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Exploring the Relationship Between Mindfulness, Self-Compassion, and Empathy in Student Therapists

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Exploring the Relationship Between Mindfulness, Self-Compassion,
and Empathy in Student Therapists

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A Clinical Research Project submitted to the faculty of The Illinois School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Chicago, Illinois
April 2020

The Doctorate Program in Clinical Psychology
Illinois School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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Dedication

To Franklyn, being your mother has been the greatest and most joyful
adventure of my life.

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Abstract

Literature suggests that the practice of mindfulness may foster self-compassion within the practitioner. Mindfulness is also associated with increased empathy towards others. The current study explored the relationship between a mindfulness intervention and student clinicians' levels of self-compassion and empathy towards a mock "client." Graduate student clinicians were randomly assigned to two groups: one that participated in a mindfulness exercise then viewed a mock client video, and another that did not participate in the mindfulness exercise and went directly to viewing the mock client video. Participants' levels of empathy towards the client and self-compassion were measured. The results revealed no significant difference in self-compassion between the mindfulness group and the control group. Similarly, there was not a significant difference in reported empathy towards the client between the groups. Self-compassion was not found to mediate the relationship between mindfulness and empathy. There was a significant positive correlation between participants' levels of self-compassion and the frequency with which they practiced mindfulness. Limitations to the study were the brevity of the mindfulness intervention, the computer-based administration, and the simulated nature of the client video. Future research should utilize an in-person mindfulness intervention that includes multiple administrations. Significant findings from this study show that respondents who reported higher levels of self-compassion also reported practicing mindfulness more frequently. This suggests that a devoted beginner who practices mindfulness regularly can experience positive changes in self-compassion fairly quickly, with no expert status needed. This finding can be used to inform clinical training as well as self-care practices among student therapists.

Chapter 1: Introduction

As a client-centered therapist, empathy is at the center of my work. I believe that empathy is the single most powerful tool that therapists possess and that it is often a lack of empathy that causes dysfunction within clients. Former United States President Barack Obama appeared to agree with the importance of empathy when he said,

The biggest deficit that we have in our society and in the world right now is an empathy deficit. We are in great need of people being able to stand in somebody else's shoes and see the world through their eyes. (Obama, 2010)

During my first semester of graduate school, I enrolled in a class that instructed students to listen empathically to a classmate for 50 min each week in “therapy” sessions. Our only instruction as therapists in training was to listen and respond throughout the sessions in ways that conveyed our understanding of what our classmate was saying and feeling, nothing more, nothing less.

Not only was this assignment challenging, but it quickly showed me how much my capacity for empathy varied day-to-day. During some sessions, I felt intimately connected to my classmate, while during others, it was a struggle to keep my mind from wandering and I had to constantly pull myself back into the present moment again and again. Now, as I reflect back on my years of clinician training, I can see this same personal empathic variability. It has led me to ask the question: What contributes to the variability in my capacity for empathy?

Through experimentation, I have found that on days when I practice meditation, in some form, my capacity for empathy feels robust; staying with and feeling the immediate experience of my clients leans in the direction of feeling effortless. However,

on days when I am sleep deprived and feel disconnected from my body, my capacity for empathy seems to wane and feel effortful and disengaged.

The practice of mindfulness has been integrated into many orientations within the practice of psychology, including acceptance and commitment therapy and dialectical behavioral therapy. Although the benefits of having a mindfulness practice for individuals struggling with psychopathology has been studied at length, few published researchers have studied the effects of mindfulness on clinicians. Certainly the field of psychology has embraced mindfulness as a construct for aiding healing in clients, but do therapists practice what they preach? And if so, how is it impacting their work? Pema Chodron, an American Buddhist nun and prolific author, wrote, “Only when we know our own darkness well can we be present with the darkness of others” (Chodron, 2002, p. 74). Clinicians are often with their clients as they face the darker aspects of life and the struggles that come with them. Would being with their own experience, however upsetting or distressing it may be, help aid them in being with their clients’ experience? Similarly, the underlying mechanisms through which mindfulness delivers these benefits have been more often neglected. This study aimed to explore the connection between self-compassion and empathy within the context of a mindfulness practice for clinicians in training.

Chapter 2: Literature Review

Empathy

In order to study empathy, it is important to first understand its components. One study defined empathy in three parts: mentalizing, experience sharing, and compassion (Zaki & Cikara, 2015). Mentalizing refers to inferring the mental states of another, experience sharing refers to taking on the internal affect or feeling of another vicariously, and compassion refers to feeling concern for another and wishing well-being onto them. Another study described the importance of cognitive perspective taking involved in empathy and the ability to “step into another’s shoes,” so to speak. The study authors hypothesized that because this is a cognitive activity, those who are more cognitively active may be more apt to think of others and more easily able to mentally put themselves into the experience of another, though this hypothesis has not been tested (Nezlek, Feist, Wilson, & Plesko, 2001). Lastly, nearly all research has found that empathy must include some affective response. This means the person feeling empathy must affectively feel the emotions of another. The extent to which they must feel such emotions is not specified, but it is believed empathy is a process that involves both intellectual cognitive perspective taking as well as physiological emotion and affect. (Bluck, Baron, Ainsworth, Gesselman, & Gold, 2012).

Individuals’ beliefs about the nature of empathy can also impact their capacity for empathy. One study showed that when subjects believed empathy to be malleable and developed through practice, they produced more empathic effort in trying to step into the experience of another person compared to subjects who believed empathy is fixed (Schumann, Zaki, & Dweck, 2014). This empathic effort on the part of subjects who believed (or were told) empathy is malleable led these subjects to spend a greater amount of time listening to someone with different views from themselves, even when that

person was from a racial out-group (Schumann et al., 2014). This study found that it was, in fact, this belief that empathy is malleable that led subjects to want to improve on their empathic abilities.

The malleability of empathy relates to research on state-based empathy, or the belief that empathy can have day-to-day variability based on one's environment, mood, and other factors, in contrast to more fixed "trait" based empathy. In one study, state-based self-report measures of empathy were administered to introductory psychology students twice daily for 10 weeks along with self-report measures of positive and negative mood, and daily activity. The authors found that overall trait- and state-based empathy were strongly related, but it was state-based empathy that varied throughout the day depending on the mood and daily events of the participants (Nezlek et al., 2001).

One study suggested that paying attention to one's own personal experience ultimately leads to deep attunement and empathy to the experience of another. This connection was displayed in a study that presented participants with vignettes featuring an individual describing their physical pain. The participants in this study were undergraduate students at a university who were randomly assigned to either a control or experimental group. The experimental group was asked to recall a time when they themselves experienced pain, while the control group was asked to recall a character in a film that had experienced pain. Participants were then given an Interpersonal Reactivity Index, which is a self-report measure assessing empathy. The authors found that the group who recalled an autobiographical account of personal pain showed significantly higher levels of empathy towards the individual in the vignette compared to the control group (Bluck et al., 2012). In other words, by attuning to their personal history they were able to more readily connect to the experience of another.

Mindfulness and Self-Compassion

The practice of mindfulness involves being present and aware of one's current experience, in the moment, and with a nonjudgmental attitude. Mindfulness is an open, gentle, and curious paying attention to one's current experience, whatever that may be, through the lens of compassion. To operationalize mindfulness for the purposes of this paper, it will be discussed as a "construct," but it is important to note that mindfulness is an intentional paying attention that is not something one does, but rather a state of being. Emphasis is placed on the present moment, without concern for interpretation or attachment to a particular outcome (Huston, Garland, & Farb, 2011). It is also described as "an intention-based process, emphasizing an observant and nonreactive stance towards one's thoughts, emotions, and body states" (Tarrasch, 2014, pp. 1322–1323). Some mindfulness techniques direct individuals to focus on their breath and bodily sensations, followed by their thoughts, feelings and other sensory experiences (Farb, 2014). Mindfulness begins as an intentional, ideally daily practice, but the aim is eventually to expand the practice by incorporating it informally throughout one's everyday life by being more present and aware as one moves throughout the world.

Often mindfulness meditation practices begin with attending to the physical sensations of the body, with the intention of heightening one's awareness to the constantly shifting attention while being able to note when one's mind has wandered so that it can then be redirected back to the present moment. (Farb, Anderson, & Segal, 2012). In doing so, practitioners are often able to suspend negative self-critical cognitions (Farb et al., 2012). The process of redirecting one's awareness back to a central focus, such as the breath, allows one to become less attached the content of their thoughts.

When mindfulness practices were applied to patients with affective disorders, the authors cited above found that redirecting one's cognitions from negative emotions to their momentary present experience resulted in a reduction in negative self-evaluation, as well as an increased tolerance for negative affect and pain (Farb et al., 2012). More specifically, one study found that expert meditators, those who had at least 10,000 hr of formal meditation practice, compared to a group who had no history of formal meditation practice, reported a significant reduction in unpleasantness as a result of short-term physical pain when practicing an open awareness style of meditation (Perlman, Salomons, Davidson, & Lutz, 2010). In order to experience this, the practice teaches individuals how to shift awareness from cognitions involving memory and cognitive elaboration to attention on the present moment in a nonjudgmental way. Similarly, nondirective meditation is linked to decreased blood pressure and the reduction of mental symptoms outside of meditation (Lagopoulos et al., 2009). The authors of this study described nondirective meditation as a style of meditation that does not require the practitioner to direct their attention to any particular focus but allows thoughts, feelings, and sensations to pass freely through their awareness.

One could conclude that by emphasizing the cultivation of a nonjudgmental attitude while accepting the whole of one's experience, the very nature of mindfulness encourages self-compassion. In fact, one study found a statistically significant association between mindfulness and self-compassion (Bluth & Blanton, 2013). This study measured self-compassion through the Self-Compassion Scale (SCS), which defines the construct as "the ability to hold one's feelings of suffering with a sense of warmth, connection, and

concern” (Neff & McGehee, 2010, p. 226). Self-compassion was shown to be a mediator between mindfulness and emotional well-being in adolescents (Bluth & Blanton, 2013).

Research has suggested that the ability to relax into one’s current experience, that is, to attend to and accept whatever is happening right now in the present moment, tends to increase over time as individuals maintain a mindfulness practice. These effects seem to trend exponentially with experience, as one study found that seasoned yoga practitioners had lower heart rates than beginners (Chugh-Gupta, Baldassarre, & Vrkljan, 2013). Mindfulness practices vary in nature from practices that incorporate physical mindful movement like yoga to meditations specifically geared towards fostering empathy and love towards others and oneself. In “loving kindness” or “metta” meditation, the practitioner directs kind thoughts towards a person they care deeply about, a person they have interpersonal conflict or difficulty with, and finally themselves. Research has suggested that a mindfulness practice that incorporates this loving kindness meditation is particularly effective in increasing self-compassion among health care workers (Raab, 2014).

