COMPASSION IN PROFESSIONAL COUNSELING: A DELPHI STUDY

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ABSTRACT

Compassion is related to the work of counselors, yet scholars have not agreed upon a standard definition of compassion beyond a superficial dictionary explanation. A Delphi study was conducted to discover the opinions of a panel of counseling experts on the subject of compassion. The purpose of the study was to identify and define compassion as it relates to the context of professional counseling, as well as identify associated skills, attributes, and behaviors. The study also explored how experienced counselors distinguish compassion as it is experienced or expressed professionally and personally. Fifteen panelists participated in three rounds of data collection via online survey. Panelists also received feedback from subsequent rounds. Themes emerged on perceptions of compassion, skills and abilities that convey compassion, situations that create compassion obstruction, and support of knowledge, training, and education on compassion. The results indicate that assumptions exist on understanding what compassion is and how to express it in a professional manner. Results further show that compassion is an understudied and unnoticed concept that needs more examination.

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GENERAL AUDIENCE ABSTRACT

People generally understand compassion to be an act of understanding the pain and suffering of another person with a desire to ease their pain. However, applying the concept to the work professional counselors do can be problematic because of the codes of conduct and principles needed to keep both the counselors and clients safe. Compassion is at the heart of counseling with the goal being to help individuals and families positively focus on their mental health to improve many areas of their lives. Currently, the counseling profession recognizes the importance of compassion but needs to research this concept more fully. This study used a Delphi methodology to learn from a group of expert counselors and counselor educators how they define compassion specific to the occupation of counseling. An additional purpose was to identify things counselors do and know that express or communicate compassion in counseling settings. The group of experts revealed that counselors know the healthy boundaries needed to keep the relationships between the client and themselves healthy. Counselors also know what may get in the way of showing or feeling compassion with their clients. The results of the study did define compassion in counseling, identified ways counselors show compassion, and helped set up a way to develop compassion over the occupational lifespan.

Dedication

I lovingly dedicate this dissertation to Betty Lou Hash Raymond, my mother, and all of the other strong and amazing women within my heritage from both sides of my family lines. I am in admiration of these unbelievable women and the brave and hard-working men who stood beside them. As a first-generation college and graduate student, the recognition of their struggles brought out a fire and courage in me that I previously did not know existed. The memory of my mother inspires and encourages me every day not to forget my dreams. I have reached this point in both my ancestors' and my own wildest dreams.

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Chapter One

Compassion and empathy are the cornerstones of the counseling profession. Empathy is a well-established and researched counseling trait, while compassion is mentioned in cursory ways and suffers from a lack of empirical studies (Fulton, 2018; Stuntzner, 2017). The common understanding of compassion includes being empathetic to the suffering of another together with a yearning to lessen their pain. Despite the documentation of compassion as a fundamental characteristic in counseling (Beaumont, Durkin, Hollins Martin, & Carson, 2016; Figley, 2002; Fulton, 2016, 2018; Lawson, 2018), there lacks documented evidence in the next step of empathy as it combines with the desire to help another. Professionally we have established that empathy is paramount in both cultivating counseling relationships with people and in creating the therapeutic environment which can nurture transformation (Bodenhorn & Starkey, 2005; Kohut, 2010; Rogers, 1975, 1981). Numerous researchers, educators, and theorists have supported the need for counselors to encourage a therapeutic climate and empathetic understanding. The therapeutic environment necessary for change also includes the compassion of the counselor to encourage and promote change. The literature on compassion does not contain an in-depth examination, as does the precursor, empathy.

The counseling profession is distinguished for providing therapeutic services through a holistic approach and a wellness model. These paradigms of approaching a client through an examination of the entire system and augmenting positive choices help achieve the beneficial development of the individual (Myers, 1991). Additionally, a holistic philosophy is a distinctive feature of the counseling profession. Counselors seek to appreciate the whole being of the client, recognize and reinforce positive behaviors, and address areas of concern. By recognizing the strengths and challenges within clients' lives, counselors are trained to offer encouragement for

insight, perspective, and methods for making a change. There is, however, a professional expectation that counselors seek to understand client worldviews and perspectives.

One way counselors become familiar with and understand the perspective of clients is through empathetic understanding (Kohut, 2010; Rogers, 1975, 1981, 1992). Empathetic understanding conveys a comprehension of what the client is experiencing (Clark, 2010b; Rogers, 1981, 1992). Counselors work to better understand clients by using empathy, which cultivates compassion. By having clients explore their feelings and share their points of view, a counselor can gain perspective into their clients' world and convey that perception back to the client for confirmation. Not only does this exhibit to the client that the counselor is listening, but also that the counselor 'gets it' (Kohut, 2010; Rogers, 1975, 1981). Empathetic understanding validates the client while establishing trust and rapport. Client satisfaction with the counselor increases with this understanding and aids in client willingness to further engage with the counselor (Bodenhorn & Starkey, 2005; Clark, 2010b; Kohut, 2010). Empathy is vital in the therapeutic alliance to foster connection (Young, 2017; Zaki, 2014). Much of the literature supports the empathetic understanding of a client, and that empathy is a common component in the therapeutic relationship (Feller & Cottone, 2003; Young, 2017). Gaining understanding, through empathy, will be the same process for a counselor if being completed in a professional or personal environment. There would be no difference in how a person would try to make sense and try to understand a varying point of view.

While empathy is crucial to gain understanding, it is not the only characteristic that supports the counselor-client relationship. Compassion, or the desire to alleviate another person's suffering (Dalai Lama, 2003; Strauss et al., 2016), is another factor in the continuation of the therapeutic relationship (Fulton, 2018). To develop compassion, according to the Dalai

Lama (2003), an initial examination of the self should occur to discover what personally nurtures kindness towards the self and others. It is important to know the causes of what draws one toward and pulls one away from being compassionate (Dalai Lama, 2003). Self-reflection aids in identifying positive and negative emotions in nonjudgmental ways (Dalai Lama, 2003; Neff, 2015). These powerful emotions can create or impede contentment and development. Counselors are interested to learn their client's inner struggles and dissatisfaction (Clark, 2010a; Kohut, 2010; Rogers, 1975, 1992). Additionally, counselors work with clients to lessen those struggles and dissatisfaction with current situations and empower people to cope effectively (Niles & Harris-Bowlsbey, 2017). Clients expose counselors to their pervasive emotions and situations, which can cause additional mental and emotional stress on the counselor (Figley, 2002; Lawson, Venart, Hazler, & Kottler, 2007).

Counseling can be stressful for clients, professionals, and counselors-in-training (Cummins, Massey, & Jones, 2007; Lawson, 2007; Sackett & Lawson, 2015). Compassion can cultivate healing and adjustment for both the client and the counselor (Stuntzner, 2017). Unfortunately, the literature is lacking in research regarding the skills, attributes, and behaviors associated with compassion as a vital counseling disposition. Recent studies on compassion have examined job satisfaction, compassion satisfaction, self-compassion, compassion fatigue, burnout, secondary traumatic stress/vicarious traumatization, and wellness. Despite research on these aspects of compassion, few invoke a cohesive definition that can be used to inform practice, guide policy, and support research (Fulton, 2018; Grover, 2015; Sinclair et al., 2016; Stuntzner, 2017).

As a whole, the counseling profession operates from a holistic perspective and strives to appreciate the client as a unique individual (Myers, 1991). Professional guidelines and standards

provide structure and reflect the contemporary body of the profession (American Counseling Association, 2014; Association for Counselor Education and Supervision, 2011). The educational focus is on preparing counselors to have the skills and knowledge in core foundational standards to safeguard professional dispositions and help counselors-in-training generate a strong professional identity (CACREP, 2015). Historical research has stressed the value of particular qualities of the counseling setting that create a therapeutic environment that is supportive and collaborative between the counselor and the client (Bodenhorn & Starkey, 2005; Duffey & Trepal, 2016; Jordan, 2017; Rogers, 1981, 1992). Compassion has been studied within the counseling field, but in ways that have yet to explore as a professional behavior and a clear definition relating to the profession does not exist. Nor have researchers explored the trait of compassion of the counselor within the ethical guidelines of practice and within the professional counseling setting.

In other helping professional communities, there has been some exploration of compassion similar to those in counseling. Research within the medical community points out the importance of compassion, but does not address the conceptual nature of compassion beyond abstract or theoretical definitions (Sinclair et al., 2016). In a medical study exploring health care in palliative cancer patients in Canada, Sinclair and colleagues (2016) state that compassion is "a hallmark of quality care" (p. 193) and define compassion as "suffering with or a deep awareness of the suffering of another, coupled with a wish to relieve it" (p. 194). While in the profession of nursing in the United Kingdom (UK), a study to examine the social construction of the concept of compassion outlines that "compassion is described and constructed as being both an inherent attribute and something which could be nurtured/developed through practice and experience" (Bond et al., 2018, p. 3086). Similarly, with the profession of social work in the United States, a

basic definition is offered as "a deep sense or quality of knowing or 'awareness of the suffering of another coupled with the wish to relieve it'" (Radey & Figley, 2007, p. 207). Recently, a better definition has begun to emerge in the field of psychology in the UK, Strauss and colleagues (2016) conducted a review of existing literature within the field to derive a definition of compassion within psychology that combined various definitions and existing measures of compassion. Compassion in psychology is defined as "a cognitive, affective, and behavioral process consisting of...five elements that refer to both the self- and other-compassion" (Strauss et al., 2016, p. 19). When exploring compassion in the counseling literature, definitions are rudimentary, like those in the medical, nursing, and social work fields. The more recent definition that has emerged in a different helping profession was derived from reviewing historical literature for themes and current measurements of compassion that measure aspects of job satisfaction or the breakdown of compassion. Due to the lack of research exploring compassion in counseling, a foundational study is needed to explore how counselors understand compassion and how experienced counselors and counselor educators differentiate compassion professionally and personally.

Statement of the Problem

Research has explored compassion in relation to job satisfaction, or compassion satisfaction (Hunter, 2012; Salloum, Kondrat, Johnco, & Olson, 2015), and on how counselors or other helping professionals look for positive gratification in work to negate stress and weariness (C. Harr, 2013; Radey & Figley, 2007; Yilmaz & Üstün, 2018). Many studies have examined what happens when counselors experience compassion fatigue or burnout when continually working with clients who share their stories of emotional stress (Lawson, 2018; Thompson, Amatea, & Thompson, 2014). These studies on burnout and compassion fatigue also connect

with studies of secondary traumatic stress, where counselors who are working with clients experiencing trauma become traumatized themselves (Thompson et al., 2014). Also, there has been a wealth of research related to self-compassion and wellness as it relates to a counselor taking care of themselves (Cummins et al., 2007; Fulton, 2016; Lawson, 2007; Lawson & Myers, 2011; Lawson et al., 2007; Stuntzner & Hartley, 2014). An additional set of studies connect compassion with resilience (e.g., Friedli, 2009; Westphal & Bonanno, 2007). More recently, research in rehabilitation counseling highlights how compassion can be helpful for clients to adjust to disabilities (Grover, 2015; Stuntzner, 2017; Stuntzner & Dalton, 2014; Stuntzner & Hartley, 2014).

Studies on compassion have been explored either within the self to foster resilience and wellness, or in ways that examine compassion post mortem. Because counseling operates from a wellness model (Lawson & Myers, 2011; Myers, 1991), further examination needs to be conducted to investigate compassion within the counseling field from a professional context before counselors experience the stress and strain of the occupation. However, unlike empathy, compassion as a characteristic may be different if explored personally versus professionally. Little research exists to support the professional aspect of compassion in the context of counseling. This lack of empirical support gives rise to critical questions such as 'what is compassion?' and 'how do counselors view compassion within a professional context?' Further, the lack research undermines one of the central characteristics of effective counselors and the therapeutic environment.

Purpose of the Study

Counselors help create the therapeutic environment and continue the working relationship through empathy and compassion (Bodenhorn & Starkey, 2005; Kohut, 2010; Rogers, 1981,

1992; Young, 2017). The purpose of this study is to define compassion as it relates to the context of professional counseling and identify associated skills, attributes, and behaviors. Asking experienced counselors and counselor educators to provide their input in creating a common understanding of compassion in counseling can identify a needed definition. Through exploring this purpose, the counseling profession may have an increased awareness of the concept of compassion in the professional setting and allow for identification of measurements for future work. Results may help inform current practices to advise future behaviors and could allow for the exploration of this trait to safeguard against compassion fatigue and burnout.

This research explores the opinions regarding compassion from experienced counselors and counselor educators. Experienced counselors from multiple disciplines within the field of counseling can provide credible professional perspectives (Iqbal & Pipon-Young, 2009) and a deep understanding of the counseling profession (Okoli & Pawlowski, 2004). Counselor educators and supervisors know the training and educational levels of counselors-in-training and new counselors. Additionally, because the counseling profession as a whole has struggled historically to have a unified definition of professional counseling and intra-professional research has been fragmented (Myers, Sweeney, & White, 2002), this research was an endeavor to find commonality across disciplines to help strengthen the counseling profession's understanding of compassion.

To address the lack of scholarship that surrounds compassion in counseling, a methodology that relies on a panel of counseling experts to provide the foundational information regarding compassion was employed. A Delphi research design was chosen as it allows for a group of experts to provide opinions, can be completed electronically, and does not require participants to meet physically (Okoli & Pawlowski, 2004). The Delphi methodology also

operates under the assumption that the opinion of the group holds more value than that of the individual (Keeney, McKenna, & Hasson, 2010). The current study was constructed to be a three-round, online data collection process to achieve consensus on the emerging data.

Research Questions

Compassion is an essential and effective element in counseling (Day, Lawson, & Burge, 2017), yet there has been no clearly defined shared understanding of this phenomenon separate from discussions of empathy. The following questions were used to guide the research to address the purpose of this study:

1. How do counselors and counselor educators define compassion?
2. What skills, attributes, and behaviors are indicative of compassion in counseling?
3. How do experienced counselors and counselor educators differentiate compassion as it is experienced professionally and personally?

Significance of the Study

The US Department of Labor's Bureau of Labor Statistics 2018 report identified approximately 804,000 counseling related community and social-service jobs. These numbers include counselors practicing in substance abuse, behavioral disorders, clinical mental health counselors, marriage and family therapists, rehabilitation counselors, school, and career counselors (Bureau of Labor Statistics, 2019). This reported number does not include any counselor who may be self-employed and does include those with bachelor's degrees performing entry-level or para-professional jobs.

Additionally, the 2016 National Survey on Drug Use and Health, conducted by Substance Abuse and Mental Health Services Administration (SAMSA), revealed that in the United States, almost one out of every five adults reported experiencing mental illness (National Institute of

Mental Health, 2017). Counselors can be one of those five adults struggling with a mental illness. Counselors work with many clients with mental illness, as well as many with life adjustment issues. Counselors need to be able to foster the connection with clients and maintain the relationship without damaging the desire to help lessen the suffering.

Counselors, while being dedicated to helping others, are reliant on the work of the client to produce outcomes, which can lead to frustrations when the counselor's best efforts do not meet expected outcomes (Lawson, 2018). The work can be demanding and stressful. In turn, counselors can become burned out, fatigued, and even traumatized. Therefore, counselors need to recognize their stressors to mitigate feelings of burnout and increase satisfaction within their jobs (Lawson, 2007, 2018; Lawson & Myers, 2011; Merriman, 2015). Despite the identification of compassion as a fundamental aspect of counseling (Fulton, 2018), the empirical literature support lacks a distinct description. Thus, the profession needs to have a deeper exploration of compassion. Without a clear definition, the profession could be missing ways to keep professional counselors viable, well, and effective.

Definition of Terms

The following are the working definitions for this study.

Burnout: "A psychological syndrome in response to interpersonal stressors on the job" (Maslach et al., 2001, p. 399). Three components characterize burnout: physical and emotional exhaustion, depersonalization/cynicism, and a reduction in personal efficacy (Biali, 2018; Lawson, 2007; Maslach et al., 2001; Thompson et al., 2014).

Compassion Fatigue: "A state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal associated with the patient" (Figley, 2002, p. 1435).

Compassion Satisfaction: The fulfillment a counselor has with the performance in doing well at their job through helping the welfare of others (C. Harr, 2013; Lawson & Myers, 2011; Sacco & Copel, 2018).

Empathy: "The ability to take the perspective of another person's point of view" (Fulton, 2018, p. 45). Empathy is a state of perception to the internal frame of reference of another (Clark, 2010a) with cognitive and affective attunement to another's experience (Bodenhorn & Starkey, 2005).

Empathetic Understanding: The ability to understand the client from an objective accurately or distanced perspective through intellectual means (Bayne & Hays, 2017; Ohrt, Foster, Hutchinson, & Ieva, 2009).

Secondary Traumatic Stress (STS): The stress that results from helping or being compassionate towards a suffering client. STS includes behaviors and emotions that occur from being confronted with the traumatic events of clients (Figley, 2002).

Self-Compassion: An awareness and recognition of one's suffering (Neff, 2015). It also includes acknowledgment of personal shortcomings and challenges, while embracing the ideology that human beings are flawed and inadequacies are a natural occurrence within the human experience (Fulton, 2016, 2018; Neff, 2015; Solomon & Barden, 2016).

Therapeutic Relationship: The professional and working relationship where the counselor engages with the client to develop a trusting, safe, and accepting rapport (Rogers, 1981; Stuntzner, 2017).

Trauma: An exposure to, by experiencing or witnessing, an event or situation that is shocking and dangerous with the perception that threatens life, potential for physical or emotional harm, and causes an overwhelming or significant distress (Finklestein, Stein, Greene,

Bronstein, & Solomon, 2015; Flint, 2018; Foreman, 2018; Sartor, 2016; U.S. Department of Veteran Affairs National Center for PTSD, 2016).

Wellness/Self-Care: Consisting of a balanced integration of social, emotional, spiritual, mental, and physical elements of a person throughout their lifetime (Myers, 1991). Both Wellness and self-care emphasize prevention and optimization of functioning (Lawson & Myers, 2011; Myers, 1991).

Working Alliance: A collaborative representation of the therapeutic relationship (Horvath & Luborsky, 1993). The working alliance applies to a variety of relationships: counselor-client, supervisor-supervisee, or counselor educator-counselor trainee.

Vicarious Trauma/Traumatization: A term that may be used interchangeably with secondary traumatic stress or compassion fatigue. It is a cumulative effect from working with traumatized clients by having repeated exposure to the traumatic experiences while witnessing and empathizing with the clients' fear and pain (ACA Traumatology Interest Network, 2011b, 2011a; Butler, Carello, & Maguin, 2017; Devilly, Wright, & Varker, 2009; Pearlman & Mac Ian, 1995).

Organization of the Study

Uncovering how counselors define compassion is vital to provide a foundation for future work to differentiate this trait in personal and professional contexts. The presentation of this study is in five chapters. The following chapters will highlight the steps proposed for conducting this necessary research. In Chapter One, the purpose, context of the study and the statement of the problem are outlined. A study to identify how experts within the profession of counseling and counselor education understand compassion is essential because compassion does not have an existing definition from a professional context. Chapter Two provides a review of the

literature related to this study. Included in Chapter Three is a detailed description of the Delphi methodology, the rationale for selection of a Delphi approach, panelist criteria and selection, details of each round of data collection, and how the data was analyzed. The results are presented in Chapter Four. Finally, Chapter Five provides a discussion of the results and ways the research impacts the counseling profession.

Chapter Two

Literature Review

Counselors strive to approach each client in a way that recognizes and appreciates the uniqueness of the individual. Counselor training emphasizes a holistic approach and a wellness model (Meyers, 2015). These comprehensive elements aid counselors in being empathetic and compassionate with clients, as well as creating a connected relationship to aid in healing. People are social by nature and crave connection with others (Barrett, 2013). Positive relationships allow for development to occur. Even within a helping environment where growth and learning occur within an individual, such as in a counseling relationship or during counselor training, people still seek out the connection with others (Barrett, 2013). The therapeutic relationship begins with the counselor being able to have an empathetic understanding of their client, combined with the desire to help lighten the struggle and pain of the client. A counselor has to use empathy with skill, and must also be able to put those skills into action through their compassion to help their clients. To accomplish this, counselors must understand the complexity of compassion within the boundaries of a professional relationship, to protect wellbeing for clients and themselves. However, only basic definitions and discussion exist in the professional literature regarding compassion. Exploring the history of compassion and what the counseling profession has been currently researching or discussing is an initial aspect to examine.

The following review of the literature will discuss the definitions of humane and humanism, explores humanism within counseling theories, and will highlight compassion and connection in a variety of world religions. The importance of empathy, which is a component of compassion, will be presented, followed by an exploration of compassion in the helping

professions. Then, a discussion on the examination of studies surrounding compassion is presented.

Humane and Humanism

Being humane is a way of behaving or acting that produces the least potential harm to others. The definition of humane is developed in concert with evoking the characteristics of tenderness, sympathy, and compassion, along with consideration of the suffering or distress an individual, or an animal, in concert with the changing sensibilities about people and animals (Maisel, 2017). Humanity is the collective term for all human beings. Additionally, humanity is considered a virtue connected with principles of self-sacrifice and a way of operating with moral and ethical excellence (Peterson & Seligman, 2004). The root of both of these words is human. The word human represents a characteristic of people, such as 'human strength.' When used in this manner, it elicits a distinctive representation of the word that follows and provides a descriptive quality. The phrase human can also depict a category of beings or the people as a whole, as in 'the human race' or humanity.

Furthermore, 'human' can be an adjective or characteristic that describes sympathy, compassion or being humane. All of these words connect back to the attributes of humankind and not animals or machines. The human quality is what generally conveys an authenticity, an attentive and fundamental benevolence. Through the exploration of the definitions, there is an overall association of connection and similarity. As different and unique as individuals within the human race can be, there are still fundamental qualities, such as compassion, that connects all people.

Counselors, operating with the foundation of the holistic and wellness model, assist in generating healthy life choices through compassion and encouragement of the client's human

capabilities (Myers, 1991). Clients and counselors bond when conversing and examining

concerns. The humanity of the authentic counselor allows for empathy and compassion to

establish the relationship (Scholl, 2011). The concept of connectedness and interdependence is

brought up frequently throughout various topics that intersect compassion. This interconnection

people have, by definition, is also upheld by many philosophies and religions, such as Buddhism

and Christianity (Belaire, Young, & Elder, 2005; Peteet, 2014; Stewart-Sicking, Deal, & Fox,

2017). The frameworks in counseling contain the connection to humanism.

Humanism in Counseling Theory

Humanism, the third force in counseling, provides a philosophical foundation for many

counseling theories, including person-centered and existentialism (ChÁvez, Fernandez, Hipolito-

Delgado, & Rivera, 2016).   Viewing human beings through this lens, individuals are

fundamentally worthy and responsible for identifying their purpose. Carl Rogers (1986), a U.S.

Psychologist and the founder of person-centered counseling, describes one foundation to the

person-centered approach as trust in the directional movement a client has toward a more

multifaceted development. Rogers asserts that the client has the internal resources for self-

understanding and the ability to adjust their self-concept to promote changes in their thinking and

behaviors (Rogers, 1981). Having a belief that the client is capable of growth and change, the

humanity of the counselor is the crucial factor in a counseling relationship (Pierce, 2016). The

existential philosophy adds depth to humanistic counseling by recognizing that people are not in

a static state, are continually trying to make meaning, and discover their own identities (Corey,

2005; Ibrahim, 1984). Existentialism focuses on the distinctiveness of the individual and the

uniqueness of the process of understanding (Pierce, 2016). Authentic relationships between

individuals, such as counselor-client, instructor-student, or supervisor-supervisee, indicate that

all people are impacted and changed by the encounters (Pierce, 2016). From a relational cultural lens, the emphasis is on connectedness with others through relationships that promote and nurture development (Corey, 2005; Duffey & Trepal, 2016; Ibrahim, 1984; Jordan, 2017; Ruiz, 2005). Overall, Humanistic counselors operate from a place of respect and empathy for individuals and thus seek to understand the world of the client through their subjective perspective by creating a powerful counselor-client relationship (Rogers, 2007). This relationship is paramount in trying to create an environment for change and growth (Duffey & Trepal, 2016; Jordan, 2017). Regardless of the theoretical approach, the working relationship created is the foremost pillar of the counseling profession.

Counselors are trained to address issues and concerns a client may bring up in sessions, including working within the client's belief system. Counselors also must meet competency requirements in addressing spiritual and religious issues in counseling (ASERVIC, 2018). The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) is a division of the American Counseling Association (ACA) that supports the infusion of these values within the counseling profession and educational preparation (ASERVIC, 2018). It is a best practice to recognize that the belief systems of the client and the counselor, have an influential factor in how an individual can view the world, themselves, and daily functioning (Giordano, Prosek, & Lankford, 2014).

Connection and Compassion in World Religions

For many, spirituality and religion are ways to make meaning for a place in humanity (Stewart-Sicking et al., 2017). Religion and spirituality can provide traditions and approaches to understanding connection and compassion. The idea of how people are connected and the motif of compassion are concepts that have ancient historical roots tracing back to early Egypt, Greece,

and Confucian times (Blackburn, 2003; Brill & Nahmani, 2017). A fundamental universal moral rule exists "in some form in almost every ethical tradition" (Blackburn, 2003, p. 79). Different cultures and religions may express this interchange in a variety of wording, in either affirmative action or adverse action. Loosely, the principle that guides the treatment of others is 'treat others the way you want to be treated' ("History of Golden Rule Day," 2018). This maxim is known as the 'golden rule.' The term for this common standard model and gauge for ethical treatment for others started being used in the 16th century because of the immeasurable value it holds across cultures (Rakhshani, 2017).

One of the principals in the Buddhist philosophy is that all sentient beings, or anything with a separate identity and individual conscience, have the natural tendency to attain happiness and be free from pain and suffering. There is no difference whatsoever in sentient beings, meaning that all are equal.   The fourteenth Dalai Lama, Tenzin Gyatso, writes in "The Compassionate Life" that a central law of nature is that people are interdependent and are all connected (Dalai Lama, 2003). Because of the interconnectedness, others are a primary source of many of our emotional experiences (Dalai Lama, 2003).

Additionally, the Dalai Lama professes that compassion is one of the predominant ideas in Buddhism (Dalai Lama, 2003). Compassion, as described in Buddhist philosophy is having the desire to remove the pain and suffering of another driven by the wish for freedom from suffering (Peteet, 2014). It is compassion that grounds and grants the ability to relate to events in life from "a broader perspective" (Dalai Lama, 2003, p. 2). He writes that people "not only need compassion and human affection to survive, but they are ultimate sources of successes in life" (Dalai Lama, 2003, p. 15). Although a Buddhist perspective defines compassion as positive thoughts and feelings, it is not merely an emotional response when we see someone suffering.

Compassion is a commitment, a choice, founded on reason with a focus on the needs of others. As the Dalai Lama (2003) eloquently states, "genuine compassion is based not on our own projections and expectations" (p. 21). Compassion should be developed through "constant and conscious effort" (Dalai Lama, 2003, p. 31). Developing compassion first requires identification of what personally fosters feelings of kindness and compassion towards the self and others. Through performing an exam of what may obstruct kindness and compassion towards the self and others, an individual may then consciously nurture these findings to better understand themselves. It is essential to know both what draws toward and pulls away from being compassionate (Dalai Lama, 2003). Gaining perspective on what may arouse or repulse compassion within the self can help a person recognize potential blind spots and points of strength in extending the abilities to ease suffering of the self or others.

Not only is the theme of compassion and connectivity highly prominent in the Buddhist belief system, but it is a motif recorded in sacred texts of other religions, such as Judaism, Islam, and Christianity (Brill & Nahmani, 2017). The Torah, in Judaism, is known as the law and refers to the five books of Moses (Rich, 2011). The term 'Torah' can also refer to the entire body of Jewish teachings. The written Torah, also called the Tanakh, outlines many commandments of treating all people with kindness (Rich, 2011). The Torah commands believers to protect each other, prevent harm to others, and help those in need (Rich, 2011). Jewish followers are instructed in Deuteronomy 10:19 to love the strangers ("Strangers and Gentiles," 2019) and to love all human beings ("The book of Vayikra (Leviticus): Chapter 19," 2019).

Rabbi Shai Held (2014), Director of the Center for Jewish Leadership and Ideas, discusses the Judaism Talmud teachings on the integration of the emotion and action, or of caring and doing. Rabbi Held explains how the Jewish teachings and laws demand followers to

care genuinely about others and to act in concrete ways to alleviate their suffering (Held, 2014).

One of the morals of the Jewish culture is that of the real need of others and the action to help.

Within the ELITalk by Rabbi Held, he states the ideal of Judaism is "the full integration of my

heart and my hand," which best describes the compassion of the Jewish belief system (Held,

2014). Jewish teachings, traditions, and commandments support the Golden Rule regardless of

the belief system of the other.

Christianity, which started as a sect of Judaism when the Roman Empire was ruling in the

first century, shares some of the same scriptures from the Jewish Torah (Hopfe, 1987; Illsley,

2018; Rich, 2011). Despite the variety of beliefs and practices, such as Catholics, Protestant, and

Eastern Orthodox, within the overarching religion of Christianity, some universal principles exist

(Illsley, 2018). The Holy Bible, consisting of two sections containing laws and commandments

for Christians, is believed to have been divinely inspired. The Bible is a term derived from the

Greek word *ta Biblia* meaning 'the books' (Wellman, 2013). The Old Testament, containing 39

books and believed to be written before the birth of Jesus Christ, shares some common books

with the Jewish Torah with similar teachings (Rich, 2011). The New Testament, consisting of 27

books, surrounds the teachings of Jesus and the new covenant between God and his people. This

historical text provides foundational support to the beliefs and teachings in Christianity.

The shared Jewish scriptures of Leviticus 19:18 and Deuteronomy 10:19, which are

found in the Christian Old Testament, instruct Christians in the same manner, to love all human

beings, and to love strangers. In the New Testament book of Luke, the passage states, "do to

others as you would have them do to you" (Luke 6:31, New International Version). Another

declaration found in the New Testament book of Matthew is: "So in everything, do to others

what you would have them do to you, for this sums up the law and prophets" (Matthew 7:12,

New International Version). While not explicitly written as the 'Golden Rule,' this aphorism is evident in the teachings of Christ.

Compassion in Christianity is expressed as a form of love and produces actions to alleviate the suffering of others. While compassion is not limited only to those who are Christians, there is a directive to the Christian believers to nurture this characteristic (Elwell, 2000). The instruction is to live a life focused on God so that the sinful and selfish nature diminishes while allowing the love and compassion of Christ to begin to flow through the believer (Elwell, 2000; Stanley, 2018). The Psalmist writes: "let your compassion come to me that I may live, for your law is my delight" (Psalms 119:77 New International Version). From a Christian perspective, compassion is a natural part of human nature that motivates the actions of mercy and kindness (Elwell, 2000). Christians believe that experiencing the unconditional love of God can empower an individual to love "both others and themselves" (Peteet, 2014, p.1193). Similar to the Jewish belief, Christians are directed to be kind and compassionate toward others, regardless of the other person's belief system.

This theme of ethical reciprocity and compassion can be found in Islamic teachings as well. The Islamic moral principle was recorded multiple times by the Prophet Muhammad, the founder of Islam, who is believed to be the final prophet of Allah (Elias, 2013; Hopfe, 1987). Writings in the Quran, the central religious text, are considered to be divinely ordained and guided by Allah as it was revealed to the Prophet Muhammad and interpreted by prophets and messengers ("Quran," 2018). The Islamic teachings state, "No one of you is a believer until he loves for his Islam brother what he loves for himself" (Frank, 1954, p. 267). Furthermore, Islamic followers believe that the messenger An-Nawawi stated that this principle of treating others is at the essence of good character and conduct (Elias, 2013). The Islamic faith also holds

sacred four prophetic traditions, one of which is the commandment for believers to love each other, to have good intentions to help others, and not to have harmful intentions for others (Elias, 2014).

Another religion that has confirmed the golden rule is Hinduism. Recorded teachings in Hinduism echo that of the other religions. Some refer to Hinduism as *Sanatana Dharma*, the eternal law (Dimock et al., 2018). Truth, according to the Hindu belief, must be pursued from many sources and not accepted because of doctrine (Dimock et al., 2018). The Mahabharata, one of the ancient Hindu texts within the Vedas, contains religious and moral material (Dimock et al., 2018; Rakhshani, 2017). The Hindu version of the golden rule leads to the way of eternal bliss (Rakhshani, 2017) and is stated as "that is the sum of duty; do naught to others which if done to thee, would cause thee pain" (Frank, 1954, p. 267).

Compassion, known as *Karuna*, is considered a higher virtue and is essential to enlightenment in Hinduism (Jayaram, 2019). Hindus believe that all living beings are part of a grander, universal family, known as *vasudaika kutumbam* (Jayaram, 2019). Because of this connection to a greater universal presence, believers are urged to recognize this connectivity and extend feelings of love and care to all beings (Hopfe, 1987; Jayaram, 2019). Compassion can be a pure action from a Hindu to those suffering, or compassionate actions can be impure or dark (Jayaram, 2019). Impure compassion can be motivated by pride or selfishness, while dark compassion stems from a desire to deceive others or cause them harm (Jayaram, 2019).

Other aspects of Hinduism also found in Buddhist philosophy that connects to compassion are *karma* and reincarnation. *Karma* is a continual succession of birth, death, and rebirth that is believed by numerous world religions, such as Buddhism, Hinduism, and Jainism (Hopfe, 1987). Reincarnation is the belief that upon dying, the soul comes back to life in another

body or form (Hopfe, 1987). When people live multiple lives through reincarnation, past relationships may not be distinct, nor may the associations be the same with each manifestation. The Dalai Lama (2003) instructs that all people should be treated well, as it is unknown if the person in the present was a best friend or worst enemy in a previous life. Hindus find it challenging to treat people according to only the present time, keeping this broader frame in mind. Due to the interconnection and understanding of the desire to seek happiness of all sentient beings, one can extend compassion to another. Therefore, all people deserve to be treated well and with respect (Dalai Lama, 2003).

Confucianism is a way of life established by Confucius in China during the 6th-5th century BC ("Confucianism," 2005; Sun, 2013). Confucianism is a philosophy that is humanistic and can be practiced in harmony with other religions ("Confucianism," 2005; Hopfe, 1987). A central principle in the Confucian philosophy is that of *ren*, or humaneness or benevolence (Sun, 2013). A written conversation between a disciple and Confucius in the Analects of Confucius depicts the golden rule: "is there any one maxim which ought to be acted upon throughout one's whole life? Surely the maxim of living-kindness is such. Do not [do to] others what you would not [want others to do to] you." (Frank, 1954, p. 267). Some translations use the term '*shu*,' or reciprocity, rather than living-kindness as the adage spoken by Confucius (Rakhshani, 2017). The heart of the Confucian philosophy is one of being humane.

The Dalai Lama (2003) communicates that genuine compassion is universal, and "all major world religions teach love, compassion, and forgiveness" (p. 47). He further imparts that without compassion, even religious beliefs can become detrimental when there is a lack of focus on that connectivity with each other (Dalai Lama, 2003). The golden rule is the most widely acknowledged moral principle found in nearly all world religions, philosophies, and ethics (Brill

& Nahmani, 2017; Huang, 2005). It may be the most global common denominator when it comes to the treatment and actions toward others (Rakhshani, 2017). Compassion and connection are the points of intersection that come together from a wide range of belief systems, religions, philosophies, and ethical considerations.

Overall, compassion is non-discriminatory and needs approaching with composure and level-headedness towards others (Dalai Lama, 2003). Interestingly, because compassion conjures images of working with and caring for others, it is the Buddhist teaching that points out the way to help is to exchange the self for others (Chodron, 1994). Compassion, which starts as being loving and kind inward to the self, then extends the desire to act on removing the suffering from others (Chodron, 1994). The action of compassion is taking responsibility and lightening the burdens of others. Counselors make a career of the act of compassion, yet there lacks support on the importance of compassion within the counseling profession (Sinclair et al., 2016; Stuntzner, 2017).

The Profession of Counseling

The counseling profession began with both a desire to understand the concerns of their clients (empathy) and to ease their distress (compassion). Career guidance was pioneered in the early 1900s in the United States with a systematic process of decision making that was developed by Frank Parsons to help young people make occupational decisions (Niles & Harris-Bowlsbey, 2017). Society had undergone an important shift from an agricultural-based economy to one based on manufacturing and industry; thus, the need for assistance in job-seeking emerged. People needed ways to gain access to newly created occupations. People also needed assistance in figuring out what jobs might best match their skill sets and traits (Niles & Harris-

Bowlsbey, 2017). Counselors wanted to help people overcome their struggles and assist in developing an understanding of their interests and capabilities.

As the profession matured and increased in areas of assistance, theories developed and adapted; however, one similarity with almost every theory is the significance of the working relationship between the client and the counselor. Despite the theoretical orientation of the counselor, the key is the relationship. This relationship is also known as the therapeutic alliance (Bucci, Seymour-Hyde, Harris, & Berry, 2016). Empathy is a key factor in the development of the therapeutic alliance (Kohut, 2010; Rogers, 1975, 1981, 1992). Empathy is a variable that affords the counselor to provide effective services (Figley, 2002). Figley (2002) further states that "without empathy, there will be little if any empathetic response to the suffering of clients. Thus, the ability to empathize is a keystone both to helping others and being vulnerable to the costs of caring" (p. 1436). Figley (2002) warns that there is potential for counselors to take on undue stress when working with clients. The strain of working with clients over time can lead to impairment.

Professional counselors face various risks, such as burnout and compassion fatigue (Biali, 2018; Lawson, 2007; Lawson & Myers, 2011; Sangganjanavanich & Balkin, 2013; Sprang, Clark, & Whitt-Woosley, 2007). Impairment can occur from either a personal aspect or a professional aspect, or both. Counselors need to be aware of their own, as well as colleagues' risks of becoming impaired enough to impact their work with clients (Lawson, 2007). It is imperative to know and understand the boundaries that keep counselors safely protected within ethical guidelines.

Counselors are expected to act ethically, and in a professional manner that promotes understanding of their clients, protects the trusting relationship built with clients, and honors the

responsibilities of being a counselor. Even within the professional counseling associations, such as the American Counseling Association (ACA) and the Association for Counselor Education and Supervision (ACES), guidelines exist regarding professional ethics and standards of practice to advance and improve the counseling profession. The current *ACA Code of Ethics* outlines core professional values within the preamble, including to enhance human development, support the uniqueness of clients, safeguard the counseling relationship, and practice competently and in an ethical manner (American Counseling Association, 2014). Furthermore, the fundamental principles of ethical counseling behavior within the *ACA Code of Ethics* direct counselors to avoid actions that may result in harm to clients and to do work that promotes wellness in mental health (American Counseling Association, 2014).

Also included in the *ACA Code of Ethics* (2014) in Section C on Professional Responsibility, counselors are to practice "within the boundaries of professional and personal competence" (p. 8) as well as participate in self-care activities to best meet the professional responsibilities. This section also addresses counselor impairment from either physical, mental, or emotional aspects (American Counseling Association, 2014).

The professional counseling organizations and educational accreditation organizations agree that counselors need to be: knowledgeable about the guidelines of ethical and legal standards, aware of characteristics to enhance the counseling process, protective of the relationships created in therapeutic settings, and work within the professional, ethical guidelines at all times. Additionally, each of the major professional organizations within mental health (e.g., American Psychological Association, National Association of Social Workers, American Psychiatric Association) operates under their specific ethical codes (Corey, Schneider Corey, & Corey, 2018). Even with the differences amongst the professions, there are still similarities.

Some common themes are: significance of client welfare, avoiding harm, establishing and supporting appropriate professional boundaries, differentiation of personal values and professional values, confidentiality, practicing within a high level of ethical and legal frameworks, and understanding the importance of self-care to practice in a competent manner (Corey et al., 2018). Overall as mental health professions, these standards have been thought out and agreed upon as pillars of the helping professions.

From the onset, counselors and other mental health helping professionals strive to operate from a place of empathy while working not to harm the clients. Ethical guidelines with the professional associations, educational and training guidelines, and best practices for those training or supervising counselors all honor the relationship and have a basis of empathy and compassion for the client.

Empathy

Before a focus on the importance of compassion in counseling can occur, there needs to be an exploration of empathy. Empathy is the instigator of compassion. In the most literal form, empathy is defined as an action of understanding, or vicariously experiencing, the thoughts, feelings, and experiences of another. Empathy is having the capacity for the sensitivity and imaginative perception of understanding an experience from the past or the present, when fully and explicitly communicated. It can be described as "the ability to take the perspective of another person's point of view" (Fulton, 2018, p. 45). According to the Dalai Lama (2003), the "first task of a practitioner of compassion and a good heart is to gain an understanding" (p. 29). First, a counselor needs to seek this understanding before being able to help with the removal of pain and suffering. Previously mentioned, Humanistic counseling theories focus on respect and

empathetic understanding of the unique perspective of the client (ChÁvez et al., 2016; Corey, 2005; Pierce, 2016; Rogers, 2007).

The humanity of the counselor allows for the empathetic understanding. Empathy establishes the relationship, and the relationship creates the environment (Duffey & Trepal, 2016; Jordan, 2017). Carl Rogers (1975, 1981) posited that the environment created between the counselor and the client is what is most assistive in fostering change or growth in the client. Furthermore, Rogers identifies three requirements in relationships to cultivate an environment that supports growth: congruence, unconditional positive regard, and empathetic understanding. Congruence is the counselor being genuine in who they are as a person and professional. The counselor acknowledges being invested in the relationship and is transparent with the thoughts and feelings occurring during the counseling sessions. The counselor creates a therapeutic climate through unconditional positive regard or accepting and caring for the client as they are in the present moment. Finally, empathetic understanding is the counselor actively listening to the client to sense the feelings and associated meanings with the ability to effectively communicate these back to the client for confirmation (Rogers, 1975, 1981, 1992).

To broaden the focus on empathetic understanding, Rogers (1975) begins by describing empathy as a "very special way of being with another person" (p. 1). Rogers (1975) further states that empathy is "one of the most delicate and powerful ways we have of using ourselves" (p.1). Through this statement, Rogers begins a shift from the previous counseling thought where the counselor is the expert, to one that would take account of the counselors' supportive role in the process of the clients' healing. In 1959, Rogers gave a more thorough definition of empathy that described it as a state of perception to the internal frame of reference of another (Clark, 2010a). Roger's description of empathy expanded to include the emotions and the meanings

associated with the other person. In this definition, understanding the client "as if" the thoughts, feelings, and events are occurring to the counselor must be persistent, or the state of identification is lost (Clark, 2010a). Over time, Rogers continued to investigate empathy in further complexity. In his 1964 work, Rogers outlines empathy in three ways: subjective, interpersonal, and objective. Subjective empathy allows for identification with a client based on the counselors' insight and imagination. Interpersonal empathy occurs when the counselor explores the phenomenological perspective of the client. Objective empathy is the use of theoretically-driven knowledge and data in attempts to understand the client (Clark, 2010b).

Rogers updates his definition of empathy again in 1975 with a modification that empathy is a complex process, rather than only a trait or state (Rogers, 1975, 1992). He further embraces the concept of experiences, which aid in giving a 'felt meaning' to what the person may be having at the moment (Rogers, 1975). During the time of Rogers' 1975 writing, there had been an increase in approaches in counseling that held the counselor as the expert. These approaches, including Gestalt therapy, rational-emotive therapy, and transactional analysis, involve the counselor actively directing the counseling sessions for the best interest of the client. Rogers (1975) recognized a change in willingness to examine counseling that shifted the power back to the client as the expert to evoke self-directed change. He further indicated that "the empathetic process can be defined in theoretical, conceptual, subjective, and operational ways" (Rogers, 1975, p.4).

