The Relationship Between Empathy and Work-Related Stress in a Sample of Child and Youth Care Counsellors

by

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Abstract

Empathy has long been considered integral in the development of the therapeutic relationship and an essential aspect of effective psychotheraputic treatment (Rogers, 1959). Empathy has been ascribed many definitions, but it is generally agreed upon that it is a multidimensional construct that includes both intellectual and emotional elements, as well as the ability to regulate one's emotions in the face of difficult material (Decety, 2011; Gerdes, Segal & Lietz, 2010). Recently, the use of empathy in a therapeutic context has been included as a predisposing risk factor in the development of secondary stress reactions, specifically vicarious trauma (VT) and compassion fatigue (CF). This is a troubling claim and, considering the importance that empathy plays in all helping professions, one that requires further research.

This dissertation is organized into three papers, which in their entirety provide a detailed examination of empathy in the helping professions and support our understanding of the relationship between empathy and secondary stress. The first paper provides a state-of-the-art review of empathy research as it pertains to the helping professions. The second paper tests the assumption put forward by VT and CF researchers that empathy is a causal factor in the development of secondary stress reactions among those working with trauma victims. In this study, 200 child and youth care counsellors from 21 agencies across Alberta were recruited and completed comprehensive research packages. Path analysis was used to examine the relationship between personality variables, aspects of empathy, and VT and CF. Interestingly, empathy was not found to be a significant causal factor in the model, as VT and CF were best predicted by a combination of personality variables and emotional volatility. Finally, in the third paper, a mixed-methods sequential design was used to

describe the experiences of a select group of child and youth care counsellors (CYCCs) working with high risk youth in residential care. Specifically, the participants needed to have *at least* average levels of cognitive and emotional empathy and *average* to *low average* levels of secondary traumatic stress (STS) to be included in the study. The CYCCs participated in a focus group and were asked to describe the advantages (and potential disadvantages) of using empathy in their work. The results of this study included four themes all related to relationship development: (1) establishing an initial connection, (2) feeling understood, (3) safe and supportive environment, (4) facilitating positive change.

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CHAPTER 1

INTRODUCTION

The use of empathy in counselling and other professions is regarded as fundamental to therapeutic change and progress (Rogers, 1957, 1995). Empathy was originally described and defined in a therapeutic context in the early 20th century (Black, 2004). Later, Carl Rogers wrote extensively about the importance of empathy in psychotherapy and famously described it as one of the "necessary and sufficient conditions for therapeutic change" (Rogers, 1957, 1995). However, in the decades after Rogers' initial descriptions of the empathy construct, research in the area dwindled as a result of significant conceptual difficulties and disagreement over an accepted definition (Duan & Hill, 1996). Some researchers argued that empathy was essentially an emotional construct, comprised of the ability to experientially react on a deeply emotional level to another being (Corcoran, 1982, 1983; Mahrer, Boulet, & Fairweather, 1994). Other researchers and practitioners argued for a more "external" or cognitive model of empathy, whereby empathy consists of the ability to understand or perceive with accuracy the thoughts and feelings of another person (Mahrer, Boulet, & Fairweather, 1994). This conceptual disagreement resulted in little progress in empathy research, partially due to a lack of accepted instruments for the assessment of the empathy construct (Duan & Hill, 1996).

The modern revival of empathy in the literature was spurred on by several factors, most notably the acceptance by a majority of researchers that empathy is, in fact, a complex and multidimensional construct. Mark Davis (1980, 1983) was one

of the early proponents of this conceptualization and he created one of the first (and still the most widely used) measure of both emotional and cognitive empathy, the Interpersonal Reactivity Index (IRI). However, the acceptance of a multidimensional empathy construct did not gain momentum until a group of social cognitive neuroscientists began studying empathy in the early 1990s. These neuroscientists, most prominently Jean Decety, Philip L. Jackson, and Yoshiya Moriguchi, began publishing research examining the neurobiological origins of empathy. Using fMRI technology these researchers began studying the human brain and began isolating areas, brain structures, and interconnected systems that are activated in response to the behaviour and emotional responses of others (Decety, 2010, 2011). Based on observations and findings from hundreds of such studies, these researchers have proposed a model of empathy that identifies four mutually exclusive, but synergistic, components: (1) affective sharing, (2) self-awareness, (3) mental flexibility and perspective taking, and (4) emotional regulation (Decety, 2011). This model has been widely adopted by researchers and practitioners and has provided a much needed framework for understanding and measuring the empathy construct.

Another reason for this resurgence in research has been a resounding interest in the use of empathy in the medical professions, specifically in medicine and nursing. The importance of empathy in the medical professions has been extensively studied in the past two decades and, not surprisingly, there is definitive evidence that the use of empathy with patients can have a positive impact on general satisfaction, medical progress, and adherence to medical advice (Epstein et al., 2007; Strug et al., 2003). The relationship between empathy and positive

outcomes in medicine have been so substantial that it has led some researchers to affirm "empathy should be viewed as an integral component in physician competence" (Hojat et al., 2011, p. 362). Empathy has also drawn attention from an array of other fields, such as business and management, and continues to be a prominent area of practice and research in counselling (Dietz & Kleinlogel, 2014; Whiteside & Barclay, 2014; Elliot, Bohart, Watson, & Greenberg, 2011). In fact, Elliot, Bohart, Watson, and Greenberg (2011) recently reported that the use of empathy in the therapeutic relationship accounts for 9% of the variance associated with positive change, thus making empathy more impactful than specific interventions or therapeutic orientation.

The evidence that empathy can be effective and helpful in an assortment of occupations is unquestionable (Peloquin & LaFontaine, 2010). Nevertheless, a growing body of inquiry, particularly in trauma research, has introduced the idea that empathy can also be harmful and result in debilitating emotional stress. This idea has been most widely cited by researchers in the fields of Vicarious Trauma (VT) and Compassion Fatigue (CF) (Figley, 2002; Pearlman & MacIan, 1995). VT and CF are growing areas and, although there are some conceptual differences between these constructs, there are far more commonalities. In essence, VT and CF are negative emotional, physiological, and cognitive alterations and reactions impacting helping professionals who work primarily with victims of trauma (Cunningham, 2003; Figley, 2002). According to VT and CF proponents, helping professionals working with victims of trauma in an empathic manner are at a high risk of developing VT and CF, which may result in PTSD-like symptomology (e.g.,

heightened startle responses and difficulties sleeping) and alternations in belief systems (e.g., becoming highly suspicious of the intentions of others) (Alkema, Linton, & Davies, 2008).

It is of little surprise that bearing witness to emotionally charged and distressing descriptions of traumatic situations can be difficult and, at times, emotionally exhausting. However, there is scant evidence that empathy, per se, is at the heart of these debilitating emotional reactions. Some researchers, including Carl Rogers, believed that poor emotional boundaries and neurotic personality characteristics are more likely causal factors in counsellor stress (Rogers, 1975). In addition, Christina Maslach, a pioneer in burnout research and the creator of the Maslach Burnout Inventory (MBI), shared in this opinion when she stated "the person whose feelings are easily aroused (but not necessarily easily controlled) is going to have far more difficulty in dealing with emotionally stressful situations" (Maslach, 1982, p. 70). It seems highly plausible that any number of factors, aside from empathy, may be significant contributing variables to VT and CF. Furthermore, if empathy is contributing to the development of secondary stress and trauma, this would be important information to share with those working in the helping professions.

Research Rationale

Considering the importance of empathy in counselling and other helping professions it is imperative that, if there are risks associated with "being empathic", these risks should be thoroughly examined and understood. Despite a lack of empirically substantiated evidence, VT and CF researchers have continued to claim

that empathy is an important causal variable in the development of secondary stress reactions (Figley, 2002; Pearlman & MacIan, 1995). As previously mentioned, empathy is now understood to be a complex multidimensional construct composed of emotional and cognitive aspects, as well as the ability to regulate one's emotions (Decety, 2011). It would be important to differentiate between these components of empathy when making assumptions about the causal relationship between empathy and secondary stress reactions and to test the validity of these claims empirically.

Another presumption associated with VT and CF is the idea that everyone is at risk of developing these reactions. This is a particularly interesting claim, as it has been well established in the trauma research that a vast majority of individuals do not develop PTSD after a traumatic incident(s) (Breslau et al., 1998). If this is true, and considering the supposed overlap between VT, CF, and PTSD symptomology, would this not also be the case for those working with trauma survivors? Although an assortment of variables could help to explain the relatively low incidence of PTSD following trauma, personality variables are considered to be a primary causal factor. Miller (2003) reported that a number of personality factors, including high neuroticism and low extraversion, significantly increase the likelihood of PTSD development. The role of personality and the relative impact of "who you are" as a helping professional are areas not yet explored in the VT and CF research.

To further muddy the waters, there has been an increase in research examining the positive impact that trauma work can have on those in the helping professions. Some researchers are calling the positive attributes of trauma work post-traumatic growth or vicarious resilience (Barrington & Shakespeare-Finch,

2012; Hernandez, Engstrom, & Gangsei, 2010). Recent research has found that a majority of trauma therapists report affirmative outcomes in therapy, including improved relationship skills, an appreciation for human resilience, and personal satisfaction associated with being helpful (Arnold, Calhoun, Tedeschi, & Cann, 2005). Furthermore, in a recent study conducted by Pack (2014) it was reported that most VT symptomology was generally fleeting and that most counsellors were able to effectively deal with the emotional toll of trauma work independently. This body of research seems to contradict some of the claims from VT and CF researchers and provides evidence that a review and potential revision of the causal model for secondary stress reactions is sorely needed.

Including Child and Youth Care Counsellors in VT and CF Research

Child and youth care counsellors (CYCCs) typically provide care to at-risk children and youth in residential care settings (Savicki, 1993). These counsellors fill a variety of roles, acting as a central care figure, and their job is unique from other helping professions, as they work within the life space of the children and youth in their care (Krueger, 1991). These counsellors often develop strong relationships with children and youth and provide both formal and informal (or milieu) therapy.

CYCCs are at a high risk of developing secondary trauma reactions, such as VT and CF, as children and youth in care often come from traumatic and abusive backgrounds and rely on these counsellors for emotional and psychological support. In a study by Brady and Caraway (2002), 97.6% of their sample of children and youth in care experienced at least one traumatic incident in their lives with a majority reporting multiple incidents. Furthermore, in another study examining the

incidents of trauma among children and youth in care, Alexander and Huberty (1993) found that "most of the children studied have been physically or sexually abused and neglected" (p. 381). Few (if any) studies have been conducted examining secondary trauma in CYCCs; however, there has been research linking high incidents of VT and CF in social workers, which is considered a related field (Adams, Figley, & Boscarino, 2008; Bride, 2007). Based on the role that CYCCs have in residential care, it is highly probable that these workers are prime targets for secondary trauma.

Dissertation Format

This dissertation is organized into five chapters. Chapter 1 provided a brief summary of the current state of empathy research and introduces the reader to a variety of concerns in the VT and CF literature, which are in need of remediation. Chapter 2 is a state-of-the-art literature review meant to introduce the reader to the current state of empathy research. It is intended to be a helpful and practical introduction to empathy for those in the helping professions and provides a context to the following papers. This paper clearly explains why empathy is a highly important therapeutic skill and also introduces the reader to some of the proposed “risks” of being empathic.

Chapter 3 is a large scale quantitative study in which 200 child and youth care counsellors (CYCCs) from 21 agencies across Alberta, Canada were recruited and completed comprehensive research packages. These packages included measures of empathy, vicarious trauma, compassion fatigue, personality, and other variables. A path model was created, based on empathy, VT, CF, and trauma

literature, and was tested using path analysis. The model integrated a variety of factors, including personality, empathy, and secondary trauma, in order to determine whether empathy is a causal predictor of VT and CF in a sample of CYCCs.

Chapter 4 is a sequential mixed-methods study whereby a group of CYCCs were selected based on prescribed criteria from volunteers from the larger quantitative study. A focus group was conducted with 8 CYCCs and the participants were asked about the advantages and potential disadvantages of utilizing an empathic approach when working with at risk children and youth. Finally, Chapter 5 provides a summary of the dissertation as a whole and final thoughts/future directions are discussed.

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CHAPTER 2

EMPATHY AND THE HELPING PROFESSIONS: A REVIEW OF THE LITERATURE

"The gentle and sensitive companionship of an empathic stance…provides illumination and healing. In such situations deep understanding is, I believe, the most precious gift one can give to another."

~ Carl Rogers, 1975

Introduction and Purpose

The term empathy was coined by the psychologist Edward B. Titchener in 1909 as a translation of the German word einfuhlung which, roughly defined, means a deep and comprehensive understanding of one person's thoughts and feelings by another (Black, 2004; Jahoda, 2005). Over the years numerous psychologists, psychiatrists, counsellors, social workers, and other helping professionals have incorporated empathy into therapeutic theory and practice (Corcoran, 1982). Throughout the 1940s and 1950s, psychoanalysts, such as Heinz Kohut and Theodor Reik, influenced the empathy debate. Kohut (1959) defined empathy as "vicarious introspection" (p. 463) and further reported that empathy is an "essential constitute of observation" (p. 463). As psychoanalysis gave way to person-centered therapy, it was Carl Rogers who most prominently advocated for the importance of empathy in therapy. Rogers (1957, 1995) famously described empathy as one of the "necessary and sufficient conditions for therapeutic change". In addition, Rogers wrote extensively about the importance of empathy in therapy, maintaining that the employment of an empathic approach is critical in developing and maintaining a

therapeutic relationship and facilitating healthy change and personal growth in clients (Rogers, 1975).

According to Gerdes, Segal and Lietz (2010), it was the social and developmental psychologists, such as C. Daniel Batson, Martin Hoffman, and Nancy Eisenberg that continued to advance and influence empathy research during the 1980s and 1990s. These researchers viewed empathy as an important adaptive process that is biological in nature and serves as the basis of altruistic behaviour (Batson, 1997; Hoffman, 1981). Altruistic behaviour has been defined by Hoffman (1981) as "behaviour that promotes the welfare of others without conscious regard to one's own self-interests" (p. 124). According to Hoffman (1981), the ability to think and feel like another person is an essential component in helping behaviour between human beings. Today, empathy continues to be considered an important concept in the helping professions as it "allows one to quickly and automatically relate to the emotional states of others, which is essential for the regulation of social interactions, coordinated activity, and cooperation toward shared goals" (de Waal, 2008, p. 282).

Despite the fact that empathy is universally recognized as being important in therapy and human relations, until recently empathy research in many disciplines (including counselling and social work) had diminished substantially due to a variety of factors. These factors included a lack of conceptual and definitional clarity and a dearth of valid and reliable research instruments for the measurement of empathy (Duan & Hill, 1996). However, developments in professions such as neuroscience and medicine have breathed new life into the field, which has resulted

in a substantial increase in empathy research. The developments in these fields could have importance for numerous professions; however, as a majority of this research is taking place in a select few disciplines, it is possible that many helping professionals are unaware of these findings. Therefore, it is timely and important to provide a thorough summary and review of the state of empathy research over that past decade in order to facilitate further growth in the field and to provide a comprehensive, practical, and up-to-date account of empathy research as it pertains to the helping professional.

Method

A number of methods were used to identify relevant articles for the current literature review. A search of several internet-based databases (PsycINFO, Academic Search Complete, and Web of Science) was conducted using *empathy* as a keyword. In order to ensure that the review would be focused on the most up-to-date information on empathy, the search was limited to articles published between 2002–2015. However, articles considered seminal to the topic published prior to 2002, as well as several references and quotations from books, were also incorporated. Further exclusion criteria included the use of English-only and peer-reviewed journal articles. When the initial search was completed, articles were selected based on their historical and practical relevance to the helping professions. Finally, upon completing the literature search, articles considered to meet the above criteria were categorized using RefWorks. A total of 9, 028 articles were reviewed from the three databases and, of these, 196 met all criteria for the current literature review.

Empathy: An Overview

Emotional Empathy

Since the earliest descriptions of empathy in the literature, debate has existed as to whether empathy is an affective or "feeling" reaction to the state of another or a more intellectual and "perspective taking" response (Davis, 1980; Duan & Hill, 1996). The earliest descriptions of empathy recognized it primarily as being emotional in nature or a "quick, involuntary, seemingly emotional reaction to the experiences of others" (Davis, 1980, p. 3). However, such a visceral and uncontrollable emotional response has more recently been defined as "emotional contagion", considered a precursor to emotional empathy, and most researchers now agree that emotional empathy does involve a conscious decision take on the emotions of another (Duan & Hill, 1996; Hatfield, Cacioppo, & Rapson, 1993; Smith, 2006).

The level of "affective sharing" necessary to facilitate positive change in clients has also been a source of debate. Some have argued that in a therapeutic context, the helping professional should emotionally align with the client and disengage from their own individuality (Corcoran, 1982, 1983; Mahrer, Boulet, & Fairweather, 1994). Corcoran (1983), a major advocate of this position, has gone so far as to assert that "higher levels of emotional separation are associated with lower levels of empathy" (p. 670). However, others have questioned this position and argued for a more external model of emotional empathy, dubbed the "in the patient's shoes" model by Mahrer, Boulet and Fairweather (1994), where the therapist may share the client's feelings, but avoid an emotional "merging".

Supporters of the “in the patient’s shoes” model of emotional empathy would advocate that emotional sharing without detachment could result in confusion and the crossing of emotional boundaries.

Cognitive Empathy

Mahrer, Boulet and Fairweather (1994) describe cognitive empathy as an "external model of empathy" where the counsellor attempts to understand the client's perspective without having to experience the client’s feelings. Cognitive empathy is also viewed by some researchers as the type of empathy that can be taught to psychologists, medical students, social workers and others in the helping professions to improve relations with their clients and patients (White, 1997). Comparatively, emotional empathy is generally considered more of an innate aspect of empathy that is closely aligned with an individual’s personality and, therefore, not amenable to training (Smith, 2006).

Perhaps the most well-known and often cited definition of cognitive empathy was provided by Carl Rogers (1959) who explained that "the state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition." (p. 210). It is the conscious attempt to perceive and understand what another person is thinking and feeling which differentiates cognitive empathy from emotional empathy, as emotional empathy involves the voluntary experiencing of emotion. From a developmental perspective, cognitive empathy is thought to develop after emotional

empathy as a child begins to foster an awareness and understanding of the unique experiences of others (Decety, 2010).

Emotional Regulation

According to Gerdes, Segal and Lietz (2010), the ability to control and regulate one's emotions while experiencing empathy towards another human being has been the most recent addition to the empathy construct. Some researchers, including Carl Rogers, have hypothesized that being an emotionally stable individual is an important aspect of experiencing empathy. According to Rogers, individuals who are "free of discomfort and confident in interpersonal relationships" are better able to experience empathy than those who exhibit personality disturbance and emotional dysregulation (Rogers, 1975). The ability to regulate and control one's emotions allows the professional to avoid becoming overwhelmed by the visceral and uncontrollable aspects of emotional empathy, also termed *emotional contagion*. The recent field of cognitive neuroscience has provided a neurobiological account for the importance of emotional regulation in empathy. Decety and Jackson (2006) included emotional regulation, along with emotional and cognitive empathy, as the third primary component of the empathy process. These researchers have singled-out the importance of brain areas such as the posterior cingulate and the right temporo-parietal junction, as being significant in the differentiation of one's emotions from the emotions of another. They hypothesize that maintaining a sense of "whose feelings belong to whom" reduces distress and anxiety when working with others.

A Multidimensional Approach to Empathy

Over the past century, debate has existed regarding the nature and definition of the empathy paradigm. Research focusing on one specific aspect of empathy has been common practice and many of the most used empathy measures focus entirely on either emotional or cognitive aspects of empathy (Yu & Kirk, 2008). However, many other researchers believe that defining empathy as a unitary concept is too simplistic and instead have chosen to classify empathy as a multidimensional concept consisting of both affective and cognitive elements. According to Sams and Truscott (2004), "most widely accepted conceptualizations of empathy recognize that both affective and cognitive elements influence and interact with each other" (p. 35). However, the manner in which emotional and cognitive empathy relate to one another remains to be conceptually and empirically clarified (Duan & Hill, 1996).

Since the development of his Interpersonal Reactivity Index (IRI) in the early 1980s, Mark Davis (1980, 1983) has been one of the main proponents of the multidimensional approach to empathy research. Davis' research has focused on bringing together the cognitive and emotional aspects of empathy and he has explained that these two aspects of empathy cannot be fully understood without considering their influence on one another (Davis, 1980). The IRI is considered to be the most used multidimensional self-report measure of empathy and has excellent psychometric properties (Pulos, Elison, & Lennon, 2004).

Conflicting Terminology: Empathy Versus Sympathy and Other Related Constructs

In order to understand why empathy is such an important construct in the helping professions it is necessary to examine how it relates to other similar paradigms, such as pity, compassion, and consolation. According to Morse, Bottorff, Anderson, O'Brien, and Solberg (2006), pity is a feeling of regret or sorrow towards the situation of another. Similarly, compassion also involves feelings of sorrow for the plight of another, but differs from pity in that the individual expressing compassion actually shares in the suffering. Consolation is different still in that the person expressing the consolation offers soothing and encouragement in an attempt to ease pain and suffering (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). Finally, personal distress is much more self-focused than pity, compassion, and consolation in that it involves a self-oriented desire to minimize one's own aversive reaction to another individual's pain and suffering (Eisenberg & Fabes, 1990). Although all of these terms share some similarity with empathy it has been the relationship between empathy and sympathy that has received the most attention in the literature.

Sympathy has been defined as "an affective response that consists of feelings of sorrow or concern for a distressed or needy other (rather than sharing the emotion of the other)" (Eisenberg, 2000, p. 677). The key difference between sympathy and empathy is that empathy requires an attempt to understand the perspective and emotions of another while sympathy does not necessarily involve a perspective-taking stance (Gerdes, 2011). Gerdes (2011) explains that being

empathic does not mean that the one being empathic wishes to eliminate or reduce the feelings of another in a direct manner. On the other hand, the relief of painful feelings is the goal when one is offering sympathy. From the perspective of the helping professional, this difference has important qualitative implications when conducting effective counselling. Empathy involves an attempt to gain deeper knowledge of the client's feelings and motivations in order to facilitate positive treatment outcomes (Clark, 2010). This deeper understanding is not necessary when offering sympathy. Contrarily, sympathy is viewed as being important in facilitating healthy relationships, but should be mostly avoided in a counselling environment when change and learning are the focal points of treatment (Clark, 2010). Furthermore, Gerdes (2011) has indicated that sympathy in a therapeutic relationship can lead to heightened distress, anger, and resentment due to loss or depletion of emotional energy resulting from taking on the client's burden. Despite these important conceptual (and practical) differences, empathy and sympathy are often mistakenly used interchangeably, which could have harmful implications in the helping professions and result in a heavy burden placed on those offering help and support.

Empathy in the Helping Professions

A Brief History of Empathy in the Helping Professions

Tracing back the history of empathy, both from a theoretical standpoint and from a therapeutic context, is no easy task. As mentioned in the introduction to this paper, the term empathy was a translation from the German word "einfuhlung", which had its origins in German aesthetics (Black, 2004; Jahoda, 2005). In the late

19th century and early 20th century, psychologists such as Brentano, Lipps, and Prandtl were early pioneers in the study and philosophical discussion of empathy and these researchers "used Einfuhlung to explain how a person grasped the meaning of aesthetic objects and the consciousness of other persons" (Eisenburg, 1987, p. 20). In 1909 the prominent British psychologist Edward B. Titchner translated the word einfuhlung into empathy (Black, 2004). In his book *Beginner's Psychology*, published in 1915, Titchner wrote of empathy:

> We are told of a shocking accident, and we gasp and shrink and feel nauseated as we imagine it; we are told of some new and delightful fruit, and our mouth waters as if we were about to taste it. This tendency to feel oneself into a situation is called empathy, - on the analogy of sympathy, which is feeling together with another. (p.198).

In the first part of the 20th century psychoanalytic therapists and personality researchers became interested in the concept of empathy. One of the earliest explanations of empathy (as it relates to helping others) was provided by Sigmund Freud when he stated that empathy is "the mechanism by means of which we are enabled to take up any attitude at all towards another mental life" (Freud, 1922). However, during these early days of empathy debate and research, confusion existed in the literature regarding the therapeutic use of empathy (Eisenburg, 1987).

It was not until Carl Rogers, the father of person-centered counselling, entered the debate in the 1950s that the importance of empathy in therapy truly gained universal recognition. According to Rogers (1957, 1995), accurate empathy

is one of the "necessary and sufficient conditions for therapeutic change". Rogers and his students carried out numerous studies exploring the impact of empathy on client self-exploration and feelings of unconditional positive regard (Rogers, 1975). In his influential article *Empathic: An Unappreciated Way of Being*, Rogers provides a lengthy definition of empathy and summarizes several important findings based on his research (and the research of others). These findings include the idea that the ideal therapist must be empathic, that empathy is related to self-exploration, that empathy is related to therapeutic success, that even experienced therapists often fall short of being empathic, and that empathy can be taught (Rogers, 1975). It is difficult to surmise where empathy research in the helping professions would be today without the work of Rogers, but his influence on therapy and counselling has been enormous and his focus on empathy has certainly influenced numerous researchers and practitioners in the helping professions.

Despite the fact that empathy has been defined and conceptualized in many different ways over the past century, it is clear that empathy is fundamentally important in counselling, medicine, social work, police work, and related professions. It has been hypothesized that empathy is important because it helps to facilitate a positive relationship as well as provide the helping professional with a deep knowledge and understanding of the client's problems (Ahn & Wampold, 2001; Peloquin & LaFontaine, 2010). Over the past decade, this relationship building aspect of empathy has piqued the interest of researchers in medicine and nursing, mostly because of a concern of a lack of empathy in these fields and research which has demonstrated the importance of empathy in patient satisfaction and treatment

compliance (Hojat et al., 2011; Kim, Kaplowitz, & Johnston, 2004; Pedersen, 2009; Yu & Kirk, 2008). In fact, a majority of empathy research is now being conducted in these fields, focusing on two important questions: what evidence exists supporting the use of empathy in the helping professions and can empathy be taught?

Is Empathy Effective? Empirical Evidence Supporting the use of Empathy

Carl Rogers (1975) once asserted that "empathy is clearly related to positive outcome" (p. 5). According to Rogers (1975), the use of empathy in therapy serves to dissolve alienation and increase feelings of nonjudgement and unconditional acceptance. Consistent with Rogers' assertions, there is a growing body of evidence that demonstrates the effectiveness of empathy in client satisfaction, compliance, and treatment outcome (Conway, 2014; Moyers & Miller, 2013). A meta-analytic study conducted by Bohart, Elliott, Greenberg, and Watson (2002) examining the relationship between empathy and therapeutic change indicated that empathy has a moderate impact on therapeutic outcome. A follow-up meta-analysis (Elliott, Bohart, Watson, & Greenberg, 2011) confirmed this previous finding and found that empathy accounts for roughly 9% of the variance associated with outcome in therapy. It is important to note that it is the client's perception of therapist empathy (and not the therapist's self-reported empathy rating) that is the most important indicator of positive outcome. According to the researchers, this proportion of variance is similar to previous studies looking the therapeutic alliance and greater than the variance associated with specific treatment methods in therapy.

One of the few studies exploring the role of empathy in therapy found that both cognitive and emotional aspects of empathy were related to client-rated

session “depth”, but were unrelated to the “smoothness” of the session (Duan & Kivlighan Jr., 2002). The researchers used the Session Evaluation Questionnaire (Stiles & Snow, 1984) to measure session depth and smoothness. Based on this scale, session depth involves the “power and value of the session”, while session smoothness was defined as session “comfort and pleasantness” (Duan & Kivlighan Jr., 2002, p. 28). The results indicate that empathy leads to a greater degree of client exploration in the therapy session, but not necessarily to the ease of the session. Another recent study examining the importance of empathy when counselling boys with Attention-Deficit/Hyperactivity Disorder (ADHD; Conway, 2014) found that empathy was essential in the development of the therapeutic relationship, as well as the ability to self-reflect on affective material.

A majority of empathy outcome research over the past decade has been conducted in the fields of medicine and nursing. Neumann and colleagues (2007) found that physicians who adopt an empathic approach to patient care are able to gather more detailed information about the patient's symptoms, which leads to more accurate diagnoses and an increase in patient health and satisfaction. However, the researchers also noted that physician stress had a negative effect on empathy, thereby reducing the overall level of client care. Several other studies have identified empathy as being significantly related to treatment compliance (Hojat et al., 2011; Kim, Kaplowitz, & Johnston, 2004; Pollak et al., 2007). Based on their findings, Hojat and colleagues (2011) reported that “empathy should be viewed as an integral component of physician competence” (p. 362). They hypothesized that empathy is associated with mutual understanding and trust between the physician

and the patient, which leads to increased patient sharing and "better alignment between the patients' needs and treatment plans and thus more accurate diagnosis and greater adherence" (p. 362).

