

Appendix

Discussions on the Measurement of Empathy

(Last updated: December, 2000)

The Measurement of Empathy: Construct Problems

One of the most challenging problems facing empathy research is the measurement of empathy.¹ Conclusions from research using empathy measurement devices continue to contribute to how empathy is integrated into human service training and practice.² Within the last two decades, hundreds of articles have cited using an empathy measurement device as a part of research design. Within these many articles are cited many different empathy measurement devices (many are listed in Table 10).

Table 10: Empathy Measurement Devices

Tests that include scores for empathy

Barrett-Lennard Relationship Inventory³

California Psychological Inventory*

Caring Relationship Inventory*

Cardall Test of Practical Judgment*

Communication Response Styles Assessment Purpose*

Comprehensive Personality Profile*

Individual Effectiveness Analysis*

Personal Style Assessment*

Relationship Questionnaire⁴

Sorenson's Relationship Questionnaire⁵

* see reference ⁶

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Tests designed for the measurement of empathy

Accurate Empathy Scale⁷

Carkhuff's Empathic Understanding in Interprocess Scale⁸

Empathic Understanding Scale of the BLRI⁹

Empathy Construct Rating Scale¹⁰

Empathy Test¹¹

Hogan Empathy Scale¹²

Hornblow's General Empathy rating¹³

Interpersonal Reactivity Index¹⁴

Kagan's Affective Sensitivity Scale¹⁵

Questionnaire Measure of Emotional Empathy¹⁶

Empathy measurement approaches can be divided into six categories including observer ratings, client perceptions, tests predicting empathy and tests that are designed to evoke and then measure empathy.¹⁷ In addition there is research focusing on the physiological measures of empathy.¹⁸

These varied measurement approaches include a variety of different empathy measurement devices (see Table 10). Of these, the two most widely used¹⁹ are Barrett-Lennard Relationship Inventory, BLRI²⁰ (Table 11), and Carkhuff's Empathic Understanding in

Table 11: The Empathy Subscale of the Barrett-Lennard Relationship Inventory²¹

1. She/he tries to see things through my eyes.
2. She/he understands my words but not the way I feel.
3. She/he is interested in knowing what my experiences mean to me.
4. She/he nearly always knows exactly what I mean.
5. At times she jumps to the conclusion that I feel more concerned about something than I actually do.

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6. Sometimes she/he thinks that I feel a certain way because she/he feels that way.
7. She/he understands me.
8. Her/his own attitudes toward some of the things I say, or do, stop her/him from really understanding me.
9. She/he understands me.
10. She/he appreciates what my experiences feel like to me.
11. She/he does not realize how strongly I feel about some of the things we discuss.
12. She/he responds to me mechanically.
13. She/he usually understands all of what I say to him/her.
14. When I do not say what I mean at all clearly, she/he still understands me.
15. She/he tries to understand me from her/his own point of view.
16. She/he can be deeply and fully aware of my most painful feelings without being distressed or burdened by them herself/himself.

The respondent is asked to mark each of the above statements according to how strongly the statements according to how strongly the statement was felt to be true or untrue:

- +3 I strongly feel that it is true.
- +2 I feel it is true.
- +1 I feel that it is probably true, or more true than untrue.
- 1 I feel that it is probably untrue, or more untrue than true.
- 2 I feel that it is not true.
- 3 I strongly feel that it is not true.

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Interpersonal Process Scale²² (Table 12). These various empathy measures can be grouped into two categories: objective or subjective, i.e., rated by an external observer or self-reported.²³ The Barrett-Lennard Relationship Inventory and Carkhuff's Empathic Understanding in Interpersonal Process Scale are representative of these two categories.

Overview of Strengths and Limitations of Empathy Measurement Devices

A review of empathy research that discusses the “obstacles that may account for theoretical confusions and empirical difficulties” suggests that the confusion in empathy research is related to the wide variation in empathy definitions.²⁴ In addition, regarding the two empathy measures mentioned, “these measures were designed to assess the degree to which the therapist temporarily “lives” in the client’s view” However, the validity of such self-report, client-report, or observer-report methods is questionable”.²⁵ There are questions surrounding application of the empirical approach to empathy, and to advanced empathy, research.

Table 12: The Carkhuff Empathic Understanding in Interpersonal Process Scale²⁶

Level 1	The verbal and behavioral expressions of the helper either do not attend to or detract significantly from the verbal and behavioral expressions of the helpee(s) in that they communicate significantly less of the helpee’s feelings and experiences than the helpee has communicated himself.
Level 2	While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he subtracts noticeable affect from the communications of the helpee.

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- Level 3 The expressions of the helper in response to the expressions of the helpee(s) are essentially interchangeable with those of the helpee in that they express essentially the same affect and meaning.
- Level 4 The responses of the helper add noticeably to the expressions of the helpee(s) in such a way as to express feelings a level deeper than the helpee was able to express himself.
- Level 5 The helper's responses add significantly to the feeling and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings levels below what the helpee himself was able to express or, in the event of ongoing, deep self-exploration on the helpee's part, to be fully with him in his deepest moments.

