

COMPASSION –FATIGUE AND SATISFACTION: THE STRESS BUFFERING
EFFECTS OF MINDFULNESS AND SELF-COMPASSION FOR MENTAL HEALTH
PROFESSIONALS

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COMPASSION –FATIGUE AND SATISFACTION: THE STRESS BUFFERING
EFFECTS OF MINDFULNESS AND SELF-COMPASSION FOR
MENTAL HEALTH PROFESSIONALS

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ABSTRACT

Mental health professionals have a propensity to become secondarily affected by the suffering of their clients, which in turn may negatively impact their psychological wellbeing and increase their propensity to develop negative conditions, such as compassion fatigue. Barnett, Baker, Elman, and Schoener (2007) identified the incorporation of self-care practices as an ethical imperative for practicing clinicians in order to combat these negative effects and promote more effective counseling practice. Nonetheless, mental health professionals, both experienced and in training, struggle to incorporate and practice self-care. In light of this, wellness efforts and techniques are essential to promote clinicians' self-care and stress management, in order to foster compassion satisfaction and decrease the susceptibility for compassion fatigue. The current study explored the role of mindfulness and self-compassion, as two constructs that may buffer against the impact of perceived stress on compassion fatigue and enhance compassion satisfaction. The results demonstrated that compassion satisfaction was highest among participants who endorsed higher mindfulness regardless of stress level. The observing subscale of mindfulness was associated with greater

compassion fatigue, while the describing subscale of mindfulness buffered against the development of compassion fatigue. In contrast, although self-compassion was negatively associated with stress, compassion fatigue, and positively associated with compassion satisfaction there was not a significant moderating relationship between stress, self-compassion, and compassion fatigue and satisfaction. There were also differences observed between trainees and experienced mental health professionals on aspects of mindfulness and self-compassion.

Keywords: mental health professionals, trainees, stress, mindfulness, self-compassion, compassion fatigue, secondary traumatic stress, and compassion satisfaction

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Education have examined a dissertation titled “Compassion –Fatigue and Satisfaction: The Stress Buffering Effects of Mindfulness and Self-Compassion for Mental Health Professionals” presented by Jennifer Lynn Schaafsma, candidate for the Doctor of Philosophy in Counseling Psychology, and certify that in their opinion it is worthy of acceptance.

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CHAPTER 1

A CONCEPTUAL UNDERSTANDING OF THE RELATIONSHIPS AMONG COMPASSION –FATIGUE, COMPASSION –SATISFACTION, MINDFULNESS AND SELF-COMPASSION AS STRESS BUFFERS IN MENTAL HEALTH PROFESSIONALS

Mental health professionals work with clients who experience stress and distress, which may cause them to become secondarily affected by the suffering of their clients (Figley, 2002; Stamm, 2010). Extending compassion and empathy towards clients in an effort to understand their experienced suffering in turn causes mental health care professionals to suffer (Figley, 2002). Figley (2002) identified this as the “costs of caring” (p. 1436), which can lead to physical and psychological strain for mental health professionals. Experiencing distress within the mental health field, both as a result of clinicians’ personal circumstances and/or their work with clients, is common: 74.3% of clinicians surveyed reported experiencing distress and 36.7% believed their distress negatively impacted the clients they served (Guy, Poelstra, & Stark, 1989). Distress is considered a subjective response to the circumstances in ones’ life (Carter & Barnett, 2014); however, if clinicians’ distress is not attended to it may lead to conditions such as compassion fatigue.

Therefore, wellness efforts are essential in order to combat the potentially negative effects this may have for mental health providers, both professionally and personally. Perhaps because of this, Barnett, Baker, Elman, and Schoener (2007) identified the incorporation of self-care practices as an ethical imperative for practicing clinicians, so that they may engage in effective practice. Even though there is an ethical mandate to engage in actions to prevent distress, it is proposed that mental health providers are not taking the

necessary preventative and corrective responses (Barnett et al., 2007), nor have they learned how to take the time to care for and nourish themselves (Sapienza & Bugental, 2000). This can lead to the development of conditions such as compassion fatigue, which is defined as emotional strain resulting from helping someone who has experienced trauma or suffering (Figley, 2002).

