THE DEVELOPMENT AND INITIAL VALIDATION OF THE EMPATHY SCALE FOR SOCIAL WORKERS: THE ESSW

by

STEPHEN HALL KING, JR.

(Under the direction of Michael J. Holosko)

ABSTRACT

The concept of empathy is an organizing principle and valuable practice skill essential to the profession of social work. Despite this emphasis, little empirical study of this concept has been undertaken by social work researchers. The purpose of this study was to develop and initially validate the Empathy Scale for Social Workers (ESSW). The ESSW is a 42 item self-report questionnaire designed to assess empathy in social work practitioners. A sample of N=271 social workers who had attained the degree of M.S.W. completed an electronic survey containing the ESSW and three related measures. Data were analyzed using a quantitative-descriptive design, and utilized a variety of empirical testing procedures to evaluate the scale's initial validity including factor analysis. Findings revealed promising psychometric properties of the ESSW, and the use of exploratory factor analysis (EFA) demonstrated content, construct and factorial validity. These results were encouraging and they lay the initial ground work for the continued development of the ESSW. This scale addresses the gap in knowledge regarding the empirical evaluation of empathy for social workers. The results have implications for social work education, practice, research, and theory development. It

may be used to assess student training needs and as a screening tool for educators, supervisors and practitioners. The ESSW draws theoretical constructs from a variety of fields in its evaluation of the nature of empathy in helping behaviors and could benefit other direct practice helping professionals. The ESSW provides insight and depth to the processes of social work theory development and research.

INDEX WORDS: Empathy, Caring, Congruence, Perspective taking, Interpersonal sensitivity, Therapeutic relationship, Social work, Scale development.

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A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2009

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ACKNOWLEDGEMENTS

I would like to thank all those who supported this process and this project in particular. Each member of my doctoral committee provided unique and invaluable individual resources toward this effort.

I am indebted to Deborah Bandalos, for her patience and methodological expertise to further this research. Early in this journey, Larry Nackerud reminded me of the importance of the term philosophy in the degree I was seeking, and I have thought of his words frequently. His willingness to discuss my project, and the process involved, never wavered, and I can truly say that every piece of advice and counsel he shared with me turned out to be true. Patricia Reeves re-introduced me to the concept of social work theory, which after fifteen years of practice was invigorating. Her message of how the multiple realities that exist in how social work is understood, and practice is explained, set the "hook" in me early on. Ed Risler introduced me to the concept of measurement in social work research. Until this point, I understood practice effectiveness to be determined by what I thought had worked for clients in the past, or what I was told would work, as I ran down the agency hallway to the next crisis. This empirical way of examining social work practice was instrumental in my journey and in the development of this project.

As my committee chair, Michael Holosko provided an invaluable and unflagging interest and excitement for my efforts to develop the ESSW. He always made me feel that this was a unique and important project. His patience and support, during the times

I was sure I had “bitten of more than I could chew”,was always present. Most of all, he insisted that I stretch myself as a student and as a research practitioner. His “apprentice model” worked well for me. His high standards and expectations influenced my own expectations of myself profoundly. He, most of all, has sharpened my excitement for research, writing and my confidence to ask provocative research questions.

I want to express my enduring gratitude to my family for their support during this long and at times stressful adventure. My children, Justus and Chloe, have always been patient with the strange demands of doctoral education and have helpfully asked, “Shouldn’t you be working on your paper?”

My wife and partner, Garnet, supported all of us during this time and never once balked at the twists and turns the process has taken along the way. Few students are afforded the luxury you have given me to pursue this goal. I cannot think of a time when you were impatient or frustrated with me or the process. None of this would have been possible without you. You have always believed in me, and my capacity to accomplish things that I was unsure I could do. Your loyalty has inspired me and energized me in many ways and I will always be grateful.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS iv

LIST OF TABLES viii

LIST OF FIGURES ix

CHAPTER

1 INTRODUCTION 1

Statement of Purpose 6

Rationale 7

Definitions 10

2 LITERATURE REVIEW 12

Evolutionary Theories and Neurological Indicators 12

Philosophical and Societal Explanations 16

Empathy and Therapeutic Relationships 20

Empathy and Social Work 28

Theoretical Framework 37

3 METHOD 49

Scale Construction 49

Sample 49

Study Design 50

Data Collection 51

Instruments of Study 52

Data Analysis Procedures 54

4 RESULTS AND DISCUSSION 55

Demographic Data 55

Psychometric Properties of the ESSW and Other Measures 57

Sub-Group Analyses 72

Item Analysis 78

Factor Analysis 80

5 SUMMARY 97

Limitations 98

Conclusions 101

Implications for Social Work 107

REFERENCES 111

APPENDICES 127

A. The ESSW 128

B. The JSE (Clinical Social Work Version) 131

C. The SRA 132

D. The VAS 134

E. Survey Cover Letter 136

F. The Three Factor Skree Plot 137

G. The Four Factor Skree Plot 138

LIST OF TABLES

Page

Table 1: The 15 Most Highly Endorsed Items on the ESSW 59

Table 2: The 10 Most Highly Correlated Items on the ESSW.. 61

Table 3: Intercorrelations of the Four Main Scales 63

Table 4: Empathy Construct Correlations.. 64

Table 5: Empathy Domain Correlations... 65

Table 6: Comparisons between Practice Setting Groups on the ESSW 75

Table 7: Initial Eigenvalues of the ESSW 85

Table 8: Factor Structure Matrix of the ESSW 86

Table 9: Factor Pattern Matrix of the ESSW 87

Table 10: The ESSW Factor Correlation Matrix 91

LIST OF FIGURES

Page

Figure 1: The Concept of Empathy: Dimensions and Constructs 38

CHAPTER ONE

INTRODUCTION

Given that human relationships serve as a basic foundation for the growth and development of individuals in any society, effective communication within these relationships becomes necessary. How we communicate in terms of listening, language, and helping shapes and defines our culture. Helping behaviors provide an imperfect but necessary and universal social safety net that supports a civilization's capacity to successfully develop and mature.

Helping is essential for human capacities to flourish. For instance, helpful parenting facilitates the survival and development of an infant. Collective helping to navigate environmental hazards protects and promotes the cohesive nature of group relationships. Helpful education regarding what is known about a phenomenon promotes creativity and the expansion of group culture, knowledge and expression.

Helping in society has developed into increasingly complex and formal systems. The shaman of the earliest social groups was charged with protecting and preserving the physical, emotional, and cultural health of the tribe or group. While still integral to defining the functioning of a modern society, changes in helping behavior have been dramatic. In present society these roles have typically been defined, divided, and compartmentalized into particular professions and specialties (McClenon, 1997; Wampold, 2007).

The helping professions of today retain their historical focus of intervention to individuals or groups in order to heal or mitigate the consequences of problems, troubles, illnesses, or injuries. As society has grown more complex, however, helping has seen the separation and specialization of its efforts into sub-groups of formal and informal helpers with various orientations and skill sets. By way of some examples, the practice of medicine delivers its helping via medical professionals with their extensive training and knowledge of human biology and its sub-systems. The ability to diagnose and treat a wide array of physical ailments is the hallmark of their profession. Similarly, educators are charged with the task of providing instruction in a wide array of subjects and preparing novice learners to function successfully in our society. As the diversity of essential knowledge and skills increases (e.g., language, literacy, and technical skills) teachers play an ever increasing and essential helping role in society today.

Psychology has provided much to our understanding of human intellectual and personality functions. Psychologists have developed theories and techniques that inform the diagnostic and treatment efforts that help alleviate learning, communication, and mental health problems. Social work has historically focused its helping efforts toward vulnerable and oppressed groups within society. The delivery of social work services is informed by an understanding of the social and environmental forces impacting individuals, families, groups, and communities.

The evolution of helping has moved beyond a specialization of skill sets and a simple desire to help others. As those seeking help may lack the specialized knowledge of the helper, self-imposed discipline-specific guiding principles and ethics have been

developed. These efforts have helped to define each profession and clarify what service recipients can minimally expect from helping practitioners.

As these helping traditions have evolved, so have the formal structures that organize, define, and guide their codes of ethics, accreditation standards, education, and licensure requirements. Professional organizations have created guidelines and expectations of effective and ethical practice for each of these helping professions. Additionally, these organizations have delineated guiding principles and professional values that their practitioners are expected to embrace which characterize and define that profession's helping identity. Association certification and governmental licensing procedures provide additional safeguards and assurances to the general public and other professionals as to the competency of the helping practitioner.

Particular similarities among the noted helping professions stand out upon examination. Each group's set of these guiding principles carefully articulates a mandate to anticipate and assume certain basic needs and rights that each helping recipient has and can expect to receive. In each profession such principles promote an understanding of the unique situations and problems faced by individuals seeking help.

The American Medical Association (AMA) is the primary professional organization for physicians in the U.S. It publishes and regularly updates a set of guiding principles for medical practitioners. The first of these principles states, "a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" (American Medical Association, 2001, p.1). The American Psychological Association (APA) uses similar language in its own set of guiding principles for psychologists. Its *Ethical Principles and Code of Conduct* states,

"Psychologists respect the dignity and worth of all people, and the rights to privacy, confidentiality, and self-determination" (American Psychological Association, 2003, p.1).

The preamble of the National Education Association's (NEA) *Code of Ethics of the Education Profession* also embraces similar guiding principles. It states, "The educator, believing in the worth and dignity of each human being, recognizes the supreme importance of the pursuit of truth, devotion to excellence, and the nurture of the democratic principles" (National Education Association, 1975, p.1).The profession of social work has paid particular attention to similar principles in its own *Code of Ethics* (NASW, 1999). Social work draws its specific professional guidelines from a core set of discipline specific values. NASW provides specific professional guidelines in association with its values. An example is, "Social workers respect the inherent dignity and worth of the person" (NASW, 1999, p.1). The common thread unifying these four helping professions and their codes of ethics is that they are based on the tenet that for helping to occur, these relationship conditions, at a minimum must be present.

The importance of an understanding and appreciation for the situations, perspectives, and attitudes of those to be helped has retained a place of prominence in the professionalization process of many helping disciplines. The anticipation of acknowledging an individual's needs and the helper's anchoring of the helping process within these guiding principles is integral to the initiation of successful helping.

While ethical principles guiding the practices of helping have been codified by professional associations, an increasing focus on the empirical demonstration of their effectiveness has evolved. Traditionally, social workers have relied on the authority of supervisors, fellow practitioners, or educators to learn techniques of effective helping

(Dillenburger, 2004). Within these learning relationships, the novice practitioner is dependent on the practice wisdom that the supervisor/teacher shares. While an important starting point for practitioners, this tradition of practice wisdom typically lacks objectivity and is vulnerable to the particular experiences and biases of the teacher (Thyer & Kazi, 2004). The introduction of a more scientific approach to understanding helping has altered this traditional approach to some extent, and has led to a greater level of transparency into the process of helping.

Social work as a profession has undergone its own journey toward an increasingly empirical focus on the evaluation of client outcomes. According to Thyer and Kazi (2004), “From the earliest beginnings of our field we were exhorted to apply the best methods of social work intervention that were believed to exist and to evaluate empirically the outcomes of social work and social welfare services” (p. 1).

While social work researchers and scholars have demonstrated that a more objective approach to practice evaluation can improve practice outcomes, this transfer of knowledge into social work practice has been a difficult and inconsistent endeavor at best. This has resulted in a longstanding schism between practitioners and social work researchers (Holosko, 2004). As a result, a culture of distant relationships, tension, and professional disconnection has developed (Ivanoff, Robinson, & Blythe, 1987; Ronen, 2004).

Despite the struggle to connect empirical social work research to practice strategies, the objective evaluation of client outcomes has become more specific. The growth of the use of evidence-based practice (EBP) models in outcome research has been significant within governmental bodies, third party payers, and accredited

professional schools of social work (Holosko, 2004; Sheldon & Chilvers, 2004; Thyer & Kazi, 2004).The movement towards an emphasis on EBP has not, however, brought about the demise of an educational and practice focus on the reflective process skills that are the primary tools used by social workers.

The basics of effective social work training and practice skills continue to depend heavily on the interpersonal and empathic skills of the individual social worker (Freedberg, 2007). These helping process techniques have been described and operationalized by social work scholars and are present in social work texts at all levels of instruction. Indeed, these skills are well rehearsed and refined in undergraduate and graduate classroom and field placement experiences.

These core practice skills include but are not limited to reflective listening techniques and empathic inquiry into the social and contextual influences that define the nature of problems presented by clients in a wide variety of situations and practice settings. The effective use of empathy figures prominently in the education of all professional social workers (Freedberg, 2007; Hepworth & Larsen, 1982; Hollis & Woods, 1981; Lantz, 2001; Rothery & Tutty, 2001: Saulnier, 1996).

Statement of Purpose

The purpose of this research is to develop and initially validate a measure to assess empathy among social work practitioners. It is intended to extend social work research further into the empirical study of one of the essential process skills used by social workers.

The scale is designed to assess the theorized multi-construct nature of empathy. Empathy is considered to be a construct with cognitive, affective, and behavioral

expressions (Davis, 1983). This study will explore the underlying structure of empathy using six constructs. Based on an extensive review of the literature, at present, these constructs are: perspective taking (Baron-Cohen & Wheelwright, 2004; Cliffordson, 2002; Davis, 1980), altruism (Batson, Eklund, Chermonk, Hoyt & Ortiz, 2007; Jollife & Farrington, 2005; Koss-Chioino, 2006), caring (Danby, 2004; Engster, 2005; Skovholt, 2005), congruence (Freedberg, 2007; Rogers, 1951; Rothery & Tutty, 2001), interpersonal sensitivity (Carney & Harrington, 2003; Hall & Mast, 2007; Snodgrass & Rosenthal, 1985) and the therapeutic relationship (Rogers, 1951; Rothery & Tutty, 2001; Wickman & Campbell, 2003) These constructs are proposed as expressions and evidence of empathy in social workers.

Rationale

Despite its acceptance as an important underlying aspect of human personality, interpersonal relationships, and the helping process empathy's definition remains undifferentiated. Measurement and assessment of many social phenomena through objective instrumentation is common in the social and behavioral sciences. Empathy, however, has not been explicated and evaluated in a similar manner.

The understanding and practice of empathy as a particularly important theoretical construct and human attribute in social work education, research, and practice has been well documented. Surprisingly, the measurement of empathy has not been pursued by the field of social work despite the emphasis it has received.

Social work practice texts are replete with references about the importance of empathy in the successful implementation of face-to-face practice with individuals, groups, families, and communities. Students often receive specific training in the use of

empathy skills and rehearse these in the classroom and in field placement experiences prior to beginning their professional careers (Hepworth & Larsen, 1990; Woods & Hollis, 2000).

The interpersonal qualities of openness and empathy are considered essential attributes of a competent social worker. The field emphasizes empathy, tolerance, and genuine concern for the welfare of vulnerable populations in society. The ability to better understand and evaluate empathy would assist educators, students, and practitioners in delivering a more comprehensive social work education and better prepare social workers for practice.

Social workers have a long history of providing in-home services to clients. As the profession matures, the preparation of social work students to practice empathically in such settings has evolved as well. Field placement students conducting in-home services need to develop strong empathy skills to effectively navigate the challenges they face in their practice realities (Allen & Tracy, 2008).

Cultural diversity and social justice content in social work education is considered an essential component of the educational process. A clearly articulated way of teaching these subjects has yet to be determined despite ongoing efforts by social work scholars and researchers. In this context, empathy has been identified as a critical motivator for students from privileged backgrounds to embrace core social work values (Snyder, Peeler, & May, 2008).

The National Association of Social Workers (NASW) specifically addresses the role of empathy in competent social work practice. NASW provides information to practitioners about delineating feelings of sympathy, often elicited by client problems

and situations, from the effective use of empathy. NASW (2008) stated, "…as a general rule, social workers are understanding and sensitive to the problems that others are experiencing; they simply do not express pity or sorrow at another's distress, but rather they empathize with their client's feelings" (p. 1).

Human behavior and development theories which inform and direct social work place significant emphasis on the role of empathy in developing a therapeutic relationship between worker and client. For instance, psycho-dynamic theories such as self-psychology and object relations require an empathic therapist for their delivery (Martin, 2001). Cognitive-behavioral approaches as well as crisis intervention models describe an explicit need for empathy skills on the part of the practitioner (Knox & Roberts, 2001). Humanistic theories such as client-centered theory (Rogers, 1951; Rothery & Tutty, 2001) and existential social work (Lantz, 2001) also focus the applications of their theoretical frameworks on empathy and its adjacent interpersonal attributes and skills. Theoretical frameworks informing social work rely on the empathic skills of the social worker yet the objective evaluation of empathy in social work education and training is not readily available.

A hallmark characteristic of the social work profession is its focus on vulnerable populations within our society. Throughout the history of social work, the institutionalized oppression of women and minority populations has been of particular concern for social work. Empathy is deemed an essential skill in feminist and cross-cultural theoretical approaches to social work that specifically focus on working with these populations (Allen-Mears & Burman, 1999; Freedberg, 2007; Pinderhughes, 1979; Saulnier, 1996). Given the role empathy plays in working with marginalized

groups in society, it is surprising that the measurement of empathy has not been pursued more vigorously by the field.

A recent review of available empathy measures in the literature revealed no instrument designed to measure empathy for social workers. Current available instruments noted in cognate disciplines have inconsistent psychometric properties and unclear theoretical frameworks guiding their construction. Notably, the lack of an objective measure of empathy for social workers represents a knowledge gap in the social work practice and research literature. It leaves social work educators lacking an important tool for enriching the training and evaluation of students. It is problematic that so little is known about the assessment of empathy in social workers given the profound impact of their interventions.

Definitions

The clarification of key terms used in this study seems warranted. While different definitions for these terms exist they are presented here with greater specificity and how they will be used in this study.

Empathy has been originally described as consisting of two dimensions, affective and cognitive (Davis, 1980; Mehrabian & Epstein, 1972). In this research, however, empathy is proposed to consist of three broad domains that contain affective, cognitive and behavioral components. Affective domains of empathy include emotional connectedness, concern, and compassion for a client’s feelings. In this study the affective dimension of empathy is delineated into two constructs, caring and congruence. The cognitive dimension of empathy involves an objective conceptualization of a client’s experience and evaluation of client behaviors and

expressions. Here cognitive aspects of empathy are defined by the constructs interpersonal sensitivity and perspective taking. The behavioral dimension of empathy consists of outwardly focused actions directed into a helping relationship. Behavioral manifestations of empathy are proposed here to consist of the underlying constructs altruism and the therapeutic relationship.

The terms *scale, instrument,* and *measurement* are used synonymously with the more inclusive title, *multi-construct, empathy questionnaire.* Objective measurement efforts use various methods of gathering data such as formal interviews administered by researchers and researcher observation scales. While these methods are useful for data collection and analysis procedures the use of a questionnaire format for this research can aid in the ease of instrument administration and the collection of large quantities of data (Rubin & Babbie, 2005; Spector, 1994).

This quantitative-descriptive study proposes to compare and evaluate the relationships between different variables (Holosko, 2006). The design objective of the study is to develop an instrument/scale/measure. The term *variable* in this study is used interchangeably with the terms *items* or *scale items*.

The literature documenting the analysis of scale development procedures often uses a variety of different methods described using the term *factor analysis.* Principle Components Analysis (PCA) and Confirmatory Factor Analysis (CFA) are two such examples. For the purposes of this study *factor analysis* is used synonymously with the term *Exploratory Factor Analysis (EFA).*

CHAPTER 2

LITERATURE REVIEW

This literature review will describe a variety of converging explanations and definitions of empathy as a social and psychological construct. It will include the origins of empathy and outline its unique development as a human helping tool in general and in social work practice specifically. The literature is organized into three main headings and sub-headings. First, empathy will be examined in terms of evolutionary and neurological theories and then by philosophical and sociological theories. Then, empathy and its role in therapeutic relationships is described including the origins of empathy in helping and then the development of empathy as a therapeutic tool. Finally the relationship between empathy and social work is examined from theoretical and empirical social research perspectives.

Evolutionary Theories and Neurological Indicators

Theories of evolution and natural selection inform many avenues of scientific inquiry. Social and psychological phenomena are theorized to have developed in this manner as well. Psychological attributes that facilitate relationships are proposed to have been selected through genetic heritability (Davis, 1983). As well, social and cultural mores beneficial to society have, formally and informally, been passed from one generation to the next. The interplay between genetic heritability and environmental influences has been studied in relation to empathy and attempts to answer the question of how empathy may have evolved (Davis, 1983).

The complexity of human society and relationships requires an ability to anticipate the motivations and intentions of others. Empathy helps one anticipate the behavior of another and amend one's own decisions and actions accordingly. It also can facilitate cooperative and mutually beneficial relationships. The evolution of this primarily interactive function results in social expertise, that if inherited by one's offspring ensures the continuation of a social group's ability to communicate effectively, inform accurate decision-making, and detect deception on the part of another. These are deemed important abilities for the protection and success of an individual and/or a social group (Smith, 2006). The capacity to understand the distress of another helps enable a group to offer protection and care for itself and its members. During times of hunger, threatening environments, and health concerns (e.g., childbirth) expressing empathy and acting in an altruistic way helps to preserve the familial ties and lineage. This behavior also promotes non-kin relationships that are reciprocal and mutually beneficial, furthering group survival and growth (Smith, 2006).

