EMPATHY: A DISCURSIVE PSYCHOLOGICAL EXPLORATION OF THE CONSTRUCT WITHIN THE CONTEXT OF THE THERAPEUTIC RELATIONSHIP

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Thesis Abstract

Introduction: Empathy is considered to be an important therapist offered condition. Historically the exploration of empathy has employed quantitative methodologies. It is argued that these methodologies cannot capture the socially constructed nature of psychological concepts and instead regard empathy as problematic due to its inconsistently applied definition.

Objectives: This study aimed to explore therapists' discourse around empathy by employing a qualitative methodology and acknowledging the importance of context. A further objective was to encourage a theoretical and methodological shift in the way that psychological concepts are conceptualised and investigated.

Design: A discursive psychological approach was taken in the analysis of data from discussion groups.

Method: Discourse was collected from two discussion groups conducted at an NHS Primary Care Trust: the first with a group of clinical psychologists and the second with a group of cognitive behaviour therapists. In addition some documentary information was collected from the research site in order to contextualise the service.

Results: In both discussion groups, empathy was considered fundamental to the therapeutic relationship between the client and therapist. Therapists constructed empathy in two ways: as a limited therapist experience and as a quality that might develop over time. Further patterns emerged in the data; the clinical psychologists made

frequent use of case studies whereas the cognitive behavioural therapists cited research evidence and made use of theoretical models.

Discussion: The results are discussed with reference to a particular model of discursive psychology where the activity done through discourse is emphasised. It is argued that through particular constructions of empathy, therapists were working up their professional accountability. It is suggested that therapists work up their constructions of empathy as factual and therefore indisputable through discursive devices, identified as the use of case studies and research evidence.

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Table of Contents

Thesis Title Page	**Page 1**
Thesis Abstract	**Pages 2-3**
Acknowledgements	**Page 4**
Contents Page	**Pages 5-6**
JOURNAL PAPER	**Pages 7-45**
Journal Abstract	Page 8
Introduction	Pages 9-14
Method	Pages 14-19
Analysis and Discussion	Pages 20-36
General Discussion	Pages 36-39
Conclusions	Pages 39
References	Pages 40-45
EXTENDED PAPER	**Pages 46-141**
Extended Background	Pages 46-62
Extended Methodology	Pages 63-93
Extended Analysis	Pages 94-114
Extended General Discussion and Reflexive Section	Pages 115-125
References	Pages 126-141

APPENDICES **Pages 142-183**

Appendix A – IAPT Competency Document Page 142

Appendix B – Stepped Care Model Page 143

Appendix C – IAPT Competency Map Page 144

Appendix D – Screen Clippings Page 145

Appendix E – Participant Information Pack Pages 146-151

Appendix F – Interview Schedule Pages 152-153

Appendix G – Transcription Notation System Pages 154-155

Appendix H – Ethics Approval Letters Pages 156-165

Appendix I – Diagram of Analysis Page 166

Appendix J – Framework for Analysis Page 167

Appendix K – Publication Requirements (BJCP) Pages 168-169

Appendix L – Service Document Summary Pages 170-179

Appendix M – Extended Extract Pages 180-183

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Empathy: a discursive psychological exploration of the construct within the context of the therapeutic relationship

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Abstract

Objectives: This study aimed to explore therapists' discourse on therapeutic empathy. A further objective was to encourage a theoretical and methodological shift in the way that therapeutic empathy is conceptualised and investigated.

Design: A discursive psychological approach was taken for data analysis.

Method: Two discussion groups were conducted: the first with clinical psychologists and the second with cognitive behavioural therapists.

Results: In both groups, empathy was considered fundamental to the therapeutic relationship between the client and therapist. However, therapists in both groups identified limits to their experience of empathy with their clients. This created a dilemma which was reconciled by constructing empathy as a limited resource. Therapists used the presentation of case studies, extreme case formulations and category entitlement as discursive devices to present limits to empathy as factual. It was proposed that by legitimising limits to empathy, therapists were managing their professional accountability.

Conclusions: This study offered a novel approach to the exploration of empathy. It challenges the taken-for-granted assumptions about the nature of psychological concepts like empathy. Furthermore, it confirmed that conceptualisations of empathy are idiosyncratic and constructed live, rather than representing a universal truth. The implications for psychology professionals are discussed.

Introduction

This paper adopts a discursive psychological approach to explore the ways in which psychotherapists (clinical psychologists and cognitive behaviour therapists) talk about and make sense of empathy in the context of their relationships with their clients. It represents a move away from traditional cognitivist notions of language as being representative of some objective reality which leaks out in the process of interaction. Instead, interaction is seen as the primary site where psychological phenomena are constructed (Potter, Edwards & Wetherell, 1993).

Empathy is widely regarded as an important construct in psychology, with empathy deficits being implicated in a range of clinical disorders (Farrow & Woodruff, 2007; Mahrer, Boulet & Fairweather, 1994). Furthermore, empathy is considered to be fundamental to the development of an effective therapeutic relationship between the client and the clinician in counselling and psychotherapy. Empathy is one of three components identified in Rogers' (1957) 'triad' of therapist offered conditions regarded necessary in order to bring about therapeutic change.

Empathy first appeared in the English language at the turn of the 20th century as a translation from the German word *Einfühlung*. At its creation, the word carried no meaning; it was inert (Shlien, 2001). However, it has been reified through its use and through the context of its use.

Empathy in the context of the therapeutic relationship.

Much of the literature that has looked at empathy, and its role within the therapeutic relationship, is dated. This is perhaps symbolic of a general shift in research emphasis from the late 1980s, with psychotherapy research moving away from its focus on general therapeutic factors, towards efficacy studies (particularly in cognitive behaviour therapy) and clinical trials of psychiatric medication. It is useful however to provide a brief overview of the literature.

The publication of Rogers' work in 1957 generated a wave of research interest in therapist offered facilitative conditions (for reviews see Gladstein, 1983; Lambert, DeJulio, & Stein, 1978; Safran, Crocker, McMain, & Murray, 1990). Marks and Tolsma (1986) proposed empathy to be the most widely cited and studied process variable in counselling and psychotherapy. In their review however, they found inconsistent evidence for the role of empathy, leading them to conclude that its impact on outcome was not as strong as proposed by Rogers. Conversely, Lambert (1992) found that the therapeutic relationship, incorporating empathy, could account for more treatment change than the therapeutic modality; finding that up to 30% of the variance could be accounted for by the quality of the relationship alone. This would suggest that effective therapists are those who are, amongst other things, empathic towards their clients. As this brief review illustrates, there is mixed support for the role of empathy in the therapeutic relationship.

The problematisation of empathy.

Duan and Hill (1996) suggested that the mixed support might be accounted for by the numerous and varied operationaliations of empathy; if researchers are talking about and measuring different constructs then the research evidence generated will be inconsistent. On account of this variability being viewed as problematic (Clark, 1980; Marks & Tolsma, 1986; Sexton & Whiston, 1994) the empathy literature is replete with calls for a consistent and universal definition (Pedersen, 2008; 2009).

In this paper, it is argued that such variability is only problematic from an ontological position which seeks consistency as evidence of an objective reality. It is suggested that the epistemology which views language as a *window on the mind* (Edwards & Potter, 1993) is problematic and should be abandoned in favour of one in which variability is the central topic of interest. This is not a unique position; Edwards (1999) encouraged further exploration of emotional discourse in psychology stating that if people use concepts inconsistently, then that is precisely what we need to study.

An alternative epistemology, social constructionism, rejects the concept of a *universal* reality. Instead, people are viewed as constructing *versions* of reality which are specific to a particular time, place and culture (Gergen, 1985). Gergen (1994) identified as a basic assumption of a social constructionist science, that "the terms by which we account for the world and ourselves are not dictated by the stipulated objects of

such accounts" (p. 49). This is in keeping with the main tenant of this paper; empathy is socially constructed thereby accounting for its variable definitions and this should be the research focus. Therefore, this study proposes a departure from what has been the traditional approach in psychology, towards an approach that views language as constructive.

Methodology: discursive psychology.

Cameron (2001) regarded discourse analysis as an *umbrella term* for a group of methodologies. These methodologies represent the move away from the traditional positivist view of language outlined above. Potter (2003) defined discourse analysis as "...the study of how talk and texts are used to perform social actions" (p.73). According to Wetherell and Potter (1988), discourse analysis is essentially about developing theories about the purposes and consequences of discourse. They argued that since variation is the consequence of language being orientated towards different functions, it can be used as a clue in identifying these functions.

Discursive psychology as defined by Potter (2003) is the application of discourse analysis to the investigation of psychological phenomena. Discursive psychology was developed by the Loughborough School[1], represented by Jonathan Potter, Derek Edwards, Margaret Wetherell and colleagues. Potter, Edwards and Wetherell (1993) argued for a

[1] Loughborough University Discourse and Rhetoric group.

"distinctive discursive psychology" (p. 384) to mark the constructionist shift in research paradigm, which is gaining currency throughout psychology. Edwards and Potter (2005) outlined how discursive psychology can be utilised to "explore the situated, occasioned, rhetorical uses of the rich common sense psychological lexicon or thesaurus" (p. 241). Willig (2008) regarded discursive psychology as being concerned with how particular versions of reality (i.e. particular definitions of empathy) are manufactured, negotiated and deployed in conversation. It is argued that the application of a discursive psychological approach to the exploration of the construct of empathy would produce an understanding of the processes through which empathy is talked into being. Furthermore, Spong (2010) suggested that by adopting an analytical approach based on models of usefulness rather than models of truth, discursive psychology can help counsellors and psychotherapists to critically explore their discipline and practise.

Discursive psychology has been applied to the exploration of a range of psychotherapy related phenomena: Seymour-Smith (2008) explored men and women's presentation of their self-help group identities; Bysouth (2007, unpublished doctoral thesis) explored how bipolar disorder *gets done* during the course of psychotherapy sessions; and Antaki (2004) deconstructed the concept of Theory of Mind (ToM) and the 'taken-for-granted' claim that it can be checked against a known object as a model to explain clinical diagnoses like Schizophrenia. Antaki concludes that when people use terms such as ToM, they should be seen as *doing* something, not merely reporting something. Therefore

discursive psychology provides an approach which is well suited to the aims of this study:

1. To explore the construct of empathy
2. To do so in an operationally defined context
3. To apply an appropriate language based methodology

Method

The data for this study consisted of audio recordings from two discussion groups conducted with therapists[2] at the research site.

Recruitment.

Therapists were recruited from a Primary Care Mental Health Trust (PCT). Within the service two groups are represented: Clinical Psychologists[3] and CBT therapists. The inclusion criterion was any therapist engaging therapeutically with users of the service at the time of recruitment.

The researcher was introduced to therapists during departmental business meetings. During the meetings, information packs containing further information about the research, were distributed.

Participants.

Seven therapists volunteered to take part in the study; four clinical psychologists and three CBT therapists (see tables one and two).

[2] *Therapist* will be used throughout the paper where participants are referred to collectively.

[3] Because of the awkwardness of repeating the full title *clinical psychologist* and *clinical psychologists*, at times the *clinical* prefix has been dropped in favour of *psychologist* or *psychologists*.

Therapists were divided into two discussion groups for the following reasons: first, the optimum number of participants for a discussion group is considered to be between three and four members (Willig, 2008); second, the participants fell into two professional groups, psychologists and CBT therapists; and third, the psychologists met together in an established group providing an opportunity to utilise this format for the research (see extended methodology). This led to different procedures being followed in the groups and therefore, they will be discussed separately.

Table 1: descriptive information about therapists in discussion group one (clinical psychologists)

Therapist ID	Gender	Length of time qualified	Therapeutic orientation(s)
C1	M	1-3 years	Community Psychology/ Narrative/ Integrative
C2	F	1-3 years	Narrative/ ACT/ Mindfulness
C3	F	1-3 years	Integrative
C4	F	Less than a year	CBT

Table 2: descriptive information about therapists in discussion group two (CBT therapists)

Therapist ID	Gender	Length of time qualified	Therapeutic orientation(s)
T1	F	1-3 years	CBT
T2	F	Less than one year	CBT
T3	M	Less than one year	CBT

Interview schedule.

The interview schedule was used only in the discussion group with the CBT therapists. A list of five questions was developed covering the following broad areas: the nature of empathy; whether empathy can be learnt; was empathy was covered in therapists' training; therapists' use of empathy in their work with clients; and the importance of empathy in the therapeutic relationship. The development of the interview schedule was informed by a pilot study (further details are contained within the extended methodology).

Procedure.

Discussion group one: clinical psychologists.

Discursive psychology favours naturalistic data (Edwards & Potter, 1992; Willig, 2008). There was an opportunity with the clinical psychologists to gather partially naturalistic data, i.e. in the absence of the researcher. The psychologists regularly met as a professional group for reflective practice sessions (RPS) where they would discuss various topics relevant to their practice. This matched the aims of the discussion group.

On the day of the RPS, the researcher met briefly with the psychologists to gain consent, set up the recording equipment, and set a topic for discussion. Directly following this, the researcher left the room. Psychologists were then able to talk freely and direct the flow of the discussion without interference. The topic for discussion was

presented on a sheet of A4 paper as follows: *what is empathy within the context of the therapeutic relationship.* A member of the discussion group operated the voice recorder.

Discussion group two: CBT therapists.

Unlike the psychologists, the CBT therapists did not ordinarily meet as a group. Therefore the researcher facilitated the discussion group using the interview schedule. After each topic was presented, therapists were able to self-direct the focus of the discussion without any further prompts. Each subsequent topic was introduced once the previous discussion had come to a natural pause (indicated by a break of five seconds or more).

Transcription and analysis.

Both discussion groups were recorded using a digital voice recorder in order to allow for the transcription of the recordings; an adapted version of the Jeffersonian transcription notation system was used for this purpose (Rapley, 2007; appendix G).

Discursive psychologists argue that there is no rigid step-by-step guide to analysis; rather it represents a critical interrogation of the data (Potter & Wetherell, 1987). In order to maintain transparency, what follows is a brief outline of the analytic approach adopted. The first author familiarised herself with the data through repeated readings of the transcript. In the initial stages, the aim was to identify patterns in the way that empathy was constructed. This included looking for how

therapists defined empathy and characteristics they applied to empathy. Any patterns that emerged were transferred into data files. Potter and Wetherell (1987) refer to this process as coding. The final process was to approach the analysis with the following questions posed by Potter and Wetherell, "why am I reading this passage in this way [and] what features produce this reading?" (p. 168).

Ethics.

Ethical approval for the study was gained through Nottingham Research Ethics Committee and a local NHS Research and Development department (R & D)[4] (see appendix H). Informed consent was gained from the participants that included permission to record the discussion group and to use quotes in the dissemination of the study findings. Participants were informed that quotes would be anonymised through the use of an alphanumeric code.

Quality issues.

It is widely recognised that the quality criteria of validity and reliability adopted in traditional positivist psychological investigation, are not suitable for analyses which depart epistemologically from this tradition (Antaki, Billig, Edwards & Potter, 2003; Madill, Jordan & Shirley, 2000). However, it is good practice to address quality issues in qualitative research. Qualitative research has tended to draw on criteria which reflect the particular epistemological concerns of the research (a full

[4] I have not revealed which R & D department gave ethical approval in order to avoid compromising the anonymity of the participants.

review can be found in Madill el al., 2000). In response, this study aimed to meet the quality criteria set out by Potter (1996a) for discursive psychological research. These include internal coherence, participants' understanding, and openness of the analysis to reader evaluation.

Internal coherence refers to the degree to which the analysis tells a coherent story. The analyst also measures analytic interpretations against participants' own understandings. For example, does the participant orient to another's talk in a way that is consistent with the reading of the talk? Reader evaluation enables the reader to critically evaluate the analysis based on the data presented in support of the analysis. These points will be illustrated in the analysis and discussion.

Additional measures employed to maintain quality included keeping a reflexive journal, maintaining a reflexive stance throughout the paper and acknowledging the non-neutrality of the findings by recognising that the analyst is also responsible for construction (Horton-Salway, 2001).

Analysis and Discussion

This analysis section presents data from a larger study. Only selected findings are presented and discussed here (please see extended analysis and discussion). In the analysis that follows, extracts from the discussion groups have been used to illustrate the arguments presented. This serves to aid reader evaluation (Potter, 1996a). Each

extract is numbered and its location in the main transcript is identified by line number.

The analysis focuses on two related constructions of empathy, *empathy is limited by therapist fatigue* and *empathy is limited by the therapist's moral code*; both are captured under the broader interpretative repertoire[5] of *empathy is a limited therapist experience*. The focus of the analysis section on this repertoire seemed appropriate given that it permeated the data. Furthermore, the identification of this repertoire was considered analytically interesting given the general consensus outlined in the literature that 'good' therapists are empathic therapists (Lambert, 1992). Moreover, therapists themselves talked about empathy as a 'fundamental' (T1, line 736) or at the very least an 'important' (C2, line 704) aspect of the therapeutic relationship. If good therapists are deemed to be those who are empathic, what happens when a therapist reports not feeling empathic towards their client? Does this make the therapist a bad therapist? Seymour-Smith et al. (2002) identified dichotomous categories such as 'good versus bad' as a common feature of psychological discourse. As such, in line with a discursive psychological approach, consideration was given throughout the analysis to the function of the broader repertoire.

[5] Potter and Wetherell (1987) define interpretative repertoires as "recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena" (p. 149)

Empathy is limited by therapist fatigue

Extract one is taken from discussion group one. Immediately prior to this section of the discussion, the group has been talking about what their clients would say if asked 'what is empathy within the therapeutic relationship', the question set for the discussion group,

Extract 1

838.**C2:** yes that's very true (.) yeah we know what empathy

839. is <u>not</u>

840.**C4:** yeah

841.**C2:** ((laughs))

842.**C4:** it seems much more obvious though doesn't it

843. ((.....someone enters room to ask for directions....)) but

844. then I wonder if that is about your own emotions as well

845. and how you're feeling (and where you are) cos I there's

846. definitely even with the same person you can (1) have a

847. session where you just think I can't I haven't I just

848. haven't got it today and I can't give it today

Here, empathy is identified as limited, almost as if it is a resource that can be worn out with too much empathising. This is offered as a reason for not always empathising despite the recognised importance of empathy in the therapeutic relationship. In lines 847 and 848, C4 talks about sessions where you haven't got 'it' (the capacity to empathise). She talks about 'sessions where you just think I can't I haven't', and then rephrases using the extreme case formulation (ECF, Pomerantz, 1986)

'I *just* haven't got it today'. Pomerantz identified a number of situations in which an ECF might be used in order to portray a series of events as believable, obvious or compelling (these are discussed further in the extended paper). The extreme case formulations are so called because they provide the strongest version of a claim to bolster against scepticism. For example C4 doesn't stick with her initial response of sessions where you haven't got empathy; she makes it stronger and more compelling by the use of 'just' in line 847, and 'haven't got it *today*' as opposed to haven't got it per se. Through this we experience C4 as presenting a convincing version of empathy as being a limited resource, rather than experiencing her as covering for her lack of ability to empathise. This argument is further developed in the next section of the discussion group shown in extract two. Here the idea of empathy being limited by therapist fatigue is further developed where empathy is spoken about as something that can be limited if the resource is already 'drained' (first introduced in line 863).

