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Does Therapeutic Discourse on Mass Media Provide Anything More than Just "Infotainment"? Comparing Expressed Empathy in Dr. Phil and Recorded Psychotherapy

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Abstract: Television talk shows frequently address psychological difficulties, but their formats and purposes differ from those of recorded psychotherapy sessions. This observational study compared expressed empathy in selected segments of four Dr. Phil episodes and four recorded psychotherapy sessions featuring two practitioners. Using an adapted empathic communication coding scheme, the study coded client-created empathic opportunities and practitioners' verbal and nonverbal responses. The dataset contained 476 verbal and 324 nonverbal response ratings. Higher mean expressed-empathy scores were observed in the selected psychotherapy recordings than in the Dr. Phil excerpts for both verbal responses (3.90 versus 2.89) and nonverbal responses (1.29 versus 0.58). In a subset of 96 opportunity-response sequences, verbal scores showed a setting-by-phase interaction in the reported analysis, whereas nonverbal scores did not show a comparable phase effect. Positive opportunities were absent from the sampled Dr. Phil segments, preventing a full comparison by emotional valence. Sequence duration was positively associated with verbal scores within both sets of recordings. The contribution is an opportunity-centered, two-channel description of expressed empathy that separates observable responses from underlying empathic capacity and client-perceived empathy. Because the recordings differ in purpose, editing, participants, and interactional context, the results describe these selected materials and cannot establish treatment effectiveness or differences in the practitioners' underlying empathic capacities.

Keywords: empathic communication, expressed empathy, therapeutic interaction, televised counseling, observational coding

Psychological difficulties are increasingly discussed in public-facing media as well as in professional mental health care. Television programs can provide accessible stories and information, but a televised encounter is not equivalent to an ongoing therapeutic relationship. Beyond the content of advice, an important and more observable question concerns how a person's expressed difficulty is acknowledged and explored in the exchange. Prior studies have examined mental health portrayals and treatment recommendations in popular media, including Dr. Phil, while raising questions about their implications for audiences (Rasmussen & Ewoldsen, 2013; Vogel et al., 2008). The present study examines this moment-to-moment communication by focusing on the response that follows an emotional disclosure.

A Comparison Across Communication Settings

Dr. Phil is a useful case for studying televised therapeutic discourse because the program features discussions of personal distress and recognizable advice-giving episodes. Previous scholarship has examined the program as a form of popular psychological communication and described its confrontational presentation style (Henson & Parameswaran, 2008; Martinez et al., 2011). Such observations invite closer analysis, but they do not establish whether the host lacks empathy or whether viewers benefit from the show. The program is produced for a public audience, often includes additional guests, and is shaped by editorial selection. Recorded psychotherapy demonstrations, by contrast, are structured around the client and the demonstration of therapeutic practice. The two settings therefore create different opportunities and pressures for communicating understanding.

A comparison between these settings is most informative when it focuses on a clearly observable process rather than treating either format as inherently therapeutic or harmful. This study accordingly examines how the responding person reacts to an identifiable emotional concern, challenge, or positive development. The comparison is confined to the sampled videos and not framed as a contest between all television hosts and all psychotherapists. Hereafter, the term focal speaker denotes a psychotherapy client or a television guest, while responder denotes the psychotherapist or television host.

From Empathic Capacity to Expressed Empathy

Empathy has several distinguishable meanings. Cognitive empathy concerns understanding another person's perspective, whereas affective empathy concerns an emotional response to that person's experience (Duan & Hill, 1996; Reniers et al., 2011). In an interaction, however, another person cannot directly observe this internal understanding. What matters within an observable encounter is how that understanding is communicated. This article defines observer-coded expressed empathy as a verbal or nonverbal response that a coder identifies as acknowledging, exploring, or otherwise engaging sensitively with the focal speaker's disclosed experience. Such a rating neither measures the responder's inner emotional state nor verifies that the focal speaker felt understood.

This distinction has practical and theoretical importance. Psychotherapy research associates perceived therapist empathy with better outcomes, but observed behavior, the client's perception, and the therapist's self-assessment are not interchangeable constructs (Elliott et al., 2011). Studies of coaching similarly document the potential gap between how support is intended or reported and how it is experienced by the recipient (Will et al., 2016). More recently, Liu et al. (2025) found that coach and beginning-teacher reports of need support often diverged. These findings come from coaching rather than psychotherapy and are used here to motivate a conceptual distinction, not to infer how the clients in the present videos felt. The therapeutic alliance offers a further reason to study communicated understanding. Research has linked the quality of the working alliance and therapeutic bond with psychotherapy outcomes (Horvath & Symonds, 1991; Saunders, 2000). Yet the present videos contain neither client-rated empathy nor treatment outcome measures. Accordingly, higher observer-coded scores must not be interpreted as evidence of improved clinical outcomes. Its object is narrower and more directly observable, namely patterns of empathic responding during recorded interaction.

An Empathic Opportunity and the Response it Elicits

Empathic communication can be examined as an interactional sequence. An empathic opportunity occurs when the focal speaker makes an explicit emotional statement, reports progress or a challenge, or displays an overt emotional cue. The responder can then acknowledge, explore, confirm, or dismiss that opportunity. The resulting opportunity-response sequence supplies a defined unit of observation, comprising the cue and the response that follows. This approach builds on the Empathic Communication Coding System developed for medical encounters by Bylund and Makoul (2005), together with earlier work on patient concerns and physician responses (Branch & Malik, 1993; Suchman et al., 1997).