The heritability of psychological and personality characteristics has been well documented. The study and comparison of identical (monozygotic) and fraternal (dizygotic) twins has contributed heavily to this line of research. While findings concerning the relationships of personality traits in identical twins are not as strong as the relationships between physical characteristics such as height or weight, many studies report that as much as 50% of the variation in personality characteristics such as introversion, assertiveness and anxiety may be attributed to genetic heritability (Davis, Luce, & Kraus, 1994).

Cognitive traits like intelligence have typically been genetically associated in traditional twin studies. Additional research into the genetics of empathy has demonstrated a different pattern. Cognitive traits (i.e., intelligence) have typically been positively genetically associated in traditional twin studies. However, one such study by Davis et al. (1994) found a stronger genetic relationship regarding the affective components of empathy (such as concern for others) than the more cognitive components (such as perspective taking).

A recent study examined how the impact of environmental factors plays an important role in the overall understanding of the origins of empathy (Volbrecht, Lemery-Chalfant, Aksan, Zahn-Whaller, & Goldsmith, 2007). As with most psychological or personality characteristics the nature versus nurture debate concerns empathy as well. Volbrecht et al. used Structural Equation Modeling (SEM) to assess the role genetics plays in the development of empathy. Their research examined a sample of N= 292 pairs of twins in the second year of life. The authors theorized that environmental influences on empathy expressions and other helping behaviors would be present in children at this stage of their earliest development. Environmental factors (i.e., parental nurturing) had more impact on affective expressions of empathy (e.g., positive affect and altruistic helping) in study participants than heritability. The more cognitive aspects of empathy (e.g., hypothesis testing) retained the strongest relationship with genetic influences (Volbrecht et al).

Researchers in the field of neuro-science and neuro-psychology have used Functional Magnetic Resonance Imaging (fMRI) to detect and record brain wave activity. Their studies suggest that specific parts of the brain are particularly active when

empathic emotions and cognitive perspective taking occur in study participants (Leslie, Johnson-Frey, & Grafton, 2003; Oberman & Ramachandran, 2007). Sensations and expressions of pain stimulate specific neurons in an individual brain. When one witnesses another in pain, the identical neurons in the brain are stimulated and observable through fMRI (Decety & Jackson, 2006). They stated "…these results lend support to the idea that common neural circuits are involved in representing one's own and other's affective pain related states" (p. 55).

The tendency of people to mimic or mirror the facial expressions of others occurs on an unconscious and instinctual level. This mimicking of another's mannerisms, postures and facial expressions is known as the 'chameleon effect' (Blair, 2005; Leslie, et al., 2004; Obermen & Ramachandran, 2007). Primate studies reveal that observing or hearing a particular activity stimulates the same area of the brain as when the activity itself occurs. This phenomenon has been called motor resonance or mirroring. Leslie et al. documented empirical support for their claim that "… there may be a seamless integration among perception, socially relevant mimicry, emotional experience and empathy" (p. 601).

Evolutionary and neuroscience theories begin to offer explanations of the human experience of empathy (Davis et. al., 1994; Decety & Jackson, 2006; Leslie et al., 2003; Singer, 2006; Smith, 2006; De Vignemont & Singer, 2006). Even as empirical evidence of empathy's existence and function has grown, the precise nature of its definition remains incomplete. The role of empathy in human evolution and brain function provides convincing evidence of the construct's origins and physiological indicators.

Philosophical and Societal Explanations

The field of sociology has developed numerous explanations and theories regarding human behavior and interpersonal communication. At the beginning of the twentieth century, the American philosopher and social theorist George Herbert Mead made a number of valuable theoretical contributions to the understanding of empathy. Mead's theories have been described as one within the micro-interactionist tradition. These groups of theories emphasize the cognitive and emotional development of an individual's concept of self as the primary result of interactions with the environment and in particular interpersonal relationships (Collins, 1994; Gillespie, 2005).

Mead (as cited in Collins, 1994) described a sequential process of human development that required increasingly more abstract processes of an individual's capacity to recognize another's attitude or point of view. This reflexive and empathic interpersonal process reaches greater levels of complexity as an individual develops and matures. An ability to recognize and understand the attitude or perspective of greater and greater numbers of people or distinct groups signals this process.

Children learn this way by first understanding the attitudes of their mother (e.g., sad, happy, anxious, etc.). Then through imaginary play by themselves and with others, they learn the roles and viewpoints of the teacher and student, or the cop and the robber (Collins, 1994; Gillespie, 2005). Organized games require an individual to understand the emotions and perspective of multiple others. In the game of football, a specific player must understand the needs and attitudes of teammates to achieve success. A receiver must be aware if s/he is to block their opponent or catch the ball depending on the situations of other players and how they unfold on the field. These

everyday examples help build a theory that explains how empathy develops and functions within individuals and society (Gillespie, 2005).

The missing piece in this sociological tradition is an articulation of the significance of emotions in this learning. The capacity for humans to detect the underlying emotional world of another is an extension beyond just a cognitive understanding of another's situation. Humans cannot interact without an underlying emotional network that connects them to one another. Various feelings arise and fluctuate in all human discourse, and this is the glue that holds society together. Collins (1994) stated, "…the bedrock of social interaction, the outmost frame around all the lamentations of social situation and self-reflexive conversation, is always the physical co-presence of people warily attending to each other" (p. 289).

Theorists, scholars, researchers and philosophers have considered the origins and effects of empathy in terms of social relationships between specific individuals (Carse, 2005; Cottle, 2002) as well as groups or nations of people (Kristjan, 2004; Russo, 2004; Schwebel, 2006). Empathy is theorized to involve contours that guide moral decision making and behavioral choices in relationships of all types. Humans are inherently dependent on one another. None of us is truly autonomous and most of us depend on complex networks of other people to function and survive. Some of the internal and dynamic roots of empathy are described in Cottle's (2002) contention, "… to say we have relationships is to suggest that people live strictly outside of us, like furniture and cars" …. "this isn't the case with other people, for we all recognize that people live outside of us and within us as well" (p. 67).

The nature of social human relationships involves an interplay of dependence, independence, and interdependence. Empathy threads itself through these human interactions in various ways. As infants, we are totally dependent on our caregivers to provide for all of our needs. These relationships are not symmetrical or reciprocal. The partiality of the caregiver makes us susceptible to the judgments and decisions made. A caregiver's empathic abilities are instrumental in the infant's survival and healthy development. Carse (2005) stated, "Empathy is regarded as a crucial antidote to potentially serious harms and violations, one that must supplement – and, indeed supplant – abstract, emotionally disengaged judgment with contextually attuned emotional engagement" (p. 170). In other words, at times empathy informs ethical decision-making to ensure the safety and/or survival of others. For example, an adequately empathetic parent prevents a child from retrieving a desired object (e.g., a toy) from a potentially life-threatening situation (e.g., the street).

Contoured empathy informs more complex interdependent personal relationships as well (Carse, 2005). In contoured empathy, an additional level of abstraction is used by the helper to think beyond the most immediate needs of another. Contoured empathy can lead to helping responses that seem counter-intuitive. For example, an alcoholic may depend on family members to shield him or her from the personal and social consequences of problem drinking. This, in turn, safeguards their role as the financial provider for the family. Contoured empathy is involved when family decides to confront the problem, risking financial hardship for all, in order to preserve the health of the alcoholic. (Carse, 2005).

Peace building and social justice efforts include the ethics of empathy. To negotiate a peaceful, just settlement between warring societies, an understanding of the other group's perspective is basic (Schwebel, 2006). The role of empathy in addressing social conflicts and injustice includes not only seeing the perspective of one's enemy, but a realistic and honest appreciation of the way one is perceived by an enemy. The 'rose colored glasses' nations wear in misunderstanding how their own motives and behaviors are perceived by others must be removed for productive negotiations. Social conflicts ranging from war between societies, to oppression within a society, to conflicts concerning the use and abuse of environmental resources would benefit from both groups use of empathy as a starting point for problem solving (Schwebel, 2006).

The internal and dynamic concepts of justice and subsequent moral, pro-social behavioral choices depend on an individual's empathic ability and concern. Social justice theorists have differing opinions as to which construct applies, sympathy or empathy. Both involve an understanding of the social situation of injustice and the physical and emotional toll it takes on vulnerable individuals and populations (Kristjansson, 2004).

The importance of teaching and researching empathy and social justice in higher education has been proposed by educators in many fields. A utilitarian approach to higher education emphasizes the accumulation of specific technical skills preparing students to function in society. A liberal arts curriculum traditionally emphasizes a student's exposure to a broad spectrum of ideas and perspectives from a range of disciplines. General education principles attempt to combine both approaches (Russo, 2004), but social justice and empathy as concepts are notably missing in many college

curricula, regardless of the educational pedagogy. Russo (2004) suggested educators begin "… incorporating introductory concepts of social justice into their courses by developing the foundations of future action – awareness of forms of injustice and empathy toward victims of injustice" (p. 104).

Empathy and Therapeutic Relationships

Origins

Historically, the presence of a particular community helper (e.g., healer, priest, or shaman) has been universally a part of all communities. This individual's helping or healing ability is afforded by a collective consensus regarding the same cultural explanatory belief system. These individual and collective beliefs and behaviors are theorized to be the result of the 'cognitive imperative' (McClenon, 1997). This theory posits that humans are driven to create organized systems of casual beliefs to explain individual, collective and environmental phenomenon (McClenon, 1997). An important part of the healing process involves the healer taking on the pain or illness of others and serving as a human conduit for the relief or resolution of the identified problem (Harvey, 2006; McClenon, 1997; Singh, 1999). The evolution of empathy finds expression in the healer's unique knowledge and in the use of therapeutic agents (e.g., medicinal plants, herbs, etc.) and techniques (e.g., chanting, prayer, etc.) to arrive at the desired outcome. The shamanic tradition also includes the use of empathy so as to incorporate individual, relationship and cultural contexts into the healing process (Koss-Chioino, 2006).

Empathy in helping is culturally bound, and the helper must understand and capitalize on the cultural narratives defining illnesses and how they can be cured.

Understanding the perspectives of the injured or ill is essential for a community to accept a particular healer as effective (Coulehan, 2005). The meaning ascribed to a technical healing agent by those in need provides as much healing power as the technique itself. An inclusive and flexible explanatory system for therapeutic change enhances helping outcomes (Coulehan, 2005). The empathic relationship between the healer or therapist and the client completes the cultural context for effective helping (Koss-Chioino, 2006).

The practice of psycho-social therapies is one of a group of healing practices and disciplines present in our society today. Empirical research involving meta-analysis has repeatedly demonstrated therapeutic efficacy in addressing individual psycho-social problems (Wampold, 2007). Psychotherapy can also effect change in a variety of mental health disorders such as depression, anxiety, and Post-traumatic Stress Disorder (PTSD) (Wampold, 2007).

Therapeutic Helping

While the effectiveness of the therapeutic process has been documented the empirical explanation of why and how it works is much less clear. Wampold (2007) suggested psychotherapy meets a number of necessary criteria for effective healing. First, the therapist must provide an alternative explanation for the client’s problems. The explanation must coincide with enough of the client’s worldview so as not to be seen as implausible, but distinct enough to be a true alternative. The alternative explanation is delivered via an identified and specific treatment. This requires a therapist fluent in the explanation as well as treatment. Finally, the nature and quality of the relationship

between therapist and client is critical to the effectiveness of the treatment itself (Wampold, 2007).

The role of empathy as a necessary condition for the success of psychotherapy has been repeatedly demonstrated. Empathy has been identified as the single most consistent condition of a productive therapeutic relationship in outcome research. This holds true across all varieties of treatment modalities and theoretical orientations. Empathy has been credited with as much as 40% of the variance in successful therapeutic change (Sinclair & Monk, 2005). The majority of empathy studies find positive relationships between the presence of empathy and positive clinical outcomes. It has been suggested that the use of empathy in psycho-social treatment efforts is the primary change agent (Sinclair & Monk, 2005).

The therapeutic relationship or alliance has been identified as a significant agent of change or growth in a variety of helping relationships and clinical settings (Allen-Meares & Burman, 1999; Lambert & Barley, 2001; Olio & Cornell, 1993; Stewart, 1984). This relationship consists, in part, of a sense of trust and a bond between client and therapist (Dykeman, Nelson, & Appleton, 1995). A helping alliance is one in which a helper is accepting, non-judgmental, supportive, and empathic. Other identified defining characteristics are affirmation skills, caring and respect (Allen-Meares, 1999; Lambert & Barley, 2001).

The importance of the therapeutic relationship is a central construct in most theories of human behavior and therapeutic change. Psychodynamic theorists and researchers describe this alliance as a foundation explaining the therapeutic benefits of clinical intervention (Kradin, 2005). Theorists from existential, feminist, behavioral, and

family systems schools of thought associate, if not center, their models around a therapeutic alliance/relationship (Lantz, 2001; Lejuex & Hopko, Levine, Gholkar, & Collins, 2006; Minuchin & Fishman, 1981; Saulnier, 2001).

The client-centered approach to helping relationships has figured prominently in social work practice and theory (Holosko, Skinner, & Robinson, 2007). This came about (in part) through the collaboration between the psychologist, Carl Rogers, and a number of his social work colleagues (Holosko et al, 2007; Rogers, 1951; Rothery & Tutty, 2001). This existential approach posits that the beneficial therapeutic alliance consists of three central skills: congruence, unconditional positive regard, and empathy (Rogers, 1951; Wickman & Campbell, 2003). This theoretical perspective has had an important influence on the definition of empathy and how psychotherapists understand and utilize it within the therapeutic alliance process.

Existential theories of human behavior and psychotherapy emphasize a client's understood meaning of personal life events, relationships and situations. Emphasis is placed on self-actualization, self-efficacy, and self-determination. This approach to healing explores the meaning ascribed to individual experiences by a client. These meanings define the problem for the client and therapist and provide insight into possible solutions. Empathy as a tool for helpful treatment efforts figures prominently in these theoretical frameworks (Lantz, 2001; Rothery & Tutty, 2001).

To apply empathy effectively from the existential viewpoint, the therapist seeks to understand the unique experience of the client. An experience is the meaning a person attributes to the visceral sensation that is felt while interacting with one's environment (Vanaerschot, 2007).For example, a motorist skids to a stop, just missing a pedestrian.

The driver and the pedestrian both feel intense sensations of fear, anger, self-doubt, indignation, etc. Each of them will ascribe some meaning to the event. Simultaneously, the driver thinks they may have been traveling too fast, that the pedestrian was being careless, and that city planners must have poorly designed the intersection. The pedestrian wonders if s/he was not looking at the light, assumes the driver was being reckless, etc.

The experience of each is translated into a meaningful explanation that they then try to put into words. Their descriptions of the event only approximate the true nature of their experience and are not adequate to completely mitigate the sensations of that experience (Vanaerschot, 2007). In this case, despite an observer's confirmation that the pedestrian was not paying attention, both will consider and re-experience the visceral, body-felt sensations of the event repeatedly. In other words, it is not easy to forget the experience regardless of what explanation or meaning we or others ascribe to it.

Healthy or adaptive responses to such an event involve an individual's openness to an internal process or dialogue that considers multiple meanings of an event. The ability to process experiences this way avoids prescriptive and constrained explanations of an experience that lock one into a dysfunctional meaning system. For example, sexual abuse survivors may internalize personal and cultural narratives that affix blame to the victim resulting in chronic problems of low self-esteem, guilt, depression, etc. (Sinclair & Monk, 2005). This structure-bound functioning or meaning making occurs when rigid belief systems disallow the full range of possible meanings available to an individual.

Thus, no escape valve is available to a healthier alternative meaning and functioning (Vanaerschot, 2007).

Empathy plays a significant role in the therapist's attempts to understand and remediate the dysfunctional meanings ascribed to the events in a client's life. The therapist must simultaneously be open to the meanings presented by the client as well as other potential alternative meanings. This internal process depends on the empathic abilities of the clinician. All possible meanings of an experience need be available to a therapist, including the client's perspective. Vanaerschot, (2007) concluded, "the quality of the therapist's empathic understanding is largely determined by the degree that his or her experiences are not structure bound but 'optimally implicit'…I would call the therapist a surrogate experiencer" (p. 317).

This experiential empathic process guides therapist interventions which are aimed at unlocking the rigid boundaries of meaning held by clients about their struggles (Lantz, 2001). Many of these interventions seek to intensify the experience of the client so as to uncover meanings immediately unavailable to the client. How a client perceives ongoing interactions and experiences with the therapist is another way of intensifying the empathic process. The use of metaphor and exaggerated scenarios serve to magnify the client's experience within the safety of the relationship, and are extensions of empathy further into the therapeutic process and the collaborative search for alternative meaning (Vanaerschot, 2007).

Empathy is necessary for the development of an effective therapeutic relationship. Surprisingly, consideration of the therapeutic relationship in the development of empathy measures is a relatively recent practice (Hojat et al., 2004;

Hojat, Mangione, Kane & Gonella, 2005; Hojat, 2007). As noted, empathy and its behavioral expressions appear repeatedly in the therapeutic alliance literature. Multiple measures of the helping alliance have been used in the assessment of therapeutic outcomes (Coady & Marziali, 1994), but the extent of the role that empathy plays in this process remains undetermined. It is important to include the therapeutic relationship in the empirical study and measurement of empathy as empathy is a central aspect of this alliance.

The concepts of the therapeutic relationship and empathy complement and facilitate each other. Goal setting and boundary negotiation within the therapeutic alliance require the effective use of empathy (Callaghan, Naugle, & Follette, 1996). Despite empathy's role in contrasting therapeutic techniques and theoretical orientations, it has an essential role in the formation of a therapeutic alliance and it is assumed to be a critical condition for positive clinical outcomes (Lambert & Barley, 2001; Marziali & Alexander, 1991; Smith, Thomas, & Jackson, 2004).

Postmodern thought reworks how one understands what is real and true in the world and the role of empathy within it. It rejects the modernist view that social and interpersonal realities can be universally defined and explained. It claims that what is real is unique to each of us, and is constructed by overarching influences in society and one's own individual experiences and perceptions. Reality is as unique as how each of us perceives it.

Postmodern theorists have criticized the emphasis on empathy at times and its use in the therapeutic process. Empathy as a source of change from existential and client-centered perspectives can isolate the client, and implies that self-actualization is

available and applicable to all. Postmodern critics of client-centered approaches suggest the absence of an emphasis on cultural context is a glaring weakness in the use of empathy within these theoretical systems (Buckman, Reese, & Kinney, 2001). Their lack of consideration of the cultural forces such as racism, sexism, and economic disparities and their dramatic influences on clients simply reinforces the dominant discourses within our society (Sinclair & Monk, 2005).

Postmodern theories of human development and therapeutic change challenge the modernist view of how we perceive and understand the world. In this view, how people think, feel, and behave is a result of the reality imposed on them by dominant groups within society. Often, these dominant discourses have profound detrimental consequences to vulnerable or powerless groups of people (Buckman et al., 2001).

Sinclair and Monk (2005) described this dominant discourse as the cultural conversation that privileges and empowers certain social groups over others. Social positioning is the phenomenon of a society's placement of certain people at various levels of power or marginalization. They pointed out that participation in the dominant discourse in society determines where each of us is positioned within it. This impacts the helping process in general and the development of a therapeutic relationship in particular.

Discursive empathy is the concept of acknowledging how aspects of illness and social discourse function together to shape the meaning of what constitutes a problem, and how it may be resolved. In this light, empathy has an additional role to play in psychotherapy. It can serve as a way to de-construct these narratives that paralyze

clients and keep them locked into seeing their struggles as their own doing, uninfluenced by overarching social structures (Sinclair & Monk, 2005).

Empathy and Social Work

Theoretical Influences

Social work has experienced much debate regarding its theoretical foundations and epistomological orientations regarding research, education and practice (Barnes & Hugman, 2002; Ivanoff, Robinson, & Blythe, 1987; Nagel, 1988; Thyer, 2002). Practice areas have been divided into various social or individual approaches. Which one is (or should be) social work's main orientation to practice, research, and education remains unanswered (Barnes & Hugman, 2002).

Direct social work practice is by its nature an interactive and mutual process. Practice areas such as mental health, child welfare and geriatrics have unique structural and clinical systems, but all capitalize on the empathic skills of the social worker. Empathy facilitates client objectives and positive clinical outcomes. Effective social work then depends on the empathic abilities and interpersonal relationship skills of the practitioner (Hepworth, Rooney, Dewberry-Rooney, Strom-Gottfried, & Larsen, 2006).

Helping professionals will often utilize empathy skills to deliver technologies or products unique to that profession (Mullan & Dickson, 1991). Physicians may use empathy to introduce medical procedures to a patient. Nurses find empathy useful in the application of medical treatments and overall patient care. The service delivered in the practice of social work is a set of process skills informed and guided by empathy (Freedberg, 2007; Hepworth et al., 2006; Hollis & Woods, 1981).

Social work has been, in many respects, defined by the person-in-situation approach to case work. This theoretical approach requires insight into the causal relationship between a client's environment and the resulting psycho-social problems (Woods & Hollis, 1981). The concept of cross-cultural competence is an example of social work values, practice and situational focus coming together. Efforts by social workers from a specific cultural background to understand the issues particular to clients from another are crucial to the development of empathic and competent social work practice (Allen-Meares & Burman, 1999; Dubois & Miley, 2005; Hepworth et al., 2006).

