A Comparison of Empathy and Sympathy Between Counselors-in-Training and Their Non-Counseling Academic Peers

The Professional Counselor
Volume 8, Issue 4, Pages 341–354
http://tpcjournal.nbcc.org

doi:10.15241/zdb.8.4.341

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Empathy plays an integral role in the facilitation of therapeutic relationships and promotion of positive client outcomes. Researchers and scholars agree that some components of empathy might be dispositional in nature and that empathy can be developed through empathy training. However, although empathy is an essential part of the counseling process, literature reviewing the development of counseling students' empathy is limited. Thus, we examined empathy and sympathy scores in counselors-in-training (CITs) in comparison to students from other academic disciplines (N = 868) to determine if CITs possess greater levels of empathy than their non-counseling academic peers. We conducted a MANOVA and failed to identify differences in levels of empathy or sympathy across participants regardless of academic discipline, potentially indicating that counselor education programs might be missing opportunities to further develop empathy in their CITs. We call for counselor education training programs to promote empathy development in their CITs.

Keywords: **empathy, sympathy, counselor education, counselors-in-training, therapeutic relationships**

Empathy is considered an essential component of the human experience as it relates to how individuals socially and emotionally connect to one another (Goleman, 1995; Szalavitz & Perry, 2010). Although empathy can be difficult to define (Konrath, O'Brien, & Hsing, 2011; Spreng, McKinnon, Mar, & Levine, 2009), within the counseling profession there is agreement that empathy includes both cognitive and affective components (Clark, 2004; Davis, 1980, 1983). When discussing the difference between affective and cognitive empathy, Vossen, Piotrowski, and Valkenburg (2015) described that "whereas the affective component pertains to the experience of another person's emotional state, the cognitive component refers to the comprehension of another person's emotions" (p. 66). Regardless of specific nuances among researchers' definitions of empathy, most appear to agree that "empathy-related responding is believed to influence whether or not, as well as whom, individuals help or hurt" (Eisenberg, Eggum, & Di Giunta, 2010, p. 144). Furthermore, empathy can be viewed as a motivating factor of altruistic behavior (Batson & Shaw, 1991) and is essential to clients' experiences of care (Flasch et al., in press). As such, empathy is foundational to interpersonal relationships (Siegel, 2010; Szalavitz & Perry, 2010), including the relationships facilitated in a counseling setting (Norcross, 2011; Rogers, 1957).

Rogers (1957) intuitively understood the necessity of empathy in a counseling relationship, which has been verified by the understanding of the physiology of the brain (Badenoch, 2008; Decety & Ickes, 2009; Siegel, 2010) and validated in the counseling literature (Elliott, Bohart, Watson, & Greenberg, 2011). In a clinical context, empathy can be described as both a personal characteristic and a clinical skill (Clark, 2010; Elliott et al., 2011; Rogers, 1957) that contributes to positive client outcomes (Norcross, 2011; Watson, Steckley, & McMullen, 2014). For example, empathy has been identified as a factor that leads to

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changes in clients' attachment styles, treatment of self (Watson et al., 2014), and self-esteem development (McWhirter, Besett-Alesch, Horibata, & Gat, 2002). Moreover, researchers regularly identify empathy as a fundamental component of helpful responses to clients' experiences (Beder, 2004; Flasch et al., in press; Kirchberg, Neimeyer, & James, 1998).

Although empathy is lauded and encouraged in the counseling profession, empathy development is not necessarily an explicit focus or even a mandated component of clinical training programs. The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) identifies diverse training standards for content knowledge and practice among master's-level and doctoral-level counselors-in-training (CITs), but does not mention the word *empathy* in its manual for counseling programs. One of the reasons for this could be that empathy is often understood and taught as a microskill (e.g., reflection of feeling and meaning) rather than as its own construct (Bayne & Jangha, 2016). Yet empathy is more than a component of a skillset, and CITs might benefit from a programmatic development of empathy to enhance their work with future clients (DePue & Lambie, 2014).

