Re-examining the Role of Counsellor Empathy in Compassion Fatigue and Compassion Satisfaction

by

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Abstract

Figley's (1995; 2002a) model of compassion stress/fatigue was used as a reference-point to re-examine the role of therapist/counsellor empathy in predicting therapist/counsellor compassion fatigue (CF) and compassion satisfaction (CS). The therapeutic alliance was also examined as a predictor of therapist/counsellor CF and CS. Participants included 146 female-identifying Canadian therapists/counsellors, aged 24-73 years. The Empathy Assessment Index (EAI), a social cognitive neuroscience-based empathy scale, gauged therapist/counsellor empathy; and the Working Alliance Inventory – Short therapist version (WAI-S) gauged therapist/counsellor perceptions of the strength of the therapeutic alliance. The Professional Quality of Life scale – Fifth edition (ProQOL-V) was the outcome measure for therapist/counsellor CF and CS. Contrary to Figley's model, partial least squares path analyses determined that therapist/counsellor empathy was a significant *inverse* predictor of therapist/counsellor CF (R^2 = .40 for total empathy-based CF model) and a significant positive predictor of therapist/counsellor CS (R^2 = .16 for total empathy-based CS model). The therapeutic alliance likewise proved to be a significant inverse predictor of therapist/counsellor CF (R^2 = .37 for total therapeutic alliance-based CF model) and a significant positive predictor of therapist/counsellor CS (R^2 = .29 for total therapeutic alliance-based CS model). Personal Characteristics including age and years of clinical experience, and Workplace/Organizational factors including supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseloads, predicted less risk for therapist/counsellor CF and greater likelihood for therapist/counsellor CS. Additional analyses revealed that the therapeutic bond was equivalent to empathy in predicting therapist/counsellor CF, and stronger than empathy in predicting therapist/counsellor CS.

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Chapter 1

OVERVIEW

During the early 1990s to mid 2000s there was a heightened interest in the literature that focused on the harmful effects for helping professionals of working with trauma-based populations (Buchanan, Anderson, Uhlemann, & Horowitz, 2006; Jacobson, 2012; Sabin-Ferrell, & Turpin, 2003). A number of influential secondary traumatic stress (STS) theories were proposed that tried to account for these negative helper outcomes. Secondary traumatic stress is a term used to describe a set of psychological symptoms that mimic posttraumatic stress disorder (PTSD; Figley, 2002a). Unlike PTSD, however, STS symptoms are acquired through indirect exposure to others' trauma and suffering rather than direct exposure (Baird & Kracen, 2006). Charles Figley's theory of compassion fatigue (CF) was perhaps the most influential STS construct. Figley defined CF as: "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal associated with the patient" (2002a, p. 1435). Figley (1995; 2002a) expounded his theory through the development of his model of compassion stress/fatigue, where he described the factors that he believed contribute to psychotherapist CF. Despite the influence of the model over the past few decades, it has been criticized for failing to explicitly address helper *compassion* (S. Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017) and for conflating the terms compassion and empathy (Klimecki & Singer, 2012). S. Sinclair, Beamer, et al. (2017) defined compassion as: "a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action" (p. 444). Empathy has been defined, in the present study, as an affective response to another's trauma and suffering, moderated by an observer's cognitive processes of perspective-taking, self-other awareness, and

emotion regulation (see Decety & Jackson, 2004; Decety & Lamm, 2006; Decety & Moriguchi, 2007; Preusche & Lamm, 2016). S. Sinclair, Beamer, et al. (2017) characterized compassion as an action-oriented response to others' suffering, while differentiating empathy as a duty-based response aimed at supporting and understanding others' suffering through emotional resonance.

Figley's (1995; 2002a) primary assumption in the compassion stress/fatigue model is that *empathy* puts helpers at greatest risk for CF. However, this has not been supported empirically (see Thomas, 2013; Wagaman, Geiger, Shockley, & Segal, 2015). In contrast, new findings from social cognitive neuroscience (SCN) have pointed to empathy as a skill that promotes therapist/counsellor self-regulation (see Coutinho, Silva, & Decety, 2014) and helper compassion *satisfaction* (CS; Stamm, 1993; see Wagaman, et al., 2015).[1] Compassion satisfaction has been defined as "the sense of fulfilment or pleasure that therapists derive from doing their work well" (Larsen & Stamm, 2008, p. 282). Qualitative and quantitative studies spanning the past ten years have likewise identified empathy as a source of resilience (Hernández, Engstrom, & Gangsei, 2010; Hernández, Gangsei, & Engstrom, 2007) and CS for helpers (Coutinho et al., 2014; Harrison & Westwood, 2009; Hunter, 2012; Wagaman et al., 2015; Yu, Jiang, & Shen, 2016). What's more, questions have been raised about the predictive factors that Figley identified in his theoretical model, including how concepts like *empathic ability* and *empathic response* are operationally defined (Sabo, 2011). Figley's predictive factors have received mixed support in empirical studies. New understandings from STS and SCN research have prompted the need for a re-examination of Figley's compassion stress/fatigue model and the development of empirically-based models that predict both the negative and *positive* effects of therapist/counsellor empathy on therapist/counsellor wellbeing outcomes.

Introduction

The belief that helping professionals can be adversely impacted by their work with patients/clients in distress is nothing new. Turgoose and Maddox (2017) suggested that it can be traced back to the psychoanalytic concepts of transference and countertransference. Yet, the past few decades have seen rapidly growing interest in these STS outcomes (Buchanan, Anderson, Uhlemann, & Horowitz, 2006; Jacobson, 2012; Hafkenscheid, 2005; Sabin-Ferrell, & Turpin, 2003). Researchers have spent considerable time and energy examining the cognitive, emotional, behavioural, and physical consequences for therapists that can result from exposure to clients' trauma material (Halevi & Idisis, 2018). Organizations too, have increasingly planned for the inevitability of helper STS, allocating resources towards proactive prevention, rather than presuming that helpers are inherently resilient (Molnar, Sprang, Killian, Gottfried, Emery, & Bride, 2017). Secondary traumatic stress has been used as an umbrella term to describe a family of constructs that includes CF, vicarious traumatization (VT), and burnout (BO; Maslach & Jackson, 1981; 1986). McCann and Pearlman (1990) described VT as the harmful set of changes to therapists' cognitive schemata that result from exposure to clients' trauma-material (McCann & Pearlman,1990); and Stamm (2010) defined BO as "feelings of hopelessness and difficulties in dealing with work or in doing your job effectively" (p. 13). Figley (1995) believed that these STS consequences are "normal and natural byproducts" of working with trauma victims (p. 573). In his model of compassion stress/fatigue (1995; 2002a) he attempted to delineate the causal factors that contribute to psychotherapist CF. The compassion stress/fatigue model has served as a reference point for STS research across helping professions. Yet, it has also generated considerable debate (see Coetzee & Laschinger, 2017; Sabo, 2006, 2011). Figley based his model on the assumption that therapist empathy is the primary *risk* factor for therapist CF, after

he studied the indirect PTSD-like symptoms he observed among combat veterans who worked in helping capacities on the front lines. This assumption, however, has not been backed by empirical support (Sabo, 2006, 2011; Thomas, 2013; Wagaman et al., 2015), and questions remain about the role of therapist/counsellor empathy in therapist/counsellor wellbeing outcomes. Figley was not alone in identifying therapist empathy as the primary risk factor for therapist STS. McCann and Pearlman (1990) proposed that therapist empathy is the principal risk factor for therapist VT. They described the effects of VT as a permanent disruption of therapists' cognitive schemata as a result of exposure to clients' trauma material. Figley focused his theory of CF on the socio-emotional factors associated with secondary exposure to trauma. Despite different theoretical underpinnings, the terms CF and VT have oftentimes been used interchangeably. Burnout, a work-related stress construct, has also been included in the STS discussion. The conceptual overlap and interchangeable use of these constructs has resulted in a confusing body of literature (Coetzee & Laschinger, 2017; Ledoux, 2015). Conceptual confusion and the ongoing debate about the role of therapist/counsellor empathy as a risk or protective factor, warrant the need for a re-examination of the role of therapist/counsellor empathy in therapist/counsellor CF. Moreover, in light of the growing number of studies that have identified positive and protective wellbeing outcomes for empathic practitioners, it is additionally important to use Figley's model as a reference point to evaluate the role of therapist/counsellor empathy in therapist/counsellor CS.

Compassion Fatigue

Figley (1983) first used the term "secondary victimization" to describe the indirect PTSD-like symptoms he observed among combat veterans who worked in helping capacities on the front lines. His research expanded from there to examining the effects of STS on a broader range

of secondary-trauma victims, including psychotherapists. Figley defined STS as "…the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized person" (Figley, 1995, p. 7). He later adopted Joinson's (1992) "compassion fatigue" as a more "user-friendly" term for helper STS experiences (Figley, 2002b, p. 3). Joinson initially coined the term to capture the feelings of burnout and lost "ability to nurture" that she witnessed among emergency room nurses (p. 119). Figley later defined CF as: "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal associated with the patient" (2002a, p. 1435). Figley did not limit his understanding of STS or CF to exposure to client trauma, but to client suffering more generally. Figley further placed an emphasis on the importance of a strong therapeutic bond stating that: "The most important ingredient in building a therapeutic alliance is the client liking and trusting her or his therapist . . . these feelings are directly related to the degree to which the therapist expresses empathy and compassion" (2002b, p. 2). He argued that this "liking" is a function of psychotherapists' empathy and compassion. Yet, Figley likened empathy to a double-edged sword and described it as the means by which helpers become most susceptible to CF.

Model of Compassion Stress/Fatigue

Figley expounded his CF theory through the development of the compassion stress/fatigue model (1995; 2002a; see Figure 1). The model is based on Figley's belief that empathy is both the key to effective intervention with suffering clients but also the primary risk factor for psychotherapists. Figley outlined eight proposed *risk* factors for CF in the model, of which three are empathy-related: (a) *empathic ability*—psychotherapists' aptitude for noticing the pain of

Figure 1. Model of Compassion Stress/Fatigue

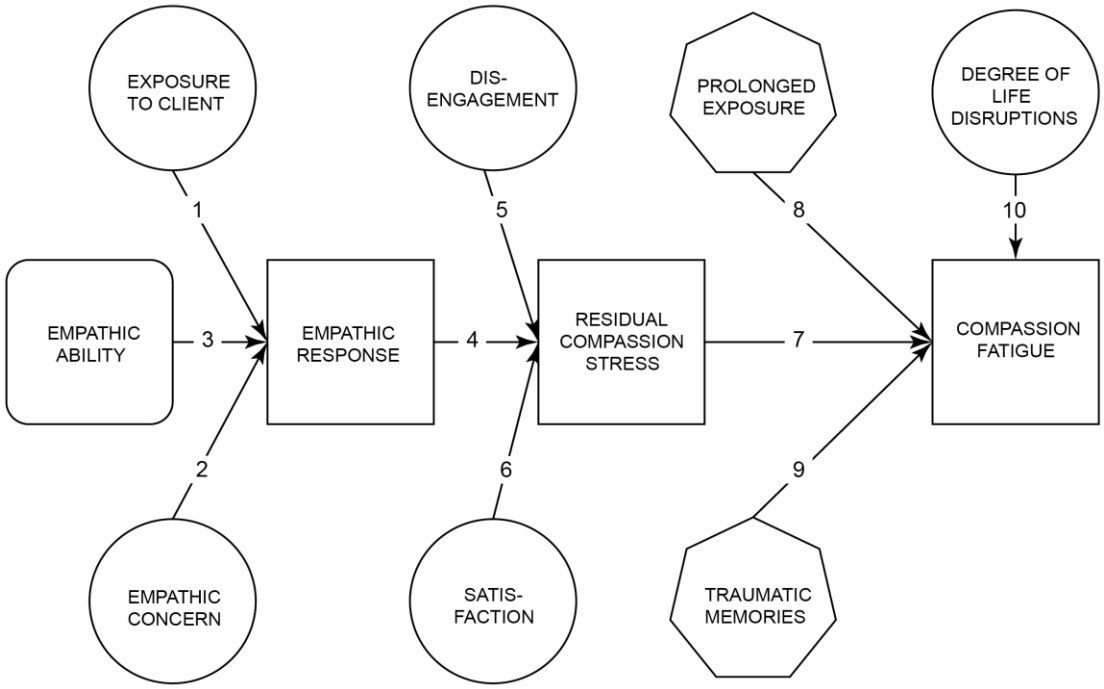

Figure 1. Figley's (1995; 2002a) theoretical model of compassion stress/fatigue.

others, (b) *exposure to the client*—psychotherapists' direct exposure to clients' suffering, (c) *empathic concern*—psychotherapists' motivation to respond to people in need, (d) *empathic response*—psychotherapists' efforts to reduce clients' suffering through empathic understanding, (e) *residual compassion stress*—psychotherapists' stress that results from the ongoing demands of trying to relieve clients' suffering, (f) *traumatic memories*—memories provoked by certain types of clients that connect to the trauma experiences of individual psychotherapists and trigger PTSD-like symptoms for those psychotherapists, (g) *degree of life disruptions*—unexpected changes in a psychotherapists' schedule or routine, and (h) *prolonged exposure*—the ongoing sense of responsibility for the care of the suffering. Figley (2002a) described the onset of CF as sudden. Yet, he also said that with proper steps CF is "highly treatable" (p. 1436). Figley identified factors in the compassion stress/fatigue model that he maintained can mitigate the risks

for CF. These protective factors are: (a) *disengagement*—the degree to which psychotherapists' can distance themselves from clients' trauma between sessions, and (b) *satisfaction*—the extent that psychotherapists are satisfied with efforts to support their clients from the ongoing demands of trying to relieve clients' suffering.

In his model Figley (1995; 2002a) described empathy as key to establishing a strong therapeutic alliance—paying particular attention to the connection between empathy and a strong therapeutic *bond*. Empathy has long been considered a core component of the therapeutic relationship (Feller, Coltons, 2003; Lambert, Barkley, 2002). Research from the past few decades has continued to substantiate the importance of helper empathy for positive patient/client outcomes (Buckman, Tulsky, & Rodin, 2011; Gerdes, Segal, & Lietz, 2010; Lietz et al., 2011). Yet, less attention has been paid to the role of empathy in *helper* outcomes (Thomas, 2013; Wagaman et al., 2015). Figley's (1995; 2002a) model of compassion stress/fatigue has brought greater awareness to the adverse outcomes experienced by some empathic practitioners. However, the past few decades have seen a growing number of empirical studies that have identified helper empathy as a source of helper resilience (Hernández, Engstrom, & Gangsei, 2010; Hernández, Gangsei, & Engstrom, 2007) and satisfaction (Harrison & Westwood, 2009; Hunter, 2012; Yu, Jiang, & Shen, 2016). There is growing recognition that the role of therapist/counsellor empathy as it pertains to *therapist/counsellor* outcomes needs further exploration (Coutinho et al., 2014; Craig & Sprang, 2010; Linley & Joseph, 2007). A clearer understanding about the role of empathy—and how empathy is defined and operationalized—is essential for informing therapist/counsellor training and professional practice. New understandings about helper empathy can be put towards mitigating the risks of therapist/counsellor CF and promoting therapist/counsellor CS.

Chapter 2

LITERATURE REVIEW

Figley (2002a) based his compassion stress/fatigue model on the assumption that empathy and emotional energy are the "driving force" behind reducing clients' suffering and establishing and maintaining an effective therapeutic alliance (p. 1436). Yet, Figley also described empathy (comprising *empathic ability*, *empathic concern*, and *empathic response*) as the primary risk factor for psychotherapist CF. Despite the influence of Figley's compassion stress/fatigue model, it has not been received without criticism. Researchers have raised concerns about Figley's use of "compassion" fatigue, despite not addressing compassion in the model (Ledoux, 2015; S. Sinclair, Raffin-Bouchal, et al., 2017), the linear description of Figley's empathy processes (Sabo 2006, 2011), and Figley's assumption about empathy as the primary *risk* factor for CF (Coetzee & Laschinger, 2017; Sabo, 2006, 2011). These concerns have become increasingly important in light of the growing evidence that has recognized helper empathy as a source of helper resilience (Hernández, Engstrom, & Gangsei, 2010; Hernández, Gangsei, & Engstrom, 2007) and helper CS (Harrison & Westwood, 2009; Hunter, 2012; Yu et al., 2016).

In the delineation of the compassion stress/fatigue model, Figley defined empathy within a stress-process framework (Adams, Boscarino, & Figley, 2006; Figley, 2002a). He argued that psychotherapists must first possess *empathic ability,* or an aptitude for "noticing the pain of others" (2002a, p. 1436). He proposed that once empathic helpers have noticed others' pain, they then prepare to act through what he described as *empathic concern*, or a motivation to provide the highest quality of care to those who need it. Figley argued that in the final stage, psychotherapists' *empathic response* enables them to take the "perspective of the client" (p. 1437). He claimed, that in so doing, psychotherapists, ironically, become most vulnerable to

taking on their clients' trauma-material. Figley identified the empathic response as the action that puts psychotherapists at greatest risk for *residual compassion stress* or "…residue of emotional energy from the empathic response to the client" (Figley, 2002a, p. 1437). He claimed that, ultimately, residual compassion stress can result in CF if left unchecked. The compassion stress/fatigue model, however, has been criticized for its linear description of these empathy processes, for failing to make the definitions of processes like *empathic ability* and *empathic concern* explicit, and for failing to adequately describe how the processes interact with one another (Sabo, 2006; Sabo, 2011). Generally speaking, there has been a lack of consensus about empathy's definition in the psychotherapy literature (Batson, 2009; Bohart & Greenberg, 1997; Dohrenwend, 2018; Gleichgerrcht & Decety, 2013). Taken together, this has underscored the need for a more current understanding of empathy, based on empirical research, which can be used as the basis for re-examining Figley's assumption about empathy as a primary risk factor.

Empathy

Empathy has long been a focus of study in health care professions like nursing, medicine, social work, counselling, and psychology (Fields, Mahan, Tillman, Harris, Maxwell, & Hojat, 2011). Freud (1913) first used Lipps' (1903) term *Einfühlen*—translated *feeling into* by Titchener (1909)—to describe psychoanalysts' "sympathetic understanding" of a patient (p. 140). Freud believed that some understanding of a patient's experience is necessary for establishing an effective therapeutic relationship. For Freud, however, the analyst was to act as a detached observer. Ferenczi (1928) later broke from classical psychoanalysis by drawing awareness to analysts' subjective experiences and their potential to influence the course of therapy. Ferenczi's "empathy rule" described how analysts' capacity for empathy can "protect [analysts] from unnecessarily stimulating the patient's resistance, or doing so at the wrong

moment (p. 203). Ferenczi recognized that analysts' moment-to-moment interactions with patients could be triggering *or* facilitative for the patient. It was not until the mid-20th century, however, that empathy was recognized as playing a prominent role in the therapeutic relationship (Elliot, Bohart, Watson, & Greenberg, 2011). Rogers' (1957) work was pioneering in terms of how he defined empathy in a therapeutic context. He considered empathy the most important therapy *process* and part of a "triad" of necessary therapist conditions for therapeutic personality change; therapist congruence and therapist unconditional acceptance making up the other two components (Kariagina, 2017). Rogers (1957) described *empathic understanding* as a therapist's ability to "sense the client's world as if it were your own, but without ever losing the 'as if' quality" (p. 243). There has been general consensus about this "as if" quality of empathy since Rogers' description (Deutsch & Madle, 1975). However, apart from this rudimentary agreement, there has remained a lack of a consensual, comprehensive understanding about how to define the construct (Batson, 2009; Bohart & Greenberg, 1997; Clark, Robertson, & Yong, 2018; Dohrenwend, 2018; Gleichgerrcht & Decety, 2013). Debate over the past few decades has focused on whether empathy is primarily a cognitive or an affective process (Barkham, 1988; Israelashvili & Karniol, 2018), an attitude or a behavioral dimension (Barkham, 1988; Clark et al., 2018).

Most scholars have now conceded that empathy comprises both (bottom-up) affective and (top-down) cognitive components (Clark et al., 2018; Coutinho et al., 2014; Decety & Lamm, 2006; Israelashvili & Karniol, 2018; Pajevic, Vukosavljevic-Gvozden, Stevanovic, & Neumann, 2018). Some have deemed empathy a primarily cognitive process mediated by emotional factors, while others have defined empathy as an affective response mediated by cognitive processes (Barkham, 1988). The notion of affective empathy was bolstered by the work of Chartrand and

Bargh (1999) and Preston and de Waal (2002). Chartrand and Bargh proposed the "chameleon effect", what they described as the nonconscious mimicry of another's postures, facial expressions and behaviors. Preston and de Waal later formulated the perception-action model (PAM) based on primatology research. The model stated that: "[the] perception of the object's state automatically activates the subject's representations of the state . . . and that activation of these representations automatically primes or generates the associated autonomic and somatic responses, unless inhibited" (2002, p. 4). Other researchers have defined affective empathy as an observer's corresponding emotional response to another's emotional state (Pajevic et al., 2018); emotional resonance with the patient (S. Sinclair, Beamer et al., 2017); or the quick assessment of another's emotions based on facial expressions, body gestures and voice prosody (Reniers, Concoran, Drake, Shryane, & Völlm, 2011). Most researchers have agreed that affective empathy can occur largely without consciousness. In contrast, cognitive empathy refers to an empathizer's ability to understand another's feelings without necessarily taking-on another's affective state (Walter, 2012). Cognitive empathy is *conscious* emotional processing that involves more complex cognitive processes (Chrysikou & Thompson, 2016; de Waal, 2007). Freud (1913) perhaps first tapped into cognitive empathy when he described the necessity of therapists having some understanding of patients' experiences in order to establish an effective therapeutic relationship. Freud described the importance of therapists having "detached reflexivity" to guard against transference and countertransference. Cognitive empathy has been closely associated with constructs like mentalizing and theory of mind (Spreng, McKinnon, Mar, & Levine, 2009; Walter, 2012). There is ongoing debate surrounding whether these processes are subsumed under cognitive empathy or are related but separate phenomena (Walter, 2012). *Perspective-taking* is most often associated with cognitive empathy and involves understanding

another person or adopting another person's point of view (de Waal, 2007; Preston & de Waal, 2002; Reniers et al., 2011).

