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The Influence of Moral Judgment on Empathy

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The concept of empathy is ubiquitous in the counseling literature and is featured in every introductory counseling course. The attention to empathy is in part attributed to the emergence of humanism—following psychoanalysis and behaviorism—and the influence of Carl Rogers who emphasized that empathy is a sufficient and necessary condition for psychological change (Rogers, 1959). Although Carl Rogers is the theorist who is typically credited with the concept empathy, a definition of empathy made its entrée into the psychological nomenclature as early as the 16th and 17th centuries in the writings of theorists such as Smith in *Theory of Moral Sentiments*, and Spencer in *The Principles of Psychology* (Davis, 1983).

At the turn of the 20th century Titchener used the German word *emfühlung* to coin the term *empathy* which he translated to mean “a process of humanizing objects, of reading or feeling ourselves into them” (Duan & Hill, 1996, p.261). Twenty-first century theorists are yet to reach consensus on a definition and have examined empathy from three perspectives: (i) as an affective phenomenon (Allport, 1961; Mehrabian & Epstein, 1972); (ii) as a cognitive response to the experiences of others (Kohut, 1971; Rogers, 1986); and (iii) as both affective and cognitive elements (Gladstein, 1983; Jolliffe & Farrington, 2006).

Some theorists have suggested that empathy is a personality trait or the innate ability to know what the other person is experiencing (Book, 1988; Buie, 1981; Davis, 1983; Duan & Hill, 1996; Sawyer, 1975). The assumption that undergirds the trait theory perspective is that some individuals are more empathic than others because they are naturally predisposed to be empathic. The term *dispositional empathy* is commonly associated with this perspective. However, other theorists have asserted that empathy is a situation specific affective-cognitive state and is a vicarious response to a phenomenon or a person (Batson & Coke, 1981; Duan & Hill, 1996; Rogers, 1957, 1959). The assumption that underlies a situation specific cognitive or affective response challenges the notion of the innate characteristics of dispositional empathy and suggests that the empathic response is influenced by the situational factors which may override dispositional empathy.

In examining situational variables, cognitive scientists have examined the interpretation of actions and the accompanying influence of moral judgment in the evaluation of these actions (Knobe, 2003; Knobe, Leslie, & Cohen, 2006; Petit & Knobe, 2009). In addition, the level of attribution of blame, the perceptions of the trustworthiness of the explanations for their actions, and whether the explanation for actions are believable are being cited by the researchers as influential in making moral judgment about a given situation. This suggests that there may be a confluence of several variables that may influence our cognitive, affective and behavioral appraisal of a given situation.

Framework for the Current Study

Limited empirical studies have been conducted that examine the influence of situational variables on the empathic response. The focus of this study is to provide empirical data that examines whether the propensity to be empathic is an innate construct or whether it is influenced vicariously by variables governing a specific situation. In addition extensive review of the literature reveals that no studies have examined the role of situational variables in relation to the level of empathy displayed using students in counseling or related disciplines as participants. This omission in the scholarly inquiry guided the researcher to invite participation from two groups of students to determine whether there were any salient differences between students who are pursuing careers in mental health and their non-mental health counterparts relative to levels of basic empathy and situational empathy. The following research questions guided this exploratory study.

Question 1. Do mental health trainees and non-mental health trainees differ with respect to general empathy?

Question 2. Do mental health trainees and non-mental health trainees differ with regard to their ability to demonstrate empathy in a specific situation?

Question 3. Do mental health trainees and non-mental health students differ in their attribution of blame?

Question 4. Are mental health trainees more inclined to believe an individual's explanation for their actions than non-mental health trainees?

Question 5. Are there differences between mental health trainees and non-mental health trainees in their determination of intent?

Method

Participants

The participants were 168 graduate and undergraduate students attending a university located in the Midwest region of the United States. There were 109 (64.9%) females and 59 (35.1%) males. The participants were registered in the following majors: psychology 2 (1.2%); social work 13 (7.7%); counseling 67 (39.9%); engineering 15 (8.9%); and undecided 71(42.2%). The psychology, social work and counseling majors were clustered and formed the mental health trainee group n=82 (49%) and the engineering and undecided participants formed the non-mental health trainee group n=86

(51%). The participants' ages ranged from 18 to 58 years with an average age of 26.8 (SD=8.79). There were 109 (64.9%) graduate and 59 (35.1%) undergraduate students. Participants who identified themselves as Caucasian (83.9%) constituted the largest proportion of the sample followed by those who identified as Black (8.3%), as other (6.5%), and as Asian-American (1.2%).