Person-Centered therapy is not the only theory to proclaim the value of empathy. Other theories that include empathy as a construct are: self-psychology, existential therapy, cognitive and cognitive-behavioral therapies, psychoanalytic therapy, and a few different contemporary approaches (Bodenhorn & Starkey, 2005; Clark, 2010a). One such theory is self-psychology,

originated by Heinz Kohut (2010), an Austrian-American psychoanalyst. Self-psychology emphasizes using interpersonal relationships to develop a sense of self and contends that empathy is vital in creating the therapeutic relationship which can mitigate mental health disturbances (Clark, 2010a; Corey, 2005; Kohut, 2010). In a final speaking engagement, Kohut (2010) described empathy as "vicarious introspection" or a way of examining physical and internal events of clients both theoretically, as well as through others' accounts that were there first hand. He further stated that empathy is a therapeutic and beneficial action, which supports Rogers' explanations (Kohut, 2010).

Kohut does warn of the negative side to empathy, which echoes the Hindu teachings on the impure and dark components to compassion (Jayaram, 2019; Kohut, 2010). The Dalai Lama also highlights human nature for the potential to be good and loving, but also to "have the potential to be miserable and harmful to others" (Dalai Lama, 2003, p. 11). Ultimately, a choice exists on how to treat others. Kohut (2010) explains using empathy with harmful intent by telling the story of the Nazi military bombings during World War II. The Nazi's bomb construction had a mechanism that whistled as the bomb left the plane and plummeted towards the target. The Nazis negatively used empathetic understanding through understanding how the whistling noise would elicit fear in the people while awaiting the impending impact (Kohut, 2010). People hearing the bombs falling through the sky also created an understanding of what was happening to others in the line of fire. The Nazi military was using empathy as an emotional manipulator in creating an environment of fear, helplessness, and mortality. For counselors, being empathetic with clients in and of itself does not nurture a positive environment for change. It also requires the desire to help and to do no harm (American Counseling Association, 2014).

Since Rogers' initial concept of empathy, which includes intellectual and emotional components, numerous counselor researchers have defined empathy with various constructs (Bodenhorn & Starkey, 2005; Duan & Hill, 1996; Fulton & Cashwell, 2015; Trusty, Ng, & Watts, 2005). Initially, empathy was considered a human trait, an intrinsic ability to perceive and appreciate another person's thoughts and feelings (Bodenhorn & Starkey, 2005). Over time, the complexity of empathy was recognized (Bayne & Hays, 2017; Clark, 2010b, 2010a; Kohut, 2010; Rogers, 1975, 1981, 1992). Despite the view of empathy as a key construct for therapeutic relationship development and treatment outcomes, there is a lack of a standard or consistent definition (Bayne & Hays, 2017).

Bodenhorn and Starkey (2005) identified a central theme in the counseling literature defining empathy, which is cognitive and affective attunement to the experience of another. In more recent research, Bayne and Hays (2017) conducted a broad review of empathy and discovered an assortment of conceptual frameworks and definitions. Dimension groups for the conceptual definitions are as follows: affective, moral, cognitive, behavioral, and neurological (Bayne & Hays, 2017).

The affective, or emotional, dimension is a counselor being able to genuinely connect with the emotional expressions/experiences of and have feelings of concern for the client (Bayne & Hays, 2017; Fulton & Cashwell, 2015; Ohrt et al., 2009; Trusty et al., 2005). This dimension includes an internal sensitivity of the counselor's emotional responses and a realization about the influence of the relationship with the client (Steward, Powers, & Hanik, 1998).

According to Dr. Frans de Waal (2009), a Dutch American biologist and primatologist known for work surrounding the behavior and social intelligence of primates, empathy is connected to morality and cooperation (de Waal, 2009; Keltner, Marsh, & Smith, 2010). In the

world of primates, de Waal discovered that attention must be paid to the goals and activities of others to be able to work together effectively (de Waal, 2009; Keltner et al., 2010). Similarly, counselors attend to client goals and activities; another identified dimension of empathy linked to morals. The moral dimension of empathy is the motivation of the counselor to connect and understand the client's reality (Bayne & Hays, 2017). Zaki (2014) suggests that empathic processes are contextually dependent, and while empathy can be intuitive, it may not always be automatic. There is a natural ability to feel empathetic, but the context will drive whether a move towards or away from, empathy will be made (Zaki, 2014). Based on the context of the situation, people must intentionally decide on expressing empathy (Bayne & Hays, 2017; Zaki, 2014). There is a choice in applying empathy, in either positive, negative, or neutral ways, as Kohut (2010) and the Hindu or Buddhist philosophies previously warned (Dalai Lama, 2003; Jayaram, 2019). Empathy is fragile and can be switched on or off (de Waal, 2009; Keltner et al., 2010). For example, Zaki (2014) points out how conflicts between two groups can lead to being less empathetic to the other group members, such as in a rivalry or during wartime.

Another contextual example by Zaki (2014), where empathy is not automatic, is within the medical profession. Physicians or nurses may not always be able to fully express their empathetic understanding of patients as it may interfere with being able to fully complete their job tasks, which may include inflicting further pain to benefit the patient's wellbeing (Zaki, 2014). Based on this information, a counselor exhibiting empathetic connection ties into the purpose of choosing to connect with clients (Bayne & Hays, 2017). This work also connects with the disengagement counselors use to reasonably set aside their thoughts and feelings that come up when working with clients to aid in protecting their compassion stress and potential fatigue (Figley, 2002).

Being able to understand the client accurately from an objective or distanced perspective through intellectual means describes the cognitive dimension (Bayne & Hays, 2017; Ohrt et al., 2009). An empathetic understanding of a client can be enhanced when counselors draw upon their knowledge and use "theoretically informed resources" (Clark, 2010b, p.351). Therapeutic relationships and interactions with clients enrich when leaning on the cognitive dimension. This dimension also includes drawing upon the understanding of the phenomenological world of the client and being able to integrate treatment strategies and interventions which best suit the need of both the situation and the individual client need (Clark, 2010b). Moving from empathetic understanding to interpreting and explaining is what bridges creating the helping environment toward a healing environment. Kohut (2010) relates this as a movement from a lower to a higher form of empathy.

The behavioral dimension is best expressed as the counselor's ability to intellectually take the point of view of the client and communicate verbally and non-verbally the perception of the client's experiences in a non-judgmental way (Bodenhorn & Starkey, 2005; Fulton & Cashwell, 2015; Rogers, 1975). When a counselor can convey an awareness of the client's viewpoint, the outcome is that clients feel understood, understand themselves better, and communication is deepened and made more personal (Bodenhorn & Starkey, 2005).

Finally, the neurological dimension is an observation of another's experience that creates a vicarious response in the observer (Bayne & Hays, 2017). Neuroscience research indicates that observing someone else in action activates similar neurological reactions in the brain of the observer as the individual performing the act (Clark, 2010a). This simple neurological response of empathy is also known as mirror neurons (Echterling, Presbury, & Cowan, 2012). Through the neuroscience research, we know that mirror neurons can be found throughout the brain and

are considered the building blocks of empathy (Echterling et al., 2012; Ferrari, 2014; Keltner et al., 2010). Based on studies of primates by de Waal (2009), empathy comes naturally and evolves with more complexity, but is still based on earlier, simpler forms of empathy (de Waal, 2009; Keltner et al., 2010). Physiological measures in the skin, heart rate, undetectable facial reactions, and electromyography (EMG) assess the changes within muscles that can be made during an empathetic response (Ohrt et al., 2009). Functional magnetic resonance imaging (fMRI), which measures brain activity, has been used in studies to measure responses to real and imagined pain of a loved one (Ohrt et al., 2009). The findings of these studies revealed activity in the thalamus, the insula, somatosensory cortices, and the anterior cingulate cortex (Ohrt et al., 2009). The anterior cingulate cortex, a part of the brain that is towards the front of the head, connects the cognitive and emotional sides of the brain (Echterling et al., 2012; Ohrt et al., 2009). When mirror neurons are triggered for a counselor while observing or listening to a client share emotions and experiences, that counselor's own previous experiences and emotions aid in the potential empathetic understanding of the client.

Many researchers in counseling extend Rogers' empathetic framework which provides support for using the various and complementary means of understanding a client (Bodenhorn & Starkey, 2005; Clark, 2010b, 2010a; Fulton & Cashwell, 2015; Ohrt et al., 2009; Trusty et al., 2005). Empathy and introspection can inform counselors of appropriate actions through an understanding of the inner life of a client (Kohut, 2010). Exploring multiple ways to gain that empathetic understanding of a client can reduce possibilities of biases and distortion (Clark, 2010b). Literature supports that empathy is complex, and counselors draw from a multitude of cognitive and affective processes to create connection and understanding with clients. Empathy is an integral part of the therapeutic process.

Importance of Empathy in Counseling

Empathy is a cornerstone in creating a relationship with a client and is essential in the therapeutic process to foster change (Clark, 2010a; Rogers, 1975), which has been well researched and documented in the counseling literature. Many theoretical approaches acknowledge the importance and value of empathetically understanding and connecting with a client (Bodenhorn & Starkey, 2005; Clark, 2010a; Figley, 2002; Fulton & Cashwell, 2015; Ohrt et al., 2009; Trusty et al., 2005). Professional literature has achieved a consensus that empathy is a "core condition in facilitating the treatment relationship in counseling and psychotherapy" (Clark, 2010, pp. 348). Counselors develop rapport and trust with clients through empathy (Bodenhorn & Starkey, 2005). It is considered a fundamental helping skill and a vital element in counselor training to foster a successful therapeutic relationship (Bodenhorn & Starkey, 2005; Fulton & Cashwell, 2015; Ohrt et al., 2009; Trusty et al., 2005). When clients believe their counselor has an empathetic understanding of them, they are more satisfied with counseling, are more involved, and have higher probabilities of compliance with treatment (Clark, 2010a, 2010b; Fulton & Cashwell, 2015). Gaining investment from clients in counseling is crucial in establishing a good working alliance (Trusty et al., 2005).

However, the counselor may not have similar enough experiences to allow for a genuine enough connection to the client's experiences. A counselor with limited perceptions or life experiences may have difficulties relating to a client. The same is true when counselors have a very different cultural background from clients.   Because of past experiences as individuals, counselors can have difficulties identifying with clients or finding commonalities with similar incidents. Clark (2010b) states that counselors who experience difficulties moving out of a state of identification with the client hinder the counseling work. Counselors may use their intuition,

imagination, connection, and self-experience to understand clients, but may not realize the link with empathy. The training a counselor has undergone provides the impartial empathy, which is based on counseling theories and empirical resources to assist the counselor in conceptualizing and understanding a client in a way that enhances the self-report of the client (Clark, 2010a). It is valuable for counselors to know and understand the various counseling theories and leverage resources in training to enhance empathy.

The initial and ongoing education of counselors intersects the point of the professional relationship with clients. This background of the counselor helps to enrich the interactions and relationships with clients. By leaning into a multifaceted approach to empathetic counseling, counselors may be able to integrate variable counseling approaches and different knowledge bases to understand a client better (Clark, 2010a). The importance is placed on the relationship to foster change; therefore, the therapeutic relationship and working alliance are a central part of the counseling process (Rogers, 1981; Sackett & Lawson, 2015).

Therapeutic Relationships and Working Alliance

Counseling places humanity at the heart of the counseling relationship because counselors are working to connect with their clients on individual levels (Pierce, 2016). Previous research has established that people are social and crave connections with others (Barrett, 2013; Jordan, 2017). From a philosophical and religious point of view, there is a connection between humans and other living organisms (Dalai Lama, 2003; de Waal, 2009; Hopfe, 1987). Regardless of specific religious or spiritual affiliation, people have a primary natural and instinctive drive to make connections with each other. Because of this desire for connection, mental health is fundamental to the basics of humanity (Dalai Lama, 2003). Psychological benefits of empathy and compassion are increasing inner strength, a decrease in fear, and more

self-confidence (Bond et al., 2018; Dalai Lama, 2003; Gladstein, 1983; Trusty et al., 2005). Additionally, because the professional relationships between clients-counselors, supervisors-supervisees, and counselor educators-counselors-in-training are necessary to foster growth and change, a brief exploration of the therapeutic working alliance will follow.

A working alliance, whether between a counselor-client, supervisor-supervisee, or counselor educator-counselor-in-training, is defined as a collaborative representation of the therapeutic relationship (Horvath & Luborsky, 1993). This developing relationship is positive with a reality-grounded viewpoint; it combines the skills and knowledge of the supervisor, or counselor, with the supervisee, or client (Bernard & Goodyear, 2014; Horvath & Luborsky, 1993). Because the alliance is dynamic, change within the relationship occurs as the needs vary across time (Horvath & Luborsky, 1993). Additionally, regardless of the theoretical approach of the counselor, much of the success in treatment can be attributed to the therapeutic relationship, which is a necessary element of the counseling process (Sackett & Lawson, 2015).

Initially, the counselor engages with the client to develop a trusting, safe, and accepting relationship (Rogers, 1981; Stuntzner, 2017). Counselors lean into their empathy to gain understanding into the client's frame of reference to create the connection (Clark, 2010b; Rogers, 1975, 2007). Once that relationship is established, and the counseling progresses deeper into a stage of working to address client concerns, the working alliance shifts to one of working together with shared responsibilities on goal attainment (Andrade-González, Lahera, & Fernández-Liria, 2017; Horvath & Luborsky, 1993). The working alliance moves from the counselor being mostly supportive and encouraging of the client towards a sense of 'we,' which conveys the investment of the counselor and the professional bond the client may feel with the counselor (Horvath & Luborsky, 1993). Horvath and Luborsky (1993) discuss that the positive

working alliance between the counselor and client is not what causes the healing or growth of the client, but rather it is one component that encourages the client to embrace making the changes and to muster the courage to work toward goal achievement.

Each individual entering into the relationship comes with their own set of personal histories, which may potentially influence to strengthen or weaken the alliance (Horvath & Luborsky, 1993). These relationships, even though they are within professional boundaries, have an effect on both individuals, which informs their future encounters with others (Pierce, 2016). When people reinterpret previous personal experiences to make meaning from the events, there exists a potential to understand themselves, others, or things that have happened in their life (ChÁvez et al., 2016). Counselors should be aware of their histories, which can be a filter or even a barrier when working with clients. Similarly, counselors need to obtain a good account of their clients so they may be aware of experiences that may be influential in the working alliance.

Carl Rogers (1981) describes the relationship between the client and the counselor as being in a continuous, simultaneous state of building and disintegration. As one area of the bond strengthens, another area deteriorates, all of which is organic and supports the natural complexity of relationships (Rogers, 1981). This interactive ebb-and-flow of the ties can aid the client in feeling connected to higher universal consciousness. Rogers (1981) describes this more so during group work, where there is still substantial preservation of the individual selves while still feeling connected to a broader feeling of 'we-ness.' The therapeutic relationship can be one of the most significant components offered by counselors (Rogers, 1981, 2007; Sackett & Lawson, 2015). Descriptions and definitions of the therapeutic relationship echo the connections between individuals to a more significant aspect from the spiritual, religious, and philosophical perspectives. The counseling profession research has recognized that empathy is an adaptive

trait that is essential in a therapeutic relationship. Compassion is an adaptive trait as well, yet there is little discussion or support within the literature.

Compassion

Counselors need both compassion and empathy to work with clients effectively (Beaumont et al., 2016; Figley, 2002). Compassion, whether expressed towards the self or to others, is considered another fundamental aspect in counseling (Fulton, 2018). Most counselors report the reasons behind entering their chosen profession are to be of help to others or to make a difference in the lives of others (Radey & Figley, 2007). When counselors begin working with clients, they seek to gain understanding through empathizing (Figley, 2002; Giordano et al., 2014; Kohut, 2010; Rogers, 1975, 1981). Once the empathetic understanding begins to occur, and the therapeutic relationship begins to build, counselor compassion takes a more prominent role. This compassion arises because many counselors are "devoted to the cause of helping people address the challenges they are facing in life" (Lawson, 2018, p. 5). Counselors not only want to understand their clients, or show empathy, but also want to assist in lessening the distress of our clients, or show compassion (Figley, 2002).

Compassion is a conscious awareness of distress in others accompanied by a desire to alleviate their suffering. Empathy is the feeling and understanding, or the noun, where compassion is the action of supporting the client, or the verb. Neff (2015), who studies self-compassion, describes compassion more straightforwardly as "a way of relating to suffering, your own, or someone else's" (p. 187). Furthermore, compassion is more than simple awareness of distress, but empathetic understanding that engages the heart's desire to respond to another's pain (Neff, 2015). Offering understanding coupled with kindness, rather than judgement, is central in compassion (Neff, 2015). Neff (2015) states that feeling compassion and not pity for

another, connects people with the shared human experiences of suffering, failure, and imperfection.

Even within education there are descriptions of compassion as suffering together, such as "to have compassion means that you are in solidarity with those who are suffering" (Poppo, 2006, p. 33). Poppo (2006), an educator who challenges the teaching community to use the pedagogy of compassion, writes that through the connection and understanding the suffering of others, the overall human society is heightened. This solidarity with the distressed in education outlined by Poppo connects the learning as a shared purpose and echoes the work of Paulo Friere. Sinclair and colleagues (2016), in a medical study, conclude that "compassion implores vulnerability on the part of health care providers to engage and relate to patient suffering from a place of shared humanity" (p. 202). Many of the writings and definitions surrounding compassion stress the significance of the relationships and the bonds between people.

Compassion in the Medical Field

To begin the appraisal of compassion within the helping professions, an extensive body of literature exists regarding compassionate care in the medical field. The first principle of medical ethics in the *American Medical Association Principles of Medical Ethics* is "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" (American Medical Association, 2001). Empirical evidence supports improved clinical outcomes and increased patient satisfaction when physicians treat patients with compassion (Kelm, Womer, Walter, & Feudtner, 2014; Strauss et al., 2016). Studies have explored compassionate care and treatment results. Currently, there is an upward trend in examining compassionate care perceptions from both the physician and the patient viewpoint (Sinclair et al., 2016). In a review of the literature in health care, Sinclair and colleagues (2016)

comment that the "literature within health care invoking compassion, and its importance, these writings are largely theoretical, rhetorical, and fail to incorporate the conceptualizations" (p. 194). Within the medical segment of health care, compassion is a pinnacle of quality health care.

Nevertheless, empirical evidence to define the attributes of compassion is lacking, which may hinder or assist compassion in clinical settings (Sinclair et al., 2016). It may be that there is an assumption within the medical profession that the value and meaning of how to demonstrate compassion in professional settings is understood. Perhaps the view of compassion is as a natural trait for those who enter into the helping professions. While compassion may be considered "a hallmark of quality care" (Sinclair et al., 2016, p. 193) throughout health care in general, it is especially important in the field of counseling.

Recently, there has been a surge of studies in the United Kingdom (UK) within health care, nursing specifically, on how to measure and teach compassion. A report in 2012 by the Commission on Dignity in Care for Older People made some significant recommendations for increasing compassionate care in hospitals and assisted living homes (Dean, 2012). Because of the highly publicized failure of patient care in the UK over the past recent years (Bond et al., 2018; Dean, 2012), there has been an increased awareness and growing concern regarding compassion within health care on an international level (Bond et al., 2018). One recommendation by the UK Commission was to focus on compassion in the training of nurses, along with technical and clinical skills (Dean, 2012). Studies in nursing reiterate "that there remains a limited understanding of what compassion actually means in the context of health care, with a lack of coherency noted across the literature in how compassion is defined" (Bond et al., 2018, p. 3082).

Furthermore, as mentioned in other disciplines, the research is deficient, using only broad definitions in differing ways (Bond et al., 2018; Sinclair et al., 2016; Strauss et al., 2016). Currently, efforts are being made to study compassion in different health care disciplines and explore ways to incorporate training into educational settings. The overall theme within the helping professional literature is that an agreed-upon definition of compassion is lacking, both in the workplace setting as well as in the training environments.

Compassion in Education

Compassion in an educational setting has been a topic of focus since the 20th century with the work of Janusz Korczak (Poppo, 2006), John Dewey, and Marie Montessori. Each had an approach to education that was child-centered. Korczak's educational philosophy and pedagogy embrace that the child, or student, should be respected and fully understood (Lewowicki, 1994). Having the social learning and constructivist view on learning from Dewey and Montessori, combined with Korczak's ideas on respecting and understanding the student as an individual, contemporary approaches of critical compassionate pedagogy draws some strength from these roots. Paulo Freire, a Brazilian educator and literacy campaigner for Latin American education, points out that learning is a dialogue between the learner and the teacher (Kidd, 1972; T. Smith, 2019). His critical examination on the teacher-learner shifted the thinking from a one-way concept of transporting knowledge from the teacher to the learner to a liberated methodology of the teacher and learner working together to discover the subject in new ways (Kidd, 1972; T. Smith, 2019). Critical compassionate pedagogy integrates the essential thoughts of Freire and the ideology of compassionate communication to critically examine institutional practices while using compassion to be reflexive of their teaching practices (Hao, 2011). Compassionate

communication, also known as nonviolent communication, is way of listening and speaking more effectively with others that promotes connection and empathy (Rosenberg, 2003).

Critical compassionate pedagogy is a way to mutually work with students to best meet the needs of the educator and the learner; it enhances the relationships between the educator and learner through connection, understanding, and communication of feelings and needs (Hao, 2011). Just as in creating a supportive and trusting environment to foster change and growth in the counseling room, it is essential to develop that working relationship in the classroom for a learner of any age.

Having the instructor teach from a compassionate perspective is not the only example of compassion in education. Recently there has been a shift in objectives to educate and measure compassion in health care, studies are being conducted to examine how to measure and teach compassion to those in the helping professions. For example, a study published in the Journal of Clinical Nursing in 2018 investigated the socially constructed concept of compassion in health care in the UK (Bond et al., 2018). In the writings, Bond and colleagues (2018) suggest that compassion is "socially constructed through language" (p. 3802). Findings from the study support that compassion, from the data collected, is both an inherent trait and an attribute that could be cultivated through training (Bond et al., 2018). Although, there does seem to be some controversy about the idea of nurses being able to learn compassion (Bond et al., 2018). Bond and colleagues (2018) explain that through using language with a patient, compassion can communicate professional conduct and form compassion within the practitioner.

A medical study published in 2016 supports the work of Bond and colleagues regarding the unspoken language of compassion. The researchers interviewed 126 adult cancer patients in Canada to identify a patient's perspective and experiences in compassion while receiving health

care (Sinclair et al., 2016). Sinclair and colleagues (2016) explored compassion from a patient's understanding at the end of life rather than from the health care provider. This seminal work offers a model of compassion to identify and categorize core components of compassion from this specific patient population (Sinclair et al., 2016). Interestingly, this study also highlighted that patients identified compassion in their physicians as a disposition as well as non-verbal communication actions (Sinclair et al., 2016). Many of the non-verbal communication actions listed, such as listening, presence, relatedness, and creativity, are the foundational attending skills for counselors.

Negative Impacts on Compassion in Counseling

As in many of the other helping and health care professions, compassion is an assumed disposition held by counselors as it is this desire to help alleviate the suffering of others through their work in the varied counseling settings. In keeping with this, there is not currently an agreed-upon understanding of either compassion or the skills, attributes, and behaviors associated with demonstrating compassion in the counseling profession. At this time, a theory, philosophy, guideline, best practice, or textbook to reference does not exist to distinguish this counseling skill. What is existent in the body of literature is empirical evidence that touches on areas of compassion in a responsive way relating to burnout or compassion fatigue. The profession has identified what happens when our compassion for working with others begins to break down.

On the contrary, numerous studies support ways to safeguard compassion through compassion satisfaction, wellness, or self-compassion. There are markers to ascertain if a counselor is satisfied and fulfilled with their job, as well as methods to take care of the counselor's wellbeing. Unfortunately, limited research exists on compassion. Literature that has

occurred has been to explore ways to mitigate the erosion of compassion or and reactionary studies surrounding what has happened when compassion begins to fracture or fail. The following sections will review the studies on compassion in the literature, beginning with burnout and compassion fatigue.

Burnout. Burnout occurs when a person continually encounters emotionally demanding conditions in the workplace. The origins of the term 'burnout' began in the early 1970s by a psychiatrist and a social psychologist. Dr. Freudenberger was the psychiatrist who examined negative changes in coworkers at his place of employment and Maslach was a social psychologist, who interviewed human service workers on their emotions in the workplace (Maslach et al., 2001; Melvin, 2015; Thompson et al., 2014). The connection between the health care professional and the recipient was at the center of the studies. The initial research began in the caregiving and helping professions; thus, the attention surrounding the stressors from the interpersonal transactions inspired the introductory phase to explore and formulate the experience of burnout (Lee et al., 2007; Maslach et al., 2001). In the 1980s, the shift in research turned from the qualitative descriptions of burnout toward a quantitative assessment of burnout (Maslach et al., 2001). Researchers sought out ways to identify, assess, and measure variables relating to burnout. Maslach and Jacson (1981) created the Maslach Burnout Inventory (MBI), the most commonly utilized assessment for variables of exhaustion, depersonalization, and lack of achievement. The focus in the 1990s increased analyses to include other types of business and industrial organizations (Maslach et al., 2001; Melvin, 2015). This shift also saw the development of theoretical structural models and practical implications to further examine and define burnout (Maslach et al., 2001). Subsequently, the concept has been developed into "a continuum between the negative experience of burnout and the positive one of engagement"

(Melvin, 2015, p. 67). At present, there are numerous studies and models in existence on how to diminish the consequences of such intense work.

The literature has developed the concept of burnout as "a psychological syndrome in response to interpersonal stressors on the job" (Maslach et al., 2001, p. 399) and characterized by three components: physical and emotional exhaustion, depersonalization/cynicism, and a reduction in personal efficacy (Biali, 2018; Lawson, 2007; Maslach et al., 2001; Thompson et al., 2014). Exhaustion is the factor that is the most significant predictor of burnout and the most evident symptom (Maslach et al., 2001). It is the feeling most frequently mentioned when people describe experiencing burnout and can mean being overwhelmed both emotionally and physically (Maslach et al., 2001; Ray, Wong, White, & Heaslip, 2013). The exhaustion can lead to feelings of negativity or detachment from work, which may be a coping mechanism to disengage from the emotionally demanding conditions (Maslach et al., 2001; Ray et al., 2013). Furthermore, a lack of empathetic concern for the clients and potentially negative feelings about themselves and clients stem from the detachment or depersonalization of the counselor (Maslach et al., 2001; Sangganjanavanich & Balkin, 2013). Reduction in personal efficacy, the third component of burnout, can be described as lack of confidence at work and feelings of dissatisfaction and underappreciation in their job (Sangganjanavanich & Balkin, 2013; Sprang et al., 2007).

Additionally, the empathetic nature of the relationship between counselors and clients can support conditions to increase the risk of burnout (Everall & Paulson, 2004; Thompson et al., 2014). The environment that counselors work in can be particularly intense due to the issues and concerns of clients. Thus, counselors can be markedly vulnerable to burnout (Lawson, 2007). Other factors related to burnout can be linked to the working organization itself and not the

interpersonal relationships (Everall & Paulson, 2004; Lawson, 2007; Maslach et al., 2001; Melvin, 2015; Sprang et al., 2007). Evidence supports that burnout does not have a significant correlation to the counselor's reaction to exposure to their clients' distressing narratives nor countertransference, which are the personal psychological responses a counselor may have in response to the client's behaviors (Figley, 2002; Sprang et al., 2007). Examples relating to the broader job characteristics which can accelerate burnout include heavy caseloads, unsupportive co-workers and supervisors, time pressures, role conflict or ambiguity, and lack of feedback (Lawson, 2007; Maslach et al., 2001; Ray et al., 2013; Thompson et al., 2014).

Although burnout occurs mainly because of the working environment, there may also be aggravating factors stemming from a counselor's private life. Figley (2002) identified personal factors that can hinder satisfaction as life disruptions. Disruptions in routines or other responsibilities within life add to a counselor's stress levels. While usually, these stressors are manageable, when a counselor is feeling overextended or burdened by the workplace factors, the combination may intensify the possibility of burnout (Craig & Sprang, 2010; Everall & Paulson, 2004; Figley, 2002; Sprang et al., 2007).

The symptoms of burnout are real, and emphasis in the literature is on the impact of burnout. Figley (2002) explains that burnout has a slower onset than some other forms of counselor impairment and can gradually increase over time. Being overly stressed or in later stages of burnout, counselors become impaired, which in turn impacts their work with clients. Counselors can become disengaged from their jobs, colleagues, and clients (Maslach et al., 2001). Burnout can lead to physical or mental exhaustion and ineffectiveness in working with clients (Lawson, 2007; Maslach et al., 2001). Clients are impacted by their impaired counselors through missed appointments, decreased effectiveness during sessions, lack of compassion or

empathetic concern for the client, or the counselor having intentions of changing jobs (Lawson, 2007; Maslach et al., 2001). Colleagues can also be impacted due to the counselor's disengagement, increased work disputes, or potential absorption of the cynicism because of emotional attunement (Maslach et al., 2001).

As the understanding of the phenomenon of burnout expanded, so did the recognition, differentiation, and treatment. In more recent years, studies focused on burnout in conjunction with compassion fatigue, secondary traumatic stress, and vicarious trauma.

Compassion fatigue. Compassion fatigue was initially coined in research with nurses in the 1990's (Ray et al., 2013; Yilmaz & Üstün, 2018) and describes when a person loses the interest, or even ability, to help alleviate another person's suffering (Joinson, 1992). Compassion fatigue can be defined "as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal associated with the patient" (Figley, 2002, p. 1435). A counselor approaching or suffering from compassion fatigue may feel confused or helpless in working with clients and may feel somewhat isolated from their support systems (Figley, 2002; Radey & Figley, 2007; Sprang et al., 2007). Concerning burnout, compassion fatigue consists of more advanced symptoms and psychological disturbances (Figley, 2002; Sprang et al., 2007). Additionally, compassion fatigue can develop abruptly (Figley, 2002) and have factors associated with contributing to it being a cumulative response from counselors work with clients that have been traumatized (Sartor, 2016; Sprang et al., 2007). Some factors that are connected to compassion fatigue are: having a history of personal trauma which has not yet been resolved, feelings of dissatisfaction with working in counseling, inadequate or lack of self-care, and work stressors which may be out of the ability of the counselor to control (ACA Traumatology Interest Network, 2011b; Radey & Figley, 2007).

Figley (2002) expounded on the concept and in 1995 introduced a causal compassion stress and fatigue model with eleven variables, which may stimulate compassion fatigue and identify ways to help manage or repair the fatigue (Sprang et al., 2007). The model assumes that a counselor's "empathy and emotional energy are the driving force" (Figley, 2002, p. 1436) in effectively working with clients. Furthermore, a counselor's compassion and empathy, along with emotional energy, are at risk when repeatedly engaging with distressed clients (Figley, 2002). An assessment was developed by Figley and Stamm (1995) to identify the estimated status of a person's compassion. The Compassion Satisfaction and Fatigue (CSF) test is self-administered, consisting of 66 questions to determine the current potential for burnout, compassion fatigue, and compassion satisfaction (B. H. Stamm & Figley, 1996).

Through the exploration of compassion fatigue, there have been other terms connected or used interchangeably. Secondary traumatic stress and vicarious trauma are terms that will be explored to help differentiate from compassion fatigue.

Secondary traumatic stress. First, it is necessary to discuss trauma to grasp the concept of secondary traumatic stress. Many of the clients that counselors serve have been exposed to broad ranges of traumatic events to an extent at some point in their lives. The U.S. Department of Veteran Affairs National Center for Posttraumatic Stress Disorder (PTSD) (2016), reports that trauma experiences are not rare. Research supports that 60% of men and 50% of women experience a traumatic event in some measure during their lifetime (U.S. Department of Veteran Affairs National Center for PTSD, 2016). These numbers may not be a true reflection of how many people experience trauma, since many may not recognize they have been through a qualifying event. Others may mentally/emotionally process the events quickly, while others may not report their experiences out of fear. Traumatic event examples are violent crimes, a plane or

automobile crash, terrorist attacks, sexual assault, or can be from a natural occurrence, such as a flood, hurricane, or earthquake (M. Smith, Robinson, & Segal, 2018).

In addition to physical, traumatic events can be emotional and psychological. Having ongoing occurrences of a life-threatening illness, domestic violence/abuse, the unexpected or sudden death of an intimate person, or childhood neglect can all be emotional and psychologically traumatic events (Robinson, Smith, & Segal, 2018). A trauma is defined as an exposure to, by experiencing or witnessing, an event or situation that is shocking and dangerous with the perception life-threatening, potential for physical or emotional harm, and causes an overwhelming or significant distress (Finklestein et al., 2015; Flint, 2018; Foreman, 2018; Sartor, 2016; U.S. Department of Veteran Affairs National Center for PTSD, 2016). The documented 60% men and 50% women experiencing trauma within the United States is so prevalent that counselors come in direct contact with many of those clients seeking assistance. Most counselors, regardless of the workplace setting, will encounter these issues in counseling. Providing effective treatment to traumatized clients can involve having the person recalling events and providing narratives of their experiences, thus exposing the counselor to trauma vicariously through their vivid recall (Bride, Radey, & Figley, 2007).

Secondary traumatic stress (STS), also referred to as secondary traumatic stress disorder (STSD) (Figley, 2002), may be considered an occupational hazard to counselors who work with client trauma (Butler et al., 2017; Everall & Paulson, 2004). Figley (2002) defined STS as the stress that results from helping or being compassionate towards a suffering client. STS includes behaviors and emotions which occur from being confronted with the traumatic events of clients (Figley, 2002). For many years, STS was considered a disorder with "symptoms nearly identical to PTSD" (Figley, 2002, p. 1435), although there has never been documentation within health

care diagnostic manuals (Melvin, 2015). Figley (2002) distinguished the differences as PTSD being linked to the person in the traumatic situation while connecting STSD with the person hearing or knowing of the traumatic experiences of the sufferer. Earlier literature surrounding STS identified symptoms as being 'PTSD-like' (Butler et al., 2017; Everall & Paulson, 2004) and can have a rapid onset, or a "slower accumulation of experiences across many situations specifically related to dealing with clients' trauma" (Everall & Paulson, 2004, p. 26).

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), published by the American Psychiatric Association (2013), expanded the criteria of PTSD from previous editions. The development of the benchmark for PTSD now encompasses what was once considered STSD. Criterion currently includes an expansion of trauma to be death, serious injury, or sexual violence. Exposure was also updated to reflect people who directly experience the event, those who witness the event, learning the details of an accidental or violent trauma occurring to a loved one, or repeated, extreme exposure to traumatic circumstances (APA, 2013). Counselors can develop PTSD from acute exposure to traumatic information.

Numerous diagnostic criteria are indicators of the diagnosis for PTSD (APA, 2013), while resulting symptoms can include the following: disrupted sleeping patterns, intrusive thoughts surrounding clients or their stories, decreased levels of activity, irritability, emotional numbing, detaching from others, avoidance of distressing thoughts or external reminders, difficulties in concentration, and hypervigilance (APA, 2013; Devilly et al., 2009; Figley, 2002; Melvin, 2015). Experiencing these symptoms, whether or not meeting full diagnostic criteria, can be a factor in decreasing a counselor's well-being or impairment in their work performance (Figley, 2002; Flint, 2018; Foreman, 2018).

According to the literature, the seminal work of Figley in 1995 initially used the terminology compassion fatigue to describe both the exhaustion from the work counselors do and the effects of being exposed to the trauma of clients (Devilly et al., 2009; Radey & Figley, 2007). As Figley, and other researchers, continued to investigate compassion fatigue and STS, the distinctions between these two began to emerge. STS is the resulting stress of a counselor from hearing disturbing stories while assisting their traumatized clients (Bride et al., 2007; Figley, 2002; Radey & Figley, 2007). Compassion fatigue is the stress of working with clients that are having difficulties coping, which becomes overwhelming, intrusive, and interferes with the counselor's personal emotional, mental, and physical well-being (Joinson, 1992; Ray et al., 2013). Although it was initially introduced in the Social Worker field by Figley to describe STS in a more 'user-friendly' phrase (Bride et al., 2007; Figley, 2002), compassion fatigue can be a result of STS (Figley, 2002). Compassion fatigue can also be experienced by those who are nearing burnout in counseling (Flint, 2018). The terms are frequently utilized interchangeably or are discussed simultaneously in the literature.

Counselors are particularly at risk for STS due to the nature of the counseling relationship and exposure to trauma from hearing the clients' perceptions of their lived traumatic experiences. As a helping healer, counselors may experience intense emotions in their attempts to effectively empathize with their clients (ACA Traumatology Interest Network, 2011a). In addition to the emotional connection counselors have with the clients' emotional experiences of their trauma, the counselor works to understand the clients' perspective from a cognitive aspect (ACA Traumatology Interest Network, 2011a). Having these repeated exposures to the head and heart (cognitive and affective empathy), combined with the desire to alleviate the clients' suffering

(compassion) can have a cumulative effect over time (ACA Traumatology Interest Network, 2011a; Butler et al., 2017; Devilly et al., 2009; Pearlman & Mac Ian, 1995).

Vicarious trauma/traumatization. Vicarious trauma can occur when counselors, who are witnessing and empathizing with the fear and pain of their clients, have repeated exposure to hearing the traumatizing experiences (ACA Traumatology Interest Network, 2011b; Butler et al., 2017; Devilly et al., 2009). Vicarious trauma, also referred to as vicarious traumatization, is another term that may be used interchangeably with secondary traumatic stress or compassion fatigue. Vicarious traumatization was conceptualized in the 1990s (Butler et al., 2017; Pearlman & Mac Ian, 1995). The idea arose from the constructivist self-development theory (CSDT), a more contemporary form of psychoanalysis partly comprised of Kohut's self-psychology (2010) social learning, and cognitive therapy (Pearlman & Mac Ian, 1995). It was created to "provide a developmental framework for understanding the experiences of survivors of traumatic life events" (Pearlman & Mac Ian, 1995, p. 558). Pearlman and Mac Ian (1995) define vicarious trauma as a "transformation" (p. 558) that happens with those working with people who have been traumatized and their complications presented during the counseling work. By having this continual emotional engagement with the distressing stories of the clients, counselors may experience "cognitive distortions and changes in core belief systems" (Sartor, 2016, p. 2). These cognitive changes have an impact on the counselor's personal and professional relationships (Finklestein et al., 2015; Pearlman & Mac Ian, 1995; Sartor, 2016). The cognitive distortions and alterations combine with other symptoms commonly connected with experiencing trauma, such as hopelessness, isolation, tension, cynicism, preoccupation, despair, or nightmares (ACA Traumatology Interest Network, 2011b; Flint, 2018; Sartor, 2016). Symptoms can be insidious and difficult to recognize. Effects of vicarious trauma may not be noticed until extensive

because the responses can be viewed as coping mechanisms and occur as alterations to the self (Flint, 2018; Sartor, 2016).

Even though counselors do not always have direct exposure to the specific traumatic events of the clients, the risk of the effect exists (Finklestein et al., 2015). The more substantial caseload of a counselor combined with working with higher quantities of traumatized clients increases the potential for vicarious traumatization (Finklestein et al., 2015; Sartor, 2016). Additionally, the persistence of trauma work and the counselor's own ability to emotionally empathize are aspects that may contribute to vicarious trauma (Devilly et al., 2009; Pearlman & Mac Ian, 1995).

Counselors who are experiencing vicarious trauma may have disruptions in their work self-efficacy and changes in their world-views or safety (Foreman, 2018; Pearlman & Mac Ian, 1995). As the vicarious trauma increases, counselors are at risk for impairment, which can lead to endangering the welfare of the client or ethical violations (Foreman, 2018; Lawson, 2007). These disturbances that occur within the counselor happen from the subjective interpretation and meaning-making from their personal experiences in working with traumatized clients (Foreman, 2018; Pearlman & Mac Ian, 1995). As the explanations happen, the counselor adjusts and revises their perceptions of themselves and others (Flint, 2018; Foreman, 2018; Pearlman & Mac Ian, 1995). The constant adjustment towards a more negative outlook challenges a counselor's own psychological needs and beliefs (Foreman, 2018).

Vicarious trauma only differs in the literature by the description of being grounded in the constructivist self-development theory (CSDT). Both vicarious trauma and secondary traumatic stress focus on the psychological needs/beliefs of the counselor after working with traumatized clients.

The theme in these terms and related research concentrate on the negative impact working with clients has on a counselor's compassion. The negative implications decrease or stunt the counselor's desire to alleviate the suffering of their client. Despite this broad topic of exploration of the risks of compassion, only the use of superficial descriptions and definitions occur while a complete depth of discovery exists regarding empathy. In response to the adverse aspect of compassion, studies also exist on the positive characteristic of compassion, known as compassion satisfaction.

Compassion Satisfaction

Compassion satisfaction relates to the fulfillment a counselor has with the performance in doing well at their job through helping the welfare of others (C. Harr, 2013; Lawson & Myers, 2011; Sacco & Copel, 2018). Despite the hazards of working with people during vulnerable times in their lives, counselors can derive gratification and remain motivated to continue practicing. Gerard Lawson, an expert in counselor wellness, impairment, and also trauma, and Jane Myers, a wellness and counselor educator expert, (2011) point out that "to remain effective and vital in their work, counselors must be able to recognize and find joy in their ability to help others" (p. 164).

Counselors may experience feelings of gratification in working with clients and doing noteworthy beneficial actions for the whole of society (Samios, 2018). Connections have been suggested regarding compassion satisfaction and increased perceptions of the counselor-client bond (Samios, 2018). Counselors also have reported professional or personal development in working with traumatized clients (Craig & Sprang, 2010). Compassion satisfaction can be the optimal stress that acts as a counterbalance between the challenges and potential adverse effects in the work that counselors do daily (Craig & Sprang, 2010; C. Harr, 2013). Harr (2013)

contends that "compassion fatigue and compassion satisfaction may be experienced at the same time" (p. 75). Conversely, Yilmaz and Ustun (2018) posit that "compassion satisfaction is the direct opposite of compassion fatigue" (p. 206). Studies have supported that the more fatigued a counselor becomes, the less likely they are to be satisfied with their work (C. Harr, 2013; C. R. Harr, Brice, Riley, & Moore, 2014).

Much of the literature regarding compassion satisfaction directly connects with compassion fatigue and burnout (C. Harr, 2013; Lawson & Myers, 2011; Sacco & Copel, 2018; Yilmaz & Üstün, 2018). Similar to burnout and compassion fatigue, the term compassion satisfaction began surfacing in the literature in the 1980s in the social work discipline (C. Harr, 2013; Sacco & Copel, 2018). The Compassion Satisfaction and Fatigue (CSF) test developed by Stamm and Figley (1996), as previously discussed, was a revised version of the Compassion Fatigue Self-Test from the 1980s (Sacco & Copel, 2018). These topics continued examination through other allied professions, such as nursing, in the 1990s (Sacco & Copel, 2018). The assessment to measure compassion satisfaction and compassion fatigue saw another revision in the 1990s with Stamm's Professional Quality of Life scale (ProQOL; Stamm, 2005). Counseling began to explore this phenomenon in the 2000s (Lawson & Myers, 2011).