Working with clients within the context of the family is a long standing tradition in social work. Informed by systems theory, family work requires a focus on the unique cultural and relationship aspects of a specific family system and the environmental forces influencing their situation (Beels, 2002; Minuchin & Fishman, 1985). Social workers practicing within child welfare, family counseling and community mental health systems rely on an accurate assessment of family dynamics and environmental issues to inform intervention strategies. An evaluation of the client from this perspective is traditionally central to social work practice (Hepworth & Larsen, 1986).

Social work practitioners make efforts to convey information, safety and warmth to clients seeking services. In spite of this, it must be recognized that many clients experience anxiety, fear and shame about needing or requesting help. Involuntary or mandated clients referred for services by court systems, child protective service agencies, or employers are often resentful, distrustful and hopeful all at once. Skilled workers accept these feelings unconditionally and using empathy recognize they will be

of little help by rationalizing or denying the reality of these feelings and perceptions (Dubois & Miley, 2005; Woods & Hollis, 2006).

Relational-feminist approaches to direct social work practice view client struggles as a result of structural forces in society, primarily sexism and patriarchy (Freedberg, 2007; Saulnier, 1996). Clients may often not perceive these structures to be the primary source of their emotional or relationship problems. Effective social work practice requires a delicate and empathic balance of understanding the destructive personal and social consequences of exposure to these oppressive social systems and the client's particular emotional issues or concerns (Freedberg, 2007).

Independent of the practice setting, social workers need to be skilled in the use of empathy. Hepworth and Larsen (1990) proposed five levels of empathic communication in social work practice. These include: (a) low level empathic responding, (b) moderately low level empathic responding, (c) interchangeable or reciprocal empathic responding, (d) moderately high level empathic responding, and (e) high level empathic responding. Accurate assessment of a client's feelings occurs at levels three and four. The worker seeks to clarify the client's emotions in relation to the presenting problem. Here, the facts or surface level conditions, situations and subsequent feelings are reflected back to the client. This part of empathic responding includes clarifying statements or questions by the worker. "Let me make sure I understand…." and "I need to make sure I have heard you correctly…" are examples. No interpretation of possible underlying or unspoken emotions is offered at this time. Interpretation prior to confirmation sends the message that the worker has not been

listening and is not open to alternative or undiscovered issues and dynamics (Hepworth & Larsen, 1990).

Self awareness on the social worker's part plays an important role in accurate identification of client emotions. Clients often present with intense and overwhelming feelings of rage, desperation and despair. These can elicit powerful feelings within the worker such as fear, resentment, or pity. A social worker's self awareness can prevent personal reactions from interfering in assessment and treatment plan decisions. This lays the ground work for the clinician's effective use of empathy (Woods & Hollis, 2000).

Social work intervention aimed at larger social problems depends on the worker's ability to understand the negative influences of over-arching social structures on vulnerable populations. Efforts aimed at social advocacy and change come from an appreciation of the perspectives of oppressed people (Dubois & Miley, 2005). Powerful social systems such as racism, sexism and economic disadvantage oppress vulnerable populations (Mullaly, 2007). Clients often do not initially recognize the role these structures have played in the development of their problems. Important aspects of this approach to social work are the use of empathic skills to assist communities in making meaning out of their personal and situational experiences from a systemic and environmental perspective in order to effect social change (Dubois & Miley, 2005; Freedberg, 2007; Hepworth & Larsen, 1990; Mullaly, 2007).

Many students are drawn to the field of social work out of a deep felt concern for the welfare of others (Holosko, 2006; Viggiani, Charlsworth, Hutchinson, & Faria, 2005). They may have been told they are good listeners and accurately perceive themselves this way. Social work educators are charged with the responsibility of teaching empathy

to their students at all levels. Many are concerned with how this is best done as well as how to evaluate the success of their efforts (Viggiani et al., 2005). Many educators approach this task by having a student role play a variety of practice scenarios using reflective listening techniques. The student is then evaluated by the review of video or audio tapes of these sessions. Direct feedback from instructors, peers and self-reflection are ways to assess the student's interpersonal process skills and empathic abilities. While this approach to teaching practice skills has been criticized as an unrealistic method for preparing students for the realities of agency life, it remains the current educational approach of choice (Richards, Ruch, & Trevithick, 2005).

The study of contemporary fictional literature is another way for social work students to learn about and experience empathy prior to its implementation in practice settings or role play scenarios. This approach helps students to begin to identify sympathetic feelings, cultural biases and the experience of empathy. This method of teaching empathy has traditions in sociology and medicine. Fiction can be used to introduce students to a wide variety of social, economic and cultural situations they would not normally have been exposed to (Viggiani et al., 2005).

Literature addressing social work theoretical frameworks, direct practice interventions, research and education identifies social work as inextricably combined with the use of a therapeutic relationship. From its origins, the relationships that social workers have with their clients have been the primary vehicle through which services are delivered.

The utility of the helping relationship in social work has been empirically demonstrated. Indeed, the process skills of the worker provide the potential for change

and have been identified by social work clients as the single most important factor in intervention success. Empathy and other similar constructs repeatedly appear in the literature examining the therapeutic relationship (Coady & Marziali, 1994; Lejuez et al., 2006; Olio & Cornell, 1993). Social work outcome research continues to support the empathic and intuitive nature of successful social work practice (Smith, Thomas, & Jackson, 2004; Trevithick, 2003).

The majority of empirical efforts to measure empathy in helping professions have focused on quantifying the construct in general or clinical populations (Baron-Cohen & Wheelwright, 2004; Davis, 1983; Hogan, 1969; Jolliffe & Farrington, 2005). Only recently has an instrument to measure empathy within the context of the physician-patient relationship been developed (Hojat, 2007).

Empirically Based Social Work Research and Measurement

Empirical evaluation of social work practice outcomes is difficult at best. The enormously varied settings, practice goals and client relationships that comprise the practice arena make definitive outcome assessments elusive. Many are concerned that a focus on empiricism fundamentally changes the nature of social work and cannot capture the interpersonal skills of the clinician (Meyer, 1996). The application of scientific methods of research to the practice of social work has been questioned and at times denounced. This is in spite of research documenting the effectiveness of various intervention strategies and techniques (Ivanoff, Blythe, & Scott, 1997).

Measurement efforts in particular have come under the scrutiny of social work theorists, scholars and practitioners. Abuses of various personality measurement tools in the past have placed social workers in the position of defending as well as

administering measurement instruments of dubious quality and accuracy. Many of these instruments have been used to categorize and pathologize clients in ways antithetical to social work values (Whitkin, 2001). Witkin (2001) declared, “As with other capitalistic behemoths, our stance toward the testing industry should be as allies and resources for our clients. Fulfilling these roles requires us to function as mediators, interpreters and advocates for those who are the subjects of testing” (p. 102).

Another cautious but hopeful view of the use of measurement scales in social work research and practice has been described by Lutz and Flory (1993). They asserted that measurement instruments in social work are problematic due to the elusive nature of the concepts being researched, not the use of instrumentation itself. They stated, “…assessment problems in social work are due more to the nature of the phenomena than to mechanical problems of unreliable instruments” (p. 229).

How and under what circumstances measurement instruments are applied in social work settings is key to avoiding the misguided use of them. Careful consideration of the question posed by the test is critical. Any potential risk to the client must be considered and addressed before an instrument is administered. Perhaps most important of all is the informed consent of the client. This process informs the client of the implications of the test’s results. It clearly outlines the risks a client is exposed to, and how the results may be used contrary to the client’s interests (Whitkin, 2001).

Social work has embraced the idea of evaluation and assessment of practice and its outcomes. Empirical evaluation of practice outcomes has been deemed a necessity by social work scholars and educators (Hepworth & Larsen, 1990; Hepworth, et al.,

2006; Rubin & Babie, 2005). The process of being able to confirm and explain the results of clinical efforts is basic to determining their effectiveness.

The concept of measurement pervades society and is fundamental to formulating explanations of the world around us. Political, economic and meteorological forecasters speak in quantifiable terms to explain phenomena despite the inexact nature of their predictions. Evaluations and opinions of diverse topics such as global climate change, poverty and educational achievement all rely on measurement, however subjective, to define and explain themselves. Measurement profoundly influences how we understand and negotiate our lives, day to day (Cole, 1998; McClenon, 1997).

Measurement is one tool in the effort to gauge the intended benefits of social work practice. The development of objective instruments to assess the complex nature of practice by social workers is a relatively new development in the field. The process of developing and using measurement tools in social work practice and outcome research is becoming more frequent with increasingly informative results (Rubin & Babbie, 2005).

The empirical assessment of empathy has been undertaken by researchers before (Davis, 1980; Hojat, 2007). The measures and scales currently available are worthy of consideration and examination. Scales that attempt to evaluate constructs similar to empathy can also provide valuable information concerning efforts to quantify latent human attitudes and attributes. Of particular interest and importance are scales developed to assess these capacities in helping professionals. The process of assessing empathy in helping professionals is in its infancy, and the scales that are currently available serve as a starting point for the evaluation of empathy in social workers.

Available Empathy Measures

Attempts to measure empathy in the past have resulted in the development of various instruments for this purpose. Self-report questionnaires have been the most frequently used. These instruments lend themselves easily to increased reliability in replication studies. The use of factor analysis makes possible the reduction of large amounts of questionnaire/survey type data. This method also creates a strong argument for an instrument's construct validity (Benson, 1998; Clark & Watson, 1995; Spector, 1994).

Self-report questionnaires are relatively easy to administer and allow researchers to obtain large quantities of data. They are time and cost efficient to complete, and research participants can be afforded enhanced confidentiality. This method of data collection is designed to increase the objectivity of the study analysis and interpretation. This is in part due to a reduction in certain types of bias within participant response patterns using this research technique (Spector, 1994).

The available measures are presented as examples of available empathy scales and their development (Appendix 6). They are illustrations of how objective scales for the measurement of empathy have been developed. These measures are similar in their construction and analysis methods. Of note, the Jefferson Scale of Physician Empathy (JSPE) is the only empathy scale designed to assess empathy in helping professionals currently.

The related scales are examples of instruments designed to assess latent constructs similar to empathy (Appendix 7). While the construction and analysis techniques of these scales are similar, their differential use of sample choice is

noteworthy. These instruments all use samples consisting of social workers and/or other helping professionals. They also provide examples of how latent constructs have been evaluated in clinical practitioners.

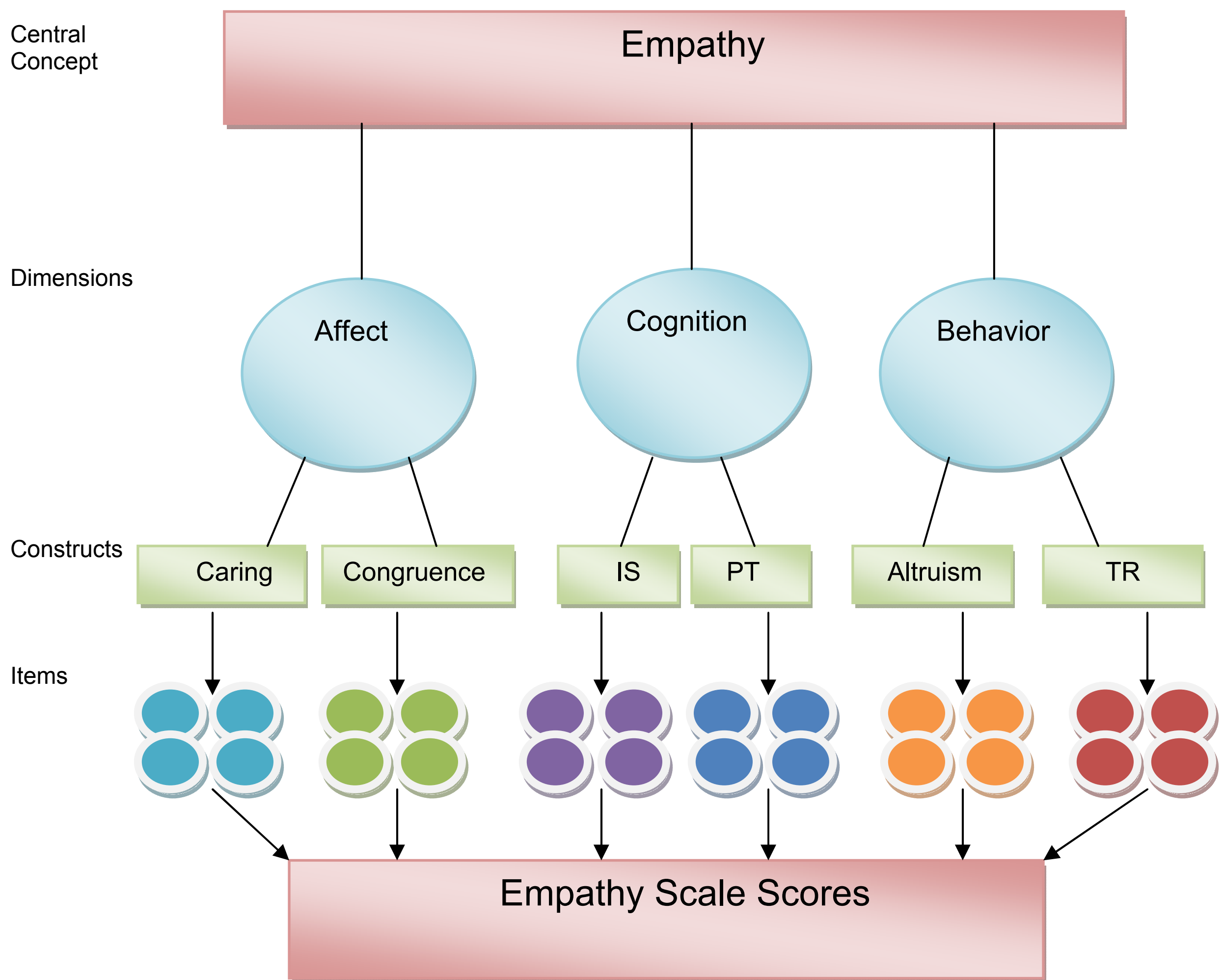
Both groups of scales use construction and analysis methods that can inform the development of new instruments designed to assess latent human constructs. Their examination and evaluation both individually and collectively provide a template for the development of this empathy scale.

Theoretical Framework

Interest in empathy has led researchers to study its underlying properties and quantify its dimensions (Davis, 1980; Dymond, 1950; Hogan, 1969; Hojat, 2007; Mehrabian & Epstein, 1972). Typically, empathy is defined as having two primary domains, affective and cognitive (Cliffordson, 2002). The framework described in Figure 1 illustrates a definition of empathy extending the primary cognitive and affective domains by incorporating its behavioral manifestations. These three domains are further broken down into six underlying constructs that provide a definition of empathy in this study. Efforts to measure the multiple dimensions of latent, unobservable constructs used in the scale construction of this study required a comprehensive theoretical scaffolding to begin to document evidence for the construct validity of this measure (Cronbach & Meehl, 1955; Nunnally, 1967; Rubin & Babbie, 2005; Spector, 1994).

The six constructs depicted in Figure1 are: (a) caring, (b) congruence, (c) interpersonal sensitivity (IS), (d) perspective taking (PT), (e) altruism, and (f) the therapeutic relationship (TR). These are taken from the literature in social work and related disciplines as they provide theoretical and empirical evidence of the existence

and importance of empathy in social relationships and helping processes. Just as the affective, cognitive and behavioral domains of empathy share components in their manifestations, so do these six specific non-mutually exclusive constructs.



*Note – Construct Abbreviations: IS= Interpersonal Sensitivity, PT= Perspective Taking, TR= Therapeutic Relationships.

Figure 1. The Concept of Empathy: Dimensions and Constructs

It is difficult to imagine affective, cognitive and behavioral components of empathy ever being stand alone concepts. Empathy, by its interpersonal and dynamic nature, is something we think, feel and do. In clinical practice the use of empathy is indeed a highly complex and dynamic process. The use of empathy in social work often requires the practitioner to have all three dimensions "turned on" at once.

Each of the constructs outlined in this theoretical framework has affective, cognitive and behavioral components and manifestations. They have been determined, for the purposes of this study, to be primarily affective, cognitive, or behavioral. For example, in this study IS is grouped within the cognitive dimension. This is not to contend that IS is solely a cognitive process. The thoughtful attunement to non-verbal communications from clients (a part of IS) will often identify or illicit intense emotional material within the client as well as the therapist. Any reflection or inquiry into this material by the therapist is then a behavioral extension of IS. The use of IS is primarily cognitive in that the non-verbal cues of the client are compared to an internal and established knowledge base within the clinician. Limited eye contact may communicate deference, anger, or psychosis depending on the social context and interpersonal dynamics of the interaction. IS in a helping relationship depends primarily on the perceptiveness and content knowledge of the clinician. Likewise, altruism is behavior rooted in emotional as well as cognitive motivations. While these affective and intellectual components are crucial to our understanding of altruism, it remains primarily a behavior.

The six constructs underlying a definition of empathy proposed here have varied meanings and connotations to a wide and disparate audience. Terms like congruence

(Rogers, 1951) and interpersonal sensitivity (Snodgrass, 1998) have been re-defined by theorists and researchers with unique meanings for a specific field or discipline. This process further complicates the definitive categorization of these concepts. The exploratory aspects of this study aim to shed light on the degrees of difference and similarity between these terms and constructs.

The Affective Dimension

The affective dimension of empathy is an interactive process of emotional connection and concern for others. It involves emotions defined by how a person feels in the context of an interpersonal experience. Perception of the emotional world of another and an emotionally empathic approach to helping are manifested by two supporting constructs, caring and congruence.

Caring. Caring as a theoretical construct has been developed and refined, in part, within the disciples of nursing, philosophy and counseling. It has been defined as behavior directed at meeting the immediate needs of another by the use of a discipline-specific skill set (Lee-Hsieh, Kuo, Tseng, & Turton, 2004; Skovholt, 2005). Alternative theories of this notion stress the importance of caring as an ethical, moral and social construct (Danby, 2004).

Nursing theorists posit that caring is a complex synthesis of these theoretical perspectives (Benner & Wrubel, 1989). Feminist theories emphasize it as arising from gender-specific ways of solving ethical problems. Gilligan (as cited in Danby, 2004), concluded that caring is the manifestation of a uniquely feminine concern for individual and relational choices and their consequences, as the criteria for addressing and resolving moral problems. Benner and Wrubel (1989) posited that caring is a part of the

existential context of mutual meaning-making expressed in a relationship experience between caregivers and recipients.

Caring as both a goal-oriented interactional behavior and a theoretical construct is notably absent in the empathy scale development literature (Davis, 1980; Hasimoto & Shiomi, 2002; Hojat, 2007; Mehrabian & Epstien, 1972; De Kemp et al., 2007). By contrast, other related constructs such as empathic concern, perspective taking and compassion repeatedly appear in this literature (Danby, 2004; Engster, 2005; Skovholt, 2005). Caring is an emotional and interactive process that taps the affective components of helping relationships. A relational connection to the feelings of another lays the groundwork for the experience and expression of caring (Brenner & Wrubel, 1989; Engster, 2005).

Congruence*.* Congruence is defined as an ability to be open, non-judgmental and honest within helping relationships. Congruence was primarily proposed by Carl Rogers (1951) as a ‘core condition’ of an empathic and productive therapist-client relationship. Congruence is a therapeutic and emotional connection frequently associated with positive outcomes in psychotherapy (Marziali & Alexander, 1991). It requires a therapist to communicate verbally as well as non-verbally that s/he is a learner anticipating understanding the client’s unique situation and perspective (Wickman & Campbell, 2003). Social work theorists and practitioners have continued to embrace congruence and empathy as change facilitating skills essential to the helping professions (Freedberg, 2007; Rothery & Tutty, 2001).

Congruence entails specific underlying affective skills that both define and facilitate its development. It is evidenced by a transparency that permits feelings and

experiences to be utilized in assessment and intervention decisions. Extending one's awareness into accurate and empathic communication has curative properties by validating a client's unique experience. An appropriate use of self-disclosure by the clinician can facilitate this process further (Lambert & Barley, 2001; Tudor & Worral, 1994).

Research regarding the measurement of empathy has captured elements of congruence without explicating it as a unique construct in its own right (Davis, 1980; Hogan, 1969; Hojat, 2007; Mehrabian & Epstein, 1972). Congruence and empathy are important concepts stemming from client-centered and humanistic schools of psychotherapy, and they have profoundly influenced the practice of social work today (Lance, 2001; Rogers, 1951; Rothery & Tutty, 2001; Wickman & Campbell, 2003). Congruence and empathy are co-occurring conditions with behavioral similarities and have been described as overlapping conditions of an effective therapeutic relationship (Allen-Meares & Burman, 1999; Houston, 1990; Lambert & Barley, 2001; Rogers, 1951; Tudor & Worrall, 1994; Wickman & Campbell, 2003). Finally here, the condition of congruence is both an interactive and emotional process. It is a helper's resonance with the feelings of another, and it supports a relationship from which healing can emerge (Freedberg, 2007; Rogers, 1951).

