Theoretical/Methodological/Review Article

Clinical Psychological Science
1–21

DOI: 10.1177/21677026261425981
www.psychologicalscience.org/CPS

Empathy Regulation in Clinical Science: Regulating the Therapeutic Emotional Circuit

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Abstract

Is a more empathic therapist more effective? Classic models in clinical science rightfully describe empathy as an important therapeutic tool, but emerging evidence indicates that it can interfere with therapeutic goals in some settings. Here, we provide a contemporary framework that addresses this tension. We propose a model in which empathy and emotion regulation combine to create a "therapeutic emotional circuit" in which emotions flow from therapist to client and back to the therapist again via empathy. Critically, therapists can use empathy regulation to modulate this emotional flow to achieve specific goals for both their own and their clients' emotional experiences. We then illustrate how optimal empathy regulation diverges across two empirically supported interventions: To best support clients, exposure therapy requires down-regulating affect sharing, whereas motivational interviewing requires up-regulating this empathic process. This model challenges classic intuition, revealing new directions for clinical research, training, and practice.

Keywords

empathy, emotion regulation, motivational interviewing, exposure and response prevention

Received 6/10/25; Revision accepted 2/3/2026

Therapists are stereotypically portrayed as empathic, striving to understand, share, and supportively respond to their clients' emotions and inner worlds. This stereotype has some basis in reality: Several therapies encourage therapists to respond empathically during sessions (Barlow et al., 2011; Beck, 2011; Greenberg, 2004; Miller & Rollnick, 2013), and clinician empathy is associated with better therapeutic relationships (Nienhuis et al., 2018) and treatment outcomes (Moyers et al., 2016). From these points, it is easy to assume that greater therapist empathy will always predict treatment efficacy. If some empathy is good, more empathy must be better.

Positive views of empathy in psychotherapy can be traced to two key historical sources. First, Carl Rogers's person-centered therapy (which emphasizes the importance of a supportive, genuine, and empathic therapeutic relationship) left an indelible mark on the field. Rogers's (1947, 1957, 1959, 1967, 1975) scholarship and teaching posited that "accurate empathy" is a necessary condition for therapeutic change: "To sense the client's private world as if it were your own, but without ever losing the 'as if' quality—this is empathy, and this seems essential to therapy" (Rogers, 1957, p. 99). Rogers saw empathy as a deep and intimate knowing of the client's inner world, allowing therapists to see reality through their clients' eyes. Rogers's work shaped core components of clinical and counseling psychology, inspiring new scales for measuring empathy (Truax & Carkhuff, 1967), empirical studies arguing that empathy is indeed necessary for effective treatment (Barrett-Lennard, 1962; Truax, 1966), and trainings for improving therapist empathy (Aspy & Roebuck, 1975). In addition, Rogers's insistence that therapists not lose the "as if" quality of

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a client's inner world maps onto the importance of distinguishing "self" from "other" in contemporary discussions of empathy (Decety & Jackson, 2004; Lamm et al., 2016).

Second, Rogers's ideas have resurged more recently through research on therapeutic common factors. Wampold and colleagues have conducted meta-analyses showing that distinct therapies produce similar effects on treatment outcomes (Wampold, 2015a; Wampold et al., 1997; Zuroff et al., 2010). Fascinatingly, these analyses suggest that more than the therapy clients receive, their outcome depends on which therapist they receive. This discovery motivated a search for the common factors that successful therapists deploy, leading to a bounty of research on the benefits of an empathic therapist regardless of treatment modality (Norcross & Wampold, 2011; Wampold, 2015b; Wampold et al., 2017). In fact, low therapeutic empathy has been labeled as "toxic" (Moyers & Miller, 2013). These arguments typically point to a meta-analysis showing a significant linear relationship between stronger treatment outcomes and greater therapist empathy (measured through observer-, client-, and therapist-rated scales; Elliott et al., 2018).

These two historical moments—Rogers's development of person-centered therapy and contemporary scholars' discovery of therapeutic common factors—have reinforced the view that empathy is a salutary therapeutic ingredient. However, even historically, some scholars expressed skepticism about a linear "more is better" model of empathy (Barkham, 1988; Duan & Hill, 1996; Gladstein, 1977, 1983; Lambert et al., 1978; Marks & Tolsma, 1986). Early critics pointed out that empathy was vaguely defined, imprecisely measured, and not always related to positive outcomes (Barkham, 1988; Duan & Hill, 1996; Irving & Dickson, 2004; Lambert et al., 1978; Marks & Tolsma, 1986). For example, Barkham (1988) shared concerns that empathy should not be thought of as a "drug" that therapists should maximally apply, and Gladstein (1983) argued that empathy should be broken down into specific subtypes and that each subtype should be applied for only specific client needs.

These critical views of therapist empathy are mostly lost to time: Gladstein's (1987) book has been cited only ≈100 times whereas Rogers's (1957) article has been cited more than 11,000 times. Nonetheless, data supporting these critiques have begun to accumulate. Greater self-reported therapist empathy is associated with worse implementation of exposure-therapy interventions (Churm, 2023; Deacon, Farrell, et al., 2013; Farrell et al., 2013), and a host of studies have shown that high provider empathy is associated with worse outcomes in therapists, caregivers, and medical doctors (Brown et al., 2023; Ewbank et al., 2020; Gleichgerrcht & Decety, 2011, 2014; Hua et al., 2021; Lee et al., 2001; Newell & MacNeil, 2010; Ogińska-Bulik et al., 2022). Thus, the time is ripe for a contemporary model that uses emerging data to build a theoretical architecture for understanding when and why therapists must regulate empathic subcomponents to achieve treatment goals. Indeed, the immense prevalence and burden of psychopathology means that the field is desperate for techniques that improve treatment efficacy (Holmes et al., 2018; Kessler et al., 2005; Rehm & Shield, 2019).

In this article, we draw on theoretical and empirical advances in affective and clinical science to argue that empathy should not be holistically maximized in therapeutic contexts but rather optimized through regulation to best achieve therapeutic goals for a given client in a given session. We first review contemporary research on empathy and emotion regulation, showing how empathy has several subcomponents that can be dissociated from each other and that people regulate their own and others' emotions to achieve instrumental goals. Next, we articulate a contemporary model of empathy regulation in clinical settings based on this evidence that goes beyond the intuition that more empathy is always better. The core of this model is a hypothesized therapeutic emotional circuit in which emotions "flow" between therapists and clients and empathy regulation acts as a "throttle" on the circuit. We then illustrate this model in two clinical interventions (motivational interviewing [MI] and exposure and response prevention [ERP]). Finally, we conclude with a discussion of the implications of this model for research, practice, and training in clinical science.

In terms of scope, the current model has been largely conceptualized within the assumptions of the cognitive-behavioral family of therapies, which emphasize the role of thoughts, emotions, behaviors, and beliefs in psychopathology and its treatment. We thus discuss the model using these terms and illustrate its relevance through contemporary evidence-based interventions. It is likely that empathy and empathy regulation can be fruitfully deployed in other therapeutic approaches (e.g., psychodynamic or third-wave approaches). However, formulating this model in terms of *any* therapeutic approach is beyond the scope of the current article, and so the histories and techniques of those treatments are not discussed.

Contemporary Views of Empathy

Although scholars debate the exact definition of "empathy," it is largely considered an umbrella term for a set of processes that allow people to connect with others'

thoughts and feelings (Ashar et al., 2017; de Waal, 2008; Decety, 2011; Leiberg & Anders, 2006; Shamay-Tsoory et al., 2009; Singer & Klimecki, 2014; Zaki, 2014; Zaki & Ochsner, 2012, 2016). There have been several recent advances into the nature of empathy that go beyond the historical views described at the start of this paper.