The underlying principles of the practice of mindfulness encourage the suspension of judgment towards oneself. Jon Kabat-Zinn, the founder of the extensively studied eight-week mindfulness-based stress reduction (MBSR) course and a prolific researcher, wrote, “Give yourself permission to allow this moment to be exactly as it is, and allow yourself to be exactly as you are” (Kabat-Zinn, 2014, p. 13). It is through this radical acceptance of the self, exactly as one is, that self-compassion is fostered.

In a qualitative study, authors analyzed themes present in the journals of 19 special education and educational counseling graduate students who were enrolled in a

two-semester practicum focused on both the practicing and teaching of mindfulness (Tarrasch, 2014). “With practice, students (58%; $n = 11$) developed an ability to disengage from repetitive thoughts or to observe thoughts that had previously appeared threatening in a more compassionate and accepting yet detached manner” (Tarrasch, 2014, p. 1328). Thirty-seven percent of students in this study noted the development of compassion and acceptance towards themselves as an outcome of their mindfulness practice (Tarrasch, 2014). It appears to be the very nature of the mindfulness practice that cultivates self-compassion in student clinicians.

Mindfulness and Empathy

One study suggested that when attending to one’s own physiological sensations, thoughts, and emotions through the practice of mindfulness, one is more able to be with the experience of another person (Atkinson, 2013). This is evidenced by structural and functional changes in neural networks that enhance the capacity for empathy. This is shown particularly in the anterior cingulate cortex and insula, which process shared experience, or the ability to simultaneously experience the emotions of another person through empathy (Atkinson, 2013).

One study found that even a brief 15-min guided mindfulness meditation exercise was associated with improved cognitive empathy in individuals with low conscientiousness and extraversion scores (Winning, & Boag, 2015). This study was unique as most studies have focused on longer mindfulness interventions.

Studies have explored the relationship between mindfulness and increased capacity for empathy. One study found that therapists who regularly practice mindfulness techniques themselves are perceived as more empathic and more able to fully stay with their client’s lived experience as reported by their client, compared to therapists without a

mindfulness practice (Greason & Welfare, 2013). More specifically, clients' self-reports of their therapists found a positive correlation between therapists' mindfulness practice and "client perceptions of counselors' level of regard, unconditionality, and congruence as well as all aspects of the working alliance" (Greason & Welfare, 2013, p. 247).

Another study examined the impact of an eight-week MBSR training on self-compassion and empathy. Participants were recruited across the span of two years through a Canadian university's continuing education program. In order to participate, participants had to be free of chronic medical conditions, and attend a minimum of six sessions (75% of the program). Participants were given both a SCS (Neff, 2003) and an Interpersonal Reactivity Index (Davis, 1980) to measure self-compassion and empathy before and immediately following the eight-week course. Both are self-report measures. The results showed significant increases in self-compassion and empathic perspective taking in participants after the program's completion as well as a significant decrease in personal distress (Birnie, Speca, & Carlson, 2010). There was no follow-up assessment to explore whether these effects endured, which is a limitation of this study.

Lastly, one study specifically examined the relationship between mindfulness and empathy by way of self-compassion. The authors of this study found strong correlations between mindfulness and perspective taking. More specifically, individuals who endorsed high levels of mindfulness were more likely to endorse high levels of perspective taking (Kingsbury & Hickman, 2009). The authors used regression analysis to find that self-compassion mediates the relationship between mindfulness and perspective taking (Kingsbury & Hickman, 2009). This study, which was carried out through an online survey, utilized the Five Factor Mindfulness Questionnaire as a

measure of self-reported mindfulness, the Interpersonal Reactivity Index as a measure for empathy, and the SCS as a measure of self compassion (Kingsbury & Hickman, 2009).

Clinicians in Training

Clinicians in training provide an optimal population of interest because they are often dealing with the stressors of graduate school while simultaneously working with clients, some for the first time. Graduate school also serves as a time period in which student clinicians may be more receptive to learning new techniques, such as mindfulness, as they are likely in the earlier stages of developing their skills compared to more seasoned clinicians. Lastly, graduate schools often place significant emphasis on the importance of self-care, which for some students may take the form of a regular mindfulness practice, although intensive programs rarely have space in their curriculum for instruction on how students can implement these strategies for themselves (Tarrasch, 2014).

In looking at mindfulness as a form of self-care, studies have shown that a mindfulness practice is associated with stress reduction, the ability to calm oneself, and improved sleep quality in graduate students (Tarrasch, 2014). Mindfulness practices have been shown to reduce indicators of job burnout, depression, anxiety, and stress within primary care clinicians (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013). These issues relate to Charles Figley's concept of compassion fatigue, which he defined as "the formal caregiver's reduced capacity or interest in being empathic" (Figley, 1995, p. 7). One study's findings suggested that the development of self-compassion through mindfulness practices can increase resiliency against this type of burnout (Raab, 2014). In fact, Raab (2014) summarized a series of research studies reporting that meditations

specifically centered around compassion have been linked to increased immune responses and decreased cortisol levels (a hormone associated with stress).

Many graduate school programs working with clinicians in training have curriculum based on understanding diversity issues. Clinicians are not immune to holding racial and ethnic biases that undoubtedly impact treatment and diagnosis, especially when working with individuals who are different from themselves. Implicit biases are likely to impact the overall therapeutic relationship as well as the clinician's ability to experience empathy for their clients. The authors of one study suggested that providing health care providers with mindfulness training could reduce implicit biases, leading to improved healthcare outcomes in patients (Burgess, Beach, & Saha, 2017). Because meditation creates an atmosphere where individuals can become more conscious of their thoughts and feelings, the authors also suggested that mindfulness meditation aids practitioners in regulating their negative emotions often associated with biases (Burgess et al., 2017).

Another study looked specifically at the impact a meditation practice had on marriage and family therapy students' therapeutic presence (McCollum & Gehart, 2010). In their literature review, McCollum and Gehart (2010) defined therapeutic presence based on previous research by Geller and Greenberg (2002) as "an availability and openness to all aspects of the client's experience, openness to one's own experience in being with the client, and the capacity to respond to the client from this experience" (McCollum & Gehart, 2010, p. 347). McCollum and Gehart went on to summarize previous research on the impact of mindfulness training on students' empathy, which formed the basis of their study. McCollum and Gehart summarized research from Shapiro and Izett (2008) which stated that mindfulness may facilitate empathy through decreasing

stress, increasing self-compassion, and “losing our identification with our personal subjective experience and thereby being better able to perceive and accept the experience of others without judgment or defense” (McCollum & Gehart, 2010, p. 348).

McCollum and Gehart (2010) conducted a qualitative study that analyzed themes present in the journals of student therapists enrolled in a master’s degree program in marriage and family therapy over the course of a semester in which they participated in formal mindfulness training. Students were encouraged to practice for 5–10 min per day and record their experiences in self-report fashion through regular journaling. The authors found several themes present in the students’ journals. Most students reported that the mindfulness practice helped them attend to their own present experience, their clients’ experience, and the client-therapist interaction in their therapy sessions (McCollum & Gehart, 2010). Students reported feeling calmer and more easily able to slow down during therapy sessions (McCollum & Gehart, 2010). One student summarized this concept by writing, “The space created for therapy by slowing down and being more aware of the current state of how I think and feel allows me to be more receptive to where my clients are” (McCollum & Gehart, 2010, p. 352). Lastly, the students reported an increased sense of self-compassion and acceptance of their own experience, which extended to their clients within sessions through “patience, reduced reactivity and reduced judgment” (McCollum & Gehart, 2010, p. 357).

This sort of in-the-moment self-awareness may be what Carl Rogers referred to as *congruence*, a necessary and sufficient condition in a person-centered therapeutic approach (Rogers, Kirschenbaum, & Henderson, 1990). Rogers considered congruence, unconditional positive regard, and empathy to be the necessary and sufficient conditions

on the part of the therapist in a person-centered approach and a necessary condition for all productive psychotherapy (Rogers et al., 1990). With respect to congruence, Rogers wrote,

The third condition is that the therapist should be, within the confines of this relationship, a congruent, genuine, integrated, person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. (Rogers et al., 1990, pp. 223–224)

While theory-specific language may differ, it appears that Rogers' construct of congruence includes the in-the-moment self-awareness that comes from the practice of mindfulness as described here.

In summary, the literature reviewed above suggests that the practice of mindfulness is associated with increased empathy towards others and seems to foster self-compassion within the practitioner. Lastly, mindfulness seems to be particularly helpful for clinicians in training as they are still developing their skills and in the foundational years of learning how to be with clients in a congruent way. Regardless of a clinician's orientation, empathy is often at the core of their therapeutic work. This literature review served as the basis for the rationale of the current study, which will be discussed in the following chapter.

Chapter 3: Rationale for the Current Study

Carl Rogers wrote,

[Being empathic] means that for the time being, you lay aside your own views and values in order to enter another's world without prejudice. In some sense it means that you lay aside your self; this can only be done by persons who are secure enough in themselves that they know they will not get lost in what may turn out to be the strange or bizarre world of the other, and that they can comfortably return to their own world when they wish. Perhaps this description makes clear that being empathic is a complex, demanding, and strong—yet also a subtle and gentle—way of being. (Rogers, 1980, p. 43)

The nature of mindfulness encourages a nonjudgmental attitude as practitioners attend to their immediate experience. Research has suggested it is this attitude that contributes to the development of self-compassion. Although previous studies have explored the relationship between mindfulness, self-compassion, and empathy, very limited research has explored whether self-compassion serves as a mediator, or underlying mechanism, through which mindfulness leads to empathy. Like Rogers (1980) suggested, in order to enter the world of another through empathy, one must feel secure and grounded in one's own experience. In his personality theory, Rogers went on to explain “the parent experiences such *unconditional positive regard* [emphasis added] only to the extent that he *experiences unconditional self-regard* [emphasis added]” (Rogers et al., p. 253). In other words, empathy is a byproduct of self-compassion; when one experiences unconditional self-regard, one is able to accept others more fully without judgment.

The current study hypothesized that within the context of mindfulness, compassion towards one's self serves as a grounding mechanism for empathy. In other words, an individual may be more fully able to step into the shoes of another if they have first stepped into their own. Mindfulness provides this opportunity. Similarly, the use of mindfulness as an intervention has been utilized largely among client populations, but limited research has been done with clinicians. Because clinicians in training have yet to fully develop their skills in working with clients while modulating their own experiences through practices like self-care, they were a population of interest when exploring these concepts. The goals of the present study were tested by exposing graduate student participants to a video of a hypothetical client during session either before (experimental group) or after (control group) participating in a mindfulness exercise, based on random assignment. Levels of self-compassion and empathy were measured to determine if self-compassion mediated the relationship between mindfulness and empathy towards the client.

In the current study, the hypotheses were as follows:

1. Participants exposed to the mindfulness intervention prior to observing the client video will report significantly higher levels of self-compassion, as measured by the SCS, than participants exposed to the same mindfulness intervention subsequent to observing the client video.
2. Participants exposed to the mindfulness intervention prior to observing the client video will report significantly higher levels of empathy, as measured by the Scale of State Empathy During Message Processing, than participants exposed to the same mindfulness intervention subsequent to observing the client video.

