

**SELF-COMPASSION, EMOTIONAL EMPATHY, AND COGNITIVE EMPATHY  
AMONG NOVICE THERAPISTS**

A Dissertation

by

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## ABSTRACT

Self-compassion is an important aspect of psychological health. Leading scholars assert that self-compassion cultivates self-awareness, which has long been considered critical for effective therapy. A large body of research indicates that effective therapy consists of the ongoing integration of the personal self and professional self. Therefore, the training of novice therapists tends to be a demanding process in which the novice therapists' self is often used in work with clients and likely includes more than simply learning and implementation of techniques. Thus, this study's purpose was to explore self-compassion in relation to emotional empathy and cognitive empathy among novice therapists. Using correlational analyses, this study employed well-established self-compassion and empathy scales to measure these variables.

A state-level sample of novice therapists in Texas ( $N = 32$ ), ages 22 to 33, completed an online survey consisting of a demographic questionnaire, the Self-Compassion Scale Short-Form (SCS-S), and the Interpersonal Reactivity Index (IRI). There was a statistical significant difference between women and emotional empathy. No other significant relationships were found. This study concludes with theoretical explanations of the findings and the implications for training and further research.

## DEDICATION

First, I want to dedicate my dissertation to my source of inspiration – to those individuals who are strong enough to be empathetic in their lives, particularly to empathic novice therapists anywhere in the world who have chosen this profession. It is my wish that we will continue expanding our knowledge on empathy, a major component of healing.

Secondly, I would like to dedicate this dissertation to Dr. Kim Vu, my undergraduate advisor, who believed in my strength and capacity to complete a doctoral program and provided me with many learning opportunities during my undergraduate education. Additionally, I would like to thank Dr. Laura Weber for her generosity with mentoring me. I also would like to thank Brett Warnecke for providing such a wonderful space to learn about meditation and compassion during my graduate school years.

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# CHAPTER I

## INTRODUCTION

Psychological and philosophical areas of study explored similar themes related to human behavior. Because of this, the psychological field perceived the need to validate and differentiate this area of study (Henriques & Sternberg, 2004). Based on this apparent necessity, the Boulder Conference in 1949 was a pivotal event in the history of psychology, in which, the scientist-practitioner model emerged (Baker & Benjamin, 2000).

Since that time, this model has become the gold standard for training and has been adopted by all the specialties in applied psychology. The community of psychologists thought that training needed to be scientific in nature so that psychologists could apply their scientific knowledge to their clinical practice (Baker & Benjamin, 2000). Despite excitement about the model, its effectiveness in training psychologists has remained questionable (e.g., Albee, 2000; DeLeon, Dubanoski, & Oliveira-Berry, 2005; Elliott & Klapow, 1997; Frank, 1984; Holtum & Goble, 2006; Long & Hollin, 1997; Meyer, 2002; Nathan, 2000; Wedding, 2005). Therefore, it is in the interest of the profession to explore the development of graduate trainees and how improvement in their training might result in greater competence among psychologists (American Psychological Association, 2003; Henriques & Sternberg, 2004; Ridley, 2005; Sue & Sue, 2012).

Research indicates that clinical competence is two-pronged in the sense that it involves both personal and professional growth (Ridley, Mollen, & Kelly, 2011). Training is unlikely to be maximally effective if the focus is solely on the acquisition of skill sets and the application of interventions while discounting the contribution of trainees' psycho-emotional

attributes to their competence. The challenge of training is complicated by the diverse backgrounds of novice therapists in training (Ronnestad & Skovholt, 2003). Trainees bring a broad array of personal experiences, values, attitudes, and personal characteristics that should be factored constructively into training.

However, there is no systematic way of accounting for individual differences among trainees. For example, novice therapists and trainees are not mandated to disclose any personal information (Fisher, 2012). Despite meeting academic criteria, trainees often find themselves challenged by the lack of structure associated with their therapeutic work with clients, and they may inadequately integrate their own personal experiences into developing clinical competence (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003). Rodolfa, Bent, Eisman, Nelson, Rehm and Ritchie (2005) indicated that an essential aspect of competency includes a “capacity to relate effectively and meaningfully with individuals” (p. 351). While Ridley, et al. (2011) in their definition of competence include cognitive and emotional aspects as opposed to solely focusing on technical skills, that is, how therapists think and feel about themselves and their own perception of their performance. Still, other researchers conceptualize competency other ways as the ability to self-assess their ability across different areas of their performance and the skill to provide quality treatment and even mindfulness and awareness of both intra and inter relationships (e.g., APA, 2012; APA, 2015; Fairburn & Cooper, 2011). In sum, experts have not come to an agreement on a definition of counselor competence.

Along these lines, students’ professional journeys are often characterized by feelings of incompetence and self-doubt (Ronnestad & Skovholt, 2003). They often struggle to reconcile these feelings with the expectation to demonstrate clinical competence. It is of interest that

therapists' use of self to facilitate healing and therapeutic change with clients has gained increasing attention (Baldwin, 2013). Considering the relationship between self-compassion and mental health (Barnard & Curry, 2011; Patsiopoulos & Buchanan, 2011), therapists' self-compassion is hypothesized to play an important role in the development of clinical competence. By exploring both personal and professional factors of trainees, insights may be gleaned to improve the quality of graduate training in applied psychology. For the purposes of this work, counselor competence is defined as the ability to establish a psychologically healthy relationship with their own selves (i.e., self-compassion) and their ability to think like the other person is thinking (i.e., cognitive empathy) and feeling like the other person is feeling (i.e., emotional empathy). The present study then seeks to understand how novice therapists' self-compassion associates with emotional empathy and cognitive empathy.

### **Statement of Purpose**

The purpose of this study is to explore the relationships between self-compassion, emotional empathy, and cognitive empathy among novice therapists. Several issues from the literature form the basis for the research problem. First, the relationship between individuals' self-compassion and their nuanced ability to empathize with other people is inconclusive (Neff & Pommier, 2013; Welp & Brown, 2014). Second, the relationship between novice therapists' emotional empathy and cognitive empathy, surprisingly, has not been explored and, as such, stands as an important gap in the literature. Third, the need for therapists to connect with their own selves and to have high levels of self-awareness is an indispensable quality for effective therapy (Malikiosi-Loizos, 2013; Rogers, 1957).

Self-compassion research is a burgeoning line of study. The research has examined the construct across different populations and notably linked self-compassion to psychological

health. The present study aims to explore this construct with novice therapists in the context of their training. Novice therapists in training are forming their professional and personal identities, and exploring self-compassion could be a promising area of research in advancing the field's understanding of becoming a competent therapist. Based on the relatively new research on self-compassion, this study hypothesized that self-compassion is associated with the types of empathy of novice therapists who were in training.

### **Definitions**

#### ***Self-Compassion***

*Self-compassion* is a caring way to relate to one's self (Neff & Dahm, in press). It consists of self-kindness, common humanity, and mindfulness. *Self-kindness* is defined as a caring self-talk that fosters acceptance and awareness of our own suffering and shortcomings. *Common humanity* is defined as viewing our own pain as a collective human experience. *Mindfulness* is defined as the experience of our own emotions and thoughts with a balanced awareness (Neff & Dahm, in press).

Overall, a neutral view on emotions and thoughts could result in allowing individuals to experience their inner subjective world more fully as opposed to denying or suppressing emotions or thoughts (Neff, 2003b). To maintain the validation of the self-compassion scale (SCS-S), the scale in the present study is the same that has been previously used across research when assessing this construct (Neff, 2003b). To date, this is the only self-compassion scale that has been used to assess this construct. Self-compassion has been positively correlated with themes relevant to psychotherapy, including self-acceptance, self-understanding and self-care (Armani, 2011; Neff & Dahm, in press; Patershuk, 2013; Ying & Han, 2009).

## *Empathy*

An examination across research suggests that *empathy* has four predominant components: emotional empathy, expressed empathy, received empathy, and cognitive empathy. This four-component structure indicates that empathy is a complex construct. However, contemporary research has focused on emotional and cognitive empathy (Duan & Hill, 1996; Gladstein, 1983; Stephan & Finlay, 1999). After reviewing social, developmental, and counseling psychology research, Gladstein (1983) pointed out that researchers appeared to agree on the idea that empathy is multidimensional in nature and that cognitive and emotional empathy are major dimensions of this construct (Gladstein, 1983; Stephan & Finlay, 1999). This investigation will similarly focus on emotional and cognitive empathy, two major components of empathy.