The opportunity matters because the practitioner does not respond in a vacuum. For example, a statement of distress can invite a different response from an expression of improvement. The opportunity's emotional valence was classified as positive or negative when a category could be assigned. A response also unfolds over time. A brief acknowledgment may be sufficient in one context, while pursuing the emotional meaning of a statement may require a longer exchange. Sequence duration is therefore an interactional descriptor, not an independent measure of empathy.

The adapted scheme assesses verbal expressed empathy using seven ordered categories, scored from 0 to 6. At the lower end, responses dismiss or give little recognition to the opportunity. Higher categories capture acknowledgment, further exploration, confirmation, and sustained attempts to help the speaker articulate meaning. These are operational categories rather than universal standards of therapeutic quality. In particular, a challenging question or self-disclosure should be evaluated in context rather than assumed to be empathic solely because of its form.

Why Verbal and Nonverbal Responses Must be Distinguished

Responses to empathic opportunities can also be communicated nonverbally. Gaze, orientation, posture, voice, and responsiveness may affect how an interaction is perceived, although the meaning of each cue depends on context (Brugel et al., 2015; Montague et al., 2013). The analysis therefore treats observer-coded nonverbal expressed empathy as a separate dimension rather than adding it to the verbal score. The adapted scheme rates nonverbal responses in three ordered categories, scored from 0 to 2, with higher scores indicating clearer recognition of the opportunity. These ordinal scores are not interchangeable with the seven-category verbal ratings.

Separating the two channels creates a sharper comparison. A practitioner may use words that explicitly recognize a concern while displaying limited or ambiguous nonverbal engagement. Conversely, attentive nonverbal behavior may accompany a short verbal response. A single global empathy score would obscure these possibilities, particularly when comparing filmed encounters organized for different purposes.

Research Aims and Original Contribution

The study asks how the sampled Dr. Phil segments and recorded psychotherapy sessions differ in observer-coded expressed empathy. Its specific contribution is to extend an established opportunity-response approach beyond medical encounters to a cross-format

comparison, keeping the focal speaker's opportunity and the responder's two communication channels analytically distinct. This approach identifies where setting-related contrasts appear in the sequence without treating either format as psychotherapy of equivalent purpose. The contextual descriptors examined are the excerpt's coded phase, the opportunity's valence, and the duration of the opportunity-response sequence. Together, these distinctions specify an observational contribution, not a causal account of empathy or therapeutic benefit.

- RQ1. How do the sampled settings differ in their levels of verbal and nonverbal expressed empathy?
- H1. Observer-coded expressed empathy will be higher in the selected psychotherapy recordings than in the Dr. Phil segments.

The next questions examine whether the overall contrast varies across features of the encounter. Early and later are operational labels for the excerpts in Appendix A, not standardized clinical treatment stages. Their meanings also differ across sources because the psychotherapy excerpts come from different sessions, whereas the televised excerpts come from different points within an episode.

- RQ2. Do verbal and nonverbal expressed-empathy scores differ by coded phase and setting?
- H2. Scores will tend to be higher in later segments than in early segments, particularly for verbal responses. The psychotherapy recordings are expected to score higher across phases.
- RQ3. How do response scores vary with the positive or negative valence of the focal speaker's empathic opportunity?
- H3. Positive opportunities will be associated with higher response scores where both valence categories are represented. Differences by setting will be examined to the extent supported by the data.
- RQ4. Is the duration of an opportunity-response sequence associated with the verbal expressed-empathy score?
- H4. Longer sequences will be positively associated with verbal expressed-empathy scores within each setting.

METHOD

Study Design and Materials

The study used an exploratory observational design based on eight video recordings. Four Dr. Phil episodes were compared with four psychotherapy recordings available through PsycTHERAPY. The psychotherapy recordings comprised two selected sessions by Amy Wenzel and two by Stephen Madigan. Videos were the units of purposive selection, whereas coded responses within those videos were the units of the reported statistical analyses. Response-level observations therefore cannot be interpreted as independent setting-level replications.

Selection of Televised Segments

Four Dr. Phil episodes were purposively selected because they involved interpersonal or psychological difficulties broadly overlapping with topics in the psychotherapy recordings. The television material was not collected as a random sample of the program. Only excerpts containing an identifiable exchange between the host and a focal guest were retained for coding. The original episodes could include other guests and editorially assembled scenes, and the selected excerpts are not complete treatment sessions. The episodes and timestamps are listed in Appendix A.

Selection of Psychotherapy Recordings

PsycTHERAPY is a collection of recorded psychotherapy demonstrations that can be used to observe clinicians' verbal and nonverbal behavior (VandeCreek, 2018; VandenBos et al., 2016). For each practitioner, excerpts were taken from the first and third sessions in the recorded series. Their topics overlap broadly with the televised episodes, but the matches are not equivalent on client characteristics, presenting problem severity, practitioner identity, duration, or recording conditions. As in the televised set, the selected recording details are documented in Appendix A. Accordingly, a source-by-phase contrast also compares within-episode positions on television with across-session positions in psychotherapy.