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Table 13: Some Applications of the BLRI

<u>Measuring the...</u>	<u>Methods</u>	<u>Results</u>
Relationship between practitioner accurate empathy and clients view of understanding ²⁷	Coached clients, trainees, audiotaped, judges rate tapes, clients evaluate session.	No significant relationship
Relationship between practitioner confidence and clients view of empathic understanding	Trained practitioners audiotaped, judges rate tape, clients evaluate session ²⁸	Linear relationship
Relationship between nursing and empathy ²⁹	Simulated clients, nurse trainees, audiotaped interviews rated by judges (Carkhuff Scale), trainees self evaluate	Relationship between training and measured empathy
Relationship between trainee's perception of supervisor empathy and trainee empathy toward clients ³⁰	Trained supervisors, practitioner trainees, taped sessions, judges rate sessions (Carkhuff Scale) trainees evaluate super.	No significant relationship.
Differences between initial and ongoing therapy sessions ³¹	Sessions recorded and analyzed, clients and therapists complete BLRI	Ongoing clients rated higher levels of empathy than did

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		initial
Relationship between four measures of empathy ³²	Form completed by nurses and trainees after interview with simulated client	The BLRI correlated with one other measure
Relationship between dropping out of therapy and client perceptions ³³	Clients complete BLRI	Dropouts see their practitioners more negatively
Relationship between students cognitive beliefs and their perceptions of therapy ³⁴	Students complete BLRI after viewing Rogers' Gloria film	Belief systems were related to variation in the BLRI measures
Effects of non-verbal mirroring on empathy ³⁵	Trained practitioners videotaped, judged by raters.	mirroring of non-verbals enhances empathy.
Differences between successful and unsuccessful couples in therapy ³⁶	Clients complete BLRI	Successful couples had a higher level of positive regard at the start of therapy

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Table 14: Some applications of the Carkhuff Empathic Understanding in Interpersonal Process Scale

<u>Measuring the...</u>	<u>Methods</u>	<u>Results</u>
Relationship between training, supervision conditions and practitioner trainee empathy ³⁷	Trainees respond to taped actor clients, supervisors provide feedback, responses were rated	Modeling with didactic supervision showed highest increase in empathy
Relationship between trainees rated accurate empathy and client's empathic understanding	Judges rate audio tapes of trainees with coached clients ³⁸	No relationship
Relationship between modeling/instruction and practitioner empathy ³⁹	Judges rate audiotapes and written responses of pastoral practitioners to simulate clients	Relationship between training and practitioner empathy
Relationship between supervisor empathy and trainee empathy ⁴⁰	Judges rate audiotapes of supervision and trainee sessions	No relationship
Relationship between training and empathy for nursing students ⁴¹	Nurse trainee interviews audiotaped and rated by judges	Modeling helped some students and rehearsal helped all improve empathy
Relationship between training and school teacher	Observers rate teachers classroom instruction before and after	Positive relationship between training

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empathy ⁴²	training	and teacher empathy
Relationship between supervision and practitioner trainee empathy ⁴³	Recorded trainees responses (tapped and written) to videotaped actors, judges rated	Low level empathy trainees benefit from didactic supervision, high level from experiential
Relationship between training and practitioner trainee empathy ⁴⁴	Judges rate taped counseling sessions by trainee	Positive relationship between training and practitioner empathy
Relationship between Myers-Briggs Type indicator and level of empathic response ⁴⁵	Trainees provide written responses to filmed actor clients, judges rate	Thinking-Feeling (high feeling) correlated with high empathy ratings
Relationship between student self reports of helping behaviors to their interview skills ⁴⁶	Judges rate videotapes of student interviews	Empathy correlated with other measures

The pros and cons of self report rated measures of empathy are that they are easy to administer and provide a “relatively differentiated measure of emotion”⁴⁷ but they also assume that participants know what they are feeling and that they can accurately report on that experience.⁴⁸ It was mentioned in this document that describing the empathy experience is difficult, for both practitioner and participant. Asking them to then narrow that description to fit into a measurement device may not only place the validity of the device in question, but question our framing of empathy as a person centered process whose interpretation should be explored, not simply measured. These pro and

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con statements reflect some of the strengths and weaknesses of the BLRI and the Carkhuff scales. The BLRI and the Carkhuff scales have each demonstrated substantial reliability. Reliability is necessary for validity but not sufficient.⁴⁹ The validity of an instrument is affected by how well the instrument measures what it purports to measure.

In this instance, there is some question about these two measures, both developed based upon Rogers' theories about empathy, and their ability to measure empathy as defined when the instruments were developed. If one uses the empathy definition provided herein then the question of whether these instruments measure empathy, as defined, becomes more problematic.

In addition, validity "is also affected by the situation in which it is determined. For example, a particular rating scale may be a good predictor or criterion measure of performance in a training program but not of actual on-the-job behavior".⁵⁰ Most of the applications and studies using these measures have been in training situations (Tables 13 and 14). What they may be measuring is effective delivery of counseling microskills⁵¹ as opposed to the concept of therapeutic empathy as defined in this document. The clinical significance and application of research done only in training situations is questionable.

The BLRI and the Carkhuff Scales are frequently applied within a research design using actors (live or filmed), simulated clients, written responses, audiotapes and videotapes (see Tables 13 and 14). This artificiality delivered in the name of scientific variable control may be moving us away from, rather than toward, an understanding of therapeutic empathy. It is well known that a gap exists between therapy research and therapy practice.⁵² "Practicing clinicians contribute very little to the research base of clinical psychology."⁵³ The clinician and the researcher bring different views to the study of the therapeutic relationship. "It is neither inadvertent nor tendentious that a relationship develops in which therapists are "insiders" and researchers are skeptical "outsiders"... from the moment outsiders

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start looking at what goes on in psychotherapy, they are likely to see a great deal that the clinician over looks and to miss a great deal of what the clinician sees.”⁵⁴ Research from the view point of the skilled practitioner, as the insider, can add insights about the healing nature of empathy which are not provided by the measurement research designed by research oriented outsiders. The focus of this document has been on providing such an insider’s point of view.