The professional quality of life is defined as "the quality one feels in relation to their work as a helper" (B. Stamm, 2010, p.8). The ProQOL scale measures both the positive and the harmful properties that influence perceptions regarding the professional conditions of a counselor's satisfaction (Lawson & Myers, 2011; B. Stamm, 2010). Measurements of the ProQOL include compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress (B. Stamm, 2010). Positive results in compassion satisfaction, predict continued service (Lawson & Myers, 2011; B. Stamm, 2010; Yilmaz & Üstün, 2018). There are ten items to

measure compassion satisfaction variables, such as: enjoying the work, being able to keep up with techniques and protocols, positive thoughts about the clients, and feelings surrounding having a positive impact (B. Stamm, 2010). The ProQOL measures two elements of compassion fatigue, burnout, and secondary traumatic stress (B. Stamm, 2010).

While defining compassion satisfaction as "the pleasure you derive from being able to do your work well" (B. Stamm, 2010, p.28), the ProQOL scale only measures the positive feelings and self-perceptions of making a difference and being 'successful' in the work being done as a counselor (Yilmaz & Üstün, 2018). These measures of compassion, both satisfactory and fatigued, surround the derived self-reward within the context of the job setting, measuring compassion satisfaction in connection with compassion fatigue (Yilmaz & Üstün, 2018). The majority of the focus is on the experiences or perceptions surrounding the ability to impact client improvement and the effectiveness of the counselor (Yilmaz & Üstün, 2018). Examining the professional quality of a counselor's work-life does have an impact on the counselor's personal life, yet neglects specific skills, attributes, or behaviors of compassion demonstrated in the counseling profession.

More recently, there has been a shift in the literature, encouraging a focus on compassion satisfaction through counselor wellness and self-care (Craig & Sprang, 2010; C. Harr, 2013; Lawson, 2007). Increasing career-sustaining behaviors, such as preserving objectivity about clients or participating in professional training, can aid in improving wellness and, thus, compassion satisfaction (Lawson, 2007). Encouraging counselors to take better care of themselves in both professional and personal contexts can mitigate compassion fatigue (C. Harr, 2013; C. R. Harr et al., 2014; Lawson, 2007). Dr. Gerard Lawson (2007) stated that "when

counselors take better care of themselves, there is a positive effect on their ability to meet the needs of their clients" (p. 20).

Self-Compassion and Wellness

Through the exploration of compassion fatigue and compassion satisfaction, the inquiry began regarding counselor wellness and self-compassion as ways to safeguard against the potential negative impact of working with clients. Counselors who are impaired or unwell are more likely to offer less than the best to their clients (Lawson, 2007). Additionally, due to the high level of counselor investment in the healing journey of clients (Hunter, 2012), counselors may experience the emotional impact and resulting fatigue, which can influence negative changes in the personal life of the counselor (C. Harr, 2013; Lawson, 2007). Compassionate care is paramount for the client (Beaumont et al., 2016). It is also meaningful for counselors in their development of self-compassion and wellness (Beaumont et al., 2016; Lawson, 2007). When a counselor can recognize their suffering and begin to consider their limitations in kindness or without harsh judgment, then the capacity to help others similarly can be increased (Fulton, 2016, 2018; Neff, 2015; Solomon & Barden, 2016). Kristin Neff (2015), a leading researcher of psychology whose studies surround self-compassion, states, "after all, compassion is the same whether we direct it to ourselves or to other people" (p. 8).

Self-compassion, by definition, is an awareness and recognition of one's suffering (Neff, 2015). It also includes acknowledgment of personal shortcomings and challenges, while embracing the ideology that human beings are flawed and inadequacies are a natural occurrence within the human experience (Fulton, 2016, 2018; Neff, 2015; Solomon & Barden, 2016). In essence, self-compassion is compassion that focuses inward, which notices suffering from the self and having the desire to alleviate that pain (Fulton, 2018).

Not only is self-compassion an elemental component of well-being, it is connected to being a strategy for healthy coping and a method for counselors to model self-kindness to their clients (Neff, 2015; Stuntzner, 2017). Self-compassion many times is located in the literature in conjunction with mindfulness (Fulton, 2016, 2018). Mindfulness is a practice of being aware of the thoughts and feelings within the present moment without delivering judgment (Fulton & Cashwell, 2015; Solomon & Barden, 2016). Having roots in the Buddhist philosophy, training in mindfulness expands self-awareness and insight, while nurturing compassion for the self and others (Dalai Lama, 2003; Fulton, 2016; Solomon & Barden, 2016). Compassion has been noted to be one of the "essential components of the practice of mindfulness" (Solomon & Barden, 2016, p. 140).

Self-compassion and mindfulness can contribute to counselor wellness, which is a critical factor in overall health (Shallcross, 2011). Many counselors are educated in their training programs to be self-reflective and attune to their own emotions (Gutierrez & Mullen, 2016). This training is known as emotional intelligence or the level of ability to detect, regulate, and utilize one's own emotions (Gutierrez & Mullen, 2016). Knowing how to monitor, control, and appropriately use one's own emotions when working with clients aids in social connections and increase in empathy, and thus compassion (Fulton, 2018; Fulton & Cashwell, 2015). Additionally, by having an increase in this kind of self-awareness, counselors may then be able to monitor better and recognize the signs and symptoms of burnout, compassion fatigue, and vicarious trauma. Having an understanding of the early detection of stress and strain of the profession offers the opportunity for counselors to monitor their ability to give and receive support (Yilmaz & Üstün, 2018). As we increase compassion and love for the self and others, inner strength grows as does serenity (Dalai Lama, 2003). When we see and experience other

people suffering, it can shift personal outlook, as well as nurture growth and change in people (Dalai Lama, 2003).

The wellness-oriented philosophy held by the counseling profession stresses prevention and optimization of functioning (Lawson & Myers, 2011; Myers, 1991). The holistic paradigm of wellness is for both the clients and the professionals that provide their helping services (Myers, 1991). In staying true with the comprehensive model, the counseling profession has shifted from the concentration of recognizing and responding to counselor impairment to advocating for counselor wellness to prevent the negative impact of their work with clients (Cummins et al., 2007). Rather than only examining what is causing dissatisfaction with work or diminished capacity for emotional availability, research began to explore "the multidimensional nature of holistic well-being" (Lawson & Myers, 2011, p. 163). Skovholt, Grier, and Hanson (2001) addressed the need for counselors to have a continuation of meaningful professional vitality throughout the career within a counselor's developmental framework for self-care. One of the six ways outlined within this professional and personal self-care framework is for counselors to give attention to a need for balanced wellness (Skovholt, Grier, & Hanson, 2001). Counselors are urged "to be assertive about their wellness" (Skovholt et al., 2001, p. 174). Having methods to support personal and professional wellness and resiliency has a positive influence on the counselor (Skovholt et al., 2001; Yager & Tovar-Blank, 2007). By focusing on the positive aspects and personal protective factors when working with clients, professional resilience may be acquired (C. Harr, 2013; Samios, 2018).

Wellness consists of a balanced integration of social, emotional, spiritual, mental, and physical elements of a person throughout their lifetime (Myers, 1991). A counselor is more apt to nurture wellness in clients if they are attending to their own wellness (Lawson et al., 2007). It

is when a counselor neglects their self-care and concentrates instead on the needs of their clients that impairment can occur (Figley, 2002; Lawson, 2007; Lawson & Myers, 2011; Lawson et al., 2007). Counselor impairment can include burnout, compassion fatigue, vicarious trauma, and overall dissatisfaction with the job. All of these, as previously discussed, can impede the effectiveness of the counselor on both personal and professional levels (Figley, 2002; Lawson, 2007; Radey & Figley, 2007; Skovholt et al., 2001).

Many of the discussions in the literature have addressed various forms of compassion, but none concentrate on the heart of compassion. The following section illustrates studies and information from the helping professions.

Studies Surrounding Compassion

The studies of burnout, compassion fatigue, secondary traumatic stress, vicarious trauma, and compassion satisfaction suggest that the reaction to the stressors of working with clients should be on a continuum (Craig & Sprang, 2010; Figley, 2002; Radey & Figley, 2007; Sprang et al., 2007). The continuum, as depicted in Figure 1, illustrates the span of experience a counselor may have regarding the range from counselor impairment to counselor wellness. It is, therefore, essential for counselors to understand the signs and symptoms to be able to conduct interventions to safeguard against any of the stressors which impact the abilities to work with

Figure 1: Continuum of Counselor Compassion from Wellness to Impairment

clients effectively.

Even though various areas of the helping professions began studying these phenomena separately, much of the literature consists of efforts to combine these ideas. Due to the diverse ways of considering and researching compassion, several studies and articles will be pointed out and discussed.

In 2013, Ray, Wong, White, and Heaslip, conducted a non-experimental, cross-sectional study to examine relationships between compassion satisfaction, compassion fatigue, work-life conditions, and burnout. Because a wide variety of disciplines provide direct care to people who require longer-term physical and mental health support, Ray and colleagues chose to include areas they considered "frontline mental health care professionals" (Ray et al., 2013, p. 254). The disciplines included nursing, social workers, psychologists, and case managers with varying backgrounds. The sample consisted of 169 participants with an average age of 43.8 years, 82% females, and the majority of the participants were in nursing providing mental health needs (Ray et al., 2013).

The study specifically sought to determine if a frontline mental health professional had similarity in their expectations and realities of the job (work-life) combined with higher levels of compassion satisfaction and lower levels of compassion fatigue could predict burnout. Work-life areas identified were workload, control, rewards, community, fairness, and values. A convenience sample received surveys via mail. Instruments used in the survey questionnaire to collect and measure the variables were subscales of the Professional Quality of Life (ProQOL) Revision IV, the Areas of Work Life Scale (AWS), and the Maslach Burnout Inventory General Scale (MBI-GS). The ProQOL measures compassion satisfaction and compassion fatigue/secondary traumatic stress with a reported Cronbach's alpha reliability of .87 for

compassion satisfaction and .80 for compassion fatigue/STS (Ray et al., 2013). The AWS is a 29 item scale that measures congruence in the person-work match or areas of work-life previously listed. The AWS is a 5-point Likert-type scale with a reported reliability coefficient range of .70 to .95 (Ray et al., 2013). The MBI-GS was utilized to measure three elements of burnout: emotional exhaustion, cynicism/depersonalization, and reduced self-efficacy. Cronbach's alpha reliability reporting for the subscales are estimated at .77, .88, and .92 (Ray et al., 2013). A demographic questionnaire collected additional characteristics of the respondents. SPSS (Statistical Package for Social Sciences) was used to analyze the data through Pearson correlations and hierarchical multiple regression. Number of years within the participant's profession provided explanation to the 3.6% variances in emotional exhaustion (burnout; $R^2 =$ .036, $F_{(1, 162)} = 6.105$, $p = .015$). There was also a reported significance with the years within the profession being a predictor of emotional exhaustion (burnout; $\beta = -.163$, $t = -2.993$, $p = .004$). Compassion satisfaction was a significant predictor of emotional exhaustion (burnout; $\beta = -.271$, $t = -.4212$, $p < .001$) and a 24.8% of variability ($R^2 = .284$, $F_{(2, 161)} = 31.952$, $p <.001$). The variable of compassion fatigue showed significant independent predictability of burnout (burnout; $\beta = .428$, $t = 7.561$, $p < .001$) and represented another 21.9% of the variance ($R^2 =$ .494, $F_{(3, 160)} = 53.961$, $p <.001$). 4.2% variance was connected to the areas of work-life and was also a significant independent predictor of burnout ($\beta = .253$, $t = -3.833$, $p < .001$).

Results of the study were reported to support the hypothesis "that higher levels of CS, lower levels of CF, and increased person-job match in the six areas of work-life predicted lower burnout" (Ray et al., 2013, p. 263). While this study was the original study to connect the variables in these ways, these findings support similar studies in examining how life and working conditions impact compassion satisfaction and compassion fatigue, as well as studies

investigating burnout predictability through exploring the overall similarities of the work-life areas.

Implications of Ray and colleagues' study suggested a higher level of work support or supervision may be needed by professionals with a personal trauma history, as this factor can contribute to higher compassion fatigue levels (Ray et al., 2013). Although the study uncovered no significant differences, participants who reported a history of trauma reflected a higher level of compassion fatigue and lower AWS scores than participants without a trauma history (Ray et al., 2013). This finding and suggestion further support previous work that personal and workplace conditions can influence an increase in compassion fatigue. Furthermore, this study draws attention to factors within the work life, such as supervision, accommodations, and empowerment, which can also be predictors of job satisfaction. The researchers provided a cautionary word regarding those with less work experience, or newer to the profession may be at higher risk for burnout. Due to the nature of these findings, this study provides support in connection with how a history of trauma can influence levels of compassion satisfaction, compassion fatigue, and burnout. It also supports the need for a richer understanding of compassion in the professional context.

Although the study conducted by Ray and colleagues (2013) continued the studies of compassion regarding satisfaction with the job or becoming fatigued with the work of those in the helping professions, it did not address counselors specifically. The study did link a unique set of variables that influence or predict burnout and compassion fatigue; however, the study did not attempt to define the characteristics of compassion itself. Recommendations were made by the researchers for longer-term studies with randomized sampling to further support their hypothesized model (Ray et al., 2013). Additionally, the researchers conclude that through a

solid "understanding of both risk and protective factors for stress-related conditions"(Ray et al., 2013, p. 265), that knowledge can be applied to develop strategies and interventions to help to establish these stress-related factors.

These findings suggest that a counselor's history of trauma can intersect and influence their present situation, as well as suggests that unfavorable working conditions can degrade job satisfaction (Ray et al., 2013). Also, conclusions drawn regarding those newer in their tenure of helping professions would benefit from additional support to prevent burnout. Limitations of the study were the cross-section of participants, which may limit causality, information collected were self-reports of the participants, and imbalance in the gender representation that may influence results (Ray et al., 2013). Through the exploration of factors that could potentially predict compassion fatigue and burnout, the authors examine specific causes that can fracture or deteriorate compassion. However, as cited in the article, minimal literature existed at the time of publication, which addressed compassion fatigue or compassion satisfaction (Ray et al., 2013). What this article lacks is foundational information about compassion itself. The definitions and supporting historical works only addressed compassion satisfaction and compassion fatigue.

A quantitative study conducted by Beaumont, Durkin, Hollins Martin, and Carson in 2016 explored the relationships between self-compassion, well-being, compassion fatigue, and burnout in counseling students and cognitive-behavioral psychotherapist students (Beaumont et al., 2016). The sample population of this study contained 54 participants who were in the final year of studies in the United Kingdom. No additional details were provided to describe the sample. The purpose of the study was to augment existing literature to provide further empirical evidence to utilize self-care approaches examining relationships using validated data collection instruments (Beaumont et al., 2016).

Four scales were used to collect data via a paper-and-pencil method. The instruments were: the Professional Quality of Life (ProQOL), the Self-Compassion Scale, the Short Warwick and Edinburgh Mental Well-being Scale, and the Compassion for Others Scale (CFO). The Self-Compassion Scale is a 26-item, 5-point Likert-type scale that measures six areas, including self-kindness, common humanity, and mindfulness. The Short Warwick and Edinburgh Mental Well-being Scale collects information regarding well-being over the two weeks before the administration and is a 14-item, 5-point Likert-type scale. The CFO Scale is a 24-item instrument that measures six areas, including kindness, common humanity, and mindfulness (Beaumont et al., 2016). The authors did not report any validity measure for the scales utilized in the study. SPSS was used for analysis of descriptive statistics, Pearson correlations, and t-tests. The results of the study reported a high mean score ($M = 41$) for compassion and a moderate mean score ($M = 3.1$) in self-compassion satisfaction. A significant negative correlational relationship was reported between self-compassion and burnout ($r = -.486$), and self-compassion and compassion fatigue ($r = -.350$). There was also a positive correlation between self-compassion and well-being ($r = .439$). Results indicate that those with higher self-compassion have greater scores on well-being ($r = .318$) and compassion satisfaction ($r = .341$) while having lower scores on burnout ($r = -.289$) and compassion fatigue ($r = -.319$) (Beaumont et al., 2016). Authors linked those having an increased well-being score ($M = 27.8$, SD = 1.8, $t(21) = -4.37$, $p \geq .001$), a lower burnout score ($M = 18.3$, $SD = 4.0$, $t (21) = 3.41$, $p \geq .001$) and a reduced compassion fatigue score ($M = 17.4$, SD = 4.0, $t(21) = 2.48$, $p \geq .05$), as significantly associated with positive scores in self-kindness. Findings were in keeping with previous research regarding the benefits of developing more self-compassion (Beaumont et al., 2016).

Implications of this study extend earlier research on trauma counselors, and the positive benefits of compassion satisfaction and self-care, by studying how an increase in self-kindness and appreciating the therapeutic alliance with clients fosters growth in compassion and reduces burnout and compassion fatigue (Beaumont et al., 2016). The work of Beaumont and colleagues' study is the foundational work in examining relationships between compassion fatigue, burnout, self-compassion, and well-being amongst counselors and psychotherapists in training. However, the study is small in sample size and collects data at only one point in time during the training period. Further limitations, as pointed out by the authors, are the lack of qualitative data to aid in complementing the quantitative data, which may also help identify cause and effect relationships (Beaumont et al., 2016). Recommendations and implications to the profession are that training programs could explore new approaches for intervention strategies to aid students to increase self-compassion. Self-care, along with self-compassion, can be beneficial to the overall well-being and prevent stress from the workplace (Beaumont et al., 2016).

Beaumont and colleagues (2016) provide a generic definition of compassion that the psychological sciences have adopted, which is "recognizing one's own or another's distress and making an attempt to alleviate it" (p. 15-16). The definition derives from the work of P. Gilbert, creator of Compassion Focused Therapy (Beaumont et al., 2016). Although this definition is broad and not counseling specific, it uses a one-sentence lead-in to describe and discuss the recent research on self-compassion. The study examines the findings regarding counseling and psychotherapist students in the United Kingdom's compassion for others, yet provides little attention supporting compassion as a stand-alone component, which further supports the need for studies to investigate compassion. More specifically, investigations are needed considering

compassion within a professional context, as the currently available measurements address compassion of the self, compassion fatigue, compassion satisfaction, or universal compassion as a common humanity.

Butler, Carello, and Maguin (2017) conducted a quantitative, non-experimental survey study to investigate how graduate students in a social work training program were impacted by training-related stress, trauma-related course content, and self-care during clinical training. The sample population in this study contained 195 participants who were 88% female, and 82% reported as non-Hispanic White. Additional characteristics of the group were 63% full-time in the program, 51% were in the first year of studies, and most students were entirely new to the profession (Butler et al., 2017). The purpose of this study was to investigate exposure to trauma during graduate training and to examine if trauma-related exposures and protective factors predict burnout.

Data were collected in an online survey format which received information about training-related exposures, training-related stress, student self-care importance, changes in student self-care, burnout, compassion fatigue, changes in health status since starting the training program, and secondary traumatic stress symptoms (Butler et al., 2017). For each variable measured, survey items were either created or adapted from existing resources. Items to measure training-related exposures were adapted or developed to ask about responses or exposure while either in a fieldwork setting or during coursework. Inspired by the 2007 work of Bride on the prevalence of STS among social workers, the measurement consisted of 5-items with a 5-point, Likert-type scale. One question was created by the researchers to measure perceptions of the stress levels of the coursework or placement within the field. Importance of and changes in self-care by the participants were gauged by two questions that had been previously tested by the

researchers. Subscales of the ProQOL were utilized to measure burnout and compassion satisfaction. Measurements using the Secondary Traumatic Stress Scale (STSS) indicated how working with traumatized clients impacted the participants' work. The STSS is a 17-item scale with a reported Cronbach's alpha of .92 for reliability (Butler et al., 2017).

The analysis was completed using bivariate correlations, multiple regressions, and logistic regression analysis through SPSS. Additionally, zero-order correlations analyzed the association of predictability with each variable with a significant association ($p < .05$ or better) (Butler et al., 2017).

Findings of this study were that nearly half of the participants (48.5%) who indicated the two highest responses were the graduate students that were exposed to coursework material that was trauma-infused, numerous reports of experiences of helplessness, fear, or shock. A significant section of students (41.7%) conveyed a reactivating of their own historical traumatic fieldwork experiences. While no significant factors regarding re-traumatization from either fieldwork or course-related work were discovered, there was a high correlation for the overall training ($r = .51$, $p < .001$). Students reported the coursework being significantly more stressful than the fieldwork ($t_{(166)} = 8.645$, $p < .001$). Unexpected findings were reports by the students not placed within clinical settings during their fieldwork, still reported addressing trauma with clients. Self-care was indicated by 90% of the students as being quite important, and over 50% noticed a decline in their efforts of self-care during the program (Butler et al., 2017). Reductions in self-care were related to those who reported higher levels of burnout and secondary traumatic stress. Age as a predictive factor was positively associated with compassion satisfaction outcomes ($r = .22$, $p < .01$). Additionally a positive association exists between STSS and emotional trauma responses during the fieldwork experiences ($r = .44$, $p < .001$). Regression

analysis of burnout predictability accounted for 18.5% of variance (Adj. $R^2 = 0.168$, $F_{(3, 142)} = 10.78$, $p < .001$). The regression analysis for STSS was 31.5% of variance (Adj. $R^2 = 0.292$, $F_{(5, 147)} = 13.51$, $p < .001$). It is reported that field stress, lower self-care efforts, and increased levels of re-traumatization during training were the predictors of higher STS among the participants (Butler et al., 2017). Predictors of higher compassion satisfaction were being an older age, fieldwork settings which addressed trauma, and increased working with traumatized clients in the field. Regression analysis of the predictors were reported for 25.7% of variance (Adj. $R^2 = 0.225$, $F_{65, 139)} = 8.002$, $p < .001$) (Butler et al., 2017).

Butler and colleagues point out that exposure to trauma and stress through clinical training may cause adverse consequences that could erode student self-care and learning. Findings support the previous research surrounding the potential increase in trauma symptoms for students who have trauma exposure during clinical training and fieldwork (Butler et al., 2017).

The authors state that this study was the first to provide empirical evidence by exploring the impact various aspects of trauma have on social workers during their training (Butler et al., 2017). Despite the groundbreaking study, limitations surfaced in the research. Data from a homogenous group of students at one location during a stressful time of the semester was collected, which may have skewed results. The results may not be generalizable to other programs that do not infuse trauma-focused curriculum throughout the coursework. Additional limitations surround the particular questions utilized within the survey, lack of data to better describe the self-care components, and difficulties in measurement of re-traumatization of the students who reported such (Butler et al., 2017).

Implications of this study suggest that a greater focus on self-care during graduate training could be beneficial for professionals to be more resilient in the future to the expected strain of working with clients. Findings also suggest training programs move toward a "trauma-informed approach to curriculum delivery" (Butler et al., 2017, p. 422). Operating from a trauma-informed approach aids clinicians to be better equipped to understand the impact on clients from traumatic historic events in their lives. Butler and colleagues (2017) also support a trauma-informed approach for students because of the nature of training programs being so self-reflective combined with the hierarchical situation within higher education. Students may have a parallel process to clients within their roles as they navigate through their training programs.

Because of the more recent exploration of trauma-informed care combined with training programs in counseling, or other helping professions, this study provides the support that self-care can mitigate burnout, compassion fatigue, and secondary traumatic stress. Self-care of a counselor, either during their training program or during their career, has been supported through the literature as a way to decrease the negative impact of working with clients. Also, it supports a more positive outlook on the working conditions, which can help to increase compassion satisfaction. While this study examines the training programs and educational needs of the social workers to help better prepare them for the vulnerabilities in working with clients, it does not address the skills, attributes, or behaviors associated with compassion. As in many studies, this aspect of compassion is left undefined; hence, the need for exploration of how counselors understand compassion.

Pow and Cashwell (2017) surveyed 235 disaster mental health counselors to discover if adult attachment security, emotion regulation, and mindfulness could be predictors of PTSD symptoms. The research by Pow and Cashwell (2017) augments the previous, yet limited,

exploration of emotion-focused coping and PTSD with the specific group of disaster mental health counselors. The purpose of quantitative methods in this study was to examine the hypothesis that the previously listed variables would predict the severity of PTSD symptoms and specifically that emotional regulation would act as a moderator in the relationships of PTSD and adult attachment security, as well as mindfulness and PTSD (Pow & Cashwell, 2017).

The sample population consisted of 67% female, majority White, and married, with a mean age of 57.95 years (Pow & Cashwell, 2017). Participants in the study completed self-reported, web-based instruments. Measurements were collected using a demographic questionnaire, the Impact of Event Scale-Revised (IES-R), the Difficulties in Emotional Regulation Scale (DERS), the Attachment Styles Questionnaire (ASQ), and the Five Facet Mindfulness Questionnaire (FFMQ). The instruments and methods of collecting data were clearly explained. The IES-R measures the acuteness of PTSD symptoms. It is a 22-item, 5-point Likert-type scale with three subscales to measure intrusion, avoidance, and hyperarousal. Cronbach's alpha for this scale is reported overall as .95, with internal consistency score during this study as .93. The test-retest reliability was .89 to .94 with an interval of six months (Pow & Cashwell, 2017). The DERS gauges difficulties in emotional regulation through a 36-item, 5-point Likert-type scale. Cronbach's alpha reported for this instrument is .93 for the overall score with the current study internal consistency reported as .93 as well (Pow & Cashwell, 2017). The ASQ measures adult attachment security through general attachment patterns in a 40-item, 6-point Likert-type scale. The ASQ collects data with two elements: anxiety and avoidance. Internal consistency is listed individually by each factor with Cronbach's alpha of .83 for the avoidance subset and .85 for the anxiety. Cronbach's alpha for the study reported avoidance as (α = .86) and anxiety (α = .89) (Pow & Cashwell, 2017). The FFMQ is a 39-item, 5-point

Likert-type scale that measures variances in the participant's mindfulness. There are five

subscales to the FFMQ to evaluate different aspects of mindfulness: observing, describing, acting

with awareness, non-judging of inner experiences, and non-reactivity to inner experiences. The

overall Cronbach's alpha reported as .96, and the researchers reported a Cronbach's alpha of .92

for the study (Pow & Cashwell, 2017).

Results of the study were reported as consistent to earlier research surrounding trauma.

Findings indicated that the severity of PTSD symptoms was increased when participants reported

an increase with all of the following factors: attachment anxiety, attachment avoidance, and with

difficulties in emotional regulation ($F_{(7, 227)} = 6.02$, $p < .01$, adjusted $R^2 = .13$) with 13% of

variance in PTSD scores (Pow & Cashwell, 2017). This finding positively confirmed the

hypothesis of the researchers. The greatest predictor within this grouping of factors was

emotional regulation ($\beta = -.32$, $p < .01$) (Pow & Cashwell, 2017). No significant moderators

were found among demographic variables. Negative correlations were discovered between

length of time as a licensed mental health professional with the resulting scores on the ASQ

(Avoidance, $r = -.13$, $p < .05$; Anxiety, $r = -.14$, $p < .05$) and the DERS ($r = -.17$, $p < .05$).

Results indicated positive correlations on licensure time and FFMQ scores ($r = .19$, $p < .01$)

(Pow & Cashwell, 2017). Time in working with trauma also had negative (ASQ: Avoidance, $r = -.16$, $p < .05$; Anxiety, $r = -.15$, $p < .05$) and positive correlations (FFMQ: $r = .23$, $p < .01$) (Pow

& Cashwell, 2017). Respondents with more recent disaster training had a positive correlation on

FFMQ scores ($r = .17$, $p < .05$) (Pow & Cashwell, 2017). Multiple linear regressions were

utilized to examine mediating effects of emotional regulation between AAS and PTSD and

between mindfulness and PTSD (Pow & Cashwell, 2017). Predictability of significance on the

"AAS and mindfulness decreased to nonsignificant levels when ER [emotional regulation] was

entered into the model" (Pow & Cashwell, 2017, p. 327). The following results were reported: ASQ-Anxiety, $F_{(5, 229)} = 7.72$, $p < .01$, adjusted $R^2 = .13$; ASQ-Avoidance, $F_{(5, 229)} = 7.35$, $p < .01$, adjusted $R^2 = .12$; and FFMQ, $F_{(5, 229)} = 7.81$, $p < .01$, adjusted $R^2 = .13$ (Pow & Cashwell, 2017).

An interesting finding that was identified to need further examination is the correlation between counselor experience and predictor variables. Those with more experience post-licensure and who were older had higher scores on mindfulness, emotional regulation, and adult attachment security (Pow & Cashwell, 2017). Through emotional regulation components, such as awareness, understanding, and acceptance of emotions, adult attachment security and mindfulness are indicators of defense against PTSD in this population of counselors (Pow & Cashwell, 2017). Other conclusions and recommendations based on the findings were including emotional regulation skill training in disaster mental health counselor preparation, employing use of emotional regulation skills to strengthen disaster mental health counselors who have difficulties coping, and educating on influences of attachment security for client work with incorporation of mindfulness and other emotional regulation skills (Pow & Cashwell, 2017).

The authors used the IES-R, which measures PTSD symptom severity. As noted within the limitations of the study, the IES-R scale also measures secondary traumatic stress because the symptom profiles are so similar (Pow & Cashwell, 2017). Also mentioned, disaster mental health counselors might be subjected to both direct and indirect traumatic stress, as these responders may even live in the communities where the disasters may be occurring (Lambert & Lawson, 2013; Pow & Cashwell, 2017). Further limitations of this study are not being able to differentiate the types of assignments completed during a disaster deployment or the kinds of work which impact the disaster mental health counselor, unknown past history of trauma or prior

mental health treatment of participants, or length of their disaster mental health training (Pow & Cashwell, 2017). Additionally, data was not collected on how recently the most current disaster event worked occurred. Those who have had several years pass since a related traumatic event may not be experiencing severe PTSD symptoms (Pow & Cashwell, 2017).

Pow and Cashwell (2017) explored how mindfulness and emotional regulation can be helpful with the lessening of PTSD symptoms. The study also examined how the participants' attachment style intersects with their ability to manage the stressful symptoms related to working with their trauma, or that of others (Pow & Cashwell, 2017). Although this study does not explicitly mention compassion, this study is relevant to discuss because the related secondary traumatic stress and PTSD symptoms from working within traumatic disasters explore the intersectionality of experiences that influence a counselor's compassion.

Finally, in 2018, Fulton set out to discover if self-compassion is the intervening factor between mindfulness and compassion. Fulton's study was a quantitative, non-experimental survey conducted with Master's level counseling graduate students from 12 CACREP-accredited programs in various geographical regions within the United States. The sample population of this study contained a total of 152 participants. The participants were mostly women (85%), having a mean age of 28.13, with 81% reporting identification as White, followed by 9% African American. Half of the sample listed being in the clinical mental health track, and the second largest group was in the school counseling track (Fulton, 2018). 38% of the participants engaged in mindfulness practices at the time of the study, with yoga as the leading form. For this study, Fulton (2018) hypothesized "that self-compassion would fully mediate the relationship between mindfulness and compassion toward others among counselor trainees" (p. 49).

Existing research supports that self-compassion and mindfulness are beneficial for the wellness of counselors (Fulton, 2018; Fulton & Cashwell, 2015; Lawson, 2007). Fulton (2018) wanted to advance the research to include the benefits of compassion by exploring these same two variables. Methods and instruments used to collect information were pencil-and-paper questionnaires, the Five Facet Mindfulness Questionnaire (FFMQ) to measure mindfulness, the Self-Other Four Immeasurables (SOFI), and a demographic questionnaire (Fulton, 2018). The SOFI is a 16-item, 5-point Likert-type instrument that measures compassion toward the self and others. Four subscales measure positive and negative qualities, but only utilized in this study were the positive subscales (Positive Qualities Toward Self and Positive Qualities Toward Others) (Fulton, 2018). Internal consistency for the SOFI has a reported range of .80 to .86 (Fulton, 2018). All instruments are self-report and administered to counselors-in-training during class time or supervision. Each of the tools was clearly explained within the body of the article and was appropriate for this method of study.

Analysis of data was conducted with SPSS using multiple regressions and bootstrapping with confidence estimates. The results of the study reported a medium effect size of .80 using a .05 level (Fulton, 2018). Multiple regression analysis examined revealing a positive association between mindfulness and compassion for others ($\beta = .04$, $t_{(150)} = 4.22$, $p = .001$) as well as mindfulness and compassion for the self ($\beta = .09$, $t_{(150)} = 6.65$, $p = .001$) (Fulton, 2018). Compassion for the self was identified as a mediator and was positively associated with the factor of compassion for others ($\beta = .27$, $t_{(150)} = 4.50$, $p = .001$) (Fulton, 2018). Bootstrapping methods were used to examine further mediation of self-compassion between mindfulness and compassion for others ($\beta = .02$, with 95% confidence interval (.01, .04)), which reinforces the relationship (Fulton, 2018).

Implications of this study extend the previously known research regarding mindfulness and self-compassion, as it relates to compassion for others. These results add support to prior theories that self-compassion should be cultivated by counselors to better have the ability to be compassionate toward others and potentially prevent burnout (Fulton, 2018). Conclusions based on the findings support that training in mindfulness and self-compassion can translate to having positive thoughts toward and compassion for others. Counselors-in-training and practicing counselors may benefit from training in compassion and mindfulness to lighten the emotional load that may occur when working with clients' distress and emotional stories (Fulton, 2018). Further implications of this study support the order of teaching mindfulness, self-compassion, and compassion, as well as the necessary inclusion of compassion to self and others when conducting studies on mindfulness and the therapeutic relationship (Fulton, 2018).

Fulton (2018) underscores how compassion has been understudied in the counseling field, especially when compared to the trait of empathy. Compassion may be a unique aspect that contributes to a counselor's effectiveness on both a personal and professional level (Fulton, 2018). Despite the supportive results, the study is limited in that the measures were self-report, and participants were counselors-in-training. Additionally, the group was mostly homogenous and thus may not be generalizable to a broader population. Those who did not respond to the survey, or current practitioners, may answer differently, potentially yielding different results. Additional research is recommended to support the findings. Fulton (2018) states that more exploration is warranted and suggests that compassion may have been combined with, or hidden by empathy or altruism. This study is significant because of the direct connection in studying compassion for the self and provides the support that self-compassion can increase overall

compassion. Additionally, Fulton points out that conducting more studies surrounding compassion need to be done.

Studies, like the ones herein discussed, have explored various aspects and variables of compassion, such as job satisfaction, compassion satisfaction, self-compassion, compassion fatigue, burnout, secondary traumatic stress/vicarious traumatization, and mindfulness. Also, recent studies have begun to explore ways counselors' historical aspects may impact and influence a counselor's compassion. This literature covers counseling, social work, behavioral psychotherapists, and nursing in both the United States and in the United Kingdom. Other studies addressed within the body of this writing have included physicians, various medical professions, other mental health first responders, and counselor educators. Given that there has been a wide range of studies covering a variety of health care professionals and educators, compassion though extensively referenced is yet poorly defined, understood, or elementally explained (Sinclair et al., 2016).

Literature in the counseling, medical, and mental health care professional journals have more recently begun to address compassion but are conceptual articles referencing within the studies of compassion fatigue and burnout. For example, in 2017, Stuntzner discusses a rehabilitation counseling theoretical model that introduces compassion and self-compassion techniques that may help people with disabilities adjust to changes in their lifestyles. Through examining the positive benefits of presenting, teaching, and using both self-compassion and other approaches to develop compassion, Stuntzner (2017) encourages the profession to explore both personal and professional knowledge surrounding compassion and self-compassion to "cultivate and integrate [these concepts] into their own lives and into the lives of the people they counsel" (p. 22).

Most recently, a corpus-discourse analysis was completed in 2018 by a group of nursing researchers in the United Kingdom (UK) to discover the social construct of compassion within the online reader responses of a UK governmental recommendation for nurses to have a year's worth of work caring for others before entering the nursing profession (Bond et al., 2018). In an attempt to define the meaning of compassion in health care, Bond and colleagues explored the comments of readers of an online newspaper and two prevalent peer-reviewed online nursing journals. The study revealed that compassion is constructed through the language as something "embodied within the clinician as well as being a skill that could be learnt" (Bond et al., 2018, p. 3088). This study sought to understand the general concept of how people in the UK are viewing compassion within the context of nursing and might be a good starting point to consider the definition of compassion within a setting.

Although Figley (2002), in his work with compassion fatigue, along with many other researchers, does mention compassion as a component in working with clients, a definition of compassion beyond a generic term is not described nor defined in the literature. Overall the mental health and medical professions have done excellent work surrounding compassion; however, the context and meaning of what compassion is within professional settings have not occurred until this most recent exploration in the UK. There is a need to think more critically about compassion within the counseling profession and the necessary ethical and healthy boundaries to maintain for the mental health and wellbeing of both the counselor and the client. What is also needed is a shift in consciousness and recognition that compassion is a skill and trait that can enhance the counseling relationship and bolster the wellbeing of the counselor. The story of a counselor consists of education, training, experience, personal background, and interactions with the clients. All of these factors intersect and blend to create a professional

counselor. The starting point for further exploration to define compassion is through an inquiry of those within the profession.

Theoretical Framework

Currently, there exists an understanding of compassion as the awareness of another's suffering and the desire to lessen that pain (Grover, 2015; Nussbaum, 1996; Sinclair et al., 2016; Stuntzner, 2017). Exploring compassion as a multifaceted concept can provide a different way of contemplating this interpretation. Examining the concept of compassion within the setting of counseling may shift the definition and current understanding. It is currently known that compassion is a foundational characteristic that helps create the necessary environment to foster change in the client and needed skill to work effectively with clients (Beaumont et al., 2016; Figley, 2002; Fulton, 2018; Rogers, 1981). As previously stated, the therapeutic relationship increases the success of the treatment, more so than the theoretical approach of the counselor (Sackett & Lawson, 2015). Compassion is a foundational element and assists in creating the therapeutic relationship and environment necessary for client change; therefore, it comes before the theory or theoretical interventions. The relationship is what fosters change more so than a theory used within the sessions. No one particular theory provides a robust framework for investigating compassion as a skill in counseling. Potentially, the idea that compassion is an element that precedes theories in the counseling setting would move away from a theoretical framework, leaning into the idea that defining compassion is pre-theoretical.

The idea being that compassion precedes theoretical consideration assumes the underlying inherent assumption of understanding what compassion is in counseling. A specific framework to guide the study in altering the concept of compassion into a more in-depth understanding may not exist. Gendlin's (1962) experiential dimension of making meaning, or

implicit knowing, may be a means to introduce a different way of thinking about a concept beyond the known description (Gendlin, 1962b, 1962a; Schoeller & Dunaetz, 2018). According to Eugene Gendlin, an Austrian American philosopher and psychotherapist, the meaning of an idea involves both the logical structure as well as the felt experience (Gendlin, 1962b, 1962a; Schoeller & Dunaetz, 2018). The feelings in the experiences can be 'prelogical,' or that the concepts can change based on the current abstract knowledge of that concept. Since the purpose of this study is to define compassion as it relates to the context of professional counseling and identify skills, attributes, and behaviors associated with compassion, then exploring compassion within the ethical and professional boundaries in counseling brings a distinct approach to re-defining this concept. By inquiring about the thoughts and experiences of counseling professionals, a shift in the understanding of compassion as it relates to the profession of counseling will occur.

Summary

This chapter highlights the importance of compassion within a professional context, and the areas where research on compassion currently exists. An extensive literature review has covered thoughts on being humane, connections of compassion to religion and spirituality from various perspectives, and connection and compassion within counseling theories. An overview was given of the profession of counseling and highlighted professional organizations that provide guidance and ethical considerations for best practices. A review of the importance of empathy in counseling, connections between empathy and compassion, and the role these play within the therapeutic alliance with clients were presented.

While recognizing compassion as a skill and trait essential to the therapeutic relationship, a standard definition has been lacking within the helping professions. Compassion has been

researched in the medical field and the educational field, while only specific areas have investigated it in the counseling profession. Exploration of the negative sides of compassion through research on burnout, compassion fatigue, vicarious traumatization, and secondary traumatic stress is supported. Positive aspects have explored compassion through studies on compassion satisfaction, self-compassion, and wellness. Many of these ideas have been examined and discussed together. Even though there is much that can be done to continue these essential areas of focus, there exists a large gap between the places where compassion begins to break down and how satisfied counselors are in their jobs. The literature is lacking and does not tell the whole story. The known parts are from either where the counselor's compassion becomes fractured or how satisfied a counselor may perhaps be with their working environment and overall job satisfaction. From this aspect, there is support for why this occurs and ways to safeguard or recover should a counselor be in these situations. Discovery of other known parts occurred through the exploration of what keeps the counselor satisfied in their job, but only reviewing the systematic aspects of the working environment. Finally, there are known aspects of being compassionate to the self and creating a plan for personal wellness to safeguard from compassion fatigue or burnout. What remains is the center point of the story. There is a common question that arises within each of the studies and discussions that is only answered by assumptions and generic definitions. That question is: what is compassion in counseling?

The answers to the question of 'what is compassion?' have implications beyond a basic dictionary definition. What is evident in the literature is that compassion matters and is being examined, but only in specific ways. As suggested in the literature, further examination is needed to explore the complexities of this topic. We need research that examines how counselors think about and understand compassion in their work. Areas of research to explore

the perceived skills, attributes, and behaviors associated with demonstrating compassion in counseling are also needed. More information can also help determine whether compassion is different as a personal experience and a professional experience.

Compassion influences the interpretation of the world and how individuals discover their place in it. How a person perceives compassion shapes the view of the self and the things encountered daily. The images and ideas regarding compassion currently are partial and incomplete.   By focusing on compassion, the profession can gain an understanding of and consideration for human frailty and strengths which can, in turn, nurture counselors in becoming better in helping others.

Chapter Three

Methodology

This chapter presents information about the methodology utilized in this investigation. First, a brief overview of the primary purpose of the study will be restated. Next the research design will provide an outline of the study, starting with the research questions that provided focus and guidance through the research. Details of a general overview of the Delphi method are examined with supporting evidence of use in Counselor Education. Explanations of the expert panel selection procedures will be discussed - followed by a thorough review of the data collection process. Specifics about the data analysis and interpretation will be discussed for each round of questions.

Research Purpose and Questions

The initial steps in a Delphi method are to perform a literature review, identify the ideas to research, develop questions to drive the research, and create a research strategy (Iqbal & Pipon-Young, 2009; Keeney et al., 2010; Okoli & Pawlowski, 2004). Chapter two provided the literature review on compassion within the profession of counseling and supported the supposition that compassion is pre-theoretical. The current literature establishes that compassion is an essential and effective element in counseling (Day et al., 2017; Fulton, 2018), yet there has been no clearly defined rationale of this phenomenon separate from discussions of empathy. Because there may be an inherent assumption of understanding of what compassion is in counseling, the purpose of the study is to define compassion as it relates to the context of professional counseling and identify skills, attributes, and behaviors associated with compassion. The primary questions guiding the research are:

1. How do counselors and counselor educators understand compassion?

2. What skills, attributes, and behaviors are indicative of compassion in counseling?

3. How do experienced counselors and counselor educators differentiate compassion as it is experienced professionally and personally?