The application of empathy, or a counselor's use of empathy-based responses in a therapeutic relationship, requires skill and practice (Barrett-Lennard, 1986; Truax & Carkhuff, 1967). Clark (2010) cautioned, for example, that counselors' empathic responses need to be congruent with the client's experience, and that the misapplication of sympathetic responses as empathic responses can interfere in the counseling relationship. In regard to sympathy, Eisenberg and colleagues (2010) explained, "sympathy, like empathy, involves an understanding of another's emotion and includes an emotional response, but it consists of feelings of sorrow or concern for the distressed or needy other rather than merely feeling the same emotion" (p. 145). Thus, researchers call for counselor educators to do more than increase CITs' affective or cognitive understanding of another's experience, and to assist them in differentiating between empathic responses and sympathetic responses in order to better convey empathic understanding and relating (Bloom & Lambie, in press; Clark, 2010).

With the understanding that a counselor's misuse of sympathetic responses might interrupt a therapeutic dialogue and that empathy is vital to the therapeutic alliance, researchers call for counselor educators to promote empathy development in CITs (Bloom & Lambie, in press; DePue & Lambie, 2014). Although there is evidence that some aspects of empathy are dispositional in nature (Badenoch, 2008; Konrath et al., 2011), which might make the counseling profession a strong fit for empathic individuals, empathy training in counseling programs can increase students' levels of empathy (Ivey, 1971). However, the specific empathy-promoting components of empathy training are less understood (Teding van Berkhout & Malouff, 2016). Overall, empathy is an essential component of the counseling relationship, counselor competency, and the promotion of client outcomes (DePue & Lambie, 2014; Norcross, 2011). However, little is known about the training aspect of empathy and whether or not counselor training programs are effective in enhancing empathy or reducing sympathy among CITs. Thus, the following question guided this research investigation: Are CITs' levels of empathy or sympathy different from their academic peers? Specifically, do CITs possess greater levels of empathy or sympathy than students from other academic majors?

Empathy in Counseling

Researchers have established continuous support for the importance of the therapeutic relationship in the facilitation of positive client outcomes (Lambert & Bergin, 1994; Norcross, 2011; Norcross & Lambert, 2011). In fact, the therapeutic relationship is predictive of positive client outcomes (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Krupnick et al., 1996),

accounting for about 30% of the variance (Lambert & Barley, 2001). That is, clients who perceive the counseling relationship to be meaningful will have more positive treatment outcomes (Bell, Hagedorn, & Robinson, 2016; Norcross & Lambert, 2011). One of the key factors in the establishment of a strong therapeutic relationship is a counselor's ability to experience and communicate empathy. Researchers estimate that empathy alone may account for as much as 7–10% of overall treatment outcomes (Bohart, Elliott, Greenberg, & Watson, 2002; Sachse & Elliott, 2002), making it an important construct to foster in counselors.

Despite the importance of empathy in the counseling process, much of the literature on empathy training in counseling is outdated. Thus, little is known about the training aspect of empathy; that is, how is empathy taught to and learned by counselors? Nevertheless, early scholars (Barrett-Lennard, 1986; Ivey, 1971; Ivey, Normington, Miller, Morrill, & Haase, 1968; Truax & Carkhuff, 1967) posited that counselor empathy is a clinical skill that may be practiced and learned, and there is supporting evidence that empathy training may be efficacious.

In one seminal study, Truax and Lister (1971) conducted a 40-hour empathy training program with 12 counselor participants and identified statistically significant increases in participants' levels of empathy. In their investigation, the researchers employed methods in which (a) the facilitator modeled empathy, warmth, and genuineness throughout the training program; (b) therapeutic groups were used to integrate empathy skills with personal values; and (c) researchers coded three of participants' 4-minute counseling clips using scales of accurate empathy and non-possessive warmth (Truax & Carkhuff, 1967). Despite identifying statistically significant changes in participants' scores of empathy, it is necessary to note that participants who initially demonstrated low levels of empathy remained lower than participants who initially scored high on the empathy measures. In a later study modeled after the Truax and Lister study, Silva (2001) utilized a combination of didactic, experiential, and practice components in her empathy training program, and found that counselor trainee participants ($N = 45$) improved their overall empathy scores on Truax's Accurate Empathy Scale (Truax & Carkhuff, 1967). These findings contribute to the idea that empathy increases as a result of empathy training.

