

EMPATHY AND COMPASSION AS PREDICTORS OF COUNSELOR BURNOUT AND
RESILIENCE

By

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DEDICATION

This study is dedicated to mental health professionals that care for our most underserved fellow humans; those that see through the symptoms and touch the humanity within the forgotten. These professionals choose to risk physical and psychological safety in service of others. My hope is that this study provides evidence for compassion trainings that begin within counselor education programs. This dissertation is also dedicated to my daughter with hopes of instilling the belief that women can achieve anything.

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TABLE OF CONTENTS

	Page
DEDICATION.....	iv
ACKNOWLEDGEMENTS.....	v
LIST OF FIGURES.....	ix
LIST OF TABLES.....	x
ABSTRACT.....	xi
CHAPTER	
1. INTRODUCTION.....	1
Statement of the Problem.....	1
Purpose of the Study.....	2
Significance of the Study.....	3
Theoretical Framework.....	3
Overview of Research Design.....	4
Primary Research Questions.....	5
Primary Research Hypotheses.....	5
Definitions.....	6
Assumptions, Limitations, Delimitations.....	7
2. REVIEW OF RELATED LITERATURE.....	9
Empathy.....	9
Basic Functions of Empathy.....	9
Empathy in Counseling.....	10
Neuroscience Studies with Empathy.....	12
Emotional Regulation and its Role in Empathy.....	13
Empathy Training.....	13
Compassion.....	15
Self-Compassion.....	19
Compassion in Counselor Education and Practice.....	21
Compassion Training.....	22
Burnout.....	23
Burnout in Counselors.....	23
Impact on Client Care as a Result of Counselor Burnout.....	24
Resilience.....	25
Predictors of Empathy and Resilience.....	26
Predictors of Counselor Burnout.....	26
Predictors of Counselor Resilience.....	26
Counselor Worldview.....	27

TABLE OF CONTENTS (Continued)

Empathy, Compassion, Burnout, and Resilience28
Summary.....30

3. METHODOLOGY.....32
Participants.....32
 Inclusion and Exclusion Criteria.....32
 Sampling and Recruitment Method.....33
Research Design.....33
Instruments.....34
 Interpersonal Reactivity Index.....35
 Sussex Oxford Compassion Scale for Others.....35
 Sussex Oxford Compassion Scale for Self.....36
 14-Item Resilience Scale.....37
 Professional Quality of Life Scale.....37
 Marlowe-Crowne Social Desirability Scale (Short Form II)38
 Researcher Created Demographics Questionnaire.....38
Ethical Considerations.....38
Data Collection.....40
Statistical Analysis.....41
 Multiple Regressions.....42

4. RESULTS.....43
Data Screening.....43
Descriptive Statistics.....44
 Researcher Created Demographic Questionnaire.....44
 Personal Demographics.....45
 Professional Demographics.....46
Predictor Variables.....48
Criterion Variables.....49
 Burnout in Clinical Mental Health Counselors and School Counselors...50
Preliminary Analysis.....51
 Correlations Among Predictor and Criterion Variables.....51
 Correlates of Dimensions of Empathy.....53
 Correlates of Dimensions of Self-Compassion.....54
 Correlates of Dimensions of Compassion Towards Others.....56
 Summary of Preliminary Analysis.....57
Statistical Analysis.....58
 Research Question One.....58
 Research Question Two.....60
 Research Question Three.....61
 Research Question Four.....64

5. DISCUSSION, CONCLUSIONS, AND RECOMMENDATION.....66
 Overview of Theory Supporting Original Hypothesis.....66

TABLE OF CONTENTS (Continued)

Discussion.....67
 The Role of Empathy in Counselor Burnout.....67
 The Role of Compassion in Counselor Burnout.....69
 The Role of Compassion in Counselor Resilience.....70
 Counselor Burnout and Resilience71
 Counselor Burnout and Resilience During COVID-19.....71
 Social Desirability, Burnout, and Resilience.....72
 Counselor Political Affiliation.....73
Limitations.....75
Implications.....77
 Theoretical Implications.....77
 Revisiting Rogers’ Core Conditions.....77
 Revisiting Compassion Fatigue.....78
 Counselor Education and Supervision.....79
 Compassion Training in Counselor Education.....81
 Future Research.....83
Summary.....84
Conclusion85

REFERENCES.....87

LIST OF FIGURES

	Page
Figure	
1. Burnout Scores Based on Credential Type.....	51

LIST OF TABLES

	Page
Table	
1. Personal Demographic Characteristics.....	46
2. Professional Demographics Characteristics.....	48
3. Descriptive Statistics for Predictor Variables.....	49
4. Descriptive Statistics for Criterion Variables.....	50
5. Main Predictor and Criterion Variable Correlation Matrix.....	53
6. Empathy Subfactors Correlation Matrix.....	54
7. Self-Compassion Subfactors Correlation Matrix.....	55
8. Compassion Towards Self Subfactors Correlation Matrix.....	57
9. Regression Coefficients of Empathy and Compassion on Resilience.....	60
10. Regression Coefficients of Empathy and Compassion on Burnout.....	61
11. Regression Coefficients of the Resilience Model.....	63
12. Regression Coefficients of the Burnout Model.....	65

ABSTRACT

CARRIE L. ELDER

EMPATHY AND COMPASSION AS PREDICTORS OF COUNSELOR RESILIENCE

Under the direction of MORGAN KIPER-RIECHEL, Ph.D.

Empathy is frequently taught as a core disposition and helping skill in counselor education programs. Recent studies have found empathy to activate the pain network within the brain and compassion to activate non-overlapping brain regions. These findings have led neuroscientists to hypothesize that empathy leads to burnout and compassion leads to resilience. These findings have implications for the field of counseling since burnout has the potential to lead to impaired client treatment. The purpose of this study is to use a quantitative, multiple regression analysis to determine if empathy is predictive of counselor burnout and compassion predictive of counselor resilience. Results indicate that increases in empathy, and decreases in self-compassion, are predictive of counselor burnout. Results also indicate that self-compassion, compassion towards others, and a decrease in empathy is predictive of counselor resilience. Furthermore, results indicate that the model that best predicts counselor burnout is empathy (fantasy, personal distress, and less ability to take the perspective of others), working outside of private practice, one to five years of experience, and lower scores on self-compassion and compassion towards others. The model that best predicts counselor resilience is compassion towards self and others, empathic perspective taking, less empathic personal distress, less empathic fantasy, working in private practice, and Republican affiliation. Results from this study indicate that compassion plays a significant role in predicting both high resilience and low levels of burnout. These findings support counselor educators in teaching compassion skills equal to empathy skills to counselors in training as a measure of self and client care.

CHAPTER 1

INTRODUCTION

This is a quantitative study conducted with counselors' empathy and compassion scores as predictors of burnout and resilience. The first chapter presents the problem statement, purpose and significance of this study, the theoretical orientation, and research design. Included are also the primary research questions, definition of terms, assumptions, limitations, and delimitations of this study.

Statement of the Problem

Professional counselors are at risk of burnout that may lead to intrapersonal distress, interpersonal challenges, and impairment in the practice of providing professional counseling (Salyers et al., 2014). Counselors who practice impaired are less likely to use ethical decision-making and therefore risk compromising the quality of care given to clients (Lawson, 2007). Some literature suggests that a contributing factor of counselor burnout is the use of empathy (Stebnicki, 2007). Empathy, however, is a foundational skill taught in helping skills as part of counselor education programs (Bayne & Jangha, 2016). It is also widely accepted as a core condition of effective counseling among practicing counselors (Clark, 2010, 2014). While empathy is taught as a helping skill, and an integral component of counseling, its use may also contribute to burnout putting both the counselor and client at risk (Stebnicki, 2007).

Similar to empathy, training in compassion has gained traction within contemplative traditions that have spread to the East. Compassion is rooted in the Buddhist tradition as a mindfulness practice of kindness towards self and others (Gu et al., 2017). Within counseling education, however, compassion terminology is most associated with the term compassion fatigue. Compassion fatigue is often used to describe burnout and secondary traumatic stress in

counselors (Stam, 2010). If theories of empathy and compassion within contemplative neuroscience are applicable to counselor burnout and resilience, there may be a need to re-examine how compassion fatigue is operationalized within the counseling profession. Additionally, the role that empathy and compassion have in counselor wellness may shape methods taught in helping skills within counselor education.

Recent studies in contemplative neuroscience that utilize functional magnetic resonance imagery (fMRI's), have found that empathy and compassion activate nonoverlapping brain regions and networks and lead to different emotional and cognitive outcomes (Klimecki et al., 2014). Empathy activates the pain network in the brain and is theorized to lead to burnout. Compassion activates brain networks responsible for positive affect and is theorized to lead to resilience. These findings highlight some of the challenges associated with the use of empathy without subsequent compassion practice. The practice of compassion requires a cognitive noticing of suffering with a desire to alleviate it. In contrast, empathy requires taking the perspective of another and feeling as-if the emotions are coming from within. The process of differentiation of self-other might make emotional regulation more difficult (Prikhidko & Swank, 2018). Understanding the role that empathy and compassion have in predicting counselor resilience and burnout may provide crucial information for counselor educators and practicing counselors. Results may provide evidence for adding compassion skills training within counselor education and practice.

Purpose of the Study

Klimecki et al. (2014) findings within contemplative neuroscience may have implications for the field of counseling and how terms such as “compassion fatigue” are operationalized. Additionally, this study examines whether empathy is predictive of counselor burnout. Also of

interest is whether compassion is predictive of counselor resilience. The purpose of this quantitative study is to examine emerging theories within contemplative neuroscience through use of multiple and hierarchical regression models to measure the predictive factors of empathy and compassion on burnout and resilience within practicing professional counselors.

Significance of the Study

Understanding the predictive qualities of empathy and compassion on burnout and resiliency may lead to a clearer conceptualization of how counselors are impacted by the skills used in delivering interventions in counseling. This study may be the first step in revisiting the use and consequences of empathy training. If empathy is found to be a significantly strong predictor of burnout and compassion predictive of resilience, further studies might focus on the impact of compassion training subsequent to empathy. Additional studies may expand the work of Carl Rogers (1951) by examining the impact of compassion, either in addition to empathy or in place of, on clients' perceptions of counseling and treatment outcomes. Such studies may lead to a new standard of teaching and practicing compassion, in addition to empathy, as a helping skill that is psychologically and physically healthier for counselors using them without compromising on client outcomes.

Theoretical Framework

This study is led by emerging theories in contemplative neuroscience. This study tests the resulting theory that compassion may reflect a new coping strategy to overcome empathic distress and strengthen resilience (Klimecki & Singer, 2014). This study, in part, aims to investigate how empathy may be predictive of burnout in counselors. In addition, this study tests the contemplative neuroscience theory that compassion builds resilience (Klimecki et al., 2014).

Klimecki and colleagues (2014) found that training in empathy activated the pain network in the brain and led to an increase of unpleasant emotions whereas subsequent compassion training led to resilience and positive affect. While that study posited to better understand the neurological differentiation of empathy and compassion, this study aims to test this theory within counselors. Using Klimecki et al.'s, (2014) research as a framework, this study analyzed the predictive relationships among the same variables outside of an experimental design. Instead, survey research was used to measure and analyze if Klimecki's theory remains true for counselors; that empathy predicts burnout and compassion predicts resilience.

Overview of Research Design

From a pragmatic worldview, a quantitative design was used to measure whether empathy or compassion are predictors of burnout and resilience in counselors. The pragmatic worldview arises from the current conceptualization of the research problem instead of antecedent conditions that arise from one system or philosophy (Creswell & Creswell, 2018). The researcher is able to choose a research design that best address the research question. From this understanding, the strategy of inquiry includes use of the scientific method and hypothesis testing. This quantitative study was based on a nonexperimental study using survey design. After data collection, multiple regression analyses were used to analyze the data. Four different regressions were used to analyze correlations among multiple factors (i.e. compassion scale scores, empathy scale scores, burnout scale scores, resilience scale scores, gender, years in practice, work setting, and political affiliation) to analyze the best predictors for burnout and resiliency.

The study sample was drawn from a population of counselors in various stages of development. Inclusion criteria includes counseling students in either practicum or internship,

clinical mental health counselors, and school counselors. Exclusion criteria includes counselors not seeing at least one client at the time of study. A power analysis was conducted to determine sample size, and participants were recruited through listserv's, professional associations, the snowball effect, and professional contacts within researchers' email lists.

For a linear regression statistical analysis, the constructs of inquiry are grouped into predictor and criterion variables. The two predictor variables are empathy scores and compassion scores. Compassion scores consist of both self-compassion and compassion towards others. The two criterion variables are burnout scores and resilience scores. Additional variables will be added into a multiple regression model consistent with current literature such as demographics (specifically gender, years of experience work setting, and political affiliation) and that were found to correlate with the criterion variables in the preliminary analysis. Multiple regressions were used to analyze the models that best predict counselor burnout and resilience independently.

Primary Research Questions

The research questions in this study are:

RQ1: Does empathy or compassion better predict resilience among counselors?

RQ2: Does empathy or compassion better predict burnout among counselors?

RQ3: What model best predicts counselor resilience?

RQ4: What model best predicts counselor burnout?

Primary Hypotheses

The research hypotheses in this study are:

H1: Compassion is a better predictor than empathy in resilience among counselors.

H2: Empathy is a better predictor than compassion of burnout among counselors.

H3: Compassion, political affiliation, years in practice, and work setting best predict counselor resilience.

H4: Empathy, political affiliation, years in practice, and work setting best predict counselor burnout.

Definitions

Many of the variables in this study have multiple definitions and are operationalized differently throughout research studies. A thorough investigation of these differences is within Chapter II. The following is a list of terms and their operational definitions for this study.

Burnout is characterized by three dimensions: “(1) feelings of energy depletion or exhaustion; (2) increased mental distance from one’s job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy” (World Health Organization, 2019).

Compassion is defined as recognizing suffering in self and others, understanding the universality of suffering, feeling for self and/or the other person suffering, tolerating uncomfortable feelings in self and others, acting or being motivated to act to alleviate suffering in self or others (Gu et al., 2019).

Empathy is experienced in two domains of cognitive empathy and affective empathy. Within these domains are perspective taking (seeing things from the perspective of someone else), personal distress (the personal anxiety or unease in response to another), empathic concern (feelings of concern oriented towards another person), and fantasy (the process of imagining themselves as the other person) (Davis, 1983).

Empathy Distress Fatigue is a term used within the nursing field (Hofmeyer, et al., 2019). and contemplative neuroscience (Klimecki, et al., 2012) to replace “compassion fatigue” as a more accurate representation of the phenomenon.

Compassion Fatigue is a state of tension and identification with client trauma experiences, avoidant behavior of reminders of client material, and the experience of anxiety associated with the client (Fige, 1995)

Contemplative neuroscience is defined as a multidisciplinary field, overlapping with the study of neural mechanisms of mindfulness meditation. It utilizes concepts and methods of neuroplasticity and how contemplative practices change the brain (Davidson, 2010).

Counselor is defined in this study as licensed professional counselor (or state equivalent), post-graduate and pre-licensed associate professional counselor (or state equivalent), CACREP-accredited graduate professional counseling student in practicum or internship, certified school counselor (or state equivalent), post-graduate and pre-certified school counselor (or state equivalent), and CACREP-accredited graduate school counseling student in practicum or internship.

Resilience is a process of environmental influences that serve to protect individuals, or help them bounce back from, from the harmful psychological effects of severe stress, enabling them to lead satisfying lives (Bogar et al., 2006).

Assumptions, Limitations, Delimitations

An assumption of this study is that internal states of the self-other distinction of empathy and compassion of counselors within a session can be captured by self-report while not in session. Another assumption is that the predictor variables in this study are stable, and dispositional, rather than state-specific. A delimitation of this study is that data will be confined to self-perceptions of empathy, compassion, resiliency and burnout. A choice was made to collect data from counselors' perceptions of their general disposition and use of empathy and

compassion instead of using an experimental and control groups testing the impact of empathy and compassion training on burnout and resilience.