Social Cognitive Neuroscience Perspective

A movement began among some researchers in the late 20th century to "re-assimilate" the divergent empathy perspectives (Barkham, 1988). Preston and de Waal's (2002) PAM, for example, was based on the belief that the different empathy conceptualizations could be "cohered into a unified whole" (2002, p. 4). The PAM laid the groundwork for a social cognitive neuroscience (SCN) understanding of empathy as a broader, multidimensional construct (Coutinho et al., 2014; Gleichgerrcht & Decety, 2013; Lietz, et al., 2011; Wagaman et al., 2015; Walter, 2012). The burgeoning field of SCN has taken influential social psychology theories of empathy and bridged them with observable brain phenomena from neuroimaging and lesion studies (Decety & Lamm, 2006; Lieberman, 2010). Social cognitive neuroscience research has identified four differentiable empathy components: *affective response*, *perspective taking*, *self-other awareness*, and *emotion regulation*.

Affective response. As already noted, the notion of an affective response was strengthened through the work of Chartrand and Bargh (1999) and Preston and de Waal (2002). However, it has more recently been corroborated in SCN research (see Decety & Lamm, 2006; Decety & Moriguchi, 2007). The affective response is described as the automatic mirroring of another's affective state. It can be observed at birth (Decety & Jackson, 2004) and is believed to occur largely in the absence of conscious recognition (Dimberg, Thunberg, & Elmehed, 2000). The affective response has been referred to as the "bottom-up" sensory-based, or affective route, of empathy (Coutinho et al., 2014; Preusche & Lamm, 2016).

Perspective taking. Preusche & Lamm (2016) argued that "bottom-up" empathy processes like affective response do not act independently, but rather, are moderated by top-down processes such that the two are "intrinsically intertwined" (p. 239). Unlike the affective response, perspective taking develops later in life and involves conscious recruitment of higher-level executive brain functions (Decety & Lamm, 2006). As previously noted, perspective taking is most often associated with *cognitive* empathy. Decety and Jackson (2004) suggested that in order for one to respond empathically to others, an inhibitory mechanism is needed to "tone down" the self-perspective to leave room for the evaluation of the other-perspective (p. 87).

Self-other awareness. Self-other awareness is another important cognitive empathy process that helps observers to differentiate between self and other by tracking the origin of sensory signals (Decety & Moriguchi, 2007). Rogers (1957) recognized the importance of self-other awareness when he described empathy's "as if" quality. This characteristic has been corroborated in SCN studies. Lamm, Batson, and Decety (2007) for example, found that an observer's response to the perceived pain and suffering of others can be either one of empathic concern and altruistic motivation, or personal distress and egoistic motivation, depending on one's capacity for self-other awareness; and Decety and Lamm (2006) argued that in the absence of separation between the affective state of self and other an "empathic overarousal" can occur (p. 1154). Preusche and Lamm (2016) suggested that this overarousal is not indicative of a truly empathic response, but rather of emotional contagion (Preusche & Lamm, 2016) while a truly empathic response necessitates a "more detached relation" through self-other awareness (Decety & Lamm, 2006, p. 1155).

Emotion regulation. Gerdes et al. (2010) described emotion regulation as the last key construct of the 20th century to be associated with empathy. Emotion regulation is another

cognitive empathy process and one that is closely intertwined with affective empathy. Preusche and Lamm (2016) argued that emotion regulation is central to the prevention of "vicarious overarousal". Decety and Jackson (2004), however, have suggested that an observer's emotional response to another's pain and suffering must be regulated in order for an empathic response to occur. They argued that emotion regulation ensures that helpers' vicarious emotion is "…not experienced as aversive" (p. 86). Vicarious overarousal, or *personal distress*, is perhaps one aspect of what Figley (1995; 2002a; 2002b) observed and documented in his description of psychotherapist CF.

Measurement of Empathy

The wide array of empathy definitions has generated a corresponding array of empathy measures with no single gold-standard (Elliott et al., 2011; Gleichgerrcht & Decety, 2013; Pederson, 2009; Spreng et al., 2009). Different methods of assessing empathy have included self-report questionnaires using Likert-type scales, behavioral/observational measures, and neuroscience approaches. None of these methods has been without shortcomings: Self-report questionnaires have been criticized for their susceptibility to self-reporting bias and failure to address empathic behavior (Yu & Kirk, 2009); behavioral/observational measures have relied heavily on inter-rater reliability and fail to capture respondents' attitudes (Yu & Kirk, 2009); and neuroscience approaches, like magnetic resonance imaging (MRI) and functional magnetic resonance imaging (fMRI), require specialized equipment, are time-consuming to administer, expensive, and can generally only accommodate small sample sizes (Neumann, Chan, Boyle, Wang, & Rae Westbury, 2015).

Despite their limitations, self-report questionnaires have been used extensively in empathy research since the 1960s due to their ease of administration, cost effectiveness and

comprehensiveness in gauging empathic attitudes and experiences (Lucas-Molina, Pérez-Albéniz, Giménez-Dasi, & Martin-Seoane, 2016; Neumann et al., 2015; Reniers et al., 2011). A handful of empathy scales have gained prominence over the past half-century. The Hogan Empathy Scale (HES; Hogan, 1969) was the first. Notwithstanding its early importance, the HES has fallen out of favor due to its poor test-retest reliability and internal consistency (Froman & Peloquin, 2001), and its omission of an affective empathy subcomponent (Reniers et al., 2011). The Empathy Quotient (EQ; Baron-Cohen, Richler, Bisarya, Gurunathan, & Wheelwright, 2003), another widely-used empathy self-report questionnaire, has been determined to be a reliable and valid measure of cognitive empathy (Lawrence, Shaw, Baker, Baron-Cohen, & David, 2004). Yet, the EQ has likewise been criticized for failing to assess affective empathy (Reniers, 2011). In contrast, the Balanced Emotional Empathy Scale (BEES; Mehrabian, 2000), while also widely administered, has drawn criticism for failing to incorporate a *cognitive* empathy component (Reniers et al., 2011). Self-report scales that have focused either on affective or cognitive empathy have been deemed incompatible with the more current understanding of empathy as a broader, multidimensional construct (Reniers et al., 2011).

Davis's (1983) Interpersonal Reactivity Index (IRI) is the most widely-administered empathy self-report scale and it has accounted for empathy's multidimensional nature (Chrysikou & Thompson, 2016). The IRI purports to measure both cognitive and affective empathy components (Israelashvili & Karniol, 2018; Spreng, 2009). The IRI subscales include: perspective taking, fantasy, empathic concern, and personal distress. Some researchers have used a "cognitive-affective" split to group IRI perspective taking and fantasy subscales into a cognitive empathy factor, and empathic concern and personal distress subscales into an affective empathy factor (Chrysikou & Thompson, 2016). This two-factor IRI, however, has not been

validated psychometrically (Chrysikou & Thompson, 2016). What's more, the validity of the IRI fantasy and personal distress subscales has been questioned, with some researchers arguing that the subscales measure imagination and emotional self-control rather than empathy (Baron-Cohen & Wheelwright, 2004). Neuroscience measures hold promise for the measurement of empathy going forward (Neumann et al., 2015). The Empathy Assessment Index (EAI) is a self-report questionnaire that has been informed by SCN research. The instrument captures empathy's multidimensional nature without the high cost and limitations of direct neuroscience approaches. The EAI has good reliability and validity (Gerdes et al., 2010; Lietz et al., 2011) and is based on the four social cognitive neuroscience components of empathy: affective response, perspective taking, self-other awareness, and emotion regulation.

Role of Empathy in Patient/Client Outcomes

The relationship between helper empathy and positive consumer outcomes has been well established (Gerdes et al., 2010; Lietz, Gerdes, Sun, Geiger, Wagaman, & Segal, 2011; Thomas, 2013). Helper empathy has been associated with positive clinical outcomes (Forrester, Kershaw, Moss, & Hughes, 2008; Miller & Baca, 1983), client *expectations* of positive clinical outcomes (Angus & Kagan, 2009), client compliance (Forrester, Kershaw, Moss, & Hughes, 2008) and the facilitation of the counselling process (Rogers, 1957). Empathy has been shown to be of great importance to therapists/counsellors due to its association with positive *client* outcomes (Elliot et al., 2011). Yet, surprisingly little research has explored how empathy impacts service *providers*, for whom empathy is an imperative aspect of their job (Jenkins & Baird, 2002; Sabo, 2006; Thomas, 2013). Even fewer studies have examined the relationship between empathy and CF in therapist/counsellor providers specifically (Buchanan et al., 2006; Craig & Sprang, 2010; O'Brien & Haaga, 2015). However, there is growing recognition that therapist/counsellor

empathy, as it pertains to therapist/counsellor wellbeing outcomes, needs further exploration (Coutinho et al., 2014; Craig & Sprang, 2010; Linley & Joseph, 2007).

Role of Empathy in Helper Outcomes

Contrary to Figley's (1995; 2002a) belief that empathy is the primary risk factor for psychotherapist CF, a growing body of research has identified empathy as a source of therapist resilience (Hernández, Engstrom, & Gangsei, 2010; Hernández, Gangsei, & Engstrom, 2007) and satisfaction (Harrison & Westwood; 2009; Hunter, 2012). The compassion stress/fatigue model has been criticized for failing to account for these positive/protective helper wellbeing outcomes (Sabo, 2011). This criticism is warranted considering the central role Figley assigned to empathy in his model. Evidence that has pointed to empathy as a positive/protective factor has come from a number of qualitative and quantitative studies. Hunter (2012) used in-depth, individual interviews to examine couples' therapists' experiences of the therapeutic bond. While every therapist interviewed deemed empathy fundamental to the therapeutic relationship, participants' responses revealed that a strong therapeutic bond provided them with "intense satisfaction" from engaging with clients' trauma-material. Badger, Royse and Craig (2008) examined the impact of helper empathy on helper STS among a sample of clinical social workers. They determined that empathy was a poor predictor of STS, but found that emotional separation was a significant *negative* predictor that accounted for 39% of STS variance. Similarly, Sommer (2008), and Lawson and Myers (2011), found that maintaining objectivity—perhaps used as a form of emotional separation—was a protective mechanism for hospital social workers and therapists against the harmful effects of STS. Linley and Joseph (2007) investigated positive and negative predictors of therapist wellbeing. Therapist CF, BO, and CS were assessed using the Professional Quality of Life (ProQOL; Stamm, 2010) scale. Therapist empathy and the

bond component of the therapeutic alliance were measured using the Jefferson Scale of Physician Empathy (JSPE; Hojat et al., 2002) and the Working Alliance Inventory therapist-Bond subscale (WAI; Horvath & Greenberg, 1989) respectively. Therapist empathy was *not* found to be a significant, positive predictor of therapist CF or therapist BO. The results established that therapists' perceived strength of the therapeutic bond was an *inverse* predictor of CF and a *positive* predictor of CS. Linley and Joseph argued that "the therapeutic bond may represent the therapist's *empathic* connection with his or her clients, and thus serve as the channel through which the therapist experiences positive psychological changes in grappling vicariously with the suffering and distress of his or her clients" (p. 399). Yu et al. (2016) examined empathy as a predictor of professional quality of life among a sample of Chinese oncology nurses. The Chinese version of the ProQOL (Shen et al., 2015) was used to gauge nurse CF, BO, and CS, and the Chinese version of the JSPE (Ma, 2007) was used to assess nurse empathy. Once again, empathy was not found to be a positive predictor of CF. Yu et al. determined that the JSPE cognitive empathy scales (perspective taking & "standing in the patient's shoes") were significant negative predictors of BO. The same two subscales were found to be significant, positive predictors of CS. Perspective taking proved to be the strongest predictor of helper CS, accounting for 23% of CS variance. Wagaman et al. (2015) likewise found that empathy was a positive predictor of CS and an inverse predictor of CF and BO for a sample of clinical social workers. The four SCN empathy components (affective response, perspective taking, self-other awareness, and emotion regulation) were used to predict social worker professional quality of life outcomes. Results demonstrated that emotion regulation was a significant inverse predictor of BO ($\beta = -36$); emotion regulation ($\beta = -.21$) and self-other

awareness (β = – .26) were significant negative predictors of CF; and self-other awareness (β = .24) and affective response (β = .19) were significant, positive predictors of CS.

Therapeutic Alliance

Figley described psychotherapist empathy as the primary risk factor for psychotherapist CF. Yet, he also identified empathy as the "keystone" of the therapeutic alliance (2002a, p. 1436). Figley (2002b) stated: "The most important ingredient in building a therapeutic alliance is the client liking and trusting her or his therapist…these feelings are directly related to the degree to which the therapist expresses empathy and compassion" (p. 2). The importance of empathy to the therapeutic alliance has been well established (Elliot et al., 2011; Figley, 2002a; 2002b; Norcross & Wampold, 2011). However, Figley (1995; 2002a) stressed empathy's contribution to a strong therapeutic *bond* while paying little attention to other key alliance factors from the literature, including therapist/counsellor-client agreement on the *goals* and *tasks* of therapy (see Castonguay, Constantino, & Hotlforth, 2006; Duff & Bedi, 2010; Martin, Garske, & Davis, 2000). The compassion stress/fatigue model (1995; 2002a) failed to account for this broader definition of the therapeutic alliance.

The therapeutic alliance has been referred to as the *working alliance, therapeutic bond,* or *helping alliance* and can be traced back to early psychoanalytic theories (Martin, Garske, & Davis, 2000). Freud (1913) acknowledged that there are aspects of the therapeutic relationship that are conscious and observable—factors that can be differentiated from unconscious positive transference. Freud referred to these factors as "friendly or affectionate feelings toward the therapist" (p. 105). Zetzel (1956) likewise made a distinction between the conscious and unconscious aspects of the therapist-client relationship, and maintained that the therapeutic alliance comprises the "stable and realistic" elements of the relationship. Greenson (1965) coined

the term *working alliance,* and similarly made a distinction between the "real" relationship and unconscious transference factors. In the 1950s, a shift took place away from a "facilitative" understanding of the therapeutic alliance to a humanistic understanding that focused on the here-and-now (Horvath, 2006). Proponents of this experiential view argued that the therapeutic relationship is healing in-and-of itself (see Rogers, 1957). The *relationship* was thought to bring about change irrespective of treatment modality (Horvath). Contemporary definitions of the therapeutic alliance have moved past notions of unconscious transference and have generally viewed the alliance as a conscious and active *collaboration* between therapist/counsellor and client (Ackerman & Hilsenroth, 2003; Castonguay et al., 2006; Duff & Bedi, 2010). Client, therapist/counsellor, and co-equal contributions have each been argued to play a part in establishing the alliance (see Bordin, 1979; Duff & Bedi, 2012; Martin, 2000) and have been shown to influence therapist/counsellor wellbeing outcomes including CF, BO, and CS.

Client Factors

Tschuschke, Crameri, Koehler, Berglar, Muth, et al. (2015) examined the relationship between therapists' treatment adherence and professional experience, with clients' severity of psychological symptoms and clients' ratings of the strength of the therapeutic alliance. Notably, only clients' severity of psychological symptoms significantly predicted their ratings of the strength of the alliance. Tschuschke et al. maintained that "the person of the therapist" had no impact on the strength of the alliance as reported by the client (p. 429). Keller, Zoellner, and Feeny (2010) found that clients who had a personal history of childhood sexual abuse (CSA) had more difficulty forming an early therapeutic alliance than clients with no personal history of CSA; and Castonguay et al. (2006), in a review of the therapeutic alliance literature, identified client avoidance, client interpersonal difficulties, and client depressogenic cognitions as negative

predictors of the therapeutic alliance. Conversely, Castonguay et al. found that client psychological mindedness, client expectation for change, and client quality of object relations positively predicted the alliance's strength. Smits, Luyckx, Smits, Stinckens, and Claes (2015) gauged client perceptions of the strength of the alliance, alongside measures of client symptomatic distress, interpersonal functioning, and personality pathology. Clients' emotional dysregulation, dissocial behavior, and self-harm behavior were found to be significantly and inversely correlated with the *Task* and *Goal* (Contract) subscales of the Working Alliance Inventory-Short form (Smits et al., 2015). No significant correlation was found between client personality pathology and client ratings of the *Bond* (Contact) component of the WAI-S. Smits et al. speculated that clients who had experienced severe distress had greater difficulty reaching agreement on the contractual element of the therapeutic alliance. These findings are interesting in light of Figley's (1995; 2002a) assumptions about psychotherapist empathy and its role in establishing a strong therapeutic alliance. Participants in the Smits et al. study rated the bond component of the alliance highly regardless of the severity of their personality pathology. Yet, clients' severity of psychological symptoms prior to treatment negatively predicted their ratings of the contractual element of the alliance despite their perceptions of having a strong therapeutic bond with their clinician. Client factors like personal history of trauma and severity of psychological symptoms presumably set limits on clients' capacity to work collaboratively with their clinicians towards agreed-upon goals and tasks.

Therapist/Counsellor Factors

There has been a dearth of research that has examined therapist/counsellor factors that impact the strength of the therapeutic alliance (Ackerman & Hilsenroth, 2003; Duff & Bedi, 2010). Considerably more attention has been paid to client factors (Ackerman & Hilsenroth,

2003; Colson et al., 1988; Dunkle & Friedlander, 1996). Hunter (2012) underscored the lack of research that has addressed therapist *experiences* of the alliance and how these experiences influence therapist wellbeing. Figley (2002a; 2002b) described therapist empathy as key to establishing a strong therapeutic alliance; Rogers' (1957) recognized that certain therapist traits are necessary for a strong therapeutic alliance, including: (a) therapist congruency, (b) therapist unconditional positive regard, and (c) therapist empathic understanding with an ability to communicate this understanding to clients; Greenson (1965) stated that: "[the therapist's] compassion, interest, warmth, all within normal limits are vital for the working alliance" (p. 379); and Ackerman and Hilsenroth (2003) found that therapist trustworthiness, flexibility, confidence, respect, and empathy were traits that tend to be present in a strong therapeutic alliance.

Duff and Bedi (2010) determined that counsellor "micro behaviours" like making encouraging statements, making positive comments about the client and greeting the client with a smile, accounted for 62% of therapeutic alliance variance in client ratings. Hunter (2012) documented the "intense satisfaction" that a strong therapeutic bond provided to therapists who work with trauma-victims. Study participants described empathy as fundamental to the therapeutic relationship. Castonguay et al. (2006) identified therapist characteristics associated with a weak alliance, including: therapist rigidity, therapist criticalness and therapist inappropriate self-disclosure. Carmel and Friedlander (2009) examined how therapists' perceived strength of the alliance predicted CF, STS, BO, and CS for therapists who work with clients who had committed sexual offenses. Strong therapist alliance ratings were significantly and positively correlated with therapist CS (r = .60), and significantly and inversely correlated with therapist CF (r = -.29), STS (r = -.38), and BO (r = -.29). Carmel and Friedlander (2009) found that age (r

= .21, $p < .05$), years of clinical experience ($r = .20$, $p < .05$), and years working with clients who had sexually offended ($r = .30$, $p < .01$) were therapist characteristics that significantly predicted the strength of the therapeutic alliance. A regression analysis determined that therapist CS was a unique and significant predictor of the alliance ($\beta = .62$, $t = 5.70$, $p < .001$) accounting for 26% of the variance in alliance scores. Carmel and Friedlander noted that therapists' level of confidence and satisfaction with their work were the most important factors in therapists' perceptions of the alliance's strength. Linley and Joseph (2007) examined factors that influence therapists' positive and negative wellbeing and found that the therapeutic bond was the best predictor of therapists' positive psychological change and CS. Therapists' sense of coherence and perceptions about the strength of the therapeutic bond inversely predicted therapist BO, a sub-component of CF.

Co-equal Contributions

In the 1980s, the understanding of the therapeutic alliance shifted from therapist *versus* client contributions to a view of the alliance as a *collaboration* between therapist and client (Horvath & Symonds, 1991). This was due largely to Bordin's (1979) conceptualization. Bordin described the therapeutic alliance as "co-equal" or "intertwined". He defined the alliance using a broad framework that could be applied across helping relationships (Horvath, 2006). Bordin's definition of the therapeutic alliance comprised three components: (a) patient-therapist agreement on goals, (b) an assignment of a task or a series of tasks, and (c) the development of bonds. Research from the past few decades has largely reflected Bordin's definition. Duff and Bedi (2010) for example, described the alliance as the counsellor's and client's subjective experiences of working together towards therapeutic goals within the context of a therapeutic bond; Castonguay et al. (2006) contended that the alliance represents the interactive,

collaborative elements of the therapeutic relationship in the context of an affective bond; and Martin et al. (2000) proposed that there are three components to the therapeutic alliance: (a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks.