*Emotional empathy* is defined as feeling similarly to another person (Duan & Hill, 1996; Gladstein, 1983). As cited by Gladstein (1983), emotional empathy is a concept that derives from early works by psychologists such as Wundt (1892, 1897), McDougall (1908), and Allport (1924). Emotional empathy has been found to be damaging for therapists as it has been positively linked to emotional exhaustion (Gladstein, 1983). Interestingly, women report higher levels of emotional empathy as compared to men (Paul & Podberscek, 2000). Previous research suggests that emotional empathy could be an indicator of emotional maturity (Neff & Pommier, 2013) and may have an age component; older individuals tend to score higher on measures of emotional empathy (Shechtman, 2002). It appears that the role of emotional empathy among novice therapists is poorly studied, with one study indicating that emotional empathy is often linked to emotional exhaustion (Gladstein, 1983).

*Cognitive empathy* is defined as thinking like another person is thinking (Gladstein, 1983). Cognitive empathy can be found in Piaget's early work (1929, 1975), Mead (1934), and Cottrell (1942) as cited by Gladstein (1983). Studies show that individuals could have intact cognitive empathy but could have deficiency in their emotional empathy and vice versa (Blair, 2005; Wai & Tiliopoulos, 2012). In contrast to emotional empathy, cognitive empathy has been associated with hostile behaviors (Shechtman, 2002). Smith (2006) hypothesized that cognitive empathy evolved to help us survive in a more primitive time when it was crucial to know what others were thinking in order for individuals to secure resources. Positive association has been found between self-compassion and cognitive empathy (e.g., Neff & Pommier, 2013).

Based on analysis of previous studies on emotional and cognitive empathy, these definitions were employed in the present study. The Interpersonal Reactivity Index (IRI), Davis, 1980) – has been frequently used across empathy research and it has well-established validity. The definitions of empathy used in this study are equivalent to those in the Interpersonal Reactivity Index (IRI).

## **CHAPTER II**

### **LITERATURE REVIEW**

The positive relationship between self-compassion and overall health is well-documented; it shows that people with greater self-compassion have better psychological health (Barnard & Curry, 2011; Patsiopoulos & Buchanan, 2011). However, research on the relationships between self-compassion and emotional and cognitive empathy is inconclusive. Conventional wisdom suggests that individuals who are more psychologically healthy could be more emotionally and cognitively empathetic towards others. To this date, four studies have explored the relationship between self-compassion and emotional empathy. All of these studies have had approximately 100 or more participants. Most research between self-compassion and emotional empathy has been found a non-significant association in adult and student population (Birnie, Speca, & Carlson, 2010; Neff & Pommier, 2013; Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). Whereas, only one study found a significant relationship between emotional empathy and self-compassion with community adults and meditators and not with student population (Neff & Pommier, 2013). Also, a total of three studies have investigated self-compassion and cognitive empathy. Two of these studies were found to be positively associated with cognitive empathy with student population, meditators and adults (Birnie, Speca, & Carlson, 2010; Neff & Pommier, 2013). To contrast these findings, one study found a non-significant association between self-compassion and cognitive empathy with adult population (Welp & Brown, 2014).

In general, research on the relationships among self-compassion, emotional empathy, and cognitive empathy is inconclusive. Furthermore, the relation of these variables has not been

examined specifically in novice therapists. Since this study is about novice therapists, it is important to note that the relationships among self-compassion, emotional empathy and cognitive empathy have yet to be studied.

### **Novice Therapists**

Training competent novice therapists to become good practitioners is a longstanding challenge that ideally involves both personal and professional growth (Ronnestad & Skovholt, 2003). This journey is complicated by the diversity of students' backgrounds (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003). Additionally, because it is considered unethical, counseling programs do not require students to disclose any sensitive information about their lives, such as a history of abuse or family of origin (Fisher, 2012). Consequently, students are often admitted to doctoral programs based solely on academic performance as opposed to their ability to empathize and effectively relate to clients (Ronnestad & Skovholt, 2003).

Since the use of self appears to be an important aspect of clinical practice, exploring the meaning of self becomes essential to training effective novice therapists. Researchers have long debated the meaning of self. For example, it has been defined variously as self-awareness, empathy, equanimity, and engagement towards clients (Mosey, 1981; Taylor, 2008) as well as the “artful” display of personality traits (Hedgedorn, 1995, as cited in Taylor, 2008, p. 5). Most recently, Punwar and Peloquin (2000) defined the use of self as therapists' “planned use of insights, judgments and perceptions as part of the process” (p. 285). The therapeutic use of self has been found to consist of two major components: therapists’ self-disclosure which is defined as sharing feelings and thoughts during session for therapeutic purposes and therapists’ transparency defined as being open about mistakes with the intention of being perceived as “a



real human being” as opposed to a perfect therapist (Knight, 2012, p. 3). The research on self has differentiated two types of therapists’ self-disclosure. The first type of there-and-then self-disclosure is defined as the sharing of therapists’ personal information and the second type of here-and-now self-disclosure is defined as the communication of therapists’ immediate reactions (i.e., thoughts and feelings) to clients during their session. Research findings suggest that therapists’ here-and-now self-disclosure is perceived as most effective by clients (Knight, 2012). This information is consistent with Rogers’ person-centered therapy, a form of psychotherapy, which emphasized the importance of therapists’ congruency (i.e., by being willing to relate to clients personally not just professionally) by providing clients with an environment of unconditional regard and empathy (Rogers, 1957).

Researchers have come to agree that the use of self consists of therapists’ willingness for self-reflection and self-revelation of their emotional reactions to clients (e.g., Knight, 2012; Tufekcioglu & Muran, 2015). Research has shown that therapists often engaged in negative self-dialogue when feeling less effective in their work with clients (Nutt-Williams & Hill, 1996). It seems that therapists’ self is challenged in the process of becoming competent in their work.

Previous research has shown that clinical work is likely emotionally taxing for therapists (Nutt-Williams & Hill, 1996; Russell, & Snyder, 1963; Thériault, Gazzola, & Richardson, 2009). Particularly, novice therapists frequently experience feelings of incompetence, anxiety, and confusion, and they fear that these emotions likely affect the quality of their work regardless of their level of clinical experience (Russell & Snyder, 1963; Ronnestad & Skovholt, 1993; Thériault, Gazzola, & Richardson, 2009). Overall, this research suggests that the use of self is a significant component of clinical work.

Based on this research, it may be important to explore therapists' thoughts and emotions. However, multiple case studies suggest that novice therapists often have not been given the physical and intellectual space to reflect on their own identities and their role in work with clients (Baldwin, 2000). Thus, cultivating the opportunity to reflect on self could be important in novice therapists' development since it has been identified as crucial for the development of clinical expertise (Ridley, et al. 2011). Although the use of self is deemed an important attribute of therapeutic work, there is no body of research that specifically examines this dynamic. Nevertheless, there are aspects of therapists' self-experience that seem relevant to the use of self in clinical settings. In particular, therapists' self-compassion and empathy may hold promise for understanding how the use of self is fundamental to therapy.

### **Self-Compassion**

Self-compassion has been found to be positively correlated with being psychologically healthy (i.e., more resiliency, more self-acceptance, etc.) across diverse settings (Barnard & Curry, 2011; Neff, Rude, & Kirkpatrick, 2007). Self-compassion has also been found to be malleable through meditation interventions with meditators, undergraduate university students (McKnight, 2012; Weibel 2007; Wong & Chi, 2011). Self-compassion has been differentiated from self-pity and self-esteem (Barnard & Curry, 2011). Therapists' self-compassion has been found to positively correlate with self-care, self-acceptance, being in the here-and-now and low emotional burnout (Armani, 2011; Patershuk, 2013), and better ways to cope with stress (Patsiopoulos & Buchanan, 2011; Ying & Han, 2009).

Although these aforementioned findings are based on self-reporting and limited participant diversity, the findings remain consistent with the overall trend that suggests that self-

compassion may benefit novice therapists' relationships with themselves. By improving their relationships with their own selves, novice therapists could be more effective with clients.

### **Empathy**

Historically, the word empathy has been used to describe a broad range of meanings (Gladstein, 1983). Research has shown empathy to be an active process essential for human connection. As Rogers (1957) explained, empathic understanding ... [occurs when the therapist] senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. This kind of sensitive, active listening is exceedingly rare in our lives. We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know (p. 116).

