberger, 1995), theatre in the United States has left strictly codified acting rules behind in favor of techniques that draw from the approaches of multiple famed actors, directors, and writers (Cohen, 2013; Grote, 1989; Schanker & Ommaney, 1999).

Empathy's place in the field of the psychology has been disputed since the term was introduced (Edwards, 2013). First, empathy, when defined as a process, was rejected by behaviorists who deemed it too subjective. Once the term gained an operational definition and was soon after named a key component of Rogers' necessary and sufficient conditions for therapeutic change, empathy was extensively studied (Elliot et al., 2011). Client-centered therapy proposed empathy was curative on its own because an individual who felt understood and valued could create their own change (Rogers, 1940, 1946, 1949,1957, 1959, 1975). Then, empathy research declined significantly for a period of about 20 years (Bohart et al., 2002; Elliot et al., 2011).

The resurgence in empathy research can be attributed, at least in part, to research that pointed towards common factors (Lambert & Barely, 2001; Lampropoulos, 2000; Wolfe & Goldfried, 1988). I discovered the depth and breadth of the on-going debate over what influences therapeutic outcomes. Some thinkers advocated for specific intervention or theoretical orientations while another faction proposed common factors might account for outcomes (Boswell & Castonguay, 2007). The therapeutic alliance was reported as the most influential of common factors, with therapist empathy identified as a key component of this complicated, synergistic phenomenon (Greencavage & Norcross, 1990). The discussion of common factors was also woven into the development of the transtheoretical stages of change (Prochaska, 2000; Prochaska & Di Clemente, 1982). According to this approach, in order to select appropriate interventions for individuals, mental health professionals need to use empathy skills to understand the individual and their readiness for change (Norcross & Wampold, 2011; Renninger, 2013).

Despite continuing disagreement about an operational definition for empathy, numerous researchers attempted to design instruments to measure it. The measures varied as widely as the definitions did, and were often found to be measuring traits or states other than empathy. My review of the literature helped me determine empathy was generally described as cognitive or affective. Furthermore, there seems to be consensus that cognitive empathy is the same as Theory of Mind. The Hogan Empathy Scale (1969) and the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1972) were two efforts to measure empathy, and together they captured both its cognitive and affective components. Davis's IRI (1980) was and still is well regarded because with its

four subscales it was a well-validated measure of both cognitive and affective empathy (Davis, 1983; Fernandez, Dufey, & Kramp, 2011; Lauterback & Hosser, 2007). The LET (Mahoney, 1960) was found to be a valid measure of cognitive empathy. The test requires the respondent to adopt the point of view of fictional characters and to demonstrate their ability to create a theory of mind. Current research trends revealed by the review of the literature included an interest in developing instruments that help identify the anatomical empathy pathways and empathy deficits in individuals with diagnoses on the autism spectrum or those who meet the diagnostic criteria for psychopathy (Harari et al., 2010; Shamay-Tsoory, 2011; Shamay-Tsoory, Aharon-Peretz, & Perry, 2009; Shamay-Tsoory et al., 2007). A second research strand that emerged from my review of the literature was the renewed interest in empathy as it contributes to treatment outcomes (Harrison & Westwood, 2009).

Although defining and measuring empathy remained contentious, both the mental health and medical fields began to explore ways in which to teach it. Both fields looked to theatre for strategies to develop clinical empathy and perspective-taking skills (Andres-Hyman, Strauss, & David, 2007; Dow et al., 2007; Goldstein, 2009; Goldstein & Winner, 2012; Larson & Yao, 2005). Stanislavski's (1936/1989) instructions to actors served as the foundation for what is called Method Acting. The Russian actor/director asked actors to analyze characters deeply and cease the old style of declaratory, surface acting. Hagen, Adler, Strasberg, and Meisner brought Stanislavski's approach to American actors (Brestoff, 1995). Each teacher emphasized different facets of the emotional and cognitive preparation acting requires, but all approaches were united by

the idea that realistic acting came from creating authentic, multidimensional characters based upon the text, imagination, emotional and sensory recall, and acting *as if*. The same *as if* played a key role in Rogers' definition of accurate empathy (1957), so using acting technique to train mental health professionals could be a logical choice.

In Chapter 3, the rationale for research design, procedures, measurement tools, data collection, and data analysis for the study are discussed. The results of the study are presented in Chapter 4 and the implications of the results are discussed in Chapter 5.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to investigate whether instruction in character analysis techniques, such as those used by actors, had an effect on cognitive empathy. In the first two chapters, I presented the outline for this study and supporting theoretical and empirical literature on the topic. The importance of empathy as a component of an affective therapeutic relationship has been established in the literature (Lampropoulos, 2000). The question of how best to train mental health professionals in cognitive empathy remains unanswered. Chapter 3 describes the research design, variables, instrumentation, participants, data collection, data analysis, limitations, and ethical considerations of the study.

Research Design

Upon approval from the Walden University Institutional Review Board (IRB; approval number 05-13-14-0039713), I solicited volunteer participants through public bulletin boards on the campus of a private university. Participants were invited to attend a one-time one to two hour meeting during which the empathy measures and intervention were completed. The research used two different but related measures, the IRI (Davis, 1980), a short self-report inventory, and the LET (Mahoney, 1969), a measure of cognitive empathy that requires a moderate amount of reading and critical thinking. A pretest-posttest model was considered in order to compare participant LET scores gathered before and after the intervention. To minimize or eliminate concerns about

repeated measures, such as habituation (Krauth, 2000) and fatigue (Mitchell & Jolley, 2004), a pretest–posttest model was discarded.

Setting and Sample

The study was conducted with a convenience sample of male and female undergraduate and graduate students recruited from a local private university through on-campus solicitations on public message boards. To participate, candidates had to volunteer and be enrolled in college or graduate-level coursework when data was gathered.

The sample size for this study was 20 participants. The search ended when that number was reached. This size was comparable to those used for similar studies and was deemed appropriate to the research design and proposed statistical analysis. An a priori power analysis using G*Power 3.1 for ANCOVA at alpha <. 05 with a power of .80 to detect a moderate to large effect size of .40 revealed a sample of 52 participants would be necessary. Based upon the type of intervention and limitations of the research as a doctoral capstone project, a sample of 52 was determined to be prohibitive. Using an alternate method of sample size calculation provided by Bausell and Li (2002), a sample of 20 total participants (ten per group) with a hypothesized effect size of 1.25 and r =. 40 resulted in an ANCOVA with a power of 0.83 with an alpha set at 0.05. The review of the literature revealed similar investigations of empathy training with samples of approximately 22 participants (Nerdrum & Ronnenstad, 2003; Shapiro, Morrison, and Baker, 2004; Dow, Leong, Anderson, & Wenzel, 2007).