In addition, many of the suggested self-care activities to combat the effects of compassion fatigue are ones that happen off the job (e.g., exercise, spending time with family or friends, sleep). Therefore, it is important for the counseling profession to not only promote the enhancement of self-care strategies (Barnett et al., 2007), but also consider what on the job and in the moment activities mental health professionals can practice when they are experiencing suffering. Mindfulness and self-compassion are arguably two suggested practices that may alleviate experienced emotional pain for the practicing mental health professional. Mindfulness entails a present and non-judgmental awareness of one's thoughts, feelings, and sensations (Kabat-Zinn, 1994), while self-compassion involves extending compassion towards oneself in order to alleviate suffering (Neff, 2003b). In this chapter I will present a conceptual overview of stress, compassion –fatigue and –satisfaction for mental health professionals, while incorporating mindfulness and self-compassion as stress buffering agents that contribute to clinician resiliency.

Compassion, Fatigue, and the Counseling Profession

The concept of compassion has extended centuries back and is a component of many world religions, yet, research on compassion itself is limited (Siegel & Germer, 2012). There has recently been a blend of Eastern and Western psychological concepts and a focus on

compassion itself through a Western psychological science and research lens. Siegel and Germer argued that the limited research on compassion is due to overlap with similar constructs that are embedded in therapeutic concepts, such as empathy, sympathy, pity, and altruism. Gilbert (2005) indicated that limited research on compassion may also be due to Western psychology's focus on personal relief as doing or achieving (e.g., building self-esteem and self-efficacy) rather than cultivating kindness to self and others, which is cited as a healing process and central to Eastern practices. Given these differences, further research on compassion is warranted.

Compassion refers to demonstrating concern and sympathy for another who is suffering and a desire to alleviate that experienced suffering (Siegel & Germer, 2012). While empathy mirrors another's feeling (e.g., "I feel happy because you feel happy"), compassion involves care and concern with motivation to act on another's behalf (Siegel & Germer, 2012; Gilbert, 2005). Klimecki, Leiberg, Lamm, and Singer (2012) assessed the affective plasticity (i.e., ability to modify emotions) of 94 female participants who were split into three different treatment groups (memory, compassion, and control) and engaged in a socio-affective video task where they watched three different videos and assessed the level of empathy and positive and negative affect they experienced. Results illustrated that compassion increased positive affect and affiliation when experiencing the suffering of others (Klimecki et al., 2012). Additionally, neuroimaging showed that a compassionate attitude activated areas of the brain that are associated with prosocial and social-approaching behaviors, and activated reward-processing areas of the brain (Kim et al., 2009).

Furthermore, due to "mirroring systems," observing others suffering activates similar areas

of the brain in the observer, which leads to the observer wanting to alleviate the pain of the observed in order to feel better themselves (Saarela, Hlushchuk, Williams, Schürmann, Kalso, & Hari, 2007; Siegel & Germer, 2012). Compassion is also associated with the caregiving system, which taps into feelings of safeness and activates the neurotransmitters oxytocin and vasopressin, hormones that are associated with pleasure and attachment (Gilbert, 2005; Siegel & Germer, 2012). Collectively, this reveals that compassion may aid individuals' in their response to suffering.

Within the last decade, research on the physical health benefits of compassion has arose. For example, Cosley, McCoy, Saslow, and Epel (2010) had participants complete a social stress task in front of either a supportive or neutral evaluator. Participants' compassion for others improved their availability and use of social support and buffered against physiological stress (Cosley et al., 2010). In addition, Crocker and Canevello (2008) assessed the impact of college freshmen's compassionate goals and self-image goals on their social support. Participants' compassion for others was linked to increased perceptions of compassion from others, which fostered a more supportive environment (Crocker & Canevello, 2008). This points to the benefit of extending compassion to others, as compassionate goals predicted increased social support.