Extract 2

853.**C2:** is it also dependent on what else going on for you

854. as well so if you've got something else going on that's I

855. think that's <u>particularly</u> taking your emo your emotions

856.**C4:** yeah

857.**C2:** not if you're just busy but you've got something

858. <u>emotional</u> going on in your own <u>life</u>. and I've had the

859. sessions where I've thought I am not emotionally I've got

860. no sort=of emotion left

861.**C4:** yes

862.**C2:** been really

863.**C4:** yes it's being drained off something isn't it when

864. you've got that feeling of being drained of it that's what I

865. am just wondering are you're drained of it

866.**C2:** drained of empathy

867.**C4:** {yeah

868.**C3:** {it's like you've got a resource and it's already been

869. sucked out of you and then you are put into a room with

870. like here's your six people for today

871.**C4:** yeah

872.**C1:** be empathic

The idea of being drained is repeated a further three times in lines 864 to 866. In line 868 C3 identifies empathy as a resource open to therapists which can become depleted or 'sucked out of you' (line 698) if called upon too much. Here the responsibility for empathising is not allocated to the therapist; the therapist is not reported as a 'bad' therapist for not empathising. Instead, when C2 says in line 858 that this limit to empathy occurs when you have something emotional going on in your own life, she is accounting for the limits to empathy rather than assuming blame for not being empathic enough. In line 855, C2 uses an extreme case formulation with the reference to something going in one's own life that's *particularly* taking up your emotions. Here it cannot be

confused with just a daily variation in empathy at the whim of the therapist. In fact, C2 suggests that it is not 'if you're just busy' (line 857); rather it is described as something more important than this. It works to set the account up as unbiased and gives it its "out-there-ness" (Edwards & Potter, 1992, p.105). This does the rhetorical business of making the account factual which counters any possible suggestion that the therapist lacks empathy because they are a bad therapist. What is interesting is how C2, C3 and C4 orientate to each other in this extract. Each therapist's response in this interactional sequence appears to confirm the others'. For instance, C4 introduces empathy as being 'drained' following C2's talk of something that's 'particularly *taking* your emotions' (line 855) and where 'I've got no emotion left' (lines 859-860). C4 says 'it's being drained off something' (863); C3 concludes with 'it's like you've got a resource and it's already been sucked out of you' (lines 868-869).This provides evidence of Potter's (1996a) quality criterion of participants' understanding. Potter states that this is achieved if the participant orientates to another's talk in a way that is consistent with the reading or interpretation of the talk. Here it is argued that the therapists are doing just this.

Empathy is limited by the therapist's moral code

Extract three is taken from discussion group one. This extract comes after C1 identifies the idea of finding it harder to 'connect' to some clients than others.

Extract 3

112.**C2**: that <u>can</u> be harder with different things though can't

113. it? like with different people somehow I don't know like I

114. do find there's certain things (.)

115.**C3**: {MMMM

116.**C2**: {which bring out empathy in me and maybe it is cos

117. it touches a chord in me and maybe it is {because it erm

118. just seems sort=of objectively (.5)

119.**C3**: {mmmm

120.**C2**: upsetting or difficult but I think there is certainly

121. some other things that sometimes I would struggle to get

122. to that point where it's harder to understand (2)

[lines omitted]

199.**C2**: I think it is hard and also if someone presents with

200. something that confli::cts with your kind=of wo::rld vie::w

201. erm so you know I've had <u>clients</u> where I have struggled

202. to find empathy because of their presentation I suppose

203. so

Here the idea of different moral values is introduced. C2 identifies the experience of working with clients where there is a conflict in world views. C2 presents the construction of empathy as a limited experience in relation to the therapist's 'moral code', suggesting that it is difficult to empathise with a client whose presentation conflicts with one's moral values.

A further example of this construction is presented in extract four from discussion group two.

Extract 4

198.**T1:** cos we were talking about weren't we

199. kind=of could we could we see criminals could

200. could would our empathy stretch that fa::r (.)

201.**T3:** mmm

202.**T1:** erm (.) er I if if you could learn empathy then

203. you would be able to but as a human being I

204. don't know if I could (1) see what I mean=

205.**T3:** =mmm (2)

T1 talks specifically about the ability to see criminals for psychotherapy. Although not explicitly stated, unlike in extract three, T1 is grappling with the notion that empathising with a criminal would be more difficult. With her statement, 'would our empathy stretch that far' (line 200), T1 like C2 is identifying that it might be harder to empathise where the client's moral code differs from the therapist's. In the way that T1 talks about 'criminals', she is setting them apart from the therapists. Criminals are identified as a distinct group contrasted with the category 'human being'. This sets up a further dichotomous category; 'us versus them'. This perhaps makes not empathising with them (criminals) an understandable and factual occurrence. She draws on the other group members to identify with her such that she is not perceived to be

isolated in this view, 'as a human being I don't know if I could' (line 204), and then invites a response with 'see what I mean'.

Together, the first four extracts construct empathy as an unstable, variable experience for the therapist. A feature of this discourse is that in all four extracts, rather than saying 'I do not experience empathy for all my clients all of the time', therapists do this in a less direct way i.e. through their construction of empathy. This is a feature identified by Edwards and Potter (1993) who suggested that people perform attributions indirectly or implicitly. This is related to what Edwards and Potter (1992) referred to as the dilemma of stake and interest. This will be discussed in detail in the next section where further features of the discourse are identified.

The use of vivid description discursive device: the case study

A further pattern that permeated the data was the use of case studies alongside therapists' constructions of empathy. In total, ten case studies were presented. Extract five immediately follows from extract three. Taking these extracts together, the sequence of construction and factual accounting done through the case study (vivid description) can be seen. This sequencing was repeated throughout the data.

Extract 5

205.**C2:** {erm I've had a client recently who has made lots of
206. very racist and sexist comments (.5) you know was
207. saying that he wanted help with erm stopping calling all

208. his friend's partners (.) you know fat and ugly and you

209. know I was kind=of well hang on a minute (inaudible)

210. how do I sort=of

211.**C3:** {mmm

212.**C2:** {hap but and it was only when Ii like you said **C1**

213. when you erm kinda got to::: when I got to know him a bit

214. more and knew a bit more about his background and the

215. kind of things that had happened to <u>him</u> and that then I

216. could fi::nd some kind=of empathy for him erm but

217. initially I didn't feel any? at all

C2 uses the ECF in talking about the client who 'has made lots of *very* racist and sexist comments' (lines 205-206). The organisation of the ECF into the case-study format strengthens the factual reporting. Edwards and Potter (1992) described the vivid description as being both rich in contextual detail and designed to create the impression of a perceptual experience, i.e. as factual and free from personal bias. According to Horton-Salway (2001), discursive devices are deployed precisely when there is a contentious or sensitive issue. It is interesting then that it appears here following the delivery of a construction of empathy which is consistent with the repertoire of empathy being a limited therapist experience, a repertoire which is incongruous with the notion that good therapists are empathic therapists. Accordingly, discursive devices manage the issue of stake and interest. For example, Edwards and Potter (1993) considered that people generally view others accounts as invested or motivated in some way. As such there is

the risk that an account can be discredited on this basis. This is referred to as the dilemma of stake or interest. To manage this dilemma people show that their reports are justified or warranted by the facts rather than prejudiced or biased through 'factual' reporting, which is achieved by discursive devices. Precisely what issue of stake and interest is being accounted for by this factual reporting will be discussed shortly.

The vivid description discursive device is linked closely with the 'narrative' discursive device (Edwards & Potter, 1992) where the plausibility of a report can be increased by embedding it in a particular narrative sequence. It appeared that generally they were deployed following the construction of empathy as a limited experience. The sequence is presented in the following way: first the construction (empathy as a limited experience); followed by the case study which presents the construction of empathy as factual and free from bias; finally the construction is restated. According to Edwards and Potter (1992) the presentation of the vivid description and narrative discursive devices together, provide the opportunity for the fusing of event description and causal explanation. Therefore, the speaker is *doing* attributional work through their talk; attributing blame to the client depicted in the case study for not feeling empathy. A further example of this attributional work and the sequence of construction-case study-construction is illustrated in extract six.

Extract 6

170.**C4:** whereas surely we've all been in situations

171. where we've worked with somebody we don't (2) we you

172. know we might see it differently but (.)

173.**C1:** mmm sure

174.**C3:** guess you have to come to some sort=of shared

175. understanding of what's happening (.5)

176.**C4:** but I think it's still bou::ndaried

177.**C3:** mmmm

178.**C4:** I I've found that erm

179. whens well I just to kind=of give an example so I've

180. just seen somebody who:: (2) talked a lot abou::t erm a

181. certain amount of sexual prowe::ss that they had und

182. talked about certain things that they've done und and

183. that clearly wanting to change etcetera but I've got to

184. admit as I and >I don't know whether I've kind=of put it

185. down to well I've< only seen this person the once so this

186. is going to take time but actually I found myself making

187. some moral (.5) judgement

188.**C3:** {mmmm

189.**C4:** {and actually it was harder for me to then empathise

190. with that person just purely because of what they were

191. coming out with was making me feel I (.5)

C4 starts this section of talk by stating 'surely we've all been in situations where..." (170-171). Potter (1996b) identified this pattern in discourse as a "stake inoculation" (p. 125). Where there is a contentious or controversial issue and where the discussant's view might be taken as invested or biased, descriptions are constructed to head off this conclusion. Here C4 is inviting the other discussants to identify with her and her experience before presenting the vivid description and finally the construction of empathy as limited stating, '...and actually it was harder for me to then empathise with that person...' (line 189). In much the same way as illustrated by C3's identification in extract three of conflicting world views (line 200), C4 identifies the possibility that 'we might see it differently' (line 172). It is following this that C4 presents a case study which describes a client who is boastful about their sexual prowess. This vivid description is designed to create a reaction in those that hear it, as in extract five.

The category entitlement discursive device

A final pattern that emerged was frequent reference to psychological models, previous experience as therapists, and the therapeutic literature. Edwards and Potter (1992) discovered that much of the time, the validity of a particular report will be secured through category entitlement. For example, in society, certain people (i.e. category members) are expected to have access to particular skills or knowledge. Often category membership is worked-up by the speaker. As such, it is argued that therapists were working up their category entitlement to

specialist knowledge about empathy through the presentation of their knowledge, skills and experience. As a result, when they construct empathy as a limited resource, they are not assumed to be biased in this construction.

Extract seven contains therapists' references to knowledge and skills, therapeutic literature and psychological models (further examples are provided in the extended paper).

Extract 7

678.**T3:** it drives me:: (.) it drives me nuts some
679. some some some of the myths about CBT
680.**T2:** oh::: I know (we use all of this)
681.**T3:** I've got a friend of mine he he's doing a
682. person-centred counselling course at the
683. moment and his tutors have been just absolutely
684. destroying CBT and it's like and see they they
685. don't give a damn about (their clients) and I'm
686. like any therapeutic relationship you cannot avoid
687. it you cannot avoid these things you know
688.**T2:** we use aspects of everything call it whatever
689. you will
690.**T1:** it's all been relabelled {hasn't it
691.**T2:** {it is it is the whole
692. thing the whole thing is always relabelled and we do use
693. psychodynamic there are here you look at their

694. personalities as the development and we do use

695. person-centred a::lways {don't we humanistic

696. yeah you know CBT CBT's just techniques isn't it

697. really

698.**T3:** {can't not

699.**T1:** yeah just applying all that plus the

700. techniques

The function of the repertoire *empathy is a limited therapist experience*: Professional accountability

From a discursive psychological perspective, constructing empathy as a limited therapist experience is doing something beyond the words used; it is performing an activity (Gergen, 1985; Potter, 2003)

As Gilbert and Mulkay (1984) suggested, the analyst cannot know what activity is performed by participants' constructions. However, through familiarity with the data, theories can be developed about the function these constructions are designed to serve. In suggesting the activity being done by the discourse, the analyst is not falling into the trap of "cognitivism in through the back door" (Potter et al., 1993, p. 387) as the analyst is said to be agnostic with respect to issues of planning or real motive (Heritage, 1984). Furthermore, Potter et al. (1992) state that the analyst is not making assumptions about what activities versions are constructed to *do,* but merely recognising that what people say is not representative of an underlying cognition.

Through the detailed reading of the data, possible interpretations of the function of the construction can be suggested and the reasons for reading the discourse in this way identified (Potter & Wetherell, 1987). The reading of the therapists' construal of empathy as a limited experience was that it possibly legitimated not feeling empathy. As referred to previously, Seymour-Smith et al., (2002) considered "dichotomously constructed categories" (p. 262) as a naturally occurring feature of discourse; if one is not a *good* therapist, then one must be a *bad* therapist. This would be challenging to a therapist's professional identity.

The idea that therapists report not empathising with clients as an uncomfortable experience is illustrated in a final extract. This extract is part of a much longer section of the transcript (please see extended paper - appendix M). Within this extract what is particularly salient is the reported emotional impact of this therapeutic encounter. Here we see many of the characteristics identified throughout this analysis; the use of the ECF, vivid description, stake inoculation, and narrative sequencing. Furthermore, in this extract C2 talks about her emotional response to the client but also she describes her empathy as very variable, such that you could chart the empathy.

Extract 8:

519.**C2:** I feel like I mean I'm I don't know if this is a good

520. example but erm I've had a erm client recently where

521. this I think if you you could sort of almost chart the

522. empathy

[Lines omitted]

532. and right near the end

533. she's gone back to the GP and said actually what I

534. wanted right at the beginning she hadn't mentioned to

535. me (inaudible) it hasn't been brought up is this ADHD

536. assessment

[Lines omitted]

551. she started shaking and saying >I can't take much more

552. of this can't take much more of this< got this book out

553. about ADHD with all these little (.) slips in it and was

554. crying and crying saying you know you don't understand

555. you've got to you know erm at that point I was like

556. <u>wooow</u> I've been so far away and I just felt like really

557. terrible afterwards I was like God I've just totally and then

558. when we started talking about it she was telling me all

559. these things that I <u>never</u> knew before that I had no idea

560. about that I hadn't asked about

[Lines omitted]

568. and

569. you know in a sense I felt like that at that level she was

570. saying YOU'RE NOT EMPATHISING WITH ME <u>AT ALL</u>

[Lines omitted]

598. I felt really awful

On line 570, C2 makes use of 'active voicing' (Johnstone, 2008). This animates her account of her client's emotional distress and the assertion 'you don't understand' (line 554). In line 570 C2 reports what she felt the client was saying with the accusatory and loud 'YOU'RE NOT EMPATHISING WITH ME AT ALL'; she draws out the salience of the client's evaluation of her as not understanding via the morally accountable absence of the professional psychological activity of empathising. Furthermore, she concludes with the statement, 'I felt really awful' which contains the ECF (line 598) to emphasise that this encounter has had an emotional impact on her.

General Discussion

This study had three aims: to explore the construction of empathy; to do so in an operationally defined context; and to apply an appropriate language based methodology.

The main repertoire that pervaded the discourse was one of empathy being a limited therapist experience rather than a global and stable orientation to the client. This was considered analytically interesting in view of the well accepted notion that effective therapists are empathic therapists. One pattern that emerged was the way in which therapists talked about empathy being limited by therapist fatigue. *Empathy fatigue* is a phenomenon which has been identified in the therapeutic literature. Stebnicki (2008) stated that "as professionals, we are constantly in a state of disaster preparedness and mental health disaster response. As a consequence, we are emotionally, physically,

spiritually and vocationally exhausted. I would propose that many of us are experiencing empathy fatique" (p. vii).

Furthermore, given the discursive psychological focus on the function of constructions, the construction of empathy as a limited resource was explored. The interpretation of the function of this construction is that therapist were legitimating not feeling empathic at all times and for all clients, in order to do professional accountability; a finding that is repeated in the broader discursive literature (Robertson, Paterson, Lauder, Fenton & Gavin, 2010).

Therapists made their construction of empathy as a limited experience, appear factual through factual reporting including the use of discursive devices that manage the issue of stake and interest. Interestingly, psychologists tended towards the vivid description discursive device whilst the CBT therapists appeared to build up their category entitlement through frequent reference to psychological models, the literature or their previous experience as therapists.

Limitations and suggestion for future research

A potential limitation of this study was the use of different procedures in the groups. This procedural difference was not accidental; it was a design feature utilised to take advantage of the opportunity to collect naturalistic data in psychologist group. This was not problematic epistemologically, however, it is certain to have impacted on the variability of the findings and potentially the means through which

therapists in the different groups *did* professional accountability. For example, if therapists were doing professional accountability as a defence of their practice, the presence of an external researcher (a trainee clinical psychologist) may have impacted on how therapists defended their practice in this group. Furthermore, it is possible that once a case study was used by one participant in the psychologist group (first appearing at three and a half minutes into the discussion), others in the group conformed to this style of professional accounting. Therefore, this could have been a feature of the way in which the groups were set up and therefore influenced by the research process and group culture or a feature of some alternative factor like the way in which therapists are trained in their individual professions. Future studies might consider exploring this further.

This study focused specifically on therapists' construction of therapeutic empathy. One question which has been left unanswered by this project is how therapists *do* empathy in the course of their therapeutic practice. This would be an interesting extension to this study.

Interaction is an important aspect of discourse according to Potter (2006). This is symbolic of the influence of conversation analysis in discursive psychology. Unlike many studies that have taken a discursive psychological approach to the exploration of psychotherapy, this study didn't focus on interactions in the analysis. However, there are times where this interaction is evident. Further analysis of this interaction would have been interesting.

Finally, given that this study focused on therapists' constructions of empathy, it would be interesting to conduct a similar study exploring how users of psychotherapy services construct empathy.