Research Design

The intention of the study was to define compassion in the domain of counseling. A Delphi approach was chosen to explore and achieve consensus regarding compassion within counseling due to the scant research currently in existence. The overarching goals were to identify and define compassion as it relates to the context of professional counseling, as well as identify skills, attributes, and behaviors associated with compassion. The expected result was to capture an explanation of compassion in professional counseling and develop a shared understanding of the meaning of compassion. This study will provide a foundational study to explore how experienced counselors and counselor educators are currently thinking about compassion. Through exploring the results, the counseling profession may have an increased awareness of the importance of compassion in the professional setting. The outcomes may inform counselors, counselor educators, counselors-in-training, and clinical supervisors about the importance of compassion in the professional setting of counseling. Results may help: inform current practices, advise future behaviors, and could allow for exploration to safeguard against compassion fatigue and burnout.

Working with the research questions to guide the study, the use of virtual surveys was chosen to execute this Delphi research design. Although defining compassion within the context of the profession of counseling may be complex, the Delphi approach is useful in obtaining agreement among a panel of experts (Keeney et al., 2010; Okoli & Pawlowski, 2004). This section will provide an overview of the history of the Delphi, an overview and description of a

Delphi study approach, examples of Delphi studies used in counselor education, and a description of the current study.

History of the Delphi

Origins of the Delphi reach as far back as ancient Greece when answers to questions were sought out by the oracle Pythia, a priestess who entered a trance-like state after inhaling ethylene fumes and foretold the future (Keeney, Hasson, & McKenna, 2010). It was believed at the time that because of the importance of oracular powers, Delphi was considered the center of the world ("Delphi," 2018). Much like the ancient times, knowledge and answers are still sought from those perceived as experts. Expert sources are believed to have the ability to predict the future and make sense of what is presently understood. This is evident today in what is known as the Delphi method.

In modern times, the Delphi method was developed by the RAND Corporation as a way to generate consensus among experts in the 1960s to forecast the impact of technology on warfare (Helmer, 1967). This method is most frequently chosen when expert opinions are needed to establish consensus about a topic when none previously exists (Franc, 2018). According to the RAND Corporation (2018), the Delphi method petitions the views and opinions of identified experts through a series of carefully designed questionnaires combined with information and feedback on opinions. The iterative process of soliciting input from a panel of experts allows for refinement of ideas until convergence and consensus is reached. The procedure involves an iterated series of rounds with surveys or questionnaires to collect responses from the panel members individually. The collected data is compiled and reported back to the panel for another round of feedback. This manner of collecting data is continued until a degree of consensus is reached.

Overview of a Delphi Study Approach

Keeney, Hasson, & McKenna (2010) describe a Delphi study survey design as the "most common type used in health care research" (p.1). A survey design can explore ideas, collect descriptive data, or compare information. The Delphi technique falls into the category of a survey design and is based on the assumption that the opinion of the group holds more value than that of the individual (Keeney et al., 2010). By soliciting a group for consensus of opinion, the reliability and validity is increased over one individual's opinion (Okoli & Pawlowski, 2004). Reliability is increased through collecting of information more than once at different points in time (Eva, 2011). This also supports the internal consistency of the study by asking the set of questions to multiple people to compare results (Eva, 2011).

Keeney and colleagues (2010) describe the Classical Delphi research methodology in detail, which includes the following characteristics: panelists are administered two or more rounds of questionnaires; initial requests are open-ended to collect opinions on a particular topic; responses are analyzed by the researcher; reports are generated and sent back to the individual panelists along with a group report; panelists then rank order statements and provide comments; continuation of rounds are completed until consensus is reached on some or all required items. This method incorporates a mixture of qualitative and quantitative techniques which allows for a more broad depiction of the topic (Iqbal & Pipon-Young, 2009). Due to the array of ways a Delphi study can be conducted, a more accurate and consistent term to describe the study is the Delphi approach (Powell, 2003). The term Delphi approach will be used throughout this study to describe the process and methods.

Use of a Delphi approach can be utilized at various points of research. Okoli and Pawlowski (2004), researchers studying electronic commerce factors in developing countries,

point out the versatility of using the Delphi method in research applications. Delphi methods can be used in:

- Identification of the research topic;

- Specification of research question(s);

- Identification of a theoretical perspective for the research;

- Selection of variables of interest/generation of propositions;

- Preliminary identification of causal relationships; and

- Definition of constructs and creation of a common language (Okoli & Pawlowski, 2004, p. 15).

General Description of a Delphi Study Approach

The procedure in using a Delphi approach begins with questions that have replies that assume some general understanding on a topic or those that may provoke ambiguous responses after a literature review has been completed (Iqbal & Pipon-Young, 2009; Keeney et al., 2010; Okoli & Pawlowski, 2004). These questions drive the research, assists in creating a research strategy, and can be developed into a questionnaire survey. Initial questionnaire survey designs are created to gather qualitative, quantitative, or both types of data (Iqbal & Pipon-Young, 2009; Keeney et al., 2010). Data are collected through sequential questionnaires, referred to as rounds, which provide opportunities for refinement of responses (Eastwood, 2012; Iqbal & Pipon-Young, 2009; Keeney et al., 2010). Initially, questions begin more open-ended and work toward agreement among the panelists in the subsequent rounds (Iqbal & Pipon-Young, 2009; Keeney et al., 2010).

When uncertainty on the topic of investigation exists, a panel of experts is identified to respond rather than the general population to help provide clarity (Eastwood, 2012; Keeney et

al., 2010; Okoli & Pawlowski, 2004). Solicitation of experts allows for more knowledgeable and appropriate responses to potentially complex ideas and specific issues that the general population may not be suitably informed to answer accurately (Okoli & Pawlowski, 2004). Identifying the expert panel involves a thorough procedure to identify and outline qualifications (Keeney et al., 2010; Okoli & Pawlowski, 2004). Categorization of qualifying experts depends upon the topic of the research and conceptualization of the 'expert' definition within the study. This is the responsibility of the researcher (Iqbal & Pipon-Young, 2009; Okoli & Pawlowski, 2004). A beneficial factor is to have a varied panel who may offer a diverse perspective (Iqbal & Pipon-Young, 2009). Example steps for a procedure on selecting experts may be: (a) prepare a list to identify relevant skills, disciplines, and academics desired; (b) identify names, organizations, academic or practitioners; (c) contact identified experts for potential participation; (d) ask identified experts to nominate others with similar qualifications; (e) rank experts based on qualifications; (f) invite experts for participation based on ranking and discipline; and (g) stop recruiting once target number of experts has been reached (between10-18) (Okoli & Pawlowski, 2004).

After the experts have been identified and agreed to be panel members, the initial round of questioning is sent out via a convenient method, such as email or website. During the Delphi process, panelists remain unidentified to each other. First round of questioning generally consists of open-ended questions or requests aimed specifically toward responding to the research questions driving the study (Iqbal & Pipon-Young, 2009; Keeney et al., 2010). Upon completion of the recommended rate of at least 70%, the data from round one is analyzed and guides the construction of the round two questionnaire (Iqbal & Pipon-Young, 2009). Results are reported back to the panelists who are given an opportunity to refine their responses based on

the themes that arose from the analysis. Initial responses of the panelists are usually included with the consolidated responses to assist with potential revision of the panelist. Round two also includes requests for the panelists to verify and categorize the overall responses from round one (Okoli & Pawlowski, 2004).

Analysis of the round two data allows for a narrowing of responses working toward consensus among the group of the most important or top factors. Following analysis and consolidation, the questionnaire for round three is developed to rank the items or factors of importance to the topic. The third round allows for the reduction of factors. Round three data will be analyzed similarly to the round two data analysis. When a satisfactory rate for each item reaches the pre-determined rate of agreement, for example a score of 70% agreement, then consensus has been reached for that item (Iqbal & Pipon-Young, 2009; Keeney et al., 2010). If consensus has not been made, then additional rounds will be completed (Keeney et al., 2010; Okoli & Pawlowski, 2004). In the last return of collected data the researcher should confirm no changes were made by the participants to determine if additional analysis is to be completed (Iqbal & Pipon-Young, 2009). The final step is to review the data collected from the panel of experts and assess the implications from the ranking of importance of the factors. Common information provided in the data analysis are "percentages, medians, interquartile ranges, means, and standard deviations" (Iqbal & Pipon-Young, 2009, p. 600). Results can be interpreted and findings reported to interested parties/shareholders along with participants (Iqbal & Pipon-Young, 2009; Keeney et al., 2010).   Figure 2: Delphi Study Design Process depicts the steps of the Delphi process.

Figure 2: Delphi Study Design Process

Step 1
- Literature Review
- Identification of Research Idea

Step 2
- Identify questions driving research
- Development of research strategy
- Develop initial questionnaire for Delphi Round One

Step 3
- Define/Identify qualifications for expert panel selection
- Create procedures for selecting experts

Step 4
- Prepare list of potential experts that meet identified criteria
- Contact/invite potential experts for participation
- Obtain nominations of other experts

Step 5
- Send out Delphi Round 1 questionnaire/survey
- Analyze completed data for themes
- Develop questions for Delphi Round 2 from results

Step 6
- Send out Delphi Round 2 questionnaire/survey
- Review completed data for revisions/alterations from panelists
- Analyze completed data for additional/altered themes & ranking of importance
- Develop questions for Delphi Round 3 from results

Step 7
- Send out Delphi Round 3 questionnaire/survey
- Review for revisions & analyze data
- If consensus met, move to step 8 – if not, repeat step 7 as Delphi Round 4

Step 8
- Prepare analysis and report findings
- Share finial analysis and findings to stakeholders & panelists

Delphi Studies in Counselor Education

Specific to research in counselor education, the Delphi approach has been used to create a

set of key competencies for research and supervision within the counseling field (Neuer Colburn,

Grothaus, Hays, & Milliken, 2016; Wester & Borders, 2014). In 2014, Wester & Borders conducted a Delphi study to identify required research competencies for quality research. Similarly, Neuer Colburn and colleagues (2016), solicited a panel of experts through a Delphi approach to identify knowledge, attitudes, and skills in supervision that doctoral counseling graduates needed to provide effective supervision. Herlihy & Dufrene (2011) also used the Delphi approach to seek consensus on the most important and emerging ethical issues facing the counseling profession at that time. All three of these studies helped to create a foundation of information to propel further research on these specific topics. Additionally, the studies validated information introduced in previous literature and identified areas that needed more empirical studies. The Delphi approach has been effective in advancing research and strengthening the counseling profession.

Current Study Description Overview

The current study consisted of a three-round Delphi approach beginning with identification of potential expert panelists. Those identified were invited to participate via email with a link to an open-ended round of questioning and informational questionnaire via electronic survey. This method allowed participants to remain anonymous to each other to reduce bias (Keeney et al., 2010). The invitational round continued until the desired range of panelists was reached. Data from the initial round was analyzed which produced the survey for the second round. Data from the second round was analyzed and returned to the group via email to provide outcome information for the subsequent round. Feedback to the panelists included statistical summary of all responses, including original questions. Each round gave the panelists the opportunity to provide additional comments, in addition to allowing for data to be statistically

analyzed for interpretation (Helmer, 1967; Keeney et al., 2010; A. West, 2011). A fourth-round of questioning was not utilized as consensus was achieved.

All survey data was submitted as self-report and identifying information was not retained with responses to ensure confidentiality. An internet-based collection method was chosen based on cost, consistency in survey delivery, and to include participants in a variety of locations. Additionally, an electronic survey is more efficient, convenient to the participant, and aids in increasing response rates (Kaplowitz, Hadlock, & Levine, 2004).

<div align="center">**Expert Panel Selection**</div>

The Delphi approach does not have formal outlines of what constitutes an expert; therefore, the researcher must clearly establish support for decisions on identifying criteria for expertise to fully explore the research question (Keeney et al., 2010; Powell, 2003; A. West, 2011). Previous researchers recommend being transparent and providing documentation for the choices that justify the selection process to aid in replication, reliability, and trustworthiness (A. West, 2011; Wester & Borders, 2014). The Delphi approach relies on a group decision from a panel of experts with wisdom in the study topic rather than depending on a statistical representation of a population, which makes the process of identifying experts crucial (Okoli & Pawlowski, 2004). For the purposes of this study, participants sought were professional counselors identified for their range of knowledge, experience, and expertise within the field.

Overall Panel Description

Professional counselors provide a range of services in various settings. These settings, such as community mental health agencies or schools, require the counselor to have additional specialized training for their chosen disciplines. Each discipline of counseling shares core training and education, but may have a different focus in approaching clients, and hence a distinct perspective. Counselors were recruited from six discipline categories of clinical mental

health, school counselors, substance abuse/addiction counselors, counselor educators,

rehabilitation counselors, and counselor supervisors (See Table 1). By soliciting counselors from

the various disciplines, attempts were made to include a range of potential panelists to better

reflect the overall spectrum in the professional counseling community. Inviting representatives

of the various counseling disciplines also allowed all groups to potentially have an opportunity

for input (Okoli & Pawlowski, 2004). Additionally, by having an assortment of counselors,

responses provided a range of valuable knowledge and experience that added complexity to the

personal history and training from each panelist (Chan, Cor, & Band, 2018).

Table 1: Counseling Discipline Categories Selected for Representation

Clinical Mental Health Counselors (Includes counselors working in agencies, hospital settings, or marriage and family counselors)	School Counselors (Includes counselors working in a primary, secondary school setting or at a college or university setting for academic counseling in either public or private education systems)
Substance Abuse Counselors	Counselor Educators
Counselor Supervisors (Includes supervisors within any counseling setting – panelists may also qualify for an additional category listed)	Rehabilitation Counselors

       Counseling discipline expertise criterion description. Potential panelists were chosen

from six counseling disciplines. These disciplines, also listed in Table 1, consist of: clinical

mental health counselors, school counselors, substance abuse counselors, counselor educators,

counselor supervisors, and rehabilitation counselors. These disciplines were chosen because of

the impact each has on a counselor's desire to work with specific groups of people. Compassion

is multifaceted; therefore, potential panelists were identified with consideration of the unique

area of expertise to use as their lens to identify the specific skills, knowledge, and behaviors to

define compassion as it is displayed in the counseling profession. Each discipline will be discussed with a rational for inclusion in this study.

Clinical mental health counselors include, but are not limited to, counselors working in agencies, hospital settings, or marriage and family counselors. Additionally included in this discipline are college or university counselors providing individual or group mental health services. Counselors are dedicated to helping others (Lawson, 2018). Counseling assists individuals with effective problem-solving and explores the unique individual experiences (ChÁvez et al., 2016; Ibrahim, 1984). The core of counseling is the relationship (Rogers, 1986; Young, 2017). According to the US Bureau of Labor Statistics (2017), there are approximately 687,150 counselors in the workforce. Clinical mental health counselors were included in this study because of the nature of work that counselors perform and the foundational component that compassion has within the helping profession. Clinical mental health counselors work with a wide range of individuals, couples, families, and groups.

For this study, school counselors include those who work in a primary or secondary school setting in either a public or private K-20 education system. Thus, counselors working at the college and university level that provide career counseling or academic advisement are classified as school counselors. According to the American School Counselor Association, school counselors are:

Certified/licensed educators with a minimum of a master's degree in school counseling, making them uniquely qualified to address all students' academic, career and social/emotional development needs by designing, implementing, evaluating and enhancing a comprehensive school counseling program that promotes and enhances student success (ASCA, 2019).

School counselors were included in this study because of the population of clients they serve. School counselors have the opportunities to work with children, parents, caregivers, and the educational system in which their clients are involved.

Substance Abuse Counselors or Addiction Specialists are counselors who have the same level of training and education, but focus on the treatment of addictive disorder and diseases, and help prevent relapse. Many states in the US require additional certification or licensure which may include specific practical training and supervision hours. Including substance abuse counselors creates areas of additional counseling specializations to be involved in the examination of how counselors are considering compassion.

The same can be said for including rehabilitation counselors. The Occupational Outlook Handbook website states that rehabilitation counselors "help people with physical, mental, developmental, or emotional disabilities…overcome or manage the personal, social, or psychological effects of disabilities on employment or independent living (Bureau of Labor Statistics, 2019)." Including the rehabilitation counselor discipline not only adds to the variety of counseling specializations, but also opens the cooperation of exploring the topic of compassion. There has been some recent exploration of compassion and self-compassion in the rehabilitation counseling literature.

Counselor supervisors were also chosen to include as part of the panel because counselors who provide supervision have the responsibility for the oversite of counselors-in-training and new post-degree counselors (Association for Counselor Education and Supervision, 2011). Additionally, supervisors can work in a variety of settings and in any of the counseling disciplines. Counselor supervisors are generally fully licensed and have had additional training and post-licensure experience. For example, in Virginia, LPC supervisors have an unrestricted

license as a professional counselor in the Commonwealth of Virginia, a minimum of two years post-licensure clinical experience, and at least 20-hours of continuing education in supervision or three credit hours of graduate-level coursework in supervision (Virginia Department of Health Professionals, 2019). Potential panelists who are identified in this category may also self-identify as both serving in a particular specialist area and as a supervisor.

The final category of discipline selected for participation is counselor educators. Counselor educators are responsible for the constructive development of the programs to train counseling students and the learners within those programs (McAuliffe & Eriksen, 2011). Counselors who are working as educators can identify as practitioners, educators, and researchers (Hall & Hulse, 2010). Moreover, counselor educators can consider education on a range of participation from part-time to full-time, adjunct, practitioner instructors, associate professors, assistant professors, and full professors. By adding in counselor educators, the perspective of those shaping the future of the profession can be incorporated. This discipline, much like the supervisors, can self-identify within this group, as a specialty discipline, and also as a supervisor.

Years of experience criterion. Experts were also identified based on the years of experience within the profession. More years of experience allows the potential for having more knowledge within the various counseling disciplines (Helmer, 1967; Keeney et al., 2010). Expert counselors are being defined within this study as counselor practitioners with more than 10 years of field experience. Counselor educators are being defined within this study as those in the counselor education field with more than five years of experience in an educational setting.

Education and licensure criterion. Counselor practitioners with more than 10 years of field experience will generally have a minimum of a master's level education and hold licensure

in their area of discipline. Counselor educators with more than five years working in an educational setting generally will hold a doctorate level education, be credentialed or licensed within their specific discipline, and may also have a range of counseling experiences in addition to the educational experiences.

Presentations and service criterion. In addition to experience, counselors and counselor educators may have a trackable history of presentations and publications. Service to the profession, via active membership or leadership participation in counseling associations, or reviewer or editor of a counseling journal will also be identified to support a commitment to the counseling profession.

Area of interest or specialization criterion. An additional criterion was utilized to identify potential panelists. The following areas of interest or specialization include, but were not limited to: trauma, wellness, intersectionality, resilience, empathy, compassion satisfaction, grief and loss, spirituality, pedagogy/educational practice, and compassion fatigue/vicarious trauma/secondary trauma stress. These specific areas of interest or specializations were used only to identify potential panelists due to the nature of these topics being closely related to or involving previous studies connected with compassion. These were not part of any exclusionary criteria for potential panelists.

Steps Taken to Identify Panel

Panelists were identified for their work in areas related to the main topic of the research, which supports credibility with the target audience of the counseling community (Powell, 2003). The following procedures were used to guide identification of panelists based on the Okoli and Pawlowski study (2004). A multiple-step process, illustrated in Figure 3, describes the process to identify potential panelists.

Figure 3: Process to Identify Potential Panelists

Step 1	Prepare Counselor Panelist Nomination Worksheet:	• Identify counseling discipline categories • Identify & review professional counseling literature • Identify professional areas of specialization
Step 2	Input names in Counselor Panelist Nomination Worksheet:	• Enter names of individuals in relevant discipline categories • Enter names of individuals from professional counseling literature • Enter names of individuals in relevant areas of specialization • Enter names of individuals with service to professional counseling organizations
Step 3	Create Expert Panelist Scoring Rubric and Rank Experts:	• Create EPSR (Scoring Rubric) • Create list for discipline category and sub-list for specializations • Categorize experts according to discipline categories and specialization • Score experts from scoring rubric & rank based on qualifications
Step 4	Invite Experts & Nominate additional Experts:	• Invite experts for each discipline category & specialization • Invite experts in rank order basked on rubric scoring within list/sub-list • Ask potential panelist to nominate other experts • Target panel size = 10-15, with a minimum of one expert per category • Stop soliciting when panel size is reached

Step one. Step one of the process to identify potential panelists was to create the counselor panelist nomination worksheet (referred to as "worksheet"), seen in Table 2. The purpose of the worksheet was to organize the criterion in an effort to avoid missing categories of counseling disciplines and to identify sources to collect specific data for scoring and ranking of potential panelists. The worksheet identified the counseling disciplines and the professional areas of interests or specializations. The worksheet also identified counseling journals, professional social media, and professional organizations that contributed to successful identification of the defined experts for this study. The lead researcher completed the worksheet, with a review by the academic research chairs. Table 2 reflects the completed Counselor Panelist Nomination Worksheet.

Table 2: Counselor Panelist Nomination Worksheet

Discipline/Specialization	Resources		
Counseling Discipline Category	Counseling Journals/Publications	Professional Social Media	Professional Organizations
1. CMHC 2. School Counselors 3. SA Counselors 4. Counselor Educators 5. Counselor Supervisors 6. Rehabilitation Counselors Areas of Specialization 1. Trauma 2. Wellness 3. Intersectionality 4. Resilience 5. Empathy 6. Compassion Satisfaction 7. Grief & Loss 8. Spirituality 9. Pedagogy/Ed Practice 10. Compassion Fatigue/VT/STS	Academic: • Counselor Education & Supervision (CES) • Journal of Counseling & Development (JCD) • Journal of College Counseling (JCC) • Counseling & Values • Journal for Humanistic Counseling Education & Development (JHCEAD) • Journal of Addictions & Offender Counseling (JAOC) • Professional School Counseling • Journal of Multicultural Counseling & Development Professional Publications: • Counseling Today	• LinkedIn • Research Gate	• American Counseling Association (ACA) • American School Counselor Association (ASCA) • Association for Counselor Education & Supervision (ACES) • American Rehabilitation Counseling Association (ARCA) • International Association of Addictions & Offender Counselors (IAAOC) • Association for Spiritual, Ethical, & Religious Values in Counseling (ASERVIC) • Other Branches & Regions of ACA

Verification sources to collect criterion data for potential panelists were: Curricula Vitae (CV), licensure boards, review or searches of counselor education and supervision journals, review of association or professional websites, and review of professional social media websites (LinkedIn and/or Research Gate). Each of the four criteria areas identified previously will have a minimum of two potential verification sources to collect scoring data for possible participants.

Step two. Step two consisted of a cursory review of literature in the identified counseling journals to ascertain an initial list of potential participants. Additional potential participants were identified by conducting a search of areas of expertise in counseling on professional social media platforms (LinkedIn and Research Gate). A brief review of the professional association websites was completed to determine participation in service to the counseling profession via leadership roles or editorial positions on journals or newsletters. Finally, potential names identified for participation were searched on counselor educator websites and professional counseling websites to obtain resumes or a CV. A threshold of 3-5 names for each discipline area of expertise was sought for review of qualifying criteria based on the expert panelist scoring rubric.

Step three. For step three, potential panelists were sorted into a counseling discipline category list to classify and confirm a pool of 4-6 identified experts for each discipline. This procedure ensured access to an adequate number of experts to reflect representation on the panel. The identification and sorting process intended to yield a resulting list of approximately 30-36 potential experts to contact for participation. A total of 34 names were identified as potential panelists. Of the 34, 7 were clinical mental health counselors, 10 counselor educators, 4 rehabilitation counselors, 4 substance abuse counselors, 5 school counselors, and 4 supervisors.

It was within this step that the researcher identified the discipline category of the potential panelist and assigned a unique identification code. During the Delphi Round 1 information questionnaire, the panelists who did choose to participate had the option to self-identify their area of expertise and discipline. Many times experts take on numerous roles, such as counselor educator/supervisor or have expertise in multiple areas (i.e., trauma, intersectionality, compassion satisfaction), and therefore may be placed into more than one category. Any discrepancies in numbers for the final panel may be due to the self-identification process into multiple groups.

As the expert names were collected, qualification information was also gathered to provide supporting documentation on expertise. Based on the guidelines utilized by Okoli and Pawlowski (2004) on identifying experts, an Expert Panelist Scoring Rubric ("scoring rubric") was created specifically for this study to identify the four criteria areas: experience, expertise, education and licensure, and service. Each criterion contains particular benchmarks that support further credentialing as a potential panelist. For every item of criteria, the potential panelist was scored on a 5-point scale ranging from $0 =$ weak to $4 =$ outstanding. Composite scores for each section of criteria areas were combined into an overall score for each potential panelist. Potential panelists for each area of specialization expertise were identified and those with the highest scores were prioritized for contact with an invitational email to participate. Appendix A provides the detailed information and scoring on the scoring rubric. Table 3 provides a brief description of the criteria areas for scoring on the scoring rubric.

Step four. Once approval for beginning the invitational Delphi Round I was granted from the Virginia Tech IRB, the highest qualifying names for each discipline were identified. Experts with the highest rank order from the scoring rubric from each discipline category and

Table 3: Expert Panelist Scoring Rubric Description of Criteria Areas

Experience	Expertise	Education & Licensure	Service to the Profession
• Length of time in counseling profession • Length of time in CES • Varied range of experience (i.e., various settings, both counseling & teaching)	• Referred journal articles published on identified topics • Books/Chapters written about identified topics • Presentation on identified topics • Courses taught on identified topics • Workshops/trainings on identified topics (as presenter)	• PhD – if in CES • Master's – if Clinician only • Licensed/certified in area of specialization	• Leadership participation in counseling associations • Active membership in counseling associations

area of specialization received a recruitment email. Invitational emails included an overview of the study and an attached research subject consent form. Specific information regarding the recruitment email and details of the Delphi I are discussed in the data administration procedures.

Within the invitation and explanation of the study, potential panelists were requested to provide up to two names of recommendation in their area of expertise for potential inclusion. The purpose was to have additional names to research and identify as qualified potential panelists to reach the overall targeted number of panelists. The overall target panel size was 10-15 participants with a minimum of one expert per discipline category. Once the desired panel size was obtained, solicitation for participation stopped.

Recruitment Procedures

Participants were sought using a mixture of convenience, purposeful, and snowball sampling in an effort to achieve the desired panel size of 10-15 expert participants with a minimum of one panelist per discipline. Due to the sample population being homogenously made up from one profession, the smaller size is appropriate (Iqbal & Pipon-Young, 2009). The possibility of attrition or participation fatigue did exist, therefore a range of participants on the

panel was employed to maintain an acceptable sample size (Keeney et al., 2010; Neuer Colburn et al., 2016; A. West, 2011). Results could be inferred as generalizable and may be considered as a representation of the larger population of professional counselors (Keeney et al., 2010). Efforts were made to work toward the goal of having a minimum of one panelist from each discipline category, based on the panel size recommendations in the Delphi literature (Iqbal & Pipon-Young, 2009; Keeney et al., 2010; Okoli & Pawlowski, 2004; A. West, 2011).

Data Collection Procedures

In order to ensure the safety and protect the rights of all potential participants, all data collection processes and procedures were outlined and overseen per the Virginia Tech IRB, Western WIRB, and the Virginia Tech Human Research Protection Program (VT HRPP). During the course of this research, the institutional review boards changed three times. The research procedures and each round of data collection information were submitted for approval to the current governing board prior to participant solicitation or rounds of data collections. The initial approval from WIRB can be found in Appendix B. All data was collected through an electronic web based survey to capture responses to the instruments and information questionnaire. By utilizing an electronic, or online, format, data can be entered by the participant directly into databases which allow for reliable access to data for reporting purposes (Dillman, Smyth, & Christian, 2014). Additionally, most online surveys are familiar to and commonly utilized among the participant population.

Qualtrics, a software package that allows for online collection of survey data, was used to create and administer all surveys. Licensure for this software is secured through Virginia Tech and adheres to the information systems standards of the university. The software is only accessible via a password through the secured campus network. All surveys created by the

researcher, as well as incoming responses, are only accessible to the researcher and committee chairs. Data collected through this software package was exported to another platform, Microsoft Excel, for more sophisticated data analyses.

In an effort to ensure confidentiality of the panelists' information, each panelist was assigned a code number that was utilized with each round of the Delphi study. This identifying code number was provided to the individual panelists within their invitational email. Identifying information was kept separate from all other data in a Microsoft Excel spreadsheet on an encrypted thumb drive stored in a locked location. Only the research team has access to this information, except for any emergency situations that the committee members would deem necessary.

Delphi I Administration Procedures

The Delphi Round I, which is customarily used to gather ideas and statements (Keeney et al., 2010), began with an invitational recruitment email to a total of 34 identified experts as potential panelists. Most likely the potential panelists had convenient access to computers and were familiar with utilizing electronic media. The initial invitational recruitment email introduced the researcher, highlighted the importance of their contribution through the emphasis of their knowledge and expertise in their discipline of counseling. Each email was personalized to the individual to point out their area of identified expertise and included a unique identification code. The message also contained pertinent details about the rationale and overall purpose for the study, directions with a link for Delphi Round I, as well as an outline of the progression with participation (Appendix C). Attached to the invitational recruitment email was the 2-page Research Subject Consent document (Appendix D) that contained statements regarding the purpose, procedures, responsibilities in participating, risks, benefits, alternatives to

participation, anonymity and confidentiality, compensation, freedom to withdraw, and information should there be questions about the research. Recruitment began March 14, 2019, and a follow-up reminder email was sent out 5 days following to those who had not responded to the survey (Appendix E).

The web-based survey link to the Delphi Round I was included in the invitational recruitment email. The initial round consisted of an introduction with the purpose of the study, an informed consent, an information questionnaire, and the Delphi Round I questions. Part of the introduction requested potential panelists to identify or nominate others who may have been beneficial to the study. Directions instructed potential panelists to identify the names and email addresses for one to two nominees that were licensed professional counselors with 10 or more years of counseling experience and/or counselor educators with five or more years' experience in counselor education. These requests were presented to potential panelists prior to the informed consent and start of the information questionnaire and Delphi Round I. This allowed the potential panelists to opt-out of participation, while still contributing nominations in a snowball method. A total of nine nominations were given by the participating panelists.

Nominees were researched using the same methods as identification for the initial recruitment group. Those meeting the criteria outlined for expert status according to this study were sent invitational recruitment email messages. A total of five second-wave invitational recruitment emails were sent out on March 19, 2019. A final reminder message (Appendix F) was sent to any initial and second-round potential panelists who had not yet responded, as well as three additional third-wave invitational recruitment emails, on March 25, 2019. Recruitment continued until the responses reached the desired panel size of 10-15 expert participants to

maintain an acceptable sample size and to guard against attrition or participation fatigue (Keeney et al., 2010; Neuer Colburn et al., 2016; A. West, 2011).

Information Questionnaire

The information questionnaire was designed to collect various characteristics about categories of identity the participants may belong, as well as include variables such as length of experience in counseling, length of experience in counselor education, areas of expertise, and information regarding professional service. The purpose of collecting this information was to enhance and confirm what may have been previously collected and entered into the worksheet for qualification as an expert. Demographic questions were used to determine the general population for the sample and provide characteristics of the panelists. These questions included age, gender, and ethnicity/race. Further items were added to gain more information regarding current status of occupation, current status of counselor education, and counseling settings. Information collected will also serve as an additional inclusion/exclusion criteria for participation. Any participant not meeting the minimum qualifications during the data collection did not have information included as part of the study. See Appendix G for the Information Questionnaire.

Delphi Round I Questions

The first round of Delphi questions included six open-ended questions to allow panel members the opportunity to provide spontaneous and unrestricted responses (Iqbal & Pipon-Young, 2009; Keeney et al., 2010). This round collected data through qualitative methods. The following directions and questions comprised Delphi Round I (see Appendix H for the survey document from Delphi I):

1. Based on your experiences and observations, use words or phrases to answer the following question: How do you differentiate between compassion and empathy?

2. For the next question, the following terms are identified as such: *Professional* = any and all interactions that occur when you are acting in professional counseling or counselor educator capacity or within a professional context *Personal* = any and all interactions that occur when you are acting within your own personal set of mores and ethics in non-professional settings or contacts How is compassion expressed or perceived differently in a professional setting versus in a personal setting?

3. Identify and describe examples or situations where a counselor might struggle to feel or display compassion with a client.

4. Based on your experiences and observations, use words or phrases to answer the following set of questions: Identify and describe specific skills that demonstrate compassion in counseling.

5. Identify and describe specific knowledge that demonstrates compassion in counseling.

6. Identify and describe specific attitudes and beliefs that demonstrate compassion in counseling.

Data Analysis Procedures

Data cleaning and preparation. Prior to beginning data analysis, information was exported from Qualtrics into Microsoft Excel spreadsheets for analysis and reporting. Microsoft Excel was chosen due to the availability, reliability, and ease of use. A smaller data set was also manageable for use with this software. Once the raw data was imported into Microsoft Excel all formatting entries were cleaned by confirming entries were correct and formatting was similar for each entry. The panelists did have the option of not responding to any portion of the

questions. In the event a panelist did omit a portion, the remaining responses for that participant were still included within the overall study. The total sample size for each question was impacted when panelists omitted responses within the survey.

Demographic information. The initial round contained data from the information questionnaire and the Delphi I questions. The information questionnaire was sorted into a separate spreadsheet from the Delphi I question responses. Data from the information questionnaire was analyzed for descriptive statistics reporting using Microsoft Excel spreadsheets. Any data collected containing text was numerically recoded for entry into the Microsoft Excel spreadsheet. By utilizing numeric representation of text or categories, responses were analyzed for descriptive statistics which allowed for description and examination of the data (Howell, 2013). Descriptive statistics aids to describe, organize, or simplify the aspects of the relevant data (Bowen, 2016). For example, the Qualtrics survey responses about age captured a range of ages such as "36-40" or "51-55" and were recorded as "3" or "6" respectively. Responses from the information questionnaire were used to evaluate the basic demographic information through descriptive statistics, such as medians, percentages, and frequency counts. The descriptive information of the panelists were completed and combined with the expert panelist scoring information to report on the qualities of the expert panel (Powell, 2003; Wester & Borders, 2014).

Delphi round I analysis. The data responses from Delphi Round I were analyzed in Microsoft Excel for qualitatively coding. Each question was sorted into a different spreadsheet keeping the combined responses from each participant intact. If no response was given, the ID code remained but the data field was left blank. Grounded theory methods were selected to analyze Delphi Round I for the following reasons: the systematic and flexible nature of the

guidelines of research, allowance for collection and analyzation of qualitative data, theories can

be constructed from the data, the iterative strategies, constant comparative methods, and the

interaction and involvement with the data (Charmaz, 2014).

The responses were reviewed in two main phases: initial coding and focused coding.

Initial coding consisted of reviewing the data and naming it into initial categories. Doing this

aided in interpreting and accounting for each piece of data (Charmaz, 2014). Each response for

every question was reviewed several times by the researcher and/or research team to identify

themes or ideas.

After the initial themes were identified, each response for the individual questions were

again reviewed and grouped into the theme that best matched the area of interest (Keeney et al.,

2010). This focused thematic coding process occurred in Microsoft Excel through a cut and

paste process for ease of use.

During the focused thematic coding, it was identified that some of the individual

responses needed to be separated out to allow for richer exploration of the data. For example,

some responses to question five asking for identification of specific knowledge that demonstrates

compassion were written as several sentences that conveyed more than one idea or may have

included a bulleted list of concepts. Each individual idea was listed on a separate line entry and

maintained the unique identification code of the panelist. Once again each line was focused

coded for collapsed themes. The findings from this round of coding was discussed and examined

with the committee chair and methodologist.

Based on the discussions and recommendations from the committee, another round of

coding was completed exploring the data differently. Following the two rounds of coding for

each question individually, all of the data was combined to examine and capture emergent

themes across all survey questions. The individual statements were combined into a Microsoft Excel Spreadsheet for analysis. Data sorting was conducted to explore the data differently in an effort to address the questions guiding the research. The unique identifying code, initial statements, initial themes, collapsed themes from the previous analysis, survey question number, and categorizations were included as categories to examine during this round of qualitative analysis. The categorizations from questions one, two, and six included: compassion, empathy, professional, personal, attitude, and belief.

When all statements were grouped together according to the overall main themed coding, the researcher made the decision to combine redundant responses and collapse themes. Documentation of these decisions were made through memo writing and a methodological journal maintained on an Excel spreadsheet (Charmaz, 2014). Reducing the number of themes served to assist in reporting a more manageable amount of information in the next round of data collection.

Results from the analysis of Delphi Round I were reduced and converted into a questionnaire survey for Delphi Round II for the panelists to provide feedback (Eastwood, 2012; A. West, 2011). This information was reviewed by the committee chair. Statement directions and questions were formulated for construction of the Delphi Round II instrument in Qualtrics.

Review and Approval

Virginia Tech IRB had the initial oversight of the study and granted approval for research in Delphi Round I to be submitted to Western IRB for review (Appendix I). A change in protocol was to have the VT IRB have information regarding the process, but the approval and oversight of changes to be completed through Western IRB (Appendix B). Prior to beginning Delphi Round II, amendments to the study were submitted to Western IRB for approval

(Appendix J). Changes included contact email and the Delphi Round II survey. Approval from WIRB was forwarded to VT IRB for tracking. VT IRB confirmed acknowledged submission for tracking and process of data collection moved forward.

Delphi Round II

Delphi Round II began with the construction of the Qualtrics survey instrument based on the data collected and analyzed from the panel of experts in Delphi Round I. The questions within the survey were designed to assist the panelists with an organized method in working through the data results. The instrument began with a welcome, introduction, included an approximation of time for completion, and instructions on how to complete the survey over multiple sessions if needed. Panelists were reminded of the option of not responding to any questions. Directions on what to do should questions arise and contact information for the investigator, faculty advisor, and Western IRB were included. Panelists were asked to use the same unique identification code that was included on the Delphi Round II email (see Appendix K for Delphi Round II email).

A total of 14 questions were constructed to provide information gathered from Delphi Round I. Data from the Qualtrics survey was imported into Microsoft Excel for analysis and all necessary conversions from characters to numerical values were completed. For 11 of the questions, panelists responded to each survey item by rating the degree of agreement. Items were not placed in any particular order within each question. The panelists were instructed to rank their agreement using the following 7-point Likert-type scale: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* A seven-point scale provides more granularity, aids in better decision making, and a minor increase of reliability scores can be achieved (Korkut Altuna & Arslan, 2016). Having a

greater progression of agreement to choose from rather than equalizing the number of positive and negative responses was decided upon to allow for potential examination of nuances in agreement. There were also three questions designed as open-ended responses to collect any additional comments following their review of the statements to allow panel members the opportunity to provide spontaneous and unrestricted responses (Iqbal & Pipon-Young, 2009; Keeney et al., 2010). See Appendix L for the Delphi Round II survey.

This round began the process of working toward consensus of the expert panel and collected quantitative and qualitative data. This, and subsequent rounds to collect similar data, are analyzed using rating or ranking methods (Powell, 2003).

The 15 expert panelists were contacted via email on May 15, 2019 (Appendix K). The email included the unique identification code for use in the survey. The instructional email informed the panelists that the rich qualitative responses from Delphi Round I were sorted to identify emerging themes and ideas. Additional information provided was that similar or duplicated data were collapsed to create the current round of questions that best captured the main concepts collected by all participants through focused coding. Reminders were sent out only to participants who had not completed the survey on May 20, 2019, and June 4, 2019 (Appendix M). A total of 11 panelists responded for the Delphi Round II, giving a response rate of 73%.

Data Analysis Procedures

Once responses were received by the panelists, the data was exported from Qualtrics to Microsoft Excel to be cleaned and analyzed. Data cleaning was similar for this round of data as from the previous round, including recoding text to a numerical representation. Each question was transported into an individual worksheet for analysis. During analysis of Question one, a

discovery was made that assigned numbers to the 7-point Likert-type scale had been transposed in Qualtrics. Those responses for *slightly agree* (4), *neither agree nor disagree* (5), *somewhat disagree* (6), and *disagree* (7), were assigned the numbers 5-8 respectively. A line-by-line comparison was made to the original data in Qualtrics and updated on the Excel spreadsheet to match the original assignment of numeric responses. Alterations to the numbers were highlighted with a different shading to confirm that the numbers may not correspond correctly with initial reports. Each response was double-checked to ensure the panelist's responses were correctly recorded. Due to the error in conversion, each question that was assigned a 4-7 response was checked to the Qualtrics data. Errors were found and corrected only within the data for question one.

Frequency analyses were completed after each question was transported into a separate worksheet. The individual items were calculated to find the minimum, maximum, mean, median, mode, count, variance, standard deviation, interquartile range (IQR), percentage of agreement, and number in agreement. The median is appropriate to use with smaller groups and is a measure of central tendency (Wester & Borders, 2014). Following these statistical analyses, the percentage of overall agreement was calculated. Each item within the question that had reached the previously established level of consensus of $\geq$ 80% was shaded in yellow. Additionally, computations were made to collect the range of the means and standard deviation for each question.

All statement items and percentage of agreement calculations were moved to a separate Excel worksheet, which was sorted by the percentage of agreement from highest to lowest. Those statement items reaching consensus were shaded in yellow. Any notations of agreement being either *neither agree nor disagree* or in a category of *disagree* were noted on the worksheet

beside of the item. These steps were completed for each of the 11 questions within this round of data analysis.

Consensus

The Delphi method is utilized when trying to gain consensus among a panel of experts (Keeney et al., 2010; A. West, 2011), which was also the goal of this research study. There is not a universal canon for establishing when a consensus has been reached by the panel and the majority of the literature recommends determining the level of statistical consensus before starting the study (Keeney et al., 2010; Powell, 2003; A. West, 2011).

Achieving statistical consensus during the quantitative analysis of Delphi Round II was set to 80% agreement. This percentage was determined when panelists would rate items from *strongly agree, agree, somewhat agree*, and *slightly agr*ee, or when panelists would have a high agreement rate with *disagree* or *strongly disagree*.

Qualitative Data

No qualitative responses were provided by the panelist during Delphi Round II.

Review and Approval

During the data analysis of Delphi Round II, oversight again was changed from Western IRB back to oversight at Virginia Tech (Appendix N). Virginia Tech Human Research Protection Program was contacted to provide all documentation from WIRB, amendments to the study, changes to the panelist contact emails, and the Delphi Round III. Following another review, suggested amendments were completed and approval from VT HRPP was granted before beginning data collection for Delphi Round III (Appendix O).

Delphi Round III

Delphi Round III began with the construction of the Qualtrics survey instrument based on the data collected and analyzed from the panel of experts in Delphi Round II (Appendix P). The questions within the survey were designed to assist the panelists with an organized method in working through the data results. The instrument began with a welcome, introduction, included an approximation of time for completion, and instructions on completing the survey. Panelists were reminded of the option of not responding to any questions if so chosen. Directions on what to do should questions arise and contact information for the investigator, faculty advisor, and Virginia Tech HRPP were included. Panelists were asked to use the same unique identification code that was included on the Delphi Round III email. A total of six questions were constructed to provide information gathered from Delphi Round II.

Two questions were the combination of statements to create a condensed overall reflection of empathy and compassion. The panelists were instructed to rank their agreement using the same 7-point Likert-type scale utilized in the previous round: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* Questions three, four, and five, instructed panelists to indicate level of importance to statements by moving statements into one of five categories: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important.* Panelists also had the option of not moving the statements into one of the categories. Question six provided an opportunity for the panelists to provide any additional comments regarding compassion in counseling.