In relation to counseling, compassion is cited as an essential component of effective psychotherapy (Germer, 2012). Foundations of compassion, such as empathy and positive regard, are essential ingredients within the therapeutic relationship (Kirschenbaum & Jourdan, 2005). Germer (2012) suggested that all models of psychotherapy should be practiced in a compassionate manner and argued that cultivating compassion in therapy is an

underlying mechanism for change. Mental health professionals extend compassion to others who experience emotional stress or distress, which can be both highly rewarding and highly stressful. Although, within the general population there is a certain level of stress that promotes optimal alertness and productive activities (i.e., the Yerkes-Dodson law: Yerkes & Dodson, 1908), yet many studies document the vast negative effects of stress for helping professionals. Stress itself is not bad, however, the repeated and chronic experience of stress and distress, within either personal and/or professional contexts, that is not attended to, may lead to risk for the development of negative effects and conditions in mental health professionals.

Furthermore, high stress can impact mental health providers' effectiveness as clinicians. In a review of literature on stress management for medical professionals, Shapiro, Shapiro and Schwartz (2000) indicated that stress led to decreases in concentration, attention, decision-making skills, and impacted the development of the therapeutic relationship. These demands, sharing in both the pain and joys of clients, can be an expected by-product of this profession. Such demands can cause mental health providers' to become secondarily affected by the suffering of their clients, which can cause negative psychological consequences depending on the severity of suffering to which a clinician is exposed (Figley, 2002; Stamm, 2010). The impact and severity of a stressful event is determined by the individuals' perception of the experienced stressor (Cohen, Kamarck, & Mermelstein, 1983), which is largely established by the ability to attend to, manage and cope with the experienced stress (Carter & Barnett, 2014). This suggests that how clinicians perceive and cope with

their experienced stress, both professionally and personally, is influential in the development of more severe conditions.

These potential conditions have been identified by multiple terms, such as vicarious traumatization, secondary traumatic stress, and compassion fatigue. Each of these terms are relatively comparable to one another and are at times used interchangeably in the field (Craig & Spang, 2010; Stamm, 2010); however, all allude to the fact that mental health professionals are vulnerable to physical and psychological consequences when caring for those who suffer. In addition, compassion fatigue has been defined using alternative terms, such as attachment fatigue or empathic distress fatigue (Germer, 2012; Klimecki & Singer, 2011). Attachment fatigue is characterized by clinging to certain outcomes (e.g., successful treatment), while empathy fatigue is suffering with the inclusion of self-oriented emotions and negative feelings that may result in the observer needing to protect oneself (Klimecki & Singer, 2011). Klimecki and colleagues (2011, 2012) posited that exhibiting compassion elicits other-related emotions, positive feelings, good health and a pro-social motivation. Thus, they argued that the term compassion fatigue is misleading and better characterized by empathy fatigue. However, since there is a lack of unanimity on these alternative terms, these conditions will be broadly referred to as compassion fatigue.

Compassion fatigue, introduced by Figley (2002), is defined as the acquired stress that results for a helper knowing about and wanting to help a significant other who has experienced trauma or suffering. Some factors that impact compassion fatigue are client resistance, client aggression and severe pathology, boundary violations, interference of therapist's personal issues, feelings of incompetence, not liking or having negative reaction

to clients, or a poor therapy relationship (Vivino, Thompson, Hill & Ladany, 2009).

Symptoms of compassion fatigue include, but are not limited to, increased negative arousal, depression, decreased feelings of competency, loss of hope, difficulty creating a balance between work and personal life, lowered frustration tolerance, and intrusive thoughts (Gentry & Baranowsky, 2013). The physical and mental resources and the emotional response of the caregiver influence the propensity to experience compassion fatigue, which is both preventable and treatable (Figley, 2002).