A limitation of this study is the type and degree of empathy and compassion training that participants have received either in a counselor education program or in continuing education workshops or lectures. Another major limitation will be the social desirability of participants responses. Majority of survey items inquire about the skills that are commonly understood to be crucial to effective counseling. In an effort to mitigate this limitation, instructions for each survey item request participants to respond as they are, instead of as they wish to be. In addition, a social desirability scale will be used to identify data that requires removal.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Empathy

Basic Functions of Empathy

Empathy is a foundational social experience. It allows for the understanding of others' feelings even when they are viewed as different (Masten et al., 2011). This understanding, or mentalizing, is a basic cognitive component involved in the process of empathy (Firth et al., 1991). Furthermore, a deeper way of knowing the experiences felt by another person is through the affectual component of empathy. This process is, in a near literal sense, sharing the feelings occurring in someone else.

This cognitive and affectual way of intimately understanding someone else allows for prosocial behavior (Masten et al., 2011). Humans are able to better respond to others when likening an experience to oneself. Individuals who feel more empathy are more likely to have greater concern for the welfare of others (Batson, 1998). Another way of understanding this is through exploring the lack of empathy. Individuals with antisocial personality disorder, often associated with mental and physical harm to others, are characterized by a lack of activation in brain regions associated with mentalizing, an important component of empathy (Soderstrom, 2003; Velotti et al., 2018). Empathy seems to be a prosocial skill that allows for community and connection instead of isolation and violence.

The neural networks involved in empathy are predictably consistent. Each aspect of empathy, cognitive and affectual, activate distinct neural networks. The affective component activates the anterior insula and the dorsal anterior cingulate cortex. These brain regions within the limbic system are typically activated when experiencing disgust, fear, and pain. Interestingly, they

are also activated in both watching someone in physical pain and in experiencing one's own physical pain (Decety & Meyer, 2008; Singer, 2006; Shamay-Tsoory et al., 2009).

In contrast, the neural network involved in the cognitive component of empathy relies on a network responsible for mentalizing or thinking about the contents of other people's minds. This region includes the ventromedial, medial, and dorsomedial prefrontal cortices, the posterior superior temporal sulcus, and the precuneus ((Frith & Frith, 1999; Singer, 2006). This distinction becomes important in understanding that the brain differentiates experiencing someone else's pain (affect sharing and perspective taking) and thinking about someone else's pain (fantasy).

Studies that examined the brain regions associated with different states of empathy were through functional magnetic imagery studies (fMRI's). Previously, these studies focused on brain plasticity when observing physical pain in others. More recently, contemplative neuroscience studies have focused on brain plasticity and neural networks that are activated when participants are exposed to other people's emotional pain (Masten, 2011). This phenomenon is more likely to occur in counselors.

Empathy in Counseling

Viewing counselor burnout through a contemplative neuroscience lens might shed light on some of the counseling practices that can lead to burnout and how to move towards counselor wellness. Such a transition requires revisiting empathy as one of the core conditions for effective counseling. Rogers (1957) introduced it as a core condition where "the therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client" (p. 2). Since Rogers (1957) emphasized the use of empathy, it has become a widely accepted practice in helping skills taught within counselor education programs. Resulting from this, maintaining empathy with clients is considered essential for treatment

efficacy (Skovholt, 2001). Despite its continued use in counselor education, this skill set has not received much research attention (Bayne & Jangha, 2016).

Carkhuff and Truax (1965) describe empathy as a predictor of successful client outcomes. Empathy is an affective, emotional response to another person that requires the cognitive capacity to take the perspective of the other person which ultimately requires emotion regulation (Decety & Jackson, 2006). Empathy is the process where the counselor becomes the tool for empathetic understanding while maintaining and demonstrating attunement (Clark, 2010). Part of the counselor's role is to interact with clients in a caring manner that's personal, emotionally demanding, and empathic while knowing that this puts them at risk for stress and burnout (Leppma & Young, 2016). In contrast, others assert that empathy is not a core condition for effective counseling and point to research on negative outcomes related to empathy (Gladstein, 1970). Although dated, Gladstein (1970) found that empirically-based counseling studies found the use of empathy to not be necessary and that its use may lead to clients feeling misunderstood as a result of counselors relying on their own empathic understandings of personal distress. This research, however, is scarce within counseling.

As a core condition, researchers have examined the development and use of empathy within counseling practice and education. Empathy research has specified its use with specific populations such as victims of severe physical abuse (Matotta, 2003) and veterans from the Vietnam war (Miller, 1983). Empathy seems to evolve developmentally. Counseling students have more empathy in their second year than in their first demonstrating the developmental nature of empathy construction (Lyons & Hazler, 2002).

The varied definitions of empathy create challenges in teaching it as a skill to counseling students. Some conceptualizations emphasize its connection to compassion, others to

perspective-taking, and finally, to affectively attune to experiences of the client (Clark, 2004; Singer & Lamm, 2009; Stepien & Baernstein, 2006). Empathy is “such a capacity requires that one mentally simulate the other’s perspective using one’s own neural machinery” (Decety & Jackson, 2006, p. 55). It might be that the same neural network responsible for acting and perceiving is activated in order to feel someone else’s pain (Goldman, 2006). This type of neural overlap can cause anxiety and distress (Klimecki et al., 2014). While definitions of empathy vary in counseling practice and research, a common denominator is the skill set of taking the perspective of another in order to understand their emotions.

Neuroscience Studies with Empathy

In counseling, empathy is studied through self-report instruments, observation, and client response. All of these rely on perception and behavior. Neuroscience offers another view into the phenomenon of empathy. From this perspective, it is apparent that empathy extends beyond the affective experience of feeling others’ pain and suffering. Within the brain, a predictable empathy pain network activates to allow for feeling others’ pain through the first-hand experience. The empathy pain network is made up of the dorsal subdivisions of the bilateral anterior insula (AI), the mid-cingulate cortex, and the pregenual anterior cingulate cortex, which forms a ‘core’ neuronal network. This network show overlaps with the neural network activated by the first-hand experience of pain (Lamm et al., 2011).

In fMRI studies, empathy has shown to activate brain regions associated with reward (Singer et al., 2004) and emotional pain, but not physical. In other words, empathy allows for the sharing of emotions between people. The observation of emotional or physical pain is mirrored in the brain of the observer. The observer emotionally feels as if the pain is happening to them. In

contrast, the observer does not physically feel as if the pain is happening to them (Singer et al., 2004). The brain allows for affect sharing, but not shared physical responses.

Emotional Regulation and Its Role in Empathy

Emotional regulation allows for differentiation between self and other, to an extent, while experiencing empathy (Decety & Jackson, 2006). Counselors are consciously (controlled) or unconsciously (automatic), regulating emotions when working with clients. Emotional regulation (ER) requires the process of using empathy, managing countertransference, and navigating emotional responses to clients (Prikhidko & Swank, 2018). When counselors experience empathy, and the same neural networks activate in perceiving and experiencing, ER helps to separate the counselors' experiences from that of the clients.

Relatedly, counselors can experience anger towards a client or guilt when they believe they have not helped a client, or when experiencing emotions counter to what they believe the profession expects of them (Prikhidko & Swank, 2018). This shame can be associated with an outdated notion of compassion fatigue (Russel & Brickell, 2015). Research is lacking in the area of how counselors utilize ER in response to empathy and other emotional responses to self or clients. To reduce burnout, Savicki and Cooley (1982) recommend counselors to develop an attitude of detached concern which resides between overidentification and depersonalization. Perhaps this is more accurately describing the use of compassion in order to regulate emotions.

Empathy Training

While empathy is thought of as a disposition (Badenoch, 2008; Konrath et al., 2011), it is also a skill that can be taught (Ivey, 1971). Although empathy is frequently thought of as a core condition to successful client outcomes, it is not included in CACREP standards (CACREP, 2016). Instead, it seems to be a microskill taught in counselor education programs (Bayne &

Jangha, 2016). Empathy based responses require a specific skill set, training, and practice (Barrett-Lennard, 1986; Truax & Carkhuff, 1967). Furthermore, it's recommended that counselors-in-training are taught empathy not only through microskills training but given creative opportunities to practice empathy skills such as in improvisational activities in the classroom (Bloom et al., 2018).

There are various protocols for training in empathy. The empathy training provided in the study central to this research from Klimecki et al (2014) included multiple steps. First, participants were asked to consider their own suffering followed by identifying with someone else's suffering. To do this, participants were asked to share the suffering of someone they were close to, then a neutral person. To facilitate this, participants were encouraged to use statements such as "I share your suffering" and "I see your pain". Participants were then asked to extend the affective resonance with others, a neutral person, and then strangers or human beings in general.

In contrast to compassion training, pedagogy around empathy skill building is inconsistent. This seems consistent with the counseling professions inconsistencies in how empathy is defined. Since empathy is a multi-dimensional phenomenon (i.e., cognitive empathy, affective empathy, and behavioral empathy) trainings seem to target these dimensions differently. In a meta-analysis of 18 randomized controlled trials, empathy training was found to be scientifically effective at increasing dimensions of empathy regardless of the type of empathy measure used (van Berhout & Malouff, 2016). It is worth noting that scales that broadened the scope of empathy to include emotional states such as warmth and caring (which are typically associated with compassion) produced less statistical results than studies that measure empathy as understanding and feeling the emotions of another person. Additionally, Studies where

empathy training included instruction, modeling, practice, and feedback yielded slightly higher effect sizes.

Compassion

Empathy and compassion are frequently referenced as interchangeable terms to describe a caring attitude towards others. While there are some similarities, contemplative neuroscience helps to delineate between the two as separate neural systems in the brain with very different results. Consistent across definitions, empathy involves taking the perspective of another person to feel “as-if”. In contrast, compassion simply notices the suffering in another person with a desire to alleviate the observed suffering. Compassion has a long history as part of the contemplative traditions (Gu et al., 2017). As a result of the West’s adoption of mindfulness-based practices, compassion towards self and others has gained traction within the counseling profession (Leppma & Young, 2016). Compassion has been defined simply as an awareness of others suffering along with a wish to relieve it (Gilbert, 2009). Wispe’s (1991) definition is similar but includes a non-judgmental perception towards others. Kanov et al. (2004) conceptualizes compassion as embodying three facets: noticing (awareness of suffering), feeling (empathic concern), and responding (the desire to alleviate suffering).

Similarly, Neff (2003), in keeping with most contemplative traditions, focused on directing compassion towards oneself that also included three dimensions: kindness (nonjudgmental towards oneself), mindfulness (awareness of distress), and common humanity (seeing one’s suffering as part of the human condition). Strauss et al. (2016) defined compassion based on five components: recognizing suffering; understanding the universality of suffering in human experience; feeling empathy for the person suffering and connecting with the distress(emotional resonance); tolerating uncomfortable feelings aroused in response to the

suffering person so remaining open to and accepting of the person suffering, and motivation to act/acting to alleviate suffering. Lown (2016) defines compassion as an emotional state, with associated behaviors involved in recognition and empathy towards others suffering along with a relational action to change the conditions.

The Dalai Lama (2005) suggests that loving-kindness and wisdom are integral aspects of compassion. Wisdom, he believes, is in understanding the nature of one's suffering and the wish to free them, and loving-kindness is the deep intimacy and empathy that is experienced with others. While definitions differ in the level of cognitive processes or affective states, most are similar in the awareness of the suffering of others and the wish to change it (Khour, 2019). Generally speaking, compassion requires a motive to detect and approach suffering, with a commitment to try and alleviate or prevent it (Gilbert, 2019).

While empathy and compassion have some cross-over, empathy is the experience of feeling 'as if' and compassion 'feels for' (Singer & Klimecki, 2014). Compassion requires maintaining the self-other distinction while recognizing suffering with a wish to change it. Beyond definitions, the neural structures vary between each state.

Compassion likely has evolutionarily served as a neurophysiological care-giving quality (Brown & Brown, 2015; Marsh, 2019; Mayseless, 2016). Recent studies suggest that compassion training can lead to empathic accuracy (Mascaro et al., 2013); increase prosocial behavior (Leiberg et al., 2011); and helps to foster positive emotions toward people who are suffering (Klimecki et al., 2012). Expert meditation practitioners show more significant empathic neural responses when exposed to suffering (Lutz et al., 2008). Functionally, it underlies care, connection, and improved social abilities (Ferrari et al., 2019; Seppälä et al., 2017; Kirby et al., 2017a,b; Kirby, 2017; Strauss et al., 2016).

In a recent study, two weeks of compassion training enhanced altruistic behavior toward a victim encountered outside of the training context. Functional magnetic resonance imagery (fMRI) was used to investigate whether increased altruism produced neural changes in response to suffering (Weng et al., 2013). With increases in altruistic behavior, fMRI's showed increased activation in the right inferior parietal cortex (IPC) and right dorsolateral prefrontal cortex (DLPFC). This study provided further evidence for neuroplasticity in the neural circuitry that supports compassion and altruism. Importantly, the IPC, which has been implicated in the mirror neuron system (Gallese et al., 2004), was found to be a unique neural marker induced by compassion training. This area may point to an increased simulation of the suffering of others. Of additional interest, the pattern of neural changes after short term compassion training suggests that increased altruistic behavior is achieved by enhancing neural mechanisms that support the understanding of others' states, greater fronto-parietal executive control, and up-regulation of positive emotion systems (Weng et al., 2013). Compassion in response to distressing situations differs from other ER strategies, which involve an active downregulation of negative affect (Gross, 2002). It is worth pointing out that emotional regulation as a result of compassion training does not appear to be a secondary process (as in empathy) but an integral part of the neural mechanisms that increase altruistic behavior.

In further exploration Kilimecki et al. (2014) investigated the emotional regulation capacity of compassion and the neural plasticity of augmenting levels of empathy. In their study, participants underwent empathy training. As a result of empathetic responses, the participants had increased negative affect in responses to others' distress and brain activations in the anterior insula and anterior midcingulate cortex brain regions previously associated with empathy for pain. These results align with a previous cross-sectional meta-analytic findings on a the role of

insula and aMCC in empathy for pain (Fan et al., 2011; Lamm et al., 2011), as well as their involvement in self-experienced pain, and negative affect in general (Beckmann et al., 2009; Lamm et al., 2011; Shackman et al., 2011). Activation in AI and aMCC has repeatedly been found to covary with negative affect ratings, both when observing others suffering or during self-experienced pain (Jackson et al., 2005; Cheng et al., 2007; Lamm et al., 2007; Saarela et al., 2007; Singer et al., 2008; Akitsuki & Decety, 2009).

The same participants in Kilimecki et al. (2014) study then underwent compassion training. In contrast to empathetic responses, subsequent compassion training seemed to reverse the negative affect and increase the self-reports of positive affect. Compassion training increased activations in a nonoverlapping brain network spanning ventral striatum, pregenual anterior cingulate cortex, and medial orbitofrontal cortex, which are associated with positive affect (Kringelbach & Berridge, 2009), affiliation (Strathearn et al., 2009) and reward (Haber & Knutson, 2010). Empathy training not only induced painful and distressing experiences but also increased the susceptibility to negative feelings in response to everyday life situations.

Compassion training reversed these effects. Compassion and loving-kindness training have been found to increase general levels of positive affect in daily life (Fredrickson et al., 2008). From this, they concluded that compassion training might provide a coping strategy to strengthen resilience and overcome empathic distress (Klimecki et al., 2014). As compassion does not rely on the temporary denial of the negative nature of events, one hypothesis would be that compassion training would stop ripple effects, as observed in the amygdala after intentional emotion regulation (Walter et al., 2009).

Self-compassion

As reviewed compassion often involves a form of self-compassion. In Eastern contemplative practices of compassion, self-compassion is an inherent part of compassion. In Western students, self-compassion has been difficult to learn. Self-compassion in Westerners has not been an inherent piece of understanding compassion practices. Culturally, self-compassion is low in the United States compared to other countries, such as Thailand (Neff et al., 2008). For this reason, practices in the West differentiate self-compassion from compassion towards others.

Thuptem Jinpa, the Dalai Lama's English translator encountered this phenomenon while working with scientists at Stanford University. Together, they were building a Compassion Cultivation Training (CCT) at the Center for Compassion and Altruism Research and Education (CCARE) program for Westerners. It became apparent that the training program needed modification because self-compassion was an assumed disposition, or skill, that was already held by the participants. It was not.

We were surprised when we started the compassion cultivation work that we couldn't start with the traditional Buddhist compassion meditations, because the first step is based on an understanding that self-care and self-compassion are instinctual.

