DEVELOPMENT AND VALIDATION OF THE PROCESS OF INTERPERSONAL EMPATHY SCALE (PIES)

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Empathy is a consistent predictor of positive counseling outcome. As counselor educators attempted to teach and evaluate CITs' empathy competence, various conceptualizations and measurements emerged. Thus, the purpose of this study was to validate a proposed theoretical model and developed a measure based on the model. One hundred and forty-eight recorded responses were usable data. The results of the exploratory factor analysis revealed that a five-factor model could best represent counselors' empathy competence. The resulting Process of Interpersonal Empathy Scale (PIES) is a 20-item scale with promising psychometric properties. The PIES contains five subscales: Conceptualization, Emotional Complexity, Emotional Awareness, Reflections, and Exploratory Stance. Overall, the PIES shows promises for use in research and counselor education. The need of additional validation studies remains to establish consistent results.

DEDICATION

This dissertation is dedicated to the clients who helped me grow as a counselor, the counselor educators whom I learned from, and the peers and students who inspired me. All of you have played a big role in my journal of academic inquiry.

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This is especially a unique year to be completing a dissertation. It would be odd not to acknowledge the impact from the COVID-19 pandemic. This is a year of learning about self-care and patience. Thanks to my family and friends, who keep me accompanied.

Last but not least, I would like to acknowledge my significant other, Mathew. Because of you, I started, continued, and finished this doctoral program. You teach me about love and empathy that I cannot learn from books. Here's to the adventure ahead of us.

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CHAPTER I: INTRODUCTION

Empathy plays a vital role in interpersonal relationships. Rogers (1957) first discussed its importance in building therapeutic relationships when establishing the theoretical foundations of Person-Centered Therapy. As his work began receiving acclaim outside clinical settings, he expanded these concepts into multiple contexts, such as learner-centered education and international conflict resolution (Kirschenbaum, 2004). According to Rogers (1980), individuals should view empathy as a critical component in developing healthy interpersonal relationships because the non-judgmental interactions it engenders allow individuals to convey a sense of unconditional positive regard that encourages the sharing of personal stories and experiences. Within counseling practice, Rogers (1957) viewed unconditional positive regard as a necessary component for therapeutic change because it provided clients the space to broaden their self-exploration authentically. For example, when clients experience genuine empathic understanding, they are liberated to explore their thoughts or feelings without judgment.

In support of Rogers' theory, Elliott et al. (2018) conducted a meta-analysis and found that empathy was a moderately strong predictor of positive counseling outcomes. In their study, they reviewed 82 empirical studies with a combined total of 6,138 participants. The authors of these studies utilized various empathy measures, including observer-rated, counselor self-report, and client self-report instruments. Overall, the researchers found that neither client issues, the severity of their presenting problems, nor counselor orientation interfered with the relationship between empathy and counseling outcomes. In other words, across all experiences, the greater a client's perception of counselor empathy, the greater the likelihood of them having a positive therapeutic experience. Furthermore, Watson et al. (2014) discovered that clients' perceptions of counselor empathy contributed to their self-acceptance. In other words, when clients experience

their counselors as more empathic, they report less self-defeating thoughts after receiving counseling services. Collectively, these pieces of evidence indicate that empathy is a prominent component in effective counseling experiences, not only for helping build counseling relationships but also for catalyzing prolonged therapeutic change.

Since building therapeutic relationships with clients is fundamental to positive counseling outcomes, and researchers have demonstrated that empathy supports healthy relationships, counselor educators have endeavored to teach counselors-in-training (CITs) how to express empathy in counseling sessions appropriately. Examples of these instructional practices include improvisation (Bayne & Jangha, 2016), movies (Bell, 2018), and demonstration of various ways to convey empathy (Neukrug et al., 2013). The variety of pedagogical interventions introduced in the past decade has expanded the knowledge base regarding teaching CITs how to be empathic. However, little to no research has been conducted to support these practices empirically. In other words, there is no data to suggest how CITs best learn to be empathic and what techniques counselor educators should include as standard practice in counselor education programs. The lack of evidence for these practices may be related to the fact that there is no universal definition of empathy. Counselor educators have defined empathy using different conceptualizations, such as taking other perspectives or communication skills. The varied conceptualizations lead to multiple approaches to teaching novice practitioners this critical skill. Consequently, clinical practice can vary greatly depending on how and where a counselor was trained. Given the noted importance of counselor empathy on client outcomes, this inconsistency appears problematic.

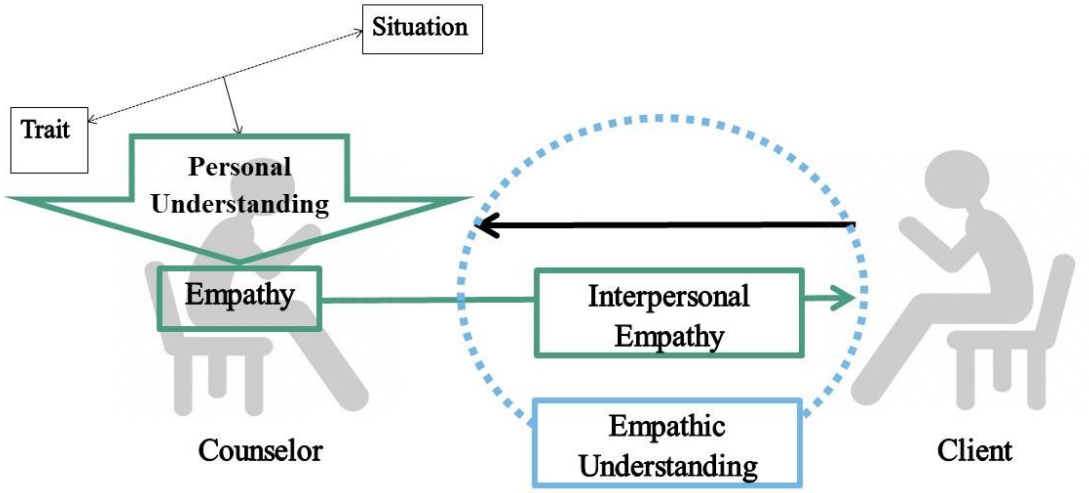
As a result of this ambiguity, Cuff et al. (2016) called for the helping profession to develop more sophisticated definitions for empathy. Specifically, they suggested that researchers from different disciplines aim to clarify their assumptions and definitions of empathy to establish

a refined way to measure the construct. A review of the literature supports the fact that most counseling researchers subscribed to the multidimensional understanding of empathy, viewing it as a construct with separate components such as affective empathy and cognitive empathy (Bohecker & Doughty Horn, 2016; DePue & Lambie, 2014; Fulton & Cashwell, 2015; Leppma & Young, 2016). However, Rogers' (1980) early views posited a different perspective, describing empathy in counseling as a process with these separate components being intercorrelated. Subsequently, several researchers (Altmann & Roth, 2013; Barrett-Lennard, 2015; Bayne & Hays, 2017) have supported and validated Rogers' notion that empathy within the counseling context should be viewed as an interactive process.

In a synthesis of the existing empathy literature, Ho (2021) proposed the Process of Interpersonal Empathy (PIE) as a new conceptualization of empathy in the counseling context. This approach defined empathy as a collection of multidimensional ingredients functioning in a sequential process with active engagement by both the counselor and the client. As shown in Figure 1, when a client expresses themselves verbally or nonverbally, it activates their counselor's cognitive processing (personal understanding) of meaning-extraction, which results in an internal emotion (empathy). The counselor then can express their understanding to the client (interpersonal empathy). Through this reciprocal interaction, the counselor and the client reach a mutual understanding, known as empathic understanding (Ho, 2021). According to Ho, cognitive complexity, perspective taking, interpersonal empathy, and emotional awareness are ingredients counselor educators could teach.

Figure 1

Process of Interpersonal Empathy



Conceptually, the PIE model captures the multifaceted and interactive nature of empathy in the counseling process. As counselor educators have presented various interventions to facilitate CITs' empathy, the PIE model may help counselor educators identify targeted ingredients they intend to teach, allowing them to select teaching interventions specifically targeting those identified growth areas. For example, Bayne and Jangha (2016) intended to enhance CITs' perspective-taking ability through improvisation, while Neukrug et al. (2013) provided creative ways to use interpersonal empathy. If proven to include the ingredients most salient to empathy expression, the PIE model can establish an empirically based instructional framework counselor educators can use to prepare future counselors.

Statement of the Problem

The lack of a universal understanding of empathy may hinder counselor preparation. When counselor educators teach empathy as a vague construct, CITs may find it challenging to grasp the idea and struggle empathizing with clients. Moreover, counselor educators may

struggle to assess a CIT's empathy capabilities when they vaguely define empathy. The complex concept of empathy has resulted in perplexing measures for decades (Cuff et al., 2016; Elliott et al., 2018). Consequently, CITs may, or may not, leave their training programs with a working understanding of this vital skill and how they can employ it in their future counseling relationships.

In the counseling literature, researchers tend to use the Interpersonal Reactivity Index (IRI; Davis, 1983) to measure empathy among CITs (Bohecker & Doughty Horn, 2016; DePue & Lambie, 2014; Fulton & Cashwell, 2015; Leppma & Young, 2016). However, Johnson and Karcher (2019) questioned the use of the IRI in the counseling context because scenarios described in some of the IRI items are not present in counseling sessions such as "when I see someone being taken advantage of, I feel kind of protective towards them." Additionally, even though the IRI measures empathy as a multidimensional construct, its focus on the intrapersonal dimensions makes it difficult for counselors to integrate its results into the counseling context (Johnson & Karcher, 2019). Thus, it might be inherently problematic to interpret the studies utilizing IRI as measuring CITs' empathy. Johnson et al (2020) developed a state-specific version of the IRI to measure in-session counselor empathy. However, the S-IRI followed the theoretical foundations of the IRI, which measured empathy as a disposition. Thus, the need remains for a more comprehensive and competence-based measure.

Although the PIE provided a distinct perspective in defining empathy in counseling relationships, there was no empirical evidence to support the emerging theory. Hence, developing an instrument based on the PIE would provide empirical evidence validating the theory and establish a tool for counselor educators and supervisors to assess CIT's empathy learning.

Targeted interventions then could be employed to help CITs improve their performance in the specific areas hindering their ability to express empathy to their clients.

Purpose of the Study

The purpose of this study was to develop a theory-driven instrument, the Process of Interpersonal Empathy Scale (PIES), and evaluate the validity evidence supporting the measure. This study served four objectives: (a) to evaluate the factor structure of the PIES, (b) to determine the internal consistency reliability of PIES scores, (c) to evaluate the validity of the PIES, and (d) to provide the empirical evidence of the PIE model.

Significance of the Study

The development and validation of the Process of Interpersonal Empathy Scale (PIES) was significant for three reasons. First, the development of a valid scale established an empirical foundation for the theoretical structure of the PIE and introduced a more sophisticated conceptualization of empathy. Second, validation of the PIES provided clinical implications as it allowed researchers to examine relationships among its factors and clients' perceptions of empathic understanding. The findings of these investigations would help identify how each PIES factor contributes to the client's perception of empathic understanding. Lastly, the complete PIES instrument introduced counselors and counselor educators to a refined way to address empathy learning and its evaluation.

Overall, the findings of this study helped shed light on empathy training protocols in counseling programs. They allowed counselor educators to restructure curricula or training standards based on the evaluation of CITs' empathy competence. The PIES would be a helpful tool for counselor educators and supervisors to evaluate CITs' empathy competence. Additionally, it served as a guide for counselor educators to teach empathy competence and

assess CITs' empathy for future researchers. Once the use of the PIES becomes commonplace across academic, supervisory, and clinical settings, professional counselors will be more equipped with empathy competence and the ability to serve their clients with a greater understanding of their condition and presenting challenges.

Research Questions

This study addressed the following research questions: (a) what inventory items are representative of the interpersonal empathy process for a sample of CITs and counselors, (b) what was the internal consistency reliability of the emerging PIES, (c) to what extent, if any, did scores on the PIES correlate with scores on another instrument measuring a similar construct, and (d) to what extent, if any, did scores on the PIES correlate with clients' perceptions of empathy?

Research Design

The overall research design included two phases and was based on best practice scale development procedures (DeVellis, 2017). During phase I, I developed the scale structure to match the PIE model and test its internal consistency and convergent validity to address research questions (a) through (d). The participants for phase I were CITs and counselors who actively provided weekly counseling services. For phase II, I planned to evaluate the empirical evidence supporting the PIE. The participants in this phase included pairs of CITs and their clients. I planned to use the data collected during phase II to evaluate the concurrent validity of the PIES by addressing the research question (e).

Assumptions, Limitations, and Delimitations

Assumptions

I made several assumptions regarding this study based on its orientation and design. First, I assumed participants responded honestly because I developed the data collection and retention procedures to ensure anonymity and confidentiality. Also, participation was entirely voluntary, and participants could withdraw from the study at any time without any negative ramifications. Therefore, I assumed the individuals who chose to participate in the study were doing so of their own free will and motivation to help improve counselor training practices. Additionally, I assumed the measures I selected for this study were content valid with my selected sample and allowed me to confidently make inferences to the theoretical constructs on which they were based.