Rogers' definition of empathy implies a cognitive aspect (e.g., personal meanings), as well as an emotional one (e.g., senses accurately feelings). Empathy is crucial in a social context. Not surprisingly, there has been an interest in understanding how therapists' empathy affects treatment (Rogers, 1957).

Therapeutic empathy was conceptualized from the need to distinguish lay people's empathy from the empathy that therapists utilize in their work with clients. Therapeutic empathy consists of four categories: empathic attunement, empathic attitude, empathic communication, and empathy knowledge. *Empathic attunement* is described as therapists' ability to stay open to perceive individuals' inner world. *Empathic attitude* refers to a therapist's personality and ability to set a tone of empathy in his or her interactions with clients. *Empathic communication* consists of therapists' ability to reflect on the client's emotional and cognitive content during therapy in a relevant manner. Finally, *empathy knowledge* consists of the implicit and explicit knowledge of

the nature of empathy acquired through reading books, attending lectures, etc. From this body of work, therapists' reflections on their clients' therapeutic work is fundamental in the evolution of therapeutic empathy (Thwaites & Bennett-Levy, 2007).

To facilitate research on empathy, contemporary researchers have distinguished two types: cognitive and emotional empathy (Duan & Hill, 1996). Unfortunately, studying empathy has been plagued by a lack of consensus of what empathy is (Gladstein, 1983). Research on empathy has been characterized by a variety of theoretical approaches (Duan & Hill, 1996), resulting in an array of scales being developed to assess empathy. Despite these challenges, empathy remains a crucial factor in working with clients (Rogers, 1957).

### **Emotional Empathy**

Emotional empathy (EE) is defined as feeling similar to another person's emotional state (Gladstein, 1983). As cited by Gladstein (1983), emotional empathy began to be conceptualized by influential psychologists such as Wundt (1892,1897) McDougal (1908), Allport (1924) and emotional empathy has been associated with an increased in mirror neuron system activity reflecting somatic and sensory of another individual's experience when compared to cognitive empathy (Nummenmaa, et al., 2008). Individuals with higher levels of emotional empathy have been found to have increased heart- rates responses when compared to individuals with lower levels of emotional empathy (Mehrabian, Young, & Sato, 1988). Additionally, research indicates that emotional empathy is influenced by subconscious mechanisms. For example, in one study, individuals with higher levels of emotional empathy were compared to individuals with lower levels of emotional empathy as measured by electromyographic (EMG). Higher-emotional empathy participants were found to be more congruent in their automatic facial mimicry

reactions (i.e., sad face) when presented with emotional stimuli (i.e., sad picture) when compared to lower-emotional empathy individuals (Sonnby-Borgström, 2002).

Interestingly, emotional empathy appears to be influenced by gender; females scored higher on measures of emotional empathy as compared to males (Neff & Pommier 2013; Paul & Podberscek, 2000; Gladstein, 1983). Emotional empathy is also likely an ability that can be learned (Cunico, Sartori, Marognolli, & Meneghini, 2012). This construct could also indicate emotional maturity (Neff & Pommier, 2013) and moral development (Smith, 2006). Overall, the emotional empathy of novice therapists is understudied, and the present study aims to expand our knowledge in this area.

### **Cognitive Empathy**

Cognitive empathy (CE) is the ability to think like another person is thinking (Gladstein, 1983). As cited by Gladstein (1983), cognitive empathy began to be discussed in the scientific literature in Piaget's early work (1929,1975) and by Mead (1934) and Cottrell (1942). Cognitive empathy has been found to be positively associated with aggressive behavior (Shechtman, 2002) and manipulation (Smith, 2006), but, unlike emotional empathy, it has not been found to be influenced by a gender (Nanda, 2013; Rueckert, Branch, & Doan, 2011). Research on cognitive empathy has found that some individuals can have deficits in emotional empathy, while their cognitive empathy remains intact, and vice versa (Blair, 2005; Wai & Tiliopoulos, 2012).

From an evolutionary standpoint, Smith (2006) hypothesized that cognitive empathy evolved because it was important to recognize what other people were thinking in order for individuals to secure resources under competition. In direct contrast, emotional empathy may have prevented individuals' obtainment of their goals because understanding other

people's emotions may have been "too distracting" (p. 6). One major limitation of this aforementioned research is the use of undergraduate students in its sampling. Thus, exploring empathy with novice therapists during their graduate training could uniquely further our understanding of this psycho-emotional, complex process.

### **Novice Therapists and Self-Compassion**

Although self-compassion appears to be positively correlated with mental health across different studies (e.g., Neff, Rude, & Kirkpatrick, 2007). More specifically, research on self-compassion has been positively associated with a better ability to cope with stress (Skovholt & Trotter-Mathison, 2014) and better emotional regulation (Finlay-Jones, Rees, & Kane, 2015) less compassion fatigue (Ringebach, 2009) among therapists. Despite the well-documented benefits of self-compassion, this construct has yet to be explored with novice therapists. Research on novice therapists has been focused on self-care (Skovholt & Rønnestad, 2003) and on mindfulness (a subcomponent of self-compassion) (Shapiro, Brown, & Biegel, 2007). Self-compassion has also been investigated with different types of professionals, such as social work students (Ying, 2009), nursing students (Heffernan, Quinn, McNulty, & Fitzpatrick, 2010) and teachers (Jennings, 2015). Since research on self-compassion is limited, this present study aims to more deeply explore self-compassion in novice therapists.

The aforementioned limited research suggests that the relationship between self-compassion and empathy has yet to be extensively explored (Neff & Pommier, 2013, Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). For instance, it was found that those individuals who scored higher on self-compassion did not necessarily experience higher levels of emotional empathy (Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). Interestingly, females tended to score higher levels of emotional empathy (Neff & Pommier, 2013; Paul & Podberscek, 2000)

and researchers have proposed that this type of empathy could be used as a marker for professional and personal maturity. While self-compassion has mainly not been associated with emotional empathy, preliminary research has shown that self-compassion and cognitive empathy are positively correlated (Birnie, Speca, & Carlson, 2010; Neff & Pommier, 2013). The picture emerging from research is plagued by mixed findings regarding the relationship between self-compassion and emotional or cognitive empathy. Understanding the role of empathy and self-compassion could be essential to the overall conceptualization of the healing process that takes place between therapist and client. It is crucial to explore a novice therapist's relationship with him or herself and its influence on the quality and nature of relationships established with others.

### **Novice Therapists and Emotional and Cognitive Empathy**

Research on empathy training programs suggests effectiveness for teaching both emotional and cognitive empathy (Butters, 2010). The effectiveness of empathy programs could be important for novice therapists since investigators found that registered nurses and medical doctors-in-training were not empathetic or had relatively low empathy levels toward their clients (Reynolds & Scott, 2000). However, Fine and Therrien (1977) found after emotional empathy and cognitive empathy training, medical students' empathy levels increased. This information is important because nurses have found to struggle with low levels of empathy (LaMonica, Carew, Winder, Haase, & Blanchard, 1976; Reynolds & Scott, 2000). Therefore, exploring empathy in novice therapists-in-training could be important to improving our understanding of how to protect their levels of empathy since research with medical students have shown a significant reduction of their emotional empathy (Bellini & Shea, 2005). Effective empathy training is relevant because novice therapists often experience high levels of stress, and individuals who are stressed tend to struggle to develop and maintain empathy (Novack, Epstein, & Paulsen, 1999;

Park, Kim, Kim, Yi, Chae, & Roh, 2015). Researchers have also suggested that emotional empathy levels could be indicators of improved professional and personal development (Butters, 2010; Logan, 2009; Neff & Pommier, 2007), and, not surprisingly, higher emotional empathy levels have been associated with better communication (Stepien & Baernstein, 2006) and improved clinical practice in medical doctors (Magee, 2002). Given these research findings, exploring empathy among therapists' training is an important area of study.