The Cognitive Dimension

Cognitive dimensions of empathy involve interpersonal perception, intellectual flexibility, and openness to understanding the experiences of another in the service of helping. It includes a group of conceptual processing and thinking skills that emphasize

a level of objectivity and distance from the emotional content evident in a client's presentation and a careful assessment of the contextual cues therein.

Interpersonal sensitivity. Interpersonal sensitivity (IS) is a communicative process between individuals based on their understanding of one another's body language and facial expressions. This skill varies considerably between individuals and is influenced by both social context and gender role expectations. IS contributes to intimate relationship success and effective helping relationships (Snodgrass, Hect, & Plotz-Snyder, 1998).

This process is characterized by two components, emotional and social. Emotional sensitivity is a relationship skill allowing one to perceive the emotional world of another guided by non-verbal cues. Social sensitivity involves appreciating the social context of an interaction and making behavioral choices considering the influences of social structures, role expectations and personality factors (Carney & Harrigan, 2003; Snodgrass, 1992). Thus, the term, metacognition, has been used to describe the process and expression of interpersonal sensitivity (Ames & Kammrath, 2004).

Any attempt to measure empathy should account for its various cognitive expressions. Interpersonal sensitivity is similar to the related construct of perspective taking in this regard (Ames & Kammrath, 2004; Underwood & Moore, 1982). As congruence is an integral aspect of emotional empathy, interpersonal sensitivity describes empathy from a cognitive perspective.

IS is considered a necessary but insufficient condition for empathy. One cannot be empathic without being interpersonally sensitive, but sensitivity does not guarantee empathy (Carney & Harrington, 2003). IS can aid in the assessment of a client's non-

verbal behaviors, and it creates an opportunity for exploration of issues not initially presented by the client (Snodgrass & Rosenthal, 1985). Hall and Mast (2007) identified non-verbal communication and IS as confirmatory and complementary processes in one's development of accurate empathy.

A clinician's ability to attend to multiple perceptions, expressions and perspectives is an advanced and complex helping skill. IS is a cognitive exploration that injects the helping process with a level of objectivity in understanding the contextual, but unspoken nature of a client's concerns (Carney & Harrington, 2003; Underwood & Moore, 1982).

Perspective taking*.* The second construct of cognition, perspective taking (PT) is the ability to accurately perceive another's point of view (Davis, 1980). PT involves the internal and cognitive interpretation and understanding of another's mental and emotional state. It is then necessary to suspend one's own perspective and understand the situational or environmental factors contributing to the thoughts and feelings of someone else (Baron-Cohen & Wheelwright, 2004; Cliffordson, 2002; Davis, 1980; Hojat, 2007; Johnson, Cheek, & Smither, 1983). Dymond, (1950) defined empathy as, "… the imaginative transposing of oneself into the thinking, feeling, and acting of another, and so structuring the world as he does" (p. 127).

Research on PT has frequently involved exploring its development in children. Such studies frequently involve story-telling through pictures. Here, individuals are asked to describe their understanding of the thoughts and opinions of different story characters. As such, children were found to be able to appreciate another's situation and view point (Oswald, 1996). PT has been described as an essential part of the

development and expression of empathy. This research has demonstrated the overlapping nature of this process as well as the close relationship between PT and expressed empathy (Oswald, 1996). Factor analytic studies of empathy measures suggest PT to be an underlying function of empathy as well (Cliffordson, 2002; Davis, 1980; Hojat, 2007; Johnson et al., 1983). Theoretical and empirical study have consistently identified PT as an important facet of empathy (Hojat, 2007).

PT is primarily a cognitive skill contributing to the development of empathy (Oswald, 1996). Flexible and objective attunement to the details of a client's perspective is required to be of help. By taking a client's perspective, a clinician enhances the chances of employing successful assessment and intervention strategies (Davis, 1980; Saulnier, 1996).

The Behavioral Dimension

Finally here, behavioral manifestations of empathy involve interpersonal actions and motivations. These are other-directed and outwardly observable expressions of empathy. They demonstrate functional aspects of the concept and its concrete applications within helping relationships. The two constructs in Figure 1 related to this dimension are altruism and therapeutic relationships.

Altruism. Altruism has been described as a pro-social behavior designed to help or assist another individual. Altruism can take the form of efforts to relieve distress, such as helping someone to stand after a fall, or goal-directed behavior such as opening a door for another. Altruistic behavior is distinct from collaboration in that all expect to benefit from this cooperative behavior. Altruism has been identified as a behavioral indicator of empathy (Batson et al., 1991; Underwood & Moore, 1982). The role of

motivation in altruistic behavior is essential to understanding the concept. The empathy-altruism hypothesis posits that altruistic behavior is purely motivated by an individual's concern for the welfare of another as an outgrowth of empathic expression (Batson et al., 1991; Batson et al., 2007). Additionally, it has been suggested that altruistic behavior is not driven by guilt within the helper or anticipation of the rewarding experience of seeing change in the recipient. (Batson et al., 1991).

Social psychologists have studied and empirically established the relationship between altruism and empathy (Cialdini, Brown, Lewis, Luce, & Neuberg, 1997). Theories of altruism vary in their assessment of the motivation behind altruism, altruistic (Bierhoff & Rohman, 2004; Underwood & Moore, 1982) versus egoistic, but retain the requirement of an empathic process. Attachment theory has been used to connect levels of interpersonal attachment relationship styles to levels of empathic and compassionate feelings expressed by altruistic behaviors (Mikulineer & Shaver, 2005). These distinct theories of altruism explain some of its connections to empathy.

While altruism serves as a behavioral indicator of empathy, most empathy measurement research does not attend to the relationship between altruism and empathy (Davis, 1980; Dymond, 1950; Hogan, 1969; Hojat, 2007; Mehrabian & Epstein, 1972). Various studies of empathy have indicated an inverse relationship between anti-social behavior and empathy (De Kemp, et al., 2007; Jollife & Farrington, 2005). As the relationship between anti-social behavior and empathy helps define what empathy is not, the pro-social behavior of altruism should be a part of the theoretical network defining what empathy is. The empirical evidence of a relationship between the concepts helps explain the theoretical overlap between them.

Altruism has been historically identified in the social work literature as a key reason why individuals enter the field of social work (Holosko, 2006). Social work researchers have repeatedly studied the qualities and attributes of individuals who become social workers. Altruism consistently emerges as a primary motivation and personality characteristic for entry level social work students (Bulcke, 1994; Pins, 1963). As an outward and other-directed behavior, altruism centers itself in the process of helping and provides a behavioral vehicle for the direct expression of empathy in social work practice. Given the centrality of altruism to the character of social work, its role in the assessment of empathy in practitioners is warranted.

Therapeutic relationships. The second behavioral construct, therapeutic relationships (TR) or alliance, has been identified as a significant agent of change and growth in a variety of helping relationships and clinical settings (Allen-Meares & Burman, 1999; Lambert & Barley, 2001; Olio & Cornell, 1993; Stewart, 1984). This relationship consists, in part, of a sense of trust and a bond between the therapist and client (Dykeman, Nelson, & Appleton, 1995). A helping alliance is one in which a worker is accepting, non-judgmental, supportive and empathic. Other identified defining characteristics are effective affirmation skills, caring and respect (Allen-Meares, 1999; Lambert & Barley, 2001).

The importance of therapeutic relationships is a central construct in most theories of human behavior and therapeutic change. Psychodynamic theorists and researchers describe this alliance as a foundation for explaining therapeutic benefits of clinical intervention (Kradin, 2005). Theorists from existential, feminist, behavioral, and family systems schools of thought associate, if not center, their models around a therapeutic

alliance/relationship (Lantz, 2001; Lejuez et al., 2006; Minuchin & Fishman, 1981; Saulnier, 2001). Empathy is a distinct process component of the worker-client relationship. Freedberg (2007) stated, "I am suggesting that an enhanced feeling of power grows out of a healthy interaction with empathically attuned others, contributing to the capacity to act in the environment with a sense of self-efficacy and purposefulness" (p. 256). Empathy is a part of a truly therapeutic relationship and the relationship depends on empathy for its eventual success.

Empathy and its ultimate behavioral and theoretical expressions appear in studies of TR. Accordingly, measures of the helping relationship have been successfully used in the evaluation of therapeutic outcomes (Coady & Marziali, 1994; Marziali & Alexander, 1991; Smith et al., 2004). While a reflective and thoughtful process, the helping alliance is an outwardly focused behavior initiated by the helper. The TR requires motivation and direct action by the clinician to provide a relational and behavioral vehicle for change.

In sum this sub-section, based on a review of the literature in social work primarily and three of its cognate helping professions medicine, nursing and psychology presents three main dimensions and six constructs associated with the concept of empathy. All have empirical and theoretical justification in the literature and all will be included in the development and validation of a multi-dimensional empathy scale to assess empathy among social worker practitioners who use this skill in their day-to-day practice.

CHAPTER 3

METHOD

The research method for this study is outlined below. This includes a discussion of the sample, study design, data collection and additional instruments of study selected for this research. Each sub-section contains descriptions of its parameters and implementation.

Scale Construction

The initial items on the ESSW were chosen using various methods. First, a review of the literature involving the study of empathy and the proposed scale constructs was conducted. These studies provided descriptions of empathy that formed a large number of words and phrases from which scale items were developed. Items from existing empathy scales were carefully reviewed and phraseology related to the concept of empathy was incorporated into the item development process.

While constructing items for the ESSW, efforts to word items in the simplest and most coherent manner resulted in a number of grammatical errors. In future revisions of the scale these items will need to be worded in a way that is grammatically pristine.

Sample

The study used a non-probability, purposive sampling technique. This approach to obtaining a research sample is common in the development of measurement instruments that seek to assess a specific group's attitudes and underlying beliefs (Rubin & Babbie, 2005). The sample consisted of social work practitioners with at least

two years of direct social work practice experience and a M.S.W. degree. This inclusion criterion sought to capture a sample of social workers who had enough clinical experience to participate in the use of empathy in practice. Study participants were selected from a list of MSW graduates from the University of Georgia School of Social Work between the years 1975-2005. Study participants were also solicited from the Georgia Society for Clinical Social Work, The Group for the Advancement of Doctoral Education in Social Work, and other schools of social work in the southeastern United States. The purpose of the study was to evaluate empathy among social workers therefore the sample was discipline specific and relatively homogeneous with an initial target of N≈500.

Study Design

This study is a quantitative-descriptive research design. This design is appropriate when the study goal is the development of an objective rating scale (Holosko, 2006). Specific study objectives designed to further the purpose of the study are to describe and quantify the relationships between various study variables. In this case a single, relatively homogenous, group of participants was sought for this study. The use of a single group research design is appropriate when seeking to understand phenomena particular to that group, and in light of specific research questions or objectives (Holosko, 2006). The scale was transformed into an electronic format through the Survey Research Center (SRC) at the University of Georgia (UGA).

Data Collection

Phase 1: Expert Review

To establish a level of content validity for two of the instruments of study, key informants/experts were recruited to review the initial 42-item empathy scale. All participants were social work practitioners with advanced clinical licensure (L.C.S.W.) in the state of Georgia, N=10. Each was asked to evaluate two different scales. The Jefferson Scale of Empathy (Clinical Social Work Version) which was adapted from the Jefferson Scale of Physician Empathy (Hojat, 2007). This version of the scale was adjusted by this researcher (with the author's permission) to contain items that better reflect a clinical social work practitioner's experience. The JSPE is a scale, with sound psychometric properties, used in the assessment of empathy in physicians. The adapted version for social work was chosen to test its reliability and its convergent relationship with the ESSW. The scale under development (ESSW) was evaluated by the expert reviewers using the same criteria as well.

The expert reviewers rated each scale in three different categories. Next, the reviewers were asked to evaluate how accurate each scale was in describing empathy in social work. Then, the participants rated each scale in terms of its coherence and clarity. Reviewers were asked to rate the scale along these dimensions using a 10-point scale, 1= not at all to 10= very much. Participants were also asked to identify items on both scales that they thought were worded poorly or confusing. The mean expert review ratings for the JSE (Clinical Social Work Version) were: useful, 5.75; accurate, 6.10; Coherent, 6.10. The ESSW received mean scores of: useful, 8.20; accurate, 8.60; coherent, 8.30.

Phase 2: Study Data Collection

The ESSW was made available electronically to potential participants, after study approval by the Institutional Review Board at UGA, via a web link through the Survey Research Center at UGA. Participants then followed the link and were presented with an introductory cover letter (Appendix 5) informing them of the voluntary nature of participation in the study. In the introduction, the study purpose and the recipient's right to refuse to participate in the research project without consequence were explained. Participants were informed that absolute confidentiality could not be guaranteed when collecting data via the internet but they were assured that no indentifying information was being requested and would be cleaned from the data by the researcher should a participant submit such information. Individuals were informed they were assenting to participate in the study by continuing on to the next section of the survey. All participants were then asked to provide general demographic information in order to better describe the sample overall. The data requested were a participant's gender, age, ethnicity, years of practice experience and current practice setting. Participants then moved on to completing the ESSW and the additional scales. Once the survey became available via the internet and participants were solicited, data collection began and continued for a period of eight weeks from April 1, 2009 until June 1, 2009.

Instruments of Study

The ESSW contains 42 items describing thoughts, feelings and actions involved in the use of empathy in social work practice and other life situations (Appendix 1). Participants are asked to rate these items on a Likert-type frequency scale. The

response format for this scale is: 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always.

The JSE (Clinical Social Work Version) followed the ESSW as participants continued through the survey (Appendix 2). It is the 20- item questionnaire previously evaluated during the expert review phase of scale development in this study. The JSE (Clinical Social Work Version) uses a response set ranging from 1= Strongly disagree to 7= Strongly agree.

The Self-Report Altruism Scale (SRA) is designed to assess altruistic behavior in adults (Appendix 3). The SRA is a 20-item questionnaire with high reliability, α=.71-.80, and acceptable validity correlations with related measures (Rushton, Chrisjohn, & Fekken, 1981). The next instrument presented to the study participants was the Verbal Aggression Scale (VAS) (Appendix 4). This scale measures the degree to which someone uses verbal attacks and manipulation to influence others. Upon close examination, the items in this scale describe communication styles that are exploitive, insensitive and uncaring in nature. They appear to reflect an interactive style in significant contrast to the constructs and concepts used in this study to define empathy. These criteria were used as the basis for inclusion of this measure in the overall series of questionnaires. The VAS is a 20-item questionnaire with good reliability, α .80, and moderate validity correlations with related measures. The response categories for this scale are 1= almost never, 2= rarely, 3=sometimes, 4=often, 5=almost always (Infante & Wigley, 1989).

Data Analysis Procedures

The survey data were received in a raw data set from the SRC and were analyzed using the Statistical Program for the Social Sciences, 16.0 (SPSS). Frequency and descriptive statistics for the demographic data were analyzed.These included frequency counts and percentage values for each demographic category. Measures of central tendency were obtained and included category means. In order to examine the initial distribution of the data, the level of skew and kurtosis were computed. A series of independent sample t- test procedures and an analysis of variance (ANOVA) were conducted to compare the mean scores of different sub-groups. The internal consistency of the multi-construct empathy questionnaire were computed and assessed as well using split-half reliability tests and Cronbach's coefficient alpha (α). The correlation matrix was analyzed using Exploratory Factor Analysis (EFA) techniques. Variable coefficients (factor loadings) were computed and revealed the extent to which specific items group together to form factors. Due to the latent and undifferentiated nature of the construct being evaluated and the theoretical overlap between items, it was suggested that many variables would correlate to varying degrees. Rotation procedures that permit more detailed analysis of the data, given the theorized correlated relationships were proposed. An oblique rotation of factors was used to simplify the factor structure of the ESSW.

CHAPTER FOUR

RESULTS AND DISCUSSION

The reader will note that the tables presented herein will have slightly different sample sizes. This is because in these analyses respective missing data were deleted by item not individual.

Demographic Data

The demographic variables of study participants surveyed were gender, ethnicity, age, years of practice experience and current practice setting. These data were considered to be of importance to determine if the sample was representative of the population of clinical social workers meeting the study inclusion criteria. These data were also gathered for group comparison testing. These groups have been identified in prior studies (Hodge, 2004) to be consistently represented in this population. Of note, some sections of the demographic data were divided into sub-groups and others were not. Gender and ethnicity data were not amenable to sub-grouping due to the over representation of white females in the study sample.

Females comprised 80.9 % of the sample and males represented 19.1 %. Respondents were 85.3% white, followed by 7.5% African-American, 2.3% Hispanic, 1%, Asian and 3% reported this variable as “Other”. Participants ranged in age from 24-77 (M = 44.43, SD = 11.28) with a *median* of 45. Study participants then reported the total number of years of direct social work practice each had obtained. These data were organized into groups. Group 1 had <2 years of experience (1.5% of the total), group 2

had 2-5 years of experience (18.8% of the total), group 3 had 5-10 years of experience (25% of the sample), and lastly 54.4% had ≥ 10 years experience. Data regarding the practice settings of respondents were also requested. These categories with the resulting percentages were: Medical Social Work 16.9%; Social Work Education, 12.5 %; Community Mental Health, 11.0%; Private Practice 8.8%; School Social Work, 8.5%; Administration, 6.6%; Child Welfare, 4.4%; Community Organization/Advocacy, 4.0%; Research, 3.7%; Other 22.4%.

All demographic variables were assessed for subsequent sub-group analyses and given their percentage of the sample the following were computed: a) age was sub-divided into high and low groups using the sample median (45.00), b) years of practice experience was sub-divided into high experience as 54.4% of respondents fell into this category. All others were placed in the low age group and, c) practice setting sub-groups were chosen according to a ranking of their overall percentages in the total sample. It was found that 16.9% worked in a medical social work setting (MSW), and 12.5% stated they worked in social work education (SWE). 11% of respondents reported they worked in a community mental health setting (CMH). The only sub-group larger than these three was the "Other" category, comprising 22.4% of the study sample.

From its beginnings social work has been well represented in a wide variety of social service settings by a fairly narrow demographic group of white females (Pins, 1963). Hopps and Pinderhughes (1983) reported that 73% of NASW members (at the time) were female and 88.9% were white. Additionally, Bride, Robinson, Yegidis, and Figley (2004), in their study of secondary traumatic stress among social workers,

utilized a national sample that was primarily female (81.9 %) and Caucasian (77.5%). Similarly, Hodge (2004) in a study of professional social work demographics found 76% were female, 88% were white. This study also found that the age patterns for social workers was (*M* = 43.20, *SD* = 12.96). These statistics regarding the mean age of practitioners are very similar to those evident in the present study.

The demographic patterns found in the present study were encouraging as they closely resemble the empirical findings previously noted. They provide convincing data to support the present claim that the sample in this study is accurately representative of the social work profession. As anticipated, the current sample permits a level of generalizability of study findings, to the overall population of social work practitioners.

Psychometric Properties of the ESSW and Other Measures

The psychometric properties of the ESSW, the primary instrument of study, will be presented here. These data address the concerns of its reliability and validity. The information obtained in this stage of the scale's development will assist and guide the further refinement of scale items and the overall structure of the instrument.

The ESSW is a 42-item questionnaire which used a 5-point Likert type scale response format (see Appendix 1). The response format is: 1=never, 2=rarely, 3=sometimes, 4=often, 5=always. Higher scores on the ESSW are theorized to predict higher levels of empathy among survey respondents. The maximum score attainable on the ESSW for an individual item is 5 and 210 for the entire measure. The overall scores of the survey respondents on the ESSW were evaluated and scores ranged from 134 to 188. (*M*= 159, *SD*= 9.23). Descriptive analyses were conducted on all scale items. The

results showed a scale range (*M*= 3.01 – 4.60, *SD*= .514 – 1.11). Table 1 ranks the 15 most highly endorsed items on the ESSW with means and standard deviations.

The five lowest item means in this analysis were Item 9, “Clients expect me to think a certain way because of my gender”, (*M* = 3.01, *SD* = .638); Item13, “My relationship with a client can help them overcome their problems” (*M* = 3.55, *SD* = .680), Item 15, “It can be helpful for clients to use our relationship to practice new interpersonal skills” (*M* = 3.77, *SD* = .785), Item 21, “ I can put myself in a client’s position”, (*M* = 3.74, *SD* = .571, Item 34, “ I carefully consider the ways that social gender role expectations effect my clients”, (*M* = 3.82, *SD* = .737).

The reliability or internal consistency of a scale under development should be evaluated to assess the homogeneity of scale items. Evaluation of a scale’s internal consistency is an indicator of how well the scale items reflect a common underlying construct (Bride et al., 2004). The examination of the scale as a whole and its overall reliability was conducted in a variety of ways.