3. Self-compassion, as measured by the SCS, will mediate the relationship between mindfulness and empathy, as measured by the Scale of State Empathy During Message Processing.
4. Participants' levels of self-compassion, as measured by the SCS, will be positively correlated with the length of time the participant has practiced mindfulness.
5. Participants' levels of self-compassion, as measured by the SCS, will be positively correlated with the frequency with which the participant practices mindfulness.
6. Participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, will be positively correlated with the length of time the participant has practiced mindfulness.
7. Participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, will be positively correlated with the frequency with which the participant practices mindfulness.

Chapter 4: Methodology

Participants

Participants for this study were graduate students in the field of psychology, counseling, social work, or marriage and family therapy who completed at least three months of clinical practicum experience during their graduate training. This graduate practicum experience included working with adults or children, in any and all settings. Both master's and doctoral level students were permitted to participate in the study. Students could be any year in their program so long as they met the minimum practicum requirement. Participants must have also been proficient in reading and understanding English. Participants were at least 18 years of age. Lastly, it was a requirement that participants be able to access the survey online from a quiet location free from significant distractions and with audio capacity on their device. Graduated individuals were not allowed to participate. The projected number of participants was at least 100, with 50 participants per group, as calculated by using GPower 3.1 power analysis software (Faul, Erdfelder, Buchner, & Lang, 2009). The number of participants was calculated using an alpha of 0.05 and medium effect size of 0.82. Due to difficulty obtaining eligible participants, during the data collection phase, the sample size was decreased from $N = 100$ to $N = 50$ after receiving CRP committee and university IRB approval for this change. This decrease in sample size was a noted limitation to the study.

Measures

Participants were asked to complete four measures in this study: the SCS (Neff, 2003), the Scale of State Empathy During Message Processing Scale (Shen, 2010), a self-

designed empathy questionnaire, and a demographic questionnaire. Each of these measures is described below.

The SCS is a 26-question, self-report measure comprised of six subscales: self-kindness, self-judgment, common humanity, isolation, mindfulness, and overidentification (Neff, 2003; see Appendix A). According to the researcher who developed the measure, self-compassion is comprised of three basic components: expressing kindness and understanding towards oneself, seeing one's experience as part of a collective human experience, and keeping painful experiences and emotions in perspective rather than overidentifying with them (Neff, 2003). The measure was developed through a focus group style process comprised of both females and males with a mean age of 21.7. The measure was normed based on 391 U.S. undergraduate students with a mean age of 20.91. The ethnic background of the normed group was 58% White, 21% Asian, 11% Hispanic, 4% Black, and 6% Other. To test construct validity, responses on the measure were compared to the responses on the self-criticism scale and a negative correlation resulted (Neff, 2003).

The SCS is a Likert self-report measure which asks subjects to assess how frequently they identify with particular statements. Scores range from 1 (*almost never*) to 5 (*almost always*). Examples of questions are "I'm disapproving and judgmental about my own flaws and inadequacies," "When something upsets me I try to keep my emotions in balance," and "I try to see my failings as part of the human condition." Permission to use the scale is provided on the author's website (see Appendix B).

The author has provided instructions for scoring. Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion

score, one must reverse score the negative subscale items (for self-judgment, isolation, and overidentification) before calculating subscale means, and then compute a grand mean of all six subscale means. For the purposes of this study, an overall self-compassion score was computed using the grand mean.

The Scale of State Empathy During Message Processing is a 12-question self-report instrument using a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*completely*; Shen, 2010; see Appendix C). Based on previous research on empathy, the developer of the scale stated that it measures three dimensions of empathy: affective empathy, cognitive empathy, and associative empathy (Shen, 2010). For the purpose of this study, the total empathy score was used.

The affective empathy subscale measures “the activation and experience of affective reactions to others’ experiences and/or expressions of emotions” (Shen, 2010, p. 506). The author noted that this mutual affective experience may apply to both positive and negative affects. An example of an item on the affective empathy subscale is, “I can feel that character’s emotions” (Shen, 2010)

Second, the author defined cognitive empathy as “perspective taking.” According to Shen, this involves “recognizing, comprehending, and adopting another’s person’s point of view” (Shen, 2010, p. 506). Shen summarized research by Lazarus (1991, as cited in Shen, 2010) by noting that this aspect of empathy involves putting oneself psychologically in other’s situation. The author also noted that both cognitive and affective dimensions are necessary facets in defining empathy, as cognitive empathy without affective empathy is sympathy. An example of an item on the cognitive empathy subscale is, “I can see the character’s point of view” (Shen, 2010).

The third facet of empathy measured by this scale is associative empathy, or an individual's ability to identify with another, or vicariously experiencing what the client experiences. In summarizing the literature on associative empathy, the author reported that it is this facet that "facilitates social bonding" (Shen, 2010, p. 507). "I can relate to what the character was going through in the message" is an item that appears in this subscale (Shen, 2010).

The Scale of State Empathy During Message Processing measure was developed through data collected from two samples: one of college students from an introductory speech communication class ($N = 289$, $M age = 19.87$, $SD = 2.17$), the other of adults recruited from a large outdoor market in Athens, Georgia ($N = 189$, $M age = 34.99$, $SD = 13.03$; Shen, 2010). The alpha reliability for the scale was reported as .93 in the study using college students and .92 in the study using adults (Shen, 2010). The author also reported that the measure demonstrated solid construct validity (Shen, 2010). It should be noted, for the purposes of this study, that the word "character" was changed to the word "client" to better fit the scenario. Permission to use this scale in the present study was granted by the author via email communication (see Appendix D).

The Scale of State Empathy During Message Processing measure does not provide guidelines for scoring nor does it provide mean empathy scores or criteria for low, medium, and high state empathy. Because all participants were graduate students in psychology or a related-field, their empathy scores on this measure were expected to be higher than the students in the introduction to communications class and the general adult sample who were used to develop the scale. Therefore, for the purposes of this study, total mean scores on empathy between groups were compared without assigning a value

to the empathy scores. Thus, while this measure is somewhat limited in terms of its empirical validation and scoring specificity, it does provide a rough measure of state-based empathy. An exhaustive search of the literature revealed no other published state-based empathy scale; therefore, with recognition of its limits, this measure was approved for use in the study.

Participants were also asked to complete a self-designed empathy questionnaire (see Appendix E). The questionnaire was designed to capture more specific, qualitative factors that contribute to the participants' empathy towards a mock client presented in a videotaped vignette in the study. The questionnaire asked participants to rate, using a Likert scale, how influential different factors were in their ability to feel empathy for the client. Some factors included: client's emotional affect/manner of relating, content of the client's situation, client's appearance, and "other" with a blank space for participants to explain further. Any data in the "other" category will be provided in the results. Lastly, participants were asked on a scale of 1 to 10 how much they would like to work with this client. The items on this questionnaire were developed through the collaboration of the author, research chair, and classmates as part of a Clinical Research Proposal (CRP) Development course.

Although this measure does not address any of the main hypotheses of the study, it allows for a more in-depth look into the factors that may be contributing to the overall empathy score. This may or may not include issues of countertransference. These factors could be used for future research on examining empathy in clinicians in training. These findings could also inform academic curriculum for clinicians in training.

Finally, participants were asked to complete a demographic questionnaire (see Appendix F). The questionnaire included questions on gender, age, race, degree program, and year in graduate school. These questions were chosen so that I could provide descriptive statistics about the participants in the study. Lastly, as part of the demographics questionnaire, participants were asked how often, on average, they engage in an intentional contemplative practice like the one they participated in for the study as well as for how many years they have been engaged in this practice. These questions were included because research has suggested that the effects of mindfulness seem to increase exponentially with frequency and duration of practice (Chugh-Gupta et al., 2013). The fact that the demographic questionnaire referenced the mindfulness exercise within the study required that the control group also participate in the mindfulness exercise, as it served as a point of reference for what a mindfulness practice looks like. It is important to note that the word *mindfulness* was not used in any of the measures to reduce participants' biases, assumptions, and resistance to the practice.

Procedure

First, no data were collected until CRP committee approval and Argosy University, Chicago IRB certification was achieved. I subsequently transferred to National Louis University (NLU) and received NLU IRB certification for the study, though data collection was complete by this time. Participants were recruited through an email invitation to participate in the study sent through the Client-Centered Clinical Practice Organization at Argosy University Chicago (see Appendix L for permission letter); a Chicago-based, person-centered listerv; and my personal Facebook page. Graduate students with whom I worked with at previous practicum sites were also

contacted to aid in disseminating the survey to colleagues. Snowball sampling was employed, where my professional contacts had permission to forward the link to the survey on to their graduate student contacts. Additionally, my former and current clinical supervisors and mentors were asked to distribute the survey to their current trainees. My personal contacts were not eligible to participate in the study. It is important to acknowledge that there was a potential conflict of interest if my friends or colleagues chose to partake in the study through the above organizations. This conflict was minimized by the statement “Personal contacts of the researcher are not eligible to participate in the study” found in both the recruitment script and informed consent. It was possible, however, that personal contacts could still independently choose to participate. If this were the case, I was not aware as all participants in the study were anonymous. Participants were informed in advance that all data collected were anonymous and the specific graduate school they attended was not known.

Eligible participants were provided with a recruitment message (see Appendix G) and were directed to a link on Survey Monkey where they had access to the current study. In the recruitment message, they were told that the purpose of the study is “to understand how clinicians in training understand and relate to their clients during therapy.” All participants began by electronically endorsing the informed consent statement (see Appendix H), which stated the intent of the study while notifying potential participants that they could discontinue their participation at any time without consequence. Once informed consent was obtained, participants in the experimental condition then participated in the mindfulness exercise via an audio recording (Appendix I); participants in the control group participated in this exercise later in the survey. Next, participants

viewed a video recording of a mock “client” (see Appendix J for a vignette of the client’s comments). They proceeded by filling out the Scale of State Empathy During Message Processing, followed by the self-designed empathy questionnaire and the SCS. Participants completed the survey by filling out the demographic questionnaire. Participants were not be able to backtrack to prior survey pages once they advanced to a subsequent page so that the purpose of the study did not become evident to them. Lastly participants were provided with a debriefing script (see Appendix K).

As an incentive to participate in the study, participants were informed that they had the option to be entered into a raffle for a chance to win a \$50 Amazon gift card. participants were notified of the opportunity to participate in the raffle both in the informed consent and again at the end of the study. When the survey concluded, participants who wished to be entered into the raffle were provided with my email address and instructed to send an email with “ENTER ME INTO THE RAFFLE” in the subject line. This information was kept confidential; it remained in a separate folder and was not examined until the study concluded. Additionally, participants’ email addresses were kept separate from participants’ data responses and were in no way linked to them. The winning participant was notified via email, accepted the gift card, and all email addresses were subsequently deleted from my computer.

The study was conducted through an online survey on Survey Monkey. Inclusion criteria were as follows: participants must be a graduate student in the field of psychology, counseling, marriage and family therapy, or social work with at least three months of supervised clinical practicum experience, and they must be proficient in reading and understanding English in order to participate. Lastly, participants were

instructed that they should only complete the survey in a relatively quiet location, free from significant distractions and with audio capacity on the device with which they access the survey.