### **Self-Compassion and Emotional and Cognitive Empathy**

There are mixed findings about the influence of self-compassion on empathy. Only four articles have been published on self-compassion and emotional empathy. These four studies have found non-significant association between self-compassion and emotional empathy with adult population and college students (Birnie, Speca, & Carlson, 2010; Neff & Pommier, 2013; Welp & Brown, 2014; Wei, Liao, Ku & Shaffer, 2011). With the exception of one study which has found a positive association between self-compassion and emotional empathy with adults and active meditators, but not with student population (Neff & Pommier, 2013). A total of three studies have explored self-compassion and cognitive empathy. Two studies have shown a positive association between self-compassion and cognitive empathy with student and adult populations (Neff & Pommier, 2013; Birnie, Speca, & Carlson, 2010). Contradictory to these findings, however, Welp and Brown (2014) found a non-significant correlation between self-compassion and cognitive empathy with adult population. In general, research on the relationship between self-compassion and emotional and cognitive empathy is underdeveloped and the relationships among these variables with novice therapists have yet to be fully explored.



## **Emotional and Cognitive Empathy**

Little is known about the relationship between cognitive and emotional empathy. Only a few articles have been published on the topic (e.g., Stephan & Finlay, 1999; Duan & Hill, 1996; Gladstein, 1983). Emotional empathy appears to have neurological differences, such as increased activity in the limbic system responsible for emotion processing and increased mirroring neurological activity as compared to cognitive empathy (Nummenmaa, Hirvonen, Parkkola, & Hietanen, 2008). For instance, the findings from a study conducted with individuals diagnosed with semantic dementia (SD) and frontotemporal dementia (FD) and a healthy control group showed that those with semantic dementia (SD) had low levels of emotional and cognitive empathy, in contrast with individuals with frontotemporal dementia (FD), who showed low levels of cognitive empathy but intact emotional empathy. Based on this study's findings, emotional empathy appears to be affected by the temporal lobes, whereas cognitive empathy appears to be affected by the frontal lobes (Rankin, Kramer, & Miller, 2005). In general, these research findings evidenced different brain activity in individuals' experience of emotional empathy and cognitive empathy. From an evolutionary standpoint, emotional empathy and cognitive empathy appear to have evolved for different purposes – one for social interconnection and the latter for goal fulfilment (Smith, 2006). However, these two purposes may not be necessarily mutually exclusive. This present study aims to expand the limited understanding of the relationship between these two variables among novice therapists.

Based on the previously mentioned research, we can see that empathy training programs could be an effective way to enhance individuals' empathy levels. Also, according to extremely limited literature, the relationships on self-compassion and emotional and cognitive empathy are

understudied. Three studies have found non-significant association between self-compassion and emotional empathy (Birnie, Speca, & Carlson, 2010; Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). To contradict these findings, however, in one study, self-compassion and emotional empathy was positively associated with adult population and mediators, but not with student population (Neff & Pommier, 2013). Also, two studies have found a positive association between self-compassion and cognitive empathy among student population, and adults. (Neff & Pommier, 2013; Birnie, Speca, & Carlson, 2010). Whereas, Welp and Brown, (2014) found non-significant correlation between self-compassion and cognitive empathy with adult population. Surprisingly, research on empathy does not address the relationship between self-compassion and cognitive and emotional empathy for novice therapists.

### **Research Questions**

1. Is there an association between self-compassion and emotional empathy among novice therapists?
2. Is there an association between self-compassion and cognitive empathy among novice therapists?
3. Is there an association between emotional and cognitive empathy among novice therapists?

## CHAPTER III

### METHODS\*

#### Instrumentation

Two survey instruments were used to collect data in the present study: (a) the Self-Compassion Scale-Short Form (SCS-S) and (b) the Interpersonal Reactivity Index (IRI). The (SCS-S) consists of 12 questions with response options ranging from *almost never* to *almost always*. The (IRI) is comprised of 28 questions with a response range from *does not describe well* to *describes very well*. All appendices are found at the end of this document.

Prior to participating in this study, possible participants were presented with an electronic information sheet detailing their confidentiality rights as participants in this research to prevent any coercion, it was explained to participants that they could stop participating at any time without any consequences. Online surveys were used to explore the research questions presented in this study and were administered online. Raw data were entered and analyzed using Statistical Package for the Social Sciences (SPSS) (Version 21).

#### Procedures

G\*Power was used to conduct a power analysis (Faul, Erdfelder, Buchner, & Lang, 2009) to determine the sample size needed to provide the study with a reasonable chance of obtaining clinical significance. The power analysis indicated that a total of 32 participants were

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\* Reprinted with permission from (a) “The development and validation of a scale to measure self-compassion.” Neff, K.D. 2003. *Self and Identity*, 2(3), 223-250 and (b) Reprinted with permission from “A multidimensional approach to individual differences in empathy” by Davis, M.H. 1980. *JSAS Catalog of Selected Documents in Psychology*, 10, 2-19.

necessary to explore the research questions of the present study. The present study consists of 32 participants; consequently, it meets power analyses criterion. Additionally, Field, Miles and Zoe (2012) recommended having 10-15 participants for every variable. The present study analyzes a total of three variables and at least have participants for each variable. The sample size was based on a power level of 0.80 for a Pearson product-moment correlation coefficient (King & Hinds, 2011).

Participants were informed about their confidentiality Participants were informed about their confidentiality at the start of the study and indicated their informed consent by clicking an “agree” button before the start of the Then they were asked to fill out the Interpersonal Reactivity Index and Self-Compassion Scale -Short-Form. Participants had the option to click "to decline to answer” at any given moment while completing the two scales of this study. After completing the two scales, participants were given the option to provide their contact information and participate in a raffle with the winning prize of \$100 on an Amazon gift card.

### **Participant Selection**

A non-random purposive sampling technique was used to recruit participants. Training directors were contacted and invited to distribute this study’s survey to their novice therapists in their programs. These programs consisted of either terminal Master’s degrees (Johnson, 1997) or doctoral degrees in counseling (Church, 1993). Particularly, they were invited to participate in the online platform: Qualtrics (<http://qualtrics.com>).

The Interpersonal Reactivity Index (IRI) and Self-Compassion Short-Form Scale (SCS-SF) were uploaded and distributed to programs at the following institutions: Sam Houston State University, The University of Texas at Tyler, Texas A&M University Corpus Christi, the University of Houston, Baylor University, and Texas A&M University, College Station.

Copyright permissions to utilize the IRI and the SCS-SF were obtained. These six universities had an average of 30 students working towards terminal Master's or doctoral degrees in counseling and clinical psychology.

Based on previous research with novice therapists (Nutt-Williams & Hill, 1996; Thériault, et al., 2009), five inclusion criteria for participation in this study were identified: (a) to have accumulated more than zero clinical hours, (b) to be currently practicing counselling, (c) to hold a Master's or Bachelor's degree in counseling, (d) to be English-speaking (native or professional fluency), and (e) not to have had an internship experience.

### **Participant Recruitment**

The researcher obtained IRB approval from the following: Sam Houston State University, The University of Texas at Tyler, Texas A&M Corpus Christi, Texas A&M University, the University of Houston, and Baylor University. The researcher contacted University of Texas at Austin and University of North Dallas but received no IRB response from these two universities. All contacted universities were chosen based on geographical proximity and similarity in their type of training they provide to novice therapists. Upon receipt of the IRB approvals, the researcher contacted program directors and advisors by phone or email with a scripted description of the present study. Then, training directors were asked to send the online survey link to their listserv of novice therapists. All recruiting methods provided detailed information sheets and procedures for keeping participant identities confidential. Self-reporting scales were available for participants to take online in Qualtrics.

## Measures

The Self-Compassion Scale-Short Form (SCS-S) consists of 12 items distributed over six subscales related to six components of self-compassion (negative aspects are reverse coded): Self-kindness (“I try to be understanding and patient towards those aspects of my personality I don’t like”), self-judgment (“I’m disapproving and judgmental about my own flaws and inadequacies,”) and (“I’m intolerant and impatient towards those aspects of my personality I don’t like”), common humanity (“I try to see my failings as part of the human condition”), isolation (“When I fail at something that’s important to me, I tend to feel alone in my failure”), mindfulness (“When something painful happens I try to take a balanced view of the situation”), and over-identification (“When I’m feeling down I tend to obsess and fixate on everything that’s wrong”) (Neff, 2003). The psychometrics on this short version of the scale has a high correlation with the longer scale when analyzing total scores of the subscales. The items’ responses ranged from 1 (almost never) to 5 (almost always) (Raes, Pommier, Neff, & Van Gucht, 2011). The reversing of the negative subscale items and then the adding of all subscale scores yielded a total score for this self-compassion scale (Raes, Pommies, Neff, & Van, 2011). Using a Confirmatory Factor Analysis with 71 potential items that were assessed with two different populations validated it: college students (30 males, 38 females; median age for both groups = 21.7 years; SD = 2.32) and active meditators (16 men, 27 women; median age for both groups = 47.0 years; SD = 9.71). Meditators practiced *vipassana* a Buddhist meditation designed to increase mindfulness. Their practice of meditation ranged from 1 to 40 years (Median =7.72 years; SD = 7.64). After examining divergent and convergent correlations, the 71 items were reduced to 12 (Neff, 2003). The results were found to have test-retest reliability of 0.93 and internal consistency of 0.92 (Neff, 2003b). To date, self-compassion has not been validated against a measure of empathy; it

is unknown if the self-compassion scale may be evaluating some parts of empathy. Since the relationship between self-compassion and empathy is not well studied, this present study aims to further our understanding of the relationship between these two psycho-emotional processes.