Conclusions

To our knowledge, this is the first discursive psychological exploration of therapeutic empathy. As such this paper represents an original detailed examination that specifically attends to how empathy is actively constructed during therapists' talk. It produced an interpretation of the function of therapists' construction of empathy as a limited rather than global, stable orientation to the client as is commonly reproduced in the therapeutic empathy literature. It is hoped that through this process, the social nature of the construction of psychological terms, used in every day psychological talk, can be recognised and that rather than searching for a universal definition of such terms, we should be concerned with the effects these constructions serve. Specifically, it has been considered here that therapists do a great deal of professional accountability in their talk with other psychology professionals. It is wondered whether in fact, the identification of psychological terms and their usage in therapeutic contexts provides little more than this.

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EXTENDED PAPER

Part One: Extended Background[6]

1. Section Introduction

In this review I will draw on past and current literature that has influenced the understanding of the psychological construct of empathy. I will introduce the history of empathy and I will draw on the literature to consider the importance of the construct in psychology. This includes the two ways in which the construct has been used psychologically: as a deficit model in various psychopathologies, and as a facilitative condition within the therapeutic relationship linked to positive outcomes in psychotherapy. I will review the difficulties frequently encountered in relation to the construct of empathy within these contexts. This will include consideration of the methodological difficulties which have arisen in research into the construct, specifically problems with the definition of empathy; this will provide the focus for the current study. This study will advocate a different approach to the exploration of the construct than has been taken historically. This requires sensitivity to the epistemological position which informs this study.

My clinical interest in empathy came out of a previous research project into empathy. Like some of the literature that will be cited in this review, I considered empathy deficits to be related to violent offending. At this point I became aware of the problems with the definition and

[6] Throughout this paper I will be writing in the 1st person. This is common practice in discursive papers and my use of the 1st person serves to prevent myself (as the researcher) from appearing detached from the research process (Parker, 2003).

measurement of empathy which drew my interest to understanding this further. My focus this time is not on the literature around empathy deficits but on the therapeutic use of empathy within the therapeutic relationship. This will be reflected in the balance of the literature referred to in the literature review with a bias towards the literature in relation to the therapeutic relationship. I include consideration of the literature in relation to the deficits in empathy purely to highlight the importance of empathy as a psychological construct. This decision to focus on empathy in the therapeutic relationship comes from the recent moves to develop services in primary care mental health teams (Improving access to psychological therapies) which advocate a model of cognitive-behaviour therapy use at its core. An intervention, it has been argued, for which a positive therapeutic relationship is less important to a positive outcome (Bergin and Strupp, 1972). I have a natural curiosity about the impact of this on a service which has been designed around specific treatment outcomes. This review will start by looking at the history of empathy as a psychological construct.

1.2. History of empathy.

The history of empathy is as complicated as the confusion that now surrounds the word. Empathy first appeared in the English language 100 years ago as a translation from the German word *Einfühlung*[7]. According to Duan and Hill (1996) in their review of the literature on

[7] Throughout the thesis I will be using italics where I am presenting foreign words; this is in contrast to other emphasis that I am adding, which will be in the form of single speech marks; double speech marks will be used for direct quotes only.

empathy, Robert Vischer, a writer on the philosophy of art, should be credited with the first use of Einfühlung late in the 19th century when German aesthetics moved from artistic appreciation of objects to the working of the mind. This conceptual notion of Einfühlung was given by Lipps in 1905 to mean "the tendency for the perceivers to project themselves into the object's perception" (Lipps as cited in Wispé, 1986, p.316). This can be viewed as the first application of Einfühlung to psychology.

The literal translation of Einfühlung is 'in-feeling' or 'feeling into' (Shlien, 2001). According to Shlien the confusion surrounding empathy emanates from a linguistic oddity within the German language where two or more words are combined into one word. When 'in-feeling' became one word, it was capitalised as are all German nouns (Einfühlung) and it became a new word and a new concept.

The term *empathy* was first coined by Titchener in 1909 from the English translation of Einfühlung (as cited in Wispé, 1986). Titchener defined empathy as a "process of humanizing objects, or reading or feeling ourselves into them". Titchener's definitions of empathy introduced empathy into psychology.

1.3. Empathy and psychology.

It is generally agreed that Empathy is an important construct in psychology. A selection of the literature will be reviewed to highlight it's

filtration into a number of sub-disciplines within psychology, ultimately leading to the rationale and framework for the present study.

First, it is important to identify that there are two distinct branches of research into empathy as a psychological construct. The first initiated by Southard in 1918 uses empathy as a mechanism to understand psychopathology (cited in Mahrer, Boulet & Fairweather 1994). The second, introduced by Rogers' seminal paper 'The necessary and sufficient conditions of therapeutic personality change', focuses on empathy as a necessary condition for therapeutic change within the therapeutic relationship (Rogers, 1957).

1.4. Empathy as a mechanism to understand psychopathology.

Empathy deficits have been implicated in a number of mental health disorders. The impact of these deficits has been considered so widespread that Farrow and Woodruff (2007) devoted a book to understanding the implications of empathy deficits in mental illness. Within the book there are chapters covering a broad range of disorders including personality disorder and offending (Blair, 2007; Dolan & Fullam, 2007), psychosis (Lee, 2007) and developmental disorders (Gillberg, 2007; Hobson, 2007). Consideration is also given to the neural correlates of empathy by looking at brain activity during empathising (Decety, Jackson & Brunet, 2007; Farrow, 2007; Jones & Gagnon, 2007; Morrison, 2007) and deficits in empathy following brain injury (Shamay-Tsoory, 2007). Clearly many of the difficulties associated with empathy deficits would come to the attention of

psychologists in everyday practise in a number of sub-disciplines of psychology: forensic, developmental and clinical.

A review of the literature in these areas is beyond the remit of this literature review. However, Jolliffe and Farrington (2004) provide a comprehensive review of the literature in relation to violent offending and empathy deficits. Simon Baron-Cohen is a prolific writer on autism and theory of mind deficits; theory of mind has been considered as the cognitive component of empathy (Baron-Cohen, 1995). Reference to empathy deficits in psychosis and schizophrenia have been understood as a deficit in social cognition which again has been viewed as the cognitive component of empathy, "the mental operations underlying social interactions, which include the human ability and capacity to perceive the intentions and dispositions of others" (Penn, Roberts, Combs, & Sterne, 2007, p. 449).

1.5. Empathy and the therapeutic relationship.

I will start by providing an operational definition of the therapeutic relationship (TR) for the purpose of clarity in this review, taking the lead from Sexton and Whiston (1994). I consider the TR simply as the presence of two people who are engaged in a psychological contract (Rogers, 1957).

After many years of engaging in psychotherapy with individuals' in distress, Rogers (1957) became interested in the conditions within the TR which brought about therapeutic personality change. Considering

his own clinical experience and talking with his colleagues, Rogers identified six conditions which he felt were basic to the process of personality change: the presence of two people who are "in a psychological contract" (p. 96); the first of these people, the client, is to be in a "state of incongruence" (p. 96), being vulnerable or anxious; the second, the therapist, is to be congruent or integrated; the therapist experiences *unconditional positive regard* for the client; the therapist experiences an *empathic understanding* of the client's frame of reference; there is to be a communication of the unconditional positive regard and empathy to the client. These conditions are referred to more simply as a triad of therapist-offered conditions of empathy, genuineness, and unconditional positive regard (Josefowitz & Myran, 2005; Raskin, 2001).

It is now generally accepted that the TR and empathy's part in this is very important. However, there is still debate about how or what its influence is in the outcome of therapy. It is useful to consider the current understanding of the role of empathy in the TR and therefore, ultimately its role in therapeutic change.

Since Rogers' 1957 paper, there have been a number of reviews of the literature relating to empathy in the TR specifically, and therapist related facilitative conditions bringing about therapeutic change more generally. These reviews seem to represent three waves of research interest. Initially following Rogers' paper, there was a flux of research looking to support or refute Rogers' claims in relation to the importance of

empathy as a therapeutic device. The second wave during the late '70's and early '80's continued in this vein. The findings were mixed leading some to believe that empathy was not as important as considered by Rogers (Parloff, Washaw, & Wolfe; 1978). We currently seem to be experiencing the start of a third wave following the slow down over the last 20 years. This slow down has been attributed to a focus on Randomised Control Trials to look at the efficacy of specific therapy models which has resulted in decreasing attention given to discrete therapist factors (Beutler et al, 2004). The third and current wave will be discussed later.

1.6. Review of the literature on empathy and therapist facilitative conditions in the therapeutic relationship.

Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) looked at general factors influencing the outcome of psychotherapy and reviewed 166 quantitative studies between the years of 1946 and 1969. They found general support for Rogers' triad of therapist facilitative conditions. Empathy was directly investigated in 12 studies by a combination of tape recorded patient therapy sessions and self-report measures rated by the therapist themselves. Where empathy was rated through observation of patient sessions, there was a significant positive relationship between empathy expressed by the therapist and treatment outcome in half of the studies. The self-report measures indicated that there was a positive relationship between empathy and treatment outcome in two thirds of the studies assessing this specifically.

Luborsky et al provide sufficient details of the initial studies to comment on the methodology. It should be noted that these studies had employed empathy measures rated by the therapists themselves and it might have been more valid had the patients been asked to rate their therapist. They also found that when combined with Warmth and Genuineness, the predictive power of empathy increased perhaps suggesting that empathy interacts with the other facilitative conditions identified by Rogers, to account for positive outcomes.

Lambert, DeJulio, and Stein (1978) reviewed the counselling and psychotherapy literature over 20 years from the time of Rogers' paper on the necessary and sufficient conditions. They looked for evidence supporting the positive influence of Rogers' triad of facilitative conditions. They concluded that "only a modest relationship between the so-called facilitative conditions and therapy outcome has been found" (p. 486). However, they suggested that with better methodology, support for Rogers' facilitative conditions might be found. They also advocated extending consideration of the facilitative conditions beyond 'the Rogerian Hypothesis' to consider therapist self-disclosure, concreteness, confrontation and immediacy. Similarly, Parloff, Waskow, and Wolfe (1978) argued that more complex conditions probably exist regarding particular counsellor behaviours including facial expression and voice quality. Arguably Roger would have seen these latter counsellor behaviours as part of the communication of unconditional positive regard and empathy to the client.

In their review of the empathy research in relation to the TR, Marks and Tolsma (1986) found inconclusive findings, leading them to conclude that the impact of the TR and empathy on outcome is not as strong as proposed by Rogers. They suggested that maybe the problem is that the definition of empathy within the TR depends on the therapeutic orientation of the therapist. They called for a systematic inquiry into the construct of empathy.

Similarly, in an earlier paper, Bergin and Strupp (1972) had advocated a model whereby the theoretical orientations could be viewed along a continuum, ranging from those which view the relationship as most important to those that view techniques as most important and the relationship as either secondary or unessential. They specifically referred to humanistic, psychodynamic, and behaviouristic perspectives, with the former two viewing the TR as more important and the latter viewing the TR as unessential.

1.7. Concerns with the definition of empathy and the methods used to explore it.

Since this time there have been a number of studies looking at the suggestion that the theoretical perspective one adopts influences the definition and use of empathy in the TR. Carlozzi, Bull, Stein, Ray, and Barnes (2002) looked at therapists' endorsement of different definitions of empathy and identification with different theories of psychotherapy. They used a selection of fifteen definitions informed by professional literature selected to reflect the perspectives of the five theoretical

orientations of the participants: systemic, cognitive-behavioural, humanistic/experiential, psychodynamic, and behavioural. They asked participants to endorse the definitions of empathy they felt reflected their professional understanding of the construct and used factor analysis to identify factors. They found two factors: feeling focussed (which incorporated definitions such as 'vicarious experiencing', 'resonating with feelings expressed by others', and 'experiencing the inner life of others while retaining objectivity'); and communicative process (including the definitions 'collaborative alliance', 'communicative process', and 'expression of another's experiences'). When looking at the tables of results, it would appear that the only significant findings were that the humanistic/experiential orientated participants and the psychodynamic orientated participants aligned themselves with the 'feeling focussed' definitions.

A limitation of this study was the use of a limited list of nine definitions that the participants could endorse. A problem is caused where participants are limited to the definitions provided and are given no opportunity to include their own definitions. This narrows the focus and can result in participants acquiescing to the definition 'closest to' their view. Rather than using a list of definitions from which participants had to select, maybe participants could have been invited to initially give their view of empathy using open interview questions. A strength of the study was the large sample (N = 565) and the broad representation of

theoretical orientations, i.e. systemic, cognitive behavioural, humanistic/experiential, psychodynamic, and behavioural.

Fischer, Paveza, Kickertz, Hubbard, and Grayston (1975) looked for evidence that Rogers' triad of empathy, warmth, and genuineness were influenced by the therapeutic orientation of the therapist. They analysed and rated recorded interviews with pseudoclients, members of the research team selected to play the client (although these pseudoclients did present real personal difficulties to maintain some ecological validity). Fischer et al didn't find any significant difference between the three theoretical orientations (humanistic, psychodynamic, and behaviourist therapists) in relation to ratings of empathy, warmth and genuineness. However, considering the number of variables they were analysing in this study, the small sample size may have influenced the significance of the findings. There were only 9 therapists in each of the three theoretical orientation groups.

In their review of research studies, Lambert et al (1978) found no evidence that the relationship between therapist skills and therapy outcome interacted with theoretical orientation. Similarly, Traux and Mitchell (1971) found sufficient evidence to support Rogers' triad and suggested that it held with a wide range of therapists and counsellors, regardless of training or theoretical orientation and with a wide variety of clients.

In summary, there is mixed support for the importance of empathy in the TR, and of a good TR to positive outcomes. Maybe the clearest we

can be is to say that, "empathy in counselling/psychotherapy can be helpful in certain stages, with certain clients, and for certain goals" (Gladstein, 1983, p. 467).

Generally speaking, the explanation for the lack of consistency in the support for the 'Rogerian Hypothesis' has looked at inconsistently applied definitions and specific methodological concerns as a potential explanation for this lack of empirical support. This is highlighted in the studies above that have looked at the theory that different theoretical orientations use different definitions of empathy, and in the quotes below.

> Rather than concluding that the evidence supporting the therapeutic conditions hypothesis is untenable, the contention here is that the evidence has not been persuasive due to definitional and methodological difficulties in the research (Marks & Tolsma, 1986, p. 17).
>
> [The] definition and mechanism of empathy seem unclear (Duan & Hill, 1996, p 261).
>
> Although the evidence to date seems to support the importance of empathy in an effective counselling relationship, the definition and mechanism of empathy seem unclear (Sexton & Whiston, 1994, p. 26).
>
> The literature does neglect a clear definition and a comprehensive theoretical approach (Clark, 1980, p. 187).

> Caution is needed when we are tempted to expand our concepts because, in the face of unending uncertainty, we are all vulnerable to compromising discipline in our longing for final answers (Poland, 2007, p. 87).

With the exception of the last one, these quotes refer to the inconsistent definition of empathy. A positivist research perspective asserts that the inconsistency in the definition of empathy is problematic. In the past, I too have been guilty of trying to track down the 'Holy Grail'; the universal definition of empathy. However, Duan and Hill's position is helpful, "we believe that the confusion reflects the diversity of the ways in which empathy is conceptualized and suggest that such diversity needs to be *understood but not discouraged.* Only a good understanding of this diversity can lead to the elimination of the confusion" [emphasis added] (Duan & Hill, 1996, p. 261).

Duan and Hill are saying that definition goes further than a description and that rather than variation being reflective of different descriptions per se, the variability reflects different conceptualisations, which is a very important point in relation to this paper.

Gladstein (1983) had a further point to make in his assertion that empathy cannot be studied using traditional scientific, psychological methods, stating that "by inserting the outsider's objective measurements, we destroy what we are trying to measure. Thus the confusion that exists results from studying only a part or parts of a

totality that do not lend themselves to traditional scientific analysis" (p.490).

Here Gladstein is advocating a new approach to the study of empathy which takes account of what Duan and Hill are talking about when they refer to 'contextalization'. This is perhaps made clearer by returning to the original translation of empathy.

Empathy initially appeared as a new word; a translation from a German word (Einfühlung). As suggested by Shlien (2001), this word at its creation carried no meaning, it was inert. However, through use empathy as a construct has been reified. The variation in definition represents the different contexts of its reification. The argument here is that the exploration of empathy requires an entirely different methodological approach from the positivist empiricism which has been applied historically to the definition of empathy. A more appropriate qualitative method is indicated by the epistemological position of this study; social constructionism. Social constructionism identifies the role humans play in the construction of knowledge. People and societies create, rather than discover, constructions of reality (Raskin, 2002). A social constructionist approach to exploring psychological constructs makes sense because these constructs are language-based, and language is contextualised in culture. Adoption of a social constructivist perspective to explore the TR was encouraged by Sexton and Whiston in their 1994 review.

This would support the view that a 'universal' definition of empathy is not possible because of the way society constructs meaning. Definitions should be understood within their context. Research taking a positivist stance has attempted to generalise the definition of empathy from one study to another, taking it outside of its context. It is proposed in this study, that empathy should be operationalised within its context. Therefore a methodology that allows this, and that can be used to analyse language is needed. More appropriate language based methodologies are represented in the 'third wave' of empathy research.

1.8. The third wave

Earlier in this review, I suggested that the literature represents waves of research interest in empathy in the therapeutic relationship; each wave initiated by new interest after a period of decreased productivity in the research area. I also indicated that potentially there was a new 'third wave' of increasing productivity currently occurring; a wave answering the call for a change in methodology. This assumption is supported by reviewing two final studies which have looked at empathy in the TR. Both of these studies use a qualitative methodology; one narrative social-constructionist and the other discursive. Both of these articles appreciate the importance of the context and respond with a methodology that suits language.

McLeod (1999) referred to 'therapeutic empathy' (empathy applied to the TR) in his paper, specifically the lack of theoretical coherence between the methodology and the subject. He talked about definitions

of therapeutic empathy such as 'entering the client's frame of reference' and 'walking in the world of the other'. He reported that these definitions imply that 'frame of reference' and 'world' are fixed entities that can be observed in the same way as a picture or work of art. Instead McLeod argued that from a social-constructionist perspective experience and reality is co-constructed, requiring both the observer and the object of that observation to be active participants in the construction of reality. He asserted that the methodology chosen should reflect this. He explored empathy-in-action taking a narrative approach to understanding how therapists *do* empathy in their practise.