The *r* value of 0.40 was considered a conservative estimate of the correlation of the covariate to the dependent variable. The LET predates the IRI, so there is no empirical evidence of a correlation between the two instruments. However, the correlation between the Perspective-Taking Scale of the IRI and the Hogan Scale, another measure of cognitive empathy similar to those used in the validation of the LET, was found to be 0.40 (Davis, 1983). Furthermore, Mahoney (1969) found the LET was positively correlated ($r = 0.31$) to Kerr and Speroff's Empathy Test. The hypothesized effect size of 1.25 was based upon similar studies that employed a theatre or literature-based intervention and a measure of empathy, which yielded effect sizes ranging from .6 to 1.9 (Dow et al., 2007; Goldstein & Winner, 2012; Shapiro et al., 2004). Additional support for the hypothesized effect size was discovered in Stepien and Baernstein's (2006) review of 13 peer-reviewed studies that investigated interventions for teaching empathy to medical students. The studies reviewed yielded effect sizes of from 0.0 to 17.8.

Procedures

In order to respect the time of the study volunteers, I randomized participants prior to the meetings. I used the random number table procedures outlined by Mitchell and Jolley (2004) in order to protect individuals from being identified as research participants and to randomly assign participants to one of two groups (control or experimental). The random assignment of participants to groups is thought to balance individual characteristics and provide the research findings with internal validity (Bechhofer & Paterson, 2000). As participants volunteered for the research they were

assigned a participant number. During the first contact, participants were asked if they were currently enrolled in college or graduate-level coursework and were asked to provide a first name and contact information. Participants were invited to attend one of two sessions, depending upon whether they were assigned to the control or experimental group. There was no standby participant list. The meetings included an explanation of the purpose of the study, informed consent documents, confidentiality, and the voluntary nature of participation (see Appendix). The consent forms will be stored separately from the answer sheets and only my dissertation committee and I will know the identities of the participants. All 20 participants completed basic demographic questionnaires and respond to the IRI. Participants were educated as to the importance of not discussing the IRI with others because it is a psychological measure and they were told there are no right or wrong answers or good or bad scores.

Following the collection of participant responses to the IRI, I asked the control group members to complete the LET. After I collected their responses, I gave the control group participants an envelope with a copy of the Character Analysis PowerPoint presentation (see Appendix) and I thanked them for their time. In a separate meeting, participants assigned to the treatment group were informed they would receive a brief training in basic character analysis methods used by beginning actors and would then be asked to complete the second measure. After members of the intervention group completed the LET, they took their copy of the Character Analysis PowerPoint and were thanked for their time.

I presented the character analysis lesson to the intervention group in a conference room setting. I presented a 45-minute lesson to the intervention group. The presentation on character analysis was based upon the secondary-level textbook *Theatre: Art in Action*. I am an experienced teacher, director/choreographer, and producer of plays and musicals. I also have training in curriculum design. Participants were instructed in specific vocabulary including motivation, objective, obstacle, strategy, action, outcome, subtext, and stakes. Following the lesson, the participants were given a ten-minute break. After the break, all experimental group participants were asked to complete the LET. There was no time limit to complete the instrument and participants were informed they could leave upon completion or whenever they chose to no longer participate. It was predicted that most participants would be able to complete the LET within 50 minutes (Mahoney, 1960). All participants in the experimental group finished within 45 minutes. It was anticipated that the total time for participation would be no more than two and one-half hours.

At the conclusion of the study, all participants who requested follow-up information were notified of the study's results via electronic or United States mail. No individual scores earned from administration of the IRI or LET were released to participants.

Character Analysis Training

The objective of the character analysis training was to increase the participants' abilities to think as if he or she was the target individual/character. I explained that actors use a script, their own experiences, and their imaginations to attempt to understand the

thoughts, feelings, and behaviors of a character (Grote, 1989). The terms *objective*, *motivation*, *intention*, *obstacle*, and *stakes* were introduced, described, and then put in the context of fairy tale and popular culture characters. Instruction was presented orally with a supplementary Power Point presentation (see Appendix). A paper copy of the lecture slides was also provided to the participants. I incorporated direct instruction/lecture, modeling with examples, independent practice, and review.

Motivation

In the training, motivation was defined as the reason a character says or does something (Abel, 1999). Participants were reminded of the cliché line, "What's my motivation?" that is often included in a script for characters that are actors. Motivation was discussed as the big reason driving everything else that happens for the character. Motivation was also described as what the character wants in the "long run" (Grote, 1989, p. 69) or his or her goal. Motivation was further described as the *why* in character analysis (Schanker, 1999). Chicken Little was one example character I employed. Everything Chicken Little does is motivated by his desire to be a hero. Participants were also reminded each of them had a motivation for participating in the current study. They might have been motivated by curiosity, desire for academic achievement, or reasons unimagined by the researcher. Once a character's overall motivation is understood then scenes or moments can be closely examined by applying objective and intention.

Objective

Objective was defined as what the character wants to happen next or his or her desire for "the immediate future" (Grote, 1989, p. 69). The Stepmother from the story

Cinderella is motivated by her desire to secure the future of herself and her two daughters. Her objective is to have one of her own daughters marry the prince. A marriage to the prince will help the stepmother attain her long-term goal.

Intention

Intention was defined for participants as what the character wants right now (Grote, 1989). The intention is related to the character's motivation. For Chicken Little, each time he meets a new character along the way, his intention is to convince him or her that the sky is falling and then persuade that character to join in the journey to see the king. Chicken Little still wants to be a hero, but in each scene he also has an immediate concern. For the stepmother, her intention might be to keep Cinderella from being able to make a gown, to make Cinderella feel worthless, or to keep the prince from finding out there is another young lady in the house who ought to try on the lost slipper.

Obstacle

Once a character's motivation, objectives, and intentions are understood, an actor also considers what obstacles, or challenges the character faces. Chicken Little faces obstacles such as being stopped by multiple fowl along and having to over and over explain his urgency in getting to the king. The fox later presents another more challenging obstacle. Cinderella's stepmother also faces numerous obstacles. The stepmother wants to secure her future, but Cinderella's fairy godmother gives Cinderella a dress for the ball, the stepsisters' feet are too big for the slipper, and Cinderella manages to complete all of her assigned tasks in time to go to the ball.

Stakes

When an actor tries to think as if he or she is the character, the stakes are also of great importance. Stakes were defined for participants as what the character will gain or lose if the goal is or is not reached (Abel, 1999). For the first example in the training, Chicken Little, the stakes from the character's perspective are becoming a hero or being killed when the sky falls. Cinderella's stepmother stands to gain financial security and status if she can get the prince to marry one of her daughters.

Putting It All Together

After the key vocabulary was introduced, I provided examples and modeled the character analysis process. For example, what motivates everything the Wicked Queen does in the fairy tale "Snow White?" What does she want more than anything? The reason she is wicked is because she wants to be the fairest of them all. It is her reason *why*. Once her motivation was understood, I explained her objective in many scenes within the story is to get rid of Snow White. Getting rid of Snow White is a means to an end. Her intention in the scene when she disguises herself as a beggar is to take advantage of Snow White's trusting nature and get her to eat a poisoned apple. To summarize, what the Wicked Queen wants to do in the moment is to trick Snow White into taking an apple so that Snow White will be poisoned and die. If Snow White dies, then the Wicked Queen will finally attain her goal of being the fairest of them all. Snow White is one of the Queen's obstacles, in addition to the protective dwarves, the prince's magical kiss, the huntsman who fails to kill Snow White, and so on. Participants were be

invited to talk amongst themselves about fictional characters using this model and then share examples generated in discussion.

