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Walden University

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Walden University

College of Social and Behavioral Sciences

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Paul Affar Meenu

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Review Committee
Dr. Charles Diebold, Committee Chairperson, Psychology Faculty
Dr. Mitchell Hicks, Committee Member, Psychology Faculty
Dr. Lisa Scharff, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

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by

Paul Affar Meenu

ThD, Andersonville TS, 2018

MSc, Walden University, 2018

MM, Andersonville TS, 2016

MAT, Liberty University, 2015

MPhil, University of Ghana, 2009

MBA, University of Cape Coast, 2009

BSc, University of Cape Coast, 2003

HND, Accra Polytechnic, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

May 2021

Abstract

The importance of caregiver empathy in positive client outcomes has been established in the literature. However, helping traumatized people has a potentially deleterious emotional effect on the helping professional, putting them at risk for compassion fatigue. The stress-process model provided the framework for the study. Survey data were collected from 138 immigrant African pastors in the United States. Compassion fatigue dimensions were measured by the Professional Quality of Life Scale, and empathy dimensions were measured by the Empathy Assessment Index. Results of multivariate canonical correlation analysis revealed that empathy predicts compassion fatigue susceptibility. Pastors who scored low on empathy subscales also tended to score high on burnout scale and secondary traumatic scale and low on pastoral self-esteem. Results further indicated that low empathy puts caregivers at risk for compassion fatigue. Findings may be used for positive social change by pastoral training programs to teach empathy as a protective factor for the prevention of compassion fatigue.

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Dedication

To my parents, Apostle J. Y. Meenu & Mrs. Theresa Afua Meenu, for your 45 years of dedicated pastoral ministry in the Christ Apostolic Church Int. You are my unsung heroes. This achievement is for your honor!

To my lovely wife, Akua Tina, and my beloved son, Coffie Payinyena. The two of you have sacrificed above and beyond for this journey. I love you both to the heavens.

To the fond memories of my late elder brother, Elijah K. Meenu (1970–1998), and my late younger brother, James Wiseman Meenu (1983–2016). Although you are not here with us to celebrate this achievement, your memories are still in our hearts.

To all my siblings, Elder Ben, Elder Enock, Sister Evelyn, Manager Godwin, Lawyer Christopher, and Sister Elizabeth! You all inspired me to keep going.

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Finally, I want to thank my beloved wife, Akua Tina, and my beloved son, Coffie Payinyena. This achievement is for you. Thank you for all of the sacrifices you made for this dream to materialize.

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Chapter 1: Introduction to the Study

Compassion fatigue (CF), also known as vicarious trauma or secondary traumatization, is a phenomenon that has received increased attention in academic research (Morrissette, 2004). CF is a phenomenon that stems from a caregiver's repeated exposure to another person's trauma stories, resulting in the caregiver becoming vicariously traumatized (Figley, 1995). Caregivers whose practices are rooted in spirituality and faith also play an important role in providing emotional healing services to members of their parishes (Zust et al., 2017). Pastors, as caregivers, are often considered the epitome of hope and peace in their communities, and any sign that the pastor is troubled could be construed as a sign of spiritual weakness by their parishioners (Twumasi-Ankrah, 2011). Issues such as CF are rarely discussed in pastoral training manuals because they are considered secular (Kitchen Andren & McKibbin, 2018). Pastors, mainly driven by empathy to offer spiritual and emotional support services to their parishioners (Green et al., 2014), may be at risk for CF.

In the current study, I examined the multivariate relationships between the five dimensions of empathy (see Segal et al., 2017) and the three dimensions of CF (see Stamm, 2009) among the immigrant African pastor population in the United States and to determine whether this population is at risk for CF. CF is a phenomenon that has received much attention in the literature and among helping professionals (Morrissette, 2004). Figley (1995) found that people who put their personal interests aside to assume the responsibility of helping others heal from their emotional traumas face the danger of becoming emotionally traumatized themselves. CF has been widely researched among

many helping professions such as doctors, nurses, first responders, and psychotherapists (Hannah & Woolgar, 2018); however, researchers have not addressed the immigrant African pastor population in the United States. The current study focused on the immigrant African pastor population in the United States because the gap in the literature indicated the need for insights on the relationship between empathy and risk for CF among this population. Findings may be used to increase awareness of the risks of CF, as well as the development of self-care practices among the immigrant African pastor population in the United States.

This chapter includes the study's background information and the research problem. The chapter also addresses the purpose of the study, the research question guiding this research, the theoretical framework for the study, the nature of the study, and definitions of terns. Finally, assumptions, scope and delimitations, limitations, and significance of the study are discussed to give the reader and firm understanding of how this study was structured.

Background

Under the auspices of spiritual guidance, the primary duty of an immigrant African pastor in the United States is to provide spiritual leadership, which includes shepherding the flock, conducting worship services, and preaching the gospel (General Board of Discipleship, 2016). However, counseling service is also an integral part of a pastor's duty (Kitchen Andren & McKibbin, 2018; Zust et al., 2017). In many faith-based immigrant African communities in the United States, the immigrant African pastor is often relied on to provide care and counseling services to members of their parishes and

assist them in coping with traumatic situations (Twumasi-Ankrah, 2011). In some instances, pastors serve as first responders in crises situations due to lack of access to mental health resources for many reasons (Ecker, 2018; Payne, 2017). Immigrant African pastors, like other helping professionals, share a common goal, which is to bring care and relief to those who suffer misfortune and trauma in crises (Figley, 1995). Schuster et al. (2001) revealed through research that in the aftermath of September 11, 2001, terrorist attacks in the United States, 90% of Americans turned to their religious leaders as a coping response to the shock, grief, and trauma. The reliance on religious leaders for solace in times of crises is an indication that religious leaders, including immigrant African pastors in the United States, are revered not only for spiritual leadership but also for emotional support. They often serve as a haven for those who suffer trauma in crises (Green et al., 2014; Loizzo, 2002).

Immigrant African pastors in the United States play important roles in the lives of their parishioners and are often at the forefront of counseling services to those who may be experiencing traumatic situations such as domestic violence, unemployment, immigration issues, sexual exploitation, divorce, death, and terminal illness (Avent et al., 2015; Tedder & Smith, 2018). Immigrant African pastors in the United States are often turned to for comfort and assurance by their congregants in times of emotional suffering and pain (Twumasi-Ankrah, 2011) because in many immigrant African communities in the United States, the pastor is the epitome of peace, hope, and emotional stability (Avent et al., 2015). Research findings suggested that in faith-based communities, including the immigrant African communities in the United States, the pastor is often the first point of

contact in crisis situations associated with grief, divorce, domestic problems, chronic illness, injury, and the passing of a loved one (Ingram & Lowe, 1989; Tedder & Smith, 2018; Twumasi-Ankrah, 2011). Also, many parishioners of immigrant African churches in the United States avoid seeking mental health services for a variety of complex reasons including fear of stigmatization, poverty, and cultural barriers, and therefore rely solely on their immigrant African pastor for mental health services (W. E. Johnson, 2019).

Nguyen et al. (2016) found that trauma and post-traumatic stress disorder (PTSD) are prevalent among African Americans by virtue of their traumatic past: slavery, racial discrimination, segregation, and Jim Crow. Schwartz et al. (2005) observed that many African Americans, including immigrant African pastors, have the erroneous belief that the difficult and traumatic history of the African American people has occasioned a false sense of security against psychological injuries. Others (W. E. Johnson, 2019; Patterson, 2013) have also arrived at similar conclusions that African Americas believe they have seen enough trauma that they have become accustomed to living with the phenomenon. Although many African American pastors are no strangers to traumatic events such as Jim Crow, slavery, racial injustice, police brutality of people of color, disparity in justice delivery by the justice system, deaths, wars, natural disasters, and hardships, the notion that immigrant African pastors are immune to vicarious trauma and CF has no scientific basis (Patterson, 2013; Tedder & Smith, 2018; Twumasi-Ankrah, 2011). It has been revealed in research studies that the professional quality of life of helping professionals, including immigrant African pastors in the United States, can be negatively impacted when they are continuously exposed to the traumas of others (Patterson, 2013). The gap

in the literature revealed that the immigrant African pastor population has not been studied to examine the relationship between empathy and CF. Findings from the current study may provide insights and engender social change regarding self-care for psychological injuries that result from empathic caregiving.

Problem Statement

Gibbons (2011) reviewed the role and importance of empathic help-giving on positive client outcomes. However, helping traumatized people, including repeatedly hearing their stories of suffering and supporting their recovery, has a potentially deleterious emotional effect on the helping professional, putting them at risk for CF (Morrissette, 2004). CF is portrayed as the psychological state of extreme emotional tension and the preoccupation with the sufferings from another person's trauma to the degree that it creates an emotional disruption in the life of the caregiver (Brobst, 2014; Figley, 2002; Morgillo, 2015; Raynor & Hicks, 2018). The literature revealed that prolonged exposure to the trauma stories of others increases the risk for CF among caregivers because the trauma stories often leave emotional residue in the minds of the caregivers (Morrissette, 2004; Wijdenes et al., 2019; Yang et al., 2012). CF is a negative emotion a caregiver experiences for attempting to heal the emotional wounds of others (Hilfiker, 1994; Papazoglou et al., 2017; Pascual-Leone et al., 2017; Whitton, 2018). Those who attempt to heal the emotional wounds of others will be emotionally wounded; it is the risk inherent in a helping relationship (Figley, 1995; Morrissette, 2004).

Incidence of CF among helping professionals in careers such as medicine, nursing, psychotherapy, counseling, social work, and education has been well-

documented (Bellolio et al., 2014; Hamilton et al., 2016; Khan et al., 2015; Y. H. Kim et al., 2017; Sørengaard et al., 2019; Turgoose & Maddox, 2017). CF is a phenomenon that is gaining attention as an occupational hazard for those in helping professions, especially those who help traumatized people heal from their emotional wounds (Patterson, 2013). Considering the increased interest in the phenomenon in the literature, the opportunity to study effects of CF among the immigrant African pastor population in the United States was appropriate. A better understanding of the relationship between empathy and CF among the target population added to the existing body of knowledge on the subject. There was a gap in the literature on the issue of CF among the immigrant African pastor population in the United States, warranting a need for the current study. Therefore, there was a need to examine the relationship between empathic caregiving and CF among the immigrant African pastor population in the United States.

Krejcir (2007) found that one of the most difficult aspects of a pastor's job is helping the emotionally traumatized. Researchers have examined the relationship between empathic caregiving and the risk for CF on helping professionals such as doctors, nurses, psychologists, firefighters, counselors, social workers, and emergency medical technicians (Hamilton et al., 2016; Khan et al., 2015; Kim et al., 2017; Turgoose & Maddox, 2017). However, researchers have not focused on the immigrant African American pastor population. The lack of research on this population may negatively impact the immigrant African pastor's self-care, awareness, and mental well-being practices (Payne, 2017). I sought to close this gap by examining whether immigrant

African pastors in the United States are at risk for CF for empathic help-giving, and what role empathic help-giving plays in ameliorating the risk.

Purpose of the Study

The purpose of this quantitative cross-sectional survey study was to examine the multivariate relationships between five dimensions of empathy (affective response, affective mentalizing, self-other awareness, perspective-taking, and emotion regulation; see Segal et al., 2017) and three dimensions of CF (compassion satisfaction, burnout, and secondary traumatic stress; see Stamm, 2009) among immigrant African pastors in the United States. I investigated CF dimensions as measured by the Professional Quality of Life Scale (ProQOL-5; see Stamm, 2009) and empathy dimensions as measured by the Empathy Assessment Index (EAI; see Segal et al., 2017) among immigrant African pastors in the United States. The dependent construct in this study, CF, has been noted to significantly impact the quality of care given by helping professionals (Gallardo & Rohde, 2018), whereas the independent construct, empathy, has been suggested to be a significant predictor of CF susceptibility (Wagaman et al., 2015).

Research Question

One research question guided this study: What are the number and nature of statistically significant multivariate relationships between five dimensions of empathy and three dimensions of compassion fatigue? A multivariate canonical correlation analysis (CCA) was used to answer the research question. With three scores in the smallest of the two sets of variables, CCA would produce three independent solutions that related a weighted combination of empathy scores with CF scores. The research

question was phrased as the type answered by CCA (see Tabachnick & Fidell, 2007). Although CCA has a chain of reduction statistical tests, it is not principally a hypothesis-testing procedure (Tabachnick & Fidell, 2007) and does not test the statistical significance of each root, only the last root (Fan & Konold, 2019; Tabachnick & Fidell, 2007). Thompson (2000) stated that "statistical significance provides limited information" (p. 303) and does "not evaluate whether the sample results occur in the population" (p. 303). Therefore, for CCA, a hypothesis was not warranted. I examined the squared canonical correlations (effect size) and adequacy coefficients of the canonical variates, and the communality and relative size of function and structure coefficients of the variables to interpret the nature of the root (see Fan & Konold, 2019; Tabachnick & Fidell, 2007; Thompson, 2000).