“In sum, although a considerable amount of effort has been devoted to assessing empathy, valid measures are still lacking. Gaps between how empathy is defined and measured often exist, particularly in assessment of empathy in therapy. Problems appear to exist at both a theoretical and methodological level.... Moreover, because of the limitations of human perceptions, the traditional scale approach seems inadequate in tapping into empathy when it is defined as an inner experience (cognitive or affective) or a sequence of experiences (inner and outward).”⁵⁵

It is not clear how the instruments described herein fit within the growing consensus that empathy is a multidimensional construct.⁵⁶ Paper-and-pencil tests are inadequate for measuring the diverse range of phenomena included within the multidimensional empathy construct.⁵⁷ “Given that so many varied functional elements contribute to the empathic process, it is difficult to speak of a single capacity to empathize.”⁵⁸

“Lack of consensus on the means of measuring empathy has blocked the progress of research into the effects of the professional’s use of empathy in professional-client interaction on the subsequent well being of the client. Until this obstacle is surmounted research in this area of professional practice will lag.”⁵⁹

“...There is much to be said for using self reports. As long as we do not take their answers at face value, we may be

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able to learn more about what people are feeling simply by asking them.”⁶⁰

This simply “asking people” about their experiences, should be done in a naturalistic setting, by an insider who can bring an experienced “healer’s” perspective to the research on advanced empathy. This is what has been offered in this document.

Reflections on the Measurement of Halopathy

Although scales of empathy measurement exist they are not adequate for addressing the nature of the phenomena associated with the halopathy and the healing relationship. Using measurement devices within the design of a research experiment for ferreting out the nature of halopathy as applied in treatment would be premature. We do not have enough information about what halopathy might look like when it is applied in a naturalistic setting. A perusal of the literature indicates that with exception of some of the basic empathy traits, characteristics associated with advanced forms of empathy are virtually absent from the design of empathy measurement and yet it is these characteristics that may be a critical part of the therapeutic healing success. What has been presented in this document is a detailed portrait of advanced forms of empathy, described within naturalistic settings, in an effort to advance the research being done on empathy. Empathy research is needed which provides for practitioners a description of halopathy and the healing relationship before any measurement tools can be developed to assess the relationship between various types of empathic experiences and treatment outcome. It is hoped that this document will set the foundation for future research.

Appendix

The Question of Good Science

(Last updated: December, 2002)

The basic assumptions guiding this document describing halopathy within the healing relationship are as follows:

- Empathy is a broadly (although not universally) accepted construct.
- Some people seem to have better empathy skills than others.
- If you practice empathy you may be able to demonstrate advanced empathy skills, as some “expert” practitioners have been reported to do.

These advanced empathy skills are here termed advanced empathy and halopathy. There is very little literature describing these terms, but advanced empathy may be important to all educators of human service practitioners as a model of what to become – healer practitioners.

If, as professional who provide training, we are to promote ourselves as teachers of empathy, if we are to say that we are sending out students who can practice empathy, then we need to have an understanding of what it means to be a skilled practitioner of empathy. A rich and detailed description of the skilled empathy practitioner is presented in this document. In addition, if we hope that our students, while serving in some human service capacity, will practice empathy then they should know what it might look like to become a skilled practitioner of empathy. For those who have the

proclivity, they could use a model of progressive empathy skill development to map out their own course to becoming a skilled empathy practitioner (applicable to almost any human service domain), a facilitator of the healing relationship.

This research has proposed a model describing progressive development of empathy. Many components of the model are described in the published literature, with the exception of advanced empathy and halopathy. At this point in the research there is some suggestion from the literature that there are practitioners of advanced empathy and that they exist across cultures. Published quotes, cited within Chapter Two, provide us with a glimpse into the nature of halopathy, but not a detailed view of the inner sense of the experience.

The goal of this research has been to provide a detailed description of advanced empathy, in particular halopathy, as part of a model for the development, and training, of empathic abilities. There are methodological problems facing the researcher attempting to acquire a description of these proposed advanced empathy skills. In searching for methods that can achieve this goal the question of ‘good science’ needs to be addressed. This chapter will address both the question of what methods could be used to acquire a rich description of halopathy and the question of ‘good science’ as it pertains to this research project. The discussion of these matters will proceed as follows: 1) the nature of ‘cutting edge’ research, 2) the search for an appropriate research orientation, 3) an examination of possible methods, and 4) steps to prevent the influence of excessive bias.

The Nature of ‘Cutting Edge’ Research

This research is attempting to describe a phenomenon that is hypothesized in a model, and alluded to by published observations and reports of others. Upon its initial appearances the possibility of a ‘oneness’, or holistic, connection between two persons for the

purpose of promoting healing seems to skirt the edges of common sense. Most of us do not have any framework upon which we might come to understand such a deep moment of flow between two people that precipitates healing. The absence of published professional literature that can serve as a reference point and the absence of a common folk psychology reference point means that the researcher has to create personal reference points and then build the case for the existence of halopathy. But the problem is that in building this case we run out of building materials and have to create new ones.

New discoveries in science, cutting edge research that pushes the envelope beyond what is already established and accepted as science, always presents problems different than standard research.¹ What often happens in crossing the boundary into new areas of science is that the existing science does not have the language necessary to describe all the features found to be associated with the how the new science describes reality (examples of this include quantum mechanics, Darwin's theory, and plate tectonics). This is true in this study. There is no existing vocabulary to describe the empathic oneness experience. So several terms have been presented in this research in an effort to improve the discourse about this possible phenomenon.

In the presentation of any cutting edge idea one needs to be persuasive with language.² Breakthroughs in science are built upon a foundation of existing information and that this information is necessary for communicating the nature of the new ideas to the world.³ This author has built upon acceptable constructs (empathy, developmental theory) and proposed a new construct (halopathy). The model of halopathy has been built upon learning development theory, the concept of empathy, common sense observations and reported observations of skilled practitioners. Yet even with this foundation the idea of empathy is very hard to grasp.