Background and Status Quo

To conclude the instruction in basic character analysis, participants learned about background and status quo. Context includes, but is not limited to, the time period, culture, occupation, education, family/relationship status, health, personality, and appearance of the character. Participants were told background would include any or all of the information a mental health professional might collect during an intake session or read on a patient questionnaire. Background was also explained as all the things a family member or close friend could use to provide a complete depiction of an individual. Status quo, or present circumstances (Abel, 1999) of the character, calls for the actor to be in the moment with the character considering the obstacles, stakes, and intentions in light of the character's current mental and physical conditions. To illustrate these concepts, the participants were reminded of Cinderella's stepmother. Perhaps this character was poor prior to marrying Cinderella's father. She is a widow with three girls she must get married off. Her own beauty is fading, and she realizes the shortcomings of her daughters while she recognizes the inner and outer beauty of her stepdaughter. When the background and status quo of Cinderella's stepmother is joined with an understanding of her motivation, intentions, objectives, obstacles, and stakes, she becomes a real woman instead of a caricature.

Subtext

The last concept introduced in the training was subtext. Subtext was defined as the underlying meaning of a character's words and actions (Abel, 1999; Grote, 1999). I provided numerous examples of how individuals often do not say what they mean or mean what they say. First, I provided a demonstration of how the way something is said reveals more meaning than the words themselves. These examples included the many ways one can say "Hello" "I love you" or "No". I named additional examples "Yes" and "Goodbye", but did not provided demonstration. At the conclusion of the lesson, I responded to participants' questions.

Instrumentation

Davis developed the IRI in 1980 as an answer to the Hogan Scale (Hogan, 1969). The IRI is a 28-item self-report tool with four subscales purported to identify distinct facets of empathy – Perspective Taking, Fantasy, Empathic Concern, and Personal Distress (Davis, 1983). Individuals respond on a scale of A to E based upon how well he or she thinks each statement describes him or her. Each statement such as "I tend to lose control during emergencies" and " I try to look at everybody's side of a disagreement before I make a decision" loads on to only one of the four subscales. Nine items contained in the IRI are reverse scored (Davis, 1980).

The IRI is the third and the final version of the instrument developed by both writing original test items and selecting items from other inventories (Davis, 1980). The first version contained more than 50 items and was normed using a sample of 201 males and 251 females. A second 48-item version was normed with a sample of 427 psychology

students; this sample included 221 males and 206 females. Factor analyses yielded 28 items for the final IRI which was normed using a sample of 1161 University of Texas undergraduate psychology students who had not participated in previous stages of the index's development (Davis, 1980).

The IRI's construct validity was demonstrated by correlations of each of the 4 subscales with other instruments purporting to measure similar constructs in addition to measures of self-esteem and intelligence (Davis, 1983). The Hogan Empathy Scale (1969) and the Mehrabian and Epstein Emotional Empathy Scale (1972) were used as bases for comparison to validate the Perspective-Taking scale of the IRI (Davis, 1983). Davis also used participant scores on the Scholastic Aptitude Test, Personal Attributes Questionnaire, and Texas Social Behavior Inventory. The Hogan Scale is generally viewed as a measure of the cognitive aspects of empathy. The Mehrabian and Epstein Emotional Empathy Scale is typically accepted as a scale of emotional response to the experiences of others (Davis, 1983) The Perspective-Taking scale was found to be significantly correlated to the Hogan Scale with a mean r =. 40 while no significant correlation to the Mehrabian and Epstein Scale. Davis (1983) noted a moderately significant relationship between the Perspective-Taking scale and self-esteem, but no such correlation to intelligence was discovered in the norming sample.

Davis (1980) measured the test-retest reliability of the IRI by administering the tool to a sample of 56 male and 53 female undergraduates twice. The second set of responses was gathered between 60 and 75 days from the first set. Davis (1980) reported

test-retest reliabilities of .61 to .79 for males and .62 to .81 for females. Each of the four subscales was reported to have an internal reliability of .71 to .77 (Davis, 1980, 1983).

Mahoney (1960) developed the LET in partial fulfillment of the requirements for a doctoral degree at The University of Oklahoma. The instrument purports to distinguish bad empathizers from good empathizers (Mahoney, 1960). The LET is comprised of four subsections, each one containing a reading selection and twenty incomplete-sentence items pertaining to the reading. Scoring of the instrument is achieved according to the "formula: right minus wrong plus ten" (Mahoney, 1960, p. 24) with all subtests combined to arrive at a total empathy score. The test was designed to be administered in individual and group settings (Mahoney, 1960).

The norming sample for the LET was comprised of 1139 undergraduates from three colleges/universities. Participants enrolled in an undergraduate psychology course from Fort Hays Kansas State College, University of Oklahoma, and Drew University completed the LET during a regular class meeting (Mahoney, 1960).

The reliability of the LET ranges from .89 to .92 for the full test (Mahoney, 1960). Reliability was measured via the split-half method using 380 (or one-third of the total sample). Individual subtests' reliability ranges from .72 to .86 with the total test reliability coefficient of .92. The author also employed the test-retest method and administered the LET to 111 participants for a second time one month after the initial administration. This method yielded subtest reliability coefficients of .66 to .81 and a total test reliability coefficient of .89 for the entire test.

The construct, content, concurrent, and predictive validity of the LET were investigated thoroughly during the development of the instrument (Mahoney, 1960). Mahoney determined the LET had no predictive validity because the test's purpose was to measure empathy at the moment of test administration, not to predict future empathy levels in the individuals. Furthermore, the author stated the LET was not suited for any individual assessment in a clinical or diagnostic setting.

Data Analysis

The IRI and LET answer documents were hand scored. Total LET scores were recorded, but only the Perspective Taking subscale scores were reported for the IRI. Participants' identifying numbers, scores, and demographic information were entered into the IBM Statistical Package for Social Sciences (SPSS), version 21. Descriptive statistics were produced using a chi-square analysis in order to report on the characteristics of the sample and compare the control and the intervention group.

The LET scores of two independent samples were analyzed via one-way Analysis of Covariance (ANCOVA). A one-way design is accomplished with the inclusion of one qualitative independent variable and one or more quantitative independent variables acting as covariates to the dependent variable(s) (Wildt & Ahtola, 1983). While a *t* test would have also been appropriate, an ANCOVA offered unique benefits. Because it includes one or more covariates, ANCOVA requires a substantially smaller sample size than a *t* test and increases the statistical power of the treatment effect (Algina & Olejnik, 2003). ANCOVA also compensates for the possibility that a seemingly random sample is not so (Borm, Fransen, & Lemmens, 2007). Owen and Froman (1998) caution the

strengths of ANCOVA are lost if two conditions are not met. Researchers must be able to assume reasonably that the covariate is uncorrelated to the independent variable and is correlated to the dependent variable. In this study, a correlation between IRI and LET scores was assumed while assignment to the intervention group was not thought to have a correlation to IRI scores. Participant gender was also treated as an additional independent variable in a separate one-way ANCOVA because the review of the literature indicated there is some correlation between scores on empathy measures and gender. An ANCOVA allowed for the exploration of whether or not the character analysis training has an effect on LET scores when individuals' IRI scores were controlled for.