More recent researchers (Lam, Kolomitro, & Alamparambil, 2011; Ridley, Kelly, & Mollen, 2011) have identified the most common methods in empathy training programs as experiential training, didactic (lecture), skills training, and other mixed methods such as role play and reflection. In their meta-analysis, Teding van Berkhout and Malouff (2016) examined the effect of empathy training programs across various populations (e.g., university students, health professionals, patients, other adults, teens, and children) using the training methods identified above. The researchers investigated the effect of cognitive, affective, and behavioral empathy training and found a statistically significant medium effect size overall (g ranged from 0.51 to 0.73). The effect size was larger in health professionals and university students compared to other groups such as teenagers and adult community members. Though empathy increased as a result of empathy training studies, the specific mechanisms that facilitated positive outcomes remain largely unknown.

Although research indicates that empathy training can be effective, specific empathy-fostering skills are still not fully understood. Programmatically, empathy is taught to counselors within basic counseling skills (Bayne & Jangha, 2016), specifically because empathy is believed to lie in the accurate reflection of feeling and meaning (Truax & Carkhuff, 1967). But scholars argue that there is more to empathy than the verbal communication of understanding (Davis, 1980; Vossen et al., 2015). For example, in a more recent study, DePue and Lambie (2014) reported that counselor trainees' scores on the Empathic Concern subscale of the Interpersonal Reactivity Index (IRI; Davis, 1980) increased as a result of engaging in

counseling practicum experience under live supervision in a university-based clinical counseling and research center. In their study, the researchers did not actively engage in empathy training. Rather, they measured counseling students' pre- and post-scores on an empathy measure as a result of students' engagement in supervised counseling work to foster general counseling skills. Implications of these findings mirror those described by Teding van Berkhout and Malouff (2016), namely that it is difficult to identify specific empathy-promoting mechanisms. In other words, it appears that empathy training, when employed, produces successful outcomes in CITs. However, counseling students' empathy also increases in the absence of specific empathy-promoting programs. This begs the question: Are counseling programs successfully training their counselors to be empathic, and is there a difference between CITs' empathy or sympathy levels compared to students in other academic majors? Thus, the purpose of the present study was to (a) examine differences in empathy (i.e., affective empathy and cognitive empathy) and sympathy levels among emerging adult college students, and (b) determine whether CITs had different levels of empathy and sympathy when compared to their academic peers.

Methods

Participants

We identified master's-level CITs as the population of interest in this investigation. We intended to compare CITs to other graduate and undergraduate college student populations. Thus, we utilized a convenience sample from a larger data set that included emerging adult college students between the ages of 18 and 29 who were enrolled in at least one undergraduate- or graduate-level course at nine colleges and universities throughout the United States. Participants were included regardless of demographic variables (e.g., gender, race, ethnicity).

Participants were recruited from three sources: online survey distribution (n = 448; 51.6%), face-to-face data collection (n = 361; 41.6%), and email solicitation (n = 34; 3.9%). In total, 10,157 potential participants had access to participate in the investigation by online survey distribution through the psychology department at a large Southeastern university; however, the automated system limited responses to 999 participants. We and our contacts (i.e., faculty at other institutions) distributed an additional 800 physical data collection packets to potential participants, and 105 additional potential participants were solicited by email. Overall, 1,713 data packets were completed, resulting in a sample of 1,598 participants after data cleaning. However, in order to conduct the analyses for this study, it was necessary to limit our sample to groups of approximately equal sizes (Hair, Black, Babin, & Anderson, 2010). Therefore, we were limited to the use of a subsample of 868 participants. Our sample appeared similar to other samples included in investigations exploring empathy with emerging adult college students (e.g., White, heterosexual, female; Konrath et al., 2011).