Coding of Empathic Opportunities and Responses

The analysis adapted the Empathic Communication Coding System of Bylund and Makoul (2005) to include both verbal and overt nonverbal opportunities. The adapted procedure is referred to throughout as the empathic communication coding scheme. First, coders identified the focal speaker's explicit emotional statements, progress statements, challenge statements, or clearly observable nonverbal cues. Second, they classified the responder's verbal response. Third, they classified the responder's nonverbal response separately. MediaCoder was used to annotate the recordings (Bos & Steenbeek, 2017). Appendix B retains the original opportunity definitions, rating categories, and illustrative behaviors, with clarifications where needed.

Verbal expressed empathy was coded from 0 to 6, ranging from denial or disconfirmation to responses categorized as stimulation and reconstruction. Nonverbal expressed empathy was coded from 0 to 2, ranging from absent or ambiguous acknowledgment to clear nonverbal engagement. Both scales are ordinal, and numerical differences need not represent equal increments in empathic communication. The phase variable classified excerpts as early or later according to the original selection, and opportunity valence distinguished positive from negative disclosures. Sequence duration was examined in relation to verbal ratings. The available report does not specify whether timing covered the entire opportunity-response exchange or only the response. Because these categories depend on coder interpretation, especially for nonverbal behavior, the scores cannot be equated with the focal speaker's own perception of empathy.

Reliability and Statistical Approach

Analyses were conducted with SPSS version 23. Two independent reviewers coded one recording, with a reported Cohen's κ of .79 (Cohen, 1960). The available report does not state the exact number of jointly coded units or separate agreement estimates for the verbal and nonverbal scales, which limits the interpretation of this reliability figure. The descriptive dataset contains 476 verbal ratings and 324 nonverbal ratings, as shown in Tables 1 and 2. One-way analyses of variance compared settings for each response modality. The original study additionally analyzed a subset of 96 opportunity-response sequences for setting, phase, and opportunity valence. The selection rule for this subset is not documented in the available report. Pearson correlations assessed duration and verbal expressed-empathy scores within each setting. These original analyses are reported transparently below. Because the ordinal response ratings were analyzed as approximately continuous and many observations came from only eight recordings, conventional *p* values do not account for video-level clustering and may overstate inferential precision. Accordingly, the analyses are presented as exploratory descriptions of the sampled material rather than confirmatory tests of general setting or practitioner effects.

RESULTS

Overall Differences Between Settings

Verbal Expressed Empathy

The psychotherapy recordings contained 367 coded verbal responses with a mean score of 3.90 (*SD* = 0.99), compared with 109 responses in the Dr. Phil segments with a mean of 2.89 (*SD* = 1.53). The originally reported response-level analysis of variance yielded $F(1, 474) = 66.97$, $p < .001$.

Table 1: Verbal Expressed-Empathy Scores by Recording Source

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
PsycTHERAPY	367	3.90	.99	.05	3.80	4.00
Dr. Phil	109	2.89	1.53	.15	2.60	3.18
Total	476	3.67	1.21	.06	3.56	3.78

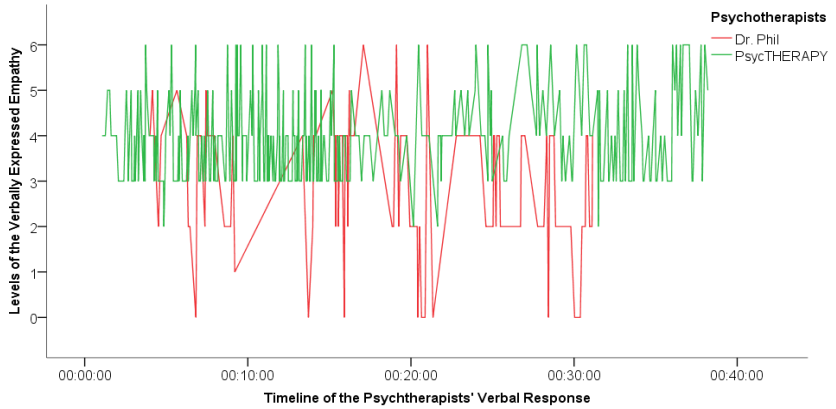


Figure 1: Verbal Expressed-Empathy Ratings Displayed Against Their Recorded Time Positions.

Table 1 summarizes the descriptive statistics, and Figure 1 displays the ordered response scores across the recording timeline. The lower average in the televised sample describes these coded responses. It does not establish that the individuals involved differed in their underlying ability to empathize. The confidence intervals in Table 1 also treat responses as independent and do not reflect video-level sampling uncertainty.

Nonverbal Expressed Empathy

The same directional pattern appeared in the nonverbal coding. The psychotherapy recordings contained 229 ratings with a mean of 1.29 (*SD* = 0.56), while the Dr. Phil segments contained 95 ratings with a mean of 0.58 (*SD* = 0.54). The originally reported response-level analysis of variance yielded $F(1, 322) = 110.83$, $p < .001$. Table 2 and Figure 2 provide the corresponding details. Although these between-setting differences are substantial in the sampled material, the scores are on a different scale from verbal scores and must be interpreted separately. As in Table 1, the confidence intervals in Table 2 are not adjusted for within-video dependence.