Physician empathy has also been found to increase patient satisfaction and interpersonal care (Epstein et al., 2007; Strug et al., 2003). A study by Epstein and associates (2007) reported that research in the field of medicine has found that failing to validate patient concerns in an empathic manner is linked to unnecessary return visits, unnecessary and unwanted somatic treatments, excessive diagnostic testing, missed diagnoses, and over-reporting of symptoms. In their own research, Epstein and his colleagues (2007) used a mutimethod design, utilizing qualitative, quantitative, and sequence analysis, and surveyed 100 physicians and 4,746 of their patients (50 patients per physician). The results of this extensive study indicated that "the use of specific empathic responses to a patient expression of worry is a marker for greater patient trust, feeling of being known, satisfaction, and feeling supported in their decision-making" (p. 1735). The researchers also reported that empathy was found to be distinct from providing reassurance, which was associated with increased anxiety on the part of the patient. This finding supports the importance of differentiating empathy from similar constructs, such as sympathy and, in this case reassurance, which may seem analogous, but associated with drastic differences in therapeutic outcome.

Although fewer studies have explored the role of empathy in nursing, a study conducted by Olson and Hanchett (1997) involved having 70 nurses and 70 patients complete measures of empathy and distress. The researchers identified a negative

relationship between nurse-expressed empathy and patient distress, which is similar to studies carried out in medicine. A literature review conducted by Brunero, Lamont and Coates (2010) reported that previous studies examining the role of empathy in nursing have consistently found positive associations between empathy and relationship building, patient responses, a reduction in reported levels of pain, and a decrease in patient distress and anxiety. Overall, the use of empathy in medicine and nursing has been identified as a pre-requisite for positive relationship development and organizations such as the Association of American Medical Colleges have identified empathy as a learning objective for physicians (Hojat et al., 2002).

The effectiveness of using an empathic approach in the helping professions has also been demonstrated in police work. A study conducted by Maddox, Lee and Barker (2011) involved collecting data from 21 females and 1 male who had been sexually assaulted within the past 18 months (but not within the past month) using interviews and questionnaires. PTSD severity, shame, and self-blame were negatively correlated with measures of police empathy. In addition, the researchers found that individuals who reported higher levels of police empathy were also more inclined to testify in court. The results are interesting and provide the impetus for more research in this area. It is concerning that, given the results of this study, there is some research suggesting a general lack of empathy among police officers (Gudjonsson & Adlam, 1983).

More research is required to continue exploring the relationship between empathy and positive outcomes in fields such as social work, child and youth care

counselling, and emergency medical responding; however, it does appear that, generally speaking, empathy has a positive impact in the helping professions.

Teaching Empathy in the Helping Professions: Can Empathy be Taught?

Based on the evidence that empathy is an important therapeutic skill, there has been an explosion of interest centering on two central and interconnected questions: can empathy be taught and, if so, how? To date, numerous educational programs have been developed in an attempt to bring awareness to the importance of empathy and to teach helping professionals how to effectively utilize empathy when working with others. Over the past decade, it has been medicine and nursing that have taken the lead in this area of inquiry, likely due to the accumulation of recent evidence supporting the use of empathy in overall improvement of patient care and outcomes, as well as due to complaints that empathy is lacking in medicine and tends to decrease as professionals advance in their training and careers (Benbassat & Baumal, 2004). Furthermore, there is evidence to support the claim that as the quality of relationships with patients improve, patient complaints and medical malpractice lawsuits decline (Stelfox, Gandhi, Orav, & Gustafson, 2005).

A majority of studies conducted in medicine and nursing have demonstrated success using various training techniques to increase empathy (Bonvicini et al., 2009; Brunero, Lamont, & Coates, 2010; Burks & Kobus, 2012; Riess, Kelly, Bailey, Dunn, & Phillips, 2012). Methods that have been used to increase empathy have included the use of education, mindfulness, self-reflection, analyzing video recordings, role-playing, and sharing stories (Bonvicini et al., 2009; Briggs, Fox, & Abell, 2012; Burks & Kobus, 2012; Fernandez-Olano, Montoya-Fernandez, & Salinas-

Sanchez, 2008; Shapiro & Rucker, 2004). The underlying rationale for many of these strategies is that by experiencing what it is like to be a patient one will begin to better understand the distress, helplessness, and vulnerability that is often difficult to fully comprehend by doctors and nurses (Stepien & Baernstein, 2006). For example, a study conducted by Bonvicini and colleagues (2009) found that an educational intervention targeted at improving communication skills increased scores on an empathy measure by 37% from baseline as compared to physicians who did not receive training.

Johanna Shapiro and colleagues have published several innovative studies examining differing training strategies to increase empathy in doctors, which include using poetry and prose (Shapiro, Morrison, & Boker, 2004), point-of-view writing (Shapiro, Rucker, Boker, & Lie, 2006), and watching movies (Shapiro & Rucker, 2004); however, evidence as to the effectiveness of these particular teaching methods is scarce. Interestingly, a longitudinal study conducted by Cunico, Sartori, Marognolli and Meneghini (2012) completed over a three-year period with nursing students found that empathy training (which included watching movies, role playing, and communication training) was effective for women, but less so for men. The researchers hypothesized that the sex differences were due to the lower initial empathy ratings for males (which they explain is a common finding in empathy research), as well as a low number of male participants in the study, which may have caused the males in the study to be less influenced by the treatment effects.

Despite the overwhelming support for differing empathy-training programs for doctors and nurses, concerns have been raised as to the legitimacy of these

findings due to a lack of conceptual clarity, a reliance on self-assessment, small sample sizes, and brief interventions (Stepien & Baernstein, 2006). In addition, some researchers have cited the lack of an accepted definition of empathy as a major roadblock in empathy research in general and have argued that empathy is insufficient to guarantee patient care in medicine (Smajdor, Stockl, & Salter, 2011).

Several studies have been conducted in professions other than medicine examining (or proposing) programs designed to increase empathy. A program designed by Gerdes, Segal, Jackson and Mullins (2011) was created to help improve the affective, cognitive, and decision-making aspects of empathy in social workers. Numerous teaching modalities were suggested including: watching and discussing movies, psychodrama, techniques adopted from Gestalt therapy, role-playing, imitative play, mindfulness, art, and education emphasizing cognitive neuroscience. Another study found that therapists who participated in a 3-day cognitive-behavioural workshop improved their level of empathy for individuals diagnosed with Schizophrenia who were experiencing hallucinations and delusions (McLeod, Deane, & Hogbin, 2002). The program involved a number of exercises focused on increasing identification and understanding of patients experiencing delusions and hallucinations. The program included role-playing (with one person taking on the role of the "patient" and the other playing the "staff member"), experiential exercises, and small group discussion and sharing of personal experiences of "perceptual disturbances". The researchers found that the program helped to increase empathy for those experiencing psychotic experiences, as well as improve self-reported satisfaction for working with this population. Finally, empathy training

has been found to be effective for improving attitudes towards non-English speaking individuals (Madera, Neal, & Dawson, 2011) and training in acting has been found to improve empathy levels in children and adolescents (Goldstein & Winner, 2012).

In a recent study conducted by Dowell and Berman (2013), the researchers studied therapist nonverbal behaviours and gestures that helped to increase client's self-reported perception of empathy. It was concluded that therapists who made frequent eye contact and employed a "forward trunk lean" elicited the highest degree of empathy from clients. Although the findings of this study seem evident, it does highlight the importance of considering all variables when examining methods to improve therapist empathy.

In summary, although numerous theoretical, conceptual and practical concerns exist in the sub-field of empathy training (as elucidated in a literature review completed by Stepien & Baernstein, 2006), the majority of research papers have demonstrated that empathy training is effective. Many programs and educational interventions have been suggested for accomplishing these goals. While some of these programs have been tested, the majority remain unverified and further research is needed.

Empathy and the Brain

For the past 20 years, investigating the role of neurobiology in the experience of empathy has dominated the field and resulted in a resurgence of interest in empathy theory and research (see Bernhardt & Singer, 2012 and Decety, 2011 for literature reviews). This line of inquiry has led to numerous breakthroughs and has

been particularly helpful in answering a question that has been a point of debate for empathy researchers for decades: what is empathy?

Empathy in Human Development

Prior to the explosion of research into the neurobiology of empathy, which has resulted in hundreds of fMRI studies demonstrating the existence of specific neurons and brain areas responsible for empathy (Coutinho, Silva, & Decety, 2014; Jackson, Meltzoff, & Decety, 2005; Lamm, Batson, & Decety; 2007), social and developmental psychologists such as C. Daniel Batson, Martin Hoffman, and Nancy Eisenberg have argued that empathy is hardwired into the human brain (Coutinho, Silva, & Decety, 2014; Decety & Jackson, 2006; Gerdes, Segal, & Lietz, 2010; Harris, 2003; Taylor, Eisenberg, Spinrad, Eggum, & Sulik, 2013). According to these researchers, empathy is part of normal human development and infants use imitation and mimicry, such as facial matching with caregivers, as part of the development of healthy attachments (Harris, 2007). Research has demonstrated that one-day old infants will cry in response to another infants crying, which suggests the presence of emotional contagion, an early precursor to the development of empathy (Hoffman, 1981). In agreement with this view, Decety and Jackson (2006) stated "developmental research has demonstrated that motor and affective mimicry are active already in the earliest interactions between infant and caregivers, raising the possibility that these processes are hardwired" (p. 55). By 4 to 6 years of age, most children are able to understand and make predictions about the mental states of others (Harris, 2007). The development of this ability, and the lack of this faculty in certain disorders such as autism spectrum disorders, has

resulted in an area of enquiry called *theory of mind* (Byom & Mutlu, 2013). Byom and Mutlu (2013) define theory of mind as the "ability to reason about the thoughts, beliefs, and feelings of others to predict behavioral responses" (p. 2).

The importance of empathy from a developmental and social perspective cannot be overstated and ranges from the development of healthy attachments (Joireman, Needham, & Cummings, 2002), prosocial moral development and judgement (Eisenberg & Fabes, 1990; Taylor, Eisenberg, Spinrad, Eggum, & Sulik, 2013), to the development of altruistic and helping behavior (Batson, 1997). The idea that humans are "hardwired" to experience empathy remained fairly theoretical until the 1990s when a group of Italian researchers discovered mirror neurons in monkeys, which resulted in a flurry of exploration into the neurobiological mechanisms of empathy and the advent of a new field of enquiry called *social cognitive neuroscience* (Gerdes, Segal, & Lietz, 2010).

The Discovery of Mirror Neurons and Current Directions in Social Cognitive Neuroscience

Investigation into the neurobiology of empathy received a large impetus in the early 1990s when a group of Italian researchers discovered "mirror neurons" in macaque monkeys (Gerdes, Segal, & Lietz, 2010; Gallese, Fadiga, Fogassi, & Rizzolatti, 1996). Although this initial research made no reference to empathy (as the focus of the research was on the monkey's reaction to a number of "meaningful movements" made by a human examiner), it was not long until empathy researchers saw the potential in the discovery of these neurons to help explain what had previously only been theory.

Building on the discovery of mirror neurons, a number of researchers (such as Jean Decety, Philip L. Jackson, and Yoshiya Moriguchi) have grown to prominence over the past decade for their studies exploring the neurobiological origins of empathy. According to Decety (2010, 2011), mirror neurons are a unique type of cell with sensorimotor properties that were originally located in the ventral premotor cortex (these neurons have since been discovered in other brain areas, such as the anterior intraparietal area and, more recently, in the primary motor cortex), an area of the brain that plays an important role in movement and understanding the actions of others. Although mirror neurons are identical to other neurons responsible for motor properties, they are in fact unique as they only respond to the actions made by other individuals (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996). Therefore, when an individual views another person in pain, sorrow, or joy, mirror neurons are activated which results in the observer experiencing a similar emotional response (de Vignemont & Singer, 2006; Decety & Meyer, 2008).

Although mirror neurons continue to be a promising and interesting area of inquiry and discovery (and help to provide a neurobiological explanation for mimicry and emotional contagion), Decety (2010) and others have reported "current neurophysiological and neurological evidence does not clearly support the idea that such a mechanism accounts for emotion understanding, empathy or sympathy" (p. 206). Decety explains that empathy, like all complex neurological processes, relies on the interaction of numerous brain structures and interconnected systems, which include (among others) the autonomic nervous

system, the hypothalamic-pituitary-adrenal axis, and the endocrine systems (Decety, 2011; Johnstone, Cohen, Bryant, Glass, & Christ, 2015). Recently, researchers have been able to identify the interconnected, but differing roles these brain regions have in the expression of the emotional, cognitive, and emotion-regulation aspects of empathy (Banissy, Kanai, Walsh, & Rees, 2012; Decety, 2010; Johnstone, Cohen, Bryant, Glass, & Christ, 2015).

The discovery of mirror neurons has been an important catalyst for empathy research and helped to stimulate an array of neurobiological studies that have resulted in a number of interesting scientific and practical discoveries (Gerdes, Segal, & Lietz, 2010). However, one of the more notable contributions of this research, and perhaps the most important from a practical standpoint, has been an operational and empirically derived definition for empathy.

A Neurobiological Derived Definition of Empathy

What is empathy? On the surface this seems like a simple question and yet it has eluded researchers and been a source of heated debate for over a century. Although it had become increasingly apparent prior to the advent of social cognitive neuroscience that empathy was multidimensional in nature, it was not until neurobiological researchers began exploring specific brain regions and neurological systems associated with differing aspects of empathy that a neurobiological definition of empathy was generated (Coutinho, Silva, & Decety, 2014; Gerdes, Segal, & Lietz, 2010). Combining previous theories about empathy with the results of numerous functional magnetic resonance imaging (fMRI) studies, Decety and Moriguchi (2007) were able to define empathy according to four related but distinct

processes. In a recent article, Decety (2011) explained how these processes were identified:

> Based on theories and data from cognitive neuroscience, behavioral neurology and developmental psychology, Decety and colleagues proposed a model that includes bottom-up processing of affective sharing and top-down processing in which the perceiver's motivation, intentions, and self-regulation influence the extent of an empathic experience, and the likelihood of prosocial behavior. (p. 93)

The processes that Decety (2011) is referring to include: (1) affective sharing, (2) self-awareness, (3) mental flexibility and perspective taking, and (4) emotion regulation. Affective sharing involves experiencing similar emotions as another human being and is considered an automatic neural response. Self-awareness is the ability to differentiate one's emotions from those of another and is an important aspect of setting healthy boundaries (i.e., listening to difficult emotional material without becoming psychologically distressed and overwhelmed). Mental flexibility and perspective taking are essentially the cognitive aspects of empathy and are defined as the ability to project oneself into the situation of another. Finally, emotion regulation is the ability to limit the intensity of one's own feelings when empathizing with another individual (Decety & Moriguchi, 2007; Gerdes, Segal, & Lietz, 2010). According to Decety (2011), these aspects of empathy are interactive in nature and involve a number of differing brain areas and neurological processes. For example, the amygdala, hypothalamus, and orbitofrontal cortex are involved in affective sharing, while emotional regulation requires several

systems involved in executive functioning, including the "intrinsic cortico-cortical connections of the OFC [orbitofrontal cortex], mPFC [medial prefrontal cortex] and dlPFC [dorsolateral prefrontal cortex" (p. 94).

Although a complete explanation of these neurological processes is beyond the scope of this review, the empirical support for a multidimensional definition of empathy derived from nearly two decades of research is overwhelming (Decety, 2010, 2011; Decety & Jackson, 2006). In terms of the interaction between the dimensions of empathy, the current belief is that all four aspects of empathy are necessary for an individual to demonstrate empathy effectively and completely (Gerdes, Segal, & Lietz, 2010). Various theories have been proposed describing the negative implications of a "partial" empathic response where one of more aspects of empathy is absent from an interaction. One of the most popular examples is the demonstration of empathy without proper emotional regulation, which has been hypothesized to result in an empathic response without proper emotional boundaries, resulting in personal distress (Decety & Jackson, 2006). Although such examples make intuitive sense and seem to coincide with previous hypotheses regarding the use of empathy by individuals with poor boundaries and emotional instability, more research is needed to clarify the interaction between these differing empathic dimensions. A better understanding of these empathic dimensions promises to help inform a number of different areas, including the development of empathy, disorders characterized by a lack of empathy, and the "healthy" use of empathy by helping professionals

Predictors of Empathy

Little research has been conducted looking at demographic characteristics and personality traits of individuals who are highly empathic. However, there is agreement in the literature that certain individual characteristics and circumstances, as well as administrative and job-related factors, can have an influence on empathy. Over the past ten years, four of the most researched predictors of empathy have been gender, level of experience, individual differences (including personality characteristics), and shared experiences.

Gender

In terms of demographic characteristics that predict empathy, arguably the most studied and researched has been gender. A majority of current studies have found that females score significantly higher on measures of empathy than males (Berg, Maidan, Berg, Veloski, & Hojat, 2011; DiLalla, Hull, & Dorsey, 2004; Garaigordobil, 2009; Kobach & Weaver, 2012; Rueckert & Navbar, 2008; Toussaint & Webb, 2005). There is evidence that these findings hold true in children and adolescents, as well as adults, and a study conducted by Garaigordobil (2009) found that girls scored significantly higher than boys on measures of empathy at every age between 10 years and 14 years. Aside from the easily predicted evolutionary and biological hypothesis used to explain the differences in empathy between males and females (i.e., women are biologically predisposed to experience empathy as a natural offshoot of motherhood), very little research has been conducted to empirically address this issue, which does appear more complex than one might expect. For example, a study conducted by Klein and Hodges (2001) found that

when they offered men and women a monetary incentive for expressing empathy, gender differences disappeared. The researchers concluded that empathic accuracy was a result of motivation rather than differences in ability or predisposition. It seems clear that more research is needed to help explain the reason for gender differences in empathy.

Progression in University Programs (and Experience in the Field)

The majority of the research that has been conducted in the past decade on empathy and job experience has focused on academic progression and level of training, particularly in medicine and nursing. Specifically, a majority of studies published in the fields of medicine and nursing have found that level of empathy decreases as students progress through their respective fields of study (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012; Chen, Lew, Hershman, & Orlander, 2007; Hojat et al., 2009; Ward, Cody, Schaal, & Hojat, 2012). A longitudinal study conducted by Hojat and colleagues (2009) found a significant decline in empathy among medical students over 3 years of study, which corresponds to the transition from the preclinical to the clinical years of medical school training in most programs. Such a decline has also been found in several other studies (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012; Chen, Lew, Hershman, & Orlander, 2007). Chen, Kirshenbaum, Yan, Kirshenbaum, and Aseltine (2012) found that this drop is not linear and reported “empathy levels increased from the beginning of medical school until the end of the preclinical years, followed by a fairly steep decline during the third year of medical school (first clinical year) that persisted through graduation” (p. 309).

Hojat and colleagues (2009) noted "it is ironic that the erosion of empathy occurs during a time when the curriculum is shifting toward patient-care activities; this is when empathy is most essential" (p. 1182). Reasons for this decline in empathy have been hypothesized to include: protective factors due to intensity of the field; long work hours and sleep deprivation; limited bedside interactions between doctor and patient; an increasing reliance on technology; and lack of role modeling in the field (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012; Neumann et al., 2011). In addition, a recent study found that, although women scored higher on measures of empathy, both women and men were equally likely to experience decreases in empathy and students who began the study with higher levels of empathy (both men and women) demonstrated a slower rate of empathy decline (Chen, Kirshenbaum, Yan, Kirshenbaum, & Aseltine, 2012).

Despite a majority of studies showing a decline in empathy in medicine, a re-examination of previous studies questioned the claim that empathy deteriorates in medical school (Colliver, Conlee, Verhulst, & Dorsey, 2010). The researchers concluded "the results do not warrant the strong, disturbing conclusion that there is a serious decline in empathy due to medical education, with the implication that something must be done about it" (p. 591). The researchers indicated methodological and statistical flaws in previous studies and the overreliance of self-report questionnaires (and not measures completed by patients) to measure empathy. Furthermore, a study conducted by Rosenthal and colleagues (2011) did not find significant decline in medical student empathy in their third year of study when students were required to take a mandatory educational program requiring

them to discuss and debrief about their experiences in the first and second years of their respective programs. Despite these counter-arguments, most studies in medicine do indicate a concerning decay in empathy during the later years of residency, which is concerning and requires attention.

Carl Rogers (1975) wrote "experienced therapists offer a higher degree of empathy to their clients than less experienced, whether we are assessing this quality through the client's perception or through the ears of qualified judges" (p. 8). Despite the obvious (and previously explicated) importance of empathy in psychology, in the last decade almost no research has been conducted looking at level of empathy, clinical training, and experience in the field in professions that involve counselling. The lone study that was identified as being relevant to this area of inquiry indicated that counselling students in their second year of study demonstrated significantly higher levels of empathy (both cognitive and affective) than their first year counterparts, which seems to support part of Rogers' claim (Lyons & Hazler, 2002; Rogers, 1975). Considering the importance of empathy in professions that involve counselling, it is advisable that further studies are completed to determine fluctuations (and factors impacting these variations) in empathy levels throughout clinical training, as well as during ones career.

Individual Differences and Personality Characteristics

In terms of individual differences, some of the researched empathy correlates have been aggression, intellectual functioning, altruism, and adjustment. Several studies have found that those with higher levels of empathy are less aggressive, more pleasant, and more tolerant than those with lower levels of empathy (Del

Barrio, Aluja, & Garcia, 2004; Duan & Hill, 1996; Lovett & Sheffield, 2007; Mehrabian, Young, & Sato, 1988; Richardson, Hammock, Smith, Gardner, & Signo, 1994). Contrary to aspects of these findings, a recent meta-analysis (Vachon, Lynam, Donald, & Johnson, 2014) found a weak association (r = -.12) between empathy and various forms of aggression, including verbal aggression, physical aggression, and sexual aggression. Based on this study, the researchers questioned the value of empathy training when counselling and rehabilitating violent offenders, which a common aspect of many such programs. Other studies have found that individuals with higher levels of intellectual functioning appear to be more empathic than the general population (Duan & Hill, 1996). It is possible that this finding is more closely tied to cognitive empathy in that being able to understand the perspective of another individual is aided by intelligence (Davis & Kaus, 1997).

Hoffman (1981) pioneered research that examined the relationship between empathy and altruism explaining that "empathic arousal predisposes the individual to altruistic action" (p. 128). Empathy is generally viewed as a precursor for helping behaviour and is a necessary component when attempting to motivate one individual to help another individual without overt incentive (Kruger, 2003). Finally, individuals who are more psychologically well-adjusted are generally more empathic (Davis & Kraus, 1997). In a meta-analysis of available research, Davis and Kraus (1997) found that individuals who had high levels of self-esteem, maturity, interpersonal adequacy, and good socialization also displayed high levels of empathy.

Little research has examined the relationship between personality and empathy. This is especially true of the Big 5 personality characteristics: Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism (Costa & McCrae, 1992). In one of the few studies looking at the relationship, Del Barrio, Aluja and Garcia (2004) used a Spanish version of the Big Five Questionnaire (Caprara, Barbaranelli, Borgogni, & Perugini, 1993) and an index of empathy for children and adolescents to examine the relationship between personality and empathy in 832 children and adolescents. The researchers found significant positive correlations with all of the Big 5 factors with the exception of Emotional Stability (more commonly referred to as Neuroticism). Their findings were at odds with several other studies that found a significant negative relationship between empathy and Neuroticism (Guarino, Roger, & Olason, 2007; Lee, 2009). In the Del Barrio, Aluja, and Garcia (2004) study the strongest personality correlate with empathy was Agreeableness. Recent research by Graziano, Habashi, Tobin, and Sheese (2007) also found a significant relationship between Agreeableness and empathic concern, as have several other studies (Mooradian, Davis, & Matzler, 2011; Munro, Bore, & Powis, 2005). A study by Mooradian, Davis, and Matzler (2011) sought to address this gap in the literature by examining the relationship between several aspects of empathy (empathic concern, perspective taking, and personal distress) and the Big 5 personality dimensions. They found that empathic concern was most closely related to agreeableness, and personal distress was related to neuroticism. Perspective taking was found to have a complicated relationship with the 5 factors.

A new line of enquiry in empathy research involves the "malleability" of empathy. Schumann, Zaki, and Dweck (2014) examined several studies looking at the ability for individuals to experience empathy in difficult and emotionally challenging situations. These researchers found that individuals who held the perception that empathy can be learned and, therefore, improved showed an increased willingness to connect with others in stressful situations.

Several studies have also identified a relationship between age and level of empathy (Richter & Kunzmann, 2011; Sze, Gyurak, Goodkind, & Levenson, 2012). In both of these studies, older individuals displayed a higher degree of empathy than younger individuals on measures of emotional empathy and empathic accuracy. It is possible that older individuals are better able to relate to others as they have had a much broader set of experiences throughout their lives (Richter & Kunzmann, 2011). In a recent study, a group of older and younger women were shown a series of film clips. It was noted that, although older women experienced a similar amount of "emotional congruence" and higher levels of sympathy than younger women, older women were also less accurate in their emotional perceptiveness (Wieck & Kunzmann, 2015). More research is needed in this area to help shed light on the reasons for these findings, as well as the implications that these results could have on empathy research in the future.

Similar Experiences

Recent research suggests a strong (but not well understood) relationship between similar experiences and level of empathy (Eklund, Andersson-Straberg, & Hansen, 2009; Fox et al., 2009; Hodges, Kiel, Kramer, Veach, & Villanueva, 2010).

These studies found that having a similar experience increases one's ability to express empathy towards another individual. In a qualitative study, researchers interviewed doctors who had experienced illness requiring hospitalization and found that "participants in our study spoke about how they felt empathy develops and manifests in specific ways, such as through increased tolerance with particular patients, as well as globally through a greater emotional connection with all patients (Fox et al., 2009, p. 1586). These findings could have important implications for numerous areas in empathy research, particularly for empathy training workshops.

Risks Associated With Empathy

It was reported by Stebnicki (2007) that "in traditional Native American teaching, it is told that each time you heal someone you give away a piece of yourself until, at some point, you will require healing" (p. 317). This is an interesting perspective and one that few helping professionals would likely reject; however, how does it relate to the use of empathy in a healing capacity? The vast majority of research studies examining the use of empathy in various helping professions focus on the benefits of adopting an empathic position with clients (Peloquin & LaFontaine, 2010). Empathy has been associated with positive relationship building, insightful understanding of client complaints and problems, and client satisfaction and gratification (Gerdes, Segal, & Lietz, 2010; Larson & Yao, 2005; Rogers, 1957, 1975; Squier, 1990). However, what is discussed and researched with far less frequency are the risks and drawbacks associated with empathic responding. For example, Duan and Hill (1996) differentiate helpful empathy from unhelpful empathy by explaining that "perhaps some kinds of empathy are helpful but others

are not, or perhaps empathy is helpful at some times but not at others, or perhaps there is an optimal level of empathy and too much or too less is unhelpful" (p. 269). Research connecting emotion regulation to empathy has shed new light on the role that individual differences play on whether empathy is helpful or harmful (Decety & Moriguchi, 2007; Gross, 1998).

Emotional regulation is essentially the ability to choose which emotions one expresses and under what conditions those emotions are expressed (Gross, 1998). Decety and Jackson (2006) have found that individuals who demonstrate poor emotion regulation have difficulty differentiating the emotions of the client from their own emotional state. This inability to practice healthy "self-other differentiation" of emotions can cause severe anxiety and distress and some researchers have described this type of unhealthy empathy as *emotional contagion* (Batson, Sager, Garst, Kang, Rubchinsky, & Dawson, 1997; Corcoran, 1983; Decety & Jackson, 2006). However, the term emotional contagion, as previously mentioned in the section on emotional regulation, has also been described as an automatic physiological mirroring of another person's emotional state that is automatic and an inherent part of our human condition. In this context emotional contagion is not necessarily a negative or unhealthy state; however, if unregulated, emotional contagion may lead to negative consequences.

