2020

Counselor Trainee Empathy, Exposure and Attitudes Towards Offenders with Mental Illness

Frances I. Ellmo

COUNSELOR TRAINEE EMPATHY, EXPOSURE AND ATTITUDES TOWARDS OFFENDERS WITH MENTAL ILLNESS

by

Frances I. Ellmo

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of Doctor of Philosophy

Major: Counselor Education and Supervision

The University of Memphis

May 2020

Dedication

This dissertation is dedicated to the justice-involved individuals who I have worked with over the past five years. The greatest honor of my life so far has been your willingness to share your stories with me. Your persistence, patience, and understanding inspire me daily to continue this line of research.

Acknowledgements

The community of family, friends, and faculty who have contributed to my academic success deserve more praise and acknowledgement than I can possibly fit on the following pages; however, I hope these words will suffice for now.

First, I would like to express my deepest appreciation to my parents for instilling in me the importance of education and providing me opportunities to learn and grow. Thank you to my mother, Denise Ellmo, for always pushing me to be my best, for being there to catch me when I fell short, and for loving me throughout my struggles and successes alike. Thank you to my father, Craig Ellmo, for his unwavering support and consistent reassurance throughout my entire life. Further, the innumerable hours you spent reading to me as a child nurtured my inquisitive side that became invaluable during my graduate studies. Additionally, I am thankful to my grandparents and extended family members who have cheered me on as I inched closer and closer to this finish line.

Special acknowledgement is due to my partner, John, for his support, cooperation, and strength during this time in our lives. Your sense of humor and endless optimism were often the only things sustaining me on particularly difficult days. You sacrificed alongside me for this degree and for that I am eternally grateful. Additional thanks goes out to my community of friends, both near and far, who always made sure I maintained an acceptable work-life balance. In particular, Brittany Bailey, Kelly Anderson, and Rachael DeSaussure, have been by my side through all of the setbacks and celebrations that have accompanied this doctorate.

I would also like to recognize my fellow doctoral students, specifically Shelly, Kiersten, William, Nicole, Amanda, Kristi, and Paul, for their role in my academic journey. They understand better than anyone the effort and energy exerted in pursuit of this degree. Thank you

for the quick responses to frantic text messages, for the countless hours spent commiserating, and most importantly for the encouragement to continue when I felt like I wouldn't be able to finish. Similarly, I am grateful to our department's office staff, Jennifer Mueller, Melynda Whitwell, and Susan Mascari, for the hard work and dedication they put in behind the scenes. You care about us students far beyond what your job requires and it doesn't go unnoticed.

I also owe a great deal of my success to the educators who have impacted me throughout my life, from elementary school all the way through graduate school. Specific thanks to Dr. Eraina Schauss, Dr. Pam Cogdal, and Dr. Dick James for their mentorship over the years. I aspire to one day touch counseling students in the same way that you all have motivated and encouraged me. To my committee members, thank you for your time, your willingness to work with me, and your instrumental feedback throughout this process. To Dr. Patrick Murphy, thank you for your sincerity and your much-needed humor in times of stress. To Dr. Steve Zanskas thank you for believing in my research abilities from the start. To Dr. Steve West thank you for always treating me with the respect and admiration of a colleague. Finally, to my chair, Dr. Leigh Holman, I am deeply indebted to you for your guidance throughout this process. There is no succinct way to describe the impact of our relationship on my professional identity but at the very least I know that without your insight, enthusiasm, and collaboration I never would have started, much less completed this research project.

Abstract

There is a large and growing population of individuals within the United States' Criminal Justice system suffering from both diagnosed and undiagnosed mental health issues. The stigma associated with their offender status and mental illness can prevent sufficient quality of mental health services from being provided to this population. Even individuals that work closely with offenders have been shown to exhibit negative perceptions of offenders with mental illness and little research exists in this area related to counselors. Further, the offender population is one that requires specialized training and consideration and it is unclear how much training or exposure counselors receive in working with this challenging population. The current study investigated empathy levels, prior exposure to offenders, and attitudes towards offenders with mental illness in a population of 100 masters-level counselor trainees. Multiple regression analyses were used to examine which study variables could predict counselor trainee attitudes towards offenders with mental illness. Results of the study showed that prior exposure and some types of empathy could predict attitudes towards this population. These findings offer intervention and training recommendations that graduate counseling programs could implement to better prepare counselor trainees to work with the population of mentally ill offenders in the US.

Table of Contents

List of Tables

Counselor Trainee Empathy, Exposure, and Attitudes Towards Offenders with Mental Illness

Chapter 1: Introduction

Background of Study

The purpose of this study was to investigate empathy and exposure to offenders, and their impact on attitudes towards offenders with mental illness in a population of masters-level trainees. Mass incarceration, or the policies that have led to a large portion of the United States (US) population being incarcerated, is a growing concern in the US criminal justice system (Nellis, 2016). Although incarceration rates are increasing, involvement with the criminal justice system still appears to invoke judgment and bias resulting in offenders, or those involved with the justice system, being stigmatized (LeBel, 2011; Hartwell, 2004).

Hartwell (2004) introduced the term "triple stigma" to refer to an individual with involvement with the criminal justice system who also suffers from mental illness and substance abuse problems. As the population of incarcerated individuals grows so do the mental health needs of offenders in the United States. The severity of mental illnesses in offender populations is rising, as well. These mental health and substance abuse issues only add to the stigma and negative perceptions of this population (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Torrey et al., 2014).

The increase in the incarceration of people with mental illness has been mostly recognized as a byproduct of the governmental deinstitutionalization efforts in the 1960s and lack of funding for community mental health in the decades since deinstitutionalization (Lamb & Weinberger, 2014; Torrey et al., 2014). An additional contribution to the incarceration of mentally ill individuals is the proliferation in mandatory and discriminatory sentencing for drug

offenders that has affected individuals with substance use disorders (Holman, Ellmo, & Pitre, 2019*;* Lamb & Weinberger, 2014). In fact, Baillargeon and colleagues (2010) found that individuals diagnosed with comorbid substance use disorder and mental illness were significantly more likely to be reincarcerated in a 6-year period compared to individuals with just mental illness or just substance use disorder alone.

Given this large population of individuals diagnosed with mental health and/or substance abuse disorders within the US criminal justice system, the quality of care and implementation of appropriate care should be a concern for the counseling community. However, criminal justice advocates agree that the stigma associated with offender status can prevent sufficient quality of services, mental health or otherwise, from being accessible (LeBel, 2011). Even providers and employees that work closely with offenders exhibit negative perceptions of offenders with mental illness (Greineder, 2013). The author could find little research that examines the perceptions of offenders in the counseling profession, specifically; however, the perceptions of counselors could be an important variable in successful mental health intervention because perceptions have been shown to influence treatment implementation and outcomes for this population (Jones, 2013; Ward, Connolly, McCormack, & Hudson, 1996). The small body of literature on this topic shows that counselors also frequently share overall negative perceptions, attitudes, and beliefs about offending clients (Adjorlolo, Abdul-Nasiru, Chan, & Bambi, 2018; Graham, 1980).

Evidence indicates that these negative beliefs could increase the risk of burnout for counselors working with offenders and could impede successful treatment for offenders with mental illness and/or those challenged with substance abuse issues (Carrola, Olivarez, & Karcher, 2016; Nelson, Herlihy, & Oescher, 2002). Attitudes towards clients can impact the

counselor's ability to empathize, and research indicates that empathy is a key factor in counseling outcomes (Gerdes, Segal, Lietz, 2010; Kottler & Balkin, 2017). Literature also indicates that increased empathy contributes to prevention of burnout among counselors working with difficult clients, such as offenders (Gerdes, Segal, Lietz, 2010). Due to the increased positive outcomes associated with higher empathy in the therapeutic relationship, the role of empathy should not be underestimated when working with offenders. Counselors with a natural empathic disposition toward a group of clients might have an advantage in the development of therapeutic relationships with offenders; however, literature indicates that for those who lack sufficient empathy towards challenging clients, such as offenders with mental illness, empathy can be increased through training and education (Duan & Hill, 1996; Fulton, 2016). However, training specifically related to offenders with mental illness is not required as a part of standardized curriculum in accredited counseling programs (Council for the Accreditation of Counseling and Related Programs, 2015). Yet there are special systemic, ethical, and legal issues related to working with the offender population that require attention (Holman, 2019; Moulden & Firestone, 2010; Ward & Salmon, 2011).

Statement of the Problem

Despite the growing population of offenders suffering from mental illness issues in the United States, there is a lack of competent mental health treatment available to this group. The offender population is one that requires specialized training and consideration, but it is unclear how much specific training counselors receive in this area or how they feel about working with this challenging population. Additionally, high levels of burnout and low levels of empathy towards offenders among mental health professionals is well documented (Lambert & Hogan, 2010; Perkins & Sprang, 2013). The literature also documents that empathy toward clients can

impact client outcomes, and one measure related to empathy is attitudes towards a population of interest (Elliott, Bohart, Watson, & Greenberg, 2011). But it is difficult to draw conclusions or better prepare counselors to work with offenders based on only minimal, and sometimes contradictory, existing literature Therefore, it is important that we have a baseline understanding of mental health counselors' attitudes towards offenders challenged with mental health issues in correctional settings. Since counselor training and development begins in graduate counseling programs, it is imperative to start the investigation with masters-level counselor trainees. However, we could find no research to date examining the variables of counselor trainee attitudes, empathy, or competence when towards the specific population of offending clients with mental illness and/or substance abuse.

Significance of Study

The attitudes and level of empathy of counselors towards offending clients directly influences treatment outcomes for clients and impacts occurrences of counselor burnout (Perkins & Sprang, 2013). Since the offender population is an underserved group needing competent mental health treatment, it is worthwhile to investigate counselor trainees' level of empathy and attitudes towards offenders with mental illness (Crane & Payne, 2011; Western & Pettit, 2010). Given counselor trainees' unique characteristics and stage of professional development, their perspective might provide valuable insight and lead to more information about how to best train and educate counselors to work with offenders. This study is significant because it will contribute to the literature gap by examining the variables of counselor trainee level of empathy and attitudes towards mentally ill offending clients, which has not been sufficiently explored in previous literature. Additionally, the results of this study could contribute to the development of counselor education standards for this population, which could then address the social justice

concerns related to competent mental health treatment for offenders with mental illness (Torrey et al., 2014).

Definition of Terms

Offender: The term offender is a label that encompasses all types of criminal justice and legal system involvement. Distinctions based on severity of crime or incarceration type or status are not usually made under this umbrella term. Examples of offenders could include someone who is incarcerated based on a criminal charge but not convicted yet, someone who was convicted of a crime but was not incarcerated, or someone on probation or parole for a criminal offense (Moore, Stuewig, Tangney, 2016; Morris, 1965).

Empathy: Ickes (1997) conceptualizes empathy as the combination of observation, memory, knowledge, and reasoning to produce insight into the thoughts and feelings of others. Several definitions focus on empathy as an evolved characteristic that allows humans to survive based on their social connections and shared resources (Batson, 1990; Porges, 2001). An additional emotion-focused component includes a sense of similarity between the feelings one experiences and those expressed by others (Thompson, 2001) and intentionally feeling for and acting on behalf of other people whose experience differ from our own (Batson et al., 1991).

Stigma: Stigma can be conceptualized as labeling, stereotyping, separation, loss, and/or discrimination based on a unique trait or experience (Link & Phelan, 2001).

Attitudes: Attitudes are an evaluation of something or a preference for something, usually a person, product, or group. Attitudes have also been correlated with exhibiting stigmatizing views and discrimination (Stangor, 2017).

Counselor Trainee: Counselor training can be defined broadly as the entire graduate-level curriculum in counseling during which a counselor-in-training develops their professional

identity, clinical competence, and interpersonal skills (Buser, 2008). For the purpose of this study, a counselor trainee is defined as a masters-level student in their graduate training program.

Research Questions

1) What are counselor trainees' trait empathy levels (as measured by the IRI) and attitudes towards mentally ill offenders (as measured by the PACAMI-O)?

2) What is the relationship between counselor trainee's trait empathy (as measured by the IRI) and attitudes towards mentally ill offenders (as measured by the PACAMI-O)?

3) What is the relationship between prior exposure to offenders and attitudes towards mentally ill offenders (as measured by the PACAMI-O)?

4) Does counselor trainee trait empathy and exposure to offenders predict their attitudes towards mentally ill offenders?

Organization

This research study is presented in five chapters. The first chapter includes the background of the study, a statement of the problem to be researched, the significance of the study, definitions of key terms, and research questions. The second chapter presents a review of relevant literature including information on offenders with mental health issues and the stigma they face, counselors' interactions, perceptions, and training to work with offenders, and an overview of the key study variable of empathy. The third chapter describes the research methodology of this study including research questions, participants, instrumentation, and data collection and procedures. The fourth chapter includes the results of the study analyses broken down into type of analysis: descriptive statistics, reliability analyses, correlational analyses, and multiple regression analyses. The fifth chapter consists of a discussion of the results, the implications of the study, the limitations of the study, and ideas for relevant future research.

Chapter 2: Literature Review

This literature review explores characteristics of offenders suffering from mental illness. It will also evaluate existing literature related to the counselors who work with this population, along with their perceptions, competence, and levels of empathy. Variables related to perception and competence, such as stigma and burnout, are reviewed. Although counselor trainees were the targeted participants for this study, we could find no research surveying this population related to the study variables. However, this review does examine counselor trainee characteristics and counselor education considerations to provide background context for the selection of study participants. Given the large amount of literature on empathy in the counseling profession, an overview of types of empathy and therapeutic outcomes related to empathy are discussed, with a focus on the specific empathy subtypes explored in this study. Due to limited research on the study variables, this literature review will also examine existing data on the study variables for similar populations, such as medical professionals, college students, and correctional officers.

The Offender Population

Offender Definition

The definition of offender varies depending on context and culture. Outside of a legal context, it is sometimes used interchangeably with criminal, inmate, prisoner, and incarcerate (Law & Roth, 2015). Criminal is a term used in reference to the legal definition of crime (Tappan, 1947). Criminal most often refers to a person who has committed a crime in the eyes of the legal system or the public. Inmate or prisoner refer specifically to someone who is currently incarcerated by the legal system but may or may not be convicted (e.g. waiting for trial, etc). The term offender is a label that encompasses all types of criminal justice and legal system involvement (Law & Roth, 2015; Moore, Stuewig, & Ttangney, 2016). Distinctions based on

severity of crime or incarceration type or status can be made (Gibbons, 1975). Examples of offenders could include someone who is incarcerated based on a criminal charge but not convicted yet, someone who was convicted of a crime but was not incarcerated in a correctional facility, or someone on probation or parole for a criminal offense (Moore, Stuewig, & Tangney, 2016).

Due to limited research on this population, this literature review includes research about different types of offenders. Additionally, literature from a variety of sources and disciplines have been reviewed and therefore it should be noted that the definition of offender utilized by other researchers could not always be ascertained. References to literature where a specific subpopulation of offender was studied (i.e. specifically prisoners, specifically sex offenders) was noted in this review. It should also be noted that the term offender has been criticized by some criminal justice advocates for its negative and dehumanizing connotations when used as a derogatory term (Law & Roth, 2015).

Offender Population Characteristics

The population of incarcerated individuals in the United States is higher per capita than any other nation in the world (Kaeble, Glaze, Tsoutis, & Minton, 2015). The issue of mass incarceration continues to increase in the US and is complicated by problems in the biased and discriminatory legal and criminal justice systems (Nellis, 2016; Torrey et al., 2014). Further, racial minorities are overrepresented in the incarcerated population (Vogel & Porter, 2016). African American and Hispanic individuals make up 56% of the incarcerated population, even though they only represent approximately 30% of the general population. Based on current population estimates, it is projected that one in three African American men born in the 21st century will be incarcerated at least once in their life (Vogel & Porter, 2016). Similarly, the rate

of incarceration disproportionately affects individuals from a lower socioeconomic status (Holzer, 2009; Nellis, 2016).

Other considerations for the demographic make-up of the incarcerated population include gender, sexual orientation, age, and health status. Although more men than women are incarcerated in the US, the rate of growth for female offenders has increased 700 percent in the last 25 years (Bronson & Carson, 2019). Individuals aged 20-34 make up most of the population of incarcerated offenders (Vogel & Porter, 2016). Sexual minorities are also disproportionately affected by incarceration in the US. For instance, male offenders who self-identify as gay or bisexual make up 9.3% of incarcerated men, while female offenders who self-identify as lesbian or bisexual make up 35.7% of incarcerated women (Meyer et al., 2017), compared to only 4.5% of the general population who identify as lesbian and/or gay (Williams Institute, 2019). Additionally, offenders demonstrate poorer health than the general population, including higher rates of traumatic brain injury (TBI), cardiovascular disease, and unnatural death (Ebin & Maposa, 2013; Shiroma, Ferguson, & Pickelsimer, 2010). However, these health outcomes are likely mediated by additional risk factors such as socioeconomic factors and lack of access to adequate healthcare (Piquero, Daigle, Gibson, Piquero, Tibbetts, 2007).

Stigma and Bias Against Offenders

Although incarceration rates are increasing, involvement with the criminal justice system still appears to invoke judgment and bias from the general population (LeBel, 2011). Hirschfield and Piquero (2010) surveyed 2,000 people in the general public about their attitudes toward offenders. They found that even though overall perception has improved some over time (likely due to the cultural normalization of mass incarceration in the United States), the offender population was still significantly stigmatized, especially among individuals who identify as

Caucasian, individuals who identify with conservative political views, and individuals from southern states.