Table 2: Nonverbal Expressed-Empathy Scores by Recording Source

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
PsycTHERAPY	229	1.29	.558	.037	1.22	1.36
Dr. Phil	95	.58	.538	.055	.470	.690
Total	324	1.08	.639	.036	1.01	1.15

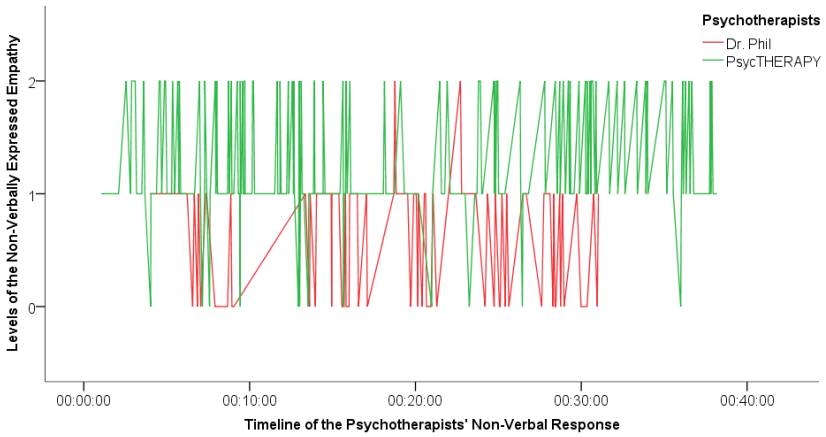


Figure 2: Nonverbal Expressed-Empathy Ratings Displayed Against Their Recorded Time Positions.

How Expressed Empathy Varies by Coded Phase

Verbal Responses by Phase

In the subset of 96 coded sequences, the originally reported factorial analysis of verbal ratings identified a source effect, $F(1, 92) = 21.74$, $p < .001$, and a phase effect, $F(1, 92) = 23.85$, $p < .001$. The interaction was also reported as significant, $F(1, 92) = 11.58$, $p < .001$. Descriptively, Dr. Phil excerpts had a mean of 2.20 in early segments and 4.44 in later

segments. The psychotherapy means were 4.39 and 4.79, respectively. Table 3 and Figure 3 show the pattern. Because the phase contrast does not use equivalent within-person time intervals across the two sources, it should not be interpreted as longitudinal therapeutic improvement.

Table 3: Estimated Marginal Means of Verbal Expressed Empathy by Source and Coded Phase

Psychotherapists	Phase	Mean	Std. Error
Dr. Phil	Earlier	2.20	.26
	Later	4.44	.38
PsycTHERAPY	Earlier	4.39	.18
	Later	4.79	.22

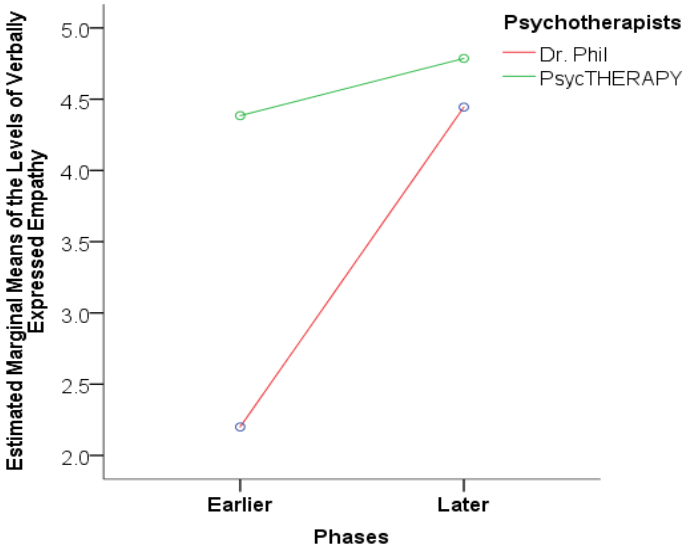


Figure 3: Estimated Marginal Means Of Verbal Expressed-Empathy Ratings by Source and Coded Excerpt Phase.

Nonverbal Responses by Phase

For nonverbal expressed empathy, the original analysis identified a setting difference, $F(1, 92) = 15.12$, $p < .001$, but not a significant overall phase effect, $F(1, 92) = 0.11$, $p = .741$, or interaction, $F(1, 92) = 0.38$, $p = .54$.

Table 4: Estimated Marginal Means of Nonverbal Expressed Empathy by Source and Coded Phase

Psychotherapists	Phase	Mean	Std. Error
Dr. Phil	Earlier	.65	.13
	Later	.78	.19
PsycTHERAPY	Earlier	1.26	.10
	Later	1.22	.10

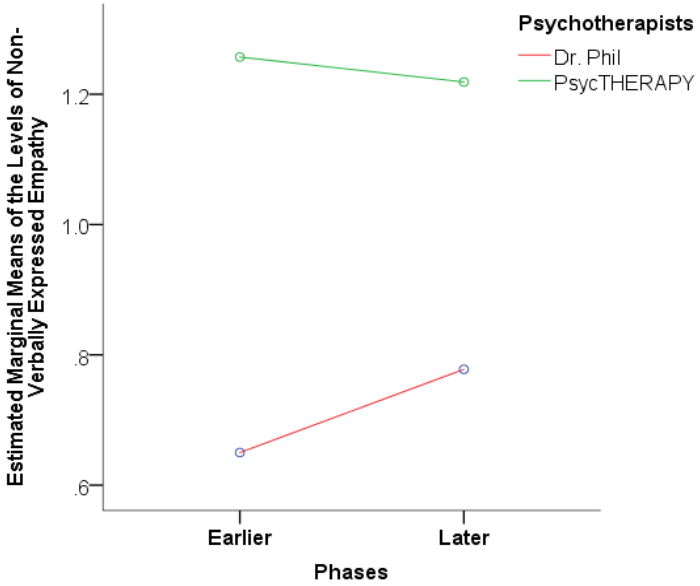


Figure 4: Estimated Marginal Means Of Nonverbal Expressed-Empathy Ratings by Source and Coded Excerpt Phase.