After electronically signing the informed consent form, participants were randomly assigned to one of two groups. Participants in Group 1, the experimental condition, participated in a 10-min mindfulness exercise, which included a guided body scan as well as instructions for observing their breath in their body. I designed this mindfulness exercise based on my experience as a participant in the MBSR program (see Appendix I for a script of the mindfulness exercise) and a decade of experience as a yoga and meditation teacher. Following the mindfulness exercise, participants in this group viewed a video of a “client,” played by an actor. Participants were instructed to imagine that they were in the role of a therapist working with the client as they listened to her in a mock therapy session. Based on her symptom presentation and manner of relating, the “client” in the video was intentionally designed to be particularly challenging for a clinician in training. Group 2, the control group, watched the same “client” video before (rather than after) participating in the mindfulness exercise, so that the potential impact of the exercise on the participants’ reported levels of self-compassion and client empathy could be compared between the two groups.

After viewing the “client” video, both groups completed the Scale of State Empathy During Message Processing followed by the self-designed empathy questionnaire. Participants were then asked to complete the SCS. Finally, participants in the control group participated in the mindfulness exercise. The survey measures

concluded with participants from both groups completing the demographics questionnaire.

The survey concluded with a debriefing script (see Appendix K). This script explained to participants that some of them engaged in the mindfulness exercise prior to observing the client, while others engaged in the exercise after observing the client. It went on to explain that the study was intentionally designed this way to examine whether participation in a mindfulness exercise impacted the participant's self-compassion and empathy towards a "client." The debriefing script concluded with a link to www.psychologytoday.com, should participants experience any distress during the study. The debriefing script also provided the email address participants needed to contact and instructed to send an email with "ENTER ME INTO THE RAFFLE" in the subject line in order to be entered into the drawing for the \$50 Amazon gift card. As emails from participants came in, the primary researcher filed the emails into a password-protected folder separate from all other data. Once the study concluded, each participant was assigned a number. I then used a random number generator (<http://www.randomnumbergenerator.com/>) to select a winner. Specifically, I used the tool to generate a random number between 1 and the total number of participants who chose to partake in the drawing. The winner was notified via email and the gift card was sent to them electronically. Once the winner was confirmed, all emails were deleted from my computer.

Data Analyses

Hypotheses 1 and 2 focused on whether or not a significant difference existed between groups. To test Hypotheses 1, a *t* test was utilized in order to determine if there

was a significant difference in reported self-compassion between the group who completed the mindfulness exercise prior to viewing the video of the client and the group who completed the same mindfulness exercise after viewing the video of the client. To test Hypothesis 2, a *t* test was utilized in order to determine if there was a significant difference in reported empathy towards the client between the group who completed the mindfulness exercise prior to viewing the video of the client and the group who completed the same mindfulness exercise after viewing the video of the client. For both Hypotheses 1 and 2, *t* tests established if there was a significant difference between mean scores for each group.

Hypothesis 3 examined whether self-compassion mediated the relationship between mindfulness and empathy (see Figure 1). In order to examine whether a mediator existed, a multiple regression analysis was used. The mediation analysis was used per the recommendation of Baron and Kenny (1986). In this four-step approach, several regression analyses were conducted and the significance of the coefficients was examined at each step (Baron & Kenny, 1986). In order to accomplish a test of mediation, the components of the model were tested individually. In order to proceed to the next step, the equation at the previous step must be significant; if not, the assumptions of the mediation test are not met (Baron & Kenny, 1986).

To test the hypothesis that self-compassion will mediate the relationship between mindfulness and empathy, the analysis began with determining the significance of the path from predictor to the criterion variable, which in this case is the relationship between mindfulness and empathy. The second step of the analysis involved analyzing the relationship from predictor to mediator, in this case, mindfulness to self-compassion. The third step of the mediation test utilized a multiple regression analysis to examine the

relationship between self-compassion and empathy.

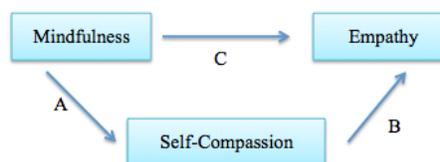


Figure 1. Mediation Model

Hypotheses 4–7 examined whether a correlation existed between the length of time and frequency with which the participants practiced mindfulness and their self-reported levels of empathy and self-compassion. A Pearson product-moment correlation (r) was used to explore each of these four correlations.

Ethical Safeguards

Several ethical safeguards were put in place both prior to and during the data collection. First, no data were collected until CRP committee approval and IRB certification was achieved. Data collection was done through Survey Monkey, an Internet survey tool which introduced minimal risk to participants and concealed participants' computer IP addresses. In the current study, participants remained anonymous and no personal identifying information was asked for at any point in the survey. I received the data with no knowledge from whom it came and all data were numerically coded.

Although participants were given the option to email me to be entered into a raffle for a \$50 Amazon gift card at the end of the survey, the participants' email addresses were kept confidential; they remained in a separate folder and were not examined until the study had concluded. Additionally, participants' email addresses were kept separate from participants' data responses and were in no way linked to them. All email messages and addresses of participants who chose to participate in the raffle were deleted from my computer once the raffle prize has been distributed.

It is important to acknowledge that there was a potential conflict of interest if my friends or colleagues chose to partake in the study through organizations in which I was involved. However, this risk was minimized through the anonymous nature of the data collection, which was noted in the informed consent document. During data collection, data were stored on a password-protected computer. Raw data from the study were only accessible to myself, the research committee, and a university statistician. Additionally, all data will be destroyed three years after completion of the study. Participants were given an informed consent prior to participation, which stated that they could withdraw from the study at any point without consequence. Similarly, after participation they were debriefed fully on the intent and nature of the study. They were also provided with contact information for individuals whom they could contact for further information (the researcher, research chair, and university IRB chair). Although the probability that a participant would experience psychological distress as a result of this study was low, a link to Psychology Today was provided at the end of the survey should participants wish to process their experience with a mental health professional.

Chapter 5: Results

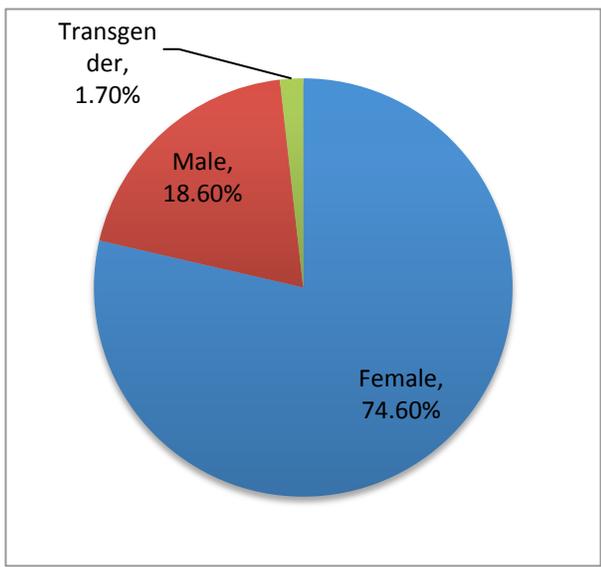
Demographic Analyses

One hundred and seven responses were obtained, including 48 (44.8%) respondents who did not complete the entirety of the survey and therefore were not included in the analyses. The *N* total was 59. The majority of respondents identified as female ($n = 44$, 74.6%), 11 (18.6%) respondents identified as male, and one (1.7%) respondent identified as transgender.

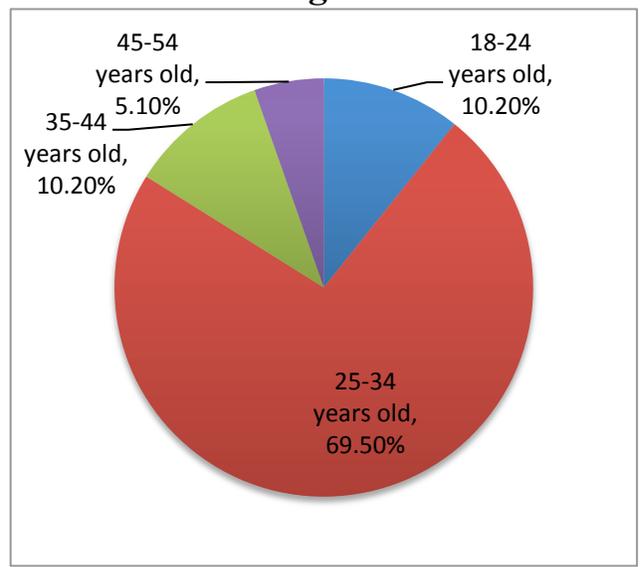
With regard to the age of respondents, the majority of respondents fell in the range of 25–34 years old ($n = 41$, 69.5%). Six respondents (10.2%) were 18–24 years old, six respondents (10.2%) were 35–44 years old, and three respondents (5.1%) were 45–54 years old.

With regard to degree type, the majority of respondents ($n = 38$, 64.4%) were currently enrolled in a Psy.D. program, 14 respondents (23.7%) were enrolled in an MA or MS program, two respondents (3.4%) were enrolled in a Ph.D. program, and two respondents (3.4%) were enrolled in an MSW program. The majority of respondents ($n = 19$, 32.2%) were in the fourth year of their graduate program. Thirteen (22%) were in their second year, 13 (22%) were in their third year, 10 (16.9%) were in their fifth year or beyond, and one (1.7%) was in their first year.