Stigma can be conceptualized as labeling, stereotyping, separation, loss, and/or discrimination based on a unique trait or experience (Link & Phelan, 2001). Others define stigma as reducing the identity of person to a specific characteristic and then using that characteristic to discredit, devalue, and exclude them (Goffman, 1963). Criminal justice advocates agree that the stigma associated with offender status follows an offender beyond release from incarceration or probation and can have long lasting consequences (LeBel, 2011). For example, individuals who have encountered the criminal justice system often have difficulty finding housing and maintaining employment due to their offender status (Pettit & Lyons, 2007). They are also often prohibited from societal reintegration because they are prevented from voting or qualifying for public assistance or financial aid for college (LeBel, 2011). Social consequences of incarceration include marital dissolution, separation from children, and loss of other meaningful relationships (Massoglia, Remster, & King, 2011; Richie, 2002). These experiences of stigma and exclusion from society may contribute to an offender's likelihood of re-offending (Hirschfield & Piquero, 2010).

Further, individuals closely involved with the justice system are not immune from biased and discriminatory actions against offenders. For instance, one qualitative study examined attitudes towards offenders among fifteen correctional officers finding that participants held an overall negative perception of the offender population (Greineder, 2013). Individual participants were quoted as referring to sex offenders in particular as "sneaky," "manipulative," and "scum." Similarly, in a quantitative study of 85 probation officers, Craig (2005) found that probation officers held unfavorable opinions about prisoners, especially sex offenders. Following a two-

day training related to working with offenders, most probation officers still held negative views but felt more competent in working with the offender population (Craig, 2005). This data is further evidence for the potential negative treatment of offenders based on their offender status both inside and out of the correctional system in the United States.

Offenders with Mental Illness

Approximately 1 million of the 2.2 million incarcerated people in the US suffer from a serious mental illness, a number that is between three to six times higher than the general population (Torrey et al., 2014). The overall severity of mental illnesses in incarcerated populations is rising as well (Peterson et al., 2014; Torrey et al., 2014). Sarteschi (2013) performed a meta-analysis to look for prevalence of mental health diagnoses and symptoms within the criminal justice system. They found that the two most common psychiatric diagnoses for mentally ill offenders were anxiety disorder and antisocial personality disorder. However, post-traumatic stress disorder was reported in approximately 22-30% of the offender population, and major depression was reported in approximately 15-19% of the offender population (Sarteschi, 2013). Additionally, at least half of inmates in state and county correctional facilities displayed at least one symptom of depression and approximately 60% showed at least one symptom of mania, which could be indicative of bipolar disorder (Sarteschi, 2013). Community corrections offenders also demonstrate high rates of mental illness compared to the general population. One study surveyed a group of offenders in jail or on probation and found 36% suffered from bipolar disorder, 23% from depression, and 19% from psychosis or schizophrenia (Castillo & Alarid, 2011), compared with less than 1% suffering from bipolar disorder, 7% from depression, and 1% from psychosis/schizophrenia in the general population (American Psychiatric Association, 2013).

The increase in the incarceration of people with mental illness has largely been attributed to the deinstitutionalization efforts in the 1960s and lack of funding for community mental health in the decades since deinstitutionalization (Lamb & Weinberger, 2014). Nationally, there are more mentally ill individuals incarcerated than there are in mental health hospitals (Desmond & Lenz, 2010; Torrey et al., 2014). However, the problem persists on a local community scale as well. Every county in the U.S. houses more psychiatric patients in their county jails than in that county's psychiatric facilities (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Further, research indicates that it is common for offenders' mental health to decline while incarcerated (Tadros, 2018). Incarcerated offenders with mental illness are also at higher risk for victimization by other incarcerates or staff and have disproportionate rates of suicide compared to non-mentally ill offenders (Torrey et al., 2014). Additionally, offenders with mental illness are more likely to be placed in solitary confinement, particularly if they are suicidal, a practice known for its negative effects leading to exacerbated mental health symptoms (Torrey et al., 2014).

Offenders with Comorbid Substance Use

An additional contribution to the incarceration of mentally ill individuals is the proliferation in mandatory and discriminatory sentencing for drug offenders that has affected individuals with substance use disorders (Holman, Ellmo, & Pitre, 2019*;* Lamb & Weinberger, 2014). Offenders with a mental health and substance use dual diagnosis are more likely to serve sentences related to substance use (Hartwell, 2004). Additionally, offenders demonstrate higher rates of alcohol and drug problems than the general population and a higher rate of co-occurring substance use with mental health disorders (Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2011). Comorbid SUDs and mental illness are common within the criminal justice system and

represent a particular challenge in treatment approaches (Holman, Ellmo, & Pitre, 2019). Additionally, suffering from SUDs is a risk factor for increased violence among individuals with mental illness, thus increasing their likelihood of coming in contact with the criminal justice system (Jaffe, Du, Huang, & Hser, 2012).

Not only are offenders with mental illness at higher risk for incarceration and for being placed in solitary confinement while incarcerated, they also exhibit higher rates of re-offending. For instance, Baillargeon and colleagues (2010) found that individuals diagnosed with comorbid substance use disorder and mental illness released from correctional facilities in the state of Texas were significantly more likely to be reincarcerated in a 6-year period compared to individuals with just mental illness or just substance use disorder alone. Similarly, Ruiz, and colleagues (2011) examined a sample of over 3,000 offenders and found that individuals with substance use disorders were more likely to have increased mental health problems, increased risk for suicide, and increased risk for aggressive behaviors. They found that incarcerated women with substance use problems had higher rates of mental health concerns, such as depression, behaviors related to traumatic stress, and features of borderline personality disorder. Additional research shows that offenders have high rates of co-occurring post-traumatic stress disorder and substance use disorders (Najavits, 2007).

Stigma Against Offenders with Mental Illness

Additional stigma exists for offenders with mental health issues and/or substance abuse problems. In fact, Hartwell (2004) introduced the term “triple stigma” to discuss an individual with mental illness, substance abuse problems, and involvement with the criminal justice system. Additionally, offenders suffering from both mental illness and substance use self-report experiences of stigma across multiple studies (Mezey, Youngman, Kretzschmar, & White, 2016;

van Olphen, Eliason Freudenberg, & Barnes, 2009). One qualitative inquiry found that women with substance use disorders leaving prison struggled to re-integrate into society and self-reported the stigma of incarceration as an overarching reason for their difficulty (van Olphen et al., 2009). Additionally, Mezey and colleagues (2016) found that offenders with mental illness reported significantly higher levels of stigma and discrimination than non-offending individuals with mental illness.

The public also reports stigmatizing views of offenders with mental illness. For instance, Faruqui (2011) conducted a qualitative study about public perceptions of mentally ill offenders. They interviewed 8 students and coded the transcribed interview data. Thematic analysis revealed participants' perceptions of stigma were negatively influenced by the portrayal of mental illness in media. Specifically, participants focused on the perceived connection between mental illness and violent crime. Although some statistics indicate approximately 5% of violent crime is committed by mentally ill individuals, the majority of mentally ill individuals do not commit violent crime. Further, effective treatment for the mentally ill significantly decreases the likelihood for violent episodes, even among those at risk of violent behavior (Glendinning & O'Keeffe, 2015; Jorm & Reavley, 2013; Torrey, 2011), which indicates more support for the need to provide competent mental health care to offenders.

Offenders with Trauma History

A complicating factor is that many individuals involved with the justice system have also experienced frequent trauma throughout their lives (Procter et al., 2017). Trauma during childhood, also known as adverse childhood experiences (ACEs) including events such as abuse, neglect, or a separation from a parent due to divorce or incarceration, can lead to physiological changes in the brain (Procter et al., 2017, van der Kolk, 2014). These brain changes are

associated with higher rates of mental health and substance disorders in adulthood (Douglas et al., 2010; Felitti et al, 1999; Kessler et al., 2010). ACEs are also associated with increased risk for offending behaviors, which can lead to increased risk for incarceration (Perez, Jennings, & Baglivio, 2018). Additionally, traumatic experiences in adulthood can have similar consequences (Procter et al., 2017).

The intersection of trauma, mental health, and substance use is particularly common as individuals attempt to self-medicate trauma and mental health symptoms with substances (Holman, MacGillivray, Wesam, & Tarbett, 2018). Historically, the use of addictive behaviors to cope with trauma was perceived as a moral deficiency that deserved punishment, such as incarceration, also called the Moral Model of Addiction (Broadus, Hartje, Roget, Cahoon, & Clinkinbeard, 2010). More recently, research on trauma is helping to shift views toward a disease model of addiction, which acknowledges the biological and physiological changes in brain chemistry that influence behavior. However, the criminal justice system, as well as public perceptions of individuals suffering from addiction and mental illness, have been slow to change (Holman, 2019).

Treatment for Offenders with Mental Illness

The lack of access to competent mental health and substance abuse treatment for those involved with the justice system is an increasing social justice concern for mental health and criminal justice advocates alike (Western & Pettit, 2010). The Supreme Court asserts that all incarcerated individuals have an 8th amendment right to healthcare, including appropriate mental healthcare (Klein, 1978). However, the implementation of this care varies greatly in both quantity and quality (Torrey et al., 2014). This treatment is often limited to psychiatric medication management and/or case management by correctional officers (Cloyes, Wong,

Latimer, & Abarca, 2010; Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012). The criminal justice system is criticized for failing to provide the minimum standard of care needed. Additionally, when intervention occurs, these interventions tend to focus on controlling behavior, rather than on long-term holistic interventions addressing underlying mental health issues, which motivate offending behaviors (Galanek, 2015; Morgan et al., 2012; Torrey et al., 2014).

Further, the services available for those involved with the justice system outside of correctional facilities is even more limited. For example, about 95% of incarcerated individuals with mental illness are eventually released back into the community, and are twice as likely to re-offend and return to a correctional facility than those without mental illness, due to lack of ongoing mental health care (Caron & Golinelli, 2013; Cloyes et al., 2010). Effective diversion, probation, and reentry programs could help to mitigate this type of recidivism. Research indicates that the most effective programs for offenders outside of correctional facilities include individualized care of both mental health and substance abuse issues, in addition to more traditional concerns like housing, employment, and medication adherence (Johnson & Cullen, 2015; Wolff et al., 2014).

The current standard of care is case management and medication management, which has limited benefits for the integrated care; however, services offered by providers with specific training in mental health, trauma, and substance abuse demonstrate greater benefits and result in lower recidivism rates (Chandler, Fletcher, & Volkow, 2010; Desmond & Lenz, 2010; Roskes, Feldman, Arrington, Leisher, 1999). In a review of literature, Morgan and colleagues (2012) found six effective treatment strategies for mentally ill offenders: 1) collaborative psychopharmacology, 2) community reintegration, 3) family psychoeducation, 4) employment assistance, 5) illness management, and most importantly 6) integrated dual diagnosis therapeutic

treatment. Dual diagnosis interventions by trained mental health clinicians provides treatment for mental illness and substance abuse simultaneously and recognizes the role trauma can play in the presentation of these disorders. Research also indicates that trauma-informed interventions have positive therapeutic outcomes for offenders due to their focus on safety, trust, therapeutic relationship, collaboration, and empowerment (Procter et al., 2017). Unlike most correctional counselors who have bachelor's level training in social work or criminal justice or associate's degrees in substance abuse counseling, clinical mental health counselors are competently trained at the masters or doctoral level to provide the trauma-informed, integrated dual diagnosis treatment demonstrated effective for these individuals (Crane & Payne, 2011).

Counselors, Counselor Trainees, and Perceptions of Offenders

Counselor Attitudes and Counseling Outcomes

Perceptions and attitudes have been a long-studied phenomenon in the social sciences. Research on attitudes has been used to clarify meaning, inform practice and policy, and better understand individuals and groups. Attitudes can be defined as an evaluation of something or a preference for something, usually a person, product, or group. Attitude formation is commonly attributed to modelling by others and environmental learning (Bandura, 1977). Research documents that an individual's attitudes towards a group of people are correlated with both helping behaviors and discrimination, both of which should be of interest to the counseling profession (Stangor, 2017).

Counselor attitudes are key factors in treatment outcomes for clients (Sandell, Lazar, Grant, Carlsson, Schubert, & Broberg, 2007). In fact, research establishes that counselors who hold more positive perceptions of their clients are generally more effective with those clients (Jackson & Thompson, 1971). Further, when examining counselor perceptions of certain

stigmatized groups, research demonstrates that in spite of multicultural counseling training, counselors continue to hold dispersant attitudes and perceptions towards stigmatized groups, and those attitudes could influence treatment (Barrett and McWhirter, 2002; Wright, 2008). For example, Wright (2008), in a quantitative study examining stigma and attitudes of counselors towards clients with HIV/AIDS, presented vignettes to counselors in order to elicit their perceptions about hypothetical female clients with HIV/AIDS. They found a significant difference for counselor perceptions and emotions towards clients with HIV/AIDS and those without HIV/AIDS. Similarly, Barrett and McWhirter's (2002) quantitative analyses of 162 counselor trainees revealed that client sexual orientation significantly impacted perceptions of clients. Therefore, we know that counselors have problematic attitudes and beliefs about minority groups, and offenders are an example of a minority group with its' own culture.

Counselor Attitudes and Perceptions Towards Offenders

Little research to date examines the perceptions of counselors working with the offender population; however, it is important to examine the perceptions of the counselors working with the offender population because multiple recent studies indicate that perceptions have an effect on treatment implementation (Jones, 2013; Ward, Connolly, McCormack, & Hudson, 1996). Additionally, attitudes associated with negatively stigmatized groups, like offenders, are commonly associated with perceived safety risks (Glendinning & O'Keeffe, 2015).

The majority of literature on this topic focuses on counselors' perceptions of sex offenders, specifically (Carmel & Friedlander, 2009; Chudzik, 2016; Elias & Haj-Yahia, 2019; Hardeberg, Bach, Demutth, 2018). For instance, a meta-analytic exploration examined 18 published studies related to therapists' experiences of working with sex offenders finding that therapists perceive working with the sex offenders to lead to increased mental, physical, and

emotional exhaustion (Hardeberg, Bach, Demuth, 2018). They attribute this phenomenon to a variety of factors such as the difficult content of the work, difficulty in successful rehabilitation of sex offenders, and lack of support counselors feel in these roles (Hardeberg, Bach & Demuth, 2018).

Additionally, although potentially ineffective and stereotypical, some clinicians have described sex offenders as unmotivated, passive, disengaged, oppositional, and unwilling to fully participate in therapy (Chudzik, 2016). These findings are further supported by a phenomenological study on the perceptions of 19 social workers providing treatment to sex offenders on probation in Israel (Elias & Haj-Yahia, 2019). The researchers conducted a content analysis of the interview transcripts, which revealed themes such as feelings of disgust, shock, and agitation towards their offending clients. One participant described sex offenders as "an image of a monster" and admitted to holding stigmatizing views of the population (p. 856).

On the other hand, Carmel and Friedlander (2009) found that the majority of the 106 sex offender therapists surveyed said they enjoyed their work and scored high on a measure of compassion satisfaction. In fact, some counselors have described working with sex offenders to be interesting, challenging, and satisfying (Elias & Haj-Yahia, 2019). Further, Nelson, Herlihy, and Oescher (2002) investigated 432 counselors' attitudes toward sex offenders using the Attitudes Toward Sex Offender Scale (ATS) and found they reported fewer negative perceptions of sex offenders when compared to other professional groups who interact with sex offenders (e.g. correctional officers, police officers). Given the conflicting findings among these studies, it is difficult to draw conclusions that might generalize to the population of offenders with mental illness, other than sex offenders.

A few isolated studies examine mental health providers' attitudes towards general offenders (i.e. non-sex offenders). Graham (1980) provided 100 psychotherapists with offender and non-offender client intake data then surveyed their perceptions of these hypothetical clients. When the researchers controlled for additional diagnostic criteria, the psychotherapists were more likely to rate the offender clients as unmotivated to change, less insightful, and inappropriate for therapy compared to the non-offenders. Similarly, a recent study in Ghana, Africa investigated mental health professionals' attitudes toward offenders with mental illness and found them to be unsympathetic toward offenders, have overall negative attitudes, and rate the offenders high on criminal blameworthiness (Adjorlolo, Abdul-Nasiru, Chan, & Bambi, 2018). Interestingly, mental health providers who had been practicing for more than six years were significantly more likely to hold these negative perceptions than newer professionals, although it is not clear why (Adjorlolo et al., 2018).

Counselor Countertransference Towards Offenders

In addition to counselors' negative attitudes towards client-groups resulting in negative client results, negative attitudes of a counselor towards particular client-groups can also result in countertransference. Countertransference has been defined as a clinician's emotional response to a client and is influenced by attitudes, beliefs, and prior experiences (Friedrich & Leiper, 2006; Machado et al., 2014). Countertransference alone is not indicative of ineffective therapy; however, if unattended or ignored, it can lead to negative consequences in the therapeutic relationship or inability to remain empathic with the client (Fredrich & Leiper, 2006). The therapist's own issues and characteristics, the impact of the client's issues, and the interaction between the two each influence countertransference reactions (Friedrich & Leiper, 2006).

Research identifies countertransference when counseling offenders as a concern, due to the severity of diagnoses, types of crimes committed, and trauma in the offender population (Mulay & Cain, 2018). However, research also indicates that countertransference reactions towards offenders could be ameliorated through supervision, self-reflection, self-care, and quality training directed at counselor attitudes towards offenders (Cox, 1996; Mulay & Cain, 2018; Nelson, Herlihy, and Oescher, 2002). However, literature indicates that if a counselor does not attend to countertransference it can contribute to burnout (James & Gilliland, 2017; Neumann & Gamble, 1995).