But we found that many of our Western students needed additional help to learn to have self-compassion; they couldn't start with this as step one! (Jinpa, 2020)

Together, the combined practices of self and other compassion equal the standard compassion practice consistent within contemplative traditions.

Self-compassion involves the practice of being understanding and kind, and assuming a supportive stance towards oneself during pain or failure rather than being self-critical (Berking & Whitley, 2014). It is a way of relating to oneself in times of suffering with greater mindfulness and less overidentification with thoughts and feelings with an increase in self-kindness, reduced self-judgment, increased feelings of common humanity and decreased isolation (Neff, 2003b).

Self-compassion has been widely studied and shown to improve mental health. Self-compassion skills have been found to promote resilience and mediate against mental health problems (Golbert et al., 2004; Trompetter et al., 2017), counteract self-criticism in individuals with depression (Ehret et al., 2015; Kaurin et al., 2018), increase resilience and compassion satisfaction and decreasing secondary trauma and burnout in a sample of nurses (Delaney, 2018), reduce emotional discomfort in divorce (Sbarra et al., 2012), mediate the relationship between family/cognitive factors and well-being (Neff & McGhee, 2010), aid in emotional regulation difficulties in psychologists (Finlay-Jones et al., 2015), and predict emotional well-being in doctors (Sabir, et al., 2018).

There is some evidence that self-compassion lowers the body's nervous system reaction to stress. Individuals with high self-compassion showed lower stress-induced reactivity of salivary alpha-amylase (sAA), an indicator of sympathetic nervous system activation (Breines et al., 2015). The sympathetic nervous system reaction is correlated with stressful experiences. This suggests that self-compassion, on a biophysical level, may serve to regulate emotional reactivity and act as a buffer against traumatic events, crisis situations, and psychopathology by reducing the body's physiological reaction to stress. This process may explain the role that resilience may have in buffering against burnout.

Compassion in Counselor Education & Practice

As the counseling profession begins to embrace contemplative practices, various aspects of compassion have begun to be integrated into counselor education research and practice. Compassion-focused therapy (CFT) is the third wave of psychotherapy to treat disorders, anxiety, and depression (Pauley & McPherson, 2010). CFT is a combination of social, developmental, and Buddhist psychologies and neuroscience (Sadeghi et al., 2018).

Portions of Loving-kindness meditation (LKM) (Salzberg, 1995) were used in several of the compassion training and subsequent fMRI studies (Klimecki et al., 2014). Lepmma (2012) recommends using LKM within counseling. Interestingly, recent compassion studies in counselor education use compassion as a means of increasing empathy. Fulton and Cashwell (2015) found that compassion (toward others) was the only significant predictor of affective empathy, whereas both awareness and compassion (toward others) were significant predictors of cognitive empathy. Leppma and Young (2016) found that counseling students who received LKM as an intervention experienced an increase in dimensions of empathy. Results also suggested a significant relationship between the quantity of meditation and perspective-taking. Self-compassion interventions have also been recommended for counselor educators to mentor mothers in academia to help cope with their emotional stressors (Solomon & Barden, 2016).

Compassion may provide an antidote for self-expectations of counselors. In a study examining levels of burnout among psychotherapists (N=264), results included finding irrational beliefs that one should operate at peak competency and efficiency with all clients at all times (Deutsch, 1984). According to Gerber, et al. (2015) self-compassion is an integral aspect of compassion practice. In reference to Deutsch's (1984) study, it is curious as to whether compassion practice might mitigate self-imposed expectations among therapists. Such a

phenomenon may contribute to counselor resilience in that kindness towards self may weaken the impact of resulting upset when self-expectations are not met.

Compassion Training

There are various protocols for training in compassion. The empathy training provided in the study central to this research from Klimecki et al (2014) was founded on loving kindness practice consistent with Eastern contemplative traditions. Participants were asked to visualize their own suffering and to relate to it with warmth and care. To foster this, participants were trained to use statement such as “May I be safe”. Participants were asked to extend this practice to self, a close person, a neutral person, and finally to strangers or other human beings in general. These practices are carried out in-person and in silence. The goal of the training was to foster the participants ability and capacity to experience warmth and caring when faced with ones own suffering or the suffering of others.

Most studies use some form of loving kindness meditation in compassion training. This is most likely because it is a core mindfulness and meditation practice to increase compassion in contemplative practices. The fact that Leppma and Young (2016) included empathy training as part of the study further supports the need for studies examining the differences between empathy and compassion trainings and their consequences. In a quasi-experimental study of counseling students (N=) loving kindness meditation was also offered as a form of compassion training (Leppma & Young, 2016). Training consisted of psychoeducation of meditation and counselor wellness, mindfulness and loving kindness practice, psychoeducation on how thinking patterns impact wellness, and psychoeducation on connectedness and empathy. While the intention of the training was to teach compassion skills through loving kindness meditation, it appears that empathy training was also introduced. Outcome measures of the study suggested

that wellness interventions with a loving kindness (compassion) component increase cognitive empathy in counseling students.

Burnout

Burnout, first described by Freudenberger (1974), is a psychological syndrome occurring after exposure to long-term interpersonal and emotional stress at work. It is often defined as a function of experiencing chronic interpersonal and emotional stressors within a professional environment which leads to overload (Puig et al., 2012). It is thought to contain three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1981). It entails a process of psychological reaction to stress at work over long periods of time (Schaufeli & Maslach, 1993). It is influenced by individual and contextual factors (Leiter & Maslach, 2003).

Other ways of conceptualizing burnout focus more on the impact it has on an employee rather than direct experience. The World Health Organization classifies burnout as an occupational phenomenon that arises from workplace stress that cannot be managed effectively and results in a change in health status (WHO, 2019). The organization characterizes it with three dimensions: feelings of energy depletion or exhaustion; reduced professional efficacy; increased mental distance from one's job and feelings of negativism or cynicism related to one's job.

Burnout in Counselors

Compared to other professionals, people in helping professions are thought to be more likely to experience burnout (Maslach & Coldberg, 1998). Professional Counselors have frequent exposure to clients with complex and challenging life events. Between 82% and 94% of clients in treatment report having some form of trauma experience (Bride, 2004). From this, counselors

are susceptible to vicarious trauma which may contribute to social withdrawal, anxiety, depression, and a more rigid belief system (Saakvitne & Pearlman, 1996). At the least, counselors are at risk of burnout. Counselor burnout can increase experiences of cynicism towards clients and the profession (Gündüz, 2012). Burnout can also result in mental health problems such as exhaustion, fatigue, anxiety, depression (Killian, 2008) depersonalization, and a reduced sense of personal accomplishment (Maslach, et al., 1996).

In the counseling field, compassion fatigue has been used interchangeably with terms such as burnout. Research has indicated that novice counselors are at a higher risk for compassion fatigue (Lyndall & Bicknell, 2001; Sheehy et al., 2009). The term compassion fatigue was first coined by Joinson (1992) when she noticed the paradox that the same characteristic that led to nurses pursuing the field ultimately put the nurse at risk for this form of burnout. Figley (1995) adopted the terminology to further the description of secondary stress disorder in those who treat the traumatized, such as in counselors.

Impact on Client Care as a Result of Counselor Burnout

Burnout is thought to be a factor that threatens counselor wellness and contributes to impairment. Burnout can lower the quality of care provided by the counselor (Salyers et al., 2014). In addition, impairment in counselors can also lead to ethical violations (Lawson, 2007). Counselors who are unwell, or impaired, are more likely to cause harm to clients (Lawson et al., 2007). Specifically, counselors with high levels of anxiety are less competent and capable in their practice (Bandura, 1956; Kelly et al., 1989). Partially due to this, the American Counseling Association Code of Ethics requires counselors to monitor and seek assistance concerning their wellness (American Counseling Association [ACA], 2014). Ideally, counselor educators can teach helping skills to prevent burnout in counselor trainees before impairment begins. Little

research is available regarding empirically-based methods of reducing burnout in counselors in order to help protect counselor and client.

Resilience

Osborn (2004) called for a shift in counseling from prioritizing burnout prevention, which can deplete resources, to focusing on counselor stamina, resiliency, and endurance. Resilience is a process of environmental influences that serve to protect individuals, or help them bounce back from, the harmful psychological effects of severe stress, enabling them to lead satisfying lives (Bogar et.al., 2006). Resilience is characterized as the ability to adapt to or recover from the perception of adversity (Hodges et al., 2008). It can be inherent, genetic, or learned (Wagnild, 2009). The Resiliency Model describes stages of “biopsychospiritual homeostasis, interactions with life prompts, disruption, readiness for reintegration and the choice to reintegrate resiliently, back to homeostasis, or with loss” (Richardson et al., 1990, p. 310). Wagnild, and Young (1990) identified 5 factors of resilience, termed the Resilience Core, which consists of purpose, perseverance, equanimity, self-reliance, and existential aloneness (authenticity). Resilience has been found to be a predictor of lower psychological distress, burnout, and secondary traumatic stress (Harker, et al., 2016).

A survey of mental health professionals (N= 148) found mindfulness as a significant mediator between well-being and self-care (Richards et al., 2010). In another study of counselors (N = 98) daily spiritual experiences and gratitude were significant negative predictors for burnout (Browning et al., 2019). Klimecki et al. (2014) found compassion led to positive affect after research participants experienced burnout as an effect of empathy training. From this, it was theorized that compassion practice may promote resilience. Two of the hypotheses in the current study are in response to the theory that compassion may promote resilience. Counselors, since

they are trained in dimensions of empathy, may benefit from training in compassion as well to promote resilience.

Predictors of Burnout and Resilience

Predictors of Counselor Burnout

There are inconsistencies in the literature regarding factors that contribute to counselor burnout. Maslach (2003) identified several environmental variables that lead to counselor burnout such as work overload, lack of control, and unsupportive work environment. Women have been found to experience higher levels of compassion fatigue than men (Star, 2013, Sprang et al., 2007). Similarly, Sprang et al. (2007) also found a relationship between gender and burnout, yet these findings are not mirrored in other studies (Gonzalez et al., 2019; Harker et al., 2016; Thompson et al., 2014). Counselor age also has a negative correlation with burnout (Browning et al., 2019). Counselors work setting alone is also predictive of burnout (Lakioti et al., 2020; Star, 2013). For example, counselors in private practice report less burnout than other settings (Lent & Schwartz, 2012; Sprang et al., 2007). On its own, years of experience has also shown to have a significant inverse relationship with burnout (Boscarino et al., 2004; Thompson et al., 2014). While there is some evidence of personal and work-related factors that are predictive of counselor burnout, literature on whether empathy is among those factors is lacking.

Predictors of Counselor Resilience

There aren't a significant number of studies examining factors that contribute to counselor resilience. Resilience in the general population, however, has shown to have a relationship with compassion. Self-compassion has served as a protective factor against self-criticism among individuals with depression (Ehret et al., 2015). A small study (N=15) of healthcare professionals demonstrated the impact of resilience training on compassion

satisfaction and burnout over time (Klein et al., 2018). In a study of (N=75) trauma focused mental health professionals, resilience correlated with burnout, compassion fatigue, and compassion satisfaction (David, 2012). Additionally, findings suggest that social justice work can increase professional resilience for African American male counselor educators (Dollarhide et al., 2018).

Counselor Worldview

In addition to age, years of experience, and work setting, there are likely other horizontal factors related to empathy and compassion and how these may predict counselor burnout and resilience. A counselors' worldview can be indicative of dispositions, such as empathy, towards clients (Solomonov & Barber, 2019). These factors include aspects of the sociopolitical climate that counselors are practicing within (Solomonov & Barber, 2019). Student training and counseling practice do not occur within a vacuum (von Raffler-Engel, 1989). Instead, a counselors' political affiliation relevant to the level of client similarity may impact counselor empathy (Gartner et al., 1990; Solomonov & Barber, 2019). While this points to a trait-type of empathy, which is not being measured in this study, dispositional empathy and compassion may also be related to political affiliation (Hasson et al., 2018).

There is a lack of research within counselor education regarding political identity (LaMothe, 2010). Political identity, however, is a salient component of counselor identity (Bayne). Generally, political identity includes the degree to which an individual holds beliefs about political and social issues tied to their political affiliation (Rekker et al., 2017). These beliefs are formed from cultural and familial influences in adolescence and adulthood (Rekker et al., 2107). Once formed, dissimilar views are often dismissed (Kaplan et al., 2016). Interestingly, and relevant to this study, neural processes in the brain change

depending on when an individual with strong political beliefs is willing to consider counterarguments (Kaplan et al, 2017). Through fMRI studies, some of the same regions involved in empathy are activated, such as the insula (Kaplan et al., 2017).

Counselors may be in a position to use empathy and/or compassion in response to clients discussing their own political identities and resulting experiences. Counselors are required to include clients intersecting cultural identities without imposing their own political values (ACA, 2014). On a neurological level, it can be difficult to suspend one's own political views (Kaplan et al., 2017). This may be especially challenging given that there is a disproportionate representation of political liberalism among mental health professionals compared to the general public (Jones, 2019). This phenomenon is seen in a qualitative study (N=16) that found turning away and turning towards behaviors in response to relationships with people with different political ideology during the 2016 U.S. presidential election (Bayne et al., 2020). Empathy and compassion may be used by counselors to overcome the political divide with clients.

Since there is current literature pointing to a relationship among political identity, empathy, and compassion, it is a variable of interest in the current study. On the other hand, the literature does not reflect a clear relationship among political identity, burnout and resilience. For this reason, political identity is hypothesized to contribute to counselor burnout and resilience only within empathy and compassion models.

Empathy, Compassion, Burnout, and Resilience

Despite interest in the field of counseling generated around compassion-based practices and the consequences of empathy, research is yet to include findings from relevant neuroscientific advances. There are, however, a few studies analyzing a portion of the variables

of interest in this study, but not within the same sample and not in counselors. For example, in a sample of medical students (N=353) high levels of personal distress related to empathy were predictive of increased levels of burnout (von Harscher, 2018). In this study, empathic concern alone was related to low levels of burnout. In a sample of counselors-in-training (N=86) aspects of empathy were not predictive of compassion satisfaction, which is partially made up of burnout (Can & Watson, 2019). These two studies are in contrast to the neuroscience findings that empathy leads to burnout.

In contrast to the literature that indicates empathic concern (a subfactor of empathy) is predictive of lower levels of burnout, other studies found no relationship. In a sample of medical physicists, empathy was found not to have a relationship at all with burnout (Di Tella et al., 2020). The results with medical students suggest that while empathic concern alone does not predict burnout, the personal distress that is a part of empathy, does. In the sample of counseling students, burnout scores were not directly analyzed. The various findings in the relationship between empathy and burnout may be job specific since many of the instruments were similar, if not the same, in these studies.

Studies have also been conducted looking at the relationship between compassion and resilience, but not in counselors. In study of college students (N=296) self-compassion was shown to have a significant relationship with resilience (Shebuski et al., 2020). In a similar study self-compassion training was found to statistically increase resilience (Smeets et al., 2014). These two studies seem consistent with fMRI studies where compassion is theorized to predict resilience based on brain functioning.

There are no known studies analyzing empathy, compassion, burnout, and resilience in the same sample, let alone in a sample of counselors who may be most impacted by this type of

analysis. Literature reflecting an analysis among some of these variables in non-counselor samples are also sparse. To address this gap in the literature, the present study will test emerging neuroscience theories of empathy and compassion as respectively predictive of burnout and resilience in counselors.

Summary

In summary, empathy has been taught and practiced within the counseling field for decades. Counselors are already at-risk for high rates of burnout from exposure to client case material (Bride, 2004; Maslach & Coldberg, 1998). It is possible that the use of empathy may exacerbate experiences of burnout (Klimecki et al., 2014). Within contemplative neuroscience studies, compassion training was found to mitigate the impact of negative feelings resulting from empathy training (Klimecki et al., 2014). Consequently, empathy is theorized to lead to burnout and compassion is thought to lead to resiliency.

