Importance of Empathy for Social Work Practice: Integrating New Science
Karen E. Gerdes and Elizabeth Segal

Empathy is more important than ever to a national population worried about difficult political and socioeconomic situations. During the last 10 years, an enormous amount of research has been carried out to elucidate the nature, mechanism, and function of empathy. New research from social–cognitive neuroscience and related fields indicates that, like language or eye–hand coordination, empathy is an innate human capability that can be greatly enhanced by purposeful and informed guidance. Empathy is particularly important to social work practice. Clients experiencing empathy through treatment have improved outcomes. Empathic social work practitioners are more effective and can balance their roles better. Social work practitioners can and should learn about emerging research on empathy and use that information to better serve their client populations. This article, emphasizing research of the past decade, focuses on empathy and its benefits as an asset to social work practitioners.

KEY WORDS: affective sharing; emotion regulation; empathy; perception–action coupling; social–cognitive neuroscience

During the last decade of the 20th century, then–President Bill Clinton made a political catch phrase of the term “I feel your pain.” As mawkish as this may have sounded to cynics, it resonated with voters. Eight years after Clinton left office, Barack Obama won the presidency in part by calling attention to an “empathy deficit” in government and public service. Identifying with another person’s emotions—the phenomenon we call empathy—is the foundation on which all useful public service and, indeed, the social contract itself is predicated.

Empathy is particularly important to social work practice. Clients experiencing empathy through treatment have improved outcomes. Empathic social work practitioners are more effective and can balance their roles better. Social work practitioners can and should learn about emerging social–cognitive neuroscience research on empathy and use that information to better serve their client populations. This article focuses on empathy as an asset to practitioners.

WHAT IS EMPATHY?
Barker (2003), in the Social Work Dictionary, defined empathy as “the act of perceiving, understanding, experiencing, and responding to the emotional state and ideas of another person” (p. 141). Barker’s definition is an abbreviated summary of the numerous definitions that have been put forward by influential thinkers over the past 90 years. These luminaries include psychoanalysts (Freud, 1921; Kohut, 1959; Reik, 1948), humanistic therapists (Rogers, 1957), psychologists (Davis, 1994), and social and developmental psychologists (Batson, 1987; Hoffman, 2000; Ickes, 1997).

In 2004, Decety and Jackson surveyed the numerous definitions and conceptualizations of empathy found in academic and professional literature. They identified three subjective experiences and three communicative abilities that, in one form or another, are universally cited as signature ingredients of empathy (see Table 1).

As Table 1 reveals, there are two components to empathy: the emotional and the cognitive. Vinton and Harrington (1994) noted the difference between the two elements, as have many others (for example, Davis et al., 2004). They labeled them (1) emotional empathy—the ability to be affected by the client’s emotions—and (2) expressed [cognitive] empathy—the translation of such feelings into words.

Historically, there has been some controversy as to the relative primacy of the emotional/affective elements of empathy and the expressed/cognitive elements (Cliffordson, 2001; Decety & Jackson, 2004; Funk, Fox, Chan, & Curtiss, 2008). For example, Rogers (1957) and Hoffman (1981) focused more on empathy as an innate and involuntary response to an affective signal or prompt, whereas behaviorists focused more on empathy as a learned
communication, or as conscious role taking (Batson, 1991; Davis, 1996). Kohut (1959) was one of the first to articulate that both the conscious (for example, perspective taking) and implicit or unconscious (for example, emotion sharing) processes are vital to empathy and must be integrated to achieve a true empathic reaction or response.

EMPATHY IN EXISTING SOCIAL WORK LITERATURE
It is hardly new to proclaim that empathy is a critical and essential ability for effective social work practice; this has been stated explicitly by many social work educators (for example, Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006; Orlinsky & Howard, 1975; Shulman, 2009). Yet actual research on empathy, as well as evidence of empathy training in the social work curriculum, remains scarce and sketchy. NASW’s Encyclopedia of Social Work (Mizrahi & Davis, 2008) contains no entry for “empathy”—a glaring omission that illustrates the generally narrow and haphazard consideration of empathy in the social work literature (Freedberg, 2007; Raines, 1990).