Counselor Burnout Working with Offenders

Burnout can be defined as chronic interpersonal and/or emotional distress related to one's job (Machado et al., 2014). Symptoms of burnout include depersonalization, inefficacy, exhaustion, and depression (Maslach, Jackson, Leiter, 1986; Wallace, Lee, & Lee, 2010). Burnout occurs frequently among counselors, due to the highly personal nature of the job and the tendency to be highly motivated, idealistic, passionate, and carry high expectations for client change (Selye, 1976). However, for those clients who have trauma histories comorbid with mental health and substance use disorders, as many offenders do, counselors are at increased risk for developing both compassion fatigue and burnout (Burke, Carruth, & Prichard, 2006; Lambert & Hogan, 2010; Oddie & Ousley, 2007; Perkins & Sprang, 2013). In one study, Gallavan and Newman (2013) surveyed mental health providers and found that therapists that scored higher on negative attitudes towards prisoners tended to have the highest levels of burnout indicating that perceptions of the population influenced burnout levels. Further, the psychological effect of working with difficult clients, such as offenders, can contribute to counselor burnout (Carrola, Olivarez, & Karcher, 2016). For instance, counselors working with offenders are at risk for

secondary traumatic stress. Secondary traumatic stress has been conceptualized as "traumatic countertransference." In these cases, counselors experience similar trauma reactions, such as symptoms of post-traumatic stress syndrome, as if they experienced first-hand the trauma their clients process in counseling. In addition to the difficulty of working with offending clients, organizational factors such as limited autonomy, lack of administration and supervision support, work overload, and harassment are factors that might contribute to burnout among offender counselors (Holman, 2019).

Research indicates that the risk of developing burnout is approximately 50% for those counselors who work with offender populations (Steed & Bicknell, 2001; Way, VanDeusen, Martin, Applegae, & Jandle, 2004). Counselors working with sex offenders, in particular, report higher levels of anxiety, avoidance, hypervigilance, and intrusive thoughts in session when compared to counselors working with the general population, all of which are symptoms of post-traumatic stress disorder (Steed & Bicknell, 2001). Research also indicates that counseling offenders, in general, can result in the providers' experiencing mood and emotion regulation concerns (Edmunds, 1997; Farrenkopf, 1992). When counselors experience burnout, they demonstrate lower levels of compassion and empathy, genuineness, and positive regard towards clients (Moulden & Firestone, 2010). Given that counselor burnout can negatively impact both the counselor's and client welfare, it is important to consider how we can inoculate emerging counselors through their training.

Counselor Training and Competence to Work with Offenders

Counselor training is broadly defined as the entire graduate-level curriculum in counseling during which a counselor-in-training develops their professional identity, clinical competence, and interpersonal skills (Buser, 2008). The Council for Accreditation of Counseling

and Related Programs (CACREP) accredits counseling programs in the United States to ensure standards for counselors across the profession (CACREP, 2015). Therefore, all CACREP-accredited graduate programs include common core curriculum related to ethics, diversity, human development, career development, helping relationships, group work, assessment, and research, and must include opportunities for professional fieldwork practice, otherwise known as practicum and internship (CACREP, 2015). During graduate school, counselor trainees learn the required knowledge, practice skills to become a counselor; develop competency and professional identity in counseling; and to learn to function at the basic professional level (CACREP, 2015; Ronnestad & Skovholt, 2003).

Although counseling students receive training in working with mental health populations and diverse clientele, no training specifically related to offenders with mental illness is required as a part of CACREP's minimum standards of competence (CACREP, 2015). However, offenders with mental illness are a special group of diverse clients who have unique experiences and needs, which are social justice concerns for the counseling profession. Further, if counselors are working with this population without any prior training or supervision then they may be working outside the boundaries of their competence. However, currently, there are no specific competencies related to offenders or forensic mental health counseling outlined by the American Counseling Association (ACA) or the International Association of Addiction and Offender Counselors (IAAOC), the ACA division authority on issues concerning the treatment of offenders. Therefore, it is unclear if counselors or counselor trainees are competently serving this population.

To examine this issue, Magaletta and colleagues (2013) surveyed doctoral-level clinical and counseling psychology programs to examine the availability and implementation of training

to work with offenders. They also wanted to learn more about what factors hindered the implementation of further training to work with offenders. They found that only 21% of these programs offered a fieldwork placement in corrections and none of the programs offered a specific course dedicated to correctional counseling. Additionally, some programs endorsed factors that limit this training including low student interest in corrections (46.5% of all programs surveyed), student's desire to work with clients more similar to themselves (27.6%), lack of awareness of corrections as a practice environment (14.7%), student's concerns about safety in corrections (14.1%), and student's lack of empathy for offenders (7.1%).

A study of masters-level counseling program directors, utilizing a modified version of the Magaletta et al. (2013) study protocol, found that 67.6% of respondents offered at least one fieldwork placement in a correctional setting and 2.9% offered a course dedicated to offenders or correctional counseling (Ellmo, Holman, Ritter, and James, 2019). The programs also endorsed factors that limited training in this area including counseling program directors' perceptions of student attitudes, including limited student interest in corrections (44.1% of all programs surveyed), student's desire to work with clients more similar to themselves (42.6%), lack of awareness of corrections as a practice environment (41.2%), student's concerns about safety in corrections (44.1%), and student's lack of empathy for offenders (29.4%).

Some issues that training programs may need to address, which are unique to the offender population include navigating mandated counseling, duty to warn potential victims, punitive aspects of the justice system**,** and advocating for the rights of clients (Holman, 2019; Ward & Salmon, 2011). Moulden and Firestone (2010) also described the multiple roles related to working with offenders and emphasized the additional assessment and legal expertise necessary to fulfill those roles. Individuals with exposure to the criminal justice system, especially those

incarcerated, tend to develop specific coping skills to deal with their dangerous and chaotic environment that a competent professional should be aware of, but frequently are not (Moulden & Firestone, 2010).

Additional training concerns for offender counselors in forensic settings involve knowledge of specialized, colloquial language used by incarcerated individuals and navigating their understandable mistrust of professionals involved with the system, both of which can impact the counselor's ability to engage the client in treatment. In fact, research indicates that mental health professionals working with offenders often misinterpret client mistrust as resistance, lack of motivation, or unwillingness to change (Rotter, McQuistion, Broner, & Steinbacher, 2005).

These negative attitudes towards offenders can then contribute to the countertransference and burnout issues described previously. Counselors also express concerns about safety when working with offenders (Ellmo, 2019). One example illustrated in the research is the need for counselors to learn to manage interpersonal boundaries with offenders as important for the safety of the counselor (i.e. avoiding exploitation or manipulation) and for the well-being of the client (Voorhis, Braswell, & Lester, 2009). Given the documented negative attitudes mental health professionals have towards offenders, the large numbers of offenders in need of competent care, and the impact of negative attitudes on client outcomes, training emerging counselors about working with offenders may be an important trend for the counseling profession. One type of training on this topic illustrated in the literature includes Rotter and colleagues (2005), who consider offenders a specific cultural population. As such, they developed a program which teaches professionals working with offenders how to work with, rather than against, "the culture of incarceration" (p. 265). They found that professionals who attended their half day workshop

were more willing to work with offender clients and felt more competent in their effectiveness with offenders. Other research has found similar results where increases in education, awareness, and experience are associated with decreases in negative attitudes and stigmatization (Angermeyer & Matschinger, 2005; Glendinning & O'Keeffe, 2015).

Empathy

Attitudes towards other individuals is closely tied to the concept of empathy. Empathy is also an important concept in the counseling profession. Below I will briefly discuss the historical relevance of the empathy construct in the counseling profession, define empathy in general and then the concepts of state and trait empathy, and then discuss empathy related to some of the core concepts of the current study.

Historical Origins of Empathy

Carl Rogers (1957), the father of the client-centered theory of therapy, is known for popularizing and defining the concept of empathy in the therapeutic relationship. According to Rogers, empathy is one of three core conditions that are necessary and sufficient for therapeutic change to occur, along with congruence/genuineness and unconditional positive regard. Rogers believed if therapy clients felt understood and accepted then they would also feel less alone, less alienated, and more connected to other humans (Tudor, 2011).

Although Rogers is associated with client-centered therapy, he was not the only early psychotherapist to consider empathy and its implications for therapy. Empathy and its related concepts are believed to be important and useful by many other theorists as well. Adlerian therapy encourages the therapist to communicate respect, confidence, and empathy to the client. Alfred Adler and Rogers were colleagues and there is evidence to conclude that Adlerian concepts influenced Rogers' development of his client-centered perspective (Watts, 1996). Self-

psychologists believe vicarious introspection of the client's experience is a tool used to gather data about the client (Kohut, 1977). Aaron Beck, the founder of cognitive therapy, considers empathy to be necessary but not entirely sufficient for successful therapeutic outcomes (Beck, Rush, Shaw, & Emery, 1979). Although Albert Ellis did not specifically mention empathy in the development of Rational-Emotive Behavior Therapy (REBT) he did consider Rogers' other concepts of genuineness and positive regard to be key components of REBT (Ellis, 1996). Sigmund Freud, the forefather of psychoanalysis, was influenced by Vischer and included empathy in his writings on aesthetic sympathy (Tudor, 2011). Gestalt therapy, existential therapies, and psychodynamic theories, such as object relations, also consider empathy to be essential to the success of the therapeutic relationship (Duan & Hill, 1996; Pearson, 1999).

Defining Empathy

In the decades following Rogers' popularization of empathy in the counseling field, researchers sought to confirm and measure the concept. Some limitations of this research include the varying definitions of empathy and differences in measurement. Therefore, researchers pursued clarifying the definition of empathy and determining what smaller components make up the greater phenomenon. Sagi and Hoffman (1976) studied infants who listened to tapes with either other infants crying, a non-human crying, or no sounds. They found that infants who heard other infants crying cried significantly more than the other groups. They coined this phenomenon "empathic distress reaction" and used it to describe the experiencing of distress in relation to others experience of distress. Duan and Hill (1996) asserted that there were both cognitive and affective components to empathy that reciprocally affected each other. Davis (1980) created four categories he believed contributed to empathy development: 1) perspective taking, 2) empathic concern, 3) fantasy, and 4) personal distress. Perspective taking is a cognitive component of

empathy and describes the ability to take the perspective of others. Empathic concern is an emotional component of empathy and illustrates the ability to feel the emotions of others and be concerned for the well-being of others, particular others experiencing misfortune. Fantasy describes an individual's ability to identify with fictional characters (Davis, 1980). Absorption in fantasy role-playing and identification with works of fiction has been shown to strongly correlate with empathy and individuals who are prone to fantasy involvement often score higher on measures of empathy (Nomura & Akai, 2012; Rivers, Wickramasekera, Pekala, & Rivers, 2016).

As research closes gaps in literature and furthers our understanding, researchers continue to use a variety of definitions to describe empathy. Some emotion-focused definitions include: sense of similarity between the feelings one experiences and those expressed by others (Thompson, 2001) and intentionally feeling for and acting on behalf of other people whose experience differ from our own (Batson et al., 1991). Other definitions acknowledge a cognitive component in empathy. Ickes (1997) conceptualizes empathy as the combination of observation, memory, knowledge, and reasoning to produce insight in to the thoughts and feelings of others. Several definitions focus on empathy as an evolved characteristic that allows humans to survive based on their social connections and shared resources. In other words, humans need to be able to relate to each other in order to survive (Batson, 1990; Porges, 2001).

More recently researchers have looked beyond the traditional definitions of empathy and instead have looked at empathy as a neurophysiological phenomenon (Gerdes, Segal, & Lietz, 2010). From this research, terms such as embodied empathy or somatic resonance have been introduced to describe the therapist's bodily reaction to empathic attunement with their client. This goes beyond simply affective or cognitive empathy and includes the expression and performance of empathy in the body (Decety & Ickes, 2009). Neuroscience studies have found

evidence of empathy experiences in brain imaging. Zaki and colleagues (2009) used fMRI imaging to study empathy. They examined the brain images of participants as they viewed videos of people describing highly emotional events. The results showed activation in the area of the brain that "mirrored" the video individuals self-reported emotion.

Trait and State Empathy

Banissy, Kanai, Walsh, and Rees (2012) also studied brain imaging as it relates to empathy. They examined differences between dispositional and situational empathy. They found that high dispositional empathy, or trait empathy, was correlated with differences in gray matter in specific areas of the brain. Trait empathy has been conceptualized as a naturally empathic trait or stable empathic ability. The underlying assumption of dispositional or trait empathy is that some people are innately more empathic than other people (Duan & Hill, 1996). Dispositional empathy has been shown to impact an individual's social connectedness, prosocial behaviors, and expression of state empathy (Balconi & Canavesio, 2012; Konruth, 2012).

Situational empathy, also known as state empathy, has been conceptualized as empathic responses to a specific stimulus or person (Duan & Hill, 1996). State empathy is usually invoked by direct exposure to another person's emotions or based on assumptions from environmental and social cues (Eisenberg, Spinrad, Morris, 2014). Empathic responses can be influenced by a variety of personal characteristics, including attachment style and emotion regulation. Both types of empathy can be a learned response influenced by socialization and prior experiences or contextually dependent on a person's perceptions or motivations, similar to the development of attitudes. (Eisenberg, Spinrad, Morris, 2014; Hein, Roder, Fingerle, 2018; Shen, 2010). Additionally, some demographic differences in both state and trait empathy have been found. For example, women are more likely to demonstrate higher levels of both state and trait empathy

(Aucion, 2018; Christoy-Moore et al., 2014) and people are more likely to have state empathy for individuals from their own racial group (Chiao & Mathur, 2010; Neumann, Boylee, & Chan, 2017).

Empathy and Therapeutic Outcomes

Empathy is almost universally regarded as an essential component of the counseling relationship (Gerdes, Segal, Lietz, 2010). Research indicates empathy, along with the therapeutic alliance, are stronger predictors of therapeutic success than any one therapeutic modality, theory, or technique (Kottler & Balkin, 2017; Lamberg & Simon, 2008). The relationship between empathy and therapeutic outcome is extensively represented in the literature, dating back to the beginning of the counseling profession. For instance, Traux and Mitchell (1971) rated audiotapes of therapy sessions and found a strong relationship between empathy and therapeutic change. Florentine and Hillhouse also (1999) studied empathy in the counseling relationship between addictions counselors and their clients and found a positive relationship between empathy and client treatment engagement and maintenance of abstinence during and after outpatient drug treatment.

More recent research supports these earlier findings. Leibert (2011) described empathy as one of the common factors known to enhance the effectiveness of counseling. Additionally, Kwon and Jo (2012) studied 48 real-life counselor-client relationships and assessed empathic accuracy of the counselor and counseling outcome. They reported a significant relationship between empathic accuracy and counseling outcome and observed that empathic accuracy provided a mediating effect between counselor experience level and counseling outcome. In other words, empathy helps to explain the relationship between counselor level of experience and therapy outcomes.

A meta-analysis of 57 studies that looked at the connection between therapist empathy and client success found a medium effect size (r = .30) for the positive relationship between empathy and therapeutic success. They also found empathy predicted therapeutic outcomes across a variety of theoretical orientations and types of client presenting problems (Elliott, Bohart, Watson, & Greenberg, 2011). Additionally, the role of empathy has been highlighted as important to therapeutic outcome when treating clients with depression (Malin & Pos, 2015), anxiety (Hara, Aviram, Constantino, Westra, & Antony, 2017), schizophrenia and psychosis (Pienkos & Sass, 2012), and alcohol and drug addiction (Moyers, Houck, Rice, Longabaugh, & Miller, 2016; Urbanoski, Kelly, Hoeppner, & Slaymaker, 2012).

Moyers and Miller (2013) studied counselors working with addiction clients, and found counselors with higher empathy scores had higher success rates with addiction clients, regardless of theoretical orientation than counselors with low empathy scores. However, counselors with low empathy scores were correlated with higher treatment drop-out rates, increased relapse rates, and decreased client change. Their results suggest that training counselors to increase empathy could help to improve treatment outcomes and prevent harm to clients in addiction treatment.

Empathy Training and Development

Due to the increased positive outcomes associated with increased empathy in the therapeutic relationship, the role of empathy cannot be overstated. Those individuals with a natural empathic disposition might have an advantage in the development of therapeutic relationships (Fulton, 2016); however, empathy can be increased through training, education, and shared experiences (Duan & Hill, 1996).

Didactic empathy training demonstrates effectiveness with a variety of different professional populations. For instance, Batt-Rawden, Chisolm, Anton, and Flickinger (2013)

conducted a meta-analysis of research related to increasing empathy among medical students. Out of the 18 studies examined, 15 produced significant increases in empathy among medical students, resulting from empathy training. Although each study utilized a different method or theory of empathy training (i.e. creative arts, communication skills training, experiential learning, etc), this analysis shows us the potential for empathy development interventions. Similarly, Brunero, Lamont, and Coates (2010) conducted a review of empathy education within nursing schools. Out of the 17 studies they examined, 11 of them reported significant positive changes in empathy among nursing students. The most common form of empathy training investigated was any intervention including case scenario-based learning. They also found differences in empathy related to trait empathy score, gender, and personal values (Brunero, Lamont, & Coates, 2010).

Research demonstrates that sharing experiences and interactions with others can improve levels of empathy. For instance, Hodges, Kiel, Kramer, Veach, and Villaneuva (2010) conducted an experiment with three groups: new mothers, pregnant women, and non-mothers. They found that members of each group were more likely to empathize with their own group members, indicating the shared experience of motherhood or pregnancy contributed to their ability or willingness to empathize.