Instruments

The participants completed the Basic Empathy Scale (BES), a demographic questionnaire, and a questionnaire developed for the study to measure situational empathy.

Demographic questionnaire. The demographic questionnaire was used to gather information about the participant's major, student status, age, race, and gender.

The Basic Empathy Scale (BES). The BES (Jolliffe & Farrington, 2006) is a 20 item scale that is divided into two subscales: cognitive empathy (9 items; $\alpha=.79$) i.e., the ability to understand another person's experiences; and affective empathy (11 items; $\alpha=.85$) i.e., measuring an observer's congruence (emotional) with another person's emotions. Responses are scored on a 5-point Likert scale ranging from 1=*strongly disagree* to 5=*strongly agree*. In this study the Cronbach's reliability coefficient for cognitive empathy was $\alpha=.72$ and affective empathy $\alpha=.78$. Total empathy was calculated by summing all items ($\alpha=.85$). An Italian validation study of the BES by Albiero, Matricardi, Speltri, and Toso (2009) reported total empathy $\alpha=.87$; cognitive empathy $\alpha=.74$; and affective empathy $\alpha=.86$.

The Situational Questionnaire. This questionnaire consists of items measuring situational empathy, intent, believability, and attribution of blame. Since there are no established instruments to measure situational empathy, the researcher developed items specifically to measure situational empathy.

The content of the questionnaire was guided by the literature and the observation that previous researchers have relied primarily on the vignette method to examine the variables addressed in the aforementioned research questions (Kelly, Stich, Haley, Eng, & Fessler, 2007; Machery, 2008; Machery, Mallon, Nichols, & Stich, 2004; Nadelhoffer, 2006; Nahmias, Morris, Nadelhoffer, & Turner, 2006; Nichols, 2002). The researcher was of the opinion that this method provides only partial insight into the cognitive and affective processes at hand. As a result written scenarios were supplemented with a visual stimulus. A real life video segment was used of a paraplegic who was ejected from his wheelchair by a police officer. A hypothetical scenario was developed around the selected footage. In the scenario a supervisor makes a hiring decision even though he was given information that the person whom he intended to hire had a poor previous track record. The new employee is depicted in the video footage as the police officer who ejects a paraplegic from his wheelchair. The supervisor provides an explanation for his decision. The participants responded to items that measured their cognitive and affective response specifically as it related to whether they found the supervisor's explanation for his actions plausible; whether they found the supervisor to be blameworthy; and whether they believed that he was intent on causing harm.

Data Collection Procedure

Participants who were preparing for careers in the mental health profession (counselor education, social work, and psychology) were recruited. In addition individuals preparing for careers unrelated to the mental health field were invited to participate and formed the non-mental health trainee group.

Each participant was handed a packet that consisted of three parts. The first section instructed the participants to complete the demographic questionnaire and the Basic Empathy Scale. The second section required the participants to read a report and to watch a 30 second video segment. The video segment was actual footage of a police officer ejecting a paraplegic, who had committed a minor traffic offense, from his wheelchair. The participants then completed an item that explored their attribution of blame. The third section required participants to read an additional report and to complete questions related to situational empathy, and believability. Finally the participants read a scenario and responded to questions related to intent. Information was also solicited from the participants to determine whether they had any prior exposure to the video segment.

Results

Independent Samples t-test Analyses

To compare trainee mental health professionals with their non-mental health counter-parts independent-samples *t* tests were conducted (See Table 1). Following are the results of the analyses as it relates to the specific research questions.

Research question #1: Do mental health trainees and non-mental health trainees differ with respect to general empathy? The independent samples *t*-test comparing the means scores of mental health trainees and non-mental health trainees found a statistically significant difference between the means of the two groups ($t(166)=2.781$, $p<.01$). The mean scores of basic empathy for mental health trainees were significantly higher ($m=77.36$, $sd=7.07$) than non-mental health trainees ($m=73.93$, $sd=8.79$).

Research question #2: Do mental health trainees and non-mental health trainees differ with regard to their ability to demonstrate empathy in a specific situation? The independent samples *t* -test comparing the means scores of mental health trainees and non-mental health trainees found a statistically significant difference between the means of the two groups ($t(166) = -3.685$, $p<.01$). The mean scores of the situational empathy for non-mental health trainees were significantly higher ($m=12.94$, $sd=2.52$) than mental health trainees ($m=11.49$, $sd=2.59$).