Ethical Considerations

Participants' rights and safety were of utmost concern in this study. All participants were notified, in writing, of the potential risks and benefits of their participation in the study. The possibility that the empathy training might increase personal distress in participants who interact with individuals in pain was presented as a risk of participation while improved interpersonal relationships in personal and professional interactions was offered as a potential benefit (Hatcher & Nadeu, 1994; Batson, Early, & Salvarani, 1997). The informed consent form included information regarding confidentiality, records storage, and whom to contact with questions during or following the study. All electronic data are stored on a password-protected hard drive and paper documents are stored in a locked file cabinet in my home. After seven years, all electronic and paper records shall be securely destroyed.

Individual scores from the IRI and LET were not released to the participants because without explanation and elaboration, the results may be distressing to some participants. Upon the conclusion of the test administration, participants were debriefed and provided a hotline phone number in the event that any component of the research was upsetting. Assignment to the treatment or control group was an additional ethical concern in this research design (Krauth, 2000). In order to address possible participant distress related to their not receiving the character analysis training, I gave control participants the option of receiving the training and provided training materials upon the conclusion of the study (Krauth, 2000). In order to avoid coercion, participants were not compensated for participation in any element of the study.

Summary

My review of the literature revealed that therapist empathy is an important component of the therapeutic relationship across several treatment modalities. The LET (Mahoney, 1960) is a little-used yet reliable and valid measurement of cognitive empathy. The IRI (Davis, 1980) is a widely used measure of empathy that purports to measure four aspects of empathy, which can be categorized as either cognitive or affective. While there are myriad definitions of and measures of empathy, few studies have addressed how to improve cognitive empathy. The convenience sample included male and female individuals recruited from one private university campus in Southern California via public bulletin boards. All consenting participants completed demographic questionnaires and responded to the IRI. The intervention group received a 45-minute training in character analysis techniques similar to those used by actors and then

completed the LET. The control group responded to the LET with no intervention. All data collected was analyzed using ANCOVA with LET scores as the dependent variable, training in empathy and gender as independent variables, and scores on the IRI Perspective-Taking Scale as the covariate.

Chapter 4 describes the data collection process and participant characteristics. Control group and intervention group procedures are reported as well. Descriptive statics and the results of the ANCOVA conclude Chapter 4. The results are interpreted in Chapter 5.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to investigate whether character analysis strategies, such as those used by actors, could be used to increase cognitive empathy. The research question for this study was: Do individual LET scores differ between individuals who received character analysis training and those who did not, after controlling for IRI scores? An ANCOVA was conducted to test the following hypotheses:

Null hypothesis: There is no statistically significant relationship between training in character analysis techniques and cognitive empathy, as measured by scores on the Literature Empathy Test, in the study participants when IRI scores are removed.

Alternate hypothesis: There is a statistically significant relationship between training in character analysis techniques and cognitive empathy, as measured by scores on the Literature Empathy Test, in the study participants when IRI scores are removed.

This chapter describes the administration of the intervention and data collection procedures, including sample recruitment and demographics. Finally, the results of the ANCOVA are presented with respect to the research question and hypotheses.

Data Collection

Upon receiving approval to conduct the research from Walden University's Institutional Review Board, fliers were posted on the public bulletin boards of a private university campus in May and June of 2014. Twenty-three individuals responded. Only

candidates who met the screening criteria and indicated that they would be available in July 2014 were included in the randomization procedures.

Participant Characteristics

The population for the study was initially adults 18 years of age or older who were also enrolled in undergraduate or graduate psychology courses. However, in order to gain IRB approval, the inclusion criteria for the sample were broadened to include any adults enrolled in undergraduate or graduate course work. The sample was not representative of the population because 70% of the sample was female. Twenty participants (n = 20) were randomly assigned to the control or intervention group (without standby participants). Each group had 10 participants. The age range of the final sample was 18-69 years. Fourteen (70%) of the participants were female and 6 (30%) were male. Both the intervention and control groups consisted of 7 females and 3 males. Half of the participants were in undergraduate study and half were in graduate-level work. The control group consisted of 6 undergraduates and 4 graduates. The intervention group included 4 undergraduates and 6 graduates. Table 1 contains frequencies and percentages for the sample's demographics.

Table 1

Demographic Characteristics of the Study Sample

Demographic	*n*	%
Gender		
Male	6	30
Female	14	70
Current Course Enrollment		
Undergraduate	10	50
Graduate	10	50

Control Group Procedures

Data collection took place over two dates in July 2014. All participants attended their assigned session and there were no dropouts during either session. The control group session took place first. Participants were notified of Informed Consent and were asked to provide their name, age, gender, and level of education. Next, the individuals responded to the IRI using pens and pencils provided by the researcher. All participants completed the 24-item IRI in less than 10 minutes. The researcher handed out the LET and read the printed instructions aloud. There was no time limit stated and participants were notified they could leave when they completed the LET or whenever they chose not to participate any longer. Most research volunteers completed the LET in approximately 40 minutes. Participants handed in the test questions and answer sheets, received a copy of the Character Analysis PowerPoint (see Appendix), and had the option to turn in an e-mail or physical address if they wanted to receive information about the study upon its completion. The total participation time for the control group members was approximately one hour.

Intervention Group Procedures

The intervention, Character Analysis Training, was presented as described in Chapter 3. After Informed Consent was explained and participants completed demographic forms, all participants responded to the IRI. Similar to the control group participants, the intervention group members completed the IRI in approximately 10 minutes. After IRI responses were collected, participants received a handout containing PowerPoint slides for the intervention (see Appendix). Slides were projected on a large screen while the presenter explained the concepts and examples. All ten participants attended to the presentation, as evidenced by their note-taking or nonverbal indications of understanding. Some participants were observed checking electronic devices during the intervention. No electronic devices emitted alert sounds during any data collection session. Participants were not directed to refrain from accessing any electronic devices they brought with them, nor were they required to take notes during the intervention. There were no adverse events related to the intervention; no participants reported distress or discomfort during the session and the presentation was uninterrupted. The Character Analysis training was presented in approximately 48 minutes.

Following the Character Analysis training, participants received a 10-minute break. All participants returned from the break and the LET questions and answer documents were distributed. The researcher read the instrument's printed instructions aloud and asked participants to begin when they were ready. Participants in this group were also informed they could leave after completing the LET or whenever they chose not to participate further. The researcher remained in the room during the data collection.