Theoretical Framework

The theoretical underpinning for this study was the stress-process model (SPM; Aneshensel & Avison, 2015; Pearlin & Bierman, 2013; Pearlin et al., 1981). According to the SPM, the most critical elements for the formation of therapeutic or healing relationships between a helping professional and a client are compassion that is rooted in empathy and emotional energy, and that stressful environments impact the emotional intelligence of the parties in the healing relationship (Aneshensel & Avison, 2015). The SPM encapsulates key elements for caregiving: empathic ability, empathic response, and residual compassion stress (Sabo, 2011). According to Figley (1995), empathic ability reveals the caregiver's aptitude for noticing the pain of the client to extend a helping hand. The SPM further reveals the cascading psychological effects that ensue when a

helping professional is repeatedly exposed to sufferings and trauma stories of those they are helping to heal from their emotional wounds (Elliott, 2014).

Although the immigrant African pastor's desire to help traumatized members of their parishes may be driven by empathy, it is also possible that the empathic relationship could put the immigrant African pastor at risk for vicarious trauma or CF. The risk for CF becomes apparent with repeated exposure to the trauma stories of the suffering client (Figley, 1995; Morrissette, 2004). This repeated exposure to the trauma stories by the caregiver leaves negative emotional residue that results in a disruption of the emotional homeostasis of the empathic caregiver. The SPM suggests that the stressful relationship in empathic caregiving negatively impacts emotional well-being as well as the mental health of the caregiver (Pearlin et al., 1981).

Nature of the Study

This research was a quantitative cross-sectional survey study. A cross-sectional design is a type of observational study that allows the researcher to measure and predict outcomes among the study participants at the same time (Kaushal, 2017; Setia, 2016). With the aid of the statistical analysis tool, SPSS, I conducted a multivariate CCA to examine the relationship between five dimensions of empathy (dependent variables) and the three dimensions of CF (independent variables) among the targeted population for this study. Although I was primarily interested in the multivariate CCA relationship, I conducted follow-up multiple regressions separately regressing compassion satisfaction, burnout, and secondary traumatic stress on the five dimensions of empathy to provide further insight.

Definitions

Affective mentalizing: As caregivers are exposed to stories or explanations of events, and as they are hearing the information, their mind develops a picture of the events. This allows caregivers to develop perceptions of another's experiences (Segal et al., 2017).

Affective response: Often referred to as "mirroring" in the literature, this is an unconscious, automatic, and involuntary way of physiologically simulating the experiences of others (Segal et al., 2017).

Burnout: The psychological syndrome resulting from exposure to chronic stressors at work (Maslach & Leiter, 2016). Burnout is often associated with stressful working conditions. Burnout refers to overwhelming emotional exhaustion, depersonalization, and feelings of professional insufficiency (Wagaman et al., 2015).

Compassion fatigue (CF): The emotional response culminating in a decrease in feelings toward others due to repeated exposure to other people's trauma stories; CF has implications for caregiving (Kelly, 2020). According to Stamm (2010), CF encapsulates burnout and secondary traumatic stress.

Compassion satisfaction: The joy or pleasure derived from caregiving (Stamm, 2010).

Emotion regulation: The ability to sense another's feelings without becoming overwhelmed by the intensity of the other person's experience (Segal et al., 2017).

Empathy: Empathy is the ability to understand what other people are feeling and thinking and is an essential skill in facilitating social agreement and successfully navigating personal relationships (Wagaman et al., 2015).

Perspective-taking: The ability to cognitively process what it might be like to personally experience the experiences of another (Segal et al., 2017).

Secondary traumatic stress (STS): Also known as vicarious trauma, STS occurs when a caregiver experiences stress while caring for the trauma or event. Although burnout is associated with the stress and frustration of caregiving, secondary trauma can be thought of as an occupational hazard and the risk of knowing and caring for traumatized people (Kelly, 2020).

Self-other awareness: A person's ability to recognize the difference between their experiences and another person's experiences (Segal et al., 2017).

Assumptions

Two assumptions were necessary in this study. First, I assumed that the chosen sample would be representative of the immigrant African pastor population in the United States. Care was taken to eliminate biases in selecting the sample from this population using snowball sampling, a type of convenience sampling that enables researchers to reach their target audience by following the leads of those respondents who have already been reached (Setia, 2016). Second, I assumed that respondents would answer the questionnaire truthfully. Considering that the instruments adopted for this study were self-report measures, I assumed that respondents would be truthful with their responses. Also, I assumed that respondents would understand the questions as they were written by

the instrument's developers. To encourage honest responses, I assured research participants of their anonymity and privacy. The instrument used in this study did not collect personal identifying information that would have endangered participants' privacy and anonymity. Research participants were volunteers who willingly accepted to partake in the study under no coercion or duress.

Scope and Delimitation

The purpose of this cross-sectional quantitative study was to examine the multivariate relationship between empathy and the risk for CF among immigrant African pastors. The study focused on the immigrant African pastor population in the United States because an analysis of the literature revealed a gap among the target population. The relationship between empathic help-giving and CF has been widely studied on populations such as doctors, lawyers, nurses, first responders and psychologists (Yu et al., 2016). However, researchers had not targeted the immigrant African pastors in the United States. Pastors are helping professionals who provide many useful mental health services to their parishioners. The current study was limited to immigrant African pastors in the United States. I hoped to gain useful insights that would add to the body of knowledge on the subject and promote social change among the target population.

The study was explorative in nature because there was no research that targeted this population. The sample included 138 immigrant African pastors in the United States. The sample size was calculated using power analysis. Data were collected using adopted self-response instruments that had been widely accepted for measuring the constructs in this study. Recruitment of respondents for the study occurred via snowball sampling to

reach the target population. The gathered data were analyzed using a multivariate CCA. The study was delimited to the immigrant African pastor population in the United States. Therefore, results cannot be generalized to immigrant African pastor populations outside of the United States.

Limitations of the Study

This study had limitations that may have impacted the findings and conclusions. First, the instruments for measuring the constructs were self-report measures. The constructs measured in this study were defined in a way that was consistent with the measures adopted for collecting data for the study. Components of the constructs of interest that were not included by the measures were not assessed. Also, this was a cross-sectional quantitative study, so I was unable to construct a more complex narrative about the perceptions of research participants, as would have been the case in a qualitative or mixed-methods study. Considering that self-report instruments were used for this study, response biases may have been apparent.

Second, this study focused on immigrant African pastors in the United States. Consequently, generalizations of the results to other pastors were limited. Third, time constraints in this study meant that this study would capture data from a snapshot in time. Data from the respondents may have varied over time. Finally, resource constraints meant that a sample of 138 immigrant African pastors in the United States would be studied. Future research could include a larger sample size and data from a more diverse population.

Significance of the Study

CF, which is the emotional, physical, social, and spiritual exhaustion that overtakes a caregiver and causes a decline in their desire, ability, and energy to feel and care for others (McHolm, 2006; Wijdenes et al., 2019), is a topical issue for self-care among helping professions. The need to assess the relationship between empathy and the risk for CF among the immigrant African pastor population in the United States was significant. Studies on CF have focused on helping professionals in careers such as medicine, nursing, psychotherapy, mental health counseling, social work, and education (Hannah & Woolgar, 2018). Researchers had not addressed CF among the immigrant African pastor population.

The current study was significant because it provided an opportunity to examine the relationship between empathy and the risk for CF among the target population for two reasons. First, the persistent global challenges associated with mental health and mental well-being means that the services of the immigrant African pastor as a helping professional will continue to be relevant in supporting the recovery and healing of traumatized members of their congregations (Taylor et al., 2006). Second, the need to be aware of the emotional cost of helping among the target population cannot be overemphasized for increased awareness on the subject and help in facilitating self-care practices among the targeted population.

Summary

I sought to examine the relationship between empathy and the risk for CF among immigrant African pastors in the United States. I conducted a cross-sectional quantitative

study designed to test the psychological constructs of empathy and the risk for CF on a population that had yet to be studied. Numerous studies on empathic caregiving and CF on helping profession populations such as doctors, nurses, first responders, psychotherapists, and counselors, were found in the literature. What was missing was a similar focus on the immigrant African pastor population in the United States. By the nature of their work and the service they provide to their communities, immigrant African pastors are also helping professionals who provide useful mental health services to members of their parishes. Insights from this study may help increase the diversity and scope of the literature on the subject. Results may also be used to promote social change in terms of self-care and increased awareness mental wellness among the target population. In addition, results may inform training manuals of pastoral services to help prepare pastors for the difficult job of empathic caregiving.

The widely researched and accepted EAI (see Segal et al., 2017) and the ProQOL-5 (see Stamm, 2009) were the instruments used to measure five dimensions of empathy and three dimensions of CF among the immigrant African pastor population in the United States. The EAI is a reliable 22-item instrument addressing empathy-related feelings or beliefs using a 6-point Likert-type scale (1 = *Never* to 6 = *Always*) developed and revised over several years with over 3,500 participants (Gerdes et al., 2012; Gerdes & Segal, 2009; Lietz et al., 2011; Segal et al., 2017). The ProQOL-5 is a reliable 30-item instrument addressing compassion satisfaction and CF (burnout, secondary traumatic stress) using a 5-point Likert-type scale (1 = *Never* to 5 = *Very Often*) that was adapted from Figley's (1995) original 40-item Compassion Satisfaction and Fatigue Test. The

ProQOL-5 has been used in hundreds of published papers and is the most used measure of CF (Stamm, 2010). Chapter 2 includes a review of related literature for this study.

Chapter 2: Literature Review

The relationship between empathic helping and risk for CF has received increased attention in the literature (Patterson, 2013). Providing empathic caregiving to traumatized people by repeatedly hearing their stories of suffering and supporting their recovery has a potentially deleterious emotional effect on the helping professional, putting them at risk for CF (Morrissette, 2004). The topics of empathy and CF have been studied on helping professions such as medicine, psychology, and social work (Figley, 1995; Morrissette, 2004). However, there was a gap in the literature on the immigrant African pastor population in the United States, warranting a need for the current study. Immigrant African pastors in the United States are also helping professionals who provide useful mental health services to their parishioners. This quantitative cross-sectional survey study addressed the multivariate relationships between five dimensions of empathy (see Segal et al., 2017) and three dimensions of CF (see Stamm, 2009) among immigrant African pastors in the United States to determine whether findings in the literature were also present in the immigrant African pastor population.

To provide a comprehensive background to this study, I conducted a systematic literature review to establish a theoretical foundation and define the constructs of this study. The literature review included a search for peer-reviewed articles that addressed the five dimensions of empathy and the three dimensions of CF chosen for this study. In this chapter I discuss the search strategy used for the literature review, the theoretical foundation for the study, the constructs of CF and empathy, and professional impairment the results from CF.

Literature Search Strategy

Using Walden University's online library resources and other online tools, I searched for peer-reviewed articles published between 2015 and 2020 to provide better understanding of the constructs addressed in this study. However, some of the sources reviewed in this chapter were older than 5 years because I considered them important. Also, the literature search included seminal articles that provided useful information to guide this study. The databases searched included ProQuest Central, PsycARTICLES, APA PsycNET, PsycINFO, SAGE Research Methods, and ScienceDirect. Google Scholar was also used to access open articles. Key terms used in the search included *compassion fatigue*, *burnout*, *secondary trauma*, *vicarious trauma*, *traumatology*, *empathy*, *secondary stress*, and *stress process*.

Theoretical Foundation

The SPM was chosen as the conceptual framework for this study. According to Pearlin et al.'s (1981) description of the SPM, the most critical elements needed for the formation of empathic caregiving relationships are *compassion* and *emotional energy*. Compassion has been described as a caregiver's ability to suffer with those who are hurting while mastering the emotional energy or the inner drive to keep helping (Segal et al., 2017). Although many in pastoral ministry will profess that empathy is a virtue, not many can claim that they have the emotional energy or the inner drive to carry on with their job as a pastor (Avent et al., 2015; Tedder & Smith, 2018). The stresses associated with being a pastor causes many to struggle under the intense emotional exposure (Twumasi-Ankrah, 2011). Gonzales (2017) found that 60–80% of those who enter

pastoral ministry do not last 10 years. Chan and Chen (2019) and McGarity (2016) also found that pastoral burnout is harming pastors and churches across the United States and other parts of the world. The SPM provided insights into what could be the reasons behind the high burnout rate among pastors in the United States and other parts of the world when providing empathic caregiving services by explaining that stressful environments and stressful relationships negatively impact the mental well-being of the caregiver (see Aneshensel & Avison, 2015).

The SPM includes three essential features of an empathic caregiving relationship: *empathic ability*, *empathic response*, and *residual compassion stress* (Sabo, 2011). Empathic caregivers such as immigrant African pastors in the United States need these three features to provide care and support to their suffering members. There is an opportunity cost that comes with empathic caregiving: an emotional cost to the caregiver (Zhao, 2019). The ability of a caregiver to appreciate the care receiver's state of mind as well as their frame of reference as a basis for the formation of a therapeutic alliance is key to the process of healing (Bennett, 2003). In pastoral ministry, the pastor is expected to demonstrate the ability to empathize with a suffering member of their congregation for a therapeutic relationship to occur. Segal et al. (2017) defined empathy as the glue that holds communities together. It is an emotional process in which one person can come to know the internal state of another and can be motivated to respond with sensitive care (Segal et al., 2017). Without empathic ability, a caregiver's effort with a suffering client will not be deemed authentic (Bennett, 2003), and without authenticity, there will be no trust. The principles in the SPM suggest that through empathic ability the immigrant

African pastor will be able to see through the presenting problems from the perspective of the suffering parishioner to be able to emotionally understand and offer support for their healing.