Assessing Empathy in Counselor Education

If empathy is regarded as necessary for competent counseling practice, then counselor education programs must look at how counselor trainees develop this vital characteristic. One area to consider is how empathy might naturally develop over time, during counselor training and exposure to clients. Lyons and Hazier (2011), for instance, examined how a counseling student's developmental stage influenced their scores on an empathy measure. They compared

1st and 2nd year counseling masters students finding that 2nd year counseling students demonstrated significantly higher empathy than 1st year students. Similarly, DePue and Lambie (2014) measured empathy and competence levels of 87 counseling students before and after their first fieldwork (i.e. practicum) experience. They utilized the Interpersonal Reactivity Index (IRI) to assess for empathy and the Core Competencies Scale (CCS) to assess for counselor competency, as rated by supervisors. Their results showed that both student empathy and student competency significantly increased after exposure to clients during practicum training.

Other researchers have focused on the characteristics and traits that counseling students bring with them in to their counseling programs. Trusty, Ng, and Watts (2005) explored the effect of attachment style on the empathy of masters-level counselor trainees. Their study demonstrated that students with low avoidance and high anxiety attachment styles exhibited the highest levels of empathy. Similarly, Hiebert, Uhlemann, Marshall, and Lee (1998) found that excess anxiety among counselor trainees can interfere with level empathy toward clients. Gutierrez, Mullen, and Fox (2017) also found that higher emotional intelligence was significantly related to higher empathy in counselor trainees. Less research has investigated interventions or training specifically designed to increase empathy among counseling graduate students, although data suggests that mindfulness training can be helpful in cultivating empathy among counselor trainees (Shapiro & Izett, 2008). Fulton (2006) measured self-reported mindfulness in counselor trainees and found a medium effect size (r = .30) for influence on perceived empathy. Additionally, research indicates that greater levels of multicultural training are positively related to higher empathy levels among counselor trainees, and both training and empathy demonstrate a positive relationship to a counseling student's ability to conceptualize a

culturally diverse client (Constantine, 2001). Considering the previously discussed literature indicating that offenders are a unique cultural group, this is potentially significant.

Empathy and Burnout Among New Counselors

The link between burnout and working with difficult clients, such as offenders, was established earlier in this literature review. Research also demonstrates that experiences of burnout are likely to increase after finishing counselor training and continue increasing over time throughout a counselor's career, especially when working with challenging client groups. For instance, Wagaman, Geiger, Shockley, and Segal (2015) surveyed 173 social workers utilizing the Empathy Assessment Index and found that higher levels of empathy were associated with lower levels of burnout, indicating that as empathy increases burnout decreases. These results imply that high levels of empathy can help prevent or reduce burnout when working with difficult clients. Further, Pearlman and MacIan (1995) found evidence of counselor burnout tends to emerge in sessions with clients as a loss of empathy and an increase negative attitudes towards clients. Similarly, given the established relationship between empathy and burnout, research illustrates the tendency for empathy to decline over time. Although dispositional empathy is relatively stable over time, context-dependent and situational empathy have been shown to decline after training throughout one's clinical career (Bonuso, 2013).

Empathy, Attitudes, and Stigma

Further, research indicates that increased empathy tends to reduce a counselor's stigmatizing views towards their clients. Webb and colleagues (2016) conducted a study to measure empathy and stigma responses in a group of college students towards five different individuals who were each identified by a different stigmatized characteristic. They found that the most stigmatized character was a homeless individual, followed by a person with severe

psychological illness. However, their analysis showed that stigma was inversely related to empathy scores and individuals with higher empathy scores were less likely to hold stigmatizing views of the presented characters. Another study showed that medical professions experiencing empathy extinction, or decreased empathy, were more likely to hold stigmatizing views of their chronic pain patients (Cohen, Quintner, Buchanan, Nielsen, & Guy, 2011). Batson and colleagues (1997) tested the relationship between empathy and attitudes towards a stigmatized group, showing that higher empathy resulted in improved attitudes toward the group over a period of 2 weeks. Therefore, it is important for the counseling profession to understand both levels of empathy and attitudes towards challenging clients, for client welfare and for counselor sustainability.

Empathy for Offenders

Little research to date examines counselor or counselor trainee levels of empathy when working with the offender population. One study in Great Britain of therapists working with incarcerated sex offenders found higher levels of therapist empathy to be positively related to therapeutic change ($p < .05$, $r = .38$) (Marshall, 2005). A study of therapists working with female offenders found institutional and social dynamics prohibited empathic helping (Straussner & Phillips, 2005).

Other research examines empathy training among non-counseling professionals working with offenders in the United States. In one early study, Janoka and Scheckenbach (1978) conducted empathy training with inmates, correctional staff, and case workers at a correctional facility. They utilized a Carkhuff rating for empathy before and after the empathy training. All three groups (inmates, correctional staff, and case workers) showed significant increases from the pre-test to the post-test measurement. Other studies have shown similar results of additional

empathy training for correctional officers specifically working with sex offenders in the US (Craig, 2005; Greineder, 2013). Boag and Wilson (2013) measured the empathy of criminology students towards the offender population before, during, and after, an one day visit to a correctional facility. Their findings show even this brief engagement helped to humanize the offenders and increased the criminology students' empathy and tolerance scores towards the group.

Further research shows how other populations and the general public exhibit empathy towards offenders. Peterson and Silver (2015) explored factors that influence empathy for both victims and perpetrators after violent events. To complete their study they had a sample of over 800 college students read one of 6 possible vignettes about a mass shooting event and answer a survey and questionnaires to gather demographic information and assess for empathy for the victim and perpetrator, positive community responses, negative responses toward the perpetrator, and ability to make sense of the event. The vignettes differed in the amount of information provided about the victim (basic background information or increased positive background information) and the amount of information provided about the perpetrator (basic background information, increased positive background information, or extra information about his traumatic childhood). The study found that gender and dispositional empathy were the biggest predictors of victim empathy, and background information about the victim and perpetrator did not have a significant effect on the empathy scores. The same factors, gender and dispositional empathy, also resulted in higher levels of empathy toward the perpetrator when the vignette included background information and trauma information. Finally, these researchers found that race and dispositional empathy were the significant factors related to positive community response and on negative responses toward the perpetrator.

Conclusion

In summary, this literature review has examined the population of mentally ill offenders in the United States and the counselors that work with them. Literature related to the variables that will be investigated in this study, empathy and attitudes towards offenders, were presented. The current state of training for counselors working with offenders is unknown, which calls in to question the quality of care they are receiving. Limited research shows that counselors might hold stigmatizing views and attitudes towards this population and be experiencing burnout related to working with offenders. If true, counselors and their offending clients are both likely at risk. Empathy is an important variable in therapeutic outcomes and has also been shown to protect against stigma and burnout. However, the empathic responses of counselor trainees related to the population of offending clients with mental illness has not been studied until now.

Chapter 3: Method

Introduction

The purpose of this study was to add to the general base of knowledge in the counseling profession regarding the state of emerging counselor's attitudes and level of empathy towards offenders with mental illness. This study utilized demographic data and survey questions on two instruments to explore counselor trainee attitudes and levels empathy towards offenders with comorbid mental illness and substance use disorders among a sample of masters-level counseling students, referred to as counselor trainees. The research utilized correlational methods to examine the relationship between empathy and prior exposure to emerging counselors' attitudes towards offenders. It also utilized multiple regression analyses to analyze empathy and prior exposure to offenders as possible predictors for counselor trainee attitudes towards offenders with mental illness.

Research Questions

1) What are counselor trainees' trait empathy levels (as measured by the IRI) and attitudes towards mentally ill offenders (as measured by the PACAMI-O)?

2) What is the relationship between counselor trainee's trait empathy level (as measured by the subscales of the IRI) and attitudes towards mentally ill offenders (as measured by the PACAMI-O and its subscales)?

3) What is the relationship between prior exposure to offenders and attitudes towards mentally ill offenders (as measured by the PACAMI-O)?

4) Does counselor trainee trait empathy level and exposure to offenders predict their attitudes towards mentally ill offenders?

Variables

- Exposure to offenders – continuous variable created based on answers to dichotomous prior exposure questions on demographic questionnaire
- Trait empathy – ordinal variables measured using Davis' (1980) Interpersonal Reactivity Index (IRI)
- Attitudes towards offenders – ordinal variables measured using Glendinning and O'Keeffe's (2015) "Police and Community Attitudes towards Offenders with Mental Illness Scale" (PACAMI-O)

Instrumentation

Three instruments have been utilized for this study. The first is a demographic questionnaire, which the author developed to gather information about participants and their graduate program. The other two instruments are previously empirically validated to measure the constructs of attitudes towards mentally ill offenders and trait empathy levels.

Demographic Questionnaire

Demographic information about participants was collected including gender, race/ethnicity, age, program concentration/specialization, and length of time in program. Questions related to forensic mental health courses, professional experience, personal experience, or prior exposure with offenders were also collected and used to create the "exposure to offenders" variable. See Appendix C for the full questionnaire.

The PACAMI-O

Glendinning and O'Keeffe (2015) developed an assessment to measure attitudes towards mentally ill offenders, known as the "Police and Community Attitudes towards Offenders with Mental Illness Scale" (PACAMI-O). The PACAMI-O is an alternative version of the Community Attitudes towards Mental Illness Scale (CAMI) developed by Taylor and Dear (1981). The PACAMI-O expands on the CAMI by including attitudes towards the specific population of mentally ill offenders, rather than mentally ill individuals in the general public. The PACAMI-O is a 40 item self-report measure. Responses are made based on a 5-point Likert-type scale from 1 meaning "Strongly Agree" to 5 meaning "Strongly Disagree." Higher scores on the PACAMI-O indicate more positive attitudes towards offenders with mental illness. In its original study, the PACAMI-O was found to have high internal reliability ($\alpha = 0.929$).

The PACAMI-O is made up of 4 subscales: Self Preservation, Societal Reservation, Mental Health Awareness, and Treatment Ideology. Self Preservation refers to a respondent's concern for their personal well-being and safety, and a sample item from this subscale is: "Locating forensic mental health facilities in a residential area downgrades the neighborhood." Societal Reservation relates to a respondent's reluctance to treat offenders with mental illness as a normal part of society. A sample item from this scale is: "Offenders with mental illness should

not be treated as outcasts of society." The Mental Health Awareness scale indicates an awareness of mental health issues and how they affect offenders, a sample item from this subscale is: "Mental illness is an illness like any other." The Treatment Ideology subscale examines how a respondent feels about treatment options for mentally ill offenders. A sample item from this scale is: "We have the responsibility to provide the best possible care for offenders with mental illness." See Appendix A for the full scale.

The IRI

Davis (1980, 1983) developed a self-report assessment to measure dispositional empathy in respondents, known as the Interpersonal Reactivity Index (IRI). The IRI consists of 28 items. Responses to the measure are made on a 5-point Likert-type scale from 1 meaning "Does not describe me well" to 5 "Describes me very well." Higher scores on each subscale indicate higher identification with that particular aspect of empathy; however, there are no cut off scores that indicate "high" or "low" empathy. The original measurement development study used over 1,000 respondents (n = 579 males and n = 582 females) to validate the IRI. Factor analysis and reliability coefficients ranging from α = .70 - .78 suggest sufficient internal reliability. Retest reliability was measured after 60 days with reliability coefficients ranging from α = .61 to 81, suggesting sufficient test-retest reliability.

The IRI consists of four subscales: perspective taking, empathic concern, personal distress, and fantasy. Each subscale is made up of seven questions. The perspective taking subscale measures an individual's attempt to take on the perspective of another person and a sample item includes, "I try to look at everybody's side of a disagreement before I make a decision." The empathic concern subscale measures an individual's feelings of compassion, concern, and warmth toward others, and a sample item from this subscale includes, "I often have

tender, concerned feelings for people less fortunate than me." The personal distress subscale measures an individual's feelings of anxiety that arise when taking the perspective of another person, and a sample item includes, I sometimes feel helpless when I am in the middle of a very emotional situation. The fantasy subscale measures an individual's ability to identify with people from fantasy media (i.e. books, movies, etc), and a sample item includes, "after seeing a play or movie, I have felt as though I were one of the characters." See Appendix B for the full scale.

Participants

Participants were 100 graduate counseling students over the age of 18 who were enrolled in CACREP-accredited masters counseling programs in the United States. Counseling students enrolled in certificate programs, doctoral counseling students, and faculty or community practitioners were excluded due to greater variation in professional identity. 125 counseling students started this study. One participant was excluded due to being unsure of the CACREP status of their counseling program. 24 additional participants were excluded due to only partially completing the survey instruments, leaving 100 cases for analysis. Of these 100, 18 identified as male, 79 identified as female, and 3 identified as non-binary or chose not to identify. Participants ranged in age from 22 years old to 78 years old and the mean age of participants was 31.92. The racial identity of participants was as follows: 12% identified as African American or Black, 1% identified as Asian, 63% identified as Caucasian or White, 8% identified as Latinx, 2% identified as Middle Eastern, 11% identified as Multiracial or Biracial, and 3% identified as Native American.

Participants were asked which state their counseling program was housed in. The researcher then used US census categories to identify how many programs were in different geographic areas of the country. Participants were enrolled in counseling programs across the

United States with 5% enrolled at a program in the Northeastern area of the US, 20% enrolled at a program in the Midwestern area of the US, 43% enrolled at a program in the Southern area of the US, and 32% enrolled in a program in the Western area of the US. 75% of participants identified Clinical Mental Health Counseling as their primary program concentration or specialization, 10% of participants were in a School Counseling program, 1% student was in a Rehabilitation Counseling program, 10% were in a Marriage & Family Therapy Counseling program, 3% were in an Addictions Counseling program, and 1% was in a Community Counseling program. 65 out of the 100 participants had not yet had any program specific fieldwork (i.e. practicum or internship) experience yet, and 35 had at least one fieldwork experience so far in their program. See Table 1 for more information about participants.

Data Collection and Procedures

This research study was approved by the Institutional Review Board (IRB) at the University of Memphis in December 2019 prior to the commencement of data collection in January of 2020. Data collection for this study ended in March of 2020. An online survey, hosted through Qualtrics, including the instruments and demographic questions mentioned above, was distributed through online convenience sampling and snowball recruiting. These sampling efforts included dissemination through the Counselor Education and Supervision Network – Listserv (CESNET-L) the American Counseling Association Connect Listserv and targeted emails to program directors of CACREP-accredited programs asking them to forward the survey to the targeted participant population of counseling masters students.

Once a participant opened the Qualtrics survey link, they read an informed consent document outlining the risks, benefits, and goals of the study before continuing to the survey questions (Appendix D). All survey responses were collected anonymously and no identifying

information was collected. As participants responded to the survey, their completed data was stored on the University of Memphis Qualtrics server. Raw data was maintained on a password protected computer and only accessible to the primary investigator.

Chapter 4: Results

Introduction

Chapter 4 reports the data analysis procedures and findings of this study. First, data was downloaded from the data collection platform, Qualtrics, into the data analysis software IBM SPSS Statistics Version 25. Data cleaning procedures were utilized, including the reverse coding of necessary items. On the Interpersonal Reactivity Index (IRI), items 3, 4, 7, 12, 13, 14, 15, 18, and 19 were reverse coded. On the Police and Community Attitudes Towards Mentally Ill Offenders (PACAMI-O) scale, items 2, 4, 5, 7, 10, 12, 13, 15, 18, 20, 21, 23, 26, 27, 28, 29, 31, 34, 36, and 39 were reverse coded. Missing data was examined and any participants who did not complete the entirety of the IRI and the PACAMI-O were excluded from any further analyses.

An additional variable was created by the primary investigator to represent overall Exposure to Offenders by combining participant answers to the following four questions on the demographic questionnaire: question 9 (Have you completed a dedicated course on forensic mental health counseling or offenders with mental illness as a part of your graduate curriculum?), question 10 (Have you competed another course that included information on issues related to forensic mental health counseling or mentally ill offenders?), question 12 (Have you had a fieldwork experience, a job, or other professional experience working with a mentally ill offender?), and question 13 (Have you had any personal experience with a mentally ill offender?). An affirmative answer on any of those four questions was translated into a summed quantitative “Exposure to Offenders” variable with scores ranging from 0 (meaning none of the

four exposure questions was answered affirmatively) to 4 (meaning all four of the exposure questions were answered affirmatively).

Following data cleaning and preparation, descriptive statistics were run for the IRI, the PACAMI-O, and the demographic variables to provide background information for this study and to answer research question #1: "what are counselor trainee's trait empathy levels and attitudes towards mentally ill offenders?". Reliability analysis were run on the two instruments used in this study. Additionally, Pearson product-moment correlational analyses were run to measure strength of relationships between variables and answer research question #2 "what is the relationship between counselor trainee trait empathy level and attitudes towards mentally ill offenders?" and question #3: "what is the relationship between prior exposure to offenders and attitudes towards mentally ill offenders?" Although the IRI and the PACAMI-O consist of ordinal Likert-type data, research supports the use of robust parametric tests, such as Pearson correlation, when other assumptions have been met and sample size is sufficient (Norman, 2010). Lastly, multiple regression analyses were run to answer research question 4 "does counselor trainee trait empathy level and exposure to offenders predict their attitudes towards mentally ill offenders?"

Descriptive Statistics

Subscale scores, including mean and standard deviation, for the Fantasy subscale (M = 24.83, SD = 5.78), the Perspective Taking subscale (M = 27.38, SD = 4.05), the Empathic Concern subscale (M = 29.43, SD = 3.62), and the Personal Distress subscale of the IRI (M = 15.95, SD = 5.08) , as well as total scores for the IRI (M = 97.90, SD = 11.47) were computed. Summated scale scores, or the average response for each subscale item, were also calculated.