First, dominant clinical models (besides Gladstein's prescient writing in the 1980s) largely write about empathy as a singular construct that should be holistically maximized, but evidence has accumulated to show that empathy has three distinguishable subcomponents—affect sharing, perspective taking, and empathic concern. Second, a framework has emerged for understanding empathy as motivated by factors internal and external to an individual, spurring a field of research on empathy regulation. Because our model rests on the notion that therapists regulate individual subcomponents of empathy, we briefly review work on these topics below.

Empathic subcomponents

Affect sharing refers to feeling—or "taking on"—the emotional experiences of other people (Morelli, Lieberman, & Zaki, 2015; Pittinsky & Montoya, 2016; Schachter & Singer, 1962; Waters et al., 2014; Wild et al., 2001). This component captures the affective part of empathy. Indeed, people report feeling happy, euphoric, sad, stressed, or angry when they encounter others feeling those emotions (Morelli, Lieberman, & Zaki, 2015; Pittinsky & Montoya, 2016; Schachter & Singer, 1962; Waters et al., 2014; Wild et al., 2001) and further take on the facial expressions (Dimberg & Thunberg, 1998), physiological arousal (Levenson & Ruef, 1992; Vaughan & Lanzetta, 1980; Waters et al., 2014), and even affective linguistic patterns (Nook et al., 2023) of people around them.

Mentalizing refers to a cognitive component of empathy through which people form internal models of others' experiences and make inferences about their thoughts, emotions, intentions, and beliefs. For example, when people see a child cry and run to her mother after falling, they draw inferences about the child's emotions (e.g., pain, shock) and beliefs (i.e., the child believes her mother will soothe her) without necessarily sharing those states. A vast body of research on mentalizing has characterized its developmental trajectory, psychological structure, and relations with social functioning (Baron-Cohen, 2000; Dodell-Feder et al., 2014; Dunn & Cutting, 2001; Sprong et al., 2007).

Empathic concern refers to the motivation to improve others' well-being. Studies show that self-reported empathic concern drives helping behaviors more reliably than other facets of empathy, such as affect sharing (Batson, 2011; Batson et al., 1981; Batson & Moran, 1999; Bekkers, 2006). Empathic concern is also a consequence of other empathic components (Kang et al., 2025). For example, perspective-taking exercises (which encourage mentalizing) reliably drive empathic concern and—in turn—prosocial behaviors (Batson et al., 1991).

Affect sharing, mentalizing, and empathic concern often "travel together." For instance, in a study examining experiences of empathy throughout the day, participants reported experiencing all three components of empathy on 75% of prompts (Depow et al., 2021). That said, 25% of these moments involved only one or two components of empathy, indicating that they are not synonymous. Neuroscientific evidence also supports the separability of these components because each component is thought to be supported by separate neural networks. Affect sharing is thought to emerge through "neural resonance"—the brain's tendency to produce similar patterns of activity both when undergoing an experience and when observing someone else undergo that experience (Wheatley & Sievers, 2016; Zaki & Ochsner, 2016), specifically in networks that contribute to movement, sensation, affect, and interoception (Carr et al., 2003; Gallese & Caruana, 2016; Keysers & Gazzola, 2009; Lamm et al., 2011; Leslie et al., 2004; Molenberghs et al., 2012; Morelli, Sacchet, & Zaki, 2015; Nummenmaa et al., 2008; Zaki et al., 2014). By contrast, the mentalizing network includes areas of the brain involved in self-projection, memory, and counterfactual reasoning (Decety & Jackson, 2004; Mitchell, 2009; Overwalle & Baetens, 2009; Saxe, 2006; Shamay-Tsoory et al., 2009; Zaki & Ochsner, 2012), and empathic concern is most consistently associated with regions implicated in the computation of value and self-control (Ashar et al., 2017; FeldmanHall et al., 2015; Waytz et al., 2012; Zaki et al., 2014). Indeed, a recent meta-analysis showed that some tasks primarily recruit regions implicated in affect sharing, some tasks primarily recruit regions implicated in mentalizing, and other tasks recruit both sets of regions, further supporting their dissociability (Schurz et al., 2022). That said, more naturalistic tasks (e.g., inferring emotions from facial expressions) recruited a mix of regions, suggesting that people often deploy multiple empathic subcomponents in rich social situations. Nonetheless, this accumulation of behavioral and neural evidence regarding the separability of subcomponents allows people to regulate each component of empathy individually to reach particular goals (Weisz & Cikara, 2021; Zaki, 2020).

Historical more-is-better models of empathy largely miss these nuanced distinctions between empathic subcomponents. As we argue and illustrate below, treating empathy as a single construct can result in worse outcomes for clients in some contexts, particularly when high affect sharing is counterproductive to supporting

clients in achieving long-term gains. Understanding empathy as multifaceted allows for more nuanced questions about which type of empathy is most useful to clinical interactions under which contexts.

Motivated empathy and empathy regulation

Early models of empathy often depict it as a reflexive or automatic response to others' emotions (Gallese, 2003; Hatfield et al., 1993; Hoffman, 1985; Lipps, 1903; Titchener, 1909). In a clinical context, this would mean that therapists would be unable to increase, decrease, or modulate their empathy in response to the needs of a particular situation. More recent accounts have overturned this view, emphasizing the fact that empathy is a motivated phenomenon subject to psychological forces that drive people toward or away from empathy (Hodges & Wegner, 1997; Ickes, 2011; Keysers & Gazzola, 2014; Zaki, 2014). For example, people approach empathy because they enjoy sharing positive affect, wish to affiliate with others, or believe it will provide them with reputational gains. Conversely, people can be motivated to decrease their empathic responses to avoid taking on another person's negative affect, to avoid the monetary or temporal costs of helping others, or to ensure empathy does not interfere with their ability to compete with others (Cikara et al., 2011; Cikara & Fiske, 2012; Hudson et al., 2019; Porat et al., 2016).

If empathy is motivated, then it can be regulated. That is, people can deploy psychological and behavioral strategies that up-regulate (increase) or down-regulate (decrease) their level of empathy to reach their goals (Bruneau et al., 2015; Cameron et al., 2016; Hodges & Biswas-Diener, 2007; Shaw et al., 1994; Zaki, 2014). Indeed, people more readily share a target's feelings when they wish to affiliate with that target (Aylward, 2008), they more accurately understand another's emotions when they find that person physically attractive (Ickes et al., 1990), and they are motivated to behave prosocially to fit in with observed social norms (Nook et al., 2016). Neuroimaging evidence also supports the possibility of empathy regulation. One functional-MRI study revealed that choosing to increase or decrease one's empathic approach to stories about people in distress modulates amygdala activity (a component of the network thought to subserve affect sharing) and the amygdala's functional connectivity with the mentalizing network (Bruneau et al., 2015).

Dominant historical views of empathy in clinical practice largely presume that therapists should try to increase their empathic responding. Although this implies that empathy can be regulated, the broader theoretical architecture for understanding the forces that motivate empathy has only recently been developed.

Contemporary Views on Emotion Regulation

Besides empathy, a second key component of our model is emotion regulation (i.e., the ways in which people purposefully modify emotional experiences). To understand our argument that empathy regulation functions to strategically alter one's own and others' feelings, it is important to review the field's recent advances in interpersonal emotion regulation and instrumental emotion regulation.