Limitations

As this study was voluntary, it is more likely that participants were predisposed to be more empathic. Since I planned to recruit a nationwide sample, I recruited my participants and administered my survey online. While this procedure facilitated gathering a national sample, it limited my ability to answer any questions while participants filled out their surveys, resulting in them leaving some items unanswered (i.e., missing data). Additionally, using online communities to recruit participants could prevent the access to this study from counselors who were not part of these listservs, or did not utilize online communication. Moreover, as COVID-19 spread impacted workforce and universities to transition into work-from-home, individuals were more likely to experience digital fatigue, and thus less inclined to fill out an online survey. Participants in phase II consisted of CITs and their clients at the Texas A&M University-Corpus Christi Counseling and Training Clinic (CTC). Thus, any correlational relationships noted between PIES scores of CITs and their clients' perceptions of their empathy might be limited to explaining only the phenomenon between CITs and their clients.

Delimitations

As for study delimitations, the definition of empathy used in this study was specific to therapeutic relationships in the clinical context. It eliminated Rogers (1980) considered empathy a therapeutic factor because of a counselor's constant exploration. Hence, the PIES instrument aimed to measure the frequency in which counselors attempted to engage in the interpersonal empathy process, rather than the extent of these counselors' perceptions of their efforts. Additionally, since I developed the PIES as a tool for counseling training purposes, the items included in the PIES measured only those ingredients that can be taught or influenced by training and clinical experiences. They did not capture those ingredients that might be an innate part of a counselor's personality or interpersonal style.

Definition of Terms

Counselors-In-Training (CITs): individuals enrolling in and matriculating through graduate counselor preparation programs.

Empathy: an emotion resulting from a counselor's understanding of their client's verbal and nonverbal expressions.

Personal Understanding: a counselor's cognitive process to extract meanings from their client's verbal and nonverbal expressions of their experience.

Cognitive Complexity: a counselor's capacity to differentiate and integrate gathered information (Wilkinson & Dewell, 2019). This capacity allows counselors to extract meanings in the cognitive process.

Perspective-Taking: a counselor's capacity to think from their clients' perspectives without judgment, also known as entering another person's frame of reference (Rogers, 1980). This capacity allows counselors to process their clients' experiences without judgment.

Interpersonal Empathy: a counselor's capacity to express their understanding of their clients' experiences to their clients, including emotions and meanings.

Emotional Awareness: an individual's capacity to experience a broad range of emotions and differentiate them.

Empathic Understanding: a counselor and client's mutual understanding about the client's experience that is achieved through their in-session interactions.

CHAPTER II: REVIEW OF THE LITERATURE

In this chapter, I provided an overview of the empathy construct and its related literature. First, I introduced the theoretical framework underlying this study. Next, I reviewed the development of the definition of empathy over time, culminating with the current iteration of the construct I defined in Chapter One. I then discussed existing empathy instruments and their respective features and qualities. Furthermore, I reviewed the empirical evidence for the constructs comprising the Process of Interpersonal Empathy (PIE) model. Lastly, I consolidated the critical concepts and identified gaps in the current scholarly literature.

To systematically review the literature, I used various strategies to search for source material. First, I identified the primary texts associated with Carl Rogers' seminal work on empathy. I then searched through electronic databases, PsycINFO, and Academic Search Complete. PsycINFO includes behavioral and mental health-related documents. Academic Search Complete contains sources from social science-related disciplines. As I was more familiar with the literature about empathy, I narrowed my searches to literature specific about empathy in counseling and counselor education. Therefore, I searched through journals published by various professional counseling organizations. Throughout the search, I used "empathy," "perspective taking," "cognitive complexity," and "emotional awareness" as keywords to locate topic relevant sources. Additionally, I utilized footnote chasing while reviewing my search results. This strategy allowed me to identify other relevant sources. Overall, I used these search strategies to review abundant sources while focusing on empathy in the counseling context.

Theoretical Framework

This study was grounded in the theoretical foundations of Person-Centered Therapy (PCT; Rogers, 1951;1961), which Rogers developed from his clinical work early in his career.

Upon graduating from Columbia University's Teacher College, Rogers began working with troubled youth at the Society for the Prevention of Cruelty to Children in upstate New York. Although trained in the psychoanalytic approach, Rogers' clinical experience working with these children changed his view on how therapy worked. Rogers (1942) introduced and discussed his ideas in his seminal work *Counseling and Psychotherapy*. Instead of believing the counselor was the expert in the therapeutic relationship, he recognized that clients could direct their therapy when counselors appropriately attend to clients' experiences. In his subsequent publication *Client-Centered Therapy*, Rogers (1951) distinguished his counseling approach from a counselor-centered approach. Using his client-centered approach, Rogers noticed his clients' positive change and researched this phenomenon. Then he published *Psychotherapy and Personality Change* about how counselors' non-directive approach may induce client personality change (Rogers & Dymond, 1954). Rogers continued refining his ideas and grasped the humanistic philosophy, which posited a positive view of human nature. Eventually, Rogers (1961) published *On Becoming A Person: A Therapist's View of Psychotherapy*, which finalized his approach as Person-Centered Therapy. Although his early work in 1942 was deemed controversial and received criticism (Mearns & Thorne, 2007), the American Psychological Association recognized his work in 1956 with the Distinguished Scientific Contribution Award, solidifying his ideas as part of the professional lexicon.

Based on the humanistic philosophy, PCT suggests individuals tend to grow to their best potentials under nurturing environments (Rogers, 1961). Individuals can cultivate a nurturing environment with unconditional positive regard, which refers to accepting one's experience with no conditions (Rogers, 1957). Conditionality is an evaluative attitude towards experiences and beliefs. According to Rogers (1959), the tendency to seek conditional positive regard leads to an

experience of incongruence between one's ideal self and real self. For example, a child only gets their parents' positive attention when they earn good grades. This child may grow up with conditional self-regard based on their performance (i.e., parental love depends on how the student performs academically). Thus, this individual's self-worth will become dependent on others' approvals and manifest itself throughout life and in all relationships. Additionally, conditionality hinders one's ability to self-actualize. This individual may turn out to prioritize others' approval over what they truly aspire to do. Since unconditional positive regard can happen with others and within oneself, the goal of counseling is for counselors to experience unconditional positive regard for their clients and eventually build unconditional positive self-regard within the clients (Sharf, 2015).

Rogers' seminal work in 1957 about necessary conditions of change defined how the counseling profession conceptualized an ideal counseling relationship. Specifically, conditions like experiencing incongruence and empathic understanding can facilitate clients' personality change because the sequential experience of such conditions delivers unconditional positive regard. For instance, when clients are in counseling, they may experience incongruence through self-exploration about the clash between their real self and ideal self. As the client experiences incongruence, negative emotions may arise. Therefore, the counselor's empathic responses are key to demonstrating unconditional positive regard and helping their client deepen the exploration. Rogers (1975) explained that empathy is an interactive process involving both counselor and client. The counselor expresses their understanding of the client to ensure it aligns with the client's experience. This process helps reach a mutual empathic understanding. As the empathic understanding conveys unconditional positive regard, it facilitates the client's deeper self-exploration towards building a congruent self and self-actualize (Rogers, 1980).

Based on Rogers' conceptualization of empathy, the PIE depicted empathy as an interpersonal process. Moreover, the PIE integrated contemporary empirical studies surrounding empathy to portray this process from cognition, to emotion, and to interpersonal interaction. In subsequent sections, I discussed the literature surrounding each ingredient in the PIE. Although there was no empirical investigation of the PIE model, this study aimed to test the model and develop a theory-derived instrument.

Empathy

Origins in Counseling

Empathy has been rooted in counseling and psychotherapy. Although Carl Rogers is widely credited with introducing the notion of empathy as a necessary condition for client change, he was not the only individual recognizing the value of empathy in the therapeutic relationship. Heinz Kohut (1959) also highlighted the importance of empathy in psychoanalysis. As a Neo-Freudian psychoanalyst, Kohut argued empathy was a way of approaching another's inner world. Rather than viewing empathy itself as the change agent as Rogers did, Kohut considered empathy more of an aid for psychoanalysis to be performed. Whereas Rogers and Kohut held different assumptions about human nature, both theorists established the significance of empathy in counseling and psychotherapy.

Due to their divergent assumptions about counseling and psychotherapy, Rogers and Kohut viewed the meanings of empathy differently. Rogers (1975) further explained his definition of empathy and how it could be therapeutic. He described empathy as an interpersonal communication process where a counselor endeavored to enter their client's frame of reference. This process would prove therapeutic because the exploratory stance and the non-judgmental attention conveyed unconditional positive regard, which was also a foundational condition for

client change (Rogers, 1957). On the other hand, Kohut (1984) discussed the mechanism of therapeutic change under the psychoanalytic lens. Specifically, he identified empathy as an essential factor to inform analysts to make accurate and timely interpretations, which led the cure to happen. Although recognizing the crucial role empathy played in counseling, Kohut disagreed that empathy itself would be the cure. In sum, Rogers and Kohut agreed that empathy was an important factor in counseling. However, they disagreed on the specific mechanisms through which empathy contributed to counseling outcomes and whether it alone could facilitate client growth and positive change.

Development of Conceptualization

Researchers became interested in investigating empathy as Rogers popularized the concept of empathy by applying it to educational studies (Rogers, 1969) and cross-national conflict resolution (Rogers, 1987). Numerous researchers set out to operationalize and assess empathy. One of Rogers' students, Godfrey Barrett-Lennard (1962), developed the Barrett-Lennard Relationship Inventory (BLRI) based on Rogers' theory. The purpose of the BLRI was to measure the core conditions of relationships, including the level of regard, empathy, unconditionality, and congruence. Additionally, two editions of the measure, me-to-other (MO) and other-to-self (OS), assess the relationship between two individuals. Typically, MO was for respondents to complete based on their actions toward others (counselor perspective), while OS was for respondents to complete based on their reactions to others (client perspective). This structure aligned with Rogers' conceptualization of empathy, which emphasized the mutual understanding between the counselor and the client (Barrett-Lennard, 2015).

Rogers (1975) supported the use of BLRI and cited the scale as one of the operational definitions of empathy. Barrett-Lennard (1981) also proposed the empathy cycle to depict the

reciprocal nature of empathy. The empathy cycle illustrated how empathy transited in the interpersonal process. First, a counselor actively attended to their client to create an empathic set. With their client's expression, the counselor would experience an empathic resonation, which the counselor entered their client's private world. Next, the counselor communicated their empathic resonation to the client. As the client also actively attended to the counselor, the client either confirm or correct the counselor's understanding of their experience. Barrett-Lennard (1981) noted that this reciprocal interaction would establish empathic understanding, which the BLRI could measure.

Likewise, Clark (2010a) discussed three ways of knowing in the counseling process based on Rogers' theory: subjective empathy, interpersonal empathy, and objective empathy. Subjective empathy referred to a counselor's awareness of their internal reactions to their client's experience. Interpersonal empathy referred to a counselor conveying their understanding of the client's experience to them. Objective empathy referred to a counselor using knowledge outside of a client's frame of reference to conceptualize the client theoretically. For example, a counselor may use their knowledge (objective empathy) about transgender identity development to understand a transgender client's transitioning experience. As the counselor is aware of (subjective empathy) their reaction to the client's experience related to the transgender identity development, the counselor can then covey (interpersonal empathy) such understanding to the client. In sum, researchers extended Rogers' theory with additional parameters.

The development and validation of the Interpersonal Reactivity Index (IRI; Davis, 1983) set the foundations of defining empathy as a multidimensional construct, including affective empathy and cognitive empathy (Davis, 1983). The subscales Empathic Concern (EC) and Personal Distress (PD) are affective empathy while Perspective Taking (PT) and Fantasy (FS) are

cognitive empathy. In essence, affective empathy captures individuals' emotional tendency to feel for others, while cognitive empathy is individuals' cognitive tendency to understand or imagine others' experiences. Most researchers subscribed to the multidimensional definition of empathy and used the IRI in their research (Bohecker & Doughty Horn, 2016; DePue & Lambie, 2014; Fulton & Cashwell, 2015; Leppma & Young, 2016). When researchers discussed cognitive empathy, most of them referred to perspective-taking. However, Cuff et al. (2016) argued that cognitive empathy was not limited to perspective-taking. Moreover, they expanded the conceptualization of cognitive empathy to include reading facial expressions, access relevant memories, imagining, and projection.

Amid technological advances that have advanced our understanding of the human condition, neuroscience researchers further examined empathy as a brain function set. The psychological term "theory of mind" is commonly used to explain the capacity to infer others' thoughts and feelings without necessarily exposed to similar experiences (Countinho et al., 2014). Specifically, they concluded that empathy is an automatic process that includes emotional stimulation, conceptual and perspective-taking processes, and emotion regulation processes (Countinho et al., 2014; Elliott et al., 2018). This evidenced the existing definitions of affective empathy and cognitive empathy constructs. Furthermore, it confirmed that empathy was not only multidimensional but functioned as a sequential process.

Cuff et al. (2016) conducted a systematic literature review and examined 43 articles with discrete definitions of empathy. They suggested that each discipline should clarify their assumptions about empathy to make a clear distinction from others because different disciplines embedded various assumptions of empathy in their definition. Johnson and Karcher (2019) were in line with this perspective as they questioned the use of IRI in the counseling context. In the

counseling context, Rogers (1975) defined empathy as an interpersonal process where counselors endeavored to understand their clients by expressing their understanding. Neukrug et al. (2013) provided novel ways of empathetic responses for counselors to utilize in counseling sessions to facilitate counselor expression. Therefore, there is a behavioral component added to the conceptualization of empathy in the counseling context.