This hard to grasp aspect is also the nature of 'cutting edge' research because such research offers a new paradigm and as such it

offers a new way of looking at the reality we have always seen. The new paradigm is developed because it is recognized “that something has gone wrong with the existing knowledge and beliefs.”⁴ The new paradigm is created because the old paradigms do not adequately account for all the reported observations that fall within the domain covered by paradigm. This is true in this study. The old models describing empathy do not account for all the reported phenomena. The new model presented herein attempts to describe the full range of empathy experiences, accounts for the disparity in published descriptions, and possibly can be used to further research in the field of empathy by clarifying the type of empathy one is doing research on and for what purpose. Furthermore the new model may help to serve as a guide for students with empathic talents where no such guide existed previously.

Before entering human service work I was employed as a research scientist in an oil company with an emphasis on model development. The difficulties a researcher faces when doing ‘cutting edge’ research is that because a new paradigm is being offered it has yet to stand the test of empirical scrutiny across multiple domains. This means there is a seldom large amount of data to support the new paradigm and the new models. In the early stages of model development much of the argument is based on a preliminary exposure of patterns hidden in existing information. An important part of the researcher’s stance while doing such exploratory investigations is the role of the heuristic scientist looking for a rich description of the phenomenon under study:

“The heuristic scientist seeks to discover the nature and meaning of the phenomenon itself and to illuminate it from direct first-person accounts of individuals who have directly encountered the phenomenon in experience...The focus in a heuristic quest is on re-creation of the lived experience, full and complete depictions of the experience from the frame of reference of the experiencing person”⁵

Attempting to discover a rich description of the halopathic experience requires a “re-creation” of the lived experience. This approach has been included within the design of this research. Further discussions on the role of the hermeneutics, as applied to this research, are addressed at the end of Chapter Four.

The Search for an Appropriate Research Orientation

When venturing into previously unexplored scientific territory to design a new model the orientation is different than one where you set up experiments to test certain aspects of a hypothesis. At this very early stage of ‘cutting edge’ research there is not a hypothesis. There is not a theory. Instead there are only ideas, some of which are loosely held together in a model. The orientation of this research is two fold, one to present a model that provides an explanation for existing information, and two, to use a pilot study that will elaborate (or refute) the model.

The orientation used within this ‘cutting edge’ research project is mostly interpretive with no goal of ‘proof’ but rather a goal of elucidation. This is a distinction that needs to be part of the research design. The researcher has an idea that something beyond the folk psychology knowing of empathy is being, has been, practiced. He also has the idea that it promotes well being. Beyond that he has no other ideas related to the detailed nature of how others might report on this phenomenon. He is not even sure that others can report about it, in any detail. There is no goal of trying to prove that such a phenomenon exists but rather to acquire rich descriptions of the phenomenon from others. The purpose of trying to find these rich descriptions is to elaborate (or refute) the model. This is definitely theory-dependent (or model-dependent) research but it is not proof dependent.

The central reason for the focus on description and interpretation with ‘cutting edge’ research is that there is not enough

known about the phenomenon being studied (in this case halopathy) to be able to design empirical research. We are not sure that the phenomena are represented in reality. It is much like cutting edge research in the physical sciences. A scientist proposes that dark matter, or gamma ray bursts, exist in the universe or that the continents are part of a network of shifting plates covering the Earth. Then the scientist seeks to document observations related to effects that could be attributed to these phenomena. At first the observations are few, and the supportive documentation limited. Early research in electricity, magnetism, gravity and quantum mechanics has followed similar lines. Geology, often an explanatory science, frequently follows these lines of inquiry. Plate tectonics started as an idea in need of observations to support it and it took many years to collect those effect observations (we still have only interpretations regarding the causal process for plate movement).

‘Cutting edge’ research is, by design, aimed at providing descriptions of previously unknown, or poor described, phenomena. There is some question whether the empirical guidelines used to evaluate ‘good science’ can be applied to research in this early stage of development⁶ and if doing so threatens the creative process needed for the development of new paradigms.⁷

One of the empirical guidelines for ‘good science’ has been study of observable phenomena. Empathy is not directly observable, although one may be a witness to its effects. This observation of effects has been a component of ‘good science’ even when we could not observe the causal processes. We do not know the causal processes of gravity, but from our knowledge about its effects we can predict causal relations. We may not be able to know the causal processes of halopathy (or other forms of empathy). Any suggestion regarding cause (underlying process) is interpretive, as it is with respect to phenomena like gravity or magnetism. But we can know about the effects that might be attributed to the phenomenon. This is the focus of this study, to describe the effects that might be attributed to advanced forms of empathy.

‘Good science’ is also evaluated using the concept of the falsifiable hypothesis.⁸ But not all hypotheses are immediately falsifiable because we may lack the knowledge to know what to test or how to test the falsifiable statement.⁹ The developmental model of empathy described herein proposes advanced forms of empathy. It is also proposed that there are effects associated with these advanced forms of empathy, but that we do not have a clear description of these effects. Without the description one is faced with trying to write a falsifiable statement about a hypothetical unobservable phenomenon that has no description. With a clear description of the effects that might be associated with halopathy one can develop a falsifiable statement.

Another criteria frequently applied to the critique of ‘good science’ is one of explanatory success.¹⁰ This is an important part of cutting edge research in that a new paradigm is proposed because it purports to provide an improved explanation.¹¹ The empathy developmental model presented includes a broad range of empathy descriptors and explains the disparity in published empathy definitions with greater explanatory success than had previously been available. The model’s success for predicting causal relations as a part of its explanatory success (e.g., a predictable event sequence tied to the six characteristics of the healing relationship) will have to await further research.