Empathy requires perspective sharing, which can lead to short-term personal distress, along with the added step of regulating emotions to differentiate experiences of self from experiences of others (Klimecki et al., 2014). The experience of placing oneself in another's worldview "as-if" activates the pain network within the brain (Klimecki et al., 2014). Given this, the theory that empathy leads to burnout is plausible. Since compassion does not require fantasizing and perspective taking, but instead requires noticing suffering of others with the desire to alleviate it, there seems to be no added steps of emotional regulation and differentiation of self from other. This lends itself towards working as a protective factor in how relatedness can occur. It is possible that compassion could lead to resilience and mitigate, or reduce, burnout in counselors from the use of empathy. There is a growing body of conceptual literature in the counseling field questioning the role that empathy may play in burnout. Most recently, Phillips

(2020) suggests that empathy may contribute to counselor burnout and recommends self-compassion as a method of self-care.

This study aims to address the gap in the literature regarding empathy as a possible factor in counselor burnout, as theorized in recent fMRI studies. While compassion has previously shown to have a relationship with multiple positive mental health outcomes, including resilience, no clear evidence exists where a full conceptualization of compassion (by combining self-compassion and compassion towards others) is analyzed as a predictor of counselor resilience. The second aim of the study is to address this gap within the literature to better understand the role compassion may play in counselor resilience.

CHAPTER 3

METHODOLOGY

The purpose of this study is to determine if professional counselor's empathy and compassion scores are predictive of either resiliency or burnout. The Methods Chapter will be divided into four subsections. First, the characteristics of the participants will be described. Second, the psychometric properties of each instrument will be detailed. The Interpersonal Reactivity Index will be used to measure empathy. The Sussex-Oxford Compassion Scales for self and others will be used to measure compassion. The Resilience Scale will be used to measure counselor resilience. The Professional Quality of Life scale will be used to measure burnout. The Marlowe–Crowne Social Desirability Scale (Short Form II) will be used to identify participants data that is high in the response bias of social desirability. A researcher created Demographic Questionnaire will be used to gather information related to each participant. Third, procedures will be described about the research design and how data will be collected. Finally, the use of multiple regressions to analyze the data will be discussed.

Participants

Inclusion and Exclusion Criteria

Inclusion criteria includes participants who are (a) practicing either as a student, post graduate counselor, or school counselor and (b) practicing at the time of the study. Exclusion criteria will include (a) counselors or students who are not currently engaged in the practice of counseling clients, (b) other mental health professionals such as social workers, marriage and family therapists, art therapists, psychologists, or other clinicians in related fields. Demographic information (i.e., gender, age, race, ethnicity, religious group identity, credentials, primary language, and highest degree) were collected within the survey. Work setting, specifically, is

divided into categories consistent with research findings. Categories include inpatient mental health facility, outpatient facility, medical setting, private practice, residential treatment setting, K-12 school, college and / or university, and community based mental health center. Additional data regarding participants information which has shown to correlate with burnout, compassion, and empathy will be collected. This information includes political affiliation (Lawrence, 2016; Mankiw, 2016), years of experience in counseling (Boscarino et al., 2004; Thompson et al., 2014), and workplace setting (Lent & Schwarts, 2012).

Sampling & Recruitment Method

The total sample size estimation is based on a G*Power (Erdfelder et al., 1996) a priori power analysis for a linear multiple regression with a fixed model, R^2 deviation from zero with four predictors. With a medium effect size ($f^2 = .15$), the alpha level = .05, and the minimum power recommendations of .08 (Balkin & Sheperis, 2011) the total sample size for this study is $N = 85$ (Faul, 2009; Faul 2013). A multistage, or clustering procedure, was used to identify organizations that are likely to have groups of people that meet the inclusion criteria. Snowball sampling was also used to encourage distribution of the participant recruitment process. Participants were recruited through listservs such as the Counselor Education and Supervision Network (CESNET), social media and distributed to other counseling organizations including state counseling associations. Recipients of the recruitment email were encouraged to distribute to other counselors and counseling organizations.

Research Design

This study aims to understand the relationship among empathy, compassion, resilience and burnout in professional counselors. A survey design is best suited for collecting this data. Survey data includes the use of questionnaires to gather self-reports. In this study, self-reports

were used to gather data on demographics of participants as well as empathy, compassion, resiliency, and burnout scores in counselors. Data was collected cross-sectionally, at one point in time. Surveys were dispersed, and data collected through the internet. This is advantageous as it enabled participants to respond from across the country, does not require cost, data is available directly after participants complete the survey, and is convenient to the participant.

Instruments

Interpersonal Reactivity Index (IRI)

Davis's (1980) Interpersonal Reactivity Index (IRI) was used to measure participants' empathy. The brief form of the index will not be used due to two of the subscales (empathic concern and perspective taking) not having adequate reliability (Ingoglie, et al., 2016). The IRI measures dispositions to empathic responsiveness for adults. The index has four clear subscales, two cognitive and two emotional. Dimensions of this scale measure personal distress (PD), perspective taking (PT), empathic concern (EC), and fantasy (FS). Personal distress measures feelings of personal unease and anxiety in tense interpersonal settings. Perspective taking measures the spontaneous adoption of another person's point of view. Empathic concern measures the feelings of sympathy and concern for the misfortune. Fantasy measures the tendency for respondents to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays. Higher scores on each subscale, and totaled together, indicate higher levels of empathy (Davis, 1980).

The IRI has 28 scale items, a clear and coherent factor structure, and meaningful association with external criteria. It also has measurement invariance across gender and age, and adequate internal consistency. The final version of the IRI was normed in 1,161 college students (579 men and 582 women). Alpha coefficients for each subscale range from .75 to .78. Items are

answered on a five-point Likert scale ranging from 1 “*Does not describe we well*” to 5 “*Describes me very well.*” A sample item is “I often have tender, concerned feelings for people less fortunate than me” (Davis, 1980).

The IRI has been used in counselor education research to measure empathy in counseling students after LKM (compassion) training where the coefficient alpha = .76 (Leppma & Young, 2014), empathy levels, specifically empathic concern and perspective taking, in parents attachment orientation where the coefficient alpha for empathic concern = .71 and perspective taking = .77 (Ruckstaetter, 2017), and empathy levels, specifically perspective taking, in adult attachment styles where the coefficient alpha = .86 (Corcoran & Mallinckrodt, 2000).

Sussex Oxford Compassion Scale for Others (SOCS-O)

The Sussex-Oxford Compassion Scale for Others (SOCS-O) is a 20-item self-report survey that measures compassion toward others. Responses to items are given on a five-point Likert-type scale ranging from 1 “*Not at all true*” to “*Always true*”. The SOCS-O has five subscales measuring the recognition of suffering in others, understanding the universality of suffering, feeling for the person suffering, tolerating uncomfortable feelings, and acting or being motivated to act to alleviate suffering. Each dimension is represented by four items. An example of a scale item measuring the recognition of the suffering of others is “I recognize signs of suffering in others.” The scale was normed in two stages, once with 1,319 healthcare workers and then with 371 college students where Cronbach’s alpha coefficient = .94 and subscales ranging from .74 to .92 (Gu et al., 2019) suggesting excellent internal consistency. Total scored range from 20 to 100 by adding responses from all items. A higher score indicates higher levels of compassion towards others. Since this scale is fairly new at the time of this study, it has not

been used in many research studies. In a recent study, SOCS-O was used to measure compassion as it relates to empathy and altruism (Nilsson & Minelius, 2020).

Sussex-Oxford Compassion Scale for Self (SOCS-S)

The Sussex-Oxford Compassion Scale for Self (SOCS-S) is a 20-item self-report survey that measures compassion toward self. This scale is included in addition to the SOCS-O for two reasons. First, including compassion towards self is consistent with contemplative studies and mindfulness traditions where compassion is operationalized as kindness towards others as well as self. Secondly, Americans in compassion training tend to lack the assumed skill of having compassion towards self as a prerequisite for extending the compassion to others (Jinpa & Bullard, 2020). Since this study was conducted within the U. S., data is being collected on both compassion towards self and others as a way to avoid the assumption that participants have the self-compassion skills as part of compassion towards others.

Responses to items in the SOCS-S are given on a five-point Likert-type scale ranging from 1 “*Not at all true*” to 5 “*Always true*”. The SOCS-O has five subscales measuring the recognition of suffering in self, understanding the universality of suffering, feeling for self when suffering, tolerating uncomfortable feelings, and acting or being motivated to act to alleviate one’s own suffering. Each dimension is represented by four items. An example of a scale item is “When I am upset, I try to do what’s best for myself.” The scale was normed in two stages, once with 1,319 healthcare workers and then with 371 college students where Cronbach’s alpha coefficient = .93 and subscales ranging from .75 to .92 (Gu et al., 2019) suggesting excellent internal consistency. Total scored range from 20 to 100 by adding responses from all items. A higher score indicates higher levels of self-compassion.

14-Item Resilience Scale (RS)

The 14-Item Resilience Scale (RS-14) is a self-report survey created to measure capacity towards resilience, with a focus on strengths and what is going right (RS-14; Wagnild, 2009). The shorter form was adapted from the original 25-item Resilience Scale questionnaire (RS; Wagnild & Young, 1993). Items are rated on a seven-point Likert-type scale from 1 “*Strongly disagree*” to “*Strongly agree*.” Items are scored by summing all responses which ranges from 14 to 98, with higher scores indicating higher resilience. An item example is “When I’m in a difficult situation, I can usually find my way out of it.” This instrument has displayed strong internal consistency in behavioral health responders where Cronbach’s alpha = .92 (Gonzalez et al., 2019).

Professional Quality of Life (ProQOL)

The Professional Quality of Life (ProQOL, Stamm, 2010) instrument measures positive and negative workplace impacts from the previous 30 days. The ProQOL is made up of compassion satisfaction and compassion fatigue (secondary traumatic stress and burnout). In this study, the items related to burnout will be used. A sample item from the ProQOL is “I feel worn out because of my work as a [helper].” This self-report survey consists of 30 items and is rated on a five-point Likert-type scale ranging from 1 “*Never*” to 5 “*Very often*.” Scores are summed with higher numbers indicating higher levels of burnout. This instrument has moderate to strong internal consistency with a mental health population where Cronbach’s alpha = .79 (Thompson et al., 2014). The ProQOL has been used in the counseling field to measure burnout in counselors as a result of wellness-based supervision (Callender & Lenz, 2018), to understand professional counselors level of burnout in a normative cross-sectional sample (Lawson & Myers, 2011), in substance abuse counselors who work with offenders (Perkins & Sprang, 2012), and most

relevant to this study, to measure the relationship between burnout and self-compassion in student counselors (Beaumont et al., 2016).

Marlowe–Crowne Social Desirability Scale (Short Form II)

Participants also completed the MCSDS Short Form II to identify participants with the response bias of social desirability (MC-II; Loo & Thorpe, 2000; Strahan & Gerbasi, 1972). This scale is a 10-item instrument shortened from the original 33-item Marlowe–Crowne Social Desirability Scale (Crowne & Marlowe, 1960). The MCSDS is one of the most widely researched social desirability scales (Beretvas et al., 2002; Fischer & Fick, 1993). A sample item from the scale is, “I have never intensely disliked someone.” Participants respond by indicating each item as either true or false. The scale can range from 0 to 10, with higher scores indicating a higher response bias. This scale has a high correlation ($r=.90$) with the original 33-item MCSDS (Strahan & Gerbasi, 1972).

Research Created Demographic Questionnaire

A researcher created 14-item Demographic Questionnaire was used to gather traditional demographic information along with items related to variables that have previously shown to have relationships with burnout, resilience, empathy, and / or compassion. The Demographic Questionnaire includes questions related to age, racial, ethnic, and cultural group identity; biological sex; transgender identity; primary language; religious, spiritual, and belief identification; number of clients seen weekly; years in practice; professional status; degree(s) earned; field of study; credentials; work setting; and political affiliation.

Ethical Considerations

Ethical considerations for this study include the use of a dissertation committee, researcher completed Collaborative Institutional Training Initiative Program, a review process

from the university, intentionality in the process of recruiting participants, communicating details about the study to potential participants, obtaining informed consent, and safeguarding confidentiality during data collection and analysis. CITI Program completion and Institutional Review Board (IRB) approval was sought prior to any other steps in this study. In addition, the dissertation committee was utilized throughout the study design process, participant recruitment, data collection, and analysis.

An email outlining the details of the study along with any known benefits and risks (potential breach of privacy) was sent to potential participants. Included in the recruitment email is contact information for the primary researcher, dissertation committee chair member, and the IRB at Mercer University. The email also included the voluntary nature of the study and approximate time needed to complete the survey. An incentive was given for the study in the form of a \$100.00 Amazon Gift Card to one participant chosen randomly. This incentive was not expected to cause distress to participants, or those who choose not to participate. The incentive was expected to increase the likelihood of participation in the study.

Within the recruitment email was an anonymous link to the study within Qualtrics. Informed consent was required in order for participants to participate in the study. All data collected within Qualtrics is anonymous, except if participants chose to enter into the raffle for the incentive at the end of the study. At the end of the study participants were given the option to enter into a raffle for a \$100.00 Amazon Gift Card by entering an email address for the gift card to be sent. The incentive winner was chosen at random prior to the exportation of data. All email addresses were removed from the data spreadsheet exported for analysis.

Preventative measures were used to safeguard the confidentiality of participants data collected through this study. Confidentiality of data was maintained by using Qualtrics, which is

password protected. All data was kept in the primary researcher's computer which is also password protected. Exported data was kept within excel and SPSS in a password protected file on the researcher's computer. Email addresses or other identifying information was not be shared.

Data Collection

Upon Institutional Review Board (IRB) approval, a letter of recruitment was posted on counseling listservs such as CESNET, social media, through electronic-mail, and other forms of communication that described (a) the details of the study and the benefit to the profession, (b) clear parameters of the anonymity of the responses, (c) a description of what participation would entail, (d) details about an incentive of a \$100.00 Amazon gift card, (e) inclusion criteria for participation, (f) IRB and Mercer University contact information, and (g) any known risks (potential breach of privacy), and (h) a request for the recipients participation in the study.

Respondents who selected the link in the letter of recruitment were directed to a Qualtrics survey on the internet. The survey contained the following: (a) a consent for research, (b) demographics questionnaire, (c) items on the compassion, empathy, resiliency, and burnout scales, (d) and an option to provide an email address to be entered into, and notified if randomly selected, for the raffle for the Amazon Gift Card. The consent for research contained the approved consent information approved by the IRB. Participants first saw information about informed consent that explained that transmission of survey data via the internet as not always being secure and that complete confidentiality of the data could not be guaranteed. Participants will be told, however, that once the data is received by the researchers, steps to maintain confidentiality were followed. Steps to protect participants data included (1) gathering data through the password protected website Qualtrics, (2) storing and accessing participant data on

the researcher's password protected computers, (3) assuring that email addresses are only seen by the primary researcher, and (4) email addresses were kept separate from other data include demographic information.

Participants who agree to the informed consent statement (agreement will be indicated by clicking on text reading "I have read this page, and I would like to take this survey") were given the survey, which included demographic information, and items on the compassion for self and others scales, empathy, and burnout scales. Participants were given an option of giving their e-mail address for entry and notification of winning the raffle. No other identifying information was collected.

To reduce including incorrect data in the analysis four measures were used. First, the recruitment email was only be posted on counseling related sites. Secondly, inclusion criteria was included in the recruitment letter. Thirdly, one of the demographics survey questions validates the profession and credential(s) of the respondent. Lastly, the 13-item Marlowe-Crowne Social Desirability (MCSDS) was used to determine the response bias of social desirability.

Statistical Analysis

A descriptive analysis was conducted based on all variables (scores on empathy, compassion, resiliency, and burnout). Preliminary data analysis was conducted to determine the estimated sample size for power, test for normality, and to obtain descriptive statistics on demographic information and each of the research variables. Correlations were conducted to analyze the relationships among the variables and to determine the variables to include in the regression models. Lastly, multiple regressions were used to analyze the predictive relationship among criterion and predictor variables.

Multiple Regression

Within SPSS, a multiple regression allows for multiple predictor variables to predict a criterion variable (Steinberg, 2011). In this study, data analysis will be conducted to determine if professional counselors' scores on empathy or compassion are a better predictor for resilience or burnout. A multiple regression was used to determine whether empathy or compassion was a better predictor of counselor resilience. Both empathy and compassion were entered as predictor variables in order to compare the significance and degree to which each variable was predictive of resilience. A regression was also used to determine if empathy or compassion was a better predictor of counselor burnout. Both empathy and compassion were entered as predictor variables in order to compare the significance and degree to which each variable was predictive of burnout. Multiple regressions were also used to answer the last two research questions regarding the best model to predict both counselor burnout and resilience. Predictor variables were chosen by analyzing the significance of their relationship in the correlation matrices.