Sinclair and Monk (2005) provided a post-structuralist critique and review of the role of empathy in the TR. They explained how discourse can be used in therapy to demonstrate empathy. They talked about the liberal-humanist approach which focuses on the individual and isolates them from their cultural milieu, neglecting the full impact of culture in the therapy arena, versus a post-structural use of discourse to incorporate an appreciation of the cultural milieu through the discourse in therapy settings. They used Foucauldian contributions which relate to discourse, positioning, and deconstruction.

1.9. Section summary

The literature reviewed in this paper has called for an alternative methodology to explore the role of empathy in the TR. In short, this approach needs to be sensitive to the socio-cultural milieu and to the

nature of language. These issues will be discussed further in the extended methodology. The aims of the current study were as follows:

1. To explore the construct of empathy
2. To do so in an operationally defined context
3. To apply an appropriate methodology to explore empathy within the operationally defined context (Discursive Psychology as defined by Potter, 2003)

The methodology chosen for this study is discussed in detail in the extended methodology section which follows.

Part Two: Extended Methodology

2. Section Introduction

In this research I aimed to explore the concept of empathy within the therapeutic relationship; the relationship between the therapist and client. I aimed to do this in a way that was sensitive to language, the medium through which psychological concepts are constructed, and to the variability inherent in the definition of psychological constructs. Furthermore, given my view that psychological concepts are socially constructed (driven by my epistemological position), I decided that this exploration needed to be sited within a specific therapeutic context; in this case an Improving Access to Psychological Therapies (IAPT) service[8].

Initially I intended to structure this methodology using methodology sections from articles published in discursive journals[9]; however, the methodology sections contained in these journals are brief and unstructured. I wanted to provide more structure throughout the methodology both to contain sufficient detail and to improve readability. Therefore, I have largely followed the flow of a discursive article from the *Journal of Health Psychology* but I have included more subheadings where I felt this would aid clarity.

[8] Any other service would have been equally suitable. What was important was that the research context was pre-defined.

[9] Discursive journals, i.e. journals containing articles applying discourse analytic procedures, include: *Discourse and Society*, and *Talk and Text*. The *Journal of Health Psychology* also contains a large number of discursive articles.

My aim throughout this paper is to be transparent about the methodological decisions I have made. Therefore, I have not contained my reflections in a reflexive section, rather I have aimed to evidence my reflexivity throughout the paper by referring to decisions I have made at the relevant stages in the design of the study.

2.1. Epistemology, Methodology and Methods

2.1.1. Epistemology: social constructionism.

In the literature review, I identified the history of empathy in psychology both as an explanation for psychopathology and as a therapeutic tool. I made reference to my personal history with empathy and the realisation that there is great variability in the definition of empathy.

The literature I reviewed regarded this variability as problematic. It can be argued that this is the case for two reasons: first, variability is problematic from a positivist[10] framework which seeks consistency as evidence of generalisability; and second, empathy, like all psychological concepts (personality, intelligence and psychopathology to name a few), employs a linguistic label to represent it; its meaning is reified through its use and through the context of its use, therefore variability is inherent. I too have been guilty in the past of searching for the Holy Grail[11] of a universal definition of empathy. My training in psychology, with a firm

[10] A positivist framework or philosophy of science is based on the principle of there being an objective 'reality' with the researcher's task being to identify that reality through traditional empirical methods.

[11] The Holy Grail is commonly thought to be the cup used by Jesus at the Last Supper and is said to possess miraculous powers, however I use it here to represent not the cherished object itself, but the quest to find it.

emphasis on traditional psychological approaches (empiricism[12]), led me to think that there was a knowable 'truth' out there, when in fact through my exploration of empathy I have been able to see an alternative framework, a framework which is guiding my thinking now. This is a social constructionist framework which views variability not as problematic but the central feature of interest. At the same time it sees language not as a cognitivist would (i.e. as a route to mental states), but as a device to explore people's constructions of their own realities. This is a view I share with Gergen (1985) who characterised social constructionism as a movement towards re-defining psychological concepts as constructed processes, whereby each concept is "cut away from an ontological base within the head and is made a constituent of social process" (p. 271). This calls for a methodology that allows for, and seeks out, variability through the medium of language; the very way in which constructions are represented.

2.1.2. Methodology: discourse analysis.

There were two parts to this study, an exploration of service documents and an analysis of therapists' discourse obtained through discussion groups. The data collected in these two parts was treated differently as discussed in the method section (2.1.3). Here I discuss the methodology that was applied to the discussion groups (discourse analysis, DA). Rapley (2007) summarised DA in the following way:

[12] Empiricism refers to the use of quantitative methods such as questionnaires and experiments.

> Rather than see it as a single, unitary, approach to the study of language-in-use, we could see it as a field of research, a collection of vaguely related practices and related theories for analyzing talk and texts, which emerge from a diverse range of sources (p. 4).

DA has been described as an 'umbrella term' (Cameron, 2001) for as many as five different approaches (Wetherell, Taylor & Yates, 2001[a]). These include (but are not limited to) Critical DA (CDA), Foucauldian DA (FDA), and Discursive Psychology (DP)[13]. These traditions share a move away from the positivist tradition of seeing language as merely a route to things beyond such as attitudes, events or cognitive processes. Instead, they view participants' discourse as of primary importance. In its most basic form, DA asks 'how is discourse put together and what is gained by this construction?' (Potter & Wetherell, 1987).

Each approach has its own unique vocabulary and is designed to focus on particular aspects in relation to the activity done through discourse. For example, in DP a broad range of technical terms are used, with different analysts focusing on different aspects. For example Edley (2001) talks about subject positions, ideological dilemmas, and interpretative repertoires whilst Potter and Wetherell (1987), and Gilbert and Mulkay (1984) refer just to interpretative repertoires. Getting to grips with a particular approach can be a time consuming business and

[13] Full reviews of these approaches can be found in Cameron, 2001; Hepburn & Potter, 2003; Rapley, 2007; Wetherell, Taylor, & Yates, 2001[a]; Wetherell, Taylor, & Yates, 2001[b]; and Willig, 2008.

for this reason I have provided a brief glossary of the terms which will be used throughout the remainder of the thesis (Table four); this will be specific to the particular discursive approach adopted in this study. First, I will introduce the approach adopted in this study; discursive psychology (DP).

DP perhaps best typifies the move away from the view of language outlined above. It applies the theory and methods of DA to psychological phenomena (Edwards, 1999), drawing on principles from conversation analysis (CA) (Potter & Hepburn, 2008) and ethnomethodology (Garfinkel, 1967; Heritage, 1984). Willig (2008a) describes DP in the following way:

> Discursive psychology is concerned with *how* particular versions of reality are manufactured, negotiated and deployed in conversation. This means that discursive psychology does not seek to understand the 'true nature' of psychological phenomena such as memory, social identity or prejudice. Instead it studies how such phenomena are constituted in talk as social action....In other words, discursive psychology does not seek to produce a knowledge of *things* but an understanding of the *processes by which they are 'talked into being'.* (p.108)

Willig's quote well illustrates the position taken in this research because DP, as described here, enables the exploration of how therapists talk about empathy and how, through this process, 'empathy' is constructed.

Many published studies talk only in terms of interpretative repertoires or tropes (Seymour-Smith et al., 2002) however, I am taking my lead from Potter, Edwards & Wetherell (1993) who suggested that we are unlikely to get at the workings of social practices through identifying particular 'tropes' or interpretative repertoires and coding them. Instead they suggest that these should be studied in context for their specific construction, sequential placement, and rhetorical organisation. Therefore I decided to use the Discursive Action Model (DAM) to structure my analysis in order to think about what therapists were doing with their constructions of empathy.

The discursive action model.

In response to their suggestion that we need to take 'reality' as something constructed by participants in the course of social practices, Potter et al. (1993) suggest that factual reports be taken as the central research topic i.e. "studying the way that particular versions (reports) are made to appear factual and independent of speakers or writers and-equally important-investigating the different activities that can be done with factual discourse" (pp. 386-387). This is the heart of a 'discursive psychology'.

Edwards and Potter (1992) argue that versions are made to appear factual through the use of discursive devices. The identify nine: category entitlement, vivid description, narrative, systematic vagueness, empiricist accounting, rhetoric of argument, extreme case formulations, consensus and corroboration, and lists and contrasts.

One particular example of a discursive device is the extreme case formulation (ECF). Pomerantz (1986) described ECFs as being deployed in discourse when we are "attempting to have our fellow interactants arrive at certain conclusions" (p. 219). Pomerantz argued that a state of affairs is portrayed as believable, obvious, compelling, unreasonable, illogical etc in the way a description of it is formed. Three uses of the ECF have been identified:

1. to defend against or counter challenges to the legitimacy of complaints, accusations, justifications, and defences;
2. to propose a phenomenon is 'in the object' or objective rather than a product of the interaction or the circumstances;
3. to propose that some behaviour is not wrong, or is right, by virtue of its status as frequently occurring or commonly done.

DP challenges traditional attribution theory in psychology. According to Edwards and Potter (1992) the psychology of attribution (or everyday causal reasoning) has little regard for the way versions of events are actively put together to promote particular causal stories and undermine others. DP has traditionally been applied to areas in psychology such as memory work where memories are seen as something which are *done* by participants rather than some physical entity which is neutral and free from bias. With regards to memory Edwards and Potter suggested that events were inextricable from their various constructions, each of which allowed for inferences about motives and morality. This has been my core business in this study. I have applied this approach

to the use of psychological concepts, viewing them as constructed by participants in their talk, within a specific temporal and social situation, such that in another situation or at another time, participants' constructions would be different. This discursive psychological approach to language-in-use (Horton-Salway, 2001) is summarised in the discursive action model (DAM) in table four.

Table 3: *The Discursive Action Model*

Action

1. The research focus is on *action* rather than *cognition* or *behaviour.*
2. As action is predominantly, and most clearly, performed through *discourse*, traditional psychological concepts (memory, attributions, categorizations, etc.) are reconceptualised in discursive terms.
3. Actions done in discourse are overwhelmingly situated in broader *activity sequences* of various kinds.

Fact and interest

4. In the case of many actions, there is a *dilemma of stake or interest*, which is often managed by doing attribution via factual reports and descriptions.
5. Reports and descriptions are therefore constituted/ displayed *as* factual by a variety of discursive devices.
6. Factual versions are *rhetorically organized* to undermine alternatives.

Accountability

7. Factual versions attend to agency and accountability *in the reported events.*
8. Factual versions attend to agency and accountability in the current speaker's actions, including those done *in the reporting.*
9. Concerns 7 and 8 are often related, such that 7 *is deployed for 8, and 8 is deployed for 7.*

(Table taken from Potter et al. 1993; p. 389)

Table 4: *Glossary of discursive terms*

Term	Meaning
Discourse	I will use 'discourse' as I have come to understand it which is, in its broadest sense, all forms of talk and writing (Gilbert & Mulkay, 1984)
Action, fact & interest, & accountability	These are the three elements of the discursive action model (Edwards & Potter, 1992). Action refers to the view that discourse is performative. Fact and interest are an amalgam of factual versions and stake and interest. Accountability refers to attributional work done through discourse such that a particular report can imply accountability of the actors it refers to
Stake and interest	According to the DAM, people view each other as entities with biases, motivations, and allegiances and these are

	represented in their reports and attributional inferences. When Edwards and Potter talk about the dilemma of stake or interest, they are referring to how people manage their reports or versions of events so as to make them appear disinterested and unbiased (or in other words, factual).
Factual versions	There is considered to be a specific way of reporting which gives a report it's out-there-ness (Edwards and Potter, 1992, p.105) or factuality
Discursive devices	Factuality is *done* through discursive devices which are features of text which make a report difficult to dispute.
Rhetorical organisation	Discursive devices are rhetorically organised such that they cannot be disputed or that they are difficult to dispute

2.1.3. Methods.

This methods section is divided into two sub-sections; 'text' and 'talk'. This is intended to represent the two phases of data collection. I have described each phase in detail in the relevant section; however, I think it is important to briefly explain what I mean by text and talk. I use text to refer to service-based data in the form of documents accessed by therapists to inform their practise. I use talk to refer to therapists' discourse as accessed through discussion groups. Text and talk did not gain equal weight in this study as my main concern was with therapists discourse; the rationale for the collection of textual data is given in the text section. I will discuss text first as this was the first phase of data collection and was carried out whilst ethical approval was gained to collect talk.

Text.

Throughout the literature review and the beginning sections of this methodology, I referred to the importance of exploring psychological concepts in their specific context of use. Therefore, I needed some gauge of the service context because I was interested in how therapists construct empathy within a defined context (the IAPT service). This was informed by reviewing documents in the service that were considered to be regularly accessed by all therapists in the service. I acknowledge that as an external researcher to the research setting, I

would never have access to all the influences[14] on therapists' discourse. Therefore, I had to be specific in what I would use as a gauge of the context, whilst acknowledging that I was influencing this process. By acknowledging my influence on the contextual data collected, I am being mindful that other contextual resources may say something different.

To explore the context, I decided to look at documents in the service which were considered key for the therapists. I did this by emailing the clinical leads (the lead clinical psychologist and the clinical lead for the IAPT and CBT practitioners) to ask them what documents they considered influential to therapeutic practise in the Service. The documents suggested were the IAPT competency framework (considered important at a service-level and used in the supervision of clinical psychologists and IAPT therapists) and four key text-books which are recommended as key training texts by the IAPT training course. I will start by introducing the IAPT competency framework.

IAPT competency framework.

The Centre for Outcomes Research and Effectiveness (CORE) is based at University College London's (UCL) Research Department of Clinical, Educational, and Health Psychology. It was established in December 1995 with the aim to use psychological theory and expertise to promote

[14] Furthermore, I doubt this is an achievable task for anyone let alone a researcher as there are an infinite number of influences on the development of discourses, some which will be identifiable and others which will not.

the increased effectiveness of a broad range of health care interventions.

One of the research goals of the department was to develop competency frameworks for psychological interventions; these describe the knowledge and skills associated with the effective delivery of psychological therapies. The department developed a set of competency frameworks; the first of which is the competence framework for Cognitive Behavioural Therapy (CBT) (Roth & Pilling, 2007). There are two further frameworks, the psychodynamic (Lemma, Roth & Pilling, 2009) and humanistic competencies (Roth, Hill, & Pilling, 2009); with a fourth in production.

The first application of the CBT framework was to the Improving Access to Psychological Therapies (IAPT) programme[15]. At the research site, as in all IAPT services, the competencies are used in training and supervision of staff delivering high and low intensity CBT interventions[16]. The framework[17] describes the activities that the therapist needs to bring together in order to carry out CBT effectively, and in line with best-practice. There are five different domains of competence: general therapeutic competencies; basic CBT competencies; specific Behavioural and Cognitive Therapy competencies; problem-specific

[15] IAPT services are NHS mental health services in selected Primary Care Trusts (PCT). They have Cognitive Behavioural interventions as their core therapeutic approach. This is based on recommendations by the National Institute of Health and Clinical Excellence (NICE) relating to clinical effectiveness.
[16] The intensity of CBT intervention in IAPT is determined by the 'Stepped-Care' delivery model which is described elsewhere (Department of Health, 2008). Appendix C is a pictorial representation of how the different IAPT therapists work into the stepped-care model.
[17] The competency framework map is shown in appendix C.

competencies; and, meta-competencies. Each domain is linked to a document (an example is given in appendix A) containing a list of competencies, or requirements, the therapist must demonstrate to be considered competent in their practise.

I searched each of these documents for 'empathy'. In addition, I considered it important in advance of the search to identify a list of synonyms for empathy, which would also be searched for within the document. This included 'empathise', 'empathising', 'empathic', 'empathetic', and 'empathetically'. Finally, I looked for these synonyms with alternative spellings, for example 'empathize'. I decided to restrict the search criteria in this way because broadening the search criteria beyond this, i.e. to other words (for example 'compassion' or 'warmth'), would have been me imposing my personal understanding of empathy, therefore I minimised my influence by searching only within these predetermined criteria. All of the documents are pdf files and as such, at the top right hand corner of each file is a tool bar with an option to search for a given word within the document (appendix D).

This highlighted any use of 'empathy' within the document, which meant that excerpts containing empathy could be extracted. Initially these excerpts were entered into a Microsoft Office OneNote file.[18] At this point it is important to state that I selected the specific excerpts from their broader context, i.e. the document itself, thereby determining what

[18] Microsoft Office OneNote is a programme which allows the manipulation of data onscreen such that it can be annotated.

would be reviewed. Blommaert (2010) highlighted a methodological problem in doing this in that the relevance of the frame of reference is decided by the researcher. My knowledge and biases determined how much of the context was included therefore I need to make explicit why I framed the excerpts in the way that I did. I took the decision to include in the excerpt all sentences prior to and following the initial sentence where I felt these linked to the point made in the main 'empathy' containing sentence (the same procedure was applied to the extraction of excerpts from the key texts and is discussed further in the following section). I acknowledge that in this process, I have been responsible for deciding which texts to include, and which excerpts to extract from the texts. Therefore, I have been an active agent in producing the material as 'data' (Rapley, 2007).

Key text-books.

The service lead for the IAPT therapists identified four key texts recommended by the High Intensity Trainee course.[19]

The four texts were as follows:

1. Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide (Hawton, Salkovskis, Kirk, & Clark, 1989)
2. Cognitive Therapy for Anxiety Disorders (Wells, 1997)

[19] Post-Graduate Diploma accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) for CBT therapists.

3. Oxford Guide to Behavioural Experiments in Cognitive Therapy (Bennett-Levy, Butler, Fennell, Hackman, Mueller, & Westbrook, 2004)
4. Assessment and Case Formulation in Cognitive Behaviour Therapy (Grant, Townend, Mills, & Cockx, 2008)

I conducted an online search of these books to make identification of the appearance of 'empathy' (and synonyms) easier and less time consuming because empathy was not contained in the indices of the books. This was done using Amazon where, once you have located the book of interest, there is an option to review the book for content. An example is shown appendix D. Through this search, I was able to identify where in the book empathy was mentioned. I acknowledge that this is not an ideal way of looking for every instance of empathy mentioned and therefore I may not have found every mention of empathy. However, the aim was to get a feel for how empathy was being constructed in the texts rather than conducting a fine-grained analysis of the texts.

Appendix D shows that 'empathy' was contained once within Hawton et al (1989) on page 147 of the book. I was then able to access the book and read and extract the sentence containing empathy. I extracted sentences prior to and following the empathy containing sentence where doing so aided the interpretation of the excerpt.[20] I repeated this

[20] The unit carrying the meaning isn't necessarily defined at the sentence level it can be "above the sentence" (Cameron, 2001; p. 90) therefore, where necessary, I incorporated surrounding sentences into the excerpt.

procedure for the remaining three texts. All of the excerpts were typed up into the same Microsoft Office OneNote file as contained the competency framework excerpts.