Current Definition and Characteristics

Taken together from the literature, Cuff et al. (2016) proposed a clearer conceptualization of empathy as a multidimensional and complex process. It occurs when a person encounters an emotional stimulus, such as conversations with others or watching movies. This stimulus then activates one's cognitive processing to extract meanings from the received information. This further results in the formulation of emotion similar to their perception of the emotional stimulus, thereby generating the emotion regulation process. Additionally, one can recognize that the source of the emotion is not one's own. According to Cuff et al. (2016), the empathy process may be influenced by one's personality traits and the situations in which they find themselves.

Moreover, counselors need to express their understanding of their clients' experiences to them in the counseling context because appropriately responding to clients is crucial for therapeutic gains. Hence, the characteristics of empathy are threefold: emotional, cognitive, and behavioral. An individual who has the emotional capacity to receive others' emotions is more prone to experience the automatic empathy process. An individual who has higher cognitive complexity is more capable of interpreting the received information accurately. Individuals who have the emotional capacity to regulate their own emotions are more prone to be aware of their produced emotion at the end of the empathy process. As for the counselors, they have to be aware of their emotions and thought process and be able to express such understanding to their

clients. Consequently, counselors with more extensive repertoires of counseling skills may be more capable of responding to their clients' experiences.

Process of Interpersonal Empathy (PIE)

Drawn from the previous literature review, I incorporated every vital element and proposed the model, Process of Interpersonal Empathy (PIE), to define empathy as a collection of multidimensional ingredients functioning in a sequential process with active engagement by both the counselor and the client. As shown in Figure 1, when clients express themselves verbally or nonverbally, it activates their counselor's cognitive processing (personal understanding) of meaning-extraction. As a result, there is an automatically generated emotion (empathy) similar to the counselor's perception of the client's expression. Additionally, the counselor's emotional awareness identifies this internal emotion with a sense of self-other distinction. With the identified emotion associate with their understanding, the counselor expresses such an understanding to the client (interpersonal empathy). Receiving the counselor's expression, the client then may clarify or further explore their experience. Through this reciprocal interaction, the counselor and the client reach a mutual understanding, known as empathic understanding.

In Rogers' (1957) definition of empathy, there were three essential elements: "sensing the client's private world," "endeavors to communicate," and "as if." Sensing the client's private world was the common understanding of affective and cognitive empathy. However, the other two elements were often overlooked. Endeavors to communicate characterized the counselor's intention to understand their clients correctly. This feature emphasized the effort to communicate for an accurate understanding. Thus, the attempts to understand were monumental regardless of the accuracy in one attempt. Meanwhile, "as if" highlighted the importance of the self-other

distinction, which related to the counselors' emotion regulation. Hence, the PIE captured the contemporary understanding of empathy and grasps the crucial elements of Rogers' original theoretical framework.

Traits and circumstances were the ingredients that may influence the counselor's internal empathy process. These two ingredients were dispositional and thus might not be able to be taught during training. Counselor educators might be able to screen CITs' traits related to empathy. Additionally, counselor educators might take considerations into situations when evaluating CITs' empathy competence. These external factors that influenced the empathy process could be going into a session after a stressful discussion with colleagues or feeling sick. Therefore, the ingredients counselor educators could teach included personal understanding, emotional awareness, and interpersonal empathy.

Personal Understanding

Personal understanding refers to a counselor's cognitive process to extract meanings from their client's verbal and nonverbal expressions of their experience. Namely, this cognitive process shapes individuals' perceptions and interpretations of others' experiences. Because such perceptions or interpretations may not be accurate (Cuff et al., 2016; Rogers, 1986), I intentionally phrased it as personal understanding to distinguish it from empathic understanding. In other words, a counselor's perceptions remain internal and possibly inaccurate until they communicate them with their clients. Based on the literature review regarding cognitive aspects of empathy, this cognitive process includes elements such as knowledge, cognitive complexity, and perspective-taking.

Knowledge

Knowledge entails relevant information related to the counseling context, such as counseling theories and other theories related to client issues (e.g., addiction, identity development, acculturation stress). Clark (2010a) proposed objective empathy was a counselor using knowledge outside of a client's frame of reference to conceptualize the client theoretically. For example, the *CACREP standards* (Council for Accreditation of Counseling and Related Educational Programs, 2015a) govern a systematic curriculum encompassing eight areas of foundational knowledge for counselor preparation. Additionally, the *ACA 2014 Code of Ethics* (American Counseling Association, 2014) warrants counselors' use of evidence-base practice. It requires counselors to seek empirical studies to understand their client's presenting issues further. Barrett-Lennard (1962) mentioned empathy involved recognizing clients' directly communicated feelings and inferring clients' implied or indirectly expressed content. Therefore, a counselor's knowledge about emotions allows them to identify clients' directly expressed feelings, whereas a counselor's knowledge about counseling theories allows them to interpret clients' implied meanings. In other words, relevant conceptual theories, empirical studies, and observations inform a counselor how to extrapolate a client's unexpressed communication, thus allowing the counselor to apprehend the pivot of the client's story.

Cognitive Complexity

Cognitive complexity in counseling literature stems from personal construct theory (Kelly, 1955). Personal construct theory depicts cognitive complexity as the number of interpersonal constructs an individual can use to describe another person (Kelly, 1955). For example, instead of using good versus bad to describe a friend, an individual with higher cognitive complexity may utilize several adjectives to portray this friend's characteristics like caring, foolish, unreasonable, and opinionated. This ability allows individuals to perceive the

world more comprehensively. In the counseling context, a counselor's ability to differentiate various interpersonal constructs for a client is as crucial as integrating the interpersonal constructs into themes of case conceptualization (Welfare & Border, 2010). Wilkinson and Dewell (2019) further articulated these two domains from Perry's (1970) cognitive development model. Differentiation marks a counselor's cognitive development from dualistic to multiplistic thinking. Integration characterizes a counselor's development from multiplistic to relativistic thinking. In other words, a counselor with higher cognitive complexity can not only describe their clients comprehensively but also determine which client's characteristics are more relevant to their presenting issues.

Although studies linking the positive relationship between cognitive complexity and empathy are outdated (Castillo, 2018), the evidence is undeniable. Counselors with lower cognitive complexity are prone to make biased judgments (Spengler & Strohmer, 1994), and thus they may not be able to enter the client's frame of reference. Consequently, counselors with higher cognitive complexity provide empathic responses more consistently (Lutwak, 1993; McAuliffe & Lovell, 2006; Strohmer et al., 1983). In a word, there is a coherent logic to suggest a theoretical relationship between cognitive complexity and empathy.

Perspective-Taking

Perspective-taking refers to an individual's ability to adopt others' viewpoints (Davis, 1983). This capacity allows counselors to process their clients' experiences without judgment. Adopting clients' points of view involves the ability to consider opposite sides of opinions, invite clients' explanations on topics, and imagine clients' reactions to events (Johnson et al., 2020). Researchers often conceptualize perspective-taking as cognitive empathy (Bayne & Hankey, 2020; Bell, 2018); however, it requires knowledge and higher cognitive functions to accomplish

cognitive empathy (Countinho et al., 2014). Thus, although knowledge, cognitive complexity, and perspective-taking are separate constructs, they are intertwined and influence the overall cognitive processing. Consequently, I hypothesized that these elements would belong to one factor. I developed items addressing each of them.

Emotional Awareness

Emotional awareness refers to an individual's ability to attend to and differentiate their emotions. According to Tangen (2017), emotional awareness involves sophisticated components like range, dialecticism, and granularity. First, range indicates the ability to experience a variety of emotions with broad intensity. Dialecticism denotes the ability to experience multiple emotions at one time. Lastly, granularity described the ability to distinguish these emotions. Thus, a counselor's emotional awareness can identify a wide range of emotions, acknowledge there may be multiple emotions in an experience, and articulate emotions in depth. For instance, when working with a grieving client, a counselor may be aware of a wide range of emotions simultaneously. The counselor then may distinct these emotions into sorrow, relief, anger, and guilt. Emotional awareness is crucial for counselors as it provides the information they can use to reflect to their clients (Peace & Smith-Adcock, 2018). As emotional awareness requires intentionally attending to the emotional experience with openness (Peace & Smith-Adcock, 2018), a counselor's emotion regulation contributes to this process. With the attention given to emotions in a counseling session, counselors' emotion regulation is intrinsic and intentional (Prikhidko & Swank, 2018). It is similar to mindfulness because mindfulness regulates one's attention to observe, describe, and be non-judgmental of the inner experience (Baer et al., 2008). Per Clark (2010a), subjective empathy is a counselor's awareness of their internal reactions to the experiencing of a client. Whereas counselors may temporarily feel as if the client in a

session, they may also have other feelings associated with their own experience as a counselor. Counselors' emotions aroused in counseling sessions may include emotions toward oneself (e.g., guilt) and emotions toward a client (e.g., anxiety; Prikhidko & Swank, 2018). Such emotions without proper regulation often hinder counselors' empathy. Especially among beginning counselors, the performance anxiety results in a counselor's self-centered focus rather than client-centered (Rønnestad & Skovholt, 2003). Fulton and Cashwell (2015) found that mindfulness awareness significantly predicted higher empathy and lower anxiety among CITs. Consequently, emotion regulation is important for CITs to regulate their emotional arousal and be empathic (Countinho et al., 2014; Prikhidko & Swank, 2018). Additionally, as Rogers (1957) identified self-other distinction as a key to empathy, emotional awareness also consists of counselors' conscious understanding that clients' emotions are not their emotions. Without such understanding, counselors may experience compassion fatigue or burnout (Prikhidko & Swank, 2018). In sum, emotional awareness entails a counselor's ability to experience a broad range of emotions and differentiate them, while their emotion regulation may influence emotional awareness.

Interpersonal Empathy

Interpersonal empathy is a counselor's intentional expression of their understanding of their client. Researchers usually refer to interpersonal empathy as skillful responses. Truax (1967) conceptualized it as observable responses with nine levels of empathic accuracy. The higher level a counselor is in, the more their responses resonate with their client. Ivey et al. (2011) proposed a set of microskills that help counselors build rapport with their clients. Specifically, counselor educators often teach "reflections of feeling" as the equivalency to empathy. When teaching empathic responses, Egan and Reese (2018) further suggested learners

use a formula “you feel … because…” as a guide. However, Rogers (1986) opposed using the term “reflections of feeling” because it diverted the original purpose of empathy. Although counselors should reflect feelings, the underlying purpose is to clarify whether the counselor’s understanding is correct. In other words, it is to show the counselor’s attempt to understand clients truly. Rogers even suggest alternative terms like “testing understanding” or “checking perceptions” to describe such counselor behavior. Other ways to deliver counselors’ understanding, for instance, include visual imagery, analogy, and targeted self-disclosure (Neukrug et al., 2013). In addition to verbal communication, counseling researchers also proposed that non-verbal communication like attitudes and attunement may be a part of interpersonal empathy (Decker et al., 2014). Attitudes that align with the purpose of interpersonal empathy are non-judgmental, accepting, and validating. Attunement is a counselor’s intentionally adjusting their non-verbal communication (e.g., tone of voice) to match their client’s mood or energy. Overall, skill training may equip CITs with ways to convey their understanding of clients. On the other hand, such training should not focus on the accuracy but on the counselor’s attempts to explore. Additionally, counselors’ non-verbal expressions may also assist in communication.

Altogether, these PIE ingredients were vital to explore further how they translate clinically into building a therapeutic relationship. Nevertheless, no instrument comprehensively measuring these ingredients exists. In the following section, I reviewed contemporary empathy instruments specifically to counseling contexts, which were either widely used or newly developed.

Contemporary Empathy Instruments

Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962, 2015)

Following guidance from Rogers, Barrett-Lennard established a research agenda focused on exploring the necessary conditions proposed by Rogers. He operationalized these conditions and developed the Relationship Inventory (Barrett-Lennard, 1962), also known as Barrett-Lennard Relationship Inventory (BLRI). This inventory is theory-driven because Barrett-Lennard (1962) generated items based on Rogers' (1957) theory of necessary conditions for personality change. He recruited counselor-client dyads to collect data to examine the relationship between perceived empathy and client outcome. The initial sample consisted of 42 clients and 21 counselors from a counseling center. As the purpose is to measure the quality of a relationship, the items on the BLRI are to be answered separately by the counselor and client. The BLRI provided empirical evidence of the PCT approach as researchers were able to use it to study how the quality of counseling relationships may influence counseling outcomes.

As researchers exploring common factors associated with counseling outcomes have consistently identified the counseling relationship as the variable most accounting for positive counseling outcomes (Wampold & Imel, 2015), the counseling relationship has become the de facto foundation in counseling regardless of a counselor's theoretical approach. Thus, counseling researchers expanded the use of BLRI to examine counseling relationships not only from the PCT lens. After the initial development, the BLRI has undergone updated versions (Barrett-Lennard, 2015). The current BLRI is a 40-item self-report measure, with four 10-item subscales, to measure relationship quality with two versions, including me-to-other (MO) and other-to-self (OS). The four subscales are Level of Regard (R), Empathy (E), Unconditionality (U), and Congruence (C). Each item is rated on a 6-point scale ranging from –3 (No, I strongly feel that it is not true) to +3 (Yes, I strongly feel that it is true) about how much they experienced the conditions. Higher scores indicate better quality of a relationship. The MO edition is for

respondents to complete based on their actions to others while the OS edition is for respondents to complete based on their reactions to others. The scores on the 10-item Empathy subscale yielded satisfactory reliability (α = .84; Barrett-Lennard, 2015). A sample of depressive clients' (n = 66) scores on the Empathy subscale also revealed good reliability (α = .95; Watson et al., 2014). As the BLRI is still prevalent in use, the evidence for its psychometrics property is continuously being updated.