Hunter (2012) used a grounded theory methodology to identify therapeutic alliance factors that influence family therapists' professional quality of life. Therapists described a "deep sense of satisfaction" from working with clients who were invested in the therapeutic process (p. 183). Conversely, the same therapists found it difficult to gain satisfaction from working with resistant or aggressive clients. Negash and Sahin (2011) determined that marriage and family therapists (MFTs) likewise had a difficult time showing respect to clients who were troubled, dangerous, or inappropriate. They speculated that MFTs' lack of respect for their more challenging clients was an underlying risk-factor for CF. Tschuschke et al. (2015) examined the relationship between the therapeutic alliance, therapist treatment fidelity, therapist professional experience and client severity of psychological problems. A significant association was found between therapists' professional experience and clients' severity of psychological problems such that highly experienced therapists fared better with clients who had a higher severity of psychological problems than did therapists with less experience. Dunkle and Friedlander (1996) found that clients whose therapists reported less hostility, access to strong social support and greater comfort with closeness, were more likely to rate the emotional bond component of the therapeutic alliance favorably. Negash and Sahin (2011) determined that MFTs' heavy exposure to clients with trauma-backgrounds had a negative impact on the strength of the therapeutic alliance and tended to be associated with therapist CF.

Secondary Traumatic Stress/Work Related Stress Constructs in Relation to Compassion Fatigue

Despite the considerable concern over the past few decades about the risks of secondary traumatic stress (STS) for helping professionals, the relationship between therapists/counsellors and STS has remained unclear (Buchanan et al., 2006; Craig & Sprang, 2010; Sabin-Ferrell & Turpin, 2003). To further complicate matters, STS constructs have been used interchangeably in the literature (Baird & Kracen, 2006; Craig & Sprang, 2010; Lerias & Byrne, 2003; H. Sinclair & Hamill, 2007). For example, VT and CF have oftentimes been used interchangeably (Baird & Kracen, 2006; Craig & Sprang, 2010; Lerias & Byrne, 2003), and Figley himself stated that despite their differences in theoretical origins, CF and VT will be referred to as "compassion fatigue" (Bride, Radey, & Figley, 2007). Also, STS constructs have lacked conceptual clarity (Baird & Kracen, 2006; Craig & Sprang, 2010; Sabin-Farrell & Turpin, 2003). Illustrating this is burnout (BO; Maslach & Jackson, 1981, 1986), a *work-related* stress construct, that has been characterized as a consequence of exhaustion due to workplace/organizational factors irrespective of vocation, while STS constructs like CF and VT, have highlighted empathy as a risk factor for *helping professionals* (see Figley, 1995a; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). Despite the theoretical differences, a meta-analysis by Cieslak, Luszczynska, Shoji, Douglas, Melville, and Benight (2014) identified substantial shared variance between CF and BO, suggesting that the two constructs tap into the same underlying risk factors. Stamm (2009) stated that efforts to "ferret out" distinctions between STS and work-related stress constructs have largely been unsuccessful. Craig and Sprang (2010), de Figueiredo, Yetwin, Sherer, Radzik, and Iverson (2014), Sabin-Farrell and Turpin (2003), and Tabor (2011) have all pointed to the conceptual overlap between STS/work-related stress constructs; and Voss Horrell,

Holohan, Didion, and Vance (2011) proposed that CF, BO, and VT could be part of a larger homogeneous group of consequences with a common set of predictive factors.

Burnout

Burnout is a term that has almost become synonymous with work-related stress. It has likewise been used interchangeably with STS syndromes like CF and VT (Sabin-Farrell & Turpin, 2003). However, BO differs conceptually from CF and VT in that symptoms are not due to helpers' *empathic engagement* with clients who are traumatized or suffering. Burnout has been described as a process where once-dedicated workers disengage from their job due to work stress and strain over time. Compassion fatigue, in contrast, can occur for helpers from exposure to a single trauma event (Conrad & Kellar-Guenther, 2006). Burnout has been defined as a state of: (a) *emotional exhaustion*—feeling depleted of one's emotional resources; (b) *cynicism*—the negative, callous, and detached response to aspects of one's job; and (c) *lack of professional efficacy*—a diminished sense of accomplishment and productivity in the workplace (Leiter & Maslach, 2016; Maslach, Jackson, & Leiter, 1997; Maslach & Leiter, 2008). Maslach and Leiter (1997) expanded Maslach and Jackson's (1981, 1986) original definition to include six organizational components, including: (a) workload, (b) control, (c) rewards, (d) community, (e) fairness, and (f) values. Maslach and Leiter proposed that matches on these components—between employee expectations and actual job experience—enhance work engagement, while mismatches leave employees prone to job BO. Some researchers have argued that Maslach and Jackson's (1981; 1986) definition of BO places too much emphasis on affective symptoms reported by human services/health care professionals, and should be defined more broadly to include elements of physical and cognitive exhaustion (Demerouti et al., 2003; Kristensen et al.,

2005; Shirom & Melamed, 2006). Unlike CF, BO is not specific to helping professionals, but can impact workers irrespective of vocation (Pines & Aronson, 1988).

While there are distinctions between BO (Maslach & Jackson, 1981; 1986) and CF (Figley, 1983a) based on theoretical origins, the constructs are intertwined in the professional quality of life (ProQOL) framework, where BO and STS are identified as subcomponents of CF (Stamm, 2010). Figley and Stamm (1996) collaborated early-on to develop the Compassion Fatigue Self-Test (CFST). The CFST was the first of several iterations of the scale that would later become the ProQOL instrument. The most current iteration of the ProQOL is the ProQOL-V (Stamm, 2010). In the ProQOL-V manual Stamm defined BO as: "feelings of unhappiness, disconnectedness, and insensitivity to the work environment…[including] exhaustion, feelings of being overwhelmed, bogged down, being 'out-of-touch' with the person he or she wants to be, while having no sustaining beliefs" (2010, p. 21). Maslach's Burnout Inventory (MBI; Maslach & Leiter, 2008) has historically been the most widely-administered measure of job BO (Demerouti, Bakker, Vardakou, & Kantas, 2003). However, Stamm argued that the ProQOL scale is an alternate and likewise widely-accepted measure of BO. In a recent meta-analysis, Cieslak et al. (2014) found that ProQOL-related measures had surpassed the MBI as the most widely-used instruments for assessing job BO. The strength of the ProQOL-V is that it assesses CF, BO, and CS in a single questionnaire (Conrad, & Kellar-Guenther, 2006). What's more, ProQOL-related instruments are compatible with Figley's theory of CF (Cieslak, et al., 2014).

Vicarious Traumatization

Like Figley (1995; 2002a), McCann and Pearlman (1990) identified empathy as the primary therapist risk factor in their influential theory of VT. McCann and Pearlman defined VT as: "profound psychological effects, effects that can be disruptive and painful for the helper and

can persist for months or years after work with traumatized persons" (p. 133). Pearlman and McIan (1995) later elaborated on this definition, describing VT as: "the transformation that occurs within the therapist as a result of empathic engagement with clients' trauma experiences" (p. 558). As noted earlier, vicarious traumatization and CF have oftentimes been used interchangeably (Baird & Kracen, 2006; Craig & Sprang, 2010; Lerias & Byrne, 2003). However, there are theoretical distinctions between the two constructs. Whereas CF has been characterized by its emphasis on socio-emotional symptoms (Jenkins & Baird, 2002), VT is characterized by its impact on helpers' cognitive schemata and psychological development (Jenkins & Baird, 2002; Sabin-Farell &Turpin, 2003). McCann and Pearlman (1990) maintained that changes from VT are longstanding, cumulative and potentially permanent. In contrast, Figley (2002a) described the onset of CF as rapid, and the effects more transient than those of VT. Theoretically, VT can be further differentiated from CF by its constructivist self-development theory (CSDT; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). The underlying premise of CSDT is that therapists' exposure to clients' trauma material can be disruptive to therapists' cognitive schemata, including therapists' beliefs about safety, trust, power, esteem, and intimacy (McCann & Pearlman, 1990). McCann and Pearlman (1990) and Pearlman and MacIan (1995) argued that symptoms of VT develop through therapist-client interaction, such that therapists' severity of symptoms is contingent on the similarity between therapists' existing beliefs about the world and clients' trauma experiences. Pearlman and Saakvitne (1995b) maintained that the impacts of VT can "profoundly change" therapists' frames of reference and cognitive schemata.

Helper Positive Wellbeing Constructs

Compassion Satisfaction

Critics of Figley's (1995; 2002a) compassion stress/fatigue model have argued that it fails to account for the positive wellbeing outcomes that can result from therapists'/counsellors' empathic engagement with clients, such as resilience and hope (Sabo 2011; H. Sinclair & Hamill, 2007), and CS (Stamm, 1993). Secondary traumatic stress research has tended to neglect these positive helper outcomes, choosing instead to focus on the negative outcomes experienced by empathic practitioners (Linley & Joseph, 2007; Samios, Abel, & Rodzik, 2013; Sodeke-Gregson, Holttum, & Billings, 2013). Despite this, there is a growing recognition of the positive and protective outcomes of helpers who work with trauma-victims (Sodeke-Gregson, et al., 2013). Compassion satisfaction is one such outcome. The concept of CS originated with Stamm (1993) during development of the CFST. Stamm described CS as: "the pleasure you derive from being able to do your work…[to] feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society" (2010, p. 12). Larsen and Stamm (2008) maintained that CS is unique to therapists and results from the empathic bond shared between therapist and client. Despite Figley's (2002a; 2002b) emphasis on the harmful effects of therapist empathy, he too acknowledged that therapists have the capacity to derive satisfaction from their work with trauma victims. Figley described CS as a mechanism that protects psychotherapists from the harmful effects of CF. He later advocated for a "paradigm shift" toward research that identifies factors that promote CS (see Radey & Figley, 2007). Other definitions of CS have included: "the ability to receive gratification from caregiving" (Simon, Pryce, Roff, & Klemmack, 2006, p. 6); the degree to which helpers feel successful in their jobs

and supported by their colleagues (Conrad & Kellar-Guenther, 2006); and, the positivity involved in caring (Phelps, Lloyd, Creamer, & Forbes, 2009).

Moderators of Empathy and Helper Wellbeing

As has been noted from the outset of this manuscript, Figley (1995; 2002a) identified therapist empathy as the central factor in the compassion stress/fatigue model. Yet, as described earlier on page 4, he identified other therapist risk factors in the model, including: (a) *life disruption*—unexpected changes in routine and/or the management of life responsibilities, (b) *traumatic recollections*—memories that trigger PTSD symptoms, and (c) *prolonged exposure to clients' trauma material*—the ongoing sense of responsibility for a client's care over an extended period of time. Also to be noted, however, is that Figley identified protective factors that he proposed can guard therapists against the harmful effects of CF. These include: (a) *psycho-education about CF*, (b) *desensitizing therapists to traumatic stressors*, (c) *promoting therapists' sense of achievement*—the extent to which the therapist is satisfied with his or her efforts to help the client, (d) *exposure therapy*, (e) *disengagement*—the extent the therapist can distance him or herself from the suffering of the client between sessions, and (f) *utilization of social support networks*. There have been few empirical studies (Hunsaker, Chen, Maughan, & Heaston, 2015; Killian, 2008; Maslach & Leiter, 2008; Perkins & Sprang, 2013) that have tested these factors. However, evidence has pointed to workplace/organizational factors like prolonged exposure to clients' trauma material, as factors that can put therapists/counsellors at increased risk for CF (see Craig & Sprang, 2010; Hensel et al., 2015; Killian, 2008; Lawson & Meyers, 2011; Sprang, Clark, & Whitt-Woosley, 2007). Therapist/counsellor disengagement and utilization of social support networks have been shown to be protective factors (see Bourassa, 2011; Hensel et al., 2015; Hunter & Schofield, 2006; Iliffe and Steed, 2000; Jacobson, 2008; Maytum, Bielski

Heiman, & Garwick, 2004). Additionally, helper personal characteristics including age (Craig & Sprang, 2010; Hensel et al., 2015; Hunsaker et al., 2015; Sprang et al., 2007;) and years of clinical experience (Hensel et al., 2015) have been shown to be protective factors against CF, while female gender (Rossi et al., 2012; Sprang et al., 2007) and personal history of trauma (Hensel et al., 2015; Killian, 2008; Thomas, 2013) have been associated with increased risk.

Workplace/Organizational Factors

Hunter and Schofield (2006) determined that clinical supervision was an important organizational coping strategy for counsellors who worked with trauma victims: Less-experienced counsellors reported a need for more frequent supervision than counsellors who had greater clinical experience. de Figueiredo et al. (2014) established that supervision protected against CF and promoted CS for a multidisciplinary group of helpers who worked with trauma-victims. Sodeke-Gregson et al. (2013) found that trauma therapists' perceived level of managerial and supervisory support predicted therapist CS, while therapists' perceived lack of managerial support predicted therapist BO. Despite these findings, Sodeke-Gregson et al. were unable to identify the specific elements that constitute good management support. Baird and Kracen (2006), in a review of STS studies, determined that supervision had a buffering effect against CF; and Hunsaker et al. (2015) concluded that managerial support was a positive predictor of CS (adjusted R^2 = .12) and an inverse predictor of CF (adjusted R^2 = .06) and BO (adjusted R^2 = .15) for a sample of emergency room nurses. Like Sodeke-Gregson et al., however, Hunsaker et al. did not operationally define managerial support, but implicated that it could involve managers building positive relationships with nurses, providing counsel to less-experienced nurses, and fostering an environment of open communication with nurses.

Contrary to these findings, Bourassa (2011) found that adult protective social workers preferred less supervision and increased independence as means of protecting themselves against CF. Participants did, however, report a need for support from *colleagues*. Hunter and Schofield (2006) and Iliffe and Steed (2000) likewise found a need among counsellors for peer-support (informal debriefing with colleagues) in addition to supervision from managers. Killian (2008) established that social support ($\beta = .46$), together with weekly hours of clinical contact ($\beta = -.37$) and therapist locus of control ($\beta = .22$), accounted for 41% (adjusted R^2) of the variance associated with CS for a trauma therapist sample; Hensel, Ruiz, Finney, and Derva (2015), in a meta-analysis, determined that work support and social support had small but significant effect sizes across studies as protective factors against STS; and Jacobson (2008) found that crisis intervention workers rated social support as the most effective coping strategy to protect against work-related stress. Perhaps these findings tapped into the *control* and *community* criteria described by Maslach and Leiter (1997), where professional autonomy and quality of social context are described as important factors in the prevention of BO. The endorsement of peer and social support as protective factors for therapists/counsellors is consistent with Figley's (1995; 2002a) compassion stress/fatigue model. Figley described the need for therapists to increase both the number and variety of supportive relationships in their lives, and to build relationships that help therapists to see themselves outside of their therapist role. In addition to recognizing supervision and peer support as protective factors, the studies noted above also recognized these factors as predictors of helper *CS* (de Figueiredo et al., 2014; Hunsaker et al., 2015; Killian, 2008; Sodeke-Gregson et al., 2013).

Figley (1995; 2002a) identified prolonged exposure to clients' trauma material, and therapist disengagement as workplace/organizational factors that influence therapist CF. There is

empirical evidence that has associated these variables with helper CF, BO, and CS. For example, Lawson and Myers (2011), found significant positive correlations between counsellor BO and percentage of "trauma survivors" (r = .14, p = .002, r^2 = .02) and "high-risk" clients (r = .20, p < .001, r^2 = .04) on counsellor caseloads. Conversely, Lawson and Myers found a negative correlation between the percentage of high-risk clients on counsellor caseloads and counsellor CS (r = – .18, p < .001, r^2= .03). Sprang et al. (2007) found that the percentage of clients with posttraumatic stress disorder (PTSD) on counsellor caseloads proved a significant positive predictor of counsellor CF ($R^2\Delta$ = .20) and BO ($R^2\Delta$ = .03). Hensel et al. (2015) identified significant effect sizes for trauma caseload volume, trauma caseload frequency, and trauma caseload ratio as helper risk factors for STS. Craig and Sprang (2010) determined that both percentage of PTSD clients on counsellor caseloads and use of evidence-based practices were significant predictors of CF: percentage of PTSD clients on counsellor caseloads proved to be a significant positive predictor of counsellor CF, while the use of evidence-based practices significantly and inversely predicted counsellor CF. Killian (2008) similarly found that therapists' weekly hours of clinical contact with trauma victims was a significant negative predictor of therapist CS.

Maytum et al. (2004) used open-ended interviews to identify factors that contribute to CF and BO for a sample of pediatric nurses. Nurses described an inability to draw appropriate professional boundaries as a threat for CF and BO. Systemic risks like work overload and a lack of time for self-care were also identified. Killian (2008), likewise found that work drain was a significant and positive predictor of CF (β = .32) and BO (β = .49). Bourassa (2011) examined risk factors and experiences associated with CF for adult protective services (APS) social workers, using a grounded theory methodology. Themes were grouped into two categories: (a)

personal characteristics—education, past personal history of crisis, worker's overall sense of achievement, worker's job experience, and individual preventive actions used to prevent CF; and (b) *professional factors*—level of co-worker support and lack of supervisory support. Based on data from these categories Bourassa created a working hypothesis: "Personal characteristics and professional factors experienced by the APS social workers led to the creation and utilization of boundaries that protected these social workers from the effects of compassion fatigue" (p. 1703).

Personal Characteristics

Helper personal characteristics including gender, age, years of clinical experience, and personal trauma history have also been associated with CF, BO, and CS in empirical studies. Sprang et al. (2007) found that female gender was associated with higher levels of CF among health providers; Baum, Rahav, and Sharon (2014), in a meta-analysis of STS studies, found that female helping professionals experienced considerably higher STS than their male counterparts; and Rossi et al. (2012) found that female gender predicted an 11% increase in CF scores. Linley and Joseph (2007) found that female therapists were more likely to experience CS than their male colleagues; and Thompson, Amatea, and Thompson (2014) did not find that gender was a significant predictor of CF or BO, in a counsellor sample. Sprang et al. (2007) established that practitioner demographic variables including age and gender, were significant predictors of CF, BO, and CS: Young age and female gender significantly predicted CF ($R^2\Delta = .01$) and BO ($R^2\Delta = .04$), while older age and male gender significantly predicted CS ($R^2\Delta = .04$). Craig and Sprang (2010) likewise found that age was an inverse predictor of BO; Hunsaker et al. (2015) determined that age ($R^2 = .04$) was a significant positive predictor of CS and a significant negative predictor of BO ($R^2 = .01$); and Hensel et al. (2015) identified small but significant

negative effect sizes for age and clinical experience as predictors of STS. Conversely, Thomas (2013) did not find that gender or years of work experience were significant predictors of CF.

Ray et al. (2013) identified number of years in the profession as a significant positive predictor of emotional exhaustion—a sub-component of BO (R^2 = .04), and Yu et al. (2016) determined that oncology nurses with greater clinical experience had higher levels of CF. Personal history of trauma has also been identified as a factor that puts helpers at increased risk for CF. Thomas (2013) determined that personal trauma history was a significant positive predictor of CF for a sample of clinical social workers (β = .19); Sodeke-Gregson et al. (2013) concluded that trauma-therapists who had experienced a traumatic event themselves, were at increased risk for STS; Killian (2008) identified personal history of trauma as a significant positive predictor of CF (β = .23) for a sample of trauma therapists; and Hensel et al. (2015) identified a small but significant effect size for personal trauma as a risk factor for CF in a meta-analysis of STS studies.

Purpose of Study

Figley's (1995; 2002a) compassion stress/fatigue model has described psychotherapist empathy as essential for positive client outcomes, but also the primary risk factor for psychotherapist CF. Consequently, due to the influence of Figley's model—and other influential STS theories (see VT; McCann & Pearlman 1990; Pearlman & McIan, 1995)—empathy has been viewed by helping professionals as a double-edged sword. Yet, the past few decades has seen a growing number of studies recognize empathy as a source of helper protection (Coutinho et al., 2014; Linley & Joseph, 2007) and satisfaction (Harrison & Westwood, 2009; Hunter, 2012; Wagaman et al., 2015; Yu, Jiang, & Shen, 2016). This has therefore prompted a need to better understand the role of therapist/counsellor empathy for therapist/counsellor CF and CS

wellbeing outcomes, and the associated implications for therapist/counsellor training and clinical practice. Figley also recognized the importance of the therapeutic alliance, paying particular attention to the therapeutic *bond* for client outcomes. However, the compassion stress/fatigue model has failed to address how a strong therapeutic alliance impacts therapist wellbeing. The aim of the present study is to re-examine the role of therapist/counsellor empathy and therapist/counsellor perceptions of the therapeutic alliance, through the development of empirical models that can be used to predict therapist/counsellor CF and CS. Therapist/counsellor Personal Characteristics and Workplace/Organizational factors identified from the literature will also be examined in the predictive models.

Research Questions and Hypotheses

Question 1(a): Is therapist/counsellor empathy a risk or a protective factor for therapists/counsellors? Does therapist/counsellor empathy predict therapist/counsellor CF, CS, or both?

- *H1(a)*: Therapist/counsellor empathy will negatively predict therapist/counsellor CF.

  Analysis: Path model 1(a) will demonstrate a significant ($\alpha = .05$) negative direct effect of therapist/counsellor empathy on therapist/counsellor CF.

- *H1(b)*: Therapist/counsellor empathy will positively predict therapist/counsellor CS.

  Analysis: Path model 1(b) will demonstrate a significant ($\alpha = .05$) positive direct effect of therapist/counsellor empathy on therapist/counsellor CS.

Question 1(b): What therapist/counsellor Personal Characteristics and Workplace/Organizational factors work together with therapist/counsellor empathy to predict therapist/counsellor CF and CS?

- *H1(c)*: Therapist/counsellor age and clinical experience will predict therapist/counsellor empathy, and will indirectly and inversely predict therapist/counsellor CF; while a lack of supervision and peer support (combined into one indicator), and percentage of distressing clients on therapist/counsellor caseload will predict therapist/counsellor CF.

Analysis: Path model 1(a) will demonstrate a significant ($\alpha = .05$) positive direct effect of therapist/counsellor age and clinical experience on therapist/counsellor empathy, and a significant ($\alpha = .05$) negative indirect effect on therapist/counsellor CF. Path model 1(a) will demonstrate a significant ($\alpha = .05$) direct effect of lack of supervision and peer support and percentage of distressing clients on therapist/counsellor caseloads, on therapist/counsellor CF.