From both parts of the textual data-collection, I was able to develop an appendix of excerpts to organise the analysis (appendix L is a section from the book excerpts). The excerpts were reviewed for content and for their specific use of empathy and therefore were not an analysed in any formal way. The results of this cursory exploration are presented in the extended results section.

Talk.

Design.

Phase two of the research employed a discussion group design[21]. Potter and Hepburn (2005) cautioned against the use of interviews as a "taken-for-granted" (p. 283) design in qualitative research. My decision to use discussion groups was informed in part by their criticisms of interviews, but also by a pilot of the interview schedule which is discussed further in the materials section. According to Willig (2008a), the strength of a discussion group is its ability to "mobilize" (p. 31) participants to respond to, and comment on one another's contributions. In this interaction statements are challenged, extended, developed, undermined, or qualified generating rich data for the researcher. It

[21] Discussion groups are more commonly referred to as focus groups (Morgan, Fellows, & Guevara, 2008). I use 'discussion group' to distinguish it from the use of 'focus group' in market research.

allows the researcher to see how concepts are socially constructed through the discussion, and how participants jointly construct meanings. This is something which I am interested in and something that I wanted to access in the research and is therefore the rationale for a discussion group design.

The research data was obtained from two separate discussion groups, one with the clinical psychologists and one with the IAPT CBT therapists. The reasons for splitting the therapists into two separate discussion groups are discussed further in the procedure.

Pilot study.

The interview schedule was initially piloted using a one-to-one [22] interview to see whether it achieved the aim stated above which it did. However, when I piloted the interview schedule in this format, I found that responses were brief and I found myself significantly prompting the interviewee. This is something I was concerned about as I wanted to gain access to therapist discourse. Therefore, I took the decision to conduct discussion groups rather than one-to-one interviews in order to generate as much discussion as possible in keeping with Willig's view that discussion groups "mobilize" participants (Willig, 2008a, p. 31). Furthermore, Cameron (2001) identified that participants construct a certain representation of themselves for the researcher's benefit, not to

[22] I initially proposed to conduct one-to-one interviews with therapists from the service because I wanted to capture therapists discourse on empathy and interviews are the most frequently used method of doing this in DA research (Wetherell, Taylor, & Yates, 2001[b]).

mislead the researcher, rather they respond to the researcher's questions on the basis of what they think the researcher's motive is in asking. I wanted to minimise any potential biases in the data which might come directly from my involvement as a researcher. Therefore, a reduction in the need to prompt interviewees would reduce the biasing influence of prompts.

Participants and sample size.

The inclusion criterion was any therapists working within the IAPT service. I defined 'therapist' as any member of the service engaging therapeutically with users of the service. Broadly the therapist group at the research site consisted of CBT practitioners, IAPT Psychological Wellbeing Practitioners (PWP), IAPT high-intensity therapists, and Clinical Psychologists; all were invited to participate. I met with teams of therapists for 5-10 minutes during their various departmental meetings in May 2010. In the meetings I introduced the research by giving a brief overview of the rationale and distributed the information packs consisting of the participant information sheet, the consent form, and demographic information sheet (appendix E).

With regards to sample size, the success of a DA study is not dependent on sample size; the crucial determinant is the research question (Potter & Wetherell, 1987). Furthermore, in DA studies, the researcher is not concerned about the amount of data being analysed but with the depth of analysis conducted (Potter & Wetherell, 1987).

Willig (2008b) suggested six participants as a maximum for a discussion group.

Four clinical psychologists took part in the first discussion group which took place on 17th June 2010. Three CBT therapists took part in the second discussion group which took place on 8th July 2010.

Materials.

Interview Schedule[23]

The interview schedule was used only in the discussion group with the IAPT CBT therapists. This was because, unlike the discussion group with the clinical psychologists, I facilitated the discussion. Further information about these procedural differences is given in procedure section.

According to Cameron (2001), "the interviewer needs to find the right balance between maintaining control of the interview and where it is going, and allowing the interviewee the space to redefine the topic under investigation and thus to generate novel insights for the researcher" (p. 24). Despite Cameron's reference to interviews here, the same can be said of discussion groups; in designing the interview schedule, there was a need to balance control with gaining free discourse from the group members. Therefore, the interview schedule

[23] I use 'interview' schedule here despite its use in a 'group discussion', to identify that its role is the same, i.e. to generate responses from participants.

was designed to be as open as possible so as not to lead the therapists in their responses.

I developed a list of five questions to be discussed in the discussion group (appendix F); no further prompts were given. The questions broadly covered five areas which were included to generate discussion. These were: the nature of empathy; whether empathy can be learnt; whether empathy was covered in therapists' training; use of empathy in therapists' work with service users; and the importance of empathy in the therapeutic relationship.

Demographic information sheet

I included a demographic information form with the participant information pack. This was to collect demographic information about the therapists in the two discussion groups and also to establish their therapeutic approach and job title (i.e. IAPT CBT therapist or clinical psychologist).

Recording and transcription equipment

The discussion groups were recorded on an Olympus DS-30 digital voice recorder so that recordings could be transcribed following the discussions. The Olympus AS-2300 transcription kit was used to transcribe the recordings from the discussion groups.

Procedure.

DP favours the use of naturalistic data[24], therefore the discussion groups, where possible, were conducted by accessing existing opportunities at the research site where therapists meet in a group format. There was an opportunity to do this with the clinical psychologists as they regularly met for reflective practice sessions (RPS) where topics in psychology are discussed which contributes to their continuing professional development (CPD). Therefore, this was ideal for the purpose of this research.

In contrast, the CBT therapists did not normally meet as a group. Therefore, I facilitated this discussion group. This was the rationale for having two separate discussion groups – one for the clinical psychologists, and one for the CBT therapists.

The discussion groups were conducted between June and July 2010. At the beginning of both, I obtained consent from therapists and asked them to complete the demographic information sheet. During this process, the demographic information sheets were anonymised using an individual identification code which was then used during the transcription of the digital recordings of the discussion group. The consent forms, which contained the only personally identifiable information, were stored at the University in a locked cabinet. At this

[24] Naturalistic data "refer[s] to informal conversation which would have occurred even if it was not being observed or recorded, and which was unaffected by the presence of the observer and/or recording equipment" (Taylor, 2001, p.27).

point I was able to answer any final questions before commencing the discussion group.

For the discussion group with the clinical psychologists, I explained to a group member how to operate the digital recorder and left the discussion group. For the CBT therapists, I started the digital recorder and worked through the interview schedule. My progress through this was marked by a change in the interactional nature of the discussion such that where the interaction slowed or stopped, I took this as an indication to move onto the next question. I did not provide further prompts.

Transcription and analysis.

I decided to describe the transcription of the recorded discussion groups here in the methodology despite transcription being viewed as the first stage of analysis (Cameron, 2001). It makes sense to include it here as I am describing the procedural aspects of the transcription.

My decision to transcribe the recordings of the group discussions myself, was informed by Cameron's view, and also by Willig's (2008a) view that interview data is transformed through the process of transcription such that the transcripts can never be a mirror image of the interviews themselves. Therefore, it was important to transcribe the discussion groups myself, rather than inviting in an external transcription service. This meant that I would be able to reflect on the

process of the transcription, rather than this process being lost to an agency external to the research process.

To transcribe the data, I used an adapted Jeffersonian light transcription notation system (Rapley, 2007; appendix G). According to Kitzinger and Frith (2001), most discourse analysts use an adapted version of the Jeffersonian system, adapting it on the basis of the amount of detail required. The advantage of the Jeffersonian system, over alternative systems, is that it allows for the incorporation of greater detail, for example pauses, hesitations, and overlaps in speech, which was particularly useful within the discussion groups where more than one therapist spoke at a time.

My analysis was informed by the following sources: Potter and Wetherell (1987); Horton-Salway (2001); and the DAM (Edwards & Potter, 1992; Edwards & Potter, 1993; and Potter, Edwards & Wetherell, 1993).

Potter and Wetherell (1987) pointed out that discourse cannot be analysed in a mechanical way. Rather, the analysis involves close 'interrogation' of the relevant accounts by reading and re-reading the transcript with special attention being paid to patterns of language use that appear in the data. Two questions were kept in mind – why am I reading this passage in this way, and what features produce this reading?

Horton-Salway (2001) reviewed the discursive action model (DAM) as one approach to analysing data. She said that within the analysis, the analyst should look for three things:

- How events are described and explained
- How factual reports are constructed
- How cognitive states are attributed

Finally, my analysis was informed directly by the DAM. I noticed similarities between what Edwards and Potter (1992) were describing in their book as features of everyday mundane talk, and what I was finding in my data. This will be drawn on further in the analysis and discussion section where I present a model I developed through the application of the DAM to my data. To summarise, I was looking for how therapists constructed empathy, how these constructions were designed to appear factual (discursive devices), and the activities done through these factual versions. I have also enclosed a framework for analysis in appendix J which presents the steps I took in my analysis.

2.2. Ethics[25]

Ethical consideration was only relevant to the discussion groups with therapists. This was because the textual sources were in the public domain and therefore I did not need ethical approval through the research ethics committee (REC) to access them.

[25] Ethics approval for this study was gained through Nottingham Research Ethics Committee (REC) 1, on 11 February 2010. A substantial amendment in relation to the change in procedure from one-to-one interviews to a discussion group was submitted on 7 May 2010, and a favourable opinion was given by the REC on 8 June 2010.

Confidentiality.

Confidentiality was an important consideration given that therapists would be taking part in a discussion group. There were extra ethical considerations in that: first, therapists would be discussing their experiences in a group setting; and second, it would be possible for therapists to identify one another from any published work. This was discussed during the initial recruitment meetings with therapists as discussed in the methods section. In addition, although accessing an existing group format for the clinical psychologists, they were informed that the specific RPS slot would be used for the research and therefore therapists were able to decide whether they wished to attend the discussion group.

In relation to subsequent publication of the research findings, extracts of therapist discourse were anonymised using an alphanumeric code. Other ethical considerations such as the right to withdraw and the storage of data were identified and discussed on the 'information about the research' sheet (appendix E).

Informed consent.

As I would be recording the interviews for transcription, I asked therapists to provide written consent for the interview to be recorded, and for excerpts from their interviews to be used in future publications (appendix E).

2.3. Quality Issues

It has been recognised that we cannot apply quantitative ideas of reliability and validity to qualitative research (Elliot, Fischer & Rennie, 1999; Reicher, 2000). We cannot measure a discursive psychology project against truth or reality when, from its epistemological position, it rejects these notions in favour of recognising the existence of multiple interpretations each of which is equally valid. To draw my evaluation of my own work back to notions of truth or reality would be contradicting my starting point in this study.

It is however recognised that it is desirable to evaluate the quality of discursive research. Furthermore, Antaki, Billig, Edwards and Potter (2003) highlighted analytical short-comings in poor quality discursive research. Denzin and Lincoln (1998) identify that we need some way of agreeing on the value of qualitative work, yet no unitary approach has been agreed (Taylor, 2001). This is perhaps reflective of different epistemologies and methodologies residing within the broader discipline of qualitative research. If I were realist in my position, I would be more likely to look for reliability and validity, but from a social constructionist and relativist position, I do not view concepts as stable therefore if I were to interview the same participants in the same room months from now, I wouldn't be expecting their construction of empathy to be identical.

Madill, Jordon and Shirley (2000) identified the importance of evaluating a qualitative study by the logic of justification entailed by its stated

epistemology. My ontological starting point is that language is constructive of things not constructed by thing; this is identified by Madill et al. as Radical Constructionism. I am not looking for triangulation by asking others to analyse my data and take part in comparing our ideas about what the data is doing. As Rennie suggests, with his metaphor of 'shifting-horizons', we wouldn't be expecting anyone else to find what we find in our data because we cannot separate the researcher from the researched. Instead, objectivity and reliability are regarded as rhetorical devices in radical constructionist epistemology.

Alternative criteria have been proposed by Potter (1996). These are internal coherence, deviant case analysis and openness of the analysis to reader evaluation.

Internal coherence.

Internal coherence is regarded as the degree to which the analysis hangs together or is non-self-contradictory. However as Madill et al. point out, this in itself could be a contradiction. We have said from the beginning that we do not expect consistency in the way that therapists talk about empathy because I view empathy as socially constructed. Also as a researcher, I need to acknowledge that I too through the process of this thesis (and any work which continues after) will change my view on what the data is *doing*. This is a process that I have actually been through during the analysis and write-up stages. Therefore inconsistencies and contradictions might be inherent in the

approach. What Madill et al. suggest as an alternative criterion is the absence of "abhorrent contradictions" (p. 13).

Deviant case analysis.

The second criterion suggested by Potter (1996) is deviant case analysis. This is where the analyst seeks out material which appears to challenge their developing theory.

Openness of the analysis to reader evaluation.

Finally, in this last criterion, the analyst appeals to the reader to answer two questions: has the study contributed to the reader's understanding of the phenomenon (i.e. empathy and therapists' construction of it) and does the research facilitate productive action i.e. has it contributed to the development of the field?

Also another point in this criterion is openness. Throughout their work, Potter and colleagues (for example Horton-Salway, 2001; Edwards & Potter, 1992) have been open in their reflexivity through their use of dialogue boxes to make explicit their reflexivity. This is good practice and something which I have aimed to do throughout the thesis and it is my reason for writing in the 1st person. This is an approach was supported by Parker (1999) who suggested that writing in the 3rd person detached the researcher from the research process. The only change to this has been in writing the journal paper where I have used the 3rd person for stylistic reasons based on the journal of choice (British Journal of Clinical Psychology).

The three criteria mentioned here will be reviewed in the discussion section to see whether I have met them in this research.

Trustworthiness.

As guided by Hayes and Oppenheim (1997) I have also attempted to increase dependability (trustworthiness) through my use of a "dependability audit" (p. 34) to account for changes to methodology and strategy throughout the research process. Therefore my aim will be to increase the trustworthiness of the analysis; what I aim to demonstrate is transparency in my approach and accountability. Subjectivity will be managed through a reflexive diary.

Part Three: Extended Analysis and discussion[26,27]

3. Section Introduction

It is perhaps fruitful to provide a brief introduction to this extended analysis and discussion section in order to orientate the reader to some of the salient points established in the previous sections.

In the extended background, literature was presented that considered empathy (amongst other therapist offered qualities) to be an important facilitative condition in the relationship between client and clinician. However the construct of empathy has been described by the positivist tradition as problematic due to variability in its definition. In this thesis I am offering a different way of looking at empathy which incorporates a new epistemology as proposed by Potter and colleagues in discursive psychology (Edwards & Potter, 1992; Edwards & Potter, 1993; Potter, Edwards & Wetherell, 1993). This marks a move away from the traditional philosophy of viewing language as representative of some internal reality, to a position that sees language as performative in social actions and explores it as such. This is an approach that extends beyond this study and I encourage others to look at psychological concepts in a similar way. Therefore my aim is not to tell the reader

[26] I intend to maintain the approach to reflexivity introduced in the extended background and methodology by writing this section in a reflexive way. However, certain pertinent extracts from my research diary will be included in the general discussion for this thesis. I also maintain the use of 'I' to refer to myself as the researcher.

[27] The analysis and discussion are discussed together in this section as is common practice in discursive articles (e.g. Seymour-Smith, Wetherell & Phoenix, 2002; Wiggins, Potter & Wildsmith, 2001; APA, 2010).

what empathy *is,* but to utilise the uncertainty that exists surrounding the term to look at how therapists construct it. As an analyst, I am interested in what definitions, categories and issues the therapists construct and make relevant in their talk, for example, when therapists 'remember' sessions with clients they are performing a discursive action; they have decided to recall an event, at this point, and for some reason.

In this extended analysis and discussion, I have been necessarily selective in what is presented. This is due to the vast quantity of data collected for this thesis. Given that discursive psychology is concerned with quality and depth of analysis, rather than the amount of data analysed (Willig, 2008a), in order to do justice in my analysis I have focused on some patterns which emerged in the reading and re-reading of the transcript.

With regards to being selective, I acknowledge that another analyst may notice different patterns emerging in the data and therefore may present a very different analysis and discussion section from the section I am presenting here. Also, this analysis is just a snapshot capturing my analysis of the data at a specific point in time. On looking at the data six months from now, I too would be likely to find different things in the data. This is what David Rennie (personal communication, August 25, 2010) would refer to as "shifting horizons" for which he recommends "disclosed reflexivity".

First, I will present the results of the exploration of service documents; second, I will talk about the structure of the discourse produced in the

discussion groups; third I will consider some points of overlap between the groups' definitions of empathy; fourth, I will look at the constructions of empathy; and finally, I present a final finding from the clinical psychologists discussion group which I am left puzzling over.

3.1. Service documents.

An exploration of the service documents was conducted following the suggestion of Hammersley and Atkinson (1995). They identified the importance of analysing documents that might be part of the context, as opposed to interviewing without providing insight into the context.

My aim was to explore the context of the service via an exploration of the kinds of textual resources that inform the work of therapists in the PCT. Therefore this section of the thesis is not expected to be where the real action is.

I looked at the documents in a stepwise fashion, initially looking at the number of times empathy was mentioned in documents (as advised by Silverman, 2001), before moving on to look at how empathy is used to create particular effects in the documents.

The table below is a summary of the number of times empathy was mentioned in the documents. Following this, I give a brief discussion of the findings from reviewing these documents.

Table 5: *Summary of documents*

Resource	**Section**	**Number of times empathy is mentioned**
IAPT competency framework	Domain one – generic competencies	1
	Domain two – CBT basic competencies	Not mentioned
	Domain three – CBT specific competencies	2
	Domain four – problem specific competencies	6
	Domain five – generic competencies	Not mentioned
Key training texts – IAPT	Hawton, Salkovskis, Kirk & Clark	1
	Wells	Not mentioned
	Bennett-Levy, Butler, Fennell & Hackman	5

	Grant, Townend, Mills & Cockx	18 (including a full section on empathy)

Competency framework.

General findings-the overall impression from reading all the quotes from the competency framework, is that empathy is seen as a mechanistic and practical entity akin to a skill. Empathy is described as 'an ability' throughout domains one, three and four. The dictionary definition of an ability is "the state of being able; the power to do; talent; and skill". The documents link empathy frequently to Socratic questioning – a particular therapeutic technique aimed at eliciting information from the client. Linking the two implies that empathy, like Socratic questioning, is a therapeutic technique that can be used rather than a thing that is in us innately. In domain three, empathy is considered as a "source of information" which can be used to draw truths from the client.