The SPM explains a caregiver's (e.g., pastor's) ability to set aside their personal problems to offer empathic support for the emotional healing of a suffering client is rooted in empathic response (Segal et al., 2017). However, a caregiver's ability to respond in an empathic way to the suffering client is also driven by the caregiver's access to psychological resources. Zhao (2019) explained that variations in the impact of stressors on a caregiver are often a function of which psychosocial resources, such as social support and mastery, are mobilized to offset the otherwise deleterious effects of exposure. For example, if an immigrant African pastor's psychological resources (e.g., support from close family, friends, and institutional leadership) are depleted, they will not be in a good position to offer empathic caregiving services to their suffering members who need emotional support. Psychosocial resources act as a buffer to the effects of stressors on the pastor's well-being so that the challenges of care will not wear them down (Zhao, 2019).

According to G. E. Kim and Chung (2016), the SPM does not only identify the basic conditions that cause stress among caregivers, but it also shows how these conditions are interrelated. The SPM reveals that there are stressors, mediators, and outcomes inherent in an empathic caregiving relationship, and that stressors are conditions or experiences that cause problems to the caregiver (Kim & Chung, 2016). For example, by virtue of their work, a pastor may experience stress and challenges including

loneliness, isolation, and doubts about their ability (Cafferata, 2017). Many factors account for these stressors in a pastor's life, including background and contextual factors, objective stressors, subjective burden, and psychosocial resources (Kim & Chung, 2016). The process of empathic caregiving is fraught with psychological stressors, and a caregiver's role in a stress process emanates from the person's location in the social system as indexed by status characteristics (Aneshensel & Avison, 2015). For instance, by virtue of their roles in society as empathic caregivers, the immigrant African pastor is obligated to work with traumatized and suffering members of their congregation to provide emotional support. The empathic gesture, however, does put them in direct risk for CF due to exposure to other people's traumas.

I sought to measure two constructs: empathy and CF. These constructs are latent constructs that encapsulate different dimensions. Empathy encapsulates five dimensions: affective response, affective mentalizing, self-other awareness, perspective-taking, and emotion regulation (Segal et al., 2017). CF is also a latent construct that encapsulates three dimensions: compassion satisfaction, burnout, and secondary traumatic stress (Stamm, 2009). The SPM provided a model to interpret and explain the relationships between empathy and CF. As suggested by the SPM, empathic caregiving is fraught with risk, resulting in a negative impact on the mental well-being of the caregiver.

Compassion Fatigue

CF, also referred to in the literature as secondary traumatization or vicarious traumatization, is a subject that has received increased attention in the helping profession due to its impact on the work and quality of life of helping professionals (Morrissette,

2004). CF impacts the quality of life of the caregiver as well as the quality of care given (Morrissette, 2004; Stamm, 2010). Researchers and students of traumatology traced the roots of CF to the early study of traumatology in the 19th century in Egypt when medical scholars began examining human reactions to events in their environment (Loscalzo et al., 2018; Morrissette, 2004). Figley (1995) coined the umbrella term *compassion fatigue* to encapsulate the negative emotional residue that is vicariously contracted by a caregiver due to their continued exposure to trauma stories of clients. Studies on CF have indicated that this phenomenon is the result of repeatedly hearing of and/or continued exposure to another person's trauma experience, often causing a deleterious effect on the caregiver (Yager et al., 2016).

The negative emotional residue carried by a caregiver makes them an indirect victim of another person's trauma (Wittekind et al., 2016). Yager et al. (2016) found that the risk for CF is high among caregivers who work with trauma survivors, and that the continuous exposure to the trauma stories eventually takes an emotional toll on the caregiver. The presence of an empathic helping relationship between a caregiver and a trauma victim or survivor means that the possibility of CF or vicarious traumatization exist among those caregivers. Immigrant African pastors, as empathic caregivers, are not excluded from the risk of CF because they provide useful mental health services to their parishioners. As an empathic caregiver, the pastor is continually exposed to the trauma stories of others, and negative emotional responses may emerge in their life (Morrissette, 2004). The negative emotional responses are symptoms of vicarious trauma: intrusive thoughts about the parishioner's trauma event, increased negative emotional arousal,

sleep disturbances, mood disturbances, withdrawal, avoidance, and functional impairment (Laureate Education, 2014). Other symptoms of secondary trauma include isolation, nightmares, hopelessness, cynicism, lethargy, and despair (Flint, 2018). The risk of vicarious traumatization is that although the caregiver (in this instance, the immigrant African pastor) finds some satisfaction with the job of helping others heal from their trauma experiences, the empathic gesture also comes with disturbances in the emotional well-being of the caregiver (Figley & Ludick, 2017).

CF is a natural consequence of continued exposure to trauma stories of others stemming from a caring relationship between a caregiver and a trauma victim or survivor, often driven by empathy and the altruistic tendency of the caregiver (Figley, 1995; Hubbard et al., 2017). The risk for CF begins with an exposure to a trauma survivor's experience, which is sufficient to evoke an arousal or an emotional response from the caregiver (Greinacher et al., 2019). The caregiver's vulnerability to the client's trauma experience may be exacerbated by their preexisting trauma experiences or risk factors that produce greater sensitivity to the elements in the trauma survivor's experience (Hubbard et al., 2017). The likelihood that a caregiver's exposure to a trauma survivor's story of suffering could lead to an absorption of the suffering is heightened because of risk factors inherent in a caregiver's history (Hubbard et al., 2017). The caregiver's vicarious trauma condition is the result of the feelings, thoughts, or attitudes received from the trauma survivor through empathic caregiving and the exposure to graphic depictions of the traumatic events of the survivor (Hubbard et al., 2017; Pearlman & Saakvitne, 1995).

Three Dimensions of Compassion Fatigue

In the literature, many terms have been associated with compassion fatigue, resulting in confusing definitions. For the purposes of this study, the three constructs that were examined were burnout, secondary traumatic stress, and compassion satisfaction. These terms, especially burnout and secondary traumatic stress, have been used interchangeably in many studies, which has led to considerable confusion in distinguishing these terms from one another (Craig & Sprang, 2010). Although there is no clear-cut distinction in the literature to suggest these terms are conceptually different from one another, it is widely accepted that caregivers who are continuous exposed to the trauma stories of others face the high risk of becoming traumatized themselves (Craig & Sprang, 2010).

Burnout

Craig and Sprang (2010) noted that burnout is the term most closely associated with CF and was the first to appear in the literature. Burnout is often associated with work-related stress. Burnout is defined as the erosion of engagement with one’s job; it is the situation in which a person’s character and temperament do not match the demands of their job, leading to a feeling of disillusionment (Maslach et al., 2001). Maslach et al. (2001) further explained that burnout encapsulates three components: *exhaustion, cynicism*, and *inefficacy*. First, burnout leads to emotional exhaustion and prolonged work-related stress due to the feeling of hopelessness and difficulties in dealing with one’s work or the discharge of one’s job duties effectively (Stamm, 2009). Second, burnout causes cynicism or depersonalization in an individual as a negative response to

the perceived lack of appreciation or value for their contribution on the job. The result is that the person develops an attitude of just going through the motions on the job; there is no sense of satisfaction for the job they do. Third, burnout breeds inefficacy or a feeling of hopelessness with one's job, leading to a feeling of reduced sense of personal accomplishments (Maslach et al., 2001; Panagioti et al., 2018).

Maslach et al. (2001) have further argued that the root cause of burnout lies in the need to believe that one's life and work in an organization are meaningful, and that the things they do are useful and important to the organization (Pines, 2017). Thus, in burnout situations, the self-esteem is often preserved but the dissatisfaction lies with the value and appreciation of the work of the individual to his organization. Pines (2017) averred that the comparison between personal goals and job-related stressors shows in a personally relevant way in that most burnout-causing aspects of a person's work are those that prevent them from achieving their personal goals and expectations. Put in another way, the most emotionally damaging aspect of a work situation is the lack of existential significance on the part of the individual involved, and that focusing on the importance of deriving a sense of significance from work can guide attempts to cope with and prevent burnout (Pines, 2017).

Secondary Traumatic Stress

According to Stamm (2009), STS is the second component of CF and it has everything to do with continued exposure to accounts of extremely or traumatically stressful events from those who experienced them first-hand. STS is acquired vicariously from working with a trauma survivor. Samhsa (2012) has stated that:

> Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening that has lasting adverse effects on the individual's functioning physically, socially, emotionally, or spiritual well-being. (p. 2)

The reactions include trauma symptoms such as intrusions, avoidance, and arousal (Passmore et al., 2019). Often called the 'caregiver burden,' Figley (1995) detailed STS as involving the reexperiencing of trauma events of others (intrusion) that results in reduced affect (avoidance), and/or difficulty concentrating (arousal). Although it is relatively normal to experience a visceral reaction to traumatic events, it is only when these reactions last longer than a month that it becomes STS (Passmore et al., 2019). Also, Figley (1995) has explained that the symptoms of STS are nearly identical to posttraumatic stress disorder (PTSD) even though sufferers have not experienced trauma directly.

Compassion Satisfaction

Stamm (2010) defines CS as the pleasure one derives from being able to do their work well as a helping professional. According to Stamm (2010), CS has to do with the positive feelings about one's ability to help others and relates to quality of work life of the caregiver. In direct contrast to burnout or STS, a caregiver's sense of achievement, sustained motivation, or even inspiration and enjoyment from emotionally demanding involvement in helping trauma survivors heal from their traumas (Wagaman et al., 2015). CS has been viewed by researchers as an effective means of reducing burnout and STS as

it provides motivation, stamina, interest, and a sense of accomplishment in the caregiver (Bride et al., 2007; Sinclair et al., 2017).

CS explains the intangible benefits caregivers experience when their empathic helping effort is perceived as yielding positive results as evidenced in their clients' improved functioning, personal growth, or therapeutic gains (Pooler et al., 2014). This job-related positive feeling experienced by the caregiver can be both soothing and exciting in the sense that the positive feelings energize the caregiver to carry on. CS is most seen in heightened performance, positive attitude toward work, enhanced value, or greater hope for positive outcomes that resonate among successful caregivers (Kulkarni et al., 2013). Interestingly, CS may be viewed as antithetical to CF, where exhaustion or hopelessness takes over a caregiver's work, leading to burnout (Sheppard, 2015).

Compassion Fatigue Trajectory

As previously discussed, CF is the culmination of burnout and STS combined. It is characterized by a gradual erosion of empathic caring over time. Stamm (2009) has explained that CF is present in a caregiver when burnout and STS combine to make his or her work undesirable and emotionally draining. The emotional exhaustion that emanates from the combined effect of burnout and STS eventually manifests itself in ways that are akin to the symptoms of Post-Traumatic Stress Disorder (PTSD) in a caregiver. The irony with CF is that the caregiver still has the compassion and desire for his or her job as a helping professional but lacks the passion to carry on with the job (Figley, 1995).

As the caregiver's empathy and compassion erodes over time, the continued exposure to the suffering and pain of trauma survivors becomes emotionally draining for

the caregiver, putting him or her at risk for CF. Zaparanick (2008) has explained that when caregivers put themselves up for the role of helping others heal from their trauma experiences, they open themselves up to the risk of becoming emotionally traumatized themselves due to the continued exposure to the tragic stories of the people they are seeking to help. Although it is in the literature that CF is the fate that eventually befalls a caregiver for putting him or herself up to help others heal from their traumas, the literature reveals clearly that a caregiver is in danger of the phenomenon though continued exposure to trauma stories of others (Zaparanick, 2008). For example, Wysomierski (2017) highlighted the inherent dangers in empathic caregiving in a study of army reserve chaplains that when CF is present, a caregiver may become emotionally tired and psychologically impotent to give quality care to the client. Accordingly, Zaparanick (2008) has detailed the four phases of CF that caregivers typically experience as follows: *zealot phase, irritability phase, withdrawal phase*, and the *zombie phase*.

Zealot Phase

The first phase, commonly referred to as the *zealot phase*, is akin to CS (Zaparanick, 2008). At this stage, the caregiver is beaming with motivation and shows the willingness to put him or herself out there to help alleviate the suffering and pain of those traumatized. This stage is underscored by the caregiver’s zeal and commitment to make a difference in the lives of others (Zaparanick, 2008). At the zealot stage, the caregiver is willing to leave no stone unturned as he or she digs deep into their emotional arsenal to marshal all available resources to help the trauma survivor (Fournier & Mustful, 2019; Zaparanick, 2008). Also, the zealot state, the caregiver is driven by intrinsic rewards

derived from satisfaction he or she gets for standing up to be counted when the moment arrived, and somebody needed to make a difference in the lives of those suffering. In the zealot stage, the caregiver is willing to make personal sacrifices such as putting in long hours to help their clients heal. The caregiver is emotionally invested with his or her caregiving job and proudly brags about their 'calling' as a caregiver (Zaparanick, 2008). The caregiver's enthusiasm is high at the zealot stage.