### **Emotional Empathy and Cognitive Empathy**

The Interpersonal Reactivity Index (IRI) (i.e., empathy scale) is self-reported with a total of 28 items answered on a Likert scale consisting of five-point responses. Interpersonal Reactivity Index (IRI) has a total of four scales with seven items each: Perspective-taking, Empathic Concern, Fantasy, and Personal Distress. This scale has been widely used to assess emotional and cognitive empathy because it has shown good divergent and convergent validity (e.g., Carey, Fox, & Spraggins, 1988; Cliffordson, 2001; Pulos, Elison, & Lennon, 2004). Convergent validity was assessed using related but different constructs for each dimension tested: social competence/interpersonal functioning, self-esteem, emotionality, sensitivity to others, and intelligence.

Perspective-taking was found to be positively correlated with self-esteem (female  $r = 0.26$ ; male  $r = 0.20$ ) and negatively correlated with shyness (female  $r = 0.20$ ; male  $r = 0.13$ ) and audience anxiety (female  $r = 0.12$ ; male  $r = -0.10$ ). Empathic concern was found to positively correlate with shyness (female  $r = 0.07$ ; male  $r = 0.14$ ), social anxiety (female  $r = 0.12$ ; male  $r = 0.14$ ), and audience anxiety (female  $r = 0.13$ ; male  $r = 0.19$ ). Also, perspective-taking and personal distress were consistently inversely correlated for both genders ( $r = -0.25$ ). This measure has a test-retest reliability coefficient of 0.61 to 0.81 and internal reliability of 0.70 to 0.78 (Davis, 1980).

### **Demographic Questionnaire**

Participants were asked to indicate the following demographic information: whether they were novice therapists, gender, ethnicity, age, internship experience, theoretical orientation (e.g., interpersonal, feminist), highest degree achieved, and experience level of counseling (Williams, Judge, Hill, & Hoffman, 1997).

### **Study Design**

The design for the study was based on a cross-sectional sampling using a computerized survey. Survey research is commonly used to measure an individual's internal experience including but not limited to thoughts and feelings.

A survey commonly consists of a list of questions given to a random or a purposive sample (Wright, 2005). In the present study, the survey was distributed by availability to a sample of target novice therapists. A correlational analysis was used to explore the relationships among these variables.



## **CHAPTER IV**

### **RESULTS**

#### **Demographic Data**

Demographic variables of the study sample, including age, gender, ethnicity, highest educational level, theoretical orientation, and number of clinical hours. The target population for this study was novice therapists who had obtained a minimum of a Bachelor's degree, was currently seeing clients, and who have had no internship experience. A total of 18 novice therapists provided their contact information; six novice therapists responded from Texas A&M counseling psychology program, two from Texas A&M psychology program, two novice therapists were from Sam Houston University, two from Baylor University, one from University of Houston. The researcher was unable to determine the corresponding universities of five respondents because they did not provide enough identifiable information. A total of 49 participants completed the survey, eight had internship experience and nine had zero clinical hours; consequently, they did not meet the criteria and were excluded from the data analyses. Participants' age ranged from 22-33 years old. The mean age of the participants was 27 years with a standard deviation of 3.47. The sample consisted of 32 adults (89% female and 12% male). The ethnic breakdown was 37% Caucasian, 28% Asian, 16% Hispanic, 12% African American and 6% other (i.e., biracial). Participants reported two different educational levels: 28% Bachelor's degree and 71% Master's degree. As far as participants' theoretical background, a total of 31% participants identified cognitive behavioral therapy 12% participants indicated humanistic/existential, 12% interpersonal and 43% participants reported other theoretical orientation (i.e., psychodynamic, integrative, Adlerian) not previously listed. Over a third of

participants reported practicing mindfulness. Participants reported an average of 544 clinical hours. All demographic data were obtained by self-report.

## Research Questions

This study explored the relationships between self-compassion, emotional empathy, and cognitive empathy among novice therapists. These variables were evaluated using the Interpersonal Reactivity Index (IRI) and Self-Compassion Scale-Short-Form (SCS-S) scales. The present work centered on three research questions:

1. Is there an association between self-compassion and emotional empathy among novice therapists?
2. Is there an association between self-compassion and cognitive empathy among novice therapists?
3. Is there an association between emotional empathy and cognitive empathy?

Data were tested for normality by using both parametric and non-parametric measures in the distribution of the three variables of this sample, with  $N = 32$  and  $\alpha = 0.05$ . Non-parametric correlation coefficients along with Pearson linear correlation coefficients indicated that at least one score within the cognitive empathy distribution was likely an outlier.

The score of 17 was an outlier in the cognitive empathy distribution which was removed from the analysis resulting in normal distributions for all three variables. Normalcy was also evidenced by the visual inspection of the three distributions using normal quantiles plots (Q-Q plots). Also, based on Shapiro-Wilk tests of normality, at a 5% significance level, the hypothesis that self-compassion, emotional empathy, and cognitive empathy are normally distributed cannot be rejected (all p-values  $> 0.05$ ) (Razali & Wah, 2011).

Table 1 presents non-significant correlation between self-compassion and emotional empathy and between self-compassion and cognitive empathy.

**Table 1.** Self-Compassion and Emotional and Cognitive Empathy. Pearson Correlations.

		<b>Self-Compassion</b>		<b>Emotional Empathy</b>		<b>Cognitive Empathy</b>	
<b>EE</b>	Pearson Correlation	-0.26		1		0.12	
	Sig. (2-tailed)	0.14				0.48	
	N	31		31		31	
<b>CE</b>	Pearson Correlation	-0.03		0.12		1	
	Sig. (2-tailed)	0.87		0.48			
	N	32		31		32	
<b>SC</b>	Pearson Correlation	1		-0.26		-0.03	
	Sig. (2-tailed)			0.14		0.87	
	N	32		31		32	

Table 2 shows emotional empathy, self-compassion and cognitive empathy compared across gender, race and education. Non-parametric test was used because of the small sample size and the ordinal nature of the three dependent variables.

**Table 2.** Gender, Ethnicity, and Education and Self-Compassion and Emotional and Cognitive Empathy.

		<b>Self-Compassion</b>			<b>Emotional Empathy</b>			<b>Cognitive Empathy</b>		
<b>Demographic Variable</b>		Mean	Median	Standard Deviation	Mean	Median	Standard Deviation	Mean	Median	Standard Deviation
<i>Gender</i>	Male	38.2	40.0	5.8	25.4	25.0	1.1	28.0	27.0	2.0
	Female	38.3	39.0	6.4	28.7	29.0	2.3	29.2	30.0	3.6
<i>Race</i>	Caucasian/White	36.5	34.0	6.6	28.4	28.5	2.4	29.7	30.0	2.6
	African American/Black	40.8	41.5	3.6	28.3	29.0	3.0	29.5	29.0	3.7
	Asian	38.0	41.0	5.8	27.1	26.5	2.3	26.7	27.5	3.9
	Hispanic	40.2	39.0	7.9	30.0	29.0	2.7	31.4	31.0	2.2
	Other	40.0	40.0	8.5	28.5	28.5	0.7	29.5	29.5	0.7
<i>Highest Degree Achieved</i>	Undergraduate degree (Bachelor)	39.7	41.0	6.7	27.3	28.0	2.5	30.0	30.0	2.2
	Graduate degree (Master)	37.7	39.0	6.0	28.5	29.0	2.4	28.6	29.0	3.7

Table 3 shows gender and emotional empathy and cognitive empathy and self-compassion. Kruskal-Wallis test showed significant difference in the mean levels on emotional empathy across gender groups. Women scored higher on the emotional empathy scale than men.