The reliability of the ESSW was evaluated using three related procedures. The coefficient alpha for the ESSW was found to be α =.829. Normally, coefficient alpha levels exceeding $\alpha \geq .80$ are considered sufficient (Nunnally. 1967) to very good. Kline (2005) reported that a coefficient alpha statistic of .70 was adequate for reliability evaluation. Split-half procedures were then conducted to further assess the ESSW’s reliability. Split-half procedures are most appropriate when scale items are scored on a response format with three or more choices. Split half procedures have been described as providing supportive evidence for the overall coefficient alpha by way of their proximity to it (Nunnally, 1967). The first split-half procedure divided the instrument by

Table 1

The 15 Most Highly Endorsed Items on the ESSW (N = 271)

Most Highly Ranked Items	*M*	*SD*
1. I try to let my clients know I am concerned for their welfare.	4.64	.538
2. It is important for my clients to be able to trust me.	4.62	.571
3. I try to give my clients a warm greeting when meeting them.	4.62	.571
4. Having an intimate relationship with a client is appropriate.	4.61	1.110
5. If a client cannot afford treatment I try to find a way for them to receive the help they need.	4.57	.572
6. I am kind to my clients.	4.54	.514
7. My clients tell me I can be insensitive.	4.51	.570
8. I try to take a client's cultural context into account when working with them.	4.50	.577
9. I try to understand a client's viewpoint before making suggestions.	4.43	.572
10. I enjoy helping people.	4.40	.561
11. It is important for my clients to know that I care about them.	4.38	.649
12. I can disagree with a client and still appreciate their position.	4.37	.572
13. I am attentive to my client's non-verbal cues.	4.35	.536
14. An unbiased approach is helpful to clients.	4.34	.652
15. I pay close attention when a client's tone of voice changes.	4.31	.604

separating items 1 through 21 from items 22 through 42. The Guttman correlation computed for this split-half reliability procedure was r = .68. The second split half procedure divided the scale by odd versus even numbered items. The Guttman correlation for this analysis was r = .81. These findings provide moderate to strong evidence of the internal consistancy of the ESSW.

An inter-item correlation matrix was computed and the relationships tested for statistical significance. The Pearson product-moment correlation coefficient (r) tests the linearity, direction and significance of the relationship between two variables (Nunnally, 1967). The Pearson coefficient can be considered a measure of effect size as well (Green & Salikind, 2005). The matrix generated from the data was quite large with a total of 1,764 entries on the 42 x 42 matrix. A selection of the 10 highest inter-correlations is presented in Table 2.

Four items in Table 2 appeared repeatedly with these top ranked correlations. They were item 23 “My relationship with a client can be therapeutic in and of itself”; item 19. “The personal dynamics of my relationship with a client are beneficial to the treatment process; item 15, “It can be helpful for clients to use our relationship to practice new interpersonal skills.” And item 4, “I enjoy helping people”.

The three additional instruments administered as part of the overall survey were also assessed for internal consistency. The Jefferson Scale of Empathy (Clinical Social Work Version) (JSE), was analyzed and determined to have a coefficient alpha of α =.72. The Self Report Altruism Scale (SRA) was determined to have a coefficient alpha of α = .93. Coefficient alpha for The Verbal Aggressiveness Scale (VAS) was α = .62.

Table 2

The Ten Most Highly Correlated Items on the ESSW (n = 271)

ESSW Items	Correlations
Item 32. I am attentive to my client's non-verbal cues. Item 22. I pay close attention when a client's tone of voice changes.	**r = .571**
Item 19. The personal dynamics of my relationship with a client are beneficial to the treatment process. Item 23. My relationship with a client can be therapeutic in and of itself.	**r = .559**
Item 4. I enjoy helping people. Item 10. I enjoy helping people even when I am not at work.	**r = .523**
Item 11. Helping clients is rewarding in and of itself. Item 10. I enjoy helping people even when I am not at work.	**r = .503**
Item 15. It can be helpful for clients to use our relationship to practice new interpersonal skills. Item 13. My relationship with a client can help them overcome their problems.	**r = .485**
Item 40. I discuss personal boundary issues with clients. Item 42. Discussing the professional nature of my relationship with a client is important.	**r = .473**
Item 7. Knowing a client's personal situation is important if I am really going to help them. Item 12. Understanding a client's background makes me more helpful.	**r = .463**
Item 15. It can be helpful for clients to use our relationship to practice new interpersonal skills. Item 19. The personal dynamics of my relationship with a client are beneficial to the treatment process.	**r = .454**
Item 4. I enjoy helping people. Item 11. Helping clients is rewarding in and of itself.	**r = .439**
Item 15. It can be helpful for clients to use our relationship to practice new interpersonal skills. Item 23. My relationship with a client can be therapeutic in and of itself.	**r = .433**

These findings compare well to previous empirical assessments of the psychometric properties of each. While no internal consistency testing has been conducted on the JSE (Clinical Social Work Version) until now, psychometric assessments of the JSPE (from which the JSE was adapted) have reported coefficient alpha ranges of reported coefficient alpha ranges of α = .81 - .89 (Hojat, 2007; Hojat, Gonnella, Nasca, Mangione, Vegare & Magee, 2002). Previously the SRA was reported to have coefficient alpha ranges of α = .71 - .80 (Rushton Chrisjohn and Fekken, 1981). When the internal consistency of the VAS was evaluated α = .80 was reported (Infante and Wigley, 1989).

These additional measures assessed the significance and direction of the scales' relationships with each other. This procedure is meant to evaluate the construct and discrimminant validity of the ESSW. Pearson correlation coefficients were computed for these scales' relationships with one another and the level of significance in each.

It was hypothesized that the ESSW would correlate with both the JSE and the SAS in a positive direction and to a statistically significant degree. This would provide evidence that the ESW was measuring a construct defined theoretically as empathy and closely related constructs. The comparison of the ESSW against the VAS was hypothesized to correlate in a negative direction with the ESSW to a significant level as well. Table 3 displays the results of these analyses.

As previously theorized the concept of empathy in social work practice is broken down into six constructs; caring, congruence, IS, PT, altruism and TR. These are proposed to group into the following domains, affective (caring and congruence), cognitive (PT and IS) and behavioral (altruism and TR). Internal consistency tests were

conducted on the six constructs and the three domains. These tests revealed α = .53 for caring, α = .54 for congruence and α = .67 for the affective domain. The cognitive domain achieved α = .70, with its constructs each scoring α = .52 for IS and α = .66 for PT. The behavioral domain was determined to have α = .636 with its accompanying constructs TR α = .53 and altruism α = .58.

Table 3

Intercorrelations of the Four Main Scales (N = 271)

Scales	ESSW	JSE	SAS	VAS
Empathy Scale For Social Work (ESSW)	1.00	.335**	.120*	-.204**
Jefferson Scale of Empathy (JSE)	.335**	1.00	.067	-.238*
Self-Report Altruism Scale (SAS)	.120*	.067	1.00	-.033
Verbal Aggressiveness Scale (VAS)	-.204**	-.238**	-.033	1.00

Note 1. **Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Inter-item correlations were computed to provide the data for Pearson correlation matrices testing the significance of the relationships among the 6 constructs. It was hypothesized that the six constructs would correlate with one another, positively and to a statistically significant level. They were compared against each other and the results of these analyses are presented in Table 4.

Table 4

Empathy Construct Correlations. (N=268)

	Caring	Congruence	IS	PT	Altruism	TR
Caring	1.00	.455**	.341**	.332**	.472**	.267**
Congruence	.455**	1.00	.368**	.438**	.388**	.363**
IS	.341**	.368**	1.00	.462**	. 369**	.351**
PT	.332**	.438**	.462**	1.00	.248**	.350**
Altruism	.472**	.388**	.369**	.248**	1.00	. 305**
TR	.267**	.363**	.351**	.350**	.305**	1.00

Note 1. ** Correlation is significant at the 0.01 level (2-tailed).

In this analysis, all of the relationships between the empathy constructs were found to be statistically significant. The relationships ranged between r = .472 and r = .248. A ranking of the five highest correlations is as follows. The highest correlation found was between altruism and caring at r = .472. The relationship between IS and PT was r = .462. Caring and congruence were correlated at r = .455 and altruism and congruence were correlated at r = .388. Then, altruism and IS were correlated at r = .369. These findings provide support for some of the expected relationships between the six constructs. They also raise questions about proposed construct relationships and their relative significance in the definition of empathy in social work practice.

To examine the relationships of the theorized domains of empathy a similar testing procedure was computed. It was hypothesized that all three domains would correlate with one another in a positive and statistically significant way. The domains of

affective, cognitive and behavioral empathy were analyzed for the Pearson correlation coefficients with the resulting 3x3 matrix (Table 5).

Table 5

Empathy Domain Correlations

	Affective	Cognitive	Behavioral
Affective	1.00	.508**	.539**
Cognitive	.508**	1.00	.491**
Behavioral	.539**	.491**	1.00

Note 1. ** Correlation is significant at the 0.01 level (2-tailed).

Statistically significant relationships were found between the affective, cognitive and behavioral domains at the 0.01 level. In rank order: affective and behavioral domains were correlated at $r = .539$; cognitive and affective domains were correlated at $r = .508$; and cognitive and behavioral domains were correlated at $r = .491$. These findings of significant relationships within close range of one another indicate the importance of further analyses to attempt to tease out the specifics of the underlying factor structure of empathy in social work practice.

The following discussion will focus on the analyses of the psychometric properties of the ESSW and how these findings are related to the theorized underlying constructs of the ESSW will also be examined.

The rank ordering of the highest 15 reported means of scale items (see table 1). This table revealed groupings of items representing the constructs of caring and congruence (see Figure 1). Item 1, “I try to let my clients know I am concerned for their

welfare", (*M* = 4.64, *SD* = .538); Item 14, "It is important for my clients to be able to trust me", (*M* = 4.62, *SD* = .571) Item 24, "I try to give my clients a warm greeting when meeting them", (*M* = 4.62, *SD* = .571) have the top three highest means in this group. Caring and congruence are theorized to be affective components of empathy and items representing them are evident in seven of the top 15 item means.

Of note, none of the items with the lowest mean scores were from the caring and congruence construct grouping. Item 9, "Clients expect me to think a certain way because of my gender", (*M* = 3.01, *SD* = .640) represents the construct of IS. Item 13, "My relationship with a client can help them overcome their problems", (*M* = 3.55, *SD* = .680) represents the TR construct and Item 21, "I can put myself in a clients position", (*M* = 3.75, *SD* = .571) represents the construct of PT.

The standard deviations of the top fifteen item means were all <.649 except for one. Item 41, "Having an intimate relationship with a client is appropriate" stands out with (*M* = 4.60, SD = 1.110). This item was identified as confusing by various study participants after they completed the survey. They reported the item problematic due to a lack of certainty of the meaning of the word "intimate". These participants understood intimacy as an important aspect of a therapeutic relationship but were concerned that the word carried sexual connotations. In this context the large standard deviation confirms that the wording of this item is in need of refinement.

Affective or emotional empathy (caring and congruence in this study) has been recognized as a significant aspect of empathy in previous empathy measurement studies (Davis, 1980; Dymond, 1950; Hogan, 1969; Mehrabian & Epstein, 1972). Debate has existed around the nature of empathy and the level to which emotional

aspects of the construct define it. These data provide convincing evidence of the central role emotional components of empathy play in its empirical definition.

As noted previously, empathy has been identified as a central value and intervention technique employed by social workers (Hepworth and Larsen, 1990). These findings also support the contention that empathy in social workers can be, in part, attributed to the helping specific constructs, caring and congruence. The emphasis on the training of social workers in the importance of empathy in practice is corroborated by these particular findings.

Analyses of the reliability of the ESSW were conducted next. With a coefficient alpha statistic of $\alpha = .829$, support for the internal consistency of the ESSW can be assumed. This finding suggests that a consistent or common construct is being tapped by the scale. Further analyses by split-half procedures were conducted to assess the reliability of the scale in more depth.

The first split-half analysis produced a Guttman coefficient $r = .686$ which is evidence of a moderately consistent relationship between both halves of the scale. This procedure divided the scale at its exact midpoint and the grouping of the highest item standard deviations was at the bottom half of the scale. These items may be in need of further evaluation or elimination due to the potential confusion regarding the item's wording. The specific items were: Item 39, "I try to help clients even if they have not sought treatment voluntarily" ($M = 3.79$, $SD = 1.060$); Item 40, "I discuss personal boundaries with clients" ($M = 3.55$, $SD = .994$) Item 41, "Having an intimate relationship with a client is appropriate", ($M = 4.60$, $SD = 1.114$); Item 42, "Discussing the professional nature of my relationship with a client is important", ($M = 4.25$, $SD = .851$).

The close proximity of these items toward the last half of the scale may have contributed to the less than optimal psychometrics found by this procedure.

The second split-half procedure divided the scale by odd/even numbered items. This analysis produced a Guttman coefficient, r = .808. This improved coefficient indicates a stronger level of relationship between these two divisions of the scale and may be the result of better diffusion or spreading of the items from one another, which offsets the previous measurement error noted.

The placement of items on the scale seems to have been an important factor in these analyses and it indicates a need for further study of these items for their continued inclusion in the scale. In sum, these findings indicate the need for further in depth analysis of the ESSW, due to these preliminary positive psychometric indications.

Next, an inter-item correlation matrix was computed and the patterns of item correlations examined. Table 2 reports the highest inter-item correlations were all statistically significant at the 0.01 level. These items were grouped in ways that reflected a variety of the theorized underlying constructs of empathy. Of the top ten inter-item correlations, four were grouped in the therapeutic relationship construct and four represented altruism. Items 19, “The personal dynamics of my relationship with a client are beneficial to the treatment process”, and Item 23, “My relationship with a client can be therapeutic in and of itself”, were correlated r = .559. These both represent the construct TR. This data provides insight into the importance of a construct not as heavily represented in the prior assessment of item means.

The idea of the therapeutic relationship as a potential component of empathy (Rogers, 1951) in social work is supported in this study. Facets of this construct are

described in terms of the relationship as being curative in and of its self (Freedberg, 2007; Rogers, 1951). The importance of professional and personal boundary negotiation were represented in the sample's understanding of the role the therapeutic relationship plays in social work practice. Items representing altruism were also frequently correlated and were four of the top ten item correlations. For example, item 4, "I enjoy helping people" correlated with item 10, "I enjoy helping people even when I am not at work" at r = .523. Items 4, "I enjoy helping people" and item 11, "Helping clients is rewarding in and of itself" were correlated at r = .439.

Items with high correlations representing the construct of altruism demonstrate the sample's consistent endorsement of this construct in clinical social work. The lack of an expectation of personal gain (a defining aspect of altruism) in the process of practice was also a theme endorsed in these items. Examination of the items revealed a close relationship between enjoying helping in life in general, with helping behavior in practice. Altruism was not limited to a rehearsed clinical skill but is defined as an overall trait of social worker practitioners in this sample. The history of social work in North America has been profoundly influenced by altruism (Lubove, 1963).

Upon further examination, these items from both of these constructs tend to use very similar language in their construction. All but one of the items grouped as therapeutic relationship items include the word relationship. Altruism items relied heavily on the use of the term "helping". This leads to theoretical questions as to whether there is a blending of the construct of altruism with a construct of "helping" that is being inadvertently tapped by the ESSW. This unexpected finding is worthy of further theoretical and empirical research. This use of redundant language and the presence of

confounding constructs in the construction of these scale items ,while problematic in this study, provides further direction for the elimination or refinement of scale items in the future development of the ESSW.

The construct and discriminant validity of the ESSW was evaluated by computing the inter-correlations amongst all of the scales used in the survey. These included the JSE, SRA, and the VAS. These analyses were designed to test three hypotheses. First it was hypothesized that the ESSW would have a positive and significant relationship with the SRA and the JSE. Second, the ESSW was hypothesized to have an inverse and statistically significant relationship with the VAS. The correlations between the ESSW and the JSE as indicated in Table 3 were expected and therefore not surprising. In fact the highest correlation between all of the scales was between the JSE and the ESSW at r = .335. The predecessor of the JSE (the JSPE) has been found to be a valid measure of empathy in medical practice (Hojat, 2007). The significant correlation with the amended version for social work and the ESSW lends support to the construct/convergent validity of the ESSW's ability to assess empathy in social work practice.

The correlation of the SRA with the ESSW was also significant r= .120. This result was also anticipated in part due to the theoretical and empirical evidence of altruism as an enduring and overarching trait of social work and social workers. The relationship between these scales raises further research questions about the quality and nature of altruism in general life experiences versus its use in social work practice. An interesting research question arises from these findings. Is altruism an innate personal trait that draws people to the field of social work as has been postulated

previously (Pins, 1963) or does altruism develop and increase as a result of practicing social work?

Altruism is the only theorized construct in this study that is measured by an individual scale, the SRA. This may result in a confounding of the construct of altruism with the concept of empathy as it is emphasized by and threads itself through the SRA, JSE and ESSW. Both theoretical explanations point to the similarities found between altruism and empathy altruism and suggest the need for their further differentiation.

As expected the ESSW was significantly inversely correlated with the VAS, $r = -.204$. This relationship indicates the study sample found the items on the VAS to reflect the lack of a direct contrast with the construct(s) being evaluated by the ESSW. The choice of this scale as a discrimminant measure for comparison with the ESSW was due to the nature of what the scale items attempt to measure. The VAS assesses an individual's interactional style. The use of empathy in social work is also a specific type of interactional style theorized to be the antithesis of the items on the VAS. Upon examination of the items on the ESSW the dissertation research committee determined this scale was appropriate for initial testing in this manner.

The findings of the analyses evaluating the relationships between the proposed empathy constructs in Table 4 shed more light on the emerging definitions of empathy in social work practice. The second highest correlation between empathy constructs was the relationship between PT and IS ($r = .462$). This finding provides evidence for the assertion that these two constructs are parts of a common concept, in this study identified as the cognitive domain. The third highest correlation ($r = .455$) supports the assertion that caring and congruence comprise, in part, a common component of

affective empathy. Surprisingly, the relationship between altruism and TR had the lowest correlation, r = .305. These constructs were theorized to define a behavioral aspect of empathy.

The highest correlation in Table 5 is worthy of note. The correlation between affective and behavioral aspects of empathy were r = .539. The prominence of this relationship in these analyses suggest an expression of empathy in social work practice that relies heaviest on emotional and behavioral constructs at the expense of a more cognitive approach with clients. While the correlations of the proposed domains ranged from r = .491 (behavioral and cognitive), cognitive and affective, r = .508, r = .539 (affective and behavioral) these relationships were significant at the 0.01 level. When the above correlations are squared to determine the level of overlap between constructs as well as domains some evidence emerges of their distinct nature.

Sub-Group Analyses

Some of the demographic data collected in this study were more amenable to sub-group comparisons than others. For instance, the disproportionate percentages in the gender and ethnicity categories made additional analyses problematic with potentially misleading results. As noted previously (see page 64), the overwhelming percentage of white females in the sample closely reflected the racial and gender patterns found in social work as a profession (Pins, 1963). The age categories were sub-divided at the overall median age (44) of the sample which closely reflects the median age of practicing social workers in other studies (Hodge, 2004; Hopps & Pinderhughes, 1987). To evaluate the relationship between the high and low age respondents variable on empathy scores, an independent-samples *t*- test was

conducted between these two groups. The hypothesis to be tested was that the older social workers would score higher on the ESSW. The higher age participant's ESSW scores, out of a possible total score of 210, were (M = 167.83, SD = 11.58) compared with the lower age group (M = 172.39, SD = 9.51). Levene's Test for the Equality of Variances was not significant at the 0.05 level, F (266) = 2.972, p = .086, indicating that the assumption of equal variances was violated and the t value computed with unequal variances assumed should be reported (Green & Salikind, 2005). Here t (240.42) = -3.49, p = .001. The 95% confidence interval for the difference in mean scores ranged from -7.132 to -1.986. These results indicated a significant difference in the mean empathy scores of high versus low age respondents, with the low age group scoring directionally higher on the scale. These findings did not support the proposed hypothesis for this comparison of groups.

To assess the relationship of empathy scores between different levels of direct practice experience another analysis of potential differences in mean empathy scores was conducted. The hypothesis to be tested was that social workers with ≥10 years of experience would score higher on the ESSW than social workers with<10 years of experience. Due to the fact that 54.4 % of respondents reported ≥10 years of clinical experience it was possible to break this group in two categories. The first was considered a high experience level with 10 years or more of practice experience and the other a lower experience level with less than10 years practice experience. The higher experienced group scored, out of a possible 210, (M = 169.87, SD =11.58) and the lower experienced group (M = 170.64, SD = 9.89). Levene's test for the equality of means was not significant F (270) = 2.151, p = .144) indicating the t score obtained

when equal variances are not assumed should be reported (Green & Salikind, 2005). The *t*- test for the equality of means then revealed no significant differences in mean empathy scores between the two groups, t (243.298) = -.584, p = .560. These finding provide evidence in support of the stated hypothesis.

Three groups were selected from the practice setting category for sub-group analyses and a one-way (ANOVA) was conducted to test the relationships between these groups (independent variables) and empathy scores (dependent variable). The hypothesis to be tested by this procedure was that social workers from different practice arenas will score differently on the ESSW to a statistically significant degree.

These sub-groups were selected as each one accounted for more than 10% of the sample total in the current practice setting category. Two of the practice specialties chosen for this sub-group analysis (medical social work, and community mental health) are currently and historically known as some of the more distinct areas of practice (DuBois and Miley, 2005) making the empirical study regarding the use of empathy of special interest. The percentage of social work educators in the sample was also noteworthy. This is a population that has historically relied on the practice experience of its faculty to educate social work students (Hollis & Woods, 1981). Historically, the critical relationship between social work education and practice has been strained due to varied expectations of new social workers (Lubove, 1963) despite the practice experience of most faculties. These and similar concerns that social work values and practice skills (e.g. empathy) have not been taught to students effectively (Stein, 1965) makes this sub-population of social workers worthy of inclusion in a study regarding empathy in practice.