Irritability Phase

The second phase in the CF trajectory is the *irritability phase*. According to Fournier and Mustful (2019), the irritability phase is characterized by a shift from enthusiasm to a feeling of despair. At this juncture, the caregiver begins to pull back and gradually withdraw support and care to the suffering client because he or she views the encounter with clients as emotionally draining and undesirable (Zaparanick, 2008). The caregiver's services at this stage is riddled with excuses and feigned illnesses in order to avoid meeting clients. Zaparanick (2008) averred that this stage of CF is defined by caregiver avoidance of client contact, intolerance of any use of humor in conversations with the caregiver and forgetfulness or lack of concentration during therapeutic sessions. As the irritability grows, the desire to withdraw one's services becomes apparent.

Withdrawal Phase

Fournier and Mustful (2019) stated that at the *withdrawal phase* of CF, the caregiver has reached the point where he or she is so emotionally exhausted that the need to detach from clients is inevitable. This is the stage where the caregiver's enthusiasm has turned sour and he or she has withdrawn from working with clients as well as not taking

care of their close relationships. The emotional exhaustion is so overwhelming for the caregiver to the extent that a consideration to leave the helping profession entirely is on the table (Traumatology Institute [Producer], 2015). The caregiver's life at this stage is a definition of frustration and shattered dreams.

Zombie Phase

The *zombie phase* is the last stage in the trajectory. This stage is riddled with a feeling of hopelessness, anger, hypervigilance, and excessive worrying. The caregiver at this stage loathes his or her job as a caregiver and is living a life filled with anxiety and feeling that the world underneath is caving in on them. It is indeed a zombie experience as the caregiver becomes irrational in his or her thinking (Zaparanick, 2008).

In summary, CF is defined by the PTSD-related symptoms that is vicariously contracted by a helping professional for daring to help traumatized people heal from their trauma and sufferings (Traumatology Institute [Producer], 2015). The danger here is that when CF sets in, the caregiver begins to rationalize their negative behaviors with the good things they have done in the past or are involved in. For instance, a caregiver may throw temper tantrums at their significant other and later rationalize that behavior with an excuse that he or she was reeling a work-related incident. As discussed earlier, CF breeds intrusive memories, leads to hypervigilance and the distorted perception that everything around the caregiver is conspiring to make life unbearable.

At this time, there is no research that demonstrates a linear progress in the CF phases discussed above. Thus, these phases largely remain theoretical, and research is needed to provide more insights on the subject.

Role of Empathy in Caregiving

Empathy is a widely used term but difficult to define (Segal et al., 2017). In a helping profession such as pastoral ministry, empathy is seen as critical and essential skills required of pastor to successfully serve his or her parishioners (Baard, 2017). Segal et al., (2017) calls empathy the “glue that holds communities together” and the skill that promotes “being in tune with others, coordinating activities, and caring for those in need” (p.1). Considering that the majority of a pastor’s job involves interaction with people in the parishes, the need for empathic skills cannot be overstated (Marks & Dollahite, 2018). Empathy has been defined as the ability to understand what other people are feeling and thinking and is an essential skill in facilitating social agreement and successfully navigating personal relationships (Wagaman et al., 2015). Empathy helps to create and maintain social relationships and bonds by enabling individuals to comprehend, share, and respond to the emotions, gestures, thoughts, and experiences of others (Wagaman et al., 2015). To aptly put it, empathy is the umbilical cord that connects a caregiver to a client’s suffering and pain. In the helping profession, the ability to emotionally connect to a client is considered an essential skill a caregiver must possess to provide quality care to the client (Gerdes & Segal, 2011).

According to Segal et al. (2017), the concept of empathy was first developed in the early 1900s by two psychologists: Theodor Lipps (1903) and Edward Titchener (1909) to describe the psychological phenomenon of inner imitations. In other words, empathy depicts how one person experiences another’s pain and suffering through feelings and emotional connection. Zaki (2018) views empathy as a moral compass that a

caregiver must have in order to be successful at helping people. Without empathy caregivers will see suffering people as objects without emotions and will not feel compelled to offer help. Empathy encapsulates cognitive and affective components that enable caregivers to understand the sufferings of others and be able to relate to them through thoughts, feelings, and emotions (Segal et al., 2011). Cognitive empathy requires perspective-taking and mentalizing so that a caregiver can put him or herself in the shoes of the suffering client (Keum & Shin, 2019).

Evidence abounds in the literature to suggest that empathy is the bedrock of a successful and productive helping relationship (Bayne & Jangha, 2016; Elliott et al., 2018; Watson, 2016). Empathy has been found to be a driver of positive moral character development, as well as a facilitator of positive prosocial behavior development (Eisenberg & Eggum, 2009; Elliott et al., 2018; Wilkinson et al., 2017). Although a pastor's primary calling is to propagate the gospel, this mandate demands that the pastor has the skills and the temperament to effectively relate with people. Empathy is one of the virtues required for effective pastoral work. Without empathy, the pastor's service to his parishioners will be impotent and distant to the emotional needs of the people. Empathy drives the establishments of helping relationships between a pastor and his or her congregation (Doehring, 2018). Empathy fosters working alliance between a caregiver and the emotionally traumatized client. The danger, however, is that the empathic helping relationships that the pastor establishes with his or her parishioners is the same that puts him or her at risk for compassion fatigue (Kim, 2020).

Five Dimensions of Empathy

Although Wagaman et al. (2015) have argued that differing and inconsistent definitions of empathy have been professed over the years, this study is premised on the following five dimensions of empathy as identified by Segal et al. (2017): (a) affective response, (b) affective mentalizing, (c) self–other awareness, (d) perspective taking, and (e) emotion regulation. Segal et al. (2017) detail these five dimensions in the following extract:

Affective Response

The brain includes neurological pathways that are capable of physiologically simulating the experiences of others. Often referred to as “mirroring” in the literature, this ability is unconscious, automatic, and involuntary. For example, if a person starts crying in front of you, even if you do not understand why, you too will feel like crying. Affective response can run through all types of emotions (happy, sad) as well as physical sensations (feeling pain when watching another person being physically hurt). Humans appear to be hard- wired to mimic one another, setting the stage for experientially connecting to another person.

Affective Mentalizing

Not all physiological reactions or mirroring come from the actual viewing of an event or experience. Often, we are exposed to stories or explanations of events, and as we are hearing the information, our mind develops a picture of the events. This allows us to develop perceptions of another’s experiences. It may also trigger an affective or

physiological response. When this occurs, we are "mentalizing" or imagining the event and potentially experiencing it as if it is happening to us as well.

Self-Other Awareness

Once the affective response occurs, we need to recognize the difference between the experiences of another person from our own. We may feel like crying (as in the example above) but it is the other person's experience and not our own. This moves empathic response into a cognitive or conscious arena.

Perspective-Taking

Assuming that one successfully mirrors and then processes the affective response to understand that it belongs to the other person, it becomes possible to cognitively process what it might be like to personally experience the experiences of another. This is what we commonly refer to as "stepping into the shoes of another."

Emotion Regulation

The last component helps us to move through these affective and cognitive processes without becoming overwhelmed or swept up into someone else's emotions. This is the ability to sense another's feelings without becoming overwhelmed by the intensity of the other person's experience. (p. 121).

Over the years, pastors have and continue to act as first responders to crisis situations (Van Straten, 2019). Hays and Payne (2020); Payne (2017) have discussed the dichotomy between a pastor's calling and purpose when working and counseling in urban resource-poor communities. These researchers found that pastors, including the immigrant African American pastor, are driven by their desire to emotionally connect

with their parishioners to offer many mental health services (Hays & Payne, 2020; Payne, 2017).

As reviewed from the forgoing discussions, affective response is a physiological component that involves the automatic and unconscious process of affect sharing, or the mirroring of another person's actions (Wagaman et al., 2015). When a member of their community/parish is traumatized, the pastor will likely sit with and listen to the tragic/traumatic story of the trauma survivor. As the story of suffering and pain become gory and intense as they are recounted, coupled with tears, the pastor might begin to have teary eyes as he or she feels connects emotionally with the traumatized member and begins to feel the pain of the traumatized (Brown, 2019; Wagaman et al., 2015). This is a result of the automatic mirroring action that is going on unconsciously.

The human mirroring neuron system activates the same physiological sensations as if he or she is doing the action (Wagaman et al., 2015). However, rather than beginning to cry, the other dimensions of empathy, which are cognitive processes, are then triggered inside the immigrant African pastor to help him or her process the affective response (Wagaman et al., 2015).

When triggered, self–other awareness enables the immigrant African American pastor to recognize and understand his or her own emotions and thoughts as well as the ability to distinguish the self from the other (Wagaman et al., 2015). This is very important because the pastor or caregiver need to demonstrate emotional self-control in order to be able to help the traumatized member of the congregation. Perspective taking involves the pastor's ability to understand the traumatized member's experiences while

maintaining awareness of the self and the distinction from the other (Wagaman et al., 2015). Finally, the immigrant African pastor needs to learn emotional regulation; the ability to control or regulate one's emotions under challenging circumstances (Brown, 2019; Wagaman et al., 2015).

Compassion Fatigue and Professional Impairement

Salwen et al. (2017) have expressed concerns about pastoral mental health, arguing that it is a topic that has received little attention in the psychological literature. Royal and Thompson (2012) have also opined that a pastor's mental health can have significant impact on churches, communities, and even nations. When fulfilling their mandate as pastoral counselors, the immigrant African pastor often must work with traumatized members of their congregation in order to help them heal from their emotional sufferings and pain. However, this empathic helping gesture with traumatized members of their communities could potentially put immigrant African pastors at risk for CF due to continued exposure to the trauma stories of pain and sufferings of their parishioners. Most pastors, including the immigrant African pastor, feel incompetent to provide mental health services to their parishioners for many reasons (Van Straten, 2019). Lack of training could result in professional impairment when the pastor begins to show symptoms of trauma that interfere with effective discharge of their functions (Morrissette, 2004).

According to Strong (2017), professional impairment from psychological distress is a subject that is rarely discussed in the African pastoral community in the U.S. for possibly a lack of understanding or appreciation of the seriousness of the subject among

the target population (Kondrath, 2019). Salwen et al. (2017) have also argued that historical and cultural dynamics often do influence resistance to professional psychological help among pastors, because many pastors perceive acceptance of psychological help as a demonstration of spiritual weakness and a decline in their spiritual faith. There are also pernicious beliefs within the church community about psychological services and mental health counseling (Hankerson et al., 2018). For instance, Hankerson and colleagues talks about the people being stigmatized for daring to access mental health services within the church community rather than resort to prayer and faith in dealing with their emotional pains. Consequently, the need for a research study that targets immigrant African pastors on empathic helping and CF could help start the discussion on how to guard against professional impairment among the target population.

Also, empathy and CF are subjects that goes to the core of the mental well-being of the immigrant African pastor and could define how well they are able to effectively carry their spiritual and physical mandate as pastoral counselors in helping the traumatized members of their congregation. Studying the relationship between empathy and CF among the immigrant African pastor population will help bring to the fore the importance of self-care among the target population (Salwen et al., 2017). The job of a pastor, just as other health professionals is such that they are constrained to self-disclose as they are expected to set an example for their congregants to follow (Salwen et al., 2017). Chandler (as cited in Salwen et al., 2017) has noted that pastors face stress and loneliness because of a multiplicity of demands on them which negatively impacts their

quality of life, yet they are expected to project hope and optimism to their congregation. These demands, coupled with exposure to the trauma stories of others can become emotionally draining, leading to professional impairment of the immigrant African pastor. However, there is a gap in the literature that discusses causes and coping mechanisms for the target population for this research study.

Barsky (2015) has noted that there are ethical obligations required of every professional in the discharge of their duties. Although pastors are often seen as the epitome of hope and peace among their communities (Strong, 2017), the immigrant African pastor might be at risk for emotionally suffering stemming from empathic helping. Considering that there is a gap in the literature on this subject target at the chosen population, this research study could provide more insights on the subject.

Summary

As explained in this chapter, the SPM offer insights into how stressful environments and relationship affect the wellbeing of a caregiver. Immigrant African pastors are caregivers who often find themselves in situations where they must work with traumatized members of their parishes to help them cope with their pain and emotional sufferings. The SPM suggests that stressful situations could trigger mental health challenges for the caregiver. Jacobson et al. (2013) have suggested that pastors need a consistent self-assessment of their mental health to function effectively as pastoral counselors.

Similarly, issues concerning empathic helping and the risk for CF among pastors are hardly researched or discussed because of the fear that self-disclosures by pastors

could erode public confidence in their abilities to serve as spiritual leaders (Van Straten, 2019). The reluctance to discuss psychological injuries that results from a pastor's empathic caregiving is rooted in the notion that the pastor must not come across as emotionally distressed; a disposition could send wrong signals among members of their parishes that they are spiritually weak (Tedder & Smith, 2018). Pastors are expected to present as spiritually strong, mentally healthy, and emotionally strong. Any actions or behaviors on the part of the pastor that questions these variables could be wrongly misconstrued by their parishioners as unfit to be their spiritual leader (Strong, 2017).