The participants included in this investigation were enrolled in one of six majors and programs of study, including Athletic Training/Health Sciences (n = 115; 13.2%); Biology/Biomedical Sciences/ Preclinical Health Sciences (n = 167; 19.2%); Communication (n = 163; 18.8%); Counseling (n = 153; 17.6%); Nursing (n = 128; 14.7%); and Psychology (n = 142; 16.4%). It is necessary to note that students self-identified their major rather than selecting it from a preexisting prompt. Therefore, the researchers examined responses and categorized similar responses to one uniform title. For example, responses of *psych* were included with *psychology*. Further, in order to attain homogeneity among group sizes, we included multiple tracks within one program. For example, *counseling* included participants enrolled in either clinical mental health counseling (n = 115), marriage and family counseling (n = 24), or school counseling (n = 14) tracks. Table 1 presents additional demographic information (e.g., age, race, ethnicity, graduate-level status). It is necessary to note that, because of the constraints of the dataset,

counseling students consisted of master's-level graduate students, whereas all other groups consisted of undergraduate students.

Table 1

Participants' Demographic Characteristics

Characteristic		*n*	Total %
Age	18–19	460	52.4
	20–21	155	17.9
	22–23	130	15.0
	24–25	58	6.7
	26–27	36	4.1
	28–29	27	3.1
Gender	Female	692	79.7
	Male	167	19.2
	Other	8	0.9
Racial Background	Caucasian	624	71.9
	African American/African/Black	101	11.6
	Biracial/Multiracial	65	7.5
	Asian/Asian American	40	4.6
	Native American	3	0.3
	Other	25	2.9
Ethnicity	Hispanic	172	19.8
	Non-Hispanic	689	79.4
Academic Enrollment	Undergraduate	709	81.7
	Graduate	152	17.5
	Other	5	0.6
Academic Major	Athletic Training/Health Sciences	115	13.2
	Biology/Biomedical Sciences/ Preclinical Health Sciences	167	19.2
	Counseling	153	17.6
	Communication	163	18.8
	Nursing	128	14.7
	Psychology	142	16.4

Note. $N = 868$.

Procedure

The data utilized in this study were collected as part of a larger study that was approved by the authors' institutional review board (IRB) as well as additional university IRBs where data was collected, as requested. We followed the Tailored Design Method (Dillman, Smyth, & Christian, 2009), a series of recommendations for conducting survey research to increase participant motivation and

decrease attrition, throughout the data collection process for both web-based survey and face-to-face administration. Participants received informed consent, assuring potential participants that their responses would be confidential and their anonymity would be protected. We also made the survey convenient and accessible to potential participants by making it available either in person or online, and by avoiding the use of technical language (Dillman et al., 2009).

We received approval from the authors of the Adolescent Measure of Empathy and Sympathy (AMES; Vossen et al., 2015; personal communication with H. G. M. Vossen, July 10, 2015) to use the instrument and converted the data collection packet (e.g., demographic questionnaire, AMES) into Qualtrics (2013) for survey distribution. We solicited feedback from 10 colleagues regarding the legibility and parsimony of the physical data collection packets and the accuracy of the survey links. We implemented all recommendations and changes (e.g., clarifying directions on the demographic questionnaire) prior to data collection.

All completed data collection packets were assigned a unique ID, and we entered the data into the IBM SPSS software package for Windows, Version 22. No identifying information was collected (e.g., participants' names). Having collected data both in person and online via web-based survey, we applied rigorous data collection procedures to increase response rates, reduce attrition, and to mitigate the potential influence of external confounding factors that might contribute to measurement error.

Data Instrumentation

Demographics profile. We included a general demographic questionnaire to facilitate a comprehensive understanding of the participants in our study. We included items related to various demographic variables (e.g., age, race, ethnicity). Regarding participants' identified academic program, participants were prompted to respond to an open-ended question asking "What is your major area of study?"

AMES. Multiple assessments exist to measure empathy (e.g., the IRI, Davis, 1980, 1983; The Basic Empathy Scale [BES], Jolliffe & Farrington, 2006), but each is limited by several shortcomings (Carré, Stefaniak, D'Ambrosio, Bensalah, & Besche-Richard, 2013). First, many scales measure empathy as a single construct without distinguishing cognitive empathy from affective empathy (Vossen et al., 2015). Moreover, the wording used in most scales is ambiguous, such as items from other assessments that use words like "swept up" or "touched by" (Vossen et al., 2015), and few scales differentiate empathy from sympathy. Therefore, Vossen and colleagues designed the AMES as an empathy assessment that addresses problems related to ambiguous wording and differentiates empathy from sympathy.