**Table 3.** Gender, Self-Compassion, and Emotional and Cognitive Empathy. Kruskal-Wallis Test.

	<b>Self-Compassion</b>	<b>Emotional Empathy</b>	<b>Cognitive Empathy</b>
<b>Mann-Whitney U</b>	67.500	13.500	48.000
<b>Wilcoxon W</b>	82.500	28.500	63.000
<b>Z</b>	-0.126	-2.853	-1.118
<b>Asymp. Sig. (2-tailed)</b>	0.900	0.004	0.263
<b>Exact Sig. [2*(1-tailed Sig.)]</b>	0.903	0.003	0.290

a. Grouping Variable: Gender

## **CHAPTER V**

### **DISCUSSION**

The purpose of this study was to explore the association between self-compassion and emotional empathy as well as the association between self-compassion and cognitive empathy among novice therapists. Existing investigations indicate that novice therapists often experience psycho-emotional distress during their graduate training (Ronnestad & Skovholt, 2003). Research on self-compassion has been found to be positively correlated with psychological health and may have positive implications for how novice therapists relate to themselves and how they relate to their clients (Barnard & Curry, 2011; Patsiopoulos, & Buchanan, 2011).

This study contributes to the existing body of research on self-compassion, emotional empathy, and cognitive empathy. The present study findings suggest non-significant correlation between self-compassion and emotional empathy, and between self-compassion and cognitive empathy. Also, a significant group mean difference was found between emotional empathy and females.

#### **Self-Compassion and Emotional Empathy**

Theoretically, it would appear that self-compassion and emotional empathy would have a strong positive association. However, upon close examination of the empathy scale, it does not evaluate common humanity and mindfulness (Birnie, Speca, & Carlson, 2010). Common humanity is defined as the view of suffering as a common linkage to one's humanity as opposed to an isolated experience. Mindfulness is defined as the ability to view reality as it exists; without exaggerating or denying one's reality (Birnie, Speca, & Carlson, 2010; Neff & Pommier, 2013).

Also, emotional empathy may involve understanding of another's perspective or feelings, but it does not mean there is no evaluation of those perspective or feelings. By contrast, self-compassion emphasizes accepting perspectives and feelings without judgment. More research is needed, however, because self-compassion has not been associated with positive global evaluations of the other (Neff & Pommier, 2013).

Self-selection bias could be influencing this non-significant relationship between self-compassion and emotional empathy. Self-selection bias occurs when participants select themselves to participate in a study, and because of this, the sample may have different responses than those participants who did not participate in the study (Bethlehem, 2008). Because of the knowledge and interest, adults and active meditators may be the reason why self-compassion and emotional empathy have been found to be positively associated only with these two populations (Neff & Pommier, 2013). It may be argued that meditators and novice therapists have above average knowledge and interest on self-compassion and empathy which could complicate the assessing of these two variables. Self-selection bias is also particularly relevant since some novice therapists in this study knew the researcher outside of the study, which could further confound the assessment of these constructs.

The person-centered theory has informed a humanistic psychotherapy approach which aims to specify the essential core aspects of effective therapy. According to this theoretical work, in order for therapy to be constructive, the therapist should be congruent, empathetic and experience unconditional regard for clients. Therapist's congruence is defined as "his actual experience accurately represents his awareness of himself" (Rogers, 2007, p. 242). In other words, one's self-concept corresponds to one's experience. This definition of congruency implies that when congruent therapists experience uncomfortable emotions, they do not deny or exaggerate these experiences; this suggests mindfulness a subcomponent of self-compassion.

Rogers (2007) also viewed therapist's congruency as being "freely and deeply himself" (p. 242). This component seems to relate to themes of self-acceptance and self-forgiveness, another subcomponent of self-compassion: gentle self-talk. Unconditional regard is defined as the ability for therapists to accept their client with "weakness and problems as well as his potentialities" (p. 243). This definition of unconditional regard shows that value of humanity including suffering which is consistent with shared humanity construct another self-compassion subdivision. It seems that person-centered theory provides underpinning principles which are consistent with self-compassion.

Based on this psychotherapy theory, congruency and unconditional regard are "necessary and sufficient" components for effective therapeutic work with clients (Rogers, 2007, p. 240). More specifically, congruency and unconditional regard are critical components to therapists' empathy, which Rogers describes as the ability to "sense the client's anger, fear or confusion as if it were your own, yet without our own anger, fear or confusion getting bound up in it" (p. 243). Rogers definition of empathy appears to imply emotional empathy (i.e., sense the client's anger). Overall, this theoretical approach to psychotherapy supports that notion that self-compassion components are inherent to therapists' emotional empathy.

However, the present study results do not support this foundational theoretical context, so it is not possible to conclude the theoretical association between self-compassion and emotional empathy.

This study provides initial support for the concept of *wounded healer* which is defined as therapists' ability to use their emotional wounds (i.e., emotional abuse, family of origin conflict, etc.) to work well with clients (Groesbeck, 1975). In other words, feeling somewhat uncomfortable or vulnerable may be helpful for the increase of emotional empathy (Brown, 2006). Along the same lines, Trusty and Watts (2005) found a significant positive correlation



between higher levels of anxiety and higher levels of emotional empathy among novice therapists. In another study effective therapists reflected on how painful situations (i.e., oppression, family crises) have increased their ability to empathize with their clients (Wolgien & Coady, 1997). This information suggests that therapists' emotional pain is likely a relevant component to their emotional empathy.

### **Self-Compassion and Cognitive Empathy**

Research findings on self-compassion and cognitive empathy are contradictory. On one hand, two studies found a positive association (Birnie, Speca & Carlson, 2010) with a community sample. Consistently, Neff and Pommier (2013) found a positive association between self-compassion and cognitive empathy among college students, community population, and meditators. Unlike these two studies findings, however, Welp and Brown (2014) found a non-significant correlation between self-compassion and cognitive empathy with an adult population, which is consistent with current study findings.

One alternative explanation may be the way cognitive empathy was assessed. Research has found that "observer reported empathy scales show a mean effect nearly four times larger than that of self-report measures" (Butters, 2010, p. 88). This information suggests that self-report may be not capturing the empirical nature of novice therapists' empathy. As such, more investigations should be directed to this area.

Also, individuals' motivation to think like another person is thinking may be influenced by how painful or costly one perceives this type of empathy to be. This information is consistent with an evolutionary perspective in which resources were limited so survival depended on the competition with individuals outside of our immediate social circle (Zaki, 2014). In other words, our ability to think like the other person is thinking may be based on our perceived closeness

when relating to others (Zaki, 2014). For instance, Duan (2000) found that our evaluation of the future of our relationship with another person may increase our cognitive empathy. Consistent with this notion, cognitive empathy has been found to be a more conscious decision when compared to emotional empathy (Langdon & Mackenzie, 2012). Overall, motivation to engage in cognitive empathy could also an important role in explaining current study findings.

More research is needed to determine how cognitive empathy is related to motivation and self-compassion. This is particularly important since clients, within this evolutionary theoretical perspective, could be considered “outgroup members” and as such, cognitive empathy may be more “costly” for novice therapists (Zaki, 2014, p.1612). It is possible that an individual’s levels of motivation to engage in cognitive empathy may fluctuate regardless of his or her level of self-compassion. Such an interpretation may lend to the explanation of the present study findings.

A study provided evidence for the differential brain activity in cognitive empathy, mainly less activity in the mirror neurological and limbic systems when compared with emotional empathy (Nummenmaa, et al., 2008). However, there is also evidence that mirror neurological activity may be involved, but current understanding of this mirror activity may not be sufficient to capture the complexity of the brain activity involved in cognitive empathy (Spunt, Satpute, & Lieberman, 2011).

Researchers have attempted to identify “the self” in humans’ brain; however, no consensus has been reached (Gillihan & Farah, 2005). Thus far, studies have investigated the mammalian caregiving system (increases oxytocin, reduces cortisol) when experiencing self-compassion (Neff & Dahm, in press). Future research then could investigate that intricate neurological differences between self-compassion and cognitive empathy. It is possible that no neurological correspondence exists which would explain current study’s findings.