Most research on emotion regulation focuses on intrapersonal processes, or people's management of their own emotions. Most famously, Gross's (1998, 2015) process model outlined a clear taxonomy of intrapersonal emotion-regulatory processes, including situation selection (choosing which environments to enter), attentional deployment (distracting oneself or shifting what one pays attention to), cognitive reappraisal (changing how one thinks about or interprets a situation), and expressive suppression (attempting to hide one's emotional reaction). Gross's process model has inspired both basic and translational research, and substantial data have shown that (a) symptoms of psychopathology are reliably associated with disruptions in emotion regulation and (b) effective psychotherapy involves the restoration of adaptive intrapersonal emotion regulation (Aldao et al., 2010; Berking et al., 2008, 2013; Gross & Jazaieri, 2014; Radkovsky et al., 2014).

More recently, psychologists have built on the earlier process model to document forms of interpersonal emotional regulation, or strategies through which people influence others' emotions. For instance, people can influence others' environment, attention, interpretations, and behavioral reactions. Empirical research has shown that providing interpersonal emotional regulation is associated with higher-quality relationships (Niven, Holman, & Totterdell, 2012; Williams et al., 2018), increased popularity (Niven et al., 2015), and even better mental health in the person who provides interpersonal emotional regulation (Doré et al., 2017; Niven, Totterdell, et al., 2012).

Therapy can be conceptualized as a therapist using interpersonal emotional regulation to help restore healthy emotions in clients through attentional deployment, cognitive reappraisal, and other techniques (Marroquín, 2011). The promise of this framework is illustrated by recent empirical demonstrations that reappraisals from another individual seem to be more helpful both in the moment and at a delay than self-generated reappraisals (Sahi et al., 2021, 2025).

Like empathy, the role of interpersonal emotional regulation in therapy can be complex. Hofmann (2014), for instance, clarified how some interpersonal strategies may be maladaptive for clients. He gave the example of clients relying on others for perceived safety (i.e., safety signals) or therapists providing excessive reassurance as unhelpful strategies that only reinforce the clients' underlying beliefs that they cannot handle threats in the world on their own. Our model extends these ideas in a key way: We describe how these maladaptive instances of interpersonal emotional regulation are intimately tied to empathy and empathy regulation. For instance, therapists who provide excessive reassurance (although interpersonally down-regulating the clients' anxiety) are likely doing so because they are sharing too much of the clients' anxiety and cannot tolerate their own distress. In this way, interpersonal emotional regulation and empathy regulation are intimately connected.

A final recent advance in affective science is the recognition that people regulate their emotions to achieve specific goals. That is, people are instrumental in how they regulate their emotions (Tamir, 2016; Tamir et al., 2008, 2020). Although it is reasonable to assume that people generally want to feel fewer negative emotions and more positive emotions (i.e., they have hedonic goals to maximize pleasure and minimize distress), data suggest that this is not always the case. Sometimes, people seek to increase negative emotions and reduce positive emotions (i.e., they pursue contra-hedonic emotion-regulation goals). For instance, people intentionally increase their experience of anger before confronting others (Tamir et al., 2008), and they amplify their sadness before seeking aid from others (Hackenbracht & Tamir, 2010). Importantly, these theories posit that the desire to increase one's negative affect in the short-term is merely a necessary step in the pursuit of long-term goals that optimize one's overall well-being (Kim et al., 2015; Tamir, 2009).

Thus, contemporary perspectives on emotion regulation have shifted from a constrained focus on how people reduce their own negative affect to more extended models in which (a) people regulate each other's emotions and (b) people instrumentally align their emotions with their goals (even if that produces elevated negative affect in the short-term). However, these two processes can operate simultaneously because people may choose to increase others' negative affect to achieve their own goals (i.e., people can engage in instrumental interpersonal emotion regulation). For example, people choose to expose a teammate to anger-inducing music if they believe doing so would help them on an aggressive computer game (Netzer et al., 2015).

In sum, theorizing and empirical studies show that people regulate their own and others' emotions to achieve instrumental goals. This is an important framework for understanding psychotherapy because a key goal of therapy is often to change the emotions clients feel. As we note above, though, there has been little consideration of how therapist empathy and empathy regulation directly connect to their intrapersonal and interpersonal emotion regulation. The stage is now set to demonstrate how exactly these constructs are related and why they are important for successful psychotherapeutic intervention.

A Contemporary Model of Empathy Regulation in Clinical Science

Combining the theoretical advances described above yields a more nuanced picture of empathy in clinical settings than a linear more-is-better model. In summary, these perspectives argue that (a) empathy comprises three main components, (b) each component can be regulated according to one's goals, (c) these empathic goals are intimately connected to one's intrapersonal and interpersonal emotion-regulation goals, and (d) emotion-regulatory goals can be either hedonic (i.e., trying to make oneself or another person feel more positive) or contra-hedonic (i.e., trying to make oneself or another person feel less positive).

Integrating these theories leads to the conclusion that people can regulate specific subcomponents of empathy to achieve goals for how they want to feel and how they want others to feel. A full treatment of this theoretical synthesis can be found in Zaki (2020). Here, we build on this general theoretical idea (and other prior work; Cameron, 2018; Cameron, Conway, & Scheffer, 2022; Cameron et al., 2016; Cameron, Scheffer, et al., 2022; Gleichgerrcht & Decety, 2011; Hodges & Wegner, 1997; Ickes, 2011; Keysers & Gazzola, 2014; Maibom, 2019; Weilenmann et al., 2018; Weisz & Cikara, 2021; Weisz & Zaki, 2018) to articulate how this model functions in therapeutic settings. The essence of this model is captured in Figure 1, and below, we walk through each component of the model.

We argue that psychotherapy can be viewed as a series of interpersonal regulatory interactions that involve regulation of both empathy and emotion with the ultimate goal of resolution of a client's presenting concerns. This perspective can be applied even at the assessment stage, when a therapist learns about a client's symptoms, formulates a sense of the causes of the client's difficulties, and plans interventions. These are represented by the first two bubbles at the top of Figure 1.

For example, when treating clients with panic disorder who want to experience fewer panic attacks, clients and therapists may decide to pursue a course of