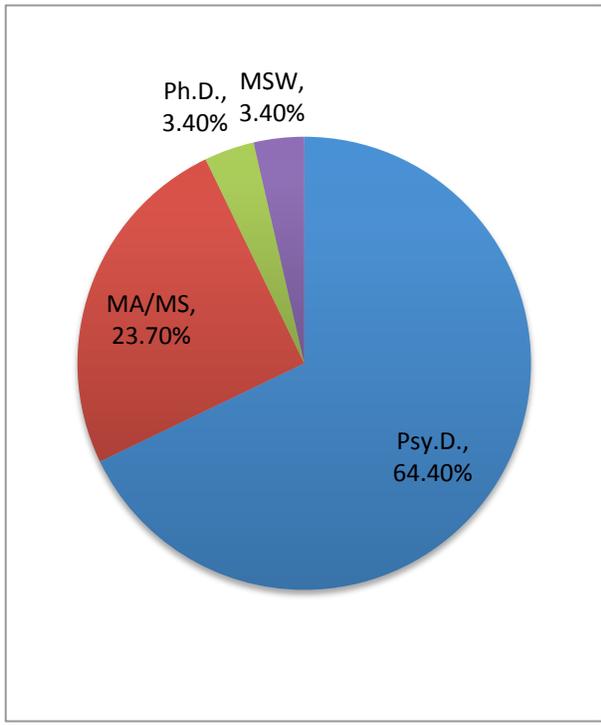
Gender



Age



Degree Program



Year in Program

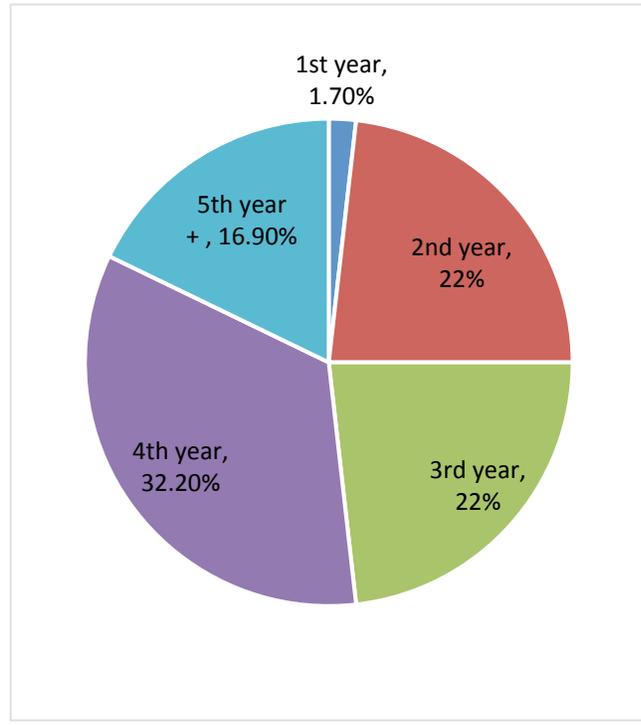


Figure 2. Demographic data.

Primary Analyses

The primary analyses involved the impact of the mindfulness intervention on respondents' self-reported levels of self-compassion and empathy. Additionally, it was hypothesized that self-compassion would mediate the relationship between mindfulness and empathy. Respondents were randomly assigned to two conditions. A total of 30 respondents (50.8%) were in the experimental condition. These respondents participated in the mindfulness intervention prior to observing the client video. Twenty-nine respondents (49.2%) were in the control condition. These respondents were not exposed to the mindfulness intervention before observing the client video.

Hypothesis 1 stated that participants exposed to the mindfulness intervention prior to observing the client video would report significantly higher levels of self-compassion as measured by the SCS than participants exposed to the same mindfulness intervention subsequent to observing the client video. To test this hypothesis, an independent samples *t* test was conducted to determine if there was a statistically significant difference in reported self-compassion between the group who completed the mindfulness exercise prior to viewing the video of the client and the group who completed the same mindfulness exercise after viewing the video of the client. The results of the *t* test showed that there was not a statistically significant difference in reported self-compassion between the group who completed the mindfulness exercise prior to viewing the video of the client ($M = 85.8$ $SD = 13.8$) and the group who completed the same mindfulness exercise after viewing the video of the client ($M = 85.2$, $SD = 3.27$); $t(57) = .144$, $p = .886$. Thus, Hypothesis 1 was not supported.

Hypothesis 2 stated that participants exposed to the mindfulness intervention prior to observing the client video would report significantly higher levels of empathy as measured by the Scale of State Empathy During Message Processing than participants exposed to the same mindfulness intervention subsequent to observing the client video. To test this hypothesis, an independent samples t test was conducted in order to determine if there was a statistically significant difference in reported empathy towards the client between the group who completed the mindfulness exercise prior to viewing the video of the client and the group who completed the same mindfulness exercise after viewing the video of the client. The results of the t test showed that there was not a statistically significant difference in reported empathy towards the client between the group who completed the mindfulness exercise prior to viewing the video of the client ($M = 31.02, SD = 7.42$) and the group who completed the same mindfulness exercise after viewing the video of the client ($M = 32.52, SD = 7.43$); $t(57) = -.767, p = .446$. Therefore, Hypothesis 2 was not supported.

Lastly, Hypothesis 3 stated that self-compassion, as measured by the SCS, would mediate the relationship between mindfulness and empathy, as measured by the Scale of State Empathy During Message Processing. In order to examine whether a mediator existed, a multiple regression analysis was conducted per the recommendation of Baron and Kenny (1986). In this four-step approach, several regression analyses were conducted and the significance of the coefficients were examined at each step (Baron & Kenny, 1986). In order to accomplish a test of mediation, the components of the model were tested individually. In order to proceed to the next step, the equation at the previous step

was required to be significant; if not, the assumptions of the mediation test would not be met (Baron & Kenny, 1986).

To test the hypothesis that self-compassion would mediate the relationship between mindfulness and empathy, the analysis began with determining the significance of the path from predictor to the criterion variable, which in this case was the relationship between mindfulness and empathy. This path was not statistically significant, meaning that there was no significant relationship between the mindfulness intervention and participants' scores on the Scale of State Empathy During Message Processing. The second step of the analysis involved analyzing the relationship from predictor to mediator, in this case, mindfulness to self-compassion. Again, this path was not statistically significant, meaning there was no statistically significant relationship between the mindfulness intervention and each participant's score on the SCS. The third step of the mediation test, utilizing a multiple regression analysis, was to examine the relationship between self-compassion and empathy. This path was also found to be not statistically significant, meaning there was no statistically significant relationship between participants' scores on the SCS and the Scale of State Empathy During Message Processing. Thus, Hypothesis 3 was not supported.

The study also explored how respondents' preexisting mindfulness practice might have influenced their levels of self-compassion and empathy towards the client. To address this, respondents were asked about the frequency and duration of their mindfulness practice. Hypotheses 4–7 examined whether a correlation existed between the length of time and frequency with which the participants practiced mindfulness and

their self-reported levels of empathy and self-compassion. A Pearson product-moment correlation (r) was used to explore each of these four hypotheses.

Hypothesis 4 stated that participants' levels of self-compassion, as measured by the SCS, would be positively correlated with the length of time the participant practiced mindfulness. There was no significant correlation found between participants' levels of self-compassion and the length of time (duration) they practiced mindfulness $r = -.037, n = 45, p = .807$. This means there was no significant relationship between participants' reported levels of self-compassion, as measured by the SCS, and the length of time in which they practiced mindfulness. Thus, Hypothesis 4 was not supported.

Hypothesis 5 stated that participants' levels of self-compassion, as measured by the SCS, would be positively correlated with the frequency with which the participants practiced mindfulness. There was a statistically significant positive correlation found between participants' levels of self-compassion and the frequency with which they practiced mindfulness, $r = .302, n = 56, p = .024$. This means there was a positive relationship between participants' levels of self-compassion, as measured by the SCS, and the frequency with which they practiced mindfulness. Respondents who reported higher levels of self-compassion also reported practicing mindfulness more frequently. Thus, Hypothesis 5 was supported.

	Frequency	Percent
1 – not at all	3	5.4
2 – rarely	15	26.8
3 – occasionally	15	26.8
4 - sometimes	12	21.4
5 – frequently	9	16.1
6 - daily	2	3.6
Total	56	100.0

Figure 3. Frequency with which participants practice mindfulness.

As seen in Figure 3, the majority of participants reported practicing mindfulness rarely (26.8%) or occasionally (26.8%). 21.4% of participants reported practicing mindfulness sometimes, while 16.1% reported practicing it frequently. 5.4% of participants reported practicing mindfulness not at all, and 3.6% reported practicing daily.

Hypothesis 6 stated that participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, would be positively correlated with the length of time they practiced mindfulness. There was no significant correlation found between participants' levels of empathy and the length of time (duration) they had practiced mindfulness, $r = -.001$, $n = 45$, $p = .995$. This means no significant relationship was found between participants' self-reported empathy, as measured by the Scale of State Empathy During Message Processing, and the length of time the participant reported practicing mindfulness. Thus, Hypothesis 6 was not supported.

Hypothesis 7 stated that participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, would be positively correlated with the frequency with which they practiced mindfulness. There was no significant correlation found between participants' levels of empathy and the frequency with which they

practiced mindfulness, $r = .058$, $n = 56$, $p = .672$. This means there was no significant relationship between participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, and the frequency with which they participant practiced mindfulness. Thus, Hypothesis 7 was not supported.

Secondary Analyses

The additional analyses involved understanding qualitative factors that may have contributed to the respondents' felt empathy towards the client. The Self-Designed Empathy Questionnaire provided several factors and inquired about how influential each factor was in the participants' ability to feel empathy for the client in the video. Participants were asked to indicate a rating for each of the listed factors on a Likert scale ranging from 1 (*not at all*) to 5 (*extremely*). Most influential was the "client's emotional affect/manner of relating" ($M = 3.68$, $SD = 1.07$), followed by the content of the client's situation ($M = 3.54$, $SD = 1.00$), the respondent's level of energy/fatigue at the time of viewing this video ($M = 2.95$, $SD = 1.17$), the client's gender ($M = 2.92$, $SD = 1.32$), and the respondent's mood at the time of viewing this video ($M = 2.86$, $SD = 1.18$). Less influential were the client's appearance ($M = 2.64$, $SD = 1.09$) and the client's race/ethnicity ($M = 2.17$, $SD = 1.16$). It is worth noting that none of the mean ratings were particularly high and the highest mean rating ($M = 3.68$) was only slightly above average.

The self-designed empathy questionnaire included an optional write-in section where participants could list a factor that impacted their ability to connect with the client. Three respondents provided written in responses to this question. One respondent wrote, "Past experiences with clients having a similar presentation," while another respondent

wrote, “Personal experiences of aloneness and fear.” Lastly, another respondent reported feeling distracted by the quality of acting and the video recording and stated, “It seemed like the person was reading from something just outside of the shot so I was, at times, distracted by their eye movement.”

Table 1

Ratings of Influential Factors Related to Clinician Empathy for the “Client”

Factors Related to Respondent’s Empathy for the “Client”	Mean
Clients emotional affect/manner of relating	3.678
Content of the client's situation	3.542
Your level of energy/fatigue at the time of viewing this video	2.949
Client's gender	2.915
Your mood at the time of viewing this video	2.864
Client's appearance	2.644
Client's race/ethnicity	2.169

Chapter 6: Discussion

The nature of mindfulness encourages a nonjudgmental attitude as practitioners attend to their immediate experience. Prior research has suggested that the practice of mindfulness is associated with increased empathy towards others and self-compassion within the practitioner (Bluth & Blanton, 2013; Greason & Welfare, 2013). Mindfulness may be particularly helpful for clinicians in training as they are still developing their skills and in the foundational years of learning how to be with clients in a congruent way. Regardless of a clinician's orientation, empathy is often at the core of their therapeutic work (Rogers, 1980). Although previous studies have explored the relationship between mindfulness, self-compassion, and empathy, very limited research has explored whether self-compassion serves as a mediator, or underlying mechanism, through which mindfulness leads to empathy.