The 15 expert panelists were contacted via email on August 21, 2019 (Appendix Q). The email included the unique identification code for use in the survey. The instructional email

informed the panelists that quantitative responses from Delphi Round II were analyzed and were developed to create Delphi Round III. A compiled statistical summary report was attached for reference and review (Appendix R). The link to Delphi Round III was included and an estimated time of completion was provided. Reminders were sent out only to participants who had not completed the survey on August 27, 2019, and August 29, 2019 (Appendix S). A total of 13 panelists responded for the Delphi Round III, giving a response rate of 87%.

Data Analysis Procedures

For Delphi Round III data analysis, the raw data was downloaded from Qualtrics and imported into Microsoft Excel. Data cleaning was similar for this round of data as from the previous round. Each question was transported into an individual worksheet for analysis. Once each question was transported into a separate worksheet, analysis was completed. Questions one and two were calculated to find the minimum, maximum, mean, median, mode, count, variance, and standard deviation. Following these statistical analyses, the percentage of agreement was calculated for each category of the 7-point Likert-type scale: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* Additionally, the calculation for the percentage of overall agreement was made.

Questions three, four, and five, were examined individually but the analysis was identical for each data set. The group categories for ranking the items were: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important.* Calculations for percentage of agreement were conducted for each item ranked within each category. Any individual item within the question that had reached the previously established level of consensus of $\geq 80\%$ was shaded in yellow. Next, each category was examined for the

top three to four statements in agreement. Any item that was not previously shaded in yellow from reaching consensus was shaded in green.

Calculations for combining the categories of *extremely important* and *very important* were done by adding the two percentages for each item. A darker outlined box was placed around those items that reached a consensus of 80% or greater. Additional worksheets were created to contain the item statements, individual rankings for each category, and the percentage ranking of importance.

Data from question 6 was examined individually. One statement was solely related to technical difficulties when completing the survey and was removed. The other three statements remained for reporting purposes. Once all data analysis was completed, the information was compiled into an overall report similar to the one for Delphi Round II.

Consensus

The target for achieving statistical consensus during the quantitative analysis of Delphi Round III remained at the predetermined ≥ 80% agreement as utilized in Delphi Round II. This percentage was determined when panelists rated items for questions one and two from *strongly agree, agree, somewhat agree*, and *slightly agree* or a high agreement rate with *disagree* or *strongly disagree*. Consensus would be achieved for questions three, four, and five, when panelists rated items as *extremely important* or *very important*. These two statistics were combined for examination of criteria for consensus. Individual items that achieved consensus were noted.

Reliability, Validity, and Trustworthiness

The current study was a mixture of qualitative and quantitative measurements on a subject that had little historical empirical support. By having a Delphi study with the aim to

explore knowledgeable opinions from a group of experts on compassion in a qualitative way, the quantitative measurements of rigor, namely reliability and validity, may not apply in the same ways (Hasson & Keeney, 2011). According to Hasson and Keeney (2011), the numerous changes on ways to conduct a Delphi study has increased the difficulties in testing rigor.

One of the guidelines recommended by Keeney, McKenna, and Hasson (2010) to aid in reliability is to confirm the applicability of the method to the study. The Delphi approach was chosen because of the scant research previously completed and is considered by some researchers as "a method of last resort used only when no other scientific method can be deployed" (Hasson & Keeney, 2011, p. 1696). The necessity of this study has been documented and rationale for the Delphi approach provided, as has been the choices for expert panel selection, data collection procedures, and consensus levels (Powell, 2003).

An additional recommendation that can aid reliability is in the selection of the panelists and their level of expertise (Keeney et al., 2010; Powell, 2003). The panel consisted of a group of experts in the field of professional counseling; therefore, the opinions expressed as collected and interpreted in the study are more valid than soliciting input from individuals or those outside of the context of counseling (Hasson & Keeney, 2011; Iqbal & Pipon-Young, 2009). Because the opinions were sought from experts in a qualitative manner in Delphi I, this lends to appropriateness and validity of the subsequent scales as they are derived from the results of Delphi I (Keeney et al., 2010).

A third effort to support reliability was in the design and administration of the questionnaire (Keeney et al., 2010). Due to the panel not meeting face-to-face during the data collection process, group bias and group think were avoided which contributes to reliability (Keeney et al., 2010). The method of delivery was via an online survey which was efficient.

The efficiency of the surveys produced high response rates of 73% for Delphi II and 87% for Delphi III that improves the credibility of the study (Iqbal & Pipon-Young, 2009).

Finally, having a pre-determined goal of consensus amongst the panelists is another guideline recommendation to aid reliability (Keeney et al., 2010). The consensus levels were set at agreement of 80% or greater prior to the beginning of the data collection. This level was based on the recommendation of numerous researchers that have conducted Delphi Studies (Keeney et al., 2010; Powell, 2003; A. West, 2011).

Each subsequent round of data was reported back to the panelists via a report. Based on the research recommendations by Okoli and Pawlowski (2004), reporting the round findings back to the panelists for confirmation that the researcher understands the meanings contributes to the construct validity. Furthermore, providing the outcomes from each round helps to be sure that the experts' definitions are accurate and increases the possibility of the results being generalizable to the counseling profession as a whole (Hasson & Keeney, 2011; Keeney et al., 2010).

Additionally, with the panel being comprised of experts within the counseling community, there is the assumption that the expert opinions provide content validity (Hasson & Keeney, 2011). The Delphi method is based on another assumption that the opinion of the group holds more value than that of the individual (Keeney et al., 2010). By soliciting a group for consensus of opinion, the content validity is increased over one individual's opinion (Okoli & Pawlowski, 2004).

Credibility, dependability, conformability, and transferability are the qualitative strategies to address trustworthiness of the study (Hasson & Keeney, 2011). The iterative process of the Delphi method increases the credibility, which is comparable to the quantitative internal validity

(Hasson & Keeney, 2011). The rounds of data collection allow for information to come in more than once at different points in time (Eva, 2011). This also supports the credibility of the study by asking the set of questions to multiple people to compare results (Eva, 2011; Hasson & Keeney, 2011). Providing the feedback via the reports also support the credibility of the current study (Hasson & Keeney, 2011).

Dependability, the qualitative kin to reliability, was established through seeking out a wide range of counselors from various disciplines and providing a representative sample from the counseling community (Hasson & Keeney, 2011). Conformability was evaluated by the detailed documentation of each round of data collection, data analyses, and potential panelist identification (Hasson & Keeney, 2011; Keeney et al., 2010). Transferability of the study is addressed in chapter 5 and outlines ways that the findings can be applied in the profession of counseling (Hasson & Keeney, 2011).

As a final point, reviews and examinations were completed throughout the study via the committee to ensure the findings and processes are consistent and replicable.

Summary

This chapter provided an overview of the history of the Delphi research design, stated the purpose of the study, outlined the research questions, and reviewed the selection of expert panelists. Also, the instrumentation, data procedures, and data analysis were discussed. All instruments used to select and recruit the expert panelists were described to participate in this study. Willing participants completed surveys which contained the informed consent, information questionnaire, and the Delphi multiple rounds. Each round of the Delphi approach was discussed in detail with the methods for analyzing and managing the data. Results were

analyzed using qualitative and quantitative methods to better understand how expert panelists

define and consider compassion.

Chapter Four

Results

This study was designed to capture what a panel of national counseling scholars and experienced practitioners indicated as a definition of compassion in counseling, and identify skills, attributes, and behaviors associated with compassion. Included in this chapter is a description of the participating panelists of the study, as well as the results of the data collection and analysis for each round of the Delphi study. The chapter will provide results to address the following questions guiding the research:

1. How do counselors and counselor educators define compassion?

2. What skills, attributes, and behaviors indicative of compassion in counseling?

3. How do experienced counselors and counselor educators differentiate compassion as it is experienced professionally and personally?

Panelists

The panelists for the study were professional counselors or counselor educators with a Masters or Doctoral degree. Professional counselors were recruited and selected for their range of knowledge, experience, and expertise within the field. Recruitment considerations included counselors from the six discipline categories of clinical mental health, school counselors, substance abuse/addiction counselors, counselor educators, rehabilitation counselors, and counselor supervisors. Additional expertise required counselor practitioners having ≥ 10 years of field experiences and counselor educators with ≥ 5 years working in an educational setting.

An overall total of 15 professional counselors and counselor educators responded to the invitational round that collectively produced a diverse range of expertise and experience related to the counseling profession. Demographic information collection occurred during the initial

recruitment and part of Delphi Round I. The total pool of participants consisted of one substance abuse/addiction counselor, four clinical mental health counselors, three counselor educators, one rehabilitation counselor, four school counselors, and two counselor supervisors. The researcher identified the disciplines through the process of identification as potential panelists. There were four males and 11 females. The race/ethnicity identified was reported as one African American, one Bi-racial, and one Hispanic/Latinix, and 12 Caucasian/White. The age range was from 36 to 66+, with 4 in the age range of 36-40, 2 in the age range of 41-45, 2 in the age range of 46-50, 3 in the age range of 51-55, 3 in the age range of 61-65, and 1 in the age range of 66+. The average age range for the panelists was between 48-52 years of age. Geographic locations for panelists were nine from the Southeast US, three from the Northeast US, one from the Northwestern US, one from the Non-contiguous US, and one who preferred not to report. Highest educational degrees were represented by three with a Master's degree, two with an Educational Doctorate, nine with a Ph.D., and one reported as other. Demographics for the panelists can be found in Charts 1 and 2.

Chart 1

Participant Counseling Discipline

- Substance/Addiction Counselor
- Clinical Mental Health Counselor
- Counselor Educator
- Rehabilitation Counselor
- School Counselor
- Counselor Supervisor

SA/Addiction Counselor, 1
Clinical Mental Health Counselor, 4
Counselor Educator, 3
Rehabilitation Counselor, 1
School Counselor, 4
Counselor Supervisor, 2

Chart 2

Race/Ethnicity of Particpants

Each panelist provided additional information about the number of years working in the counseling profession and the area(s) of their work setting. Each panelist stated their number of years' experience in the counseling profession with 2 having 10-14 years' experience, 4 with 15-19 years' experience, 1 with 20-24 years' experience, 5 with 25+ years' experience. The mean range of experience in the counseling profession was from 18-22 years.

During the informational survey, panelists had the option to self-identify as a counselor educator, since some may additionally have employment as adjunct professors. Panelists who self-identified as counselor educators provided additional information about the number of years working in counselor education, a description of their roles in counselor education, and the educational setting in which they work. A total of 5 self-identified counselor educators stated the number of years working in counselor education with 1 having 5-9 years' experience, 3 having 10-14 years' experience, and 1 having 15-19 years' experience. The average range of experience within counselor education was between 13-17 years. The panelists who self- identified as counselor educators reported their roles as two Professors, one Associate Professor, and two

Adjunct Professors. Out of the five total counselor educators, three were at a research-level one institution, and the two others reported being at research-level II institution.

All panelists identified their current workplace settings and were able to select more than one option. The panelists represented work settings were five at a private practice location, one at a hospital or inpatient facility, one at a college or university, two at an elementary school, two at a middle school, three at a high school, and three working at other settings.

Additionally, panelists were asked to self-identify their area of expertise from the following options: Trauma or vicarious trauma; wellness and resilience; intersectionality; spiritual or religiosity; compassion satisfaction; grief and loss; pedagogy or educational practices; compassion fatigue; empathy; or other. Each could choose multiple options. Table 4 summarizes the responses.

Table 4: Panelist Identified Areas of Expertise

Identified Area(s) of Expertise	Number of Responses
Trauma/Vicarious Trauma	7
Wellness/Resilience	12
Intersectionality	2
Spiritual/Religiosity	4
Compassion Satisfaction	5
Grief and Loss	9
Pedagogy/Educational Practices	5
Compassion Fatigue	4
Empathy	10
Other	6

Delphi Round I

The first round of a Delphi method began with open-ended questions to solicit and generate ideas on the chosen topic (Keeney et al., 2010; Okoli & Pawlowski, 2004). All of the questions for Delphi Round I were designed to address the questions guiding the research to explore how experts in the field of counseling were thinking about compassion. The round included two open-ended questions and four questions that requested panelists to use words or phrases that would identify and describe responses. The qualitative structure of these questions allowed panelists the opportunity to share their thoughts in an unobstructed manner.

Question 1: Compassion and Empathy

The opening question on Delphi I was: "Based on your experiences and observations, use words or phrases to answer the following question: how do you differentiate between compassion and empathy?" A total of 14 panelists responded. Responses ranged from a few words to several detailed sentences describing the difference between compassion and empathy. Each response was separated into single statements and initially coded for emergent themes, in addition to being classified into one of two categories: compassion and empathy. The expert panel generated a total of 60 statements. Following the initial coding, the collapsing of themes occurred and the second round of coding was completed (See Appendix T). The second round of coding resulted in 30 statements connected to compassion, 28 statements relating to empathy, and one statement was related to skills. One additional statement related compassion and empathy but did not specify a distinction between the two.

Question 2: Professional vs. Personal

The second question on the Delphi I questionnaire included an explanation and directions for answering the following:

For the next question, the following terms are identified as such: *Professional* = any and all interactions that occur when you are acting in professional counseling or counselor educator capacity or within a professional context. *Personal* = any and all interactions that occur when you are acting within your own personal set of mores and ethics in non-professional settings or contacts. How is compassion expressed or perceived differently in a professional setting versus in a personal setting?

There were a total of 13 overall responses. Each response was broken into individual statements and initially coded for emergent themes, in addition to being classified into one of two categories: professional or personal. There were 51 individual statements generated to be analyzed. Twenty-one of the statements categorized as personal, 31 were professional, and seven statements were not identifiable as either personal or professional.

Themes that emerged related to how counselors express compassion in personal settings were: feeling unconstrained in sharing emotions or thoughts, acceptance in personal life, and showing compassion as a personal or situational choice. Examples of unconstrained themed statements include: "the personal setting unleashes those (professional) filters to create vulnerability, sharing of very personal information"; "In personal settings, compassion may be expressed more overtly"; and "there are fewer restraints for expression of compassion in personal life." One panelist stated "compassion cultivation is perhaps more accepted as something people practice in their personal life." Another statement regarding compassion in a personal setting conveys "the idea that it is "okay" to practice compassion in one's personal life."

Several statements in the professional category centered on compassion as a display of empathy. For example, one panelist wrote "in professional settings compassion may be reflected

in a general attitude of care and concern," while another commented "Compassion may not be expressed as directly or may be expressed as empathy." Other themes from the professional category were surrounding ethical and professional boundaries, or that compassion is less customary but present in the therapeutic alliance. A panelist wrote that "compassion is less common in counseling relationships as the counseling relationship does not directly mirror other social relationships." Several items addressed how ethical and professional boundaries filtered the expression or perception of compassion, such as "the structure and boundaries of the professional relationship filter the depth, degree, and exposure of expressing compassion."

Some statements were not able to be categorized into either personal or professional. These statements were general ideas about the topic, such as "the settings dictate the level and types of expression" of compassion and "compassion in all social settings is appropriate." One panelist comment was "I don't believe that it is all that much different" when expressing compassion in a personal or a professional setting.

Question 3: Compassion Obstruction

The third Delphi I question asked panelists to "identify and describe examples or situations where a counselor might struggle to feel or display compassion with a client." A total of 14 panelists responded with descriptions or explanations. The paragraphs were broken down into individual statements that retained the fundamental nature of the response. Separating the statements generated 41 items to code for emerging themes. Following examination of the themes, the second-round recoded the statements into focused themes that identified when a counselor might struggle to display compassion with a client. Eight compassion obstruction themes emerged from the responses shown in Table 5. Themes that had two or more statements

were only identified by the obstruction theme to avoid sharing any specific information in the
subsequent round that may identify the type of counselor who responded.

Table 5: Identified Compassion Obstruction Themes

Compassion Obstruction Themes
Burnout
Bias
Hostile Clients
Perpetrators
Identification with client and situations (potentially over-identification/counter-transference)
Counselor struggling with an ethical dilemma
Disagree with the client (their thoughts and behavior)
Working with clients whose morals or ethics are not congruent with the counselor

Eight additional statements did not fall into a compassion obstruction category. These
individual statements included an array of topics. Examples of these unique statements include:
"counselors can easily struggle to display compassion because it can be perceived by the
counselor as a non-objective stance and form of self-disclosure" and "counselors can struggle to
feel compassion as they become experienced in the field and can feel more removed from their
own emotional responses." Most statements provided situations or ideas of when a counselor
might grapple with showing compassion; however one statement attested "a counselor can
always provide compassion for clients."

Question 4: Skills

In question four, the panelists were given the directions to respond: "based on your
experiences and observations, use words or phrases to answer the following set of questions." In
question four, panelists were asked to "identify and describe specific skills that demonstrate

compassion in counseling." Question four yielded a total of 14 overall responses. Each response was broken into individual statements and initially coded for emergent themes. There were a total of 41 individual statements for coding. A second-round of coding identified themes that could be collapsible into one of two categories: attending skills or environmental skills.

Attending skills mentioned by the panelists included "unconditional positive regard, positive body language, active listening, non-judgments, empathic support" and "allowing periods of silence for the client to experience emotions." Coding occurred to a total of 31 statements that highlighted multiple attending skills. Statements that listed several attending skills together were kept intact and not broken down further for coding. A total of 16 attending skills originated from the statements. Table 6 presents the complete list of attending skills that convey compassion.

Table 6: Attending Skills that Convey Compassion

Attending Skills	
Acceptance	Active Listening
Being fully present	Being open-minded
Caring	Connecting both verbally and non-verbally
Reflective listening	Rephrasing
Unconditional positive regard	Warmth
Non-verbal behaviors (eye contact, tone of voice, facial expressions, softness/hardness of body language	

Only six statements supported the environmental skills theme. These statements centered on creating and supporting the environment for the therapeutic relationship. Statements such as the counseling skill to convey compassion are in "creating a safe place within the counseling relationship to discuss what needs to be aired." Another example was in "offering tissues or a breathing break if the conversation gets tough for the client."

There was one statement that did not fall into either category. This panelist shared, "I can't say that I have ever considered compassion skills in counseling."

Question 5: Knowledge

Delphi I question five instructed panelists to "identify and describe specific knowledge that demonstrates compassion in counseling." Question five resulted in a total of 12 overall responses. Each response was broken into individual statements and initially coded for emergent themes, which led to 25 individual statements to be analyzed. A second-round of coding identified collapsible themes. Statements were grouped into themes that were related to a counselor's knowledge of awareness, cognitive frameworks, communication, comprehension, foundational knowledge on compassion, and training. One statement by a panelist reported "[I] am not aware of any specific knowledge that demonstrates compassion in counseling."

Numerous statements supported counselors "knowing theoretical framework and models" or having "foundation knowledge regarding certain client experiences (e.g., trauma, oppression, those related disorders)" would be demonstrative of compassion. Further statements to support training included counselors having "knowledge of ethical practice."

Other panelists provided statements that described working knowledge, and cognitive comprehension, such as "compassion requires a more intuitive understanding of another's emotional landscape" or that "it is knowledge, comprehension, and awareness" that conveys compassion. "The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice."

Question 6: Attitudes and Beliefs

Delphi I question six instructed panelists to "identify and describe specific attitudes and beliefs that demonstrate compassion in counseling;" which yielded a total of 14 overall responses. Some panelists wrote sentences that identified and described attitudes and beliefs, while others listed words or phrases. Each response was broken into individual statements or words and initially coded for emergent themes, which led to 42 individual statements to be analyzed. Additionally, each statement classified into one of two categories: attitude or belief. There were 32 individual statements categorized as an attitude and ten statements categorized as beliefs.

Collapsing themes occurred in the second round of coding, followed by grouping statements into themes according to categories. Themes that contained multiple responses included seven statements related to attending skills, four related to a counselor being open-minded, 12 statements surrounding positive acceptance of a client, and four that were values-based. The remaining five individual statements in the attitude category remarked on "curiosity," "expressing hope/working together with client," "embracing counselor part in [the] relationship," "self-awareness," and "providing skills and resources."

Statements of belief centered on clients. Four statements addressed clients in believing in "optimal development" and the "capacity for clients to change." One statement touched on connectivity, which "involves both empathy and compassion." Other responses supported "belief on impact to clients," "believing there is positive in every situation/optimistic," and to "believe in the process."

Overall Findings

A total of 266 statements from the entire study were coded a third time into overall themes, with an identification of 16 themes. Table 7 outlines the themes and occurrences. Two

of the themes, empathy and the struggle to display compassion, were pulled from the group to be

analyzed separately. The remaining 14 themes associated with compassion were reviewed for

areas of overlap to allow for condensing the data. Each theme of the data was placed into a

separate worksheet for further investigation. Statements related to defining compassion or

explaining what compassion means were combined into one refined theme to define. The

combined data relating to ability, awareness, and engagement went into one group. Attending

skills, environmental skills, and therapeutic relationship themes merged into another group. Also

combined were transference/countertransference statements with professional boundaries.

Table 7: Overall Coding Themes and Occurrences

Identified Overall Theme	Number of Statements
Attending skills	57
Struggle to display compassion	41
Empathy	28
Defining statements	25
Ability	19
Personal	18
Other (miscellaneous)	16
Awareness	13
Education	13
Meaning (of compassion)	8
Professional boundaries	8
Environmental skills	7
Therapeutic relationship	6
Assessment	3
Engages	2
Transference/countertransference	2

The final groups to explore that are related to compassion were defining compassion; personal statements; ability, awareness, and engagement; attending skills, environmental skills, and therapeutic relationship; education; personal; professional boundaries; and other miscellaneous statements. The two other identified theme groups were empathy and the struggle to display compassion. The data was examined and arranged in an order that would allow for a better transition from question to question during the second round of data collection. A discussion of each theme will follow.

Theme: Empathy. Of all the unique answers, a total of 28 statements fit into the category of differentiating empathy from compassion. The panelists identified empathy using words and phrases. Of the 28 statements, 12 fell under the theme of identification. These responses included direct statements like "empathy involves identifying emotions of others," and "empathy allows more for identification without the quality of experiencing another's emotions." Each statement had examination and comparison of the wording to other similar statements. Those whose meanings reflected the same idea were removed leaving one statement which represented the core concept to be included in for the next round of data collection. A few of the statements were condensed versions of what the panel provided initially. This process continued in the same manner for each grouping of similar items. The review and reduction resulted in a total of 14 statements related to empathy for inclusion in Delphi Round II.

Theme: Defines. This theme contained 31 statements for further review. Within this theme were responses from questions one, two, and six. The statements were coded again into collapsed themes. The following collapsed themes pinpointed were: caring, display of empathy, environment, exclusively emotional, includes self-compassion, other, supporting, and understanding. Statements were then grouped into the collapsed themes to review the wording.

The goal of this was to reduce the number of statements without compromising the integrity of the data presented by the expert panel. The refining process resulted in a total of 20 statements that may define compassion for inclusion in Delphi Round II.

Theme: Counselor abilities. After combining the coded statements for abilities, awareness, and engagement, then a total of 34 statements were to be examined. Statements that were duplicates were removed, leaving the statement that best captured the concept for inclusion in the next round of data collection. There were 17 unique statements regarding ability, ten unique statements relating to awareness, and two regarding engagement. A combined total of 29 statements for counselor abilities were for inclusion in Delphi Round II.

Theme: Attending skills. Basic helping skills are the therapeutic building blocks that foster a therapeutic relationship, which is a crucial factor in client outcomes (Young, 2017). This category combined the previous themed codes of attending skills, environmental skills, and the therapeutic relationship. When examining the data with all information together, many responses to question 4 (identify and describe specific skills that demonstrate compassion in counseling) and question 6 (identify and describe specific attitudes and beliefs that demonstrate compassion in counseling) yielded words or phrases that were consistent with basic attending skills in counseling. There were a total of 70 overall statements that fell into this category. The panelists commonly listed many basic attending skills. Once extracted, the primary attending skills identified are listed in *Table 4.3 – Attending Skills that Convey Compassion*.

The balance of statements was carefully examined and reduced into 20 statements that are reflective of counseling skills. These skills included various other attending skills, environmental skills, and those related to the therapeutic relationship. The next round of data collection incorporated these statements.

Theme: Perceptions. The category that contained other or miscellaneous statements and themes coded as challenging or perceptions were combined. A total of 16 statements compromised this theme. Statements were then reviewed for commonality and reduced without compromising the integrity of the data presented by the expert panel. The refining process resulted in a total of 12 statements that may define compassion. Delphi Round II included these statements.

Theme: Compassion Obstruction. All statements related to compassion obstruction, or when a counselor might struggle to display compassion for a client, were removed from the overall data for review. The panel produced 41 of these types of statements. Examples of statements include "counselors may be challenged in feeling or extending compassion to a client when they are experiencing personal burnout," and "clients with low motivation for change might create a struggle for the counselor to show compassion." Statements in this theme were lengthier than others and some included personal examples as illustration. Upon a more in-depth review of all of the data, eight general themes became apparent, outlined in Table 8. Eight

Table 8: General Themes of Compassion Obstruction

General Theme
Identification with client and situations (potentially over-identification/countertransference)
Disagree with the client (their thoughts and behaviors)
Burnout
Working with clients whose morals or ethics are not congruent with the counselor
Counselor struggling with an ethical dilemma
Bias
Hostile clients
Perpetrators

statements that remained did not fall into one of the eight general themes. Delphi Round II included these statements.

Theme: Knowledge, training, and education. After combining the coded statements for education, assessment, and countertransference, a total of 16 statements were for examination. Statements that were duplicates were removed, leaving the statements that best captured the concept for inclusion in the next round of data collection. A total of 9 unique statements remained for inclusion in Delphi Round II.

Theme: Professional boundaries. The categories containing professional boundaries and theme coded as transference were combined. A total of eight statements compromised this theme. A review of the statements for commonality revealed one statement to be removed that provided duplicate information. The refining process resulted in a total of seven statements that may define compassion for inclusion in Delphi Round II.

Theme: Personal expression. Statements identified in the personal category were examined, revealing a total of 18 statements by the expert panel. Then the statements were grouped into the following themes: acts of care, fewer restraints, overt expression, and other. Grouping by these themes allowed for reviewing the statements for commonality and potential removal from the inclusion in the subsequent round of data collection. A total of 11 statements representative of ways expression of compassion happens in personal settings. Statements from this category include "in personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch)" and "the personal setting unleashes those professional filters to create vulnerability, and sharing of very personal information."

Overall Summary of Delphi Round I

To summarize, the data from Delphi Round I was initially analyzed by each specific question. Initial thematic codes were created to see what emerged from the data. The data was then examined again during the second round of coding using the themed codes. It was at this point that the data was reviewed and discussed with the critical friend and the committee chair. The next round of data analysis integrated the feedback, which consisted of examining the overall data exploring for additional themes and overall context to the information generated from the expert panel.

The third round of data analysis included separating the information relating to empathy and when counselors would struggle to display compassion in a counseling setting. These two topics were analyzed to identify themes, repetition of ideas, and reduction of statements to be included in the subsequent round of data collection. The remaining data all was associating with compassion. This data set was coded and identified into the categories of defining compassion; counselor abilities; attending skills; perceptions of compassion; knowledge, training and education; professional boundaries; and personal expression of compassion. Each category was reviewed, placed into similar groupings within, cleared of duplicate ideas, and prepared with a finalized listing of statements included in the next round of data collection.

Once the final reduction of all statements occurred, then the categories were organized for optimal flow. Construction of the Delphi Round II instrument included statement directions and questions from the results of data analysis of Delphi Round I.

Delphi Round II

The collapsed responses from the panel guided the development of Delphi Round II. A Qualtrics survey was utilized to collect data for this round. The questions for Delphi Round II

were designed to assist the panelists in reviewing the data from Delphi Round I in an organized way. The round included 14 questions. Eleven of the questions requested panelists to rate the degree of agreement using the following 7-point Likert-type scale: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* The remaining three questions were open-ended questions to capture additional comments of the panelists following the review of the statements.

Consensus

Although there are no definitive rules for establishing consensus, the research team decided to establish an *a priori* of 80% or higher as an indication of agreement. It is a common practice amongst Delphi researchers to set an indication of agreement before the beginning of the study (Eastwood, 2012; Keeney et al., 2010; Powell, 2003). During the analysis for each question from Delphi Round II, if at least 80% of the panel agreed upon their rating of a statement, it was considered a consensus from the group. The overall size of the panel during this round was 11, which translated to having nine or more panelists in agreement. For this study, less than 80% meant the panel was too far apart on agreement, and these statements would not be included for further study in the next round of data collection.

Question 1: Empathy

Delphi Round II started with the following explanation to participants:

The following statements are related to empathy. A few are direct statements, while a few are condensed versions of what was returned. Please rate your agreement with the following statements regarding empathy.

There were a total of 14 statements listed in no particular order. Panelists were asked to rank agreement on the 7-point Likert-type scale. All participants answered each item within this

question. Overall results of this question reflected nine of 14 panelists in agreement for an overall 64% agreement. The panelists were above 90% agreement in three of 14 statements. All panelists agreed with the statement "empathy involves working to understand how others are emotionally impacted." Ten out of eleven panelists agreed with the statement "when people feel empathy; they try to put themselves in the shoes of another person to get an idea of what it might be like to be them." The other statement that all but one panelist agreed with was that "empathy allows more for identification without the quality of experiencing another's emotions." One statement that was at 82% agreement was reverse coded as either a *somewhat disagree, disagree*, or *neither agree* nor *disagree*. This statement was that "empathy does not necessarily involve compassion" and was included in the overall analysis to assist in the differentiation between compassion and empathy.

The mean scores ranged from 1.73 (empathy involves working to understand how others are emotionally impacted) to 5.09 (empathy does not necessarily involve compassion). The standard deviation scores ranged from 0.47 (empathy involves working to understand how others are emotionally impacted) to 2.06 (empathy involves the ability to feel what another person is experiencing). A lower standard deviation is desirable since the standard deviation is an indicator of the level of variance among the responses. The higher the standard deviation indicates a lower level of agreement and a wider range of, or inconsistent responses.

On conducting a thorough review of the statements regarding empathy that reached consensus, the concepts overlapped. Many statements were nuances on the meaning of empathy. All statements were combined to create a three-sentence reflection of empathy. This reflection was included in Delphi Round III.

Question 2: Define Compassion

Question two requested panelists to rank their agreement with 20 statements that may define compassion on the 7-point Likert-type scale. All participants answered each item within this question. The overall results of this question reflected 10 of 20 items in agreement for an overall 50% agreement. Three items were at 100% agreement. These statements were as follows:

- Compassion does not necessarily require that people go through the exact same experiences to feel or express it;

- When it comes to a person's professional life, people may work in an environment that is conscious or aware of the benefits of encouraging compassionate practices or cultivation as a part of its culture; and

- Compassion is an on-going process.

All but one panelist agreed with the statement, "compassion means caring for others."

The mean scores ranged from 1.91 (compassion does not necessarily require that people go through the exact same experiences to feel or express it) to 4.45 (The concept of compassion is growing within our society). The standard deviation scores ranged from 0.30 (compassion does not necessarily require that people go through the exact same experiences to feel or express it) to 1.92 (the concept of compassion is growing within our society). The high standard deviation score of 1.92 (the concept of compassion is growing within our society) means that the panelist responses reflected more inconsistencies as substantiated by the varying range of agreement with this item.

Similar to the question of empathy, the items that reached 80% or greater consensus was examined and condensed to make a statement regarding compassion. The condensed statement was included in Delphi Round III.

Question 3: Counseling Abilities

Question three centered on having panelists rate their "level of agreement to the following statements regarding counselor abilities in connection with compassion." Twenty-nine items were presented from the previous round of data, using the 7-point Likert-type scale. Overall results of this question reflected 22 of the 29 items with $\geq$ 80% agreement for an overall 76% agreement. There were nine items at 100% agreement and seven statements with 90% agreement. The statements achieving 100% agreement were as follows:

- Compassion is the ability to be kind, caring, tolerant, and forgiving of others;

- In a professional setting, I strive to have compassion for all of the individuals I encounter;

- Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients;

- Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially inspire compassion;

- A counseling skill is utilizing appropriate compassion levels and approaches;

- The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice;

- As counselors, we need to be cognizant of how our actions and words are impacting clients;

- Counselors need to recognize if we are not having an impact, what can we do differently; and

- Counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client.

The mean scores ranged from 1.45 to 4.09 (compassion is the skill of containing the natural impulses to protect self from trauma through interruptions, redirection, or protective interventions). Two items had a mean score of 1.45; "as counselors, we need to be cognizant of how our actions and words are impacting clients" and "counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client." The standard deviation scores ranged from 0.52 to 1.86 (cultivating compassion throughout the day helps professionals to be more productive). The same two items that had a mean score of 1.45 also shared the standard deviation of 0.52. These two items having a lower standard deviation supports little variance within the responses amongst the panel. All items that reached 80% or greater consensus were compiled for inclusion in Delphi Round III.

Question 4: Attending Skills

The basic attending skills that were identified and extracted from questions four and six from Delphi Round 1 data analysis were combined to develop question four. This question stated that "many attending skills were listed as skills that convey compassion in counseling" and the attending skills that convey compassion were listed (see Table 4.3). The mean score was 1.64, and the standard deviation was 0.67. A total of 11 participants responded to this question (N = 11). 100% of the panelists were in agreement with the listing of attending skills that

convey compassion in counseling. Ten of the panelists ranked their level of agreement as *strongly agree* and *agree*. Only one panelist ranked their level of agreement as *somewhat agree*. The mean score and standard deviation support the higher level of consensus among the expert panel with this question. Since the agreement was at 100% among the panelists, this information was not included in Delphi Round III.

The panelists were allowed to provide any additional comments regarding attending skills conveying compassion. No responses were recorded.

Question 5: Counseling Skills

Question five requested panelists to rank their agreement with 20 statements regarding counseling skills that demonstrate compassion on the 7-point Likert-type scale. For this question, 10 of the 11 panelists answered each item within this question, except for one item that nine panelists answered. The overall results of this question reflected 15 of 20 items in agreement for an overall 75% agreement. There were seven items at 100% agreement and five at 90% agreement. The statements reaching 100% agreement were as follows:

- Allowing periods of silence for the client to experience emotions;

- An attitude of understanding of human struggles;

- Mindfulness/being aware in the moment;

- Creating a safe place within the counseling relationship to discuss what needs to be aired;

- Structure the session so that the client feels heard and seen;

- Compassion is also very useful in development of therapeutic relationship and alignment; and

- Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective.

The mean scores ranged from 1.80 (compassion is also very useful in development of therapeutic relationship and alignment) to 5.70 (compassion is less common in counseling relationships as the counseling relationship does not directly mirror other social relationships). The statement with the mean score of 5.70 reflected an inverse agreement of *disagree* and *strongly disagree*. Since the consensus was reached in disagreement with this statement, it was included in the overall data analysis. The standard deviation scores ranged from 0.32 (believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective) to 1.76 (although controversial, controlled tearfulness might be useful). The lower standard deviation reflects less variance around the agreement that connecting to the client with empathy and compassion is critical.

The 15 statements with 80% or greater consensus were compiled for inclusion in Delphi Round III.

Question 6: Perceptions About Compassion

Question six requested panelists to rank their agreement with 20 statements about perceptions of compassion on the 7-point Likert-type scale. A total of 12 items comprised this question. For this question, 10 of the 11 panelists answered each item within this question, except for one item that nine panelists answered. The overall results of this question reflected eight of 12 items in agreement for an overall 67% agreement. There was one item at 100% agreement (compassion in a professional setting is perceived as understanding and support) and two at 90% agreement ("many people still find it challenging to give themselves permission to

cultivate compassion" and "society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being").

The mean scores ranged from 2.40 (society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being) to 5.09 (I can't say that I have ever considered compassion skills in counseling). The standard deviation scores ranged from 1.10 (I don't believe that compassion and empathy are all that much different) to 1.81. Two statements shared a standard deviation of 1.81: "The settings dictate the level and types of expression of compassion"; and "in a professional setting compassion indicates an over-identification with the emotional experiences of a client." These overall means and standard deviations represent having a higher variance to all responses within this question.

The panelists were allowed to provide any additional comments regarding perceptions of compassion. No responses were recorded.

Question 7: Compassion Obstruction – Themes

Question seven was regarding themes that emerged from Delphi Round I data about what may hinder a counselor with the ability to display compassion for clients or compassion obstruction. Panelists were requested to rank their agreement with eight items containing "general themes about when a counselor might struggle to display compassion with a client" on the 7-point Likert-type scale. For this question, 10 of the 11 panelists answered each item within this question. Overall results of this question reflected an overall 100% of the items in agreement of 80% or greater. There were four items at 100% agreement and two at 90% agreement. The following themes were at 100% agreement:

- Burnout;
- Bias;

- Hostile clients; and

- Perpetrators.

The mean scores ranged from 1.60 (burnout) to 3.00. Two items had a mean score of 3.00 which were: "disagree with the client (their thoughts and behavior)" and "working with clients whose morals or ethics are not congruent with the counselor." The standard deviation scores ranged from 0.52 (burnout) to 1.56 (working with clients whose morals or ethics are not congruent with the counselor).

Because of the 100% consensus being reached at this level, responses for this question were not included in Delphi Round III.

Question 8: Compassion Obstruction – Statements

The compassion obstruction themes that emerged from the Delphi Round I statements that centered on what may hinder a counselor in their ability to display compassion for clients were presented in question eight. The panelists were requested to "please rate your level of agreement with the following general themes about when a counselor might struggle to display compassion with a client" on the 7-point Likert-type scale. Of the 11 panelists, 10 completed all items within this question. Overall results yielded a 50% agreement across all eight of the items. There were a total of four items that reached consensus of 80% or greater. Three were at 90% agreement. These statements were:

- As clients demonstrate urgency and anxiety, counselors might experience emotion contagion;

- Ironically if a counselor can get to a place of compassion with particular individuals (not excusing their behavior, but separating it from the individual) the work will be more effective; and

- Counselors might risk assuming understanding of the client experience without exploring more deeply.

The mean scores ranged from 2.60 (ironically if a counselor can get to a place of compassion with particular individuals (not excusing their behavior, but separating it from the individual) the work will be more effective) to 5.00 (there is a fine line between compassion fatigue, lack of compassion, and over active compassion). The standard deviation scores ranged from 0.94 (counselors might risk assuming understanding of the client experience without exploring more deeply) to 1.85 (a counselor can always provide compassion for clients).

The statements with 80% or greater consensus were compiled for inclusion in Delphi Round III.

Question 9: Knowledge, Training, and Education

Statements that were related to the knowledge, education, and training from Delphi Round I were grouped in question nine. Panelists were asked to rank their level of agreement on the 7-point Likert-type scale. Ten panelists responded to four items, nine panelists responded to four items, and eight responded to one item. Overall results yielded 78% agreement across all nine of the items. There were a total of seven items that reached a consensus of 80% or greater. Two items were achieving 100% agreement, one at 90%, and the remainder at 89% agreement. The statements achieving 100% consensus were: "even though compassion is less common in the counseling relationship, it can still be present through teaching and supervision relationships, along with empathy" and "it is important for counselors to have some additional training in compassion and self-compassion as a part of their education and professional practice."

The mean scores ranged from 2.10 (even though compassion is less common in the counseling relationship, it can still be present through teaching and supervision relationships,

along with empathy) to 4.00 (having an attitude and belief of value-based and therapeutic counseling demonstrates compassion). The standard deviation scores ranged from 0.57 (even though compassion is less common in the counseling relationship, it can still be present through teaching and supervision relationships, along with empathy) to 1.76 (having an attitude and belief of value-based and therapeutic counseling demonstrates compassion). The statements with 80% or greater consensus were compiled for inclusion in Delphi Round III.

The panelists were allowed to provide any additional comments regarding knowledge, training, and education. No responses were recorded.

Question 10: Professional Boundaries

Question ten was regarding compassion and professional boundaries. Panelists were requested to rank their agreement with seven items on the 7-point Likert-type scale.   For this question, 10 of the 11 panelists answered each item within this question. Overall results of this question reflected an overall 71% of the items in agreement of 80% or greater. There were three items at 100% agreement. The following items were at 100% agreement:

- Professional settings must incorporate many ethical boundaries (i.e., involving touch, limits of involvement, referrals, disclosure);

- When I am in a professional context my role and goal is on behalf of the client; and

- In a professional setting I hold myself to a higher standard of attention.

The mean scores ranged from 1.60 (in a professional setting I hold myself to a higher standard of attention) to 4.00 (compassion in a professional setting opens the possibility of counter-transference). The standard deviation scores ranged from 0.42 (when I am in a professional context my role and goal is on behalf of the client) to 1.83 (the structure and

boundaries of the professional relationship filter the depth, degree and exposure of expressing compassion). The statements with 80% or greater consensus were compiled for inclusion in Delphi Round III.

Question 11: Personal Expression

Question 11 addressed ways compassion is expressed in personal settings. Panelists were requested to rank their agreement with 11 items that reached consensus in Delphi Round I on the 7-point Likert-type scale. For this question, ten of the 11 panelists answered ten items within this question, and eight panelists answered one item. Overall results of this question reflected an overall 91% of the items in agreement of 80% or greater. There were three items at 100% agreement. The following items were at 100% agreement:

- In personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch);

- In a personal setting, compassion can be perceived as condescending or patronizing; and

- The other extreme in a personal setting that could also be possible, when compassion is perceived as loving and supportive.

Of the statements reaching consensus, three statements were not ranked as *agree*. One statement at 100% agreement (in a personal setting, compassion can be perceived as condescending or patronizing) was primarily selected as *slightly disagree,* and other responses were *disagree* or *neither agree nor disagree*. The statement with 88% agreement (there may be issues or individuals what make me feel compassion for their experience, but I discover or encounter them) was ranked by eight panelists as *neither agree nor disagree* with only one selecting *slightly agree*. The remaining statement that was inversely agreed upon at 80% (in a personal

setting compassion is more situational) had eight panelists responding with *neither agree nor disagree* with the other two responding with *slightly agree* or *slightly disagree*. Because of the importance of the inverse agreements for the statements, this data was included in the final analysis

The mean scores ranged from 1.90 to 5.90 (in a personal setting, compassion can be perceived as condescending or patronizing). There were two items that had a mean score of 1.90, which were "in personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch)" and "the other extreme in a personal setting that could also be possible, when compassion is perceived as loving and supportive." The standard deviation scores ranged from 0.32 (in personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch)) to 1.83 (there are fewer restraints for expression of compassion in personal life).

Overall Analysis

For Delphi Round II data analysis, the raw data was downloaded from Qualtrics and imported into Microsoft Excel. Upon reviewing the item statements on the topic of empathy that had reached consensus, similar statements were grouped and were able to be combined in a concise overall reflection of empathy. The brief overall reflection comprised of four sentences. These statements were combined to be included in Delphi Round III.

Similarly, the same review occurred for the item statements on the topic to define compassion. Those items reaching consensus were grouped by similarities and were combined to create a concise overall reflection of compassion. The brief overall reflection was comprised of four sentences. These statements were combined to be included in Delphi Round III.

The item statements related to the counselor's abilities to convey compassion that reached consensus totaled 22. These items were to be included in on Delphi Round III to have the panel of experts assist in indicating those statements of greater importance.