Several authors have suggested a relationship between empathy and burnout (Astrom, Nilsson, Norberg, & Winblad, 1990; Miller, Birkholt, Scott, & Stage, 1995; Williams, 1989). In fact, nearly 30 years ago Christina Maslach (1982), an expert on burnout and the author of the Maslach Burnout Inventory (MBI), explained that:

> understanding someone's problems and seeing things from his or her point of view should enhance your ability to provide good service or care. However, the vicarious experience of that person's emotional turmoil will increase your susceptibility to emotional exhaustion. Emotional [contagion] is really a sort of weakness or vulnerability rather than a strength. The person whose feelings are easily aroused (but not necessarily easily controlled) is going to have far more difficulty in dealing with emotionally stressful situations than the person who is less excitable and more psychologically detached. (p. 70)

Maslach is echoing a concern previously voiced by Carl Rogers (1975) and others, which is that individuals who have poor emotional regulation and who are unable to properly engage in emotional differentiation are at an increased risk of developing emotional exhaustion. Despite this early warning as to the potential harm associated with employing an empathic stance without proper emotional control with one's clients, very little research has been conducted to substantiate this claim. Williams (1989) found a significant positive association between emotional empathy and emotional exhaustion and personal accomplishment. However, Astrom, Nilsson, Norberg, and Winblad (1990) found a negative correlation between empathy and burnout, which they attributed to workers being less able to empathically connect with their clients due to being burnt out. Gross (1994) produced the only study found at the time of this review that looked at the effects of both emotional empathy and cognitive empathy on level of burnout. Gross (1994) hypothesized that emotional empathy would be more strongly associated with burnout, which was

partially confirmed in the study. It is likely that the reason very few studies have examined the relationship between burnout and empathy is that burnout has traditionally been considered a result of difficult work conditions rather than individual differences (Maslach & Leiter, 2008).

Unlike burnout, vicarious trauma (VT) and compassion fatigue (CF) are considered to be the result of individual differences rather than organizational dynamics. Vicarious trauma (VT) and compassion fatigue (CF) are two hypothesized stress reactions that are specific to working in the helping professions (Figley, 2002; Pearlman & MacIan, 1995). Vicarious trauma is a construct developed by McCann and Pearlman (1990) that suggests that human service professionals who work with victims of trauma are at risk of having their fundamental beliefs about safety, trust, dependency, esteem, power, intimacy, and frame of reference altered. Whereas helpers may once have believed the world to be safe, predictable, and orderly, they are now concerned for their safety and may become hypervigilant and cynical. These changes can result in numerous negative symptoms including depression and anxiety (Cunningham, 2003). Compassion fatigue is similar to VT in that it also results from work with trauma survivors (Figley, 2002). However, the symptoms of CF mirror the posttraumatic stress disorder (PTSD) symptoms of the professional's clientele. Where VT is mainly concerned with changes in cognitive schemata, symptoms of CF include an increased startle response, inability to sleep, nightmares, and avoidance (Alkema, Linton, & Davies, 2008).

Although CF and VT are slightly different from one another, the precipitating factors that are hypothesized to lead to VT and CF are basically identical.

Additionally, researchers in both of these areas have proposed that empathic engagement is causally related to the development and maintenance of these stress reactions (Sabin-Farrell & Turpin, 2003). Empathy has long been considered one of the necessary conditions for the development of VT and CF (Figley, 2002; McCann & Pearlman, 1990). If this is the case, then empathy acts as a "double-edged sword". Empathy is considered a requirement for the effective understanding and healing of client problems, but it is also the starting point for the development of VT and CF (Figley, 2002; Maslach, 1982; McCann & Pearlman, 1990; Peloquin & LaFontaine, 2010). This concern has been raised by numerous researchers, but very little has been published that explores the relationship between empathy and work-related stress reactions such as burnout, VT, and CF (Kadambi & Truscott, 2004; Sabin-Farrell & Turpin, 2003). A study conducted by MacRitchie and Leibowitz (2010) found a moderate positive relationship between empathy and secondary traumatic stress (STS; a dimension of CF). The researchers reported empathy and direct exposure accounted for 20% of the variance associated with STS. Although more research is needed to explore potential mediating and moderating variables which could impact the relationship between empathy, VT, and CF, the implication of this line of inquiry is concerning and needs to be addressed.

Current Issues in Empathy Research and Recommendations for the Future

Despite the importance that empathy plays in the helping professions (Conway, 2014; Moyers & Miller, 2013), several key limitations continue to plague the field and expose concerns that impact the validity of research findings in the area. Perhaps the most problematic and pressing issue is the lack of a universally

accepted definition (Gerdes, Segal, & Lietz, 2010). This has made the development of valid and reliable measures difficult (Sams & Truscott, 2004). Despite the relative agreement that empathy is a multidimensional construct, many of the measures that are available today evaluate either emotional empathy or cognitive empathy, but not both (Gerdes, Segal, & Lietz, 2010). In addition, few measures take into account dimensions of empathy identified through recent neurobiological research, including emotion regulation and self-awareness (Coutinho, Silva, & Decety, 2014; Decety & Moriguchi, 2007).

Evaluating empathy as a unitary construct offers a limited and incomplete perspective (Levenson & Ruef, 1992). Additionally, many empathy assessments do not provide a clear definition and explanation for the type of empathy assessed by the measure (Pedersen, 2009). These issues are now being addressed through social cognitive neuroscience, as research in this area has provided an empirically supported framework for understanding and defining empathy. A recent effort to develop a self-report inventory (the Empathy Assessment Index) based in social cognitive neuroscience could be an important step in clarifying the empathy construct (Gerdes, Lietz, & Segal, 2011). Until these theoretical and conceptual difficulties are addressed the confusion that has plagued the empathy field will continue to hinder progress in the area (Gerdes, Segal, & Lietz, 2010).

In addition to conceptual issues, there has also been debate as to how empathy should be measured. The most typical method of measuring empathy is through the use of self-report inventories; however, concerns have been raised as to the accuracy of these inventories (Gerdes, Segal, & Lietz, 2010). Therefore,

triangulating self-report measures with other methods has been recommended (Gerdes, Segal, & Lietz, 2010; Yu & Kirk, 2008). Some studies have used observation methods where a "rater" provides an empathy score for a third party - such as their therapist (Gerdes, Segal, & Lietz, 2010). An example of this type of inventory is the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) where a client rates their therapist based on how much they felt understood. However, these types of inventories are limited by perception errors, as the client may believe their therapist understood their cognitive and emotional experience regardless of the therapist's actual empathic accuracy (Duan & Hill, 1996). In order to reduce perception errors researchers have developed physiological measures of empathy where bodily processes such as heart rate and skin conductance are measured (Gerdes, Segal & Lietz, 2010). It has been proposed that the closer these physiological signals match between two participants the more accurate is the empathic response (Gerdes, Segal & Lietz, 2010; Marci, Ham, Moran & Orr, 2007). However, this process is expensive and time consuming and rarely used in research studies on empathy. In addition, physiological measures do not address the multi-faceted definition of empathy that has become increasingly accepted in the literature (Coutinho, Silva, & Decety, 2014; Decety & Moriguchi, 2007)

The use of workshops and seminars to teach empathy has become increasingly popular, especially in the field of medicine. However, whether or not empathy can be taught, which aspects of empathy are most educable, and the best and most effective ways to teach empathy are areas of enquiry needing considerably more research. Researchers have used numerous methods to teach empathy

including role-playing, watching videos, sharing stories, and self-reflection (Bonvicini et al., 2009; Briggs, Fox, & Abell, 2012; Burks & Kobus, 2012) and evidence does suggest that empathy ratings improve in students who participate in these training programs. However, as with most empathy research, these results are mostly based on self-reports rather than actual accounts by patients/clients (Stepien & Baernstein, 2006). In addition, very few longitudinal studies have been conducted to determine whether or not short-term improvements in empathy ratings are maintained over time. Considering the importance of empathy and the popularity that empathy-training workshops have garnered over the past decade, more research is needed in this area.

A final important consideration that is rarely addressed in the literature, but has been alluded to by numerous researchers (Astrom, Nilsson, Norberg, & Winblad, 1990; Duan & Hill, 1996; Gross, 1994; MacRitchie & Leibowitz, 2010) is the potential risks associated with being empathic in the helping professions. Empathy allows the helping professional to more clearly understand, through both cognitive and emotional means, the difficulties, anxieties, and fears of another human being. However, the long-term impact of this experiencing may take its toll and, as hypothesized by vicarious trauma (VT) and compassion fatigue (CF) researchers, might result in stress and secondary traumatic symptoms. It was Charles Figley (2002), a leading trauma researcher and a founding father of compassion fatigue, who stated "the very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer" (p. 1434). Although the claims that empathy leads to stress,

burnout, and secondary traumatic symptomology make intuitive sense to those in the helping professions (which likely accounts for the explosion of workshops, training seminars, conferences, and publications in VT and CF research over the past decade), almost no research has explored the relationship between empathy and these different forms of work-related stress. Numerous questions remain unanswered, including:

- Are individuals who are more empathic more likely to develop these reactions?
- Who is most (and least) at risk?
- Are there variables that moderate or mediate the relationship between empathy and burnout, VT, and CF?

These are important questions, which need to be addressed to better understand empathy (as well as burnout, VT, and CF) and could have important implications for empathy training in the future.

Conclusion

The importance of empathy in the helping professions cannot be overstated (Conway, 2014; Moyers & Miller, 2013). The use of empathy to facilitate positive relationship development and therapeutic change dates back over 100 years (Jahoda, 2005). However, empathy has proven to be an elusive construct and disagreement over an accepted conceptualization and definition has led to limited research in the area for many years. The past decade has marked a turning point in empathy research, resuscitated by a combination of factors, but most notably the emergence of social cognitive neuroscience (Coutinho, Silva, & Decety, 2014;

Johnstone, Cohen, Bryant, Glass, & Christ, 2015), which has helped to provide an empirically supported framework for understanding the multidimensionality and complexity of empathy. Those in the helping professions have responded favourably to this new line of inquiry and research in the field has flourished. However, as is always the case, research tends to propagate more questions than answers, which will serve to keep those interested in empathy research engaged in new projects for many years to come.

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CHAPTER 3

EMPATHY – A DOUBLE-EDGED SWORD? AN EXAMINATION OF THE PREDICTORS CONTRIBUTING TO THE DEVELOPMENT OF VICARIOUS TRAUMA AND COMPASSION FATIGUE

"I do not ask the wounded person how he feels, I myself become the wounded person" –

~ Walt Whitman, Song of Myself

Introduction

For more than a century psychiatrists, psychologists, counsellors, social workers, and medical doctors have advocated for an empathic approach when working with clients. Empathy has been called an "essential constitute of observation" (Kohut, 1959, p. 463), a "facilitative communication skill" (Corcoran, 1982, p. 63), and one of the necessary and sufficient conditions for therapeutic change (Rogers, 1957).

The use of therapeutic and accurate empathy in a helping relationship has been associated with numerous positive outcomes in a variety of fields. It was Carl Rogers, the father of person-centered therapy, who best explained the importance of therapeutic empathy in the mid-20th century. Rogers (1975) reported that the ideal therapist is "first of all empathic" (p. 6) and recounted, based on his research and the research of others at the time, that empathy was predictive of client self-exploration, successful therapeutic outcomes, and the development of a healthy therapeutic relationship.

A recent meta-analysis conducted by Elliot, Bohart, Watson and Greenberg (2011) found that empathy accounted for 9% of the variance associated with client

outcome in therapy. Furthermore, over the past decade the fields of medicine and nursing have become increasingly focused on the importance of empathy in health care. Recent studies have found that empathy in medicine has been associated with treatment compliance (Hojat et al., 2011; Kim, Kaplowitz, & Johnston, 2004; Pollak et al., 2007), quality and detail of information provided by the patient (Neumann et al., 2007), patient satisfaction and interpersonal care (Epstein et al., 2007; Strug et al., 2003), and reduced patient stress (Olson & Hanchett, 1997).

Given the sheer volume of empirically derived evidence supporting the use of empathy in the helping professions it is indisputable that empathy plays a critical role in effective professional relationships. What is far less clear is whether there is also a downside to empathy? For some time there have been concerns that empathy could be contributing to an array of stress reactions among helping professionals. These concerns have been based on the valid assumption that empathic responding to the emotional needs of another human being can be stressful and emotionally draining. In an attempt to describe the dual nature of empathy, as both an agent of positive change and a potential contributor to stress, Duan and Hill (1996) described empathy as a "double-edged sword".

Recently, the originators of two interconnected stress-related constructs, Vicarious Trauma (VT) and Compassion Fatigue (CF), have incorporated empathy into the definitions and presumed etiology of these reactions. These theorists argue that VT and CF relate to the alteration of one's belief systems, as well as negative physiological reactions (such as hypervigilance, loss of sleep, and intrusive thoughts), that develop when one works with victims of trauma in an empathic

manner for a period of time (Figley, 2002; McCann & Pearlman, 1990). Their theories about these stress-related conditions seem to resonate with helping professionals and have become increasingly popular over the past two decades, resulting in numerous publications, workshops, training programs, and international conferences.

Charles Figley, recognized as the originator of CF, and Lisa McCann and Laurie Anne Pearlman, creators of the VT construct, have both explicitly stated that empathy is a core component in the development of VT and CF. Figley has stated that "the very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer" (Figley, 2002, p. 1434). Likewise, Pearlman and McCann (1990) define vicarious trauma as the cognitive changes that occur in a therapist or counsellor as a result of empathic engagement with the traumatic experiences of others. These arguments seem to make intuitive sense; however, the language one uses to explicate a construct or theory is important and holds consequences. The importance of empathy in counselling and other similar professions necessitates that careful consideration should be employed when implicating it as a causal factor in VT and CF models.

Despite these reported concerns and the hypothesized relationship between VT, CF, and empathy, there is very little evidence to support the notion that empathy is involved in the development of these stress-reactions, or with any other negative outcomes in helping professions. Figley and colleagues (Adams, Figley, & Boscarino, 2008) have acknowledged this gap in the research stating that "the role of empathy

also needs to be incorporated into future studies, given its prominence in CF causal models" (p. 247). This sentiment was also shared in Sabin-Farrell and Turpin's (2003) critique of the CF and VT research. These researchers called for more research examining the proposed relationship between empathy and VT in order to facilitate further understanding of the hypothesized relationship between these variables.

Aside from empathy, other factors have been hypothesized to share a role in the development of VT and CF. The majority of these predictor variables have been external variables, in that they are not inherent characteristics in an individual, but are instead environmental and situational factors. These factors include length of time in the field (Pearlman & MacIan, 1995), amount of trauma exposure (Adams & Riggs, 2008), and having previous trauma experiences (Baird & Kracen, 2006). The research that does exist looking at internal factors has focused on age and the experience of the trauma worker (Creamer & Liddle, 2005; Ghahramanlou, & Brodbeck, 2000) and gender (Kassam-Adams, 1999; Wee & Myers, 2002). Interestingly, very little research has been conducted looking at the role that personality serves in the development of VT and CF, especially considering that there is ample evidence of a strong relationship between post-traumatic stress disorder (PTSD) and personality (Miller, 2003; O'Toole, Marshall, Schureck, & Dobson, 1998)

It is well established that the vast majority of individuals exposed to a traumatic situation do not develop PTSD (Jaksic, Brajkovic, Ivezic, Topic, & Jakovljevic, 2012; Miller, 2003). To this point, Miller (2003) reported "the

assumption that trauma exposure is the primary etiological factor in PTSD has been contradicted by accumulated empirical evidence" (p. 374). Miller (2003) goes on to explain that personality plays an important role in the development of PTSD. Some studies have found that high levels of neuroticism and negative emotionality are particularly important predictors in the development of dysfunctional beliefs and PTSD symptomology (Miller, 2003); however, other personality variables have also been identified as leading to these reactions. Although very few studies have extended this argument to VT and CF research, a study by Mairean and Tuliac (2013) found that neuroticism is the best predictor of vicarious trauma. Based on these and other similar studies (Lerias & Byrne, 2003; Zeidner, Hadar, Matthews, & Roberts, 2014), it seems that the role of personality in the development of VT and CF is important and has been greatly under-researched.

Literature Review

Empathy

"Empathy is about finding echoes of another person in yourself" – Mohsin Hamid

What is empathy? Responses to this question vary enormously among laypeople, academics, researchers, and practitioners. Even among those who specialize in empathy research, agreeing on a definition of empathy is no easy task. For most of the 20th century, debate existed as to whether empathy was an emotional construct, comprised of feeling and experiencing the emotions of another person, or a cognitive construct, involving understanding the experiences of another person from an intellectual or perspective taking standpoint (Mahrer, Boulet, & Fairweather, 1994). Emotional empathy has also been called "affective sharing" and

involves the helper entering into the client's emotions, facilitating a shared understanding of what the client is experiencing (Corcoran, 1983; Mahrer, Boulet, & Fairweather, 1994). By contrast, cognitive empathy is considered to be an external model of empathy whereby the helping professional attempts to perceive or understand what a client is experiencing, which does not necessitate the sharing of emotion.

In the 1980s and 1990s a multidimensional view of empathy emerged and gained acceptance among empathy researchers. During this time, Davis (1983), the author of one of the first multidimensional measures of empathy (the Interpersonal Reactivity Index) reported that an acceptance of the integrative model of empathy, incorporating both emotional and cognitive elements, was imperative to gaining and better understanding empathy as a whole. This multidimensional view of empathy received momentum in the mid-1990s when neurologists and neurobiologists became interested in empathy after a group of Italian researchers discovered *mirror neurons* in macaque monkeys (Gerdes, Segal, & Lietz, 2010; Gallese, Fadiga, Fogassi, & Rizzolatti, 1996).

Mirror neurons are a type of cell with sensorimotor properties located in several areas of the brain (including the ventral premotor cortex, the anterior intraparietal area, and the primary motor cortex) that are similar to neurons responsible for motor movements, but which only respond to the movement and actions of others (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996). Despite the fact that most researchers now acknowledge that empathy requires the interaction of numerous brain regions and neurological systems (Decety, 2011), the discovery of

mirror neurons resulted in an explosion of fMRI studies exploring the nature and development of empathy in humans and the associated neurological processes that allow us to experience empathy towards others. This research has resulted in a new subfield of empathy inquiry, called *social cognitive neuroscience*, and although many important discoveries have resulted from this area of investigation, perhaps its most important contribution has been an empirically derived definition of empathy that acknowledges the multidimensionality of the construct.

Building upon years of empathy theory and research and combining that information with data collected from fMRI studies, Decety and Moriguchi (2007) concluded that empathy is a combination of four dimensions. These dimensions included: (1) affective sharing, (2) self-awareness, (3) mental flexibility and perspective taking, and (4) emotion regulation. Affect sharing is essentially emotional empathy, while mental flexibility and perspective taking is cognitive empathy. Self-awareness is the ability to differentiate one's own emotions from the clients and is important for setting healthy boundaries. Finally, emotional regulation, as the name implies, is the ability to regulate and control one's emotions when in an emotionally intense situation. Emotional regulation is a fairly recent addition to the empathy construct; however, numerous researchers have hinted at the importance of being an emotional stable individual when working in a helping capacity. Carl Rogers (1975) once stated "personality disturbance in the therapist goes along with lower empathic understanding, but when he is free from discomfort and confident in interpersonal relationships, he offers more of understanding" (p. 7). Researchers in the area of social cognitive neuroscience have helped to solidify

the multidimensionality of empathy, which has facilitated a renewed interest in empathy research.

Although there is overlap between empathy and other related constructs (e.g., sympathy, pity, and compassion), empathy is unique and the differences between empathy and other related concepts are practically and theoretically important. Empathy can involve a sharing of emotional content and an attempt to understand and "put yourself in another person's shoes" (Mahrer, Boulet, & Fairweather, 1994). However, empathy involves an attempt to share similar feelings and thoughts as the client, which could involve a variety of both positive (e.g., happiness, relief, exhilaration) and negative (e.g., anger, resentment, distrust) feelings. This differentiates it from concepts such as pity and compassion, where feelings are generally of sorrow or regret, reflecting a limitation in the range of emotions experienced by the helping individual.

In addition, experiencing empathy towards a client only requires attention, interest, and active listening. This is different from concepts such as consolation or sympathy, where the helper generally feels obligated to reduce or eliminate the negative and hurtful feelings of the client (Gerdes, 2011). Finally, of critical importance when differentiating empathy from other related constructs, is the goal of empathy. A primary purpose of empathy in a counselling capacity is to facilitate client self-exploration, which in turn leads to increased trust, client disclosure, and positive therapeutic outcomes (Clark, 2010; Rogers, 1975). This is important from a therapeutic perspective and, more than any other reason, differentiates empathy from other constructs. It is for this reason, that unlike in the case of empathy, the

use of pity, consolation, compassion, and sympathy can result in boundary violations, heightened levels of anxiety and distress, and resentment (Gerdes, 2011).

Several recent studies have examined the relationship between empathy and personality and this area of inquiry is garnering increased attention from researchers. It is generally established that empathy has a strong positive relationship with agreeableness (Del Barrio, Aluja, & Garcia, 2004; Graziano, Habashi, Tobin, & Sheese, 2007) and a strong negative relationships with neuroticism (Lee, 2009; Guarino, Roger, & Olason, 2007). A study by Mooradian, Davis and Matzler (2011), which examined the relationship between aspects of empathy and the Big 5 personality dimensions, found that empathic concern (emotional empathy) was most closely allied with agreeableness, while the best predictor of personal distress (emotional regulation) was neuroticism. The researchers found that perspective taking (cognitive empathy) has a complex relationship with the 5-factor model, demonstrating significant correlations with all factors, most notably with agreeableness and openness.

Vicarious Trauma

The concept of vicarious trauma was developed by McCann and Pearlman in the early 1990s to describe harmful changes to the belief systems of therapists who work with trauma victims (McCann & Pearlman, 1990; Pearlman & MacIan, 1995). It is through the act of bearing witness to numerous accounts of human cruelty, natural disaster, and other traumatic material that the clinician's beliefs about self, others, and the world become negatively altered (Canfield, 2005; McCann & Pearlman, 1990). After working with numerous victims of violence and crime,

counsellors may find themselves questioning the motives of others, worrying about personal safety and the safety of their family, while also experiencing feelings of helplessness and despair, and feeling less compassion for the human race (McLean, Wade, & Encel, 2003; Neumann & Gamble, 1995).

McCann and Pearlman (1990) explain that these cognitive changes can be disruptive and painful for the clinician, but that they are a normal response to empathic engagement with their clients. Vicarious trauma can have negative effects on the clinicians' ability to conduct their work as well as being detrimental to the organizational environment and personal and professional relationships (Adams & Riggs, 2008; Canfield, 2005; Pearlman & MacIan, 1995; Way, VanDeusen, & Cottrell, 2007). Those suffering from vicarious trauma often feel isolated and alone while the people close to them struggle to understand the emotional and psychological consequences associated with the indirect exposure to traumatic material (Lerias & Byrne, 2003).

McCann and Pearlman (1990) have suggested that vicarious trauma can impact the memory system of trauma therapists. Aspects of the numerous traumatic events reported to the trauma counsellor may be stored in the counsellor's memory and these images can be triggered by external stimuli (McCann & Pearlman, 1990). For example, the trauma therapist may become hypervigilant and anxious at the sound of an infant crying after working with victims of child abuse. Some vicarious trauma researchers have even suggested that trauma counsellors may experience some of the psychological consequences of post-traumatic stress disorder including intrusive thoughts and images, nightmares, and

flashbacks (McCann & Pearlman, 1990; Sexton, 1999). These symptoms also overlap with another similar stress reaction, compassion fatigue.

Compassion Fatigue

Figley (1995) was one of the first researchers to describe the concept of compassion fatigue, also called "secondary traumatic stress" in the literature (Bride, Radey, & Figley, 2007), as a way to explain the development of post-traumatic stress disorder (PTSD) symptoms in those who conduct trauma work. As with vicarious trauma (Pearlman & MacIan, 1995), compassion fatigue is thought to result from empathic engagement with clients who have suffered traumatic events such as sexual abuse, physical assault, or environmental disaster (Adams, Figley, & Boascarino, 2008). Adams, Figley and Boascarino (2008) explain that over time trauma counsellors begin to develop PTSD symptoms that parallel those of their clients. These symptoms can include difficulties sleeping, hypervigilance, obtrusive thoughts, emotional distress and depression, and avoidance reactions (Alkema, Linton, & Davies, 2008).

Bride, Radley and Figley (2007) also report cognitive changes and significant impairment of the human service workers' ability to effectively conduct their job as additional symptoms of compassion fatigue. As a result of the symptoms of compassion fatigue, human service workers may find it difficult to experience empathy for their clients and this may lead to poor clinical decision-making, boundary violations and misdiagnosis (Bride, Radley, & Figley, 2007; Everall & Paulson, 2004).

Empathy, Vicarious Trauma and Compassion Fatigue

As mentioned throughout this paper, the benefits of employing empathy in counselling are numerous. However, over the past few decades, the role of empathy in the development of significant and often debilitating stress-reactions among helping professionals has become increasingly discussed, albeit without much tangible evidence (Conrad & Kellar-Guenther, 2006; Trippany, White Kress, & Wilcoxon, 2004). Several studies have also found that this relationship between empathy and debilitating stress in helping professionals, if it does exist, is complex and may be related to certain specific aspects of the empathy construct, such as a lack of emotional boundaries and poor self-other differentiation (Thomas & Otis, 2010).

Some researchers have hypothesized that it is the emotional regulation aspect of empathy, specifically an inability to control and manage one's emotions in difficult situations, that leads to personal distress on the part of the helping professional (Batson, Sager, Garst, Kang, Rubchinsky, & Dawson, 1997; Corcoran, 1983; Decety & Jackson, 2006). Others have argued that it is a lack of self-awareness (also called *self-other differentiation*) meaning a deficit in the ability on the part of the helping professional to differentiate their emotions from the emotions of those they are helping, which can lead to a form of empathic stress (Decety & Jackson, 2006). Although there is little evidence for either of these theories, a recent study conducted by MacRitchie and Leibowitz (2010) found a "moderate positive relationship" between empathy and secondary traumatic stress; however, the sample size of this study was small (N = 64).

Thomas and Otis (2010) recently summarized the relationship between empathy, VT, and CF by reporting that empathy was a "double edged sword" and the use of empathy exposed clinicians to a high degree of risk. The assumption of a relationship between empathy, VT, and CF was also indicated in a review of the compassion fatigue literature conducted by Najjar, Davis, Beck-Coon and Doebbeling (2009). These researchers found that the relationship between empathy and CF continues to be prominent in the literature and, when discussing a number of stress reactions (such as VT, CF, and burnout), the researchers reported that empathy was a causal component; however, the authors did not provide any empirical evidence to substantiate this claim.

Based on the research conducted in social cognitive neuroscience, which demonstrates that empathy is a multi-faceted construct (Decety & Moriguchi, 2007), it will be important to identify which aspects of empathy, if any, result in secondary stress reactions, such as VT and CF. Empathy is an important component of effective therapy and relationship development and, as such, describing it as a double edged sword may be premature without further study.

Personality and the Development of Vicarious Trauma and Compassion Fatigue

Some of the most cited predictors of VT and CF have been previous trauma (Baird & Knacen, 2006), length of time in the field (Pearlman & MacIan, 1995), amount of vicarious trauma education (Adams & Riggs, 2008), and the amount of exposure to traumatic material (Adams & Riggs, 2008; Baird & Kracen, 2006; Cunningham, 2003; Kassam-Adams, 1994; McLean, Wade, & Encel, 2003). As

compared to these external predictors of VT and CF, comparatively little research has been published looking at the role that internal predictors, specifically personality, play in the development of secondary forms of traumatic stress. In one of the few articles exploring personality and VT, Mairean and Tuliuc (2013) found that extraversion and conscientiousness predicted lower levels of VT among medical staff, while neuroticism was the best predictor of vicarious trauma. Furthermore, a number of studies have demonstrated the important role that personality and emotional functioning play in the development of direct forms of trauma, specifically post-traumatic stress disorder (PTSD; Lerias & Byrne, 2003; Miller, 2003; Zeidner, Hadar, Matthews & Roberts, 2014).

Research has demonstrated that, as with PTSD, there are numerous contributing variables that can lead to secondary trauma reactions and symptoms (Lerias & Byrne, 2003). Such factors can include a history of previous trauma, life stress and mental health concerns, level of social support, and gender (Lerias & Byrne, 2003). There is also evidence to suggest that, as with PTSD, most helping professionals do not develop clinical levels of secondary trauma (Cornille & Meyers, 1999; Dominguez & Rutledge, 2009; Ortlepp & Friedman, 2002); however, in all studies a significant minority reported symptoms of stress. In the PTSD literature, research has demonstrated that certain dispositional traits are among these moderating variables (Miller, 2003; O'Toole, Marshall, Schureck, & Dobson, 1998). The role of neuroticism in the development of PTSD is widely recognized and several studies have reported that high levels of neuroticism predicted later development of PTSD among soldiers (Miller, 2003; O'Toole, Marshall, Schureck, &

Dobson, 1998). Higher levels of introversion have also been shown to increase the risk of developing PTSD (Fauerbach, Lawrence, Schmidt, Munster, & Costa, 2000). As an explanation of these significant relationships, Miller (2003) argued that traumatic incidents seem to "activate" or accentuate personality traits, which in turn lead to a series of either negative or constructive coping mechanisms. As there is a high degree of overlap between the causal variables that predict the development of direct and indirect forms of trauma (Lerias & Byrne, 2003), it is highly plausible that personality would also play an important role in the development of VT and CF.