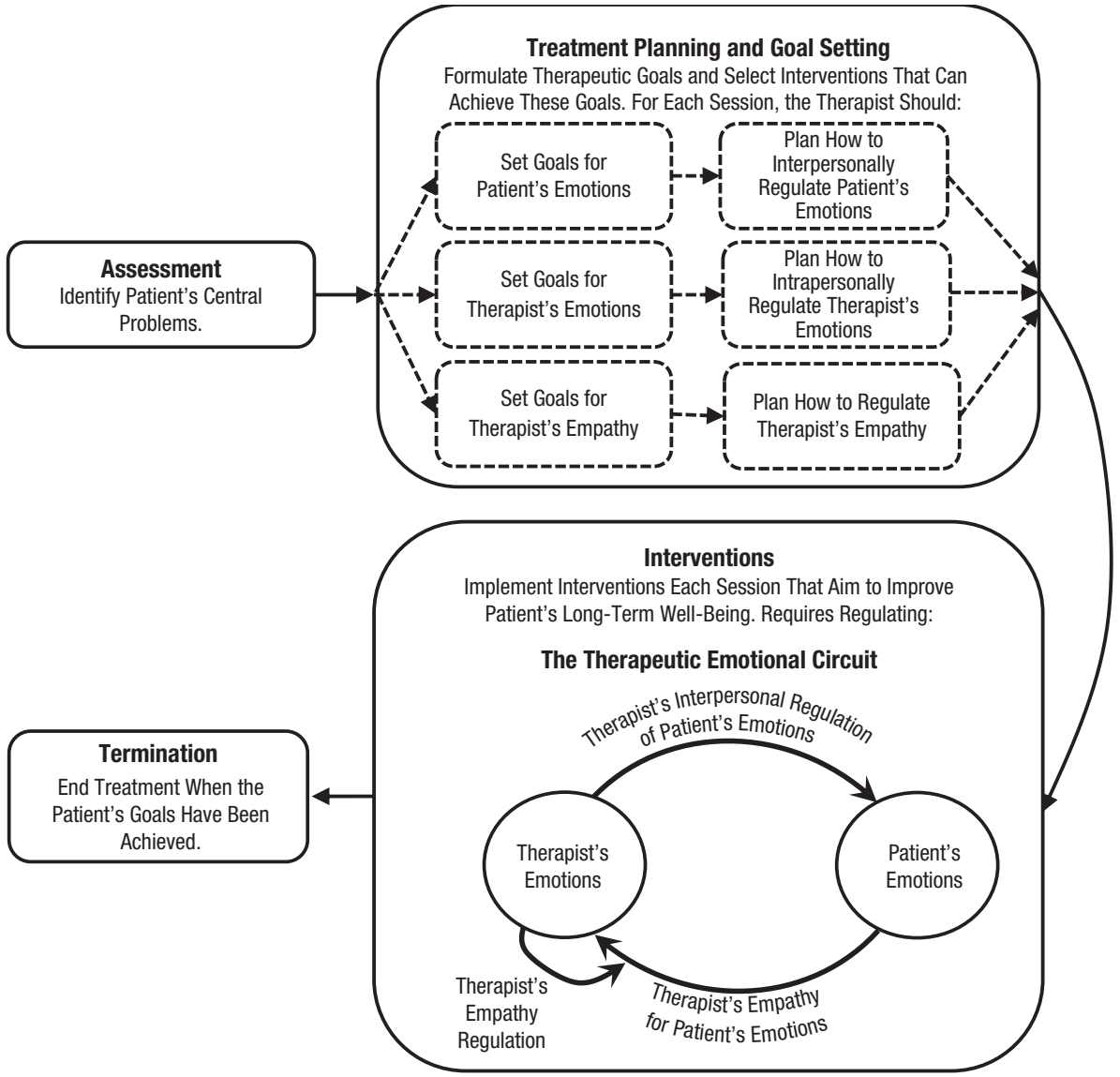

Fig. 1. Overview of conceptual model. After assessing and formulating the client's presenting problems, the therapist and client select therapeutic interventions that will help the client reach their goals. Interventions require clients to experience certain emotions, so the therapist sets goals for the emotions that the client should experience in each session. This requires determining what strategies the therapist can use to interpersonally regulate the client's emotions and intrapersonally regulate the therapist's own emotional experiences. In each session, a "therapeutic emotional circuit" is activated: There is a bidirectional flow of affect between the therapist and client whereby a therapist's emotions shape how the therapist regulates the client's emotions, and these emotions flow back to the therapist via empathy (denoted by the two arrows connecting the therapist's and client's emotions). Empathy regulation can help a therapist modulate the strength of this flow. The extent to which sharing a client's emotions is beneficial to treatment depends on the therapist's current therapeutic goals. Thus, therapists must regulate their empathy to increase or decrease how strongly they take on a client's emotions. Treatment terminates when the client's therapeutic goals have been met. We developed the idea of a therapeutic emotional circuit independently from a recent article by Weilenmann et al. (2018) which described a similar cycle. We consider these complementary models because theirs is focused on medical settings and more specifically articulates the inputs to physician emotions, whereas ours focuses on empathy regulation and psychotherapeutic settings.

cognitive-behavioral therapy (CBT) with two main phases: (a) psychoeducation in which clients learn about panic attacks and (b) exposures in which clients confront panic-like sensations and learn they can cope with them as they arise. Therapists should then set empathic and emotional goals during each intervention. For example, it would be ideal for clients to feel engaged, curious, and understood during psychoeducation to help them

learn, and during exposures, it is important that they fully come into contact with the sensations, anxiety, and distress they normally avoid (Craske et al., 2014). Therapists should also set goals for their own emotions and empathy, considering how these will affect the success of any given session. This includes monitoring the affect they "bring into the room" (i.e., their current level of fatigue/alertness/hunger, or reactions to events in their personal lives or the world around them) and their emotional reactions to what is occurring "in the room" (i.e., their emotional responses to their clients). Crucially, however, our model emphasizes that therapists' emotional state will be strongly affected by their clients' emotions via empathic affect sharing.

In each session, therapists must regulate what we call the "therapeutic emotional circuit" (lower bubble in Fig. 1). In our model, we posit that there is a bidirectional flow of emotions between a therapist and a client. The left circle in Figure 1 in the circuit represents the therapist's emotional state. For many reasons, therapists' emotions shape how they interact with the client, including how they implement interventions in session. These words and actions (represented by the top arrow in the circuit, Fig. 1) influence the client's emotional states (right circle, Fig. 1). Thus, the therapist's behavior interpersonally regulates the client's emotions, and the therapist's own affect (left circle, Fig. 1) shapes how this process unfolds. Empirical evidence suggests that providers' emotions influence their behavior in therapeutic and medical settings (Liu et al., 2022; McConnell, 2024). For example, a therapist's feeling of calm when entering a session predicts a client's perceptions of the effectiveness of that session (Chui & Hill, 2020), doctors arrive at diagnoses faster following positive mood inductions (Estrada et al., 1997), and they report engaging less with clients when experiencing negative mood (Kushnir et al., 2011). The client's emotions then flow to the therapist (bottom arrow, Fig. 1) via empathy, particularly affect sharing. This starts the cycle over again as therapists' empathic reactions to clients' emotions influence what they say and do in the session, which alters how they interpersonally regulate clients' emotions, and so on.

Crucially, however, therapists can regulate their empathy to influence how strongly they take on clients' affect (lower left arrow, Fig. 1). In this way, empathy regulation functions as a "throttle" or "resistor" that regulates the flow of emotions through the circuit. Importantly, therapists can regulate each empathic subcomponent separately. In daily life, empathic subcomponents can dissociate in degree (e.g., one can maintain relatively higher levels of perspective taking than affect sharing), yielding medium-sized correlations between empathic subcomponents (rs = .45–.49; Depow et al., 2021). Most relevant to the circuit itself is regulating affect sharing because it influences the flow of emotion through the circuit. As we illustrate below, some therapeutic contexts require up-regulating affect sharing, and others benefit from the opposite empathic profile. To be clear, it seems likely that therapeutic outcomes always benefit from clinicians up-regulating both mentalizing and empathic concern because these components of empathy are oriented toward understanding a client's perspective and benevolently improving a client's well-being. Indeed, if empathic concern is defined as "motivation to improve the well-being of another," then ethically, this should always be up-regulated by the therapist and never down-regulated. That said, it is critical to unpack the nuanced relationship between empathic concern and prosocial decision-making.

The research reviewed above mostly focused on prosocial motivation for removing an individual's short-term discomfort, and in fact, almost all literature on the relation between empathy and altruism focuses on short-term hedonic regulation (Zaki, 2020). We call this "proximal empathic concern." At times, this is the optimal goal of treatment because it can facilitate the client's long-term goals (e.g., supportive comfort in the face of recent loss). Yet at other times, removing a client's short-term distress runs counter to the client's long-term well-being (as in the panic-disorder example above and the exposure-therapy example below). Thus, in our model, therapists must prioritize what we call "distal empathic concern," which refers to alleviating long-term distress by helping clients work to build meaningful and healthy lives even if this induces some short-term discomfort. This is what exposure-based providers have practiced for decades: Integrating instrumental emotion-regulation theory (i.e., coaching others to increase short-term distress; Tamir, 2009, 2016; Tamir et al., 2020) with the philosophy of paternalistic helping (Martin et al., 2016) can result in beneficial long-term outcomes.