The completion of the model awaits a detailed description of the effects that could be attributed to halopathy. The orientation of this research is one of discovery. There is a delicate balance between the framework of the model (theory-dependent) and the openness of the researcher to accept (and document) anomalies that might not fit the researcher’s present view (limiting excessive bias). The orientation is not toward trying to prove that halopathy exists, but rather to explore sources of information to see if there are descriptors that collectively might fit the hypothetical description of halopathy. In addition, during the search for these possible

halopathy effect descriptors, the researcher needs to remain open to alternative interpretations of the reported effects (this is discussed in Chapter Four). The research orientation also includes a focus on acquiring a detailed description of the reported effect – to the exclusion of other research avenues (biographical, ethnographical, philosophical, religious). The pros and cons of this purposefully focused view are presented at the end of Chapter Three.

The Insider View: “Alienating Distanciation versus Participatory Belonging”

Because the focus of this study is on getting a detailed description of the effects possibly associated with the halopathy event it is doubtful that such a description could be obtained using the outsider view of “alienating distanciation” versus the insider view of “participatory belonging”.¹² The view of the outside observer to the therapeutic relationship is that “much of what takes place between therapist and client may seem to be very much like a social conversation.”¹³ But the view from inside the halopathic relationship is likely to be quite different. It is proposed here that the insider view can provide access to the rich description needed for the purposes of this research.

Shamanic folk healers in Europe have been studied using the outsider perspective and what was missing from the research was a rich description that the “insider way” could have provided.¹⁴ “Although researchers have studied the tradition [of indigenous healing] for decades, most of them observed and reported on it without any personal experience.”¹⁵ Because of this lack of personal experience, not having the insider view, there was an absence of rich detail in their published work. The ethnologist, Holger Kalweit, said that when he gave up the detached view of the ethnographer and allowed himself to join with the healer he could “enter into his state of mind, experience in sympathy with him.”¹⁶ He also stated that what ethnologists have missed in the study of tribal healers is a

“genuine, intimate, friendly contact with shamans, they have neglected to truly enter into the worldview of the shaman.”¹⁷ With this insider perspective he was able to write a review of indigenous healer’s that has a perspective not found in other writings on the same topic. Dr. Kakar, a psychoanalyst, in an observational study of healers in India, attempted to draw some parallels between Eastern and Western healing practices, but stated that he was very much aware of the rift between himself and the indigenous healers and said “this gulf made me doubt whether the significance of their healing efforts could ever be fully grasped.”¹⁸ Researchers standing on the outside of healing practices, reporting what is observed, provide a certain descriptive perspective, which often focuses on techniques, practices, and the reports of “cures”.¹⁹ Medical anthropology has begun to recognize the importance of the insider view to gaining a richer understanding of the healing process²⁰ but has yet to apply it to studies of the empathic healing relationship.

The concept that distant viewing is somehow equal to credibility needs to be examined when one is studying empathy. Standing outside and viewing some object (or relationship) may give certain types of research more credibility but when one is seeking to describe details of advanced empathy it is difficult to acquire a rich understanding from such a distant perspective. The research orientation of maintaining distance has entered into all aspect of human service following the scientific model of care, but as we implement such an orientation in pursuit of ‘credibility’ we also distance ourselves from empathy, turning people into objects (diseases, diagnoses, disabilities).²¹ Seeking a detailed description of halopathy with such a distance orientation seems unlikely to be successful. The insider’s view, using participatory belonging, is more likely to be successful in attaining a rich description.

The importance of the insider view in research can also be described as: “one must not only be one in order to understand one; one must also be one in order to understand what is most worth understanding.”²² The insider professes to be a member of a group

of persons who have “privileged access” to certain kinds of knowledge and thus have knowledge of what is most worth understanding within that given inquiry. But the division between insider and outsider is not constant.²³ The insider perspective provides the researcher with historical information on the nature of the phenomenon being studied - both in terms of personal experience and from previous research. Yet the researcher is still an outsider when it comes to fully entering the world of another who is part of the new phenomenon under examination.

The researcher does not maintain a continual focus of attention, during the entire research endeavor, using only the insider view. “Insider and Outsider perspectives can converge through reciprocal adoption of ideas and the developing of complementary and overlapping foci of attention”²⁴ At many stages in the research the researcher enters into the insider view, sharing that view with the informants, in order to obtain a richer and deeper understanding of the phenomena under investigation. At other times the researcher steps back from the research and attempts a more objective stance, particularly when writing about the findings. This shifting from the insider to the outsider perspective is similar to what a counselor might do, at one moment being one with the client, and then at another moment objectively reflecting on the findings of that moment.

Therapeutic empathy, by definition, is a relationship between two people. Standing outside this relationship and making observations provides information different from can be observed from within the relationship. “Empathy can be conceived of only inadequately as an intrapsychic process, that both analyst and analysand contribute to it in meaningful ways.”²⁵ During this mutual process “analyst and patient develop a ‘private language’ of allusion, cryptic references, symbolic gestures and other forms of privileged communication to which outsiders have no access.”²⁶ Outsiders cannot have access to the deep inner working of an empathic meeting due to the privileged nature of the communication. This gap

between the knowledge provided by the outsider versus the insider view widens as the nature of empathic communication becomes more privileged, as it is likely to do with advanced forms of empathy. The outsider view used by past researchers has failed in obtaining a rich description of advanced empathy. The pilot study used in this research incorporates the insider view, as it seems most likely to obtain a rich description of the halopathic experience.