The AMES is a 12-item empathy assessment with three factors: (a) Cognitive Empathy, (b) Affective Empathy, and (c) Sympathy. Each factor consists of four items rated on a 5-point Likert scale with ratings of 1 (*never*), 2 (*almost never*), 3 (*sometimes*), 4 (*often*), and 5 (*always*). Higher AMES scores indicate greater levels of cognitive empathy (e.g., "I can tell when someone acts happy, when they actually are not"), affective empathy (e.g., "When my friend is sad, I become sad too"), and sympathy (e.g., "I feel concerned for other people who are sick"). The AMES was developed in two studies with Dutch adolescents (Vossen et al., 2015). The researchers identified a 3-factor model with acceptable to good internal consistency per factor: (a) Cognitive Empathy ($\alpha = 0.86$), (b) Affective Empathy ($\alpha = 0.75$), and (c) Sympathy ($\alpha = 0.76$). Further, Vossen et al. (2015) established evidence of strong test-retest reliability, construct validity, and discriminant validity when using the AMES to measure scores of empathy and sympathy with their samples. Despite being normed with samples of Dutch adolescents,

Vossen and colleagues suggested the AMES might be an effective measure of empathy and sympathy with alternate samples as well.

Bloom and Lambie (in press) examined the factor structure and internal consistency of the AMES with a sample of emerging adult college students in the United States (N = 1,598) and identified a 3-factor model fitted to nine items that demonstrated strong psychometric properties and accounted for over 60% of the variance explained (Hair et al., 2010). The modified 3-factor model included the same three factors as the original AMES. Therefore, we followed Bloom and Lambie's modifications for our use of the instrument.

Data Screening

Before running the main analysis on the variables of interest, we assessed the data for meeting the assumptions necessary to conduct a one-way between-subjects MANOVA. First, we conducted a series of tests to evaluate the presence of patterns in missing data and determined that data were missing completely at random (MCAR) and ignorable (e.g., < 5%; Kline, 2011). Because of the robust size of these data (e.g., > 20 observations per cell) and the minimal amount of missing data, we determined listwise deletion to be best practice to conduct a MANOVA and to maintain fidelity to the data (Hair et al., 2010; Osborne, 2013).

Next, we utilized histograms, Q-Q plots, and boxplots to assess for normality and identified non-normal data patterns. However, MANOVA is considered "robust" to violations of normality with a sample size of at least 20 in each cell (Tabachnick & Fidell, 2013). Thus, with our smallest cell size possessing a sample size of 115, we considered our data robust to this violation. Following this, we assumed our data violated the assumption for multivariate normality. However, Hair et al. (2010) stated "violations of this assumption have little impact with larger sample sizes" (p. 366) and cautioned that our data might have problems achieving a non-significant score for Box's M Test. Indeed, our data violated the assumption of homogeneity of variance-covariance matrices ($p < .01$). However, this was not a concern with these data because "a violation of this assumption has minimal impact if the groups are of approximately equal size (i.e., largest group size ÷ smallest group size < 1.5)" (Hair et al., 2010, p. 365).

It is necessary to note that MANOVA is sensitive to outlier values. To mitigate against the negative effects of extreme scores, we removed values (n = 3) with standardized z-scores greater than +4 or less than -4 (Hair et al., 2010). This resulted in a final sample size of 868 participants.

We also utilized scatterplots to detect the patterns of non-linear relationships between the dependent variables and failed to identify evidence of non-linearity. Therefore, we proceeded with the assumption that our data shared linear relationships. We also evaluated the data for multicollinearity. Participants' scores of Affective Empathy shared statistically significant and appropriate relationships with their scores of Cognitive Empathy (r = .24) and Sympathy (r = .43). Similarly, participants' scores of Cognitive Empathy were appropriately related to their scores of Sympathy (r = .36; $p < .01$). Overall, we determined these data to be appropriate to conduct a MANOVA. Table 2 presents participants' scores by academic discipline.