In contrast, mental health professionals also experience compassion satisfaction, “the pleasure you derive from being able to do your work well” (Stamm, 2010, p. 12), which may protect against compassion fatigue. Some factors that promote compassion within therapy include therapists’ ability to feel their clients’ suffering, liking and identifying with clients, clients’ involvement in counseling, understanding the client dynamics, and a good therapy relationship (Vivino et al., 2009). Furthermore, certain variables that may buffer the influence of compassion fatigue and sequentially further compassion satisfaction include clinician experience (Craig & Sprang, 2010), specialized trauma training (Sprang, Clark, & Whitt-Woosley 2007), self-care strategies (Alkema, Linton, Davies, 2008), emotional-separation (Badger, Royse, & Craig, 2008), utilizing evidenced-based practices (Craig & Sprang, 2010), person-job congruence (Ray, Wong, White, & Heaslip, 2013), coping strategies and self-efficacy (Cicognani, Pietrantoni, Palestini, & Prati, 2009). Some therapists refer to their reported growth and feelings of wellbeing as compassion satisfaction (Craig & Sprang, 2010). Yet, compassion satisfaction has been either omitted or narrowly

studied in many studies focused on compassion fatigue; therefore, it is important to extend the scant research on compassion satisfaction as it relates to mental health professionals.

Professional Training and the Self Care Imperative

Compassion fatigue not only impacts experienced professionals, but also can significantly impact those in training. These stressors may be more pronounced for beginning therapists, as they are younger and less experienced, and therefore may be more susceptible to occupational stress. Craig and Sprang (2010) examined the effect of evidence-based practice (i.e., EMDR, Cognitive therapy, Behavioral Therapy, Psychodynamic Therapy, Eclectic Therapy, and Solution Focused Therapy) on compassion fatigue and compassion satisfaction, with consideration of the impact of age and years of experience. Younger participants endorsed higher levels of burnout, a component associated with compassion fatigue, while more experienced health professionals (in relation to chronological age) endorsed higher levels of compassion satisfaction (Craig & Sprang, 2010). Furthermore, women tend to exhibit both higher chronic and daily stress compared to men, and according to the American Psychological Association (APA)'s Center for Workforce, studies demonstrate that women compose 76% of newly admitted psychology doctorates and 74% of early career psychologists (Matud, 2004; Willyard, 2011). Therefore, this stress has potential to create significant discomfort for clinicians in training that could impede their clinical effectiveness. This also may suggest that more experienced mental health providers have learned to cope with emotional feelings related to compassion fatigue.

Skovholt and Rønnestad (2003) commented on the exhaustion trainees experience due to the need to access, integrate, and synthesize information; and suggested that clinicians

in training experience stressors such as acute performance anxiety and fear, high stress evaluation, rigid emotional boundaries, a fragile and incomplete practitioner-self, inadequate conceptual map (to guide the clinician), and glamorized expectations. All of these stressors likely make their early years of training difficult. Dubin (1991) suggested that trainees' self-placed pressure and urgency impacted their ability to be with a client and be open to what clients were communicating. In a review of literature Shapiro et al., (2000) found that stress impacted health care professionals' ability to pay attention and make decisions, as well as reduced concentration and the ability to establish a strong relationship with their client.

Martin (2009) identified several challenges that may impact the wellbeing and distress of early career psychologists, including receiving mixed messages about the importance of self-care and the difficulty of setting limits and boundaries. Doran (2014) discussed the unspoken reality of self-care and specifies that self-care in graduate school is a struggle; trainees receive mixed messages about performing at a high enough level to meet all training demands, but also simultaneously making time for oneself outside the program. A survey conducted by the APA Advisory Committee on Colleague Assistance (ACCA) at APA's 2006 Annual Convention found that 82.8% of students surveyed said their training program did not offer material on issues related to self-care and stress, 63.4% indicated their training program did not provide activities to promote self-care, and 59.3% reported their program did not promote an atmosphere of self-care (Munsey, 2006). Collectively, this shows the lack of education and availability of coping strategies to aid in stress management, as well as how differences in stress and compassion fatigue may be reflected across training and experience level.