Because the halopathic experience is defined as a “holistic empathy” experience, or a moment of empathic oneness, it likely contains components that can be understood more fully through direct experience. This is the nature of the oneness moment, that is, there are components of the moment that cannot be understood using the outsider view. There are aspects of the experience that can only be known through having shared the experience. This is the insider perspective obtained from “getting inside the process”. The researcher who is seeking to understand the rich details of the healing halopathic experience can help to obtain a rich description of that experience by being a part of it. Furthermore, if the researcher has had such experience then s/he may have some knowledge of the difficulties informants would face in trying to describe the ‘oneness’ event. The “insider view” not only allows the researcher greater insight, it also helps the informants to feel more comfortable in describing what they experienced (which creates conditions for a rich description to be revealed).

The insider view has been incorporated within the pilot study used for this research. This researcher has selected the position of viewing advanced empathy from inside the relationship as opposed to being an “objective observer” in order to facilitate the acquisition of a rich description of the effects possibly attributed to halopathy. This insider orientation will be incorporated into any ‘cutting edge’ modification of methods that need to occur in order to get at the central focal point of a new paradigm offered in this research – the description of possible halopathy effects.

The new paradigm containing halopathy is likely to be difficult to grasp. It asks us to think about empathy in new ways, to reformulate how we previously mapped the boundaries of our reality.

“Paradigms provide scientists not only with a map but also with some of the directions for map making... When paradigms change there are usually significant shifts in the criteria determining the legitimacy both of the problems and of the proposed solutions.”²⁷

In this study a new paradigm is being presented and with that new paradigm come questions about the legitimacy of this research topic (a proposed phenomenon called halopathy) and the methods used (which had to be modified from conventional methods in order to address the topic). This is the usual course for ‘cutting edge’ research.

An Examination of Possible Methods

In addition to the philosophical guidelines presented above, asking the question of ‘good science’ also means asking if the methods used to describe the reported effects (in this study those hypothesized to be related to halopathy) fall within the purview of ‘good science’.

This research is focused on describing halopathy, a suggested form of advanced empathy. Empathy research might be best served by qualitative studies that examine the processes involved within an empathic therapeutic relationship.²⁸ “What seems to be lacking are studies of empathy in naturalistic settings.”²⁹ Empathy research is needed that is “more context-sensitive.”³⁰ In addition, “there is very little in the psychoanalytic literature on the experience of the person who is the “object” of empathy.”³¹ In addition to these problems with the existing empathy research, there is almost no research on

advanced level of empathy, such as halopathy. The pilot study presented here examines the processes associated with halopathy, in a naturalistic setting, while presenting the voice of the person who is the object of empathy.

The research explored within the pilot study is focused on describing the nature of a particular set of phenomena associated with how participants experience halopathy. Research that is descriptive can be placed under the qualitative umbrella.³²

“When a phenomenon is new or has not been explored previously, hypothesis formation may be premature until more is known. Qualitative methods are ideal for exploratory studies.”³³

This ‘cutting edge’ research, aimed at exploring a new phenomenon (halopathy), uses qualitative methods in an attempt to discover a rich description of the phenomenon’s effects.

The ways that qualitative researchers would likely pursue this research topic are that they would interview practitioners who have experienced the phenomenon and/or interview participants who claim to have experienced the phenomenon. Since this is ‘cutting edge’ research and the aim of this research is to obtain an in-depth description of halopathy effects both of these approaches have limitations.

Practitioners with the talent of helping people move through suffering and into well being have historically been the informants in qualitative research,³⁴ as discussed in Chapter Two. And, as presented previously, there are glimpses of possible halopathy effects in some of this information, but there is nowhere to be found a detailed description of how the participant (client) describes the effects of the experience. The glaring absence of this description from hundreds of qualitative studies that have included interviews with practitioners is because the methodology does not allow such a

detailed description to become easily revealed in the discourse, or observed in the behavior.

The frontier nature of this work suggests that research being done on phenomena that are not part of common knowledge, and for which there is not common descriptive language, that are based initially upon a model, often require communication about that model prior to being able to engage in discourse. Simply introducing the research question, or the focus of inquiry, to a potential informant, introduces bias. There is no way around this problem. The phenomena in question have to be introduced in order to acquire from the informant a detailed description of its effects. This research is already very theory-dependent and introducing such theory bias into the interview with informants introduces unacceptable bias. This is not an appropriate methodology for this research study. The distance observation approach for this study will not work because this is 'cutting edge' research and because a detailed description is needed.

Another possible methodological approach would involve the observation of persons who are participants in the halopathy process. Such information would be a welcome addition as there is very little published work containing any voice except that of the practitioner and the researcher.

Acquiring a description of possible halopathy effects from a participant other than the practitioner is methodologically problematic. First the researcher is faced with the same problems of introduced theory-dependent bias that will occur when the researcher is trying to interview practitioners – with the same potential of having unacceptable bias. Second, the researcher is faced with locating participants who have experienced these effects.

This issue of locating participants is not just a matter of convenience. It is also an issue of agreeing upon definitions and addressing the influence of memory decay. To locate participants

the researcher must find people who know participants who may have experienced these similar phenomena. This entails providing information to practitioners about the nature of the experience in question so that participants can be located. This raises the question of whether the practitioner's definition of the experience corresponds to the phenomena serving as the focal point of this study. Since this is 'cutting edge research' it is difficult to get agreement on terms without introducing some basic definitions. This introduction of language can help to find participants who may have experienced halopathy but it also may introduce the bias of having the participants shape their description of the experience to fit the definition provided. In addition there is likely to be some time gap between when the experience occurred and when the researcher does the interview. What happens to the rich details of the oneness experience during this time gap is a matter for interpretation, but if the bias of definition is introduced into the gap then nature of how one interprets, and describes, the experience may be altered. Standing outside the participant's involvement with a probable halopathy experience, and trying to acquire a rich description if it, months or years later does not fit the focus of this research, which is to acquire a rich description of the halopathy experience.