CHAPTER 4

RESULTS

Chapter four describes the statistical analyses and results of the hypothesis testing in this study. Hypotheses in this study are (1) compassion is a better predictor of resilience than empathy, (2) empathy is a better predictor of burnout than compassion, (3) compassion, political affiliation, years in practice, and work setting best predict counselor resilience, and (4) empathy, political affiliation, years in practice, and work setting best predict counselor burnout.

The process of data screening is presented followed by descriptive statistics of the data sample. Preliminary statistics were conducted and presented next in this chapter. Preliminary statistics included correlational analyses of all criterion and predictor variables including subscales for the empathy and compassion inventories. Next, the statistical analysis of hypotheses testing is presented. Multiple regressions were used to test all four hypotheses.

Data Screening

Since the call for participation was sent through multiple counseling listserv's, and was encouraged to be distributed through the snowball effect, a total number of counselors who received the call for participation is unobtainable. What is known is that a total of three hundred and twenty-nine participants began the questionnaire for this study. Out of those, two hundred and seventy-four completed the survey. The data from 22 participants were removed for not meeting the inclusion criteria. Data was further screened for missing values. No missing values were identified. The final sample size ($N = 252$) was determined to be more than sufficient considering the G*Power analysis indicating a minimum of 85 participants were needed to find a statistically significant effect (Cohen, 1992). Post hoc G*Power analysis indicated statistical

power over .95 for the current study. Given the large data set, accuracy of the data set was analyzed through assessing skewness, kurtosis, and outliers (Heppner & Heppner, 2004).

In large data sets it is recommended to use histograms to test for normality (Tabachnik & Fidel, 2013). After analysis of the data, most histograms appeared to follow a normal curve. In the cases where the data did not appear evenly distributed from the mean, boxplots were used to determine if outliers were within three standard deviations from the mean (Leys et al., 2013). Of these, five boxplots showed outliers outside of three standard deviations (SOCS-S, SOCS-O UUS, SOCS-O FFPS, SOCS-O AMARS, and RS). In deciding to remove outliers, all data was assessed through skewness and kurtosis values using a ± 2 range (Garson, 2012). The values for both skewness and kurtosis were within an acceptable ± 2 range for all subscales including the five scales in question. Outliers were retained since skewness and kurtosis were within an acceptable range.

Descriptive Statistics

Researcher Created Demographic Questionnaire

Total participants in this study equaled two hundred and fifty-two (N=252). A high-level summary describing the sample is presented. The personal and professional descriptive statistics from the Researcher Created Demographic Questionnaire are presented separately in Table 1 and Table 2. Overall, the mean age of participants in this study is 40.5. Participants in this study are mainly female (85.7%) White / European American (81.3%). The majority of participants in this study have one to 10 years of experience (67.5%) and work in private practice (27.8%). Most of the sample are credentialed as a clinical mental health counselor (72.2%). The political affiliation most represented in this study is Democratic (71%). The majority of participants scored low

(63.9%) and moderate (36.1%) on the burnout scale. Similarly, most participants scored moderately high on resilience (42.5%) followed by moderately low resilience (23.8%).

Personal Demographics

Table 1 shows the frequencies of personal characteristics in the Researcher Created Demographics Questionnaire. Participants mean age is 40.5. Participants gender were female (85.7%), male (13.5%), and transgender (.4%). Participants ethnicity were European American / White (81.3%), African American / Black (7.1%), Latino/a or Hispanic (3.6%), Asian or Pacific Islander (3.2%), Biracial (.8%), Middle Eastern (.8%), Native American (.8%), White / Native American (.8%), African American / Hawaiian (.4%), Eastern European (.4%), and White / Spanish (.4%). The majority of participants' political affiliation was democrat (71%), followed by republican (17.1%), libertarian (7.9%), and green (4%).

Table 1*Personal Demographic Characteristics*

Personal Variables	<i>M</i>	Range	n	%
Age (in years)	40.50	20-73	252	
Gender				
Female			216	85.7
Male			34	13.5
Transgender			1	.4
Ethnicity				
European American / White			205	81.3
African American / Black			18	7.1
Latino/a or Hispanic			9	3.6
Asian or Pacific islander			8	3.2
Biracial			2	.8
Middle Eastern			2	.8
Native American			2	.8
White / Native American			2	.8
African American / Hawaiian			1	.4
Black / Latino/a			1	.4
Eastern European			1	.4
White / Spanish			1	.4
Political Affiliation				
Democrat			179	71
Republican			43	17.1
Libertarian			20	7.9
Green			21	4.0

Professional Demographics

Table 2 shows the frequencies of the professional characteristics in the Researcher Created Demographics Questionnaire including years practicing, work setting, and the type of credential held by participants. Over 20 different credentials were reported by the participants in this study, therefore; credentials were grouped into categories of clinical mental health counseling credentials (licensed professional counselor, national certified counselor, licensed mental health clinician), school counseling credentials (national certified school counselor, state certified school counselor), both clinical mental health counseling credentials and school

counseling credentials (clinical mental health counseling credentials plus state or national school counseling credentials), and no credentials (student status). Most participants had clinical mental health counseling credentials (72.2%), followed by no credentials / student status (11.9%), then school counseling credentials (10.7%), and the least represented credential being participants with both clinical mental health counseling credentials and school counseling credentials (5.2%).

Years of practice varied from less than a year to over 41. Participants had been practicing counseling less than a year (9.5%), one to five years (35.7%), six to 10 (21.8%), 21 – 25 (6.7%), 26-30 (2.4%), 31 – 35 (1.2%), 36 – 40 (2%), and more than 41 years (.8%). Participants reported providing counseling in the following work settings: private practice (70%), outpatient (20.6%), k-12 school (18.3%), college / university (11.5%), medical setting inpatient (4.4%), other (3.6%), medical facility (2.4%), and residential (1.6%).

Table 2*Professional Demographic Characteristics*

Professional Variables	n	%
Years Practicing		
< 1	24	9.5
1-5	90	35.7
6-10	55	21.8
11-15	29	11.5
16-20	21	8.3
21-25	17	6.7
26-30	6	2.4
31-35	3	1.2
36-40	5	2.0
> 41	2	.8
Work Setting		
Private practice	70	27.8
Outpatient	52	20.6
K-12 school	46	18.3
College or University	29	11.5
Community-based	25	9.9
Inpatient	11	4.4
Other	9	3.6
Medical facility	6	2.4
Residential	4	1.6
Credentials		
Clinical Mental Health Counselor	182	72.2
None / Student Status	30	11.9
School Counselor Credential	27	10.7
Both	13	5.2

Predictor Variables

Table 3 shows the descriptive statistics for predictor variables including the mean, standard deviation, possible range, and Cronbach's alpha for each scale. The IRI ($M = 70.47$, $SD = 10.734$, $\alpha = .803$), SOCS-S ($M = 78.14$, $SD = 9.701$, $\alpha = .926$), SOCS-O ($M = 86.72$, $SD = 7.184$, $\alpha = .89$), and MCSDS ($M = 5.25$, $SD = 1.949$, $\alpha = .58$). All scales had robust to high internal reliability except the Marlowe-Crowne Social Desirability Scale Short Form II with

satisfactory internal reliability ($\alpha = .58$) and the SOCS-O subscale for tolerating uncomfortable feelings ($\alpha = .65$) which had adequate internal reliability (Tabler, 2018).

Table 3

Descriptive Statistics for Predictor Variables

Predictor Variable	<i>M</i>	<i>SD</i>	Variance	Possible Range	α
IRI Total	70.47	10.734	115.222	0-96	.803
IRI-FS	17.85	5.162	26.646	0-28	.78
IRI-PT	21.11	3.509	12.311	0-28	.721
IRI-EC	22.75	3.639	13.240	0-28	.71
IRI-PD	8.76	4.920	24.206	0-28	.814
SOCS-S Total	78.14	9.701	94.701	20-100	.926
Recognizing suffering	15.91	2.374	5.634	4-20	.851
Understanding universality of suffering	18.98	1.408	1.873	4-20	.712
Feeling for the person suffering	14.27	2.757	7.60	4-20	.841
Tolerating uncomfortable feelings	13.87	2.784	7.753	4-20	.812
Acting/motivated to relieve suffering	15.11	2.740	7.510	4-20	.876
SOCS-O Total	86.72	7.184	51.612	20-100	.89
Recognizing suffering	17.06	1.963	3.813	4-20	.842
Understanding universality of suffering	19.07	1.377	1.896	4-20	.757
Feeling for the person suffering	17.30	2.036	4.146	4-20	.77
Tolerating uncomfortable feelings	16.87	1.908	3.639	4-20	.651
Acting/motivated to relieve suffering	16.43	2.397	5.744	4-20	.83
MCSDS	5.25	1.949	3.798	0-10	.583

Note. IRI = Interpersonal Reactivity Index, FS = Fantasy Scale, PT = Perspective Taking, EC = Emotional Concern, PD = Personal Distress, SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Self, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II

Criterion Variables

Descriptive statistics including mean, standard deviation, variance, possible range, Cronbach’s alpha, and frequencies for the criterion variable are shown on Table 4. Burnout (ProQOL-BO) ($M = 20.99$, $SD = 5.515$, $\alpha = .807$) has three levels (Stamm, 2010) where

participants scored low (63.9%), moderate (36.1%), and high (0%). Resilience (RS) ($M = 83.91$, $SD = 8.141$, $\alpha = .872$) has six levels (Wagnild, 2009) where participants scored very low (.4%), on the low end (1.2%), moderately low (22%), moderately high (42.5%), and high (23.4%). Cronbach's alpha is above .7 for each scale and considered to have good internal reliability (Kline, 2000).

Table 4
Descriptive Statistics for Criterion Variables

Criterion Variable	<i>M</i>	<i>SD</i>	Variance	Possible Range	α	n	%
ProQOL-BO	20.99	5.515	30.410	10-50	.807	252	
Low				10-22		161	63.9
Moderate				23-42		91	36.1
High				43-50		0	0
RS	83.91	8.141	66.279	14-98	.872	252	
Very low				14-56		1	.4
On the low end				57-64		3	1.2
Moderately low				65-73		22	8.7
Low				74-81		60	23.8
Moderately High				82-90		107	42.5
High				91-98		59	23.4

Note. ProQOL-BO = Professional Quality of Life Burnout Scale, RS = 14-item Resilience Scale.

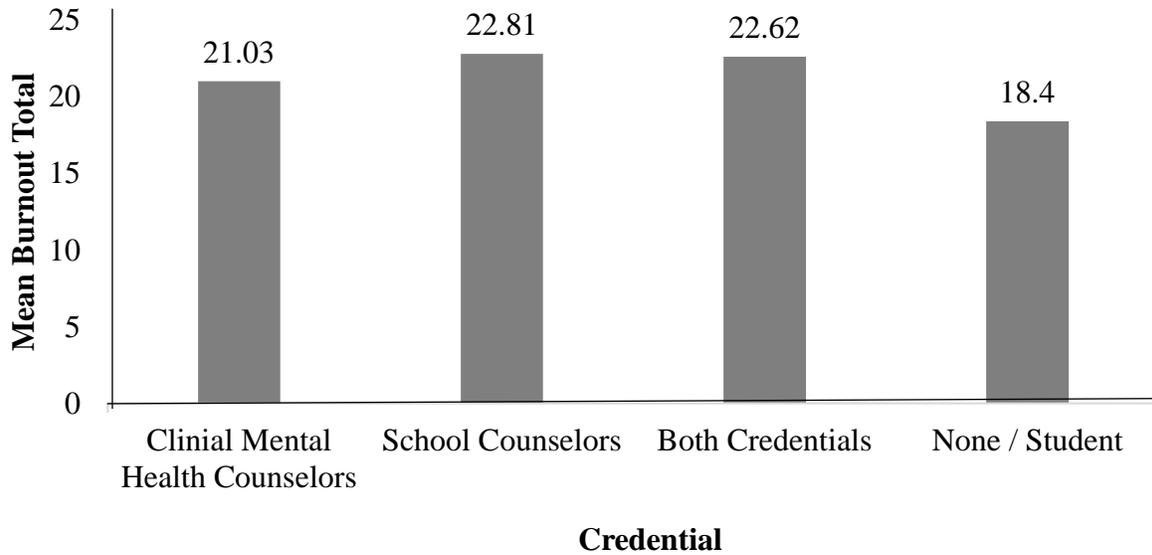
Burnout in Clinical Mental Health Counselors and School Counselors

Interestingly, compassion for self and others, empathy, and resilience scores were very similar among the types of professionals in this study. As evident in Figure 1 burnout scores, however, varied the most among clinical mental health counselors, school counselors, counselors who were both school and professional counselors, and counseling students who were not yet credentialed. Students scored the lowest in burnout ($M = 18.40$), followed by professional

counselors ($M = 21.03$), then counselors who held both school and professional counseling credentials ($M = 22.62$), and the highest being school counselors ($M = 22.81$).

Figure 1

Burnout Scores Based on Credential Type



Preliminary Analysis

Correlations Among Predictor and Criterion Variables

Table 5 shows the main predictor and criterion variables in this study, not including the subfactors or dimensions of the scales. Multicollinearity was assessed for significant relationships with a Pearson coefficient of $r = .7$ or more. No correlations of this strength are noted. Counselors who have practiced one to five years have a significant medium positive relationship with empathy ($r(250) = .27, p < .01$). The work setting of private practice has a small positive relationship with self-compassion ($r(250) = .20, p < .01$). Counselors identifying as libertarian have a small negative relationship with self-compassion ($r(250) = -.19, p < .01$). Republicans, on the other hand, have a small positive relationship with self-compassion ($r(250)$

= .13, $p < .01$) and a small negative relationship with burnout ($r(250) = .15, p < .05$).

Republicans have a small positive relationship with resilience ($r(250) = .19, p < .01$). Social desirability is also positively correlated with a medium effect size with compassion for others ($r(250) = .26, p < .01$) and a medium negative relationship with burnout ($r(250) = -.27, p < .01$). Burnout has a significantly large negative relationship with self-compassion ($r(250) = -.50, p < .01$), and a more moderately significant negative relationship with compassion towards others ($r(250) = -.22, p < .01$). Burnout also has a significantly small relationship with counselors working in private practice ($r(250) = .15, p < .05$) and medium negative relationship with 1-5 years of counseling practice ($r(250) = .32, p < .01$). Resilience has a small negative relationship with empathy ($r(250) = -.13, p < .05$) and a large positive relationship with self-compassion ($r(250) = .61, p < .01$). Resilience also has a medium relationship with compassion for others ($r(250) = .31, p < .01$). Work place and resilience also share a small positive relationship ($r(250) = .19, p < .01$).

Table 5*Main Predictor and Criterion Variable Correlation Matrix*

Variable	1	2	3	4	5	6	7	8	9
1. IRI	-								
2. SOCS-S	-.03	-							
3. SOCS-O	.37**	.32**	-						
4. 1-5 yrs.	.27**	-.08	.05	-					
5. PP	-.07	.20**	-.05	.00	-				
6. Lib	-.11	-.08	-.19**	-.07	.05	-			
7. Rep	-.09	.13*	.07	-.10	.00	-.13*	-		
8. MCSDS	.06	.10	.26**	.02	.03	-.01	.08	-	
9. BO	.12	-.50**	-.22**	.15*	-.32**	.01	-.15*	-.27**	-
10. RS	-.13*	.61**	.31**	-.11	.19**	-.05	.19**	.23**	-.59**

Note. IRI = Interpersonal Reactivity Index, SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Others, 1-5 yrs = time practicing counseling, PP = Private Practice work setting, Lib = Libertarian, Rep = Republican, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II, BO = Professional Quality of Life Burnout Scale, RS = 14-Item Resilience Scale.

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

Correlates of Empathy Dimensions

Table 6 shows a correlation matrix with the dimensions of empathy and all predictor criterion variables that were significant and had at least a small effect size. Burnout is correlated with three of the empathy subscales, the fantasy scale ($r(250) = .14, p < .05$), perspective taking ($r(250) = -.26, p < .01$), and personal distress ($r(250) = .35, p < .01$). Resilience is negatively correlated with the fantasy scale ($r(250) = -.16, p < .05$), positively correlated with perspective

taking ($r(250) = .32, p < .01$), and has a strong negative correlation with empathic personal distress ($r(250) = -.40, p < .01$).