Illustrating the Model Through Two Example Interventions

We illustrate our model through two empirically supported therapeutic interventions: ERP and MI.

ERP

ERP is an empirically supported treatment for obsessive compulsive disorder (OCD; Chambless & Ollendick, 2001; Deacon & Abramowitz, 2004; Foa & Goldstein, 1978; Foa & McLean, 2016; Olatunji et al., 2010). The goal of ERP is to help clients approach feared situations without engaging in behaviors that reduce distress (Abramowitz, 1996; Chambless &

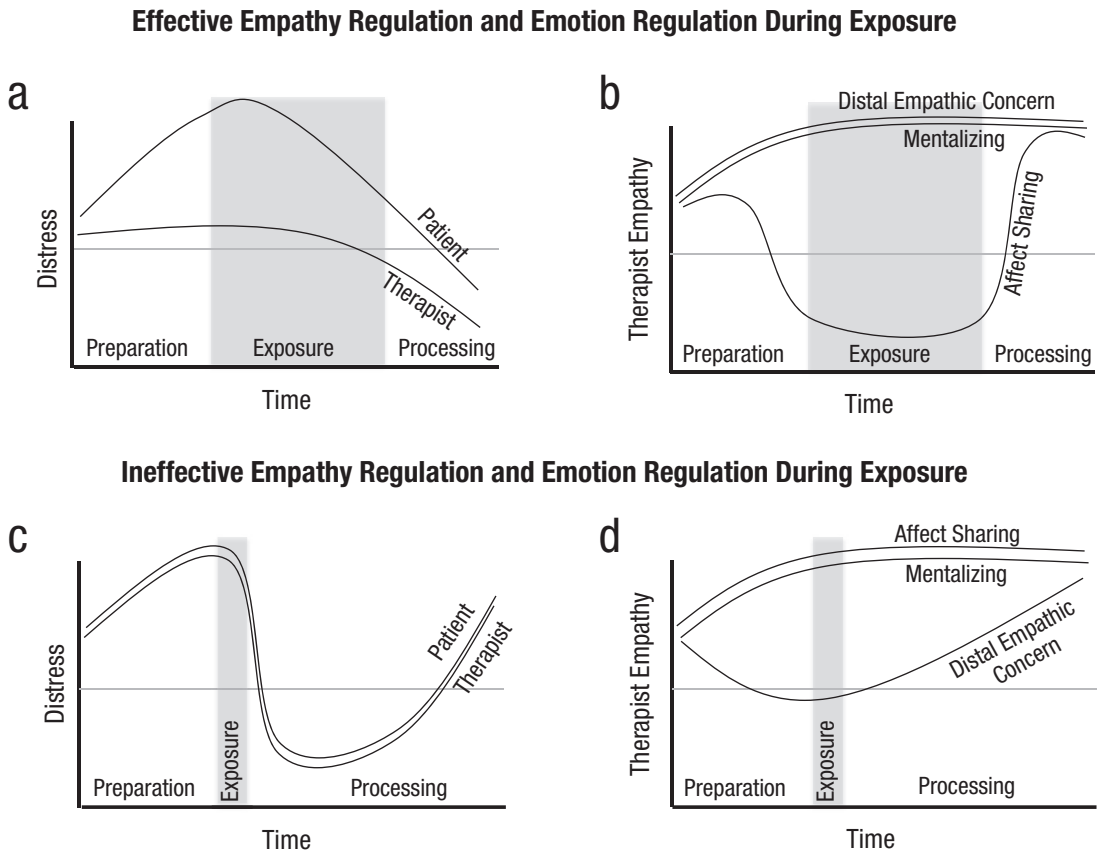

Fig. 2. Visual depictions of effective and ineffective empathy regulation and emotion regulation in exposure and response prevention. In all figures, gray-shaded regions represent time spent doing an exposure. (a) During an effective exposure, the client approaches a feared stimulus the client typically avoids, leading to increased distress that gradually habituates even while contact with the stimulus is maintained. A skilled therapist maintains low levels of distress, allowing the therapist to support the client as the client maintains immersion in the exposure. The therapist and client can then achieve shared relief when they celebrate the completion of the exposure and the client's treatment progress. (b) Subcomponents of therapist empathic responding during effective exposure treatment. Therapists increase their understanding of their client's perspective on the situation (mentalizing) to increase awareness of what their client may wish to avoid, and they also increase their desire to help the client achieve long-term improvement (distal empathic concern). However, effective therapists down-regulate affect sharing during the exposure to diminish the flow of distress through the therapeutic emotional circuit. (c) Ineffective exposures arise when both the client and therapist experience intense distress during the exposure because this motivates the therapist to allow the client to escape the exposure early before the client has learned that the client can tolerate this exposure. Although this abrupt exposure brings them both relief in the short-term, their distress levels return as they realize that they have not made progress toward the client's long-term recovery. (d) This ineffective exposure can occur when the therapist maintains high levels of affect sharing during treatment and loses focus on the long-term well-being of the client (distal empathic concern) in favor of more proximate relief from distress. This floods the therapist with the client's emotions, through the therapeutic emotional circuit, ultimately leading to a shortened and ineffective exposure.

Ollendick, 2001; Craske et al., 2012, 2014). We walk through a case of using ERP to treat someone with germs and contamination OCD who washes compulsively to prevent fears of getting sick. Figure 2 illustrates the importance of empathy regulation during these exposure sessions.

"Betsy" fears and avoids touching doorknobs because she believes doing so will expose her to germs that could cause her to get sick and potentially die. To avoid this disastrous possibility, she washes her hands whenever she feels nervous about being contaminated with germs. Handwashing reduces her distress in the short term, but it only maintains her catastrophic fears of germs, leading her to wash harder and longer in the future. This cycle has been reinforced so strongly over the course of her illness that she spends hours each

day washing, damaging her skin and distracting her during work. In a CBT framework, Betsy needs help learning that (a) she holds unrealistically catastrophic beliefs about germs and (b) embracing the distress of touching "contaminated" surfaces will help her change her beliefs about germs. Together, these interventions will help free Betsy from this obsessive-compulsive cycle. Through psychoeducation, the therapist ensures that Betsy has a clear understanding of the nature of her disorder and the goals of ERP before beginning an exposure. Betsy and her therapist then move on to planning an ERP session. They decide to complete an exposure in which she will spend 15 min holding onto a doorknob and then not wash her hands until her next meal.

Research suggests that ERP is most effective when clients fully approach feared situations, observe their distress rise at the start of the exposure, and then observe it naturally fall over the course of the session without the need for compulsive behaviors (Craske et al., 2014). Thus, the therapist sets the goal that Betsy's distress rises as she engages with the exposure (Fig. 2a). This goal will be achieved through several interpersonal regulation strategies meant to increase negative affect, including encouraging Betsy to touch the doorknob even if she wants to avoid it, having her keep her hand on it even if she wants to pull away, and having her do any other things she can do to fully approach the feared situation. To help coach Betsy through this exposure, her therapist should strive to remain in a relatively neutral emotional space. If the therapist feels too distressed, the therapist may decide to down-regulate this distress by ending the exposure early or allowing Betsy to avoid full exposure to her fears (Fig. 2c; Deacon, Lickel, et al., 2013; Foa & McLean, 2016; Gillihan et al., 2012; Gola et al., 2014).