Overall, the BLRI adheres to Rogers' empathy theory. It is helpful in evaluating the quality of counseling relationships from counselors' and clients' perspectives. However, in this inventory, empathy is measured as a unidimensional construct. Additionally, since it is measured as the quality of a relationship, the BLRI may not be useful to address the multidimensional nature of empathy. Thus, the proposed PIES aims to measure empathy as a multidimensional construct from the training perspective, which may help CITs target specific areas of growth for their empathy competence.

Interpersonal Reactivity Index (IRI; Davis, 1983)

Davis (1983) developed a measurement to capture empathy as a multidimensional personality trait. After reviewing the literature, he defined empathy with affective and cognitive dimensions. The initial sample for the scale development consisted of 452 undergraduate students enrolling in a psychology course. The resulting IRI is a self-report 5-point Likert-type scale with 28 items. Participants respond on a scale ranging from (1) the item does not describe me well to (5) describes me very well. There are four subscales, each containing seven items, to measure the multidimensional aspects of empathy, including Empathic Concern (EC), Personal Distress (PD), Perspective Taking (PT), and Fantasy (FS). Higher scores in each subscale indicate stronger tendencies in the respective empathy domain (Davis, 1983).

Since the IRI has been a prominent instrument to measure both cognitive and affective aspects of empathy, counselor educators have administered the IRI to CITs to investigate the relationship between empathy and relevant counselor characteristics like self-efficacy (Butts & Gutierrez, 2018) and mindfulness awareness (Fulton & Cashwell, 2015). Although the IRI was designed initially to examine empathy as a multidimensional personality trait, counselor educators have also used it to evaluate the effectiveness of training experiences in increasing the scores on IRI among CITs, such as meditation (Bohecker et al., 2016; Leppma & Young, 2016) and university-based practicum experiences (DePue & Lambie, 2014). However, counseling researchers raised concerns regarding such use to CITs (Bayne & Hankey, 2020; Johnson & Karcher, 2019).

Bayne and Hankey (2020) noted that the internal consistency of scores on the IRI was low to acceptable among CITs ($\alpha < .75$). Johnson and Karcher (2019) reviewed the items on the IRI and indicated the scenarios described in some of the IRI items were not present in counseling sessions, such as “when I see someone being taken advantage of, I feel kind of protective towards them.” Additionally, items in the EC scale seemed to depict sympathy: “I often have tender, concerned feelings for people less fortunate than me” and “Other people's misfortunes do not usually disturb me a great deal.” Sympathy is distinct from empathy because sympathy is feeling for others while empathy is feeling with others (Cuff et al., 2016). Although sympathy may allow counselors to show their caring to their clients, only empathy may facilitate the therapeutic experience in counseling sessions (Clark, 2010b). Hence, the underlying issue in the definition of empathy might explain why it was not applicable in the counseling context. In sum, the use of IRI may help counselor educators evaluate CITs personality traits regarding empathy, but it may not assist counselor educators in training effective counselors. The proposed PIES

aimed to measure empathy as a multidimensional competence, so counselor educators and supervisors could use it in training CITs' different components of empathy competence.

Therapist Empathy Scale (TES; Decker et al., 2014)

Decker et al. (2014) aimed to develop an objective empathy instrument to measure observable counselors' expressed empathy in a session. The resulting Therapist Empathy Scale (TES) is a 9-item observer-rated scale. Empathy is measured as a single factor with overlapping aspects, including cognitive, affective, attitudinal, and attunement. The raters rated counselors' expressed empathy on a 7-point Likert-type scale (1 = not at all, to 7 = extensively). Higher scores indicated a counselor's frequent demonstration of empathy. The data used consisted of 315 audiotaped sessions conducted by 91 Motivational Interviewing trainees. The initial data yielded high internal consistency (α =.94).

Counselor educators may use the TES to evaluate CITs' performance of expressed empathy during a session and provide relevant feedback. However, as empathy is measured as a single interpersonal factor, counselor educators may not be able to examine the internal process related to expressed empathy and to facilitate deeper learning experience. Additionally, an observer-rated scale minimizes counselors' and clients' subjective experiences, which is a key component, according to Rogers (1975). Since Decker et al. (2014) did not validate the TES with a client-rated scale, the TES itself may not provide the evidence that the higher scores would result in higher empathy received by clients. In other words, regardless of observers' rating of a counselor's expressed empathy, a counseling session may not be practical if the client does not perceive the same way.

Although Decker et al. (2014) argued an observer-rating scale would provide more objective results to measure in-session empathy, Rogers (1957; 1975; 1986) reiterated that only

clients could access their frame of reference and others can only attempt to move closer to it. In other words, even though an observer may be able to differentiate a more empathic response, they still cannot accurately represent a client's perspective. Hence, in this study, I planned to develop a self-report scale with frequency as the response format, thereby responding to Rogers' theory describing counselors' endeavors to understand.

Empathic Counselor Response Scale (ECRS; Bayne & Hankey, 2020)

To further assist in evaluating CITs' empathy competence, Bayne and Hankey (2020) developed the Empathic Counselor Response Scale (ECRS) as an aptitude test to measure CITs' ability to discriminate among levels of empathic responses. Bayne and Hankey (2020) first invited participants to produce statements describing a potential scenario for counseling. They then distributed the statements to participating counselors so that counselors could provide empathic responses. Next, Bayne and Hankey sent the counselors' responses back to the clients and other participating raters to rank the empathic level of each response. Lastly, they analyzed the data and compiled their results into the final ECRS scale.

The final ECRS contains four client scenarios, each with six counselor responses, thus a total of 24 items. Participants score each response on a 4-point Likert-type scale (1-very unempathic, 2-somewhat unempathic, 3-somewhat empathic, and 4-very empathic). As each scenario contains a correct answer, each response is scored with two points to the correct answer, one point to the partial credit answer, and the remaining two answer choices with zero points. The possible point range of scores is 0 to 48, with a higher final score representing higher accuracy in differentiating levels of empathic response.

The main strength of ECRS is incorporating client perspectives in determining levels of empathic responses. It is useful in assisting counselor educators in evaluating CITs' cognitive

ability to differentiate levels of empathic responses. As this is a new instrument, the reliability presented in their initial development was not satisfactory (person reliability = 0.63, separation values = 1.3). Thus, the scale may need further investigation to increase its sensitivity to discriminate between high and low-scoring individuals consistently.

State-Interpersonal Reactivity Index (S-IRI; Johnson et al., 2020)

Johnson et al. (2020) modified the IRI item descriptions specifically to measure in-session empathy in the counseling context. They contacted Davis to acquire approval to edit the IRI items so that the scale's utility would be meaningful in a clinical context. A total of 245 mental health professionals (e.g., counselors, psychiatrists, social workers) responded to the State-Interpersonal Reactivity Index (S-IRI). They did not report reliability because they argued that the scores of the S-IRI should not be expected to be consistent due to its state-specific nature.

The S-IRI provided counselor educators an instrument to assess counselor empathy specific to a single counseling session. However, the same underlying theoretical issue of mixing empathy and sympathy that plagued the IRI remains because Johnson et al. (2020) only changed the item wording to fit the items in the clinical context. Thus, further modification regarding the theoretical foundations of the S-IRI may be needed.

Summary

In this chapter, I reviewed the development of conceptualization of empathy in the counseling literature. I discussed how the Process of Interpersonal Empathy (PIE) depicted empathy in counseling as a multidimensional process. I distinguished between the ingredients of the PIE that could be taught and the ones that were dispositional. Consequently, I identified the need for a scale to measure the ingredients that can be taught effectively. Although some existing

scales were relevant in the counseling context and had been used among CITs, there was a gap in theoretical understanding and measuring the construct of empathy. These assessments addressed either intrapersonal or interpersonal empathy. However, empathy in counseling was a complex process that involved internal processing and consequential external expression. Thus, I aimed to fill the gap by developing a scale that captured the comprehensive nature of the process of interpersonal empathy. Additionally, the proposed scale, PIES, would be a self-report scale with items describing a counselor's thoughts, awareness, and actions to address each PIE ingredient in the counseling context. This scale would assist counselor educators and supervisors in responding to CITs' empathy learning needs.

CHAPTER III: METHOD

The purpose of this study was to develop the Process of Interpersonal Empathy Scale (PIES) and evaluate the validity evidence supporting this new measure. I accomplished these tasks using procedures designed to establish validity evidence for test content, internal structure, and relationships with related constructs. The findings of this study provided counselor educators a tool to assist students' empathy learning experience. In this chapter, I discussed the criteria used to recruit my participants, the sampling approach used to procure my sample, instrumentation, research procedures, and data analyses used to answer my research questions.

Participants

Since the PIE discussed how empathy flowed in the counseling process between counselors and clients, the targeted population included both counselors and their clients.

Phase I

The inclusion criteria for the participants in phase I were individuals who provide weekly counseling services to at least one client. Although DeVellis (2017) stated 300 as an ideal sample size for scale development, they also suggested the size should depend on the expected number of items. For example, if the expected number of items is less than 20, 300 participants would be too much. One other common rule of thumb is to include 10 participants per item (Nunally, 1978). On the other hand, Boateng et al. (2018) emphasized that a larger sample size stabilizes the estimate errors. They concluded 200 to 300 was an acceptable range of sample sizes. Nonetheless, they also recognized the sample size might be constrained by the available resources and funding. In summary, I expected to recruit no less than 200 participants while there will be no limit to the maximum number.

Phase II

The inclusion criteria for the participants in phase II were individuals who were (a) at least 18 years of age and able to provide legal consent to participate and (b) had been receiving counseling services for at least two sessions from a counselor already participating in this study. Other than calculating how many participants are needed to sufficiently power a study using available power analysis software (e.g., G*Power), Jenkins and Quintana-Ascencio (2020) proposed an alternative method to decide sample size by determining the minimal sample size needed to match data distribution with an alternative hypothesis. Using this approach, they concluded that 25 participants would suffice.

Sampling Approach

When researchers decide their sampling approach, it is more important to consider the representativeness of their sample rather than striving for true randomness (Balkin & Kleist, 2017). As this study aimed to develop an instrument, the main research method was survey administration. Generally, survey response rates in counseling and counseling psychology are low (14%; Van Horn et al., 2009). Using public email lists to access licensed professional counselors, Bloom et al. (2015) concluded that a usable response rate of 7% was a closer approximation. Therefore, to maximize the response rate in the online survey setting, I used a nonprobability sampling approach to reach as many potential participants as possible.

Phase I

There were two venues I used to reach potential participants. First, I accessed the Council for Accreditation of Counseling and Related Education Programs (CACREP) website where a current list of contact information of counseling program coordinators was publicly available. I sent the recruitment email for program coordinators to distribute to their students (see Appendix A). Second, I posted the research invitation to various online communities, including CESNET,

ACA Connect, Counsgrads, and Diversegrad (see Appendix B). CESNET is an email listserv consisting of English-speaking counselor educators. ACA Connect is an online forum exclusive to members of the American Counseling Association (ACA). Counsgrads and Diversegrad are email listservs designed for CITs to discuss and share topics of interest. Third, I searched the available contact information of directors of counseling training clinics in other universities and sent them the recruitment email. Finally, as the sampling approach of this study was nonprobability sampling, I also used personal contacts of counselor educators to distribute the research information.

Phase II

To properly link the counselor and client dyads for data collection in phase II, I collaborated with the Counseling Training Clinic (CTC) staff at Texas A&M University-Corpus Christi. I recruited CITs who were providing counseling services. Additionally, these CITs introduced the research opportunity to their clients using the recruitment script I created (see Appendix C).

Instrumentation

Demographic Questionnaire

I used a demographic questionnaire as an initial instrument to screen participants based on my established inclusion criteria. The questionnaire was also used to understand the characteristics of the participants and the representativeness of the sample. Items on the demographic questionnaire in phase I asked participants to provide information on their (a) age, (b) gender identity, (c) racial identity, (d) affectional orientation, (e) ability status, (f) education level, (g) counseling specialty area, (h) CACREP accreditation status of their training program, (i) length of field experience, (j) counseling agency setting, and (k) language used in sessions.

Items on the demographic questionnaire used with clients in phase II included (a) age, (b) gender identity, (c) racial identity, (d) affectional orientation, (e) spiritual identity, (f) education level, (g) employment status, (h) ability status, (i) reasons for counseling, (j) number of sessions with the current counselor, and (k) mental health help-seeking history.

Instrument Development

For the instrument development phase, I primarily followed the guidelines established by DeVellis (2017). In addition, I utilized contemporary counseling research literature to further inform the development process within the context of counseling research.

Determine the Construct

For the first step, I specified the purpose of the PIES, defined the construct being measured, and specified the scale content based on the theoretical framework (Boateng et al., 2018; DeVellis, 2017; Lambie et al., 2017). My intention in creating the PIES was to provide empirical support for the PIE as a theoretical framework. The PIE presented a theoretical model for counselor educators to teach the concept of empathy. The PIES would extend the model's utility for counselor educators to evaluate CITs' empathic capability and learning progress. The PIE was based on a synthesis of existing literature and compartmentalized empathy into cognitive, emotional, and behavioral aspects (delineated earlier in Chapter 2). Among these three aspects, the PIES substantially measured only those ingredients that could be taught or influenced by training and experiences.

Generate an Item Pool

The general guideline for generating items was that they always should reflect the purpose of the scale (DeVellis, 2017) and add specificity to the defined domains (Lambie et al., 2017). To meet these guidelines, I created an item pool spreadsheet to aid in the item generation

process. Specifically, the spreadsheet consisted of the purpose of the scale as a guideline, followed by the definition of the different domains and the created items corresponding to the specific domains.