A generation of social workers, including the present authors, were schooled using Rogers’s (1959) conceptualization of empathy as the ability to perceive the internal emotional state of another “as if” they were that person. A nonjudgmental, accepting reflection of the client’s emotional state was critical to the effectiveness of the practitioner–client relationship. Later, Rogers (1975) revised his conceptualization of empathy from a “state” to more of a “moment-to-moment process of felt meaning,” in which the practitioner was constantly checking the accuracy of his or her interpretation of the client’s “felt meaning.”

In the 1980s, Rogers’ conceptualization of empathy was overshadowed by psychologists and social workers who were more concerned with implementing cognitive–behavioral interventions and wanted empirical measurements for both affective and cognitive components of empathy (Bryant, 1982; Davis, 1983). The glaring problem in the current clinical outcome literature is that there is still no agreed-on conceptualization of empathy. As a result, “operational definitions of empathy are not consistent across studies” (Pithers, 1999, p. 258). Measurement techniques for empathy vary so much that it has been difficult to engage in meaningful comparisons or make significant conclusions about empathy and how to cultivate it effectively in social workers and clients (Cliffordson, 2001).

Today, numerous disciplines are researching and analyzing empathy. Recent groundbreaking research on this issue has emerged from primatology and ethology (de Waal, 2003); neuroscience (Ramachandran, 2000); developmental psychology (Batson, 2006; Batson et al., 2003); and, perhaps most important, the nascent field of social–cognitive neuroscience (Decety & Jackson, 2004; Decety & Lamm, 2006). This article is meant to bring findings from this last field into social work’s body of literature, thus reopening a discussion that could have powerful influence on the way social workers conceptualize and measure empathy and, more important, how they practice it.

IMPORTANCE OF EMPATHY TO SOCIAL WORK
Research demonstrates that empathy is an important tool for positive therapeutic intervention (Watson, 2002). Clients experiencing empathy through treatment by others inhibits antisocial behavior in children and adolescents (Eisenberg, Spinard, & Sadovsky, 2005; Hoffman, 2000). Empathy inhibits aggression toward others (Weisner & Silbereisen, 2003) and promotes healthy personal development (Hoffman, 2001). The lack of empathy is correlated with bullying, aggressive behavior, violent crime, and sexual offending (Gini, Albieri, Benelli, & Al toe, 2008; Joliffe & Farrington, 2004; Loper, Hoffschmidt, & Ash, 2001; Sams & Truscott, 2004).

A practitioner’s own level of empathy is correlated with positive client outcomes (Forrester, Kershaw,
Moss, & Hughes, 2008). Jensen, Weersing, Hoagwood, and Goldman (2005) completed a review of 52 child psychotherapy treatment studies and concluded that therapist empathy, attention, and positive regard are essential to effective outcomes. Forrester et al. (2008) found that empathy is central to effective communication in child protection situations. Empathy is critical to both practitioner and client outcomes.

**SCIENCE OF EMPATHY: NEW FINDINGS AND THEIR IMPLICATIONS**

New research on empathy is rich and varied. Some of the emerging research is highlighted in Table 2. An exhaustive analysis of all findings falls well beyond the scope of a single article. This article focuses on what we believe to be one of the most important bodies of work, the comparatively new field of social–cognitive neuroscience, and its implications for social work practice. Researchers in this field, basing their work on observations from primatology, have identified the major physiological mechanism of empathy and begun to elucidate how the experience of empathy actually occurs in the brain. Their findings give empirical support to research on empathy in social interactions.

Connecting these areas of research yields an important and exciting conclusion: Empathy can be taught, increased, refined, and mediated to make helping professionals more skillful and resilient. Understanding how empathy works can help social workers “in the trenches” connect more empathically with clients from a wider range of sociocultural backgrounds while making them less vulnerable to becoming overwhelmed, burnt out, or dysfunctionally enmeshed with clients.

**MIRROR, MIRROR: HOW EMPATHY OCCURS IN THE BRAIN**

One day, a researcher who was studying brain activity in monkeys stumbled on a strange phenomenon: The monkey the researcher was studying showed