The attending skills that were presented by the panel from Delphi Round I that convey compassion in counseling were agreed upon at 100% during this round. This data is to be included in the final findings and was omitted from Delphi Round III.

Question five included 20 statements for the panelists to rank their level of agreement regarding counseling skills that demonstrate compassion. Fifteen item statements reached consensus. Due to the volume of agreement, the statements were to be included in on Delphi Round II to have the panel reduce the items to include those ranked with most importance.

There were a total of eight statements that reached a consensus that were concerning perceptions of compassion in this round. These were included in Delphi Round III to have the panel of experts identify those statements of greater importance.

The panel had presented statements of when counselors may be hindered in displaying compassion towards a client during Delphi Round I. Those statements that were similar were combined into general themes. The themes of what may hinder a counselor were agreed upon at 100% during this round. This data is to be included in the final findings and was omitted from Delphi Round III.

There were three questions from Delphi Round II that did not meet the overall consensus that was not included in Delphi Round III. As each question was evaluated and analyzed, those that only had a few statements related to the specific topic, the decision was made to only include this data in the final findings and was omitted from Delphi Round III. This will additionally aid in maintaining a lower volume of data for ranking in the following round. These were Delphi

Round II questions eight (statements when counselor might struggle to display), nine (statements on counselor knowledge, training, and education), and ten (statements regarding ways compassion is expressed in personal settings).

Statements from question eight that did not fit into the general themes of compassion obstruction were presented in Delphi Round II as statements of when a counselor might struggle to display compassion to a client. There were a total of eight statements and four reached consensus. Question nine included nine statements for the panelists to rank their level of agreement regarding counselor knowledge, training, and education. Seven item statements reached consensus. Of the seven statements included in question ten about compassion and professional boundaries, five reached consensus. A total of 16 statements were not included for re-evaluation in Delphi Round III which will be reported in the final findings.

Statements in which the panelists were asked to rank their level of agreement regarding ways compassion is expressed in personal ways reached a 91% overall consensus. Because of the consensus being met, this data is to be included in the final findings and was omitted from Delphi Round III.

A Delphi II Overall Report was prepared to return to the panelists for their review and use. This was created as a Microsoft Word Document and was converted into a PDF file (Appendix R). The overall report results included the measures of central tendency and measures of variability for each question and overall. The full wording of the questions was presented, and each question had a separate page. The individual question pages included the question, statements that reached a consensus of 80% or greater with the corresponding percentage of agreement, and the corresponding measures of central tendency and measures of variability.

Overall Summary of Delphi Round II

To summarize, the data from Delphi Round II was analyzed by each specific question. Measures of central tendency and measures of variability were utilized to analyze the data. It was at this point that the data was reviewed and discussed with the committee chair. Feedback was folded into the next round of data analysis, which consisted of decisions on what to include in Delphi Round III and what to retain for the final overall analysis.

The next round of data analysis consisted of an examination of the data for inclusion in Delphi Round III. Once all statements were reduced, the categories were organized for optimal flow. Statement directions and questions were formulated for construction of the Delphi Round III instrument.

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Delphi Round III

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Delphi Round III consisted of six questions in total. It was created to aid the panelists in identifying statements of higher importance that had reached consensus in Delphi Round I and Delphi Round II. Two questions addressed an overall condensed reflection of empathy and compassion asking panelists to rank level of agreement on the 7-point, Likert-type scale used in the previous round. Three questions asked panelists to identify the importance of statements in categories: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important.* One question provided the opportunity for the panelists to provide any additional comments regarding compassion.

Consensus

During the analysis for each question from Delphi Round II, if at least 80% of the panel agreed upon a statement, it was considered a consensus from the group. The overall size of the panel during this round was 13, which translated to having 11 or more panelists in agreement.

For this study, less than 80% meant the panel was too far apart on agreement, and these statements would be excluded for further study in the next round of data collection.

Question 1: Empathy

Delphi Round III began with the statements that reached 80% or greater consensus regarding empathy, which was combined to indicate the overall reflection of empathy from the expert panel. Panelists were asked to rank agreement on the 7-point Likert-type scale to the following reflection:

Empathy is the internal feeling for and connecting on a deeper level with another. Empathy is neither differentiated nor an emotionally distant awareness of another individual. It is working to understand the emotional impact, specific to the thoughts, feelings, and experiences of others without the quality of undergoing the same events. Empathy does not necessarily involve compassion.

All 13 participants answered this question. Overall results of this question reflected four ranked as *strongly agree*, six ranked as *agree*, and three ranked as *somewhat agree*. There was an overall agreement of 100% consensus with 77% in agreement as *agree* to *strongly agree*. The mean was 1.92, and the standard deviation was 0.73, which is indicative of low variance in responses.

Question 2: Compassion

The second question on the Delphi Round instructed panelists to rank their agreement on the 7-point Likert-type scale. Information was included that statements which reached 80% or greater consensus regarding compassion were combined to indicate the overall reflection of compassion, and panelists could review the overall statements from Delphi Round II in the

overall report attached to the instructional email. The following condensed reflection was presented:

> Compassion is an on-going process of caring for others that is more outwardly expressed than empathy. It is feeling with, alongside others. Compassion is having sympathetic concern for the problems of the self and others. It does not necessarily require that people go through the exact same experiences to feel or express compassion.

> All 13 participants answered this question. Overall results of this question reflected two

ranked as *strongly agree*, nine ranked as *agree*, one ranked as *somewhat* agree, and one ranked

as *strongly disagree*. There was an overall agreement of 92% consensus with 85% in agreement

as *agree* to *strongly agree*. The mean was 2.31, and the standard deviation was 1.43. Despite

the outlier score of strongly disagree, the overall agreement reached consensus.

Question 3: Abilities

Question three began by instructing panelists to indicate the level of importance for each

item by moving statements into one of five categories: (1) *extremely important;* (2) *very*

important; (3) *moderately important;* (4) *slightly important;* or (5) *not as important*. Panelists

also had the option of not moving the statements into one of the categories. Question three

consisted of the 22 statements about counselor abilities in connection with compassion.

There was only one individual item reaching a consensus of $\geq 80\%$ within question three.

This statement was: "as counselors, we need to be cognizant of how our actions and words are

impacting clients." The statement was in 80% agreement with eight panelists ranking this as

extremely important. When combining the rankings of *extremely important* and *very important*,

nine items reached consensus of 80% or greater. Table 9 reflects the items and percentage of

agreement.

Table 9: Counselor Abilities Consensus

9 Items that reached ≥ 80% consensus in ranking statements as Extremely Important or Very Important	
As counselors, we need to be cognizant of how our actions and words are impacting clients	100%
Counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client	100%
The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice	91%
Counselors need to recognize if we are not having an impact, what can we do differently	90%
Respect for other cultures	90%
Compassion is the ability to be kind, caring, tolerant, and forgiving of others	82%
Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	82%
In a professional setting, I strive to have compassion for all of the individuals I encounter	80%
A counseling skill is utilizing appropriate compassion levels and approaches	80%

Two of the top three ranked items as *extremely important* were the same two statements that reached 100% consensus when combining the rankings of *extremely important* and *very important*. The third-ranked *extremely important* statement was "a counseling skill is utilizing appropriate compassion levels and approaches."

Question 4: Skills

Question four consisted of 15 statements that achieved consensus from Delphi Round II on counselors' skills that demonstrate compassion in counseling settings. Panelists were provided the same instructions as in question three of moving statements into one of five

categories: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important.* Panelists also had the option of not moving the statements into one of the categories.

Results yielded two individual items reaching a consensus of ≥ 80%. One item within the *extremely important* category, counselors should be "creating a safe place within the counseling relationship to discuss what needs to be aired," was listed as the top priority with 83% consensus. The other statement reaching consensus was within the *very important* category. Panelists agreed 82% that compassion could be demonstrated by "allowing periods of silence for the client to experience emotions." When combining the rankings of *extremely important* and *very important*, seven items reached consensus of 80% or greater. These statements are outlined in Table 10.

Table 10: Counselor Skills Consensus

7 Items that reached ≥ 80% consensus in ranking statements as Extremely Important or Very Important	
Creating a safe place within the counseling relationship to discuss what needs to be aired	100%
Allowing periods of silence for the client to experience emotions	91%
An attitude of understanding of human struggles	91%
Compassion is also very useful in development of therapeutic relationship and alignment	83%
Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	83%
Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	83%
Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	82%

Upon examination of the top rankings in the *extremely important* category, the leading statement was the same that achieved 100% consensus when combining the rankings of *extremely important* and *very important*.

Question 5: Perceptions

Question five consisted of eight statements that achieved consensus from Delphi Round II regarding perceptions of compassion. Panelists were provided the same instructions as in question three and four of moving statements into one of the following five categories: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important*. Panelists also had the option of not moving the statements into one of the categories.

No individual items reached a consensus within this question. When combining the rankings of *extremely important* and *very important*, two items reached consensus of 80% or greater. One statement reported that "compassion in a professional setting is perceived as understanding and support." The other statement supported "the idea that it is "okay" to practice compassion in one's personal life." Both of these statements were ranked as the top two in the *extremely important* category, and one had the highest rank in the *very important* category.

Question 6: Additional Comments

The panelists were allowed to provide any additional comments regarding compassion in counseling in question six. There were a total of four comments made. One comment was related to technical difficulties experienced during the survey. The remaining three statements were as follows:

- I struggled to rate many of the items above as they seemed out of context - sometimes about counseling generally and not always directly related to compassion;

- Compassion is why we got into the field of counseling. We are compassionate people and work with others to cope and understand what they are going through; and

- I have JUST conducted two back to back sessions regarding compassion and empathy, so to say it is relevant and pertinent would be an understatement.

Due to only having three statements, no coding was performed. Information will be presented in overall results.

Overall Summary for Delphi Round III

To summarize, the data from Delphi Round III was analyzed by each specific question. Measures of central tendency and measures of variability were utilized to analyze some of the data, and percentage of agreement was utilized to highlight the items the panel felt most important. It was at this point that the data were reviewed and discussed with the committee chair.

Delphi Round III achieved consensus on the overall reflections of empathy and compassion. Statements provided by the expert panel were reduced, and the *extremely* and *very important* items were revealed. Overall conclusions were that no further rounds of data collection would be necessary for the study.

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Summary

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The Delphi method was used to identify how counselors understand compassion, the perceived skills, attributes, and behaviors associated with demonstrating compassion, and how

experienced counselors and counselor educators differentiate compassion as experienced professionally and personally. A panel of 15 experts in the counseling profession agreed to participate in the study. Each panelist independently participated in each of the three rounds.

The Delphi Round I consisted of six open-ended questions related to the guiding questions. A total of 15 expert panelists participated in this round. Results generated from the panelists in this round were 14 statements that distinguished empathy, 20 statements that defined compassion, 29 statements regarding counselor abilities in connection to compassion, a list of 13 attending skills that convey compassion, 20 statements about counselor skills that demonstrate compassion, 12 statements about perceptions of compassion, 8 general themes on what may hinder a counselor to display compassion with a client, 8 statements that support other times when a counselor might struggle to display compassion with a client, 9 statements on counselor knowledge, training, and education, 7 statements on professional boundaries, and 11 statements regarding ways a counselor may express compassion personally. These results were used to generate the questions for Delphi Round II.

Delphi Round II consisted of 11 questions for panelists to rank their agreement on a 7-point Likert-type scale and three open-ended questions to collect additional comments. Panelists used the following 7-point scale: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* A total of 11 panelists of the original 15 completed this round of data collection. The consensus for this round was established as an 80% agreement or greater. Results generated from the panelists in this round were 100% consensus agreement on the attending skills that demonstrate compassion in counseling and general themes that may hinder their ability to display compassion to clients. There was a 91% consensus agreement regarding ways to express compassion in personal

settings. Due to the higher level of agreement on statements regarding when counselors may struggle to display compassion with their clients, the knowledge, training, and education, as well as the statements related to professional boundaries were not to be included in the subsequent round. The number of statements in agreement totaled 16, which was a small enough number of statements to report in the final results.

The results from five other questions yielded 64 statements that were too far from consensus or needed further refinement from the panel. Items related to empathy were condensed into several sentences that indicated the overall reflection of empathy. Similarly, condensing the items related to defining compassion into several sentences that indicated the overall reflection of compassion. Forty-five item statements were remaining relating to counselor's abilities, counseling skills, and perceptions of compassion that needed to be reconsidered by the panel. These results were used to generate the questions for Delphi Round III.

Delphi Round III consisted of a total of six questions. Two questions requested panelists to rank their agreement using the same 7-point Likert-type scale: (1) *strongly agree;* (2) *agree;* (3) *somewhat agree;* (4) *slightly agree;* (5) *neither agree nor disagree;* (6) *disagree;* (7) *strongly disagree.* Three questions instructed panelists to indicate the level of importance for each item by moving statements into one of five categories: (1) *extremely important;* (2) *very important;* (3) *moderately important;* (4) *slightly important;* or (5) *not as important.* Panelists also had the option of not moving the statements into one of the categories. The final question was an open-ended question to collect additional comments regarding compassion.

A total of 13 of the original 15 panelists completed this round of data collection. The consensus for this round was also established as an 80% agreement or greater. Results generated

100% agreement on the condensed statements to reflect empathy and 93% agreement on the condensed statements to reflect compassion. Three individual statements reached consensus. A total of 18 individual statements reached consensus when combining the categories of *extremely important* and *very important*. The open-ended questions yielded three comments.

In summary, the expert panel reached consensus on several points. Panelists agreed unanimously on the statements that reflect empathy. The panel unanimously agreed that "as counselors, we need to be cognizant of how our actions and words are impacting clients." Additionally, the panelists reached a consensus that the two skills most important to note regarding compassion are that of "creating a safe place within the counseling relationship to discuss what needs to be aired," and the importance of "allowing periods of silence for the client to experience emotions." Further, the panelists agreed that there are some basic attending skills to convey compassion in the counseling setting.

Additionally, the panel concurred on some general themes and times when counselors may strain to be compassionate or to show compassion. For example, counselors who are working with hostile clients or who may be experiencing burnout may struggle to display compassion with a client. The panel reflected little division when discussing how the expression of compassion happens personally and how professional boundaries impact the expression of compassion when working with clients. Numerous statements were also agreed on by the panel regarding how the knowledge, training, and education of a counselor impacts compassion expression.

Finally, overall ideas emerged about the differences in empathy and compassion, as well as some consensus on essential items that may impede or enhance the expression of compassion in professional settings.

Chapter Five

Discussions and Implications

This chapter summarizes the three-round Delphi study on compassion in professional counseling and discusses the implications. Presentation of implications for the profession are addressed, followed by the limitations. Also included in this chapter are recommendations for further research.

Description of the Study

A three-round Delphi method was utilized to gain consensus from a panel of experts within the counseling profession on ways counselors consider compassion. The total overall panel consisted of 15 members. Representation from the profession included clinical mental health counselors, counselor educators, substance abuse and addiction counselors, rehabilitation counselors, school counselors, and counselors who provide supervision. In each round of data collection, panelists were asked questions to potentially capture a definition of compassion in counseling, and identify skills, attributes, and behaviors associated with compassion. The following questions guided the research:

1. How do counselors and counselor educators understand compassion?

2. What skills, attributes, and behaviors indicate compassion in counseling?

3. How do experienced counselors and counselor educators differentiate compassion as it is experienced professionally and personally?

Delphi Round I solicited responses to two open-ended questions and four questions that requested panelists to use words or phrases that would identify and describe responses. Round I also included an information questionnaire to capture demographic data about the panelists. Each panelist was able to respond independently and provide their opinion to the questions.

Responses were free from inter-respondent bias, as the panelists were not aware of other's

opinions during this round of data collection. Following the data analysis of these responses, the

Delphi Round II survey was constructed based on the findings from Delphi Round I.

In Delphi Round II, the panelists ranked their agreement with statements generated from

Delphi Round I. There were a total of 11 questions that panelists were asked to rank their level

of agreement using a 7-point Likert-type scale. During the analysis, if 80% of the panel reached

an agreement on a statement item within each question, then consensus was achieved. Items

eliminated for inclusion in subsequent rounds did not reach the desired consensus of $\geq$ 80%.

Questions that achieved an overall consensus of 100% during this round were not included in

Delphi Round III but reported in the overall study findings. Additionally, three questions had a

lower number of items, with the majority reaching consensus. These questions were also not

included in Delphi Round III. The overall study findings included the data from those three

questions. While there is some concerns for excluding statements in Delphi Round III that have

reached consensus in Delphi Round II, the decision ultimately was to make the extensive data set

more efficient and reduce participation fatigue for the panel (Keeney et al., 2010; A. West,

2011).

Remaining items reaching 80% or greater consensus in Delphi Round II were utilized to

create the Delphi Round III survey. In the email notification for Delphi Round III, the panelists

received an overall report of the Delphi Round II results.   Delphi Round III consisted of six

questions. Two questions asked panelists to rank their level of agreement using a 7-point Likert-

type scale, three questions for ranking statements for a level of importance, and one open-ended

question.

Findings

Assessing the experts in the counseling field has unveiled that some of the items reaching consensus can be connected to the existing body of research in counseling, while other consensus items are not directly linked. Each of the findings will be discussed individually, followed by an overall discussion of the findings.

Empathy

While it may seem on the surface that only the description of compassion is under investigation, it is vital to identify what differentiates compassion from empathy. Knowing what these working definitions mean for the profession is incredibly important. Empathy is a robust, empirically supported area of study in the field of counseling. Existing literature interchanges empathy and compassion (Kelm et al., 2014), blankets compassion under altruism (Fulton, 2018; Gilbert, 2019), or shies away from compassion because of the historic religious associations (Fulton, 2018). Empathy was included in this study to ascertain how the panel would distinguish compassion apart from empathy.

Panelists identified and reached 100% consensus on an overall condensed statement that reflects empathy. The overall idea from the panel is that empathy is an internal feeling that allows a counselor to connect on a deeper level with another individual. As a person utilizes empathy, they are working to understand the emotional impact, specific to the thoughts, feelings, and experiences of another without the quality of undergoing the same events. One panelist specified that "empathy involves working to understand how others are emotionally impacted." This comment was the leading statement amongst the panel when identifying empathy in the study.

A panelist described that "empathy involves connecting on a deeper level to experience what [others] feel." These findings support the work of Rogers (1975, 1981) and others embodying empathetic understanding, which is one of the essential requirements in establishing a therapeutic relationship and creating a supportive environment (Clark, 2010b; Duffey & Trepal, 2016; Jordan, 2017; Kohut, 2010). Results from this study also confirmed that experts in the field of counseling support the works of Figley (2002) and others in that having the ability to empathize is critical in helping others and providing effective services (Bayne & Hays, 2017; Clark, 2010a, 2010b).

Overall, the panelists were able to identify and agree upon distinctions of empathy from compassion. Results from the panel about empathy yielded statements that were similar and provided generally the same meaning. Despite the complexity of definitions on empathy that exist in the literature (Bayne & Hays, 2017), the panelists converged in conveying the essence of empathy during the initial round. This finding was evident and anticipated due to the nature of counseling preparation. Early in the counselor training, students are taught to look inward to understand and reflect on their thoughts and feelings to foster understanding of others. Being aware of one's own experiences and developing from the self-understanding aids in becoming a more effective and reflective practitioner (Young, 2017). Empathy is also one of the primary attending skills to foster connection and gain an understanding of the client's point of view (Bayne & Hays, 2017; Bodenhorn & Starkey, 2005; Fulton, 2018; Ohrt et al., 2009; Young, 2017). Furthermore, the overall description provided by the panelists echoes the work of de Waal in that empathy connects to morality and cooperation (Keltner et al., 2010).

Interestingly, the panelists also identified two statements of what empathy was not. First, the panel agreed that "empathy does not necessarily involve compassion." This statement

offered a distinction between empathy and compassion. The panelist arrived at a definition of empathy that aligns with other researchers, such as Kelm and colleagues (2014) and Clark (2010). Kelm and colleagues (2014) offer the definition of empathy as a cognitive ability to understand and express that understanding of another person's emotional state(Kelm et al., 2014)(Kelm et al., 2014)(Kelm et al., 2014)(Kelm et al., 2014). This distinction upholds that "a counselor's awareness of the appropriate use of empathy" (Clark, 2010b., p. 100) allows the capability to enrich the therapeutic relationship. Empathy is the motivation of the counselor to connect with and gain an understanding of the client's reality (Bayne & Hays, 2017).

Panelists also agreed that empathy was not a more "differentiated and emotionally distant awareness of the [client's] experience." There were no additional comments to explain or expound on this statement. The interpretation assumes that empathy is not a separate type of feeling, nor is it a feeling of detachment from the emotional aspects of the client's experience. This agreement supported the panelists' endorsement of empathy being "more of an internal feeling for an individual." These agreed-upon statements can be linked back to Roger's (1975) explanation of empathy as being able to explore another's world while remaining rooted in their own.

Compassion

When addressing compassion directly, the panelists reached a consensus on an overall understanding of compassion. The panelists identified that compassion is an on-going process of caring for others that is more outwardly expressed than empathy. Agreement with this statement provides support to the proposed definition of compassion, in the work of Strauss and colleagues (2016), that includes the emotional resonance element. Compassion is, therefore, surmised as the outward expression of empathetic understanding. This outward expression of compassion is

the action of extending kindness, love, and benevolence toward the self or another person (Chodron, 1994; Dalai Lama, 2003; Stuntzner, 2017).

Another aspect of the overall reflection of compassion is the sympathetic concern for the problems of the self and others. The supportive sympathetic concern as pointed out by the panel, parallels the belief in connectivity between individuals and the understanding of the experiences of others that is promoted in the major religions and some philosophies (Brill & Nahmani, 2017; Chodron, 1994; Dalai Lama, 2003; Elias, 2014; Elwell, 2000; Held, 2014; Huang, 2005; Jayaram, 2019; Rakhshani, 2017). The panelists fully agreed with the statement that "compassion does not necessarily require that people go through the exact same experiences to feel or express it." In a sense, this statement resembles the Humanistic counseling theories that focus on the empathetic understanding of the unique perspective of the individual (ChÁvez et al., 2016; Corey, 2005; Pierce, 2016; Rogers, 2007).

Two distinctions that the panelists agreed on were "compassion involves empathy" and "includes the concept of self-compassion as these two concepts are inter-related." Each of these quotes provided by the panel supports the Buddhist teachings of compassion (Chodron, 1994; Dalai Lama, 2003). Compassion, according to the Buddhist philosophy, is non-discriminatory and starts inward before expanding the desire to remove the suffering of others (Chodron, 1994; Dalai Lama, 2003). Empathy being a component of compassion is part of the mainstream definition as a conscious awareness of others' distress along with a desire to alleviate it. Neff (2015) also describes compassion as "a way of relating to suffering, your own, or someone else's" (p. 187).

Personal Expression. The ten consensus items from Delphi Round II identified ways that compassion was expressed or perceived differently in personal settings. Panelists, without

doubt, agree that during personal settings, expression of compassion may be through acts of care. These acts of care were identified as hugging, touching, making a meal, advice-giving, and involving a greater expression of intimacy. The panelists easily and clearly provided examples of the distinction of how to personally express compassion. These distinctions ensure that counselors are aware of the ethical implications of becoming too personal with their clients. Ethical guidelines surrounding client welfare, appropriate professional boundaries, and practicing within an ethical and legal framework are core pillars within the counseling profession (American Counseling Association, 2014; Corey et al., 2018).

Professional Boundaries. Five consensus items from Delphi Round II identified ways compassion was expressed or perceived in professional settings. In a professional setting, the panelists identified that a higher standard of attention was the utmost consideration, followed closely by incorporating ethical boundaries (i.e., involving touch, limits of involvement, referrals, and disclosure) and when in professional context the role is as a representative of the client. The involvement of the counselor within the professional context is clearly delineated through the professional counseling associations, such as the ACA, as well as the counselor educational guidelines regarding professional ethics and standards of practice to advance and improve the counseling profession through ACES (American Counseling Association, 2014; Association for Counselor Education and Supervision, 2011). Responses from the panelists supported the training and standards of the profession.

Perceptions. When collecting the data from Delphi Round I about the perceptions of the skills, attributes, and behaviors associated with demonstrating compassion in counseling, concepts were identified by the panelists about ways the idea of compassion is recognized. Eight statements from Delphi Round II reached consensus. A separate category was created to include

statements that did not identify specific skills, attributes, or behaviors that arose from the data. Noteworthy statements provided indications of how counselors are, or are not, thinking about compassion. For example, one panelist stated "I can't say that I have ever considered compassion skills in counseling" and another panelist stated, "[I] am not aware of any specific knowledge that demonstrates compassion in counseling." Not considering or being aware of ways compassion is demonstrated or applied in the counseling setting supports both the facts that studies surrounding compassion need to occur and that the profession may be missing opportunities on key foundational aspects (Fulton, 2018; Gilbert, 2019). There is also the potential underlying meaning with these statements that trying to identify specific skill sets or knowledge base may not be the strategy to capture the essence of compassion in counseling; which further supports the need for additional exploration.

An additional statement that the panelists deemed to be very important to report was that there is a perception that "it is "okay" to practice compassion in one's personal life." The perception of the acceptable practice of compassion from a personal aspect connects to another statement from the panel that "many people still find it challenging to give themselves permission to cultivate compassion." These ideas indicate that there may be a preconceived way the profession has been considering compassion. The professional literature mostly contains empirical support for compassion fatigue. The studies and collected works may have framed the concept of compassion in a negative manner. It indicates that counselors could be thinking about compassion in a negative way, such as avoiding over-connection or over-identification with the clients to avoid burnout or the breakdown of compassion. The literature also discusses the safeguarding of compassion through wellness, compassion satisfaction, and self-compassion.

All of these centers on the wellness and job satisfaction of the counselor. The literature is lacking in connecting compassion in positive ways between the counselor and the client.

Further information on perceptions of compassion from the current study is that "compassion in a professional setting is perceived as understanding and support." This perception reached consensus, and the experts deemed as another *very important* factor for reporting. A way to identify compassion through "understanding and support" in a professional setting is near the same way empathy is identified by this same group of experts. The overlap in these unique expressions maintains that a standard definition and methods to assess compassion are needed (Bond et al., 2018; Sinclair et al., 2016; Strauss et al., 2016; Stuntzner, 2017).

Skills and Abilities

The panelists shared thoughts and ideas on the skills and abilities of a counselor that may exhibit compassion. The findings revealed information on attending skills, counseling skills, and counselor abilities.

Attending Skills. The panelists provided a large number of skills and attitudes that demonstrated compassion in counseling. Many of these skills are categorizable as the basic attending skills, or common factors, that generate healing and change in therapeutic relationships (Corey, 2005; Hunter, 2012; Young, 2017). The data provided by the panelists combined into 12 attending skills and four non-verbal behaviors which convey compassion. The panel unanimously agreed when presented with the full list. The attending skills, which are utilized by all counselors regardless of their theoretical approach, according to the panelists, are indicative of compassion. Compassion identified as an attending skill has not previously been documented before in the literature. This finding does support that the idea of compassion can be identified as a characteristic of the quality of care provided by counselors and other health care providers

(Bond et al., 2018; Grover, 2015; Sinclair et al., 2016). Furthermore, basic attending skills foster the connection between the counselor and the client. This interconnectedness is at the core of the humanistic nature of counseling and that "connection confers power and enables action" (Jordan, 2017, p. 231). Compassion, as stated by the panel, is the outward action of expression of supportive cognitive concern and affective caring of another.

Counseling Skills. All of the panelists who participated in the final round reached a consensus that a counselor's skill to demonstrate compassion is being able to create "a safe place within the counseling relationship to discuss what needs to be aired." This statement was top-ranked as *extremely important* or *very important* for all panelists. Many of the skills named by the panelists highlighted the therapeutic environment created by the counselor, the therapeutic relationship development, and the understanding and comfort with the different counseling issues that can be brought in by the clients. The skills emphasized by the panelists confirms the importance of the fundamental components of creating the foundation of change (Young, 2017). Awareness of the environmental skills of the counselor that can support the client by maintaining the therapeutic space is foundational to the profession. The findings of this study confirm that counselors do have an awareness of the way these skills create the foundation of change (Corey, 2005; Young, 2017).

Abilities. According to the results of this study, the panelists stated that "as counselors, we need to be cognizant of how our actions and words are impacting clients." The other top-ranking statement of a counselor's abilities to convey compassion is that "counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client." Each of these statements addresses the importance of being a reflective practitioner. Once again,

these findings pull from foundational teachings on using reflection and self-awareness to help create a connection (Corey, 2005; Young, 2017).

Conveying Compassion in Counseling. Following the question guiding the research around the skills, attributes, behaviors that indicate compassion in counseling, results support actionable skills that are fundamental to creating change and supporting the client in a compassionate manner. Figure 4 outlines the aspects of compassion in counseling.

Figure 4: Aspects of Compassion in Counseling

Self	Skills & Knowledge	Attributes	Behavior & Ability
	Self-Awareness	Unconditional Positive Regard	Belief in Capacity to Change
Others	Reflexivity	Caring & Empathetic	Understanding Human Struggles
	Creating Safe Place for Clients	Warmth & Acceptance	Allowing Silence

The skills and knowledge of a counselor support compassion through actions of the self and towards others. Self-awareness within the counselor is crucial. A panelist pointed out that "counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client." Not only is it important that a counselor have awareness of their own beliefs and experiences that may influence ways they are working with a client, but also have recognition of their counseling strengths and weaknesses. Counselors must know if they need

additional training in an area or if a client should be referred out to a more specialization of care. Furthermore, the counselor's skills and knowledge can focus on others. Compassion can be transmitted through their knowledge and use of counseling skill. One example is through a counselor's reflexivity, or examination of the cause and effects. Reflexivity can be the counselor's own awareness of their emotions and responses, or also those causes and effect regarding the client's perspective. The metacognitive component aids in elevating the way compassion can be expressed.

The attributes of a counselor can also convey compassion and be directed toward the self or others. Having unconditional positive regard for the client, or themselves, helps the skill of creating the safe space for the client to connect with the counselor and increase their willingness to change. Many of the basic attending skills (e.g., such as warmth, empathetic understanding, acceptance) communicate the desire to alleviate the suffering of a client.

When working with others, counselors' ability to know the theories and use appropriate interventions are also key factors imparting compassion. One panelist stated the importance in having "an attitude of understanding of human struggles." A counselor can provide compassionate care when offering the understanding that all people have some difficulties in their lives. The panel agreed that compassion is also supported through the counselor's ability to allow for "periods of silence for the client to experience emotions." A skilled counselor has the ability of knowing when to slow a session down or highlight particular talking points.

Compassion Obstruction

There may be instances or particular organizational hazards that could obstruct or hinder a counselor's ability to display compassion for their client (Beaumont et al., 2016; Lawson, 2007; Melvin, 2015). One of the themes that emerged from the statements with 100%

consensus, which may hinder a counselor in their ability to display compassion, was burnout. When counselors experience burnout, feelings of negativity or detachment may occur that facilitate the counselor disengaging from the emotionally demanding work happening with clients (Everall & Paulson, 2004; Lawson, 2007; Maslach et al., 2001; Ray et al., 2013). Feeling detached or cynical about work has an impact on the counselor's ability to extend compassion to the client (Lawson, 2007; Maslach et al., 2001).

Additionally, the themes of when counselors may experience compassion obstruction support the idea that counselors may be thinking about compassion from that negative perspective. Numerous statements that identified the general themes gained consensus during the second round of data collection. The data endorse that counselors have the quick ability to know when compassion is breaking down or not functioning, which supports the previous exploration of compassion fatigue and burnout within the literature.

Knowledge, Training, and Education

"It is important for counselors to have some additional training in compassion and self-compassion as a part of their education and professional practice." The panel had a 100% consensus with this statement. Including compassion and self-compassion as part of the educational and professional practice may be advantageous; however, little exists on how to measure this attribute, which could make it difficult to provide training and education. In more recent times there have been training and education on self-compassion with the focus on counselor wellness (Cummins et al., 2007; Fulton, 2016; Lawson, 2007; Lawson & Myers, 2011; Lawson et al., 2007; Stuntzner & Hartley, 2014).

Additional statements concerning counselor knowledge, training, and education regarded the counselor having foundational knowledge on various client experiences and disorders, as

well as the theories that would best be utilized in those milieus. CACREP (2015) standards ensure that training programs are addressing the teaching of the theories and numerous client experiences (i.e., trauma, grief, oppression) are part of the educational process, which has occurred for generations of counselors.

Overall

In exploring how counselors understand compassion in this study, many expected ideas emerged along with some surprising and exciting indications. The panel of experts identified that compassion is a supportive concern for the problems of both the self and others. Counselors provide support through treatment of symptoms, helping clients to manage psychosocial aspects of their lives, and provide as an emotional scaffold. The concern for clients keeps counselors connected, engaged, and interested in their struggles and victories. The panel further defined compassion as an on-going process of caring for others that are outwardly expressed to create an experience or environment for the client. The environment fosters the connection between the counselor and the client. It also aids in promoting change within the client. The panelists concurred that compassion is perceived as understanding and support.

Additionally, the panelists agreed that empathy and self-compassion are components of compassion. Empathy, or the ability to understand another person's experience, is an essential characteristic that precedes compassion (Zaki, 2014). A counselor must first be able to gain awareness and understanding of the phenomenology of another to be supportive and concerned about the problems of others. The other component pointed out by the panel was self-compassion. The support of the panel for self-compassion reinforces previous studies and teachings that compassion starts within, through self-exploration and being kind to the self

before being able to extend the desire to act on removing the suffering of others (Chodron, 1994; Dalai Lama, 2003; Neff, 2015).

There were some interesting perceptions about compassion that emerged from the data. One perception is that in Western society, it is more acceptable to practice compassion in one's private life than in one's professional life. This idea supports statements from this panel about the professional and ethical boundaries that counselors are obligated to adhere. The professional and ethical boundaries also support another perception pointed out by the panel that it is challenging to allow self-permission to cultivate compassion.

Upon evaluating all of the individual statements about compassion collected during Delphi Round I, the statements were divergent, ambiguous, and presumptive. Ideas generated ranged from specific meanings, such as "compassion means caring for others" or "compassion is more externally demonstrative;" to nebulous ideas, such as "compassion is a general state" or "compassion may not be expressed as directly or may be expressed as empathy." Some statements assumed an understanding of the concept of compassion such as "compassion is expected and welcomed typically in a professional setting." Having a more extensive range of responses substantiates the recommendations surrounding the need for definitions and supports the lack of consensus on agreed-upon definitions (Bond et al., 2018; Sinclair et al., 2016; Strauss et al., 2016; Stuntzner, 2017). Although this was not surprising, it does reinforce the literature that compassion reflects an understudied, unnoticed concept because of the focus on empathy, confused or assumed with empathy, or studied once fractured (Fulton, 2018; Gilbert, 2019).

When examining how counselors understand compassion through the differences between compassion and empathy, the statements were much more focused, specific, and similar. Many statements only had nuances of being different from others and reflected what has

been widely studied and taught within the counseling profession. The panel described empathy as an internal feeling or understanding of another. The panelists supported that a counselor can experience empathy without involving compassion. Because the responses were narrow with regards to empathy and more broad with compassion, it comes as no surprise to discover statements that reflected no previous consideration about compassion. Statements such as: "I can't say that I have ever considered compassion skills in counseling" and "[I] am not aware of any specific knowledge that demonstrates compassion in counseling" both reached consensus within the panel. While another statement, "I don't believe that compassion and empathy is all that much different," reached an agreement of 70%, the candidness of the panel supports the possibility that many within the profession may not separate compassion from empathy, or may not think about compassion as a factor at all.

In addressing the question of the perceived skills, attributes, and behaviors associated with demonstrating compassion in counseling, the key points are on attending skills, counseling skills, and the abilities of the counselor. The panelists established that the basic attending skills employed by all counselors convey compassion. Because empathy is a component of compassion, it would make a logical connection that these same skills that communicate empathy would impart compassion as well. The same is valid for counseling skills communicating compassion. The panelists also pointed out that counseling skills (e.g., understanding human struggles, allowing silence, mindfulness, creating safe space, structure session, connectivity with client, expressing hope, wisdom) demonstrates compassion. The counseling skills are fundamental elements of creating change (Young, 2017).

Furthermore, the abilities of the counselor (e.g., self-awareness, reflexivity, belief in the capacity to change, respect for others, awareness of our impact on others) also demonstrate

compassion. The abilities of the counselor can be described as the foundational awareness to create connection. The counselor can put the attending skills and counseling skills into action. More shape to how counselors realize compassion can be formed since the panel pointed out these fundamental essentials, but there still lacks concrete distinction between empathy and compassion.

The final question to guide the research concentrated on how experienced counselors and counselor educators differentiate compassion as it is experienced professionally and personally. Panelists agreed that experiencing compassion in a personal manner was identified through greater expressions of intimacy. Examples given were through touch (e.g., hugging) or actions (e.g., advice-giving, making a meal). The panelists agreed that compassion in professional settings requires a higher standard of attention, incorporating ethical boundaries (e.g., touch, limits of involvement, personal disclosure), and being present as a representative of the client. The panelists also identified obstructions to compassion, such as burnout, bias, or working with hostile clients. Counselors know what stops or interferes with the expression of compassion, which may be associated with the negative frame of compassion fatigue created by the existing literature. These representations of compassion were not revolutionary but did support the notion that counselors are considerably aware of the level of professionalism and ethical duties that protect the therapeutic relationship.

Compassion defined. Establishing a definition of compassion within the context of professional counseling brings together the information provided by the panel of experts and the basic understanding of compassion. The definition of compassion in the profession of counseling that emerged from the study is an on-going process of supportive cognitive concern and affective caring for the self and others that is outwardly expressed through counseling

behaviors. It includes the recognition and understanding that as human beings, we all experience

hurt, pain, loss, and disappointment. Compassion in counseling encompasses the attending and

counseling skills along with the wisdom of expression within the professional, ethical

boundaries.

The findings from this study support the proposed definition from the psychology

literature from Strauss, Taylor, Gu, Kuyken, Baer, Jones, & Cavanaugh (2016):

Definition of compassion as a cognitive, affective, and behavioral process consisting of

the following five elements that refer to both self- and other-compassion: 1) Recognizing

suffering; 2) Understanding the universality of suffering in human experience; 3) Feeling

empathy for the person suffering and connecting with the distress (emotional resonance);

4) Tolerating uncomfortable feelings aroused in response to the suffering person (e.g.,

distress, anger, fear) so remaining open to and accepting of the person suffering; and 5)

Motivation to act/acting to alleviate suffering (p. 19).

Compassion Development Model. Regardless of the developmental or cognitive growth

model approach taken, the commonalities exist that as a counselor educator or supervisor, the

goal is accommodation and adaptation to support growth to the developing counselor/student

(McAuliffe & Eriksen, 2011). Through the exploration of a different dimension of the teaching-

learning process in counselor development, more specifically, the ways of knowing and

understanding compassion, the following compassion development model (CDM) will add to the

cognitive constructivist approach of counselor education (McAuliffe & Eriksen, 2011) and

supportive methods in supervision. The model outlines the developmental process of

compassion for counselors beginning at the foundational training and education process into

becoming an experienced and expert counselor. The CDM is the exploration of compassion in a

more sophisticated way. Similar to the introduction of the Discrimination Model (Bernard,

1979) in counseling supervision, the CDM provides a framework for implementation and the

opportunity to stimulate further study.

Figure 5: Compassion Development Model

Student learning can occur in continual and cumulative ways, as well as discontinuous

and successive stage ways. The CDM outlines progressive stages, similar to the familiar

counseling developmental models of supervision, such as the Integrative Developmental Model

(IDM) (Stoltenberg & McNeill, 2011) and counselor development through the Phases of

Therapist/Counselor Development model (Rønnestad, Orlinsky, Schröder, Skovholt, &

Willutzki, 2019; Rønnestad & Skovholt, 2003). The developmental progression starts with the

lay helper and moves through to the expert senior counselor (see Figure 5). Each stage discusses

what may be occurring with the counselor at each developmental level, provides supervision and

training, consider the metacognitive changes, as well as highlights the potential development of compassion.

The first stage of the CDM is the lay helper. The lay helper is someone before entering into a counselor training program with a desire to help others (Radey & Figley, 2007). Before the initial stages of counseling development and training, entering students embark with a common perception of many counseling "skills" (e.g., listening, problem-solving, empathy, compassion) but lack the formal training in theories or helping skills (McAuliffe & Eriksen, 2011). The learning theory of metacognition (Flavell, 1979) and the Integrative Developmental Model (Stoltenberg & McNeill, 2011) both support this kind of starting point of knowledge. Thoughts about counseling at this stage may center around their previous personal understanding or declarative knowledge (Flavell, 1979). The pre-training, brand new students, may draw on experiences of listening to their family or friends share their feelings or advising others on ways to navigate their life struggles. Ronnestad & Skovholt (2003) point out that lay helpers are quick to identify a problem, offer advice to solve problems, blur emotional support boundaries, and provide sympathy rather than empathy. Compassion at this stage is at a basal level of understanding and centers on the personal knowledge at the metacognitive level of the lay helper. This person may recognize that another is suffering and want to alieve that pain, but they may not be fully empathetic and understand the other person's perspective. Additionally, the lay helper is not familiar with the ethical boundaries at the professional level.

At the beginning student stage, a counselor begins the foundational level of training and education. Students learn about necessary counseling skills, such as empathy and empathetic understanding, and the steps within the helping process (Young, 2017). Introduction to the profession begins through coursework on ethics and theoretical content knowledge (McAuliffe &

Eriksen, 2011). Beginning students can become overwhelmed by the counseling culture and may struggle with the ambiguity (McAuliffe & Eriksen, 2011; Young, 2017). The teacher/instructor provides structure and supervision (Bernard, 1979; Bernard & Goodyear, 2014; McAuliffe & Eriksen, 2011). During this stage, beginning students have high motivation to achieve and high anxiety surrounding the complexity of the profession along with balancing their work/school/personal life (McAuliffe & Eriksen, 2011). The cognitive complexity begins to shift after learning and practicing the counseling microskills (Duys & Hedstrom, 2000). It is in the beginning stages where students have categorical thinking, are limited with self-awareness, and strive to learn the "correct" answers (McAuliffe & Eriksen, 2011). Students encounter initial challenges to their thinking and begin self-reflection through coursework. Concepts, once understood by the students in straightforward ways, such as empathy or listening, begin to take on additional, more complex meanings. At this stage, the beginning student is supported by counselor educators with the linear introduction to topics while gradually layering in complexity (Bernard & Goodyear, 2014; McAuliffe & Eriksen, 2011). Beginning students learn how empathy, a precursor to compassion, allows the intimacy to grow in the professional counseling relationship (Young, 2017). The concept of compassion may still be around the basal level. Additionally, with the beginning student's self-focus being higher at this point in the training, self-compassion and wellness can be introduced. Incorporating these concepts during this stage can begin foundational measures to safeguard against future burnout while reinforcing methods of deliberately supporting complexity.