## **Emotional Empathy and Cognitive Empathy**

Consistently with previous research, emotional empathy and cognitive empathy were not significantly correlated in this present study. Although the IRI is considered to be the most commonly used scale to assess these variables, participants may not be reporting their automatic, and perhaps visceral, reaction that this scale was designed to do (Chrysikou & Thompson, 2016). For instance, the IRI scale used questions such as: “I sometimes find it difficult to see things from the "other guy's" point of view” to assess cognitive empathy; and this scale used questions such as: “when I see someone being taken advantage of, I feel kind of protective towards them” to assess emotional empathy. In this latter question, it is not clear if individuals are actually assessing their own emotional states or reflecting on how they relate to people which it will more likely to be cognitive empathy. In other words, this scale may increase participants’ response bias which, in turn, may be influencing documented lack of differentiation between cognitive empathy and emotional empathy (Chrysikou & Thompson, 2016; Siu & Shek, 2005).

Current study findings are consistent with the documented different neurological activity between these two constructs. It may be possible that these two processes are indeed differentiated from each other (Nummenmaa, et al., 2008). To further our understanding of these variables more research should be done to differentiate and refine our understanding of the intricate specific neurological mechanisms.

While there is evidence that cognitive empathy and emotional empathy may be due to different processes, personality traits may influence both two types of empathy. For example, Song and Shi (2017) found that agreeableness (i.e., friendliness or compassion) was found to be positively associated with both emotional and cognitive empathy with Chinese medical students.

This research provides support for the notion that although these may be two types of empathy, still personality traits may influence both of them. These research findings could advance by exploring further how consistent personality traits influence our ability to think and feel like the other which may have implications for novice therapists' clinical work with clients.

There are mixed findings of the influence of self-compassion on empathy. Research results show a positive correlation between self-compassion and cognitive empathy on an adult sample (Birnie, Speca, & Carlson, 2010), college students, and active meditators (Neff & Pommier, 2013). Meditators in this study had an average of six years and their meditation practice range from beginner to advance (20 or more years). To contrast, however, Welp and Brown (2014) found a non-significant correlation between self-compassion and cognitive empathy with an adult population. A non-significant correlation was also found between self-compassion and emotional empathy with college students and community population (Birnie, Speca, & Carlson, 2010; Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). Neff and Pommier (2013) found a significant correlation between self-compassion and emotional empathy with a community sample and active meditators, but not with college students. In general, research on the relationship between self-compassion and emotional and cognitive empathy is underdeveloped. The relationships among these variables with novice therapists should be explore further.

## Emotional Empathy and Women

A significant group difference was found between emotional empathy and females in this current study. Although this finding is consistent with several studies, researchers have noted that these gender differences are not consistently found across all studies (e.g., Neff & Pommier, 2013; Trusty & Watts, 2005). To explain these findings from an evolutionary standpoint, it is possible that gender differences developed due to different demands in their environment. For example, emotional adaptations may have evolved in a more primitive context, in which, women had to be more emotionally sensitive to their offspring; in contrast, men needed to obtain resources (i.e., food) for their survival (Ickes, 1997). Gender differences have been found in cross-cultural research; women tend to score higher on neuroticism which is defined as emotionally reactivity when compared to men (e.g., Lippa, 2010; Watson, 2001) which by implication will likely impact their awareness of individuals' emotions (Lahey, 2009).

Historically, women tend to be in lower- powered- work positions when compared to men (Brine, 1999; Ickes, 1997). Specifically, in the present time, women hold 26 (5.2%) of CEO positions out of a total of 500 influential companies (Catalyst, 2017). This is relevant because individuals from higher socioeconomic status were found to be less likely to be emotionally sensitive (i.e., ability to identify other people's emotions) when compared with individuals with a lower socioeconomic status (Kraus, Côté, & Keltner, 2010). Thus, women perhaps have to be more emotionally sensitive to others to be able to function in their environment; in contrast, men may not have the same social demands to emotionally focus on the others (Cunico, et al., 2012; Ickes, 1997).

Added to that, Bandura (1977) proposed in his social learning theory that behavior that tends to be repeated also tends to be the most frequently rewarded. Therefore, the inconsistent gender differences found between these two variables could be because women's sensitivity to others' emotions may have been rewarded regularly (Levant, 1992) in some samples, and not so much emphasized on other samples-perhaps in less patriarchal cultural contexts. It would be of investigative interest to explore these variables in more gender-equalitarian systems (Gornick & Meyers, 2008).

In sum, it appears that both evolutionary theory, social class, and social learning theory may be at work in the association between females and emotional empathy. More research is needed to determine why certain samples, and not some others, show a positive association between emotional empathy and females. One important aspect, it is to study changes in emotional empathy over time, as individuals acquire more power throughout their lives as it most likely to be the case among novice therapists. Particularly relevant since indeed research has shown that emotional empathy in the community college population has declined since 2000 (e.g., Konrath, O'Brien, & Hsing, 2011).

### **Limitations**

The current study consists of a small sample size, which limited the generalizability of findings. Additionally, this study was a convenience sample and, as such, could be over-representing some individuals of the population. This aspect is important given that studies that have explored these variables are large samples. Particularly, these previous studies consisted of more than 100 participants compared to current study sample which consisted of 32 participants.

On a similar vein, a larger sample may be needed to reflect moderate to small effect sizes found in the literature. For instance, for an effect size of .05, the sample size will need to consist of 52 participants and for an effect size of .04 sample will need to consist of 71 participants (Faul, Erdfelder, Buchner, & Lang, 2009). Future research could also focus on exploring these variables using different statistical analyses. For instance, a hierarchical linear modeling (HLM) could be used to account for all the factors and understand better the possible moderators (i.e., gender, age, clinical experience, theoretical orientation) (McCoach, 2010).

The use of Self-Compassion Scale-Short Form (SCS-S) and Interpersonal Reactivity Index (IRI) scales to measure self-compassion and empathy as self-reported measures could be improved. Researchers have noted that the addition of behavioral observations may be useful, such as the nature of novice therapists' empathic communication in clinical practice, which could be assessed by peers or clients (Reynolds & Scott, 1999; Wei, Liao, Ku, & Shaffer, 2011).

## **CHAPTER VI**

### **CONCLUSIONS**

Based on the results of this dissertation and mixed results from the literature, it is difficult to confirm that there are indeed relationships between self-compassion and these two types of empathy. Therefore, better theoretical models may be necessary to advance knowledge in this area and by implication more complex research designs.

The present study advances knowledge and understanding in the relatively unexamined areas of novice therapists' empathy and self-compassion. Some analyses of the data were even contradictory to previous work. Self-compassion was not significantly correlated with cognitive empathy and emotional empathy.

Research on the relationships between self-compassion and emotional and cognitive empathy is still inconclusive. The limited research that has been published shows that higher levels of self-compassion correlate with increased levels of cognitive empathy (Birnie, Speca, & Carlson, 2010), but with no significant change in levels of emotional empathy, in a community and student populations (Wei, Liao, Ku, & Shaffer, 2011; Welp & Brown, 2014). In contrast, Neff and Pommier (2013) found a positive correlation between high levels of self-compassion and individuals' levels of both emotional empathy and cognitive empathy in adult population and meditators. Further research is needed to understand how emotional and cognitive empathy are related to higher levels of self-compassion. Finally, it is important to gain a better understanding of self-compassion: How does it relate to stress during graduate training and the development of novice therapists' effectiveness with clients? Also, novice therapists' relation to self and their ability to empathize need to be better understood within the context of novice therapists'



training. The present study provides important information about the relationships between self-compassion, emotional empathy, and cognitive empathy in novice therapists. As society continues to need competent therapists, it is critical for researchers, practitioners, and trainers to improve understanding of the training of effective therapists. One of the major implications of the present study is the expansion of the understanding of how novice therapists relate to themselves and how this relationship affects their ability to empathize. This area of study is extremely limited and yet crucial given that empathy has been consistently considered essential for effective therapy. By exploring our understanding of these variables as they pertain to novice therapists, the training of future psychologists may be improved.

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## APPENDIX A

### TEXAS A&M UNIVERSITY HUMAN SUBJECTS PROTECTION PROGRAM

#### INFORMATION SHEET

Project Title: Self-Compassion and Emotional Empathy and Cognitive Empathy among Novice Therapists

**My name is Liliana Gandara, and I am a researcher from Texas A&M University. I am conducting a study with novice therapists, your participation is confidential and completely voluntary. If you decide not to participate then you will not face any penalties.**

#### **Why Is This Study Being Done?**

The purpose of this study is to explore self-compassion, and emotional empathy and cognitive empathy among novice therapists.