Self-care is imperative in developing a line between personal and professional selves and critical in providing appropriate and ethical care to clients (Barnett et al., 2007). Baker (2003) and Barnett et al. (2007) specifically draw attention to the importance of self-awareness, self-regulation and coping, and a balancing of self and others interests. In accordance with the *APA Ethical Principles of Psychologists and Code of Conduct* (APA ethics code; APA, 2010) psychologists must abide by Principle A, “Beneficence and Nonmaleficence,” which states that they must be aware of the impact of their health on their ability to help clients. Self-care can aid in maintaining the physical and mental health of clinicians. However, many mental health professionals, both experienced and in training, struggle with conflicts and restraints to their own self-care. And, as mentioned, training programs are limited in the self-care services they provide to their students (Munsey, 2006). Learning and providing self-care techniques can affect counseling professionals’ educational and training experiences, as well as their clinical work (Baker, 2003; Weiss, 2004). Self-care strategies may then prevent compassion fatigue and promote resiliency (Alkema et al., 2008; Skovholt & Trotter-Mathison, 2011).

Shapiro et al. (2000) reviewed the effectiveness of self-care and stress management interventions on reducing stress in trainees and experienced mental health professionals. Despite the positive effects of incorporating self-care and stress management interventions, few training programs actually provide education on self-care and stress management. Most accredited counseling training programs emphasize the importance of self-care; however, it is typically presented as an personal responsibility and few programs directly teach such strategies (Christopher & Maris, 2010). In light of these findings, there is a call for

initiatives and techniques to promote mental health care professional's stimulation of self-care and stress management (Barnett & Cooper, 2009). Mindfulness and self-compassion may serve as two techniques that increase clinicians' psychological wellbeing and buffer against the adverse impact of stress.

Mindfulness and Self-Compassion as Stress-Buffers

Frequent stress, whether experienced within the work environment, client environment, and/or personal environment, can have an impact on mental health professionals' physical and mental wellbeing, which can lead to symptoms of compassion fatigue and impact mental health clinicians' abilities to care for themselves and their clients (Barnett et al., 2007; Stamm, 2010). McCann and colleagues (2013) reviewed previous literature, which examined the individual and contextual factors that contribute to enhancing resiliency in various health professions. Overall, developing stress resiliency in health care professionals reduced the negative outcome of professionals' degree of stress experienced, while increasing positive outcomes, such as higher job satisfaction and compassion satisfaction (McCann et al., 2013). Genetic, epigenetic, developmental, psychological, and neurochemical factors enhance individuals' resilience and vulnerability to stress (Wu et al., 2013). More specifically, in a review of current research, Wu et al. (2013) identified cognitive processes, personality traits, optimism, humor, social support, exercise, pro-social behavior, and active coping, as psychological mechanisms that aid in building resiliency. These findings point to the role of psychological factors in promoting coping strategies and buffering against the adverse impact of stress. Self-compassion and mindfulness are two psychological constructs that may serve as buffering agents in the impact of perceived stress

on compassion fatigue and compassion satisfaction.

The stress-buffering model posits that there are certain resources that alleviate the negative health influences of stressful events (“Stress Buffering Model,” 2008). These buffering resources may lessen one’s affective response to stressful situations and bolster the ability to cope with experienced stress (Thoits, 1995). The stress-buffering hypothesis was first proposed in relation to social support; however, its applications have extended to other constructs, such as positive events (Cohen & Hoberman, 1983), sensation seeking (Smith, Ptacek, & Smoll, 1992), and physical activity (Unger, Johnson, & Marks, 1997). It stands to reason that other factors, such as mindfulness and self-compassion, may similarly facilitate the stress-buffering model. Both self-compassion and mindfulness aid in enhancing emotion regulation, reactivity, and coping (Allen & Leary, 2010; Hill & Updegraff, 2012; Neff, 2003b; Shapiro, Brown, & Biegel, 2007), which have been shown to impact resilience and vulnerability to stress (Troy & Mauss, 2011). Therefore, self-compassion and mindfulness may protect and enhance coping resources and act as methods of self-care and stress management for mental health professionals.