Child and Youth Care Counsellors and Risk of VT and CF

Child and youth care counsellors provide care for children and youth who are without parents or guardians or whose parents or guardians are unwilling or unable to adequately care for their basic needs (Krueger, 1991; Mattingly, 1995; Savicki, 1993). The child and youth care counsellor works in numerous settings, such as in hospitals and schools; however, their main place of work is in residential group care settings, group homes, temporary shelters, and psychiatric hospitals (Krueger, 1991). These facilities house many children and youth who generally live within the settings for extended periods of time ranging from days to years (Krueger, 1991).

Perhaps the most unique aspect of child and youth care work that differentiates it from other helping professions is the amount of time these workers spend in the "life-space" of the children and youth in their care. Child and youth care counsellors have the unique opportunity to form strong relationships with their clients as they spend a tremendous amount of time in their presence (Cavaliere, 2004). These relationships can provide the foundation for effective

counselling with children, adolescents, and families in need of support (Cavaliere, 2004). In fact, in a study looking at trauma among children and youth in care, Brady and Caraway (2002) found that the primary source of support of children and youth in care came from child-care staff.

Numerous studies have identified a high degree of trauma and abuse among children living in group homes and residential treatment center settings (Brady & Caraway, 2002; Kurtz, Hick-Coolick, Jarvis, & Kurtz, 1996; Powers, Eckenrode, & Jaklitsch, 1990; Overcamp-Martini & Nutton, 2009). Incidence of trauma included physical abuse, sexual abuse, verbal abuse, neglect, and other forms of maltreatment (Powers, Eckenrode, & Jaklitsch, 1990; Rivard et al., 2003). In one study, Brady and Caraway (2002) observed that 97.6% of their sample of children and youth in residential care had experienced at least one traumatic incident while many had experienced several incidents. In another study looking at trauma in children in care, Alexander and Huberty (1993) found that most of the children in their sample had been physically or sexually abused or neglected. Aside from first-hand experiences of abuse, these children and youth have witnessed numerous potentially traumatizing situations including drug and alcohol abuse, violence, and murder (Rivard et al., 2003).

Rationale and Hypotheses

VT and CF researchers have long argued that empathy plays a fundamental role in the development of vicarious trauma and compassion fatigue in those who work with victims of trauma. However, this purported relationship has not been demonstrated and is largely unexplored and poorly understood. Figley (2002)

explained that empathy is a driving force in effective work with trauma victims; however, paradoxically he also reported it to be primary factor contributing to the development of CF. Likewise, Pearlman and MacIan (1995), founders of the VT construct define vicarious trauma as “the transformation that occurs within the therapist (or other trauma worker) as the result of empathic engagement with clients' trauma experiences and their sequelae" (p. 558). Considering the importance that VT and CF researchers place on the role of empathy in the development of VT and CF it is surprising to find that there is almost no empirical evidence for any correlation between empathy, VT and CF.

In general, there have been few studies examining stress reactions, both of a primary or secondary nature, in child and youth care counsellors. These counsellors work with children and youth who have experienced a high degree of stress and trauma and provide formal and informal counselling on a daily basis (Brady & Caraway, 2002). Although their role is certainly different from that of a specialist in trauma counselling, the high degree of exposure they have to accounts of trauma, in combination with their role as informal counsellors, suggests that they are at a high risk of developing both VT and CF (Brady & Caraway, 2002; Overcamp-Martini & Nutton, 2009). It is for these reasons that they are the focus of the current study.

The role of personality in the development of VT and CF is a variable that has received little attention in the literature. The lack of research examining the role of personality in VT and CF symptomology is surprising, especially considering ample research showing its importance in the etiology of PTSD. Miller (2003) reported that certain personality traits, such as high neuroticism and low extraversion, increase

the likelihood of the development of PTSD, which helps to explain why a majority of individuals who are exposed to trauma do not develop PTSD.

Given the widespread agreement in the literature supporting the relationship between empathy and VT and CF, we will begin with the assumption that empathy does contribute to the development of VT and CF. The core components of empathy (i.e., emotional and cognitive empathy) will be tested in the model. In addition, in order to coincide with Decety and Moriguchi's (2007) four-factor definition of empathy, a variable called "emotional separation" is being included in the model, as this variable coincides with the self-awareness dimension of empathy. The initial causal variables (i.e., exogenous variables) in the model will not be empathy, but aspects of personality, which have been empirically shown to correlate with empathy, VT, and CF. These personality aspects include neuroticism, extraversion, agreeableness, and openness. It should also be noted that although a specific measure of emotional regulation was not included in the model (which is the final dimension of the four-factor model of empathy), neuroticism is highly related to emotional instability and poor self-regulation (Mooradian, Davis, & Matzler, 2011). The following hypotheses will form the basis of this study (see Figure 1):

1. Emotional and cognitive empathy will be positively correlated with VT and CF and will contribute significant variance in a causal model.
2. Having poor self-awareness (i.e., "emotional separation") will be a significant predictor of VT and CF in a causal model.

3. Higher levels of neuroticism and lower levels of agreeableness and extraversion will be associated with higher levels of VT and CF in the causal model.
4. As well as demonstrating direct effects on VT and CF, empathy will mediate the relationship between aspects of personality and VT and CF.

Method

Participants

A total of 200 child and youth care counsellors were recruited from 21 child and youth care agencies from across Alberta, Canada. The criteria for participating in the study were: (a) child and youth care counsellors working in direct contact with children and youth (b) a minimum of 6 months of experience, and (c) fluency in reading, writing, and speaking English.

In terms of demographic characteristics of the sample, 21% of the sample was male and 79% was female. The average age of the child and youth care counsellors was 33 years old [*SD* = 9.85] and ranged between 21 years and 62 years. The average number of years in the field was reported as being 8 [*SD* = 7.11], with a range of 1 year to 36 years. In terms of the number of hours worked per week, 1.0% reported working 0-20 hours, 0.5% worked 21-25 hours, 4.1% worked 26-35 hours, 80.6% worked 36-45 hours, and 11.2% worked greater than 45 hours. With regards to ethnicity, 82.1% identified themselves as Caucasian, while 5.1% reported being Aboriginal, 3.1% Black/African-Canadian, 3.1% Asian, 2.6% East Indian, 1.5% Hispanic, 0.5% Middle Eastern, and 0.5% other.

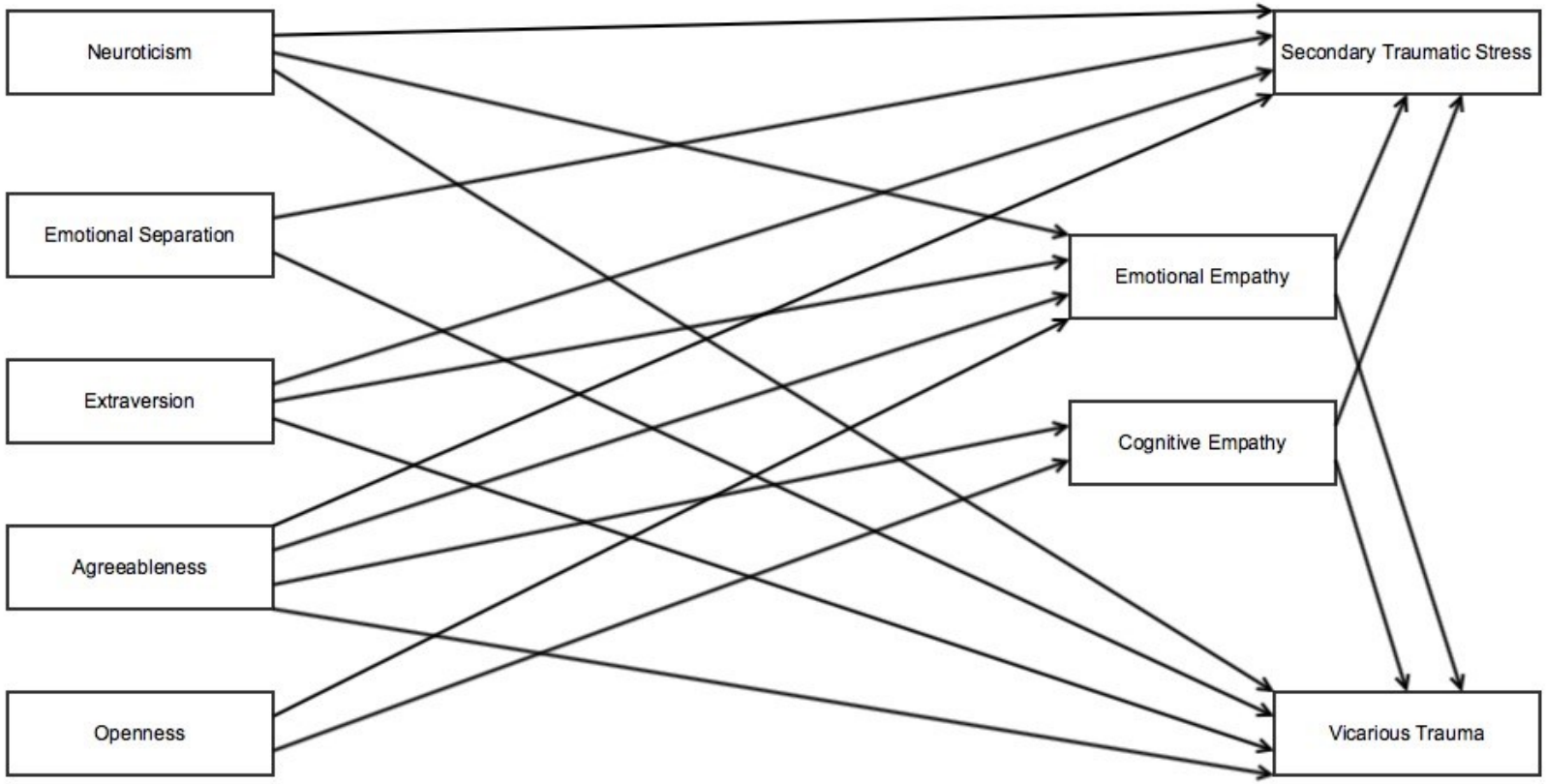

Figure 1. Hypothesized model representing the relationship between personality constructs and emotional separation with cognitive empathy, emotional empathy, secondary traumatic stress, and vicarious trauma.

A majority of the respondents reported being single (33.2%) while 32.1% reported being married, 29.1% in a common-law or other long-term relationship, and 5.1% were divorced. Many of the participants reported achieving a university degree (50%), while 38.8% had achieved a university diploma, 4.1% a master's degree, 2.6% a high school diploma, and 4.1% other. A majority of the sample reported earning 40,000 – 50,000 dollars per year (33.2%), while 23.0% earned 30,000 to 40,000 dollars, 19.9% earned 50,000 – 60,000, 13.3% earned more than 60,000 dollars, 8.2% earned 20,000 to 30,000 dollars, and 1.0% earned under 20,000.

Measures

Interpersonal Reactivity Index (IRI). The Interpersonal Reactivity Index (IRI; Davis, 1980) is a multidimensional self-report measure of empathy. The scale is composed of four subscales that measure both cognitive (the fantasy and perspective-taking subscales) and emotional (the empathic concern and personal distress subscales) aspects of empathy. Davis (1980, 1983) reported that the fantasy subscale measures the respondents ability to identify with fictional characters in books, movies, and plays. The other measure of cognitive empathy, perspective-taking, measures one's ability to view the world from the perspective of another. The first of the emotional empathy subscales, empathic concern, is a measure of compassion for those undergoing negative experiences (Davis, 1980). The final subscale of the IRI, personal distress, is a measure of anxiety and distress when witnessing another individual in a potentially hurtful or dangerous situation.

The IRI is comprised of 28 items with 7 items measuring each of the four-subscales using a Likert style response format consisting of 5 possible responses

ranging from "does not describe me well" to "describes me very well". The IRI is considered an excellent measure of empathy and is the most widely used self-report measure of empathy (Pulos, Elison, & Lennon, 2004). Test-retest reliability has been found to be adequate ranging from .61 to .79 for men and .62 to .81 for women over a period of 60 to 75 days (Davis, 1980). Davis (1983) found the IRI to have excellent convergent and discriminate validity with each of the scales interacting in the expected manner with a number of related indices as well as other measures of empathy. Several factor analytic studies have been completed with some studies confirming the original four-factor structure of the IRI (Carey, Fox, & Spraggins, 1988; Davis, 1980) while other more recent factor analyses have identified three discrete dimensions (Alterman, McDermott, Cacciola, & Rutherford, 2003; Pulos, Elison, & Lennon, 2004). In the current study, Cronbach's alpha for the subscales in this study were found to be: fantasy .75, perspective taking .76, empathic concern .73 and personal distress .79.

Professional Quality of Life Scale – Version 5 (ProQOL). The Professional Quality of Life Scale (ProQOL; Stamm, 2009) is the most used measure of compassion fatigue found in research databases (Stamm, 2009). The measure has 30 items and uses a Likert scale consisting of 5 possible responses ranging from "never" to "very often". The instructions ask the respondent to answer each of the questions considering how the respondent has felt in the past 30 days. The compassion fatigue scale is separated into two dimensions (burnout and secondary traumatic stress) which, taken together, provide an overall indicator of compassion fatigue. Figley and others (Adams, Figley, & Boascarino, 2008; Figley, 1995, 2002)

found that adding the burnout aspect to the secondary traumatic stress construct helps to explain the exhaustion element of working with trauma survivors; however, this is a relatively new change to the CF construct. Secondary traumatic stress has been defined by Stamm (2009) as a measure of work-related secondary exposure to traumatic material. There is a third subscale on the ProQOL, compassion satisfaction, which is a measure of how much pleasure and satisfaction one experiences when doing his or her job well (Bride, Radey, & Figley, 2007; Stamm, 2009). Bride, Radey and Figley (2007) have explained that the relationship between compassion fatigue (CF) and compassion satisfaction (CS) is not clear. However, it has been suggested that a worker can feel both of these experiences simultaneously (Bride, Radey, & Figley, 2007).

The validity and reliability of the English form of the Professional Quality of Life Scale is acceptable with the alpha reliability of the compassion satisfaction, burnout, and compassion fatigue scales calculated at .88, .75, and .81 respectively (Stamm, 2009). The shared variances between the three scales is very low indicating that they measure different constructs (Stamm, 2009). Convergent and discriminate validity has been confirmed using a multitrait multimethod analysis based on numerous published studies using the ProQOL (Stamm, 2009). In this study, Cronbach's alpha was found to be .75 for secondary traumatic stress, .89 for compassion satisfaction, and .76 for burnout.

Trauma and Attachment Belief Scale (TABS). The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) is an 84 item, self-report, measure of vicarious trauma. The scale assesses five beliefs about self and others including: safety, trust,

esteem, intimacy and control. For each of these five beliefs a composite score can be calculated for "beliefs about self" and "beliefs about others". A total score assessing overall level of vicarious trauma can also be calculated. The scale is based on McCann and Pearlman's (1990) constructivist self-development theory and normative data was gathered using a sample of 1743 individuals between the ages of 17 and 78. Pearlman and colleagues (Varra, Pearlman, Brock, & Hodgson, 2008) recently conducted a factor analysis on an earlier version of the TABS (the TSI Belief Scale, Revision L) and found that the analyses confirmed two distinct factors termed "self" and "other".

In terms of reliability, Pearlman (2003) has reported the following internal consistencies for each of the 10 possible scales: self-safety (.83), other safety (.72), self-trust (.74), other trust (.84), self-esteem (.83), other esteem (.82), self-intimacy (.67), other intimacy (.87), self-control (.73), other control (.76), and total (.96). An earlier version of the TABS was found to have good concurrent validity as it correlated moderately with burnout (McLean, Wade, & Encel, 2003). The TABS has been used in a variety of settings and on a diverse population of individuals including battered women, sexual assault survivors, and therapists and counsellors (Varra, Pearlman, Brock, & Hodgson, 2008). In the current study, Cronbach's alpha was fairly similar to the internal consistencies reported by Pearlman (2003); however, several of the subscales demonstrated very poor reliability. Cronbach's alpha in this study was found to be: self-safety (.70), self-trust (.71), self-esteem (.84), self-intimacy (.56), self-control (.72), other-safety (.51), other-trust (.81), other-esteem (.66), other-intimacy (.86), other-control (.71), and total (.95).

NEO Five-Factor Inventory (NEO-FFI). The NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992) is a 60 item measure of five personality dimensions commonly referred to as the Big Five. The Big Five are: Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism. The NEO-FFI is a shorter version of the NEO Personality Inventory - Revised (NEO PI-R) and generally takes between 10-15 minutes to complete. Many of the items selected for the NEO-FFI are also included in the NEO PI-R and were selected using the highest positive and negative item loadings from the NEO PI-R as well as some other items used to diversify the content of the NEO-FFI. The NEO-FFI uses a five point Likert format with responses ranging from "strongly disagree" to "strongly agree".

The NEO-FFI has displayed excellent psychometric properties. Alpha coefficients for the five personality dimensions are: .86 for Neuroticism, .77 for Extraversion, .73 for Openness, .68 for Agreeableness, and .81 for Conscientiousness (Costa & McCrae, 1992). Considering many of the items for the NEO-FFI are the same or similar to the NEO PI-R much of the psychometric research conducted on the validity of the NEO-FFI has involved the degree of correlation between the NEO PI-R and the NEO-FFI. Costa and McCrae (1992) report that the correlations between the NEO-FFI and the NEO PI-R were .92 for Neuroticism, .90 for Extraversion, .91 for Openness, .77 for Agreeableness, and .87 for Conscientiousness. The NEO PI-R shares a relationship with other related personality scales such as the Myers-Briggs Type Indicator (Myers & McCaulley, 1985), the Wiggins' Revised Interpersonal Adjective Scales (Wiggins, Trapnell, & Phillips, 1988), and the California Psychological Inventory (Gough, 1987). The NEO-

FFI has been used on numerous populations including college students (Becker, 2006), offenders (Kunst & Hoyer, 2003), and adolescents (Pullmann, Raudsepp, & Allik, 2006). In the current study, Cronbach's alpha was .86 for Neuroticism, .78 for Extraversion, .73 for Openness, .74 for Agreeableness, and .85 for Conscientiousness.

Maintenance of Emotional Separation Scale (MES). The Maintenance of Emotional Separation Scale (MES; Corcoran, 1983) was developed as a measure of emotional separation (similar to the "self-awareness" dimension of empathy). Individuals with low emotional separation find it difficult to differentiate their emotions from those of their clients, which can lead to emotional distress (Decety & Jackson, 2006). The MES consists of seven items and employs a Likert scale consisting of six possible choices ranging from "completely false for me" to "completely true for me". Corcoran (1982, 1983) used principal component analysis to reduce the number of items included in the scale from 16 to 7. Corcoran (1983) has reported that the instrument produced adequate reliability and validity. Internal consistency has been reported to be .71 (Corcoran, 1982). Discriminative validity was confirmed through the lack of a significant relationship with the Marlow-Crown social desirability scale (Corocoran, 1982). Cronbach's alpha was found to be .79 in the current study.

Procedures

The participants were recruited using a variety of methods; however, in all cases participants gave their free and informed consent. Typically, managers from the agencies agreed to allow their agency to be involved in the study and voluntarily

distributed packages to their employees according to set ethical guidelines provided by the researchers. Research packages included a number of measures including: the Interpersonal Reactivity Index (IRI; Davis, 1980); the Professional Quality of Life Scale (ProQOL; Stamm, 2009); the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003); the NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992); the Maintenance of Emotional Separation Scale (MES; Corcoran, 1982); and a demographic sheet. The packages took roughly 45 minutes to complete.

Once the managers agreed to participate in the study, a number of research packages were mailed to the agency with a set of explicit instructions describing how the data should be collected. These instructions included ensuring the packages were placed in a secure and private location and that completed packages be sealed and placed in envelopes in a secure area. The participants were not required to place their names on the envelopes and were completely anonymous to the researchers. After several weeks the packages were mailed back to the researchers.

Results

Data Cleaning

Code and value cleaning was conducted in order to ensure the data contained appropriate numerical codes and errors were not made during data entry. Data that fell outside the acceptable ranges for the scales were identified and corrected as needed. The data set was then screened for missing data and outliers. Four participants were excluded from the analysis due to not completing several of the protocols. As the missing data were deemed to be missing at random (MAR) (Meyers, Gamst, & Guarino, 2006), expectation-maximization imputation was used

to impute missing data in order to retain as much of the data as possible (Little & Rubin, 2002). Outliers were identified using box-and-whisker plots; however, using the *outlier labeling rule* as explained by Hoaglin, Iglewicz and Tukey (1986) no true outliers were found in the data and, therefore, no corrections were necessary.

The data were then examined further for violations of statistical assumptions, such as normality, linearity, and homoscedasticity. The use of histograms, box plots, p-p plots and skewness and kurtosis values were utilized as part of this analysis. Skewness and kurtosis were inspected using both z-score analysis and visual inspection of the histograms for each of the variables. A majority of the variables in the study fell within acceptable ranges of skewness and kurtosis using a cut-off value of ± 3 (Fung & Seneta, 2007; Kline, 2011). However, several of the negative variables representing constructs such as stress and emotional dysregulation were positively skewed, which is typical of such constructs. These variables included vicarious trauma (as measured using the TABS scale; 3.41), secondary traumatic stress (as measuring using the ProQOL; 3.65), and neuroticism (as measured using the NEO-FFI; 3.59). Although methods are available to correct skewed data (e.g., bootstrapping), such data transformation techniques were decided against in the current study as statistical significance for skewness and kurtosis are often achieved in larger data sets of roughly 200 participants and, therefore, it is more important to inspect the distribution of the scores visually (Field, 2009). An inspection of the aforementioned variables (vicarious trauma, secondary traumatic stress, and neuroticism) showed that the variables appeared to

be fairly normal in shape and approximated a normal distribution. Therefore, data transformation was not used to correct the shape of the distribution.

Preliminary Analyses

The next step in data analysis involved an examination of means, standard deviations, and correlations for each of the variables used in the subsequent analyses (see Table 1). Pearson product-moment correlations were computed, as all variables used in the analysis were continuous.

Development of the Causal Model

A path model was tested using the maximum likelihood method in AMOS 22.0 (Arbuckle, 2003; see Figure 1). Path analysis is an extension of multiple regression (Streiner, 2005) that can be used when variables are observable and the model is recursive. Path analysis allows for an evaluation of the overall model, based on theory and research, and is therefore a more powerful tool for evaluating complex relationships between variables than multiple regression (Lleras, 2005). The path analysis was intended as the principal test of the four hypotheses.

Previous research and theoretical predictions dictated the development of the causal model. In some cases paths were determined from previous research looking at the relationship between personality and the development of PTSD and other stress reactions (Jaksic, Brajkovic, Ivezic, Topic, & Jakovljevic, 2012; Miller, 2003). For example, ample evidence has demonstrated a strong relationship between neuroticism and the development of PTSD, as well as lower levels of extraversion and agreeableness (Miller, 2003; Jaksic, Brajkovic, Ivezic, Topic, & Jakovljevic, 2012).

Table 1

Correlations for Primary Measures and Demographic Characteristics

Variables	M (S.D.)	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	33.45 (9.85)	-	.72**	.10	.12	-.30**	-.12	-.03	-.15*	-.02	.04	.11	.08	-.14	.05
2. Length of Time in the Field	7.86 (7.11)		-	.06	.09	-.32**	-.10	-.05	-.09	.03	-.05	.06	.07	-.16*	.09
3. Perspective Taking[a]	25.83 (4.08)			-	.29**	-.22**	-.24**	-.06	-.29**	.21**	.43**	.32**	.24**	-.13	.27**
4. Empathic Concern[a]	27.47 (3.84)				-	.03	-.12	.06	.03	.26**	.18*	.30**	.17*	.11	.37**
5. Personal Distress[a]	15.14 (4.35)					-	.38**	.32**	.51**	-.32**	-.18*	-.14*	-.28**	.47**	-.28**
6. Vicarious Trauma[b]	177.27 (37.87)						-	.47**	.73**	-.50**	-.25**	-.55**	-.44**	.53**	-.43**
7. Secondary Traumatic Stress[c]	20.47 (4.67)							-	.52**	-.21**	-.11	-.20**	-.24**	.52**	-.40**
8. Neuroticism[d]	18.56 (7.43)								-	-.43**	-.30**	-.45**	-.41**	.51**	-.36**
9. Extraversion[d]	31.34 (5.72)									-	.21**	.38**	.27**	-.27**	.39**
10. Openness[d]	29.45 (5.80)										-	.16*	.13	-.13	.26**
11. Agreeableness[d]	33.80 (5.08)											-	.21**	-.23**	.29**
12. Conscientiousness[d]	34.30 (6.17)												-	-.23**	.34**
13. Emotional Separation[e]	17.43 (5.41)													-	-.31**
14. Compassion Satisfaction[e]	40.23 (5.40)														-

Note. * $p < .05$ ** $p < .01$

Note. [a] Interpersonal Reactivity Index
[b] Trauma and Attachment Belief Scale
[c] Professional Quality of Life Scale
[d] NEO Five Factor Inventory
[e] Maintenance of Emotional Separation Scale

Therefore, paths were created between these personality variables and VT and STS. In addition, individuals having poor self-awareness (i.e., emotional separation) have been implicated as being at a higher risk of developing secondary stress and trauma (Thomas & Otis, 2010) and paths were created to test these relationships.

Paths were created between emotional and cognitive empathy and personality variables. It is generally accepted that empathy and agreeableness are positively correlated (Del Barrio, Aluja, & Garcia, 2004; Graziano, Habashi, Sheese, & Tobin, 2007) and empathy and neuroticism are negatively associated (Lee, 2009; Guarino, Roger, & Olason, 2007). In addition, a recent study conducted by Mooradian, Davis and Matzler (2011) found that openness was a strong predictor of cognitive empathy. The resulting model was parsimonious and appeared to make theoretical sense (see Figure 1).

Variables in the Causal Model

In the path model that was tested, aspects of personality and self-awareness (known as emotional separation in the model) were treated as exogenous variables and vicarious trauma, secondary traumatic stress, emotional empathy, and cognitive empathy were considered endogenous variables.

In terms of the empathy construct, the Perspective Taking and Empathic Concern subscales from the IRI were used as measures of cognitive empathy and emotional empathy, respectively. The Personal Distress subscale was not included in the model, as it negatively impacted model fit and it was deemed to overlap with other variables, such as neuroticism (from the NEO-FFI) and emotional separation (from the MES). The agreeableness, neuroticism, openness and extraversion

subscales from the NEO-FFI were used to measure aspects of personality. The Maintenance of Emotional Separation (MES) was used as a measure of self-awareness. The overall composite score from the Trauma and Attachment Belief Scale (TABS) was used as a measure of vicarious trauma. Finally, the Secondary Traumatic Stress (STS) subscale from the ProQOL was used to measure the primary aspects of compassion fatigue, that being PTSD symptomology and secondary stress.

Testing the Path Model

The first model tested (see Figure 2) was not significant, X^2 (8, N = 196) = 14.51, $p < 0.07$, which suggests a good fit for the model. Other fit indices that are less impacted by the size of the sample were also inspected, as suggested by Kline (2011). These other fit indices also indicated a good fit for the model: NFI = .973, CFI = .990, GFI = .984, RMSEA = .054. All of these indices meet the criteria for the most stringent model fit recommendations, which indicates that the overall model is a good fit based on the data (Byrne, 2010; Kline, 2011).

Model trimming is recommended to simplify the model and eliminate paths that are statistically nonsignificant (Kline, 2011). Several non-significant paths existed in the model (represented by dotted lines), reducing the parsimoniousness of the model. These paths were eliminated and an analysis of model fit was repeated to determine whether or not the model trimming impacted the model fit. The overall chi-square of the final model (see Figure 3) was not statistically significant, X^2 (14, N = 196) = 19.32, $p < 0.15$, which indicates an adequate fit.