Betsy's therapist must prevent becoming too distressed in response to Betsy's anxiety (Fig. 2b). In the therapeutic emotional circuit, the exposure is increasing the client's distress, which could, in turn, increase the therapist's distress if the therapist maintains high levels of affect sharing. Indeed, high dispositional affect sharing is associated with greater affective and physiological linkage when exposed to someone in distress (Brown et al., 2021). Thus, the therapist should plan to down-regulate affect sharing during the session to help maintain a neutral level of emotion. By contrast, the therapist should up-regulate mentalizing to keep a clear vision of what Betsy is feeling, why she is feeling it, and what behaviors she might use to avoid the distress induced by the exposure. However, through all of this, it is crucial that this down-regulation in affect sharing stems from an up-regulation in distal empathic concern: The therapist must ensure to keep the focus on helping Betsy approach the doorknob and related fears to help her find freedom from her symptoms. As in daily life (Depow et al., 2021), the relative magnitude of each empathic subcomponent is dissociable such that empathy regulation can reduce the degree of a therapist's affect sharing without either bringing it to zero or bringing down other subcomponents.

An effective ERP session is illustrated in Figures 2a and 2b, and an ineffective ERP session is illustrated in Figures 2c and 2d. If the session proceeds effectively, the therapist will encourage Betsy to fully engage with her feared situation (i.e., touching the doorknob) and resist any urges to avoid or compulse during the exposure. This will increase Betsy's distress dramatically. However, as Betsy remains in contact with the doorknob, she will likely notice that her distress dissipates naturally without the need to engage in compulsive behaviors. By the end of the session, Betsy may have habituated and might be able to touch the doorknob with little distress. Betsy and her therapist can then celebrate her progress and process her feelings, a time in which the therapist will likely increase affect sharing to capitalize on Betsy's pride and joy. One way that the ERP can proceed ineffectively is if Betsy's therapist struggles to successfully regulate the therapeutic emotional circuit, taking on Betsy's distress (Schumacher et al., 2015), allowing her to end the exposure early, providing reassurance, or enacting similar "pitfalls" in ERP (Figs. 2c and 2d; Gillihan et al., 2012; Meyer et al., 2020). In our model, these unhelpful reactions all serve to down-regulate both Betsy's and her therapist's distress, but they arise because the therapist has lost sight of distal empathic concern: The therapist is attending more to alleviating Betsy's (and the therapist's own) momentary distress at the cost of helping Betsy learn to tolerate emotions and change her behaviors that can be extremely helpful in the long-term.

This example provides a counterpoint to the intuitive notion that greater empathy de facto produces better treatment outcomes. Instead, it highlights the need for therapists to engage in wise regulation of specific empathic subcomponents to achieve clinical goals. Consistent with this framework, high therapist empathy is associated with worse exposure therapy (Deacon, Farrell, et al., 2013; Farrell et al., 2013). In the context of ERP, therapists' own catastrophic anxieties about exposure-based treatments lead therapists to not select such treatments or to deliver them cautiously (de Jong et al., 2020; Gunter & Whittal, 2010; Meyer et al., 2020; Pittig et al., 2019; Waller & Turner, 2016) even though doing challenging exposures involving close contact with feared stimuli is the ethical treatment of choice because it can effectively relieve symptoms (Craske et al., 2014; Gillihan et al., 2012; Olatunji et al., 2009;

Peris et al., 2017; Wolitzky-Taylor et al., 2012). Conversely, "exposing" therapists to exposure-based interventions alleviates these concerns and motivates future use of these extremely effective techniques (Balkhi et al., 2016; Deacon, Farrell, et al., 2013; Farrell et al., 2016; Schumacher et al., 2017), potentially because it reduces therapists' own stress responses (Schumacher et al., 2017). Thus, helping therapists learn how to increase a client's distress (while down-regulating affect sharing) is an important step in successful ERP.

MI

MI is an empirically supported intervention for substance use disorders (Chambless & Ollendick, 2001; Hettema et al., 2005), although MI principles are woven into several treatment approaches (Barlow et al., 2011; Linehan, 1993). A hallmark feature of MI is its emphasis on a collaborative and nonjudgmental approach to behavior change. In MI, therapists resist the urge to instruct clients to do things that they already know would be helpful or make comments that communicate a judgment of clients' current behaviors. Instead, the MI therapist's job is to fully embody the Rogerian person-centered approach (Rogers, 1959) and create a space in which clients can collaboratively explore, share, and reflect on the motivations underlying their choices. Supportive exploration of clients' ambivalence allows them to clarify and embrace their motivations for changing their behaviors.

Thus, MI continues to champion Rogers's accurate empathy (Truax & Carkhuff, 1967), in which therapists attempt to fully understand and connect with clients' feelings, beliefs, experiences, and "inner worlds." Accurate empathy (as described) largely coincides with mentalizing, but Rogers's definition traipses into the realm of affect sharing because he claimed empathy "involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person . . . temporarily living in his/her life, moving about in it" (Rogers, 1975, p. 4). Translating to our framework, successful MI involves up-regulating mentalizing to fully appreciate a client's motivations even if doing so may induce uncomfortable affect sharing by "living in" the feelings of the client. Rogers (1975) also emphasized the importance of congruence by therapists, meaning that they act as themselves, genuinely connecting with what they say to their clients and not "pretending." To achieve such congruence when also saying that they genuinely understand a client's situation implies they should aim to resonate with those feelings. We walk through an example of empathy regulation in MI using the vignette of "Charles," who meets criteria for cannabis use disorder (Fig. 3).

Charles knows marijuana is causing him problems, and he has sought help from other therapists, but he feels like they "talk down to him." This sense of judgment has made him leave sessions feeling so stressed and angry that he immediately starts using again. In our model (Fig. 1), Charles's therapist should begin by planning goals for both Charles's emotions and the therapist's own emotions. Target emotions for Charles are a mix of feeling supported and accepted while he explores the impacts of his choices. Charles's therapist aims to enact accurate empathy: gaining precise understanding of Charles's perspective, resonating with Charles's emotions, and validating whatever perspective he brings into the session. Achieving these goals requires Charles's therapist to up-regulate all three subcomponents of empathy: affect sharing (to genuinely share his feelings so he feels understood and connected), mentalizing (to fully understand his situation as he sees it), and distal empathic concern (to help him work toward his long-term personal, romantic, and occupational goals). Charles's therapist will need to up-regulate affect sharing even though genuinely sharing his negative emotions might be painful to experience. In the therapeutic emotional circuit, up-regulating affect sharing will allow Charles's negative emotions (e.g., guilt, shame, frustration, powerlessness, craving) to spill into the therapist's own feelings. Thus, in MI, therapists at times must engage in contra-hedonic empathy regulation in which they allow themselves to feel clients' negative feelings to help them reach their goals.

In Figure 3 (left), an effective MI intervention is characterized by strong up-regulation of affect sharing, mentalizing, and distal empathic concern. In particular, the effective MI therapist (a) validates and resonates with Charles's emotions even to the point of saying that the therapist "can feel the difficulty of the situation," (b) leans into his resistance to change rather than inserting the therapist's own goals and ideas, and (c) asks open clarifying questions that help the therapist learn more about Charles's perspective on his motivations, goals, and obstacles. Through these empathic responses, the therapist shares Charles's difficult emotions and consistently seeks to see the situation from his point of view. Charles feels supported, understood, and safe to discuss whatever topics come to mind. These feelings flow back into the therapist through affect sharing, providing a warm connection that strengthens the therapeutic alliance and allows the dyad to work together to achieve behavior change.