Since I created the conceptual model PIE from a review of the literature, I used deductive methods to generate items (Boateng et al., 2018). Based on my literature review, I listed the definitions of each domain in the spreadsheet. I then wrote items that described the corresponding definitions to ensure the initial item pool fully captured the constructs I aimed to assess. When writing the actual items, I followed the guidelines suggested by Kline (2005). These guidelines included (a) only using one central thought in each item, (b) being precise, (c) achieving brevity, (d) avoiding awkward wording or dangling constructs, (e) avoiding irrelevant information, (f) presenting items in positive language, (g) avoiding double negatives, (h) avoiding terms like all or none, and (i) avoiding indeterminate terms like frequently or sometimes.

Although there is no recommended number of items to include in an initial item pool, redundancy is crucial during the early stage of scale development. Redundancy allows researchers to generate diverse items to measure the central concept, and the best options in terms of item inclusion would emerge in subsequent steps (DeVellis, 2017). Hence, I produced several alternatively phrased items for each domain to capture nuanced ways of addressing the same construct. The resulting initial item pool consisted of 62 items.

Determine Measurement Format

Determining measurement format early on helps develop the scoring system of the scale (DeVellis, 2017). According to Rogers' (1980) conceptualization, the therapeutic factor of empathy does not land on accuracy; rather, it stems from the counselor's constant attempts to

understand their clients. Therefore, I used a Likert-type scale to measure the frequency with which counselors attempted to engage in the interpersonal empathy process. I included frequency terms on the entire measurement continuum to make it an interval scale (Boateng et al., 2018). The options include rarely (0-20%), seldom (20-40%), sometimes (40-60%), usually (60-80%), always (80-100%).

Expert Review

I invited a panel of experts to review the initial item pool to maximize the scale's content validity (Boateng et al., 2018; DeVellis, 2017). The selection criteria for the experts were based on their history of publications on the topic and experience in the content and scale development. Based on their expertise, the experts provided insights regarding the suitability of each item in accurately assessing the proposed construct. In the invitation emails, I attached files to facilitate the process, such as what I expected regarding feedback and ratings, construct definitions, and an item pool spreadsheet that included the rating and comment sections. Based on the relevance of items to the construct and item clarity, the reviewers rated each item as either "essential," "useful but not essential," or "unnecessary." The reviewers also provided quality feedback for revising items.

Five experts agreed to review the initial item pool for this study. Per the American Educational Research Association et al. (2014) guidelines, I documented the reviewers' qualifications, demographic characteristics, and pertinent experience. Two reviewers were scale development experts while the other three reviewers possessed expertise in the construct of empathy and scale development. All reviewers were faculty members in the counseling-related profession, including two assistant professors, one associate professor, and two professors. The reviewers' ages ranged between 37 to 64 (M = 49.20, SD = 11.63). Three reviewers identified as

cisgender females while two reviewers identified as cisgender males. Four reviewers identified as White while one reviewer preferred not to be identified. Lastly, all reviewers had more than five publications in scale development and/or empathy. Their numbers of publications ranged between 6 to 50 (M = 18.60, SD = 18.19).

After receiving the ratings, I calculated the content-validity ratio (CVR; Lawshe, 1975) for each item using the following formula: (ne - N/2)/(N/2), where ne = number of panelists indicating "essential" and N = the total number of panelists. This ratio yielded values ranging from +1 to -1. Positive values indicate that a majority of panelists rated the item as essential. I also incorporated the reviewers' feedback to modify the items. Among the initial 62 items, 25 of them had negative CVR values, indicating the need for item deletion. However, content experts provided valuable feedback to rephrase some of these items that might better capture the essence of the construct. Thus, the finalized item pool contained 46 items.

Including Validity Items

In addition to testing the content validity of the initial items, I included other measures in my study as another way of providing validity evidence (DeVellis, 2017).

Social Desirability. It is a phenomenon in which individuals tend to present themselves in a favorable manner regarded by society (DeVellis, 2017). Since empathy is a desired quality in counselor preparation programs, participants may be prone to respond to this self-report scale in a certain way. As such, I incorporated the10-item social desirability scale (Strahan & Gerbasi, 1972) as a tool to detect items triggering social desirability. Ideally, the items in the PIES should have no correlation to the total social desirability score (DeVellis, 2017). Consequently, I excluded items that had a significant correlation with the total social desirability score.

Convergent Validity. Construct validity describes the ability of a scale to measure the exact construct it intends to (DeVellis, 2017). To further establish that the PIES measured what it purported to measure, I included a scale measuring similar construct to develop evidence for convergent validity (Swank & Mullen, 2017). In this study, I used the Barrett-Lennard Relationship Inventory – MO edition (BLRI; Barrett-Lennard, 2015), a scale commonly used to measure counselor empathy. I conducted a bivariate correlation analysis (Swank & Mullen, 2017) assuming that a strong and positive relationship between the scores on PIES and BLRI exists.

Concurrent Validity. Criterion-related validity adds a practical aspect to a scale because it examines the scale's ability to predict an external outcome (Balkin, 2017; DeVellis, 2017). The PIE illustrated the relationship between counselor expressed empathy and client perceived empathy. Therefore, including a client perceived empathy scale not only investigated the concurrent validity of the PIES, but the predicted outcome would confirm the assumptions of the PIE. In this study, I used the Barrett-Lennard Relationship Inventory – OS edition (BLRI; Barrett-Lennard, 2015). To examine criterion-related validity, Balkin (2017) recommended using multiple regression when there are multiple predictors with a single criterion. Hence, I planned to conduct multiple regression analysis with the assumption that a strong and positive relationship between the scores on PIES and BLRI exists.

Administer Items

After finalizing the item pool, I administered the items by distributing the surveys to online communities. As mentioned previously, I expected the sample size for the scale development to be no less than 200 participants.

Evaluate Individual Items

After receiving the data, I assessed the suitability of each item to the scale. This step allowed me to reduce poor performing items (DeVellis, 2017; Field, 2018). First, I created an intercorrelation matrix for all items in the draft version of the scale. When items have higher intercorrelation, it indicates the scale reliability will be higher (DeVellis, 2017). However, reliability estimates that are too high can be problematic. As such, Field (2018) advised eliminating items with low correlation ($r < .20$) for lack of representativeness of the construct and items with high correlation ($r > .80$) for multicollinearity. I also conducted a correlation analysis between the total social desirability scores and the PIES items. I deleted items with a significant correlation with the social desirability scale.

Optimize Scale Length

I finished addressing redundancy in this step based on the data I gather. As indicated above, I removed some items based on the comments received during the expert review stage. Next, I removed the poor performing items and items related to social desirability since they may hinder the reliability of the scale (DeVellis, 2017). The main task in this step was to balance the scale's length with its reliability because a long scale may contribute to respondent fatigue. In contrast, a short scale may lead to unstable reliability due to too few data points (DeVellis, 2017). The goal was to ensure the scale reliability of the PIES falls in a range from acceptable (α value in the .70s) to very good (α value in the .90s; DeVellis, 2017).

Measurement of Related Construct

Reporting information about the quality and suitability of correlated measurements is required when scale developers use them for validity evidence (AERA et al., 2014). In this section, I introduced the measure used to assess validity and reported its psychometric properties.

Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 2015)

The BLRI is a 40-item self-report measure used to measure relationship quality, with two editions, including me-to-other (MO) and other-to-self (OS). Each item is rated on a 6-point scale ranging from –3 (No, I strongly feel that it is not true) to +3 (Yes, I strongly feel that it is true) about how much they experienced the conditions. Twenty items are reverse scored and the possible range of scores for each subscale is -30 to +30. Higher scores indicate more positive perceptions of the relationship qualities (Barrett-Lennard, 2015). The MO edition is for respondents to complete based on their actions to others while the OS edition is for respondents to complete based on their reactions to others. Thus, counselor perception is measured by the form MO while client perception is measured by the form OS. The BLRI contains four 10-item subscales, Level of Regard (R), Empathy (E), Unconditionality (U), and Congruence (C).

As the initial purpose of the BLRI was to evaluate therapeutic relationships between counselors and clients, the samples used for examining reliability and validity were from such pairs. The scores on the 10-item Empathy subscale yielded satisfactory reliability (α = .84; Barrett-Lennard, 2015). A sample of counseling clients' (n = 66) scores on the Empathy subscale revealed good reliability (α = .95; Watson et al., 2014). These clients were in counseling for depressive symptoms and were predominantly of European descent (89%). In this study, I used the Empathy subscale of MO edition to evaluate convergent validity because it was a widely used empathy measure. I planned to use the OS edition to evaluate concurrent validity because examining the relationship between counselor expressed empathy (PIES) and client perceived empathy (BLRI) may determine the ability of PIES to predict a therapeutic relationship.

Procedures

In this section, I reviewed the research procedures regarding participant recruitment and data collection in phase I and phase II. Participant recruitment was how I approached potential participants. Data collection was how I distributed the surveys and stored the collected data.

Participant Recruitment

After receiving approval from the institutional review board (IRB) of Texas A&M University-Corpus Christi, I created the surveys on Qualtrics. The survey in phase I included an information sheet for the study and a compilation of three questionnaires: (a) a demographic questionnaire, (b) the item pool for the PIES, (c) the Barrett-Lennard Relationship Inventory – MO edition (BLRI; Barrett-Lennard, 2015), and (d) short form of Social Desirability Scale (Strahan & Gerbasi, 1972). The survey in phase II included an information sheet for the study and two questionnaires: (a) counselor information, (b) a demographic questionnaire, and (b) Barrett-Lennard Relationship Inventory – OS edition (Barrett-Lennard, 2015).

I sent the recruitment email to the CACREP program coordinators, counseling training directors, and online communities identified earlier in the sampling approach section. The recruitment email included research information and a link to the Qualtrics survey. Interested individuals linked to the survey from the recruitment email. Meanwhile, I sent out a recruitment email to the director at the CTC and recruited their CIT to participate in phase II of the study. Additionally, I provided a client recruitment script to the CTC director. The recruitment script was inserted in CITs' intake script to inform potential client participants about this study. Although the CTC staff delivered the recruitment script, they were not required to answer questions related to this study. In the recruitment script, I indicated that individuals could contact me with any potential questions related to the study. If the clients indicated an interest in

participating in this study, the CTC staff would email them the Qualtrics link to the phase II survey.

Data Collection

When potential participants linked to the survey, they reviewed the information sheet first. They then gave consent to participate in the study once they agreed they satisfied all inclusion criteria. Participants were not restricted in the amount of time they had to complete the surveys. Following completion, participants were provided a prompt thanking them for their participation. Qualtrics provided a function that converted the collected data into a Statistical Package for the Social Sciences (SPSS) data file to be used in subsequent quantitative analyses.

I chose to anonymize responses when setting up the survey on Qualtrics. Additionally, although counselor information was collected during phase II, it only served the purpose of pairing up the counselor-client dyads for data analysis. When the data was compiled, the counselor information would be immediately decoded into de-identifiable codes. Thus, I did not record any personal information or contact association.

Data Analysis

Preliminary Analysis

Data Cleaning

After I gathered the collected data, I would first ensure its quality by employing various data cleaning procedures for addressing missing values and outliers. I used SPSS functions to identify missing values and outliers. The pattern of missing values determined how I address the issue. According to Osborne (2013), data missing not at random (MNAR) renders more investigation about the potential cause because it could create biased results. On the other hand, if data were missing at random, the missingness itself had less influence in the analyses and

researchers could ignore it. Additionally, the percentage of missing values would also affect how I address missing values. For example, if more than 20% of the data is missing, replacing the mean scores of the sample could artificially lessen the data variance (Osborne, 2013). Thus, multiple imputation would be a more appropriate procedure (Osborne, 2013). For outliers, I inspected the skewness and kurtosis statistics as well as the Shapiro-Wilk normality test to examine whether the assumption of normality was met for my outcome variable. According to Osborne (2013), skewness and kurtosis statistics closer to 0 denoted normal distribution. As for the Shapiro-Wilk normality test, the distribution is deemed normal when $p > .05$. If the collected data violated the normality assumption, I would transform the data to acquire a more normalized score distribution.

Model Assumption

The assumption to conduct exploratory factor analysis is to ensure whether the collected data is factorable by examining the correlations among items (Mvududu & Sink, 2013; Watson, 2017). There are two common statistical procedures for this model assumption: Kaiser–Meyer–Olkin (KMO) test and Bartlett's test of sphericity. The KMO test examines the strengths of the correlation relationships, and thus KMO value ranges between 0 and 1 (Mvududu & Sink, 2013). The assumption is met when KMO test value is over .60 (Watson, 2017). Bartlett's test of sphericity examines whether the intercorrelation matrix is an identity matrix, meaning the items are not correlated at all (Mvududu & Sink, 2013; Watson, 2017). Consequently, when the *p* value is less than .05, the results of Bartlett's test suggest that the intercorrelation matrix is not an identity matrix.

Primary Analysis

Estimating Factor Structure

Although the PIES is a theory-driven instrument, the initial item pool contained alternatively phrased items as an attempt to capture the construct fully. Thus, while confirmatory factor analysis (CFA) allows researchers to examine a proposed scale structure, exploratory factor analysis (EFA) would be useful in this study to evaluate the representativeness of the items to the proposed PIE model.