Creswell and Lindsay (2014) presented a mindfulness stress-buffering framework, based on previous research, to explain how mindfulness lessens the appraisal and reactivity to stress, thus effecting health outcomes. They posited that greater effects of mindfulness were observed in high stress situations and that the effects on health are predicted in populations where stress is a known trigger of behaviors that lead to negative health outcomes (Creswell & Lindsay, 2014). Further, Brown, Weinstein, and Creswell (2012) examined within a laboratory setting how mindfulness buffered the psychological stress

response to a social stress test. Their research supported the mindfulness-stress buffering hypothesis, since mindfulness buffered the effect of cortisol responses, negative affect, and anxious responses to social evaluative stress situations. Similarly, Creswell, Pacilio, Lindsay, and Brown (2014) confirmed that mindfulness meditation training reduced stress reactivity in response to social evaluative stress. Although in its infancy, according to Creswell and Lindsay (2014) these initial results confirmed the buffering effects of mindfulness in acute stress exposure.

While there is no proposed model examining self-compassion as a buffering agent, Neff and colleagues argued that self-compassion reduced stress, acted as a buffer against emotional distress, facilitated coping and provided greater emotional resiliency (Allen & Leary, 2010; Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, Kirkpatrick, & Rude, 2007; Neff, 2011). In particular, Neff and colleagues (2007) examined undergraduate students' psychological functioning in response to ego-threat questions within a laboratory setting and found that self-compassion buffered the effect of anxiety. Similarly, Leary et al. (2007) found that self-compassion buffered against college student's negative self-feelings in response to experiencing adverse events. Thus, I seek to expand the stress buffering literature by providing further exploration of the relationships among mindfulness, self-compassion, and compassion –fatigue and –satisfaction for mental health professionals within this framework.

Mindfulness

Mindfulness is the English translation of *Sati*, the Pali word for a state of attention, awareness, and memory, which is foundational to Buddhist teachings (Germer, 2013).

Mindfulness is rooted in Eastern philosophy and has been practiced for thousands of years. Mindfulness entered Western psychology through Jon Kabat-Zinn's use of mindfulness in his Mindfulness-Based Stress Reduction (MBSR) program in the late 1970s, which is a structured training that incorporates mindfulness through meditation, yoga, and body scan practices (Kabat-Zinn, 1982). Mindfulness is now considered mainstream, as it is heavily researched, practiced, and incorporated within psychotherapy.

There is not a precise definition and meaning of mindfulness, as mindfulness is described as a theoretical construct, cultivating practice, or psychological process (Germer, 2013). Mindfulness has been studied as both a single and multifaceted construct, as well as a formal and informal practice; therefore, further suggesting disparity in a consensual definition. However, a basic definition offered by Kabat-Zinn (1994) is a non-judgmental moment-to-moment awareness of one's thoughts, emotions, and sensations. Shapiro, Carlson, Astin and Freedman (2006, p. 375) expanded off of this definition and identified three components of mindfulness: intention ("on purpose"), attention ("paying attention"), and attitude ("in a particular way"). According to Baer, Smith, Hopkins, Krietemeyer, and Toney (2006), as a multifaceted construct mindfulness includes observing, describing, non-judgment, non-reactivity, and acting with awareness. This further sheds light on the discrepancy in defining mindfulness.