The descriptive statistics for these groups were as follows: 16.90% worked in a medical social work capacity (MSW) with ESSW scores (*M* = 166.43, *SD* = 10.68); 12.50% identified themselves as working in social work education (SWE) with (*M* = 173.85, *SD* = 10.58); 11.00% of the sample worked in a community mental health setting (CMH) with (*M*= 173.06, *SD* = 9.80). The ANOVA detected statistically significant differences in empathy means between groups, $F(2, 109) = 6.16$, $p = .003$. To further evaluate these between group differences post hoc procedures were conducted using Fisher's Least Significant Difference (LSD) test. While other procedures, such as the Fisher-Hayter, are more robust in controlling for error (Keppel & Wickens, 2004) the LSD test can serve as a significance test prior to additional evaluations of outcome differences between multiple independent variables. Table 6 illustrates the significance of the differences between means when all possible pairings of the three groups were analyzed.

Table 6

Comparisons between Practice Setting Groups on the ESSW

Practice Settings		Mean Difference	Significance
1. CMH	MSW	6.631	.008*
	SWE	-.786	.764
2. MSW	CMH	-6.631	.008*
	SWE	-7.418	.002*
3. SWE	CMH	.786	.764
	MSW	7.418	.002*

(Note 1). * Sig. at 0.05 level

The difference in empathy scores between CMH workers and MSW workers was found to be significant, p =.008. A difference was also found between The SWE and MSW groups, p = .002. However, no significant differences between the CMH and SWE groups were found, p = .764.

When the sample was sub-divided into high and low age groups, a difference in empathy scores was detected. Mean scores for the higher age group were larger than for the lower age group. This leads to suggesting of a developmental or “evolving” concept of empathy that is affected more by the life span than individual experiences. When the empathy scores of clinicians in high and low groups of practice experience were compared no statistically significant difference was found. This finding also supported the need for further study about whether empathy in social workers may not be attributed to the amount of practice experience one has but rather an inherent individual function.

When specific practice setting groups were broken out of the sample, and their empathy scores compared, some interesting patterns were found. Empathy scores between SWE and CMH workers were not significantly different while MSW practitioners’ scores were different from both of the other groups. Medical social workers comprised a large portion of this sample (16.9%) and these findings bring into question the different roles that empathy plays in various social work practice settings.

Social work educators may have similar levels of empathy as mental health workers due to the over representation of social workers in this practice area (Dubois and Miley, 2005) and the majority of educators being former practitioners. Social work educators are charged with direct field instruction supervision and the teaching of

specific interpersonal practice skills. They may also use empathy skills learned in practice as a model for student learning as well as a tool for guiding students through the instructional and field placement experiences.

Research into questions about practice areas that may call for different levels or qualities of empathy could inform the clinical training of social work students. Clinical supervisors and field instructors would benefit from a more thorough understanding of student and agency needs regarding empathy and its role in a specific practice setting.

The items on the ESSW were created in an effort to assess empathy as an overarching concept supported by more specific constructs related to social work. The group differences found in this study support the importance of a measure designed in this way. If empathy is a developmental phenomenon in individuals, only loosely related to life experiences, an instrument general enough to capture empathy despite situational differences is needed. In contrast various practice specialties may call for different levels or even “types” of empathy for effective practice and the ESSW may be one tool in evaluating direct practice curricula regarding presently identified social work specialties (e.g. school social work, gerontology, community organization and psychotherapy).

Finally here, social work has a broad and diverse professional practice base (Hodge, 2004; Hollis & Woods, 1981; Hopps & Penderhughes, 1983). These findings support continued development of the ESSW with a broad understanding of what constitutes empathy in social work. Scale items addressing situational specific approaches or skills may need to be removed or altered to reflect a more generalist use of empathy in social work practice.

Item Analysis

An item analysis was conducted to evaluate specific scale items for retention or deletion from the ESSW. Item frequency and distribution values were computed and evaluated to empirically inform this decision making process.

The skewness and kurtosis of an item are indicators of the normality of its distribution. Skewness and kurtosis values outside of the 2.0 to -2.0 are generally considered problematic and suggest a closer examination of an item for evidence of its appropriateness for retention. This process revealed four items meeting these criteria.

Item 20, “I can put aside my own feelings and listen attentively to a client” was kurtosis = 3.389. Frequency data showed that 67.3% of respondents endorsed, “often” and 24.6 endorsed “always” on this item. This item had 15 low (statistically insignificant) relationships with all other scale items suggesting it may not be tapping the same theoretical concept. The mean inter-item correlation for all scale items is r = .113 and item 20 had 12 inter-item correlations lower than the mean. The corrected item-total correlation considers an item’s relationship with itself and is then correlated with the total scale score. Item 20 had a corrected item-total correlation of r = .311. The scale’s overall coefficient alpha can be strengthened by the deletion of specific scale items. The Cronbach’s alpha, α= .829, of the ESSW would be increased to α= .833. Upon examination, the wording of item 20 appears problematic. It asks two questions within one item making it potentially confusing to respondents. The processes of “putting aside one’s feelings” and “listening attentively” are two distinct behaviors making this a “double barreled” item.

Theoretically, the combination of two concepts in one item detracts from its ability to discriminate between concepts effectively. The wording of this item and item 26, “I am able to put aside my own feelings to be in accordance with a client’s emotions” is redundant. Empirically the overall reliability of the scale is improved by its deletion and the distribution of item responses indicated 92% of respondents endorsed “often”, or “always” bringing into question the discriminatory power of the item. Item 20 is in need of reformulation or elimination from the ESSW.

Item 25, “I am careless when working with clients”, had a kurtosis value of 2.778. Frequency data revealed that 60.3% of respondents endorsed “rarely” and 32.7% endorsed “never”. Item 25 had statistically insignificant relationships with 23 other scale items and 23 inter-item correlations lower than the scale mean correlation $r = .113$. When item 25 was deleted the overall coefficient alpha improved to $\alpha = .835$. The corrected item-total correlation for item 25 was $r = .266$. The wording of this item may detract from its ability to truly tap the construct (caring) behind it. Intuitively, few social workers or helping professionals would be expected to endorse “careless” behavior with clients and its validity diminished by a level of social desirability bias on the part of respondents. Item 25 is also in need of reformulation or elimination from the scale.

Item 26, “I am able to put aside my own feelings to be in accordance with a client’s emotions”, had a computed kurtosis value of 1.960. Its proximity to the 2.0 criteria for distribution abnormality warranted its continued analysis. Of the study respondents, 65% endorsed “often” and 11.4% endorsed “always”. Item 26 had 17 statistically insignificant relationships with other items and 15 inter-item correlations lower than the mean scale inter-item correlation. The corrected item-total correlation for

item 26 was .320 and the coefficient alpha for the scale, α= .829 was improved to α=.833 when it was deleted. Combined with the double barreled nature of this item's wording and the similarity of word choice to item 20, these data suggest this item has limited discriminative ability and combines clinical behaviors that each may need "an item of its own".

Item 41, "Having an intimate relationship with a client is appropriate" obtained a kurtosis value of 6.093 and a skewness value of -2.778. This item was overwhelmingly endorsed "never" (93%) by study respondents. When this item was deleted the Cronbach's alpha for the entire scale rose to α= .838. Study respondents responded anecdotally to this item with questions about the meaning of "intimacy' in this scale. The concept of intimacy had sexual connotations for many respondents who also indicated a "type" of intimacy was called for in therapeutic relationships. The confusing nature of this item and its perceived irrelevance to empathy in social work practice indicates its exclusion from the ESSW is appropriate.

Factor Analyses

At the onset of this study various journals, texts and studies related to scale development were systematically reviewed. Of concern was determining the most appropriate empirical procedures and techniques for the development and initial validation of the proposed empathy scale for social workers (ESSW). It has been repeatedly documented that factor analysis is considered a valuable tool in the development of standardized scales that measure latent human personality traits and constructs (Floyd & Widaman, 1995; Gorsuch, 1983; Nunnally, 1967). Costello and Osborne (2005) surveyed the PsycINFO data base over a two-year time frame and

reported over 1700 references to the use of EFA as a tool for scale development or revision of multiple standardized scales. The reviewed journals: *Psychological Assessment, Journal of Personality Assessment,* and *Assessment* all focused on the empirical evaluation of questionnaire data and EFA is a frequently used method of analysis in these studies (Reise, Waller & Comery. 2000).

In this study a systematic review of the journal *Research on Social Work Practice* (RSWP) over a 10 year period was conducted. Factor analysis techniques were used in 50 articles involving standardized scale development with 30 of them published in *RSWP* over the last five years. These findings demonstrate an increasing trend in social work research, regarding scale development, and the growing use of factor analysis in this process. To further evaluate the choice to utilize factor analysis techniques in this study an examination of current empathy scales and instruments assessing similar constructs was conducted. Factor analysis was the most frequently used method for developing these scales.

Appendix 7 documents the similarities in scale construction steps that these studies share. Examples include the use of expert review to establish content validity, Likert-type scaling response sets, sample sizes and the use of factor analysis as a measure of construct validity.

This review of previous “recipes” of how similar scales were constructed provided a point of departure to proceed from in this study. A systematic review of the “ingredients” used in previous scale development studies lends legitimacy to the steps taken in this research and provides strong support for the use of EFA in the initial development and validation of the ESSW.

When conducting factor analyses in scale development, researchers are hard pressed to cite consistent guidelines or “rules” when determining the correct sample size for their analyses. In fact, the empirical evidence for most “rules of thumb” is deemed limited (Osborne & Costello, 2004). The two most common recommendations for determining sample size are either the total N of the study or the subject to variable ratio (SVR).

Factor analysis is considered a large sample technique by most and the largest sample possible is preferable. Researchers disagree as to what is an adequate sample size to realistically conduct a factor analysis with hopes for any meaningful or interpretable results. Different recommendations have been made such as N= 100-200 as moderate and 200-300 as large (Kline, 2005). However, extremely large samples tend to report inflated factor loadings and unrealistic relationships between variables. Others have suggested that a total N=200 is adequate (Kline, 1994).

A SVR of 10:1 is the traditional recommendation for an adequate sample size (Nunnally, 1967). Other influential researchers have reported that an SVR of 5:1 is appropriate for conducting a factor analysis (Gorsuch, 1983). Some have conducted analyses with SVRs of 3:1 or smaller (Kline, 1994; Spreng, McKinnon, Mar, & Levine, 2009). Recent reviews of published factor analysis studies reveal a wide range of SVRs indicative of the lack of consensus among researchers on this issue (Costello & Osborne, 2005).

It has been suggested that both “rules of thumb” be considered together along with other criteria. For example, if the communalities on the covariance matrix are high (≥.7), then the sample size is deemed appropriate (Farbrigar, Wegener, MacCallum,&

Strahan, 1999). Others have concluded that in the social sciences communalities of .40 - .70 indicate an adequate sample size (Costello & Osborne, 2005). Another post hoc check of sample size adequacy is how many variables load significantly on each factor. This combination of criteria for the sample size in factor analysis seemed a prudent approach to the issue and will be used in this study.

In the development and analyses of the ESSW, a sample size of N=272 and a SVR of 6.6:1 were used. Considering the above, the sample size in this study meets the *a priori* criterion of a large sample size and an appropriate SVR. Meeting these preliminary criteria provided evidence that the sample size in this study was appropriate for the choice of factor analysis used as an exploratory tool to determine the underlying structure of the ESSW and its validity for this initial analysis phase of its construction.

The next step was determining the type of factor analysis to be conducted and the method by which underlying factors would be extracted from the data. The unweighted least squares method of factor extraction was chosen from the SPSS menu. This process generates communalities which represent the amount of variance in each variable that can be explained by the factors (Kline, 1994). Upon follow up, using the principle axis factoring method of factor extraction, only minimal differences were found in the resulting analyses.

After extraction the five items with the highest communalities were: item 15, “It can be helpful for clients to use our relationship to practice new interpersonal skills” (.435); item 17, “It is important for my clients to know that I care about them” (.420); item 19 “The personal dynamics of my relationship with a client are beneficial to the treatment process” (.410); item 4, “I enjoy helping people” (.397); item 13 “My

relationship with a client can help them overcome their problems" (.397). To help illustrate further the range of the communalities, the items with the five lowest values were: item 41 "Having an intimate relationship with a client is appropriate" (.004); item 30, "I have little sympathy for clients who are victims of their own doing" (.091); item 16, "Clients perceive me as having more power than they do" (.104); item 5 "I can tell by a client's body language if they are upset" (.118); item 42 "Discussing the professional nature of my relationship with a client is important" (.132).

The decision regarding the number of factors to be retained for further analyses and the choice of rotational procedures then followed. When the default criteria of retaining factors with eigenvalues of ≥ 1 were used, 14 factors met this criterion as depicted in Table 8. Upon examination, 11 of these factors had eigenvalues ranging between 1.77 and 1.0. The scree plot (Appendix 8) showed a marked bend in direction indicating a three factor solution. The following table depicts the results of the initial, un-rotated factor analysis for all eigenvalues ≥ 1 and their explained variance.

Considering the findings depicted in Table 7, the scree plot (Appendix 8) and the importance of parsimony a three factor solution was imposed on the data. After five iterations, a three factor solution was computed by SPSS. When a four factor solution was computed for comparison purposes, no meaningful differences were found (see Appendix 9).

In EFA the unrotated solution is not considered the most interpretable or "best" solution. Rotating the factors and re-computing their factor loadings provides more interpretable factors considering the goal of achieving simple structure and parsimony in the solution (Gorsuch, 1983; Kline, 1994; Nunnally, 1967). An oblique rotation (Oblimin

with Kaiser Normalization) was used in the following analyses. This procedure takes into account the common occurrence of factor correlation in the study of human behavioral and personality characteristics in the social sciences (Costello & Osborne, 2005; Kline, 1994). Table 8 displays the rotated solution and the resulting factor structure matrix. Table 9 displays the factor pattern matrix.

Table 7

Initial Eigenvalues of the ESSW (N=271)

Factor	Eigenvalues	% of Variance	Cumulative %
1	6.857	15.628	15.682
2	3.578	8.520	24.202
3	2.196	5.228	29.430
4	1.775	4.226	33.656
5	1.602	3.815	37.471
6	1.592	3.789	41.260
7	1.486	3.539	44.799
8	1.353	3.223	48.022
9	1.322	3.148	51.170
10	1.273	3.031	54.200
11	1.143	2.721	56.922
12	1.085	2.584	59.506
13	1.041	2.478	61.984
14	1.006	2.396	64.380

Table 8

Factor Structure Matrix of the ESSW (N=271)

Items	Factor 1	Factor 2	Factor 3
Item 1	**.356**	.046	-.281
Item 2	.224	**.363**	-.181
Item 3	.294	**.306**	-.223
Item 4	.157	.134	**-.608**
Item 5	.241	.158	-.274
Item 6	**.352**	.209	**-.408**
Item 7	.280	**.418**	-.024
Item 8	**.365**	.069	-.100
Item 9	-.165	.210	.228
Item 10	.078	.128	**-.572**
Item 11	.198	.198	**-.582**
Item 12	**.370**	**.432**	.039
Item 13	.119	**.626**	-.057
Item 14	**.329**	**.411**	-.226
Item 15	.225	**.650**	-.061
Item 16	-.050	.297	-.022
Item 17	**.364**	**.544**	-.293
Item 18	**.310**	.219	-.246
Item 19	.191	**.613**	-.171
Item 20	**.462**	-.026	-.266
Item 21	**.301**	**.372**	-.079
Item 22	**.533**	.106	**-.345**
Item 23	.169	**.587**	-.120
Item 24	**.315**	.136	**-.366**
Item 25	**.412**	-.113	**-.376**
Item 26	**.419**	.098	-.173
Item 27	**.467**	.166	-.236
Item 28	**.317**	-.151	-.251
Item 29	**.593**	.099	-.163
Item 30	.291	.018	-.167
Item 31	**.518**	**.315**	.010
Item 32	**.554**	.118	**-.341**
Item 33	.199	-.290	**-.352**
Item 34	**.405**	.215	.059
Item 35	**.328**	-.093	**-.492**
Item 36	**.403**	-.183	**-.493**
Item 37	**.430**	-.050	-.192
Item 38	-.198	.204	**.392**
Item 39	.102	**.408**	.000
Item 40	**.307**	.298	.075
Item 41	.009	-.058	-.029
Item 42	.281	.238	.046

Note. ESSW Items in Appendix 1.

Table 9

Factor Pattern Matrix of the ESSW (N=271)

Items	Factor 1	Factor 2	Factor 3
Item 1	.296	-.006	-.184
Item 2	.109	**.346**	-.152
Item 3	.188	.274	-.167
Item 4	-.082	.162	**-.639**
Item 5	.140	.137	-.231
Item 6	.206	.178	**-.344**
Item 7	.224	**.375**	.042
Item 8	**.372**	.000	.022
Item 9	-.152	.234	.173
Item 10	-.159	.170	**-.628**
Item 11	-.039	.218	**-.600**
Item 12	**.350**	**.364**	.146
Item 13	-.024	**.632**	-.077
Item 14	.204	**.376**	-.167
Item 15	.093	**.633**	-.043
Item 16	-.134	**.323**	-.072
Item 17	.189	**.514**	-.242
Item 18	.217	.182	-.179
Item 19	.019	**.613**	-.177
Item 20	**.443**	-.106	-.118
Item 21	.237	**.328**	-.009
Item 22	**.466**	.023	-.193
Item 23	.019	**.586**	-.125
Item 24	.196	.106	**-.304**
Item 25	**.372**	-.177	-.250
Item 26	**.400**	.025	-.042
Item 27	**.416**	.091	-.102
Item 28	**.307**	-.205	-.142
Item 29	**.607**	-.015	.036
Item 30	.271	-.031	-.078
Item 31	**.538**	.211	.182
Item 32	**.489**	.031	-.182
Item 33	.161	**-.314**	-.293
Item 34	**.448**	.128	.202
Item 35	.214	-.124	**-.420**
Item 36	**.322**	-.235	**-.383**
Item 37	**.439**	-.131	-.045
Item 38	-.126	.220	**.346**
Item 39	.027	**.403**	.001
Item 40	**.321**	.235	.175
Item 41	.021	-.060	-.024
Item 42	.293	.181	.138

Note. ESSW Items in Appendix 1.

Of note, eight items did not load significantly onto any of the three identified factors. Item 1," I try to let my clients know I am concerned for their welfare" had a factor loading of .296 on factor one indicating it may be appropriate to reconsider this item for inclusion in factor one. This item had a skewness value of -1.160 keeping it within the range of the established criteria. On this item, 66.9% of respondents endorsed "always" and 30.1% endorsed "often". The overwhelming positive endorsement of this item indicates retention of the item is appropriate as the communication of concern for a client is theoretically a tradition in social work and an important construct underlying empathy in practice.

Item 3," Facial expressions say a lot about what a client is feeling", had a factor loading of .274. This is also close to the cut off criteria and indicates consideration of this item for retention on the ESSW is warranted. The skewness and kutosis values were well within the expected limits. This was another item with many respondents responding in similar ways. On this item 55% of respondents endorsed "often" and 30% endorsed "always". The wording of this item appears awkward and may need reformulation but it seems to be tapping the theoretical construct of IS.

Item 5, "I can tell by a client's body language if they are upset" loaded on factor three of -.231. It had 71% of respondents endorsing "often" and 10.7% endorsing "always". The phrasing of this item may be problematic. The term "upset" is vague and can have multiple meanings to various individuals. While many respondents endorsed this item in a positive way, reformulation of the item may help clarify its contribution to a specific factor and the scale overall.

Item 9 loaded onto factor 2 at .234. This item, “Clients expect me to think a certain way because of my gender”, was more widely distributed but 65% endorsed “sometimes”. This response is not a completely neutral response but may be the “best” choice for respondents to a question that is confusing, and/or highly specific. It is requesting information about two different concepts, “thinking” in general and “gender” specifically. This item was designed to assess IS but needs reformulation to make it less confusing. It also blends components of the TR to the extent it may need to be reformulated into more than one item.

Item 18,”An unbiased approach is helpful to clients”, had its highest loading on factor one at .217. This item had no significant skewness or kurtosis values and was slightly more evenly distributed with 44.5% of respondents endorsing “often” and 43.8% endorsing “always”. The wording of this item does not reference who is “unbiased” and reformulation could make this item more easily understood by future respondents. It is designed to evaluate the construct of congruence and reformulation of the item would help delineate this construct more clearly.

Item 30, “I have little sympathy for clients who are victims of their own doing”, had a factor loading of .271 on factor one. The proximity of this item to the cutoff criteria makes it worthy of consideration for retention on the scale. This item was endorsed “rarely” by 58% of study respondents. The wording upon examination is problematic and possibly in need of reformulation. Its phrasing contains a personal value judgment (“victims of their own doing”). It also uses the term “sympathy” which, like empathy has undifferentiated meanings, many of which are related to empathy itself.