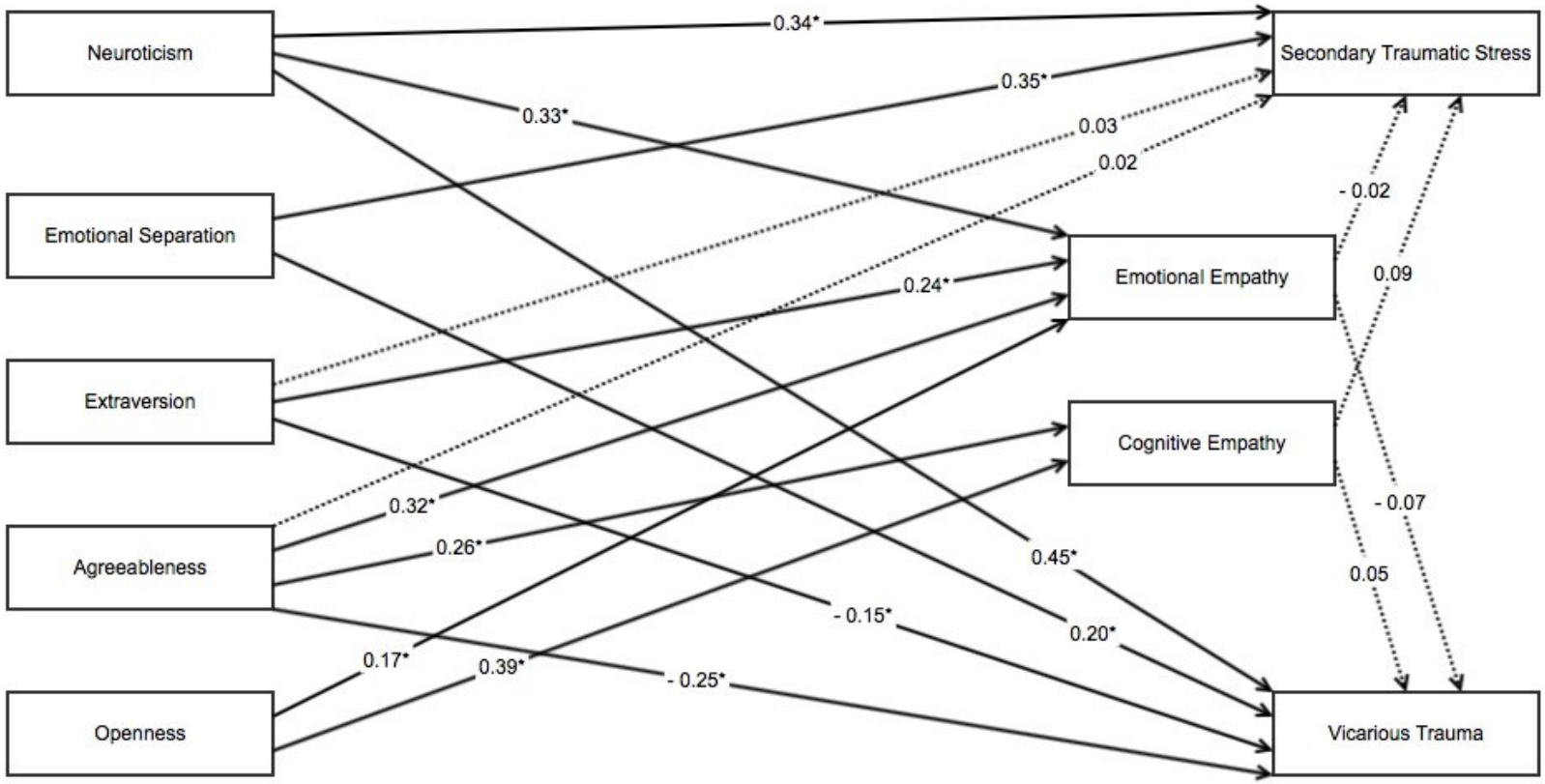

Figure 2. Initial model representing the relationship between personality constructs and emotional separation with cognitive empathy, emotional empathy, secondary traumatic stress, and vicarious trauma prior to model trimming. *p < .01.

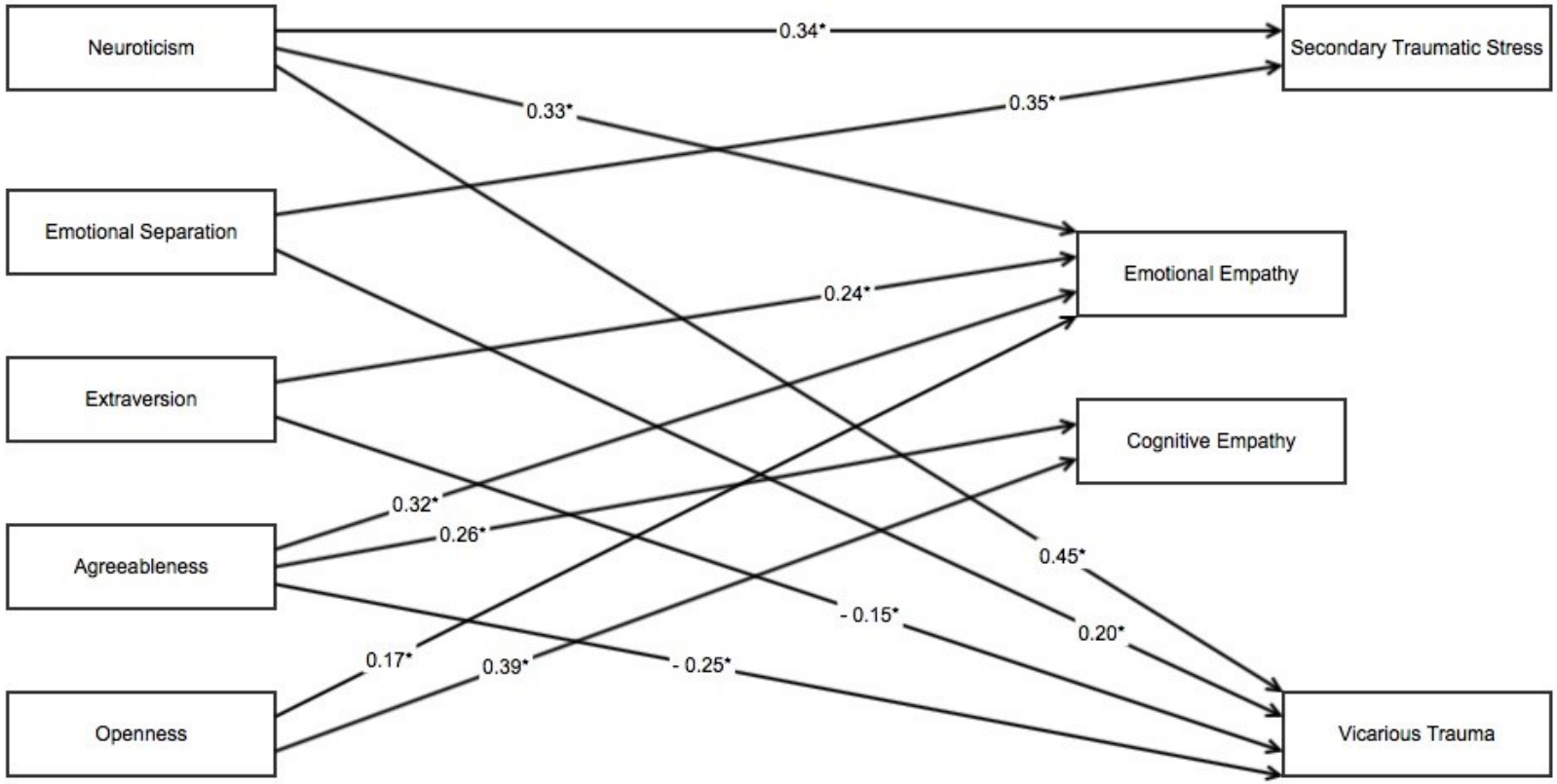

Figure 3. Final model representing the relationship between personality constructs and emotional separation with cognitive empathy, emotional empathy, secondary traumatic stress, and vicarious trauma after model trimming. *p < .01.

The results of the other fit indices were: NFI = .967, CFI = .990, GFI = .978, and RMSEA = .044. Although both the initial model and the final model were found to have adequate fit, the final model was more parsimonious and had significant relationships between all the variables. As no statistically significant direct effects between empathy and STS and VT existed after model trimming, no mediational analyses were necessary.

The standardized path coefficients are shown in Figure 2. Neuroticism was a predictor of Vicarious Trauma (β = .45), Secondary Traumatic Stress (β = .34), and Emotional Empathy (β = .33). Openness was a predictor of both Cognitive Empathy (β = .39) and Emotional Empathy (β = .17). Extraversion predicted Vicarious Trauma (β = -.15) and Emotional Empathy (β = .24), while Agreeableness predicted Vicarious Trauma (β = -.25), Cognitive Empathy (β = .26) and Emotional Empathy (β = .33). Finally, Self-Other Differentiation predicted both Vicarious Trauma (β = .20) and Secondary Traumatic Stress (β = .35).

In terms of the total amount of variance explained in the model, 65% of the variance for the Vicarious Trauma construct was explained by a combination of Neuroticism, Extraversion, Agreeableness, and Emotional Separation, while 36% of the variance associated with Secondary Traumatic Stress was explained by Neuroticism and Emotional Separation. Relatively less of the variance associated with Cognitive Empathy and Emotional Empathy was explained by variables from the model. Specifically, 25% of the variance in Cognitive Empathy was explained by a combination of Openness and Emotional Separation and 20% of the variance

associated with Emotional Empathy was explained by Neuroticism, Openness, Extraversion, and Agreeableness.

Evaluation of Hypotheses

1. *Emotional and cognitive empathy will be positively correlated with VT and CF and will contribute significant variance in a causal model.*

   Disconfirmed. Emotional and cognitive empathy shared no correlations with VT and CF. In fact, cognitive empathy was negatively related to VT. Also, both cognitive and emotional empathy were positively correlated with compassion satisfaction.

2. *Having poor self-awareness (i.e., emotional separation) will be a significant predictor of VT and CF in a causal model.*

   Confirmed. Having poor emotional boundaries significantly predicted both VT and CF.

3. *Higher levels of neuroticism and lower levels of agreeableness and extraversion will be associated with higher levels of VT and CF in the causal model.*

   Partly Confirmed. Higher levels of neuroticism were associated with high levels of both VT and CF. High levels of agreeableness were unrelated to CF, while a negative correlation existed between agreeableness and VT. Extraversion shared no relationship with CF, but shared a weak negative relationship with VT.

4. *As well as demonstrating direct effects on VT and CF, empathy will mediate the relationship between aspects of personality and VT and CF.*

Disconfirmed. As empathy was uncorrelated with both VT and CF, no meditational analyses were possible. Cognitive and emotional empathy were best predicted by a combination of personality variables.

Discussion

The current study proposed a path model integrating research from several interconnected areas of enquiry (i.e., empathy, personality, vicarious trauma and compassion fatigue). The purpose of the study was to demonstrate, through the use of path analysis, the role that both empathy and personality play in the development of two similar secondary stress reactions in a sample of child and youth care counsellors, those being vicarious trauma and a dimension of compassion fatigue (CF) known as secondary traumatic stress (STS). It also allows for the analysis of both the direct and indirect impact of variables in the model and provides a framework for mediation analyses.

The present study began with the assumption that adopting an empathic stance in the treatment of those who have experienced trauma is an important causal factor in the development of vicarious trauma (VT) and secondary traumatic stress (STS; Adams, Figley, & Boscarino, 2008; Figley, 2002; Pearlman & MacIan, 1995). It was hypothesized that higher levels of emotional and cognitive empathy would relate to an increase in self-reported VT and STS symptomology. The possibility that empathy directly effects VT and STS was tested in the model, as were the indirect effects of empathy acting as a mediator between several personality variables, self-awareness (i.e., emotional separation) and VT and STS. The results of

the correlational analysis (see Table 1) and the path analysis (see Figure 3) demonstrated that neither cognitive nor emotional forms of empathy were associated with higher levels of VT or STS. In fact, cognitive empathy was found to be a significant negative correlate with vicarious trauma. In addition, the model suggested that cognitive and emotional empathy do not play a causal role in the development of VT or STS in child and youth care counsellors, which contradicts previous assumptions by numerous VT and STS researchers (Conrad & Kellar-Guenther, 2006; Trippany, White Kress, & Wilcoxon, 2004).

The lack of a direct or indirect effect between cognitive and emotional empathy and VT and STS, while surprising, was not wholly unexpected. There had been no empirical evidence demonstrating the potential harmful impact that being empathic could potentially have on the helping professional prior to the conceptualization of the VT and CF constructs. The purpose of empathy has never been to entangle oneself in the emotional turmoil of the client, but to demonstrate understanding, facilitate relationship building, and to help the client with self-exploration (Clark, 2010; Rogers, 1975). Rogers (1975) believed strongly that, in order to effectively express empathy in a therapeutic context, the counsellor must be psychologically healthy and emotionally stable. Therefore, if empathy is in fact a multidimensional construct, perhaps identifying which *aspects* of empathy (if any) are responsible for the development of VT and CF would help to provide a more accurate definition of these constructs.

The current study is consistent with a growing body of research challenging the tendency to prematurely pathologize those working with victims of trauma. An

emerging movement in trauma research is to focus on the positive benefits of working with victims of trauma, an idea dubbed vicarious post-traumatic growth or vicarious resilience (Barrington & Shakespeare-Finch, 2012; Hernandez, Engstrom, & Gangsei, 2010). In their landmark study, Arnold, Calhoun, Tedeschi and Cann (2005) conducted research examining the positive consequences of working with victims of trauma. The researchers interviewed 21 psychotherapists and found that 100% of the participants reported positive consequences of trauma work, which went along with the obvious negative aspects (i.e., emotional exhaustion, hearing descriptions of traumatic events, high levels of stress). These positive consequences included the experience of viewing their client's post-trauma growth, an appreciation of the human spirit and resilience, improved relationship skills, and the satisfaction produced from being part of the healing process. In another study, Pack (2014) found that vicarious traumatization was much more fleeting and transient than initially thought and that most counsellors were able to navigate the initial distress of trauma therapy in a healthy and effective manner.

Although the current study did not explicitly examine positive aspects of empathic engagement with victims of trauma, a moderate positive relationship was found between compassion satisfaction and both emotional and cognitive empathy (see Table 1). Compassion satisfaction is defined as the pleasure one feels from being able to do work with others in pain (Stamm, 2009). This is an interesting finding, as it does suggest that those who experience higher levels of emotional and cognitive empathy experience a greater sense of satisfaction with their work. The results of this study, as well as the emerging fields of vicarious post-traumatic

growth or vicarious resilience, seem to indicate that it is not the cognitive or emotional aspects of empathy that predispose the helping professional to a higher risk of VT and CF.

The integration of emotional regulation and self-awareness by Decety and Moriguchi (2007) into the empathy construct is a relatively new and interesting addition to empathy research. Traditionally, the measurement of empathy has focused on either cognitive or emotional forms of empathy, or a combination of both. At the time of this research, there were no self-report measures of empathy that integrated all four aspects of the empathy construct. However, in the current study, there was evidence to support the idea that poor self-awareness (measured using the Maintenance of Emotional Separation scale; MES) and a lack of emotional regulation (measured using the Neuroticism scale from the NEO-FFI) related to higher levels of both VT and CF.

Neuroticism, which has been defined as "the tendency to experience frequent and intense negative emotions in response to various sources of stress" (Barlow et al., 2014, p. 344), has also been previously identified as the most important factor in the development of VT and CF (Mairean & Tuliuc, 2013) and has also been strongly implicated in the development of post-traumatic stress disorder (PTSD; Lerias & Byrne, 2003; Miller, 2003). In the current study, neuroticism was the best predictor of VT and demonstrated a moderate relationship with STS. Based on these findings, the importance of being emotionally hardy, stable, and less reactive to stressful situations is exceptionally important for the avoidance of heightened levels of VT and CF. Furthermore, the current study demonstrated the importance of an

appropriate level of self-awareness when working with victims of trauma. Self-awareness (measured using the MES) was the best predictor of STS and was a significant correlate with VT, which does indicate that having healthy emotional boundaries helps to buffer the impact of VT and CF. As suggested by Rogers nearly 40 years ago, emotional stability is an important characteristics for empathic understanding and healthy engagement with victims of trauma (Rogers, 1975).

The current model was able to account for 65% of the variance associated with VT. The variables that were found to account for this variance were neuroticism, emotional separation, agreeableness, and extraversion, which coincides with previous personality research examining personality variables associated with the development of PTSD (Miller, 2003). Based on these findings, individuals who are emotionally fragile, aloof, reserved and have poor emotional boundaries may be at risk of developing VT in the residential care of troubled youth. It is suggested by the results of this study that who you are as a person has profound implications regarding your risk of developing secondary stress reactions when working with victims of trauma, particularly in regards to the development of VT.

The combination of neuroticism and self-awareness were the sole predictors of STS after model trimming, accounting for 36% of the variance. Although previous studies implicated the role of extraversion and agreeableness in the development of traumatic reactions (Jaksic, Brajkovic, Ivezic, Topic, & Jakovljevic, 2012; Miller, 2003), this was not the case when the variance associated with neuroticism and self-awareness were taken into account. However, both extraversion and agreeableness shared significant correlations with STS. Considering the comparatively small

amount of total variance accounted for by the predictors of STS in this study (as compared to the predictors of VT), it seems likely that personality variables impact the development of STS less than VT. The differences in the predictive value of personality between the STS and VT constructs also provides some evidence that they are indeed different types of secondary stress reactions, with vicarious trauma being more related to personality variables.

The reason that the model was better at accounting for variance associated with VT was likely due to the fact that VT pertains more to changes in beliefs and attitudes that result from working with victims of trauma, as opposed to STS, which focuses more on PTSD symptomology. There is an obvious link between our personality structure and the way we view, interact, and think about the world around us. As CF is more focused on overt physical symptoms (e.g., avoidance, nightmares, flashbacks, etc.), it follows that personality would account for less of the variance associated with this construct. However, 36% is still a large amount of variance and, therefore, personality certainly deserves to be considered in any etiological studies of STS in the future.

In the current study, a smaller amount of the variance associated with emotional (20%) and cognitive (25%) aspects of empathy were accounted for by personality variables. However, the longstanding relationship between agreeableness and empathy was confirmed in the path model, as it was a significant predictor for both cognitive and emotional empathy. It appears that individuals who are warm, cooperative and sympathetic are inherently better at empathizing with others. Along with agreeableness, openness was the other significant predictor of

both cognitive and emotional empathy, which is a personality variable that has also been shown to relate to empathy in at least one other study (Mooradian, Davis, & Matzler, 2011). Openness is a multifaceted personality variable and those who score highly on this construct are typically curious, open to new concepts and ideas, imaginative, and thoughtful, which are attributes that would be important and valuable when attempting to empathize with another person.

The strongest personality variable associated with emotional empathy was higher levels of neuroticism. This is an interesting finding, as it suggests that being more emotionally reactive serves to enhance ones ability to share in the emotional experience of another person. This finding coincides with previous research and it has been theorized that this relationship is due to an underlying tendency to respond to situations in an emotional manner, as opposed to a thoughtful and detached approach (Mooradian, Davis, & Matzler, 2011).

The last predictor of empathy in the model was between emotional empathy and extraversion. Weak associations between these variables have also been found in previous studies (Mooradian, Davis, & Matzler, 2011), which indicates that individuals who are engaging, energetic, and sociable are also good at emotional engagement when interacting with others. One could theorize that extraverted individuals are more motivated to engage with others in a social manner, which could be seen as an important precursor for emotional empathy to take place.

Conclusion

The current study calls into question the role that empathy plays in the development of VT and CF. The purpose of empathy in a therapeutic context does

not necessitate that counsellors and helping professionals become overly immersed in the client's experiences and stories. Instead, the results of this study suggest there is little risk in expressing both emotional and cognitive forms of empathy when working with victims of trauma, which contradicts the notion that empathy is a "double-edged sword". Furthermore, recent research has found that working with trauma victims can be emotionally and psychologically beneficial to the counsellor (Barrington & Shakespeare-Finch, 2012; Hernandez, Engstrom, & Gangsei, 2010).

The current study does provide evidence for the idea that counsellors who have poor emotional boundaries and psychological instability are at a greater risk of developing both VT and CF. These dimensions, which are now widely considered part of the empathy construct, do seem to impact the quality of the empathic relationship that is formed between the therapist and the client. One hypothesis for this relationship is that these individuals lack the necessary emotional hardiness for informal trauma work and are at risk of becoming overwhelmed by client's emotions and traumatic experiences.

As there is an obvious lack of evidence supporting an etiological link between empathy and VT and CF, it is misleading to continue implicating empathy as a causal factor in the development of these stress reactions. The inclusion of empathy as part of the definition for VT and CF is unfounded and could have detrimental consequences in the helping professions. The most egregious outcome of linking empathy with VT and CF is the potential for those in the helping professions to avoid engaging in a potentially helpful and therapeutic empathic relationship with their clients, due to a misguided fear that they will develop VT and CF. Using an

empathic approach has been shown to produce numerous positive outcomes in the helping professions (Elliott, Bohart, Watson, & Greenberg, 2011; Feller & Cottone, 2003) and, as Rogers pointed out (1975), is perhaps the most important attribute of an effective counsellor.

The proposed model provides evidence for a new line of enquiry into the predictors of VT and CF. Previous studies looking at predictors of VT and CF have focused mostly on external factors (i.e., amount of experience in the field, history of trauma, and level of training) and have largely ignored the significant role of personality in the development of these reactions. However, it seems increasingly likely that, as with PTSD, most trauma workers do not develop these reactions and many trauma workers actually derive feelings of success and fulfillment from their work with trauma victims (Arnold, Calhoun, Tedeschi, & Cann, 2005). Furthermore, the results of this study suggest that dispositional traits significantly impact the development of VT and CF, at least as much (if not more than) environmental factors.

Limitations of the Study and Future Directions

Several limitations of the current study are important to address. Firstly, the generalizability of the current study to other populations of trauma workers is debatable. Although child and youth care counsellors work with many children and adolescents who have been victims of trauma, their role is different from trauma counsellors, social workers, nurses, and others in the helping professions. It will be important to conduct subsequent studies using participants from a variety of helping professions.

Second, the accuracy of self-report questionnaires as a measure of empathy has been called into question (Duan & Hill, 1996). In addition, an integrated measure of empathy containing all four dimensions of empathy described in the social-cognitive neuroscience literature is sorely needed. To help address these concerns, Gerdes, Lietz, and Segal (2011) have attempted to fill this gap in empathy research by publishing the Empathy Assessment Index, which does purport to align with research in social-cognitive neuroscience. This measure was not used in the current study, as it was not available at the time of data collection and research is needed to determine its validity and reliability.

Finally, this is the only study (as far as the researchers are aware) attempting to integrate personality, empathy and VT and CF into a coherent causal model. There are many choices that go into creating a causal model, and these can significantly impact the hypothesized paths between the variables in the model. The current model is based on research examining the role of personality in both empathy and, for the most part, PTSD research. It would be important to include different variables in future models to help expand upon research in this area.

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CHAPTER 4

AN EXPLORATION OF EMPATHY AND THE THERAPEUTIC RELATIONSHIP IN CHILD AND YOUTH CARE WORK: A MIXED METHODS STUDY

"When people talk, listen completely…most people never listen." – *Earnest Hemingway*

Introduction

The results from the path analysis study (Chapter 3) demonstrated that the main components of the empathy construct (i.e., cognitive and emotional empathy) did not share direct or indirect relationships with vicarious trauma (VT) or secondary traumatic stress (STS). This was an illuminating finding, considering previous allegations that empathy is a causal variable in both of these secondary stress reactions (Figley, 2002; McCann & Pearlman, 1990). The path analysis study did suggest that other dimensions of empathy, namely emotional regulation and self-awareness, were significant predictors of VT and STS. These unique findings have contributed to our understanding of the empathy construct and its relationship with secondary trauma; however, there are still gaps in our understanding of how empathy leads to positive outcomes in the helping professions. Specifically, there has been little published on the personal experiences of therapeutic empathy among those in the helping professions and the role that empathy plays in relationship development (Feller & Cottone, 2003; Moyers & Miller, 2013; Rogers, 1975). In order to help address this gap in the literature and to broaden our understanding of the therapeutic importance of empathy a follow-up mixed methods (MM) study was undertaken.

This mixed methods study was conducted after a majority of the data was collected for the larger quantitative study (Chapter 3) and was meant to provide an in depth examination of the experiences of empathy among a group of child and youth care counsellors. It is important to note that, although the participants for the MM study were selected after data from the quantitative study was collected, these studies were conducted concurrently, particularly in terms of analysis. Therefore, the results and findings of the quantitative study will not be cited in this research, as they were not available. These studies were meant to address differing aspects of empathy using a variety of research techniques in order to provide a thorough and complete picture of empathy in the helping professions.

A sequential MM design was utilized in order to identify participants based on a prescribed set of criteria, namely those who reported at least average levels of empathy and who were not reporting elevated levels of secondary trauma. It was anticipated that this group would be able to engage in meaningful and rich dialogue regarding the importance of empathy in relationship development with children and youth in care, as they were both empathic and were not experiencing a high degree of secondary trauma. The quantitative phase (Phase 1) of this MM study was smaller in scope than the qualitative phase, and was used solely to identify participants for the focus group. The qualitative phase of this study (Phase 2) involved a single focus group consisting of 8 child and youth care counsellors from a variety of agencies in Edmonton, Alberta.

This MM study was meant to complement my larger quantitative paper, but, in my opinion, proved to be no less valuable as the participants provided rich and

detailed accounts of empathic encounters with troubled children and youth. I found their stories fascinating and their descriptions both served to bolster my previous thoughts about empathy in the helping professions, as well as provide new ideas and lines of enquiry for future studies, both quantitative and qualitative. The accounts and rich descriptions generously provided by the focus group participants were compared and contrasted to literature in the area. The purpose of this study is to examine the role of empathy in the development and maintenance of the therapeutic relationship among a select group of child and youth care counsellors. This study is meant to provide a deeper understanding of both the positive and, potentially, negative aspects of adopting an empathic approach when working with "at risk" children and youth in a therapeutic capacity.

The following study is organized into five sections. The first section is a literature review and provides a brief, but comprehensive account of the empathy literature. The second section describes the method of analysis for the study, as well as a description of my philosophical beliefs regarding mixed-methods research. The third section is a combined results/discussion section and provides a description of the research findings, as well as some interpretations of the participant descriptions. Finally, the fourth section provides a general conclusion to the study and the final section discusses this studies limitations and directions for future research in the area.

Literature Review

Definition of Empathy

The use of empathy in the helping professions has a long and important history. It was a central concept in psychoanalytic practice and research and one of the earliest definitions of empathy from a therapeutic perspective was provided by Sigmund Freud, who stated that empathy is "the mechanism by means of which we are enabled to take up any attitude at all towards another mental life" (Freud, 1922). However, it was Carl Rogers, the father of person-centered therapy and a pioneer of psychotherapeutic research, who argued that empathy was necessary for human growth and positive outcome in therapy (Rogers, 1957, 1995). Rogers believed that the ideal therapist was first and foremost empathic and that through the therapist's use of empathy the client would feel accepted, appreciated, and understood (Rogers, 1975). Decades of research has identified the working alliance as one of the fundamental ingredients in effective psychotherapy and empathic understanding is at the heart of alliance development (Ahn & Wampold, 2001; Coutinho, Silva, & Decety, 2014; Feller & Cottone, 2003). Although Rogers' theories and research relate to counselling and the relationship between the therapist and client, most other helping professions have adopted similar beliefs regarding the importance of empathy in human interaction (Larson & Yao, 2005; Satterfield & Hughes, 2007; Yu & Kirk, 2008). In fact, it was a renewed interest in the use of empathy in medicine and nursing that helped to spark a resurgence in empathy research nearly two decades ago, which continues today (Epstein et al., 2007; Strug et al., 2003).

Today empathy is conceptualized as a multidimensional construct composed of both emotional and cognitive elements (Davis, 1980, 1983). Emotional empathy is an instinctive and unconscious form of empathy that is present in very young children and consists of a "mirroring" of the affective material of other human beings (Davis, 1980, 1983; Hoffman, 1981). Cognitive empathy is conceptualized as the ability to recognize and understand the perspective of another individual without having to "take on" their emotional material (Duan & Hill, 1996). For years, researchers have attempted to understand how these two similar, but distinct empathic dimensions interact with one another (Sams & Truscott, 2004).

Recently, Decety and Moriguchi (2007) explained that in order for a complete empathic reaction to occur four components (affective sharing, self-awareness, mental flexibility and perspective taking, and emotional regulation) involving both emotional and cognitive empathy, as well as other variables, are needed. This research is based on neurological studies that have exploded in the past decade and have created a new frontier in empathy research called social cognitive neuroscience (Gerdes, Segal, & Lietz, 2010). Affective sharing relates most closely with the concept of emotional empathy, while mental flexibility and perspective taking refer to the intellectual elements of the empathy reaction. Self-awareness relates to the ability to differentiate another person's emotions from your own, while emotional regulation relates to the ability to respond to a situation with a range of emotions and to limit one's own emotions depending on the situation (Decety & Moriguchi, 2007; Gerdes, Segal, & Lietz, 2010). According to Decety and

Moriguchi (2007) all of these elements are necessary for a complete empathic response to occur.