According to Watson (2017), the steps for EFA include factor extraction, factor retention, factor rotation, and factor interpretation. First, I used principal axis factoring (PAF) as the extraction method to avoid concerns related to multivariate normality (Mvududu & Sink, 2013). Next, I used eigenvalue and scree plot to determine the number of factors to retain. Specifically, Kaiser Greater-Than-One Rule Criterion provided the guide to retaining only factors with eigenvalues greater than 1 (Watson, 2017). The scree plot is plotted as each eigenvalue on the Y-axis corresponding to the associate factor on the X-axis (Field, 2018). As the first few extracted factors are with higher eigenvalues, there would be a decline in the curve. I would inspect the point of decline in determining factor retention (Field, 2018; Johnson & Morgan, 2016). Next, I rotated the factor structure because the original structure would be hard to interpret after the initial calculation (Johnson & Morgan, 2016). I chose the oblique promax rotation method because this method was suitable for the assumption that the factors were correlated (Watson, 2017). Lastly, I interpreted the final factors and named the factors based on theoretical viewpoints.

Estimating the Internal Consistency Reliability

I computed coefficient alpha to estimate the internal consistency reliability of the final PIES. In addition to its being a staple measure to represent scale reliability, coefficient alpha was suitable because it could be used for the Likert-type scale (Bardhoshi & Erford, 2017). Since

unidimensionality is a requisite for a coefficient alpha, researchers need to report the coefficient for each factor (DeVellis, 2017). The interpretation for alpha was adequate consistency (> .70), good consistency (> .80), very good consistency (> .90; DeVellis, 2017).

Estimating Convergent Validity

To examine the extent of correlation between scores on the PIES and scores on another instrument measuring a similar construct, I conducted a bivariate correlation analysis between scores on the PIES and the BLRI-MO. If $p < .05$, I noted a statistically significant relationship between the scores of the PIES and the BLRI-MO. Additionally, I evaluated the effect size of this relationship as large ($r > .40$), moderate ($.21 \leq r \leq .40$), and small ($r < .20$) using conventional benchmarks provided by Swank and Mullen (2017).

Estimating Concurrent Validity

To examine the extent of correlation between scores on the PIES and the BLRI-OS, I planned to conduct a multiple regression analysis. If $p < .05$, there would be a statistically significant relationship between the scores of the PIES and the BLRI-OS Additionally, I would report unstandardized and standardized beta weights, standard error, *t*-test results, and adjusted R^2 (Balkin, 2017).

CHAPTER IV: FINDINGS

In this chapter, I presented the findings of the data analyses associated with my stated research questions. The research questions in this study included (a) what inventory items are representative of the interpersonal empathy process for a sample of CITs and counselors, (b) what was the internal consistency reliability of the emerging PIES, (c) to what extent, if any, did scores on the PIES correlate with scores on another instrument measuring a similar construct, and (d) to what extent, if any, did scores on the PIES correlate with clients' perceptions of empathy? I first reported the participant demographics to depict the overall characteristics of the sample. Next, I discussed the data cleaning procedures and model assumptions. Lastly, I displayed the findings of the primary analyses.

A total of 148 participants provided usable data for the phase I. Due to the COVID-19 impact, the Counseling Training Clinic (CTC) at Texas A&M University-Corpus Christi transitioned to a telehealth-based service delivery method. Consequently, the recruitment process was compromised for the phase II, and no individuals chose to participate in this study. Therefore, the presented findings were limited to phase I and answering research questions (a) to (c). While there was no available data for analysis in phase II, the phase II research design merited independent research to further examine the concurrent validity of the PIES. Moreover, the data from phase I would provide empirical evidence exploring the representing factors of counselor empathy and validating the initial PIES. Thus, the findings of this study could still be sufficient to develop an initial scale and evaluate its psychometrics regarding reliability and convergent validity.

Participant Demographics

The participants aged between 21 to 71 (M = 33.33; SD = 10.04). Table 1 summarized the sociodemographic characteristics of participants whereas Table 2 summarized the professional demographic characteristics of participants. The participants were primarily cisgender female (n = 125; 84.46%), heterosexual (n = 107; 72.30%), and able bodied (n = 126; 85.14%). Additionally, half of the participants identified as White (n = 85; 57.43%). As for the professional background, participants consisted of students enrolled in master's programs (n = 90; 60.81%), doctoral programs (n = 40; 27.03%), as well as practitioners who held either a master's degree (n = 13; 8.78%), or a doctoral degree (n = 4; 2.70%). Most participants' enrolled or graduated program were CACREP-accredited (n = 120; 81.08%). Additionally, participants' counseling specialty area was primarily in Clinical Mental Health Counseling (n = 101; 68.24%). The length of clinical experience of individuals who graduated from a master's program ranged from one year to 27 years (M = 7.44; SD = 5.89). Otherwise, CIT participants were enrolled in either practicum (n = 44; 29.73%), internship I (n = 18; 12.16%), or internship II (n = 25; 16.89%).

Table 1

Sociodemographic Characteristics of Participants

	n	%
Gender Identity		
Cisgender female	125	84.46
Cisgender male	18	12.16
Other	2	1.35
Transgender female	1	0.68
Gender expansive	1	0.68
Prefer not to answer	1	0.68
Racial Identity		
White	85	57.43
Latino/Latina/Latinx	20	13.51
African American or Black	18	12.16
Biracial or Multiracial	14	9.46
Asian	8	5.41

American Indian or Alaska Native	1	0.68
Other	1	0.68
Prefer not to answer	1	0.68
Affectional Orientation		
Heterosexual	107	72.30
Bisexual	18	12.16
Pansexual	6	4.05
Questioning	5	3.38
Gay	3	2.03
Lesbian	3	2.03
Asexual	2	1.35
Queer	2	1.35
Prefer not to answer	2	1.35
Spiritual Identity		
Having spirituality	61	41.22
Believing in a religion	53	35.81
Other	20	13.51
Atheist	11	7.43
Prefer not to answer	3	2.03
Ability Status		
Not living with a disability	126	85.14
Living with a disability	17	11.49
Prefer not to answer	5	3.38

Note. $N = 148$

Table 2

Professional Demographic Characteristics of Participants

	n	%
Education		
Enrolled in a master's program	90	60.81
Enrolled in a doctoral program	40	27.03
Holding a master's degree	13	8.78
Holding a doctoral degree	4	2.70
Missing value	1	0.68
Specialty Area		
Clinical Mental Health Counseling	101	68.24
School Counseling	20	13.51
College Counseling	7	4.73
Marriage, Couple, and Family Counseling	7	4.73
Other	7	4.73
Addiction Counseling	4	2.70
Clinical Rehabilitation Counseling	2	1.35
Clinical Settings		
Community agency	65	43.92

University/College	36	24.32
Private Practice	35	23.65
K-12 School	22	14.85
Other	19	12.84
Hospital	9	6.08
CACREP Accreditation		
Yes	120	81.08
No	24	16.22
Not sure	4	2.70
Master-Level CIT Experience		
Practicum	44	29.73
Internship I	18	12.16
Internship II	25	16.89
Language used in counseling		
First language	127	85.81
Not first language	9	6.08
More than one languages	12	8.11

Note. N = 148. CIT = counselors-in-training

Preliminary Analysis

Data Cleaning

A total of 170 individuals accessed the phase I survey link of this study. Among them, I removed 21 entries that had less than 25% of the completion rate as they were not deemed usable (Osborne, 2013). Next, I identified six missing values out of 6,854 possible values (0.09%) and determined the data was missing at random (MAR). Since there were no problematic patterns of missing data, and the percentage of missing values was minimal, I chose to replace the missing values with series mean as it would not artificially lessen the data variance (Osborne, 2013). Lastly, I used SPSS functions and identified one outlier. After eliminating the outlier, the final sample consisted of 148 participants. I then examined the skewness and kurtosis statistics as well as the Shapiro-Wilk normality test. According to Osborne (2013), skewness and kurtosis statistics closer to 0 denoted normal distribution. As for the Shapiro-Wilk normality test, the distribution is deemed normal when $p > .05$. The results indicated that the data distribution was approximately normal ($p = .26$, skew = -.20, kurtosis = -.52).

Model Assumption

To ensure the collected data was factorable, I examined the intercorrelations among items by performing Kaiser–Meyer–Olkin (KMO) test and Bartlett's test of sphericity. Kaiser-Meyer-Olkin (KMO) test indicated that the sampling adequacy was meritorious (= .84). Bartlett's test of sphericity showed that the intercorrelation matrix was not an identity matrix ($p < .001$), meaning there is redundancy between the items that can be summarized by a smaller group of latent factors. Altogether, the results suggested that the data from the final sample met the EFA assumption of factorability.

Primary Analysis

Factor Structure

Evaluating Individual Items

First, I conducted a bivariate correlation analysis to examine whether the participants' scores in the Social Desirability Scale had significant correlations with any item in the PIES item pool. The results showed that ten items were significantly and positively correlated with social desirability. In other words, participants who were more prone to present themselves in a favorable manner regarded by society were more likely to score higher in those ten items. Since empathy was a desired quality in counselor preparation programs, I decided to remove these ten items so that the PIES might measure respondents' self-reported empathy competence more accurately.

Table 3

Significant Correlations between PIES items and Social Desirability Scale

PIES item pool	*r*	*p*
10. Among all my clients' characteristics, I knew which were more relevant to explain their presenting issues.	.14	.047
11. It was easy for me to see things from my clients' points of view.	.16	.03

12. I could understand my clients' concerns by imagining how it looked from their perspectives.	.18	.02
15. When trying to understand my clients' presenting issues, I considered how multiple perspectives from my clients' social network may have influenced them.	.26	.001
28. I recognized the emotions I felt in sessions might not be my own.	.17	.02
29. When I felt for my clients (e.g., sorry, protective), I could keep my feelings from influencing how I understood my clients.	.24	.002
30. When I felt for my clients (e.g., sorry, protective etc.), I could keep my feelings from influencing how I responded to my clients.	.29	.00
31. When I was distracted from something outside of sessions (e.g., anxiety for supervision, anger from news etc.), I was able to stay focused on understanding my clients.	.17	.02
44. I paid attention to adjust my non-verbal expressions (e.g., tone of voice, body language) with clients' mood.	.19	.01
46. I used descriptions and language that I knew would resonate with my clients.	.16	.03

Next, I examined the communality of each item to ensure the extracted factors could explain the shared variance in the remained items. Pett et al. (2003) suggested that researchers should retain items with communality values between .40 and 1.0. Thus, I further removed item 14, 27, and 45, with communality values of .39, .36, .32, respectively.

Evaluating Factor Structure

First, I performed principal axis factoring (PAF) as the extraction method and used eigenvalues (as shown in Table 4) and the Scree plot (as shown in Figure 2) to determine the number of factors to retain. Specifically, Kaiser Greater-Than-One Rule Criterion provided the guide to retaining only factors with eigenvalues greater than one (Watson, 2017). There were 33 extracted factors, while only eight of them had eigenvalues above one. I then inspected the point of decline in the scree plot for further information about factor retention. The scree plot in Figure 2 showed approximately 5 to 6 factors to extract for the maximum explanation.

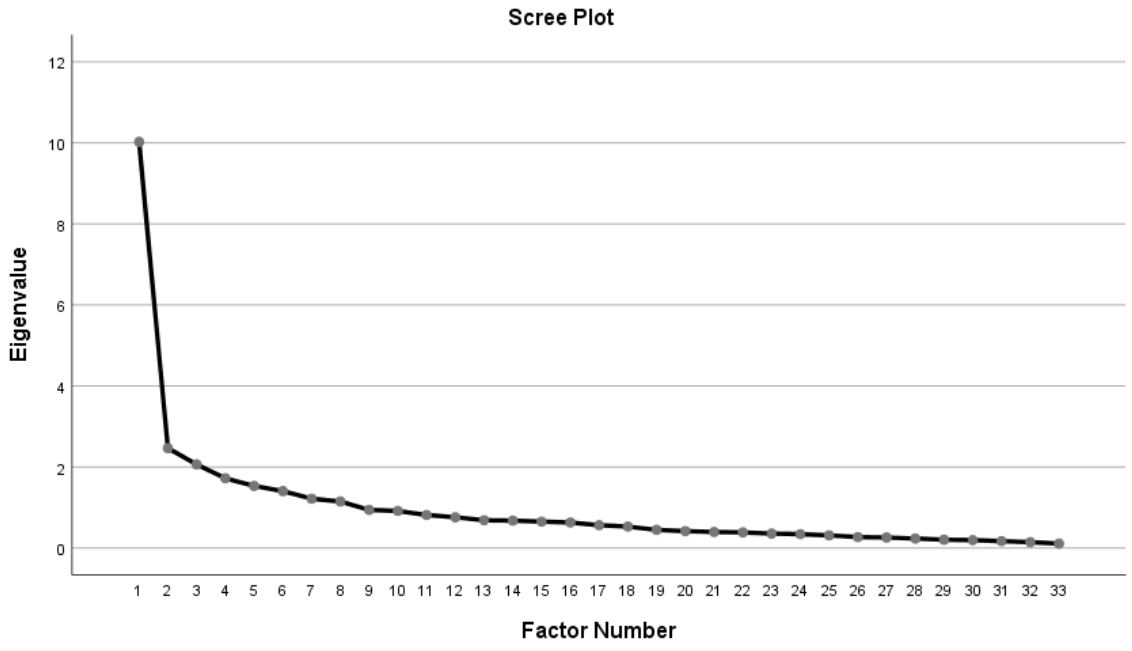
Table 4

Factor Eigenvalues and Variance Explained

Factor	Eigenvalues	% of Variance	Cumulative %
1	10.02	30.37	30.37
2	2.47	7.47	37.84
3	2.06	6.25	44.09
4	1.72	5.21	49.30
5	1.53	4.64	53.94
6	1.40	4.26	58.20
7	1.22	3.69	61.89
8	1.15	3.48	65.37

Figure 2

Scree Plot



Next, I rotated the factor structure because the original structure would be hard to interpret after the initial calculation (Johnson & Morgan, 2016). I chose the oblique promax rotation method because this method was suitable for the assumption that the factors were correlated (Watson, 2017). According to Yong and Pearce (2013), a smaller sample size requires

larger factor loadings to prove significant relationships between items and factors. Thus, although researchers generally used .40 as the cut-off (Tabachnick & Fiddell, 2013), I eliminated seven items with factor loadings below .60. After interpreting the rotating factor structure, I decided to retain the first five factors because the other factors included less than three items. Item 35 had cross-loadings between factor 1 and factor 2. However, the loading differences were above .10, so I determined it should fit under factor 2, where it had a higher factor loading. As shown in Table 5, a total of 20 items were in the final scale, with six items in factor 1, four items in factor 2 and factor 3, and three items in factor 4 and factor 5. Collectively, the five factors could explain 53.94% of all the variable variances.