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<th>Field</th>
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<td>Primatology</td>
<td>Monkeys have mirror neurons or mirror cells that respond to the goal-directed actions of others (that is, the monkeys have neurological responses to the experiences of other individuals, “feeling” the experience secondhand, the necessary condition for empathy). This discovery led to the identification of the physiological mechanism for perception–action coupling in humans (Rizzolatti &amp; Craighero, 2004).</td>
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<td>Social–cognitive neuroscience</td>
<td>Perception–action coupling and mirror neurons have been observed in humans as well—that is, the perception of emotion in one individual activates neural mechanisms in an observer, allowing the observer to resonate with the emotional state of the individual being observed (Preston &amp; de Waal, 2002).</td>
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<td>Perspective taking—that is, cognitively adopting the perspective of another—evokes stronger empathic concern. In other words, thinking about another’s experience adds more empathy than does simply observing it (Batson et al., 2003; Jackson, Bruner, Melzoff, &amp; Decety, 2006; Lamm, Batson, &amp; Decety, 2007).</td>
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<td>Self-awareness is an essential condition for making inferences about the mental states of others (Decety, 2005; Decety &amp; Sommerville, 2003; Sommerville &amp; Decety, 2006).</td>
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<td>“Empathy relies both on bottom-up [or unconscious] information processing (shared neural systems between first-hand emotional experience and the perception or imagination of the other’s experience), as well as top-down [conscious–cognitive] information processing that allows modulation and self-regulation. Without self-regulation, information processing would lose flexibility and would become primarily bound to external stimulations” (Decety &amp; Lamm, 2006, p. 1160).</td>
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<td>Empathy deficits with different etiologies (for example, brain lesions or degenerative neurological conditions) are highly correlated with sociopathy, conduct disorders, narcissistic personality disorder, and antisocial behaviors (Decety &amp; Jackson, 2004).</td>
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<td>Gender-related studies of empathy and brain function suggest that female humans may use mirror neurons more extensively than male humans. This adds support to the theory that men and women rely on different neurological strategies to assess other’s subjective experiences and that, in general, women have a higher tendency toward empathic experiences than do men (Schulte-Ruther, Markowitsch, Shah, Fink, &amp; Piefke, 2008).</td>
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<td>Psychology</td>
<td>Neuroplasticity allows us to deliberately change negative emotional states by understanding and observing the operation of our own brains (Lutz, Greischar, Rawlings, Ricard, &amp; Davidson, 2004; Schwartz &amp; Begley, 2003).</td>
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brain activity that indicated he was eating when in fact he was motionless. After some investigation, the researcher realized that the monkey’s brain was reacting to seeing another animal eat. In short, part of the motionless monkey’s brain appeared to be actually experiencing the other monkey’s sensations (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996).

Much more research followed, with social–cognitive neuroscientists picking up on the results from primatology. Ultimately, the neuroscientists identified a class of cells in the brain (both animal and human) that they named “mirror neurons.” These cells fire when an individual observes another person or animal having some sort of experience or sensation. The discovery of mirror neurons shows that the phrase “I feel your pain” may be literally true—not that the speaker is actually experiencing the other person’s feelings, but that the speaker’s brain creates very real sensations in response to that other person’s experience (Kaplan & Iacoboni, 2006). Mirror neurons appear to be the primary physiological mechanism of empathy (Wolf, Gales, Shane, & Shane, 2001).

Is this innate physiological ability mutable? Can people lacking sufficient empathy be taught to be more empathic? Further research has shown that the brain is changeable, a phenomenon known as “neuroplasticity,” and deliberately changing one’s mental state begins with observing that mental state. Social workers are trained to be self-reflective, and this ability is central to enhancing empathy. Cognitively adopting the perspective of another evokes stronger empathic concern. In other words, thinking about another’s experience adds more empathy than simply observing it (Batson et al., 2003; Jackson, Brunet, Meltzoff, & Decety, 2006; Lamm, Batson, & Decety, 2007). The practice of actively observing clients’ behaviors and simultaneously processing those behaviors cognitively are not new to social work practice, but they have not been identified as critical to developing practitioner empathy.

**COMPONENTS NECESSARY TO GENERATE EMPATHY**

Following Kohut’s lead in combining the affective and cognitive aspects of empathy, Decety and Jackson (2004) and Decety and Lamm (2006) proposed the first truly interdisciplinary conceptualization of the phenomenon. There are three necessary, functional components that dynamically interact to generate the subjective experience of empathy. Any one component on its own, the authors claimed, is insufficient to produce empathy. Those components are as follows:

- affective sharing between the self and the other, based on perception–action coupling that lead[s] to shared representations;
- self–other awareness. Even when there is some temporary identification, there is no confusion between self and other; [and]
- mental flexibility [that is, emotion regulation] to adopt the subjective perspective of the other and also regulatory processes. (Decety & Jackson, 2004)

The first component of the model, affective sharing with others, is largely an unconscious or automatic experience. When we listen to someone describe his or her feelings verbally or observe gestures, facial expressions, and vocal tone, and so forth (that is, perception and action coupling), neural networks in our brains are stimulated by the “shared representations” and generate similar feelings within us. This is the involuntary action of mirror neurons and is therefore automatic.