The current study sought to explore the above question. It was hypothesized that within the context of mindfulness, compassion towards one's self serves as a grounding mechanism for empathy. In other words, an individual may be more fully able to step into the shoes of another if they have first stepped into their own. Similarly, the use of mindfulness as an intervention has been utilized largely among client-populations but limited research has been done with clinicians. Because clinicians in training have yet to fully develop their skills in working with clients while modulating their own experiences through practices like self-care, they were a population of interest when exploring these concepts. The goals of the present study were tested by exposing graduate student participants to a video of a hypothetical client during session either before (experimental group) or after (control group) participating in a mindfulness exercise, based on random

assignment. Levels of self-compassion and empathy were measured to determine if self-compassion mediated the relationship between mindfulness and empathy towards the client.

In the current study, the hypotheses were as follows:

1. Participants exposed to the mindfulness intervention prior to observing the client video will report significantly higher levels of self-compassion, as measured by the SCS, than participants exposed to the same mindfulness intervention subsequent to observing the client video.
2. Participants exposed to the mindfulness intervention prior to observing the client video will report significantly higher levels of empathy, as measured by the Scale of State Empathy During Message Processing, than participants exposed to the same mindfulness intervention subsequent to observing the client video.
3. Self-compassion, as measured by the SCS, will mediate the relationship between mindfulness and empathy, as measured by the Scale of State Empathy During Message Processing.
4. Participants' levels of self-compassion, as measured by the SCS, will be positively correlated with the length of time the participant has practiced mindfulness.
5. Participants' levels of self-compassion, as measured by the SCS, will be positively correlated with the frequency with which the participant practices mindfulness.

6. Participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, will be positively correlated with the length of time the participant has practiced mindfulness.
7. Participants' levels of empathy, as measured by the Scale of State Empathy During Message Processing, will be positively correlated with the frequency with which the participant practices mindfulness.

There was not a statistically significant difference in reported self-compassion found between the group who completed the mindfulness exercise prior to viewing the video of the client and the group who completed the same mindfulness exercise after viewing the video of the client. Similarly, there was not a statistically significant difference in reported empathy towards the client between the groups. Contrary to previous predictions, self-compassion was not found to mediate the relationship between mindfulness and empathy. Participants' levels of self-compassion were not positively correlated with the length of time they practiced mindfulness, but participants' levels of self-compassion were positively correlated with the frequency with which they practiced mindfulness. Participants' levels of empathy were not positively correlated with the length of time or frequency with which they practiced mindfulness.

Limitations with Mindfulness Exercise

There were several limitations to the study that can be assumed to have impacted the results. First, flaws related to the nature of the mindfulness intervention may have led it to not be as effective as previous research would suggest. One of these limitations was the fact that there was no way to guarantee participants had completed the mindfulness exercise in its entirety. It is common for graduate students to multitask throughout their

day, so it is possible this occurred during the mindfulness intervention. Respondents were required to check a box that noted they had completed listening to the audio recording before they could continue on in the survey, but it is possible participants clicked to another page during the recording or simply left it playing in the background without full participation before proceeding. This could explain why there was no significant difference in self-compassion or empathy between the mindfulness and control conditions for Hypotheses 1 and 2.

Similarly, participants engaged in the mindfulness exercise in front of a screen, as the survey was only accessible through phone, tablet, or computer. It is possible that the light from the screen decreased the effectiveness of the mindfulness intervention. It is also possible that participants engaged in the exercise in a workplace setting where they were unable to fully engage. Although respondents were instructed to complete the survey in a place relatively free from distraction, it is still possible that participants received email, text message, or social media notifications on their device during the mindfulness exercise, which prevented them from participating fully. Typically, cell phones, computers, and other electronic devices are stowed away or turned off during mindfulness classes like MBSR. All of these limitations would explain similar means on empathy and self-compassion measures for the mindfulness and control groups in Hypotheses 1 and 2. For future research, mindfulness interventions should be conducted in person in a controlled setting rather than through a screen if possible. Future research could also include a mindfulness intervention that is led in a live-streaming video format where participants could provide feedback and process their experiences of the exercise

afterwards. Additionally, future research could inquire more about both formal and informal mindfulness practices of participants.

Another hypothesis as to why the mindfulness exercise proved ineffective in this study is that it featured my voice. Because I have extensive experience leading mindfulness classes, I used my own voice; however, it is possible that participants could have known me, recognized my voice, and found it distracting enough that they were unable to fully engage in the exercise. Although the recruitment messages noted that my personal contacts were not eligible to participate, there is no way of knowing if people who knew me ignored this message and participated regardless, as all survey participants were de-identified. For future research, it would be advised to have someone other than the researcher audio record the mindfulness exercise.

Although there was no statistically significant difference between the mindfulness and control groups with regard to empathy, the control group actually had a slightly larger mean empathy score. This was the opposite result of what was hypothesized based on prior research. It is possible that the mindfulness exercise led to frustration or discomfort, from which participants were unable to disconnect when they viewed the client video. It is a common misconception that mindfulness is intended to make people feel good; rather, the intention of mindfulness is to connect people to how they feel, which may include a variety of emotions, including discomfort. It is possible that participants felt frustration or discomfort during the exercise and that this had the opposite effect of what was intended and slightly impeded their empathy for the client (Hypothesis 2). This would also explain why the control group reported slightly higher (though not significantly higher) levels of empathy towards the client. It is possible that

by attending to their immediate thoughts, feelings, and bodily sensations, participants became distressed or agitated to a degree that inhibited their ability to focus on the “client.” In other words, especially to the inexperienced practitioner, internal stimuli may have inhibited the connection to external stimuli. It is important to note, that although participants in the mindfulness condition had lower empathy scores than anticipated, they did not fall in the low range. Likewise, the fact that it is particularly challenging to feel self-compassion when in a state of distress or discomfort might be attributed to the finding of no significant relationship between mindfulness and self-compassion (Hypothesis 1). Although this is a possible explanation for the results, it is important to note that the differences between the experimental and control group were not statistically significant.

Perhaps the most obvious limitation to the mindfulness exercise in this study was the fact that it was a single 10-min exercise. Most mindfulness research involves mindfulness interventions that are longer in duration. For example, the MBSR course is eight weeks in duration and includes weekly instruction and daily practice. Mindfulness is intended to be practiced regularly. It is likely that the brevity of the mindfulness intervention was not sufficient enough to bring about the change in participants’ levels of self-compassion and empathy (Hypotheses 1 and 2). Further research should include a longer course mindfulness intervention or utilize participants who regularly practice mindfulness in their daily lives. Similarly, the mindfulness intervention primarily consisted of a body scan, which welcomed participants to direct their awareness to various parts of their body and breath. Future research should explore the impact of a “loving kindness” or “metta” meditation on participants’ levels of self-compassion and

empathy. In this style of meditation, the practitioner sends loving and affirming words to both themselves and others. Prior research has suggested that a mindfulness practice that incorporates this loving-kindness meditation is particularly effective in increasing self-compassion among health care workers (Raab, 2014).

Limitations with “Client” Video

The nature of the “client” video may have also contributed to results that were not significant. The client video was a simulated scenario designed to replicate the experience of sitting with a client in a therapy session. The client was played by an actor and may not be generalizable to real life work with clients. Additionally, the video quality was poor and the actor can be seen reading the script off screen during parts of the video. In fact, one participant commented that they could notice the actor reading and found it distracting. Additionally, the client video was only a couple of minutes long. Most therapeutic work involves longer and more frequent interactions. The brevity of the client video strays far from ongoing therapeutic work with clients where rapport is built over several sessions. These limitations may have contributed to participants’ ability to feel empathy for the client (Hypothesis 2). This lack of generalizability may have led to an overall decreased ability to connect to, and feel empathy towards, the client. Future researchers are encouraged to utilize “client” scenarios that are as realistic as possible to increase the validity of measurement in this area.

Limitations with Scales

Issues with the scales used in this study may have also contributed to the insignificant results. For example, both the SCS and Scale of State Empathy During Message Processing were normed with undergraduate college student samples, with

mean ages ranging from 19–20 years old. The majority of participants in the current study were between the ages of 25–34 years old. Additionally, neither scale was normed for graduate students or therapists. The Scale of State Empathy During Message Processing was originally designed to measure the impact of television PSA's for health promotion. The scale was not originally intended to be used on therapists in clinical settings or to measure therapist-client interactions. The scale may not have captured the type of empathy experienced by therapists. Additionally, the current study did not look at the three subscales on the empathy measure but rather assessed the total empathy score. It is possible the scales did not fully capture empathy and self-compassion given the population of the current study strayed significantly from the population for which the scales were normed, which could have contributed to the insignificant results for Hypotheses 1, 2, 3, 4, 6, and 7.

Lastly, the results suggest that participants were more empathic than average, which is not surprising given that the sample was comprised entirely of student therapists. It is possible that the Scale of State Empathy During Message Processing was not sensitive enough to accurately distinguish differences in levels of empathy among a naturally very empathic sample. Future researchers should seek out more refined measures of empathy that are normed for this population.

Overall Limitations

Additional factors that may have impacted the results of the study pertained to the demographics of the participants in the study. A large number of people failed to complete the survey in its entirety; only 55.2% of respondents who began the survey completed it. It is possible that there could be critical differences between those who

ended the survey prematurely and those who completed it. The high attrition rate could have been influenced by the amount of time the survey took to complete, as graduate students are typically inundated with assignments, studying, and practicum responsibilities. This may have been compounded by the fact that the majority of the data collection for this study occurred towards the end of the spring semester when graduate students were reaching the end of their training year, navigating finals, client terminations, and potentially feeling some burnout. The timing of data collection could have contributed to both the attrition rate of participants as well as participants' overall ability to engage with the mindfulness exercise and with the "client" video.

It is also worth noting that the overall $N = 59$ was quite small. Due to difficulty obtaining participants, I submitted an amendment to IRB to decrease the N required for the study in March 2019. This amendment was approved, but overall the decreased N likely contributed to the nonsignificant results for six of the seven hypotheses and served as a limitation to the overall study.

Understanding Significant Findings

Although it was not part of the core hypotheses, the current study inquired about factors that related to the respondents' feelings of empathy for the client. The respondents ranked the "client's emotional affect/manner of relating" and "content of the client's situation" highest with means of 3.68 and 3.54, respectively, on a scale of 1–5. Participants wanted to make clear that they were focused on what they "should" be focused on: the client and her experience. It is worth noting there were no mean ratings in the 4–5 range, suggesting respondents may have been cognizant about being perceived as biased. Again, it is possible that this was influenced by impression management and the

desire to portray oneself as a “good therapist” free from biases. It is also possible that the respondents were drawn in to the depth of the client’s emotionality and found her intense presentation engaging. Given the client’s acute distress, emotionality, and stated relationship concerns, it is very possible the respondents developed some genuine empathic feelings towards her.

In contrast, respondents rated the “client’s appearance” and “client’s race/ethnicity” as being the least related to their empathy for the client with means of 2.64 and 2.17, respectively. Psychology (and related fields) graduate school curriculum typically places emphasis on multiculturalism and diversity, and most programs even address the role bias plays in clinical work. Perhaps impression management, along with the desire to appear culturally competent, led respondents to rank appearance and race/ethnicity lower than all other factors. Surprisingly, the respondents ranked the client’s gender ($M = 2.95$) as being more strongly related to their empathy of the client than race/ethnicity (2.17), though it is not known if this difference is statistically significant. It is also very possible that the client’s demographic factors were not influential to respondents’ empathy towards her. For example, the client’s comments did not involve her identities or experiences as a White woman. Perhaps if the client held more marginalized identities and spoke about experiences of discrimination based on those identities, the respondents would have evaluated them as more impactful towards their empathy. Future research might incorporate client content involving experiences of discrimination based on identity factors.