Item 41, “Having an intimate relationship with a client is appropriate” had very low loadings with the strongest being -.060. As discussed previously this item had a significant skewness value (-2.771 and significant kurtosis value (6.093). These data indicate a non-normal distribution. Respondents overwhelmingly endorsed “never” and the item has limited differentiating ability when assessing empathy in social work practice. This item could not be captured by any of the identified factors and the term “intimate” may have meanings to practitioners that diverge significantly from the concept of empathy. This item should be deleted from the ESSW.

Item 42, “Discussing the professional nature of my relationship with a client is important” loaded onto factor one at .293. This value is close enough to the .30 cutoff criteria to warrant its close examination and possible retention on the scale. Its distribution was much wider with 47% of respondents endorsing “always”, 34.6% endorsing “often” and 15.4% endorsing “sometimes”. This item seems appropriate to retain for the scale due to its adequate factor loading and the normality of its distribution. The use of the term “important” in this (and other items) may need rewording as it is a vague quantitative term with value judgment connotations and potentially different meanings to different people

The rotated solution reveals a more parsimonious and interpretable factor solution in the factor pattern matrix. Simple structure is the desired result when the most interpretable factor pattern is computed (Harman, 1976). Items 12 and 36 are the only variables that load significantly on the same factor. Each factor has at least three variables loading ≥ .40 which are considered substantial (Nunnally, 1967). Gorsuch (1983) reported factor loadings of ≥ .30 to be salient enough to interpret factors in large

matrices with larger sample sizes, as was the case of this study. Another important guideline to define what constitutes the full or true achievement of simple structure in addition to factor loading patterns involves the logical and coherent grouping of variables into factors that can be named (Gorsuch, 1983; Kline 1994; Nunnally, 1967).

As reported above factors underlying latent human personality traits and behavior frequently correlate with one another. Understanding the extent to which factors are inter-correlated gives researchers empirical evidence to guide future theory revision regarding the true nature of the constructs underlying phenomena such as empathy. Table 10 reports the factor inter-correlations for the ESSW found in this study.

Table 10

The ESSW Factor Correlation Matrix (N=271)

Factor	1	2	3
1	1.000	.186	-.327
2	.186	1.00	.021
3	-.327	.021	1.00

The use of EFA is a well documented and frequently used analysis technique in the development and initial validation of standardized scales such as the ESSW. EFA can be particularly helpful in the development of scales purporting to measure latent human traits and abilities in the social sciences (Costello & Osborne, 2005; Floyd & Widaman, 1995; Gorsuch, 1983; Nunnally, 1967).

The initially extracted communalities in this study were moderate to low and potentially were influenced by the homogenous nature of the sample. Heterogeneous samples tend to produce higher communalities that explain higher proportions of the variance in item scores due to an underlying factor (Kline, 1994). The narrow inclusion criteria stipulated by the purpose of this study (to evaluate empathy among social work practitioners) resulted in a homogenous sample that limits any efforts to apply the study findings to a broader population. The specificity of the sample inclusion criteria contributed to findings potentially affected by a ceiling effect with many participants responding to scale items in very similar ways. Given the importance of empathy in social work education (Hepworth & Larsen, 1990) and practice (Freedberg, 2007) the limitations of a homogenous sample were unavoidable if the nature of empathy in social workers was to be evaluated.

When the eigenvalues of the initial factors were examined the first three were able to account for a cumulative 29.43% of the explained variance in empathy scores. If the fourth factor (eigenvalue = 1.78) had been included in the solution the cumulative explained variance would increase to 33.7%. The decision to include or exclude this factor in future analyses is worthy of exploration due to its proximity to eigenvalue ≥ 2.0. In subsequent analyses a four factor solution was imposed on the data with no significant differences found. This suggests the three factor solution to be the more parsimonious solution. After the fourth factor, the descending factors with eigenvalues of ≥ 1 explained less and less of the variance making their inclusion in the following analyses unproductive as they represent difficult to interpret “nuisance” factors. Use of the scree plot is considered an appropriate check on the decision of which and how

many factors to retain (Harman, 1976) and the nature of its “elbow bend” supported the retention of the first three factors in this study. In the subsequent four factor analyses of the data the scree plot was virtually identical in appearance and also supported a more parsimonious three factor solution (see Appendices 8 and 9).

When the three factor solution was imposed on the data, the resulting factor structure matrix (Table 9) was somewhat difficult to interpret. Many variables loaded onto more than one factor and the first factor consisted of 23 items with salient loadings confounding its interpretation.

The oblique rotation of the three factor solution revealed a more coherent and interpretable factor solution in the factor pattern matrix (Table 10). The computed values for the cumulative variance explained decreased somewhat to 24.36% but a much clearer picture of the ESSW’s factor structure emerged. The pattern matrix solution contained 34 of the 42 items of the ESSW loading significantly onto the three factors. The first and largest factor had 15 salient loadings, the second had 13 salient loadings and the third had 8. This depicts much more balanced and interpretable factors.

The first factor contained five items representing the IS construct. Item 22, “I pay close attention when a client’s tone of voice changes” and item 32, “I am attentive to my clients’ non-verbal cues” reflect the non-verbal behaviors of clients that social workers attend to. The other aspect of this construct is a social worker’s ability to understand and appreciate the unspoken social role expectations and the contextual dynamics inherent in most relationships (e.g. the unspoken power differential in helping relationships). Examples of this aspect of IS were item 34,”I carefully consider the ways

that social gender role expectations affect my clients" and item 29, "I try to take a client's cultural context into account when working with them".

The construct of PT (perspective taking) was represented by three items on the first factor. Examples of PT items on factor one were item 8, "I can disagree with a client and still appreciate their position" and item 31,"I try to understand a client's viewpoint before making suggestions". These two constructs combined for a total of 8 of the 15 salient loadings on factor one, both representing the cognitive domain of empathy.

Factor one also contained three items from the congruence construct and one from the caring construct for a total of four items representing the affective domain of empathy. Reflecting the congruence construct were items 20, "I put aside my own feelings to listen attentively to a client, item 28, "I lose track of what a client is telling me" (reverse scored) and item 26, "I am able to put aside my own feelings to be in accordance with a client's emotions". Caring was reflected in item 25, "I am careless when working with clients" (reverse scored). These constructs were considered when naming this first factor. The items on the ESSW were worded to capture the frequency of behaviors expressing empathy in social work practice. The process of naming the factors also reflected this design resulting in the naming of factor one as a *"compassionate contextual assessment".*

Factor two had 13 salient items including five items from the TR (therapeutic relationship) construct. For example, item 13, "My relationship with a client can help them overcome their problems"; item 19, "The personal dynamics of my relationship with a client are beneficial to the treatment process"; "My relationship with a client can be therapeutic in and of itself". The affective domain was represented by three items

from the caring construct such as, item 33, “My clients tell me I can be insensitive” (reverse scored); item 14, “It is important for my clients to be able to trust me”; item 17, “It is important for my clients to know that I care about them”. Congruence was reflected in item 2, “Unconditional acceptance helps clients”. PT and IS each contributed two items to factor two pulling four items from the cognitive domain. PT was reflected by item 7, “Knowing a client’s personal situation is important if I am really going to help them” and item 21, “I can put myself in a client’s position”. The IS items on factor two were item 12, “Understanding a client’s background makes me more helpful” and item 16, “Clients perceive me as having more power than they do”.

Factor two consisted of almost equal occurrences of the three theorized domains of empathy in social work practice. TR was the predominate construct present in factor two and demonstrated the importance of the therapeutic relationship in this factor. An effort to capture all three domains was made in the naming of this factor an *“accepting and attentive collaborative inquiry”.*

The third and final factor consisted of eight salient loadings. The construct of altruism was represented by items such as item 4, “I enjoy helping people” and item 10, “I enjoy helping people even when I am not at work” and item 11, “Helping clients is rewarding in and of itself”. The caring construct was represented by 3 items: item 6, “I feel compassion for my clients”; item 24, “I try to give my clients a warm greeting when meeting them”; item 35, “I am kind to my clients”. The influence of these two specific constructs led to naming the third factor “intrinsic helping and emotional support”.

The factor correlation matrix (Table 10) was computed when an oblique rotation procedure was used in the analyses. With the assumption that factors underlying

empathy would correlate to some degree, this step was helpful in providing specific information regarding the nature of the factor relationships found in this evaluation of the ESSW. One of the benefits of using an oblique rotation was that if the factors did not correlate (have an orthogonal relationship) this would be revealed in the factor correlation matrix. The factor correlation matrix (Table 11) confirmed that the factors were inter-correlated as there were no zero order correlations. Factors three and one had the strongest relationship at -.327, factors two and one were correlated at .186 and factor three and two were correlated at .021.The third factor consisted of mostly negative loadings. Therefore, the -.327 correlation between factors one and three is interpreted as a positive relationship. These findings revealed low levels of correlation between factors one and two and factors two and three. The moderate correlation between factors one and three suggests the extent of the overlapping nature of the constructs underlying empathy on the ESSW. The process of scale revision is also informed by examination of the factor specific items.

CHAPTER 5

SUMMARY

The impetus behind the development of the ESSW was a noted theoretical and empirical gap in the social work literature regarding one of the profession's defining practice and educational tenets. Social work grounds itself in a tradition that emphasizes direct service to the most vulnerable groups in society and defines itself with an evolving search for effective practice methods that consider the unique needs of clients from a growing diversity of cultures, perspectives and problems. The social worker's use of empathy in practice is a long assumed skill necessary to this end and is emphasized heavily in the education and training of practitioners. While the concept of empathy figures so prominently in social work, an empirical understanding and evaluation of empathy has drawn little attention from the social work research community. This gap in the social work knowledge base was surprising and the empirical study of empathy in social work seemed both timely and warranted.

The design of an objective measure to evaluate such a construct required a preliminary assessment of how empathy has been discussed and examined previously. This revealed a complex "universe" of constructs that were similar to empathy but retained their unique and differentiated meanings. These constructs were considered within the context of supporting theoretical and empirical literature, and certain concepts emerged as useful and retained for the present study. This list of six empathy components: caring, congruence, perspective taking, interpersonal sensitivity, altruism,

and the therapeutic relationship, is by no means exhaustive but captures ideas ancillary yet essential to social work theory development and informed practice methods. However, during the process of this thesis, important limitations became evident which warrant examination.

Limitations

One limitation of the present study is the diffuse nature of the concept of empathy. The constructs chosen here for measurement were drawn from literature specific to helping professions and while potentially distinct concepts they may have limited applicability to other meanings of empathy in the greater population.

The theoretical constructs chosen for this study were: caring; congruence; perspective taking; interpersonal sensitivity; altruism; and the therapeutic relationship. Upon examination, these constructs involved other latent variables that were not considered for measurement in this study. For instance, caring is a construct that was interpersonal, social and behavioral in nature and not clearly differentiated from the concept of empathy used in this study. Congruence as a construct in social work would be considered theory specific (Rogers, 1951) and included elements of human concentration, patience and listening skills, suggesting potential overlap with the identified behavioral aspects of empathy. Interpersonal sensitivity (IS) was a term originating from the field of social psychology and included other constructs such as body language, role expectations and non-verbal cues. The role of IS in the context of a therapeutic relationship was in need of more empirical study as a construct of its own. Altruism was also related to other latent human capacities, such as sharing and social conscientiousness. Finally, therapeutic relationships was recognized within such a wide

variety of theoretical and helping traditions that despite the support of an extensive body of literature, its empirical study and assessment remains a veritable “work in progress”.

The choice of an electronic survey as a tool for scale development had inherent limitations as well. As with all survey research, this approach limits the generalization of findings by capturing the views of the most highly motivated respondents. This introduced a potentially important level of bias toward positive study findings. The study survey was fairly lengthy with four different measures for a total of approximately 100 items. Thus, participants may have experienced a capitulation or exhaustion effect as a result influencing a positive response. As well, many standardized scales use structured interviews and focus groups in their development, and these research methods were not a part of the development of the ESSW and would have been informative.

As noted before, the sample, was a highly homogenous group of individuals, and would be inclined to answer questions regarding empathy and social work practice in similar ways. Greater variation in the target sample for example, including social work students would have provided a more detailed representation of empathy in social workers. Given the theoretical and educational emphases on empathy in clinical social work practice, a level of social desirability bias could also have influenced these study findings.

The sub-group analyses conducted were informative, but as expected, left other important issues unanswered. Repeated studies of empathy differences between males and females have been conducted, and higher levels of empathy among women have been found repeatedly. The sample in this study was too unbalanced in terms of their gender division to examine this notion more thoroughly. Further testing of the ESSW

that replicated prior findings would provide additional evidence of known group criterion validity. The claims of significance in the differences in empathy between age, experience level and work setting are tendered with caution until confirmatory analyses replicate these initial differences.

The use of factor analyses contributed to the construct validity evidence for the ESSW, but the procedure itself is not without inherent limitations. Factor analytic solutions can be replicated by random data sets or different solutions can be apparent using the same data set. Factor analyses require subjective decision-making on the part of the researcher. This leaves study findings open to alternative conclusions and criticism of the analyses procedural steps chosen by the researcher in favor of alternatives (e.g. the type of factor analysis to be used, factor retention criterion and rotation procedures).

The flexibility of factor analyses is one of its advantages as a technique, but it also exposes some of the procedure's limitations. For example, the decision in this study to constrain the factor analytic solution to include only three factors is one such potential point of contention. As noted previously, if all factors with eigenvalues ≥ 1.0 had been included in the subsequent analyses, the variance explained by the factors and the number of factors would have been much greater. This study does not include a CFA which often follows an EFA procedure in similar studies involving the development of a standardized scale. This extension of the current study would be a logical and informative next step in the development of the ESSW.

Conclusions

The study conclusions will be stated below. Each main conclusion is numbered and italicized and its context and/or rationale is presented thereafter.

1. *Empathy appears to be a complex and dynamic grouping of affective, cognitive and behavioral components that impact social work practice in a significant way.* The ESSW is an important first step in the objective evaluation of empathy among social workers. The constructs theorized in this study to define empathy in social work practitioners were supported by the study findings. Direct social work practitioners in this study endorsed the concepts introduced here as relevant and influential in their use of empathy in practice.
2. *The results of this study informed social work from a theoretical standpoint in a variety of important ways.* All study respondents had an MSW and therefore, had achieved the terminal degree in social work, with significant exposure to social work theory and practice skills training available in social work education. Study findings indicated that social work education's historical emphasis on empathy resonates with practitioners and is, therefore, worthy of an enhanced role in guiding social work theory development.
3. *Empathy provided a theoretical model for understanding human problems within a social context, and is the prominent practice tool used by social work practitioners.* The study of various human abilities and attributes inform and shape theory and practice in other helping professions. For example, teachers use an understanding of learning theories and the underlying

components of this human ability to shape the nature and scope of educational practice. Much of the field of psychology organizes its theory base around the diagnosis and assessment of mental illness and human personality types and functions. Empathy as described by the respondents in this study, suggested it plays a central and organizing theoretical role in social work practice.

4. *Levels of empathy may be influenced by personality or other individual characteristics rather than years of direct service practice experience.* Sub-group analyses demonstrated differences in empathy scores based on individual and group variables. Respondents above the age of 45 were found to have significantly higher levels of empathy than those under the age of 45. Interestingly, the level of experience of the respondents showed no such difference. It appears that empathy may inherently evolve or change in individuals over the life span. The lack of a difference in empathy scores in terms of years of experience may indicate a ceiling effect or a “burn out” factor not empirically detected in this study, but never the less of concern for the field of social work.
5. *When study participants were sub-divided according to practice specialty, social work educators reported levels of empathy very similar to those of mental health clinicians.* Social work educators are often former practitioners which may account for some of these similarities. Educators are also frequently exposed to the concept and importance of empathy in direct practice instruction and the supervision of field placement students. Social

work educators teach empathy, observe its development, and evaluate its use as a central part of educating students to become practitioners.

6. *Social workers gained access to clients' emotional material through the use of empathy, thereby informing clinical assessment and intervention in practice.* The significant relationship found between affective and behavioral components of empathy in study respondents revealed an important connection. Social workers were inclined to access emotional material presented by clients in an empathic way. This connection to feelings experienced by clients is also an important part of a student's education. Students and practitioners are encouraged to understand the emotional reactions regarding client's feelings as diagnostic as well as potential intervention tools. Interestingly, the study respondents endorsed the concept of empathy as a behavioral manifestation in practice.
7. *The psychometric properties of the ESSW lend empirical support to the study's theoretical claim that empathy consists of a variety of discreet, but overlapping constructs and expressions similar to other latent human abilities and attributes.* The internal consistency of the instrument was high indicating the measure is indeed tapping a commonly understood concept by study participants labeled as empathy in this study. The underlying dimensions of this overarching construct were well correlated but to a lesser degree, indicating the detection of latent constructs similar to empathy but separate enough to indicate a level of differentiation from empathy itself.

8. *The factor analyses of the study data reinforced the idea that empathy in social work practice consisted of various expressions, rather than a singular all inclusive concept.* The relationships between scale items and item groupings revealed complex relationships not clearly or easily separated. The three factors chosen for further evaluation were conglomerations of differing levels of all of the constructs theorized to underlie empathy. The labeling of each factor was indicative of conclusions drawn by the researcher from these analyses. As social work is an applied profession, and this study involved the study of social work practitioners, the factors were named in a way to reflect empathy as an active and dynamic process, rather than a static and isolated concept.
9. *The first factor was named "a compassionate contextual assessment", and it described a framework for understanding the experience of receiving and delivering social work services.* The terms assessment and compassionate "bookend" the term contextual in factor one. Assessment describes what action the practitioner is taking, and compassionate means the interpersonal approach or how services are rendered in the practice of social work. The term contextual represents the perspective or position from which the practitioner considers the client's individual circumstances. Social work theory emphasizes human behavior in the context of the social environment and makes this identification of this first factor appropriate and understandable.
10. *The second factor identified in the analyses was "accepting and attentive collaborative inquiry".* This label also described a method of social work

intervention, marked by a collaborative relationship with clients. Social work as a profession has progressively placed greater and greater emphasis on viewing the client as a significant source of unique strengths and assets brought to the helping process. In turn, the social worker provides facilitation and resource knowledge skills to this dynamic process. The terms “accepting and attentive” capture and connote the style with which the practitioner approaches working with a client. Interestingly, this phrase is drawn directly from the study participants’ endorsement of items reflecting the concept of congruence.

11. *The third factor was named “intrinsic helping and emotional support”*. This was the smallest factor in some ways when compared with the previous two factors, but in other ways it was the most interpretable. It consisted of items representing caring and altruism constructs. The role that altruism plays as a consistent personality marker and behavioral expression of the social work profession has been explored and empirically documented as discussed previously. The emergence of this factor from the data serves to confirm some of these previous findings. In interpreting this factor, altruism was believed to be a behavioral expression of caring. This factor shares with the other factors a combination of empathy constructs expressed in behavioral terms and endorsed by study participants.
12. *Few other professions have included in their title the term “work”. This behavioral moniker reinforces the role of action in how social work regards itself.* The findings of this study provide a level ofevidence for the significance

of behavioral expressions of empathy in social work practice. The factors found to underlie empathy in this study also reflected the active and dynamic nature of the profession and its practice. These findings underline the importance of empathy in social work overall, and begin to specify what is meant by empathy in social work practice.

13. *This study of empathy facilitated the understanding of what makes social work distinct and unique as a helping profession.* In many ways, empathy is overly inclusive in its meanings, and in other ways, not expansive enough. The term is used frequently and easily with an assumed understanding of its meaning in the general population. When these are explored in relation to the practice of social work, multiple meanings and at times contradictory definitions, emerge. These serve to cloud the understanding of the concept and limit its utility, yet its pre-eminent role in the practice of social work remains and continues to spread its influence throughout the field. The importance of empathy in social work can be confirmed by reviewing the glossary, index, or table of contents in virtually any introductory or advanced social work practice text. The term is almost universally listed in these sub-sections or described in other chapters delineating specific helping skills for practice. The measurement of the rather elusive and complex concept of empathy in social work practice is a relatively new endeavor for the field. Social work theory, when viewed through the lenses of empathy and the ESSW, achieved new levels of clarity and demonstrates the linkages between empathy and social work as a profession.

Implications for Social Work

The concepts outlined and tested in this study help to clarify the profession's understanding of empathy and extend its meanings and expressions into important implications for the field. These will be summarily discussed below.

The ESSW can provide social work educators with valuable information in designing and refining social work curricula. For example, this process informs educators about which concepts and professional skills social work students are taking with them into practice and which need reinforcement and greater emphasis or possible exclusion from future curricula. This improved understanding of the unique role empathy plays in social work permits educators to determine which theories and skills students have adopted or rejected, and is informative in the refinement of theories of human behavior in the social environment. The ESSW can provide educators with information about the type and extent of theoretical and practical student training needs as articulated by social work practitioners themselves. This process allows the ESSW to function as a feedback loop or conduit for information flowing reciprocally between educators, students, and practitioners.

When administered to social work students at regular intervals in the educational process, the ESSW may give educators information about how empathy skills develop in social work students. This process can help determine if specific time frames or experiences of students need particular attention during the development and use of empathy. For example, some students may find field placement experiences overwhelming and stressful. This process provides an opportune time to evaluate empathy in students and guide field placement supervision needs. Nascent students

often over-identify with clients' problems and situations and need guidance regarding the experience of empathy and how to manage professional and personal boundaries with clients. As well, students who become fearful in a field placement experience, or discouraged and confused by agency policies and staff behaviors, have different needs in terms of how empathy can be used as a tool to utilize the learning processes offered by the field placement experience. The use of the ESSW as an evaluation tool of empathy skill development among social work students brings important insights into a student's experiences, and facilitates more comprehensive and effective student supervision and learning.