Research question #3: Do mental health trainees and non-mental health trainees differ in their attribution of blame? The independent samples *t* -test comparing the means scores of mental health trainees and non-mental health trainees found a statistically significant difference between the means of the two groups ($t(166)=2.629$, $p<.01$). The mean scores for the attribution of blame for mental health trainees were significantly higher ($m=3.95$, $sd=1.07$) than non-mental health trainees ($m=3.50$, $sd=1.15$).

Research question #4: Are mental health trainees more inclined to believe an individual's explanation than non-mental health trainees? The independent samples *t*-test comparing the means scores of mental health trainees and non-mental health trainees found a statistically significant difference between the means of the two groups (t

(166)=2.473, $p<.05$). The mean scores for the perception of believability for trainee mental health professionals were significantly higher ($m=3.38$, $sd=1.04$) than non-mental health trainees ($m=2.99$, $sd=.99$). Please note that higher scores for this item are inversely proportional to believability.

Research question #5: Are there differences between mental health trainees and non-mental health trainees in their determination of intent? The independent samples *t*-test comparing the means scores of mental health trainees and non-mental health trainees found a statistically significant difference between the means of the two groups ($t(166)=2.202$, $p<.05$). The mean scores for perception of intent for trainee mental health professional were significantly higher ($m=2.83$, $sd=1.29$) than non-mental health trainees ($m=2.41$, $sd=1.19$).

Table 1
Summary of Independent Samples t-Tests

	Groups	n	M	SD	t-test for Equality of Means		
					t	df	Sig.
Basic Empathy	MH	82	77.36	7.07	2.781	166	.006**
	NMH	86	73.93	8.79			
Situational Empathy	MH	82	11.49	2.59	-3.685	166	.000**
	NMH	86	12.94	2.52			
Attribution of Blame	MH	82	3.95	1.07	2.629	166	.009**
	NMH	86	3.50	1.15			
Perception of Intent	MH	82	2.83	1.29	2.202	166	.029*
	NMH	86	2.41	1.19			
Perception of Believability	MH	82	3.38	1.04	2.473	166	.014*
	NMH	86	2.99	.99			

Note. MH=Mental health trainees; NMH= non-mental health trainees

* $p<.05$, two tailed. ** $p<.001$, two tailed.

Correlation Analyses

In addition to the independent samples *t*-test a Pearson's product –moment correlation matrix to assess the magnitude of the inter-correlations between Attribution of Blame, Perception of Believability, Perception of Intent, General Empathy and Situational Empathy was generated and is presented in Table 2. Examination of the inter-correlations reveals that there is a negative relationship between Situational Empathy and Attribution of Blame; Perception of Believability; and Perception of Intent. There is a modest correlation between Basic Empathy and Perception of Blame. However there is an inverse relationship between Perception of Blame and the Perception of Believability. There is a positive relationship between the Perception of Blame and the Perception of Intent. The correlations suggest that there is no relationship between Situational Empathy and Basic Empathy.

Table 2

Summary of Inter-correlations between Attribution of Blame, Perception of Believability, Perception of Intent, Basic Empathy and Situational Empathy

	1	2	3	4	5
1. Blame	1.00	-.393**	.223**	.161*	-.413**
2. Believability	-.393**	1.00	.225**	.077	-.415**
3. Intent	.223**	.225**	1.00	.025	-.272**
4. Basic Empathy	.161*	.077	.025	1.00	-0.46
5. Situational Empathy	-.413**	-.415**	-.272**	-.046	1.00

Note. * $p < .05$, two tailed. ** $p < .001$, two tailed.

Discussion

Results suggest that participants who were students in counseling, social work, and psychology evidenced higher basic empathy or dispositional empathy scores than participants who were undecided majors or enrolled in engineering degrees. This is an expected finding when considering the assertion by researchers that the individuals who are more disposed to help enter fields such as counseling, therapy, and social work (Harton & Lyons, 2003).

However, relative to situational empathy, the sample of non-mental health participants evidenced higher level of empathy than the mental health participants. This finding has to be seen within the context that mental health participants attributed more blame to the supervisor, perceived the supervisor to have, with intent, indirectly harmed the paraplegic, and found the supervisor's explanation for this actions to be less plausible than non-mental health participants. Furthermore, correlation data indicate that blame, intent, and believability were inversely related to situational empathy which suggests that higher levels of attribution of blame, perception of intent, and lack of believability may explain why the mental health participant's level of situational empathy was lower than their non-mental health counterparts.