It is also worth noting that 74.6% of respondents identified as female, the same gender identity as the actor who played the client. Similarly, most (69.5%) respondents

were between the ages of 25–34; the actor who played the client was in her late 20s during the time the video was recorded. Lastly, the actor who played the client was White (she had blonde hair, fair skin, and blue eyes), and although data were not collected on respondents' racial/ethnic identity, it is known that graduate psychology (and related fields) programs tend to be disproportionately White. This means that the majority of respondents likely matched the “client” in gender, age, and race/ethnicity. It is possible that demographic factors may have been more impactful if the client had several different identifies than the participants. Future research could explore the same client scenario with an actor who holds different racial/ethnic, age, and gender identities from the one used in this study. The current study surveyed respondents about the client's gender and race/ethnicity, but did not inquire about the impact of the client's age. Further research might explore how the client's age related to the therapists' felt empathy.

Alternately, it is possible that inquiring about the role race/ethnicity played in the respondents' empathy was done too directly. It is known that unconscious bias is perhaps the most damaging and pervasive, particularly in clinical practice (Burgess et al., 2017), so future research might explore the role of race/gender in a subtler, more indirect way. This would also address the degree to which impression management may influence respondent responses.

The current study found that there was a significant positive correlation between participants' levels of self-compassion and the frequency with which the participant practices mindfulness, $r = .302$, $n = 56$, $p = .024$. Respondents who reported higher levels of self-compassion also reported practicing mindfulness more frequently. It is worth noting that while the frequency with which someone practices mindfulness was

significantly related to self-compassion, the duration for which someone has practiced mindfulness was not significantly related to self-compassion. This is hopeful because it shows that people do not need to have practiced mindfulness for years and years to experience its benefits. These results suggest that a devoted beginner to the practice who commits to practicing regularly can experience positive changes in their self-compassion fairly quickly, no expert status needed.

Given how challenging and depleting graduate school can be, this research could be used to inform clinical training. Despite regularly emphasizing the idea of self-care, few graduate programs actually integrate mindfulness into the curriculum. Clinicians are sometimes instructed how to teach mindfulness to clients, but what about learning to practice it themselves? Can they really preach what they do not practice? Similarly, graduate schools tend to attract high-achieving, often self-critical students who could benefit from an increased sense of self-compassion. Although this study focused on clinicians in training, this research could be used to highlight the benefits of a mindfulness practice for those already working as licensed mental health clinicians. A regular mindfulness practice could serve as a part of self-care for both trainees and those already working in the mental health field.

When practiced regularly, mindfulness becomes less of one more thing to “do” and more of a way of “being.” A former mindfulness teacher once explained that mindfulness is like brushing your teeth: It is more beneficial to do it for a couple minutes each day rather than for an hour every Saturday. Although it is comical in nature, this saying seems to echo what the current study has found to be true: Do not underestimate the power of a small intentional practice done daily.

Chapter 7: Conclusion

The current study found no significant difference in reported self-compassion between the mindfulness and control groups. Similarly, there was not a statistically significant difference in reported empathy towards the “client” between the groups. Self-compassion was not found to mediate the relationship between mindfulness and empathy. Participants’ levels of self-compassion were not positively correlated with the length of time they practiced mindfulness, but participants’ levels of self-compassion were positively correlated with the frequency with which they practiced mindfulness. Participants’ levels of empathy were not positively correlated with the length of time or frequency with which they practiced mindfulness.

Future research should incorporate mindfulness interventions that are conducted in person rather than through a screen to minimize distraction and to ensure full participation in the exercise. Similarly, future research should include a longer course on mindfulness intervention or utilize participants who regularly practice mindfulness in their daily lives, as the brevity of the mindfulness intervention in the current study was a significant limitation.

When assessing for therapists’ felt empathy towards clients, future researchers should utilize “client” scenarios that are as realistic as possible to increase the validity of measurement. Additionally, researchers should seek to utilize measures of empathy that are normed for a student therapist population. Other ideas for future research include assessing how demographic identity factors between the student therapist and client influence the therapists’ felt empathy towards the client. Overall, it is recommended that future researchers utilize a larger sample size.

The current study found that respondents who reported higher levels of self-compassion also reported practicing mindfulness more frequently. This shows that someone does not need to have practiced mindfulness for years and years to experience its benefits. These results suggest that a devoted novice to the practice who commits to practicing regularly can experience positive changes in their self-compassion fairly quickly.

This research could be used to inform clinical training by integrating mindfulness into graduate school curriculum. Similarly, graduate schools tend to attract high achieving, often self-critical students who could benefit from an increased sense of self-compassion. Although this study focused on clinicians in training, this research could also be used to highlight the benefits of a mindfulness practice for those already working as licensed mental health clinicians. A regular mindfulness practice could serve as a part of self-care for trainees as well as those already working in the mental health field. Overall, the results of this study exemplify how powerful a daily contemplative practice can be towards fostering more self-compassion in those whose work centers on showing compassion towards others.

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Appendix A

Self-Compassion Scale (SCS; Neff, 2003)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never					Almost Always
1	2	3	4	5	

- _____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
- _____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- _____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
- _____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
- _____ 5. I try to be loving towards myself when I'm feeling emotional pain.
- _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- _____ 8. When times are really difficult, I tend to be tough on myself.
- _____ 9. When something upsets me I try to keep my emotions in balance.
- _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- _____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
- _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

- _____ 14. When something painful happens I try to take a balanced view of the situation.
- _____ 15. I try to see my failings as part of the human condition.
- _____ 16. When I see aspects of myself that I don't like, I get down on myself.
- _____ 17. When I fail at something important to me I try to keep things in perspective.
- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix B

Permission to Use Self-Compassion Scale (SCS)

The author of the measure has the following message on her website (<http://self-compassion.org>) granting permission for researchers to use the scale:

“To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. Masters and dissertation students also have my permission to use and publish the Self-Compassion Scale in their theses. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.

Associate Professor Educational Psychology Dept. University of Texas at Austin

e-mail: kneff@austin.utexas.edu”

<http://self-compassion.org>

Appendix C

Scale of State Empathy During Message Processing (Shen, 2010)

Please rate the following items on a Likert scale between 0-4 based on your experience of the client in the previous video:

0 = not at all 4 = completely

Dimensions:

Items:

Affective Empathy:

1. The client's emotions are genuine.
2. I experienced the same emotions as the client when watching this message.
3. I was in a similar emotional state as the character when watching this message.
4. I can feel the character's emotions.

Cognitive Empathy:

5. I can see the client's point of view.
6. I can recognize the client's situation.
7. I can understand what the client was going through in the message.
8. The client's reactions to the situation are understandable.

Associative Empathy:

9. When watching the message, I was fully absorbed.
10. I can relate to what the client was going through in the message.
11. I can identify with the situation described in the message.
12. I can identify with the client in the message.

Appendix D

Permission to Use State Empathy Scale

Permission to Use Scale of State Empathy

Inbox x

**Nicole Montes Buckley** <nicolemontesbuckley@gmail.com>

Mar 10 (4 days ago) ☆



to lus32 ▾

Dr. Lijiang Shen,

My name is Nicole Montes Buckley, I'm a third year doctoral student in Clinical Psychology at Illinois School of Professional Psychology. As part of my program requirements I need to complete a dissertation research study. I've chosen to focus my research on the relationship between mindfulness and state-based empathy in clinicians in training.

I'm writing because your scale of state empathy during message processing seems to measure exactly what I'm interested in studying. I'm writing to ask permission to use this measure in my dissertation research. I would be happy to forward you the results of the study when I'm finished.

Thank you for your consideration,

**Lijiang Shen**

Mar 12 (2 days ago) ☆



to me ▾

Dear Nicole,

Thanks for your interest in my work. You have my permission to use the scale in your research.

Best!

LJ

Lijiang Shen, Ph.D.
Associate Professor
Department of Communication Arts & Sciences
Pennsylvania State University
211 Sparks Building
University Park, PA 16802
Phone: [814-865-1736](tel:814-865-1736)

Appendix E

Self-Designed Empathy Questionnaire

On a scale of 1-5 (1 = not at all, 5 = extremely) how influential was each of these factors in your ability to feel empathy for the client in the video. Please indicate a rating for each of the listed items. You may also add other factors which influenced your felt empathy for the client in the video.

- ___ Client's emotional affect/manner of relating
- ___ Content of the client's situation
- ___ Client's appearance
- ___ Client's race/ethnicity
- ___ Client's gender
- ___ Your mood at the time of viewing this video
- ___ Your level of energy/fatigue at the time of viewing this video
- ___ "Other" (please explain): _____

On a scale of 1 to 10 (1=not at all, 10=very much so) how much would you like to work with this client? _____

Appendix F
Demographic Questionnaire

1. Gender:

Female____ Male____ Transgender____

2. Age:

18-24 ____

25-34 ____

35-44 ____

45-54 ____

55-64 ____

65 + ____

3. Please indicate your graduate degree program:

Psy.D. ____

Ph.D. ____

Ed.D. ____

MA/MS____

MFT____

MSW ____

4. On average, how often do you engage in an intentional contemplative practice

like the one you participated in today as part of this study:

1 – not at all

2 – rarely

3 - occasionally

4 – sometimes

5 – frequently

6 – daily

5. For how many years have you been engaged in this practice:

- 0/I don't do this

- less than a year

- 1-3 years

- 3-5 years

- 5 – 9 years

- 10 or more years

6. What year are you currently in graduate school:

1st year

2nd year

3rd year

4th year

5th year +

Appendix G

Recruitment Message

Dear potential participant,

I am a doctoral student in the Clinical Psychology program at the Illinois School of Professional Psychology, at Argosy University, Chicago. I am inviting you to participate in a study that will take approximately 25- 30 minutes to complete. The purpose of the study is to understand how clinicians in training understand and relate to their clients during therapy. This study is part of my Clinical Research Project, a project similar in scope to a dissertation, which is a requirement for my doctoral degree. This study has been approved for distribution by my research committee and by the Argosy University, Chicago Institutional Research Board (IRB). This study is anonymous so you will not be asked any personal identifying information if you choose to participate in the study.

In order to participate, you must be a current graduate student in the field of Psychology, Counseling, Marriage and Family Therapy, or Social Work with at least 3 months of supervised clinical practicum experience. Graduated individuals are not allowed to participate. Personal contacts of the researcher are not eligible to participate in the study. Interested persons must be 18 years or older to participate in this study. Participants must also be proficient in reading and understanding English. If you choose to participate, the survey should be completed in a relatively quiet location free from significant distractions. Participants will need the use of audio on their devices to participate in the study. In return for your participation, at the end of the survey you will be given the opportunity to enter a lottery to win a \$50 Amazon Gift Card with an approximate 1/50 chance of winning the raffle.