The summated scores are as follows: total IRI = 3.50, Fantasy = 3.55, Perspective Taking = 4.05, Empathic Concern = 4.20, and Personal Distress 2.28. See Table 2.1.

Subscale scores, including mean and standard deviation, for the Self Preservation subscale (*M* = 49.01, *SD* = 8.86), the Societal Reservation subscale (*M* = 44.7, *SD* = 5.84), the Mental Health Awareness subscale (*M* = 35.46, *SD* = 4.72), and the Treatment Ideology subscale of the PACAMI-O (*M* = 18.85, *SD* = 2.33), as well as total scores for the PACAMI-O (*M* = 154.41, *SD* = 19.72) were computed. Summated scale scores, or the average response for each subscale item, were also calculated. The summated scale scores are as follows: total PACAMI-O = 3.86, Self Preservation = 3.5, Societal Reservation, 4.06, Mental Health Awareness = 3.55, and Treatment Ideology = 3.77. See Table 2.2.

Reliability Analyses

A reliability analysis using Cronbach's alpha was performed to examine the internal consistency of the 28-item Interpersonal Reactivity Index, as well as the 7-item Fantasy subscale, the 7-item Perspective Taking (IRI) subscale, the 7-item Empathic Concern subscale, and the 7-item Personal Distress subscale. Results for the Interpersonal Reactivity Index indicated acceptable reliability (Cronbach's $\alpha = .83$). Results for the Fantasy subscale indicated acceptable reliability with the alpha for the subscale equal to .85. Results for the Perspective Taking subscale indicated acceptable reliability with the alpha for the subscale equal to .77. Results for the Empathic Concern subscale indicated acceptable reliability with the alpha for the subscale equal to .76. Results for the Personal Distress subscale indicated acceptable reliability with the alpha for the subscale equal to .84. See Table 2.1.

Additionally, internal reliability of the 40-item Police and Community Attitudes Towards Mentally Ill Offenders scale (PACAMI-O), as well as the 14-item Self Preservation subscale, the

11-item Societal Reservation subscale, the 10-item Mental Health Awareness subscale, and the five-item Treatment Ideology subscale, were investigated using Cronbach's alpha. Results for the PACAMI-O indicated acceptable reliability with the alpha for the total scale equal to .92. Results for the Self Preservation subscale indicated acceptable reliability with an alpha for the subscale equal to .86. Results for the Societal Reservation subscale indicated acceptable reliability with an alpha for the subscale equal to .76. Results for the Mental Health Awareness subscale ($\alpha = .59$) and the Treatment Ideology subscale ($\alpha = .53$) do not meet the recommended acceptable alpha of .70 or greater, indicating possible issues with the reliability of these subscales. However, they are still above the unacceptable alpha cut off of $\alpha \leq .50$. Further, Cronbach's alpha is sensitive to the number of items in a scale and scales with 10 or fewer items, such as the Mental Health Awareness subscale and the Treatment Ideology subscale, are more likely to have a lower alpha score and still be reliable (George & Mallery, 2003; Hinton, Brownlow, McMurray, & Cozens, 2004). See Table 2.2.

Correlational Analyses

Pearson product-moment correlational analysis was conducted for all scales of the PACAMI-O and the IRI, as well as between the PACAMI-O and the Exposure to Offenders variable. As the correlation coefficients presented in Table 3.1 reveal, overall the relationships between the subscales of the IRI to each other ranged from non-significant to strong. All IRI subscales were significantly correlated to each other at the .05 level or higher, with the exception of the relationship between the Fantasy Scale and the Perspective Taking scale ($r = .179$, $p = .068$) and the relationship between the Empathic Concern scale and the Personal Distress scale ($r = .049$, $p = .623$). Additionally, as the correlation coefficients presented in Table 3.2 reveal, overall the correlations between the subscales of PACAMI-O showed moderate to large

correlational relationships. All the PACAMI-O subscales were significantly correlated to each other at the .05 level or higher.

The correlation coefficients for the relationships between each subscale of the PACAMI-O and each subscale of the IRI are presented in Table 3.3. The total PACAMI-O score was found to have a moderate positive correlation with the Fantasy scale of the IRI ($r = .376$, $p < .001$), a large positive correlation with the Perspective Taking scale of the IRI ($r = .526$, $p < .001$), and a moderate positive correlation with the Empathic Concern scale of the IRI ($r = .37$, $p < . 001$). The total PACAMI-O score was not significantly correlated with the Personal Distress scale of the IRI ($r = .131$, $p = .200$). The total PACAMI-O score was found to have a small positive correlation to the Exposure to Offender variable ($r = .232$, $p = .022$).

The Self Preservation scale of the PACAMI-O was found to have a moderate positive correlation with the Fantasy scale of the IRI ($r = .309$, $p = .002$), a large positive correlation with the Perspective Taking scale of the IRI ($r = .506$, $p < .001$), and a moderate positive correlation with the Empathic Concern scale of the IRI ($r = .342$, $p = .001$). The Self Preservation scale of the PACAMI-O was not significantly correlated with the Personal Distress scale of the IRI ($r = -.117$, $p = .256$). The Self Preservation scale of the PACAMI-O was found to have a small positive correlation to the Exposure to Offender variable ($r = .244$, $p = .016$).

The Societal Reservation scale of the PACAMI-O was found to be significantly correlated with all subscales of the IRI. It was found to have a small positive correlation with the Fantasy scale of the IRI ($r = .275$, $p < .001$), a moderate positive correlation with the Perspective Taking scale of the IRI ($r = .421$, $p < .001$), a small positive correlation with the Empathic Concern scale of thee IRI ($r = .261$, $p = .009$), and a small negative correlation with the Personal Distress scale of the IRI ($r = -.286$, $p = .004$). The Societal Reservation scale of the PACAMI-O

was found to have a small positive correlation to the Exposure to Offender variable (r = .297, p = .003).

The Mental Health Awareness scale of the PACAMI-O was found to have a moderate positive correlation with the Fantasy scale of the IRI (r = .348, p < .001), a moderate positive correlation with the Perspective Taking scale of the IRI (r = .328, p = .001), and a moderate positive correlation with the Empathic Concern scale of the IRI (r = .463, p < .001). The Mental Health Awareness scale of the PACAMI-O was not significantly correlated with the Personal Distress scale of the IRI (r = .094, p = .358). Similarly, the Mental Health Awareness scale of the PACAMI-O was not significantly correlated with the Exposure to Offenders variable (r = .088, p = .389).

The Treatment Ideology scale of the PACAMI-O was found to have a moderate positive correlation with the Fantasy scale of the IRI (r = .356, p < .001), a moderate positive correlation with the Perspective Taking scale of the IRI (r = .449, p < .001). and a moderate positive correlation with the Empathic Concern scale of the IRI (r = .463, p < .001). The Treatment Ideology scale of the PACAMI-O was not significantly correlated with the Personal Distress scale of the IRI (r = -.073, p = .474). Similarly, the Treatment Ideology scale of the PACAMI-O was not significantly correlated with the Exposure to Offenders variable (r = .106, p = .299). See Table 3.3 for cross variable correlation relationships.

Multiple Regression Analyses

A multiple regression was conducted to predict a total PACAMI-O score from the four subscales of the IRI (Fantasy scale, Perspective Taking scale, empathic Concern scale, and Personal Distress scale) and the combined Exposure to Offenders variable. Together these five predictors significantly predicted about 40% of the variance in the total PACAMI-O scores (R =

.632, R^2 = .399, F = 11.697, p < .001). Three predictor variables were statistically significant: Fantasy (t = 3.64, p = .000), Perspective Taking (t = 3.091, p = .003), and Exposure to Offenders (t = 2.401, p = .018). Two predictor variables were not statistically significant: Empathic Concern (t = 1.090, p = .279) and Personal Distress (t = .189, p = .189). The Durbin-Watson statistic was in normal range at 2.10. The effect size for this analysis was large (f^2 = .66). See Table 4.1.

A multiple regression was conducted to predict the Self Preservation subscale score of the PACAMI-O from the four subscales of the IRI (Fantasy scale, Perspective Taking scale, Empathic Concern scale, and Personal Distress scale) and the combined Exposure to Offenders variable. Together these five predictors significantly predicted about 34% of the variance in Self Preservation subscale scores (R = .586, R^2 = .344, F = 9.219, p < .001). Three predictor variables were statistically significant: Fantasy (t = 2.690, p = .009), Perspective Taking (t = 3.252, p = .002), and Exposure to Offenders (t = 2.399, p = .019). Two predictor variables were not statistically significant: Empathic Concern (t = .828, p = .410) and Personal Distress (t = -.535, p = .594). The Durbin-Watson statistic was in normal range at 2.06. The effect size for this analysis was large (f^2 = .52). See. Table 4.2.

A multiple regression was conducted to predict the Societal Reservation subscale score of the PACAMI-O from the four subscales of the IRI (Fantasy scale, Perspective Taking scale, Empathic Concern scale, and Personal Distress scale) and the combined Exposure to Offenders variable. Together these five predictors significantly predicted about 34% of the variance in Societal Reservation subscale scores (R = .581, R^2 = .338, F = 8.971, p < .001). Three predictor variables were statistically significant: Fantasy (t = 3.506, p = .001), Personal Distress (t = -2.980, p = .004) and Exposure to Offenders (t = 2.424, p = .017). Two predictor variables were

not statistically significant: Perspective Taking (t = 1.585, p = .116) and Empathic Concern (t = .707, p = .481). The Durbin-Watson statistic was in normal range at 2.01. The effect size for this analysis was large (f^2 = .51). See. Table. 4.3.

A multiple regression was conducted to predict the Mental Health Awareness subscale score of the PACAMI-O from the four subscales of the IRI (Fantasy scale, Perspective Taking scale, Empathic Concern scale, and Personal Distress scale) and the combined Exposure to Offenders variable. Together these five predictors significantly predicted about 17% of the variance in Mental Health Awareness subscale scores (R = .416, R^2 = .173, F = 3.685, p = .004). Only one predictor variable was statistically significant: Fantasy (t = 2.688, p = .009). All other predictor variables were not statistically significant: Perspective Taking (t = 1.756, p = .083), Empathic Concern (t = -.036, p = .972), Personal Distress (t = .564, p = .574) and Exposure to Offenders (t = 1.420, p = .159). The Durbin-Watson statistic was in normal range at 2.15. The effect size for this analysis was moderate (f^2 = .21). See Table 4.4.

Lastly, a multiple regression was conducted to predict the Treatment Ideology subscale score of the PACAMI-O from the four subscales of the IRI (Fantasy scale, Perspective Taking scale, Empathic Concern scale, and Personal Distress scale) and the combined Exposure to Offenders variable. Together these five predictors significantly predicted about 33% of the variance in Treatment Ideology subscale scores (R = .577, R^2 = .333, F = 8.787, p < .001). However, none of the predictor variables were significant: Fantasy (t = 2.444, p = .017, Perspective Taking (t = 2.056, p = .043), Empathic Concern (t = 2.572, p = .012), Personal Distress (t = -1.070, p = .288) and Exposure to Offenders (t = 1.076, p = .285). The Durbin-Watson statistic was in normal range at 2.13. The effect size for this analysis was large (f^2 = .499). See Table 4.5.

Chapter 5: Discussion

Introduction

Chapter 5 includes summaries of major findings as well as a discussion of the implications of the results for counselor education theory and research. The chapter ends with a discussion of limitations, areas for future research, and concluding remarks.

Research Question One

The summated scale scores for the IRI and its subscales were used to determine levels of trait empathy in our population of counselor trainees. The summated score for the total IRI instrument is 3.50, indicating a general positive trend in responses and therefore high overall empathy scores. However, empathy is a complicated construct with many facets so it is important to look at the specific types of empathy measured in the subscales of the IRI. The highest summated score was for the Empathic Concern scale at 4.20, indicating this construct is elevated in our population of counseling students. The lowest summated score was for the Personal Distress subscale at 2.28. This subscale was the only scale of the IRI with a summated score below the neutral point, signifying counseling students do not frequently experience anxiety or distress when dealing with others' emotions. One reason for lower scores on the Personal Distress scale could be that counseling students conceptualize this as an inability to handle crisis situations (i.e. Question 27: "When I see someone who badly needs help in an emergency, I go to pieces"), which they receive specific training in. The 2016 CACREP standards instruct counseling programs to provide instruction related to: effects on crisis and disasters across the lifespan, crisis intervention and suicide prevention models and strategies, and procedures for identifying trauma and abuse, and assessing risk of aggression or danger to others, self-inflicted harm, or suicide (p. 11-12; CACREP, 2016). It is possible this standardized training

makes the Personal Distress subscale less relevant for measuring empathy in helping professions, including counselors and counseling students.

The summated scale scores for the PACAMI-O and its subscales were used to determine general attitudes towards offenders with mental illness in our population of counselor trainees. The summated score for the total PACAMI-O instrument was 3.86, indicating a general positive trend in the responses from counselor trainees. In addition, every subscale of the PACAMI-O fell on the higher side of neutral, meaning each individual scale produced a positive attitudinal response towards offenders with mental illness. The highest summated score, and therefore the most positive overall response, was 4.06 for the Societal Reservation subscale of the PACAMI-O, indicating counseling students generally wish to see offenders with mental illness as normal citizens and do not see them as outcasts of society. The lowest summated score was 3.5 for the Self Preservation subscale of the PACAMI-O, indicating that counseling students feel more concerned about their safety and well-being around offenders with mental illness than the other constructs measured. It should be noted that this is still an overall positive score and does not indicate a hindering level of concern in students. However, the lowest rating on the Self Preservation scale does reinforce previous research that found some level of concern in helping professionals when working with offenders and reinforces the need for educational curriculum on safety and boundary setting when working with an offending population (Ellmo, 2019; Magaletta et al, 2013; Voorhis, Braswell, & Lester, 2009)

Research Question Two

Correlational analyses looked at the relationship between counselor trainee scores on the four subscales of the IRI (Fantasy, Perspective Taking, Empathic Concern, and Personal Distress) and their scores on the PACAMI-O and its subscales (Self Preservation, Societal

Reservation, Mental Health Awareness, and Treatment Ideology). Total PACAMI-O scores were found to have significant positive correlation with all subscales of the IRI, with the exception of the Personal Distress subscale, which showed a non-significant relationship. In other words, as scores on these three IRI subscales measuring aspects of empathy increase, scores indicating positive attitudes towards offenders also increase. In particular, the Perspective Taking subscale score had the largest correlation with total PACAMI-O score. This finding indicates that the ability to consider others points of view is a closely related construct to positive attitudes towards mentally ill offenders. Perspective taking in counseling students could be fostered through class activities, such as role plays, designed to allow students time to practice taking the point of view of another student or client.

Looking at the subscales of PACAMI-O shows us more specifically which aspects of attitudes towards offenders could be targeted in counselor training. Self Preservation scores, Mental Health Awareness scores, and Treatment Ideology scores showed a similar relationship pattern to the IRI subscale scores as the total PACAMI-O score did to the IRI subscales. All three of these subscales were found to have significant correlational relationships to the subscales of the IRI, with the same exception for non-significance with the Personal Distress subscale. The remaining subscale of the PACAMI-O, Societal Reservation, showed a statistically significant correlation to all subscales of the IRI, including the Personal Distress subscale. However, the relationship between Societal Reservation and Personal Distress showed a negative or inverse relationship, meaning as Personal Distress scores increased Societal Reservation decreased.

It is clear the Personal Distress subscale is the outlier for this population of counseling students. As outlined under Research Question One, the Personal Distress scale might not be an

accurate measure of empathy in counseling students. Additionally, previous research also indicates the Personal Distress subscale has been found to have fewer correlations to related constructs in populations of medical students and has been shown to decline over time in medical students (Bellini & Shea, 2005; Hojat, Mangione, Kane, & Gonnella, 2005).

Research Question Three

Correlational analyses looked at the relationship between counselor trainee prior exposure to offenders and attitudes towards offenders with mental illness. Scores on the Exposure to Offenders variable showed significant positive correlations with total PACAMI-O scores, Self Preservation subscale scores, and Societal Reservation subscale scores. Learning through experiences and modelling have been established in previous research as indicators for attitude formation (Angermeyer & Matschinger, 2005; Bandura, 1977; Glendinning & O'Keeffe, 2015), so it was expected that prior exposure to offenders would be related to attitudes towards offenders, as seen in the significant relationships with these scores. The correlation between higher Self Preservation scores and prior Exposure to Offenders indicate that participants who perceived offenders with mental illness to be less dangerous might have learned this through modelling from professors in classes or other individuals in professional or personal experiences. Similarly, the correlation between higher Societal Reservation scores and prior Exposure to Offenders suggest that participants who see offenders with mental illness as people, and not outcasts of society, might have adapted this attitude based on their classroom or real life exposure to the population.

However, scores on the Exposure to Offenders variable were not significantly correlated with the Mental Health Awareness nor the Treatment Ideology subscales. There are a few possible explanations for the lack of significant correlation with these remaining subscales. Both

of these subscales showed questionable reliability coefficients during reliability analysis, so it is possible that these measures are not reliable in this population of counseling students. The PACAMI-O instrument was developed and normed on two populations: police officers and the general public. It is possible that counseling students differ significantly from those populations. The Mental Health Awareness and Treatment Ideology scales might not be sensitive enough to measure these constructs in a population who receive extensive training in these areas. These subscales are retained in this study's analysis for informational purposes but the researcher urges caution in drawing conclusions related to these specific subscales in this study.

Research Question Four

Multiple regression analyses were run to determine if the four subscales of the IRI along with the Exposure to Offenders variable would be significant predictors for PACAMI-O scores and its subscale scores. Although analyses were run for the Mental Health Awareness and Treatment Ideology scales of the PACAMI-O and the five selected predictor variables did predict a statistically significant portion of variance in these scores, the implications from these analyses are limited due to low reliability and non-significant correlations under Research Questions Two and Three.