In this study it is important to take into consideration that supervisor and his supervisee are members of the police department and the police are sanctioned by society to uphold the law and protect the citizenry. When examining the empathic response of the two groups it is possible that the mental health participants aligned themselves with the paraplegic and saw him to be the more aggrieved party than the reason explanation provided by the supervisor. The non-mental health group on the other hand may have viewed the police officers as maintaining law and order and aligned themselves more with the supervisor than with the paraplegic who had broken the law and this may account for higher levels of empathy directed toward the supervisor.

This interpretation finds support in the literature in that researchers have suggested that individuals who evidence authoritarian traits usually are more punitive towards those who violate established norms, adhere to traditional values, and identify and submit to powerful figures (Bray & Noble, 1978; Dillehay, 1999; Green, Heilbrun, Fortune, and Nietzel, 2007; Narby, Cutler, & Morgan, 1993). Personality traits may have

been a factor and may explain why the mental health participants attributed more blame to the supervisor and were less believing of his reason explanation than the non-mental health participants who may have been more responsive to the authority figure, who was asserting authority to uphold the law and maintain order in society, than the person with a visible disability.

Gender and race distribution of the participants have to be considered when analyzing the results of this study. Sixty-five percent of the participants were female. When examined further, the gender distribution relative to the mental health participant group and the non-mental health group reveals that the mental health group consisted of 76% females and 14% males while the non-mental health group comprised of 50% females and 50% males.

Recent studies have consistently found that women tend to score higher on empathy measures than men (Albiero, et al., 2009; Davis, 1983; Jolliffe & Farrington, 2006). The findings of this study confirm previous empirical investigations with regard to affective and cognitive empathy. However, when situational factors were entered into the equation the reverse is evident. Men scored higher on the situational empathy measure than females. One can make inferences relative to this finding. It is possible that the males in the non-mental health group aligned themselves with the male police officer in the video segment and the supervisor whereas the larger number of females in the mental health group aligned themselves more closely with the paraplegic rather than the supervisor which may account for greater situational empathy demonstrated by the non-mental health participants.

In summary, the findings in this exploratory study suggests that despite mental health participants evidencing higher levels of general empathy than their non-mental health counterparts, situational variables, specifically the determination whether an individual's actions were deemed to be right or wrong, i.e., the infusion of moral judgment, may play a larger role in understanding the phenomenological experiences of others. These findings are of significance to mental health professionals and counselor education programs.

Implications for Mental Health Professionals

Empathic understanding and the accompanying empathic response is influenced by several variables including internalized prejudices and biases. Prejudice and biases are often outside our conscious awareness and may inadvertently impact the manner in which we are able to enter the phenomenological world of clients. Awareness is one of the three pillars on which multicultural counseling competencies are premised and has application here (see Ivey, Zalaquett, & Bradford Ivey, 2010). It is important for counselors and supervisors to be intentional about becoming aware of their value system, associated moral judgment, and the influence that it may have on demonstrating empathic understanding.

It is evident in this study that judging the police officer's actions as culpable, impacted—perhaps inadvertently—the empathic response of the mental health participants. This has implications for counselors who work with certain categories of the client population such as perpetrators of domestic violence, sex offenders, and other clients who may challenge the counselor's value system. Counselors have to intentionally examine their values and their concomitant moral judgment and be cognizant of how this may

impact the therapeutic alliance when working with a client who is, for example, contemplating abortion for an unwanted pregnancy, or demonstrates ethnocentric and racist tendencies, or may be homophobic, and so forth. The principle here is that professional counselors ought to subscribe to the ethical standards of the American Counseling Association (ACA) of causing no harm and make the necessary referral when it becomes untenable to work with a client (ACA, 2005).

Another important subset of mental health profession is the role that supervisors play in the development of their supervisees. It is important for supervisors to be cognizant of their internalized values system and that of their supervisees and to be aware of how their rigid values or beliefs, and those of their supervisees, may impact the therapeutic alliance with the client and address this where applicable during supervision. It is recommended that the influence of moral judgment be addressed when it arises during supervision and becomes an integral didactic component in the supervisor-supervisee relationship.