The Dr. Phil means were 0.65 in early segments and 0.78 in later segments. The corresponding psychotherapy means were 1.26 and 1.22. Table 4 and Figure 4 therefore do not support a general claim that nonverbal expressed empathy increases from earlier to later segments.

Opportunity Valence and the Missing Comparison Cell

Verbal Responses by Opportunity Valence

No positive-valence empathic opportunities were identified in the sampled Dr. Phil segments. Consequently, a setting-by-valence interaction cannot be estimated from these data.

Table 5: Verbal Expressed-Empathy Means by Source and Opportunity Valence

Psychotherapists	Valence	Mean	Std. Error
Dr. Phil	Negative	2.90	.24
	Positive	. [a]	. [a]
PsycTHERAPY	Negative	4.52	.16
	Positive	5.33	.74

Note. a. The empathic opportunities with positive valence were not observed in Dr. Phil's videos; therefore, the corresponding population marginal mean is not estimable.

Within the psychotherapy recordings, the reported verbal means were 4.52 for negative opportunities and 5.33 for positive opportunities. For Dr. Phil, the negative-opportunity mean was 2.90. The original analysis reported a setting effect, $F(1, 93) = 31.73$, $p < .001$, and a nonsignificant valence term, $F(1, 93) = 1.16$, $p = .28$. However, because one

cell was empty, the analysis does not provide a balanced test of whether valence has the same association with responses in both settings. Table 5 presents the available cell estimates.

Nonverbal Responses by Opportunity Valence

The nonverbal data have the same missing positive-opportunity cell for Dr. Phil. Among the available observations, the mean was 0.69 for negative opportunities in the televised segments and 1.23 and 1.33 for negative and positive opportunities in the psychotherapy recordings. The original reported tests were $F(1, 93) = 18.14$, $p < .001$, for setting and $F(1, 93) = 0.09$, $p = .77$, for valence. As with the verbal analysis, the absence of a positive televised cell precludes a complete factorial interpretation. Table 6 records what can be compared and what remains unobserved.

Table 6: Nonverbal Expressed-Empathy Means by Source and Opportunity Valence

Psychotherapists	Valence	Mean	Std. Error
Dr. Phil	Negative	.690	.106
	Positive	. [a]	. [a]
PsycTHERAPY	Negative	1.234	.071
	Positive	1.333	.330

Note. a. The empathic opportunities with positive valence were not observed in the Dr. Phil's videos, thus the corresponding population marginal mean is not estimable.

Sequence Duration and Verbal Expressed Empathy

Correlations Within Each Setting

Longer opportunity-response sequences were associated with higher verbal expressed-empathy scores in both datasets. The reported correlations were $r = .284$, $n = 67$, $p = .020$, for the psychotherapy recordings and $r = .501$, $n = 29$, $p = .006$, for Dr. Phil. These results are consistent with the idea that some more elaborated responses require additional time, as also observed in medical encounters (Bylund & Makoul, 2005). Yet a longer exchange can contain many different behaviors. The association cannot show that increasing response duration by itself would make a response more empathic.

DISCUSSION

What the Comparison Reveals

This comparison began with a narrow question that has broad relevance. When people communicate psychological distress in public and clinical settings, what observable signs of understanding follow? In the selected videos, practitioner responses from recorded psychotherapy received higher scores than those from Dr. Phil on both the verbal and nonverbal scales. Phase-specific summaries also differed by response channel, with a reported source-by-phase interaction for verbal but not nonverbal ratings. The missing positive-valence cell and duration correlations further constrain what can be inferred about the processes underlying these differences.

The findings should first be understood as interaction patterns. An empathic opportunity is created within a specific exchange, and the response that follows reflects not only a responder's communicative choices but also the opportunity presented, the relationship, and the setting. The data therefore support a descriptive statement about selected recordings, not a fixed ranking of professional compassion, diagnostic competence, or clinical quality.

Verbal Responses Through Acknowledgment and Exploration

The verbal pattern suggests that the psychotherapy recordings more often displayed responses in the upper portion of the adapted coding scale, where the speaker's concern is explicitly acknowledged and explored. The Dr. Phil excerpts showed lower average ratings on the same scale. These differences are intelligible in light of the contrasting communication tasks. The recording formats may support different kinds of exchanges, with psychotherapy demonstrations oriented toward clinical work and televised segments also oriented toward an audience. The present design cannot determine which feature caused the observed difference. Henson and Parameswaran (2008) described a distinctive confrontational presentation in Dr. Phil, but this broader characterization does not independently verify the intentions or impact of individual responses.

Expressed empathy is thus best treated as a contingent interpersonal accomplishment. The meaning of the response depends on how it addresses the concern that prompted it. An affirming phrase can miss its mark if it bypasses what the person has expressed, while a direct question may communicate careful understanding when it is relevant and sensitively delivered. This interpretation is consistent with observational approaches that examine the relationship between the client's opportunity and the practitioner's actual reply (Bylund & Makoul, 2005; Suchman et al., 1997).