Why are we Interested in Empathy?

The use of empathy in the helping professions is a fundamentally important concept. Rogers (1957, 1995) described empathy as one of the "necessary and sufficient conditions for therapeutic change". It was further described by Brenner (1982) as the "heart and definition of therapy" (p. 2). Empathy is important in the helping professions because it helps to facilitate a therapeutic alliance between the helper and the client, as well as to provide a platform for understanding (Ahn & Wampold, 2001; Peloquin & LaFontaine, 2010). In therapy, empathy has been associated with client self-exploration and the combination of empathy and unconditional positive regard can remove the client's concern that he or she will be judged negatively (Coutinho, Silva & Decety, 2014; Feller & Cottone, 2003; Rogers, 1975). Therefore, it comes as no surprise that empathy has been found to relate to positive treatment outcomes with numerous populations of individuals (Elliot, Bohart, Watson, & Greenberg, 2003; Moyers & Miller, 2013).

Empathy is important in any field that deals with human interactions including medicine, nursing, teaching, social work, and emergency responders (Larson & Yao, 2005; Satterfield & Hughes, 2007; Yu & Kirk, 2008). It is important to note that empathy is often confused with other similar constructs, such as sympathy, pity, compassion, and consolation. However, unlike many of these other emotional responses, which are often more personalized and reactive than empathy (and less therapeutic), empathy involves a conscious attempt to explore and

examine the reality of another person. According to Gerdes (2011), the purpose of empathy is not to console, comfort, or "make better", but is instead to gain a deep and meaningful knowledge of the other person's experiences and emotions. This understanding may serve to facilitate positive change by prompting client self-exploration (Clark, 2010). It is because of the unique nature of empathy to facilitate growth and change that helping professionals and researchers from all disciplines and occupations have demonstrated an interest in the topic.

Although a majority of the research on empathy has examined its therapeutic potential, there has been growing concern that empathy also has the potential to result in harm and emotional distress on the part of the helping professional. Some researchers have explicated that sharing another individual's thoughts and feelings when traumatic and distressing material is being discussed can result in a host of negative and potentially long-lasting symptoms on the part of the helper (Duan & Hill, 1996; Gross, 1994). Such a theory seems to make intuitive sense to those in the helping professions; however, little research has explored this theory and many questions remained unanswered and need to be investigated.

Evidence for the Helpful Nature of Empathy

Carl Roger's (1975) once stated that empathy "is clearly related to positive outcome [in therapy]" (p. 5). Although such a statement makes sense to those working in the helping professions, until recently there has been little empirical evidence to substantiate this claim. In fact, for nearly two decades after Roger's published his landmark paper in 1975, *Empathic: An unappreciated way of being*, there was a paucity of papers exploring the importance of empathy in creating

positive therapeutic change. This was mostly due to conceptual concerns that impacted the empathy literature, which resulted in issues with measuring and accurately defining empathy . This has changed significantly over the past two decades due to a variety of factors, most notably the growing acceptance of the importance of empathy in medicine and nursing and the emergence of social cognitive neuroscience, which has served to provide an empirically supported definition for the empathy construct (Bernhardt & Singer, 2012; Neumann et al., 2011).

A review of the most recent literature demonstrated that interest in the positive impact of empathy comes from a wide array of fields and disciplines. Several recent studies in the business and management literature have found empathy to be related to fair and moral behavior among managers (Dietz & Kleinlogel, 2014; Whiteside & Barclay, 2014). For example, in a study conducted by Dietz and Kleinlogel (2014), the researchers found that managers who scored higher on measures of empathy were less likely to cut employees' wages, even when requested to do so by authority figures. The researchers concluded that "these findings imply that empathy can serve as a safeguard for ethical decision making in organizations during trying times without generally undermining organizational effectiveness" (p. 461). The importance of empathy has also been established in numerous other fields, including among dieticians (Parkin, de Looy, & Farrand, 2014), police officers (Maddox, Lee, & Barker, 2011), and teachers (McAllister & Irvine, 2002).

As previously mentioned, no other field has conducted as much research examining the importance of empathy in positive treatment outcomes as medicine and nursing. Research conducted in these fields has found positive relationships between empathy and amount of detail collected during patient interviews (Neumann et al., 2007), treatment compliance (Hojat et al., 2011; Kim, Kaplowitz & Johnston, 2004; Pollak et al., 2007), patient satisfaction and interpersonal care (Epstein et al., 2007; Strug et al., 2003), and a reduction of patient distress (Olson & Hanchett, 1997). In a recent study conducted by Steinhausen and colleagues (2014), 127 patients were surveyed using a subjective evaluation 6-weeks after being discharged from hospital after surgery. The researchers found that the level of surgeon empathy was found to positively predict the evaluation of treatment effectiveness, which is interesting considering that success in surgery has generally been associated with medical skill and expertise, as opposed to interpersonal aptitude.

From a therapeutic perspective, empathy accounts for a significant amount of the variance associated with positive outcome in counselling. A recent meta-analytic study conducted by Elliott, Bohart, Watson and Greenberg (2011) found that empathy accounted for 9% of the variance associated with positive change in therapy. This is more variance than is accounted for by specific interventions and therapeutic orientation combined. A recent study conducted by Watson, Steckley and McMullen (2014) found that therapist empathy was associated with a significant improvement in the ability of clients to form healthy attachments with others. Specifically, the researchers found that "[clients] were less mistrustful about

others' care and support, felt less worried about others' approval, experienced less discomfort with closeness, and felt more worthy" (p. 296). Such studies finally provide empirical evidence to support Carl Rogers original assertions about empathy, mainly that empathy is related to client satisfaction, compliance, and treatment outcome (Rogers, 1975).

Can Empathy be Harmful?

The idea that empathy results in therapeutic relationship development is firmly established in the literature (Couninho, Silva, & Decety, 2014; Elliott, Bohart, Watson, & Greenberg, 2011; Feller & Cottone, 2003). However, what has been debated is the potential harm and risk involved on the part of the helper when interacting with a client in an empathic manner. Some researchers have labeled empathy as being a "double edged sword", suggesting that the helpfulness of empathy is context specific and may be helpful in some situations, but harmful in others (Duan & Hill, 1996). There is some evidence supporting the idea that it is the helper's inability to regulate their emotions when utilizing an empathic approach that results in a negative emotional reaction (Decety & Jackson, 2006). Some researchers have proposed that the ability to regulate one's feelings and emotions, as well as the ability to be self-aware when working with clients, are key aspects of the empathy construct and allow the helper to engage in a healthy and complete empathic connection with the client (Decety & Moriguchi, 2007). If a helper becomes overly involved with the client's negative emotional material they may develop "emotional contagion", which is a negative consequence of empathy and

results in feelings of being overwhelmed by negative emotion (Batson, Sager, Garst, Kang, Rubchinsky, & Dawson, 1997; Corcoran, 1983).

The use of empathy in a therapeutic context has also been implicated as a potential cause of burnout, vicarious trauma (VT), and compassion fatigue (CF). Over 30 years ago, Christina Maslach (Maslach, 1982), an expert on burnout and the author of the Maslach Burnout Inventory (MBI), reported that "the person whose feelings are easily aroused (but not necessarily easily controlled) is going to have far more difficulty in dealing with emotionally stressful situations than the person who is less excitable and more psychologically detached" (p. 70). This sentiment has also been shared by several other researchers (Astrom, Nilsson, Norberg & Winblad, 1990; Gross, 1994; Miller, Birkholt, Scott & Stage, 1995; Williams, 1989).

Vicarious trauma (VT) and compassion fatigue (CF) are fairly new concepts and relate to the negative emotional, cognitive, and physiological reactions that stem from empathic engagement with victims of trauma and abuse (Figley, 2002; Pearlman & MacIan, 1995). Although conceptual differences between these constructs have been proposed, the terms are often used synonymously and interchangeably in practice and research. One of the aspects of VT and CF that is similar is the inclusion of empathy as a precipitating factor in their development and maintenance (Figley, 2002; McCann & Pearlman, 1990). The originators of these stress reactions, as well as others, have proposed that empathic engagement with victims of trauma can result in "PTSD-like" symptoms, changes in beliefs and values, boundary violations with clients, an impaired ability to form a therapeutic bond with the client, and other negative consequences (Conrad & Kellar-Guenther, 2006;

Corcoran, 1982, 1983; Hesse, 2002; Thomas & Otis, 2010; Trippany, White Kress, & Wilcoxon, 2004). Although much less evidence exists supporting the potential harmful impact that empathy has on the development of stress reactions in helping professionals, it is a growing area of concern and requires careful consideration and further research.

Rationale

After completing a thorough review of the literature, several gaps were identified which inspired this MM study. Firstly, there is a lack of explanation as to why and how empathy facilitates therapeutic relationship development. We have a tremendous amount of information examining the significant relationships between empathy and positive outcomes in counselling, medicine, and other professions; however, we know very little about the specific aspects of empathy that make these outcomes possible. According to Kamberelis and Dimitriadis (2011), focus group research is ideal when answering why and how questions, which are often left unaddressed by positivistic research methods.

Secondly, although empathy has been implicated as a causal factor in the development of secondary trauma, there has been little explanation of the specific aspects of empathy which lead to these negative reactions. As the conceptualization of empathy as a multidimensional construct is a relatively new idea it is important to identify which aspects of empathy may be contributing to these stress reactions. When examining a new line of enquiry it is often helpful to begin by collecting information from an informed group of individuals and focus group research has

been identified as a useful methodological tool for this purpose (Stewart & Shamdasani, 1990).

As a result of the emotional and psychological impact of bearing witness to traumatic incidents and events, it has been proposed that therapists may begin to depersonalize their clients and struggle to form therapeutic relationships (Hesse, 2002). Therefore, a MM design was chosen for this study, as I wanted to isolate a group of participants who were not exhibiting higher than average levels of secondary trauma, but who were also empathic individuals.

Methods

Research Foundations

In the current study, a mixed-methods sequential design was used (MMSD) to examine the experiences of empathy among a select group of child and youth care counsellors (CYCCs; see Figure 4). According to Ivankova, Creswell, and Stick (2006), mixed-methods designs (MM) are optimal in situations when neither quantitative or qualitative research designs alone are considered sufficient or optimal to answer a particular research question. Mixed-methods research involves combining quantitative and qualitative data, either concurrently, sequentially, or through embedding the data at various stages of the research (Creswell & Plano Clark, 2011). This design generally allows for a more "robust analysis" and provides an opportunity for researchers to explore data at a more comprehensive and vigorous level (Creswell, 2011; Teddlie & Tashakkori, 2011).

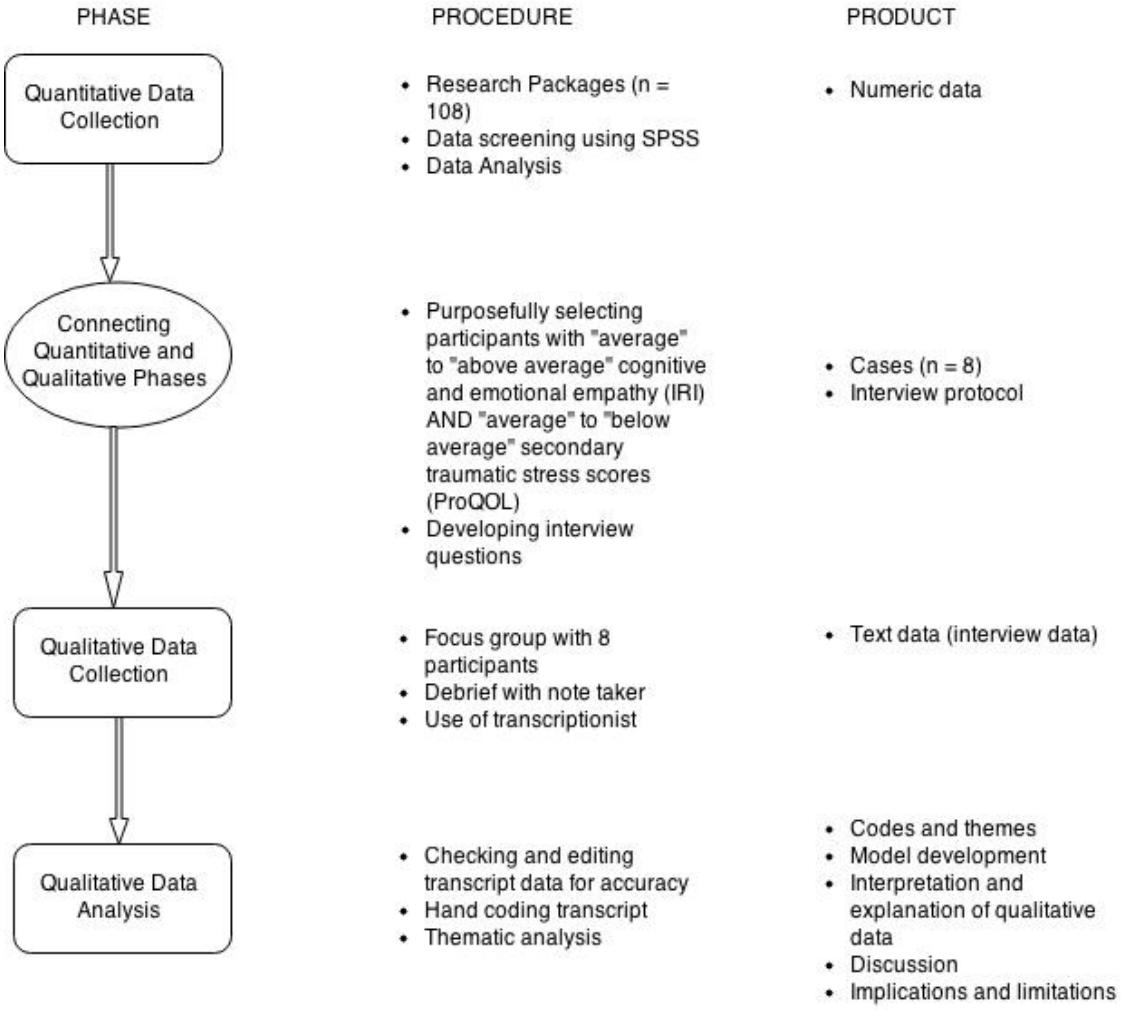

Figure 4. *Visual Model for Mixed-Methods Sequential Design Procedures*

In the current study, MM techniques were used to help explain the role of empathy in child and youth care work among a specific group of participants. In MM studies, the focus of the research can be on either the quantitative or the qualitative phase of the study, or uniformly on both phases (Creswell & Plano Clark, 2011). In this study, the focus will be primarily on the focus group; however, the quantitative phase was also important and was used to select participants.

Philosophical Assumptions

As is common in mixed methods research, I have adopted a pragmatic approach to research design and data analysis. According to Green and Hall (2010), pragmatism involves choosing research techniques and designs based on the best methods available to answer a specific research question. A pragmatic approach requires that the question is of primary importance when designing a research project (Creswell & Plano Clark, 2011). It allows for the use and integration of both quantitative and qualitative data collection and analysis techniques and implies that there is no singular reality guiding the acquisition of knowledge (Tashakkori & Teddlie, 2003). Researchers who adopt a pragmatic approach to research design avoid involving themselves in debates regarding philosophical orientation (i.e., postpositivist versus interpretive approaches; Creswell & Plano Clark, 2011). Pragmatic researchers have been described as being "action oriented" and utilize techniques and research methods that provide practical and workable solutions to complex problems (Green & Hall, 2010).

Quantitative Data Collection (Phase 1)

Initial Data Collection. The initial stage (Phase 1) of the current study involved collecting research packages from 108 child and youth care workers in Edmonton, Alberta. The criteria for participating in the study were: (a) child and youth care counsellors working in direct contact with children and youth (b) a minimum of 6 months of experience, and (c) fluency in reading, writing, and speaking English. The participants were provided with an additional consent form, which, if completed, gave me permission to contact these participants for the

qualitative phase (phase 2). Of these 108 participants, 41 agreed to be contacted for phase 2, ranging in age from 22 to 56 years (M = 34.36, SD = 10.45). The majority of the participants (N = 35) were women, while a minority (N = 6) were men. Most of the participants identified themselves as being Caucasian (90.2%), with the remaining participants classifying themselves as Aboriginal (2.4%), Hispanic (2.4%), and East Indian (4.9%). In terms of educational background, most participants reported having a university degree (46.3%), while a significant minority reported having a university diploma (41.5%) and the remainder had a master's degree (4.9%) or an alternative ("other") level of education (7.3%).

As mentioned, the research packages were used as part of a larger quantitative study and included the following measures: the Interpersonal Reactivity Index (IRI; Davis, 1980); the Professional Quality of Life Scale (ProQOL; Stamm, 2009); the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003); the NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992); the Maintenance of Emotional Separation Scale (MES; Corcoran, 1982); and a demographic sheet. Of these measures, only the IRI, the ProQOL and the demographic forms were used in the current study. These packages were mailed to 12 child and youth care agencies in Edmonton, Alberta and were typically distributed and collected by management at these agencies. The managers followed a set of explicit guidelines provided by the researchers in order to ensure confidentiality. Participation in the study was voluntary.

Measures Used for Selection of Participants in Phase 2

The Interpersonal Reactivity Index (IRI). The Interpersonal Reactivity Index (IRI; Davis, 1980) is a multidimensional self-report inventory, which is used to measure different aspects of the empathy construct. There are four subscales in the IRI, which include the empathic concern, personal distress, fantasy and the perspective-taking subscales. Each of the four subscales are mutually-exclusive, meaning an overall composite score measuring empathy cannot be determined. The empathic concern and personal distress subscales measure aspects of emotional empathy, while the fantasy and the perspective-taking subscales measure cognitive aspects of the empathy construct. The IRI consists of 28 items (7 items measuring each of the 4 subscales) and utilizes a Likert style response format. The IRI is the most commonly used self-report inventory for measuring empathy (Pulos, Elison, & Lennon, 2004). It has been found to have excellent psychometric properties (Carey, Fox & Spraggins, 1988; Davis, 1980, 1983).

Professional Quality of Life Scale – Version 5 (ProQOL). According to Stamm (2009), the Professional Quality of Life Scale (ProQOL; Stamm, 2009) is the most widely used and cited measure of compassion fatigue used in research. It is composed of 30 items and uses a Likert scale format, with responses ranging from "never" to "very often". The ProQOL has three dimensions, which measure two aspects of compassion fatigue (secondary traumatic stress and burnout) and a concept that Stamm (2009) has labeled "compassion satisfaction". The secondary traumatic stress subscale measures "work-related, secondary exposure to extremely or traumatically stressful events" (Stamm, 2009, p. 17). The burnout aspect of

compassion fatigue was included in the ProQOL to address the mental exhaustion element of work with victims of trauma (Adams, Figley, & Boascarino, 2008; Figley, 1995, 2002). Finally, the compassion satisfaction dimension is meant to address the reward and satisfaction that can result from working with trauma victims (Bride, Radey, & Figley, 2007; Stamm, 2009). The research that is available regarding the psychometric characteristics of the ProQOL indicate that it has adequate reliability, as well as appropriate convergent and discriminant validity (Stamm, 2009).

Qualitative Data Collection and Analysis (Phase 2)

Participant Selection. Participants for Phase 2 were selected based on two criteria. Firstly, participants were selected who reported "average" to "above average" levels of both emotional and cognitive empathy. In addition, participants also needed to demonstrate "average" to "below-average" scores on the secondary traumatic stress subscale from the ProQOL. The personal distress subscale from the IRI was used as a measure of emotional empathy, while the perspective taking subscale from the IRI was used as a measure of cognitive empathy. In this study, average was defined as falling within 1 standard deviation from the overall group mean (N = 108) of the sample, while below average could include anything below 1 SD and above average was anything above 1 SD.

The rationale for these criteria for participant selection was twofold. Firstly, I thought it would be important to include individuals who were able to empathize with the children and youth in their care and who did not tend to experience lower levels of empathy than most child and youth care counsellors (CYCC's). As the purpose of this study was to discuss the importance of empathy in child and youth

care work, it would only make sense to include individuals who were, in fact, empathic in nature. In addition, I thought it important to include individuals in the focus group who had not already developed heightened levels of secondary trauma. There is evidence to support the idea that VT and CF can impact the counsellor's ability to develop therapeutic relationships with clients, which would likely effect the quality and richness of the focus group discussions, as relationship development was a topic of primary interest in the current study (Coutinho, Silva, & Decety, 2014; Feller & Cottone, 2003; Hesse, 2002).

Based on these criteria, of the 41 participants who volunteered to participate in phase 2 of the study, 34 met the previously identified requirements. In addition, of these 34 participants, 3 did not include contact information and 5 had transferred to new jobs outside the child and youth care profession at the time of contact, which left 26 possible participants. All 26 potential participants were contacted and asked to participate in the phase 2 of the study and, of these, 8 agreed to participate.

These 8 child and youth care counsellors shared a number of important similarities, as they all worked with high risk child and youth in some capacity. However, they were also a diverse group and brought forth varied and unique experiences. A majority of the participants identified themselves as CYCCs; however, 1 reported being a success coach and 2 reported being in management positions. The average age of the participants was 41.30 years old (SD = 8.70) and the youngest participant was 27 years, while the oldest was 53 years. A majority of the group was female (7) and Caucasian (7). The 1 non-Caucasian participant identified herself as being East Indian.

The group, as a whole, reported a great deal of experience in the field, with the average number of years being 15.62 (*SD* = 10.12). Most of the participants (4) reported being married, while 3 were single and 1 reported being divorced. All 8 participants stated that they had some level of education, with 2 completing diplomas and 6 possessing university degrees. Most of the participants worked for a government organization (5), while the remaining 3 participants reported working for a private child and youth care agency.

Means and standard deviations were computed for the original sample of 108 participants and the 8 participants selected for the focus group. The mean levels of cognitive empathy, emotional empathy, and secondary traumatic stress (STS) for the original sample were as follows: 26.27 (*SD* = 4.16), 27.72 (*SD* = 3.98), and 20.60 (*SD* = 4.52). In contrast, the average scores for cognitive empathy (*M* = 28.50, *SD* = 2.33) and emotional empathy (*M* = 31.25; *SD* = 2.55) were higher than the original sample, meaning the focus group participants were, on average, more empathic than the original sample. In addition, the focus group participants also reported lower levels of STS (*M* = 16.63, *SD* = 1.77). In addition, based on a comparison of the standard deviations between the original sample and the focus group participants, it is clear that there was far less variation in scores on the measures of empathy and the measure of STS for the focus group participants, which suggests a fairly homogenous grouping of scores.

Focus Group. A focus group was chosen as the method for data collection, as they provide a large amount of information in a relatively short time span (Mack, Woodsong, MacQueen, Guest, & Namey, 2005; Krueger & Casey, 2009). In addition,

focus groups are often used to supplement quantitative data, as they help answer the "why" and "how" questions that are often left unanswered by positivistic research methods (Kamberlis & Dimitriadis, 2011). A focus group was audio recorded and conducted with 8 participants, the primary researcher, and a note-taker. The research participants were deemed to be what Patton (2002) has described as "information rich cases" as they came from a variety of backgrounds and worked in numerous settings within the child and youth care field.

An interview guide was developed based on a number of research questions; however, the current study focuses on the role of empathy in relationship development. Prior to beginning the focus group, the primary researcher discussed a number of important issues and set ground rules with the participants, which included discussing confidentiality, informed consent, and respect for fellow participants. The focus group lasted for 2 hours, which included a 15 minute break. After the focus group, the note-taker and myself debriefed the session and recording interesting ideas and potential themes, which were used to aid in data analysis.

Qualitative Data Analysis. As the current study involved only one focus group, the typical process of concurrent analysis throughout the data collection process was not used (Merriam, 2009). However, a general progression of ideas utilizing iterative analysis, and refinement of codes and themes was an essential component of the process. Once the focus group was completed, a professional transcriber was used to transcribe the audio recording. As is recommended by Patton (2002), I ensured the accuracy of the transcription by listening to the entire transcription and correcting any mistakes or inaccuracies. I also began creating

memos and notes as a way of outlining potential themes and categories at this stage of analysis. Memos are an important aspect of qualitative research and were used to record my preconceptions regarding the transcriptions, general perceptions, initial thoughts, and to record how focus group data coincided and differed from my previous research in the area (Maxwell, 2005).

The data were analyzed using thematic analysis and, specifically, a pragmatic approach to thematic analysis outlined by Braun and Clark (2006). Braun and Clark's 6-step approach to data analysis (2006) is formulaic and approachable and, compared to some other qualitative data analysis techniques, fairly simple to apply to qualitative data. It is important to note that in qualitative research, data analysis typically begins though an inductive approach whereby individual data units are identified and compared to one another (Merriam, 2009). This process is about organizing and refining a large body of text into more manageable units of information and, eventually, into categories or themes (Merriam, 2009; Patton, 2002).

According to Braun and Clark, the first phase of thematic analysis involves familiarizing yourself with the data, which, as mentioned, was conducted once the transcription was completed. The second phase involved generating initial codes. A "code", according to Braun and Clark (2006), is "a feature of the data that appears interesting to the analyst" (p. 88). Codes have also been described as "labels" and the process of coding allows the researcher to begin linking data to important ideas of concepts (Morse & Richards, 2002). I began this phase by reading through the transcript several times and creating "open codes", which seemed to encapsulate

important elements within the narratives (Merriam, 2009). This process was "data driven" and inductive in nature, as opposed to theory driven, as I attempted to simply identify interesting and important pieces of text and had no specific questions in mind during this initial phase of analysis. In order to facilitate accuracy and differentiation between codes, I created a coding list, which included the code name, definition, "exclusion criteria", and an example of the code from the transcript (see Table 2). The code definition and name were created by myself after the open coding process and were refined throughout the analysis procedure. The definition provided an organizational structure and basis for inclusion in order to help identify similar codes. The exclusion definition was important, as it helped to further distinguish between similar codes. The "code example" provided a practical example of how a particular code might appear in the transcription.

The third phase of data analysis outlined by Braun and Clark (2006) involves searching for themes. After several iterations of the transcription, the codes were refined and the transcript was completely coded and collated. I recorded by codes on cue cards and began manually sorting them into categories or "theme piles". Due to the limited data set, it was difficult to identify particular sub-themes within each category, and, therefore, the main focus at this stage of analysis was identifying broad themes.

The fourth stage involved reviewing and refining the initial themes. It was at this stage that the process of data analysis began to transition from an inductive process to a more deductive analysis, whereby codes and themes were checked against the initial data set for accuracy (Patton, 2002).

Table 2

Example of a code from the coding list

CODE NAME	CODE DEFINITION	CODE "EXCLUSION" DEFINITION	CODE EXAMPLE
Genuineness and Honesty	Empathy creates an overall feeling of "being authentic" and "real". It can create an atmosphere where the client is more willing to be honest.	This pertains to both the helping professional and the client. It is about creating an "atmosphere" that is open, honest, and authentic. It is an important (but not necessary) aspect of relationship building.	"I really think it [empathy] transcends the paid work into more humanness, gives a sense of genuineness [and] is beyond just getting paid to work with them [clients], that you actually do care and are concerned about what's going on in their lives"

In some cases, themes were combined, as they were deemed to be highly similar in content and contained several overlapping codes.

The final stage of the analysis, stage five, involved defining and naming the themes. After spending time refining my codes and themes, I began defining my themes and writing descriptions, which eventually formed the foundation of my final analysis. As indicated by Braun and Clark (2006), it is important to ensure that themes are more than just a summary of the data, but provide a story which helps to answer the research question. I noticed that the themes all seemed to relate to different processes of relationship development and maintenance, which provided the context for an emerging theory. However, I was also careful not to overgeneralize or over-interpret my results, as more research (and focus groups) would be required for theory building to occur.

Qualitative Rigour. In the current study, qualitative rigor was sought through the use of an audit trail, reviewing the research findings with external experts, triangulation of findings with related literature, careful note taking, purposeful sampling, and researcher reflexivity (Guba & Lincoln, 1994). In addition, a secondary external researcher re-coded a section of the transcription using the coding list and a discussion of similarities and differences between codes was conducted. Some vague and ambiguous codes were refined based on this discussion and the overall process helped to polish the coding list.

Results and Discussion

It became apparent after numerous readings of the participant's stories and narratives that empathy played an integral role in their work with children and youth in care. All of the group participants had a history of group care work, but the specific programs they worked in differed widely. These individuals were all empathic and reported at least average levels of empathy, which made them ideal for participating in a discussion of empathy use in child and youth care work. It was also important that these participants were not impacted by high levels of secondary traumatic stress, which could have limited their ability to express empathy towards the children whom they were supporting. The selection of participants based on these criteria allowed for the creation of fairly homogenous group of individuals (in terms of empathy and STS). These individuals, on average, scored higher on measures of cognitive and emotional empathy and lower on a measure of STS, which helped to create an atmosphere of both unique perspective and mutual understanding among the group members.