Generally it feels like the documents were completed in a hurry, there are typos and missing words. I did wonder if the documents were designed for some other purpose by UCL but brought in hurriedly for the IAPT initiative.

Specific quotes-empathy is mentioned in generic competencies but not CBT basic competencies. This indicates that despite it being an important competency in "all therapeutic approaches", it is not written

Frequently, 'appropriate' was used next to empathy in the documents. This pairing of words is referred to word contiguity – appropriate next to

empathy changes the meaning of empathy and suggests that there is also inappropriate empathy. Interestingly 'inappropriate empathy' and the dangers of empathy were highlighted in the CBT therapist group.

3.2. Emergent structure of the discussion groups.

Both groups, despite different procedures, spent the early part of the discussion group defining empathy (these definitions are presented in section 3.3). This will be drawn on further in the reflexive section of the thesis. It seemed at the early stages that therapists had brought into the group, their existing knowledge in the area which included definitions of empathy gathered from cultural knowledge, i.e. dominant therapeutic discourses around empathy. However, once the groups had been running for a while, therapists seemed to relax into the discussion and started to construct versions of empathy 'live'.

3.3. Definitions of empathy[28]

Broadly, both groups agreed in the early stages on two definitions of empathy – the first was that of empathy being a therapeutic tool, and the second was that of empathy being something much deeper, a felt congruence with the client. These are represented in the extracts which follow. Extracts nine and ten present some of the definitions provided by the psychologists and extracts eleven to thirteen present some of those provided by the CBT therapists. In both cases these are a

[28] I distinguish between definitions and constructions of empathy – definitions seemed to echo those in the literature whereas constructions seemed to be produced 'live' and I was interested in what activities these constructions were performing

selection of definitions and are intended to evidence the two general definitions.

Clinical psychologists

Extract 9:

42. **C2:** yeh it's something abou::t (.) I think for me
43. something about sort of .hhhh being where they are I
44. guess
45. **C3:** ermm
46. **C2:** so I know I suppose when I first look at the word it
47. makes me think about erm .hh sort=of being able to put
48. yourself in somebody's shoes or imagine what they're
49. kind=of feeling

Extract 10:

19. **C1:** ...since coming back from my break
20. actually I I I tried putting in a few statements like that
21. thinking oh I I ought to say an empathic statement at this
22. point and then saying it and it not fee::::ling right it feeling
23. really forced
24. **C2:** yeah
25. **C1:** and uncomfortable which makes me think it's not to
26. do with what you <u>say</u> its mo::re to do with perhaps
27. actually having that connection if if if you <u>are</u> feeling and
28. understanding what they're feeling and I think it might be
29. a non-verbal process where it's not about what you say

30. you know that this is how you feel it might be something

31. about how you just are? with that person? (.)

Extract nine presents the definition of empathy as a therapeutic tool; extract ten presents the definition of empathy as a felt congruence with the client. The key element in extract nine appears to be the use of 'being able to put yourself in somebody's shoes' (line 48) which is an element referred to throughout the empathy and general therapeutic literature as 'theory of mind' and this has been considered to represent a more cognitive and 'purposeful' element to empathy (Hogan, 1969) hence its description here as a therapeutic tool.

In extract ten, C1 contrasts the previously presented definition with one which takes on more of an emotional aspect to empathy by the statement of empathy being about actually having that connection with the client and 'feeling' (line 28) what the client is feeling.

CBT therapists

Extract 11:

1. **R:** **what do you understand by the**

2. **word empathy (8)**

3.**T1:** I suppose for me:: empathy is ((coughs))

4. erm (1) about (1) being (1) able to see from

5. another person's perspective (.) erm (1) and

6. about being alongside somebody in that jou=in

7. that experience so not in it but erm one one f foot

there and one foot with them almost and being

alongside them in in that er understanding (.) or a

a willingness to understand and hear (2)

Extract 12:

T3: (I'd have) to agree really it's about having

that theory of mind isn't it it's (definitely around)

you know understanding what what the person's

going through perhaps what >the feelings might

be what their emotions might be what their

thoughts might be bu::t (being objective)

having one one foot in both camps which you're

not really not experiencing with them you are you

are understanding what they're going through

(obviously) having that objective (.) (view of

someone) (2)

Extract 13:

R: **how do you think you use empathy**

in your practise with clients

[lines omitted]

T3: very different views on that aren't they cos

some people would say that like its fine to kind of

cry on a with a client

therapist I've heard kind=of

therapists saying {(inaudible)

617.**T2:** {really

618.**T3:** yeah

619.**T2:** I wouldn't do that

620.**T3:** erm (2) I wouldn't either no it is that too

621. much empathy but I have had clients say that

622. they've had previous therapy before and they've

623. mentioned the fact that their therapist cried

624. (inaudible) and it's then I guess would take a

625. very different and that's you know what's too

626. much empathy cos there's some people would

627. say that's was absolutely fine and was showing

628. you are completely congruent with the client

629. {(inaudible)

630.**T1:** {I think it depends on the (tears) I think it

631. depends for me because there's I I don't I've

632. never cried with a client but I've <u>welled</u> you know

633. my eyes {have watered

634.**T2:** {well yeah yeah yeah

635.**T1:** but for me I am showing that I am being

636. impacted and I am being impacted by their

637. material I am not getting lost in the transference

638. of their material touching my material I am not

639. crying for myself and that's the difference I think

640. and I think that's where the client's are very good

641. at picking that up that inconsistency because a

642. genuine for me this is just my experience if it's a

643. genuine congruence of of showing the

644. impact people need to see that they have an

645. impact too::

Extract eleven is the first statement in the CBT discussion group. Here the distinction is drawn between empathy meaning 'being alongside somebody' in their experience and actually being 'in it' (line 7). The objectivity of empathising is established which seems similar to the clinical psychologists' idea of empathy as a tool rather than a congruence. Similarly, the 'willingness to understand and hear' (line 10) seems to be the central idea that empathising is not necessarily beyond this but so long as the therapist has such willingness then this is sufficient.

Also supporting the idea of empathy as a therapeutic tool is the discussion in extract twelve where there is the direct reference to Theory of Mind (line 21). As discussed in the clinical psychology discussion group, this is frequently described in the literature as cognitive element to empathy.

Extract thirteen sets up more of an emotional congruence with the client in demonstrating that they are being 'impacted' (line 636) by what the client brings. This extract is referred to later when the issue of the dangers of empathy, is discussed.

3.4. Therapists' 'doing' of professional accountability through their construction of empathy.

Introduced in the journal paper was the idea that with their discourse, therapists were *doing* professional accountability. This is captured in the diagram in appendix I. Extract five (presented in the journal paper) introduced the second construction of empathy identified in the data. This construction of empathy was *empathy is something that can develop over time*. This is illustrated again in extract fourteen in the same sequential form as identified following extract five, i.e. construction, case study, construction. Here the second construction is that of empathy as something that develops in keeping with extract four. This was further presented by the clinical psychologists and the CBT therapists at various points during the discussion groups: this is illustrated in extracts fifteen and sixteen.

Extract 14

223.**C3**: absolutely I had a really interesting experience (2)
224. it was a while ago now it was when I did my screens back
225. to back and I screened the first person and had a fairly
226. horrific long history of child abuse erm she ju just one of
227. the most difficult stories of abuse I'd heard and then the
228. person who I screened immediately after her was
229. somebody who wanted help because he had been an
230. abuser in the past
231.**C4:** {yeah

232.**C3:** {erm was worried that he might

233. (2) have a relapse (1) and I found empathy between

234. those two screens that came one after the other I was

235. the same person but (it was) really different

236.**C4:** yeah yeah

237.**C3:** erm (.) what was I guess what was interesting with

238. that was that because they were screens I didn't have

239. the chance to build up that relationship to see if it

240. changed

241.**C2:** yes

242.**C3:** like with the second person if I'd seen him say for

243. 16 times would that have changed

Extract 15:

510.**C3:** I think there's a lot of things that impact on it as well

511. or can do like I suppose I am thinking about in other jobs

512. where I have had a caseload of sort=of eight or nine and

513. I've had time to re-read notes and get more of an

514. understanding of people in a way I suppose there has

515. been more chance for me to:: (.) develop empathy say

516. in=between sessions. because I am re-reading things

517. whereas here with 30 people a week it's although I like

518. to think in the sessions I am (.)

In extract fifteen C3 makes specific reference to pressures of work by contrasting her current post (a caseload of 30) with a previous post (a

caseload of 8). Her empathy is presented as developing with her understanding of the client.

This is further extended where understanding and formulation specifically are said to help empathy to develop – then it is specifically set up as a skill the psychologist has in being able to bring about empathy.

Extract 16:

622.**C1:** I think >maybe< (.) >maybe< the work might involve
623. working towards trying to get er if if you are working
624. towards trying to get and understanding and formulation
625. then perhaps you perhaps that might be similar to
626. working towards getting empathy

Accountability is managed in two ways: responsibility is put onto the client in the same way as limited empathy was in the journal paper i.e. accountability is given to the client's because of what they are presenting with. Furthermore, by putting accountability onto other people in the story, she is managing her own accountability by saying we are responsible for making this empathy happen.

Specifically in the CBT group, empathy is conceptualised as something that the therapist controls to a degree to do their job which requires therapeutic skill.

Extract 17:

334.**T2:** mmm (.) and is it something we control (.) to

335. a degree (.) because <with some clients kind=of

336. just giving them the empathy (.) is not

337. necessarily erm (.) therapeutic> so do we kind=of

338. control what you know if things if there was a

339. knob ((laughs)) I don't know do we kind=of

340. control what we do and where we do that really

341. (.) you know (.)

[lines omitted]

597.**T2:** yeah yeah but that's what I mean you need

598. you've got a knob haven't you how much you

599. turn on and off an and sometimes you have to be

600. a bit strict instead something like being a parent

601. isn't it ((general laughter))

Extract 18:

217.**T3:** but does empathy develop=is is empathy

218. always there from the first minute of that first

219. session (.) or can you develop it I think wi wi with

220. some people you can be more <u>with</u> them they

221. can be more similar to you and you can really

222. appreciate what they are going through might be

223. similar to a previous client and so perhaps that

224. empathy is kind=of there at full tilt from that first

225. moment of the first session (.) with a perpetrator

226. perhaps with say erm someone who=is erm

227. (chronically feel) is is that horrible when you see

228. that screening that that that's that's all you

229. {see

230.**T1:** {its=biased yeah

231.**T3:** that's all you see you don't know anything

232. about that person and when you start {working

233. with them

234.**T2:** {it's

235. judgement isn't it {(we're judging)

236.**T3:** {and after after two three

237. or four sessions that that's the point of not you

238. might {see it (a=lot else)

239.**T1:** {personal (account)

240.**T3:** (you've got more about them) develop

241. understanding perhaps empathy will develop

242. o::ver the sessions

3.5. Other interesting findings.

3.5.1. *Confusion.*

In the psychologist discussion group, the issue of professionalism appeared under a further point of interest in the data: confusion. This section doesn't represent constructions of empathy as such, but refers specifically to the action done through the discussion of confusion.

In the literature, empathy is considered to be a confusing concept which is inconsistently applied and defined hence my research interest in it. Interestingly this confusion also appeared in the psychologist group. First I will present two extracts which represent the topic of confusion before moving on to the discussion of what the psychologists are doing with their talk and how it relates to the DAM (extracts nineteen and twenty).

Extract 19:

344.**C2**: So what's the difference between the two then

345. sympathy and er empathy

346.**C1**: Hhhh (.) because you I guess (.) I guess empathy (.) s s

347. sympathy I guess (.) certainly (.) >I I don't know<

348. sympathy would suggest to me like you feel so:::rry for

349. someone

350.**C2**: yeah

351.**C3**: ((laughs))

352.**C1**: emp:::athy is more about you can perhaps have an

353. understanding of someone but not feel sorry for them

354. you could perhaps have empathy for someone and

355. respect them

Extract 20:

699.**C1**: ...I dunno I I I (.)

700. yeah I don't know exactly what empathy is and how

701. these things all relate (2)

702.**C2:** I do think it's important to feel empathy

703.**C1:** definitely (4) whatever it is

704.**C2:** what it is yeah I don't know what it is really (9)

705.**C1:** .Hhh understanding and connecting on an emotional

706. level with someone

In extract nineteen C1 is responding to C2's question about the difference between empathy and sympathy. To provide some context to this extract, prior to this extract, C1 uses empathy and sympathy within the same sentence. This comparing and contrasting between empathy and sympathy is commonplace in the literature of empathy (Curwen, 2003). In direct questioning of the difference between the two, C1's response seems to illustrate confusion. This confusion is picked up on through the pauses in C1's speech, and the speeded up "I don't know" which is followed by laughing from C3. Despite this, C1 follows this with a succinct formulation of the difference between empathy and sympathy.

Similarly in extract twenty another period of confusion is illustrated. This extract is taken from 28 minutes into the discussion (approximately two thirds of the way through the discussion group) where already a number of definitions of empathy have been given and where psychologists have been actively constructing empathy within the group. Here the directly proceeding section was around how clients would answer the question set as the topic for the discussion group, i.e. what is empathy in the context of the therapeutic relationship. Despite the

group having already had a lengthy and varied discussion around what empathy is or is not, they come to an apparent state of confusion. This is indicated by the long delays of two, four, and then nine seconds. C2 and C1 are engaged in both saying they don't know what empathy is, then following the last pause of nine seconds, C1 produces a succinct definition of empathy.

In both of these examples there is the feeling that psychologists are motivated to provide a universal definition. Instead of explicitly stating an uncertainty or confusion about empathy and leaving it there, C1 finalises[29] this with a fully formulated definition.

If we return to the DAM, specifically with regards to the action done by the discourse, we can suggest a possible interpretation of why C1 in both extracts moves to finalise empathy in this way. This could sit with an intolerance of uncertainty. By providing a definitive answer in both situations, it could be that the psychologist is managing his professional accountability in front of his colleagues by being confident in providing an answer to the question set by his colleague in the first extract and to the broader group topic set for the discussion.

[29] I have adopted the term 'finalisation' from Brett Smith (personal communication, August 23, 2010). Smith refers to finalisation as a worrying trend creeping into qualitative research where the analyst attempts to find a final overarching account in the data; I use it in the same sense here to refer to the desire to find a definitive answer to the question of what empathy is.

3.5.2: The use of the category entitlement device

There has already been discussion of the vivid description discursive device and the category entitlement discursive device. Below are further extracts from the discussion group with the CBT therapists which illustrate how category entitlement was worked up by therapists.

Extract 21: Reference to experience

367.**T2:** there is an ass erm (.) with IAPT there is (2) I

368. think people they took people on for training that

369. obviously had had some experience they weren't

370. people that we just wasn't it there it wasn't a

371. novice really that you took on

Extract 22: Reference to skills base

402.**T2:** but I think that was kind of a s there was an

403. assumption that we had those skills

Extract 23: Reference to literature

52.**T1:** its=like Rogers talks about it being a way of

53. <u>being</u> well that's how <u>do</u> you define a way of

54. being (.) it's not really its

[lines omitted]

130.**T2:** I don't know because (.) don't they say your

131. personality's formed °isn't it° sort=of before

132. around a 5 (.) so:: is it learned behaviour isn't it

133. what you learn from: you know is it that nature

134. nurture debate that we're back to of how much of

135. it is learnt and how much of it is sort=of very

136. innate in

Extract 24: reference to models

706.**T1:** it is what we were talking about yesterday

707. in mindfulness that's the that was touching on

708. the paradoxical theory of change in that we're

709. just Gestalt which is not to run away from but to

710. be here

Part Four: General Discussion and Reflexive Section

4.1. Section Introduction

This discussion section is organised into four subsections: a summary of the findings; consideration of limitations and suggestions for future research; and a reflexive section which is further divided into methodological, epistemological and personal reflections. I will start by summarising the results from the study.

4.2. Summary of the Findings

The original objective of this study was to explore how therapists construct empathy and to generate hypotheses about why therapists construct empathy in this way. A secondary objective was to encourage similar explorations of the psychological lexicon by adopting a social constructionist position. This was encouraged by Edwards (1999). It was identified that it has been the tradition in psychology to adopt a cognitivist approach to language. However, this has not acknowledged the variability in language use and the use of language in performing action. This tradition in psychology has been challenged by Potter and colleagues and the general view of language as representative of some internal reality has been rejected by social constructionists and all forms of discursive approaches (Wetherell, Taylor & Yates, 2001). Potter and Hepburn (2005) summarise this in the following way, "analysis in discursive psychology does not follow a fixed pattern. Rather it works with hypotheses about what the talk is

doing, with the aim being to develop an explanation that will account for both the patterns that are in the material and the deviations from these patterns" (p. 341).

The story generated about the data in this study was that through their constructions of empathy, therapists (psychologists and CBT therapists) were managing their professional accountability. Professional accountability has been identified in a previous studies utilising discursive psychology. Robertson, Paterson, Lauder, Fenton & Gavin (2010) conducted a study in a healthcare setting where they explored how nurses talked about their experience of completed suicide by a patient on their ward. According to Edwards and Potter (1992) and Potter et al. (1993), accountability is a core feature of everyday discourse and I wonder if professional accountability would have been equally evident had I asked therapists views on any of the other therapist-offered conditions (Rogers, 1957).

Surprisingly, the main difference between the clinical psychologists and the CBT therapists was not in their construction of empathy. Rather it was in the way that they 'worked-up' their constructions as factual and therefore indisputable. My interpretation was that clinical psychologists' used vivid description in the form of case studies and that CBT therapists worked-up their category entitlement throughout the discussion group. This is drawn on further in the methodological reflexivity section. It is drawn on in this section because it was

considered that maybe the reason for this was the application of a different methodology in these groups.

I also wondered about the discursive devices. The hypothesis was that the CBT therapists used the evidence base and psychological models to work up category entitlement, whereas the clinical psychologists use case studies. In terms of quality, the case study is considered the poorest quality of evidence whereas RCT's and evidence bases are considered the Gold Standard (Oxford Centre for Evidence-based Medicine Levels of Evidence, 2001). I wondered if the CBT therapists were aiming for this level of evidence to back up their claims whereas the clinical psychologists appeared more relaxed and seemed to use intuition and clinical judgement rather than citation of evidence.