All members of the intervention group completed the measure within 45 minutes. Participants returned the LET questions and answer documents, but kept their PowerPoint handouts. The research volunteers also had the option to submit contact information if they wanted to receive a research summary after the completion of the study. The intervention group members' total participation time was approximately two hours as compared to the control group's members who completed Informed Consent procedures, the IRI, and LET in one hour.

Covariate Inclusion

The IRI was chosen as a covariate because of its assumed correlation to the LET, its brevity, and its wide use in similar research. A pretest-posttest model would have required participants to complete the lengthy LET two times in one sitting. It was proposed that another self-report measure of cognitive empathy could be used in an ANCOVA analysis in order not put undo burden on research participants. The review of the literature provided no evidence of any correlation between the two instruments because the LET predates the IRI. In the sample of scores gathered from this research, the LET and IRI Perspective Taking subscale were found to be strongly correlated, $r(18) = .692$, $p < .01$.

Results of the Study

The participants' responses to the IRI and LET were hand-scored by the researcher after all data was collected. The total score for the LET and the score for the IRI's Perspective Taking subscale were entered in the statistical analysis software along with participant age in years, gender, current course enrollment, and group assignment.

IBM Statistical Package for Social Sciences (SPSS), Version 21 was used for all data analyses.

Sample Independence

Fisher's Exact Test (FET) was used to determine the independence of the nominal variables. The FET analysis corrects for smaller sample sizes particularly when cell counts are below 10. When sample sizes are small, the FET is considered to result in fewer Type I errors than a chi-square but there is a slightly more Type II errors (Biddle & Morris, 2011). The sample for this study was 20 total participants and the expected count for multiple cells was 5 or less. With a significance level of $p < .05$, the FET indicated participant education level and assignment to the intervention or control group were independent of one another ($p = .328$). The same test also confirmed participant gender and group assignment were independent of one another ($p = 6.86$). The results of the FET indicated the relative proportions of one variable were independent of the second variable.

Statistical Analyses

The sample's mean (*M*) for the IRI Perspective Taking Scale was 17.25 with a standard deviation (*SD*) of 5.68. Female participants were found to have a mean (*M*) score of 18.36 and a standard deviation (*SD*) of 5.06 while male participants were found to have a mean of 14.67 and standard deviation of 6.69. For the LET, the sample had a mean (*M*) of 87.90 and standard deviation (*SD*) of 16.36. Again, basic descriptive analysis revealed gender differences in participant scores. Female participants' scores on the LET ranged from 75-120 and yielded a mean of 93.36 (*SD* = 12.65). Male

participants' scores on the LET ranged from 55-102 with a mean of 75.17 (*SD* = 17.97). The means and standard deviations for the two empathy measures are presented in Table 2.

Table 2

Means and Standard Deviations for Empathy Measures for Full Sample

Measure	*M*	*SD*
IRI	17.25	5.68
LET	87.90	16.36

Participant IRI scores highlighted differences between the control and intervention group. All participants completed the IRI prior to any intervention. The control group mean (*M*) IRI score was determined to be 14.40 (*SD* = 5.13) and the intervention group mean (M) IRI score was 20.10 (*SD* = 4.89). The intervention group's mean LET score was 93.70 (*SD* = 11.70); the mean (*M)* of the control group was found to be 82.10 (*SD* = 18.80). Table 3 contains means and standard deviations by group assignment.

Table 3

Means and Standard Deviations for Empathy Measures by Group

Measure	*M*	*SD*
IRI		
Control Group	14.40	5.13
Intervention Group	20.10	4.89
LET		
Control Group	82.10	18.80
Intervention Group	93.70	11.70

A one-way between subjects ANOVA was conducted to compare the LET scores of the control and intervention group. Receiving the intervention did not have a significant effect on LET scores at the $p < .05$ level, $F(1,18) = 2.74$, $p = 0.115$. The results of the ANOVA make up Table 4.

Table 4

ANOVA for LET Scores by Group Assignment

Source	*SS*	*df*	*MS*	*F*	*p*
Between Groups	672.80	1	672.8	2.74	0.115
Within Groups	4413.00	18	245.17		
Total	5085.80	19			

Next, participant IRI Perspective Taking Scale scores were added as a covariate. There was a linear relationship between participant IRI and LET scores and there was homogeneity of regression slopes as the interaction term was not statistically significant, $F(1,16) = .607$, $p = .447$. The analysis of covariance (ANCOVA) indicated there was no statistically significant difference in LET scores between the intervention and control groups when IRI Perspective Taking scores were controlled for, $F(1,17) = .003$, $p = .960$. The null hypothesis could not be rejected. The results of the ANCOVA directly addressing the research question are presented in Table 5. A separate ANCOVA was conducted comparing control group and intervention group LET scores, controlling for participant gender and that analysis did not find a statistically significant relationship between the independent and dependent variables, $F(1, 17) = 3.783$, $p = .069$, $\eta^2 = .182$. No post hoc analyses were conducted for the non-significant ANCOVAs.

Table 5

ANCOVA for LET Scores by Group Assignment While Controlling for IRI Scores

Source	*SS*	*df*	*MS*	*F*	*p*
IRI	1762.654	1	1762.654	11.306	0.004
Intervention	0.413	1	0.413	0.003	0.960
Error	2650.346	17	155.903		
Total	5085.80	19			

The results of the ANCOVA indicated that the Character Analysis Training had no significant effect on participant LET scores, $F(1,17) = .003$, $p = .960$, $\eta^2 < .0005$. The mean difference (Intervention-Control) was .335, $M = .335$, $p = .960$, 95% CI [-13.404, 14.074]. The null hypothesis could not be rejected. Therefore, it was concluded differences between the LET scores of the control and intervention participants could not be attributed to group assignment or receiving the Character Analysis Training.

Summary

The purpose of the study was to determine whether instruction in character analysis strategies would enhance cognitive empathy in the research participants. The sample and intervention procedures described above were used to answer the research question: Do individual LET scores differ between individuals who received character analysis training and those who did not, after controlling for IRI scores?

Twenty individuals in the sample were assigned to the control group or the intervention group. All participants signed Informed Consent forms and completed the IRI. The control group participants responded to the LET immediately; individuals in the intervention group participated in the character analysis training and then completed the

LET after a brief break. There were no adverse events to report. There was no missing data. Fisher's Exact Test was used to determine there were no significant differences between the two groups.

The results of the statistical analyses indicated there was no statistically significant difference between the invention group's and the control group's LET scores after controlling for participants' IRI Perspective Taking scale scores. An ANCOVA conducted using participant gender as the covariate also did not reveal a statistically significant relationship between participating in the character analysis training and LET scores.