However, the other regression analyses revealed promising findings and are discussed in detail below. The main multiple regression with total PACAMI-O score as the dependent variable found the 5 predictor variables (subscales of the IRI and Exposure to Offenders) to account for 40% of the variance in the scores, with Fantasy scores, Perspective Taking scores, and Exposure scores as statistically significant individual predictor variables. The next analyses with Self Preservation as the dependent variable showed 33% variance explained, and had the same statistically significant individual predictors. The analyses with Societal Reservation as the

dependent variable showed 34% variance explained by the predictors; however, while Fantasy and Exposure to Offenders were still statistically significant variables, Perspective Taking was not significant and Personal Distress was significant instead.

As a predictor variable, Personal Distress was weak in these analyses. This is not surprising given its lack of correlation to the PACAMI-O and its subscale scores under Research Question 2. Overall, Fantasy scores and Exposure to Offenders appear to be the most worthy of consideration moving forward in this study. These variables show the most significance within the results of this study and should therefore be looked at more closely in future research. Implications for these areas within counselor education are discussed in more detail below.

All of these regression analyses indicated there is still a large piece of variance unexplained by the study variables. Future research should consider other possible predictor variables for empathy and/or attitudes, such as gender or racial identity. Previous research has established a strong relationship between these variables and empathy and therefore might fit into this model. People have been shown to display more empathy for individuals from their own racial group, and, in general, people are less likely to show empathy for non-white individuals (Aucion, 2018; Chiao & Mathur, 2010; Neumann, Boyle, & Chan, 2017). When it comes to sex and/or gender differences, women have also demonstrated higher levels of both dispositional empathy, situational empathy, and cross-racial empathy (Aucion, 2018; Barrett, Lane, Sechrest, & Schwartz, 2000; Christov-Moore et al., 2014).

Implications for Counselor Education

Results showed 96% of counseling masters students in this study have not taken a course dedicated to Forensic Mental Health Counseling and 58% of them had not even studied the population in any of their other classes. Meaning less than half of counseling students have

discussed this type of client or been given information about this population in a classroom setting. Given that exposure to offenders, including classroom exposure, was a significant predictor variable for attitudes towards offenders, it seems that exposing students to this population in their coursework has a positive influence on overall attitudes towards the population, which in turn can lead to positive client outcomes for offenders (Sandell et al., 2007; Stangor, 2017). The results of this research study suggest incorporating opportunities to learn about offenders with mental illness in to graduate program coursework could benefit both the students and their future offending clients. Although the majority of counseling curriculum is dictated by CACREP standards and CACREP currently doesn't have any recommendations or standards related to offenders (CACREP, 2016), there are opportunities in existing core classes, such as Multicultural Counseling courses or Addiction Counseling courses, to include forensic mental health counseling issues.

Related to lack of focus on offenders in coursework, only 22% of counselor trainees said they had encountered or worked with an offender in a professional experience (i.e. through an internship, volunteer experience, etc). Given the growing number of offenders dealing with mental health issues in the US, it is likely a counselor will encounter a member of this population during their career (Nellis, 2016; Torrey et al., 2014). Fieldwork experiences are a valuable learning experience for counselor trainees, where they develop vital counseling skills that can not be acquired in a classroom alone (CACREP, 2016). Therefore, counseling programs could consider adding additional fieldwork opportunities in forensic mental health counseling, in order to support supervised student growth and training in working with this population. However, given the specialized training needed to work with offenders (Holman, 2019) it is also

recommended that increasing fieldwork opportunities are accompanied by increased classroom exposure as well.

Lastly, the results of this study provide insight about how to incorporate offenders into curriculum. In particular, the strong connection between Fantasy, Perspective Taking, and Exposure to Offenders to attitudes indicate these may be valuable tools to consider in the classroom. Counselor educators could encourage students to seek out new and different experiences related to this population, which would translate to exposure, by incorporating them into the syllabi or as extra credit opportunities. Similar research on counselors' level of empathy for clients dealing with addictions and substance abuse also recommends the use of experiential learning activities to increase empathy (Giordano, Stare, & Clarke, 2015). Even when students can't have direct contact or exposure to offenders, class activities that work to increase skills related to the Fantasy and Perspective Taking scales could have an indirect impact on attitudes. In particular, class activities that incorporate fictional media might be helpful for students to visualize client interactions or possible interventions, given the high correlation between attitudes towards offenders and the Fantasy scale of the IRI.

Limitations and Future Research

A possible limitation of this study is its reliance on self-report data. The possibility of social desirability bias influencing self-report data has been documented; however, in this study the research variables are being investigated with a new population (i.e. counselor trainees) for the first time and self-report data is considered sufficient for exploratory evaluation. Future research should consider the implementation of observer, supervisor, or client rated data on measures of counselor empathy to combat possible social desirability bias of self-report data.

Similarly, because the study variables haven't been used with counselor trainees some of the instrumentation has not yet been normed on this population. The Interpersonal Reactivity Index has been widely used and shown reliable and valid with a variety of different populations; however, the Police and Community Attitudes towards Offenders with Mental Illness Scale has been used in fewer research studies. The total scale was found to have high internal reliability in its original study and in this study; however, the two of the subscales were found to have questionable reliability in this study and so conclusions drawn from those two scales are limited. Future research should determine whether improvements could be made to this instrument for use with counseling students or if an entirely new instrument needs to be developed for use with counseling students and other helping professionals.

Additionally, the PACAMI-O doesn't distinguish between attitudes towards offenders and attitudes towards offenders with mental illness, nor does it distinguish between different types of offenders or different types of mental illness. As mentioned in Chapter 2 of this study, previous research does indicate varying attitudes based on type of offender. In particular, sex offenders and offenders with comorbid mental illness and substance abuse have been known to face additional stigma not seen in other types of offenders (Hardeberg, Bach, & Demuth, 2018; Hartwell, 2004). Future research should include a thorough investigation of how these specifiers might impact both empathy and attitudes.

Lastly, future research should look more closely at the variables highlighted in the discussion section of this study (Fantasy, Perspective Taking, and Exposure to Offenders) and how they related to attitudes and other similar constructs, such as countertransference and burnout, in other populations of helping professionals. In particular, future research could look at these variables in a population of counselors (post-graduation) to determine if any differences are

related to professional identity development and/or years of practice that are not seen in this study's population of masters level counseling graduate students.

Conclusion

This study reinforces the literature that outlines the association between empathy and attitudes (Webb et al., 2016). Further, it supports the idea that attitudes towards offenders with mental illness are directly influenced by empathy and prior exposure to offenders, which in turn have been shown in previous literature to relate to burnout in counselors and effective treatment outcomes for clients (Perkins & Spring, 2013) The results of this study are important when considering counselor education standards for counselor trainees, and support the inclusion of offenders with mental illness as part of graduate curriculum. Lastly, the results of this study indicate that the Personal Distress subscale of the IRI and the Mental Health Awareness and Treatment Ideology subscales of the PACAMI-O might not be good measurement tools for counselors or counseling students due to significant training in these areas complicating the measurement of these variables.

References

Adjorlolo, S., Abdul-Nasiru, I., Chan, H. C., & Bambi, L. E. (2018). Mental health professionals' attitudes toward offenders with mental illness in Ghana. *International Journal of Offender Therapy and Comparative Criminology*, 62(3), 629–654. Doi: 10.1177/0306624X16666802

American Counseling Association. (2014). *ACA Code of Ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author

Angermeyer, M. H., & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany. *The British Journal of Psychiatry*, 186, 331-334.

Aucion, E. (2018). Empathy leads to death: Why empathy is an adversary of capital defendants. *Santa Clara Law Review*, 58(1), 100-135.

Baillargeon, J., Penn, J. V., Knight, K., Harzke, A. J., Baillargeon, G., & Becker, E. A. (2010). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and Policy in Mental Health and Mental Health Services Research*, 37(4), 367-374.

Balconi, M. & Canavesio, Y. (2012). Emotional contagion and trait empathy in prosocial behavior in young people: The contribution of autonomic (facial feedback) and Balanced Emotional Empathy Scale (BEES) measures. *Journal of Clinical and Experimental Neuropsychology*, 35(1), Doi: 10.1080/13803395.2012.742492

Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, New Jersey: Prentice Hall.

Barrett, K. A. & McWhirter, B. T. (2002). Counselor trainees' perceptions of clients based on client sexual orientation. *Counselor Education and Supervision*, 41, 219-232.

Barrett, L. F., Lane, R. D., Sechrest, L., & Schwartz, G. E. (2000). Sex differences in emotional awareness. Personality and Social Psychology Bulletin, 26(9), 1027-1035.

Batson, C. D. (1990). How social an animal? The human capacity for caring. *American Psychologist*, 45, 336–346.

Batson, C. D., Batson, J. G., Slingsby, J. K., Harrell, K. L., Peekna, H.M., & Todd R. M. (1991). Empathic joy and the empathy-altruism hypothesis. *Journal of Personality and Social Psychology*, 61, 413–426.

Batson, C. D., Polycarpou, M. P., Harmon-Jones, E., Imhoff, H. J., Mitchener, E. C., Bednar, L. L., Klein, T. R., & Highberger, L. (1997). Empathy and attitudes: Can feeling for a member of a stigmatized group improve feelings toward the group? *Journal of Personality and Social Psychology*, 72(1), 105-118.

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Bellini, L. M. & Shea, J. A. (2005). Mood change and empathy decline persist during three years of internal medicine training. *Academic Medicine*, 80(2),164.

Boag, E. M. & Wilson, D. (2013). Does engaging with serious offenders change students' attitude and empathy toward offenders? A thematic analysis. *Journal of Forensic Psychiatry & Psychology*, 24(6), 699-712. Doi: 10.1080/14789949.2013.841973

Bonuso, C. F. (2013). Empathy in the clinical encounter: A study of situational and dispositional empathy levels as associated with clinical training and practice. *ETD Collection for Pace University*.

Bronson, J., and Carson, E.A. (2019). *Prisoners in 2017*. Washington, DC: Bureau of Justice Statistics. Retrieved from: https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6546

Brunero, S., Lamont, S., & Coates, M. (2010). A review of empathy education in nursing. *Nursing Inquiry*, 17(1), 65-74.

Burke, P. A., Carruth, B., & Prichard, D. (2006). Counselor self-care in work with traumatized, addicted people. *Journal of Chemical Dependency Treatment*, 8(2), 283-301.

Buser, T. J. (2008). Counselor training: Empirical findings and current approaches. *Counselor Education & Supervision*, 48(2), 86-100, doi: 10.1002/j.1556-6978.2008.tb00065.x

Carmel M. J., Friedlander M. L. (2009). The relation of secondary traumatization to therapists' perceptions of the working alliance with clients who commit sexual abuse. *Journal of Counseling Psychology*, 56(3), 461–467. 10.1037/a0015422

Carrola, P. A., Olivarez, A., & Karcher, M. J. (2016). Correctional counselor burnout: Examining burnout rates using counselor burnout inventory. *Journal of Offender Rehabilitation*, 55(3), 195-212. Doi: 10.1080/10509674.2016.1149134

Castillo, E. D., & Alarid, L. F. (2011). Factors associated with recidivism among offenders with mental illness. *International Journal of Offender Therapy and Comparative Criminology*, 55, 98-117. Doi:10.1177/0306624X09359502

Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association*, 301(2), 183-190. Doi: 10/1001/jama.2008.976

Chiao, J. Y. & Mathur, V. A. (2010). Intergroup empathy: How does race affect empathic neural responses? *Current Biology*, 20(11), 478-480. Doi: 10.1016/j.cub.2010.04.001.

Christov-Moore, L., Simpson, E. A., Coudé, G., Grigaityte, K., Iacoboni, M., & Ferrari, P. F. (2014). Empathy: Gender effects in brain and behavior. *Neuroscience Behavior Review*, 46(4), 604-627. Doi: 10.1016/j.neubiorev.2014.09.001

Chudzik, L. (2016). Therapeutic assessment of a violent criminal offender: Managing the cultural narrative of evil. *Journal of Personality Assessment*, 98(6), 585-589. Doi: 10.1080/00223891.2016.1215321

Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior, 37*(2), 175-187.

Cohen, M., Quintner, J., Buchanan, D., Nielsen, M., & Guy, L. (2011). Stigmatization of patients with chronic pain: The extinction of empathy. *Pain Medicine*, 12(11), 1637-1643. Doi: 10.1111/j.1526-4637.2011.01264.x

Constantine, M. G. (2001). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling*, 23(4), 357-372.

Council for Accreditation of Counseling & Related Education Programs (2015). 2016 CACREP Standards. Retrieved from: http://www.cacrep.org/wp-content/uploads/2017/07/2016-Standards-with-Glossary-7.2017.pdf.

Cox, M. (1996). Dynamic psychotherapy with sex-offenders. In I. Rosen (Ed.), *Sexual deviation* (3rd ed., pp. 300-336). Oxford: Oxford University Press.

Craig, L. (2005). The impact of training on attitudes towards sex offenders. *Journal of Sexual Aggression*, 11, 197-207. Doi: 10.1080/13552600500172103

Crane, D. R., & Payne, S. H. (2011). Individual and family therapy in managed care: Comparing the costs of treatment by the mental health professions. *Journal of Marital and Family Therapy, 37*(3), 273–289. doi:10.1111/j.1752-0606.2009.00170.x

Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. *Catalog of Selected Documents in Psychology*, 10, 85-104. Retrieved from http://www.uv.es/~friasnav/Davis_1980.pdf

Decety, J., & Ickes, W. (Eds.). (2009). *Social neuroscience. The social neuroscience of empathy.* Cambridge, MA, US: MIT Press.

DePue M. K. & Lambie, G. W. (2014). Impact of a university-based practicum experience on counseling students' levels of empathy and assessed counseling competencies. *Counseling Outcome Research and Evaluation*, 5(2), 89-101. Doi: 10.1177/2150137814548509

Desmond, B. C. & Lenz, P. J. (2010). Mental health courts: An effective way for treating offenders with serious mental illness. *Mental & Physical Disability Law Reporter*, 34(4), 525-530.

Douglas, K. R., Chan, G., Gelernter, J., Arias, A. J., Anton, R. F., Weiss, R. D., Brady, K., Poling, J., Farrer, L., & Kranzler, H. R. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. *Addictive Behavior*, 35(1), 7-13, Doi: 10.1016/j.addbeh.2009.07.004

Duan, C. & Hill, C. E. (1996). The current state of empathy research. *Journal of Counseling Psychology,* 43, 261-274.

Ebin, A. J. & Maposa, S. (2013). Cardiovascular risk factors among prisoners: An integrative review. *Journal of Forensic Nursing*, 9(1), 52-64.

Edmunds, S. B. (1997). The personal impact of working with sex offenders. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (p. 11-26). Brandon, VT: Safer Society Press.

Eisenberg, N., Spinrad, T. L., & Morris, A. (2014). Empathy-Related Responding in Children. In Killen, M. & Smetana, J. G (Eds). *Handbook of Moral Development*. New York, NY: Psychology Press.

Elias, H. & Haj-Yahia, M. H. (2019). On the lived experiences of sex offenders' therapists: Their perceptions of intrapersonal and interpersonal consequences and patterns of coping. *Journal of Interpersonal Violence*, 34(4), 848-872. Doi: 10.1177/0886260516646090

Elliott, R., Bohart, A.C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

Ellis, A. (1996). The humanism of rational emotive behavior therapy and other cognitive behavior therapies. *Journal of Humanistic Education and Development*, 35, 69-88.

Ellmo, F. I. (2019*). Counselor trainees' perceptions of offenders: A qualitative study*. Unpublished manuscript.

Ellmo, F., Holman, L., Ritter, L., & James, R. (2019). *Educating counselors about offenders with mental illness: An exploratory study.* Manuscript submitted for publication.

Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? *Journal of Offender Rehabilitation*, 18, 217-223

Faruqui, R. (2011). Mental illness and moral panic: a qualitative study of perceptions of a link between violent crime and mental illness. *European Psychiatry*, 26, 529. Doi: 10.1016/S0924-9338(11)72236-2

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine,* 14(4), 245–258.

Florentine, R. & Hillhouse, M. P. (1999). Drug treatment effectiveness and client-counselor empathy: Exploring the effects of gender and ethnic congruency. *Journal of Drug Issues,* 29(1), 59-74. Doi: 10.1177/002204269902900104

Fredrich, M. & Leiper, R. (2006). Countertransference reactions in therapeutic work with incestuous sexual abusers. *Journal of Child Sexual Abuse,* 15(1), 51-68. Doi: 10.1300/J070v15n01_03

Fulton, C. L. (2019). Mindfulness, self-compassion, and counselor characteristics and session variables. *Journal of Mental Health Counseling,* 38(4), 360-374. Doi: 10.17744/mehc.38.4.06.

Galanek, J. D. (2015). Correctional officers and the incarcerated mentally ill: Responses to psychiatric illness in prison. *Medical Anthropology Quarterly, 29*(1), 116-136.

George, D. & Mallery, P. (2003). SPSS for Windows step by step: A simple guide and reference 11.0 update (4th ed.). Boston: Allyn & Bacon

Gerdes, K. E., Segal E. A., & Lietz, C. A. (2010). Conceptualizing and measuring empathy. *British Journal of Social Work,* 40, 2326-234. Doi: 10.1093/bjsw/bcq048

Gibbons, D. C. (1975). Offender typologies – Two decades later. *British Journal of Criminology,* 15(2), 140- 156.