Interpreting Factor Structure

I initially proposed the PIE model to have three factors: personal understanding, emotional awareness, and interpersonal empathy. Although the final factor structure seemed to differ from the initial model, the grouped items still aligned with the initial concepts. Specifically, items in factor 1 and factor 4 were derived from items generated for emotional awareness. Similarly, items in factor 2 and factor 5 were from ones originally generated for interpersonal empathy. Factor 3, on the other hand, consisted of items for personal understanding. Specifically, these items represented counselors using knowledge and cognitive complexity in conceptualizing clients. In other words, the results of the EFA refined the proposed PIE model and separated two additional factors from the original three factors. For instance, when discussing emotional awareness, I reviewed the concept as both an individual's ability to be aware of their own emotions and differentiate various dimensions and intensity of emotions. Thus, it was clear that factor 4 represented emotional awareness, whereas factor 1 would depict another component named emotional complexity. When I reviewed the construct of interpersonal

empathy, I hypothesized that counselors' intentions of their responses were as crucial as their attempts of responding to their clients. Hence, it was apparent that factor 2 characterized the central idea of interpersonal empathy about counselors responding to clients with reflections, while factor 5 identified the counselors' exploratory stance. There is a more sophisticated discussion in the next chapter. In summary, the final PIES was a 20-item instrument with five subscales: emotional complexity, reflections, conceptualizations, emotional awareness, and exploratory stance.

Table 5

Factor Analysis Results of the Process of Interpersonal Empathy Scale (PIES)

PIES item	Factor loading
Factor 1: Emotional Complexity	
21. I knew various ways to address different types and intensity of feelings of my clients.	.80
20. I knew the terms to address different types and intensity of feelings of my clients.	.78
23. I was able to distinguish the intensity of my clients' emotional expressions.	.70
22. Other than surface feelings (e.g., sad, angry, happy), I could identify my clients' deeper feelings (e.g., regret, betrayal, relief).	.70
24. I could sense multiple emotions when my clients expressed themselves.	.64
32. I tried different ways (e.g., analogy, metaphor) to express my understanding to my clients.	.62
Factor 2: Reflections	
36. When appropriate, I tried to reflect the emotions that my clients were unable to express fully.	.84
35. When appropriate, I tried to reflect deeper feelings to my clients.	.80
37. When appropriate, I tried to reflect the thought processes my clients might have.	.72
38. I tried to reflect the intensity of my clients' emotions accurately.	.63
Factor 3: Conceptualization	
4. I utilized formal resources (e.g., published studies, textbooks, workshops etc.) to understand my clients' demographic characteristics (e.g., race, immigration status, affectional orientation, socioeconomic status etc.).	.86
5. I utilized formal resources (e.g., published studies, textbooks, workshops etc.) to understand my clients' presenting issues (e.g., depression, blended family dynamics, social media addiction etc.).	.65
8. I tried to explore various factors contributing to my clients' presenting issues.	.62

9. I tried to explore various characteristics about my clients.	.61
Factor 4: Emotional Awareness	
18. I drew cues from my body to understand what emotions I felt during sessions.	.83
19. I was aware of my emotions in sessions.	.73
26. I could tell when my emotions were influenced by my clients expressed emotions.	.68
Factor 5: Exploratory Stance	
43. When I responded to my clients, I demonstrated my desire to understand more about their experiences.	.75
42. I asked questions to show my clients that I was curious about their experiences.	.75
41. When I reflected my clients' experiences, my intention was to check whether my understanding of their experiences matched their perceptions.	.70

Note. $N = 148$. The extraction method was principal axis factoring with the oblique promax rotation. All items had factor loadings above .60.

Internal Consistency Reliability

As shown in Table 6, the internal consistency of the resulting 20-item Process of Interpersonal Empathy Scale was $\alpha = .89$. Each subscale also showed substantial internal consistency: Emotional Complexity ($\alpha = .85$), Reflections ($\alpha = .84$), Conceptualization ($\alpha = .76$), Emotional Awareness ($\alpha = .79$), and Exploratory Stance ($\alpha = .77$). The interpretation for alpha was adequate consistency (> .70), good consistency (> .80), very good consistency (> .90; DeVellis, 2017). Overall, the PIES exhibited good reliability.

Table 6

Reliability of the Process of Interpersonal Empathy Scale (PIES)

Scale	Number of items	Cronbach's Alpha
Total	20	.89
Subscale		
Factor 1: Emotional Complexity	6	.85
Factor 2: Reflections	4	.84
Factor 3: Conceptualization	4	.76
Factor 4: Emotional Awareness	3	.79
Factor 5: Exploratory Stance	3	.77

Convergent Validity

To examine the extent of correlation between scores on the PIES and scores on another instrument measuring a similar construct, I conducted a bivariate correlation analysis between scores on the PIES and the BLRI-MO. The results indicated a statistically significant relationship between the scores of the PIES and the BLRI-MO, $r = .54$, $p < .001$. According to the conventional benchmarks provided by Swank and Mullen (2017), the effect size of this relationship was large ($r > .40$).

Summary

The factor analytic techniques suggest the Process of Interpersonal Empathy Scale (PIES) as a 20-item scale that displays promising psychometric properties. First, the results of an exploratory factor analysis indicated a five-factor structure could best explain the empathy process in counseling. Second, the PIES established good internal consistency with coefficient alphas ranged from .76 to .89 across the five second-order factors. Additionally, the inclusion of expert reviewers' feedback strengthened the content validity of the PIES. Lastly, the significant correlational relationship between the PIES and a scale measuring similar construct established convergent validity.

CHAPTER V: DISCUSSION AND CONCLUSION

In this final chapter, I review the study results and discuss their potential meanings. Then I provide the implications drawn from the findings for counselor educators and supervisors. Further, I describe the limitations of this study and make recommendations for future researchers. Lastly, I conclude the chapter by providing an overview of the study.

Discussion

This study aims to develop a scale measuring counselors' empathy competence based on a theoretical model of empathy development. The scale is developed following best practice principles, with the resulting items administered to a nationwide sample of CITs and counselors. The results of an exploratory factor analysis indicate that a five-factor structure may best explain the empathy process in counseling, accounting for 53.94% of explained variance. The five factors include Conceptualization, Emotional Awareness, Emotional Complexity, Reflections, and Exploratory Stance. To further interpret the results, I inspect the item removal process to discuss item representativeness. I also elaborate on the factor structure and explain its potential meanings and contributions to future research and clinical applications.

Item Representativeness

The administered item pool contained 46 items. After I removed 26 items based on the results of data analyses, there were 20 items in the finalized PIES. First, I eliminated ten items due to their significant correlations with social desirability. I did not notice any themes as these items were spread across multiple factors and the phrasing of each item was diverse. I then dropped 16 items because of their overall low correlations (< .60; Costello & Osborne, 2005) with the rest of the scale. Although the remaining items represented the construct best, the removed items could still potentially be relevant to the construct of empathy. Thus, I reviewed

the item retention process to examine the overall item representativeness. This review was based on the hypothesized constructs, including the cognitive aspect, the emotional aspect, and the interpersonal aspect.

First, to better capture counselors' attempts of utilizing knowledge in understanding their clients, one expert reviewer suggested to include items describing counselors' use of informal resources. Instead of loading on the hypothesized factor for conceptualization, the two items load as a separate factor by themselves. I decide to rule out this factor because a factor with only two items is unstable (Costello & Osborne, 2005). Since these items form their own factor, I need to include additional items to further test the factor in the future. Additionally, I hypothesized perspective-taking would be grouped into personal understanding because counseling researchers consistently defined perspective-taking as a counselor's cognitive empathy (Bohecker & Doughty Horn, 2016; DePue & Lambie, 2014; Fulton & Cashwell, 2015; Leppma & Young, 2016). Nonetheless, the items written based on the construct of perspective-taking are removed entirely. Although the results seem to contradict counseling researchers, there are potential explanations existing in the literature. First, cognitive empathy is not limited to perspective-taking (Cuff et al., 2016). Additionally, in Clark's (2010a) definition of empathy, objective empathy refers to a counselor using knowledge outside of a client's frame of reference to conceptualize the client theoretically. Thus, the ability of perspective-taking in counseling may not mean thinking from the clients' perspectives. Rather, it is related to gathering objective information. This explanation would fit into the updated factor structure because the items loaded on the Conceptualization subscale describe a counselor's efforts in utilizing formal resources and gathering information in understanding their clients.

Next, items written based on the construct of emotion regulation are completely removed. The removal of these items may have been phrasing-related as some of these items are removed because of their relationship to social desirability. On the other hand, I hypothesize emotion regulation would be grouped into emotional awareness because Rogers (1957; 1975) emphasized the self-other distinction component of empathy. If a counselor is not aware of the "as if" quality of empathy, they may experience compassion fatigue or burnout (Prikhidko & Swank, 2018). Additionally, Countinho et al. (2014) described emotion regulation as part of an individual's automatic empathy process because it prevented them from being affected by others' emotions. The potential explanation for the result could be that emotion regulation does not influence counselors' attempts to understand their clients, even though it is important to counselors' self-care and wellness. In other words, a counselor without the awareness of self-other distinction is competent in understanding their clients; however, the lack of emotion regulation may compromise counselors' wellness and make them more vulnerable to experience compassion fatigue and burnout.

Lastly, items about resonating with clients are removed. These items include counselors ensuring their responses resonate with clients and nonverbally attuning to clients' expressions. I hypothesized these items belonging to interpersonal empathy because Rogers (1986) emphasized the purpose of counselors' reflections was to clarify whether their understanding resonated with their clients' experiences. Decker et al. (2014) also proposed that nonverbal communication like attunement could be a part of interpersonal empathy. The results may indicate that counselors showing their intentions to explore with their clients is more important than nonverbally attuned to clients' expressions. On the other hand, the two items written for checking the accuracy are loaded on factor 7, I decide to rule out this factor because a factor with only two items are

unstable (Costello & Osborne, 2005). Since these items turn out to form their own factor, I will need to add more items to further test the factor in the future.

Factor Structure

The results of this study reveal that a five factor model can adequately depict the empathy process in counseling. Initially, there were three factors in the hypothesized PIE model: personal understanding, emotional awareness, and interpersonal empathy. Although the final factor structure seems to differ from the initial model, the grouped items still align with the initial constructs (see Table 7).

Table 7

Factor Structure Comparison

Hypothesized Factors	Resulting Factors
Personal Understanding	Conceptualization
Emotional Awareness	Emotional Complexity
	Emotional Awareness
Interpersonal Empathy	Reflections
	Exploratory Stance

Emotional complexity and emotional awareness are the premises of how a counselor experiences empathy as an emotion. Additionally, interpersonal empathy denotes a counselor's responses about their understanding of their clients and their exploratory stance. Thus, the results of the EFA refine the factor structure of the proposed PIE model. Moreover, the five-factor model explains 53.94% of the total variance of the data. In other words, participants' scores on the PIES can represent more than half of their empathy competence. This finding aligns with the assumptions of the PIE model which suggest that only certain ingredients can represent CITs' empathy competence. Other ingredients such as personality traits and situations may introduce variance in the measurement (Cuff et al., 2016; Ho, 2021). The results reveal significant

correlational relationships among all factors, but how these ingredients interact in the process is unknown.

Conceptualization refers to a counselor's attempt to gather information to understand their clients. Its items include "I utilized formal resources (e.g., published studies, textbooks, workshops etc.) to understand my clients' demographic characteristics (e.g., race, immigration status, affectional orientation, socioeconomic status etc.)," "I utilized formal resources (e.g., published studies, textbooks, workshops etc.) to understand my clients' presenting issues (e.g., depression, blended family dynamics, social media addiction etc.)," "I tried to explore various factors contributing to my clients' presenting issues," and "I tried to explore various characteristics about my clients." This factor aligns with Clark's (2010a) conceptualization of objective empathy, which refers to a counselor using knowledge outside of a client's frame of reference to conceptualize the client theoretically. Essentially, counselors gather multiple sources of information about clients' presenting concerns as well as their demographic characteristics.