A practice of mindfulness can be either a formal meditation, informal practice, or non-meditation based exercises (Hick, 2008). As a formal meditative practice, mindfulness typically includes three kinds of meditation practices: focused attention, opening, and loving-kindness (Germer, 2013). Mindful meditation is focused on increasing awareness of the

moment-to-moment experience in order to become more present. Meditative practices can lead to the enhancement of mindfulness, however, mindfulness is not only a product of meditation (Bishop et al., 2004; Brown & Ryan, 2004). As an informal practice, mindfulness can be applied to everyday life activities, such as engaging in mindful awareness while you are walking or eating (Germer, 2013).

Origins and Development of Mindfulness

The general population differs in their predisposition to be mindful, as evidenced by dispositional/trait and state mindfulness measures (Brown & Ryan, 2003). However, it is unclear what contributes to individual differences in trait mindfulness. It is well known that mindfulness can be cultivated through informal and formal meditation and non-meditation exercises for adults. Preliminary findings suggest that mindfulness may aid in the development of child and youth resiliency; however, little research has examined the application of mindfulness to children and youth (see Greenberg & Harris, 2012 for a review). Therefore there is narrow evidence on how mindfulness operates across the lifespan. Bishop et al. (2004) posited that mindfulness is more aligned with a state as opposed to a trait and suggested that once mindfulness skills are learned individuals are able to evoke mindfulness in situations when needed. This suggests that mindfulness is a learned skill that requires practice and may not be contingent on age or development.

Mindfulness, Health, and Therapy

Research on the effect of mindfulness on clinical populations is substantial (e.g., Baer, 2003; Hofmann, Sawyer, Witt, & Oh, 2010; Miller, Fletcher, & Kabat Zinn, 1995). More recently research is emerging on the application of mindfulness to psychotherapy and

the effects of mindfulness based interventions. Keng, Smoski, and Robins (2011) reviewed empirical studies on mindfulness and psychological health and separately addressed the effects of self-reported mindfulness, mindfulness meditation, and mindfulness-based stress reduction on psychological health. Overall, their review showed that greater mindfulness was correlated with psychological health, specifically decreases in psychological symptoms and emotional regulation and improved behavioral regulation (Keng et al., 2011).

Furthermore, greater mindfulness was associated with higher levels of emotional intelligence (Brown & Ryan, 2003; Schutte & Malouff, 2011), which suggests that mindfulness may facilitate greater awareness of a person's emotional states. Davis and Hayes (2011) also reviewed current literature on mindfulness in an effort to synthesize the empirical benefits of mindfulness and practical application for mental health professionals. They classified the numerous benefits into affective, interpersonal, and intrapersonal categories. For instance, mindfulness aided in reducing reactivity to stressful or negative situations (i.e., affective; Cahn & Polich, 2006), promoted greater relationship satisfaction and enhanced ability to respond to relational stress (i.e., interpersonal; Barnes, Brown, Krusemark, Campbell, & Rogge, 2007), and contributed to the brain's neuroplasticity and altered the structure and function of the brain (i.e., intrapersonal; Davidson et al., 2003).

Several therapies and programs address the importance of mindfulness in aiding client wellbeing. A clinician may either practice mindfulness in order to cultivate greater presence in session with clients, engage in mindfulness-informed psychotherapy (i.e., using a theoretical frame informed by mindfulness) and/or explicitly teach mindfulness exercises through mindfulness-based psychotherapy (Germer, 2013). These specific therapies and

programs include, but are not limited to, Dialectical Behavior Therapy (Linehan, 1993), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), and Mindfulness Based Stress Reduction (Kabat-Zinn, 1982). Other more eclectic/integrated forms of psychotherapy may either incorporate mindfulness techniques, or as mentioned, the clinicians themselves use these techniques to strengthen the therapeutic relationship (Germer, 2012).