Giordano, A. L., Stare, B. G., & Clarke, P. B. (2015). Overcoming obstacles to empathy: The use of experiential learning in addictions counseling courses. *Journal of Creativity in Mental Health*, 10(1), 100-113. Doi: 10.1080/15401383.2014.947011

Glendinning, A. L. & O'Keeffe, C. (2015). Attitudes towards offenders with mental health problems scale. *The Journal of Mental Health Training, Education and Practice*, 10(2), 73-84. Doi: 10.1108/JMHTEP-08-2014-0023

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Prentice Hall

Graham, S. A. (1980). Psychotherapists' attitudes toward offender clients. *Journal of Consulting and Clinical Psychology*, 48(6), 796-797.

Greineder, B. (2013). Correctional officers' perceptions of sexual offenders in the United States: A qualitative analysis. *International Journal of Criminal Justice Sciences*, 8(1), 24-35.

Hara, K. M., Aviram, A., Constantino, M. J., Westra, H. A., & Antony M., A. (2017). Therapist empathy, homework compliance, and outcome in cognitive-behavioral therapy for generalized anxiety disorder: Partitioning within- and between-therapist effects. *Cognitive Behavior Therapy*, 46(5), 375-390. Doi: 10.1080/16506073.2016.1253605

Hardeberg Bach, M. & Demuth, C. (2018). Therapists' experiences in their work with sex offenders and people with pedophilia: A literature review. *European Journal of Psychology*, 14(2), 498-514, doi: 10.5964/ejop.v14i2.1493

Hein, S., Roder, M., & Fingerle, M. (2018). The role of emotion regulation in situational empathy-related responding and prosocial behavior in the presence of negative affect. *International Journal of Psychology*, 53(6), 477-485. Doi: 10.1002/ijop.12405

Hiebert, B., Uhlemann, M. R., Marshall, A., & Lee, D. Y. (1998). The relationship between self-

talk, anxiety, and counseling skill. *Canadian Journal of Counseling*, 32, 163-171.

Hinton, P. R., Brownlow, C., McMurray, I., & Cozens, B. (2004). SPSS explained. London: Routledge.

Hirschfield, P. J. & Piquero, A. R. (2010). Normalization and legitimation: Modeling stigmatizing attitudes toward ex-offenders. *Criminology*, 48(1), 27-55.

Hodges, S. D., Kiel, K. J., Kramer, A. D. I., Veach, D., & Villanueva, B. R. (2010). Giving birth to empathy: The effects of similar experience on empathic accuracy, empathic concern, and perceived empathy. *Personality & Social Psychology Bulletin*, 1-12, doi: 10.1177/0146167209350326

Hojat, M., Mangione, S., Kane, G. C., & Gonnella, J.S. (2005). Relationships between scores of the Jefferson scale of physician empathy (JSPE) and the interpersonal reactivity index (IRI). *Medical Teacher*, 27(7), 625-628.

Holman, L. F., Ellmo, F., Pitre, L. (2019). Counseling People with Addictive Behaviors in Forensic Settings. In L.F. Holman (Eds). *Forensic Mental Health Counseling: When Mental Illness and the Law Intersect*. San Diego, CA: Cognella.

Holman, L. F., MacGillivray, L., Salem, W., & Tarbett, L. B. (2018). Book club groups to aid relationship connection and trust among addicted trauma survivors. *Journal of Creativity in Mental Health,* 14(1), 37-53, Doi: 10.1080/15401383.2018.1502706

Holman, L. F. (2019). *Forensic mental health counseling: When mental illness and the law intersect.* San Diego, CA: Cognella.

Holzer, J. J. (2009). Collateral costs: Effects of incarceration on employment and earnings among young workers. In S. Raphael & M. A. Stoll (Eds.) *Do prisons make us safer*? New York: Russell Sage Foundation.

Ickes W. (1997). *Empathic Accuracy*. New York: The Guilford Press.

Jaffe, A., Du, J., Huang, D., & Hser, Y. (2012). Drug-abusing offenders with comorbid mental disorders: Problem severity, treatment participation, and recidivism. *Journal of Substance Abuse Treatment*, 43(2), 244-250. Doi: 10.1016/j.jsat.2011.12.002

James, R. K., & Gilliland, B. E. (2017). *Crisis intervention strategies.* (8th ed). Belmont, CA: Brooks/Cole-Cengage.

Janoka, C. & Schekenbach, A. (1978). Empathy training with inmates and staff utilizing the Carkhuff model. *Corrective & Social Psychiatry & Journal of Behavior Technology, Methods & Therapy*, 24(1), 6-12.

Johnson, C. L. & Cullen, F. T. (2015). Prisoner reentry programs. *Crime and Justice*, 44(1), 517-575.

Jorm, A. F. & Reavley, N. J. (2013). Public belief that mentally ill people are violent: Is the USA exporting stigma to the rest of the world? *Australian & New Zealand Journal of Psychiatry*, 48(3), 213-215. Doi: 10/1177/0004867413509697.

Kaeble, D., Glaze, L., Tsoutis, A., & Minton, T. (2015). *Correctional populations in the United States, 2014.* Washington, DC: Bureau of Justice Statistics, US Department of Justice, 2015.

Kessler, R. C., McLaughlin, K. A., Greif Green, J., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., et al. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry*, 197, 378–85.

Klein, S. B. (1978). Prisoners' rights to physical and mental health care: A modern expansion of the Eighth Amendment's cruel and unusual punishment clause. *Fordham Urb. LJ*, *7*, 1.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Konruth, S. (2012). The empathy paradox: Increasing disconnection in the age of increasing connection. In Luppicini, R. (Eds) Handbook of Research of Technoself: Identity in a technological society. IGI Global.

Kottler, J. A., & Balkin, R. S. (2017). *Relationships in Counseling and the Counselor's Life*. Alexandria, VA: American Counseling Association.

Kwon, K. I. & Jo, S. Y. (2012). The relationship among counselor experience level, empathic accuracy, and counseling outcome in the early phase of counseling. *Asia Pacific Education Review*, 13(4), 771-777. Doi: 10.1007/s12564-012-9235-8

Lambert, E. G. & Hogan, N. L. (2010). Wanting change: The relationship of perceptions of organizational innovation with correctional staff job stress, job satisfaction, and organizational commitment. *Criminal Justice Police Review*, 21(2), 160-184. Doi: 10.1177/0887403409353166

Law, V. & Roth, R. (2015). Names do hurt: The case against using derogatory language to describe people in prison. Retrieved from: https://rewire.news/article/2015/04/20/case-using-derogatory-language-describe-person-prison/

LeBel, T. P. (2011). Invisible stripes? Formerly incarcerated persons' perceptions of stigma. *Deviant Behavior*, 33(2), 89-107. Doi: 10.1080/01639625.2010.538365

Leibert, T. W. (2011). The dimensions of common factors in counseling. *International Journal for the Advancement of Counselling*, 33(2), 127-138. Doi: 10.1007/s10447-011-9115-7

Lyons, C. & Hazier, R. J. (2011). The influence of student development level on improving counselor student empathy. *Counselor Education and Supervision*, 42(2), 119-130. Doi: 10.1002/j.1556-6978.2002.tb01804.x

Machado, D. D. B., Coelho, M. D. C., Giacomelli, A. D., Donassolo, M. A. L., Abitante, M. S., Dall'Agnol, T., & Eizirik, C. L. (2014). Systemic review of studies about countertransference in adult psychotherapy. *Trends in Psychiatry and Psychotherapy*, 36(4), 173-185.

Magaletta, P. R., Patry, M. W., Patterson, K. L., Gross, N. R., Morgan, R. D., & Norcross, J. C. (2013). Training opportunities for corrections practice: A national survey of doctoral psychology programs. *Training and Education in Professional Psychology*, *7*(4), 291.

Malin, A. J., & Pos, A. E. (2015). The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. *Psychotherapy Research*, 25, 445-459. Doi: 10.1080/10503307.2014.901572

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, 17(2), 109-116. Doi: 10.1007/s11194-005-4598-6.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory* (3rd ed.). Palo Alto, CA: Consulting Psychologistts Press.

Massoglia, M., Remster, B., & King, R. D. (2011). Stigma or separation? Understanding the incarceration-divorce relationship. *Social Forces,* 90(1), 133-155.

Meyer, I. H., Flores, A. R., Stemple, L., Romero, A. P., Wilson, B. D. M., & Herman, J. L. (2017). Incarceration rates and traits of sexual minorities in the United States: National inmate survey, 2011-2012. *American Journal of Public Health*, 107(2), 267-273. Doi: 10.2105/AJPH.2016.303576

Mezey, G., Youngman, H., Kretzschmar, I., & White, S. (2016). Stigma and discrimination in mentally disordered offender patients – a comparison with a non-forensic population. *The*

Journal of Forensic Psychiatry & Psychology, 27(4), 517-529. Doi: 10.1080/14789949.2016.1172658

Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. *Deviant Behavior*, 37(2), 196-218. Doi: 10.1080/01639625.2014.1004035.

Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., & Steggan, J. S. (2012). Treating offenders with mental illness: A research synthesis. *Law and Human Behavior*, 36(1), 37-50. Doi: 10/1037/h0093964

Morris, A. (1965). The comprehensive classification of offenders. *Journal of Criminal Law and Criminology*, 56(2), 197-202.

Moulden, H. M. & Firestone, P. (2010). Therapist awareness and responsibility in working with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 22(4), 374-386. Doi: 10.1177/1079063210382047

Moyers, T. B., Houck, J., Rice, S. L., Longabaugh, R., & Miller, W. R. (2016). Therapist empathy, combined behavioral intervention and alcohol outcomes in the COMBINE research project. *Journal of Consulting and Clinical Psychology*, 84(3), 221-229. Doi: 10.1037/ccp0000074.

Moyers, T. B. & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, 27(3), 878-884. Doi: 10.1037/a0030274

Mulay, A. L. & Cain, N. M. (2018). Managing countertransference in correctional treatment settings: An updated perspective. *Journal of Forensic Psychology Research and Practice*, 18(1), 1-18. Doi: 10.1080/24732850.2017.1402166

Najavits, L. M. (2007). Seeking safety: An evidence-based model for substance abuse and trauma/PTSD. In K. A. Witkiewitz & G. A. Marlatt (Eds.), *Practical resources for the mental health professional. Therapist's guide to evidence-based relapse*. San Diego, CA, US: Elsevier Academic Press

Nellis, A. (2016). *The Color of Justice: Racial and Ethnic Disparity in State Prisons*. Washington, D.C.: The Sentencing Project.

Neumann, D. L., Boyle, G. J., & Chan, R. C. K. (2017). Empathy towards individuals of the same and different ethnicity when depicted in negative and positive contexts. *Personality and Individual Differences*, 55(1), 8-13. Doi: 1016/j.paid.2013.01.022

Nomura, K. &. Akai, S. (2012). Empathy with fictional stories: Reconsideration of the Fantasy scale of the Interpersonal Reactivity Index. *Psychological Reports*, 110(1), 304–314. Doi: 10.2466/02.07.09.11.PR0.110.1.304-314

Norman, G. (2010). Likert scales, levels of measurement and the "laws" of statistics. *Advances in Health Sciences Education,* 15(5), 625-632, Doi: 10.1007/s10459-010-9222-y

Oddie, S. & Ousley, L. (2007). Assessing burn-out and occupational stressors in a medium secure service. *The British Journal of Forensic Practice*, 9(2), 32-48. Doi: 10.1108/14636646200700011

Osher, F., D'Amora, D. A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. Council of State Governments Justice Center Criminal Justice/Mental Health Consensus Project. Retrieved from: https://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral-Health-Framework-final.pdf

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558-565. Doi: 10.1037/0735-7028.26.6.558

Pearson, Q. M. (1999). Integrative empathy: Training counselors to listen with a theoretical ear. *Journal of Humanistic Counseling, Education and Development*, 38, 13-18.

Perez, N. M., Jennings, W. G., Baglivio, M. T. (2018). A path to serious, violent, chronic delinquency: The harmful aftermath of adverse childhood experiences. *Crime & Delinquency*, 64(1), 3-25. Doi: 10.1177/0011128716684806

Perkins, E. B. & Sprang, G. (2013). Results from the Pro-QOL-IV for substance abuse counselors working with offenders. *International Journal of Mental Health and Addiction*, 11(2), 199-213.

Peterson, J. K., Skeem, J., Kennealy, P., Bray, B., & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?. *Law and human behavior*, *38*(5), 439.

Peterson, J. K. & Silver, R. C. (2015). Developing an understanding of victims and violent offenders: The impact of fostering empathy. *Journal of Interpersonal Violence*, 32(3), 399-422. Doi: 10.1177/0886260515586361

Pettit, E. M., & Lyons, C. J. (2007). Status and the stigma of incarceration: The labor-market effects of incarceration, by race, class, and criminal involvement. In *Barriers to Reentry?: The Labor Market for Released Prisoners in Post-Industrial America.* Russell Sage Foundation.

Pienkos, E. & Sass, L. A. (2012). Empathy and otherness: Humanistic and phenomenological approaches to psychotherapy of severe mental illness. *Pragmatic Case Studies in Psychotherapy*, 8(1), 25-35. Doi: 10.14713/pcsp.v8i1.1119

Piquero, A. R., Daigle, L. E., Gibson, C., Piquero, N. L., & Tibbetts, S. G. (2007). Are life-course persistent offenders at risk for adverse health outcomes? *Journal of Research in Crime and Delinquency*, 44(2), 185-207. Doi: 10.1177/0022427806297739

Porges, S. W. (2001). The polyvagal theory: phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology*, 42, 123–146.

Procter, N., Ayling, B., Croft, L., Degaris, P., Devine, M., Dimanic, A., Di Fiore, L., Eaton, H., Edwards, M., Ferguson, M., Lang, S., Rebellato, A., Shaw, K., & Sullivan, R. (2017) *Trauma-informed approaches in forensic mental health: A practical resource for health professionals*, University of South Australia, SA Health, Adelaide

Rivers, A., Wickramasekeera, I. E., Pekala, R. J., & Rivers,. J. A. (2016). Empathic features and absorption in fantasy role-playing. *American Journal of Clinical Hypnosis*, 58, 286-294. Doi: 10.1080/00029157.2015.1103696

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.

Ronnestad, M. H. & Skovholt, T. M. (2003). The journey of the counselor and hgtherapist: Research findings and perspecives on professional development. *Journal of Career Development*, 30(1), 5-44, doi: 10.1177/089484530303000102

Roskes, E., Feldman, R., Arrington, S., & Leisher, M. (1999). A model program for the treatment of mentally ill offenders in the community. *Community Mental Health Journal*, 35(5), 461-472.

Rotter, M., McQuistion, H. L., Broner, N., & Steinbacher, M. (2005). The impact of "incarceration culture" on reentry for adults with mental illness: A training and group treatment model. *Psychiatric Services*, 56(3), 265-267.

Ruiz, M. A., Douglas, K. S., Edens, F. J., Nikolova, N. L., Lilienfeld, S. O. (2011). Co-occurring mental health and substance use problems in offenders: Implications for risk assessment. *Psychological Assessment*, 24(1), 77-87. Doi: 10.1037/a0024623

Sagi, A. & Hoffman, M. L. (1976). Empathic distress in the newborn. *Developmental Psychology*, 12, 175-176.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J, & Broberg, J. (2007). Therapist attitudes and patient outcomes: II. Therapist attitudes influence change during treatment. *Psychotherapy Research*, 17(2), 196-204, Doi: 10.1080/10503300600608439

Sarteschi, C. M. (2013). Mentally ill offenders involved with the U.S. criminal justice system: A synthesis. *SAGE Open*, 1-11. Doi: 10.1177/2158244013497029.

Shapiro, S. L., & Izett, C. D. (2008). Meditation: a universal tool for cultivating empathy. In S. F. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (p. 3–18). New York: The Guilford Press.

Shen, L. (2010). On a scale of state empathy during message processing. *Western Journal of Communication*, 74, 504–524.

Shiroma, E. J., Ferguson, P. L., & Pickelsimer, E. E. (2010). Prevalence of traumatic brain injury in an offender population. *Journal of Correctional Health Care*, 16(2), 147-159. Doi: 10.1177/1078345809356538.

Stangor, C. (2017). *Principles of social psychology*. Minneapolis, MN: BCcampus OpenEd.

Steed, L., & Bicknell, J. (2001). Trauma and the therapist: The experience of therapists working with the perpetrators of sexual abuse. Australasian Journal of Disaster and Trauma Studies. Retrieved from: http://www.massey.ac.nz/%7Etrauma/issues/2001-1/steed.htm

Straussner, S. L. A. & Phillips, N. K. (2005). The role of empathy in work with women offenders. *International Journal of Prisoner Health*, 1(2), 255-262. Doi: 10.1080/17449200600554637

Tadros, E. (2018). How mental health clinicians can address issues of diversity with incarcerated individuals. *International Journal of Social Sciences Studies*, 6(9), 44-46.

Tappan, P. W. (1947). Who is the criminal? *American Sociological Review*, 12(1), 96-102.

Thompson E. (2001). Empathy and consciousness. *Journal of Consciousness Studies*, 8, 1–32.

Torrey, E. F. (2011). Stigma and violence: Isn't it time to connect the dots? *Schizophrenia Bulletin*, 37(5), 892-896. Doi: 10.1093/schbul/sbr057.

Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of states.* Arlington, VA: Treatment Advocacy Center. Retrieved from: https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf

Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biascotti, M. C., & Fuller, D. A. (2014). The treatment of persons with mental illness in prisons and jails: A state survey. Treatment Advocacy Center.

Traux, E. B. & Mitchell, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In E. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (p. 229-344). New York: Wiley.