- *H1(d)*: Therapist/counsellor age and clinical experience will predict therapist/counsellor empathy and indirectly and positively predict therapist/counsellor CS; while greater supervision and peer support (combined into one indicator), and percentage of non-distressing clients on therapist/counsellor caseload will directly predict therapist/counsellor CS.

Analysis: Path model 1(b) will demonstrate a significant ($\alpha = .05$) positive direct effect of therapist/counsellor age and clinical experience on therapist/counsellor empathy. Path model 1(b) will demonstrate a significant ($\alpha = .05$) positive direct effect of supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseloads, on therapist/counsellor CS.

Question 2(a): Do therapist/counsellor perceptions of the strength of the therapeutic alliance predict therapist/counsellor CF, CS, or both?

- *H2(a)*: Therapist/counsellor perceptions of the strength of the therapeutic alliance will negatively predict therapist/counsellor CF.

Analysis: Path model 2(a) will demonstrate a significant (α = .05) negative direct effect of therapist/counsellor perceptions of the strength of the therapeutic alliance on therapist/counsellor CF.

- *H2(b)*: Therapist/counsellor perceptions of the strength of the therapeutic alliance will positively predict therapist/counsellor CS.

Analysis: Path model 2(b) will demonstrate a significant (α = .05) positive direct effect of therapist/counsellor perceptions of the strength of the therapeutic alliance on therapist/counsellor CS.

Research Question 2(b): What therapist/counsellor Personal Characteristics and Workplace/Organizational factors work together with therapist/counsellor perceptions of the strength of the therapeutic alliance to predict therapist/counsellor CF and CS?

- *H2(c)*: Therapist/counsellor age and clinical experience will predict therapist/counsellor perceptions of the strength of the therapeutic alliance, and indirectly and inversely predict therapist/counsellor CF; while a lack of peer support and supervision (combined into one indicator), and percentage of distressing clients on therapist/counsellor caseloads will predict therapist/counsellor CF.

Analysis: Path model 2(a) will demonstrate a significant (α = .05) positive direct effect of therapist/counsellor age and clinical experience on therapist/counsellor perceptions of the strength of the therapeutic alliance, and a significant (α = .05) indirect inverse effect on therapist/counsellor CF. Path model 2(a) will demonstrate a significant (α = .05) direct effect

of lack of supervision and peer support, and percentage of distressing clients on therapist/counsellor caseload, on therapist/counsellor CF.

- *H2(d)*: Therapist/counsellor age and clinical experience will predict therapist/counsellor perceptions of the strength of the therapeutic alliance, and indirectly and positively predict therapist/counsellor CS; while greater supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseloads, will directly predict therapist/counsellor CS.

Analysis: Path model 2(b) will demonstrate a significant ($\alpha = .05$) positive direct effect of therapist/counsellor age and clinical experience on therapist/counsellor perceptions of the strength of the therapeutic alliance. Path model 2(b) will demonstrate a significant ($\alpha = .05$) direct effect of supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseload, on therapist/counsellor CS.

Chapter 3

METHODS

Ethics Approval

Ethics approval for the present study was received from the Human Research Ethics Board (HREB) on November 7, 2016. Data collection began in January 2017 and was completed in September, 2017. The Board of Record Approval Reference number for the study is BC16-344 (see Appendix A).

Participants and Procedures

One hundred-and-forty-six participants identifying as female were recruited from the British Columbia Association of Clinical Counsellors (BCACC) and the Canadian Counselling and Psychotherapy Association (CCPA). Participants' ages ranged from 24-73 years (M = 42.4, SD = 11.9). The final sample comprised 54% of the 268 individuals who filled-out the FluidSurveys online survey-packet. Cases from 109 respondents (41%) were excluded from final analyses, using list-wise deletion, due to incomplete questionnaires (cases were excluded if even a single item was left incomplete on any of the questionnaires included in the survey-packet). Thirteen (5%) further cases were excluded (those identifying as male = 11, other = 2) from final analyses due to gender underrepresentation, resulting in an achieved sample homogeneous for participants identifying as female. This coincidentally provided a more robust test of Figley's assumption about therapist empathy as a risk factor: Studies have found that females are at greater risk for CF and STS (Baum, Rahav, & Sharon, 2014; Rossi et al., 2012; Sprang et al., 2007) and report being more empathic than males, on average, on self-report scales (Davis, 1983). Male-identifying participants whose cases were excluded from final analyses were sent an email outlining the rationale for the exclusion of their data—specifically explaining that male

versus female gender comparisons could not be made due to the small number of male-identifying respondents. These participants were invited to contact the primary researcher if they had any questions or concerns about the study, or feedback related to the low participation rate of male-identifying therapist/counsellors. The BCACC has a membership of 2,800 registered clinical counsellors (RCCs) and the CCPA has a membership of over 5,000 Canadian certified counsellors (CCCs) Canada-wide. A variety of methods was used to recruit study participants. Members of the BCACC were recruited via an advertisement placed in the BCACC's weekly e-newsletter. Additionally, one stand-alone advertisement was sent out to BCACC members through a listserv broadcast email. Invitations to CCPA members were distributed by listserv broadcast emails sent out on seven separate occasions, and an advertisement posted on the CCPA website under a section for student research. British Columbia provincial government employees from lower mainland child and youth mental health (CYMH) programs (Abbotsford, Chilliwack, Mission, & Langley offices) and Fraser health authority programs (START crisis program East, START crisis program North, & adolescent day treatment program East) were given the opportunity to participate via email invitations distributed by respective program team leaders. Invitations made explicit that staff choosing to participate must also be registered BCACC or CCPA members. Two separate advertisements were used for recruitment: one designed for distribution to BCACC members (see Appendix B) and the other for distribution to CCPA members and BC provincial employees (see Appendix C). Both advertisements noted that participants would be entered into a $100 draw as compensation for their time. Advertisements included a brief description of the study as a project that was investigating "how counsellors/psychotherapists can improve their professional quality of life", and included a link that took participants to the online surveys. Once directed to the online survey-packet,

participants were instructed to read the Letter of Information (see Appendix D) which outlined the purpose and objectives of the study, importance of the research, rationale for participant selection, risks, benefits and compensation. Participants were informed that participation would require 15 to 20 minutes of their time and would involve filling-out background and caseload information and the completion of six different surveys (one of which was later excluded from final analyses). Participants were then asked to "check" that they consented to the terms before they were directed to the online survey- packet.

Background and Caseload Information

Participant background and caseload information was obtained from participants from a questionnaire included in the online survey-packet (see Appendix E). Background information included: age, gender, years of clinical experience, highest degree earned, professional credentials, primary and secondary work settings, primary and secondary delivery modes and various professional roles engaged in during a typical week. Caseload information included: percentage of client-caseload comprising clients impacted by the effects of past or present trauma, percentage of client-caseload that participants found personally distressing, and participants' hours of direct clinical contact during a typical week.

Measures

Professional Quality of Life Scale-Fifth edition (ProQOL-V; Stamm, 2010). The ProQOL-V was used to assess therapist/counsellor professional quality of life (see Appendix F). The ProQOL-V is a 30-item scale comprising CF (STS and BO) and CS subscales. Secondary traumatic stress and BO subscales were summed in the present study to create the CF variable, as per the direction of the ProQOL manual (Stamm, 2010). The ProQOL in its various editions is the "most commonly used measure of the positive and negative effects of working with people

who have experienced extremely stressful events" (Stamm, 2010, p. 12). Cieslak et al. (2014), in a meta-analysis of STS and BO studies, determined that ProQOL-related measures are the most popular instruments for assessing STS (65.85% of studies) and BO (60.98% of studies). Across the 16 studies Cieslak et al. identified from the literature that made use of the ProQOL, internal consistency for total scores ranged from good to excellent (Cronbach's $\alpha = .71$ to $\alpha = .87$). Participants were asked to rate the frequency of work experiences, like: "I feel overwhelmed because my caseload seems endless" and "I get satisfaction from being able to help people", using a response format ranging from 1 (*Never*) to 5 (*Very Often*). The cut-off scores for the ProQOL-V are: *Low* (22 or less), *Average* (23−41), and *High* (42 or more). In the present study, for the STS subscale, zero participants (0%) scored in the High range, 56 participants (38%) scored in the Average range, and 90 participants (62%) scored in the Low range; for the BO subscale, zero participants (0%) scored in the High range, 64 participants (44%) scored in the Average range, and 82 participants (56%) scored in the Low range; and for the CS subscale, 70 participants (48%) scored in the High range, 76 participants (52%) scored in the Average range, and zero participants (0%) scored in the Low range. Stamm (2010) reported internal consistency values for each of STS ($\alpha = .81$), BO ($\alpha = .75$), and CS ($\alpha = .88$). For the present study, internal consistency was excellent for CF (STS & BO; $\alpha = .87$) and CS ($\alpha = .89$). Stamm (2005) stated that the construct validity of the ProQOL has been "well established with over 200 articles noted in the peer-review literature" (p. 9). A multi-trait multi-method approach to convergent and discriminant validity (Campbell & Fiske, 1959) demonstrated that the ProQOL subscales measure discrete constructs (Stamm, 2005).

Support Appraisal for Work Stressors (SAWS) inventory (Lawrence, Gardner, & Callan, 2007). The SAWS inventory taps direct supervisor, work colleague, and

partner/family/friend support; 12 items making up each subscale. In the present study, however, only direct supervisor and work colleague support was measured (see Appendix G). These sources were found to be associated with helper CF and CS in the literature, while less evidence was found that directly linked partner/family/friend support to these helper wellbeing outcomes. The SAWS gauges four separate supportive functions across sources, including: (a) emotional support, e.g. "How much can you rely on your (direct supervisor/work colleague) to listen to you when you need to talk about work-related problems?", (b) informational support, e.g. "How much can you rely on your (direct supervisor/work colleague) to provide information which helps to clarify your work-related problems?", (c) instrumental support, e.g. "How much can your (direct supervisor/work colleague) be relied on to help when things get tough at work?", and (d) appraisal support, e.g. "How much can you rely on your (direct supervisor/work colleague) to acknowledge your efforts to resolve your work-related problems?" Participants were asked to rate the reliability of support from each source by using a response format ranging from 1 (*Not At All)* to 4 (*Very Much).* There are no set cut-off scores for the SAWS. Lawrence et al. (2007) established criterion-related validity for the SAWS by examining the bivariate correlations of the four SAWS supportive functions with measures of negative network orientation (Vaux, 1985) and closeness (Vaux & Harrison, 1985). Significant negative bivariate correlations were identified across all four SAWS supportive functions with negative network orientation, both for direct supervisor and work colleague sources, as predicted. Significant positive bivariate correlations were identified across all four SAWS supportive functions with measures of closeness, both for direct supervisor and work colleague sources, as predicted. Lawrence et al. (2007) also identified strong internal consistency for the four SAWS direct supervisor supportive functions (Cronbach's alpha coefficients: emotional support, $\alpha = .87$,

informational support, α = .86, instrumental support, α = .88, and appraisal support, α = .90) and good internal consistency for the four work colleague sources of support (Cronbach's alpha coefficients: emotional support, α = .81, informational support, α = .76, instrumental support, α = .82, and appraisal support, α = .80).

Stressful Life Experiences Screening-Short form (SLES-S; Stamm, 1997). The SLES-S was used to assess study participants' experiences of stressful or traumatic life events (see Appendix H). The unedited SLES-S measure comprises 20 items, with a response scale that ranges from 0 (*Did not experience*) to 10 (*Exactly like my experiences*). However, to enhance clarity, the response format was changed in the present study to include a Likert-type response format ranging from 0 (*Not At All)* to 3 (*Very Much).* Participants were first asked to respond *Yes* or *No* to items including: "I have witnessed or experienced a natural disaster, like a hurricane or earthquake", and "I have witnessed a serious accident or injury". They were then asked to use the response scale to indicate how stressful each experienced event is to them presently. Jacobson (2012) reported good internal consistency (Cronbach's α = .75) for the original, unedited measure.

Empathy Assessment Index (EAI; Lietz et al., 2011). The EAI is a 16-item questionnaire (see Appendix I) that was used to gauge participants' empathy levels on four SCN empathy components, including: (a) affective response, (b) self-other awareness, (c) perspective taking, and (d) emotion regulation. Participants were asked to rate items like: "Watching a happy movie makes me feel happy", and "I can imagine what it's like to be in someone else's shoes", on a Likert-type scale ranging from 1 (*Never*) to 5 (*Always*). Lietz et al. (2011) initially created a 17-item EAI that included a three-item empathic attitudes subscale. However, this subscale was later dropped due to poor internal consistency and content validity. Lietz et al. (2011) also determined

that the affective response subscale, from the original 17-item EAI, lacked content validity. They recommended that the following items be added to strengthen the subscale: “I understand other people’s emotional signals”, and “I am good at judging other people’s emotional states”. These items were added to the EAI in the present study, for a total of 16 items. There are no established cut-off scores for the EAI. Lietz et al. (2011) identified a strong correlation between the perspective taking and self-other awareness (r = .86) components of the EAI. The researchers maintained that it is not surprising that the relationship between constructs is strong as they are “closely intertwined” and “function simultaneously, though separately, in the brain” (p. 117). Lietz et al. (2011) reported good reliability for the 17-item EAI total scale (Cronbach’s α = .82), stating: “The results indicate acceptable internal consistency” (p. 115). The reliability for the EAI total scale in the present study was also good (Cronbach’s α = .78). Lietz et al. reported test-retest reliabilities for each of the 17-item EAI subscales: affective response (r = .74, Spearman’s rho = .74), self-other awareness (r = .69, Spearman’s rho = .67), emotion regulation (r = .76, Spearman’s rho = .75), and perspective taking (r = .77, Spearman’s rho = .78). According to Cohen’s (1988) guidelines, these correlations indicate healthy test-retest reliability.

Gerdes et al. (2010), in a pilot administration of the EAI, found statistically significant correlations between the empathic concern and perspective taking components of the Interpersonal Reactivity Index (IRI; Davis, 1980; 1983) and affective response and perspective taking components of the EAI (Pearson’s values ranged from r = .48 to r = .75). Lietz et al. (2011) examined the concurrent validity of the emotion regulation and self-other awareness components of the 17-item EAI, with the CERQ-short (a measure of emotion regulation coping strategies) and MAAS (a mindfulness scale where lower scores indicate greater mindfulness). A moderately strong, positive correlation was found between the emotion regulation subscale of the

EAI, and the CERQ-short (r = .51, Spearman's Rho = .49, p = .001). A modest negative correlation was identified between the EAI self-other awareness component and the MAAS (r = -.27, Spearman's Rho = -.27, p = .001).

Working Alliance Inventory-Short form (WAI-S, therapist version; Tracey & Kokotovic, 1989). The WAI-S is an abbreviated version of Horvath and Greenberg's (1986) original WAI, which is the most widely used instrument for measuring the therapeutic alliance (Hatcher & Gillaspy, 2005). The WAI-S was used in the present study to assess therapist/counsellor perceived strength of the therapeutic alliance. The full-scale WAI is a 36-item measure that taps into therapists' (therapist version) perceptions about three aspects of the therapeutic alliance derived from Bordin's (1979) definition, including: (a) therapeutic tasks, (b) treatment goals, and (c) therapeutic bond. The WAI-S is a 12-item scale comprised of the four items from each of the WAI full-scale subscales with the highest factor loadings (see Appendix J). As for the WAI, the three WAI-S subscales include: Tasks, Goals, and Bond. Items on the WAI-S are rated on a 7-point Likert-type scale, ranging from 1 (*Never*) to 7 (*Very Often*). There are no established cut-off scores for the WAI-S. Hatcher and Gillaspy (2005) reported excellent internal consistency for WAI-S subscale scores (Goals, α = .87, Tasks, α = .85, & Bond, α = .90) as well as WAI-S full-scale scores (α = .91). The internal consistency of the WAI-S total scale was also excellent in the present study (Cronbach's α = .88). Busseri and Tyler (2003) found that the predictive validity of the WAI-S was comparable to that of the full-scale WAI. Client and therapist WAI and WAI-S ratings were regressed onto a client composite improvement index. Results indicated that client and therapist WAI and WAI-S fourth-session ratings were moderately correlated with client composite improvement scores. For the present study, the WAI-S introduction and item stems were modified to address therapist/counsellor perceptions of

the strength of the therapeutic alliance with clients more generally, rather than with one specific client as is the case in the unedited WAI-S.

Power

A statistical power analysis was carried-out for sample size estimation using GPower 3.1 software ($\alpha = .05$; power = .80; $\delta = .15$). Based on this analysis, the sample size needed for each respective model was determined ($N = 98$).

Research Design

Partial least squares path modelling (PLS-PM; Lohmöller, 1989; Wold, 1982, 1985) was used to test four models that corresponded to their respective research questions and hypotheses. The path models were analyzed using SmartPLS-3 (Ringle, Wende, & Becker, 2015) partial least squares (PLS) path modelling software. Latent variables were generated based on a review of the pertinent literature. The exogenous latent variables included: Personal Characteristics and Workplace/Organizational Factors. These variables were constant across all four models. The endogenous latent variables included: Empathy, Therapeutic Alliance, and Professional Quality of Life. Empathy was the mediating variable of therapist/counsellor Personal Characteristics and Professional Quality of Life in Models 1(a) and 1(b). The Therapeutic Alliance was the mediating variable of therapist/counsellor Personal Characteristics and Professional Quality of Life in Models 2(a) and 2(b). Professional Quality of Life was the outcome latent variable across all four models, sub-divided into negative (CF) and positive (CS) therapist/counsellor wellbeing outcomes within each set of models.

Exogenous variables. The Personal Characteristics latent variable included the following indicators: age, gender, years of clinical experience, and personal history of trauma. Age, gender, and years of clinical experience were obtained from participants' "Background Information"

page of the FluidSurveys online survey-packet (see Appendix E). Personal history of trauma was obtained from participants' scores on the Stressful Life Experiences Screening-Short form (SLES-S). The SLES-S was included in the online survey-packet (see Appendix H). The Workplace/Organizational Factors latent variable included the following indicators: supervision and peer support, and percentage of personally distressing clients on therapist/counsellor caseload. Supervision and peer support was measured using the Support Appraisal for Work Stressors (SAWS) inventory. In the present study, these two sources of support were collapsed into a single indicator variable as they became a stronger single indicator of the Workplace/Organizational Factors latent variable when grouped together versus when used as separate indicators. The SAWS was also included in the online survey-packet (see Appendix G). Percentage of personally distressing clients on therapist/counsellor caseload was reported by participants on the "Caseload Information" page of the online survey-packet (see Appendix E). Gender and personal history of trauma were ultimately dropped from the final analyses due to an overrepresentation of female-identifying participants in the sample, and the SLES-S proving to be a weak indicator of the Personal Characteristics latent variable.

Endogenous variables. The Empathy latent variable included the full-scale items of the Empathy Assessment Index (EAI); The Therapeutic Alliance latent variable included the full-scale items of the Working Alliance Inventory-Short form (WAI-S; therapist version); and the Professional Quality of Life latent variable consisted of the compassion fatigue (STS & BO) and compassion satisfaction (CS) subscales of the Professional Quality of Life Scale-Fifth edition (ProQOL-V). The EAI, WAI-S, and ProQOL-V were included in the online survey-packet (see Appendices I, J, & F). Models 1(a) and 2(a) used CF as the ProQOL-V outcome variable. Models 1(b) and 2(b) used CS as the ProQOL-V outcome variable.

Chapter 4

RESULTS

Descriptive Statistics

Descriptive statistics including mean, standard deviation, and range were calculated for variables included in the partial least squares path models (PLS-PM; see Table 1). A correlation matrix was also calculated for PLS-PM variables (see Appendix K). Frequencies and percentages for participant background and caseload information categorical variables—not included in the partial least squares path analyses—were tabulated (see Appendix L). Additionally, comparison tests were carried-out between the study sample and the greater BCACC membership using information obtained from a 2016 BCACC annual report (N = 3565). Data for CCPA membership were not available. The results of a one-sample t-test determined that the mean age of participants (M = 42.4) in the present study was significantly less than that of BCACC members (M = 49.0), $t(146) = -6.71$, $p < .001$, two-tailed. Proportionally fewer study participants (53%) were involved in private practice than those reporting to work in private practice among the BCACC membership (69%), Fisher's exact, $p = 0.00$, two-tailed. There was no statistically significant difference between the proportion of study participants who reported providing clinical supervision (25%), and those among the BCACC membership who reported providing clinical supervision (25%), Fisher's exact, $p = .40$, two-tailed.

Partial Least Squares Path Analyses

Structural models. Hypothesis *1(a)* predicted that therapist/counsellor empathy would inversely predict therapist/counsellor CF. This was supported by the results. Path-analysis 1(a) demonstrated a significant, negative direct effect of therapist/counsellor empathy on therapist/counsellor CF as predicted (see Figure 2). The strength of the effect exceeded Chin's

Table 1

Descriptive Statistics for Variables Included in Partial Least Squares Path Models

Path model variables	*M*	*SD*	Range
Age	42.4	11.9	24−73
Years of clinical experience	10.9	9.0	.25−40
Percentage of distressing clients on caseload	23.4	21.9	0−100
Percentage of non-distressing clients on caseload	76.6	21.9	0−100
Secondary traumatic stress (STS)	21.0	4.9	11−35
Burnout (BO)	22.1	5.6	10−39
Compassion satisfaction (CS)	40.9	5.0	26−50
Support appraisal for work stressors (SAWS)	71.0	16.3	24−96
Lack of supervision and peer support (SAWS reverse)	49.0	16.3	24−96
Empathy assessment index (EAI)	64.6	4.8	48−76
Working alliance inventory (WAI-S)	66.1	6.1	50−79
WAI-S Tasks	21.6	2.4	15−26
WAI-S Bond	23.4	1.9	17−28
WAI-S Goals	21.1	2.6	16−27

Note. Secondary traumatic stress and Burnout were measured using the Professional Quality of Life Scale – Fifth edition (Stamm, 2010); the Support Appraisal for Work Stressors is from Lawrence et al. (2007); the Empathy Assessment Index is from Lietz et al. (2011); and the Working Alliance Inventory is from Tracey and Kokotovic (1989). All values represent raw, non-standardized scores.