#### **Why Am I Being Asked To Be In This Study?**

You are being asked to be in this study because you are a graduate student engaged in clinical training for a psychology discipline. To be included in this study you will need to meet the following criteria: 1) Be enrolled in college 2) Be English-speaking 3) Have internet access. If you meet the following criteria you would be excluded: 1) Not having internet access 2) Not being enrolled in college 3) Not actively seeing clients 4) Non-English speaking.

#### **How Many People Will Be Asked To Be In This Study?**

270 participants from local universities will be invited for this study from a total of nine universities.

#### **What Are the Alternatives To Being In this Study?**

Your only alternative is to not participate in this investigation.

#### **What Will I Be Asked To Do In This Study?**

Firstly, you will be asked to read the information sheet; then you will begin completing the survey. Secondly, you will be given a demographic questionnaire. Thirdly, you will be presented with two scales to complete with multiple choices on a Likert response format. While completing these scales, you will also have the choice to "to decline to answer" so if desired, you could easily stop your participation in this study.

#### **Are There Any Risks To Me?**

This study does not present a greater risk than those presented in your daily life. Your information will be de-identified, stored securely to ensure your privacy and confidentiality, and

safely destroyed upon completion of the study. Please contact your student counseling center or call 211 if you need assistance.

### **Are There Any Benefits To Me?**

The benefit to you by volunteering in this study is to understand better the experience of therapists in their training.

### **Will There Be Any Costs To Me?**

There are no costs for your participation in this study.

### **Will I Be Paid To Be In This Study?**

At the end of the survey, you will be given the option to enter a raffle for a one-hundred dollar Amazon gift card by providing your email address.

### **Will Information From This Study Be Kept Private?**

The records of this study will be kept private. No identifiable personal information will be published. Research records will be stored securely and only Dr. Charles Ridley and Liliana Gandara will have access to data associated with this study.

### **Who May I Contact for More Information?**

You may contact the Principal Investigator, Dr. Charles Ridley, to inform him of any concerns or complains you may have related to this investigation. His phone number is (979) 862-6584, and his email is [cridley@tamu.edu](mailto:cridley@tamu.edu). You may also contact the Co-Investigator, Liliana Gandara; her information is the following: (323) 633-4700 and [blgandara@gmail.com](mailto:blgandara@gmail.com).

Also, if you have questions, complaints, and concerns regarding this research, you may call the Texas A&M University Human Subjects Protection Program office by phone at 1-979-458-4067, toll-free at 1-855-795-8636, or by email at [irb@tamu.edu](mailto:irb@tamu.edu).

### **What if I Change My Mind About Participating?**

This research is completely voluntary which means you have the choice to participate or not to participate as well as withdraw your participation at any given time. You will not face any penalties if you decide not to participate in this investigation.

For questions about your rights, complaints, and concerns about this investigation, you may call the Texas A&M University Human Subjects Protection Program office at (979) 458-4067 or [irb@tamu.edu](mailto:irb@tamu.edu).

By participating and completing this survey, you are giving permission for the investigator to use your information for research purposes.

Thank you.

*Liliana Gandara, M.Ed.*

## APPENDIX B

### DEMOGRAPHIC QUESTIONNAIRE

Gender:

Ethnicity:

Age:

Theoretical orientation (e.g., feminist):

Highest degree achieved:

Current hours of clinical experience:

Are you currently or in the past practiced any mindfulness? If so, how frequently? Do you have internship experience?

Are you currently seeing clients?

English fluency? (professional proficiency or native fluency)

## APPENDIX C

### INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly as you can. Thank you.

#### ANSWER SCALE:

A	B	C	D	E
DOES NOT				DESCRIBES ME
DESCRIBE ME				VERY
WELL				WELL

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
2. I often have tender, concerned feelings for people less fortunate than me. (EC)

3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
5. I really get involved with the feelings of the characters in a novel. (FS)
6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
8. I try to look at everybody's side of a disagreement before I make a decision. (PT)
9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)
10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
12. Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)

13. When I see someone get hurt, I tend to remain calm. (PD) (-)
14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)
17. Being in a tense emotional situation scares me. (PD)
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)
19. I am usually pretty effective in dealing with emergencies. (PD) (-)
20. I am often quite touched by things that I see happen. (EC)
21. I believe that there are two sides to every question and try to look at them both. (PT)
22. I would describe myself as a pretty soft-hearted person. (EC)

23. When I watch a good movie, I can very easily put myself in the place of a leading character.  
(FS)
24. I tend to lose control during emergencies. (PD)
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
27. When I see someone who badly needs help in an emergency, I go to pieces. (PD)
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

NOTE: (-) denotes item to be scored in reverse

fashion PT = perspective-taking scale

FS = fantasy scale

EC = empathic concern scale

PD = personal distress scale

A = 0

B = 1

C = 2

$$D = 3$$

$$E = 4$$

Except for reverse-scored items, which are scored:

$$A = 4$$

$$B = 3$$

$$C = 2$$

$$D = 1$$

$$E = 0$$



## APPENDIX D

### NEFF'S SELF\_COMPASSION SCALE (SHORT-FORM)

Please respond to each item by marking one box per row		Never	Rarely	Sometimes	Often	Always
1	When I fail at something important to me I become consumed by feelings of inadequacy. (R)	5	4	3	2	1
2	I try to be understanding and patient towards those aspects of my personality I don't like.	1	2	3	4	5
3	When something painful happens I try to take a balanced view of the situation.	1	2	3	4	5
4	When I'm feeling down, I tend to feel like most other people are probably happier than I am. (R)	5	4	3	2	1
5	I try to see my failings as part of the human condition.	1	2	3	4	5
6	When I'm going through a very hard time, I give myself the caring and tenderness I need.	1	2	3	4	5
7	When something upsets me I try to keep my emotions in balance.	1	2	3	4	5
8	When I fail at something that's important to me, I tend to feel alone in my failure. (R)	5	4	3	2	1
9	When I'm feeling down I tend to obsess and fixate on everything that's wrong. (R)	5	4	3	2	1
10	When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	1	2	3	4	5
11	I'm disapproving and judgmental about my own flaws and inadequacies. (R)	5	4	3	2	1
12	I'm intolerant and impatient towards those aspects of my personality I don't like. (R)	5	4	3	2	1

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, note the reverse scores (the negative subscale items - self-judgment, isolation, and over-identification) then compute a total mean.

**APPENDIX E**  
**PHONE RECRUITMENT SCRIPT**

On the Phone:

“Hello, my name is Liliana Gandara. I am a doctoral counseling candidate at Texas A&M University. I am conducting a research study on self-compassion, emotional empathy and cognitive empathy on novice therapists. I am calling to ask if you would be willing to send my email link to your listserv of novice therapists, it only takes about 30 minutes to complete the online survey.”

If interested, investigator will email out the survey link to the program directors. If you have questions, I can be reached at (323) 633-4700 or [blgandara@gmail.com](mailto:blgandara@gmail.com). Thank you for your help.”

If not interested, investigator will end the call: “Thank you for your time.”

**APPENDIX F**  
**INTRODUCTION TO STUDY**

Greetings.

My name is Liliana Gandara, and I am a counseling doctoral candidate working under the supervision of Dr. Charles Ridley from Texas A&M University. We are conducting a research study about self-compassion and emotional empathy and cognitive empathy among novice therapists. I am emailing to ask if you could send my email link to your listserv of novice therapists, it only takes about 30 minutes to complete it. Participation is completely voluntary and answers will be confidential.

If you are interested, please click on the link for the survey and additional information:

[[https://login.qualtrics.com/jfe3/preview/SV\\_6oL7UHH52Kl0rz](https://login.qualtrics.com/jfe3/preview/SV_6oL7UHH52Kl0rz)]

If you have any questions, please do not hesitate to contact me

([blgandara@gmail.com](mailto:blgandara@gmail.com)) or Dr. Charles Ridley ([cridley@cehd.tamu.edu](mailto:cridley@cehd.tamu.edu)).

Thank you in advance for your time.

Liliana Gandara

Counseling Doctoral Candidate

Texas A&M University

**APPENDIX G**

**THANK-YOU EMAIL**

Thank you for your participation!

In exchange for your participation we are giving you the opportunity to enter a raffle to win a \$100 Amazon card. If you would like to enter the raffle please enter your name and email address below. This information will not be linked to your responses. If you wish not to participate, skip this page.

Name\_\_\_\_\_

Email address\_\_\_\_\_