Table 6

Empathy Subfactors Correlation Matrix

Variable	1	2	3	4	5	6	7	8	9
1. IRI-FS	-								
2. IRI-PT	.09	-							
3. IRI-EC	.33**	.38**	-						
4. IRI-PD	.28**	-.21**	.17**	-					
5. 1-5 yrs.	.26**	.04	.11	.21**	-				
6. Lib	0.02	-.08	-.15*	-.09	-.07	-			
7. Rep	-.16*	.10	-.03	-.07	-.10	-.13*	-		
8. MCSDS	-.09	.36**	.20**	-.18**	.02	-.01	.08	-	
9. BO	.14*	-.26**	-.08	.35**	.15*	.01	-.15*	-.27**	-
10. RS	-.16*	.32**	.07	-.40**	-.11	-.05	.19**	.23**	-.59*

Note. IRI = Interpersonal Reactivity Index, FS = Fantasy Scale, PT = Perspective Taking, EC = Emotional Concern, PD = Personal Distress, 1-5 yrs. = time practicing counseling, Lib = Libertarian, Rep = Republican, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II, BO = Professional Quality of Life Burnout Scale, RS = 14-Item Resilience Scale.

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

Correlates of Dimensions of Self-Compassion

Table 7 shows the correlation matrix for the subfactors of self-compassion with the predictor and criterion variables that were significant and had at least a small effect size. Burnout is negatively correlated with all of the subscales for self-compassion. The strongest relationship is with the subfactor describing being able to tolerate uncomfortable feelings about oneself

($r(250) = -.53, p < .01$). Resilience is positively correlated with all self-compassion subfactors.

The strongest relationship is with the subfactor tolerating uncomfortable feelings ($r(250) = .59, p < .01$). Resilience is positively correlated with understanding the universality of suffering ($r(250) = .21, p < .01$) and burnout is negatively correlated with the same ($r(250) = -.21, p < .01$).

Table 7

Self-Compassion Subfactors Correlation Matrix

Variable	1	2	3	4	5	6	7	8	9
1. SOCS-S RS	-								
2. SOCS-S UUS	.32**	-							
3. SOCS-S FPS	.52**	.28**	-						
4. SOCS-S TUF	.43**	.24**	.79**	-					
5. SOCS-S AMARS	.52**	.30**	.83**	.73**	-				
6. 1-5 yrs.	-.01	.05	-.09	-.17**	-.04	-			
7. Rep	.07	.07	.14*	.10	.12	-.10	-		
8. MCSDS	.08	.02	.10	.11	.06	.02	.08	-	
9. BO	-.32**	-.21**	-.42**	-.53**	-.44**	.15*	-.15*	-.27**	-
10. RS	.39**	.21**	.55**	.59**	.56**	-.11	.19**	.23**	-.59**

Note. SOCS-S = Sussex Oxford Compassion Scale for Self, RS = Recognizing Suffering,

UUS = Understanding the Universality of Suffering, FPS = Feeling for the person

suffering, TUF = Tolerating uncomfortable feelings, AMARS = Acting or being

motivated to act to relieve suffering, 1-5 yrs. = time practicing counseling, Lib =

Libertarian, Rep = Republican, MCSDS = Marlowe-Crowne Social Desirability Scale

Short Form II, BO = Professional Quality of Life Burnout Scale, RS = 14-Item Resilience

Scale.

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

Correlates of Compassion Dimensions Towards Others

Table 8 shows the correlation matrix for compassion towards others and the predictor and criterion variables that were significant and had at least a small effect size. Resilience is positively correlated with all of the subfactors for compassion towards others. The strongest relationship is a medium positive relationship with tolerating uncomfortable feelings about others ($r(250) = .37, p < .01$). Burnout has a negative relationship with all of the subfactors for compassion towards others except the factor describing being motivated to act to alleviate suffering. The strongest relationships is with the same factor that resilience is most positively correlated with: tolerating uncomfortable feelings in reference to someone else ($r(250) = -.30, p < .01$).

Table 8*Compassion Towards Subfactors Others Correlation Matrix*

Variable	1	2	3	4	5	6	7	8	9
1. SOCS-O RS	-								
2. SOCS-O UUS	.27**	-							
3. SOSS-O FPS	.52**	.34**	-						
4. SOCS-O TUF	.38**	.35**	.56**	-					
5. SOCS-O AMARS	.44**	.20**	.68**	.42**	-				
6. Green	.14*	-.01	.05	-.02	.02	-			
7. Lib	-.09	-.19**	-.19**	-0.10	-.16*	-.06	-		
9. MCSDS	.12	.01	.25**	.29**	.24**	.03	-.01	-	
10. BO	-.14*	-.14*	-.19**	-.30**	-0.06	.07	.01	-.27**	-
11. RS	.22**	.16*	.24**	.37**	.15*	-.07	-.05	.23**	-.59**

Note. SOCS-O = Sussex Oxford Compassion Scale for Others, RS = Recognizing Suffering, UUS = Understanding the Universality of Suffering, FPS = Feeling for the person suffering, TUF = Tolerating uncomfortable feelings, AMARS = Acting or being motivated to act to relieve suffering, 1-5 yrs. = time practicing counseling, Lib = Libertarian, Rep = Republican, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II, BO = Professional Quality of Life Burnout Scale, RS = 14-Item Resilience Scale.

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

Summary of Preliminary Analyses

Burnout is positively correlated with counselors working one to five years ($r(250) = .15$, $p < .05$), empathetic fantasy scale ($r(250) = .14$, $p < .05$), and empathic personal distress ($r(250) = .35$, $p < .01$). Burnout is negatively correlated with self-compassion ($r(250) = -.50$, $p < .01$),

compassion towards others ($r(250) = -.22, p < .01$), perspective taking ($r(250) = -.26, p < .01$), and all of the subscales for both compassion towards self and others except motivation to act to relieve suffering of others.

Resilience is positively correlated with self-compassion ($r(250) = .61, p < .01$), compassion towards others ($r(250) = .31, p < .01$), working in private practice ($r(250) = .19, p < .01$), republican affiliation ($r(250) = .19, p < .01$), social desirability ($r(250) = .23, p < .01$), empathetic perspective taking ($r(250) = .32, p < .01$), and all of the self and other compassion scales with the highest being tolerating uncomfortable feelings about oneself ($r(250) = .59, p < .01$). Resilience is negatively correlated with empathy ($r(250) = -.13, p < .01$), and empathetic personal distress ($r(250) = -.40, p < .01$).

Statistical Analysis

Given that data (i.e., political affiliation, work setting) are categorical variables, dummy coding was used to transform the data into a format that could be analyzed in a multiple regression analysis. Dummy coding requires transforming categorical data into either a “1” or “0” for each category within the variable. This transformation allows for the data to meet the criteria of being continuous for a multiple regression analysis. Subsequently, all other continuous variables (IRI and subscales, SOCS-O and subscales, SOCS-S and subscales, Resilience Scale, ProQOL Burnout Scale, MC-SDS Short Form II) grand mean centering was used to transform the data by subtracting the mean from each participants’ total score (Enders & Tofighi, 2007). This transformation provides the same zero point for all variables (Enders & Tofighi, 2007).

Research Question One

The first analysis was designed to address the first research question: Is compassion or empathy a better predictor of counselor resilience? Total scores for empathy, self-compassion, and other-compassion were entered as independent variables and total resilience score entered as

the dependent variable in a multiple regression analysis. Tests for multicollinearity and outliers were completed. Multicollinearity was assessed by checking for bivariate correlations of .7 or greater (Pallant, 2020). In addition, tolerance was assessed for coefficients less than .10 and the variance inflation factor (VIF) values above 10 (Pallant, 2020). Tolerance indicates the degree to which the criterion variable is not explained by other variables in the model and the VIF represents the inverse of the tolerance value (Pallant, 2020). The Pearson correlation coefficient for each value is well below .7, the tolerance value for each independent variable is greater than 10 (IRI = .837, SOCS-S = .871, SOCS-S = .751) and all VIF values are well below .10 (IRI = 1.195, SOCS-S = 1.147, SOCS-S = 1.332); therefore, the multicollinearity assumption has not been violated. In this model, outliers were also assessed for Mahalanobi distance by using the critical value of 16.27 appropriate for three variables (Tabachnick & Fidell, 2013). The Mahal. distance (distance from the mean) maximum value for this model is 15.74 which is below the critical value indicating no problematic outliers (Pallant, 2020).

To approach research question number one a multiple regression analysis was conducted. The predictor variables, (IRI, SOCS-S, and SOCS-O) were entered into a simultaneous regression model predicting RS (resilience in counselors). The results, shown in Table 9, show that the model was significant, $R^2 = .42, f(3, 248) = 59.30, p < .01$ indicating that 42% of the variance in resilience is explained by empathy and compassion towards self and others. All independent variables significantly contribute to resilience with compassion to self contributing the most ($\beta = 0.539, p < .01$) then compassion to others ($\beta = 0.205, p < .01$) and empathy negatively contributing the least ($\beta = -0.194, p < .01$). While all the independent variables contributed to resilience, self-compassion contributed the most to resilience, confirming the first research hypothesis.

Table 9*Regression Coefficients of Empathy and Compassion on Resilience*

Model	B	SE	β	t	p	95% CI
¹ (Constant)	38.746	5.223		7.419	0.000	[28.46, 49.03]
IRI	-0.147	0.040	-0.194	-3.657	0.000	[-0.23, -0.07]
SOCS-S	0.452	0.044	0.539	10.387	0.000	[0.36, .54]
SOCS-O	0.232	0.063	0.205	3.669	0.000	[0.12, 0.36]

Note. Dependent Variable: RS = 14-Item Resilience Scale, CI = Confidence interval, IRI = Interpersonal Reactivity Index, SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Others

Research Question Two

The second analysis was designed to address the second research question: Is compassion or empathy a better predictor of counselor burnout? To approach research question number two a multiple regression analysis was conducted. The predictor variables, (IRI, SOCS-S, and SOCS-O) were entered into a simultaneous regression model predicting BO (burnout in counselors). The results, shown in Table 10, show that the model was significant, $R^2 = .275, f(3, 248) = 31.426, p < .01$ indicating that 27.5% of the variance in burnout is explained by empathy and compassion towards self and others. All independent variables significantly contribute to burnout with empathy contributing the most ($\beta = 0.150, p < .05$), then compassion to others ($\beta = -.127, p < .05$), and compassion to self contributing the least ($\beta = -0.458, p < .01$). While all the independent variables contributed to resilience, empathy contributed the most to burnout, confirming the second research hypothesis.

Table 10*Regression Coefficients of Empathy and Compassion on Burnout*

Model	B	SE	β	T	<i>p</i>	95%CI
¹ (Constant)	44.336	3.946		11.235	0.000	[36.564, 52.108]
IRI	.077	0.030	.150	2.541	0.012	[.017, .137]
SOCS-S	-.260	0.033	-.458	-7.912	0.000	[-3.25, -.196]
SOCS-O	-.097	0.048	-.127	-2.031	0.043	[-.192, -.003]

Note. Dependent Variable: BO = Professional Quality of Life Burnout Scale

CI = Confidence interval, IRI = Interpersonal Reactivity Index, SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Others

Research Question Three

The third analysis was designed to address the third research question: What model best predicts counselor resilience? Using the correlation matrices, resilience has a significant relationship with self-compassion (SOCS-S) ($r(250) = .61, p < .01$), compassion towards others (SOCS-O) ($r(250) = .31, p < .01$), social desirability ($r(250) = .23, p < .01$), working in private practice ($r(250) = .19, p < .01$), republican affiliation ($r(250) = .19, p < .01$), empathy ($r(250) = -.13, p < .05$), empathetic perspective taking ($r(250) = .23, p < .01$), fantasy scale ($r(250) = -.16, p < .01$), and empathetic personal distress ($r(250) = -.40, p < .01$). All variables were entered into a multiple regression. It is worth noting that social desirability was added to the model since it was correlated to the criterion variable and to assess whether social desirability influenced the outcome variable.

Given that there are more predictor variables than originally hypothesized to be in the best model, another G*Power analysis was conducted to include nine predictor variables. To retain the medium effect size ($f^2 = .15$) and alpha level = .05, a sample of 114 participants are

required. The current sample size is more than double the required number of participants suggesting that the increase in predictor variables does not impact the effect size or error of probability.

The Pearson correlation coefficient for each value is well below .7, and the tolerance value for each independent variable is greater than .10 except for total empathy scores (IRI = .069) and all VIF values are well below 10 except total empathy scores (IRI = 14.574) therefore, the multicollinearity assumption has been violated due to total empathy scores. It was determined that since three of the four dimensions (subscales) of empathy were entered into the regression model, multicollinearity was high. Total empathy scores were omitted from the regression model and the analysis was conducted a second time.

In the second analysis the tolerance value for each independent variable is greater than .10 (IRI-FS = .83, IRI-PT = .67, IRI-PD = .85, SOCS-S = .79, SOCS-O = .69, MC-SDS = .83), and all VIF values are well below 10 (IRI-FS = 1.20, IRI-PT = 1.49, IRI-PD = 1.18, SOCS-S = 1.26, SOCS-O = 1.44, MC-SDS = 1.21) therefore, the multicollinearity assumption has not been violated. In this model, outliers were also assessed for Mahalanobis distance by using the critical value appropriate for eight variables (Tabachnick & Fidell, 2013). The Mahal. distance (distance from the mean) maximum value for this model is 22.49 which is below the critical value indicating no problematic outliers (Pallant, 2020).

Table 11 shows the regression coefficients for the resilience model. The model was significant, $R^2 = .50$, $F(8, 243)$, $p < .01$ indicating that 50% of the variance in resilience is explained by this model. Of the variables, only self-compassion ($\beta = .49$, $p < .01$) and empathetic personal distress ($\beta = -.27$, $p < .01$) are independently significant. In this model was Resilience = $-.620 + (.096 \text{ Compassion for Others}) + (.411^{**} \text{Self-Compassion}) + (.324 \text{ Social Desirability}) +$

(.137Empathic Perspective Taking) + (-.446**Empathic Personal Distress) + (.034 Empathy Fantasy Scale) + (1.143 Private Practice) + (1.789 Republican).

Table 11

Regression Coefficients of the Resilience Model

Model	B	SE	β	t	p	95% CI
1 (Constant)	-.620	.472		-1.315	.190	[-1.549, .309]
SOCS-O	.096	.062	.085	1.559	.120	[-.025, .218]
SOCS-S	.411	.043	.489	9.619	.000	[.327, .495]
MCSDS	.324	.208	.078	1.558	.121	[-.086, .734]
IRI-PT	.137	.129	.059	1.063	.289	[-.117, .390]
IRI-PD	-.446	.081	-.269	-5.469	.000	[-.606, -.285]
IRI-FS	-.034	.078	-.022	-.438	.662	[-.189, .120]
PP	1.143	.850	.063	1.344	.180	[-.531, 2.817]
Republican	1.789	1.004	.083	1.782	.076	[-.189, 767]

Note. Dependent Variable: RS = 14-Item Resilience Scale, CI = Confidence interval, IRI = Interpersonal Reactivity Index, SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Others, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II, IRI-PT = Perspective Taking, IRI-PD = Personal Distress, PP = private practice

It was originally hypothesized that compassion, political affiliation, years in practice, and work setting best predict counselor resilience. All of the hypothesized variables, except years in practice (because preliminary analysis showed no relationship between the two variables) were entered into the model based on a review of the literature and strong correlations among variables. The results, however, do not support the hypothesis. Even though the whole model was significant, only empathetic personal distress and an inverse relationship with self-compassion were significantly predictive of resilience.

Research Question Four

The fourth analysis was designed to address the fourth research question: What model best predicts counselor burnout? Using the correlation matrices burnout has the strongest relationships with self-compassion (SOCS-S) ($r(250) = -.50, p < .01$), compassion towards others (SOCS-O) ($r(250) = -.22, p < .01$), one to five years in practice ($r(250) = .15, p < .05$), private practice ($r(250) = -.32, p < .01$), empathy fantasy subscale ($r(250) = .14, p < .05$), empathetic perspective taking ($r(250) = -.26, p < .05$), social desirability ($r(250) = -.27, p < .01$), and empathetic personal distress ($r(250) = .35, p < .01$). All variables were entered into a multiple regression. It is worth noting that social desirability was added to the model since it was correlated to the criterion variable and to assess whether social desirability influenced the outcome variable.