The aim of this research is not to duplicate the inadequacies of past methodologies, but to apply a new approach that will yield a rich description of the phenomena in question. The pilot study is designed with the purpose of adding more to the description of halopathy while simultaneously limiting theory dependent bias.

The Pilot Study

In order for the pilot study to yield a detailed description of the effects that might be associated with halopathy, and fall within the purview of 'good science', it should meet the following design criteria:

Good Science?

- 1) The pilot study should try to limit the effects of memory decay in order to acquire a rich description through a 're-lived experience'.
- 2) The pilot study should incorporate the insider perspective.
- 3) The pilot study should take steps to minimize the effects of theory-dependence within the pilot study.
- 4) The pilot study should provide the best opportunity for informants to present a rich description of the possible effects associated with halopathy.
- 5) The pilot study should closely duplicate a naturalistic setting.

The importance of each of these points, except the last, has been presented in the above discussions. Naturalistic, in this study, would refer to any natural setting in which one might anticipate the natural occurrence of halopathy as part of the regular course of human interaction. If a pilot study were designed to meet each of these points then it may also meet the purpose of this study while also meeting the criteria of 'good science'.

Each of the five design criteria can be incorporated into a pilot study but it will require some modification of the 'normal' qualitative methodology. As pointed out earlier, it is not uncommon for 'cutting edge' research to use modifications in methodology. Such modifications are done because the existing methodology cannot be used to achieve the goal of the proposed research. The modifications needed for this pilot study have introduced other potential sources of bias and these will be addressed later in this chapter.

Good Science?

In the pilot study informants will be used to acquire reports of the effects possibly related to halopathy. These informants will have had experienced a possible halopathy experience within one month to two months of the interview. The possible halopathy experience will have occurred in a naturalistic setting, similar to a therapy session. The person serving as the interviewer will have an insider's view. Finally, and perhaps most importantly, the informants will be given no information about the empathy development model, about advanced empathy, about halopathy, or about how they should report on the experience – except to describe it in rich detail. The interviews will be structured with the focus of garnering a rich description of their experiences but without interfering in the informants' freedom to describe the experience.

In order to accomplish these design criteria the researcher chose to interview past students who had possibly experienced halopathy with the researcher. This methodological modification, controversial as it might appear, was able to meet the design criteria. Informants could be interviewed within one to two months of their experience. The experience occurred within a naturalistic setting – the simulation of a therapy session. The person who did the interviews used the insider's view, not with respect to the general nature of the phenomena, but also to the specific experiences of the informants. And, most importantly, no introduction was needed to communicate about the experience thus minimizing the bias of theory-dependence. What is being reported upon, and then examined, is an experience without the attached theory of this author.

The field of human services has many examples where researchers, during the early pioneer phases of their research used subjects of familiarity: Carl Jung used his cousin as part of his Ph.D. research, Piaget used his children, Freud used his clients, and researchers in psychology often use college psychology students. Several published qualitative studies contain features similar to those

proposed for this research, in that an insiders view is part of the research.³⁵

David Karp, in his book “Speaking of Sadness”, brings into the study his own background as a person with depression. He is an insider. His insider perspective does not drown out the voices of the clients with depression, but instead his insights add richness to the book and to our understanding. David Karp’s study of people with depression also exemplifies this tapestry of weaving informant’s quotes with background literature in a very readable style.

Arthur Kleinman’s book “The Illness Narratives” is a psychiatrist’s presentation of patients who present themselves as chronically ill. His book contains many descriptions from clients and interviews with other practitioners who treat the chronically ill. But the book also contains Kleinman’s wisdom, his personal and professional reflections, drawn from his years of experience as a practitioner. In one sense, he is an insider to the process of hearing the illness narrative. This insider position adds a rich detail to his work that might not have been present if he had written from another point of view. Dr. Kleinman stated, “A text has meaning through what it has to say, but also through the wider context of associations it opens for the reader.”³⁶ The wisdom of Kleinman’s years of experience helps to make these associations and thus broadens the impact of his work.

Constructing a work that is fluid, easy to read, yet also representing ground-breaking research contributing to the human service professions, is challenging. Perhaps this research will shed some light on a principle important to all human life – the relationship that heals - and provide useful information to all those working in the role of human service provider.

Steps Taken to Limit the Possibility of Excessive Bias

Researcher always introduce bias into their projects through how researchers chooses to ask the research questions, collect data, sample that data, choose research methods and then interpret results. In qualitative research the sampling is done purposefully to ferret out a rich description of a particular phenomenon (in this case halopathy). The risk of bias increases with such a narrow and select sampling process. When the researcher is also a participant in the phenomena being investigated, it is obvious that such an insider view further increases the potential of researcher bias having undue influence on what is presented to the reader. The perception of undue influence is further enhanced by the necessity to present, in this text, the insider view from the point of the therapist involved in the halopathic relationship with the informants.

The problem is not that bias exists but that it may have undue influence, that the researcher's bias exerted such influence as to prevent other significant, and possibly more credible, interpretations from being presented. Due to this undue influence the informant's stories were not presented accurately, the dominant themes were not defined, and the meaning-making processes were not clearly discussed. The researcher had a particular point of view, an agenda, which needed to be presented that subjugated all other viewpoints. The risks of the using the insider view are that such effects due to undue researcher bias will be introduced into the study.

In an attempt to decrease some of the potential problems of researcher bias this researcher included the following as part of this study:

- 1) During the interviews the researcher purposefully switched from the role of counselor to the role of researcher, and announced this switch to the informants. Such a switch involved a change in the orientation of how the researcher interacted with the informant and the subject material –

moving to a less involved and a more objective stance. It was discovered after the very first informant interview that without a clear role distinction between counselor and researcher both the interviewer and the informant can become confused regarding the purpose of the conversation. Prior to the second interview the researcher took the natural stance that most interviewers would when asking another person about their relationship with a man. The researcher used the third person stance by asking “What did he say?” or “When you met this man what happened?”. This was awkward for the informants for the first few minutes of the interview, but then it became quite natural. The process helped to establish clear role distinctions and to facilitate richer inquiry into the informant’s experience.