Chapter 5 presents commentary on the research findings. The discussion includes limitations on the generalizability of this research. The chapter provides numerous recommendations for future research as they relate to the intervention, measurements, and sampling. It also includes this study's implications for social change on an individual, community, and societal level.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to investigate whether character analysis strategies, such as those used by actors, could be used to increase cognitive empathy. Cognitive empathy, in particular, is an area of interest for researchers who study psychopathology, autism spectrum disorder, and other diagnoses marked by empathy deficits. Furthermore, advances in neuroscience have led to discoveries about the neuroanatomical correlates to empathy. Research has also addressed the need to measure and increase cognitive empathy skills in non-clinical populations such as medical students, nurses, and members of society at large. Cognitive empathy skills instruction for mental health professionals has been addressed by few studies although empathy has long been accepted as a key component of the therapeutic relationship that transcends any one theoretical orientation (Lampropoulos, 2000; Moyers & Miller, 2013). The review of the literature demonstrated that the study of acting could be used to improve empathy in research participants (Dow, Leon, Anderson, & Wenzel, 2007; Goldstein & Winner, 2012; Goodwin & Deady, 2013). Empathy has teachable and learnable components (Georgi, Petermann, & Schipper, 2014). However, despite the large body of research described above, ongoing debates about how to define, measure, and teach empathy remain (Zaki & Ochsner, 2012).

This study used the LET to measure cognitive empathy in 20 participants, 10 each in an intervention and a control group. A one-way ANCOVA was used to test the hypotheses and address the research question: Do LET scores differ between individuals

who received character analysis training and those who did not, after controlling for IRI scores? The study found no significant difference between the LET scores of the intervention group and the control group after controlling for IRI scores. Moreover, the groups' scores did not vary significantly when the two groups' scores were compared without including the covariate.

Interpretation of the Findings

Because no statistically significant relationship was found between the dependent variable, LET scores, and the intervention, this study could not confirm previous findings that cognitive empathy is a teachable and learnable skill (Crits-Christoph et al., 2006). On the other hand, the study did pilot the Character Analysis Training, which led to insights that might guide future research. The LET and IRI Perspective-Taking Scale scores confirmed previous research findings that empathy could be divided into cognitive and affective categories (Shamay-Tsoory, Aharon-Peretz, & Perry, 2009). This study also provided preliminary data to establish a correlation between the LET and the IRI. The results of the data analysis confirmed gender differences in empathy scores (Carré, Stefaniak, D'Ambrosio, Bensalah, & Besche-Richard, 2013; Jolliffe & Farrington, 2005). The female participants in both the control group and the intervention group scored higher than their male counterparts.

Limitations of the Study

There were a number of limitations related to the sample. It is possible that a larger and more representative sample than the one used for the study might have yielded significant results. However, when the dataset was doubled and then tripled for the sake

of exploration, the analysis of covariance (ANCOVA) yielded results of $p = .940$ and $p = .925$, neither of which were significant. Repeating the study with the sample size of 52 calculated using G*Power 3.1 could clarify whether the sample's size was a significant limitation of the research. The paramount sample related concern appeared to be the disproportional representation of female to male participants. Mahoney (1960) discovered significant sex differences between LET scores while norming the measure with a sample of 1139 undergraduates. The researcher proposed reasons for these observed differences such as cultural values and reading ability of the sample. Empathy researchers have continued to find sex differences in empathy scores in participants of all ages (Baron-Cohen & Wheelwright, 2004; Davis, 1983; Fernandez et al., 2011; Johnson, 1998;Jolliffe & Farrington, 2005; Reniers, Corcoran, Drake, Shryane, & Vollm, 2011; Uzefovsky et al., 2014). Differences in cognitive empathy have been observed to be smaller, yet still significant (Carré et al., 2013).

In an effort to collect as little participant demographic data as possible, there is no record of which, if any, of the participants were enrolled in psychology courses. Walden University's Institutional Review Board argued that there were multiple majors and courses that could be potential confounding variables. The initial intent of the study was to investigate methods by which cognitive empathy could be taught to mental health professionals or individuals entering the field, but the approved research question did not justify collecting information about participant coursework beyond education level. The institutional review board's concerns about the intervention appearing as therapy or a class led to substantial changes in sample recruitment. Individuals were eligible for

inclusion, regardless of program of study, if they self-reported an age of 18 years or older and enrollment in college- or graduate-level coursework. The wide range of ages (18-65 years of age) represented in the sample of 20 participants made it impossible to draw any conclusions about relationships among empathy, age, and the intervention. The LET was normed with a sample of college undergraduates for whom no age information was reported and Walden University's Institutional Review Board recommended all adults be eligible for the study in the absence of evidence to justify age-based exclusions. Because of this limitation, this study could not confirm or refute findings that cognitive empathy is positively correlated to age (Schwenck et al., 2014; Ze, Thoma, & Suchan, 2014)

This study might have been further limited by the use of a convenience sample. Individuals on the university campus who looked at the community bulletin boards during May and June 2014 were the only people eligible to participate. It is possible that study volunteers reported IRI and/or LET scores that varied significantly from the proposed population. Convenience studies are thought to have low external generalizability because researchers can not account for existing differences between the experimental and control group (Mitchell & Jolley, 2004). Researchers are also advised to assume the convenience sample is biased (Creswell, 2002; Mitchell & Jolley, 2004). In the case of this study, it could be assumed that individuals who volunteered to participate for up to two hours for no compensation varied significantly from the population (Mitchell & Jolley, 2004).

The sample size and composition appeared to be the main limitations to the generalizability of the study, as discussed above. However, the review of the literature

and analysis of scores gathered from the participants indicated a number of confounding variables might have been present. Vachon, Lyman, and Johnson's (2014) meta-analysis of empathy and aggression studies proposed empathy research is most limited because empathy has yet to be accurately defined and empathy measures are mainly self-report. The authors also noted the low reliability of empathy measures. Future researchers will continue to be challenged with how to define, then measure, and eventually teach empathy. The recommendations for future research in the next section will present additional concerns related to the study design and instrumentation and propose possible remedies.

Recommendations for Future Research

While not designated as such, the research could be viewed as a pilot study because the findings provided insights about possible modifications to the LET and the character analysis training created for this study. Pilot studies can be used to alter the research before it is conducted with a larger sample (APA, 2009). The results and limitations of this study could justify revisions to the sample, LET, and study design.

As discussed earlier, although the small sample size of 20-22 participants was supported by the literature (Dow et al., 2007; Nerdrum & Ronnenstad, 2003; Shapiro et al., 2004), future investigations could benefit from a larger and more representative sample. Obtaining the cooperation of a university or professional association might provide access to a larger sample. Response rates might also increase by conducting research during the traditional academic year rather than in summer months. The use of a psychology class or volunteers from a local professional association would present the

same threats to generalizability because it would still be a nonrandom convenience sample (Creswell, 2002). However, there is debate over whether generalizability is as vital for social science experiments as it is for survey research or medical trials (Mook, 1983). It could be argued that for this study, the primary concern is any relationship between the independent variable and the dependent variable, so the risks of convenience sampling might not need mitigation (Paul, 2012).

A larger, more representative sample with equal numbers of male and female participants could enhance the generalizability of any findings. The body of research continues to report a relationship between gender and empathy (Reniers et al., 2011; Schwenck et al., 2014) and the field of neuroscience has begun to uncover the chemical and anatomical foundations of those relationships (Johnstone, Cohen, Bryant, Glass, & Christ, 2014; Uzefovsky et al., 2014). Because a review of the literature also revealed conflicting findings regarding the correlation between age and empathy (Schwenck et al., 2014; Ze, Thoma, & Suchan, 2014), analysis of data from a larger sample could help to explain differences between participants' scores, particularly if the sample is stratified by age (Creswell, 2002).