Given that there are more predictor variables than originally hypothesized, another G*Power analysis was conducted to include eight predictor variables. To retain the medium effect size ($f^2 = .15$) and alpha level = .05, a sample of 109 participants are required. The current sample size is more than double the required number of participants suggesting that the increase in predictor variables does not impact the effect size or error of probability.

Table 12 shows the regression coefficients for the resilience model. The critical values for tolerance, VIF, and Mahalanobis distance were all within range indicating no outliers. The model was significant, $R^2 = .41, F(8, 243), p < .01$ indicating that 41% of the variance in resilience is explained by this model. Of the variables, private practice ($\beta = -.27, p < .01$), empathetic personal distress ($\beta = .207, p < .01$), self-compassion ($\beta = -.377, p < .01$), and social desirability ($\beta = -.159, p < .05$) are independently significant. In this model was $\text{Burnout} = 21.436 + (.899 \text{ 1-5 Years}) + (-2.774^{**}\text{Private Practice}) + (.005 \text{ Empathy Fantasy Scale}) +$

(.232**Empathic Personal Distress) + (-.068 Empathic Perspective Taking) + (-.030 Compassion for Others) + (-.214**Self-Compassion) + (-.451**Social Desirability).

Table 12

Regression Coefficients of the Burnout Model

Model	B	SE	β	t	P	95%CI
1 (Constant)	21.436	0.381		56.320	0.000	[20.686, 22.186]
1-5 yrs.	0.899	0.596	0.078	1.509	0.133	[-0.275, 2.072]
PP	-2.774	0.626	-0.226	-4.431	0.000	[-4.007, -1.541]
IRI-FS	0.005	0.058	0.005	0.085	0.933	[-0.110, .120]
IRI-PD	0.232	0.061	0.207	3.824	0.000	[0.113, .352]
IRI-PT	-0.068	0.095	-0.043	-0.723	0.470	[-0.255, .118]
SOCS-O	-0.030	0.045	-0.039	-0.651	0.515	[-0.119, .060]
SOCS-S	-0.214	0.031	-0.377	-6.829	0.000	[-0.276, -.152]
MCSDS	-0.451	0.153	-0.159	-2.943	0.004	[-0.753-.149]

Note. Dependent Variable: BO = Professional Quality of Life Burnout Scale, CI = Confidence interval, , SOCS-S = Sussex Oxford Compassion Scale for Self, SOCS-O = Sussex Oxford Compassion Scale for Others, MCSDS = Marlowe-Crowne Social Desirability Scale Short Form II, IRI=FS = Fantasy Scale, IRI-PT = Perspective Taking, IRI-PD = Personal Distress, PP = private practice

The original hypothesis for this research question included years of practice, work setting, political affiliation, and empathy as the model most predictive of burnout. The hypothesis was not supported for this question and analysis. Work setting (private practice), empathic personal distress, and inverse relationship with self-compassion, and an inverse relationship with social desirability were significantly predictive of burnout.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Chapter five provides a thorough discussion of the findings for each research question. Results for each research question are discussed in reference to the underlying contemplative neuroscience theories regarding resilience, burnout, empathy, and compassion. Implications for counselor education, supervision, and future research is given. Limitations of this study are presented.

Overview of Theory Supporting Original Hypotheses

The hypotheses tested in this study are founded in recent contemplative neuroscience research. An example of this research is from Klimecki et al. (2014) who used fMRI imaging of participants after empathy and compassion training. Results indicated that following empathy training the pain network within the brain was activated and participants reported unpleasant emotions for days after. Subsequent compassion training showed activation in non-overlapping brain regions and participants reported more pleasant emotions. These findings showed that empathy and compassion training caused very different neural network activation and emotional experiences in participants. From the results of their study, Klimecki et al. (2014) hypothesized that empathy training is likely to lead to burnout and compassion training is likely to lead to resilience.

The findings and resulting hypotheses from various contemplative studies may have strong implications for counselor training and supervision. Counselors are heavily trained to use empathy as a way to understand and connect with clients (Bayne & Jangha, 2016; Carkhuff & Truax, 1965; Clark, 2010; Skovholt, 2001). Empathic states are imperative to the therapeutic relationship and successful client outcomes (Matotta, 2003; Miller, 1983; Rogers, 1956). If the

hypotheses proposed by Klimecki et al. (2014) are correct and empathy training is related to burnout, counselors and counselor educators would benefit from knowing. Counselors are required to monitor themselves for signs of impairment (ACA, 2014). Burnout has the potential to lead to impairment (Salyers et al., 2014).

To test this, a multiple regression was used with a population of counselors to test if empathy or compassion is a better predictor of burnout. Other hypotheses originate from the second theory from Klimecki et al. (2014). Based on the fMRI studies, the researchers hypothesize that compassion training leads to resilience. The current study tests this by using a multiple regression to analyze if empathy or compassion is a better predictor of counselor resilience.

Since years of experience (Boscarino et al., 2004; Thompson et al., 2014) and work setting (Lent & Schwartz, 2012; Sprang et al., 2007) have been found to predict counselor burnout, these were included in the Research Created Demographic Questionnaire. It was hypothesized that these variables, along with political affiliation, would be significant in a model with empathy predicting burnout. Similarly, it was hypothesized that a model with years of experience, work setting, political affiliation, and compassion would predict resilience.

Discussion

The Role of Empathy in Counselor Burnout

Empathy is often discussed in terms of how it relates to the clients' experience. The results in this study, however, help to explain how the use of empathy relates to the counselors' experience. Overall, mean empathy scores in this sample of counselors are higher than non-counselor samples. Counselors in this study scored higher in overall empathy, fantasy, perspective taking, and empathic concern and less in personal distress (Davis, 1980). Counselors

also scored higher than a sample of medical students (N = 353) in emotional concern and personal distress (von Harscher et al., 2018). These findings reinforce the need for counselor educators to understand the relationship between empathy training and counselor burnout.

In this study, increased empathy, more so than an increase in compassion, is significantly predictive of counselor burnout. This supports the hypothesis that empathy and burnout are related. An important dimension of empathy measured in this study is personal distress. Some definitions of empathy don't include personal distress as part of the disposition (Clark, 2004; Singer & Lamm, 2009; Stepien & Baernstein, 2006). The results in this study help to support the finding from Klimecki et al. (2014) that empathy training activates pain networks within the brain and is experienced as empathic personal distress. This suggests that when counselors are empathetic there is a slight increase in burnout from the personal distress. It's important to note that empathy does not cause personal distress. Personal distress is a foundational component of empathy. To take the perspective of a client, to fantasize about their experiences, and to have emotional concern means also having personal distress with a predicted increase in burnout. These findings mirror those found in a sample of medical students (N=353) with high levels of personal distress related to empathy that were predictive of increased levels of burnout (von Harscher et al., 2018). They concluded that students with low emotional concern and high personal distress may be in need of resilience training to help mitigate burnout.

The other dimensions of empathy (perspective taking, fantasizing, and emotional concern) are not most predictive of burnout. Perspective taking and fantasizing, however, are correlated with burnout. Surprisingly, the more a counselor takes the perspective of the client, the less burnout they experience. It could be concluded that understanding a clients' point of view provides an increased understanding of emotion or behavior seen in the client, thus

providing a buffer against negative counselor emotional responses. The more that counselors empathetically fantasize, the more burnout they experience. These relationships are significant, but with medium to small effect sizes; therefore, it's important to not be taken out of context.

Counselors' ability to share in others' perspectives might play a small role in protecting them from burnout. Counselors who fantasize are slightly more at risk for a slight increase in burnout. Emotional concern has a non-significant relationship with burnout. This means that increases in emotional concern are not related to burnout, but the personal distress is.

Fantasizing is defined as a "respondents' tendency to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays" (Davis, 1985, p. 1). For a counselor this might be better defined as "a counselors' tendency to transpose themselves imaginatively into the feelings and actions of their clients." This empathic practice is common to counselors' reaction to their clients. Results from this study indicate that this practice is related to experiencing burnout.

Alternatively, the empathy dimension of perspective taking is correlated with less burnout. This could mean that counselors who "adopt the psychological point of view" (Davis, 1980, p. 85.) of their clients are slightly less likely to experience burnout. This contrasts empathic fantasizing, which is largely an emotional process. Perspective taking is a psychological, cognitive process. It may be reasonable to conclude that the shift from emotional to cognitive perception explains its inverse relationship with burnout.

The Role of Compassion in Counselor Burnout

Interestingly, compassion also plays a role in counselor burnout. A lack of self-compassion plays a bigger role in counselor burnout than does empathy. Compassion to others also plays a significant, albeit smaller, role in burnout as well. Statistically, self-compassion is

most predictive of burnout. Burnout is negatively correlated with all of the dimensions of self-compassion. This means counselors who are able to recognize suffering in their self, understand the universality of suffering, feeling for themselves when they are suffering, are able to tolerate their uncomfortable feelings, and are motivated to act to relieve their own suffering are much less likely to experience burnout. This may be what Leppma and Young (2016) found in a 6-week long loving-kindness meditation (LKM) study where masters-level counseling students experienced increases in dimensions of empathy as a result of LKM. LKM is a traditional form of self and other compassion training. The fact that compassion was related to empathy may help to explain how a lack of compassion and an increase in empathy is predictive of burnout.

The Role of Compassion in Resilience

Of all the variables in this study, compassion seems to be the most influential in determining both empathy and resilience. The lack of compassion (primarily self-compassion) is predictive of burnout. The more self-compassion counselors have, the more resilient they are. These findings seem to mirror those in a study of college students (N=296) where self-compassion was shown to have a significant relationship with resilience (Shebuski et al., 2020). In a similar study self-compassion training was found to statistically increase resilience (Smeets et al., 2014).

These findings are consistent with other studies that found self-compassion to improve mental health and promote resilience (Golbert et al., 2004; Trompetter et al., 2017), counteract self-criticism in individuals with depression (Ehret et al., 2015; Kaurin et al., 2018), increase nurses resilience and compassion satisfaction and decreasing secondary trauma and burnout (Delaney, 2018), reduce emotional discomfort in divorce (Sbarra et al., 2012), mediate the relationship between family/cognitive factors and well-being (Neff & McGhee, 2010), aid in

emotional regulation difficulties in psychologists (Finlay-Jones, et al., 2015), and predict emotional well-being in doctors (Sabir, et al., 2018).

These results are also consistent with contemplative neuroscience studies that have found compassion training to activate the right inferior parietal cortex (IPC) associated with the mirror neuron system and altruism (Gallese et al., 2004). Compassion also activates an up-regulation of emotions. This means that compassion has a built-in capacity in the brain to regulate emotions whereas empathy requires a secondary bottom-up process of dealing with unpleasant emotions (Weng et al., 2013). The results in this study are aligned with how neuroscientists have recently understood fMRI's in compassion states.

Counselor Burnout and Resilience

Other interesting results are the actual levels of burnout and resilience in the sample of counselors in this study. The majority of counselors scored “low” on the burnout scale. Still, over a third of the counselors reported “moderate” levels of burnout. This level of burnout is characterized by moderate levels of “hopelessness and difficulties in dealing with work or in doing your job effectively” (Stamm, 2010, p.2). Over half of counselors’ scores indicated counselors with “high” to “moderately high” resilience, followed by a little less than half with “moderately low” to “low” resilience.

Counselor Burnout and Resilience During COVID-19

It is encouraging that majority of counselors’ scores indicate low burnout and high resilience. This is especially considerable given the current coronavirus pandemic at the time of this study’s data collection and the strain on mental health clinicians, who are essential healthcare workers (Brown, 2020). Still, there are a large percentage of counselors with low resilience and moderate levels of burnout. In this study, the higher resilience is predicted by self-

compassion and lower levels of empathic personal distress. Lower levels of burnout are predicted by working in private practice, social desirability, self-compassion, and less empathic personal distress.

This study provided an opportunity to compare counselor burnout scores before and almost a year into the COVID-19 pandemic. In a national survey of counselor in 2007, the same Professional Quality of Life Scale was used to measure burnout. The sample of counselors (N = 501) had a mean score of 18.37 (SD = 6.0, $\alpha = .82$) (Lawson, 2007), which is slightly lower than the mean score in this study of 20.99 (SD = 5.15, $\alpha = .81$). Burnout has increased slightly since this time. This rise in burnout scores is to be expected given the assumed personal and professional strain on counselors during the pandemic. It is surprising, however, that burnout scores were not higher than were reported. No counselor in this study reported a “high” burnout score.

Social Desirability, Burnout, and Resilience

The Marlowe-Crowne Social Desirability Scale Short Form II was used in this study to understand the way respondents’ need for social approval may influence the self-reporting as a measure of checking the trustworthiness of the data. It is possible that social desirability helps to explain the low to moderate levels of burnout reported by counselors. Social desirability was predictive of lower levels of burnout indicating that counselors may have underreported their actual levels of burnout.

Higher levels of social desirability were correlated with counselor resilience and contributed to a model predicting resilience. Ultimately, however, it was not significantly predictive on its own. It is worth noting that the internal consistency for Marlowe-Crowne Social

Desirability Scale Short Form II was not as high as the other scales in this study. Due to this, caution should be used in overinterpreting the role that social desirability played in the results.

Counselor Political Affiliation

Data for this study was collected during two significant national sociopolitical and world events. Less than a year prior to this study, the World Health Organization (World Health Organization [WHO], 2020) declared the presence of a global pandemic due to the novel coronavirus (COVID-19). The pandemic has played a surprising role in the political climate leading up to the November 2020 presidential elections. Issues such as closing businesses, sheltering-in-place, school closures, and wearing a mask have become a symbol of the polarized political divide (Rothgerber et al., 2020). In addition, the nation has been grappling with systemic racism and protests ranging from peaceful demonstrations to violence within major cities after the death of George Floyd. The Black Lives Matter movement (BLM) has also been a largely polarized topic in the 2020 election. The main criterion variables of interest in this study (empathy and compassion) have been linked to political affiliation around the current sociopolitical climate that participants are responding within (Pfattheicher et al., 2020; Ye, 2020). For this reason, it was important to include counselor political affiliation as a variable. By including political affiliation, the research study was able to remain grounded in the literature. Doing so helped to create a more inclusive and wholistic picture of personal and professional variables that work together to predict counselor burnout and resilience.

Research findings have been inconsistent in the relationship among empathy, compassion, and political affiliation. In one study, liberals expressed a desire to feel and experience more empathy than conservatives did (Hasson et al., 2018). According to the findings, they were also more willing to help others than conservatives were in the United States.

Interestingly, both liberals and conservatives wanted to feel less empathic toward outgroup members than toward ingroup members or members of a nonpolitical group (Hasson et al., 2018).

Compassion levels, however, seem to be less different among political groups (Long, 2016). In a sample of Republican and Democratic Americans, Democrats' compassion levels were found to guide their attitudes regarding more groups and under more complex circumstances than Republicans. However, there are instances when compassion is more important in informing the opinions of Republicans than it is for Democrats, specifically on the issue of abortion (Long, 2016).

Recent neuroscientific findings point to a lack of empathy when exposed to multiple people suffering (Ye, 2020). The medial prefrontal cortex (mPFC) is more engaged when participants observe one person suffering rather than large numbers of people suffering. Perspective taking, and the neural marker of the mPFC, may explain indifference to large numbers of people in crisis, such as in humanitarian disasters (Ye, 2020). Empathy training, then, seems to bolster safety considerations that people may have developed a psychic numbing towards. In four studies (total N = 3,718), empathy was found to be a motivating factor for physical distancing and wearing face masks (Pfattheicher et al., 2020).

In this current study counselors were largely democratic in their political affiliation. While political affiliation did not ultimately contribute to either compassion or empathy, it does still have a relationship with the predictor variables. Counselors with Republican affiliation were more likely to have self-compassion, primarily in the dimension of feeling for themselves when they are suffering. Additionally, Republican counselors are less likely to have empathic fantasy, or the ability to transpose themselves into the feelings or actions of others. The current study also

found Republican affiliation to be linked with decreases in burnout compared to counselors identifying as Democrat, Green, or Libertarian.