Thus said, there is a gap in the literature that could provide insights to help the clergy in the African community in the U.S. on the subject. Pastors are also helping professionals; it is imperative that the relationship between empathy and the risk for CF is thoroughly studied to provide more insights and cultural diversity to the body of knowledge that currently exist. Louw (2015) has suggested that CF among pastors portrays spiritual exhaustion, but a careful study may reveal otherwise. For all intent and purposes, a study on empathy and the risk for CF among the immigrant Africa pastor population may help provide insights, spark social change process among pastors, promote, and promote selfcare practices. This research study, therefore, is necessary to provide insights on the potentially deleterious effect of empathic caregiving among the target population. By so doing, immigrant African pastors would be equipped with the knowledge required for practicing self-care.

Chapter 3: Research Method

The purpose of this quantitative cross-sectional survey study was to examine the multivariate relationships between five dimensions of empathy and three dimensions of CF among immigrant African pastors. In this chapter, I discuss the methodology for this study. This chapter offers a thorough description of how the research was conducted and offers justification for the approach used in this study. Creswell and Creswell (2017) explained that research approaches are plans and procedures for research that include the steps from broad assumptions and interpretations. The theoretical underpinning informed the research approach selected for this study as well as the characteristics of the target population. This chapter addresses the research design and the rationale for choosing this design, the research question, and the sample population for the study. This chapter also includes the data collection approaches and the instruments used for collecting data, the data analysis procedure, and threats to validity.

Research Design and Rationale

Creswell and Creswell (2017) noted that three research approaches can be adopted in any research project to answer the research questions: (a) qualitative, (b) quantitative, and (c) mixed methods. The methodology selected for a study is dictated by the research question, not by how much is known about a particular phenomenon (Ercikan & Roth, 2006; Vogt et al., 2012). For the current study, a cross-sectional quantitative correlational survey approach was used. The research question and the exploratory nature of the study were the main reasons for choosing this approach. Considering that not much was known about the subject concerning the targeted

population to be studied, an exploratory cross-sectional correlational design was appropriate to examine the multivariate relationships between the five dimensions of empathy (affective response, affective mentalizing, self-other awareness, perspective-taking, and emotion regulation; see Segal et al., 2017) and the three dimensions of CF (compassion satisfaction, burnout, and secondary traumatic stress; see Stamm, 2009) among immigrant African pastors. Although this study was guided by a theory, a theory was not being tested but was rather being used to inform interpretation of the multivariate results. The testing of theory is rare in the social sciences (Vogt et al., 2012).

Methodology

Population

This study targeted the immigrant African pastor population in the United States for two reasons. First there was a gap in the literature that warranted this study. The review of related literature revealed that there had been many studies on the two constructs (empathy and CF) that targeted other helping professions such as doctors, social workers, first responders, nurses, psychologists, and lawyers. However, no study targeted the immigrant African pastor population. Second, a study such as this could promote social change in how pastors are prepared and trained for counseling ministry with emphasis on self-care.

Immigrant African pastors in the United States were invited using emails and social medial portals to participate in an online survey via Survey Monkey. Participation in the study was voluntary. Exclusionary criteria applied to pastors who were not of immigrant African origin, or immigrant African pastors who were not currently residing

and practicing their pastoral trade in the United States. Respondents who met the selection criteria for this study were asked to support the study through snowball sampling by forwarding the invitation email or the online survey link to other immigrant African pastors in their circles of influence. Following Walden University's IRB's approval for this study on October 28, 2020, with approval # 10-28-20-0671723, data collection occurred in the fall of 2020, between October 30 and November 23, 2020. The study was designed to answer a research question that addressed the number and nature of statistically significant multivariate relationships between five dimensions of empathy and three dimensions of CF among the target population.

Sampling and Sampling Procedures

Creswell and Creswell (2017) explained that sample size determination indicates the number of people in the sample as well as the procedure used to compute this number. Creswell and Creswell also noted that a larger sample would likely provide more accuracy in the constructs being measured and the inferences made, but recruiting participants is time-consuming and costly. Cohen (1988) devised formulas to determine target sample size for multivariate set correlations, such as canonical correlation. Following Cohen's formulas, I calculated a target sample size of 138 for correlating a 5-variable set with a 3-variable set at alpha of .05, power of .80, and expected squared canonical correlation of .13, which Cohen defined as a medium-size effect. This number was drawn from the immigrant African pastor population currently practicing their pastoral trade in the United States. There were no restrictions on denominations, creed, or

gender. However, participants had to be an ordained pastor or a duly appointed clergy member of their church.

The sampling technique used for recruiting participants for this study was snowball sampling (a type of convenience sampling). According to Ungvarsky (2017), snowball sampling allows for the recruitment of participants whereby respondents who have already participated in the study are asked to recommend others to take part in the study. Also known as chain sampling or referral sampling, snowball sampling is helpful in recruiting population samples that may not be easy to identify (Ungvarsky, 2017). Critics of snowball sampling argued that although helpful, the technique can create bias and make it difficult to determine how the study results would be applied to larger populations (Ungvarsky, 2017). Snowball sampling was considered appropriate for the current study because the immigrant African pastor population was scattered across the United States and recruiting them for this cross-sectional study could have been daunting without the help of other immigrant African pastors. Through snowball sampling, recruited participants were able to recommend other participants to be recruited to participate in the study.

An email invitation was sent to identified African pastoral groups who were personally known to me, as well as individual pastors to solicit their support for this study. Similarly, notices were posted on social media platforms and other online portals to recruit respondents who met the requirements for this study. Also, respondents were asked to support the study by forwarding the survey invitation or the online link to other potential respondents who met the selection criteria.

Procedure for Recruitment, Participation, and Data Collection

Data collection for this study was done through Survey Monkey. Data were collected between October and December of 2020. The informed consent form indicated respondents' rights of participation, the inclusion criteria, the purpose of the study, the survey questions, the time commitment, and the benefits for the study as well as the potential risks for participating in the research. Respondents were assured of their anonymity because no identifying data would be collected in this study. Respondents were at liberty to stop participating in the study at any time without injury to their relationship with me or Walden University. Participation was voluntary and without duress.

Instrumentation and Operationalization of Constructs

The instruments for data collection through an online survey were the ProQOL-5 (see Stamm, 2009) and the EAI (see Segal et al., 2017). The ProQOL-5 consists of three subscales: Compassion Satisfaction (CS), Burnout, and Secondary Traumatic Stress (STS; Wagaman et al., 2015). Each subscale has 10 questions. According to the developers of ProQOL-5, the reliability of the subscales are as follows: CS has an alpha scale reliability of 0.88, Burnout has an alpha scale reliability of 0.75, and STS has an alpha scale reliability of 0.81. These psychometrics are an accumulation of studies of 1,289 cases submitted by researchers to the ProQOL databank (Stamm, 2010). As conceptualized by the scale developers, both Burnout and STS are components of the latent construct, CF. Each item is measured on a 5-point Likert scale as follows: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, and 5 = *very often* (Wagaman et al., 2015).

The ProQOL-5 has been identified as a reliable and valid measure of CS and the components of CF (Stamm, 2010).

The second instrument for this study, the EAI, is a valid and reliable 20-item self-report instrument (Gerdes et al., 2012) that includes subscales for measuring the five dimensions of interpersonal empathy. The five dimensions are Affective Response (AR), Affective Mentalizing (AM), Self-Other Awareness (SOA), Perspective-Taking (PT), and Emotion Regulation (ER). Item breakdown are as follows: AR = 5 items, AM = 4 items, SOA = 4 items, PT = 5 items, and ER = 4 items. Items are measured on a 6-point Likert scale as follows: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *frequently*, 5 = *almost always*, and 6 = *always* (Gerdes et al., 2012). Accumulated across several studies, Gerdes et al. (2012) reported Cronbach's alpha values of the five subscales ranging from .64 to .83. Lietz et al. (2011) in a psychometric analysis from a sample of 773 participants reported scale-specific Cronbach's alpha values of .84 for AR, .81 for AM, .70 for SOA, .82 for PT, and .72 for ER.

In addition, demographic data were collected to provide context and insights in the study. Demographic data included gender, age, level of education, household income, length of time in pastoral service, marital status, and Christian denomination. Gender was measured as three levels: 1 = male, 2 = female and 3 = other. Marital status was measured as five levels: 1 = single, 2 = married, 3 = divorced, 4 = separated, and 5 = widowed. Finally, Christian denomination was measured as four levels: 1 = Orthodox, 2 = Pentecostal, 3 = Charismatic, and 4 = Other.

Data Analysis

The research question was the following: What are the number and nature of statistically significant multivariate relationships between five dimensions of empathy and three dimensions of compassion fatigue? This research question was answered using canonical correlation analysis (CCA; Tabachnick & Fidell, 2007). According to Ridderstolpe et al. (2005), CCA is an exploratory technique for analyzing the relationship between two sets of variables in which each set contains several variables. The method is used to measure the total linear relationship between the two sets of multidimensional variables. CCA is the statistical approach for analyzing latent variables or variables that are not directly observed but represent multiple variables that are directly observable (Ridderstolpe et al., 2005). In the current study, the latent variables (empathy and CF) represented multiple directly observed variables. CCA enabled me to quantify the strength of the relationship between the multiple independent variables of CF and the multiple dependent variables of empathy. The relationship that would be revealed using CCA would not imply a causal relationship. The revealed relationships would help explain how the two sets of variables (CF and empathy) correlate among immigrant African pastors in the United States. CCA was used to reduce the analysis of the relationships to the smallest most significant form possible for interpretation.

CCA was deemed the most appropriate technique for analyzing data in this study. Ridderstolpe et al. (2005) explained that CCA facilitates the measuring of the linear relationship between two multidimensional variables. CCA finds two bases, one for each variable, that are optimal concerning correlations and, at the same time, finds the

corresponding correlations (see Ridderstolpe et al., 2005). CCA was developed by Hotelling and can be viewed as an extension of multiple regression to situations involving more than one response variable (Ridderstolpe et al., 2005). CCA was deemed the appropriate statistical tool for the current study because it had been used in studies in economics and medical studies to predict the outcome of relationships (see Ridderstolpe et al., 2005).

To prepare for CCA analysis, the data were cleaned and screened for statistical assumptions and limiting conditions. First, mean composite scores for each of the eight subscales were computed. Cases with more than 30% of missing data on items that made up a subscale were eliminated from the analysis. For cases with less than 30% of items missing for a subscale, I computed a case-specific mean. Each subscale score was evaluated for univariate outliers (greater than ±3.29 standard deviations from the mean and that were discontinuous from the distribution) and normal distribution (i.e., skewness and kurtosis) with corrective taken as needed. In addition, Cronbach's alpha was computed for each subscale as an index of reliability. As a set of subscales, multivariate outliers were evaluated following Tabachnick and Fidell's (2007) procedure of regressing a random variable simultaneously on all eight subscales and identifying cases with Mahalanobis values exceeding 26.124 (i.e., critical chi-square value at alpha = .001 for eight variables). Collinearity was evaluated by correlations exceeding .70 and variance inflation factors exceeding 2.0, respectively.

Threats to Validity

Creswell and Creswell (2017) defined validity as the extent to which a researcher can draw meaningful and useful inferences from data derived from a study. Boudah (2011) asserted that validity is used to judge the quality of quantitative quasi-experimental studies. Three major types of validity are important: internal validity, external validity, and construct validity (Boudah, 2011; Creswell & Creswell, 2017).

Threats to internal validity beg the question of whether the research procedures adopted threaten the researcher's ability to draw inferences from the sampled data about the population (Krawczyk et al., 2019). To ensure internal validity for the current study, I took several steps. First, the instruments used in collecting data for this research were adopted from the time-tested and widely accepted self-report measures (EAI for measuring the dimensions of empathy and ProQOL -5 for measuring the dimensions of CF). These self-report measures had been widely used in measuring the constructs that I sought to assess. Second, Creswell and Creswell (2017) argued that internal validity is threatened if research participants become familiar with the outcome measure and remember responses for later testing. In the current study, the instrument did not afford participants the opportunity to memorize responses and reproduce them. Rather, participants were asked to rate their experiences on a Likert scale in a given moment. Third, the study was designed so that participants selected would not present certain characteristics that predisposed them to have certain outcomes. Fourth, to ensure that elapsed time did not affect responses and outcomes, the data were collected at a specific point in time. When time elapses, data collection ceases to ensure fairness. The current

study was a cross-sectional quantitative study, which meant that data were collected at a specific point in time.

External validity is “the extent to which an observed relationship among variables can be generalized beyond the conditions of the investigation to other populations, settings, and conditions (Boudah, 2011). In this study, two major factors were considered as threats to external validity: sample characteristics and setting characteristics. First, sample characteristics. This study targets the immigrant African pastor population in the U.S. This population has its unique characteristics. Therefore, the conclusions derived from this study cannot be generalized to all persons in the pastoral ministry, outside the confines of the characteristics that define the population being studied. Second, setting characteristics. There was no pre-test, post-test procedure that could affect the outcome of the data collected. All respondents will be administered the same instruments used for data collection once.

Finally, construct validity is the degree to which a researcher truly measures the construct of focus in the study (Boudah, 2011). Therefore, in this study, construct validity was ensured by adapting the time-tested self-report measures of EAI and ProQOL -5 as the instruments for collecting research data. The ProQOL -5 and the EAI are widely validated and accepted instruments for measuring the constructs being studied in this research. To this extent, the construct of focus in this study was truly measured with fidelity.