The addition of a measure such as the Questionnaire of Cognitive and Affective Empathy (QCAE) (Reniers et al., 2011) or the Basic Empathy Scale (BES) (Carré et al., 2013) would provide greater insight into any observed differences between the experimental and control group if this research were replicated. The research was reliant on the validity of the measurements chosen. The IRI is a well-validated, reliable measure of empathy (Davis, 1980; 1983). The Basic Empathy Scale (BES) is a brief self-report

instrument that would be a suitable pre-intervention measure, and it would not pose an undue time burden on study volunteers. The Basic Empathy Scale (BES) purports to address some of the IRI's (IRI) weaknesses.

If the LET is to be retained as a measure of cognitive empathy, a few adjustments to the data collection process could improve test reliability. The length of the LET and the repetitive nature of the questions across four literary selections made it unsuitable for a pretest-posttest model. The measure has 80 questions and approximately eight pages of detailed reading. Test scores would be susceptible to testing effect and participant fatigue in a pretest-posttest design (Mitchell & Jolley, 2004). Participants in this study expressed confusion about who the main character was in some stories and questioned if the same answer could be used for more than one story. If the research is repeated, adding explicit notice that questions will be repeated across the four literature selections on the test documents would possibly set the respondents' minds at ease and allow them to attend to the task rather than going back to change answers. Although there were no exit interviews conducted, study participants were overheard discussing their confusion about which character was the main character. The LET answer sheet could also be recreated with the words *main character* above each story's character name. The original answer document and test materials are labeled with Roman numerals and names of characters, but these could be misconstrued as story titles. Each vignette is a scene in which there is dialog and narrative, so research participants might find it difficult to determine which character is the focus of the questions.

If this research is repeated, the addition of intelligence scores as a covariate within an ANCOVA might deepen the discussion. The review of the literature included multiple empathy studies that included intelligence measures (Davis, 1983; Jolliffe & Farrington, 2005; Mahoney, 1960; Schwenck et al., 2014; Ze, Thoma, & Suchan, 2014). Those measures were added to the research designs to confirm or refute assertions that empathy and intelligence were one in the same. The Wechsler Abbreviated Scale of Intelligence (WASI) (Wechsler, 1999) or the Kaufman Brief Intelligence Test, Second Edition (KBIT-2) (Kaufman & Kaufman, 2004) would be appropriate for a study with a small sample or a selected subgroup of the full sample. Mahoney (1960) included individual administrations of a modified form of the Wechsler Adult Intelligence Scale for 51 volunteers out of the thousands who participated in the LET's development. Mahoney did not find a significant correlation between intelligence and LET scores, but the review of the literature revealed contradictory research that suggested a relationship between IQ and empathy (Jolliffe & Farrington, 2006; Schwenck et al., 2014).

Implications

The intervention introduced in this study did not yield significant results. However, the review of the literature and execution of this study suggested the importance of continued empathy research. The gap in the psychology literature was unexpected in light of what is known about empathy's role in treatment. The therapeutic relationship is well established as a critical factor in individuals creating change (Lingiardi, 2013; Norcross & Wampold, 2011). It has been argued that the relationship is all that is needed to create change (Rogers, 1975). Common factors theorists have found

that the therapeutic relationship was more influential than the specific treatment modality in determining therapeutic outcome (Greenberg, 2014; Lampropoulos, 2000; Lingiardi, 2013; Norcorss &Wampold, 2011; Thomas et al., 2014; Watson, Steckley, & McMullen, 2013). Empathy and the therapeutic relationship also have been identified as foundational components of evidence-based therapies including motivational interviewing, emotion-focused therapy, and twelve-step programs (Campbell, Guydish, Le, Wells, & McCarty, 2014; Greenberg, 2014; Moyers, 2014).

Despite findings that support empathy's contribution to treatment outcomes, there is a notable lack of cognitive empathy skills training for mental health professionals (Campbell, et al., 2014; Dehning et al., 2013). Graduate and doctoral-level training programs often emphasize empathic listening and attending behaviors, not perspective-taking (Dehning et al.). The body of literature related to empathy in medical students and other health disciplines continues to increase (Dehning et al.; Georgi, Petermann, & Schipper, 2014; Nunes, Williams, Sa, & Stevenson, 2011). Medical schools and residency programs have demonstrated a particular interest in how empathy in medical students declines over time. Few studies have investigated whether or not the same decline occurs in mental health professionals. The medical field has also continued to explore the use of theater, acting, literature, and the humanities to develop empathy in professionals (Dow et al., 2001; Goodwin & Deady, 2013; Hojat, 2009; Shapiro, Morrison, & Baker, 2004). Whether or not the same approaches could be applied to mental health professionals has not been researched. Although increased cognitive empathy in mental health professionals could result in more positive therapeutic

outcomes for individuals, couples, and families seeking services, it appears, up to this point, the field of psychology has been more vested in studying empathy in the clinical population than it has in professionals.

Cognitive empathy skills are vital for mental health professionals who treat individuals who meet the diagnostic criteria for placement on the autism spectrum, antisocial personality disorder, psychopathy, conduct disorder, and schizophrenia (Blair, 2005). These psychiatric disorders are marked by empathy deficits (American Psychiatric Association, 2013). With empathy training, mental health professionals will be better equipped to understand the perspective of a diverse clientele and to model or teach cognitive empathy skills to those individuals (Pankey, 2012). For instance, Baskin-Sommers, Krusemark, and Ronningstam (2014) suggested that narcissistic personality disorder, borderline personality disorder, and psychopathy are not always distinguished by a complete inability to experience emotional and cognitive empathy. Instead, these individuals are likely to overestimate their emotional empathy and demonstrate cognitive empathy only when it benefits them (Baskin-Sommers et al., 2014). Individuals meeting the diagnostic criteria for such classification are also subject to situational and motivational circumstances that influence their cognitive and affective empathy. Brook and Kosson (2013) similarly sought to expand the discussion of empathy and psychopathy. The authors investigated empathic accuracy and found individuals who meet the diagnostic criteria for psychopathy often failed to experience the full range of affect and had more difficulty processing the emotions on others in complicated situations. This research is of great importance because such individuals often were able

to demonstrate more empathic accuracy in lab settings with static stimuli such as pictures, than in naturalistic situations. Understanding the nuances of cognitive and affective empathy is vital to developing effective measures, diagnostic criteria, and interventions for such individuals.

Implications for Future Research

The length of the LET may have put an undue burden on research participants. Future research could seek to develop a shortened form of the test that would have the same reliability and validity. Reading literary fiction was identified as a means to improve empathy and theory of mind (Johnson, Cushman, Borden, & McCune, 2013; Kidd & Castano, 2013), so the LET's basic premise remains relevant more than fifty years after its inception. A modified or newly created assessment of cognitive empathy could include updated literary selections, modern vocabulary, and characters more diverse than those depicted in the vignettes featured in the LET.