Nonverbal Cues Add Information but Require Caution

Nonverbal ratings showed a similar descriptive source contrast while also showing why a separate coding channel matters. Gaze and orientation can influence how empathic an interaction appears to an observer (Brugel et al., 2015), and eye contact has been associated with patient-rated empathy in clinical encounters (Montague et al., 2013). Yet the same gesture can have different meanings depending on cultural expectations, camera position, editing, and surrounding speech. The present observer-based ratings cannot establish how the person speaking interpreted a particular gesture.

The two channels should consequently be viewed as complementary evidence. Alignment between responsive verbal and nonverbal behavior may make understanding clearer to an interlocutor, but neither scale measures internal empathy directly. This distinction helps prevent the observed differences from being turned into unsupported moral judgments about practitioners or unsupported claims about clients' experiences.

Phase Matters Differently Across Channels

The larger descriptive early-to-later contrast in Dr. Phil's verbal ratings needs careful interpretation. The later televised excerpts may have been selected at moments when

emotional disclosure or advice was more developed. Meanwhile, the psychotherapy recordings were drawn from different sessions and therapists. Phase was therefore an attribute of selected material, not an experimentally manipulated treatment stage. The original response-level tests reported a source-by-phase interaction, but it does not prove that either practitioner became more empathic over time.

Nonverbal ratings did not show a statistically detectable phase pattern. The absence of a detectable nonverbal phase effect suggests that the two rating channels need not follow identical patterns, although the sample cannot establish why. The stronger conclusion is simply that the available data did not demonstrate such a difference. Separating modalities prevents an unsupported general statement that empathy increased across both verbal and nonverbal behavior.

What Opportunity Valence Can and Cannot Explain

No positively valenced opportunities were identified in the coded Dr. Phil excerpts. This is a property of the selected material and coding decisions. The finding cannot be generalized to the program as a whole or attributed to the host's capacity to elicit positive disclosures. Negative circumstances may be overrepresented in a show organized around conflict or crisis, but the present study was not designed to test the causes of episode selection or the origin of participants' emotional disclosures. The missing cell also changes the question the data can answer. The psychotherapy recordings permit a descriptive comparison of responses to positive and negative opportunities. The televised recordings do not. Accordingly, H3 cannot be evaluated across the two settings in the originally proposed form. Future sampling should deliberately include positive and negative opportunities within each recording type so that valence can be separated from setting, topic, and individual practitioner.

Why Response Duration is an Informative but Limited Correlate

The positive correlations between sequence duration and verbal expressed-empathy scores can be read alongside the opportunity-response approach of Bylund and Makoul (2005). More elaborate forms of acknowledgment, exploration, and confirmation may require more conversational space than a brief reply. However, duration can also reflect hesitation, disagreement, interruption, or the client's contribution to the exchange. Duration is not a proxy for the quality of empathy. More precise temporal analyses would distinguish the onset, length, and overlap of the client's opportunity and the practitioner's verbal and nonverbal reactions.

Theoretical Contribution and Practical Implications

The article's theoretical contribution is to sharpen the distinction between an empathic opportunity, the observable response to it, and the focal speaker's unmeasured experience of that response. The relevant mechanism is opportunity-contingent responding, which can be examined separately in verbal and nonverbal channels. By adapting an existing coding approach to two recording formats, the analysis organizes evidence around the opportunity, the verbal response, and the nonverbal response without assuming that the channels are

interchangeable. Excerpt phase, opportunity valence, and sequence duration help situate these responses within the interaction. The study does not validate a new psychometric instrument or identify a universal causal mechanism. Its novelty is therefore a cross-format process comparison with explicit construct boundaries, rather than the discovery of empathy itself.

This separation of responder behavior from recipient experience is also consistent with dyadic coaching scholarship. Liu (2025) considers dyadic processes in need-supportive coaching, and Liu et al. (2026) synthesize evidence on need support, need satisfaction, and motivation in coach–athlete relationships. Although these studies are about coaching rather than psychotherapy, they clarify why a responder's intentions and the recipient's experience must remain conceptually distinct. They do not independently validate the present coding scheme or establish clinical consequences. Likewise, evidence that coaches' and coachees' reports diverge (Liu et al., 2025) underscores why future studies of observed therapeutic interactions should include the client's interpretation of the same episodes.

For training and supervision, the coding framework could serve as a structured prompt for reviewing recorded interaction. A supervisor might ask what the focal speaker expressed, what the responder did next, whether verbal and nonverbal responses aligned, and how the client reacted. Such reflection is not a substitute for qualified clinical judgment and does not turn a high code into proof of therapeutic success. For media research, the framework provides a way to study communication without treating televised advice as evidence of clinical effectiveness.

Limitations and Directions for Future Research

Several design constraints define the strength of these conclusions. First, four television episodes and four psychotherapy recordings constitute a small purposive sample. Setting is confounded with presenter, therapist, client, topic, audience, production, and selection of segments. For this reason, the dataset cannot support generalization to all televised counseling or to all psychotherapy, and the comparison should not be interpreted as a clinical treatment evaluation. Second, numerous response observations were drawn from a small number of videos and are likely dependent. The reported analyses do not account for within-recording dependence, and there is only one televised host, so responder identity cannot be separated from format. A larger study would sample more presenters and therapists, preserve independent recording-level replication, and use multilevel or other dependence-aware analyses. Such a design could estimate uncertainty for the difference between settings more credibly. Third, the coding scheme prioritized explicit opportunities. It did not systematically include indirect emotional clues or ambiguous disclosures, even though these can elicit significant empathic work (Levinson et al., 2000). Moreover, the verbal and nonverbal scales were observational ordinal categories. The available report gives only one interrater kappa estimate from one recording and does not provide the reliability information needed for comprehensive modality-specific validation. Future research should document coder training, blinded reliability assessment, adjudication, agreement by category, and the handling of overlapping cues. Fourth, observer-coded expressed empathy is not equivalent to empathy perceived by the person in the interaction. Neither client perceptions nor clinical outcomes were measured. The coaching literature offers a useful warning against this substitution because providers and recipients may