4.3. Limitations and future research

Methodologically, having different procedures, it was interesting to note that the CBT therapists naturally discussed the topics contained on the interview schedule before I introduced them. Therefore, in terms of the topics discussed I do not think the different methodologies were a limitation in any way. I do wonder though, if my presence in the CBT therapist group, both as a factor of my actually being there as well as my position as a trainee clinical psychologist, influenced the talk.

The issue of professional accountability is almost implicit in what we do as therapists. I wondered if this reflects the training courses undertaken as clinical psychology trainees and CBT trainees. Especially in

psychology, it almost as if our accounts are never taken at face value unless we can back it up with evidence. It is interesting then that the clinical psychologists presented case studies whilst it was the CBT therapists that provided the 'gold standard' evidence base.

Furthermore, I wondered if there was a broader issue with regards to professional accountability that might reflect the nature of the IAPT service or the current NHS climate and economic situation where therapists are feeling less secure about the future of their roles and therefore are defending them more vigorously.

If I were to do the research again, I think I would change the procedure for the CBT group to match that of the clinical psychology group. Despite my original reasons for facilitating the discussion, given that therapists naturally covered the areas I was interested in collecting discourse on, I think I would not be present during the discussion.

In the psychology group, one therapist wondered what her clients would answer to the question of 'what is empathy'. It would be interesting to conduct a similar study into this. Furthermore, as this study specifically focused on therapists' constructions of empathy I wonder also about how therapists *do* empathy. This would involve a DA of sessions for which there would potentially be the opportunity within the same service as therapy sessions are routinely recorded for supervision of therapists. Although this obviously has further ethical implications; for example how willing would participants (therapists) be to have their recordings analysed by an external researcher? This would be asking an entirely

different research question to the one asked here but it would be interesting.

4.4. Reflections on writing the journal paper

With regards to writing the journal paper for the British Journal of Clinical Psychology (BJCP; please see appendix K for manuscript requirements), to my knowledge there is only one previous discursive article in this journal (Messari & Hallam, 2003) so at best discursive articles are rare in this journal. My decision to write my paper for this journal was the broader appeal of a paper in clinical psychology over submitting the paper to a discursive journal.

This created a conflict between what was my natural 'discoursey' style of writing, a feature of which is to write in the first person, and what I have interpreted as the BJCP style. For example I have written a joint analysis and discussion section which is common for discursive journals (Seymour-Smith, Wetherell & Phoenix, 2002; Wiggins, Potter & Wildsmith, 2001) whilst from my reading of articles in the BJCP, these sections are commonly split into the results and discussion (perhaps a positivist convention but also adopted by other qualitative studies published in this journal). However, I have also followed closely the American Psychological Association (APA, 2010, p. 35) publication manual which draws attention to the use of a combined results and discussion section.

4.5. Reflexive section

I have divided this reflexive section into three further sections. The first two – methodological and epistemological reflexivity - overlap and the final section provides personal reflections on the research process generally, including how my experiences prior to and during this research have informed and been informed by the research process.

4.5.1. Reflexivity – methodology

In this section, I will discuss issues around methodology and what I have learnt from them.

In the discussion group with the clinical psychologists, I was not present as I took the opportunity to utilise a pre-existing group which met regularly in the service. The format of this group met the needs of the study in that it was a group where topics in psychology were discussed. Sometimes this would involve discussion of a research paper and at other times, discussion around a particular topic. As this was an established group, I did not feel the need to attend and was able to collect what Taylor (2001) refers to as naturalistic data which is considered to be a strength in discursive research Willig (2008a). On the other hand, the CBT therapists did not routinely meet in this way so the discussion group was an artificial situation and I wondered if the therapists would meet without meeting me. Therefore I decided on the different procedure. I do wonder what impact this had on the findings. There were definite differences in the way the groups constructed

empathy and the factual work they did with their constructions, despite the similarities discussed here. The question is whether this is problematic. Discursive psychology acknowledges there will be variability in people's reports and that this will be a factor of culture etc, and also that this will be a factor of environment. Gilbert and Mulkay (1984) found difference in the way scientists accounted for the results of studies leading them to generate two interpretative repertoires to summarise this. The most interesting finding was that the scientists would endorse both versions (or subject positions) within the same interview.

4.5.3. Reflexivity - epistemological

Despite the fact that discursive approaches in research are increasing, it is only just being accepted in educational settings (Antaki, Billig, Edwards & Potter, 2003) and those who use it are educating themselves in the area before and through conducting the research. This is difficult enough in qualitative research where there is still the view that qualitative research is the poorer relative to quantitative (David Rennie, personal communication, August 25, 2010). As a result I would argue that this leaves us as qualitative researchers feeling the need to defend ourselves.

4.5.2. Reflexivity - personal

According to Cameron (2007) in all aspects of the research process, the researcher is altering the data through their involvement with it. Even in

the transcription, the data is no longer the same as that spoken by the participant. I could only read the data in the context of my previous knowledge and history and training so far in the area. I cannot separate myself as the researcher from this history and influence. Therefore, in the data analysis I have to acknowledge that my interpretations are reflective of this. I found that therapists were primarily defining empathy as cognitive (therapeutic tool) or affective (felt congruence). In the extended analysis, I provide extracts from the discussion groups where I felt that these definitions were being used. I cannot say how much of this is reflected in the talk and how much is my reading of it because I too as the researcher am active in constructing (Horton-Salway, 2001). I have undertaken research into the construct of empathy previously. Through this process and the current thesis, I have surrounded myself with literature on empathy which frequently makes reference to the cognitive/affective divide and I may have been looking for this in the data. Alternatively, therapists themselves may have been endorsing this dichotomy because as therapists, they would have access to the same literature on these 'taken-for-granted' discourses on empathy.

In the writing of this thesis, I have been hugely influenced by two things: my epistemology which I have tried to remain true to throughout the thesis, and my attendance at a qualitative methods conference which provided the opportunity to meet other qualitative researchers.

In August 2010, I attended the British Psychological Society (BPS) Qualitative Methods in Psychology (QMIP) conference in Nottingham.

Despite this being late in the research process (i.e. by August I had already collected and mostly analysed my data), this certainly influenced how I approached the write-up and also I have made reference throughout to a number of speakers from the conference. This illuminated for me, the breadth of DA approaches, each valid for its particular use. It helped me to make sense of discursive psychology and its place in the genre of qualitative research approaches and I think has helped me to defend my position.

Of particular interest was a talk by L. Yardley (personal communication, August 24, 2010) where she suggested that as qualitative researchers we are positioned to defend our practice against the 'gold standard' of qualitative researcher in psychology. Yardley suggested that actually qualitative quantitative and research have different jobs to do. Shedrew this together with her talk on composite analysis which is how qualitative and quantitative methods can work alongside each other in their different roles to further psychology.

As mentioned above, Horton-Salway (2001) says that as researchers we are responsible for fact construction in the same way as our participants. I make my account credible by using the voices of my participants and also throughout the thesis I have made use of quotes from other DA researchers. I intend to give some background to myself and my interest in this topic.

As a clinical psychology trainee I have opinions of the idea of good versus bad therapy. Furthermore, in my own practice I am motivated to

appear a 'good' therapist. As a trainee I have worked at the research site and so I was not a stranger to the therapists involved in the study although I did not know the CBT therapists.

My interest in empathy came from a previous study I conducted as an MSc student. This study took a different philosophical position than I have adopted here. I focused on the forensic psychology and criminology literature which looks at empathy deficits in offenders. The literature on this was inconsistent in that it did not find consistent empathy deficits in offenders. From an empirical realist position at the time, I thought that differences in the study reflected differences in the way that empathy had been operationalised and therefore measured. With a different operationalisation comes a different measurement tool. I began to wonder about the concept of empathy and its nature. At the time I made sense of it as there being different dimensions to empathy advocating the cognitive/affective division represented in the literature.

My earlier view of empathy as a cognitive or affective state that comes from within the person (therefore real phenomena), came from my absorption of the empathy literature which also suggested the same. In my reading of the discourse of the therapists, I identified these two positions being represented (section 3.3). It could be that I was already programmed to look for this distinction in the way that therapists looked at empathy because of my previous work in the area; however, an alternative might be that this dichotomy was represented by the therapists in their talk because they had been exposed to the same

literature (this might be the dominant discourse in therapeutic settings and might also be represented in training as a clinical psychologist or CBT therapist). In order to explore this, we could compare it with the summary of the documentary resources reviewed in section 3.1.

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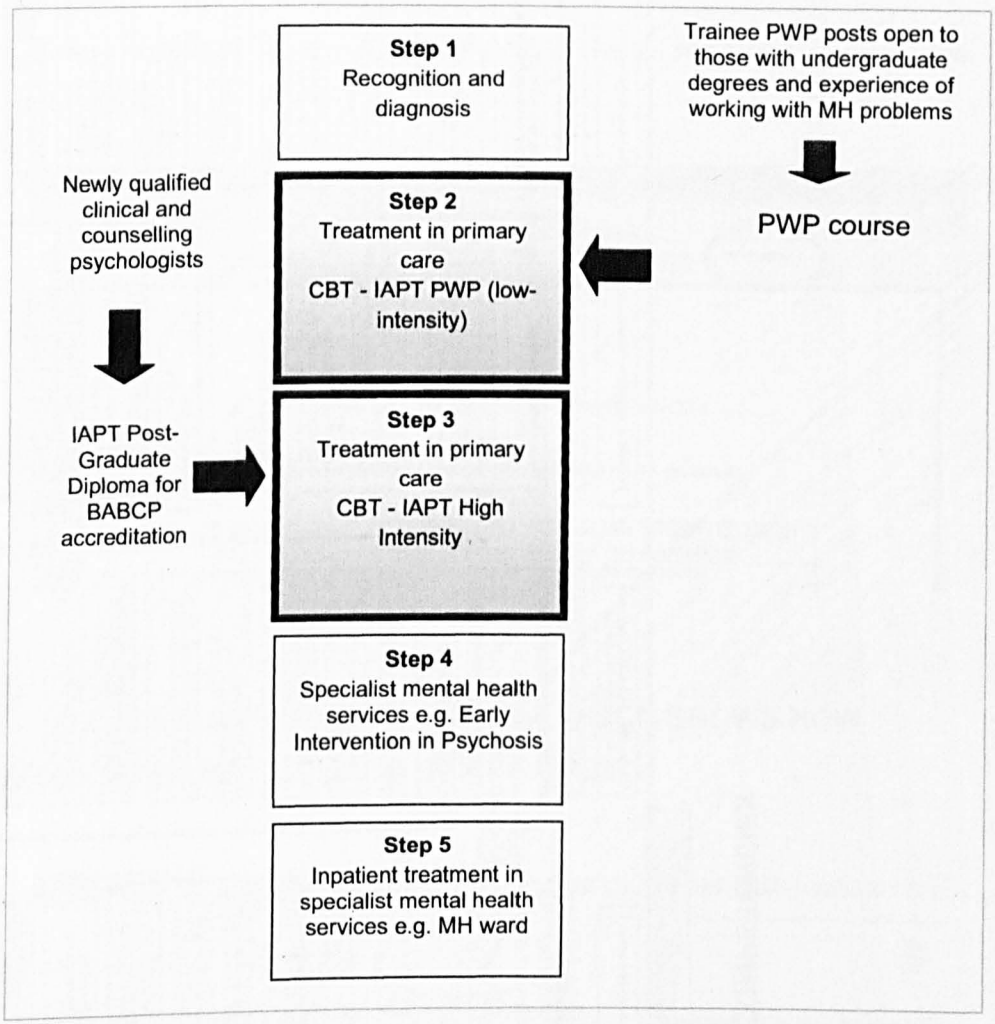
APPENDIX A: AN EXAMPLE OF AN IAPT COMPETENCY DOCUMENT

CBT COMPETENCES - BASIC COMPETENCES

Knowledge of basic principles of CBT and rationale for treatment

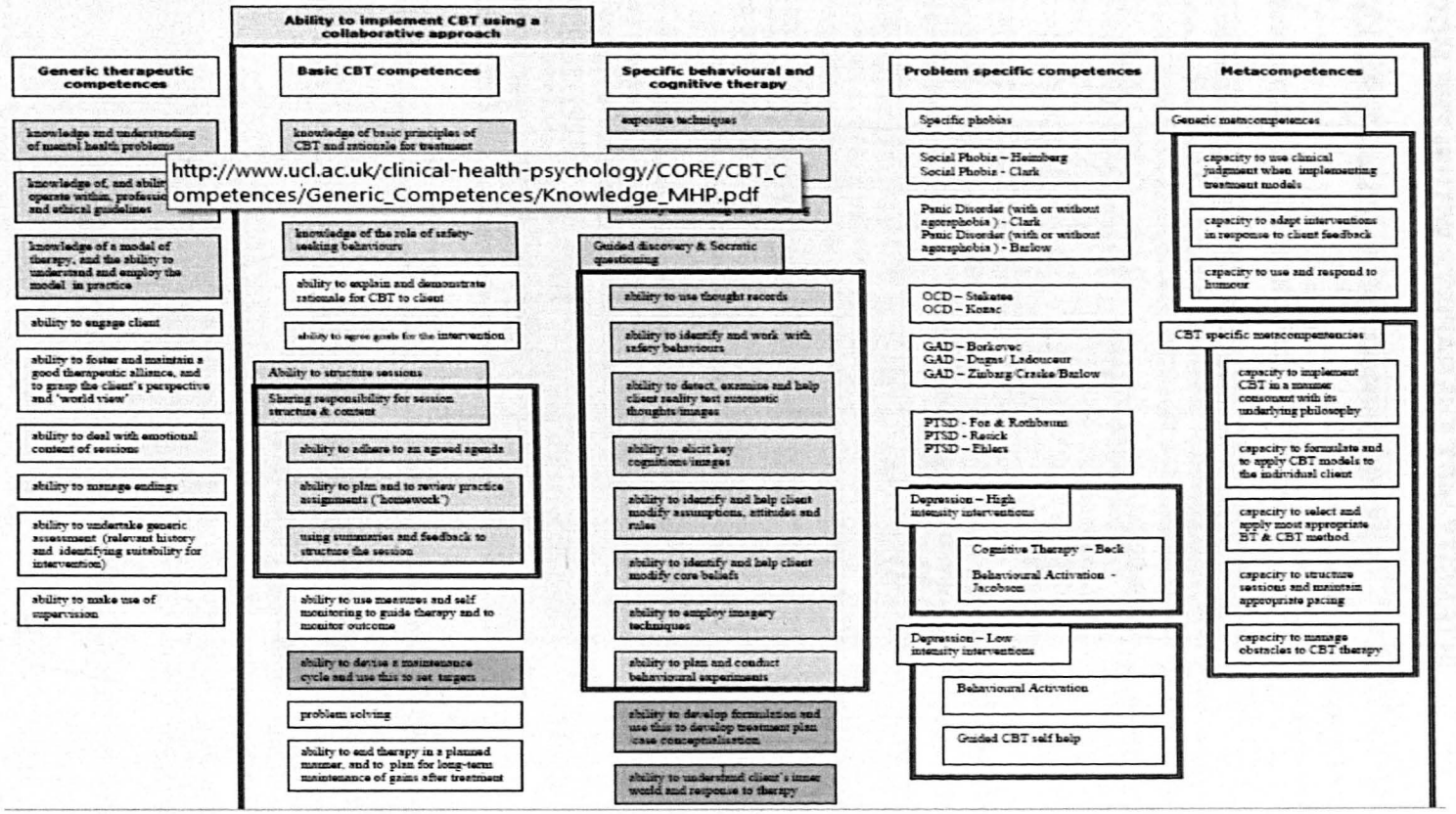
Knowledge of the behavioural component in behavioural and cognitive behavioural therapies – the ways in which people respond to distress by behaviours which can maintain or worsen their problem (for example, by avoidance or by reducing or restricting activity)
Knowledge of the cognitive component in CBT - the way people think and create meaning about events in their lives, and how this links to the ways in which they develop beliefs about themselves, others and the world in which they live
An ability to draw on knowledge of the basic principles that underpin the rationale for CBT:
the inter-relationship between thoughts and images, feelings and behaviours
the aim of helping clients to become more aware of the how they reason and ascribe meaning, to develop alternative viewpoints and explanations for their difficulties and to use behavioural experiments to test-out the accuracy of these alternatives
the aim of helping the person feel safe in order to test out their assumptions and fears and to change their behaviour
An ability to draw on knowledge of the importance of working collaboratively with the client:
a consistent philosophical and practical commitment to the notion that the client and the therapist work together to do the work
awareness that the aim of therapy is to help clients tackle their problems by harnessing their own resources
An ability to draw on knowledge and awareness of the importance of the client putting what has been learned into practice between sessions (practice assignments, or "homework")

APPENDIX B: THE STEPPED-CARE DELIVERY MODEL INCORPORATING THE LOCATION OF HIGH- AND LOW-INTENSITY IAPT THERAPISTS WITHIN THE MODEL



PWP = Psychological Wellbeing Practitioner (also known as low-intensity therapists)

APPENDIX C: CBT CORE COMPETENCIES



http://www.ucl.ac.uk/clinical-health-psychology/CORE/CBT_Competences/Generic_Competences/Knowledge_MHP.pdf

APPENDIX E: INFORMATION PACK

The University of Nottingham

NHS Nottingham City

INFORMATION ABOUT THE RESEARCH

Empathy: An exploration of the construct within the context of the therapeutic relationship.

Researchers: Tammy Walker, Dr. Saima Masud, Dr. Roshan das Nair, and Professor Nadina Lincoln

Invitation to take part in a research study on empathy

You are being invited to take part in a research study. This study will go towards the completion of the Doctorate in Clinical Psychology for the study co-ordinator, Tammy Walker.

This information sheet will tell you why the research is being done and what is involved.

Please take time to read the following information carefully and to think about whether you would like to take part in this research. It might be helpful to discuss the research with your colleagues when making your decision.

What is the purpose of the study?

Our aim in this research is to explore the construct of empathy and how it is used in therapy. Therefore, we are interested in speaking to you and other therapists to explore how therapists think about and use empathy.

Participation in the research will involve you taking part in a group discussion with the study co-ordinator and a number of your colleagues. You will also be asked to complete a brief demographic information sheet. Participation in this study is voluntary and hopefully you will find participation interesting.

Why have I been invited to take part in this research?

I am asking all therapists of the Health in Mind Service of Nottingham City National Health Service Trust to take part in this research. This includes Clinical Psychologists, Improving Access to Psychological Therapy (IAPT) low- and high- intensity workers, and Cognitive Behaviour Therapy (CBT) therapists.