The next stage is that of the advanced student. During this stage, students are working with clients in their practicum and internships. Having exposure to the complexities of counseling work may leave advanced students wavering with confidence and vulnerability levels

(McAuliffe & Eriksen, 2011). The developmental stage has the advanced student handling ambiguity better, working at setting professional boundaries, embracing a counseling theory, and requiring more intensive supervision and training (McAuliffe & Eriksen, 2011; Rønnestad et al., 2019; Rønnestad & Skovholt, 2003). Supervision shifts to provide a higher, more intense level of support (Bernard, 1979; Bernard & Goodyear, 2014; Stoltenberg & McNeill, 2011). While the advanced student is beginning to operate more independently, the increased complexity of the situations can disturb confidence (McAuliffe & Eriksen, 2011). Coursework continues to focus on case conceptualizations and more advanced or specific topics. At this stage, the students are pushing past emotional and intellectual edges, while starting to transfer focus to the client rather than themselves (Granello, 2010; McAuliffe & Eriksen, 2011). Through having better abilities to understand the client's worldview, the advanced students are capable of empathetic understanding. A shift in understanding professional boundaries starts occurring and comprehension of ethical limitations can begin to better support ways to alleviate the suffering of the client within those limits using counseling skills. The exploration of compassion can occur during the advanced student stage.

Following graduation, the student then enters into the novice professional stage. Ronnestad and Skovholt (2003) outline five themes within the developmental level of the novice professional: the need for further learning, development of a personal style of counseling, readjustment of work requirements and personality, learning to set boundaries, and the desire for mentoring. The formal training from graduate school has ended; however, many novice professionals realize the need for additional training (McAuliffe & Eriksen, 2011; Rønnestad & Skovholt, 2003). The learning shifts to understanding organizational protocols, specialized training for job-specific needs, and licensure or certification. Supervision becomes less

structured by the supervisor becoming more facilitative and conceptual (Bernard & Goodyear, 2014; Stoltenberg & McNeill, 2011). The focus of supervision may also include the integration of personal and professional, as well as career paths (Stoltenberg & McNeill, 2011). The novice professional has greater empathy and understanding. At the metacognitive level, the novice professional is more accepting of their strengths and weaknesses, as well as can focus on the client, the process, and themselves (McAuliffe & Eriksen, 2011). The higher level of empathy, understanding, and integration of the self from a professional perspective allows for a more advanced discernment of compassion. Being able to have flexibility in metacognitive knowledge through processing new experiences with reflection and comprehension of past experiences can aid in thinking more comprehensively about compassion. Counselors at this stage can begin incorporating multiple layers of perspective and knowledge while working with clients, giving them a more complex ability to aid client suffering.

The novice professional is not the final stage of counselor development. Granello (2010) points out two points of professional experience where developmental shifts occur. After a counselor has 5-10 years of professional experience, counselors can be in a multiplistic phase of development (Granello, 2010). Counselors in the experienced professional stage are at the developmental level of joining their personal and professional identities, continuation of professional growth, increasing resilience, and attempting to prevent stagnation or burnout (Rønnestad et al., 2019). Supervision may no longer be required or sought out and experienced counselors may seek consultation with peers for feedback (Bernard, 1979). Counselors at this stage could be providing supervision of counseling students or novice counselors. Training consists of continuing education and other topics as interested or needed. The developmental level may be at the multiplistic stage of development where the evaluation of information can be

realized as contextual and not absolute (Granello, 2010; Perry, 1999; E. J. West, 2004).

Research supports that counselors at this level can recognize intricacies of client characteristics

combined with the ability to match those characteristics together (Welfare & Borders, 2010).

Experience with clients at this stage allows for more robust metacognition where counselors can

use their full therapeutic self in sessions (Welfare & Borders, 2010). The development of

compassion, at the experienced professional stage, is a more skilled aspect. The professional-

level compassion expresses aid to the suffering of clients in ways that elegantly combine

empathy, empathetic understanding, self-compassion, healthy boundaries, theoretical

interventions, counseling skills, ethical behavior, and actionable counselor abilities. Counselors

at this stage can support clients and communities through a professional-compassionate lens in

individual work as well as in advocacy.

The final stage is that of the expert senior counselor (Rønnestad & Skovholt, 2003). This

stage marks the second developmental shift of experienced counselors, which occurs after 10-20

years of professional experience (Granello, 2010; Rønnestad & Skovholt, 2003). Counselors

within this stage are likely within the "late multiplistic or early relativistic stages of

development" (Granello, 2010, p.97). Descriptions of this developmental stage are around

basing opinions on information through substantiation and context (Perry, 1999; E. J. West,

2004). Training is much the same as that of the experienced professional, being based on

educational continuation requirements for licensure or certification and exploration of areas of

interest. At this stage, supervision and mentorship are being provided by this group to novice or

less experienced counselors (Bernard & Goodyear, 2014; Fouad, 2003; Rønnestad et al., 2019;

Rønnestad & Skovholt, 2003). All of the experience, training, and knowledge of the senior

counselor can allow for the most robust expression of professional-level compassion. Through

longevity within the profession, the senior counselor has had wide ranges of encounters with situations and people. When combining the vast familiarity with the inner workings and the developmental lifespan of the profession, counselors at this stage can harmonize the knowledge in a way that is beneficial and helpful for clients, communities, and colleagues.

The compassion development model allows exploration of compassion in a more sophisticated way. Through the higher-order thinking, which is described of compassion by the Dalai Lama as a commitment founded on reason with a focus on the needs of others, counselors can be more detached from the emotional anguish. Incorporating understanding of the client's feelings with their skills, knowledge, and abilities in counseling, a counselor can make more logical connections that would genuinely aid in the suffering.

An example would be an individual who is experiencing detox from drugs. A compassionate person would want to help lessen the suffering right at that moment. In this example, the quickest way to lessen the suffering may be to administer more of the drug that is causing the withdrawal. Although this would remove the immediate suffering, it may not be in the best interest of the individual. However, professional-level compassion would allow higher-order thinking. This may be the recognition that detox, or some suffering, is necessary in order to remove suffering from a broader perspective. The counselor can assist the individual in recognizing the options available and pursue healthier choices.

Implications

Before the current research, there have been limited approaches to defining or assessing ways counselors are thinking about compassion, and both need to continue to evolve. Having an understanding of how counselors view compassion allows for the conceptualization of

professional-level compassion. Implications of these findings can be beneficial to the profession as a whole. Results can inform counselor educators, counselor supervisors, and practitioners.

Counselors are aware of the importance of empathy and creating a therapeutic connection with their clients. This study assists in raising awareness of the importance of compassion, as the panel revealed that empathy is a component of compassion. Compassion is the outward expression of empathy that helps to reduce the mental pain of the clients receiving services. Gaining awareness of the importance of compassion can increase the need for further studies to identify specific ways to measure compassion and how clients perceive compassion. There is a substantial gap in the literature on the positive aspects of compassion.

Another essential consideration for counselor educators is to identify ways to frame compassion positively and incorporate self-compassion into the learning curricula. Counselor educators need to introduce compassion as a critical skill at the foundational levels of training in ways that can be measured. Self-compassion has proven to safeguard against burnout (Lawson, 2007; Lawson & Myers, 2011; Neff, 2015) and promoting wellness (Flint, 2018; Meyers, 2015; Skovholt et al., 2001; Venart, Vassos, & Pitcher-Heft, 2007; Yager & Tovar-Blank, 2007). Self-compassion can also increase the ability and compassion for others (Dalai Lama, 2003; Fulton, 2018; Grover, 2015; Solomon & Barden, 2016; Stuntzner, 2017). Through the integration of compassion at various points within the developmental span of counseling students, counselor educators can support and foster a more elegant way to use compassion to act in helpful ways to clients.

Counselor supervisors can use compassion with counselors-in-training and novice counselors during supervision sessions. Not only will the supervisors be able to model a compassionate approach, but they can also help raise the exploration of compassion within the

counseling community through supporting this skill with the next generation of counselors. Supervision can further the professional-level compassion development in novice counselors through self-awareness, utilizing theory and interventions with expertise, and incorporating a further understanding of working within the healthy boundaries of the therapeutic relationships.

Practitioners can benefit from this study to explore compassion within their practice. Although there are limited training and education regarding compassion as described in this study, counselors can seek more in-depth knowledge of compassion and self-compassion. As additional studies and empirical evidence increases, practitioners can incorporate a higher awareness of compassion and begin to model this professional-level compassion with their clients.

Future Research

This present study provided essential foundational work towards clarity in the understanding of compassion. The results provide a definition of compassion and a compassion developmental model so that future research can identify observable and measurable indicators. Further research can strengthen and refine the relevance of these findings. A replication of this study to include counselors-in-training or all counselors as a different panel of experts may be beneficial to identify if there would be similarities in the ways of considering compassion or if contrasting data would emerge. Future studies could include a continuation of this study to include aspects of alleviation of the client's mental pain and to work on clarifying a working definition of compassion within the counseling profession. More research is needed to assess ways counselors think about compassion, how they act compassionately on the empathetic feelings, and ways they behave using professional compassionate care.

Further research exploring ways to measure compassion is needed, as the counseling literature currently mainly explores compassion fatigue, compassion/job satisfaction, or self-compassion. Gaining some additional insight into how counselors convey compassion to the clients, ways to cultivate compassion within the professional boundaries, and ways clients recognize compassion in their counselor can be helpful to the overall profession. Discovering these demeanors can inform counselor educators and supervisors in making appropriate adjustments to the training or assist counselors in a better understanding of themselves in connection to the services they provide. Overall this can potentially strengthen the therapeutic alliance between the counselor and client.

A thorough literature review reveals that compassion has foundations in the spiritual and philosophical domains. In this study, only one statement mentioned this aspect, which was: "compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case." Additional research can explore how this aspect impacts or influences counselors.

Finally, research to address the perceptions of counseling clients may be valuable to gain alternative aspects of compassion in counseling. Seeking out alternative elements of compassion in counseling would concur with the recommendations of other researchers within the health care professions to explore the client experience (Sinclair et al., 2016; Strauss et al., 2016).

Limitations

Limitations of this study exist, and many will be discussed. The concept of compassion is an ambiguous construct that has previously been a limited-to-unexplored topic. Working on creating identifiable ways to assess how counselors experience compassion and differentiate from empathy is subjective; therefore, creating divisions was done in the hope of isolating the

perceptions (DiClemente, 2005).   Ways that the panelists may have internally been defining and regarding compassion impacts all rounds within this study. Not knowing the frame of reference of the panelist when responding adds to the limitation of the literature surrounding compassion in counseling. Previous studies have only explored particular aspects of compassion (e.g., compassion fatigue, compassion satisfaction, burnout, self-compassion), which the different concepts of compassion may be influencing the bias of the panelists.

Other limitations include the expert panel. All attempts were made to gain a representation of the counseling profession as a whole; however, different panelists could yield different results. The participation of the panelists can also be considered a limitation. Because the panelists are experts within the field of counseling, the demanding schedules may have led to not being able to participate in each round or time may not have allowed full, deep reflection before responding. This factor may also contribute to participation fatigue and dropout rates. Despite being invited, panelists did self-selected to participate which may introduce some bias due to interest in the subject matter. An additional note to mention about the panel is the lack of racial and ethnic diversity in the panelists. Although this may be somewhat reflective of the counseling profession as a whole, having panelists of different races and ethnicities may yield very different results. Compassion may be experienced, perceived, and defined in other ways than the results of the current study.

A further limitation was unforeseen delays that impacted the time and administration of this study. During the time of the study, there were factors beyond the control of the researcher, such as three changes in university contracts with IRB managers that impacted the length of the study. The data collection period was from March 2019 until September 2019, which does still

fit within the average length of time for a Delphi Study (Keeney et al., 2010), yet may have been a factor on participation and dropout.

The final limitations to be discussed are the collection method and the wording of the questions within each round. The data collection method employed an online survey, which may add to bias or cause panelists to opt from participation. Also, the language of the Delphi Round I included two concepts to be differentiated. Additionally, within the questions, the wording was ambiguous which allowed the panelist to identify how they chose to respond. Panelists had the directions which included "expressed or perceived." The vague wording may have caused confusion or frustration for the panelist with the text not being specifically distinct.

Conclusion

This body of research provides crucial contributions to the field of counseling through a definition of compassion and a developmental model on ways compassion shifts over the occupational lifespan. Having a definition of compassion that is unique to the counseling profession gives an innovative way to consider aiding the suffering of clients and captures a way to support the progression of compassion. The findings of this research provide a foundation for progress in research, evaluation, and assessment of compassion.

An interesting statement from the study from a panelist was: "The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice." This study provides a foundational mechanism to build on. Once the counseling profession has identified concrete skills and concepts that can be measured, then educational and professional training can occur to allow better implementation in practice.

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Appendices

Appendix A

Expert Panelist Scoring Rubric

Expert Panelist Scoring Rubric

<table>
<tr>
<th colspan="2">Criteria Area</th>
<th>Outstandi ng

4</th>
<th>Excellent

3</th>
<th>Good

2</th>
<th>Average

1</th>
<th>Weak

0</th>
<th>Total Score</th>
</tr>
<tr>
<td rowspan="3">Experience</td>
<td>Length of time in counseling profession</td>
<td>10+ years</td>
<td>8-9 years</td>
<td>6-7 years</td>
<td>5 years</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Length of time in CES</td>
<td>10+ years overall</td>
<td>8-9 years</td>
<td>6-7 years</td>
<td>5 years</td>
<td>No experience in CES</td>
<td></td>
</tr>
<tr>
<td>Varied range of experience (i.e. various settings, both counseling and teaching)</td>
<td>6+ various experiences in counseling and/or teaching settings</td>
<td>4-5 various experiences in counseling and/or teaching settings</td>
<td>2-3 various experiences in counseling and/or teaching settings</td>
<td>Experiences in 1 counseling and/or teaching setting only</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td rowspan="5">Expertise</td>
<td>Referred journal articles published on identified topics</td>
<td>7+ publications</td>
<td>5-6 publications</td>
<td>3-4 publications</td>
<td>1-2 publications</td>
<td>No publications</td>
<td></td>
</tr>
<tr>
<td>Books/Chapters written about identified topics</td>
<td>4+ books &/or chapters</td>
<td>3 books &/or chapters</td>
<td>2 books &/or chapters</td>
<td>1 Book &/or chapter</td>
<td>No publications</td>
<td></td>
</tr>
<tr>
<td>Presentations on identified topics</td>
<td>7+ presentatio ns</td>
<td>5-6 presentatio ns</td>
<td>3-4 presentatio ns</td>
<td>1-2 presentatio ns</td>
<td>No presentatio ns</td>
<td></td>
</tr>
<tr>
<td>Courses taught on identified topics</td>
<td>3+ courses</td>
<td>N/A</td>
<td>N/A</td>
<td>1-2 courses</td>
<td>No courses taught</td>
<td></td>
</tr>
<tr>
<td>Workshops/traini ngs on identified topics (as presenter)</td>
<td>3+ presentatio ns</td>
<td>N/A</td>
<td>N/A</td>
<td>1-2 presentatio ns</td>
<td>No presentatio ns</td>
<td></td>
</tr>
</table>

	Field experience with identified topics	10+ years overall	8-9 years	6-7 years	5 years	No specialty field experience	
Education & Licensure	PhD - if in CES	Yes	N/A	N/A	N/A	No	
	Master's - if Clinician only	PhD	PhD candidate, student, or course work	Extra Certification	Master's	N/A	
	Licensed/certified in area of specialization	Professional License; National Certification; Area of specialty certification	Professional License; area of specialty certification	Professional License; national certification	Professional License	N/A	
Service	Leadership participation in counseling associations	Leadership participation	N/A	N/A	N/A	No leadership participation	
	Active membership in counseling associations	Active membership in counseling associations	N/A	Memberships in counseling associations	N/A	No membership in counseling associations	

Appendix B

WIRB Approval Letter

WIRB.
Global Leader | Proven Expert

February 22, 2019

Nancy Bodenhorn, PhD
Virginia Polytechnic Institute and State University
370 Drillfield Drive
104 War Memorial Drive [MC0313]
Blacksburg, VA 24061

Dear Dr. Bodenhorn:

SUBJECT: IRB EXEMPTION—REGULATORY OPINION
            Investigator: Nancy Bodenhorn, Ph.D.
            Institution Protocol #:18-788
            Protocol Title: Compassion in Professional Counseling: A Delphi Study

This is in response to your request for an exempt status determination for the above-referenced protocol. Western Institutional Review Board's (WIRB's) IRB Affairs Department reviewed the study under the Common Rule and applicable guidance.

We believe the study is exempt under 45 CFR § 46.104(d)(2), because this research involves completion of online surveys and disclosure of the subject's responses outside of the research are unlikely to place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation.

This exemption determination can apply to multiple sites, but it does not apply to any institution that has an institutional policy of requiring an entity other than WIRB (such as an internal IRB) to make exemption determinations. WIRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions. You are responsible for ensuring that each site to which this exemption applies can and will accept WIRB's exemption decision.

Please note that any future changes to the project may affect its exempt status, and you may want to contact WIRB about the effect these changes may have on the exemption status before implementing them. WIRB does not impose an expiration date on its IRB exemption determinations.

If you have any questions, or if we can be of further assistance, please contact Sean W. Horkheimer, JD, CIP, at 360-252-2465, or e-mail RegulatoryAffairs@wirb.com.

SWH:jca
D2-Exemption-Bodenhorn (02-22-2019)
cc: Virginia Polytechnic Institute and State University
    WIRB Accounting
    WIRB Work Order #1-1156905-1

Western Institutional Review Board.
1019 39th Avenue SE Suite 120 | Puyallup, WA 98374-2115
Office: (360) 252-2500 | Fax: (360) 252-2498 | www.wirb.com

Appendix C

Invitational Recruitment Email

Unique Identification Code: XX1000

Dear "personalized name":

I hope this finds you well and enjoying the transition into spring. My name is Karen Raymond
and I am a doctoral candidate at Virginia Tech in the Counselor Education and
Supervision program. Under the supervision of my advisors, Dr. Nancy Bodehnhorn and
Dr. Laura Farmer, I am working to complete my degree requirements. I would like to
invite you to participate in a Delphi approach for my dissertation research. The purpose
of the study is to define the abstract concept of compassion within the domain of
counseling. The Western Institutional Review Board (WIRB) has approved this
document for use per work order #1-1156905-1.

You are receiving this email because you have been identified as an expert in the area of
**[PERSONALIZED: clinical mental health counseling, counselor education,
rehabilitation counseling, addictions counseling, school counseling, or as a counselor
supervisor]**. Contact information was collected from personal contact, work or academic
websites, professional social media internet sites (Research Gate or LinkedIn), and/or
recommendation from another professional counselor or counselor educator.

The concept of compassion, as it relates to the context of the counseling profession, is not well
defined in the literature. As an identified expert, your input would be most appreciated
and helpful in defining the attitudes and beliefs, knowledge, and skills necessary to define
compassion in counseling.

In order to be respectful of your time and transparent about the process as a potential panelist in
this research, you may expect the following:

- Your participation is voluntary and you are free to withdraw from the study at any time.
- All phases of this research will be conducted through an online survey program,
  Qualtrics®.

- The Delphi approach requires 3-4 rounds of data collection until a consensus has been reached (Keeney et al., 2010).
- The initial round may take approximately 20 minutes or less, with subsequent rounds taking approximately 5-15 minutes as there are fewer items.
- For each Delphi round, panelists will have ten days to respond. Once the collection timeframe for each round is closed, the data will be analyzed for subsequent rounds. Targeted completion for the study will be May 2019.
- The initial link included in this invitation will provide additional information about the study, consent form, and collection of demographic information. Also, you will be invited to share some additional names of potential panel members you know that may have counseling expertise. Following this informational portion, Delphi Round One open-ended questions will begin.
- At the top of this message, there is a unique identification code for your use throughout the Delphi. **Please make note of this code as you will need to enter this within the survey**. This code will be included for each subsequent form of contact. Your responses will not be connected with your email address; however, there is a potential risk of loss of confidentiality in all internet transactions.
- Click on the link to learn more about the study and follow instructions for completing research materials and steps: Compassion in Professional Counseling: A Delphi Study. You will first be asked to read the consent form entirely and "click" continue if you consent. A full copy of the Research Consent Form is attached to this message for your records.

Should you wish to discuss the study or your participation in further detail, please feel free to contact me at drkare70@vt.edu or one of my research supervisors at the email addresses below. Thank you for your consideration and contribution to our field.

Respectfully,

Karen Raymond

Dr. Nancy Bodenhorn: nanboden@vt.edu
Dr. Laura Farmer: lbfarmer@vt.edu

Appendix D

RESEARCH SUBJECT CONSENT

Title:	Compassion in Professional Counseling: A Delphi Study
Protocol No.:	#18-788/WIRB Work Order # 1-1156905-1

Sponsor:	Jennifer Farmer
Investigator:	Karen Raymond, MS, Doctoral Candidate, Virginia Tech
	205 Sequoia Circle, NW
	Christiansburg, VA 24073
Daytime Phone No.:	336.280.5060

Supervision:	Dr. Nancy Bodenhorn, PhD, Dissertation Co-Chair, Virginia Tech
	Dr. Laura Farmer, PhD, Dissertation Co-Chair, Virginia Tech

RESEARCH CONSENT SUMMARY: You are invited to participate in a Delphi study on Compassion in Professional Counseling. The initial Delphi I online survey should take approximately 15-20 minutes to complete. Participation is voluntary, and responses will be kept confidential to the degree permitted by the technology being used.

You have the option not to respond to any questions that you choose. Participation or nonparticipation will not impact your relationship with the researcher, faculty advisors, or Virginia Tech. Submission of the survey will be interpreted as your agreement to participate and that you affirm that you are at least 18 years of age.

Purpose:

- The purpose of the study is to define the abstract concept of compassion within the context of the profession of counseling. A panel of experts within the counseling and counselor education professions will be sought out to reach consensus to identify the skills, attributes, and behaviors associated with demonstrating compassion in counseling through a Delphi approach.

Procedures:

- The study will be conducted with a Delphi approach that will consist of a proposed three rounds of data collection, with an option for a fourth round if consensus is not achieved. All data collection and

participation will take place online, during a time that is most convenient for the panelist within the requested timeframe. For each Delphi round, panelists will have ten days to respond.

- The initial round (Delphi I) may take approximately 20 minutes or less, with subsequent rounds taking approximately 5-15 minutes as there are fewer items.
- The proposed target date for completion of data collection is early-May 2019. There is a unique identification code for the participants to use throughout the Delphi within the survey. Unique identification codes will be stored seperately and securely from other research data.

Responsibilities in Participation:

- If you agree to take part in this research, you will be responsible to provide timely and complete responses to the surveys in honest and genuine ways. Should you wish to withdraw, please inform the lead researcher.

Risks:

- This research study poses minimal risks to panelists. The data being requested may pose minor emotional discomfort. Questions are regarding a professional nature and do not require personal reflection. Panelists may experience a loss of time due to the nature of participating in the study. Effort will be made to mitigate risks. There are no associated costs with particpation, aside from the time investment.

Benefits:

- Benefits for panelists may include feeling a sense of pride and honor for being requested to participate as an expert. Benefits to the counseling profession may include awareness on the importance of compassion in the professional setting of counseling. No promise or guarantee of benefits has been made to encourage participation.

Alternatives to Participation:

- This research is not designed to diagnose, treat, or prevent any disease. You r alternative is to not take part in the research.

Anonymity & Confidentiality:

- Results of this research may be published. The information shared during the study shall be kept confidential and in full compliance with the policy and approval standards of the Western Institutional Review Board (WIRB). Information collected will be de-identified prior to analysis. Only the research team will have access to the raw data. At no time will the researchers release identifiable results of the study to anyone other than individuals working on the project without written consent. The WIRB may view the study's data for auditing purposes. The WIRB is responsible for the oversight of the protection of human subjects involved in research.

Compensation: There is no compensation for participation in the study.

Freedom to Withdraw:

- Panelists are free to withdraw from the study at any time without penalty. Panelists are free to not answer any questions without penalty.

Questions about the Research:

- If you have questions, concerns, or complaints, or think this research has hurt you or made you sick, talk to the research team at the phone number listed above on the first page.
- This research is being overseen by an Institutional Review Board ("IRB"). An IRB is a group of people who perform independent review of research studies. You may talk to them at (800) 562-4789, help@wirb.com if:
  - ✓ You have questions, concerns, or complaints that are not being answered by the research team.
  - ✓ You are not getting answers from the research team.
  - ✓ You cannot reach the research team.
  - ✓ You want to talk to someone else about the research.
  - ✓ You have questions about your rights as a research subject.

Statement of Consent:

- Submission of the survey will be interpreted as your agreement to participate and that you affirm that you are at least 18 years of age.
- A Research Consent Form is attached to the invitational email. Please refer to this and maintain for your records.

Appendix E

Reminder Email

Hello,

This is a friendly reminder regarding the invitation for you to share your thoughts about compassion in counseling. Because of your experience, knowledge, and expertise, I believe you can help identify and define the important factors surrounding compassion. Attached is the original message sent to you last week. Please consider participating.

If you have any questions, please feel free to contact me.

Thank you,
Karen

Appendix F

Final Reminder Email

Greetings 'personalized",

A few weeks ago I reached out to you extending an invitation for participation in a Delphi Study I am conducting to define the concept of compassion within the domain of counseling. You were identified as an expert and recommended for participation based on my research from within the literature, review of work or academic websites, professional social media sites, or by personal recommendation from others within the field of counseling.

I am very close to reaching my goal of participants and hope that you will consider participating in my study. Your experience, knowledge, and expertise will be paramount in identifying the important factors surrounding compassion.

The initial request is attached, but here is the information you need for participation:

Your Unique Identification Code: **XX1000**
Link for Participation: Compassion in Professional Counseling: A Delphi Study

The deadline for participation is Friday, March 29. I appreciate your time and attention.

If you have any questions, please feel free to contact me.

Respectfully,

Karen Raymond

Appendix G

Information Questionnaire

Q6 Please enter your First Name: ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

Q7 Please enter your Last Name: ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

Q8 Please identify your age range:

○ 25-30 (1)

○ 31-35 (2)

○ 36-40 (3)

○ 41-45 (4)

○ 46-50 (5)

○ 51-55 (6)

○ 56-60 (7)

○ 60-65 (8)

○ 66+ (9)

○ Prefer not to say (10)

Q9 Please list your gender identification:

○ Male (1)

○ Female (2)

○ Non-binary/Third gender (3)

○ Prefer to self-identify/Other (4)

○ Prefer not to say (5)

Q10 Please select your ethnic and racial identification:

○ Native American/Alaskan (1)

○ African American/Black (2)

○ Asian/Southeast Asian (3)

○ Caucasian/White (4)

○ Hispanic/Latinx (5)

○ Native Hawaiian/Pacific Islander (6)

○ Bi-Racial (7)

○ Multi-Racial (8)

○ Other (9)

○ Prefer not to say (10)

Q11 Please select the best representation of your geographic location:

○ Northeastern US (1)

○ Northern Midwest US (2)

○ Northwestern US (3)

○ Southeastern US (4)

○ Southern Midwest US (5)

○ Southwestern US (6)

○ Non-contiguous US (7)

○ Other (8)

○ Prefer not to say (9)

Q12 Please select your highest degree earned:

○ MA/MS (1)

○ EdD (2)

○ PhD (3)

○ Other (4)

Q13 Please identify your area(s) of counseling:

☐ Clinical Mental Health (includes career, marriage & family, group, pastoral, individual counseling at the college/university level, or is not best described by the additional categories) (1)

☐ School (includes primary and secondary in either public or private schools, and college or university level if only providing academic or career counseling) (2)

☐ Substance Abuse or Addictions (3)

☐ Rehabilitation (4)

☐ Counselor Education (5)

☐ Counselors who provide supervision (6)

Skip To: Q18 If Please identify your area(s) of counseling: != Counselor Education

Q14 Please select the number of years you have been in the counseling profession:

○ 5-9 years (1)

○ 10-14 years (2)

○ 15-19 years (3)

○ 20-24 years (4)

○ 25+ years (5)

Q15 Please select the number of years you have been in counselor education:

○ N/A (1)

○ 1-5 years (7)

○ 5-9 years (2)

○ 10-14 years (3)

○ 15-19 years (4)

○ 20-14 years (5)

○ 25+ years (6)

Q16 If you are a counselor educator, which descriptions best fit the type of employment you have had this past year? (Select all that apply)

☐ Professor (1)

☐ Assistant Professor (2)

☐ Associate Professor (3)

☐ Visiting Professor (4)

☐ Visiting Associate Professor (5)

☐ Adjunct Professor (6)

☐ Other (7)

Q17 If you are a counselor educator, which description best fits the type of higher education setting you currently are employed?

○ Research Level 1 (1)

○ Research Level 2 (2)

○ Research Level 3 (3)

○ Teaching (4)

○ Other (5)

Q18 Please identify the type(s) of counseling practice you are currently working:

☐ Private Practice (1)

☐ Agency/Community Setting (2)

☐ Hospital/Inpatient Setting (3)

☐ College/University Setting (4)

☐ Rehabilitation/Outpatient Setting (5)

☐ Residential/Partial Hospitalization Setting (6)

☐ School Setting: Elementary (7)

☐ School Setting: Middle School (8)

☐ School Setting: High School (9)

☐ Other Setting (10)

Q19 Please identify area(s) of expertise:

☐ Trauma/Vicarious Trauma (1)

☐ Wellness/Resilience (2)

☐ Intersectionality (3)

☐ Spirituality/Religiosity (4)

☐ Compassion Satisfaction (5)

☐ Grief and Loss (6)

☐ Pedagogy/Educational Practices (7)

☐ Compassion Fatigue (8)

☐ Empathy (9)

☐ Other (10)

Appendix H

Delphi I Survey

Q20 Thank you for your time invested so far in the study. This portion begins the open-ended
questions that will make up Delphi Round I.

Q21 Based on your experiences and observations, use words or phrases to answer the following
question: How do you differentiate between compassion and empathy?

_____

_____

Q22 For the next question, the following terms are identified as such: *Professional* = any and
all interactions that occur when you are acting in professional counseling or counselor
educator capacity or within a professional context   *Personal* = any and all interactions
that occur when you are acting within your own personal set of mores and ethics in non-
professional settings or contacts   How is compassion expressed or perceived differently
in a professional setting versus in a personal setting?

_____

_____

Q27 Identify and describe examples or situations where a counselor might struggle to feel or
display compassion with a client.

_____

_____

_____

Q24 Based on your experiences and observations, use words or phrases to answer the following
set of questions: Identify and describe specific skills that demonstrate compassion in
counseling.

_____

_____

_____

Q25 Identify and describe specific knowledge that demonstrates compassion in counseling.

_____

_____

_____

Q26 Identify and describe specific attitudes and beliefs that demonstrate compassion in counseling.

_____

_____

_____

Q28 Thank you. This concludes the data collection for Delphi I on the study of Compassion in Professional Counseling.

The information you have provided will be analyzed and compiled. You will be sent an email notification and directions for Delphi II soon.

Appendix I

VT IRB Approval to transfer to WIRB

VIRGINIA TECH.

Division of Scholarly Integrity and
Research Compliance
Institutional Review Board
North End Center, Suite 4120 (MC 0497)
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-3732
irb@vt.edu
http://www.research.vt.edu/sirc/hrpp

MEMORANDUM

DATE: February 20, 2019

TO: Nancy E Bodenhorn, Karen Denise Raymond

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires January 29, 2021)

PROTOCOL TITLE: Compassion in Professional Counseling: A Delphi Study

IRB NUMBER: 18-788

Dear Investigator(s):

RE: Protocol Submission for WIRB Review

The Virginia Tech Institutional Review Board (IRB) office screened this study and determined that it is ready for WIRB review.

Please download the "Instructions for the PI to Transfer the VT IRB Protocol to WIRB":

https://secure.research.vt.edu/external/irb/wirb-submission-instructions.pdf

Please go to https://connexus.wcgclinical.com to complete the protocol submission process to the WIRB.

ATTENTION:

* Nancy E Bodenhorn MUST BE LISTED AS THE PI ON THE WIRB SUBMISSION.

* All references to the VT IRB (including phone number and email address) MUST be removed from all study documents and replaced with Western IRB - (800) 562-4789, help@wirb.com.

Appendix J

WIRB Approval for Delphi II

VIRGINIA TECH.

Karen Raymond <drkare70@vt.edu>

Review of revised protocol with revised questions

Sean Horkheimer <shorkheimer@wirb.com>
To: "drkare70@vt.edu" <drkare70@vt.edu>
Cc: Jody Abts <Jabts@wirb.com>

Thu, Mar 14, 2019 at 4:57 PM

Regarding: D2-Exemption-Bodenhorn (02-22-2019)

Investigator: Nancy Bodenhorn, PhD

Institution Protocol #: 18-788

Protocol Title: Compassion in Professional Counseling: A Delphi Study

Hi Karen,

I've reviewed the revised protocol for the above-noted research. I can confirm the original D2 exemption still applies. You may begin using the revised questions for this research. Please let me know if you have any additional questions.

Thank you,

Sean

Sean Horkheimer, JD, CIP | IRB Vice Chair

Western Institutional Review Board

1019 39th Avenue SE Suite 120

Puyallup, WA 98374

o/ 360.252.2465

shorkheimer@wirb.com | www.wirb.com

WIRB. Pioneering Together for More Than 50 Years.

Appendix K

Delphi Round II Email

Delphi Round II: Compassion in Professional Counseling

Unique Identification Code: XX1000

Dear 'personalized greeting':

Thank you for your responses to the demographic questions and the Delphi I of open-ended questions. All of the rich qualitative responses were sorted to identify emerging themes and ideas. Data that was similar, or duplicated, were collapsed to create the next round of questions that best captured the main concepts collected by all participants through focused coding.

Delphi II is a questionnaire where you will be asked to rate each of the aggregate responses on a seven-point Likert-scale as such: 1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = slightly agree, 5 = neither agree nor disagree, 6 = agree, and 7 = strongly agree. Additionally, there may be a place to comment or respond to choices for the rating. Comments regarding responses are optional.

This round should take approximately 15 minutes for completion. The **preferred closing date will be Saturday, May 25, 2019**, which is 10 days from the date of the e-mail message.

Click on the link to begin the online survey: [Compassion in Professional Counseling: Delphi Round II](#) . **Please note that the survey can be completed in more than one sitting** and you **will need to utilize your Unique Identification Code** listed above.

Thank you again for your efforts and time. Your input is valuable to me. Should I not hear back from you in the next 5-6 days, I will begin to send gentle reminders. Please feel free to reach out to me if you have questions or concerns.

Sincerely,

Karen Raymond
Doctoral Candidate
Virginia Tech

Appendix L

Delphi Round II Survey

Q1 Thank you for your participation in the Delphi study on Compassion in the Counseling Profession. This survey will begin the Delphi Round 2 of the study. The survey should take approximately 15 minutes to complete. Please note, if you are not able to complete the survey in one sitting, you may complete the survey over multiple sessions. You have the option to not respond to any questions that you choose.

 Thank you for your willingness to participate in this study.

If you have any questions about the research, please contact the Principal Investigator, Karen Raymond, at drkare70@vt.edu or the faculty advisor, Dr. Nancy Bodenhorn at nanboden@vt.edu. If you have any questions about your rights as a research subject, contact the VT Institutional Review Board (IRB) at 540-231-3732.

Q2 Please enter your Unique Identification Code (located in the notification email):

_____

Q3 The survey should take approximately 15 minutes to complete. If you are not able to complete the survey in one sitting, you may click on the 'forward arrow' button at the bottom of the page or exit out of the survey. This will save your responses. To continue, click on the link from the initial email or return to the survey from your browser. This should allow you to continue from the place you left off.

The survey would be best viewed on a computer screen, however, it can be completed on a mobile device.

If you have any difficulties resuming your survey, please contact Karen Raymond at drkare70@vt.edu.

Q5 The following statements are related to empathy. A few are direct statements, while a few are condensed versions of what was returned. Please rate your agreement with the following statements **regarding empathy**.

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (5)	Neither agree nor disagree (6)	Disagree (7)	Strongly disagree (8)
When people feel empathy, they try to put themselves in the shoes of another person to get an idea of what it might be like to be them (1)	○	○	○	○	○	○	○
Empathy allows more for identification without the quality of experiencing another's emotions (2)	○	○	○	○	○	○	○
Empathy involves the ability to feel what another person is experiencing (3)	○	○	○	○	○	○	○
Empathy is specific to thoughts/feelings/experiences of another (4)	○	○	○	○	○	○	○
Empathy involves working to understand how others are emotionally impacted (5)	○	○	○	○	○	○	○
Empathy is being able to understand what someone is going through (6)	○	○	○	○	○	○	○
Empathy is caring about a client's situation through understanding (7)	○	○	○	○	○	○	○
Empathy is more of an internal feeling for an individual (8)	○	○	○	○	○	○	○
Empathy involves connecting on a deeper level to experience what	○	○	○	○	○	○	○

they feel (9)							
Empathy may allow for a more cognitively focused perspective (10)	○	○	○	○	○	○	○
Empathy is more a differentiated and emotionally distant awareness of the experience (11)	○	○	○	○	○	○	○
Empathy is a deeper concept (12)	○	○	○	○	○	○	○
Empathy is used depending on circumstances (13)	○	○	○	○	○	○	○
Empathy does not necessarily involve compassion (14)	○	○	○	○	○	○	○

Q4 Please rate your agreement with the following statements that may **define compassion**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Compassion involves empathy (1)	○	○	○	○	○	○	○
Compassion is feeling with, alongside, in the midst of some experience (2)	○	○	○	○	○	○	○
Compassion does not necessarily require that people go through the exact same experiences to feel or express it (3)	○	○	○	○	○	○	○
Compassion is characterized by sympathetic concern for (or joining with) the problems of others (4)	○	○	○	○	○	○	○
Compassion means caring for others (5)	○	○	○	○	○	○	○
Compassion is evident when the counselor seems to care about the client's issues and outcome	○	○	○	○	○	○	○

of the sessions (6)							
Compassion seems more exclusively emotional (7)	○	○	○	○	○	○	○
When it comes to a person's professional life, people may work in an environment that is conscious or aware of the benefits of encouraging compassionate practices or cultivation as a part of its culture (8)	○	○	○	○	○	○	○
Compassion is expected and welcomed typically in a professional setting (9)	○	○	○	○	○	○	○
Compassion includes the concept of self-compassion as these two concepts are inter-related (10)	○	○	○	○	○	○	○
Compassion is a general state (11)	○	○	○	○	○	○	○

Compassion in all social settings is appropriate (12)	○	○	○	○	○	○	○
Compassion and self-compassion may be related to empathy but do not require that people put themselves in another person's shoes to get the full effect (13)	○	○	○	○	○	○	○
Compassion is an on-going process (14)	○	○	○	○	○	○	○
The concept of compassion is growing within our society (15)	○	○	○	○	○	○	○
Compassion is based on the premise that as human beings, we all experience hurt, pain, loss, disappointment (16)	○	○	○	○	○	○	○
Compassion means having a filtered emotional expression demonstrating understanding (17)	○	○	○	○	○	○	○

Compassion may not be expressed as directly or may be expressed as empathy (18)	○	○	○	○	○	○	○
Compassion means to provide assistance or a service to help them through their happening (19)	○	○	○	○	○	○	○
Compassion is more externally demonstrative (giving proof/showing) (20)	○	○	○	○	○	○	○

Q6 Please rate your level of agreement to the following statements regarding **counselor abilities in connection with compassion**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Compassion is the ability to be kind, caring, tolerant, and forgiving of others (1)	○	○	○	○	○	○	○
Compassion is aligning with emotional impact on others (2)	○	○	○	○	○	○	○
In a professional setting, I strive to have compassion for all of the individuals I encounter (3)	○	○	○	○	○	○	○
Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients (4)	○	○	○	○	○	○	○
Cultivating compassion throughout the day helps professionals to be more productive (5)	○	○	○	○	○	○	○
Professionals have to be mindful and intentional of giving themselves permission to practice and cultivate compassion	○	○	○	○	○	○	○

throughout the day (6)							
Compassion requires a more intuitive understanding of another's emotional landscape (7)	○	○	○	○	○	○	○
Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially inspire compassion (8)	○	○	○	○	○	○	○
Compassion is working to understand potential impact of intersectionality and identity (9)	○	○	○	○	○	○	○
A counseling skill is utilizing appropriate compassion levels and approaches (10)	○	○	○	○	○	○	○
The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report (11)	○	○	○	○	○	○	○
Compassion is transmitting the ability to BE WITH the issues (12)	○	○	○	○	○	○	○
Respect for other cultures (13)	○	○	○	○	○	○	○

Counselors need to truly believe in the process or we will not be impactful (14)	○	○	○	○	○	○	○
The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice (15)	○	○	○	○	○	○	○
A professional may still need to compartmentalize emotions when providing compassion (16)	○	○	○	○	○	○	○
Compassion is the skill of containing the natural impulses to protect self from trauma through interruptions, redirection or protective interventions (17)	○	○	○	○	○	○	○
As counselors, we need to be cognizant of how our actions and words are impacting clients (18)	○	○	○	○	○	○	○
Counselors need to recognize if we are not having an impact, what can we	○	○	○	○	○	○	○

do differently (19)

Compassion is knowledge, comprehension, and awareness (20) ○ ○ ○ ○ ○ ○ ○

Counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client (21) ○ ○ ○ ○ ○ ○ ○

Beliefs regarding optimal development (22) ○ ○ ○ ○ ○ ○ ○

Counselors should have ability for belief in the capacity for clients to change (23) ○ ○ ○ ○ ○ ○ ○

Belief that the individuals have many paths to a fulfilled life (24) ○ ○ ○ ○ ○ ○ ○

Believing that there is a positive in every situation (25) ○ ○ ○ ○ ○ ○ ○

Belief that disorder/dysfunction as a "normal" response to "abnormal" experiences (26) ○ ○ ○ ○ ○ ○ ○

Struggles are not character flaws (27) ○ ○ ○ ○ ○ ○ ○

Compassion engages less of the perspective taking than empathy (28) ○ ○ ○ ○ ○ ○ ○

Compassion involves personal feelings of the compassionate individual (29)	○	○	○	○	○	○	○

Q7 Many attending skills were listed as skills that convey compassion in counseling. The following Attending Skills were mentioned:

Acceptance
Active Listening
Being fully present
Being open-minded
Caring
Connecting both verbally and   non-verbally
Empathetic
Non-judgmental
Non-verbal behaviors - eye   contact, tone of voice, facial expressions, softness/hardness of body language
Reflective listening
Rephrasing
Unconditional positive regard
Warmth

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Please rate your level of agreement with attending skills conveying compassion: (1)	○	○	○	○	○	○	○

Q8 If you have additional comments regarding attending skills conveying compassion, please comment.