As the results of the sub-group analyses suggested, some social work settings and specialties may require various levels or types of empathy for effective practice. As practitioners determine which area of practice is the 'best fit' for them as people and professionals the ESSW may provide objective information in this decision-making process. This opportunity for self-evaluation may be invaluable for practitioners as a guide for practice setting decisions as well as continuing education and supervision needs in the field.

Frequently, social workers find themselves in supervisory positions in a wide variety of social service agencies. Many times, social work practitioners are recruited for these positions, due in part to the inclusive communication and contextual orientation that social workers bring to practice. Ironically, often the skills of practitioners (such as empathy) may be beneficial to the functioning of an agency supervisor and the agency overall. But at other times, the various roles require a modified set of interpersonal skills and management styles. The ESSW has utility as a screening and self-evaluation tool

for potential social work supervisors, and their ability to balance and differentiate the types of empathy needed while wearing multiple “hats” within an agency setting.

As noted previously, empathy has been defined as essential for effective social work practice by its virtually universal emphasis in social work education. The ESSW can function as one of a group of self-evaluation and objective screening devices for social work students and practitioners. If empathy is central to social work practice, then social work students and practitioners lacking the capacity for empathy in general or regarding specific client groups need to be identified. The information gained by the use of the ESSW can inform schools of social work admission procedures, as well as student field placement assignments. Social work supervisors would be able to make more empirically informed decisions about clinical assignments and practitioner staffing patterns in agency settings with the use of the ESSW.

The ESSW provides social work theorists and researchers with information that brings the nature of social work into greater focus. It provides empirical research data regarding the constructs that underlie empathy. As a research tool within social work education and practice, the ESSW can provide important empirical and theoretical information about the professional education of social workers. Understanding the processes by which empathy functions in social work practice brings the concept to the forefront, in explaining how and why practitioners deliver effective services. Through repeated testing of the instrument, the ESSW can become a mechanism for the generation of an informed and improved social work theory with an emphasis on empathy as a defining and unifying theoretical construct.

Theorists from a variety of disciplines would benefit from the data collected upon future administrations of the ESSW. The ESSW could function as an effective construct and divergent validity tool in the development of scales designed to measure similar or differentiated concepts. Researchers interested in the complexities and dynamics of human cognition, communication and relationships could benefit from the continuing refinement and development of the ESSW for use in other helping professions. Future versions of the ESSW would provide insight into the similarities and differences in the constructs underlying empathy in clinical populations as varied as the developmentally disabled, juvenile offenders, substance abusers, sex offenders and child abuse victims.

Given that this research has focused on the initial development and validation of the ESSW, many of these implications for the field may be somewhat premature, and reflect a level of conjecture on the part of the researcher. However, the study implications outlined above represent the significant potential the ESSW has to impact the profession of social work and influence future research efforts. The use of varied research methodologies would be helpful in contributing to a deeper understanding of the nature of empathy in social work. Outcome studies in the teaching of empathy skills to different populations would extend the research utility of the ESSW. Research inquiries that facilitate the development of an even more detailed and comprehensive picture of the components of empathy would provide important data for inclusion in the ongoing development of the ESSW. Finally, this process would further and deepen an understanding of how and why empathy figures as prominently as it does not only in social work practice but as a unique and varied human ability and attribute.

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APPENDICES

APPENDIX A

The ESSW

ESSW (Empathy Scale for Social Work)

Instructions: The purpose of this survey is to assess empathy in social work practitioners. Please fill in the circle that most *closely* applies to you in your practice. The response choices are listed below.

1 Never ◯ **2** Rarely ◯ **3** Sometimes ◯ **4** Often ◯ **5** Always ◯

1. I try to let my clients know I am concerned for their welfare………………… ◯ ◯ ◯ ◯ ◯
2. Unconditional acceptance helps clients………………………………………. ◯ ◯ ◯ ◯ ◯
3. Facial expressions say a lot about what a client is feeling…………… ◯ ◯ ◯ ◯ ◯
4. I enjoy helping people……………………..………………………………….. ◯ ◯ ◯ ◯ ◯
5. I can tell by a client's body language if they are upset…………………..... ◯ ◯ ◯ ◯ ◯
6. I feel compassion for my clients………………………………..…………… ◯ ◯ ◯ ◯ ◯
7. Knowing a client's personal situation is important if I am really going to help them……………………………………………………………………… ◯ ◯ ◯ ◯ ◯
8. I can disagree with a client and still appreciate their position……..………… ◯ ◯ ◯ ◯ ◯
9. Clients expect me to think a certain way because of my gender…………... ◯ ◯ ◯ ◯ ◯
10. I enjoy helping people even when I am not at work…………………………. ◯ ◯ ◯ ◯ ◯
11. Helping clients is rewarding in and of itself……………............................... ◯ ◯ ◯ ◯ ◯
12. Understanding a client's background makes me more helpful…………….. ◯ ◯ ◯ ◯ ◯
13. My relationship with a client can help them overcome their problems…….. ◯ ◯ ◯ ◯ ◯
14. It is important for my clients to be able to trust me………………………….. ◯ ◯ ◯ ◯ ◯

15. It can be helpful for clients to use our relationship to practice new interpersonal skills………………………………………………………........... ◯ ◯ ◯ ◯ ◯
16. Clients perceive me as having more power than they do……………… ◯ ◯ ◯ ◯ ◯
17. It is important for my clients to know that I care about them……………….. ◯ ◯ ◯ ◯ ◯
18. An unbiased approach is helpful to clients…………………..……………. ◯ ◯ ◯ ◯ ◯
19. The personal dynamics of my relationship with a client are beneficial to to the treatment process…………………………………………………… ◯ ◯ ◯ ◯ ◯
20. I put aside my own feelings to listen attentively to a client………………..…… ◯ ◯ ◯ ◯ ◯
21. I can put myself in a client's position…………………………………………. ◯ ◯ ◯ ◯ ◯
22. I pay close attention when a client's tone of voice changes……………… ◯ ◯ ◯ ◯ ◯
23. My relationship with a client can be therapeutic in and of itself……………. ◯ ◯ ◯ ◯ ◯
24. I try to give my clients a warm greeting when meeting them……………..… ◯ ◯ ◯ ◯ ◯
25. I am careless when working with clients ***R***……………………………………… ◯ ◯ ◯ ◯ ◯
26. I am able to put aside my own feelings to be in accordance with a client's emotions………………………………………………………………….. ◯ ◯ ◯ ◯ ◯
27. I can disagree with a client and still appreciate their position……………….. ◯ ◯ ◯ ◯ ◯
28. I lose track of what a client is telling me ***R***……………………………………… ◯ ◯ ◯ ◯ ◯
29. I try to take a client's cultural context into account when working with them………………………………………………………………………..…… ◯ ◯ ◯ ◯ ◯
30. I have little sympathy for clients who are victims of their own doing ***R***……… ◯ ◯ ◯ ◯ ◯
31. I try to understand a client's viewpoint before making suggestions……….. ◯ ◯ ◯ ◯ ◯
32. I am attentive to my clients' non-verbal cues………………………………… ◯ ◯ ◯ ◯ ◯
33. My clients tell me I can be insensitive ***R***………………………………………… ◯ ◯ ◯ ◯ ◯
34. I carefully consider the ways that social gender role expectations effect my clients……………………………………………………………………………… ◯ ◯ ◯ ◯ ◯
35. I am kind to my clients……………………………………………………….. ◯ ◯ ◯ ◯ ◯
36. I am a socially responsible person……………………………………………. ◯ ◯ ◯ ◯ ◯
37. If a client cannot afford treatment I try to find a way for them to receive the help they need……………………………………………………………. ◯ ◯ ◯ ◯ ◯
38. My working relationship with a client can be detrimental to them………….. ◯ ◯ ◯ ◯ ◯

39. I try to help clients even if they have not sought treatment voluntarily…….. ◯ ◯ ◯ ◯ ◯

40. I discuss personal boundary issues with clients……………………………... ◯ ◯ ◯ ◯ ◯

41. Having an intimate relationship with a client is appropriate ***R***………………… ◯ ◯ ◯ ◯ ◯

42. Discussing the professional nature of my relationship with a client is important……………………………………………………………… ◯ ◯ ◯ ◯ ◯

APPENDIX B

The JSE (Clinical Social Work Version)

Jefferson Scale of Empathy (Clinical Social Work Version)

Instructions: Please indicate the extent of your agreement or disagreement with *each* of the following statements by marking the appropriate circle to the right of each statement.

Please use the following 7-point scale *(a higher number on the scale indicates more agreement):* Mark one and only one response for each statement.

1-------2-------3-------4-------5-------6-------7

Strongly Disagree ***Strongly Agree***

	1	2	3	4	5	6	7
1. My understanding of how my clients and their families feel does not influence the services I provide……	○	○	○	○	○	○	○
2. My clients feel better when I understand what they are feeling……	○	○	○	○	○	○	○
3. It is difficult for me to view things from my clients' perspectives……	○	○	○	○	○	○	○
4. I consider understanding my clients' body language to be as important as verbal communication in social worker-client relationships……	○	○	○	○	○	○	○
5. I have a good sense of humor that I think contributes to better clinical outcomes……	○	○	○	○	○	○	○
6. Because people are different, it is difficult for me to see things from my clients' perspectives……	○	○	○	○	○	○	○
7. I try not to pay attention to my clients' emotions during an assessment……	○	○	○	○	○	○	○
8. Attentiveness to my clients' personal experiences does not influence treatment outcomes……	○	○	○	○	○	○	○
9. I try to imagine myself in my clients' shoes when providing care to them……	○	○	○	○	○	○	○
10. My clients value my validation of their feelings, which is therapeutic in its own right……	○	○	○	○	○	○	○
11. Clients' problems can only be solved by specific intervention; therefore, emotional ties to my clients do not have a significant influence on their clinical outcomes……	○	○	○	○	○	○	○
12. Asking clients about what is happening in their personal lives is not helpful in understanding their problems……	○	○	○	○	○	○	○
13. I try to understand what is going on in my clients' minds by paying attention to their nonverbal cues and body language……	○	○	○	○	○	○	○
14. I believe that emotion has no place in addressing clients' problems……	○	○	○	○	○	○	○
15. Empathy is a therapeutic skill without which clinical success is limited……	○	○	○	○	○	○	○
16. An important component of the relationship with my clients is my understanding of their emotional status as well as that of their families..	○	○	○	○	○	○	○
17. I try to think like my clients in order to render better care……	○	○	○	○	○	○	○
18. I do not allow myself to be influenced by strong personal bonds between my clients and their family members……	○	○	○	○	○	○	○
19. I do not enjoy reading non-clinical literature or the arts……	○	○	○	○	○	○	○
20. I believe that empathy is an important therapeutic factor in social work practice……	○	○	○	○	○	○	○

APPENDIX C

THE SRA

Self-Report Altruism Scale (SRA)

Please indicate the number of times in the past month you have performed the following actions by filling in the circle with the correct answer. Use the following scale:

1 Never ◯ **2** Once ◯ **3** More than Once ◯ **4** Often ◯ **5** Very Often ◯

Item	1	2	3	4	5
1. I have assisted someone experiencing car trouble (changing a tire calling a mechanic, pushing a stalled or stuck car, etc.)……………………	◯	◯	◯	◯	◯
2. I have given someone directions…………………………………………….	◯	◯	◯	◯	◯
3. I have made change for someone…………………………………………….	◯	◯	◯	◯	◯
4. I have given money to someone who needed it (or asked for it)…………….	◯	◯	◯	◯	◯
5. I have done volunteer work for a charity…………………………………….	◯	◯	◯	◯	◯
6. I find it sometimes amusing to upset the dignity of teachers, judges, and “cultured” people………………………………………………………………	◯	◯	◯	◯	◯
7. I have donated blood………………………………………………………….	◯	◯	◯	◯	◯
8. I have helped carry another person’s belongings (books, parcels, etc.)……	◯	◯	◯	◯	◯
9. I have delayed an elevator or held the door open for another……………….	◯	◯	◯	◯	◯
10. I have allowed someone to go ahead of me in line (in a supermarket, during registration, etc.)…………………………………………………………	◯	◯	◯	◯	◯
11. I have given another a ride in my car………………………………………..	◯	◯	◯	◯	◯
12. I have pointed out a clerk’s error (in a bank, at the supermarket, etc.) in undercharging me for an item…………………………………………………..	◯	◯	◯	◯	◯
13. I have let someone borrow an item of some value to me (clothes, jewelry, stereo, etc.)………………………………………………………………………	◯	◯	◯	◯	◯

14. I have helped another with a homework assignment when my knowledge was greater than his or hers………………………………………………… ◯ ◯ ◯ ◯ ◯

15. I have offered my seat in a crowded room or on a train or a bus to someone who was standing………………………………………………… ◯ ◯ ◯ ◯ ◯

16. I have voluntarily looked after another's plants, pets, house, or children without being paid for it…………………………………………… ◯ ◯ ◯ ◯ ◯

17. I have helped another to move his or her possessions to another room, apartment or house………………………………………………………… ◯ ◯ ◯ ◯ ◯

18. I have retrieved an item dropped by another for him or her (pencil, book, packages, etc.)…………………………………………………………… ◯ ◯ ◯ ◯ ◯

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APPENDIX D

THE VAS

Verbal Aggressiveness Scale (VAS)

Instructions: This survey is concerned with how we try to get people to comply with our wishes. Indicate how often each statement is true for you personally when you try to influence other persons. Use the following scale:

Almost Always True	Often True	Sometimes True	Rarely True	Almost Never True
1	2	3	4	5
0	0	0	0	0

	1	2	3	4	5
1. I am extremely careful to avoid attacking individuals' intelligence when I attack their ideas ***R***	0	0	0	0	0
2. When individuals are very stubborn, I use insults to soften their stubbornness.	0	0	0	0	0
3. I try very hard to avoid having other people feel bad about themselves when I try to influence them ***R***	0	0	0	0	0
4. When people refuse to do a task I know is important, without good reason, I tell them they are unreasonable	0	0	0	0	0
5. When others do things I regard as stupid, I try to be extremely gentle with them ***R***	0	0	0	0	0
6. If individuals I am trying to influence really deserve it, I attack their character	0	0	0	0	0
7. When people behave in ways that are in very poor taste, I insult them in order to shock them into proper behavior	0	0	0	0	0
8. I try to make people feel good about themselves even when their ideas are stupid ***R***	0	0	0	0	0
9. When people simply will not budge on a matter of importance I lose my temper and say rather strong things to them	0	0	0	0	0
10. When people criticize my shortcomings, I take it in good humor and do not try to get back at them ***R***	0	0	0	0	0
11. When individuals insult me, I get a lot of pleasure out of really telling them off	0	0	0	0	0
12. When I dislike individuals greatly, I try not to show it in what I say or how I say it ***R***	0	0	0	0	0
13. I like poking fun at people who do things which are very stupid in order to stimulate their intelligence	0	0	0	0	0
14. When I attack a person's ideas, I try not to damage their self concepts ***R***	0	0	0	0	0

15. When I try to influence people, I make a great effort not to offend them ***R***…………………………() () () () ()

16. When people do things which are mean and cruel, I attack their character in order to help correct their behavior…………………………………………………………………………………() () () () ()

17. I refuse to participate in arguments when they involve personal attacks ***R***…………………………() () () () ()

18. When nothing seems to work in trying to influence others, I yell and scream in order to get some movement from them…………………………………………………………() () () () ()

19. When I am not able to refute others' positions, I try to make them feel defensive in order to weaken their positions…………………………………………………………………() () () () ()

20. When an argument shifts to personal attacks, I try very hard to change the subject ***R***…………() () () () ()

(copyright Infante and Wigley, 1986)

APPENDIX E

Survey Cover Letter

Development of an Empathy Scale for Social Work (ESSW)

Dear Social Worker,

The Survey Research Center at the University of Georgia is assisting Mr. Steve King, a doctoral student under the direction of Dr. Michael J. Holosko in the School of Social Work at the University of Georgia, in conducting a research survey developing a scale evaluating empathy in social workers. You have been selected for participation in the study due to your role as a social worker and your involvement in social work education and/or practice. The purpose of the study is to develop a standardized scale to measure empathy in social workers.

It is important for all participants to understand that individual participant's answers will not be tabulated or scored. Rather, the responses you provide will be analyzed to assess the merits of the scale itself. This research theorizes that empathy consists of three specific but overlapping dimensions. They are proposed to be affective, cognitive, and behavioral in nature. The data collected from all study participants will be used to evaluate the validity of these dimensions of empathy.

Your participation is very important! It is anticipated that the survey will take no more than 12-20 minutes of your time.

Your participation in this survey is completely voluntary. Any individually identifiable information you provide will be kept strictly confidential. Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the materials are received by the researcher, standard confidentiality procedures will be employed. You may refuse to participate or stop taking part at any time without penalty or loss of benefits to which you are otherwise entitled. Only summary data will be reported at the conclusion of the survey, any identifying information such as your name or email address will be separated from the responses you provide and deleted upon completion of the study. No risk or discomfort is anticipated from participation in the study, and you may choose not to answer any questions you don't wish to answer. While there is no direct benefit to you for participating, humankind may benefit through increased knowledge regarding empathy and its use in clinical social work as well as social work clients. You will have an opportunity to receive a copy of the study results if you so desire.

To begin the survey, please click on the 'START SURVEY' link below.

If you have any questions do not hesitate to ask now or at a later date. You may contact James J. Bason, Ph.D., Director of the Survey Research Center at 706-542-9082, jbason@uga.edu or Steve King at 404-483-5456, skingjr@uga.edu.

Thank you for your invaluable participation and contribution to this research study.

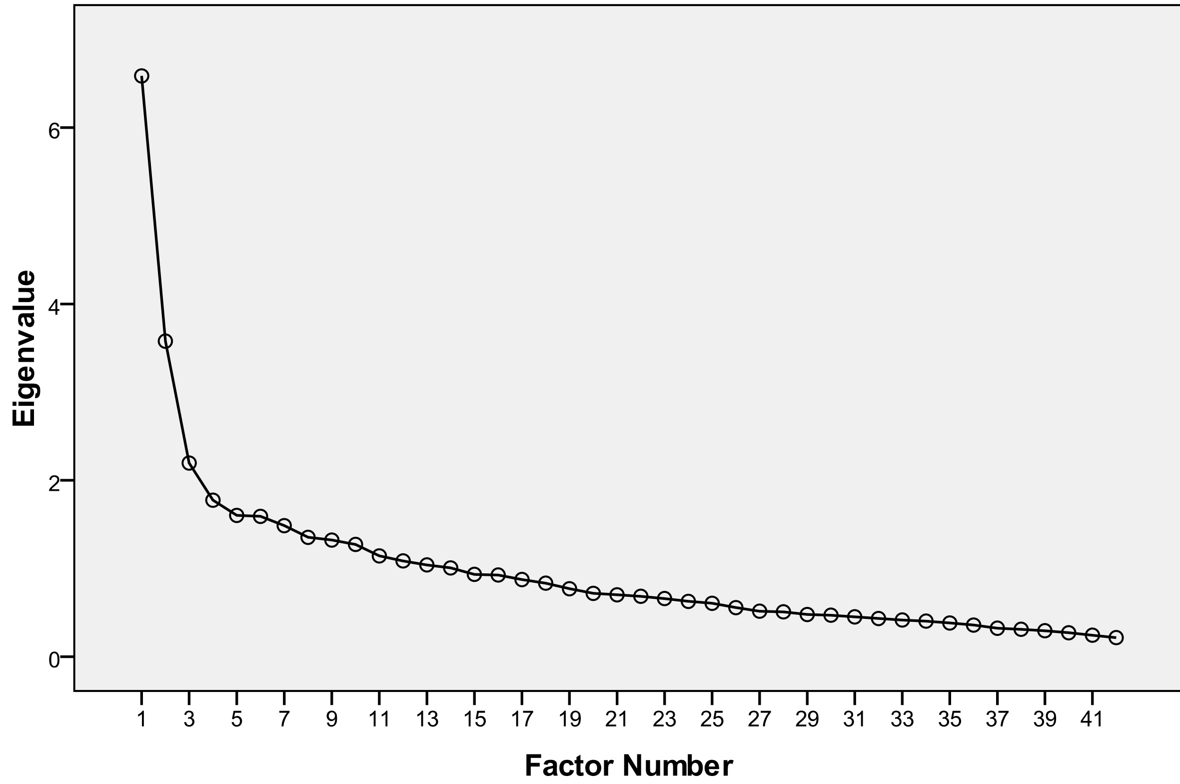
Sincerely,

James J. Bason, Ph.D.
Director and Associate Research Scientist
Survey Research Center
University of Georgia
Athens, GA 30602
(706) 542-9082
E-mail: jbason@uga.edu

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-mail Address IRB@uga.edu

APPENDIX F

Three Factor Skree Plot



APPENDIX G

The Four Factor Skree Plot