disagree about how much support was communicated (Liu et al., 2025; Will et al., 2016). Future studies should link synchronized interaction coding with client experience measures, where ethically and practically possible. Finally, no positive opportunities were observed in the Dr. Phil sample, so comparisons by valence were incomplete. Sequence duration was not established as a causal determinant of empathy and may depend on many conversational features. Balanced sampling of opportunity valence, more comparable session lengths, explicit timing conventions, and sensitivity analyses are required before stronger process explanations can be tested.

CONCLUSION

The distinction between televised counseling and recorded psychotherapy is not adequately captured by asking which is more entertaining or which participant is a more empathic person. A more answerable question concerns the observable exchange that follows a client's emotional disclosure. In the eight recordings examined here, observer-coded verbal and nonverbal expressed empathy was higher in the selected psychotherapy material than in the Dr. Phil excerpts. Verbal scores varied by coded phase, nonverbal scores did not show the same phase pattern, and longer sequences were associated with higher verbal scores. The data could not fully assess opportunity valence because positive opportunities were absent from the sampled televised segments. By placing each response in relation to the opportunity that prompted it and distinguishing communication channels, the study provides a bounded process description across two recording contexts. Stronger conclusions about client experience or therapeutic benefit await larger, more comparable, dyadic studies.

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APPENDIX A: VIDEO RECORDINGS AND CODED EXCERPTS

The dataset comprised four selected Dr. Phil episodes.

1. Season 14 episode 26: "My Gambling Addicted Mom Is $400,000 in the Hole, About to Lose Her Home and Possibly Her 14-Year-Old Son!"

   Early phase: 03:57–04:31; 04:38–04:54; & 05:25–09:12

   Later phase: 14:54–16:13 & 18:38–21:01

2. Season 16 episode 4: "Three DUIs and Multiple Arrests: Our Sweet Little Granny Has Become a Pill-Popping, Vodka-Drinking Menace to Society!"

   Early phase: 25:01–25:47; 26:28–27:00; & 27:36–29:00

   Later phase: 29:41–31:11

3. Season 16 episode 5: "I've Given My Drug Addict Son Over 3 Million Dollars, but I've Done It to Keep Him Alive"

   Early phase: 15:20–16:20 & 18:47–21:26

   Later phase: 22:38–25:33

4. Season 16 episode 139: "Our Daughter Is Starving Herself to Death and It's Killing Our Family"

   Early phase: 13:20–14:11

   Later phase: 15:17–16:42, 16:50–17:10

The other four recordings were PsycTHERAPY sessions, with two recordings featuring Amy Wenzel and two featuring Stephen Madigan. The original episode and session identifiers and selected timestamps are retained below.

1. "Cognitive Behavioral Therapy for Anxiety and Depression" (Session 1 of 6) (Amy Wenzel)

   Early phase: 01:54–16:16

2. "Cognitive Behavioral Therapy for Anxiety and Depression" (Session 3 of 6) (Amy Wenzel)

   Later phase: 23:34–38:12

3. "Narrative Therapy for Bulimia" (Session 1 of 6) (Stephen Madigan)

   Early phase: 01:00–15:56

4. "Narrative Therapy for Bulimia" (Session 3 of 6) (Stephen Madigan)

   Later phase: 09:10–24:53

APPENDIX B: ADAPTED EMPATHIC COMMUNICATION CODING SCHEME

Table B1: Criteria for Identifying Client-Created Empathic Opportunities

Level and name	Description of client-created empathic opportunities	Examples
Category 1 Emotional feeling statement	An emotional feeling statement explicitly identifies an emotion experienced by the focal speaker. This emotion should be felt at the present time. The emotional statement may be related to a physical problem or a psychosocial concern and may be either negative, as in the above examples, or positive.	''I am scared that I am going to lose my job''; ''I am so proud of myself for quitting drinking.''

Category 2 Progress statement	A progress statement is an explicit statement that the focal speaker makes about a positive development in physical or psychosocial condition that has improved quality of life, a positive development in the focal speaker's life, or a recent, very positive, life-changing event.	"By following that diet, I've gotten my weight down pretty good."
Category 3 Challenge statement	A challenge statement is an explicit statement the focal speaker makes about the negative effect a physical or psychosocial problem has on the focal speaker's quality of life, or about a recent, devastating, life-changing event.	"My husband and I decided that we are going to get divorced."
Category 4 Definite body language	An unambiguous nonverbal display indicating positive or negative emotion, coded in its interactional context.	Observable crying, visibly trembling, smiling, or markedly raised voice.