(2010) criteria ($\beta > .20$) for meaningful path relationships. Hypothesis *1(b)* predicted that therapist/counsellor empathy would positively predict therapist/counsellor CS. This too was supported by the results. Path analysis 1(b) demonstrated a significant, positive direct effect of therapist/counsellor empathy on therapist/counsellor CS as predicted (see Figure 3). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Hypothesis *1(c)*

Figure 2. Path Model 1(a). Empathy-based Model of Compassion Fatigue.

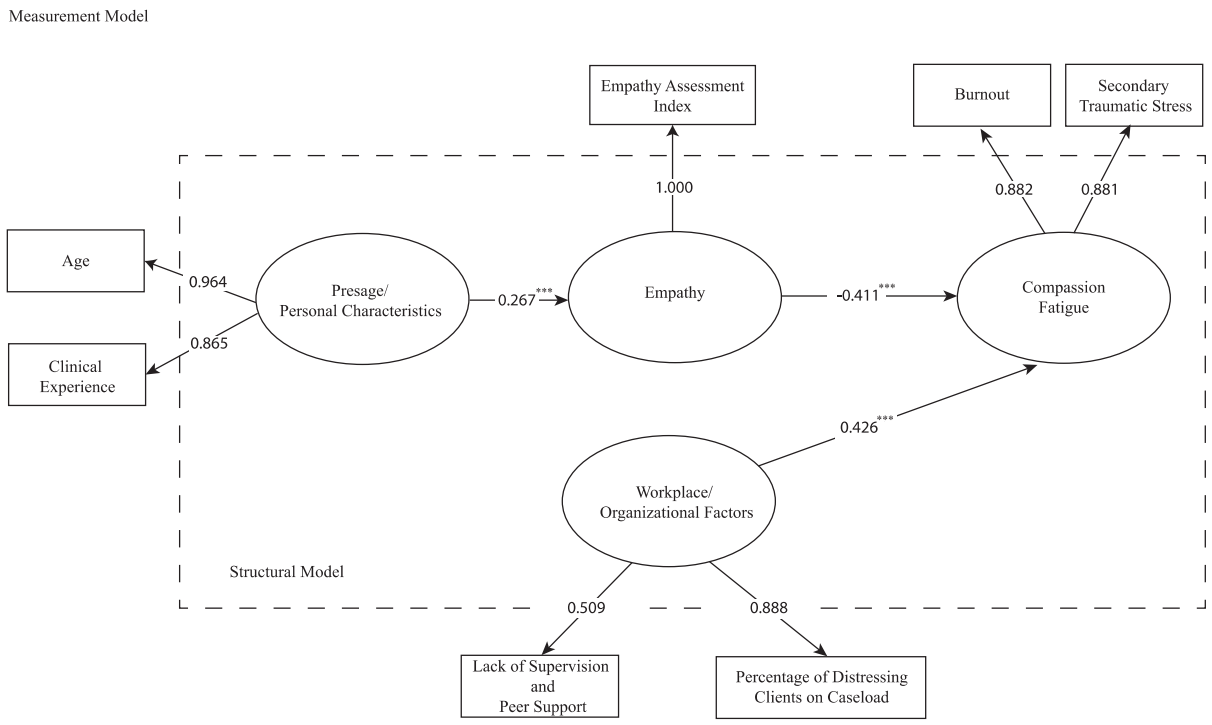

Figure 2. Partial least-squares path analysis for model 1(a). All values represent standardized scores. *** $p < .001$.

predicted that therapist/counsellor age and clinical experience would positively predict therapist/counsellor empathy, and indirectly and inversely predict therapist/counsellor CF; while a lack of supervision and peer support and a higher percentage of personally distressing clients on therapist/counsellor caseload, would predict therapist/counsellor CF. These hypotheses were also supported by the results. The strength of the effects exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Therapist/counsellor age and clinical experience had a significant, positive direct effect on therapist/counsellor empathy as predicted (see Figure 2). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships.

Figure 3. Path Model 1(b). Empathy-based Model of Compassion Satisfaction.

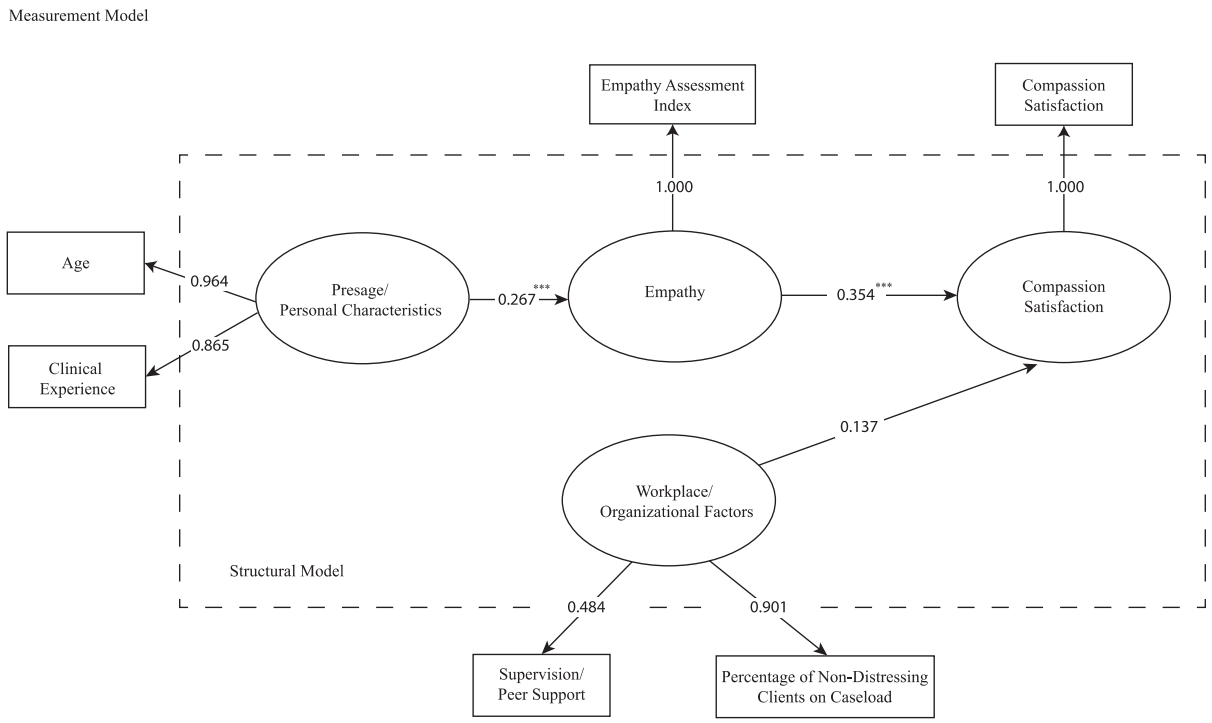

Figure 3. Partial least-squares path analysis for model 1(b). All values represent standardized scores. *** $p < .001$.

Therapist/counsellor age and clinical experience had a significant inverse, indirect effect on therapist/counsellor CF as predicted (see Figure 2). Furthermore, a lack of supervision and peer support and a higher percentage of personally distressing clients on therapist/counsellor caseload had a significant, direct effect on therapist/counsellor CF as predicted (see Figure 2). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Hypothesis *1(d)* predicted that therapist/counsellor age and clinical experience would predict therapist/counsellor empathy, and indirectly and positively predict therapist/counsellor CS; while supervision and peer support and a higher percentage of non-distressing clients on

Figure 4. Path Model 2(a). Therapeutic Alliance-based Model of Compassion Fatigue.

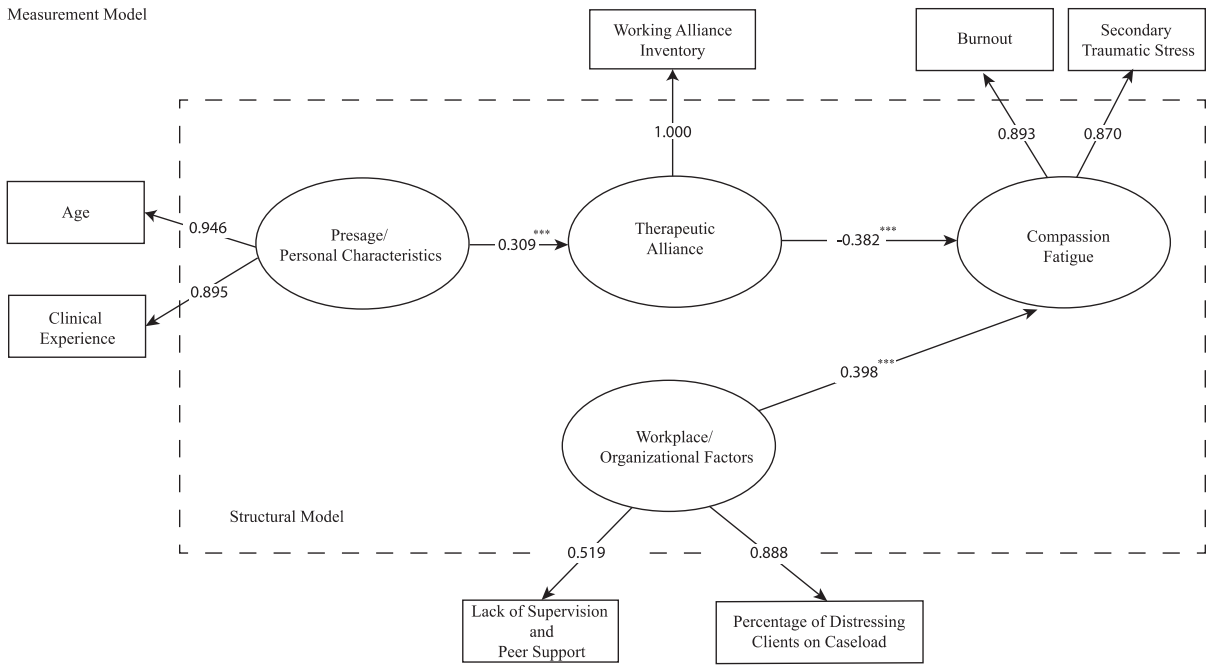

Figure 4. Partial least-squares path analysis for model 2(a). All values represent standardized scores. *** $p < .001$.

therapist/counsellor caseload, would directly predict therapist/counsellor CS. The results supported these hypotheses. Therapist/counsellor age and clinical experience had a significant, direct effect on therapist/counsellor empathy as predicted (see Figure 3). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Therapist/counsellor age and clinical experience had a significant, indirect effect on therapist/counsellor CS (see Figure 3). Therapist/counsellor supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseload, failed to have a significant, direct effect on therapist/counsellor CS but trended in the anticipated direction (see Figure 3).

Hypothesis *2(a)* predicted that therapist/counsellor perceptions of the strength of the

Figure 5. Path Model 2(b). Therapeutic Alliance-based Model of Compassion Satisfaction.

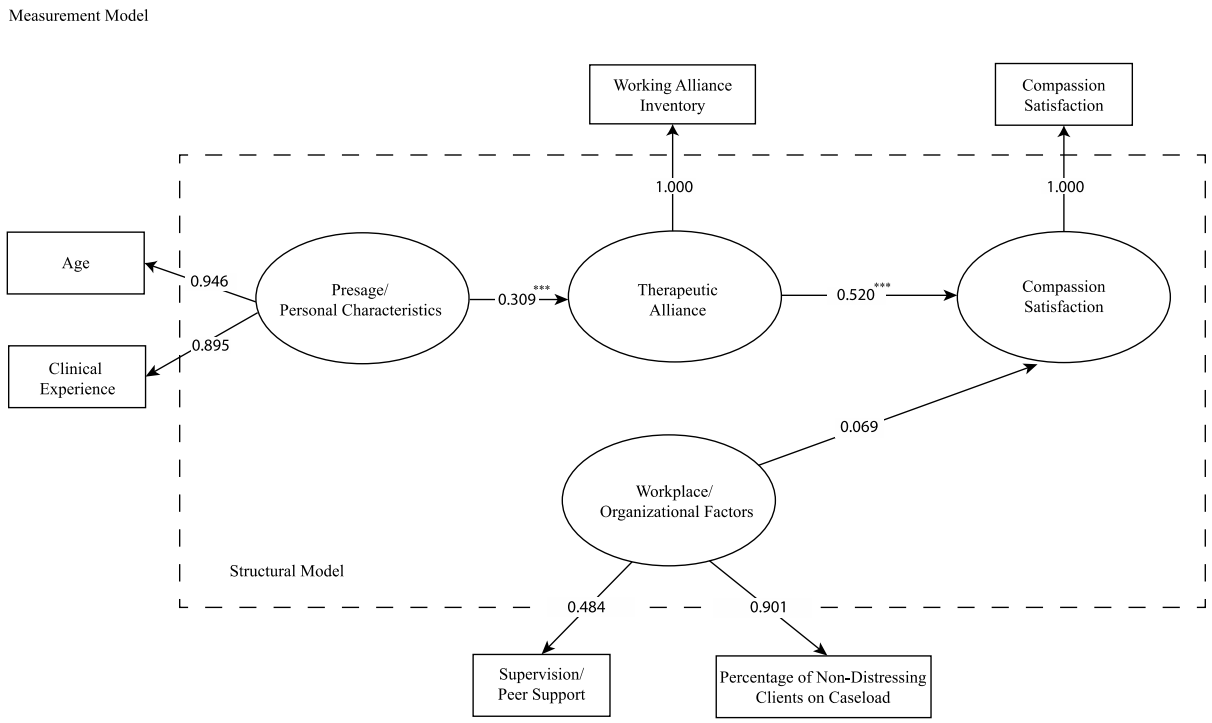

Figure 5. Partial least-squares path analysis for model 2(b). All values represent standardized scores. *** $p < .001$.

therapeutic alliance would inversely predict therapist/counsellor CF. This was supported by the results. Path analysis 2(a) demonstrated a significant, inverse direct effect of therapist/counsellor perceptions of the strength of the alliance on therapist/counsellor CF as predicted (see Figure 4). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Hypothesis 2*(b)* predicted that therapist/counsellor perceptions of the strength of the therapeutic alliance would positively predict therapist/counsellor CS. This too was supported by the results. Path analysis 2(b) demonstrated a significant, positive direct effect of therapist/counsellor perceptions of the strength of the alliance on therapist/counsellor CS as predicted (see Figure 5).

The strength of the effect exceeded Chin's (2010) criteria (β > .20) for meaningful path relationships. Hypothesis *2(c)* predicted that older age and greater clinical experience would predict therapist/counsellor perceptions of the strength of the therapeutic alliance, and indirectly and inversely predict therapist/counsellor CF; while a lack of peer support and supervision, and a higher percentage of personally distressing clients on therapist/counsellor caseload would predict therapist/counsellor CF. The results supported these predictions. Therapist/counsellor age and years of clinical experience had a significant, direct effect on the strength of the alliance as predicted (see Figure 4). The strength of the effect exceeded Chin's criteria (β > .20) for meaningful path relationships. Therapist/counsellor age and years of clinical experience had a significant, inverse indirect effect on therapist/counsellor CF as predicted. A lack of supervision and peer support, and percentage of personally distressing clients on therapist/counsellor caseload, had a significant direct effect on therapist/counsellor CF as predicted (see Figure 4). The strength of the effect exceeded Chin's criteria (β > .20) for meaningful path relationships. Hypothesis *2(d)* predicted that age and clinical experience would predict therapist/counsellor perceptions of the strength of the therapeutic alliance, and indirectly and positively predict therapist/counsellor CS; while greater supervision and peer support and percentage of non-distressing clients on therapist/counsellor caseload, would directly predict therapist/counsellor CS. The results supported these hypotheses. Therapist/counsellor age and years of clinical experience had a significant, direct effect on therapist/counsellor perceptions of the strength of the alliance as predicted (see Figure 5). The strength of the effect exceeded Chin's criteria (β > .20) for meaningful path relationships. Therapist/counsellor age and years of clinical experience had a significant, positive indirect effect on therapist/counsellor CS as predicted (see Figure 5). Therapist/counsellor supervision and peer support, and percentage of non-distressing

clients on therapist/counsellor caseload, failed to have a significant direct effect on therapist/counsellor CS, but trended in the anticipated direction (see Figure 5).

Measurement models. Composite reliability and average variance extracted (AVE) was calculated for Models 1(a) and 1(b). Composite reliability was significant and exceeded Chin's (2010) criteria for exploratory research (> .60) for each block of indicators in the empathy-based CF and CS models, respectively (see Appendix M). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) recommended cut-off (>.50; see Appendix M). Discriminant validity was established by examining the inter-correlations among latent variables (Fornell & Larcker, 1981). The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for each model (see Appendix O). In terms of model fit, the standardized root mean square residual (SRMR) was (.111) which was greater than that (< .100) recommended by Henseler et al. (2014).

Composite reliability and average variance extracted (AVE) was also calculated for Models 2(a) and 2(b). Composite reliability was significant and exceeded Chin's (2010) criteria for exploratory research (> .60) for each block of indicators in the therapeutic alliance-based CF and CS models, respectively (see Appendix N). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) recommended cut-off (>.50; see Appendix N). Discriminant validity was established by examining the inter-correlations among latent variables (Fornell & Larcker, 1981). The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for each model (see Appendix P).

Additional Analyses

After running the path analyses that corresponded with the original research questions and hypotheses, further questions of interest arose, particularly about the unique contributions of the Goals, Tasks, and Bond components of the therapeutic alliance as predictors of therapist/counsellor CF and CS. Unlike *H2(a), H2(b), H2(c),* and *H2(d)*—where the full-scale WAI-S was used as a predictor of therapist/counsellor wellbeing outcomes—in these supplementary analyses, the WAI-S Goals, Tasks, and Bond subscales were used as separate predictors of therapist/counsellor CF and CS.

Partial Least Squares Path Analyses

Structural models. Path analysis 3(a) demonstrated a significant, inverse direct effect of the therapeutic bond component of the therapeutic alliance, on therapist/counsellor CF. The strength of the effect exceeded Chin's (2010) criteria ($\beta > .20$) for meaningful path relationships (see Figure 6). The Goals and Tasks components of the therapeutic alliance failed to have a significant effect on therapist/counsellor CF (see Figure 6). Therapist/counsellor age and years of clinical experience had a significant, direct effect on each of the Bond, Tasks, and Goals components of the therapeutic alliance. The strength of the effects exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships (see Figure 6). Therapist/counsellor age and clinical experience had a significant inverse, indirect effect on therapist/counsellor CF. Lack of supervision and peer support and a higher percentage of personally distressing clients on therapist/counsellor caseload, had a significant, direct effect on therapist/counsellor CF (see Figure 6). The strength of the effect exceeded Chin's criteria ($\beta > .20$) for meaningful path relationships. Path analysis 3(b) demonstrated a significant, direct effect of the therapeutic bond component of the therapeutic alliance, on therapist/counsellor CS. The strength of the effect

Figure 6. Path Model 3(a). Therapeutic Alliance Components-based Model of Compassion Fatigue.

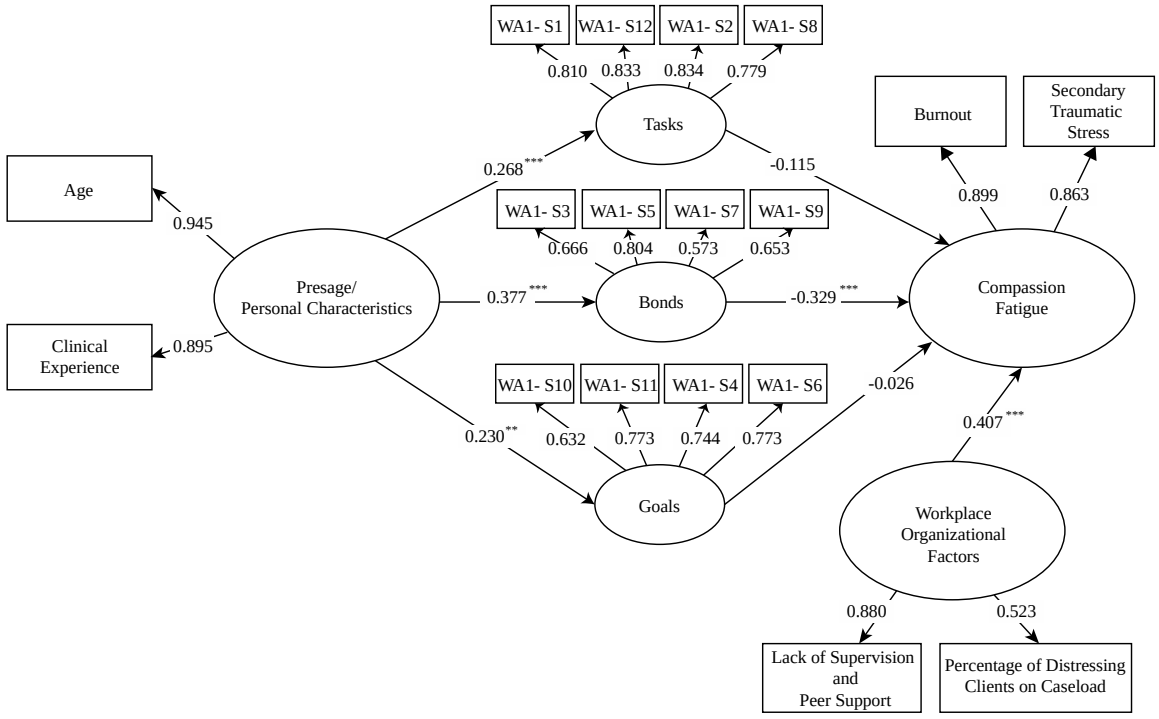

Figure 6. Partial least-squares path analysis for model 3(a). All values represent standardized scores. WAI-S = Working Alliance Inventory-Short. ** $p < .01$. *** $p < .001$.

exceeded Chin's criteria (β > .20) for meaningful path relationships (see Figure 7). The Goals and Tasks components of the therapeutic alliance failed to have a significant effect on therapist/counsellor CS (see Figure 7). Therapist/counsellor age and years of clinical experience had a significant direct effect on each of the Goals, Tasks, and Bond components of the therapeutic alliance. The strength of the effects exceeded Chin's criteria (β > .20) for meaningful path relationships (see Figure 7). Supervision and peer support, and percentage of non-

Figure 7. Path Model 3(b). Therapeutic Alliance Components-based Model of Compassion Satisfaction.