Emotional complexity refers to a counselor's attempt to identify and distinguish their clients' range and intensity of emotions. Its items include "I knew various ways to address different types and intensity of feelings of my clients," "I knew the terms to address different types and intensity of feelings of my clients," "I was able to distinguish the intensity of my clients' emotional expressions," "Other than surface feelings (e.g., sad, angry, happy), I could identify my clients' deeper feelings (e.g., regret, betrayal, relief)," "I could sense multiple emotions when my clients expressed themselves," and "I tried different ways (e.g., analogy, metaphor) to express my understanding to my clients." This factor aligns with Tangen's (2017) definition of emotional complexity, which involves counselors' understanding of a wide range and intensity of emotions. On the other hand, the last item was initially written to describe

counselors' using various ways to express themselves in interpersonal empathy. Instead, it is loaded on emotional complexity. There is a possible explanation since Tangen (2017) also describes emotional complexity as an individual's ability to articulate emotions in depth. Overall, emotional complexity refers to a counselor's ability to identify, differentiate, and illuminate clients' emotions.

Emotional awareness refers to a counselor's intentional attention to their own emotions during a counseling session. Its items include "I drew cues from my body to understand what emotions I felt during sessions," "I was aware of my emotions in sessions," and "I could tell when my emotions were influenced by my clients expressed emotions." This factor aligns with Clark's (2010a) conceptualization of subjective empathy, which refers to a counselor's awareness of their internal reactions to their client's experience.

Reflections refers to a counselor's attempt of phrasing their understanding of their clients into verbal responses. Its items include "When appropriate, I tried to reflect the emotions that my clients were unable to express fully," "When appropriate, I tried to reflect deeper feelings to my clients," "When appropriate, I tried to reflect the thought processes my clients might have," and "I tried to reflect the intensity of my clients' emotions accurately." This factor aligns with Clark's (2010a) conceptualization of objective empathy, which refers to a counselor conveying their understanding of the client's experience to them. It also validates Rogers' (1986) clarification that these expressions should be more than focusing on feelings. In other words, counselors' reflections include the unexpressed emotions and thought processes.

Exploratory stance refers to a counselor's showing their intentions to understand their clients. Its items include "When I responded to my clients, I demonstrated my desire to understand more about their experiences," "I asked questions to show my clients that I was

curious about their experiences," and "When I reflected my clients' experiences, my intention was to check whether my understanding of their experiences matched their perceptions." This factor reflects the central idea of Rogers' (1957; 1975; 1980; 1986) definition of empathy. He believed that the exploratory stance facilitated the therapeutic outcomes, because it conveyed the non-judgmental attitude and a sense of unconditional positive regard that encouraged clients' sharing of personal stories and experiences. In sum, the five-model captures counselors' multidimensional empathy competences. Each factor depicts the essence of empathy competence necessary for facilitating positive counseling outcomes in a counselor-client relationship.

Implications for Counselor Education and Supervision

Empathy is a widely studied construct; however, Cuff et al. (2016) put cautions in duplicating the definition of empathy across disciplines. Specifically, professionals from different disciplines hold various assumptions about empathy (e.g., why it is beneficial for the profession, how a professional demonstrates empathy in a specific discipline). Thus, the PIE and the PIES are my initial attempts to distinguish the construct of empathy in counseling profession. Although other professions (e.g., psychology, social work, nursing, medical fields) may find the PIE and the PIES useful in conceptualizing their definitions of empathy, I discuss the implications of this study with a focus on counselor education and supervision.

Counselor educators and supervisors may implement the results of this study in their teaching and supervision. The data in this study provides an empirical foundation for the theoretical structure of the PIE and introduces a more sophisticated conceptualization of empathy. Additionally, the PIES instrument introduces a refined way to address empathy learning and its evaluation.

Counselor educators and supervisors may use the PIES to evaluate CITs' empathy competence and utilize the evaluations to restructure curricula or training protocols. For example, counselor educators and supervisors can administer the PIES at the beginning and the end of a semester to assist CITs in reviewing their empathy learning experience. Further, they may evaluate a training protocol's effectiveness in promoting CITs' empathy competence by comparing the difference between pre-intervention scores and post-intervention scores. Although the results of this study could be promising, counselor educators and supervisors should use the PIES with cautions. Given the PIES is still in the initial development stage, there is a need for more studies to establish consistent results of the PIES. Thus, there is no sufficient evidence for using the PIES as a formal evaluation tool or in gatekeeping procedures. Counselor educators may use the PIES to estimate the effectiveness of a teaching intervention. Supervisors may use items of the PIES to facilitate conversations with their supervisees. Overall, counselor educators and supervisors should only use the PIES to support CITs' empathy learning experience and not in support of high-stakes decision-making.

The updated PIE model may inform counselor educators how they will teach the construct of empathy. For instance, counselor educators may use the PIE model and its factors to explain the empathy process in counseling sessions. They may also introduce the meanings of each factor and illustrate why they are important to counselors' empathy competence. Further, counselor educators may use the PIES factor structure to construct their course content. For instance, counselor educators should establish the importance of counselors utilizing formal resources in understanding their clients as conceptualization is a crucial factor in understanding clients. Since emotional complexity and emotional awareness are significant factors of counselors' empathy competence, counselor educators may structure their curricula with

activities that will promote CITs' emotional complexity and emotional awareness. Moreover, when introducing the concept of counselor empathy, counselor educators should reiterate the importance of counselors' exploratory stance in building counseling relationships in addition to the counselors' verbal responses of reflections. In summary, the findings of this study provide counselor educators and supervisors a theoretical framework to structure their training curricula as well as a scale for informal evaluations of CITs' empathy learning experience.

Limitations

As this study is voluntary, it is more likely that participants are predisposed to be more empathic. Additionally, using online communities to recruit participants could prevent the access to this study from counselors who are not part of these listservs, or do not utilize online communication. Prior to data collection, I suspected that online survey could result in a pattern of missing responses, because administering the survey online limited my ability to answer participants' questions about items. During the data cleaning process, I identified six missing values out of 6,854 possible values (0.09%) and determined the data was missing at random (MAR). Thus, there is no problematic patterns of missing data, and the percentage of missing values is minimal.

While the sample appears to be homogenous, based on the most recently disclosed CITs' demographics in the CACREP Vital Statistics Report (CACREP, 2015b), the demographics of the sample in this study mirrors the demographics of the counseling trainees. Specifically, 82.52% of the CITs identify as female, similar to 84.46 % of the sample in this study. There are 61.12% of CITs identifying as White, similar to 57.43% of the sample in this study. Thus, I conclude that the homogeneity of the sample is comparable to the population.

On the other hand, the main limitation for this study is its small sample size of participants. Based on literature review, I expected to recruit no less than 200 participants. However, the final usable dataset contains 148 cases. Generally, survey response rates in counseling and counseling psychology are low (14%; Van Horn et al., 2009). Using public email lists to access licensed professional counselors, Bloom et al. (2015) concluded a usable response rate of 7% was a closer approximation. I used a nonprobability sampling approach to reach as many potential participants as possible. Specifically, I posted the research information on four online counseling communities. The available data showed that CESNET listserv had 5686 recipients and ACA Connect community had 396 members. Additionally, I contacted 247 CACREP-accredited program directors and 16 counseling training clinic directors. When calculating with available data, the response rate is already lower than 2%. Lack of incentives may influence the low response rate. Moreover, as COVID-19 spread impact workforce and universities to transition into work-from-home, individuals are more likely to experience digital fatigue, and thus less inclined to fill out an online survey.

Exploratory factor analysis generally requires a large sample size because it stabilizes the variance in the data (DeVellis, 2017; Field, 2018). Otherwise, a smaller sample size requires larger factor loadings to prove significant relationships between items and factors (Yong & Pearce, 2013). For instance, five or more items with factor loadings above .50 indicate a solid factor (Costello & Osborne, 2005). A smaller sample size ($n > 150$) can be sufficient when there are several high factor loading scores (> .80) in the dataset (Guadagnoli & Velicer, 1988). In the finalized factor structure, each item has the factor loading above .60. Additionally, 25% of the items has factor loadings above .80. Altogether, the strong data may justify the accuracy of the analysis results of this study. However, the small sample size possesses threats in generalizing

the study results. Thus, although the results are satisfactory, there is a need for more validation studies. With increased sample size and replication studies, researchers then can ensure that the results are consistent.

Recommendations for Future Research

Overall, there is a need for more data to validate the results of this study. For instance, I plan to conduct more validation studies to examine whether the results of the exploratory factor analysis could be replicated with a larger sample size. Researchers can conduct confirmatory factor analysis to confirm whether the five-factor structure is consistent with counselors. Moreover, the phase II research design in this study merits independent research. Future researchers should consider conducting research based on the phase II research design to examine whether counselors' scores on the PIES can predict clients' scores on the BLRI. As described previously, this regression study will validate the client aspect of the PIE model and evaluate the concurrent validity of the PIES. Thus, it may further confirm that the counselors' empathy competence, proposed by the PIE, can predict their clients' perceptions of the counselors' empathy.

The results of this study reveal significant and positive correlational relationships among all factors, but whether they influence each other is unknown. As empathy is an automatic process (Countinho et al., 2014; Cuff et al., 2016; Elliott et al., 2018), the PIE model's theoretical assumption describes that its factors interact in a sequential process, from cognitive aspect, to emotional aspect, and to interpersonal aspect. To further examine this assumption, future researchers may also investigate whether there is mediating or moderating relationships among factors. For example, will counselors' emotional awareness mediate the relationship between

their conceptualization and reflections? Will counselors' exploratory stance moderate the relationship between emotional complexity and reflections?

When it comes to item representativeness, almost a quarter of items in the initial item pool are eliminated due to significant correlations with social desirability. It is possible that the removed items represent critical construct of empathy. However, as the purpose to develop the PIES is to evaluate counselors' empathy competence, items triggering social desirability could comprise the scale's construct validity. Thus, future researchers can test those items with rephrased descriptions. As social desirability is prevalent in self-report measures, I recommend researchers including the social desirability scale (Strahan & Gerbasi, 1972) when examining items. Additionally, future researchers may consider adding cognitive interviewing as part of the item development process. As cognitive interviewing allows researchers to access respondents' response processes (Peterson et al., 2017), it may help identify potential sources that trigger social desirability, and thus helping inform the revision decisions.

Lastly, although the PIES is an initially developed instrument, its factor structure may provide insights for researchers in interpreting their studies. Thus, when studying empathy related constructs or examining training effectiveness on CITs' empathy, researchers may consider including the PIES in a set of measurements as their instrumentation. In summary, future researchers may consider studies to further validate the psychometric properties or reexamine the item representativeness of the PIES.

Conclusion

Empathy is a consistent predictor of positive counseling outcomes. As counselor educators attempt to teach and evaluate CITs' empathy competence, various conceptualizations and measurements have emerged. Thus, the purpose of this study is to validate a proposed

theoretical model and develop a new measure based on the emerging model. The resulting Process of Interpersonal Empathy Scale (PIES) is a 20-item scale with promising psychometric properties. The PIES contains five subscales: Conceptualization, Emotional Complexity, Emotional Awareness, Reflections, and Exploratory Stance. Additionally, these factors are positively correlated with each other. Due to the small sample size used to develop the PIES, the need of additional validation studies remains to establish consistent results. On the other hand, the collected data is strong to establish stable results. Overall, the current PIES shows promises for use in research and counselor education.

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LIST OF APPENDICES

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Appendix A. CACREP Coordinator Email Script

Dear Dr. _____,

I hope this email finds you well.

I am a doctoral candidate working on my dissertation at Texas A&M University-Corpus Christi under the supervision of Dr. Joshua Watson. My dissertation project aims to develop a scale capturing the multidimensional and interactive nature of the process of interpersonal empathy in the counseling context. By measuring empathy competence of counselors-in-training (CITs), this scale is designed to assist counselor educators and supervisors in responding to CITs' empathy learning needs.

Therefore, I hope you will forward this study opportunity to master's-level CITs or doctoral counselor education students who are in their Practicum or Internship. Please see below for the detailed research information.

Sincerely,

Appendix B. Listserv Script

Dear counselor educators and colleagues,

My name is Chia-Min (Jamie) Ho, and I am a doctoral candidate at Texas A&M University-Corpus Christi. To fulfill my degree requirements, I am conducting my dissertation study under Dr. Joshua Watson's supervision. This study is approved by Texas A&M University-Corpus Christi Institutional Review Board (IRB ID: TAMU-CC-IRB-2020-12-128).

The purpose of this research study is to develop a theory-driven instrument, the Process of Interpersonal Empathy Scale (PIES), and evaluate the evidence supporting the measure. By measuring counselors' empathy competence, this scale is designed to assist counselor educators and supervisors in responding to the empathy learning needs of counselors-in-training (CIT). Therefore, I hope you will participate in this study and/or forward it to eligible students. Please see below for the detailed research information.

Appendix C. Client Recruitment Script

There are researchers currently looking for participants. This study aims to develop a survey to measure how well your counselor is able to show you empathy. As counselor empathy is related to positive counseling outcomes, the responses you provide in this study will be used to study how counselor's ability to show empathy predicts your experience in counseling. Since you are receiving counseling services at our clinic, you are qualified to participate once you have completed two sessions with your counselor.

I (or your counselor) will not be able to access any information you provide. Participation in this study is completely voluntary; however, your participation may help establish a survey used to evaluate counselors' ability to show empathy. Ultimately, this study may help training counselors and thus increasing the quality of counseling services you and others receive.

If you have any questions about this study, you can email Dr. Joshua Watson at joshua.watson@tamucc.edu or Jamie Ho at cho3@islander.tamucc.edu.

If you are interested, we will email you the information about this study. Are you interested in receiving more information about this study?