Table B2: Verbal Expressed-Empathy Coding Levels

Levels	Names	Descriptions	Examples	Descriptions of Examples
6	Stimulation and Reconstruction	The psychotherapist demonstrates understanding that extends beyond the speaker's explicit words while remaining grounded in the interaction. Psychotherapist actively stimulates the client to become more self-aware, and to gain a structured overview of the problems, without jeopardizing the cooperative therapeutic relationship.	Self-disclosure; reflecting meaning; challenging skills (giving feedback & confrontation); positive relabeling (reframing); compliment	Self-disclosure: the psychotherapist discloses a personal experience; Reflecting meaning: the psychotherapist explores an underlying meaning in the focal speaker's account; Challenging skills: (1) *Giving feedback*: providing information and the psychotherapist's honest reaction to the client; (2) *confrontation*: the psychotherapist points out discrepancies or inconsistencies and blind spots in the client's story. Positive relabeling (Reframing): the psychotherapist proposes a new, more constructive definition of the problem that fits the facts just as accurately as the old one. Compliment: a polite expression of praise or admiration.

5	Confirmation	Psychotherapist makes active and repeated efforts to understand client's worldview. Psychotherapist shows evidence of an accurate understanding of the client's point of view, although mostly limited to explicit content.	Reflecting feelings; reflecting content (paraphrasing); summarizing	Reflecting feelings is a helping response that accurately identifies the client's emotions based on the focal speaker's verbal or nonverbal communication. Reflecting content (paraphrasing) is a distilled version of the content of the client's message. The content includes significant facts, thoughts, and intentions. Summarizing is a technique in which the psychotherapist provides a distilled version of facts, feelings, and meanings that covers everything the client has said up to that point.
4	Pursuit	Psychotherapist explicitly acknowledges the central issue in the empathic opportunity and pursues the topic with the client by asking the client a question.	Inducing questions (open and closed questions) door openers	Open questions direct the client to talk about a particular subject but are less demanding in comparison to closed questions. Although they may suggest an area for exploration, they give the client a wider range of possible responses. Because of this, they encourage the client to open up rather than supply a single piece of data. Closed questions require short, factual responses, yes/no responses, or a specific answer. Door openers are invitations to talk. They are requests for the client to continue or expand.
3	Acknowledgment	Psychotherapist explicitly acknowledges the central issue in the empathic opportunity but does not pursue the topic.	Minimal encouragers; parroting	Minimal encouragers are short supportive statements that indicate that the psychotherapist is attending to the focal speaker. They are useful to nudge the client to

				continue, yet they do not intrude and distract. Parroting is the verbatim repetition of a statement. On its own, repetition does not demonstrate an accurate understanding of the focal speaker's meaning and should not be scored as strong expressed empathy.
2	Implicit recognition	Psychotherapist makes sporadic efforts to explore the client's perspective. Psychotherapist's understanding may be inaccurate, or may detract from the client's true meaning, or may not honor the client's self-value.	Distracting questions/ statements; using Clichés; giving advice/ suggestion/ teaching; labelling; describing/ objective statement	Distracting question: the psychotherapist asks a question that ignores key messages in the client's story. The psychotherapist ultimately changes the focus of the conversation. Such questions shift the conversation away from the focal speaker's expressed concern, regardless of why the responder becomes distracted. Using clichés involves formulaic reassurance that may overlook the focal speaker's specific concerns. For example, a formulaic "I know how you feel" can fail to acknowledge the focal speaker's particular experience. Unsolicited advice can move an exchange away from the focal speaker's own exploration. Labeling means describing someone or something in a word or short phrase. An objective statement describes observable facts or behaviors, with or without interpretation.
1	Perfunctory recognition	Psychotherapist gives an automatic, formulaic response, giving the empathic opportunity minimal recognition.	Little or no attention	Psychotherapist gives an automatic, formulaic response, giving the empathic opportunity minimal recognition

0	Denial/ disconfirmation	Psychotherapist either ignores the client's empathic opportunity or makes a disconfirming statement.	Denial/ disconfirmation; irrelevant response; argument with the client; judgmental statement	Psychotherapist either ignores the client's empathic opportunity or makes a disconfirming statement or argues with the client

Table B3: Nonverbal Expressed-Empathy Coding Levels

Levels	Names	Descriptions	Examples
2	High Empathy	The responder displays clear nonverbal acknowledgment of the empathic opportunity. Ratings depend on the cue's fit with the focal speaker's expressed concern.	Postural congruence: mirroring a congruent arm and leg position; movement synchrony: synchronization between the body movements of interacting partners; mirroring voice tone; synchrony of speech rate; social touch/therapeutic touch/healing touch (e.g., a handshake, hug, or pat on the back); empathic facial expression (e.g., smile, frown); social movement (e.g., offer tissues for a crying client); soft tone of voice
1	Medium Empathy	The responder shows observable but limited acknowledgment of the empathic opportunity through nonverbal cues. However, the psychotherapist gives an automatic response or limited transmission of nonverbal cues of emotion.	Head nod; eye contact/gaze; body orientation (e.g., trunk lean); note-taking; squarely face the client.
0	Low Empathy/ Undetectable Empathy	The responder shows ambiguous or no observable acknowledgment of the empathic opportunity through nonverbal cues. Alternatively, the response may display denial or misattunement through nonverbal cues. The responder may provide no observable nonverbal response.	No response; interrupting; yelling; hard tone of voice; silence; no eye contact; shake head; facial and body expression: (e.g., uninterested, poker-face, arms-crossed position); task touch/physical touch/diagnostic touch (e.g., use a stethoscope to listen to the heart)

Note. Nonverbal cues are illustrative rather than inherently empathic or unempathic. Their classification depends on timing, the focal speaker's disclosure, and the surrounding verbal exchange.