A contrasting, ineffective MI session is also shown in Figure 3 (right). This therapist insufficiently up-regulates affect sharing and mentalizing, leading the therapist to focus more on "proving the therapist's point" than helping Charles improve his long-term

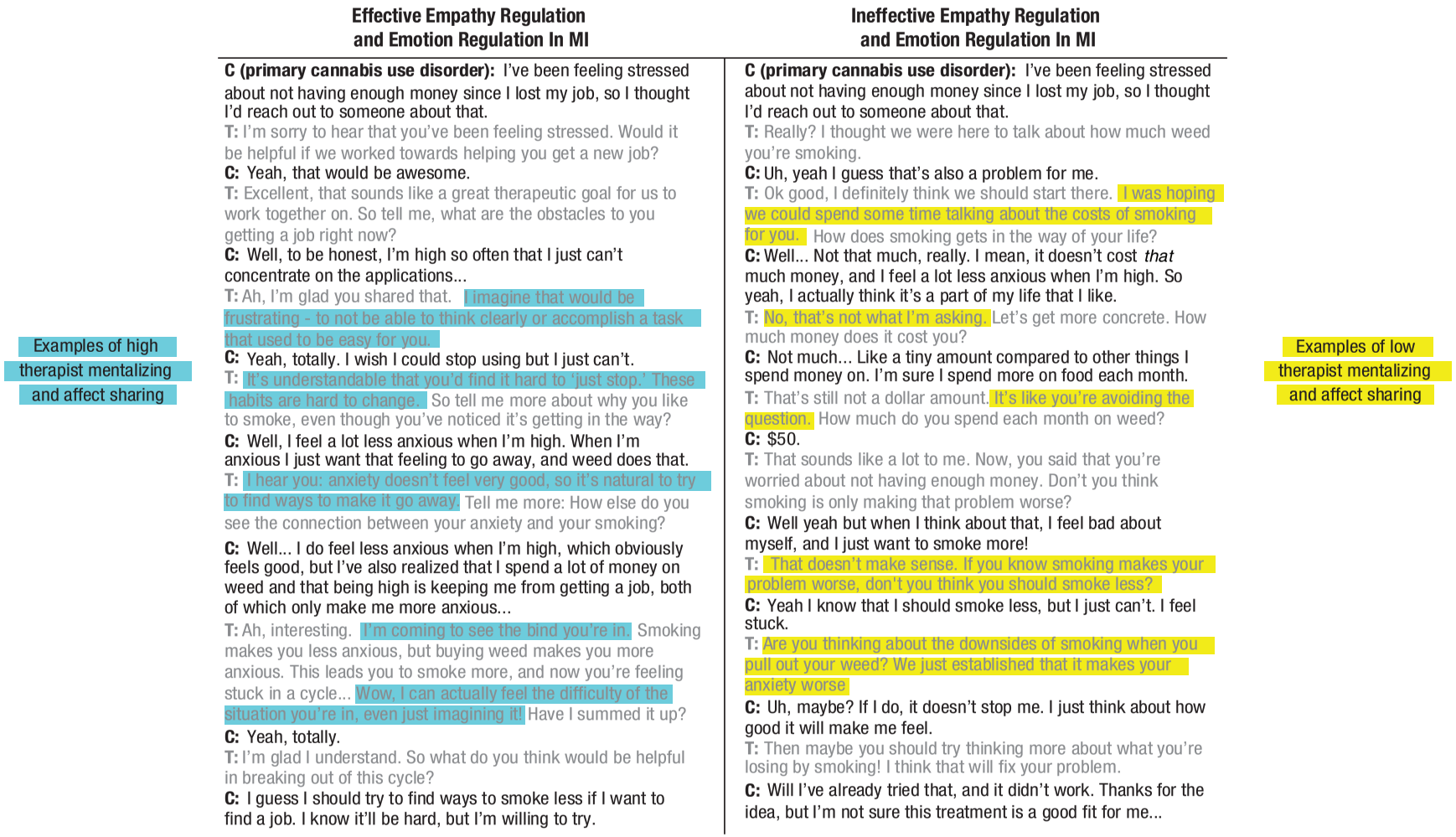

Fig. 3. Caricatured examples of effective and ineffective motivational interviewing (MI) between a therapist (T) and a client (C) with cannabis use disorder. (Left) Effective empathy regulation during MI. The therapist seeks to deeply understand, resonate with, accept, and explore the client's "inner world," even though this is likely to result in some shared discomfort around the difficulty of the client's situation. This allows the client to take the lead in soliciting and implementing strategies that will change the client's situation. Particularly strong moments of mentalizing and affect sharing are highlighted in blue. (Right) Ineffective empathy regulation during MI. The therapist is not adequately attuned to the perspectives and emotions of the client. The therapist instead ignores the client's feelings and pushes the client to adopt the therapist's own perspective. In turn, the client grows frustrated and seeks an escape from the therapeutic relationship. Particularly weak moments of mentalizing and affect sharing are highlighted in yellow.

well-being. In particular, the ineffective therapist (a) consistently ignores Charles's emotions (e.g., not validating how he feels anxious, stuck, or bad about himself), (b) argues against his resistance to change by inserting the therapist's own goals and ideas, and (c) asks closed questions that reinforce the therapist's own perspective. This therapist shuts off from Charles's emotions and perspectives and instead dominates with the therapist's own thoughts and feelings. This invalidating and confronting approach causes maladaptive interpersonal emotion regulation: Charles begins to feel defensive, unheard, and attacked. These feelings motivate him to defend himself by evading questions or justifying his behavior. Near the end, Charles expresses that he feels bad about himself, but the therapist does not sense these emotional experiences because the therapist is not engaging in affect sharing. Eventually, Charles escapes this argumentative cycle by leaving treatment.

Side by side, these examples show how MI's success hinges on empathy and emotion regulation. Up-regulation of all three empathic subcomponents allows emotions to flow through the therapeutic emotional circuit, guiding the therapist's behavior until the therapist is strongly aligned with the client's goals. Insufficient affect sharing and/or mentalizing reduces the therapist's distal empathic concern, introduces conflictual emotions that disrupt the therapeutic emotional circuit, numbs the therapist to the client's fluctuating emotions, and ultimately leads the client to pursue goals that are not in line with the client's long-term well-being. Thus, our model resonates with the overarching theory of MI (Miller & Rollnick, 2013), making it unsurprising that therapist-level accurate empathy explains substantial differences in client outcomes (Moyers et al., 2005; Moyers & Miller, 2013; Valle, 1981), the opposite pattern as what is observed in ERP. That said, readers may quibble with the assertion that effective MI *requires* high affect sharing. We chose MI as a contrasting example to ERP because they are both empirically supported interventions but differ in how strongly therapists should resonate with their clients' affect to achieve positive outcomes. Nonetheless, we note that high affect sharing may in fact not be necessary for effective MI, and the evidence for this point is much weaker than evidence that affect sharing is detrimental to ERP. One relevant finding is that greater affect sharing is associated with stronger social connections (Cheong et al., 2023), but this was outside of a therapeutic setting. Thus, some skepticism is merited regarding the idea that affective sharing must be elevated in MI, and we encourage future research on this point. We also encourage research on less formalized interventions that may also benefit from high affect sharing, such as capitalization (i.e., therapists sharing and amplifying clients' positive affect when good things happen; Brown et al., 2022; Gable et al., 2006; Langston, 1994).