- 2) When the researcher was in the role of therapist/teacher the informants were not provided with a description of what the halopathic experience might be like prior to having the experience, but they were given information on what the counselor would do in the session (for example giving instruction on guided relaxation). Neither were they provided with “suggestions” during the experience of what they might experience. They were asked, during the experience, to provide descriptions of what they were sensing. During the interview the researcher focused on helping the individuals to re-examine their own descriptions of the experience in a way unique to each individual with as little researcher bias as possible.
- 3) During the interview the questions were focused on obtaining a detailed description of the informant’s experience and their attempts to make meaning of the experience. There was no attempt to collect biographic information or to pursue other more ethnographic lines of inquiry. This introduced a bias into the data, a myopic

focus aimed at describing one phenomenon, which is clearly evident throughout this text, but also the main focus of this study.

- 4) The researcher as teacher has the potential for introducing bias in the form of ‘authority’ over the informant who responds to please the interviewer (to get a good grade). No informants were students of this researcher at the time of the interviews. This question of the influence of ‘authority’ is discussed further at the end of the next chapter (after the participant informant information).

There is also bias that can be introduced into the interpretive process that is used at various points throughout this research study. This will be discussed in more detail in Chapter 4.

Bias can be introduced in the way the informant information is presented, both within the information cited from practitioners and that from participants. In the presentation of the participant’s experiences (in the pilot study), the voice of the practitioner/researcher is nearly silent, except for some personal insights within a discussion on credibility at the end of the chapter. This is done purposefully in an attempt to present the participant’s view with minimal researcher bias. In the previously material presenting the practitioner’s view the voice of the author, as a practitioner, was present. Steps were taken to purposefully delineate this author’s views, in an effort to keep his remarks easily distinguishable from those of the practitioner informants and thus to reduce bias in the writing. But, the author must be present in the writing, for he is a participant in the study, the originator of this theory-dependent research, and in both roles as interviewer and researcher.

It was written of Jung that he always found it “difficult to realize the healing, ‘whole-making’ effect that *his personality* – even when unaided by understanding of the material [about the patient] –

had on his patients.”³⁷ Yet Jung spoke often of how important it was for the person, as being, to become personally involved in the therapeutic session. “The doctor could do little or nothing unless he also risked himself.”³⁸ Such a risk of vulnerability is a natural part of the healing relationship. It should also be a part of writing that attempts to describe components, effects, of that relationship.

Interpretation of a deeply empathic, healing, experience is a personal process. There is much within the experience that cannot be transcribed into words. Selecting what to look at in more detail, what to focus on for research, what to describe with words, and ultimately what to share with others is a reflection of the design of this research and my own decisions during the interpretation process. There should be a graceful balance between showing the insider view, showing the self in the heuristic process and maintaining enough objectivity to reflect on the nature of the informant’s information (both practitioners and participants).

How This Research was Presented

The focus of this research is to provide the reader with a rich portrait of the halopathic experience as experienced within a therapeutic setting. This is not a collection of biographical representations of people’s lives, nor is it an ethnographic investigation. I did not go into the “field” and “sit among the natives” and therefore there is little comment on the situational aspects of the phenomena being studied. I did, however, sit with people and share the halopathic experience with them. In that sense it is the description of an event. I asked the informants to describe their observation of the event. Interviews were used to obtain these descriptions but any information about the client informant did not extend to far beyond the immediate interview context. In this way the client information used in this study differs from a collection of case studies. There is little reference to pathology or course of treatment. The focus in this study was on acquiring a detailed

description of the effects that might be attributed to the halopathic experience.

The focus in the interviews followed the focus of the study. The interviews were almost entirely composed of questions that probed the informants for details on what they experienced and what the experience meant to them. Material gleaned from these interviews is arranged throughout the next two chapters in thematic categories. These are the themes that have been presented by the participant informants (and the practitioners, Chapter Five) during their attempts to describe and interpret the effects of possibly attributed to the halopathic experience. The thematic categories also serve as observations, similar to observations one would make in an ethnographic study. But, in this case, the observations come from people observing themselves interacting in a healing therapeutic relationship.

One could speculate on the relationship between biographical information and how each informant described, and interpreted, their halopathy experience. Such an academic excursion would have required additional interview time and a shift in both the research focus and the writing of this study. It may be probable that exposure to literature, media, cultural myths, alternative medicine practitioners, and our medical profession have shaped the informant's views of the halopathic experience. But to examine such effects requires more than speculation. It requires research. Research that is better left to future study.

It is believed that the thematic organization of the material presented herein is the best way of presenting the reported observed effects of the halopathic relationship. Such a presentation offers to readers a clear and concise model of how the effects of the halopathic relationship are reportedly observed. It is a model that can be used for personal and professional development. It is a model that can be used by educators seeking to instruct students on incorporating empathy into their human service careers.

Good Science?

This author focuses the writings herein on what it is like to experience the halopathic relationship, the effects reports from both from the client's (participants) and the practitioner's point of view. These potential effects of the halopathy experience then form the foundation for a discussion of interpretation and application. Once these descriptors of the halopathic experience are presented, along with credibility concerns, then a separate chapter is presented addressing interpretation, followed by another chapter focusing on applications.

References cited in the appendices

To find a reference locate the appropriate numbered footnote, remember the author's name and the year, then locate the author in the reference list at the end of this document.

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