Ethical Procedures

The American Psychological Association puts it succinctly, ethics concerns how professionals conducts themselves in each situation that arise in their line of work (Chenneville & Gabbidon, 2020). In social research such as this, the duty to ‘*do no harm’* cannot be overemphasized. Accordingly, four ethical principles would be adhered to in order to protect the privacy, autonomy, diversity, values, and dignity of each participant in this research study. The four ethical principles adapted for this research are (a) Inclusiveness: this research does not discriminate between male and female African American pastors. All members of the target population for this study have an equal chance of being selected for this study. (b) Respect for privacy, autonomy, values, and dignity of the individual respondent will be preserved. No survey item asks for identifying information and IP addresses of participants will not be collected. (c) The research study will be conducted with utmost integrity by employing the most appropriate methods deemed relevant for the purpose. (d) Concerning social responsibility, this study adopts environmentally friendly resources that pose no harm to research participants. To ensure adherence to ethical principles, approval was obtained from Walden University’s Institutional Review Board (IRB. It is instructive to point that although the researcher took all precautionary measures to do no harm with this research, psychological risks may be apparent in answering the survey questions. Accordingly, the researcher provided a list of support including free counseling services from Walden university’s IRB contact to help mitigate any unintended psychological distress that may have arisen while participating in the research study.

Summary

As discussed, the primary purpose for undertaking this cross-sectional correlational research is to examine the multivariate relationships between the five dimensions of empathy and the three dimensions of compassion fatigue among immigrant African pastors in the U.S. In this chapter, the researcher has painstakingly explained the reasoning behind the proposed research methodology for this research study. The chapter also offered the reader a thorough understanding of how the research would be conducted and the justification for choosing the approaches for the research. As revealed by Creswell and Creswell (2017), research approaches are plans and procedures for research that span the steps from broad assumptions and interpretations. The next chapter will present the research results and findings from the data collected.

Chapter 4: Results

This was a cross-sectional quantitative study aimed at examining the multivariate relationships between the five dimensions of empathy (see Segal et al., 2017) and three dimensions of CF (see Stamm, 2009) among immigrant African pastors in the United States. The lack of studies in the literature on the subject among the target population was the main motivation for conducting this study. In the existing literature, CF had been noted to significantly impact the quality of care among helping professionals such as nurses, psychotherapists, and medical doctors (Gallardo & Rohde, 2018), whereas empathy had been suggested to be a significant predictor of CF susceptibility (Wagaman et al., 2015). However, researchers had not targeted the immigrant African pastor population in the United States. In this chapter, I describe the data collection process and time frame for data collection and provide the results of the study.

Data Collection

The COVID-19 global pandemic occasioned a global shutdown that impacted timelines and modes of data collection. The online portal, Survey Monkey, was the primary vehicle for data collection. Using a snowball sampling approach, I invited respondents to voluntarily partake in the study if they met the qualifying criteria, and I encouraged them to invite others in their contact list who met the qualifying criteria to be part of the research project.

The instruments for data collection through an online survey were the ProQOL-5 (see Stamm, 2009) and the EAI (see Segal et al., 2017). The ProQOL-5 consists of three subscales: CS, Burnout, and STS (Wagaman et al., 2015). Each subscale has 10

questions. According to the developers of ProQOL-5, the reliability of the subscales of the instrument are as follows: CS has an alpha scale reliability of .88, Burnout has an alpha scale reliability of .75, and STS has an alpha scale reliability of .81. These psychometrics are an accumulation of studies of 1,289 cases submitted by researchers to the ProQOL databank (Stamm, 2010). As conceptualized by the scale developers, both Burnout and STS are components of the latent construct CF. Each item in the ProQOL is measured on a 5-point Likert scale as follows: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, and 5 = *very often* (Wagaman et al., 2015). The ProQOL-5 has been identified as a reliable and valid measure of CS and the components of CF (Stamm, 2010).

The second data collection instrument used for this study, the EAI, is a valid and reliable 22-item self-report instrument (see Gerdes et al., 2012) that includes subscales for measuring the five dimensions of empathy (Segal et al., 2017). The five dimensions are AR, AM, SOA, PT, and ER. Item breakdown are as follows: AR = 5 items, AM = 4 items, SOA = 4 items, PT = 5 items, and ER = 4 items. Items are measured on a 6-point Likert scale as follows: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *frequently*, 5 = *almost always*, and 6 = *always* (Gerdes et al., 2012). Accumulated across several studies, Gerdes et al. (2012) reported Cronbach's alpha values of the five subscales ranging from .64 to .83. Lietz et al. (2011) in a psychometric analysis from a sample of 773 participants reported scale-specific Cronbach' alpha values of .84 for AR, .81 for AM, .70 for SOA, .82 for PT, and .72 for ER.

Results

Data Cleaning

The research question was the following: What are the number and nature of statistically significant multivariate relationships between five dimensions of empathy and three dimensions of compassion fatigue? To prepare for CCA to answer the research question, I cleaned and screened the data for statistical assumptions and limiting conditions. First, mean composite scores for each of the eight subscales were computed. This was to ensure that cases with more than 30% of missing data on items that made up a subscale would be eliminated from the analysis. For cases with less than about 30% of items missing for a subscale, I imputed a case-specific mean. Each subscale score was evaluated for univariate outliers (greater than ±3.29 standard deviations from the mean, and that were discontinuous from the distribution) and normal distribution (i.e., skewness and kurtosis) with corrective taken as needed. In addition, Cronbach's alpha was computed for each subscale as an index of reliability. As a set of subscales, multivariate outliers were evaluated following Tabachnick and Fidell's (2007) procedure of regressing a random variable simultaneously on all eight subscales and identifying cases with Mahalanobis values exceeding 26.124 (i.e., critical chi-square value at alpha = .001 for eight variables). Collinearity was evaluated by correlations exceeding .70 and variance inflation factors exceeding 2.0, respectively.

Initial analysis of 140 participants indicated no missing response on any item making up any of the eight subscales. Following scoring instructions for the ProQOL-5

(see Stamm, 2009) and EAI (see Segal et al., 2017), I reverse coded five ProQOL-5 items and two EAI items. Composite mean scores for all eight subscales were computed.

Reliability Analysis

An initial reliability analysis was performed on all eight subscales to determine what changes needed to be made for the data to be meaningful for interpretation. A summary of initial, revised, and final results is presented in Table 1. Initial results on four of the five dimensions of empathy yielded acceptable reliability scores. The ER subscale was deemed not reliable for interpretation because it yielded a reliability score of .286. Item 17 was found to be negatively correlated with reverse-coded Items 5 and 10 and had a very small correlation with Item 2. Item 2 also had small correlations with Items 5 and 10. As a result, the ER subscale was redone with only the reverse-coded Items 5 and 10. Although reliability was low at .616, I included the ER subscale as useful for inclusion in the data analysis.

Reliability scores for the three dimensions of CF subscales looked good at first glance, but inspection of interitem correlations revealed issues with both the STS and Burnout subscales. For the STS subscale, Item 2 had very low correlations with the other items, ranging from a low of .018 to a high of .202 with average correlation of .089. STS without Item 2 had a reliability of .856, and the minimum inter-item correlation stood at .184 instead of .018.

Table 1

Subscale Reliability Analysis

Instrument/subscale	Cronbach's α Prior[1]	Initial[2]	Revised[2]	Final[3]	Actions
Professional Quality of Live Scale (ProQOL-5)					
Compassion Satisfaction (CS; 10)	.88	.85	na	.83	
Burnout (BO; 10)	.75	.75			
Burnout (BO; 5)			.82	.82	Retained the 5 positively worded items
Pastoral self-esteem (PSE; 5)			.66	.63	Composed of the 5 negatively worded burnout items
Secondary Traumatic Stress (STS; 10)	.81	.84			
Secondary Traumatic Stress (STS; 9)			.86	.85	Item 2 had very low correlations with all other items and was excluded
Empathy Assessment Index (EAI)					
Affective Response (AR; 5)	.84	.72	na	.72	
Affective Mentalizing (AM; 4)	.81	.66	na	.67	
Self-Other Awareness (SOA; 4)	.70	.71	na	.71	
Perspective-Taking (PT; 5)	.82	.72	na	.71	
Emotion Regulation (ER; 4)	.72	.29			
Emotion Regulation (ER; 2)			.62	.64	Retained reverse-coded Items 5 and 10; Item 17 negatively correlated with 5 and 10, Item 2 had very small correlations with 5 and 10, Items 2 and 17 had very small correlations

Note. Numbers in parenthesis following name of a scale or item indicate the number of items.
[1] Cronbach's α values for ProQOL-5 from Stamm (2010; $N = 1{,}289$); EAI values from Lietz et al. (2011; $N = 773$)); for PPVM, PLFVS, and PCAM from Mueller and Tschan (2011a; $N = 329$).
[2] $N = 140$.
[3] $N = 134$ after eliminating univariate and multivariate outliers.

The Burnout subscale initially looked good with an alpha score of .751, but an examination of the correlation matrix revealed that the positively worded items and the negatively worded items had low or negative correlations, which made this subscale unreliable for analysis. The pattern suggested that the set of items may not have been unidimensional, so a principal axis factor analysis was performed. First, a forced 2-factor analysis that allowed the factors to be correlated was performed. The Pattern Matrix,

which is the loading of each item on each factor, and the Structure Matrix, which is the correlation of each item with each factor, both indicated that the positively worded items formed one factor and the reverse-coded items formed a second factor. The factors were minimally correlated at .194. Therefore, an uncorrelated solution was conducted to determine whether results changed. The uncorrelated solution showed the same 2-factor pattern, with positive Burnout items on one factor and negative Burnout items on the other. Therefore, Burnout items were computed as two separate subscales: Burnout subscale and Pastoral Self-Esteem (PSE) subscale.

Finally, the new PSE subscale with only the 5 items (ProQOL-5 Items 8, 10, 19, 21, and 26) had very good reliability at .819 Cronbach's alpha. The newly created PSE subscale had these five items that were worded in the opposite direction of burnout:

1. ___ I am happy.

4. ___ I feel connected to others.

15. ___ I have beliefs that sustain me.

17. ___ I am the person I always wanted to be.

29. ___ I am a very caring person.

Rather than referring to these items as reverse Burnout, the content across the items suggested that these represented what should be PSE, at least on its face. Accordingly, these items were left on their original response scale so that a high score indicated high PSE and vice versa. Cronbach's alpha was a bit low at .659, but was deemed acceptable for analysis.

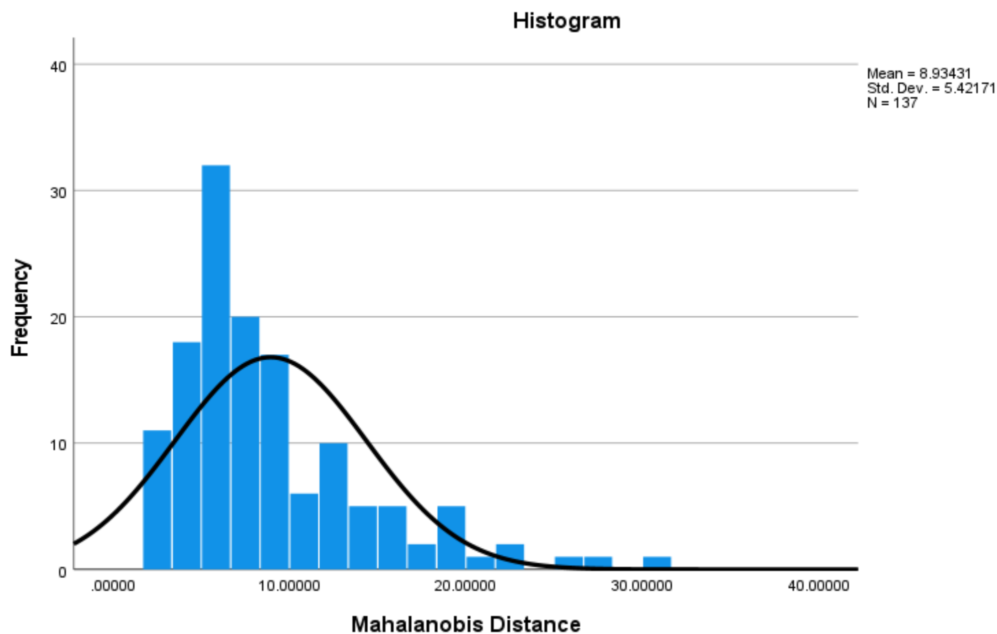
Screen for Univariate and Multivariate Outliers

Univariate outliers are cases with a variable value that exceeds ±3.29 standard deviations and/or are substantially discontinuous with the distribution of the variable (Tabachnick & Fidell, 2007). To facilitate inspection, standardized *z*-scores for each of the nine subscales were computed. Univariate outliers were noted for AM, PT, and CS. Three participants were determined to have extreme values on one of these subscales. For each of these, there was a gap (i.e., discontinuity) between these cases and the rest of the cases. Accordingly, these three cases were removed from the data. After recalculating all nine subscales, I screened multivariate outliers following Tabachnick and Fidell's (2007) procedure of regressing a random variable on the set of nine subscales. In the initial regression run, the maximum Mahalanobis value was 30.033. The critical value for nine predictors was 27.877.