Unlike affective sharing, the second and third components of the empathy model—self–other awareness and the mental flexibility to regulate one’s own emotions—are not automatic. On the contrary, they are sophisticated cognitive skills that allow humans to voluntarily take the perspective of others—and like other sophisticated cognitive skills, they can be learned, increased, and perhaps ultimately even mastered (Decety & Lamm, 2006). Social workers can benefit enormously from being educated to modulate their own experience of empathy cognitively. They can then both connect with others—even those whose socioeconomic, cultural, or physiological experience is very different from their own—and prevent “empathic overarousal,” which can lead to personal distress, egoistic behaviors, or burnout (Eisenberg, 2000).

**GUIDE FOR PRACTITIONERS: ENHANCING EMPATHY**

**Component 1: Affective Sharing/Perception and Action Coupling**

Establishing empathy is simple, though not always easy. We now know that the brain inherently and involuntarily triggers shared reactions neurologically when we are observing others’ experiences.
This is most likely due to the involuntary firing of mirror neurons, the “brain cells that reflect the activity of another’s brain cells” (Rothschild, 2006, p. 42). Beginning in infancy, mirror neurons help each human’s brain map the orofacial and manual gestures of others onto the baby’s own motor systems (Kaplan & Iacoboni, 2006). These shared representations are stored or encoded in our neural networks and, when stimulated, automatically enable us to empathize with or share the feelings of another (Decety & Lamm, 2006). Researchers now believe that autism may in part be explained by a failure to develop or form adequate neural circuitry or mirror neurons that enable language and social brain pathways to mature (Iacoboni & Dapretto, 2006).

The neural networks created by the shared representation process of gestures, body language, and vocal tone are like the “hardware” of the human brain. Other shared representations, such as words, are more like “software.” They capitalize on the innate capacity for empathy to create affective sharing through deliberate communication of feelings. Of course, such representations are more specific and controllable than the visceral, automatic empathic reactions arising from hardwired somatic responses.

Both of these neurological pathways to empathy involve paying close attention to another person: not theorizing or analyzing, but being fully attentive to another’s behavior, facial expression, tone of voice, choice of words, and so on. It is empirical observation at its purest. This means that while theory is necessary for analyzing and initiating solutions to a problem, the only thing a social worker must do to experience affective sharing or perception with a client is to truly see the client’s actions, gestures, facial expressions, and other behaviors and to truly hear the words, tone of voice, and content of the client’s story. This is referred to as “perception and action coupling” (Kaplan & Iacoboni, 2006).

Too often, educational systems focus on cognitive understanding at the expense of clear, uncomplicated perception. Training of social workers should include alerting them to the dangers of blunting or blocking their observational powers. Instructing them to observe their clients mindfully—that is, without imposing immediate cognitive categories on their behavior—can help free social workers’ brains to automatically mirror a client’s subjective experience.

For example, a male social worker who deliberately puts aside his own intellectual constructs and deeply listens to a woman’s story of a difficult childbirth, noticing her tone and words and watching her nonverbal gestures, might begin to experience the feelings of pain, fear, and joy that are associated with giving birth. Like anyone who pays close empathic attention, he may also unconsciously mimic her facial expression and body positions, a somatic “echo” of feelings that he himself could never physically experience except through empathy. Educators who familiarize social workers to the concepts of affective sharing and perception—action coupling will facilitate a more rewarding and productive experience for both the social workers and their clients.

Component 2: Self–Other Awareness
Affective sharing is crucial in all the helping professions, but as documented in the social work literature, it can also lead to emotional and physical burnout (Eisenberg, 2000). Many social workers who have a very strong capacity to share their clients’ feelings have trouble disengaging from the clients and, thus, take on many of the very burdens they are trying to ease. This degree of enmeshment is not constructive; it prevents clear and constructive action. Surgeons are not allowed to operate on people with whom they share deep emotional bonds precisely because objectivity is required as a foundation for offering help. A surgeon who fully identified with the pain of a patient’s gunshot wound or shattered bones would require help rather than be able to give it. The same is true of social workers who hope to heal the wounds of poverty, violence, or mental illness.