Discussion and Future Directions

Here, we disrupt the intuition that more empathy is better in clinical settings and develop a new model in which reaching a client's goals requires regulating distinct subcomponents of empathy to manage the flow of emotion between therapist and client. This model provides a more nuanced and flexible understanding of empathy in clinical settings than prior approaches. Our model is also able to accommodate empirical data showing that empathy is related to better outcomes in some settings (Moyers et al., 2005; Moyers & Miller, 2013; Valle, 1981) but not others (Churm, 2023; Deacon, Farrell, et al., 2013; Farrell et al., 2013), as the model emphasizes flexibly aligning treatment goals, session goals, emotional goals, and empathic goals. In this section, we conclude by discussing the key implications, limitations, and applications of this model by outlining future lines of research.

Although our model emerges from recent theories and some empirical results, a major weakness is that several claims of the model have not yet been empirically tested. Specifically, even though there is preliminary evidence that emotions "flow" from clients to providers during treatment (Schumacher et al., 2015, 2017; Weilenmann et al., 2018), empirical examination of clinician empathy is lacking. Consider even the basic idea that this construct can be decomposed into three subcomponents. Scholars have historically been frustrated by unclear measurement methods and construct validity for quantifying empathy in clinical settings (Barkham, 1988; Lambert et al., 1978; Marks & Tolsma, 1986), but definitions and measurement tools have become much more sophisticated in recent years. Ecological-momentary-assessment (EMA) techniques could subtly collect ratings of each empathic subcomponent in therapists and assess how they relate to client affect and treatment outcomes. Through this approach, researchers could address many key questions: Do therapists indeed report a decoupling of each process? Are dissociations across empathic subcomponents more or less common in therapists than the general public? How do these processes relate to client affect and treatment outcomes? Does empirical evidence suggest that empathic concern for proximate goals (i.e., helping someone feel hedonically better) and distal goals (i.e., achieving treatment goals) can be decoupled, with the latter being more closely tied to outcomes than the former? Finally, above, we claimed that up-regulating distal empathic concern and mentalizing are likely always beneficial, but are there contexts in which

down-regulating mentalizing is optimal? These are crucial tests of the model.

Next, empirical research should focus on empathy regulation, specifically asking (a) if greater empathy regulation is also predictive of better treatment outcomes and (b) how therapists implement empathy regulation. Here, researchers can borrow from the vast body of research on emotion regulation, translating both EMA measures and trait scales to ask how therapists modify their situations, attention, and cognitions to shape their empathic responses. For example, do therapists shift their eye gaze away from clients when they share high intensity affect, or do they ever intentionally reappraise the distress their clients are sharing to down-regulate affect sharing? Uniting quantitative (e.g., eye tracking) and qualitative (e.g., focus group) methods can document the rich ways therapists regulate the therapeutic emotional circuit. Using EMA methods to capture moment-by-moment changes in client and therapist empathy and emotions would greatly advance understanding of psychotherapy and allow researchers to test additional questions raised by our model. For example, recent EMA research suggests that the valence (i.e., positivity vs. negativity) of a client's emotions may be a key moderator to keep in mind (Depow & Inzlicht, 2025): Greater empathy for positive emotions has recently been associated with better outcomes for the empathizer (Depow et al., 2025), and the impact of therapist empathic accuracy on outcomes varies on both the valence of the client's emotions and interventions being used (Atzil-Slonim et al., 2019; Stolowicz-Melman et al., 2023). Could valence similarly toggle whether it is wise to up- or down-regulate therapist empathy?

In this article, we have set up anxiety disorders and substance use as two exemplar conditions that (at times) will call for divergent profiles of empathy regulation. However, these are just two example forms of psychopathology, and thus, it remains unclear which empathy-regulation profiles are most helpful for which disorders. It is reasonable that this focus on affective and empathic processes may be much less important for some diagnoses (e.g., managing hallucinations in psychosis may take precedence). Likewise, we mostly focus on the ways in which our model relates to a subset of treatment modalities (i.e., ERP, MI, and counseling), and although we believe this model can be flexibly deployed across many other interventions, there may be therapies in which the model is less prominently a part of successful interventions. Thus, both primary disorders and therapeutic modalities may serve as boundary conditions for the model we propose above, and we encourage researchers across therapeutic modalities to engage with this model to determine which parts do or do not generalize. In addition, there are several ways one can reimagine the relationship between clinician empathy and client outcomes. Here, we complicate the simple assumption of a linear relationship, showing how client symptoms and session-level goals act as moderators influencing ideal empathy levels. Another way to complicate this relationship is to consider nonlinear relationships between empathy and outcomes. In fact, a recent article observed a quadratic relationship between empathy and mental health in women (Belcher et al., 2025). Although this finding emerged outside of therapeutic contexts, it suggests that either too little or too much empathy can be an issue. Thus, future work should compare linear and nonlinear relations between empathy and outcomes.

The model also makes specific recommendations for therapeutic training. Classic intuitions suggest that therapists should select incoming students who are "high" on empathy and train them in techniques to increase their empathic responding to clients (Rogers, 1975; Watson et al., 2014). Our model adds nuance to this approach, suggesting that even if high trait empathy may benefit many clients in many settings (Moyers et al., 2016), therapeutic interventions can be enhanced by mastering skills in regulating empathy. Thus, training programs should help therapists learn strategies for empathy regulation, potentially using recently proposed frameworks that involve progressive immersion into exposure techniques (Balkhi et al., 2016; Farrell et al., 2016). Empirical research will be extremely important for (a) confirming that training therapists in empathy regulation (beyond empathy itself) is associated with better outcomes, (b) identifying which educational procedures are actually most helpful for training empathy regulation, and (c) identifying what interventions prevent the possibility of maleficent therapy (i.e., maladaptive paternalism) in which therapists lose sight of distal empathic concern. This model thus has profound implications for clinical training and accreditation, spurring new research on the science of clinical training.

Finally, we believe this model contributes to the body of research on burnout in clinical professions and caregiving relationships. Feeling exhausted or disengaged from one's work interferes with therapists' empathy and their ability to deliver quality interventions (Brown et al., 2023; Gleichgerrcht & Decety, 2011, 2014; Hua et al., 2021; Lee et al., 2001; Newell & MacNeil, 2010; Ogińska-Bulik et al., 2022). A recent meta-analysis showed that empathic subcomponents have distinct associations with burnout (Martingano et al., 2026), suggesting that skilled empathy regulation may be helpful for managing the difficult feelings providers have when exposed to people suffering (Weisz & Cikara, 2021). Research should directly test whether therapists

with more effective empathy-regulation skills are more resilient to the empathic stressors of their work.

In all, our model clarifies the understanding of empathy in clinical settings. Insights from this model can hopefully enhance the efficacy of the field's treatments, guide training programs, prompt new research, and aid therapists in their work.

Transparency

Action Editor: Pim Cuijpers
Editor: Jennifer L. Tackett
Author Contributions

Erik C. Nook: Conceptualization; Funding acquisition; Writing – original draft; Writing – review & editing.

Jamil Zaki: Conceptualization; Funding acquisition; Writing – review & editing.

Declaration of Conflicting Interests

The authors declared that there were no conflicts of interest with respect to the authorship or the publication of this article.

Funding

E. C. Nook is supported by a seed grant from Princeton Precision Health and a National Alliance for Research on Schizophrenia and Depression (NARSAD) Young Investigator Grant from the Brain & Behavior Research Foundation (No. 31386). J. Zaki is supported by a grant from the National Institute of Mental Health (NIMH R01 MH125974).

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Acknowledgments

We thank Juliet Davidow, Rebecca Fortgang, and Erika Weisz for helpful comments on drafts of the article.

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