The frequency and histogram output in Figure 1 showed a smooth distribution of values up to 22, then a sudden jump and discontinuity to three cases with values of 26.3, 27.4, and 30.0. These three cases were removed from analysis. With a final $N = 134$, the maximum Mahalanobis value was 23.3, well below the critical value and indicating the distribution was smooth and continuous.

Figure 1

Histogram of Mahalanobis Distance to Detect Multivariate Outliers



Descriptive Statistics

Demographics

There were about 5 times more male respondents than females (see Table 2). Regarding education level, 91.8 % of respondents had a bachelor's degree or higher. Similarly, 99.3 % of respondents were married, whereas Christian denomination was almost evenly distributed between Pentecostal and Charismatic. The age of participants ranged from 25 to 65 with an average age of 49.2 (*SD* = 7.4, median = 49.0). Age was relatively normally distributed with skewness and kurtosis values of -0.32 and -0.35, respectively. On average, participants had served in ministry for about 13 years (*M* = 12.9, *SD* = 7.5, median = 12.0), ranging from less than one year to 40 years. The

distribution of years in ministry was relatively normally distributed (skewness = 1.1, kurtosis = 0.9).

Table 2

Participant Demographics

Variable	Frequency	Percentage
Sex		
Male	112	83.6
Female	22	16.4
Education		
HS or GED	1	0.7
Associate's	10	7.5
Bachelor's	37	27.6
Master's	74	55.2
Doctorate	12	9.0
Marital status		
Single	1	0.7
Married	133	99.3
Christian denomination		
Pentecostal	68	50.7
Charismatic	60	44.8
Other	6	4.5

Descriptive Statistics of Final Subscale Scores

Descriptive statistics of the final subscale scores are presented in Table 3. All nine subscales were relatively normally distributed with skewness and kurtosis values generally between ±1. In sample sizes of around 100, parametric analyses are robust (if not caused by outliers; Tabachnick & Fidell, 2007) when skewness ≤ |3.0| and kurtosis ≤ |10.0| (Kline, 2016). All four of the ProQOL-5 subscale scores and four of the five EAI scores had means and medians above the midpoint value of the response scale, indicating this sample of ministers tended to score high on each construct. There was adequate variance for analysis, but potential ceiling effects should be considered. Six of the nine

subscale scores had Cronbach's alpha values between .71 and .85, which was in the desirable range for measures of psychological constructs (Rust et al., 2021). Three subscales had reliability values in the .60's, which would result in underestimates of correlations with other variables that could affect Type II but not Type I error rates (see Bonett & Wright, 2014). If correlations are near but not statistically significant or if canonical correlation coefficients are relatively smaller, these variables can still be interpreted as important.

Table 3

Descriptive Statistics of Final Subscale Scores

Variable	α	Min	Max	Mdn	*M*	*SD*	*S*	*K*
Professional Quality of Live Scale (ProQOL-5)								
Compassion satisfaction (CS; 10)	.83	3.00	4.90	4.50	4.42	0.48	-1.1	0.5
Burnout (BO; 5)	.82	1.00	5.00	3.40	3.27	1.09	-0.4	-1.0
Pastoral self-esteem (PSE; 5)	.63	3.40	5.00	4.80	4.67	0.42	-1.4	0.9
Secondary traumatic stress (STS; 9)	.85	1.11	5.00	3.44	3.44	0.88	-0.3	-0.5
Empathy Assessment Index (EAI)								
Affective response (AR; 5)	.72	3.40	6.00	5.60	5.38	0.63	-1.1	0.7
Affective mentalizing (AM; 4)	.67	3.25	6.00	5.25	5.23	0.67	-0.6	-0.5
Self-other awareness (SOA; 4)	.71	3.25	6.00	5.25	5.21	0.74	-0.6	-0.7
Perspective taking (PT; 5)	.71	3.80	6.00	5.60	5.35	0.63	-0.6	-0.9
Emotion regulation (ER; 2)	.64	1.00	6.00	3.00	3.12	1.64	0.2	-1.2

Note. N = 134. α = Cronbach's alpha; S = skewness; K = kurtosis. Possible minimum and maximum values for ProQOL-5 scales is 1 to 5, for EAI scales is 1 to 6.

Correlations Among Subscales

To determine the relationship among the subscales of empathy and CF, correlation analysis was performed, as presented in Table 4. Collinearity can potentially affect results when pairwise correlations are greater than ±.70 (Cohen et al., 2003).

Results revealed collinearity between SOA and three other EAI subscale scores: AR, AM, and PT; between PT and AR, AM; between PSE and CS; and between BO and STS. As a multivariate analysis, CCA considers the intercorrelations within each set of variables, so with potential collinearity both the standardized coefficient and structure coefficient are important for interpretation.

Table 4

Correlations Among Subscale Scores

	CS	BO	PSE	STS	AR	AM	SOA	PT	ER
CS	*.306*	-.282	**.827**	-.255	.549	.387	.420	.342	.454
BO	.001	*.240*	-.228	**.870**	-.252	-.068	-.125	-.051	-.479
PSE	< .001	.008	*.315*	-.215	.602	.451	.500	.397	.348
STS	.003	< .001	.013	*.246*	-.204	-.048	-.120	-.009	-.446
AR	< .001	.003	< .001	.018	*.361*	.661	**.764**	**.699**	.213
AM	< .001	.435	< .001	.585	< .001	*.359*	**.780**	**.726**	.036
SOA	< .001	.150	< .001	.169	< .001	< .001	*.231*	**.803**	.069
PT	< .001	.559	< .001	.916	< .001	< .001	< .001	*.311*	-.002
ER	< .001	< .001	< .001	< .001	.013	.680	.427	.982	*.908*

Note. $N = 134$. Upper diagonal contains Pearson correlations (bold values indicate potential collinearity); lower diagonal contains two-tailed p values; italicized values on the main diagonal are tolerance values within a variable's own set.

Additionally, multicollinearity was observed. Tolerance values within each variable's own set are reported on the main diagonal in Table 4. While some have stated that multicollinearity is a problem when tolerance values are < .10 (e.g., Mertler & Vannatta, 2013), others stated it to be a problem when tolerance < .20 (Menard, 1995), and Tabachnick and Fidell (2007) stated that multicollinearity may adversely affect results when tolerance is as high as .50. The proportion of variance in a variable that

other variables in its own set account for is 1 – tolerance. When tolerance is low (thus, 1 – tolerance is high) there is not much opportunity for that variable to contribute to a regression or canonical correlation solution because of the amount of variance it shares with other predictors. This is particularly the case if the shared variance is principally explained by variables within its own set. For example, 76.0% of the variance in BO is accounted for by CS, PSE, and STS. High collinearity and multicollinearity can result in a suppression effect (Cohen et al., 2003) in which, for example, a positive simple correlation with a variable in the other set becomes near zero or substantially negative in regression or CCA. Considering that canonical provides both loading coefficients (standardized canonical coefficients) and correlations of each variable with the canonical variate, results could still be interpreted even if there is evidence of suppression.

Canonical Correlation Analysis

The overall canonical correlation, Roots 1 to 4, was statistically significant, Wilks's $\Lambda = .392$, $F(20, 415.53) = 6.78$, $p < .001$, accounting for 60.8% of the generalized variance. Root 4, by itself, was not statistically significant, Wilks's $\Lambda = .996$, $F(2, 128) = 0.23$, $p = .792$. Roots 3 to 4 was not statistically significant, Wilks's $\Lambda = .968$, $F(6, 254) = 0.71$, $p = .646$, suggesting that Root 3, by itself, was not statistically significant. Roots 2 to 4 was statistically significant, Wilks's $\Lambda = .839$, $F(12, 333.66) = 1.91$, $p = .032$, suggesting that Root 2, by itself, was statistically significant. Root 1, by itself, accounted for 85.92% of the generalized variance; Root 2, by itself, accounted for 11.56%; and, together, Roots 1 and 2 accounted for 97.48% of the generalized variance.

Within Root 1, 53.3% of the variance between the two sets of variables was shared, and within Root 2, 13.3% of the variance between sets of variables was shared.

Root 1 Coefficient Results

Standardized (beta) and structure (correlation) coefficients for the two statistically significant roots are presented in Table 5. In the ProQOL-5 set of variables on Root 1, the standardized coefficients and correlations were consistent in sign and magnitude except for STS that had a near zero coefficient but correlation of .56 (considered a large correlation). In the EAI set, both AR and ER were consistent in sign and magnitude. AM and SOA had small coefficients but large correlations, and for PT there was evidence of suppression in that the coefficient was small and positive, yet the correlation was large and negative.

In general, those who had low scores on all five EAI subscales of empathy, particularly affective response (AR), and emotion regulation (ER), tended to have high scores on burnout and secondary traumatic stress, and low scores on compassion satisfaction and pastoral self-esteem.

Root 2 Coefficient Results

On Root 2, there was evidence of suppression in that CS had a large and positive standardized coefficient but a small negative correlation. PSE had a different kind of suppression in which the magnitude of the standardized coefficient was enhanced. For the EAI variables, AR, ER, and AM had consistent sign and magnitude for standardized coefficient and correlation.

Table 5

CCA Summary Results of Two-Root Solution of EAI and ProQOL Variates

	Root 1			Root 2			
	β	r	r^2	β	r	r^2	h^2
EAI							
AR	-0.624	-.806	.650	-0.303	-.530	.281	.931
ER	-0.592	-.738	.545	0.731	.644	.415	.960
AM	-0.098	-.521	.272	-0.346	-.678	.460	.732
PT	0.163	-.454	.206	-0.064	-.643	.414	.620
SOA	-0.138	-.601	.361	-0.143	-.646	.417	.778
Adequacy			.407			.397	
R_c		.730	.533		.365	.133	
Adequacy			.563			.265	
ProQOL							
CS	-0.448	-.893	.798	0.662	-.137	.019	.817
STS	0.033	.563	.317	-0.402	-.631	.399	.716
BO	0.380	.626	.391	-0.370	-.629	.395	.786
PSE	-0.398	-.863	.745	-1.216	-.497	.247	.992

Note. β = standardized function coefficient. r and r^2 = structure and squared structure coefficients but refers to canonical correlation in R_c row. h^2 = communality (% of variance in a variable jointly extracted by the two canonical functions). AR = affective response. ER = emotion regulation. AM = affective mentalizing. PT = perspective-taking. SOA = self-other awareness. CS = compassion satisfaction. STS = secondary trauma stress. BO = burnout. PSE = pastoral self-esteem.

In general, those with high scores on emotional regulation and low scores on the other four empathy variables (particularly affective mentalizing and affective response) tended to have high compassion satisfaction but very low pastoral self-esteem, low secondary traumatic stress, and low burnout.

Univariate Regression Results

The univariate regression results for each of the four ProQOL-5 variables as predicted by the five EAI variables are presented in Table 6.

Table 6

Univariate Multiple Linear Regression Results

Criterion	Statistic	EAI Predictor				
		AR	AM	SOA	PT	ER
Other EAI	1 – tol.	.639	.641	.769	.689	.092
CS $R^2 = .429$ a = 2.11	*r*	.549	.387	.420	.342	.454
	b	.303	.084	.027	-.044	.105
	sr^2	**.059**	.005	< .001	.001	**.118**
	p	< .001	.297	.764	.630	< .001
BO $R^2 = .262$ a = 5.20	*r*	-.252	-.068	-.125	-.051	-.479
	b	-.423	.114	-.076	.193	-.284
	sr^2	.022	.002	< .001	.004	**.165**
	p	.054	.586	.748	.419	< .001
PSE $R^2 = .430$ a = 2.48	*r*	.602	.451	.500	.397	.348
	b	.292	.077	.081	-.075	.061
	sr^2	**.070**	.005	.005	.004	**.052**
	p	< .001	.279	.310	.351	.001
STS $R^2 = .232$ a = 4.29	*r*	-.183	-.020	-.089	.018	-.453
	b	-.223	.104	-.172	.262	-.200
	sr^2	.011	.003	.006	.013	**.151**
	p	.176	.510	.331	.144	< .001

Note. a = constant; tol. = tolerance; sr^2 = squared semi-partial correlation. Bolded values indicate moderate to large variance in a criterion uniquely accounted for by a predictor.

These results do not consider the correlation among the ProQOL-5 variables. The set of EAI variables best explained variance in PSE subscale scores and CS scores, accounting for 43% of the variance in each. Across the four ProQOL-5 variables, AR (affective response) and ER (emotion regulation) were consistently the most important

predictors. AR and ER had positive relationships with CS and PSE, negative relationships with BO, and ER had a negative relationship with STS. The greater one's affective response and emotion regulation, the greater was one's compassion satisfaction and pastoral self-esteem, and the less was one's secondary traumatic stress and burnout.

Summary

In this chapter, data collection and data analysis processes were discussed. Following the university's IRB approval for the study to commence, data collection occurred from October 30 to November 23, 2020, using the online portal Survey Monkey. To prepare for CCA to answer the research question, data were cleaned and screened for statistical assumptions and limiting conditions. Mean composite scores for each of the eight subscales were computed. Each subscale score was evaluated for univariate and multivariate outliers and normal distribution with corrective taken as needed. In addition, Cronbach's alpha was computed for each subscale as an index of reliability. As a result, the ProQOL-5 burnout subscale was divided into a 5-item subscale of positively worded burnout items and a 5-item pastoral self-esteem scale of the negatively worded burnout items. One of the 10 items of the ProQOL-5 secondary traumatic stress subscale did not contribute and was removed to improve reliability. Two of the four items of the EAI emotion regulation subscale had negative or very small correlations with the other two items and did not highly correlate between themselves and were removed to improve reliability.