From an educational perspective, social workers should be taught that, counterintuitively, true empathy cannot exist without a strong sense of self as separate from other. Self-awareness allows us to disentangle our own feelings from the feelings of others, prevents empathic overarousal in emotion sharing, and allows us to make cognitive inferences about the mental state or perspective of others (Decety & Lamm, 2006). In other words, self–other awareness acts as a brake on the automatic link between perception and emotion that occurs in affective sharing and allows us to take a more detached perspective.

Social workers who lack the awareness of being separate from clients turn the reflexive aspects of empathy into an intolerable burden for themselves. Without perceptual boundaries, they risk experiencing a client’s feelings of anger, depression, anxiety, or joy as their own feelings. With self–other boundaries
distinct, one person’s reactions to another’s suffering are typically altruistic; in the absence of such perceptual boundaries, observation of another’s suffering can cause the observer severe distress.

The confusion of blending self and other works both ways; social workers who lack clearly perceived self–other distinction may not only experience others’ experiences as their own, but also project their own motivations onto others, misconstruing the other’s experience (for example, someone who usually weeps when angry may project anger onto another person who is weeping with grief or joy). This results not in the deep understanding of real empathy but in the confusion and misunderstanding of overidentification.

Again, mindful observation of reality can help social workers achieve clear self–other awareness while also experiencing affective sharing. If I truly see what is happening in a given situation, I not only experience empathy for others, I also remain conscious of the fact that another’s pain, confusion, or sense of disempowerment are not my own. Simply voicing this fact and teaching aspiring social workers to articulate it for themselves can help them modulate their experience of empathy later as they deal with clients.

**Component 3: Mental Flexibility and Self-/Emotion Regulation**

Mental flexibility is a sophisticated cognitive ability that allows us to toggle back and forth between absorbing another’s perspective and shutting it out, between identifying with the other and identifying solely with the self (Decety & Lamm, 2006). Eisenberg, Smith, Sadovsky, and Spinard (2004) defined emotion regulation as “the process of initiating, avoiding, inhibiting, maintaining, or modulating the occurrence, form, intensity, or duration of internal feeling states, emotion-related physiological processes, emotion-related goals, and/or behavioral concomitants of emotion, generally in the service of accomplishing one’s goals” (p. 260).

This, too, is a fundamental key to using empathy effectively and beneficially. A social worker who cannot “turn on” receptiveness to others’ experiences will never bridge the gap between his or her own experience and that of a client. By the same token, a social worker who cannot turn off the empathic awareness of a client’s despair or anxiety after the workday quickly experiences emotional burnout and can no longer serve that client.

Self-regulation is typically conceptualized as a conscious, intentional effort to control one’s thoughts, emotions, or behaviors. As a result, most theorists have emphasized that people who wish to control or change their behavior must pay close conscious attention to their behavior and exert deliberate control over it (Baumeister, Heatherton, & Tice, 1994; Carver & Scheier, 1981; Duval & Wicklund, 1972; Mischel, 1996).

Mindfulness studies suggest that self-observation is the key to controlling one’s own emotional state (Langer, 1989). Trying to force a degree of feeling or detachment is less effective than taking an observing position in regard to one’s own emotions. In other words, the way for social workers to modulate affective sharing and achieve healthy self–other awareness is to observe both the client and his or her own thoughts and feelings. The part of the brain that self-observes is the part that can successfully toggle between affective sharing and healthy detachment (Schwartz & Begley, 2003).

**CONCLUSION**

Empathy in social work practice is not new, but it has not been stressed recently in the literature. In light of new research and interdisciplinary findings, the value and importance of empathy is critical. Research documents the value of empathy, our innate abilities to be empathic, and the need to tap those innate abilities, and that this process can be learned. The three components described in this article are a start toward enhancing empathy for social work practitioners. Social work practitioners need to develop their own empathic abilities to enhance their effectiveness with clients and to protect themselves from compassion or practice fatigue and burnout. Awareness and active use of the three components of affective sharing, self–other awareness, and emotion regulation/mental flexibility will enhance empathy.

With emerging research and political commitment, now is the right time to emphasize the place of empathy in social work practice.

**REFERENCES**


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