Counselors with Democratic and Green political affiliation were not correlated with empathy, compassion, burnout or resilience based on this factor alone. A smaller group of counselors, Libertarians, were found to have less self-compassion and compassion for others, specifically in the dimensions of understanding the universality of suffering and feeling for the other person suffering.

Taking this into account, it is interesting to consider the dynamics at play, for example, in Republican counselors. In this study, Republicans have higher levels of self-compassion, and the ability to feel for themselves when they are suffering, as well as lower burnout rates. While this study does not determine causality among self-compassion and low burnout scores in Republican counselors, it's worth noting the relationship.

Limitations

Consistent with most quantitative research, this study had some significant limitations. Most participants in this study are European American / Caucasian, heterosexual, female counselors working in private practice. Due to this, the data is less generalizable to counselors from other ethnic, gender, and sexual identity groups. Since previous studies have found burnout to be lower in counselors working in private practice (Lent & Schwartz, 2012; Sprang et al., 2007), this may underrepresent a true gauge of burnout experienced by counselors in the United States. Practically this seems true because counselors report feeling symptoms of burnout during COVID-19 (Dastagir, 2021). Many counselors working in private practice have opted to see clients via telemental health thus not exposing themselves to viral contagion (Boring-Bray, 2020; Zhou et al., 2020). Counselors working in most other settings (i.e., colleges, k-12 school,

outpatient and inpatient mental health centers, medical hospitals), which are already predictive of higher burnout, are at an increased rate of COVID-19 exposure. Since the participants were mainly professional counselors working in private practice, a significant limitation of this study is that the data and analysis does not capture an equal number of counselors working in higher risk settings that may impact burnout scores.

Another limitation of this study is the use of self-report measures for the predictor and criterion variables. Self-report relies on participants to be objective about subjective personal experiences, preferences, and feeling states. While the mean for social desirability was not high in this study, the Marlowe-Crowne Social Desirability Scale Short Form II is also a self-report measure.

While this study's design is robust in establishing predictive relationships, causality cannot be determined. Counselors were not randomly assigned to groups to receive compassion and/or empathy training. The study assumes that counselors have existing levels of empathy and compassion skills from within or outside of counselor training. Previous research has found that second year graduate counseling students have greater empathy than first year students suggesting that participants in this study would have most likely received skills training by the time they met the inclusion criteria (practicum or internship) (Lyons & Hazler, 2002). It is assumed that these levels of empathy, for example, can be measured as dispositional empathy. Similarly, the multiple regression analyses used can only exam how the variables relate to one another instead of being caused from empathy and compassion training. Another limitation is the role that social desirability played in this study. Since social desirability was predictive of burnout, it's reasonable to assume that burnout scores are actually higher than reported.

Implications

Theoretical Implications

Revisiting Rogers' Core Conditions

Growing evidence of the consequences of empathy have become increasingly available to the counseling profession. To date, published literature within our profession has only focused on conceptual problems with empathy without studying any of the deleterious effects. In the process of reexamining a core disposition central to our profession, it is wise to revisit the historical roots for guidance on moving forward in a way that is conscientious of the role that empathy has played in counseling. Biles (2016) points out the absolutism that the counseling field has adopted in its adherence to the earlier works of Carl Rogers. Indeed, Rogers (1957) defined six necessary and sufficient core conditions for change to occur: psychological contact, client incongruence, therapist congruence, unconditional positive regard, empathy, and communication of unconditional positive regard and empathy. As Biles points out, subsequent work by Rogers explains his position as less fixed and more adaptable than the field has accepted. We have frozen with Rogers instead of growing with his core conditions as a starting point. In revisiting his words, it seems consistent with Rogers to continue examining empathy, such as in this study.

The major value of stating any theory in unequivocal terms is that specific hypotheses may be drawn from it which are capable of proof or disproof. Thus, even if the conditions which have been postulated as necessary and sufficient conditions are more incorrect than correct ..., they could still advance science in this field by providing a base of operations from which fact could be winnowed out from error. (Rogers, 1957, p. 228)

It is not outside of Roger's core conditions that this study exists. Instead, this study adds to the literature base of the many facets of empathy, including how it related to the counselor. While empathy is debatably a necessary and condition of effective counseling, this study supports the inclusion of compassion training as well.

Revisiting Compassion Fatigue

Compassion fatigue is the emotional and physiological effects of burnout and secondary traumatic stress among healthcare professionals (Stamm, 2010). Since compassion fatigue is already a well-established consequence of counseling, the aim of the current study was not to measure compassion fatigue. Instead, this study provided evidence for emerging trends towards replacing the term compassion fatigue with a more appropriate term: empathy distress fatigue.

Nursing, where the term compassion fatigue originated, is now one of the first fields to contest its continued use (Hofmeyer et al., 2019). Recent fMRI studies support the notion that distress arises from empathy and not compassion. A more accurate term describing burnout, fatigue, and negative affective experiences is "empathetic distress fatigue" (EDF), as suggested by Klimecki and Singer (2012). The choice of terminology matters as compassion training is the antidote to empathetic distress fatigue (Hofmeyer et al., 2019). Gladstein (1970) suggested that empathy led to distress decades ago, yet the term compassion fatigue has yet to be replaced due to a lack of empirically based research supporting this change. Adopting this language within counseling might better represent the antecedent to burnout without conflating it with the antidote.

Since an increase in empathy was found to be more predictive of burnout, a portion of compassion fatigue, this study provides evidence for substantiating the shift away from the vernacular of compassion fatigue to the more appropriately named empathetic distress fatigue.

Further evidence supports this shift comes from the finding that dimensions of compassion are inversely related to burnout, suggesting that fatigue does not arise from compassion. Instead, compassion is related to resilience.

Counselor Education and Supervision

The relationships among the dimensions of empathy and burnout have meaningful implications for counselor educators. Intentionality should be given to the process of teaching empathy skills. Guiding counseling students through the components of empathy (fantasy, perspective taking, emotional concern, and personal distress) should be thoroughly described. This study creates an ethical duty to inform counseling students of the possible consequences (increased burnout) of increased levels of overall empathy and fantasizing (taking on the emotional perspective of clients).

Based on the results in this study, it would be convenient to recommend helping skills training focus on perspective taking and not fantasy (emotional “as-if” practices). While this would certainly benefit the counselor, it is unknown how this shift would impact client perception of counseling or treatment outcomes. Until research is completed on client perception and treatment outcomes, it is most ethical to simply recommend the addition of compassion training to reduce the negative effects of empathy training.

The relationships among the dimensions of self-compassion and burnout may have meaningful implications for counselor educators. While empathy is taught as a core condition of counseling (Rogers, 1956) and taught in helping skills within CACREP programs, results from this study support the integration of compassion training, with an emphasis on self-compassion, into counselor education curriculum as well.

It is possible that counselor educators are already teaching compassion skills along with empathy skills. This is most likely the case since empathy is vaguely defined in the counseling profession and with many different ways of operationalizing it. This can be seen in counseling research and is most likely mirrored in education and in practice. For example, some definitions include feelings of warmth and caring (which is typically associated with compassion), and others do not (van Berhout & Malouff, 2016).

This study supports teaching both empathy and compassion distinctly from one another with the intention of teaching how to relate and react to clients empathetically and compassionately while building self-care skills (perspective taking and compassion) to buffer against burnout and build resilience. Since self and other compassion practices originated from contemplative traditions, they are traditionally taught under the intervention of mindfulness.

Compassion practices, such as mindfulness, is a fairly new phenomenon in counselor education and supervision. Similar to treatment efficacy, mindfulness has benefits for counselors outside of clinical practice, including gains in mental and physical health, behavioral regulation, and interpersonal relationships (Brown, et al., 2007). With mindfulness-based interventions proving to be effective in counseling, both personally and professionally, counseling education and supervision research have begun to embrace and study its use as well. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards task counselor educators and supervisors with teaching effective helping skills and utilizing the supervision relationship to help accomplish this (CACREP, 2016). Additionally, the American Counseling Association (ACA) Code of Ethics requires counselors to monitor and maintain their wellness (ACA, 2014). Counselor educators have begun using mindfulness as a way to meet

some of these standards and ethical codes. Teaching empathy and compassion skills meets both of these requirements.

Compassion Training in Counselor Education

Counseling educators are having to challenge themselves to teach students how to manage the emotional content of counseling sessions without experiencing burnout (Lawson et al., 2007; Roach & Young, 2007; Young & Lambie, 2007). To this end, emotional regulation is a necessary skill in the process of counselor development (Prihidko & Swank, 2018). Meditation and mindfulness strategies have shown to aid in emotional regulation and self-care (Sedlmeier et al., 2012; Shapiro et al., 2007). Shapiro et al. (2007) found higher levels of mindfulness correlate with increases in self-compassion and a decline in counseling students' state and trait anxiety, as well as stress levels. Similarly, mindfulness practice decreased anxiety and increased students' ability to cope with stressors after a semester-long meditation course. (Campbell & Christopher, 2012; Newsome et al., 2006; Schure et al., 2008). Another study found the Jyoti meditation, a form of spiritual meditation, helped to decrease counseling students' level of stress where emotional intelligence moderated the effect (Gutierrez et al., 2016). Testa and Sangganjanavanich (2016) recommend that counselor educators and supervisors be proactive in helping students use mindfulness to cultivate wellness during practicum and internships as they found mindfulness to be related to lower burnout scores.

Counselor educators have researched the provisions of compassion training in masters and doctoral level counseling programs for the purposes of building resilience and decreasing burnout. The implications from the current study are that an increase in ethical intentionality in empathy training, and additional self and other compassion training, are warranted. Including contemplative practices in counselor education may broaden counselors in training skill base for

self-care. Furthermore, adding compassion as an approach to clients provides a warm and caring method of attending to clients while not risking burnout.

Additionally, adding compassion skills training may aid in decolonizing counselor education practices. Academia has been criticized for perpetuating traditional Western approaches to teaching methods (McDowell & Hernandez, 2010). The civil unrest in 2020 and 2021 have forced mental health clinicians to reconsider their role in social justice and advocacy (Kelly et al., 2020). Counselor educators, and their students, can benefit from practices representative of diverse cultures. Compassion, as a part of mindfulness and meditation training, is from Eastern contemplative practices. In the current sociopolitical climate, and the counseling fields commitment to inclusion, diversity, and decolonization (Singh et al., 2020), teaching a non-Western skill may aid in decolonizing a part of the curriculum in counselor education.

Compassion skills training focuses on exercises related to building compassion towards self and others. These techniques are easily infused into helping skills curriculum, preferably after empathy skills training. One method of practicing both self and other compassion is through loving kindness meditation (Leppma & Young, 2016; Salzberg, 1995). Students are asked to repeat a mantra, or affirmation first directed towards themselves, a client who they have warm feelings towards, then a client who they do not have any particular feelings towards, and lastly a client who they do not like or feel challenged by. The mantra, or affirmation, is “May I be at peace, May I be happy, May I be well.” This serves to increase compassion towards self and others regardless of how one feels about self or a client in the moment. This exercise may be appropriate for all students in helping skills or in direct response to a student in supervision struggling with a client.

Another exercise for self-compassion is to ask students to write a compassion letter to self (Gale et al., 2017). If this is difficult, this can be modified by asking students to imagine that a person who cares for them wrote them a letter to help with a situation they are currently facing. What might this letter say? Similarly, counselors in training can be asked to draw a picture of how they wish their future to be, or how they wish a clients' future would look. These practices could help to build skills focusing on recognizing suffering (despite how they feel about the client), tolerating their discomfort, understanding that suffering is universal, and to be motivated in the session to act to relieve their suffering in a clinically sound manner.

Future Research

This non-experimental study took a first step in providing information regarding counselors existing levels of empathy and compassion and the relationship they have with counselors existing burnout and resilience. Since this study established relationships among the variables, reasonable next steps might include an experimental study to establish causality. Since resilience and burnout were correlated with, and predicted by, so many of the subscales of both empathy and compassion, training that targets each of these micro skills with subsequent resilience and burnout testing would provide useful information for counselor educators.

To date, this is the first study looking at counselor political affiliation and levels of empathy, compassion, burnout, and resilience. Instead of only asking political affiliation, a future study could use a scale that determines the extent to which someone identifies with their political affiliation, and the degree to which someone has liberal, progressing, or conservative views. A better understanding of political affiliation, and how this impacts empathy, compassion, resilience, and burnout may offer insight into how this impact client care.

Another implication for future research may be studying the implications for clients. This study focused on potential implications for clients only indirectly. Counselors experiencing higher levels of burnout may be at risk of impairment, which risks compromising the quality of care and ethical consideration given to clients. A more direct analysis of how counselors' levels of empathy, compassion, burnout, and resilience predict clients' perception of counseling, or client outcomes, would be important to understand.

Lastly, a future study could focus on the role that social desirability plays in counselor burnout and resilience using the full-length Marlowe Crowne Social Desirability Scale. In this study social desirability played a significant role in predicting counselor burnout and resilience. Gaining a broader understanding of how social desirability impacts self-reporting of burnout and resilience may aid educators and supervisors working with counselors in training. Counselors are encouraged to use supervision and counseling to manage the stressful impact of counseling. The results in this study may point to counselors' need to be viewed in a socially desirable way as prohibitive of accurate self-reporting, which is crucial to monitoring oneself for signs of impairment. Using the full-length social desirability scale may provide insight into the role that social desirability has in counselors' self-reports.

Summary

In summary, of all the variables in this study, compassion seems to be the most influential in determining both burnout and resilience. The lack of compassion (primarily self-compassion) is predictive of burnout. The more self-compassion counselors have, the more resilient they are. These results are also consistent with contemplative neuroscience studies that have found burnout to activate the pain network and resilience to activate non-overlapping regions (Klimecki et al., 2014). Other studies have found empathy to predict empathic personal

distress (Di Tella et al., 2020) and compassion predictive of resilience (Shebuski et al., 2020; Smeets et al., 2014), but not in a sample of counselors where empathy and compassion could be analyzed as predictors of burnout and resilience in the same sample.

Conclusion

Both the importance of empathy in counseling and consequences of burnout are well understood in counseling. What is less understood is how these two variables might be related. This study aimed to test the hypothesis from by Klimecki et al. (2014) that empathy leads to burnout and compassion leads to resilience. To test this, four multiple regression analyses were conducted examining (1) if empathy or compassion is a better predictor of resilience, (2) if empathy or compassion is a better predictor of burnout, (3) what model is most predictive of counselor resilience, and (4) what model is most predictive of counselor burnout. Results indicate that (1) compassion, compared to empathy, is a better predictor of resilience, (2) empathy, compared to compassion, is a better predictor of burnout, (3) self-compassion and less empathic personal distress are best predictors of resilience, and (4) private practice, empathic personal distress, and decreased levels of self-compassion and social desirability are best predictors of counselor burnout.

In conclusion, the present study supports the hypothesis proposed by Klimecki et al. (2014) that empathy is related to burnout and compassion is related to resilience. Interestingly, burnout is also related to the absence of compassion towards self and others. Compassion to self and others seems to be the variable that is most predictive of both low burnout levels and higher counselor resilience. It is important to note that the initial correlations between the variables, while significant, were mainly small to medium effect sizes.

These results have implications for counselor education. As part of self-care measures, counselor educators would do well to teach self and other compassion skills alongside skills related to empathy. This type of skills training may help bolster counselor resilience and buffer against personal distress experienced as a result of counselor empathy. In doing so, counselors may be better equipped to protect themselves from burnout that is linked to counselor impairment. Future studies should focus on causality of the variables with experimental studies of counseling students' burnout and resilience after empathy and compassion skills training. Limitations in this study include the use of self-report surveys, lack of diversity, and assumptions of empathy and compassion dispositions being indicative of skills training. Overall, the hypotheses in this study were supported by the research indicating that empathy is more predictive of burnout and compassion is more predictive resilience. An additional finding of low levels of self and other compassion predicting higher counselor burnout provides evidence for self-care measures that counselor educators can integrate into helping skills curriculum. In doing so, counselor educators are heeding recommendations to focus on counselor wellness and resilience rather than trying to cope with stress and depletion (Osborne, 2004).

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