Root 1 CCA results indicated respondents who had a pattern of low scores on affective response and emotion regulation tended to also have a pattern of high scores on

burnout and secondary traumatic stress, and low scores on compassion satisfaction and pastoral self-esteem. Affective mentalizing, perspective taking, and self-other awareness were correlated with the Root 1 scores, but because of collinearity did not substantially contribute to the canonical score. Univariate regression results of each ProQOL-5 variable predicted by the set of EAI variables generally indicated the greater one's affective response and emotion regulation, the greater was one's compassion satisfaction and pastoral self-esteem, and the less was one's secondary traumatic stress and burnout. Detailed interpretations of these results are proffered in chapter 5 of this report.

Chapter 5: Discussion, Conclusions, and Recommendations

This study's focus was to examine the multivariate relationship between the five dimensions of empathy and the three dimensions of CF. Empathy and CF have often been mentioned as vital for developing an effective caregiving relationship (Segal et al., 2017).

Segal et al. (2017) noted that empathy is part of human nature. Empathy encapsulates a complex interaction of physiological responses as well as cognitive processing. In a caregiving relationship, empathy connects the caregiver to the care receiver (Segal et al., 2017). In pastoral ministry, empathy is seen as a critical virtue for authenticity (Twumasi-Ankrah, 2011). Figley (1995) explained that empathy incurs an emotional consequence a caregiver experiences for continued exposure to a client's emotional pain and trauma sufferings when providing empathic caregiving services. The current study addressed whether empathy predicts the risk for CF among immigrant African pastors in the United States.

CF's adverse effects on the professional quality of life of an empathic caregiver and the quality of care in a caregiving relationship has been well documented (Gibbons, 2011). A pastor suffering from CF may suffer from a reduced sense of self-worth, leading to negative outcomes within the pastor's personal and professional life. I sought to examine whether the five dimensions of empathy predict CF risk among pastors, as prior studies had indicated among other helping professionals such as nurses, doctors, psychologists, police, firefighters, first respondents, and counselors (Gallardo & Rohde, 2018). Figley (1995) revealed that CF negatively impacts the quality of care in an empathic caregiving relationship, but little was known about the relationship between the

five dimensions of empathy and the four dimensions of CF among immigrant African pastors in the United States. In this chapter, I discuss the data analysis results as presented in Chapter 4. I also interpret the findings in the context of previous studies and make recommendations based on the findings.

Interpretation of the Findings

The CCA analysis for this study was premised on the basis that only statistically significant relationships observed from the data analysis would be interpreted. The CCA analysis and interpretation of results was also premised on the theoretically guided notion that CF is predicted by the dimensions of empathy. The SPM (Aneshensel & Avison, 2015; Pearlin & Bierman, 2013; Pearlin et al., 1981) suggests that empathic ability affects the emotional well-being and mental health of the caregiver. For purposes of the current study, I interpret the dimensions of empathy as directionally affecting CF; however, as a correlational study, I recognize that other theories may suggest CF affects empathic ability. Three key insights were gleaned from the research results.

First, there were statistically significant relationships between the dimensions of empathy and the dimensions of CF. Empathy predicted the risk for CF. Across the four dimensions of CF, AR and ER (two of the empathy subscales) were consistently the most important predictors. Those two empathy subscales had positive relationships with CS and PSE, and negative relationships with burnout and STS. Results showed that pastors who scored high on AR and ER also tended to score high on CS and PSE and were less likely to be at risk for CF due to low scores on STS and burnout. These findings

corroborated the findings of Wagaman et al. (2015) that AR and ER have significant predictive value for higher levels of CS and lower levels of STS and burnout.

Second, pastors who scored low on all five dimensions of empathy, particularly AR and ER, also tended to have high scores on burnout and STS and low scores on CS and PSE. This revealed that low empathy possibly indicates an increased susceptibility for CF. This finding further revealed that a lack of empathy could amplify pastoral caregivers' discontentment with their job. As indicated in prior studies, personal discomfort that stems from repeated exposure to the traumas of others could affect the quality of care in the empathic caregiving relationship (Patterson, 2013). Current findings also supported the assertion that unregulated AR has the potential to create distress in an individual's ER, a cognitive component of empathy that is association with burnout and STS (see Lee & Seomun, 2016). The ability to regulate the emotional responses to clients that are physiological in nature equips caregivers to protect themselves from repeated exposure to those who have experienced pain and trauma (see Wagaman et al., 2015).

Third, pastors who scored high on emotion regulation but had low scores on the other four subscales of empathy, particularly AM and AR, also tended to have high CS scores but very low PSE, low STS, and low burnout. Findings indicated that a deficit in any single dimension of empathy increases the risk for CF. This finding affirms earlier studies that indicated empathy is a viable skill and strategy in buffering against the negative effects of CF and may increase CS, longevity, and personal and professional well-being (see Lee & Seomun, 2016; Wagaman et al., 2015).

The three key findings from the current study provided significant insights and emphasized the importance of empathy as a protective factor against CF (see Segal et al., 2017). Protective factors contribute to the building of resiliency and mental well-being (Dias & Cadime, 2017; Pérez-González et al., 2017). Empathic caregivers face many challenges when working with a traumatized population (Morrissette, 2004). To prevent burnout and STS (two of the components of CF), caregivers need protective factors. Current study results revealed that the five dimensions of empathy (AR, AM, SOA, PT, and ER) could help prevent CF among helping professionals like pastors. If pastors are trained on these five empathy dimensions, they will be better equipped to emotionally withstand challenges of CF as they work with their traumatized parishioners (see Wagaman et al., 2015). The idea of using empathy subscales as protective factors for the prevention of CF also suggests the issue of control. For example, there are factors in the caregiving relationship, such as the client's presenting condition, emotional state, and traumatic past, that are beyond the control of the pastoral caregiver (see Figley, 1995). However, the pastor as a caregiver has control over their emotions and how they react to the client's presenting conditions. By using their empathy scales, a pastor will be better equipped to cope with the emotional residue from the traumatized parishioner's story (see Gibbons, 2011; Wagaman et al., 2015).

With empathy as a protective factor, pastors can reduce the risk for CF in the following ways. First, they can build and strengthen their social support system that gives them the ability to share their emotional load with trusted persons. For instance, a pastor with a skill in self-other awareness and perspective-taking qualities will have the

knowledge to harness the benefits of a strong social support system. Second, a pastor with empathy traits can build and sustain their self-esteem. As revealed by the current study results, pastors with low empathy also tend to have low self-esteem. Low self-esteem connotes a lack of belief in oneself and the service they provide as having a value in other people's lives (M. D. Johnson et al., 2017). Pastors with low self-esteem will likely focus more on their personal flaws, weaknesses, and mistakes rather than on their valued services and contributions to those who are emotionally wounded who need their empathic support (Ruffing et al., 2018). High self-esteem may translate into a belief in a pastor's ability, which may in turn reduce the risk for burnout and secondary stress (the two constructs that lead to CF). Finally, empathy as a protective factor may promote healthy thinking and strengthen a pastor's resiliency skills. As indicated in the literature, empathy strengthens the relationship between a caregiver and the care receiver. As a protective factor, empathy promotes healthy thinking in the sense that the caregiver, through perspective taking, emotion regulation, affective mentalizing, and self-other awareness, develops resiliency skills that prevent them from ruminating on personal mistakes; instead, the caregiver dwells on the joy of helping others heal from their traumas and emotional distress.

Limitations of the Study

The primary limitation of this study was the population. The sampled respondents for this study were drawn from the larger immigrant African pastor population the United States. This meant that the studied population had characteristics that were unique and made them distinct from other populations that could have been targeted in this research.

As a result, generalizability of the results should be limited to the population studied. Second, despite the attempt to capture all available factors that could have aided in the interpretation of the results, not all factors were captured. For instance, some of the pastors in this study work as full-time pastors whereas other have other jobs in addition to their duties as a pastor. These dynamics could have been important in the interpretation of the results. The results can therefore not be generalized to include other populations beyond the confines of the study. Also, findings from this study cannot be said to be representative of immigrant African pastors outside of the United States. Notwithstanding these limitations, the processes and procedures adopted for the study were appropriate to produce reliable results to guide any future study that expands the scope of this research.

Recommendations

Considering the significant relationships that were revealed between the five dimensions of empathy and the risk for CF, it is recommended that pastoral and caregiver training include thorough training on empathy as protective factors for preventing CF. In self-care management and the promotion of mental health, protective factors support, equip, and promote the development of resiliency skills for pastors and caregivers to face life's challenges stemming from their empathic caregiving activities. The five dimensions of empathy should be viewed as protective factors that could better equip pastors and caregivers to withstand the challenges of secondary trauma and CF. Accordingly, it is recommended that pastoral training programs as well as caregiving training programs encapsulate models on the five dimensions of empathy as protective factors to promote self-care and the prevention of CF. Results from this study revealed that pastors with

strong empathy in the areas of emotion regulation, affective response, affective mentalizing, and self-other awareness were less susceptible to secondary traumatic stress and burnout. In other words, these categories of pastors were insulated from the dangers of CF. Their strength of resilience lay in their strong empathy traits.

Also, it is recommended that inculcating interpersonal empathy skills in the training and professional development programs of pastors and caregivers will help them develop a strong social support system. A strong social support system will mean that the pastor is well placed and connected with trusted people who give them the confidence and the safe environment to share their worries and emotional burdens. Strong social support will mean that pastors and caregivers have people around them whom they can ask for help when they are feeling the emotional pressure from their caregiving responsibilities to promote mental wellness. A solid grounding in empathy in the areas self-other awareness, affective mentalizing, and affective response will mean that the pastor or the caregiver is not afraid to approach people in their social support network for help because empathy drives their behavior. Empathy makes one considerate of their own actions vis-à-vis a suffering partner or client. Thus, empathy as a protective factor will promote strong social support for pastors and caregivers.

Next, as a protective factor, pastors, or caregivers with strong empathy in the area of self-other awareness will be conscious of their emotional well-being as they care for a traumatized client. Self-other awareness and perspective-taking promote the reasoning that if a caregiver will be effective in their job, they must first take care of themselves.

Empathy drives the caregiving profession, but caregivers are not necessarily trained to understand what it means to have empathy.

Results obtained from the current study revealed that the five dimensions of empathy (see Segal et al., 2017) reduce the risk for CF. By embracing empathy as a protective factor against CF, pastors could redefine meaningful engagement with their traumatized clients and parishioners, be emotionally at peace with their work as caregivers, and develop a higher sense of purpose. Therefore, it is recommended that pastoral training and professional development programs include a model on empathy.

Implications for Social Change

The recent COVID-19 global pandemic underscored the importance of mental wellness and emotional well-being. The pandemic also revealed the important work of empathic caregivers and other helping professionals. Often these helping professionals, who are working to bring relief to the emotionally suffering population, are vulnerable to secondary traumatic stress and burnout due to repeated exposure to the trauma and suffering stories of the people they are providing care services to. Research indicated that the services of pastors, as empathic caregivers, will continue to be relevant in supporting the recovery and healing of traumatized members of their congregations (Taylor et al., 2006). Training rooted in empathy will serve as a protective factor to protect pastors and caregivers from CF.

Pastors need to be aware of the emotional cost of helping and that a strong grounding in empathy dimensions could improve their mental health and wellness. The current study revealed that pastors are susceptible to CF, and that training in the five

dimensions of empathy can help reduce the risk. Pastors should be taught how to develop empathy and increase their capacities in emotion regulation, self-other awareness, affective mentalizing, perspective-taking, and affective response. These will serve as protective factors to prevent secondary traumatic stress and burnout from caring for others who are emotionally wounded.

Conclusion

The purpose of the current study was to examine the relationships between the five dimensions of empathy (see Segal et al., 2017) and the three dimensions of CF (see Stamm, 2009). The results revealed a significant relationship between empathy and the risk for CF among the studied population. High measures of empathy were associated with high levels of compassion satisfaction and low risk for CF. Conversely, low levels of empathy, specifically in the areas of self-other awareness, emotion regulation, affective mentalizing, perspective-taking, and affective response, were associated with high levels of secondary traumatic stress and burnout, leading to high risk for CF among the studied population. Glick (2008) stated that caregivers who lack the skills to deeply understand those they care for can lead to scapegoating, distrust, and in extreme cases a destruction of the caregiving relationship.

As the current results revealed, high levels of empathy could serve as protective factors to prevent secondary traumatic stress and burnout. Gutsell and Inzlicht (2012) asserted that levels of empathy are cognitively different among people. This means that some caregivers may be high in affective mentalizing and others may be high in self-other awareness. Combined, the five dimensions of empathy serve as protective factors

for the helping professional. It is therefore recommended that pastoral training programs and other training programs for caregivers be infused with training on the five dimensions of empathy to reduce the risk for CF and improve self-care among pastors and caregivers.

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