Based on an analysis of the data, four themes were generated, which all related to different aspects of relationship development. The importance of empathy in the development and maintenance of the relationship has been widely described in the literature (Duan & Kivlighan Jr., 2002; Elliott, Bohart, Watson, & Greenberg, 2011; Rogers, 1975), and, therefore, is not surprising. However, the themes generated in this study provided a unique perspective on the importance that empathy can play at different stages of relationship development. In each stage, the participants described how empathy can promote a strengthening of the relationship. However, several of the participants also described situations where empathy can potentially cause emotional pain to either the counsellor or the child or youth in care. These themes will be explored and described in the following section, both from the perspective of the helping professional and the client. The importance of empathy in relationship development is not a novel concept; however, the notion that empathy can play a facilitative role at different stages of relationship development is unique and, as far as I know, an original contribution to the literature.

Theme 1: Establishing an Initial Connection

The establishment of an initial connection between a CYCC and a child or youth can be extremely difficult. These children and youth are often untrusting of authority figures and, in many cases, they struggle to form meaningful attachments. There was a consensus among the participants that one of the most difficult aspects of working with children and youth in care was establishing a foundation for a healthy therapeutic relationship. There was also consensus that empathy can help to

reduce feelings of mistrust, minimize barriers, and provide an opening for the CYCC to begin forming a relationship. As one interviewee described,

> They don't have to present a persona of some sort, they always have to be a different sort of personality and you have to be tough or something of that sort. Well instead they let their guard down, right, and you can really start to know the person when that takes place.

The above excerpt outlines how empathy can "cut through" the protective barrier that children and youth in care tend to develop for self-protection and preservation, which allows for the initial connection to take place.

All of the interviewees seemed to agree that little change can take place without the initial connection. For some children and youth in care, particularly those who come from backgrounds that include neglect and abuse, this stage can last a significant amount of time and require a high degree of patience and understanding on the part of the CYCC. One of the participants provided a vivid example of the importance of patience when working in an empathic manner with children and youth:

> It took her probably three months before she would open up and tell me anything, but once we had a relationship it was, it was solid and it was, you know, she would come and talk to me and then when she was ready to address some addiction issues I introduced her to someone…it only took her, you know, three weeks to connect with her. And she said it made a difference because she knew she could trust me, so it made it easier to trust someone else.

This passage highlights the impact that the initial connection with a helping professional can have on a child's life, as well as the relationship between empathy and the establishment of trust. Many children and youth in care rarely experience empathy from helping professionals. One of the participants explicated the shock and surprise that can take place when empathizing:

> When you empathize…nobody really does that with children or with youth. Adults don't do that with them…so, doing that with them is like they're shocked sometimes, you know. So it's a really effective way to connect with them on an emotional level.

The impact that empathy can have when working with children and youth in care is profound and can result in important consequences. One of these consequences is the sharing of information, which is a critical aspect of relationship development and trust building. As one participant explained,

> One of the things that I noticed with empathy is that it helps with getting a little bit more information. Sometimes they are only willing to give you the top layer and once you empathize with them, they kind of divulge to a little bit more so that you can get to some of the deeper levels of what's going on.

In summary, the participants agreed that empathy can have an impact on initially developing a therapeutic relationship with children and youth in care and, in turn, this initial connection sets the stage for the next phase of relationship development. The finding that empathy helps with the initial connection has been described in the literature (Feller & Cottone, 2003; Moyers & Miller, 2013), most prominently by Carl Rogers. Rogers (1975) reported that empathy helps to increase feelings of non-judgment and acceptance, which, in turn, can lead to an impression of safety and trust. This is an ideal foundation for the reduction of barriers, which sets the stage for, as Rogers put it, self-exploration and process movement. Furthermore, Rogers (1975) and others have reported that empathy expressed early in the therapeutic relationship is predictive of later success (Elliott, Bohart, Watson, & Greenberg, 2011), or lack thereof.

A majority of the research on empathy in the helping professions has been conducted in the fields of nursing and medicine, which are areas where prompt

relationship development and the formation of trust can be imperative to positive treatment outcomes. In one study, researchers found that initially validating patient concerns in a hospital setting helped to minimize patient symptoms and resulted in fewer unnecessary patient returns (Epstein et al., 2007). In another study conducted by Neumann and colleagues (2007), the use of empathy by physicians allowed the gathering of more information from patients, which was also a finding in the current study. As in medicine, the use of empathy to ascertain information, build trust, and reduce distress is also important when working with children and youth in care and is an important phase in the road to effective therapeutic treatment.

Theme 2: Feeling Understood

A common theme reported by the participants in the focus group was the idea that empathy can lead to feeling understood and accepted on the part of the children and youth in care. Children and youth in residential treatment are notoriously untrusting of authority figures, as they are often moved from placement to placement with little stability or continuity (Newton, Litrownik, & Landsverk, 2000). These children and youth are prone to feeling misunderstood and unfairly labeled by those in positions of authority. Therefore, the use of empathy to gain a deeper understanding of a child's current challenges and difficulties can be a powerful tool. The following excerpt was reported by one of the participants:

> Nobody could understand what she was trying to say and I was sitting here and I go "try me one more time, I'm gonna listen really hard and I am gonna try so hard to understand it" because on the surface it didn't sound like anything and listening to her and watching her body language and watching her face it clicked in. I got it, and she was so happy. Finally, somebody understood what she was trying to say and I finally could help her explain it to other people.

This participant beautifully describes how empathy can lead to positive feelings, both for the child and the helping professional. Empathy is largely about consciously attempting to understand and the inherent value in feeling understood, not about feeling sorry for the client or trying to make them better. Children and youth in care often come from incredibly difficult and horrific environments, which can result in challenging behaviors (LeSure-Lester, 2000; McAdams & Foster, 1999). The use of empathy to better understand or "walk in the shoes" of these children and youth can be an important step in developing trust and respect. As one CYCW stated: "I think that's how empathy works for us. It helps us to connect with every kid. So there's something for everyone in that."

It is also at this stage that the participants reported some potential negative outcomes of empathy. In one situation, a participant shared a powerful story which demonstrated how connecting and empathizing with a client lead to feelings of pain and vulnerability.

> I had a client that I was really close to who had just lost someone significant in their life and so had I and it was really good because I could be empathetic, but it was also very difficult because I was still dealing with my own [loss]. That was kind of a difficult time, when they were going through what I was recently going through also. I found it difficult so I had to pull myself away from that…a little too related, I related too much to what she was going through at the time.

Several other participants agreed that the sharing of similar experiences can help with empathy and understanding; however, in some situations empathizing in such a situation can bring up unwanted emotions and leave the CYCC feeling vulnerable and exposed. The need for this CYCC to "pull myself away" seems to demonstrate a protective instinct and the importance of healthy boundaries for self-preservation,

which are themes often discussed in the empathy literature (Decety & Moriguchi, 2007; Gerdes, Segal, & Lietz, 2010).

The potential positive and negative impact that empathy can have at this stage of relationship development has been fairly well documented. It is at this stage where client's likely begin to feel, what Rogers (1975) described as, "unconditional acceptance". It is because of these feelings of acceptance and connection that a deeper and, potentially, more therapeutic relationship can be developed between client and helper.

Research in medicine and nursing has also outlined the importance that feeling understood can have on patient satisfaction and treatment outcome. The increased understanding of the client's situation likely has a direct relationship with the increases in diagnostic accuracy that have been reported in medicine (Neumann et al., 2007). It is also through these feelings of mutual understanding that trust begins to develop, which also impacts how the patient may respond to the medical professional. Hojat and colleagues (2011) reported that mutual understanding and trust can lead to better alignment between the doctor and patient, which in turn leads to adherence to treatment plans and compliance.

It is interesting to note that opening up oneself to the emotional experience of another individual can lead to feelings of vulnerability and over-identification. Knowing when a client's situation "hits too close to home" also seems to be an important element of empathy. Recently, empathy researchers have added concepts such as self-awareness and emotion regulation to the empathy construct, likely to highlight the importance that knowing oneself plays in fostering a healthy empathic

response (Decety & Moriguchi, 2007; Gerdes, Segal, & Lietz, 2010). It seems very possible that helping professionals who have poor emotional boundaries may be at a higher risk for the development of secondary stress reactions (Figley, 2002; Pearlman & MacIan, 1995).

Theme 3: Safe and Supportive Environment

The cumulative impact of connecting with a child and then making an effort to understand their unique situation and perspective is, potentially, the development of a safe and supportive environment. It is in such an environment where the child feels secure, which is a prerequisite for positive therapeutic change to occur (Rogers, 1975). It is at this stage where trust continues to be fostered between the client and the child care counsellor. As one of the group participants stated, children and youth in care may never have experienced a milieu where they feel safe and where the focus is on creating a secure atmosphere.

> We're not a family member, we're not – you know - a police officer, we don't want anything from them other than what they want to give us. I think it's just the fact that they're a human being [and] we're a human being and we're just there to support them and listen to them.

One of the participants discussed the idea that children and youth in care need an environment of consistency and reassurance. When the child experiences a difficulty or challenge, such as a parent not attending a visit or a conflict with a peer, they need to experience support from someone who has a deep understanding of their unique situation. One of the focus group participants elucidated the importance of empathy at this stage when she stated,

> They just know that when something is going on for them, and they have already told you it, that when they start to feel overwhelmed by it, they'll just sit by you and be close to you and know that they are safe in that moment

> and I think that's really important when you are looking at this. Just feeling safe and knowing that somebody really understands what they're going through and they feel that reflection from them.

The idea of a "system" was brought up by one of the group members, which is a negative term often used in child care work to represent the bureaucratic aspects of the field. The participant reported that children in care often feel like a nameless case in the system and this can result in a loss of identity. This group member went on to explain that these children "are so used to being in the system" and that empathy has the power to "kick them out of the system" and humanize the child and youth care counsellor. I found this analogy powerful and I imagined the transformation of the child and youth care counsellor from a faceless cog in the system to a caring and compassionate human being.

The participants seemed to share in the opinion that the desire to keep clients safe can also result in feelings of helplessness and frustration. In some situations, the deep level of understanding and emotional connection that can result from empathy makes it difficult to feel effective. As one participant shared,

> This one particular client, I was empathizing with him, and I understood how scapegoated he felt in his family and it fired me up. It got me feeling like we gotta do something for this kid and then I realized how helpless I was to really help this kid fix this situation and so I went away feeling quite helpless. I had to work through feeling helpless and not being able to do anything for him. I am a fixer and I wanted to fix it, so it was really hard. That was a really tough spot for me.

This aspect of relationship development can last from months to years and the continued use of empathy to help provide an environment of trust, understanding and mutual respect is paramount. Research in the field of counselling has indicated that the ongoing use of empathy in therapy results in an increase in

client self-reported "depth" of the therapy session (Duan & Kivlighan Jr., 2002). In other words, therapists begin to help the client identify core difficulties, which results in greater therapeutic value and effectiveness. It seems likely that a similar effect occurs during work with children and youth. The healthy and safe environment that is created in the treatment centre, which is maintained through empathy and compassion, results in clients feeling free to explore their difficulties more closely. As with clients in therapy, children and youth in care may begin to become increasingly introspective and they may learn to choose healthier ways to react to difficult life events.

However, as illuminated by the focus group participant who reported feeling "quite helpless", the deeper relationship that develops as a result of entering the client's world often results in a profound feeling of responsibility to help the client, even when help is not possible. A quote by Stebnicki (2007) helps to explain such feelings, "in traditional Native American teaching, it is told that each time you heal someone you give away a piece of yourself until, at some point, you will require healing" (p. 317). The concepts of vicarious trauma (VT) and compassion fatigue (CF) also seem to draw upon the idea of "emotional scarring" on the part of the helper, as the enduring impact of feeling helpless can result in emotional vulnerability, burnout, and even secondary traumatic reactions (Figley, 2002; Pearlman & MacIan, 1995). The potential for burnout, VT and CF when working with children and youth in care in an empathic manner highlights the importance of education, strong emotional boundaries, and self-care. Carl Rogers (1975) clearly stated that in order for empathy to be utilized in a helpful and safe manner, the

counsellor must be healthy and emotionally stable. If helping professionals are unable to cope with feelings of helplessness and vulnerability, they are likely at a high risk of developing stress reactions in the workplace.

Theme 4: Facilitating Positive Change

The last theme that was discussed by the group members was the importance of empathy in the facilitation of positive changes in the client. As one group participant reported, positive change does not happen overnight. In some clients, noticeable changes may occur soon after realizing that their difficulties have been understood and they are living in a safe and healthy environment. However, the emotional wounds that haunt other children and youth in care may take years to resolve. As one focus group participant stated,

> The thing about caring [is that is can be a] catalyst for change, because it challenges the way the kids see the world. They often say nobody cares about me and – it's a challenge - it becomes a challenge for us to show that's not the case. You can have a different view of the world. So, and it can be that catalyst if it's consistent over a long period of time.

As this participant pointed out, empathy can be a catalyst for change, but positive change is not linear and old behaviors may resurface. However, as another participant indicated, it is also important to understand (and point out to the child) differences that are noticed when difficulties arise:

> I think with empathy…sometimes those behaviors do bubble up again and you'll see some negative behaviors, but I've seen remorse afterwards. I've had kids come and say, I am sorry I shouldn't have done that to you because I know you understand where I am coming from.

Several of the group members shared powerful stories of hope and change resulting from the use of empathy. One of the group participants discussed a scenario where a child "wanted to be somebody different than she was" and described how this

counsellor "could empathize with her struggle to become this version of herself that she desperately wanted". In this scenario, the counsellor encouraged, advocated, and empathized with this youth, which resulted in success and positive change. This counsellor also described the importance of intrapersonal success when working with youth when she reported "it was good because the gains that she made, when you look at them on paper, were not that exceptional, but from where she came from it was a huge shift". As this story illustrates, the use of empathy over time can have a profound impact on children and youth in care. Although it is important to recognize when negative emotional reactions are taking place, such as emotional vulnerability, boundary violations, enabling, or heightened negative emotions, it is essential to also acknowledge the small successes and changes that occur when empathy is used in a therapeutic context.

Although concepts such as vicarious trauma (VT) and compassion fatigue (CF) have focused on the potential harm that can arise from the use of empathy in working with victims of trauma, other concepts such as "vicarious post-traumatic growth" and "vicarious resilience" highlight the positive impact of trauma work (Barrington & Shakespeare-Finch, 2012; Hernandez, Engstrom, & Gangsei, 2010). Working with children and youth in care, many of whom have been abused or neglected, can be taxing work. Change is often slow and counsellors often feel exhausted, beaten down, and frustrated. However, the benefits of maintaining a safe, healthy, and empathic environment when working with these children can result in positive change, both for the client and the helper. The concepts of vicarious post-traumatic growth and vicarious resilience are meant to emphasize some of the

positive helper-related offshoots of client work, such as bearing witness to positive growth, witnessing profound resilience and courage, improved relationships between client and helper, and the inherent satisfaction that comes from being part of important therapeutic work (Arnold, Calhoun, Tedeschi, & Cann, 2005). It is important to remember that change is possible and utilizing an empathic approach to client work is an essential aspect of the healing process.

Research Limitations

Several limitations existed in the current study. First, conducting only a single focus group makes assessing saturation uncertain and further focus groups are needed for this purpose. The limited amount of data generated from a single focus group also made theory development difficult. The themes identified in this study point to a potential linear model consisting of different stages or phases of relationship development. More research will be needed to determine if this model continues to emerge in future focus groups. Second, this study explored the experiences of a select group of research participants. More research is needed with differing groups of helping professions to see if the results of this study generalize to other populations.

As the child and youth care field is fairly small, several of the participants worked at the same agencies and knew each other on a professional (and perhaps even a personal) level. Therefore, although a safe atmosphere for sharing was provided and issues surrounding confidentiality were discussed, it is possible that some of the participants did not feel completely open to sharing their opinions regarding certain topics.

Lastly, sampling self-report measures of empathy and secondary trauma were used in the study to help select participants. Although this is a common method for measuring these construct and the measures used were among the best in the field, self-report measures are prone to misinterpretation, over- and under-reporting, and careless responding. It could be beneficial in the future to conduct a similar study using clients' ratings of perceived empathy.

Considerations for Future Research

It is an exciting time for empathy researchers and for those in the helping professions. Empathy has re-emerged as a "hot topic" and studies in the area are being conducted in an assortment of professions and fields. Today, the most pressing issues in empathy research continue to be mainly conceptual in nature. What is empathy? How should it be measured? These are questions that led to a stagnation in empathy research for many years; however, with the help of the emerging field of social cognitive neuroscience, these questions are closer to being answered than ever before.

The fields of medicine and nursing have led the way in empathy training (Bonvicini et al., 2009; Brunero, Lamont, & Coates, 2010; Burks & Kobus, 2012). The development of empathy training programs could have a profound impact on the field of child and youth care and has the potential to create significant positive changes for children and youth in care. It is important for researchers to continue examining different aspects of empathy and the implications for treatment, as this research will help provide the foundation for training programs.

Finally, longitudinal studies examining the impact that empathy can have on client progress over time are sorely needed. Such studies would help with the development of new theories and models relating to empathy, which would help to improve our knowledge and understanding of the empathy construct.

Conclusion

This project examined the role that empathy plays in the development of the therapeutic relationship in a sample of child and youth care counsellors (CYCCs). A sequential mixed methods research design was utilized, as I wanted to select participants who were both empathic and were not suffering from higher than average levels of secondary traumatic stress. The quantitative phase (Phase 1) of the study was used to select participants, while the qualitative phase (Phase 2), which consisted of a single focus group, was the focus of this study.

A comparison of means and standard deviations between the 8 focus group participants and the larger sample of 108 CYCCs demonstrated that there were clear differences in levels of reported empathy and STS. Specifically, the focus group participants were more empathic and reported fewer symptoms of STS than the original sample, which was important for two reasons. First, as the study was about the importance of empathy in child and youth care work, it was imperative to include participants who were, in fact, highly empathic. It was clear during the focus group discussion that all 8 participants utilized empathy in their daily interactions with children and youth and believed it to be an important asset in their work. Second, there is ample evidence to suggest that individuals with higher levels of secondary trauma struggle with relationship development (Jenkins & Baird, 2002;

Trippany, White Kress, & Wilcoxon, 2011). As the purpose of this study was to examine the role that empathy plays in relationship development, it was important to select a group of participants who were not experiencing high levels of secondary trauma and stress, as this could impact their ability to connect with others. It is impossible to ascertain with certainty if the selection process served its purpose; however, the participants all engaged in the focus group process, shared stories, and seemed to agree than empathy was an essential aspect of child and youth care work.

The results indicated four themes that relate to different stages of empathy development: (1) establishing an initial connection, (2) feeling understood, (3) safe and supportive environment, and (4) facilitating positive change. Interestingly, although there has been much written on the role that empathy plays in the therapeutic relationship, I have found no research that delineates the impact that empathy can have on different phases of relationship development and preservation. Although more research is needed, the themes identified in the current study suggest a potential linear progression from one stage to the next (i.e., the initial connection leads to feeling understood, which leads to a safe and supportive environment, etc.). This progression has the potential to form a model, which may help us better understand empathy and therapeutic relationship development.

The potential for model development is an important implication of this study, which will require more research in the future. However, this was not the only unique contribution made by the group participants. Another important implication was that group members unanimously agreed that empathy is an

important construct in effective work with "at risk" children and youth, a demographic where empathy research is sparse. The group members agreed that empathy helps CYCCs connect with children and youth in care and, just as Carl Rogers (1975) stated throughout his career, it is an essential component for positive change.

Although the participants mostly described the positive attributions of utilizing an empathic approach when working with children and youth in care, there were also several concerns voiced. Some of the participants expressed unease that the use of empathy can result in negative reactions, such as feeling helpless and vulnerable. These were a real concern among some of the group members and the CYCCs described different strategies for protecting themselves against emotional contagion, such as emotionally detaching when these feelings arise. Interestingly, the negative reactions reported by the participants seemed to congregate around the concept of healthy boundaries and necessary emotional detachment. One of the participants described the practice of ensuring healthy boundaries when using empathy as "informed empathy". When speaking on the use of empathy, this participant went on to report "you learn to protect yourself more. Like I almost visualize a bubble over myself sometimes with certain kids because I know that I'll become too affected by them."

My personal "take away" message from this project has been that empathy, as a whole, is an important and necessary construct that must be used to aid in the development of a therapeutic relationship with children and youth in care. However, having an understanding of oneself and the need for healthy boundaries

when utilizing an empathic approach are, potentially, important protective factors in child and youth care work.

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CHAPTER 5

Conclusion

In the helping professions, there is no therapeutic tool more important than the use of accurate empathy. After decades of research and clinical practice, Carl Rogers wrote "a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning" (Rogers, 1975, p. 3). However, for many years after Carl Rogers' published his seminal paper, *Empathy: An Unappreciated Way of Being* in 1975, empathy research dwindled, as a result of conceptual disagreements, measurement challenges, and a lack of an agreed upon definition (Duan & Hill, 1996). Much of this debate hinged on a disagreement regarding whether empathy was chiefly an emotional or a cognitive construct. Those in the emotional empathy "camp" subscribed to the idea that empathy involves a deep emotional merging with another individual, while those who supported a cognitive definition of empathy believed empathy to be a more external, thoughtful, and deliberate attempt to understand the thoughts and feelings of another person (Mahrer, Boulet, & Fairweather, 1994). Many years passed with little movement on either side of the empathy debate, until several key influences converged, which resulted in a newfound interest in empathy research.

A resurgence and redirection of empathy research emerged in the early to mid-1990s, as a result of the developing field of cognitive neuroscience. Cognitive neuroscience is a merger of several fields, most notably psychology and neuroscience, and concerns itself with the biological underpinnings impacting mental processes. In the 1990s, a group of cognitive neuroscientists began studying

the neural mechanisms and brain areas underlying empathic responses (Decety, 2010, 2011). The result of this research has been an empirically derived definition of empathy, which proposes that empathy is, in fact, a complex multidimensional construct composed of both an affective and a cognitive component. Furthermore, these researchers proposed the addition of self-awareness and emotional regulation to the empathy model, as the ability to engage in a complete and healthy empathic response necessitates that the helping professional be emotionally stable and have healthy emotional boundaries (Decety, 2011).

The widespread acceptance of the multidimensional empathy model has led to a huge expansion of empathy research, most notably in the medical professions. Interest in the use of empathy in medicine and nursing has been spurred on by a large body of research showing that the use of therapeutic empathy leads to patient satisfaction, adherence to medical advice, and better treatment and recovery outcomes (Epstein et al., 2007; Strug et al., 2003). There is virtually no debate that empathy is helpful and results in positive results in a variety of professions (Dietz & Kleinlogel, 2014; Elliot, Bohart, Watson, & Greenberg, 2011; Peloquin & LaFontaine, 2010). However, there has been an emergence of research examining the negative emotional, physical, and psychological reactions that can result in working with trauma survivors and empathy has been implicated as a precipitating factor in these secondary trauma reactions. This is obviously concerning to those in the helping professions, due to the potential for a backlash against the use of therapeutic empathy; however, there has been very little research examining the relationship between empathy and these reactions.

The idea that empathy can be a causal factor in a host of negative reactions, including mental exhaustion, cognitive alterations (i.e., a disruption or change in core beliefs), and PTSD-like symptoms (e.g., increased startle response, inability to sleep, avoidance) is highly concerning (Alkema, Linton, & Davies, 2008; Cunningham, 2003; Figley, 2002). As we now understand, empathy is a complex and multidimensional construct and, therefore, making unmitigated statements about empathy causing these reactions is neither accurate, nor is it helpful. There are virtually no studies which examine the role that different aspects of empathy have on the development of secondary trauma, either from a qualitative or quantitative perspective. This gap in the literature severed as the imputes for this dissertation and the results of these studies have helped to further our understanding of both empathy and secondary trauma.

Research Findings

The findings of my principal quantitative study, which is described in Chapter 3, implicated a number of predictor variables in the development of secondary trauma reactions in 200 child and youth care counsellors. A path model was constructed using a combination of previous research in the area, as well as informed predictions from other areas of inquiry (e.g., PTSD and personality research). The model identified personality variables and emotional separation as exogenous variables, while emotional and cognitive empathy, as well as secondary traumatic stress (the main component in compassion fatigue) and vicarious trauma were endogenous variables. It was hypothesized that, based on arguments from numerous VT and CF researchers, emotional and cognitive empathy would be

causally related to VT and CF. However, the results of the path analysis demonstrated no such relationship and, instead, a mixture of personality variables and emotional separation showed significant direct effects with VT and STS. Specifically, high levels of neuroticism and difficulties with emotional separation and interpersonal boundaries were significant predictors of both STS and VT, while VT was also predicted by the addition of low levels of extraversion and low levels of agreeableness. These findings coincide with PTSD research, which has demonstrated that a vast majority of individuals who experience trauma do not develop clinically significant reactions (Lerias & Byrne, 2003; Miller, 2003). Furthermore, among those that do develop PTSD, personality (particularly neuroticism) plays a large part in the development, severity, and maintenance of PTSD symptoms (Lerias & Byrne, 2003; Miller, 2003).

At the time of this study there were no accepted measures of empathy that were based on a neurobiological definition of empathy and, therefore, would include measures of all four dimensions of empathy outlined in the cognitive neuroscience literature (Decety, 2010, 2011). However, the Maintenance of Emotional Separation scale (MES) is a measure of emotional boundaries and self-awareness, while a main characteristic of those who are highly neurotic is emotional instability and high reactivity when under stress (Barlow et al., 2014; Lerias & Byrne, 2003; Miller, 2003). These variables were the only shared predictors of both STS and VT in the causal model. It seems likely, if not highly probable, that although the core dimensions of the empathy construct (i.e., emotional and cognitive empathy) are unrelated to the development of STS and VT, these secondary empathy dimensions

could be related to secondary trauma among child and youth care counsellors. However, in order to further this hypothesis, a more concrete and accepted definition of self-awareness and emotional regulation needs to be defined, as these elements relate to the empathy construct.

In Chapter 4 I conducted a mixed-methods study examining the experiences of empathy among a small group of 8 child and youth care counsellors. Those selected to participate in this study reported at least average levels of empathy and average to low levels of secondary traumatic stress (as measured using the ProQOL). Therefore, these were counsellors who were had the ability to express a similar amount of empathy to children and youth in care as their colleagues, but who had not developed significant symptoms of compassion fatigue. Although this study was much smaller in scale, as compared to the quantitative study described in Chapter 3, the results were highly intriguing and added valuable insight into the various dimensions of the empathy construct. The results of this study were the identification of four themes, which all related to various facets of relationship development. These themes were: (1) establishing an initial connection, (2) feeling understood, (3) safe and supportive environment, and (4) facilitating positive change.

Integration of Studies

The studies conducted as part of this dissertation have been important in furthering our understanding of the empathy construct and its role as an important factor in the helping professions. The quantitative study (Chapter 3) provided compelling evidence that, despite claims to the contrary, the core features of

empathy (i.e., cognitive and emotional empathy) do not result in heightened levels of secondary trauma reactions. This point was elaborated upon in the focus group study (Chapter 4), as group participants endorsed numerous areas where the use of empathy was helpful in establishing healthy relationships with children and youth in care. Another common thread found between both studies was the importance of healthy boundaries and emotional stability when using empathy, as over-identification with difficult material may result in distress and emotional pain. This was demonstrated statistically in the path model (i.e., the relationships between emotional separation, neuroticism, STS and VT); however, perhaps even more captivating were the descriptions provided by the focus group participants and the need for purposeful emotional detachment for self-preservation.

As mentioned, the common theme between these papers was that empathy, for the most part, is unrelated to secondary trauma reactions; however, having healthy emotional boundaries when utilizing empathy is essential. It seems ironic that 40 years ago, long before the concepts of VT and CF were born, Carl Rogers came to a similar conclusion when he wrote of empathy:

> As I have considered the evidence, and also my own experience in the training of therapists, I come to the somewhat uncomfortable conclusion that the more psychologically mature and integrated the therapist as a person, the more helpful is the relationship he provides. This puts a heavy demand on the therapist as a person.

Clinical Implications

The findings of this study are impactful to those in the helping professions for several reasons. Firstly, the results of this dissertation suggest that empathy may not be a "double edged sword", which is helpful and therapeutic on the one hand and harmful and potentially debilitating on the other (Duan & Hill, 1996). Instead, it would be better to consider empathy as a multidimensional construct, which is profoundly helpful to relationship development, but can cause harm to those who are emotionally vulnerable and interpersonally fragile.