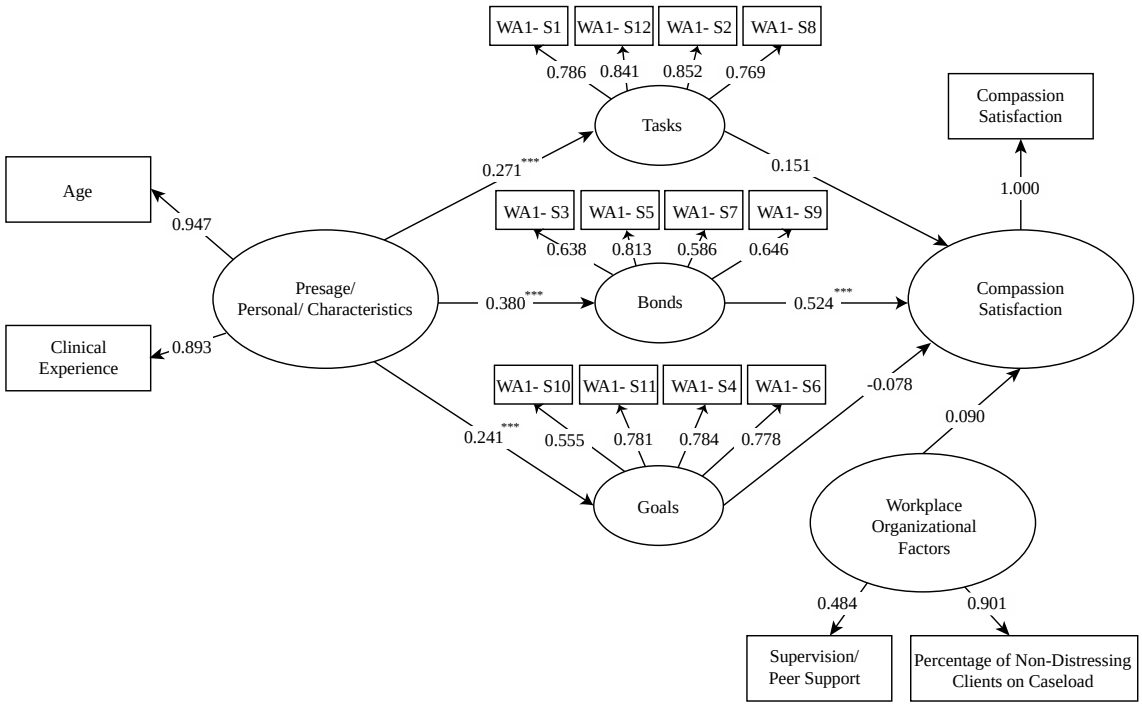

Figure 7. Partial least-squares path analysis for model 3(b). All values represent standardized scores. WAI-S = Working Alliance Inventory-Short. *** $p < .001$

distressing clients on therapist/counsellor caseload, failed to have a significant effect on therapist/counsellor CS.

Measurement models. Composite reliability and average variance extracted (AVE) was calculated for each block of latent variable indicators for Models 3(a) and 3(b). Composite reliability was significant for each block of indicators and exceeded Chin's (2010) criteria for exploratory research (>.60; see Appendix Q). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) guideline (> .50; see Appendix Q), with the exception of the therapeutic Bond component of the alliance (.46) in model 3(a).

Discriminant validity was established by examining the inter-correlations among latent variables (Fornell & Larcker, 1981). The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for each model with the exception of the intersection between the Goals and Tasks latent variables (see Appendix R).

Chapter 5

DISCUSSION

The chief purpose of this study was to re-examine the role of therapist/counsellor empathy in therapist/counsellor wellbeing outcomes, and to challenge the notion that empathy is the primary *risk* factor for therapist CF. A secondary purpose was to propose and test a model of the role of empathy in therapist/counsellor CF and CS, using the SCN empathy-conceptualization. While there had been no empirical examination of the compassion stress/fatigue model (Turgoose & Maddox, 2017), the risks to therapists/counsellors purported to result from practicing too empathically have been widely feared among practitioners (Samios et al., 2013). Figley delineated a set of predictive factors in his model that he believed moderate the effects of therapist empathy on therapist CF. These factors, however, have received mixed support in empirical studies. Turgoose, Glover, Barker, and Maddox (2017) noted that there has been no clear consensus about the correlates or predictors of CF in the literature. Other influential STS constructs from the late 20th century, like VT (McCann & Pearlman, 1990), have likewise identified empathy as the primary risk factor for therapists. Despite this, both CF and VT theories appear incongruous with a growing number of studies that have identified empathy as a source of therapist/counsellor resilience (Hernández, Ganzei, & Engstrom, 2007) and CS (Harrison & Westwood, 2009; Hunter, 2012). Additionally, Figley (1995; 2002a) identified therapist *compassion*, along with therapist empathy, as a primary risk factor for therapist CF—seemingly conflating the two constructs in the compassion stress/fatigue model. Social cognitive neuroscience research, however, has found that like helper empathy, greater helper compassion does not lead to increased risk for CF (Klimecki & Singer, 2012), but rather serves as a source of helper positive emotions (Klimecki, Leiberg, Lamm, & Singer, 2013). S. Sinclair, Raffin-

Bouchal, et al. (2017) have raised the issue of construct validity related to CF in nursing, suggesting that the moniker "compassion fatigue" is ill-defined; and SCN researchers have argued that CF can be better accounted for by terms like emotional contagion (Preusche & Lamm, 2016), "empathic overarousal" (Decety & Lamm, 2006, p. 1154), or "empathy distress fatigue" (Klimechi & Singer, 2012, p. 368)—experiences associated with helpers' lack of self-other awareness in their work with trauma-victims and suffering patients/clients.

The burgeoning field of social cognitive neuroscience (SCN) now provides a clearer understanding of empathy and its component parts. Notably, the field has used functional magnetic resonance imaging (fMRI) of brain activity to test empirically past influential social psychology theories of empathy, and through that process, identify four differentiable empathy components: *affective response*, *perspective taking*, *self-other awareness*, and *emotion regulation* (Decety & Moriguchi, 2007). This research informed the development of the Empathy Assessment Index (EAI) self-report measure used in the present study. The therapeutic alliance was also examined as a predictor of therapist/counsellor CF and CS, using an instrument based on Bordin's (1979) definition of the therapeutic alliance. Additional analyses were carried-out to explore the unique contributions of the Goals, Tasks, and Bond components of the therapeutic alliance as predictors of therapist/counsellor CF and CS. Figley emphasized the importance of a strong therapeutic *bond* in the compassion stress/fatigue model, but made little mention of therapist-client contributions to the goals and tasks of therapy. Consequently, the present study also sought to fill the need for an empirically-based set of models—empathy-based and therapeutic alliance-based—that could be used to predict both therapist/counsellor CF and CS wellbeing outcomes.

Summary of Findings

In re-examining the role of therapist/counsellor empathy in therapist/counsellor wellbeing outcomes, the present study addressed the principal question: Is therapist/counsellor empathy a risk or a protective factor? This question was tested through hypotheses *1(a)* and *1(b)*: Hypothesis *1(a)* predicted that therapist/counsellor empathy would have a direct, negative effect on therapist/counsellor CF. This prediction was central as it contradicted Figley's (1995; 2002a) belief about empathy as the primary *risk* factor for therapist CF. Hypothesis *1(b)* predicted that therapist/counsellor empathy would positively predict therapist/counsellor CS. Both hypotheses were supported by the results. Figley's belief that empathy is the primary risk-factor for therapists did not hold-up among this sample of female-identifying therapists/counsellors. Empathy proved to be an *inverse* predictor of therapist/counsellor CF. This result is consistent with a number of empirical studies, identifying a negative relationship between helper empathy and helper CF (Linley & Joseph, 2007; Wagaman et al., 2015; Yu et al., 2016), and is consistent with other SCN-informed empathy research. Wagaman et al. (2015), for example, found that self-other awareness and emotion regulation SCN empathy components negatively predicted helper STS and BO, respectively (subcomponents of CF); and Preusche and Lamm (2016) and Decety and Lamm (2006) identified self-other awareness and emotion regulation SCN empathy components as protective factors against helper vicarious overarousal. Therapist/counsellor empathy further proved to be a positive predictor of therapist/counsellor *CS* in the present study. The result is consistent with a number of studies identifying empathy as a source of resilience (Hernández, Ganzei, & Engstrom, 2007) and helper CS (see Harrison & Westwood, 2009; Hunter, 2012; Wagaman et al., 2015; Yu et al., 2016), and is again consistent with SCN-informed empathy research. Wagaman et al. (2015), determined that self-other awareness and

affective response SCN empathy components were positive predictors of CS—suggesting that empathy may be a factor that contributes to helper wellbeing and longevity. Hypotheses *1(c)* and *1(d)* examined therapist/counsellor Personal Characteristics and Workplace/Organizational factors that had been associated with therapist/counsellor wellbeing outcomes in the literature. Hypothesis *1(c)* predicted that therapist/counsellor age and clinical experience would have a direct, positive effect on therapist/counsellor empathy, and would indirectly and inversely predict therapist/counsellor CF. Hypothesis *1(c)* further predicted that a lack of supervision and peer support, and a higher percentage of therapist/counsellor caseload reported as personally distressing, would predict therapist/counsellor CF. Both hypotheses were supported by the results. Older and more experienced therapists/counsellors reported more empathy than their younger, less experienced counterparts, and had lower CF scores. This finding is consistent with a number of studies identifying an inverse relationship between helper age, and helper CF and BO (Craig & Sprang, 2010; Sprang et al., 2007; Hunsaker et al., 2015), but contrasted studies (see Ray et al., 2013; Yu et al., 2016) identifying a positive relationship between helper years of clinical experience and helper CF and BO (Ray et al., 2013; Yu et al., 2016).

Therapists/counsellors who lacked supervision and peer support, and had a higher percentage of personally distressing clients on their caseload, reported greater CF. This is consistent with past studies identifying supervision (Baird & Kracen, 2006; de Figueiredo et al., 2014; Hunsaker et al., 2015) and peer support (Killian, 2008) as protective factors against helper CF and predictors of helper CS. Path-model 1(a) accounted for 40% of the CF variance (see Figure 2). Hypothesis *1(d)* predicted that therapist/counsellor age and clinical experience would predict therapist/counsellor empathy, and would indirectly and positively predict therapist/counsellor CS. This too was supported by results. Older and more experienced

therapists/counsellors who, as noted above, reported more empathy than their younger, less experienced counterparts, also reported greater CS. This is consistent with past studies identifying a positive relationship between helper age and helper CS (Hunsaker et al., 2015; Sprang et al., 2007). Hypothesis 1*(d)* predicted that supervision and peer support, and a greater percentage of non-distressing clients on therapist/counsellor caseload, would predict therapist/counsellor CS. This result trended in the anticipated direction but was non-significant. Path-model 1(b) accounted for just 16% of the CS variance (see Figure 3). Despite this, the model demonstrated that empathy was a positive predictor of *CS* for this sample of female-identifying therapists/counsellors.

The secondary question of interest, in the present study, addressed whether therapist/counsellor perceptions of the strength of the therapeutic alliance act as a risk or a protective factor? This question was tested through hypotheses *2(a)* and *2(b)*: Hypothesis *2(a)* predicted that therapist/counsellor perceptions of the strength of the alliance would have a direct, negative effect on therapist/counsellor CF. Hypothesis *2(b)* predicted that therapist/counsellor perceptions of the strength of the alliance would have a direct, positive effect on therapist/counsellor CS. Both hypotheses were supported by the results. Therapists/counsellors who perceived having a strong therapeutic alliance with their clients, reported less CF; and therapists/counsellors who perceived having a strong therapeutic alliance with their clients reported greater CS. This is consistent with past research (see Carmel & Friedlander, 2009) identifying a negative relationship between therapists' perceived strength of the therapeutic alliance and therapist CF, and a positive relationship between therapists' perceived strength of the alliance and therapist CS (Carmel & Friedlander, 2009). Hypothesis *2(c)* predicted that therapist/counsellor age and clinical experience would predict therapist/counsellor perceived

strength of the therapeutic alliance, and indirectly and inversely predict therapist/counsellor CF. This too was supported by the results. Older and more experienced therapists/counsellors reported a stronger perceived therapeutic alliance with clients than their younger, less experienced counterparts. This is again consistent with work by Carmel and Friedlander (2009) identifying a positive relationship between therapists' age and years of clinical experience, with therapists' perceived strength of the therapeutic alliance. In turn, older, more experienced therapists/counsellors, had lower CF scores. Hypothesis *2(c)* further predicted that a lack of supervision and peer support, and a higher percentage of personally distressing clients on therapist/counsellor caseload would directly predict therapist/counsellor CF. This was also supported by the results. Therapists/counsellors who lacked supervision and peer support and had a higher percentage of personally distressing clients on their caseload, reported greater CF. Like in the empathy-based models, this is consistent with past studies identifying supervision (Baird & Kracen, 2006; de Figueiredo et al., 2014; Hunsaker et al., 2015) and peer support (Killian, 2008) as protective factors against helper CF and predictors of helper CS. Path-model 2(a) accounted for 37% of the CF variance (see Figure 4). Hypothesis *2(d)* predicted that therapist/counsellor age and clinical experience would predict therapist/counsellor perceptions of the strength of the alliance, and indirectly and positively predict therapist/counsellor CS. This was supported by the results, and is again consistent with Carmel and Friedlander's (2009) work. Hypothesis *2(d)* predicted that greater supervision and peer support, and a greater percentage of non-distressing clients on therapist/counsellor caseload, would predict therapist/counsellor CS. This result trended in the anticipated direction, but was non-significant. One possible explanation for this non-significant pathway—which was also observed in the empathy-based CS model—is that therapists/counsellors experienced less urgency to seek-out supervision and peer support

when they had fewer distressing clients on their caseloads. Percentage of non-distressing clients on therapist/counsellor caseload loaded strongly onto the Workplace/Organizational Factors latent variable, while supervision and peer support loaded poorly. It may have been that therapists/counsellors experienced greater CS simply from having fewer personally distressing clients on their caseloads. Perhaps supervision and peer support serve more as a *protective* factors against CF, rather than direct predictors of CS. As whole, however, model 2(b) was a relatively strong predictor of therapist/counsellor CS, accounting for 29% of the CS variance.

While the therapeutic alliance-based CS model accounted for 29% of the CS variance, the empathy-based CS model accounted for just 16% of the CS variance. The therapeutic alliance proved to be a stronger predictor of therapist/counsellor CS than therapist/counsellor empathy—an unexpected result. This prompted the decision to run additional analyses examining the unique contributions of the Goals, Tasks, and Bond components of the therapeutic alliance as predictors of therapist/counsellor CF and CS. Models 3(a) and 3(b) found that therapists'/counsellors' perception of the *Bond* component of the alliance was clearly the best predictor of therapist/counsellor CF and CS, respectively (see Figures 6 & 7). The relationship between the therapeutic bond and therapist/counsellor CS, in the present study, is consistent with studies (Hunter, 2012; Linley & Joseph, 2007) identifying a strong relationship between therapists' impressions of the strength of the therapeutic bond, and therapist CS. The Goals and Tasks components of the therapeutic alliance were non-significant predictors in each of the CF and CS predictive models. The result speaks to the power of therapist/counsellor perceptions of the strength of the therapeutic bond—both as a protective factor against therapist/counsellor CF but also as the primary predictor of therapist/counsellor CS. It appears that Figley (1995; 2002a) was correct to focus on the importance of the therapeutic bond over other aspects of the alliance.

However, Figley implicitly identified the therapeutic bond as a risk factor for therapists. This was not the case in the present study, where the bond component of the therapeutic alliance *inversely* predicted therapist/counsellor CF and was a strong predictor of therapist/counsellor CS.

Implications

Little attention has been devoted in the literature to examining the wellbeing outcomes of empathic *practitioners* (Thomas, 2013; Wagaman et al., 2015). Figley's belief about *therapist* empathy, as the primary risk factor for therapist CF, is the underlying assumption of the compassion stress/fatigue model (1995; 2002a). This, together with acknowledging empathy as a core condition for the therapeutic relationship (Rogers, 1957) and the fact that research has consistently shown that empathy is associated with positive *consumer* outcomes (Buckman et al., 2011; Gerdes et al., 2010; Lietz et al., 2011), perpetuates the currency of empathy in counselling as a double-edged sword that puts therapists/counsellors at risk for not only CF but also for other STS outcomes like VT. To illustrate, H. Sinclair and Hamill (2007) wrote that, "[t]hrough educational courses, the aim in counselling is to progress in one's empathic ability, therefore, it could be argued that due to the focus on the development of empathy for counsellors, this population may possess a higher level of empathy, and therefore put them at greater risk for vicarious traumatization" (p. 352). Consequently, fears of CF (and other STS outcomes) have driven therapist/counsellor training and self-care practices (Samios et al., 2013) despite a lack of evidence pointing to increased therapist/counsellor susceptibility to CF (Craig & Sprang, 2010; Sabo, 2011; Turgoose & Maddox, 2017). The present study is the first of its kind to empirically examine the relationship between therapist/counsellor empathy and therapist/counsellor CF in a Canadian sample. Past studies (Linley & Joseph, 2007; Wagaman et al., 2015; Yu et al., 2016) have found an *inverse* relationship between empathy and CF in other helper samples. Contrary to

Figley's assumptions, and like these other studies, empathy did *not* predict an increased risk for CF among the female-identifying therapists/counsellors in the present sample. This is an important finding, made more pertinent in light of past research that has found female helping professionals at greater risk for CF and STS than their male counterparts (Baum, Rahav, & Sharon, 2014; Rossi et al., 2012; Sprang et al., 2007); and Davis's (1983) work, that noted females tend to report higher empathy, on average, on self-report measures than males. It would therefore stand to reason—based on Figley's belief about therapist empathy—that a stronger effect of empathy as a *risk* factor for CF would be detected among this all-female-identifying sample, but this was not the case. A positive relationship was found between female-identifying therapists'/counsellors' empathy ratings and their ratings of *CS*.

Figley (2002a; 2002b) further described the importance of empathy for establishing a strong therapeutic alliance with clients. In the present study, therapist/counsellor perceptions of a strong therapeutic alliance predicted *decreased* risk for therapist/counsellor CF. The therapeutic alliance acted much like empathy in terms of its relationship to CF. When it came to predicting therapist/counsellor CS, however, the therapeutic alliance was a far better predictor than empathy. More interestingly, when the therapeutic alliance was broken into its component parts, analyses showed that the *Bond* component—versus the Goals and Tasks components—was clearly the strongest predictor of therapist/counsellor CF and CS. It seems that Figley (2002a; 2002b) was correct to focus on the importance of a strong therapeutic bond. Yet, Figley described the therapeutic bond as an aspect of the alliance developed through therapists' empathic engagement with their clients. He implied that it is essential for *client* outcomes but leaves therapists at risk. Figley's implication was not supported in this study: The Bond component of the alliance was inversely related to CF and was the single best predictor of

therapist/counsellor *CS.* The latter finding is consistent with studies like Hunter (2012) and Linley and Joseph (2007) who found associations between a strong therapeutic bond and therapist positive psychological change and CS. Surprisingly, the Goals and Tasks components of the therapeutic alliance were insignificant predictors of therapist/counsellor CF and CS in the present study. While research has supported the importance of therapist-client collaboration on the goals, tasks, and bond of the alliance for *client* outcomes (see Castonguay et al., 2006; Duff & Bedi, 2010; Martin et al., 2000) it may be that simply being empathic and having a strong therapeutic bond with clients is enough to promote *therapist/counsellor* CS wellbeing outcomes. This would, in turn, have implications for clinical practice given the consensus in the literature that empathy is a skill that can be learned and developed over time (see Alligood, 1992; Decety & Lamm, 2006; Hojat, 2009; Nerdrum, 1997; van Berkhout & Malouff, 2015).