Table 2

AMES Scores by Academic Major

Scale	Mean (*M*)	*SD*	Range
Athletic Training			
Affective Empathy	3.20	0.80	4.00
Cognitive Empathy	3.80	0.62	3.33
Sympathy	4.34	0.55	2.67
Biomedical Sciences			
Affective Empathy	3.12	0.76	4.00
Cognitive Empathy	3.66	0.59	3.00
Sympathy	4.30	0.61	2.00
Communication			
Affective Empathy	3.18	0.87	4.00
Cognitive Empathy	3.80	0.62	2.67
Sympathy	4.27	0.69	3.00
Counseling			
Affective Empathy	3.32	0.60	3.33
Cognitive Empathy	3.83	0.48	4.00
Sympathy	4.32	0.54	2.00
Nursing			
Affective Empathy	3.37	0.71	3.67
Cognitive Empathy	3.80	0.59	2.67
Sympathy	4.46	0.49	2.00
Psychology			
Affective Empathy	3.28	0.78	4.00
Cognitive Empathy	3.86	0.59	2.67
Sympathy	4.35	0.65	2.67

Note. $N = 868$.

Results

Participants' scores on the AMES were used to measure participants' levels of empathy and sympathy. Descriptive statistics were used to compare empathy and sympathy levels between counseling students and emerging college students from other disciplines. CITs recorded the second highest levels of affective empathy ($M = 3.32$, $SD = .60$) and cognitive empathy ($M = 3.83$, $SD = 0.48$), and the fourth highest levels of sympathy ($M = 4.32$, $SD = 0.54$) when compared to students from other disciplines. Nursing students demonstrated the highest levels of affective empathy ($M = 3.37$, $SD = .71$) and sympathy ($M = 4.46$, $SD = .49$), and psychology students recorded the highest levels of cognitive empathy ($M = 3.86$, $SD = 0.59$) when compared to students from other disciplines. The internal consistency values for each empathy and sympathy subscale on the AMES were as follows: Cognitive Empathy ($\alpha = 0.86$), Affective Empathy ($\alpha = 0.75$), and Sympathy ($\alpha = 0.76$).

We performed a MANOVA to examine differences in empathy and sympathy in emerging adult college students by academic major, including counseling. Three dependent variables were included: affective empathy, cognitive empathy, and sympathy. The predictor for the MANOVA was the 6-level categorical "academic major" variable. The criterion variables for the MANOVA were the levels of affective empathy ($M = 3.24$, $SD = .76$), cognitive empathy ($M = 3.80$, $SD = .58$), and sympathy ($M = 4.34$, $SD = .60$), respectively. The multivariate effect of major was statistically non-significant: $p = .062$, Wilks's lambda = .972, F (15, 2374.483) = 1.615, $\eta^2 = .009$. Furthermore, the univariate F scores for affective empathy ($p = .139$), cognitive empathy ($p = .074$), and sympathy ($p = .113$) were statistically non-significant. That is, there was no difference in levels of affective empathy, cognitive empathy, or sympathy based on academic major, including counseling. Thus, these data indicated that CITs were no more empathic or sympathetic than students in other majors, as measured by the AMES.

We also examined these data for differences in affective empathy, cognitive empathy, and sympathy based on data collection method and educational level. However, we failed to identify a statistically significant difference between groups in empathy or sympathy based on data collection method (e.g., online survey distribution, face-to-face data collection, email solicitation) or by educational level (e.g., master's level or undergraduate status). Thus, these data indicate that data collection methods and participants' educational level did not influence our results.