Do I have to take part?

Participation in this study is entirely voluntary. We will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You will be free to withdraw at any time, without giving a reason.

What will taking part involve?

- Participation in this study will involve contribution to a group discussion organised at a time convenient for you and other participants. The group discussion itself is likely to last between 40 and 50 minutes. During the discussion, the group will be asked a number of questions about empathy. However if you can think of anything extra that you want to add this will be very useful.

- You will be asked to complete the attached demographic information sheet and bring this with you to the group discussion. The demographic information sheet asks you some questions about your current job role.

- At the group discussion, we will be able to answer any further questions you have about the research; we will go through this information sheet and the consent form with you.

What are the potential benefits and costs of taking part in the study?

The research itself may not be of direct benefit to you. However, if the findings of this study are able to provide more information about empathy within the therapeutic relationship, the findings may be used to inform training of therapists in the future.

Although the group discussion will be conducted at a time convenient to you, it will involve the cost of time to meet with the researcher. The group discussion will be conducted at New Brook House therefore

participation will not necessitate any travel. It is expected that the interviews will take place during working hours, therefore every effort will be made to conduct this at a time that causes least disruption to you and your colleagues; this will be considered when arranging the group discussion.

What will happen with the information I give during the study?

The group discussion will be recorded on a digital audio-recorder. This is so that the discussion can be transcribed. The digital recordings will be stored in a locked filing cabinet at the University of Nottingham until they can be transcribed, at which point the recording will be erased. The transcriptions will be anonymised using a personal identification number and therefore you will not be identifiable from the typed notes.

The demographic information forms will be coded with your personal identification number which also appears on this information sheet and the consent form.

To ensure service-user safety, should any incidents be identified during the group discussion that indicates harm to a service-user, it will be the researcher's duty to deal with this information appropriately. This will be discussed privately with the therapist immediately following the discussion group, and the researcher will seek advice from Nottingham City PCT Research and Development team.

Informed consent

Prior to participating in the group discussion, you will be asked to complete the attached consent form and either bring this with you to the group discussion or return it to Dr. Saima Masud who is a member of the research team. You will be given at least 24 hours to consider whether you would like to take part in this study before the group discussion is arranged.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased, therefore this information may still be used in the research analysis.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact details are given at the end of this information sheet). If you remain unhappy and wish to complain formally, you can do this by contacting the Chief Investigator for this study, Professor Nadina Lincoln (Chair of the Institute of Work and Health Organisations ethics board), or Tom Cox (Head of School) both of whom are at this address:

I-WHO, International House
Jubilee Campus
Wollaton Road
Nottingham. NG8 1BB

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee (REC), to protect your interests. This study has been reviewed and given favourable opinion by Nottingham REC.

How do I get involved?

If you are interesting in taking part in this study we would be delighted to hear from you. Please contact the study co-ordinator using the details provided below. We will be happy to answer any further questions you may have.

FOR FURTHER INFORMATION PLEASE CONTACT
TAMMY WALKER
I-WHO, University of Nottingham
International House,
Jubilee Campus, Wollaton Road
Nottingham. NG8 1BB
E-mail: lwxtlw@nottingham.ac.uk

Ethical clearance for this research has been given by Nottingham Research Ethics Committee

The University of Nottingham

NHS Nottingham City

CONSENT FORM
(06/05/10 Version 3)

Title of Study: Empathy: An exploration of the construct within the context of the therapeutic relationship.

REC ref: 10/H0403/6
Name of Researcher: Tammy Walker

Name of Participant:
Participant ID:

Please initial box

1. I confirm that I have read and understand the information sheet (Version 3, 06/05/10) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the group discussion will be audio-recorded and that anonymous direct quotes from the discussion may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature
Name of Principal Investigator	Date	Signature

2 copies: 1 for participant, 1 for the project notes

The University of Nottingham

NHS Nottingham City

Participant ID: ☐

DEMOGRAPHIC INFORMATION FORM
(23/04/09 Version 1)

1. Please indicate the number of years you have been qualified to do the job you are doing

   Less than a year ☐
   1-3 years (inclusive) ☐
   4-6 years (inclusive) ☐
   7-9 years (inclusive) ☐
   10-12 years (inclusive) ☐
   12-15 years (inclusive) ☐
   16-20 years (inclusive) ☐
   Over 20 years please state how long_____ years.

2. How long have you been working as a therapist in this service?

   _____

3. What is your job title?

   _____

4. What would you say is your main therapeutic approach? By this I mean the main model you would work with (e.g., CBT, psychodynamic).

_____
_____
_____
_____
_____
_____
_____
_____
_____

APPENDIX F: INTERVIEW SCHEDULE

INTERVIEW SCHEDULE
(23/04/09 - Version 1)

General interview schedule for the group discussion

Thank you for volunteering your time to take part in this group discussion, it is very much appreciated.

- Cover confidentiality: Just to clarify, everything that you discuss within this group discussion is confidential between you, the other group members and me. This recording will be transcribed and assigned the participant ID given on your consent form. Therefore you will not be identifiable from the transcript except for being identifiable to other group discussion members. Do you have any questions about confidentiality and storage of data which were not answered by the information sheet?

- Refresh what will happen: It is expected that this group discussion will last for no longer than 50-60 minutes and will consist of five questions. Feel free to suggest something that you would like to talk about if you think there is something important we have not covered within these five questions. I am interested in your views on empathy within the therapeutic relationship; therefore I would welcome your comments even if these go beyond the questions in the interview schedule. These questions are only used to provide some structure to this discussion.

- Do you have any questions before we start?

Empathy questions

- What do you understand by the word empathy?

- Do you think that people learn to be empathic or is it something that is innate?

- Was empathy covered in your professional training as a clinical psychologist/IAPT practitioner/CBT therapist?

- How do you think you use empathy in your practise with clients?

- How important do you think empathy is in the therapeutic relationship you have with your clients?

Finally therapists will be given the opportunity to add anything they think is important about empathy but which hasn't been covered.

Is there anything that we have not covered in this interview about empathy that you think is important to say?

Ending the group discussion

- Thank you for taking the time to take part in this study.
- It is expected that this study will be completed in September 2011, if you are interested in the findings from this study I plan to present the findings within a business meeting here at Nottingham City PCT. I plan to email participants who have expressed an interest in the findings with the date of this presentation. Would you like me to keep a note of your email address and let you know when a date is arranged for this?

The end

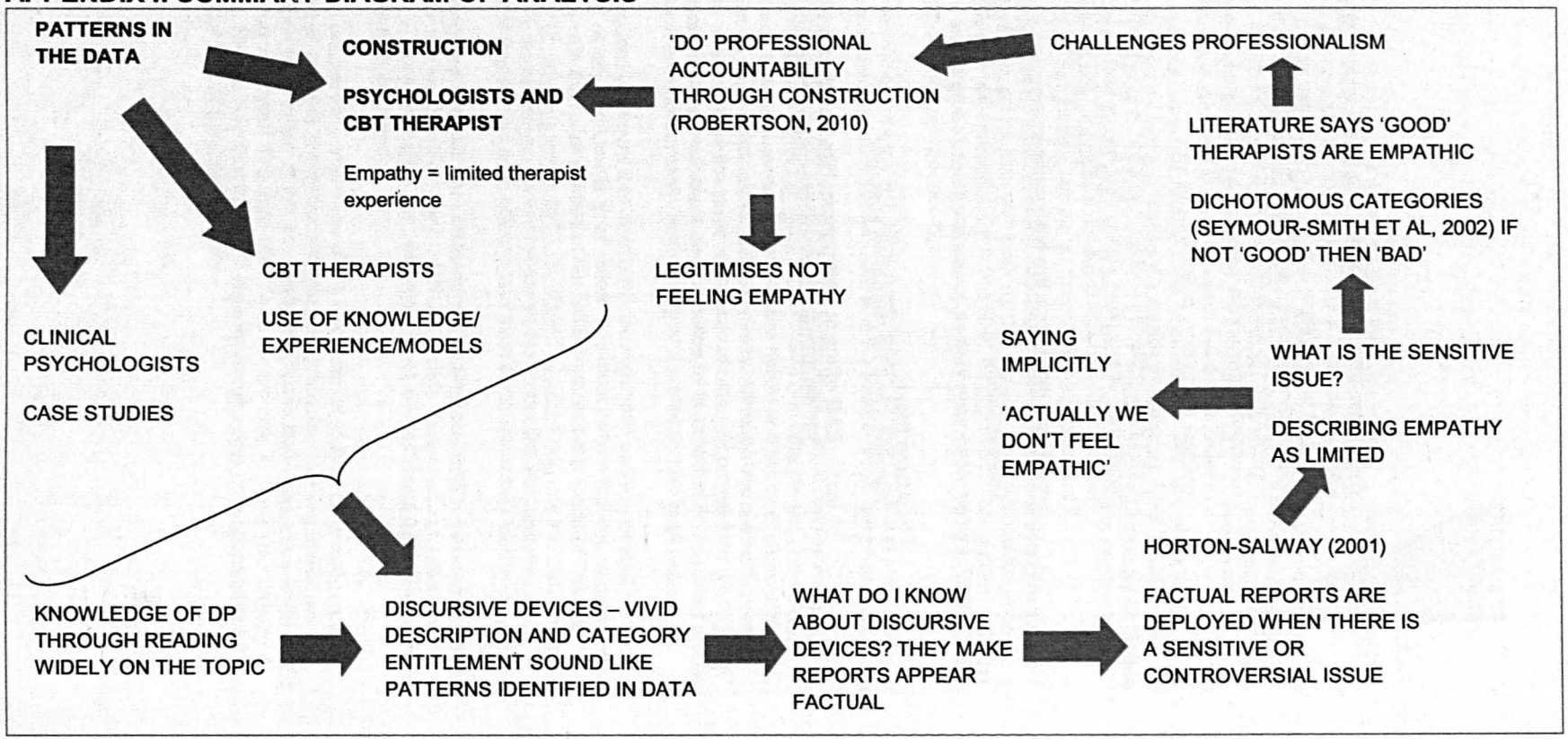
APPENDIX G: ADAPTED JEFFERSONIAN TRANSCRIPTION NOTATION SYSTEM

Symbol	Example	Explanation
(0.6)	that (0.5) is odd?	**Length of silence** is measured in tenths of a second.
(.)	right (.) okay	**Micro-pause**, less than two-tenths of a second.
:::::	I:::: I don't know	Colons indicate **sound-stretching** of the immediately prior sound. The number of rows indicates the length of prolonged sound.
_____	I know that	Underlining indicates **speaker's emphasis or stress.**
[	T: [Well at's R: [I mean really	Left brackets indicate the point at which one speaker **overlaps** another's talk.
=	you know=I fine	Equal sign indicates that there is **no hearable gap** between the words.
WORD	about a MILLION	Capitals, except at beginnings, indicate a marked **rise in volume** compared to surrounding talk.
°	°Uh huh°	Words in degree signs indicate **quieter** than the surrounding talk.
> <	>I don't think<	Words in 'greater than' then 'less than' signs are delivered at a **faster pace** than the surrounding talk.
< >	<I don't think>	Words in 'less then' then 'greater than' signs are delivered at a **slower pace** than the surrounding talk.
?	Oh really?	Question mark indicates **rising intonation.**
.	Yeah.	Full stop indicates **falling intonation.**
Hhh	I know how .hhh you	A row of h's prefixed by a dot indicates an **inbreath**, without a dot, an outbreath. The number of h's indicates the length of the in- or outbreath.
( )	What a ( ) thing	Empty parentheses indicate **inability to hear** what is said.

(word)	What are you (doing)	Word in parentheses indicates the **best possible hearing.**
(( ))	I don't know ((coughs))	Words in double parentheses contain **author's descriptions.**

(Taken from Rapley, 2007, p. 60)

APPENDIX I: SUMMARY DIAGRAM OF ANALYSIS



APPENDIX J: FRAMEWORK FOR ANALYSIS

1) I transcribed both discussion groups. This is because transcription is considered to be part of the analysis because it is where the first reading of the data occurs (Cameron, 2001; Potter & Wetherell, 1987). Following the initial transcription, I listened to the recording whist reading through the transcript a further couple of times to make sure that I had as accurate representation of the recording as possible. As Cameron would say, even by transcribing the data, we are changing it – it is only a representation of the discussion group rather than the discussion group itself. For this reason, I continued to read the transcript whilst listening to the recording as this gave richness to the data.
2) I reviewed the material in this way initially a further 20-25 times. This reading and re-reading is identified as an important step by Potter and Wetherell (1987) as it allows the analyst to gain familiarity with the data.
3) Next I coded the data although in reality, this happened at the same time as the reading and re-reading as certain patterns emerged in the data. Generally the patterns were with respect to certain constructions of empathy – not necessarily in the definitional sense although this did occur and these are referred to as interpretative repertoires – but in terms of what therapists seemed to be identifying as characteristics of empathy.
4) From this initial coding, I was able to develop 'data files' which contained sections of the transcript which seemed to 'fit' together in terms of characteristics of empathy. For example, in the psychologist transcript, the idea of empathy being a limited resource was repeated throughout the transcript and all sections where this was discussed were put into a file together.
5) The next step I took was to analyse the data in these coded files. This involved further reading and re-reading and holding in my mind three questions identified by Horton-Salway (2001) as fitting with the discursive action model. These were:
   - How are events described and explained
   - How are factual reports constructed
   - How are cognitive states attributed
6) These questions are quiet specific to the DAM but could be incorporated into Potter and Wetherell's broader questions of, "why am I reading this passage in this way?" and "what produces this reading?" (1987, p. 168). Being familiar with other work from the field of discursive psychology was helpful as I was able recognize discursive features already described in other work.

APPENDIX K: JOURNAL MANUSCRIPT REQUIREMENTS

Manuscript Requirements for Publishing in the British Journal of Clinical Psychology[30]	**RES guidelines**	**Criteria met or not applicable**
The following types of papers are invited: 1. Papers reporting original empirical investigations; 2. Theoretical papers provided that these are sufficiently related to empirical data.		Journal paper
Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures) although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.		Criteria met
Contributions must be typed in double spacing with wide margins. All sheets must be numbered.		Criteria met
Tables should be typed in double spacing, each on a separate page with a self-explanatory title. They should be placed at the end of the manuscript with their approximate locations indicated in the text	"Please place figures and tables in the text where you would have them placed"	N/A
For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results and Conclusions.		Criteria met
For reference citations, please use APA style		Criteria met

[30] Information retrieved from http://www.bpsjournals.co.uk/journals/bjcp/notes-for-contributors.cfm on 7th October 2010

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.		Criteria met

APPENDIX M: EXTENDED EXTRACT FROM C2

519.**C2:** I feel like I mean I'm I don't know if this is a good
520. example but erm I've had a erm client recently where
521. this I think if you you could sort of almost chart the
522. empathy I guess so erm she'd seen erm ((name of a
523. member of staff who has now left the service)) before
524. she left and then she's been seeing me for quite a long
525. while and erm initially it's one of those where sort=of you
526. know we didn't know what we were working on and I
527. suppose initially I felt quite a lot of empathy and then
528. times gone on and there have been times when I've
529. thought what is this about I can't get a handle on it at all
530. and then times when I've felt like we're more with the
531. problem and then I'm more there with her and then just
532. as it's come towards the end erm and right near the end
533. she's gone back to the GP and said actually what I
534. wanted right at the beginning she hadn't mentioned to
535. me (inaudible) it hasn't been brought up is this ADHD
536. assessment
537.**C3:** oh
538.**C2:** erm and I took it to supervision and thought it just
539. didn't really fit with my:: understanding of what's
540. happening doesn't make sense to me doesn't seem to fit
541. (.) erm and so we've talked about it again on on the

telephone and I've felt at this point the empathy was

pretty pretty lo::w erm I was trying to sort=of set her up

for the fact that that I didn't know if she's get an

assessment

C3: {erm

C2: {if she did I didn't know whether she'd get a

diagnosis (.) and she came in yes::terday (.) and erm we

just started talking again and I said to her you know I'm

happy to do the referral we'll just (keep your mind open)

she started shaking and saying >I can't take much more

of this can't take much more of this< got this book out

about ADHD with all these little (.) slips in it and was

crying and crying saying you know you don't understand

you 've got to you know erm at that point I was like

wooow I've been so far away and I just felt like really

terrible afterwards I was like God I've just totally and then

when we started talking about it she was telling me all

these things that I never knew before that I had no idea

about that I hadn't asked about that and I was thinking

how is it possible to go through working with someone::

and (.) not know all this other stu::ff I I just felt it was

really really strange that you can construct something

with somebody over a long period of time

C1: {sure

C3: {yes

567.**C2:** {and by the

568. end they'll go hang on you've totally missed the point and

569. you know in a sense I felt like that at that level she was

570. saying YOU'RE NOT EMPATHISING WITH ME <u>AT ALL</u>

571. and she had to like (.) sort=of really get het up for me to

572. realise that and I just wondered how that sort=of gets lost

573. sometimes (.) and I think that is what I was saying earlier

574. about this when you're on a different sort=of

575.**C3:** {erm erm

576.**C2:** {sheet or

577. whatever you're not (.) °for some reason you've° (.)

578.**C1:** It's you know talking about what the dynamic is

579. between people and and like I dunno (if this is true) if if

580. she thought you know there's definitely wrong with me

581. and that I am not being understood no one can

582. <u>understand</u> me if you have a belief that no one can

583. understand then it's going to affect their ability to <u>feel</u>

584. understood::d and so

585.**C3:** {yes yes yes

586.**C1:** {and so things that you give

587. back it might it might resist that and challenge that and

588. and think of evidence that it contradicts what you're

589. saying and (.) {if you've got a view in your head it's

590.**C2:** {I can sometimes get quite you know cos I

591. just walked away thinking I've asked the right questions

592. at all how've I missed all of this but (.)

593.**C1:** that must be really hard for you

594.**C2:** yeah it was hard, I felt really like

595.**C1:** that's my empathic statement ((laughs))

596.**C2:** yeah thanks

597. ((General laughter))

598.**C2:** I felt really awful but I really felt like at that point and

599. this for me is what the empathy is about I wasn't

600. alongside her at all I felt like I'd totally sort=of (.)

601. somehow missed the (.)

602.**C3:** {erm

603.**C2:** {you know missed the boat if you like and I think that

604. the time when that happens this for me is the (.) I think

605. one of the key things about therapy never mind what you

606. are doing I think when you've missed that it's like you've

607. missed something really important somehow (.)