Theoretical Implications

Sabo (2011) and H. Sinclair and Hamill (2007) argued that STS theories should move away from focusing on the harmful aspects of helper empathy towards better understanding how empathy protects helping professionals from the adverse effects of working with trauma-based populations. The findings from the present study support this notion. An SCN-informed approach to measuring empathy identified an *inverse* relationship between therapist/counsellor empathy and therapist/counsellor CF, and a positive relationship between therapist/counsellor empathy and therapist/counsellor CS. The results corroborate previous SCN-informed research (Decety & Lamm, 2006; Preusche & Lamm, 2016; Wagaman et al., 2015) that found an inverse relationship between helper empathy and helper CF, and a positive relationship between helper empathy and helper CS (Wagaman et al., 2015). The past decade has seen a growing body of research add fodder to the argument that empathy is a protective factor for helpers, as seen

through the development of theories like vicarious resilience (Hernández, Gangsei, & Engstrom, 2007) and studies that have recognized empathy as a source of helper CS (Harrison & Westwood, 2009; Hunter, 2012; Wagaman et al., 2015; Yu et al., 2016). Social neuroscience research has also found that, like empathy, *compassion* is not associated with increased risk for CF (Klimecki & Singer, 2012), but rather serves as a source of helper positive emotions (Klimecki, Leiberg, Lamm, & Singer, 2013). In light of these findings, and the results from the present study, further thought should be given to reconsidering the term "compassion" fatigue, as SCN-informed research identifies both empathy and compassion as helper protective factors. In Figley's (2014) later work, he too acknowledged that the compassion/stress fatigue model fails to account for the protective outcomes therapists experience from empathic engagement with their clients. He made allowance for what he described "compassion fatigue resilience". Despite Figley's acknowledgement, there still remained a need for an empirically-based set of models that could predict therapist/counsellor CF and CS wellbeing outcomes. Hunsaker et al. (2015), Killian (2008), Maslach and Leiter (2008), and Perkins and Sprang (2013), for example, noted that there are few studies that test the predictive factors identified in Figley's (1995; 2002a) model; and Turgoose, Glover, Barker, and Maddox (2017) argued that there is no clear consensus about the correlates or predictors of CF in the literature. The present study helps to fill this gap: Therapist/counsellor Personal Characteristics including age and clinical experience, proved to be inverse predictors of therapist/counsellor CF, and positive predictors of therapist/counsellor CS; while Workplace/Organizational factors including supervision and peer support, and percentage of non-distressing clients on therapist/counsellor caseload, predicted greater therapist/counsellor CS, and decreased risk for therapist/counsellor CF. In contrast, therapist/counsellor young age, clinical inexperience, lack of supervision and peer support, and

higher percentage of personally distressing clients on therapist/counsellor caseload, proved to be predictors of increased risk for therapist/counsellor CF. The partial least squares path analyses (PLS-PM), used in the present study, were a strength of the study given the exploratory nature of the research and the smaller sample size (see Chin, 2010). The findings now pave the way for future studies to carry-out continued theory-testing and corroboration of these models using larger samples and structural equation modelling (SEM) techniques. Moreover, future experimental research can test for causality between the predictor variables and therapist/counsellor wellbeing outcomes identified in the present study.

Practice Implications

In addition to the theoretical implications, the findings from the present study have important implications for therapist/counsellor training and clinical practice. The SCN empathy conceptualization provides new insight into how empathy conceivably functions to protect therapists/counsellors from the harmful effects of CF and promotes therapist/counsellor CS. Widely-used empathy scales like the Interpersonal Reactivity Index (IRI; Davis, 1980) and Jefferson Scale of Physician Empathy (JSPE; Hojat et al., 2002) appropriately gauge helper perspective taking and personal distress, but fail to address other important empathy processes, like self-other awareness and emotion regulation. Self-other awareness and emotion regulation, in particular—accounted for in the SCN empathy conceptualization—could be key to informing therapist/counsellor training and clinical practice. Lietz et al. (2011), for example, found a significant negative correlation (negative scores indicating greater mindfulness) between social work student participants' Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) scores and their Empathy Assessment Index (EAI) self-other awareness and emotion regulation subscale scores. Wagaman et al. (2015) determined that social work participants' EAI self-other

awareness and emotion regulation scores significantly and inversely predicted CF—suggesting that social workers who are better able to regulate their responses to clients' trauma material and differentiate those experiences from their own, are at less risk for CF; Leonard, Campbell, and Gonzalez (2018) found that clinicians' personal distress ratings had a significant inverse relationship with their ratings of mindfulness and strength of the therapeutic alliance; and Morgan and Morgan (2005) noted the "great potential" of mindfulness as a means to promote the self-regulation aspect of psychotherapist empathy.

Decety and Lamm (2006) underscored the dynamic relationship between top-down empathy processes like self-other awareness, emotion regulation, and perspective-taking with the bottom-up process, affective response; and Wagaman et al. (2015) suggested that unregulated affective response can lead to helper distress, particularly for social workers working with clients impacted by the effects of trauma. Perhaps it was Figley's early observations of therapists' inability to self-regulate during empathic engagement with clients—exhibited in outcomes like therapist personal distress and emotional contagion—that spurred his development of the compassion stress/fatigue model. Coutinho et al. (2014) argued that: "…training and supervision programs…must include specific learning components that help [counsellors] learn how to regulate their emotional arousal" (p. 545); Turgoose and Maddox (2017) similarly pointed to the "exciting implications" (p. 180) of mindfulness as a protective factor against CF for mental health professionals; and Wagaman et al. recommended that training programs enhance practitioner self-regulation by promoting the use of mindfulness and boundary-setting. Gentry and Baranowsky (2013) incorporate self-regulation training into CF treatment and resiliency programs, and identify self-regulation as the "most important" skill for clinicians looking to practice purposeful prevention and resiliency. Past counsellor training programs have tended to

emphasize external empathy behaviors rather than address counsellors' internal empathy processes (Greason & Cashwell, 2009). Boundary-setting training, through increased therapist/counsellor self-other awareness, and training aimed at helping therapists/counsellors to regulate their emotional responses to clients' trauma-material, are undoubtedly key future directions with implications for improving client as well as *therapist/counsellor* wellbeing outcomes.

Coutinho et al. (2014) suggested that counsellors' capacity to self-regulate could directly influence clients' capacity to regulate themselves; and DiMascio, Boyd, and Greenblatt (1957), in an early study, demonstrated that the heart rates of therapists and clients moved in opposite directions when clients became antagonistic towards their therapists. Client aggressiveness or antagonism, and severity of clients' psychological symptoms, are factors shown to be associated with a weak therapeutic alliance (Hunter, 2012; Tschuschke et al., 2015). Leonard, Campbell, and Gonzalez (2018) found that clinicians' ratings of personal distress had an inverse relationship with their ratings of the strength of the therapeutic alliance; and Smits et al. (2015) noted that clients who experienced severe distress had greater difficulty reaching agreement on the contractual element (goals & tasks) of the therapeutic alliance, despite rating the bond component of the alliance highly. These papers underscore the delicate balance needed for therapists/counsellors to establish and maintain a therapeutic bond while challenging clients towards agreed upon treatment goals and tasks. Ribeiro, Ribeiro, Gonçalves, Horvath, & Styles (2013) described the "interactive microprocesses" necessary for therapeutic collaboration (p. 295), arguing that a strong therapeutic alliance involves a dynamic interaction between therapist support and challenge, and that therapists must establish a sense of safety with their clients while alternately pushing them to confront maladaptive perspectives. Ribeiro et al. argued that if

therapist challenging occurs too quickly, or if the increment is too great, clients can lose their sense of security and the alliance can become compromised. This also speaks to the interconnected relationship between therapist/counsellor empathy and the strength of the therapeutic alliance. Coutinho et al. (2014) stated that therapeutic alliance ruptures are characterized by counsellors' "…failures in the empathic processes" (p. 545).

The bond component of the therapeutic alliance proved to be a strong predictor of therapist/counsellor CS in the present study, while the goals and tasks components of the alliance did not. This was surprising, given how therapist/counsellor-client collaboration on the goals and tasks of therapy has been indicated in the literature as necessary for promoting positive *client* outcomes (Duff & Bedi, 2010; Martin et al., 2000). The finding perhaps addresses the importance of therapists/counsellors practicing empathic self-other awareness and emotion regulation, particularly when working with clients deemed personally distressing. The path models in the present study of female-identifying therapists/counsellors, suggest that younger, clinically inexperienced therapists/counsellors are at greater risk for CF than their older, more experienced counterparts. Young therapists/counsellors, with limited direct-client-contact, are likely less versed in setting healthy boundaries with clients through self-other awareness and the management of their emotional responses to clients' trauma. These therapists/counsellors may have particular difficulty, with antagonistic clients, working collaboratively towards agreed-upon treatment goals and tasks. An SCN-based approach to empathy training can bring these vulnerabilities to trainees' awareness, and teach them to adjust their empathic responses accordingly. The path models in the present study also point to a lack of supervision and peer support, and a higher percentage of personally distressing clients on therapist/counsellor caseloads, as factors that put therapist/counsellors at increased risk for CF. Training programs

should stress the importance of regular supervision and peer support, as well as sensible case-management, such that therapists/counsellors do not experience a high percentage of their caseload as personally distressing.

Limitations

The SCN empathy conceptualization used in the present study provides new insights into how therapist/counsellor empathy impacts therapist/counsellor wellbeing, and casts doubt on Figley's (1995; 2002a) belief that empathy is the primary risk factor for therapist CF. Yet, SCN is a burgeoning field. Internal consistency for the overall Empathy Assessment Index (EAI) in the present study was good (Cronbach's $\alpha = .78$). However, the EAI subscales were not as reliable (perspective taking, $\alpha = .43$; self-other awareness, $\alpha = .53$; emotion regulation, $\alpha = .64$; & affective response, $\alpha = 67$). Further administrations of the EAI with other therapist/counsellor samples are needed to improve EAI subscale reliability and validity. Empathy has historically been a difficult concept to define (Coutinho et al., 2014; Gerdes, Segal, & Lietz, 2010; Gleichgerrcht & Decety, 2013; Sabo, 2006) and researchers have pointed to the limitations of self-report methods, particularly when measuring complex constructs (Coutinho, Ribeiro, Sousa, & Safran, 2013). Schwarz (1999) described the use of self-report questionnaires in the social sciences, more generally, as a "fallible source of data" (p. 93) and noted that small changes in question formatting, wording, and context can lead to significant changes in the results. Coutinho et al. (2014) proposed that empathy self-report scales be supported by newer measures informed by SCN, such as peripheral and central empathy biomarkers. These could include, for example, measures of cardiovascular response and electrodermic activity (EDA) during therapy sessions. A combination of these methods could provide a more comprehensive assessment of helper empathy in future studies, including useful in-session feedback about therapist/counsellor

affective response and emotion regulation, in particular. Also, the Stressful Life Experiences Scale (SLES) added little predictive utility to the path models in the present study, loading poorly onto the Personal Characteristics latent variable. In addition to being a weak indicator, therapist/counsellor personal trauma history predicted *less* risk for CF—contrary to expectations and contrary to the findings of Hensel et al. (2015), Killian (2008), Sodeke-Gregson et al. (2013), and Thomas (2013) who determined that greater helper personal trauma history put helpers at *increased* risk for CF. Ultimately, this indicator was left out of the final PLS-PM analyses in the present study. Future studies could examine the role of therapist/counsellor personal history of trauma, and its relationship to therapist/counsellor CF, through the use of an improved personal trauma history scale.

Another limitation of this study is its use of an all-female-identifying sample, which ruled-out the possibility of examining therapist/counsellor gender differences in CF. This is something that had been identified in the literature as a comparison of interest (see Linley & Joseph, 2007; Sprang et al., 2007; Rossi et al., 2012). Surprisingly, before the deletion of male-identifying participants from the sample, the proportion of female (92%) to male (7%) therapists/counsellors, represented in the present study, differed significantly from that represented in the BCACC membership. A greater proportion of female-identifying therapists/counsellors is represented in the present study than among BCACC members. Higher female participation rates are not uncommon in research-participation more broadly. Rosnow and Rosenthal (1997) determined with “considerable confidence” that females are more likely to participate in volunteer research studies than men, noting that seventy-nine percent of the statistically significant studies they reviewed favored this conclusion. In the present study, it was perhaps the compounding issues of fewer male therapists/counsellors working in the field as a

whole, in addition to the tendency for fewer males to participate in volunteer research studies that might explain the gender discrepancy. Nevertheless, it left unanswered questions about male therapists'/counsellors' susceptibility to CF and propensity for CS. Also of note, the majority of study participants rated themselves *Low* in both STS and BO, and *Average* for CS. This could suggest that the volunteers from this study are more resilient than therapists/counsellors more generally. None of the study participants rated themselves *High* for STS or BO.

Despite the significant results of the present study, it is important to note that the empathy-based and therapeutic alliance-based CF models explained just 40% and 37% of the CF variance, respectively. Sixty percent or more of the CF variance was unaccounted for in each model. More work is clearly needed to identify additional factors that influence therapist/counsellor CF. In the same vein, further work is needed to identify factors that predict therapist/counsellor CS. The empathy-based and therapeutic alliance-based CS models accounted for just 16% and 29% of CS variance, respectively. Compassion satisfaction is a relatively young construct but an important one. Figley (2002a) argued that therapists' satisfaction in their work serves as a protective factor against CF. In the present study, therapist/counsellor CS was associated with greater therapist/counsellor empathy. Due to the cross-sectional nature of the present study, however, causation cannot be inferred among variables. Namely, a determination cannot be made about whether older therapists/counsellors, with greater clinical experience, became more empathic over time due to learned experience, or if they were more empathic from the outset of their careers, which in turn protected them against CF and promoted practice longevity. Likewise, the results of the present study cannot explain whether therapist/counsellor experiences of CF cause a decrease in empathy, or if less empathic therapists/counsellors are more prone to developing

CF. These same limitations apply to the therapeutic alliance-based models. The use of longitudinal experimental designs could help to address these limitations in future studies.

Conclusion

Figley's (1995; 2002a) model of compassion stress/fatigue portrayed therapist empathy as the key to promoting positive client outcomes, but also the primary *risk* factor for therapist CF. Consequently, due to the influence of Figley's model, and other important STS theories (see McCann & Pearlman 1990; Pearlman & McIan, 1995), empathy has been viewed by helpers as a double-edged sword. Helpers have come to believe that empathy comes with a cost. The aim of the present study was to re-examine the role of therapist/counsellor empathy—alongside therapist/counsellor perceptions of the strength of the therapeutic alliance—through the development of empirically-based models that predict therapist/counsellor CF and CS. Therapist/counsellor Personal Characteristics and Workplace/Organizational factors, from the literature, were also examined as moderating variables of empathy and the therapeutic alliance. Contrary to Figley's assumption about therapist empathy as a *risk* factor, empathy did not predict increased risk for therapists/counsellors in the present study. In contrast, empathy *inversely* predicted therapist/counsellor CF, and positively predicted therapist/counsellor CS. Comparably, a strong therapeutic alliance proved to be an inverse predictor of therapist/counsellor CF, and a positive predictor of therapist/counsellor CS. These findings bolster the argument that STS theories should shift away from a focus on empathy as a helper *risk* factor, towards recognizing empathy as a source of helper protection and satisfaction (see Sabo, 2011; H. Sinclair & Hamill, 2007). A social cognitive neuroscience (SCN) conceptualization of empathy provides a new understanding about the relationship between therapist/counsellor empathy and therapist/counsellor wellbeing outcomes. Likewise, Bordin's (1979) definition of the therapeutic

alliance underscores the important role of the therapeutic *bond* for therapist/counsellor professional wellbeing. Taken together, the predictive models, developed in the present study, have important implications for theory, research, practice, therapist/counsellor training programs and work places, and for the value of regular and reliable supervision and peer support for therapist/counsellor wellbeing. Ultimately, the findings challenge the widely-held belief that therapist/counsellor empathy comes with a cost, and rather, suggest that empathy protects therapists/counsellors from the adverse effects of working with traumatized and suffering clients, and serves as a source of helper satisfaction when working with these difficult client-groups.

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Footnotes

[1]"Therapists/counsellors" will be used to describe the population of interest in this paper, but when reporting the findings from or referring to works by other authors/researchers, the population included in the study will be referred to (e.g., nurses, social workers, therapists, psychotherapists).

APPENDIX A

Board of Record
University of Victoria

Human Research Ethics Board (HREB)
Administrative Services Building
Room B202
PO Box 1700 STN CSC
Victoria, BC V8V 2Y2

Certificate of Ethical Approval for Harmonized Minimal Risk Health Study

Also reviewed and approved by:
Fraser Health

Principal Investigators:	Primary Appointment:	Board of Record Approval Reference #:
Benjamin Schulz	**University of Victoria**	**BC16-344**

Study Title: Re-examining Compassion Fatigue: Is Counsellor Empathy a Risk or a Protective Factor?
Study Approved: **7 NOV 2016** Expiry Date: **6 NOV 2017**

Research Team Members:		
	Benjamin Schulz	**University of Victoria**
	Dr. Susan Tasker	**University of Victoria**
	Dr. John Walsh	**University of Victoria**
	Dr. Todd Milford	**University of Victoria**

Sponsoring Agencies: n/a
Documents included in this approval:

Document Name	Approved version date
Research Ethics Application Form	Oct 22,2016. V2
Compassion Satisfation and Compassion Fatigue	Oct 22, 2016. V2.
Final 12-item Support Appraisal for work stressors (SAWS) Inventory	Oct 22, 2016. V2
Stressful Life Experiences Screening.	Oct 22, 2016. V2
Empathy Assessment Indes (EAI).	Oct 22, 2016. V2
Working Alliance Inventory	Oct 22, 2016. V2
Invitation to Participate (Lunch and learn sessions)	Oct 22, 2016. V2
Invitation to Participate (online survey invitation)	Oct 22, 2016. V2
Letter of Information (Implied Consent).	Oct 22, 2016. V2
List of Support Resources.	Oct 22, 2016. V2

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The "Board of Record" is the Research Ethics board designated on behalf of the participating REBs involved in a harmonized study to facilitate the ethics review and approval process. In the event that there are any changes or amendments to this approved protocol, please notify the Board of Record.

Board of Record Research Ethics Board Representative
Name: Dr. Rachael Scarth Title: Associate VP Research Operations
Signature: Date: April 28 2015

APPENDIX B

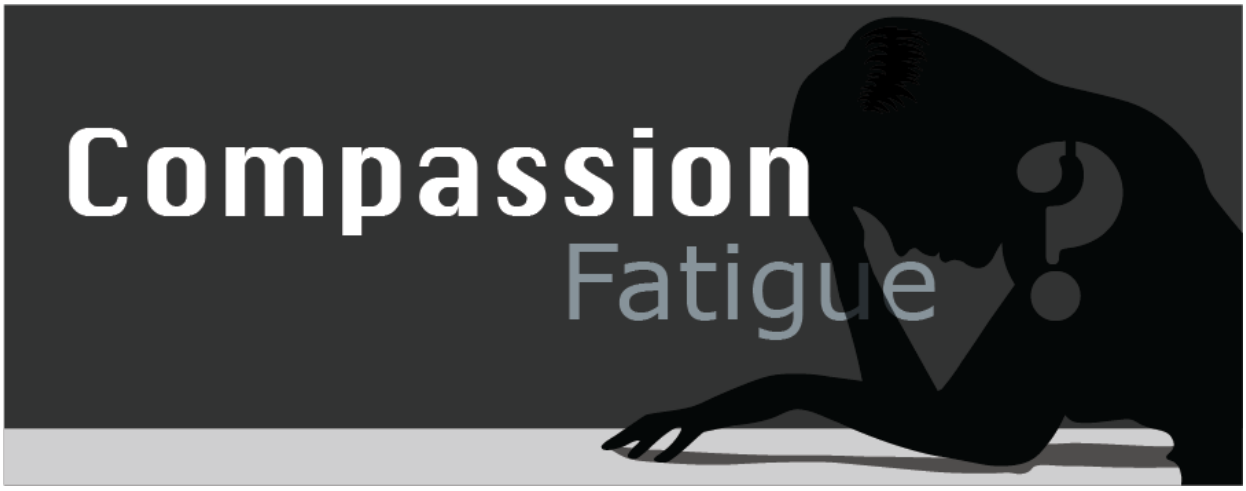
Experiencing Compassion Fatigue? Study Seeking BCACC Participants

You will be entered into a $100 draw as compensation for your time

Thank you for agreeing to take part in this important survey that assesses the risk and resiliency factors associated with counsellor/psychotherapist compassion fatigue. My name is Benjamin Schulz and I am a PhD student in the Educational Psychology and Leadership Studies (EPLS) department at UVic. This research is being conducted as part of my doctoral degree requirements. By choosing to participate, you are helping me to better understand how counsellors/psychotherapists can improve their professional quality of life. This survey should take approximately 15-20 minutes to complete. Also included in the link is a Letter of Information/Implied Consent Form. Please take the time to review it before you begin. Be assured that your responses will be kept completely anonymous. Please click on the link below to begin.

http://uvic.fluidsurveys.com/s/compassionfatigue/

APPENDIX C



You will be entered into a $100 draw as compensation for your time

Thank you for agreeing to take part in this important survey that assesses the **risk and resiliency factors associated with counsellor/psychotherapist compassion fatigue**. My name is Benjamin Schulz and I am a PhD student in the Educational Psychology and Leadership Studies (EPLS) department at UVic. This research is being conducted as part of my doctoral degree requirements. By choosing to participate, you are helping me to better understand how counsellors/psychotherapists can improve their professional quality of life. This survey should take approximately 15-20 minutes to complete. Also included in the link is a Letter of Information/Implied Consent Form. Please take the time to review it before you begin. Be assured that your responses will be kept completely anonymous. Please click on the link below to begin.

http://uvic.fluidsurveys.com/s/compassionfatigue/

APPENDIX D

The following survey packet consists of a Letter of Information, a Background/Caseload information page, and **six questionnaires**. Please review the Letter of Information before you begin:

University of Victoria

Letter of Information

Re-examining Compassion Fatigue: Is Counsellor Empathy a Risk or a Protective Factor?

You are invited to participate in a study being conducted by myself, Benjamin Schulz, a practicing Crisis Clinician with Fraser Health Authority, and a graduate student in the department of Educational Psychology and Leadership Studies (EPLS) at the University of Victoria.

As a doctoral student, I am required to conduct research as part of my degree requirements. The project is being completed under the supervision of Dr. Susan Tasker and Dr. John Walsh.