Implications for Counselor Education Programs

Researchers have suggested that our value system, especially religious values, may influence our attitudes to gender roles, racism and mental health, which in turn could impact a counselor's ability to be genuine and to demonstrate unconditional positive regard (Balkin, Schlosser, & Levitt, 2009; Duriez & Hutsebaut, 2000; Laythe, Finkel, Bringle, & Kirkpatrick, 2002; Peek, Lowe, & Williams, 1991). In a similar vein, moral judgments which are guided by our value system could impact a counselor's empathic response to their clients. Researchers have examined variables that have explained why moral development accelerates during college years, the transition from what Kohlberg (1984) referred to as conventional to post conventional morality (Cooper & Schwartz, 2007; Deemer, 1989; Derryberry & Thoma, 2000; Rest & Thoma, 1985). These researchers cite longitudinal empirical evidence which suggests that education curricula that highlight and create an environment that fosters discussion about moral issues, plays a significant role in moral development and is correlated with gains in moral development above and beyond that accounted for by maturation.

However, a review of two prominent scholarly resources for counselors reveals a conspicuous absence of research that examines the relationship between moral judgment and empathy. The *Journal of Counseling and Development* for the period 1974-2010 and the *Journal of Counselor Education and Supervision* for the period 1990-2010 yielded no studies that have explored the relationship between these variables. This suggests that even though the concepts empathy and moral judgment may be addressed in counselor education curricula, limited empirical evidence exists that highlights the interactional properties of moral judgment and empathy.

This omission in scholarly input may in part be explained by the burgeoning attention recently in the scholar inquiry to multiculturalism with moral judgment being subsumed under the multicultural banner. Pedersen's (1999) publication of *Multiculturalism the Fourth Force in Psychology* undergirds the value of the counseling professional developing awareness, knowledge and skills when working with clients who may be different relative to race, ethnicity, gender, sexual orientation, religion, class, and so forth. Although moral judgment is integral to the concepts related to multicultural

competency such as *prejudice* and *bias*, it is evident that the attention afforded to this concept has diminished over time.

The emphasis on multicultural competencies in counselor education curricula is logical given the changing demographics in the United States. The author views multicultural competencies and moral judgment as intersecting rather than divergent entities. The findings of this exploratory study suggests that empathic response by counselor trainees in this study may have been impacted by their judgment as to whether the supervisor's actions were deemed to be right or wrong. The data has implications for teaching multicultural competencies because the first step towards developing skills as a culturally competent counselor is to reflect on one's prejudices and biases and to recognize how it may inadvertently influence the empathic understanding of the client's experiences. Prejudices and biases stem from the perception of right or wrong, i.e. making a moral judgment. A beginning step for counselors is to understand their moral value system and see how it may relate to their subjective evaluation of the actions of others. Based on the findings of this study it is recommended that counselor educators who are not specifically addressing the role of moral judgment in the curricula, recognize its value in the education of mental health professionals. On the other hand given the paucity of studies relative to moral judgment, it will be helpful for counselor educators who have integrated moral judgment into their teaching to convey through conference presentations or publications as to how moral judgment is integrated into counseling curricula and outcome measures that evaluate how its inclusion of this concept enhances the knowledge and skills of counselors.

The method used to collect data in this study, the use of a video segment accompanied by step by step information about the case with questions between the steps, is experimental and its efficacy has not been documented in the research and educational literature. Some participants when asked about the case study and the video segment commented that "it was interesting," "different," and "the video made me think in a new way about the case." Further examination of this technique could be useful in determining its efficacy in making concrete aspects of the curriculum that may be abstract to the beginning counseling student. It would particularly useful for the counselor educator to work through real or hypothetical situations, e.g., ethical or clinical dilemmas that the student is likely to encounter as a mental health professional.

Directions for Future Research and Limitations

The findings of this exploratory study which examined the role that moral judgment may play relative to empathy are of significance to counselors, supervisors, counselor trainees and counselor education programs. However it is recommended that the following limitations be addressed by future researchers. First, matching the samples relative to gender and development level may yield different results. Secondly, the sample was restricted to college students in the Midwestern region of the United States. Future research ought to be extended to include a nationally representative sample of participants including practicing counselors who have had various levels of professional experiences, to explore further the maturation effect on levels of empathy and moral judgment.

A video segment and the accompanying scenarios and questionnaires were used in an exploratory sense by the researchers. Future researchers ought to continue to examine the validity and reliability of soliciting data using this format. Qualitative data collection methods in addition to the quantitative measures used in this study is likely to reveal additional information to better understand the feelings and attitudes of the respondents.

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