Second, I recommend that the fields of VT and CF reconsider making blanket statements about the causal relationship between empathy and secondary trauma. After conducting a thorough review of the literature and conducting two studies examining the relationship between empathy and VT and CF, I have found very little convincing evidence that the core aspects of the empathy construct are etiologically linked to anything but positive outcomes in therapy and other related fields. To continue linking empathy to VT and CF could have a detrimental impact on the helping professions, as some professions may begin eliminating empathy from their therapeutic arsenal. This could effect relationship development and lessen the prospects for positive change to occur.

Thirdly, as personality variables are highly predictive of the development of both VT and CF, it seems vital that individuals working in the helping professions consider whether or not they possess the necessary attributes with work in highly stressful and traumatic fields. As important as workshops, training opportunities, self-care, and employer support can be in the prevention of secondary stress and

trauma, one cannot change their personal makeup. In other words, it seems fair to conclude from this study, as well as from personality and trauma research, that some individuals are not a good fit for trauma work.

Lastly, the results of the mixed methods study have unlocked a new line of inquiry in empathy research. Specifically, the themes that emerged from this research implicated the importance of empathy at differing stages of relationship development. Specifically, the participants reported that empathy is helpful with forming an initial connection, facilitating understanding, creating a safe and supportive atmosphere, and facilitating change. Although not enough data was collected to enable the development of a model, a foundation for future studies in the area has been firmly established.

Future Directions

Considering the implications of this dissertation, further research in the areas of empathy and secondary trauma are necessary. Empathy research has come a long way in the past few decades and there is certainly more conceptual clarity in the field; however, further clarification of the empathy construct and improved measurement methods are needed. The acceptance of empathy as a multidimensional construct makes measuring empathy even more difficult. The logical question becomes, what aspect of empathy is being measured? Although tools are being developed that correspond with the research in cognitive neuroscience, these measures are in their infancy and research will be needed to ensure their validity and reliability.

This study was conducted with child and youth care counsellors, whose role in the helping professions is vastly different from psychologists, emergency responders, social workers, and medical professionals. It will be important to conduct follow-up studies examining the complex relationship between empathy and secondary trauma in other professions who work with trauma victims, in order to improve the generalizability of these findings.

There is certainly a need for more qualitative and mixed methods research examining the helpful and harmful aspects of the empathy construct. After conducting a thorough review of the literature I was able to find only a few studies in the area. It would be particularly useful to develop a study examining the role that empathy plays at differing stages of relationship develop, which could help in the development of a sequential model.

The role of personality and the inherent characteristics of the helping professional need to be considered and implicated as causal variables in the development of VT and CF. The results of my study indicate that certain individuals are at a high risk of developing secondary trauma reactions. Further research should continue examining intrinsic predictors of those in differing helping professions to determine other factors that put workers at risk of developing VT and CF.

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APPENDIX A: ADVERTISEMENT FOR PARTICIPANTS IN EDMONTON

A Study on WORK-RELATED STRESS in Child and Youth Care Counsellors

Working with children and youth in care is a difficult and emotionally demanding job. Children and youth in care often suffer from a traumatic past and it is the job of the child and youth care counsellor (CYCC) to provide care and support for this vulnerable population on a daily basis. This care and support can extract a mental and emotional toll on the child and youth care counsellor which has been hypothesized to cause work-related stress reactions often called vicarious trauma and compassion fatigue.

- **Are you a front-line child and youth care counsellor (CYCC) in direct contact with children and youth in care?**

- **Do you have 6 months of experience as a CYCC?**

- **Do you work at least 30 hours per week as a CYCC?**

My name is Sean Barford, and I am a Doctoral Student in the Counselling Psychology department at the University of Alberta. For the past 5 years I have worked as a child and youth care counsellor (CYCC) at the Yellowhead Youth Centre in Edmonton, Alberta. While working as a CYCC I have developed a keen interest in the mental and emotional difficulties of working with such a vulnerable population of children and youth.

I am currently conducting a **two phase** study to understand the relationship between empathy and work-related stress. I hope that my work in this area will contribute to our understanding of the effects of work-related stress. Additionally, I hope that this understanding will result in new policies and procedures to protect

the mental and emotional well-being of child and youth care counsellors.

If you are interested in learning more about this study, please email me,
Sean at seanbarford@gmail.com

APPENDIX B: ADVERTISEMENT FOR PARTICIPANTS OUTSIDE EDMONTON

A Study on WORK-RELATED STRESS in Child and Youth Care Counsellors

Working with children and youth in care is a difficult and emotionally demanding job. Children and youth in care often suffer from a traumatic past and it is the job of the child and youth care counsellor (CYCC) to provide care and support for this vulnerable population on a daily basis. This care and support can extract a mental and emotional toll on the child and youth care counsellor which has been hypothesized to cause work-related stress reactions often called vicarious trauma and compassion fatigue.

- **Are you a front-line child and youth care counsellor (CYCC) in direct contact with children and youth in care?**

- **Do you have 6 months of experience as a CYCC?**

- **Do you work at least 30 hours per week as a CYCC?**

My name is Sean Barford, and I am a Doctoral Student in the Counselling Psychology department at the University of Alberta. For the past 5 years I have worked as a child and youth care counsellor (CYCC) at the Yellowhead Youth Centre in Edmonton, Alberta. While working as a CYCC I have developed a keen interest in the mental and emotional difficulties of working with such a vulnerable population of children and youth.

I am currently conducting a study to better understand work-related stress in individuals that work with high-risk children and youth. I hope that my work in this area will contribute to our understanding of the effects of work-related stress. Additionally, I hope that this understanding will result in new policies and procedures to protect

the mental and emotional well-being of child and youth care counsellors.

If you are interested in learning more about this study, please email me,
Sean at seanbarford@gmail.com

APPENDIX C: INFORMATION FORM FOR MANAGERS

Empathy and Work-Related Stress

Principal Researcher: Sean Barford (PhD Student)
Supervisor: William Whelton

Information Form for Managers

This information form is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more details about something mentioned here, or information included here, please feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose:

My name is Sean Barford, and I am a graduate student at the University of Alberta in Counselling Psychology. As part of the requirements for completing my PhD degree, I am conducting a study with my supervisor, Dr. William Whelton, on the relationship between empathy and various forms of work-related stress in child and youth care counsellors.

Empathy has been hypothesized as a potential predictor of vicarious trauma and compassion fatigue. Vicarious trauma and compassion fatigue are stress reactions that effect those working with victims of trauma. These stress reactions can negatively alter one's belief system which can lead to feelings of depression and anxiety. Additional symptoms include hyperarousal, avoidance, and nightmares as well as other post-traumatic stress type reactions. Considering the traumatic backgrounds of many of the children and youth in care and the role of the child and youth care counsellor as a supportive and empathic resource for these clients further study is needed to explore the extent of these stress reactions in child and youth care employees.

It is anticipated that the results of this investigation may reveal areas where the current child and youth care system could be improved to minimize the effects of stress reactions such as vicarious trauma and compassion fatigue and this may increase employee health, satisfaction, and retention amongst child and youth care counsellors.

Participation:

As a manager at a child and youth care facility I am asking for your permission to allow staff at your work site to complete a research package. Participation in the study is entirely voluntary and I anticipate that it should take each employee about 45 minutes to complete each package. Please remember that your participation in

this project is completely voluntary, and you may choose to withdraw your consent at any time without penalty. If you do choose to withdraw your consent it will not be possible to omit completed research packages from the study as they are unidentifiable.

Confidentiality:

If you choose to participate, your testing site will be kept confidential. Research data will be combined and individual testing sites will not be recorded or identified. The research packages shall be kept in a secure location. Information transferred from the research package onto a computer program shall be password protected. A backup copy of the information collected through the research package shall be password protected and kept in a secure location. All information shall be stored for a minimum of 5 years. The findings from this study will be used in an anonymous way, only as aggregate data, for my PhD dissertation, research articles, and conference presentations. A summary of the main findings will also be available to you once the study is completed. Please keep this information form for your records.

If you have any further questions concerning matters related to this research, please contact Sean Barford: (780) 991-2567, seanbarford@gmail.com or Dr. William Whelton: wwhelton@ualberta.ca.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

APPENDIX D: INFORMATION FORM FOR PARTICIPANTS IN EDMONTON

Empathy and Work-Related Stress Study

Principal Researcher: Sean Barford (PhD Student)
Supervisor: Dr. William Whelton (Associate Professor)

PLEASE READ THE FOLLOWING INFORMATION *BEFORE* COMPLETING THE INVENTORIES INCLUDED IN THIS PACKAGE

This information is intended to give you an idea of what the research project is about and what your participation will involve. If you would like more details about anything included here, or anything else about the study, please feel free to ask. Please keep this form for your records.

My name is Sean Barford, and I am a graduate student at the University of Alberta in Counselling Psychology. As part of the requirements for completing my PhD degree, I am conducting a study with my supervisor, Dr. William Whelton, on the relationship between empathy and various forms of work-related stress in child and youth care counsellors.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

PHASE 1

If you choose to participate in Phase 1 of this study, it will entail completion of several brief research measures and a demographic form. It should take about 45 minutes to complete. Your participation is completely voluntary and you may withdraw at any time while completing the research package. Once you have returned the package your data will be anonymous and so it will no longer be possible to withdraw.

By completing and returning the research package you are consenting to participate in this study. If you do not wish to participate simply return the incomplete package.

All information gathered in this research will be kept confidential on a password-protected computer in a secure location. All information will be retained for a minimum of 5 years. The findings from this study will be used in an anonymous way as aggregate data for my PhD dissertation, research articles, and conference

presentations. A summary of the main findings will also be available to you once the study is completed.

PHASE 2

The second phase to this study will involve participation in a focus group consisting of 6-8 participants. Your identity will be kept confidential and your name will not be used anywhere except on this form, which will be kept separate from the protocols contained in this package. Focus group sessions will be audio taped for the purposes of transcription and participant identification; however, these tapes will be destroyed once transcription is complete.

If you are interested in participating in the focus group please provide your name and contact information on the next page. If you are selected to participate in Phase 2 you will be contacted using the information you provide.

PLEASE PROVIDE YOUR CONTACT INFORMATION *ONLY* IF YOU ARE INTERESTED IN PARTICIPATING IN PHASE 2 OF THE STUDY

Name (please print): _____

Signature: _____

Date: _____

Please indicate how you wish to be contacted:

☐ Phone: _____

☐ Email: _____

If you have any questions related to this research, please contact Sean Barford: seanbarford@gmail.com *or Dr. William Whelton: wwhelton@ualberta.ca.*

APPENDIX E: INFORMATION FORM FOR PARTICIPANTS OUTSIDE EDMONTON

Empathy and Work-Related Stress Study

Principal Researcher: Sean Barford (PhD Student)
Supervisor: Dr. William Whelton (Associate Professor)

PLEASE READ THE FOLLOWING INFORMATION *BEFORE* COMPLETING THE INVENTORIES INCLUDED IN THIS PACKAGE

This information is intended to give you an idea of what the research project is about and what your participation will involve. If you would like more details about anything included here, or anything else about the study, please feel free to ask. Please keep this form for your records.

My name is Sean Barford, and I am a graduate student at the University of Alberta in Counselling Psychology. As part of the requirements for completing my PhD degree, I am conducting a study with my supervisor, Dr. William Whelton, on the relationship between empathy and various forms of work-related stress in child and youth care counsellors.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

If you choose to participate in this study, it will entail completion of several brief research measures and a demographic form. It should take about 45 minutes to complete. Your participation is completely voluntary and you may withdraw at any time while completing the research package. Once you have returned the package your data will be anonymous and so it will no longer be possible to withdraw.

By completing and returning the research package you are consenting to participate in this study. If you do not wish to participate simply return the incomplete package.

All information gathered in this research will be kept confidential on a password-protected computer in a secure location. All information will be retained for a minimum of 5 years. The findings from this study will be used in an anonymous way as aggregate data for my PhD dissertation, research articles, and conference presentations. A summary of the main findings will also be available to you once the study is completed.

If you have any questions related to this research, please contact Sean Barford: seanbarford@gmail.com *or Dr. William Whelton: wwhelton@ualberta.ca.*

APPENDIX F: DEMOGRAPHIC FORM

Demographic Sheet

The following demographic questions are voluntary, but the information would be greatly appreciated for research purposes.

1. Please write your age in the space provided.
AGE:_____

2. Please indicate your gender by checking either male or female.

☐ MALE

☐ FEMALE

3. Please indicate your current status from the following list of options by checking the one(s) that apply to you:

☐ SINGLE

☐ DIVORCED

☐ MARRIED

☐ COMMON-LAW or OTHER LONG-TERM RELATIONSHIP

4. Please indicate whether your youth care facility is:

☐ GOVERNMENT

☐ PRIVATE

☐ OTHER (please specify) _____

5. Please indicate your ethnicity by checking one of the following options that describe you:

☐ CAUCASIAN

☐ ABORIGINAL

☐ BLACK/AFRICAN-CANADIAN

☐ MIDDLE EASTERN

☐ ASIAN

☐ HISPANIC

☐ EAST INDIAN

☐ OTHER (please specify)_____

6. Please specify your job title _____.

7. Please indicate your highest level of education by checking one of the following options:

☐ High School Graduate
☐ University Diploma
☐ University Degree
☐ Master's Degree
☐ Other (please specify)_____

8. How long (in years/months) have you worked as a child and youth care

counsellor: _____

9. On average, how many hours per week have you worked as a child and youth care

counsellor in the past 6 months: _____

10. Please indicate your average gross salary per year as a child-care counsellor by checking one of the following options:

☐ Under 20,000
☐ 20,000-30,000
☐ 30,000-40,000
☐ 40,000-50,000
☐ 50,000-60,000

□ 60,000 or more

Trauma Related Information

11. Have you ever been diagnosed with post-traumatic stress disorder? □ YES □ NO

If yes, please indicate how long ago you received the diagnosis. _____

12. Do you have a history of <u>childhood</u> abuse including: sexual abuse, physical abuse, verbal/psychological abuse, and/or neglect? □ YES □ NO

If yes, please indicate below how many traumatic events you have experienced <u>as a child?</u> □ 1 event □ 2 events □ 3 events □ 4 events □ 5+ events

If yes, have you sought counselling for these event? □ YES □ NO

13. Have you experienced a traumatic event as an adult? (traumatic events include: rape / other sexual abuse, natural disaster, industrial disaster, motor vehicle accident, combat trauma, witnessing a traumatic event, physical assault, captivity, torture, domestic violence, sexual harassment, etc...) □ YES □ NO

If yes, please indicate below how many traumatic events you have experienced as an adult? □ 1 event □ 2 events □ 3 events □ 4 events

□ 5+ events

If yes, did you feel intense fear, helplessness, or horror during and/or after the event? □ YES □ NO

APPENDIX G: INTERPERSONAL REACTIVITY INDEX (IRI)

The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale at the top of the page. 1,2, 3, 4, or 5. When you have decided on your answer, fill in the number in the blank next to the item. **READ EACH ITEM CAREFULLY BEFORE RESPONDING**. Answer as honestly and as accurately as you can. Thank you.

ANSWER SCALE:				
1	**2**	**3**	**4**	**5**
DOES NOT DESCRIBE ME WELL				**DESCRIBES ME VERY WELL**

___ 1. I daydream and fantasize, with some regularity, about things that might happen to me.
___ 2. I often have tender, concerned feelings for people less fortunate than me.
___ 3. I sometimes find it difficult to see things from the "other guy's" point of view.
___ 4. Sometimes I don't feel very sorry for other people when they are having problems.
___ 5. I really get involved with the feelings of the characters in a novel.
___ 6. In emergency situations, I feel apprehensive and ill-at-ease.
___ 7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.
___ 8. I try to look at everybody's side of a disagreement before I make a decision.
___ 9. When I see someone being taken advantage of, I feel kind of protective towards them.
___ 10. I sometimes feel helpless when I am in the middle of a very emotional situation.
___ 11. I sometimes try to understand my friends better by imagining how things look from their perspective.
___ 12. Becoming extremely involved in a good book or movie is somewhat rare for me.
___ 13. When I see someone get hurt, I tend to remain calm.
___ 14. Other peoples misfortunes do not usually disturb me a great deal.
___ 15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.
___ 16. After seeing a play or movie, I have felt as though I were one of the characters.
___ 17. Being in a tense emotional situation scares me.
___ 18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.
___ 19. I am usually pretty effective in dealing with emergencies.
___ 20. I am often quite touched by things I see happen.
___ 21. I believe that there are two sides to every question and try to look at them both.
___ 22. I would describe myself as a pretty soft-hearted person.
___ 23. When I watch a good movie, I can very easily put myself in the place of a leading character.
___ 24. I tend to lose control during emergencies.
___ 25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.
___ 26. When I'm reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

___ 27. When I see someone who badly needs help in an emergency, I go to pieces.
___ 28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

APPENDIX H: MASLACH BURNOUT INVENTORY (MBI) (SELECTED ITEMS)

The purpose of this survey is to discover how various persons in the human services or helping professionals view their jobs and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a "0" (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1-6) that best describes how frequently you feel that way.

Example

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

1. _____ I feel emotionally drained from my work.

5. _____ I feel I treat some recipients as if they were impersonal objects.

11. _____ I worry that this job is hardening me emotionally.

16. _____ Working with people directly puts too much stress on me.

20. _____ I feel like I'm at the end of my rope.

APPENDIX I: PROFESSIONAL QUALITY OF LIFE SCALE (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

____ 1. I am happy.
____ 2. I am preoccupied with more than one person I [help].
____ 3. I get satisfaction from being able to [help] people.
____ 4. I feel connected to others.
____ 5. I jump or am startled by unexpected sounds.
____ 6. I feel invigorated after working with those I [help].
____ 7. I find it difficult to separate my personal life from my life as a [helper].
____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
____ 9. I think that I might have been affected by the traumatic stress of those I [help].
____ 10. I feel trapped by my job as a [helper].
____ 11. Because of my [helping], I have felt "on edge" about various things.
____ 12. I like my work as a [helper].
____ 13. I feel depressed because of the traumatic experiences of the people I [help].
____ 14. I feel as though I am experiencing the trauma of someone I have [helped].
____ 15. I have beliefs that sustain me.
____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
____ 17. I am the person I always wanted to be.
____ 18. My work makes me feel satisfied.
____ 19. I feel worn out because of my work as a [helper].
____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
____ 21. I feel overwhelmed because my case [work] load seems endless.
____ 22. I believe I can make a difference through my work.
____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
____ 24. I am proud of what I can do to [help].
____ 25. As a result of my [helping], I have intrusive, frightening thoughts.
____ 26. I feel "bogged down" by the system.
____ 27. I have thoughts that I am a "success" as a [helper].

____ 28. I can't recall important parts of my work with trauma victims.
____ 29. I am a very caring person.
____ 30. I am happy that I chose to do this work.

APPENDIX J: TRAUMA AND ATTACHMENT BELIEF SCALE (TABS) (SELECTED ITEMS)

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please circle the number next to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item. Use the following response scale.

1 = Disagree Strongly 2 = Disagree 3 = Disagree Somewhat 4 = Agree Somewhat 5 = Agree 6 = Agree Strongly

If you want to change your answer, cross it out with an **X**, and circle the number for your new answer.

1. I believe I am safe.....	1	2	3	4	5	6
10. I am uncomfortable when someone else is the leader	1	2	3	4	5	6
18. Most people ruin what they care about	1	2	3	4	5	6
26. Trusting people is not smart	1	2	3	4	5	6
32. The world is dangerous	1	2	3	4	5	6
51. I am a good person	1	2	3	4	5	6
59. I often feel people are trying to control me	1	2	3	4	5	6
77. I can usually figure out what's going on with people	1	2	3	4	5	6
83. If people really knew me, they wouldn't like me	1	2	3	4	5	6

APPENDIX K: NEO FIVE FACTOR INVENTORY (NEO-FFI) (SELECTED ITEMS)

Instructions

Write only where indicated in this booklet. Carefully read all of the instructions before beginning. This questionnaire contains 60 statements. Read each statement carefully. For each statement circle the response that best represents your opinion.

Circle "SD" if you strongly disagree or the statement is definitely false.

Circle "D" if you disagree or the statement is mostly false.

Circle "N" if you are neutral on the statement, if you cannot decide, or if the statement is about equally true and false.

Circle "A" if you agree or the statement is mostly true.

Circle "SA" if you strongly agree or the statement is definitely true.

Circle only one response for each statement. Respond to all of the statements, making sure that you circle the correct response.

1. I am not a worrier.	SD	D	N	A	SA
7. I laugh easily.	SD	D	N	A	SA
15. I am not a very methodical person.	SD	D	N	A	SA
27. I usually prefer to do things alone.	SD	D	N	A	SA
37. I am a cheerful, high-spirited person.	SD	D	N	A	SA
53. I have a lot of intellectual curiosity.	SD	D	N	A	SA
55. I never seem to be able to get organized.	SD	D	N	A	SA

APPENDIX L: MAINTENANCE OF EMOTIONAL SEPARATION SCALE (MES)

Instructions:

For each item listed, use the rating scale below to determine and record the extent to which the statement is true for you.

1	2	3	4	5	6
Completely false for me					Completely true for me

___ 1. I often get so emotionally involved with my friends' problems that I lose sight of my own feelings.

___ 2. When I talk with a depressed person, I feel sad myself for quite some time after the conversation.

___ 3. Sometimes I get so involved in other people's feelings, I seem to lose sight of myself for awhile.

___ 4. When friends describe an emotional problem, I am in touch with their feelings without becoming too emotionally involved.

___ 5. I usually take the problems of others home with me.

___ 6. After listening to a friend tell of a scary experience, I have a difficult time studying or working.

___ 7. When the worries experienced by my friends concern me, I temporarily feel these worries but don't really get upset myself.

APPENDIX M: CONFIDENTIALITY AGREEMENT

This study is being undertaken by Sean Barford of the University of Alberta from the Department of Educational Psychology. The purpose of this study is to explore the relationship between empathy and several forms of work-related stress. Information collected in this study may be used in conference presentations, workshops, and in publications.

Project Title: Empathy and Work-Related Stress in Child and Youth Care Counsellors

I, _____, the Research Assistant/Transcriber, agree to:

1. Keep all research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., memory sticks, tapes, transcripts) with anyone other than the Researcher(s).

2. Keep all research information in any form or format (e.g., memory stick, tapes, transcripts) secure while it is in my possession.

3. Return all research information in any form or format (e.g., memory stick, tapes, transcripts) to the Researcher(s) when I have completed the research tasks.

4. After consulting with the Researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g., information stored on computer hard drive).

Research Assistant/Transcriber

_____	_____	_____
(print name)	(signature)	(date)

Researcher(s)

_____	_____	_____
(print name)	(signature)	(date)

If you have any questions or concerns about this study please contact:

Sean Barford, M. Ed.
seanbarford@gmail.com

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

APPENDIX N: GROUND RULES AND QUESTIONING ROUTE FOR FOCUS GROUP

"Our research is aimed to inform understandings in several areas, but is mainly concerned with Vicarious Trauma and Compassion Fatigue in child and youth care. I am also interested in the role that certain variables have in the development of Vicarious Trauma and Compassion Fatigue and ways in which we can limit the impact these reactions have on child and youth care workers"

"Before we begin I would like to provide you with definitions of empathy, Vicarious Trauma and Compassion Fatigue. Please consider these definitions when responding to questions during the focus group. These definitions are also included in your information sheet."

Definitions

Empathy

Empathy is a multidimensional concept that involves the ability to "identify with another person", which has also been dubbed "perspective taking". It also involves allowing yourself to be affected by and sharing the emotional state of another person.

In other words, empathy is attempting to know another persons internal state, including how they are feeling and what they are thinking.

Ex. "When a friend is telling us about a breakup"

Empathy does not involve attempting to "do something" about the situation, aside from just being empathic. In those instances, when we attempt to "do something" to make the situation better, the term compassion, sympathy, or remorse, would better account for our reactions. Empathy simply involves a conscious attempt to put ourselves in another person's shoes, both from an emotional and an intellectual standpoint".

ANY QUESTIONS?

Vicarious Trauma

Vicarious Trauma refers to a transformation in cognitive schemas and belief systems (your way of seeing the world and other people) resulting from empathic engagement with clients' traumatic experiences that may result in significant disruptions in one's sense of meaning, connection, identity, and worldview.

Ex. We once believe the world was a safe place and, after working with victims of random violence for a period of time, we now believe the world is dangerous and everyone is out to get us.

Ex. We used to believe that all people are inherently good and decent, and after years of working with survivors of genocide, we now believe that people are inherently evil.

It has been hypothesized that these changes can result in numerous physical and psychological symptoms, including intrusive thoughts and images, avoidance reactions, and even PTSD itself.

ANY QUESTIONS?

Compassion Fatigue

Compassion Fatigue (also referred to as Secondary Traumatic Stress) is the caregiver's reduced capacity or interest in being empathic and is a consequence of working with traumatized individuals.

With the exception that the traumatic exposure is indirect, the symptoms of Compassion Fatigue are nearly identical to posttraumatic stress including symptoms associated with posttraumatic stress disorder (PTSD) such as intrusive imagery, avoidance, hyperarousal, distressing emotions, cognitive changes, and functional impairment.

Ex. When you work with victims of rape for a period of time, you may start to have dreams about being assaulted, avoid areas where your client's told you they were assaulted, often feel "on guard" and highly aroused.

ANY QUESTIONS?

"The important thing to consider is that compassion fatigue and vicarious trauma are similar ideas and both refer to the negative impact, both psychologically and physically, that working with victims of trauma can have on helping professionals. Vicarious trauma focuses more on mental changes, while Compassion Fatigue is more focused on physical symptoms; however, there is a great deal of overlap between these constructs and the terms are often used interchangeably".

"Now I want to facilitate a discussion about these ideas in the context of child and youth care work."

<u>Before we begin I would like to discuss a few things:</u>

(1) My role in the group is to facilitate, not to participate. I am here to keep the conversation on track, to ensure everyone has a chance to express their opinion, and to ask questions.
(2) There are a few group rules in focus groups I would like to discuss:

a. ***Please speak in a clear and audible voice so that the microphones can pick up the conversation.***
b. ***Only one person speaks at a time.***
c. ***No side conversations––these obscure the taping and interrupt the speaker.***
d. ***It is important that we hear from each of you, and that no one dominates the time.***
e. ***Either you or I will steer the discussion to another topic if conversation becomes unproductive.***
f. ***The note-taker will note who is speaking, but will not participate in the discussion.***
g. ***There are 10 main or key questions, so we will allow approximately 8-10 minutes for each question.***
h. ***LASTLY – I would like to talk to you about informed consent and confidentiality***
    i. ***Do not refer to participants by name – either refer to them as "my colleague" or by their participant number***
    ii. ***The discussion from this focus group interview is considered confidential among the participants***
    iii. ***Explain to them what I will be using the information for – research, posters, etc…***
    iv. ***Remind them they are free to leave the focus group at any time if they choose.***
    v. ***They can contact me after the focus group and I can provide them with information regarding services for support if they are distressed.***

DO YOU HAVE ANY QUESTIONS? SO LET'S GET STARTED.

(1) Briefly (in one minute or less), could each of you tell us what your role is as a child and youth care worker and one thing you enjoy about the work you do with children and adolescents?

(2) Keeping the definition of empathy at the top of your sheet in mind, could you describe ways empathy plays a role in your work as a child and youth care counsellor?

(3) Again, after considering the definition of empathy at the top of your sheet, could each of you take a moment and think back to a situation where you felt empathy for a child or adolescent you were working with (no rush). Perhaps

you could tell us a little bit about the experience of feeling empathy towards that client.

Probing Questions:

1. Do you feel as though experiencing a feeling of empathy towards this client was a positive experience for the client? How?
2. Can you think of any negative aspects of feeling empathy towards that child?

(4) Do you believe that child and youth care workers are at risk of developing Vicarious Trauma and/or Compassion Fatigue? [feel free to draw on personal experiences]

Probing Questions:

1. Why are they at risk?
2. What do you believe and the biggest contributors to the development of these reactions?
3. Do you believe that empathy played a role in the development of these reactions?

(5) In what ways do you believe Vicarious Trauma and Compassion fatigue impact an individual's ability to do their job as a child and youth care worker?

(6) Could each of you take a moment and create a list of the activities, supports, and/or routines that you engage in that you think help protect you from Vicarious Trauma and Compassion Fatigue? Once you have completed your list perhaps we could have a brief discussion about what you have written down. [Give them 5 minutes] ****cut if needed***

(7) What advice would you give a beginning child and youth care worker that you think would be helpful for avoiding Vicarious Trauma and/or Compassion Fatigue?

(8) What do you think your workplace could do to help individuals avoid developing Vicarious Trauma and Compassion Fatigue?

(9) Of all the things we have discussed, what do you think is the most important?

(10) PROVIDE SUMMARY – "HAVE WE MISSED ANYTHING?"