Purpose and Objectives

The purpose of this study is to examine the positive and negative impacts on counsellors' professional quality of life, of working with clients who have experienced trauma. A particular area of interest is counsellor empathy and its impact on counsellor compassion fatigue (CF) and compassion satisfaction (CS). Considerable research has demonstrated that empathy is an important factor that contributes to a strong therapeutic alliance, and to positive client outcomes. However, far less attention has been paid to counsellor empathy as it impacts counsellors' professional quality of life – comprised of counsellor CF and CS. From a clinical perspective, a better understanding about the role of counsellor empathy can inform counsellor education and training.

Importance of this Research

The primary aim of this study is to shed light on the role of counsellor empathy, and its influence on counsellor professional quality of life (CF-CS). A greater understanding about the role of counsellor empathy can inform counsellor education and training, with the aim of reducing risk factors associated with counsellor CF.

Participants Selection
You are being asked to participate in this study because you are a registered counsellor/psychotherapist with the BC Association of Clinical Counsellors (BCACC), and/or the Canadian Counselling and Psychotherapy Association (CCPA).

What is involved
You will be asked to complete a set of web-based (or paper) surveys that will take approximately 15-20 minutes of your time. Participation is **voluntary** and all information collected will be kept **anonymous, even to the principal investigator**. Identifying information will not be collected, and data will be kept in a secure place by the researcher. By completing the surveys, you are providing implied consent to participate.

You can withdraw from the study at any point and you do not have to answer any questions on the surveys that you do not want to answer. It is also important you do not feel any obligation to participate in the study due to any personal relationship between you and the principal investigator (Benjamin Schulz).

Risks
There are some possible risks to you by participating in this research. These include the potential for some discomfort, that could be elicited, from recalling past personal trauma events and/or unpleasant workplace experiences.

However, the items on the surveys are close-ended and do not ask you to describe uncomfortable experiences in great detail. While it is possible you could experience stress and/or discomfort while filling out the surveys used in this study, it is unlikely that the stress and/or discomfort will exceed that which you normally encounter in aspects of your everyday life.

Upon request, you will be provided with a comprehensive list of support resources including accessible national online and crisis lines available 24 hours a day, 365 days a year.

Benefits
The potential benefits to you, from participating in this research, include your contributing valuable information about counsellor/psychotherapist risk and resiliency factors for counsellor CF. This is an area of research that needs greater clarity. A greater understanding about the role of counsellor empathy can inform counsellor education and training focused on improving client outcomes and minimizing risk factors associated with counsellor CF. Findings from the study will be presented at webinar and lunch and learn training sessions. So, by participating you will be directly contributing to counsellor training and professional development opportunities.

Compensation
As a way to compensate you for any inconvenience related to your participation, you will be entered into a draw for $100. If you participate in this study, the compensation should not be coercive. It is unethical for a researcher to provide undue compensation or inducements to

research participants. If you would otherwise not participate if the compensation were not offered, then you should decline.

Dissemination of Results

It is anticipated that the results of this study will be shared by means of a dissertation oral defense, and a published journal article. Findings from the study will also be presented at webinar and lunch and learn training sessions. The lunch and learn sessions will be open to all study participants, including CCPA and BCACC members, and FHA and CYMH employees.

Disposal of Data

Data from this study will be disposed of after seven years. Electronic data will be erased and paper copies will be shredded.

Contacts

You may contact me by email at brschulz@uvic.ca if you have any further questions about the study, or my supervisors, Dr. Susan Tasker (or) and Dr. John Walsh (or)

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca). If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Fraser Health REB co-Chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairs of the Fraser Health REB.

Your completion of the surveys indicates that you understand the above conditions of participation in this study, and that you have had the opportunity to have your questions answered by the researcher. By completing the surveys, you are providing implied consent for your data to be used in the study.

I have read the Letter of Information and understand the conditions of participation in this study

APPENDIX E

Background Information

Age:

Gender Identity:

Years of Clinical Experience:

Highest Degree Earned:

Professional Credentials (e.g. Social Work, Counselling, Psychology, Psychiatry, Child and Youth Care):

Your Primary Work Setting (e.g. Private Practice, Community Agency, University/College, School-Board, Hospital, Church Organization):

Your Secondary Work Setting (e.g. Private Practice, Community Agency, University/College, School-Board, Hospital, Church Organization):

Your Primary Delivery Mode (e.g. Individual, Group, Online):

Your Secondary Delivery Mode (e.g. Individual, Group, Online):

List the various professional work roles that you engage in, in a typical week (e.g. Direct Counselling, Supervision, Research, Teaching, Administration):

Caseload Information

Please estimate the percentage of your client caseload that comprises clients who have experienced, or are currently experiencing, a traumatic event in their lives:

Please estimate the percentage of your client caseload that is personally distressing:

Please estimate how many hours of direct contact (in-person or online) you have with clients in a typical week:

APPENDIX F

Questionnaire 1

Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Check the response choice that honestly reflects how frequently you have experienced each of the following thoughts and feelings in the last 30 days.

1. I am happy.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

2. I am preoccupied with more than one person I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

3. I get satisfaction from being able to help people.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

4. I feel connected to others.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

5. I jump or am startled by unexpected sounds.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

6. I feel invigorated after working with those I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

7. I find it difficult to separate my personal life from my life as a helper.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

9. I think that I might have been affected by the traumatic stress of those I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

10. I feel trapped by my job as a helper.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

11. Because of my helping, I have felt "on edge" about various things.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

12. I like my work as a helper.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

13. I feel depressed because of the traumatic experiences of the people I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

14. I feel as though I am experiencing the trauma of someone I have helped.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

15. I have beliefs that sustain me.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

16. I am pleased with how I am able to keep up with helping techniques and protocols.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

17. I am the person I always wanted to be.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

18. My work makes me feel satisfied.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

19. I feel worn out because of my work as a helper.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

20. I have happy thoughts and feelings about those I help and how I could help them.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

21. I feel overwhelmed because my case work load seems endless**.**

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

22. I believe I can make a difference through my work.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

24. I am proud of what I can do to help.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

25. As a result of my helping, I have intrusive, frightening thoughts.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

26. I feel "bogged down" by the system.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

27. I have thoughts that I am a "success" as a helper.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

28. I can't recall important parts of my work with trauma victims.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

29. I am a very caring person.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

30. I am happy that I chose to do this work.

○ Never ○ Rarely ○ Sometimes ○ Often ○ Very Often

APPENDIX G

Questionnaire 2

The following questions ask about the reliability of your Direct Supervisor in providing you with support when you experience problems at work. Please respond to each question by checking the response choice that best matches your experience.

1. How much can you rely on your Direct Supervisor to help you feel better when you experience work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

2. How much can you rely on your Direct Supervisor to be sympathetic and understanding about your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

3. How much can you rely on your Direct Supervisor to help you evaluate your attitudes and feelings about your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

4. How much can you rely on your Direct Supervisor to provide information which helps to clarify your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

5. How much can you rely on your Direct Supervisor to help when things get tough at work?

○ Not at all ○ A little ○ Somewhat ○ Very much

6. How much can you rely on your Direct Supervisor to give you practical assistance when you experience work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

7. How much can you rely on your Direct Supervisor to suggest ways to find out more about a work situation that is causing you problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

8. How much can you rely on your Direct Supervisor to listen to you when you need to talk about work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

9. How much can you rely on your Direct Supervisor to spend time helping you resolve your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

10. How much can you rely on your Direct Supervisor to reassure you about your ability to deal with your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

11. How much can you rely on your Direct Supervisor to share their experiences of a work problem similar to yours?

○ Not at all ○ A little ○ Somewhat ○ Very much

12. How much can you rely on your Direct Supervisor to acknowledge your efforts to resolve your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

Questionnaire 3

The following questions ask about the reliability of your Work Colleagues in providing you with support when you experience problems at work. Please respond to each question by checking the response choice that best matches your experience.

1. How much can you rely on your Work Colleagues to help you feel better when you experience work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

2. How much can you rely on your Work Colleagues to be sympathetic and understanding about your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

3. How much can you rely on your Work Colleagues to help you evaluate your attitudes and feelings about your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

4. How much can you rely on your Work Colleagues to provide information which helps to clarify your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

5. How much can you rely on your Work Colleagues to help when things get tough at work?

○ Not at all ○ A little ○ Somewhat ○ Very much

6. How much can you rely on your Work Colleagues to give you practical assistance when you experience work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

7. How much can you rely on your Work Colleagues to suggest ways to find out more about a work situation that is causing you problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

8. How much can you rely on your Work Colleagues to listen to you when you need to talk about work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

9. How much can you rely on your Work Colleagues to spend time helping you resolve your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

10. How much can you rely on your Work Colleagues to reassure you about your ability to deal with your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

11. How much can you rely on your Work Colleagues to share their experiences of a work problem similar to yours?

○ Not at all ○ A little ○ Somewhat ○ Very much

12. How much can you rely on your Work Colleagues to acknowledge your efforts to resolve your work-related problems?

○ Not at all ○ A little ○ Somewhat ○ Very much

APPENDIX H

Questionnaire 4

Please check whether or not you have experienced the following stressful life events. If you select yes to an item, then check the response choice that best represents how stressful that life event is to you currently.

1. I have witnessed or experienced a natural disaster; like a hurricane or earthquake.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

2. I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

3. I have witnessed or experienced a serious accident or injury.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

4. I have witnessed or experienced chemical or radiation exposure happening to me, a close friend, or a family member.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

5. I have witnessed or experienced the death of my spouse or child.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

6. I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

7. I or a close friend or family member has been kidnapped or taken hostage.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

8. I or a close friend or family member has been the victim of a terrorist attack or torture.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

9. I have been involved in combat or a war or lived in a war affected area.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

10. I have seen or handled dead bodies other than at a funeral.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

11. I have felt responsible for the serious injury or death of another person.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

12. I have witnessed or been attacked with a weapon other than in combat or family setting.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

13. As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

14. As an adult, I was hit, choked or pushed hard enough to cause injury.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

15. As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

16. As a child/teen I was forced to have unwanted sexual contact.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

17. As an adult I was forced to have unwanted sexual contact.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

18. As a child or adult I have witnessed someone else being forced to have unwanted sexual contact.

○ Yes ○ No

Stressful Currently

○ Not at all ○ A little ○ Somewhat ○ Very much

19. I have witnessed or experienced a stressful life event not already mentioned. Please Explain:

Please rate how stressful this experience is to you currently

○ Not at all ○ A little ○ Somewhat ○ Very much

APPENDIX I

Questionnaire 5

This is a questionnaire about your thoughts and feelings. Please check the response choice that best represents your experience.

1. I can imagine what it's like to be in someone else's shoes.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

2. I am aware of my thoughts.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

3. Watching a happy movie makes me feel happy.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

4. I can tell the difference between someone else's feelings and my own.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

5. When I am with a happy person, I feel happy myself.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

6. When I am upset or unhappy, I get over it quickly.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

7. I can explain to others how I am feeling.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

8. I can agree to disagree with other people.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

9. Emotional evenness describes me well.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

10. Friends view me as a moody person.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

11. I can imagine what the character is feeling in a well written book.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

12. Hearing laughter makes me smile.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

13. I watch other people's feelings without being overwhelmed by them.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

14. I can simultaneously consider my point of view and another person's point of view.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

15. I understand other people's emotional signals.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

16. I am good at judging other people's emotional states.

○ Never ○ Rarely ○ Sometimes ○ Frequently ○ Always

APPENDIX J

Questionnaire 6

Listed below are statements that describe some of the different ways a person might think or feel about working with clients in general. Check your level of agreement with each statement. Work fast, your first impressions are the ones we would like to see.

1. My clients and I agree about the steps to be taken to improve their situation.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

2. My clients and I feel confident about the usefulness of our current activity in therapy.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

3. I believe my clients like me.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

4. I have doubts about what my clients and I are trying to accomplish in therapy.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

5. I am confident in my ability to help my clients.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

6. My clients and I are working towards mutually agreed upon goals.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

7. I appreciate my clients as people.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

8. My clients and I agree on what is important for them to work on.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

9. My clients and I have built a mutual trust.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

10. My clients and I have different ideas on what their real problems are.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

11. My clients and I have established a good understanding between us of the kind of changes that would be good for them.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

12. My clients and I believe the way we are working with their problems is correct.

○ Never ○ Rarely ○ Occasionally ○ Sometimes ○ Often
○ Very Often ○ Always

Thank you for your participation. If you would like to be entered into the $100 draw, please also provide an email address or another means for us to contact you should you win (be careful to not provide any personal identifying information):

APPENDIX K

Table 2

Correlations for Variables Included in Partial Least Squares Path Models

	1	2	3	4	5	6	7
1. Age	--						
2. Years of clinical experience	.70***	--					
3. Percentage of distressing clients on caseload	-.08	-.08	--				
4. Percentage of non-distressing clients on caseload	.08	.08	-1.00	--			
5. Support appraisal for work stressors (SAWS)	-.09	-.02	-.06	.06	--		
6. Lack of supervision and peer support (SAWS reverse)	.09	.02	.06	-.06	-1.00	--	
7. Empathy assessment index (EAI)	.30***	.16	-.12	.12	.08	-.08	--
8. Working alliance inventory (WAI-S)	.32***	.23**	-.25**	.25**	.01	-.01	.51***
9. Burnout (BO)	-.19*	-.12	.32***	-.32***	-.29***	.29***	-.44***
10. Secondary traumatic stress (STS)	-.10	-.06	.45***	-.45***	-.12	.12	-.39***
11. Compassion satisfaction (CS)	.38***	.26**	-.17*	.17*	.08	-.08	.37***
12. WAI-S Tasks	.29***	.19*	-.21*	.21*	-.01	.01	.42***
13. WAI-S Bond	.35***	.27***	-.14	.14	.03	-.03	.52***
14. WAI-S Goals	.24**	.17*	-.30***	.30***	.00	.00	.43***

Table 2 (continued)

	8	9	10	11	12	13	14
1. Age							
2. Years of clinical experience							
3. Percentage of distressing clients on caseload							
4. Percentage of non-distressing clients on caseload							
5. Support appraisal for work stressors (SAWS)							
6. Lack of supervision and peer support (SAWS reverse)							
7. Empathy assessment index (EAI)							
8. Working alliance inventory (WAI-S)	--						
9. Burnout (BO)	-.47***	--					
10. Secondary traumatic stress (STS)	-.35***	.56***	--				
11. Compassion satisfaction (CS)	.54***	-.67***	-.28***	--			
12. WAI-S Tasks	.91***	-.40***	-.31***	.46***	--		
13. WAI-S Bond	.82***	-.47***	-.29***	.58***	.63***	--	
14. WAI-S Goals	.92***	-.39***	-.33***	.41***	.77***	.62***	--

Note. *$p < .05$, **$p < .01$, ***$p < .001$, two-tailed. *N = 146.*

APPENDIX L

Table 3

Frequencies and Percentages for Participant Background and Caseload Information Categorical Variables

Background Characteristics	*n*	*%*
Location of residence		
Western Canada	58	40
Central Canada	23	16
Atlantic Canada	13	9
Northern Canada	2	1
United States	2	1
Highest degree earned		
Masters	142	97
Doctorate	3	2
Diploma	1	1
Professional credentials		
Counselling	125	86
Psychology	10	7
Social work	4	3
Child and youth care	4	3
Marriage and family therapy	4	3
Education	1	1
Nursing	1	1
Primary work setting		
Community agency	62	4
Private practice	39	27
University	14	9
Health authority	11	8
School	8	5
EAP company	7	5
National organization	1	1
Secondary work setting		
Private practice	38	26
Community agency	22	15
University/college	8	5
School	3	2
Hospital/health authority	4	3

Table 3 (continued)

Background Characteristics	*n*	*%*
Primary delivery mode		
Individual	138	95
Group	8	5
Family/couples	9	6
Telephone/online	2	1
Teaching	2	1
Secondary delivery mode		
Group	61	42
Couples/family	13	9
Telephone/online	9	6
Individual	3	2
Workshops	2	1
Teaching	2	1
Supervision	2	1
Various professional work roles		
Direct counselling	130	89
Supervision	35	24
Group	14	10
Research	10	7
Workshops/training	12	8
Assessment	9	6
Coaching	4	3
Program development	3	2
Outreach	3	2
Intake	2	1
Marketing	1	1
Care teams	1	1
Faculty support	1	1
Student service events	1	1
Crisis response	1	1

Note. Percentages are rounded to the nearest tenth of a percent. Percentages may not add to 100 percent as participants were able to provide more than one response per category.

APPENDIX M

Table 4

Composite Reliability and Average Variance Extracted for Measurement Models 1(a) and 1(b)

Variable constructs	Composite reliability (internal consistency)	Average variance extracted/explained
	Model 1(a)	
Personal characteristics	0.91	0.84
Empathy	1.00	1.00
Workplace/organizational factors	0.67	0.52
Compassion fatigue (BO and STS)	0.88	0.78
	Model 1(b)	
Personal characteristics	0.91	0.84
Empathy	1.00	1.00
Workplace/organizational factors	0.67	0.52
Compassion satisfaction	1.00	1.00

Note. Composite reliability was significant and exceeded Chin's (2010) criteria for exploratory research (> .60) for each block of indicators in models 1(a) and 1(b). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) guideline (>.50) in models 1(a) and 1(b).

APPENDIX N

Table 5

Composite Reliability and Average Variance Extracted for Measurement Models 2(a) and 2(b)

Variable constructs	Composite reliability (internal consistency)	Average variance extracted/explained
	Model 2(a)	
Personal characteristics	0.92	0.85
Therapeutic alliance	1.00	1.00
Workplace/organizational factors	0.67	0.52
Compassion fatigue (BO and STS)	0.88	0.78
	Model 2(b)	
Personal characteristics	0.92	0.85
Therapeutic alliance	1.00	1.00
Workplace/organizational factors	0.67	0.52
Compassion satisfaction	1.00	1.00

Note. Composite reliability was significant and exceeded Chin's (2010) criteria for exploratory research (> .60) for each block of indicators in models 2(a) and 2(b). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) guideline (>.50) in models 2(a) and 2(b).

APPENDIX O

Table 6

Discriminant Validity (inter-correlations) of Variable Constructs for Models 1(a) and 1(b)

Latent variables	1	2	3	4
		Model 1(a)		
Compassion fatigue (BO and STS)	**0.88**			
Workplace/organizational factors	0.48	**0.72**		
Empathy	-0.47	-0.14	**1.00**	
Personal characteristics	-0.15	-0.05	0.27	**0.76**
Latent variables	1	2	3	4
		Model 1(b)		
Compassion satisfaction	**1.00**			
Workplace/organizational factors	0.19	**0.72**		
Empathy	0.37	0.14	**1.00**	
Personal characteristics	0.36	0.05	0.27	**0.92**

Note. The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for models 1(a) and 1(b).

APPENDIX P

Table 7

Discriminant Validity (inter-correlations) of Variable Constructs for Models 2(a) and 2(b)

Latent variables	1	2	3	4
		Model 2(a)		
Compassion fatigue (BO and STS)	**0.88**			
Workplace/organizational factors	0.48	**0.72**		
Personal characteristics	-0.15	-0.05	**0.92**	
Therapeutic alliance	-0.47	-0.22	0.31	**1.00**
Latent variables	1	2	3	4
		Model 2(b)		
Compassion satisfaction	**1.00**			
Workplace/organizational factors	0.19	**0.72**		
Personal characteristics	0.36	0.05	**0.92**	
Therapeutic alliance	0.54	0.22	0.31	**1.00**

Note. The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for models 2(a) and 2(b).

APPENDIX Q

Table 8

Composite Reliability and Average Variance Extracted for Measurement Models 3(a) and 3(b)

Variable constructs	Composite reliability (internal consistency)	Average variance extracted/explained
	Model 3(a)	
Bond	0.77	0.46
Goals	0.82	0.54
Tasks	0.89	0.66
Compassion fatigue	0.87	0.78
Personal characteristics	0.92	0.85
Workplace/organizational factors	0.67	0.52
	Model 3(b)	
Bond	0.77	0.46
Goals	0.82	0.53
Tasks	0.89	0.66
Compassion satisfaction	1.00	1.00
Personal characteristics	0.92	0.85
Workplace/organizational factors	0.67	0.52

Note. Composite reliability was significant and exceeded Chin's (2010) criteria for exploratory research (> .60), for each block of indicators in models 3(a) and 3(b). The average variance extracted (AVE) for each block of indicators exceeded Fornell and Larcker's (1981) guideline (>.50) in models 3(a) and 3(b) with the exception of the Bond variable.

APPENDIX R

Table 9

Discriminant Validity (inter-correlations) of Variable Constructs for Models 3(a) and 3(b)

Latent variables	1	2	3	4	5	6
			Model 3(a)			
Bond	**0.676**					
Compassion fatigue	-0.466	**0.881**				
Goals	0.624	-0.414	**0.733**			
Personal characteristics	0.377	-0.152	0.230	**0.921**		
Tasks	0.627	-0.406	0.771	0.268	**0.814**	
Workplace/organizational factors	-0.147	0.481	-0.247	-0.049	-0.178	**0.724**
	1	2	3	4	5	6
			Model 3(b)			
Bond	**0.676**					
Compassion satisfaction	0.634	**1.000**				
Personal characteristics	0.380	0.356	**0.920**			
Goals	0.634	0.424	0.241	**0.731**		
Tasks	0.636	0.475	0.271	0.777	**0.813**	
Workplace/organizational factors	0.153	0.186	0.054	0.240	0.179	**0.723**

Note. The matrix diagonal values (square root of the AVE values) were greater in each case than the off-diagonal values of corresponding rows and columns for models 3(a) and 3(b), with the exception of the intersection between Goals and Tasks latent variables.