Discussion

The purpose of the present study was to (a) examine differences in empathy (i.e., affective empathy and cognitive empathy) and sympathy levels among emerging adult college students, and (b) determine whether CITs demonstrate different levels of empathy and sympathy when compared to their academic peers. We hypothesized that CITs would record greater levels of empathy and lower levels of sympathy when compared to their non-counseling peers, because of either their clinical training from their counselor education program or the possibility that the counseling profession might attract individuals with strong levels of dispositional empathy. Participants' scores on the AMES were used to measure participants' levels of empathy and sympathy. We conducted a MANOVA to determine if participants' levels of empathy and sympathy differed when grouped by academic majors. CITs did not exhibit statistically significant differences in levels of empathy or sympathy when compared to students from other academic programs. In fact, CITs recorded levels of empathy that appeared comparable to students from other academic disciplines. This finding is consistent with literature indicating that even if empathy training is effective, counselor education programs might not be emphasizing empathy development in CITs or employing empathy training sufficiently. We also failed to identify statistically significant differences in participants' AMES scores when grouping data by collection method or participants' educational level. Thus, we believe our results were not influenced by our data collection method or by participants' educational level.

Implications for Counselor Educators

The results from this investigation indicated that there was not a statistically significant difference in participants' levels of cognitive or affective empathy or sympathy regardless of academic program, suggesting that CITs do not possess more or less empathy or sympathy than their academic peers. This was true for students in all majors under investigation (i.e., athletic training/health sciences, biology/biomedical sciences/preclinical health sciences, communication, counseling, nursing, and psychology), regardless of age and whether or not they belonged to professions considered *helping professions* (i.e., counseling, nursing, psychology). Although students in helping professions tended to have higher scores on the AMES than their peers, these differences were not statistically significant.

One might hypothesize that students in helping professions (especially in professions in which individuals have direct contact with clients or patients, such as counseling) would have significantly higher levels of empathy. However, counseling programs may not attract individuals who possess greater levels of trait empathy, or training programs might not be as effective in training their students as previously thought. Although microskills are taught in counselor preparation programs (e.g., reflection of content, reflection of feeling), microskill training might not overlap with material that is taught as part of an empathy training or enhance such training. Thus, microskill training might not be any more impactful for CITs' development of empathy and sympathy than material included in training programs of other academic disciplines (e.g., athletic training, nursing).

Another potential reason for the lack of recorded differences between CITs and their non-counseling peers could be that counseling students are inherently anxious, skill-focused, self-focused, or have limited self-other awareness (Stoltenberg, 1981; Stoltenberg & McNeill, 2010). We wonder if CITs might not be focused on utilizing relationship-building approaches as much as they are on doing work that promotes introspection and reflection. Another inquiry for consideration is whether CITs potentially possess a greater understanding of empathy as a construct that inadvertently leads CITs to rate themselves lower in empathy than their non-counseling peers. Further, it is possible that CITs potentially minimize their own levels of empathy in an effort to demonstrate modesty, a phenomenon related to altruism and understood as the *modesty bias* (McGuire, 2003). Future research would be helpful to better understand various mitigating factors. Nevertheless, we suggest that counseling programs might be able to do more to foster empathy-facilitating experiences in counselors by being more proactive and effective in promoting empathy development in CITs. Through a review of the literature, we found support that empathy training is possible, and we wonder if there is a missed opportunity to effectively train counselors if counselor education programs do not intentionally facilitate empathy development in their CITs.

Counselor training programs are not charged to develop empathy in CITs; however, given the importance of empathy in the formation and maintenance of a therapeutic relationship, we propose that counseling training programs consider ways in which empathy is or is not being developed in their specific program. As such, we urge counselor educators to consider strategies to emphasize empathy development in their CITs. For example, reviewing developmental aspects of empathy in children, adolescents, and adults might fit well in a human development course, and the subject can be used to facilitate a conversation with CITs regarding their experiences of empathy development.