Trusty, J., Ng, K., & Watts, R. E. (2011). Model of effects of adult attachment on emotional empathy of counseling students. *Journal of Counseling & Development*, 83(1), 66-77. Doi: 10.1002/j.1556-6678.2005.tb00581.x

Tudor, K. (2011). Understanding empathy. *Transactional Analysis Journal*, 41(1), 39-57. Doi: 10.1177/036215371104100107

Urbanoski, K. A., Kelly, J. F., Hoeppner, B. B., Slaymaker, V. (2012). The role of therapeutic alliance in substance use disorder treatment for young adults. *Journal of Substance Abuse Treatment*, 43(3), 344-351. Doi: 10/1016/j.jsat.2011.12.013.

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York, NY: Random House.

van Olphen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy*. Doi: 10.1186/1747-597X-4-10.

Vogel, M. & Porter, L. C. (2016). Toward a demographic understanding of incarceration disparities: Race, ethnicity, and age structure. *Journal of Quantitative Criminology*, 32(4), 515-530. Doi:

Wagaman, M. A., Geiger, J. M., Shockley, C., Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *w*, 60(3), 201-209. Doi: 10.1093/sw/swv014

Wallace, S. L., Lee, J., & Lee, S. M. (2010). Job stress, coping strategies, and burnout among abuse-specific counselors. *Journal of Employment Counseling*, 47, 111-122.

Ward, T. & Salmon, K. (2011). The ethics of care and the treatment of sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 23, 397-413.

Ward, T., Connolly, M., McCormack, J., & Hudson, S. M. (1996). Social workers' attributions for sexual offending against children. *Journal of Child Sexual Abuse,* 5, 39-55.

Watts, R. E. (1996). Social interest and the core conditions: Could it be that Adler influenced Rogers? *Journal of Humanistic Education and Development*, 34, 165-170.

Way, I., VanDeusen, K. M., Martin, G., Applegatte, B., Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence,* 19(1), 49-71. Doi: 10.1177/0886260503259050

Webb, M., Peterson, J., Willis, S. C., Rodney, H., Siebert, E., Carlile, J. A., & Stinar, L. (2016). The role of empathy and adult attachment in predicting stigma toward severe and persisten mental illness and other psychosocial or health conditions. *Journal of Mental Health Counseling*, 38(1), 62-78. Doi: 10.17744/mehc.38.1.05

Western, B., & Pettit, B. (2010). Incarceration & social inequality. *Daedalus: The Journal of the American Academy of Arts and Sciences*. 8-19.

Williams Institute, UCLA School of Law (2019). *LGBT Demographic Data Interactive*. Los Angeles, CA

Wolff, N., Epperson, M., Shi, J., Heuning, J., Schumann, B. E., & Sullivan, I. R. (2014). Mental health specialized probation caseloads: Are they effective? *International Journal of Law and Psychiatry*, 37(5), 464-472. Doi: 10/1016/j.jilp.2014.02.019.

Wright, P. M. (2008). Perceptions, emotions, and competencies of graduate level counselor trainees working with African American and Caucasian female clients with HIV/AIDS [Doctoral Dissertation] Georgia State University.

Zaki, J., Weber, J., Bolger, N., & Ochsner, K. (2009). The neural bases of empathic accuracy. *Proceedings of the National Academy of Sciences of the United States of America*, 106(27), 11382-11387. Doi: 10.1073/pnas.0902666106

Appendix A

Police and Community Attitudes towards Offenders with Mental Illness Scale

1. As soon as an offender shows signs of mental disturbance, he should be hospitalized
2. More tax money should be spent on the care and treatment of offenders with mental illness
3. An offender with mental illness should be isolated from the rest of the community
4. The best therapy for many offenders with mental illness is to be part of a normal community
5. Mental illness is an illness like any other
6. Offenders with mental illness are a burden on society
7. Offenders with a mental illness are far less of a danger than most people suppose
8. Locating forensic mental health facilities in a residential area downgrades the neighborhood
9. There is something about offenders with mental illness that makes it easier to tell them from normal people
10. Offenders with mental illness have far too long been the subject of ridicule
11. A woman would be foolish to marry an offender who suffered from a mental illness, even though he seems fully recovered
12. As far as possible forensic mental health services should be provided through community-based facilities
13. Less emphasis should be placed on protecting the public from offenders with mental illness
14. Increased spending on forensic mental health services is a waste of tax money
15. No one has the right to exclude offenders with mental illness from their neighborhood
16. Having offenders with mental illness living within residential neighborhoods might be good therapy, but the risk to residents is too great
17. Offenders with mental illness need the same kind of control and discipline as a young child

18. We need to adopt a far more tolerant attitude towards offenders with mental illness in society

19. I would not want to live next door to an offender who has been mentally ill

20. Residents should accept the location of forensic mental health facilities in their neighborhood to service the needs of the community

21. Offenders with mental illness should not be treated as outcasts of society

22. There are sufficient existing services for offenders with mental illness

23. Offenders with mental illness should be encouraged to assume the responsibilities of normal life

24. Local residents have good reason to resist the location of forensic mental health services in their neighborhood

25. The best way to handle offenders with mental illness is to keep them behind locked doors

26. Our forensic mental hospitals seem more like prisons than places where offenders can be cared for

27. Offenders with a history of mental illness should be excluded from taking public office

28. Locating forensic mental health services in residential neighborhoods does not endanger local residents

29. Forensic mental hospitals are an outdated means of treating offenders with mental illness

30. Offenders with mental illness do not deserve our sympathy

31. Offenders with mental illness should not be denied their individual rights

32. Forensic mental health facilities should be kept out of residential neighborhoods

33. One of the main causes of offender mental illness is a lack of self-discipline and will power

34. We have the responsibility to provide the best possible care for offenders with mental illness

35. Offenders with mental illness should not be given any responsibility

36. Residents have nothing to fear from offenders coming into their neighborhood to obtain forensic mental health services

37. Virtually anyone can become mentally ill

38. It is best to avoid an offender who has mental illness

39. Most women who were once patients in a forensic mental hospital can be trusted as baby sitters

40. It is frightening to think of offenders with mental illness living in residential neighborhoods

Appendix B

Interpersonal Reactivity Index

1. I daydream and fantasize, with some regularity, about things that might happen to me.

2. I often have tender, concerned feelings for people less fortunate than me.

3. I sometimes find it difficult to see things from the "other guy's" point of view.

4. Sometimes I don't feel very sorry for other people when they are having problems.

5. I really get involved with the feelings of the characters in a novel.

6. In emergency situations, I feel apprehensive and ill-at-ease.

7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

8. I try to look at everybody's side of a disagreement before I make a decision.

9. When I see someone being taken advantage of, I feel kind of protective towards them.

10. I sometimes feel helpless when I am in the middle of a very emotional situation.

11. I sometimes try to understand my friends better by imagining how things look from their perspective.

12. Becoming extremely involved in a good book or movie is somewhat rare for me.

13. When I see someone get hurt, I tend to remain calm.

14. Other people's misfortunes do not usually disturb me a great deal.

15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

16. After seeing a play or movie, I have felt as though I were one of the characters.

17. Being in a tense emotional situation scares me.

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

19. I am usually pretty effective in dealing with emergencies.

20. I am often quite touched by things that I see happen.

21. I believe that there are two sides to every question and try to look at them both.

22. I would describe myself as a pretty soft-hearted person.

23. When I watch a good movie, I can very easily put myself in the place of a leading character.

24. I tend to lose control during emergencies.

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

27. When I see someone who badly needs help in an emergency, I go to pieces.

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix C

Demographic Questionnaire

1. What is your age? (open ended)
2. What best describes your gender identity? (Woman, Man, Transgender Woman, Transgender Man, Genderqueer, Other (Please specify), Prefer not to answer)
3. What best describes your racial identity? (White, Black/African American, Asian, American Native Indian/Alaska Native/Native Hawaiian/Other Pacific Islander, Biracial/Multiracial)
4. Are you currently enrolled in a CACREP-accredited masters program? (Yes, No, Unsure)
5. Which state is your program located in? (open ended)
6. Which concentration, specialization, and/or area of study is your program? (Clinical Mental Health Counseling, School Counseling, Clinical Rehabilitation Counseling, Marriage and Family Therapy, Community Counseling, Addictions Counseling, College Counseling and Student Affairs, Career Counseling)
7. Approximately how many credit hours have you completed towards your masters degree? (open ended)
8. Have you completed or are you currently enrolled in your practicum or internship? (Yes/No)
9. Have you completed at least 1 course that was dedicated to forensic mental health counseling or mentally ill offenders as a part of your graduate curriculum? (Yes/No)
10. How many courses have you completed that have incorporated or included information on issues related to mentally ill offenders or forensic mental health counseling? (open ended)
11. How helpful have these classes/training been? (Very helpful, somewhat helpful, neither helpful or unhelpful, somewhat unhelpful, very unhelpful, not applicable)

12. Have you had a fieldwork experience (practicum or internship), a job, or other professional experience where you worked with a mentally ill offender?
13. Have you had any personal experience with a mentally ill offender?

Appendix D

Informed Consent

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about counselor trainee empathy and attitudes towards offenders with mental illness. You are being invited to take part in this research study because you are a graduate student working on a masters degree in counseling at a CACREP-accredited program.

WHO IS DOING THE STUDY?

The person in charge of this study is Frances Ellmo of the University of Memphis Department of Counseling, Educational Psychology and Research. She is being guided in this research by *Dr. Leigh Holman.*

WHAT IS THE PURPOSE OF THIS STUDY?

By doing this study, we hope to learn more about the relationship between counselor trainee empathy and attitudes towards mentally ill offenders.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You should not take part in this study if you meet one of the following criteria: you are not enrolled in a CACREP-accredited masters in counseling degree program, you are under the age of 18, or if you simply do not want to participate.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted online. The survey should take approximately 15 minutes to complete.

WHAT WILL YOU BE ASKED TO DO?

If you agree to participate in this study you will be asked to complete an anonymous survey that will ask you questions about your attitudes and beliefs.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. One of the few potentials for harm could be that you experience minor emotional or social discomfort about revealing your personal attitudes. As a reminder, your responses are completely anonymous and are unable to be traced back to you. Additionally, you are free to discontinue your participation at any time.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

You will not get any personal benefit from taking part in this study. However, your willingness to take part could help us to better understand this research topic and might lead to improved training standards for counseling students in the future.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep private all research records to the extent allowed by law. Only investigators will have access to raw data. Your information will be combined with information from other people taking part in the study. There will be no way to identify you or your specific survey responses. Data collected from this study will be kept on a password protected and encrypted computer.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

WHAT IF YOU HAVE QUESTIONS, CONCERNS, OR COMPLAINTS?

If you have questions, concerns, or complaints about the study, you can contact the primary investigator, Frances Ellmo, at fellmo@memphis.edu or her faculty advisor, Dr. Leigh Holman at lfalls@memphis.edu. If you have any questions about your rights as a volunteer in this research, contact the Institutional Review Board staff at the University of Memphis at 901-678-2705.

Appendix E

Table 1

Summary of Participant Demographic Characteristics

Variable	Categories	Frequency	Percentage
Gender	Male	18	18%
	Female	79	79%
	Other	3	3%
Age	18-28	54	54%
	29-38	22	22%
	39-48	12	12%
	49-58	9	9%
	59-68	2	2%
	69-78	1	1%
Race	African American	12	12%
	Asian	1	1%
	Caucasian	63	63%
	Latinx	8	8%
	Middle Eastern	2	2%
	Multiracial	11	11%
	Native American	3	3%
Geographic Region	Northeast	5	5%
	Midwest	20	20%
	South	43	43%
	West	32	32%
Program Concentration	CMHC	75	75%
	School	10	10%
	Rehabilitation	1	1%
	MFT	10	10%
	Addiction	3	3%
	Community	1	1%
Dedicated FMHC Course	Yes	4	4%
	No	96	96%
Other Courses Containing Info on FMHC	Zero	58	58%
	One	25	25%
	Two	12	12%
	Three or more	5	5%
Professional Experience with Offenders	Yes	22	22%
	No	78	78%
Personal Experience with Offenders	Yes	47	47%
	No	53	53%

Table 2.1

Descriptive Statistics and Reliability for Interpersonal Reactivity Index

	Mean	SD	Summated Score	Cronbach's α
IRI Total	97.90	11.47	3.50	.83
Fantasy Scale	24.83	5.78	3.55	.85
Perspective Taking Scale	27.38	4.05	3.91	.77
Empathic Concern Scale	29.43	3.62	4.20	.76
Personal Distress Scale	15.95	5.08	2.28	.84

Table 2.2

Descriptive Statistics and Reliability for Police and Community Attitudes Towards Mentally Ill Offenders Scale

	Mean	SD	Summated Score	Cronbach's α
PACAMI-O Total	154.41	19.72	3.86	.92
Self Preservation Scale	49.01	8.86	3.50	.86
Societal Reservation Scale	44.70	5.84	4.06	.76
Mental Health Awareness Scale	35.46	4.72	3.55	.59
Treatment Ideology Scale	18.85	2.33	3.77	.53

Table 3.1

Correlations for the IRI Subscales

	Fantasy	Perspective Taking	Empathic Concern	Personal Distress
Fantasy	1			
Perspective Taking	.18	1		
Empathic Concern	.36***	.48***	1	
Personal Distress	.34***	.24*	.05	1

Note. * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 3.2

Correlations for the PACAMI-O Subscales

	PACAMI-O Total	Self Preservation	Societal Reservation	Mental Health Awareness	Treatment Ideology
PACAMI-O Total	1				
Self Preservation	.92***	1			
Societal Reservation	.86***	.73***	1		
Mental Health Awareness	.74***	.56***	.48***	1	
Treatment Ideology	.62***	.42***	.52***	.46***	1

Note. * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 3.3

Correlations between the PACAMI-O Subscales, the IRI Subscales, and the Exposure to Offenders Variable

	Exposure to Offenders	Fantasy	Perspective Taking	Empathic Concern	Personal Distress
PACAMI-O Total	.23*	.38***	.53***	.37***	-.13
Self Preservation	.24*	.31**	.51***	.34**	-.12
Societal Reservation	.30**	.28**	.42***	.26**	-.29**
Mental Health Awareness	.09	.35***	.33**	.46***	.09
Treatment Ideology	.11	.36***	.45**	.46***	-.07

Note. * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 4.1

Regression Analysis for IRI Subscales and Exposure to Offenders Predicting PACAMI-O Total Score

	B	95% CI	*β*	*t*	*p*
Fantasy	1.13	(.51, 1.75)	.35	3.64	< .001***
Perspective Taking	1.45	(.52, 2.37)	.31	3.09	.003**
Empathic Concern	.58	(-.48, 1.63)	.11	1.09	.279
Personal Distress	-.48	(-1.20, .24)	-.13	-1.32	.189
Exposure to Offenders	4.52	(.78, 8.27)	.21	2.40	.018*

Note. $R = .63$, $R^2 = .40$, $F = 11.70$ ($N = 100$, $p < .001$), * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 4.2

Regression Analysis for IRI Subscales and Exposure to Offenders Predicting Self Preservation Subscale of PACAMI-O

	B	95% CI	*β*	*t*	*p*
Fantasy	.38	(.10, .66)	.27	2.69	.009**
Perspective Taking	.69	(.27, 1.12)	.35	3.25	.002**
Empathic Concern	.20	(-.28, .68)	.09	.89	.410
Personal Distress	-.09	(-.41, .24)	-.05	-.59	.594
Exposure to Offenders	2.06	(.35, 3.77)	.22	.02	.019*

Note. $R = .57$, $R^2 = .34$, $F = 9.22$ ($N = 100$, $p < .001$), * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 4.3

Regression Analysis for IRI Subscales and Exposure to Offenders Predicting Societal Reservation Subscale of PACAMI-O

	B	95% CI	*β*	*t*	*p*
Fantasy	.35	(.15, .55)	.35	3.51	.001**
Perspective Taking	.24	(-.06, .54)	.17	1.56	.116
Empathic Concern	.12	(-.22, .46)	.08	.71	.481
Personal Distress	-.34	(-.57, -.11)	-.30	-2.98	.004**
Exposure to Offenders	1.47	(.26, 2.67)	.23	2.42	.017*

Note. $R = .58$, $R^2 = .34$, $F = 8.97$ ($N = 100$, $p < .001$), * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 4.4

Regression Analysis for IRI Subscales and Exposure to Offenders Predicting Mental Health Awareness Subscale of PACAMI-O

	B	95% CI	*β*	*t*	*p*
Fantasy	.23		.30	2.69	.009**
Perspective Taking	.23		.21	1.76	.083
Empathic Concern	-.01		-.01	-.04	.972
Personal Distress	.06		.06	.56	.574
Exposure to Offenders	.74		.15	1.42	.159

Note. $R = .42$, $R^2 = .17$, $F = 3.69$ ($N = 100$, $p = .004$), * indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Table 4.5

Regression Analysis for IRI Subscales and Exposure to Offenders Predicting Treatment Ideology Subscale of PACAMI-O

	B	95% CI	*β*	*t*	*p*
Fantasy	.10	(.02, .18)	.24	2.44	.017
Perspective Taking	.13	(.01, .25)	.22	2.06	.043
Empathic Concern	.18	(.04, .32)	.28	2.57	.012
Personal Distress	-.05	(-.14, .04)	-.11	-1.07	.288
Exposure to Offenders	.27	(-.23, .76)	.10	1.08	.285

Note. $R = .58$, $R^2 = .33$, $F = 8.79$ ($N = 100$, $p < .001$), * indicates p < .05, ** indicates $p < .01$, *** indicates $p < .001$