Thank you for reading this message. I hope you will agree to participate in this study as you may find the experience to be meaningful and relevant to your graduate training. If you are willing to participate and meet the above stated criteria, please click on the following link and to access the survey. You may quit the survey at any time; your responses will not be included in the study if you do not complete the entire survey. Please feel free to forward this information to others you think may be interested.

[https:// www.surveymonkey.com/](https://www.surveymonkey.com/)

If you have any questions please contact me at NicoleMontesBuckley@gmail.com or you may contact my faculty chairperson, Dr. Susan Zoline, at szoline@argosy.edu/phone 312-777=7704.

In advance, thank you for your time and consideration,

Nicole Montes Buckley
Clinical Psychology Doctoral Student
ISPP, Chicago

Appendix H

Informed Consent Form

Informed Consent

I have been asked to participate in a research study that is designed to explore how clinicians in training relate to therapy clients. I understand that the requirements to participate in this survey are that I must be at least 18 years of age and a graduate student in the field of Psychology, Counseling, Marriage and Family Therapy, or Social Work with at least 3 months of supervised clinical practicum experience. Graduated individuals are not allowed to participate. Personal contacts of the researcher are not eligible to participate in the study. I understand that I must also be proficient in reading and understanding English in order to participate. Additionally, I understand that if I agree to participate, the survey should be completed in a relatively quiet location free from significant distractions and with audio capacity on the computer which I use. I am one of approximately 50 persons who are anticipated to participate in this study. I understand that this study is part of the academic requirements for completion of the researcher's doctoral degree in Clinical Psychology from the Illinois School of Professional Psychology (ISPP), Argosy University, Chicago.

The study is estimated to take approximately 25-30 minutes to complete. If I agree to participate, I will be asked to answer anonymous demographic questions about my age, gender, education level, and proficiency in English. I will also be asked to listen to an audio recording, watch a short video clip and complete three brief questionnaires.

By clicking on the “Consent” button below I agree to participate in the study. If I do not wish to participate I may click the “Decline” button below or simply exit the webpage. I understand that I am free to decline to answer any specific questions in the survey. I understand that my participation in this study is completely voluntary. I am free to withdraw at any time, without penalty, if I choose to do so. My decision to participate will have no bearing on my possible affiliation with Argosy University, Chicago. This is an anonymous study; therefore, I will not be asked for any personally identifiable information, only a few demographic questions. Furthermore, the school which I attend will also not be known to the researcher.

I understand that though survey research online shares many characteristics of traditional research, there is an increased risk that my identity can be exposed because the responses are transmitted via the Internet. The data collected in the study will only be shared with members of the researcher’s committee and a university statistician. The IP addresses will be turned-off in all related areas and documents. All data related to this study will be kept on the researcher’s password protected computer; printed data will be kept in a locked and secure space in the researcher’s home. Consent forms and data will be kept for a period of three years after the completion of the study, at which time they will be destroyed and deleted.

There are no anticipated risks associated with participation in this study. In return for my participation, at the end of the survey I understand that I will be given the opportunity to enter a lottery to win a \$50 Amazon Gift Card through submission of my email address to a different link. This list of email addresses will not be linked to survey data, will not be

used for any other purpose, and will be destroyed at the end of the data collection period once a raffle winner has been confirmed. As emails from participants come in, the primary researcher will file the emails into a password-protected folder separate from all other data. Once the study has concluded, each participant will be assigned a number.

The researcher will then use a random number generator

(<http://www.randomnumbergenerator.com/>) to select a winner. Specifically, the researcher will use the tool to generate a random number between 1 and the total number of participants who chose to partake in the drawing. The winner will be notified via email, if they do not respond within 14 days, a second winner will be selected using the same method.

A potential personal benefit of participating in this research study is that I may find partaking in the study to be engaging and relevant to my clinical work. A potential professional benefit of participating in this research study is knowledge that the results of the study could be used to improve clinician training.

If I experience any discomfort as a result of the study, I may stop at any time without penalty and/or contact the researcher or the faculty Chairperson at the email addresses provided at the bottom of this page. Additionally, the final page of the study provides referrals to counseling services. The link to such services is www.psychologytoday.com.

I will be financially responsible for any psychological services I choose to receive.

If I wish to receive a copy of the results of the study I may email the researcher at the email address provided at the bottom of this page for a general summary of results. My

email will be kept separate from the data, will not be used for any other purpose, and will be deleted once a general summary of the results has been sent.

I understand that this research study has been reviewed and certified by the Institutional Review Board at Argosy University, Chicago. For research-related problems or questions regarding participants' rights, I may contact the Institutional Review Board through the IRB Chair, Dr. Leah Horvath at [mailto: lhovath@argosy.edu](mailto:lhovath@argosy.edu) or at (312) 777-7681.

I have read and understand the explanation provided to me and I voluntarily agree to participate in this study by clicking the “I Consent” button below. I am encouraged to print this page to keep as a copy of the consent form.

For other research-related questions or concerns, I may contact the investigator of this study, Nicole Montes Buckley, by email at NicoleMontesBuckley@gmail.com or by phone at (312) 777-7704. I may also contact the faculty Chairperson of this study, Susan Zoline, Ph.D. at szoline@argosy.edu or (312) 777-7704.

Appendix I

Transcript of Mindfulness Exercise

Begin by finding a chair where you can remain upright but sit comfortably. You may choose to close your eyes, or you may choose to keep your eyes open and find a spot to focus on. I invite you to take a moment to check in with yourself. Consider noticing what it's like to be in your body right now at this time. Notice what thoughts might be passing through your mind, what feelings might be passing through your body. See if you can take mental inventory of how you feel right now, without trying to change it or judge it. Just noticing with a sense of curiosity.

I invite you to draw your awareness to your feet. Feel your toes, notice any material from your socks or shoes that makes contact with your feet. Can you sense the ground underneath your feet, feeling all of the places where each foot makes contact with the floor? Feel your shins, your knees, and the backs of your thighs as they make contact with your chair. Notice the foundation of the chair you're sitting in as it makes contact with your pelvis. Notice the texture and the structure of the seat under you, and feel as it supports and holds you up. Notice your spine in space, from your hips all the way up through the crown of the head, noticing any sensations or feelings in your back. Feel your shoulder blades on your back, the muscles of the shoulders, the skin on the shoulder blades. Consider now resting your awareness on your chest, noticing any material from your clothing as it makes contact with your chest. Can you feel, or maybe sense, your own heart beating? Feel your belly, and without trying to change or alter the breath can you notice that when you breathe in, the belly rises and expands like a balloon filling up with air and when you breathe out, the belly falls, like a balloon emptying with air.

Traveling back up the body start to feel the muscles in the back of your neck, and the skin on your scalp, maybe even noticing each of the places where each of the hairs on your head make contact with the skin on your scalp. Feel your hairline, the muscles on your forehead, your temples and cheeks on your face. Notice the hinge of your jaw, feel your teeth as they connect to the gums. Consider shifting your awareness to the tips of your nostrils. Feel the air in the room as it flows through two streams up the nostrils, filling up your lungs with breath, and then watch as the breath flows back out. Notice the texture of the breath, the scent, the temperature. Watch your body breathing. Notice any subtle sensations happening inside the body.

Spending these last couple of moments here just being present with whatever is happening right now in this moment, whether it's watching thoughts come and go in your mind, noticing sensations in the body, and even paying attention to what it's like to breathe. Using this as an opportunity to just be with yourself. When you're ready, begin to feel you pelvis as it makes contact with the chair and your feet as they make contact with the floor. Feel the air in the room as it makes contact with your skin. If your eyes are closed, turn your gaze to face downward and gently open your eyes.

Appendix J

Transcript of the “Client”

I'm so angry at him I could just scream. He disappointed me again. I got home from work and he was supposed to be there, we discussed it ahead of time and I walk in the door and the house is empty. He's just like my parents, there's no one in my life I can rely on.

Everyone is just out for themselves and they tell you one thing, but give it time, they will show you their true colors. In fact, I'm not even sure if I can trust you.

You know, I bet he never loved me. I bet he was just using me this whole time. I always end up alone, you know that. No matter how hard I try to get people to stay. I work so hard to get them to stay but inevitably they will leave me. You don't know the anguish of what it's like to be left. And you know, I hate him for it. I hate him for leaving me. I relied on him, and you know what, if it's going to be like this, I'm better without him. I honestly don't want someone like this in my life. I just don't know how to be alone. On top of it, I'm reminded that you will be leaving me too at the end of your training year.

Appendix K

Debriefing Script

Thank you for participating in this research study. I did not disclose the complete purpose of this study to you in the introduction so that you might respond freely to the survey questions without prior knowledge of the hypotheses. At the beginning of the survey, you were randomly assigned to one of two conditions. Some of you engaged in the mindfulness exercise prior to observing the “client” video and answering the survey questions, while others engaged in the exercise after observing the “client” video and answering the survey questions. The study was intentionally designed this way to examine how participation in mindfulness may impact your self-compassion and empathy towards a “client.”

As many of your colleagues will also be completing this survey, I ask that you please refrain from sharing the purpose of the study with them if they have not yet completed it. I greatly appreciate your cooperation in this matter.

If your participation in this study has caused you distress, I have listed a mental health referral source below for your consideration. Please note that you will be financially responsible for any psychological services you may choose to receive.

You may also contact Nicole Montes Buckley at (949) 433-8813 or NicoleMontesBuckley@gmail.com and/or Dr. Susan Zoline at (312) 777-7704 or szoline@argosy.edu with any further questions about the study.

To be entered into the raffle to win a \$50 Amazon gift card, please send an email to NicoleMontesBuckley@gmail.com with “ENTER ME INTO THE RAFFLE” in the subject line. As emails from participants come in, the primary

researcher will file the emails into a password-protected folder separate from all other data. Once the study has concluded, each participant will be assigned a number. The researcher will then use a random number generator (<http://www.randomnumbergenerator.com/>) to select a winner. Specifically, the researcher will use the tool to generate a random number between 1 and the total number of participants who chose to partake in the drawing. The winner will be notified via email, if they do not respond within 14 days, a second winner will be selected using the same method.

Referral Source: www.psychologytoday.com

Appendix L

Permission Letter from Client-Centered Clinical Practice Organization

Fwd: Permission Statement Inbox x



Nicole Montes Buckley

to nicolemontesbu. ▾

May 24 (4 days ago) ★



----- Forwarded message -----

From: **Warner, Margaret** <mwarner@argosy.edu>

Date: Wed, May 23, 2018 at 3:33 PM

Subject: Permission Statement

To: Nicole Montes Buckley <nicolemontesbuckley@gmail.com>

Dear Nicole,

As faculty advisor of the Client-Centered Clinical Practice Organization, I would be happy to forward the link to your survey to members on our email contact list.

Yours truly,

Margaret S. Warner, Ph.D.