_____

Q9 Please rate your level of agreement to the following statements regarding **counseling skills that demonstrate compassion**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be (1)	○	○	○	○	○	○	○
Allowing periods of silence for the client to experience emotions (2)	○	○	○	○	○	○	○
Although controversial, controlled tearfulness might be useful (3)	○	○	○	○	○	○	○
An attitude of understanding of human struggles (4)	○	○	○	○	○	○	○
Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires (5)	○	○	○	○	○	○	○
Expressing hope for working together with --- and maybe even through --the issues (6)	○	○	○	○	○	○	○

Knowing when to push the client and when to back off (7)	○	○	○	○	○	○	○
Mindfulness/being aware in the moment (8)	○	○	○	○	○	○	○
Wisdom (9)	○	○	○	○	○	○	○
Available to clients whenever they need (10)	○	○	○	○	○	○	○
Creating a safe place within the counseling relationship to discuss what needs to be aired (11)	○	○	○	○	○	○	○
Offering tissues or a breathing break if the conversation gets tough for the client (12)	○	○	○	○	○	○	○
Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience (13)	○	○	○	○	○	○	○
Structure the session so that the client feels heard and seen (14)	○	○	○	○	○	○	○
In the professional setting, compassion is shown by giving	○	○	○	○	○	○	○

extra time (15)							
Compassion is also very useful in development of therapeutic relationship and alignment (16)	○	○	○	○	○	○	○
Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective (17)	○	○	○	○	○	○	○
Compassion is less common in counseling relationships as the counseling relationship does not directly mirror other social relationships (18)	○	○	○	○	○	○	○
Embracing one's place in the counseling relationship (19)	○	○	○	○	○	○	○
Having knowledge of things about the client that may not have to do with their current topic (I.e. family, likes/dislikes, favorite things, etc.) (20)	○	○	○	○	○	○	○

Q10 Please rate your level of agreement with the following statements about **perceptions of compassion**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
The settings dictate the level and types of expression of compassion (1)	○	○	○	○	○	○	○
I can't say that I have ever considered compassion skills in counseling (2)	○	○	○	○	○	○	○
Am not aware of any specific knowledge that demonstrates compassion in counseling (3)	○	○	○	○	○	○	○
I don't believe that compassion and empathy is all that much different (4)	○	○	○	○	○	○	○
Many people still find it challenging to give themselves permission to cultivate compassion (5)	○	○	○	○	○	○	○
Compassion cultivation is perhaps more accepted as something people practice in their personal life (6)	○	○	○	○	○	○	○
The idea that it is "okay" to practice	○	○	○	○	○	○	○

compassion in one's personal life (7)							
Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case (8)	○	○	○	○	○	○	○
Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment (9)	○	○	○	○	○	○	○
In a professional setting compassion indicates an over-identification with the emotional experiences of a client (10)	○	○	○	○	○	○	○
Compassion in a professional setting is perceived as understanding and support (11)	○	○	○	○	○	○	○
Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being (12)	○	○	○	○	○	○	○

Q18 If you have additional comments regarding perceptions of compassion, please comment.

_____

Q11 The following themes emerged from the statements which may hinder a counselor in their ability to display compassion for clients. Please rate your level of agreement with the following **general themes about when a counselor might struggle to display compassion with a client**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Identification with client and situations (potentially over-identification/counter-transference) (1)	○	○	○	○	○	○	○
Disagree with the client (their thoughts and behavior) (2)	○	○	○	○	○	○	○
Burnout (3)	○	○	○	○	○	○	○
Working with clients whose morals or ethics are not congruent with the counselor (4)	○	○	○	○	○	○	○
Counselor struggling with an ethical dilemma (5)	○	○	○	○	○	○	○
Bias (6)	○	○	○	○	○	○	○
Hostile clients (7)	○	○	○	○	○	○	○
Perpetrators (8)	○	○	○	○	○	○	○

Q12 Please rate your agreement with the following statements regarding **when a counselor might struggle to display compassion for clients**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
A counselor can always provide compassion for clients (1)	○	○	○	○	○	○	○
As clients demonstrate urgency and anxiety, counselors might experience emotion contagion (2)	○	○	○	○	○	○	○
Counselors can struggle to feel compassion as they become experienced in the field and can feel more removed from their own emotional responses (3)	○	○	○	○	○	○	○
There is a fine line between compassion fatigue, lack of compassion, and over active	○	○	○	○	○	○	○

compassion (4)							
Ironically if a counselor can get to a place of compassion with particular individuals (not excusing their behavior, but separating it from the individual) the work will be more effective (5)	○	○	○	○	○	○	○
Counselors might risk assuming understanding of the client experience without exploring more deeply (6)	○	○	○	○	○	○	○
Counselors can easily struggle to display compassion because it can be perceived by the counselor as a non-objective stance and form of self-disclosure (7)	○	○	○	○	○	○	○

When a client breaks down into tears over grief/loss, the personal inclination would be to try to comfort a client to ease the pain (8)

   ○   ○   ○   ○   ○   ○   ○

Q13 Please state your level of agreement with regard to **counselor knowledge, training, and education**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
Even though compassion is less common in the counseling relationship, it can still be present through teaching and supervision relationships, along with empathy (1)	○	○	○	○	○	○	○
Foundation knowledge regarding certain client experiences (e.g., trauma, oppression, those related to disorders) (2)	○	○	○	○	○	○	○
Educating ones self in areas and theories that would used in the therapeutic milieus, such as grief and loss, trauma, PTSD, etc. (3)	○	○	○	○	○	○	○

Knowledge of ethical practice (4)	○	○	○	○	○	○	○
Knowledge of systems theory as well as theories of trauma, abuse, cognitive delays, and all sources of behavior that are not related to "character" (5)	○	○	○	○	○	○	○
It is important for counselors to have some additional training in compassion and self-compassion as a part of their education and professional practice (6)	○	○	○	○	○	○	○
Providing skills and resources to help reduce or remove the client's issue (7)	○	○	○	○	○	○	○
Having an attitude and belief of value-based	○	○	○	○	○	○	○

and therapeutic counseling demonstrates compassion (8)							
Compassion can assist the professional in assessing client presentation, symptoms, and severity (9)	○	○	○	○	○	○	○

Q17 If you have additional comments regarding counselor knowledge, training, and education in regard to compassion, please comment.

_____

Q14 Please rate your level of agreement with the following statements about **compassion and professional boundaries**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
In a professional setting I have less relaxed spontaneous reactions (1)	○	○	○	○	○	○	○
Professional settings must incorporate many ethical boundaries (i.e., involving touch, limits of involvement, referrals, disclosure) (2)	○	○	○	○	○	○	○
In a professional setting, I do not instill my values on others or become vocal about them (3)	○	○	○	○	○	○	○
The structure and boundaries of the professional relationship filter the	○	○	○	○	○	○	○

depth, degree and exposure of expressing compassion (4)							
When I am in a professional context my role and goal is on behalf of the client (5)	○	○	○	○	○	○	○
In a professional setting I hold myself to a higher standard of attention (6)	○	○	○	○	○	○	○
Compassion in a professional setting opens the possibility of counter-transference (7)	○	○	○	○	○	○	○

Q15 Please rate your agreement with the following statements regarding ways **compassion is expressed in personal settings**:

	Strongly agree (1)	Agree (2)	Somewhat agree (3)	Slightly agree (4)	Neither agree nor disagree (5)	Disagree (6)	Strongly disagree (7)
In personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch) (1)	○	○	○	○	○	○	○
Advice giving might be part of the personal interactions (2)	○	○	○	○	○	○	○
There are fewer restrains for expression of compassion in personal life (3)	○	○	○	○	○	○	○
Personally, I may be more open for judgement and discussion (4)	○	○	○	○	○	○	○
The personal setting unleashes those professional filters to create vulnerability,	○	○	○	○	○	○	○

and sharing of very personal information (5)

Use different language with friends and family than clients (6)   ○ ○ ○ ○ ○ ○ ○

In a personal setting compassion would allow one to join in another's deeply felt emotions (7)   ○ ○ ○ ○ ○ ○ ○

In a personal setting, compassion can be perceived as condescending or patronizing (8)   ○ ○ ○ ○ ○ ○ ○

The other extreme in a personal setting that could also be possible, when compassion is perceived as loving and supportive (9)   ○ ○ ○ ○ ○ ○ ○

There may be issues or individuals what make me feel compassion for their experience,   ○ ○ ○ ○ ○ ○ ○

| but I discover or encounter them (10) | | | | | | | |
| In a personal setting compassion is more situational (11) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

Q16 Thank you for your time and contribution to the Delphi Round II of the Compassion in Professional Counseling: A Dephi Study.   All responses will be compiled and analyzed. Upon completion of data analysis, you will be sent directions for Delphi III in the next few weeks.

    I appreciate your willingness to provide quality input and valuable responses. Should you have any questions, please do not hesitate to contact me. Sincerely,   Karen Raymond Doctoral Candidate Virginia Tech

Appendix M

Reminder Emails for Delphi Round II

Unique Identification Code: XX1000

Hello,

This is a friendly reminder regarding the Delphi Round II for you to share your thoughts about compassion in professional counseling.

Delphi II is a questionnaire where you will be asked to rate each of the aggregate responses on a seven-point Likert-scale as such: 1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = slightly agree, 5 = neither agree nor disagree, 6 = agree, and 7 = strongly agree. Additionally, there may be a place to comment or respond on choices for the rating. Comments regarding responses are optional.

This round should take approximately 15 minutes for completion. The **preferred closing date will be Saturday, June 8, 2019**.

Click on the link to begin the online survey: [Compassion in Professional Counseling: Delphi Round II](#) . **Please note that the survey can be completed in more than one sitting** and you **will need to utilize your Unique Identification Code** listed above.

If you have any questions, please feel free to contact me.

Thank you,
Karen

Appendix N

Email Notification of Transfer from WIRB to VT HRPP

VIRGINIA TECH.

Karen Raymond <drkare70@vt.edu>

IRB #18-788: Transition from WIRB back to the VT IRB – effective 5/15/2019 – PLEASE REVIEW
1 message

VT IRB Protocol Management <irb@vt.edu>   Wed, May 15, 2019 at 10:26 AM
To: Nancy E Bodenhorn <nanboden@vt.edu>, Karen Denise Raymond <drkare70@vt.edu>, Laura Boyd Farmer <lbfarmer@vt.edu>

Dear Colleague,

You are receiving this study-specific notice because your protocol is listed as being active and has been determined by WIRB to be either exempt or not human subjects research.

Your protocol, IRB #18-788, titled "Compassion in Professional Counseling: A Delphi Study" has been transferred from WIRB oversight back to the Virginia Tech HRPP/IRB for continued oversight as of today.

**Please direct all future amendments to the VT IRB only by using the IRB Protocol Management online system.

* If your study has concluded and can be closed, please follow the link below and close your protocol.

* If you are still collecting data, you *must* revise your consent information and update all references to the IRB. Please replace references to WIRB and their contact information with the Virginia Tech Institutional Review Board (IRB), 540-231-3732, and irb@vt.edu. Be sure to update online or paper surveys and other study documents that include IRB name and contact information.

You do not need to submit an amendment if this is the only change. When making future changes to your study, however, please submit an amendment, describe the new changes, and upload the revised version(s).

* If your study remains open but you are not enrolling new participants, no action is needed.

<https://secure.research.vt.edu/irb?12QlecMgMx4>

Please note that this message applies only to the study referenced above. If you have multiple studies, you will receive multiple emails. If you have active protocols approved by WIRB that were approved by a WIRB Panel (you should have received a Certificate of Action letter), separate emails will be sent regarding the next steps.

Thank you for your patience as we make this transition. We are committed to making it as seamless as possible for our investigators.

Please contact the VT HRPP Office if you have questions or concerns.

HRPP Office

Appendix O

VT HRPP Approval for Delphi Round III

VIRGINIA TECH.

Division of Scholarly Integrity and
Research Compliance
Institutional Review Board
North End Center, Suite 4120 (MC 0497)
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-3732
irb@vt.edu
http://www.research.vt.edu/sirc/hrpp

MEMORANDUM

DATE: August 21, 2019

TO: Nancy E Bodenhorn, Karen Denise Raymond

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires January 29, 2021)

PROTOCOL TITLE: Compassion in Professional Counseling: A Delphi Study

IRB NUMBER: 18-788

Effective August 21, 2019, the Virginia Tech Human Research Protection Program (HRPP) and Institutional Review Board (IRB) determined that this protocol meets the criteria for exemption from IRB review under 45 CFR 46.104(d) category(ies) 2(ii).

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit a new request to the IRB for a determination.

This exempt determination does not apply to any collaborating institution(s). The Virginia Tech HRPP and IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

https://secure.research.vt.edu/external/irb/responsibilities.htm

(Please review responsibilities before beginning your research.)

PROTOCOL INFORMATION:

Determined As: Exempt, under 45 CFR 46.104(d) category(ies) 2(ii)
Protocol Determination Date: February 22, 2019

ASSOCIATED FUNDING:

The table on the following page indicates whether grant proposals are related to this protocol, and which of the listed proposals, if any, have been compared to this protocol, if required.

IRB Number 18-788   page 2 of 2   Virginia Tech Institutional Review Board

SPECIAL INSTRUCTIONS:

This amendment, submitted August 2, 2019, makes minor changes to the protocol. Dr. Laura Farmer was removed from the list of personnel. The research protocol was revised. The Delphi Round 2 and Round 3 survey documents were updated. The D3 email was updated.

Appendix P

Delphi Round III Survey

Q7 Thank you for your participation in the Delphi study on Compassion in the Counseling Profession. This survey will begin the Delphi Round 3 of the study. The survey should take approximately 15 minutes to complete. Please note, if you are not able to complete the survey in one sitting, you may complete the survey over multiple sessions. You have the option to not respond to any questions that you choose.

 Thank you for your willingness to participate in this study.   If you have any questions about the research, please contact the Principal Investigator, Karen Raymond, at drkare70@vt.edu or the faculty advisor, Dr. Nancy Bodenhorn at nanboden@vt.edu. If you have any questions about your rights as a research subject, contact the VT Institutional Review Board (IRB) at 540-231-3732.

Q8 Please enter your Unique Identification Code (located in the notification email):

_____

Q1 The statements which reached 80% or greater consensus regarding empathy have been combined to indicate the overall reflection of empathy. For reference, you may review the original statements from Delphi Round 2 in your overall report. Please rate your level of agreement with the condensed overall statements.

	Strongly Agree	Agree	Somewhat Agree	Slightly Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Empathy is the internal feeling for and connecting on a deeper level with another. Empathy is neither differentiated nor an emotionally distant awareness of another individual. It is working to understand the emotional impact, specific to the thoughts, feelings, and experiences of others without the quality of undergoing the same events. Empathy does not necessarily involve compassion.	○	○	○	○	○	○	○

Q2 The statements which reached 80% or greater consensus regarding compassion have been combined to indicate the overall reflection of compassion. For reference, you may review the original statements from Delphi Round 2 in your overall report. Please rate your level of agreement with the condensed overall statements.

	Strongly Agree	Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Disagree	Strongly disagree
Compassion is an on-going process of caring for others that is more outwardly expressed than empathy. It is feeling with, alongside others. Compassion is having sympathetic concern for the problems of the self and others. It does not necessarily require that people go through the exact same experiences to feel or express compassion.	○	○	○	○	○	○	○

Q3 The statements which reached 80% or greater consensus regarding counselor abilities in connection with compassion are listed below. For reference, you may review the original statements from Delphi Round 2 in your overall report. Please click and drag the following statements to indicate level of importance.

Extremely important	Very important	Moderately important	Slightly important	Not as important
_____ Compassion is the ability to be kind, caring, tolerant, and forgiving of others	_____ Compassion is the ability to be kind, caring, tolerant, and forgiving of others	_____ Compassion is the ability to be kind, caring, tolerant, and forgiving of others	_____ Compassion is the ability to be kind, caring, tolerant, and forgiving of others	_____ Compassion is the ability to be kind, caring, tolerant, and forgiving of others
_____ In a professional setting, I strive to have compassion for all of the individuals I encounter	_____ In a professional setting, I strive to have compassion for all of the individuals I encounter	_____ In a professional setting, I strive to have compassion for all of the individuals I encounter	_____ In a professional setting, I strive to have compassion for all of the individuals I encounter	_____ In a professional setting, I strive to have compassion for all of the individuals I encounter
_____ Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	_____ Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	_____ Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	_____ Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	_____ Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients
_____ Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially	_____ Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially	_____ Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially	_____ Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially	_____ Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially

inspire compassion

_____ A counseling skill is utilizing appropriate compassion levels and approaches

_____ The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice

_____ As counselors, we need to be cognizant of how our actions and words are impacting clients

_____ Counselors need to recognize if we are not having an impact, what can we do differently

_____ Counselors need to be self-aware and recognize if our own beliefs or experience are

impacting our role with a client	impacting our role with a client	impacting our role with a client	impacting our role with a client	impacting our role with a client
_____ Compassion is aligning with emotional impact on others	_____ Compassion is aligning with emotional impact on others	_____ Compassion is aligning with emotional impact on others	_____ Compassion is aligning with emotional impact on others	_____ Compassion is aligning with emotional impact on others
_____ Compassion requires a more intuitive understanding of another's emotional landscape	_____ Compassion requires a more intuitive understanding of another's emotional landscape	_____ Compassion requires a more intuitive understanding of another's emotional landscape	_____ Compassion requires a more intuitive understanding of another's emotional landscape	_____ Compassion requires a more intuitive understanding of another's emotional landscape
_____ Compassion is transmitting the ability to BE WITH the issues	_____ Compassion is transmitting the ability to BE WITH the issues	_____ Compassion is transmitting the ability to BE WITH the issues	_____ Compassion is transmitting the ability to BE WITH the issues	_____ Compassion is transmitting the ability to BE WITH the issues
_____ Respect for other cultures	_____ Respect for other cultures	_____ Respect for other cultures	_____ Respect for other cultures	_____ Respect for other cultures
_____ Counselors need to truly believe in the process or we will not be impactful	_____ Counselors need to truly believe in the process or we will not be impactful	_____ Counselors need to truly believe in the process or we will not be impactful	_____ Counselors need to truly believe in the process or we will not be impactful	_____ Counselors need to truly believe in the process or we will not be impactful
_____ A professional may still need to compartmentaliz e emotions when providing compassion	_____ A professional may still need to compartmentaliz e emotions when providing compassion	_____ A professional may still need to compartmentaliz e emotions when providing compassion	_____ A professional may still need to compartmentaliz e emotions when providing compassion	_____ A professional may still need to compartmentaliz e emotions when providing compassion
_____ Struggles are not character flaws	_____ Struggles are not character flaws	_____ Struggles are not character flaws	_____ Struggles are not character flaws	_____ Struggles are not character flaws
_____ Professionals have to be	_____ Professionals have to be	_____ Professionals have to be	_____ Professionals have to be	_____ Professionals have to be

mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day	mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day	mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day	mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day	mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day
_____ Compassion is knowledge, comprehension, and awareness	_____ Compassion is knowledge, comprehension, and awareness	_____ Compassion is knowledge, comprehension, and awareness	_____ Compassion is knowledge, comprehension, and awareness	_____ Compassion is knowledge, comprehension, and awareness
_____ Counselors should have ability for belief in the capacity for clients to change	_____ Counselors should have ability for belief in the capacity for clients to change	_____ Counselors should have ability for belief in the capacity for clients to change	_____ Counselors should have ability for belief in the capacity for clients to change	_____ Counselors should have ability for belief in the capacity for clients to change
_____ The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report	_____ The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report	_____ The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report	_____ The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report	_____ The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report
_____ Belief that the individuals have many paths to a fulfilled life	_____ Belief that the individuals have many paths to a fulfilled life	_____ Belief that the individuals have many paths to a fulfilled life	_____ Belief that the individuals have many paths to a fulfilled life	_____ Belief that the individuals have many paths to a fulfilled life
_____ Belief that disorder/dysfunction as a "normal" response to	_____ Belief that disorder/dysfunction as a "normal" response to	_____ Belief that disorder/dysfunction as a "normal" response to	_____ Belief that disorder/dysfunction as a "normal" response to	_____ Belief that disorder/dysfunction as a "normal" response to

"abnormal" experiences	"abnormal" experiences	"abnormal" experiences	"abnormal" experiences	"abnormal" experiences

Q4 The statements which reached 80% or greater consensus regarding counselor skills that demonstrate compassion are listed below. For reference, you may review the original statements from Delphi Round 2 in your overall report. Please click and drag the following statements to indicate level of importance.

Extremely important	Very important	Moderately important	Slightly important	Not as important
_____ Allowing periods of silence for the client to experience emotions	_____ Allowing periods of silence for the client to experience emotions	_____ Allowing periods of silence for the client to experience emotions	_____ Allowing periods of silence for the client to experience emotions	_____ Allowing periods of silence for the client to experience emotions
_____ An attitude of understanding of human struggles	_____ An attitude of understanding of human struggles	_____ An attitude of understanding of human struggles	_____ An attitude of understanding of human struggles	_____ An attitude of understanding of human struggles
_____ Mindfulness/being aware in the moment	_____ Mindfulness/being aware in the moment	_____ Mindfulness/being aware in the moment	_____ Mindfulness/being aware in the moment	_____ Mindfulness/being aware in the moment
_____ Creating a safe place within the counseling relationship to discuss what needs to be aired	_____ Creating a safe place within the counseling relationship to discuss what needs to be aired	_____ Creating a safe place within the counseling relationship to discuss what needs to be aired	_____ Creating a safe place within the counseling relationship to discuss what needs to be aired	_____ Creating a safe place within the counseling relationship to discuss what needs to be aired
_____ Structure the session so that the client feels heard and seen	_____ Structure the session so that the client feels heard and seen	_____ Structure the session so that the client feels heard and seen	_____ Structure the session so that the client feels heard and seen	_____ Structure the session so that the client feels heard and seen
_____ Compassion is also very useful in development of therapeutic	_____ Compassion is also very useful in development of therapeutic	_____ Compassion is also very useful in development of therapeutic	_____ Compassion is also very useful in development of therapeutic	_____ Compassion is also very useful in development of therapeutic

relationship and alignment	relationship and alignment	relationship and alignment	relationship and alignment	relationship and alignment
_____ Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	_____ Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	_____ Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	_____ Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	_____ Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective
_____ Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	_____ Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	_____ Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	_____ Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	_____ Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be
_____ Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	_____ Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	_____ Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	_____ Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	_____ Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires
_____ Expressing hope for working together with --- and maybe even through --the issues	_____ Expressing hope for working together with --- and maybe even through --the issues	_____ Expressing hope for working together with --- and maybe even through --the issues	_____ Expressing hope for working together with --- and maybe even through --the issues	_____ Expressing hope for working together with --- and maybe even through --the issues
_____ Knowing when to push the client and when to back off	_____ Knowing when to push the client and when to back off	_____ Knowing when to push the client and when to back off	_____ Knowing when to push the client and when to back off	_____ Knowing when to push the client and when to back off
_____ Compassion is	_____ Compassion is	_____ Compassion is	_____ Compassion is	_____ Compassion is

NOT less common in counseling relationships as the counseling relationship does not directly mirror other social relationships

_____ Wisdom

_____ Offering tissues or a breathing break if the conversation gets tough for the client

_____ Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience

NOT less common in counseling relationships as the counseling relationship does not directly mirror other social relationships

_____ Wisdom

_____ Offering tissues or a breathing break if the conversation gets tough for the client

_____ Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience

NOT less common in counseling relationships as the counseling relationship does not directly mirror other social relationships

_____ Wisdom

_____ Offering tissues or a breathing break if the conversation gets tough for the client

_____ Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience

NOT less common in counseling relationships as the counseling relationship does not directly mirror other social relationships

_____ Wisdom

_____ Offering tissues or a breathing break if the conversation gets tough for the client

_____ Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience

NOT less common in counseling relationships as the counseling relationship does not directly mirror other social relationships

_____ Wisdom

_____ Offering tissues or a breathing break if the conversation gets tough for the client

_____ Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience

Q5 The statements which reached 80% or greater consensus regarding perceptions of compassion are listed below. For reference, you may review the original statements from Delphi Round 2 in your overall report. Please click and drag the following statements to indicate level of importance.

Extremely important	Very important	Moderately important	Slightly important	Not as important
_____ Compassion in a professional setting is perceived as understanding and support	_____ Compassion in a professional setting is perceived as understanding and support	_____ Compassion in a professional setting is perceived as understanding and support	_____ Compassion in a professional setting is perceived as understanding and support	_____ Compassion in a professional setting is perceived as understanding and support
_____ Many people still find it challenging to give themselves permission to cultivate compassion	_____ Many people still find it challenging to give themselves permission to cultivate compassion	_____ Many people still find it challenging to give themselves permission to cultivate compassion	_____ Many people still find it challenging to give themselves permission to cultivate compassion	_____ Many people still find it challenging to give themselves permission to cultivate compassion
_____ Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being	_____ Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being	_____ Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being	_____ Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being	_____ Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being
_____ The idea that it is "okay" to practice compassion in one's personal life	_____ The idea that it is "okay" to practice compassion in one's personal life	_____ The idea that it is "okay" to practice compassion in one's personal life	_____ The idea that it is "okay" to practice compassion in one's personal life	_____ The idea that it is "okay" to practice compassion in one's personal life
_____ I can't say that I have ever considered compassion	_____ I can't say that I have ever considered compassion	_____ I can't say that I have ever considered compassion	_____ I can't say that I have ever considered compassion	_____ I can't say that I have ever considered compassion

skills in counseling	skills in counseling	skills in counseling	skills in counseling	skills in counseling
_____ Am not aware of any specific knowledge that demonstrates compassion in counseling	_____ Am not aware of any specific knowledge that demonstrates compassion in counseling	_____ Am not aware of any specific knowledge that demonstrates compassion in counseling	_____ Am not aware of any specific knowledge that demonstrates compassion in counseling	_____ Am not aware of any specific knowledge that demonstrates compassion in counseling
_____ Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case	_____ Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case	_____ Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case	_____ Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case	_____ Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case
_____ Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment	_____ Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment	_____ Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment	_____ Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment	_____ Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment

Q6 Are there any additional comments you would like to make regarding compassion in counseling?

_____

_____

_____

Q9 Thank you for your continued participation in this study. Your input is valuable. Should a consensus be reached, this will be the final round of the study. You will be notified once the data has been collected and analyzed if an additional round will be necessary.

Appendix Q

Delphi Round III Email

Unique Identification Code: XX1000

Dear 'personalized greeting':

Thank you for your ratings and responses to the Delphi II.

 Information from the previous round was imported into Microsoft Excel which was utilized for data computations and analysis. Frequency analysis was completed to identify the percentages of overall responses. The median scores and interquartile range (IRQ) were also utilized to analyze the rating of items.

 Delphi III is developed based on the responses from Delphi II. This round will allow for you, as an expert panelist, the opportunity to review the statistical summary. Attached is a report of the compiled data for your reference.

As a reminder, the purpose of the study is to define the abstract concept of compassion within the domain of counseling. Continue to rate the responses through your lens as an identified expert in **PERSONALIZED: Clinical Mental Health Counseling**.

This round should take approximately 15 minutes for completion. The preferred closing date will be August 30, 2019. Should a consensus be reached, this will be the final round of the study. You will be notified once the data has been collected and analyzed if an additional round will be necessary.

Click on the link to begin the online survey: Delphi Round 3: Compassion in Professional Counseling. Please note that the survey must be completed in one sitting and you will need your Unique Identification Code listed above.

Your input is valuable to me. Should I not hear back from you in the next 5-6 days, I will send a gentle reminder. Please feel free to reach out to me if you have questions or concerns.

Thank you again for your efforts and time. We are getting close to the end!

Sincerely,

Karen Raymond
Doctoral Candidate
Virginia Tech

Appendix R

Delphi Round II Overall Report

Compassion in Professional Counseling

Delphi Round 2 Overall Report Results

	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10	Question 11	OVERALL
Min	1	1	1	1	1	1	1	1	1	1	1	1
Max	7	7	7	3	7	7	6	7	7	6	7	7
Mean	3.32	3.16	2.64	1.64	2.92	3.71	2.46	3.61	2.61	2.56	3.32	2.90
Mode	2	2	2	2	2	2	2	2	2	2	2	2
Median	3	3	2	1	2	4	2	3	2	2	3	2
Count	154	220	311	11	199	119	80	80	84	70	108	11
IRQ	3	3	2	0.45	2	4	2	3	2	2	3	2
Variance	3.17	2.57	2.01	0.67	2.05	3.46	1.29	2.54	1.69	2.28	2.67	0.65
SD	1.78	1.60	1.42	2.00	1.54	1.86	1.14	1.60	1.30	1.51	1.63	0.25

Wording of Questions
Question 1: The following statements are related to empathy. A few are direct statements, while a few are condensed versions of what was returned. Please rate your agreement with the following statements regarding empathy.
Question 2: Please rate your agreement with the following statements that may define compassion
Question 3: Please rate your level of agreement to the following statements regarding counselor abilities in connection with compassion
Question 4: Many attending skills were listed as skills that convey compassion in counseling. The following Attending Skills were mentioned: Acceptance; Active Listening; Being fully present; Being open-minded; Caring; Connecting both verbally and non-verbally; Empathetic; Non-judgemental; Non-verbal behaviors – eye contact, tone of voice, facial expressions, softness/hardness of body language; Reflective listening; Rephrasing; Unconditional positive regard; Warmth - Please rate your level of agreement with attending skills conveying compassion

Question 5: Please rate your level of agreement to the following statements regarding counseling skills that demonstrate compassion
Question 6: Please rate your level of agreement with the following statements about perceptions of compassion
Question 7: The following themes emerged from the statements which may hinder a counselor in their ability to display compassion for clients. Please rate your level of agreement with the following general themes about when a counselor might struggle to display compassion with a client
Question 8: Please rate your agreement with the following statements regarding when a counselor might struggle to display compassion for clients
Question 9: Please state your level of agreement with regard to counselor knowledge, training, and education
Question 10: Please rate your level of agreement with the following statements about compassion and professional boundaries
Question 11: Please rate your agreement with the following statements regarding ways compassion is expressed in personal settings

Question 1 Overall Results

Question 1: The following statements are related to empathy. A few are direct statements, while a few are condensed versions of what was returned. Please rate your agreement with the following statements regarding empathy.

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Empathy involves working to understand how others are emotionally impacted	100%
When people feel empathy, they try to put themselves in the shoes of another person to get an idea of what it might be like to be them	90%
Empathy allows more for identification without the quality of experiencing another's emotions	90%
Empathy is specific to thoughts/feelings/experiences of another	82%
Empathy is being able to understand what someone is going through	82%
Empathy is more of an internal feeling for an individual	82%
Empathy involves connecting on a deeper level to experience what they feel	82%
Empathy is more a differentiated and emotionally distant awareness of the experience[*]	82%
Empathy does not necessarily involve compassion	82%

	OVERALL
Min	1
Max	7
Mean	3.32
Mode	2
Median	3
Count	154
IRQ	3
Variance	3.17
SD	1.78

* This statement reflected a consensus of overall disagreement with the statement.

Question 2 Overall Results

Question 2: Please rate your agreement with the following statements that may define compassion

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Compassion does not necessarily require that people go through the exact same experiences to feel or express it	100%
When it comes to a person's professional life, people may work in an environment that is conscious or aware of the benefits of encouraging compassionate practices or cultivation as a part of its culture	100%
Compassion is an on-going process	100%
Compassion means caring for others	90%
Compassion is evident when the counselor seems to care about the client's issues and outcome of the sessions	90%
Compassion is more externally demonstrative (giving proof/showing)	90%
Compassion is feeling with, alongside, in the midst of some experience	82%
Compassion is characterized by sympathetic concern for (or joining with) the problems of others	82%
Compassion includes the concept of self-compassion as these two concepts are inter-related	82%

	Overall
Min	1
Max	7
Mean	3.16
Mode	2
Median	3
Count	220
IRQ	3
Variance	2.57
SD	1.60

Question 3 Overall Results

Question 3: Please rate your level of agreement to the following statements regarding counselor abilities in connection with compassion

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Compassion is the ability to be kind, caring, tolerant, and forgiving of others	100%
In a professional setting, I strive to have compassion for all of the individuals I encounter	100%
Cultivating compassion throughout the day helps professionals to have the ability to be more present with their clients	100%
Counselors can develop cognitive frameworks to express compassion even when clients engage in ways of being or behaviors that do not initially inspire compassion	100%
A counseling skill is utilizing appropriate compassion levels and approaches	100%
The more counselors understand the concepts and skills that can be used to cultivate compassion and self-compassion, the more equipped and comfortable they will be in implementing it into practice	100%
As counselors, we need to be cognizant of how our actions and words are impacting clients	100%
Counselors need to recognize if we are not having an impact, what can we do differently	100%
Counselors need to be self-aware and recognize if our own beliefs or experience are impacting our role with a client	100%
Compassion is aligning with emotional impact on others	90%
Compassion requires a more intuitive understanding of another's emotional landscape	90%
Compassion is transmitting the ability to BE WITH the issues	90%
Respect for other cultures	90%
Counselors need to truly believe in the process or we will not be impactful	90%
A professional may still need to compartmentalize emotions when providing compassion	90%
Struggles are not character flaws	90%
Professionals have to be mindful and intentional of giving themselves permission to practice and cultivate compassion throughout the day	82%
Compassion is knowledge, comprehension, and awareness	82%
Counselors should have ability for belief in the capacity for clients to change	82%
The ability to slow down in any given moment with a client...whether during an emotional expression or intensity of client report	80%
Belief that the individuals have many paths to a fulfilled life	80%
Belief that disorder/dysfunction as a "normal" response to "abnormal" experiences	80%

	Overall
Min	1
Max	6
Mean	2.93
Mode	2
Median	3
Count	57
IRQ	3
Variance	2.35
SD	1.53

Question 4 Overall Results

Question 4: Many attending skills were listed as skills that convey compassion in counseling. The following Attending Skills were mentioned:

Acceptance	Active Listening
Being fully present	Being open-minded
Caring	Connecting both verbally and non-verbally
Empathetic	Non-judgemental
Non-verbal behaviors (eye contact, tone of voice, facial expressions, softness/hardness of body language)	
Reflective listening	Rephrasing
Unconditional positive regard	Warmth

Please rate your level of agreement with attending skills conveying compassion

Statistics on consensus:

Min	1
Max	3
Mean	1.64
Median	2
Mode	1
Count	11
Variance	0.45
SD	0.67
IRQ	2.00
Agreement %	100%
# in agreement	11

Question 5 Overall Results

Question 5: Please rate your level of agreement to the following statements regarding counseling skills that demonstrate compassion

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Allowing periods of silence for the client to experience emotions	100%
An attitude of understanding of human struggles	100%
Mindfulness/being aware in the moment	100%
Creating a safe place within the counseling relationship to discuss what needs to be aired	100%
Structure the session so that the client feels heard and seen	100%
Compassion is also very useful in development of therapeutic relationship and alignment	100%
Believing that connectivity with the client is critical and connectivity must involve both empathy and compassion to be most effective	100%
Allowing people to get in touch with their life narrative without trying to dictate what the counselor feels it should be	90%
Comfort with levels of counseling issues--trauma, PTSD, grief--whatever compassion requires	90%
Expressing hope for working together with ---and maybe even through --the issues	90%
Knowing when to push the client and when to back off	90%
Compassion is less common in counseling relationships as the counseling relationship does not directly mirror other social relationships[*]	90%
Wisdom	80%
Offering tissues or a breathing break if the conversation gets tough for the client	80%
Slowing a client's telling of the story or expression of emotion for the moment to allow greater expression and demonstration of the emotional experience	80%

	Overall
Min	1
Max	7
Mean	2.92
Mode	2
Median	2
Count	199
IRQ	2
Variance	2.05
SD	1.54

* This statement reflected a consensus of overall disagreement with the statement.

Question 6 Overall Results

Question 6: Please rate your level of agreement with the following statements about perceptions of compassion

<u>Statements reaching consensus of 80% or greater:</u>

Statements	Consensus Level (%)
Compassion in a professional setting is perceived as understanding and support	100%
Many people still find it challenging to give themselves permission to cultivate compassion	90%
Society sends people and professionals messages that they are to keep striving, even at the expense of their own health and psychological well-being	90%
The idea that it is "okay" to practice compassion in one's personal life	89%
I can't say that I have ever considered compassion skills in counseling	80%
Am not aware of any specific knowledge that demonstrates compassion in counseling	80%
Compassion may be perceived as something that is tied a people's religious/spiritual practices; however, we now know that may not be the case	80%
Westernized society has not reached a place where "compassion cultivation" is openly encouraged within the work setting/environment	80%

	Overall
Min	1
Max	7
Mean	3.71
Mode	2
Median	4
Count	119
IRQ	4
Variance	3.46
SD	1.86

Question 7 Overall Results

Question 7: The following themes emerged from the statements which may hinder a counselor in their ability to display compassion for clients. Please rate your level of agreement with the following general themes about when a counselor might struggle to display compassion with a client

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Burnout	100%
Bias	100%
Hostile clients	100%
Perpetrators	100%
Identification with client and situations (potentially over-identification/counter-transference)	90%
Counselor struggling with an ethical dilemma	90%
Disagree with the client (their thoughts and behavior)	80%
Working with clients whose morals or ethics are not congruent with the counselor	80%

	Overall
Min	1
Max	6
Mean	2.46
Mode	2
Median	2
Count	80
IRQ	2
Variance	1.29
SD	1.14

Question 8 Overall Results

Question 8: Please rate your agreement with the following statements regarding when a counselor might struggle to display compassion for clients

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
As clients demonstrate urgency and anxiety, counselors might experience emotion contagion	90%
Ironically if a counselor can get to a place of compassion with particular individuals (not excusing their behavior, but separating it from the individual) the work will be more effective	90%
Counselors might risk assuming understanding of the client experience without exploring more deeply	90%
Counselors can struggle to feel compassion as they become experienced in the field and can feel more removed from their own emotional responses	80%

	Overall
Min	1
Max	7
Mean	3.61
Mode	2
Median	3
Count	80
IRQ	3
Variance	2.54
SD	1.60

Question 9 Overall Results

Question 9: Please state your level of agreement with regard to counselor knowledge, training, and education

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Even though compassion is less common in the counseling relationship, it can still be present through teaching and supervision relationships, along with empathy	100%
It is important for counselors to have some additional training in compassion and self-compassion as a part of their education and professional practice	100%
Compassion can assist the professional in assessing client presentation, symptoms, and severity	90%
Foundation knowledge regarding certain client experiences (e.g., trauma, oppression, those related to disorders)	89%
Educating one's self in areas and theories that would be used in the therapeutic milieus, such as grief and loss, trauma, PTSD, etc.	89%
Knowledge of ethical practice	89%
Knowledge of systems theory as well as theories of trauma, abuse, cognitive delays, and all sources of behavior that are not related to "character"	89%

	Overall
Min	1
Max	7
Mean	2.61
Mode	2
Median	2
Count	84
IRQ	2
Variance	1.69
SD	1.30

Question 10 Overall Results

Question 10: Please rate your level of agreement with the following statements about compassion and professional boundaries

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
Professional settings must incorporate many ethical boundaries (i.e., involving touch, limits of involvement, referrals, disclosure)	100%
When I am in a professional context my role and goal is on behalf of the client	100%
In a professional setting I hold myself to a higher standard of attention	100%
In a professional setting, I do not instill my values on others or become vocal about them	90%
In a professional setting I have less relaxed spontaneous reactions	80%

	Overall
Min	1
Max	6
Mean	2.56
Mode	2
Median	2
Count	70
IRQ	2
Variance	2.28
SD	1.51

Question 11 Overall Results

Question 11: Please rate your agreement with the following statements regarding ways compassion is expressed in personal settings

Statements reaching consensus of 80% or greater:

Statements	Consensus Level (%)
In personal settings, compassion may be expressed through acts of care (i.e., making a meal, sharing a hug or touch)	100%
In a personal setting, compassion can be perceived as condescending or patronizing**	100%
The other extreme in a personal setting that could also be possible, when compassion is perceived as loving and supportive	100%
Advice giving might be part of the personal interactions	90%
The personal setting unleashes those professional filters to create vulnerability, and sharing of very personal information	90%
In a personal setting compassion would allow one to join in another's deeply felt emotions	90%
There may be issues or individuals what make me feel compassion for their experience, but I discover or encounter them**	88%
There are fewer restrains for expression of compassion in personal life	80%
Use different language with friends and family than clients	80%
In a personal setting compassion is more situational**	80%

	Overall
Min	1
Max	7
Mean	3.32
Mode	2
Median	3
Count	108
IRQ	3
Variance	2.67
SD	1.63

** These statements reflected a consensus of overall neither agree nor disagree with the statements.

Appendix S

Reminder Email for Delphi Round III

Hello,

This is a friendly reminder regarding the Delphi Round III for you to review the statistical summary and refine the information about compassion in professional counseling. Attached is the original message sent to you last week. For your convenience, here is the link to the survey [Delphi Round 3 Compassion in Professional Counseling](#). Preferred closing date is **August 30, 2019**.

If you have any questions, please feel free to contact me.

Thank you,
Karen

Appendix T

Collapsed Theme Overall Analysis

Overall Analysis of Delphi Round I

Initial Review of Data

Q#	# Responses
Q1	60
Q2	60
Q3	41
Q4	38
Q5	25
Q6	42
Total	**266**

Review of Q1

Compassion Statements	30
Empathy Statements	28
Other	2
Total Responses	**60**

Q1: Collapsed Themes - Compassion

All people experience hurt/loss	1
Caring	8
Circumstantial	1
Exclusively Emotional	1
General State	1
Includes Self-Compassion	1
On-going Process	1
Personal Feelings	1
Supporting	5
Understanding	10
Total Statements	**30**

Q1: Collapsed Themes - Empathy

Caring	3
Circumstantial	1
Clinical/Economic Empathy	1
Cognitively Focused	1
Deeper Concept	1
Emotional Reserve	1
Identification	17
Not involve compassion	1
Understanding	2
Total Statements	**28**

Q1: Collapsed Themes - Other

Not involve compassion	1
Supporting	1
Total Statements	**2**

Review of Q2

Personal Statements	21
Professional Statements	31
Other	8
Total Responses	**60**

Q2: Collapsed Themes - Personal

Accepted	2
Loving & supportive	1
Personal	3
Touch	2
Unconstrained	12
Viewed negatively	1
Total Statements	**21**

Q2: Collapsed Themes - Professional

Acknowlegement	1
Aligment	1
Assist in assessment	3
Beware countertransference	2
Compartmentalize emotions	2
Compassion for all	1
Display of empathy	5
Environment	1
Ethical/Professional boundaries	5
Expected/welcome	1
Increases presence with clients	1

Review of Q3

Total Responses	41

Q3: Collapsed Themes

Always provide compassion	1
Anxious situations	1
Belief situations	2
Bias	3
Burnout	4
Detachment	1
Disagree with client	9
Fine line of compassion	1
Hostile clients	1
Identification	9
Moral situations	3
More effective with compassion	1
Non-objective/Self-disclosure	2
Perpretrators	2
Risk assumption w/o deeper exploration	1
Total Statements	**41**

Review of Q4

Attending Skills	31
Environmental Skills	6
Other	1
Total Responses	**38**

Increases productivity	1
Less common, but present	2
Mindful & intentional	1
Not encouraged	1
Over-identification with client	1
Role/Goal is on behalf of client	1
Supportive	1
Total Statements	**31**

Q2: Collapsed Themes - Other

Challenging	2
Compassion for all	1
Not much difference	1
Setting dictates expression	1
Society messages	2
Concept is growing	1
Total Statements	**8**

Review of Q5

Awareness	6
Cognitive Frameworks	3
Communication	1
Comprehension	4
Foundational knowledge on compassion	1
No known specific knowledge	1
Self-Awareness	1
Training	8
Total Responses	**25**

Review of Q6

Attitude Statements	32
Belief Statements	10
Total Statements	**42**

Q6: Collapsed Themes - Attitude

Attending Skill	7
Curiosity	1
Expressing hope	1

Open-minded	4
Positive Acceptance	12
Relationship	1
Self-awareness	1
Service/Resource	1
Value-based	4
Total Responses	**32**

Q6: Collapsed Themes - Belief

Clients	4
Connectivity	1
Optimistic	1
Struggles are not character flaws	2
Therapeutic process	2
Total Responses	**10**