Similarly, because empathy consists of cognitive and affective components, CITs might benefit from work that assists them in gaining insight into areas of strengths and limitations in regard to both cognitive and affective aspects of empathy. Students who appear stronger in one area of empathy might benefit from practicing skills related to the other aspect of empathy. For example, if a student has a strong awareness of a client's experience (i.e., cognitive empathy) but appears to have limitations in their felt sense of a client's experience (i.e., affective empathy), a counselor educator might utilize live supervision opportunities to assist the student in recognizing present emotions or sensations in their body when working with the client or in a role play. Alternatively, to assist a student with developing a greater intellectual understanding of their client's experience, a counselor educator might employ interpersonal process recall when reviewing their clinical work to help the student identify what their client might be experiencing as a result of their lived experience. To echo recommendations made by Bayne and Jangha (2016), we encourage counselor educators to move away from an exclusive focus on microskills for teaching empathy and to provide opportunities to teach CITs how to foster a connecting experience through creative means (e.g., improvisational skills).

Furthermore, the results from this study indicated that CITs possess higher levels of sympathy than of both cognitive and affective components of empathy. We recommend that counselor educators facilitate CITs' understanding of the differences between empathy and sympathy and bring awareness to their use of sympathetic responses rather than empathic responses. It is our hope that CITs will possess a strong enough understanding between empathy and sympathy to be able to choose to use either response as it fits within a counseling context (Clark, 2010). We also encourage counselor educators to consider recommendations made by Bloom and Lambie (in press) to employ the AMES with CITs. The AMES could be a valuable and accessible tool to assist counselor educators in evaluating CITs' levels of empathy and sympathy in regard to course assignments, in response to clinical situations, or as a wholesale measure of empathy development. As Bloom and Lambie encouraged, clinical training programs might benefit from using the AMES as a tool to programmatically measure CITs' levels of empathy throughout their experience in their training program (i.e., transition points) as a way to collect programmatic data.

Limitations

Although this study produced important findings, some limitations exist. It is noted that the majority of participants from this study attended universities located within the Southeastern United States. As a result, the sample might not be representative of students nationwide. Similarly, demographic characteristics of the present study including the race, age, and gender composition of the sample limit the generalizability of the findings.

This study also is limited in that the instrument used to assess empathy and sympathy was a self-report measure. Although self-report measures have been shown to be reliable and are widely used within research, these measures might result in the under- or over-reporting of the variables of interest (Gall, Gall, & Borg, 2007). It is necessary to note that we employed the AMES, which was normed with adolescents and not undergraduate or graduate students. Although we recognize that inherent differences exist between adolescent and emerging adult populations, we believed the AMES was an effective choice to measure empathy because of Vossen and colleagues' (2015) intentional development of the instrument to address existing weaknesses in other empathy assessment instruments. Nonetheless, it is necessary to interpret our results with caution.

Recommendations for Future Research

We recommend future researchers address some of the limitations of this study. Specifically, we recommend continuing to compare CITs' levels of empathy with students from other academic disciplines, but to include a more diverse array of academic backgrounds. Similarly, we suggest future researchers not limit themselves to an emerging adult population, as both undergraduate and graduate populations include individuals over the age of 29. Further, researchers should aim to collect data from students across the country and to include a more demographically diverse sample in their research designs.

Additionally, it is necessary to note that limitations exist to using self-report measures (Gall et al., 2007), and measures of empathy are vulnerable to a myriad of complications (Bloom & Lambie, in press; Vossen et al., 2015). Thus, we encourage future researchers to consider using different measures of empathy that move away from a self-report format (e.g., clients' perceptions of cognitive and affective empathy within a therapeutic relationship; Flasch et al., in press). Another area for future research is to track counseling students' levels of empathy as they enter the counseling profession after graduation. It is possible that as they become more comfortable and competent as counselors, and as anxiety and self-focus decrease, their ability to empathize increases.

There is agreement in the counseling profession that empathy is an important characteristic for counselors to embody in order to facilitate positive client outcomes and to meet counselor competency standards (DePue & Lambie, 2014). Yet scholars have grappled with how to identify the necessary skills to foster empathy in counselor trainees and remain torn on which approaches to use. Although empathy training programs seem effective, little is known about which aspects of such programs are the effective ingredients that promote empathy-building, and we lack understanding about whether such programs are more effective than simply engaging in clinical work or having life experiences. Thus, we encourage researchers to explore if counseling programs are effective at teaching empathy to CITs and to further explore mechanisms that may or may not be valuable in empathy development.

Conflict of Interest and Funding Disclosure
The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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