Implications for Social Change

Conditions marked by deficits in cognitive or affective empathy are of great interest to psychologists. The continued study of empathy will benefit mental health professionals a well as the individuals, families, and communities that they serve. Individuals who feel understood will be more likely to seek services and have more positive treatment outcomes. Cognitive empathy skills will empower mental health professionals to work with a diverse clientele and extend quality mental healthcare to underserved and underrepresented populations.

The pursuit of empathy development in individuals outside of treatment, healthcare, or correctional settings also merits attention. Renier et al. (2011) suggested that society, as a whole would benefit from methods to increase empathy because many of society's ills ranging from violence to rudeness stem from a lack of empathy. With additional research, the field of psychology will also have the knowledge about individuals who demonstrate empathy deficits that is needed to educate the public about how to protect themselves from harm (Sharp & Vanwoerden, 2014). Cognitive empathy, also known as Theory of Mind or perspective-taking, may also serve to reduce bias towards others (Shih, Stotzer, and Gutierrez, 2013). The authors found asking research participants to imagine the perspective of fictional movie characters led to reduced prejudice towards not just the target group, but all others in an *us* versus *them* setting. Johnson, Cushman, Borden, and McCune (2013) reported similar findings in their research that used the perspectives of fictional characters to increase empathy and prosocial behavior. A recent study of perspective-taking further indicated that cognitive empathy's application to conflict resolution, therapeutic relationships, and political campaigns called for additional exploration (Goldstein, Vezich, & Shapiro, 2014). In their series of six related studies, the researchers discovered perspective-taking changed the attitudes and behaviors of the perspective-takers and encouraged prosocial behaviors in the participants who felt their points-of-view were understood. Caprara, Alessandri, and Eisneberg (2012) concluded empathic self-efficacy, the belief that one is capable of understanding the thoughts and feelings of another, was a key factor in individuals' choice whether or not to engage in prosocial behaviors.

Conclusion

This quantitative study investigated the use of character analysis techniques as means to increase cognitive empathy in study participants. The study was based on the assumption that mental health professionals could enhance their cognitive empathy skills, which could lead to more positive therapeutic relationships and contribute to individuals' readiness to create change. The theoretical framework proposed that the therapeutic relationship is a common factor contributing to positive therapeutic outcomes. The review of the literature also revealed an on-going debate about the definition, development, and measurement of empathy. The study of cognitive empathy and theory of mind emerged as a trend in the field, in part because of increased interest in individuals meeting the diagnostic criteria for placement on the autism spectrum or psychopathy. There appeared to be a renewed interest in empathy. Further, a review of recent literature indicated the use of theater and literary fiction were promising means for developing empathy.

The sample was attained via flyers on public bulletin boards on a private university campus. Individuals were eligible for inclusion if they self-reported being enrolled in undergraduate or graduate coursework and were 18 years of age or older. The final sample included 14 females and six males who ranged in age from 18-69. Twenty volunteer participants completed the IRI and the LET. Half of the sample participated in a character analysis training prior to completing the LET. There was a significant difference between the intervention group's mean IRI score (M = 20.10, SD = 4.89) and that of the control group (M = 14.40, SD = 5.13). The initial difference between the

groups could account for the failure to reject the null hypothesis. An analysis of covariance (ANCOVA) was used to analyze if participation in the character analysis training had a significant effect on volunteers' LET scores when IRI scores were controlled for. The results of this study did not show that character analysis training had a significant effect on cognitive empathy in study participants.

The findings and limitations of this study indicate the need for research design modifications. A sample two to three times larger than the one that was used could improve future research by increasing statistical power. Gaining the cooperation of a local college or university, partnering with a local chapter of a professional association, or exploring the feasibility of conducting the research on-line could recruit a larger sample. The study was also limited by the gender imbalance within the convenience sample. It is further proposed that while the institutional review board required this study to be as inclusive as possible, future study of the intervention should be replicated with the intended population, mental health professionals or interns. A sample drawn from the intended population, mental health professionals or interns, would also provide a focus for future research. Finally, the findings and limitations of this study evidenced the need for modifications to the LET and the possible addition of an intelligence measure.

Psychology has focused on empathy deficits in clinical populations. It has not kept pace with the medical field in the investigation of specific strategies for developing empathy in mental health professionals. Character analysis training could help individuals learn to imagine the world of another without becoming lost in it. Gaining a better understanding of how to teach empathy will provide individuals, communities, and

society as a whole with the strategies they need to create positive relationships and prosocial behaviors.

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Appendix: Character Analysis Training

Introduction to Character Analysis

Heather Chapman

Actors Prepare

Actors use a script, their own experiences, and their imaginations to attempt to understand the thoughts, feelings, and behaviors of a character.

The goal of this actor's "homework" is to create believable, realistic characters for their audiences.

Overview

- Motivation
- Objective
- Intention
- Obstacle
- Stakes
- Background and Status Quo
- Subtext

Motivation

- What the character wants in the long run
- *Why* the character does and says what he/she does
- Example: Chicken Little
- Example: Participants in this study

Objective

- What the character wants to happen next or in the immediate future
- Example: Cinderella's stepmother

Intention

- What the character wants right now.
- In a play or movie, what they want in the current scene or moment
- Example: Chicken Little
- Example: Cinderella's Stepmother

Obstacle

- The challenges/obstacles that stand in the way of the character reaching his/her goal
- Can be other characters, society, situations, or the character himself
- Example: Chicken Little
- Example: Cinderella's Stepmother

Stakes

- What the character stands to gain or lose
- Example: Chicken Little
- Example Cinderella's Stepmother

Putting it all Together

The Wicked Queen from "Snow White"

Motivation: To be the fairest of them all

Objective: Kill Snow White

Intentions: Get Snow White to eat the poisoned apple, distract/trap the dwarves

Obstacles: Snow White, the dwarves, the huntsman's conscience

Putting it Together

- Questions?
- Think about your favorite character from fairy tales, movies, television, books, or plays
- Can you name their motivation, objective, intentions, obstacles, and stakes?

Background and Status Quo

- Actors use the text and their imagination to create realistic characters
- The information helps put the character's actions, feelings, and thoughts into context.
- Things that help create this "biography" of the character include: time period, culture, occupational education, family/relationship status, health, personality and physical appearance.

Background and Status Quo (Cont.)

- Example: Cinderella's Stepmother
  - She was a single woman with two daughters before marrying Cinderella's father
  - She is now widowed
  - She is aging
  - Her daughters are not attractive; her stepdaughter is beautiful

  Combined with understanding her motivation, intentions, objectives, obstacles, and stakes...she becomes a real woman…not a caricature

Subtext

- The underlying meaning of a character's words & actions.
- Actions speak louder than words?
- It's not what you say, it's how you say it?
- Example: Hello (How many ways can this be said to express many different ideas?)
- Example: I love you.
- Example: No.

Wrap-up

What questions can I answer?