Mindfulness in Mental Health Professionals

Although a majority of the research on mindfulness addresses application to client conditions, wellbeing, and the therapeutic relationship, research on mindfulness related to clinician wellbeing and effectiveness is expanding. Davis and Hayes (2011) noted that mindfulness promoted therapists' empathy toward their clients, increased clinicians' self-compassion, counseling skills (e.g., attentiveness, presence, comfort) and self-efficacy, and decreased stress and anxiety. Hick (2008) indicated that mindfulness is important to the therapeutic relationship and is a way to "pay [...] attention with empathy, presence, and deep listening" (p. 5). Mindfulness allowed clinicians to manage their internal experience through increasing self-awareness, staying balanced, present, patient, and attentive with clients, skillfully working on countertransference, and increasing openness and trust in the counseling process (Kane, 2010). Therefore, it is recommended that mindfulness be incorporated in training programs, since mindfulness is related to counseling abilities and skills and also can provide the foundation for teaching clients about mindfulness. The effect of mindfulness on mental health providers' qualities and the therapeutic relationship may

then positively impact treatment outcomes; however, there is limited research on whether the benefit of mindfulness for therapists translates to treatment outcomes.

In addition, mindfulness practices may promote self-care to help in stress reduction and prevent compassion fatigue in clinicians (e.g., Christopher & Maris, 2010; Shapiro et al., 2007) and act as a career-sustaining behavior that aids in the development of compassion satisfaction. In a sample of social work interns, mindfulness was significantly and positively correlated with compassion satisfaction, while significantly and negatively correlated with compassion fatigue (Decker, Brown, Ong, & Stiney-Ziskind, 2015). Furthermore, mindfulness and four of its components (describing, acting aware, non-judging, and non-reacting) were significantly correlated with compassion fatigue, while all aforementioned scales with the exception of describing were correlated with compassion satisfaction. (Decker et al., 2015). Furthermore, in a sample of traumatic bereavement volunteers and professionals, mindfulness was positively correlated with compassion satisfaction and inversely associated with compassion fatigue (Thieleman & Cacciatore, 2014). This demonstrates preliminary findings for the association between mindfulness and compassion fatigue and compassion satisfaction, yet further research is needed to explore this relationship in mental health professionals.

MBSR programs are effective at reducing stress, negative affect, rumination, and anxiety in health professionals (Dorian & Killebrew, 2014; Irving, Dobkin, Park, 2009; Shapiro et al., 2007). Irving et al. (2009) reviewed empirical research on the use of MBSR in health care professionals and suggested that mindfulness training is an effective tool to promote self-care and wellbeing. In addition, Dorian and Killebrew (2014) conducted an

exploratory study that examined the impact of a 10-week mindfulness-based seminar course. Through participants' journal papers, students addressed their understanding and reflection of mindfulness and how they sought to incorporate it into their theoretical understanding and therapy work. Their reflections suggested that mindfulness fostered an increase in acceptance, attention, and awareness, greater compassion for self and others, and improved ability to cope in aversive situations (Dorian & Killebrew, 2014).

Shapiro, Astin, Bishop, and Cordova (2005) conducted a randomized control study design with health care professionals to assess the effects of an eight-week MBSR intervention. Those who received the intervention experienced a significant decrease in perceived stress and increase in self-compassion compared to the wait-list control group. These results were further confirmed by participants' qualitative responses collected by Shapiro and colleagues, which suggested that participants became more aware and were able to manage negative emotions more effectively. In addition, Shapiro et al. (2007) investigated the effects of MBSR for therapists in training through a nonrandomized cohort-controlled design of counseling students. Those who received the MBSR intervention showed significant declines in perceived stress, state and trait anxiety, negative affect, and rumination and increases in self-compassion and positive affect (Shapiro et al., 2007).

Similarly, Christopher and Maris (2010) taught counselor trainees' self-care through a mindfulness course titled, "Mind/Body Medicine and the Art of Self-Care." The course taught students self-care skills, contemplative practices, and fostered students' awareness of the mind/body. Self-care techniques were primarily taught through mindfulness, which positively impacted the students' self-awareness and clinical work. Therefore, literature

suggests the effectiveness of mindfulness at reducing stress and the potential effects of compassion fatigue and points to the need for further research to promote additional clarification of these associations.

Self-Compassion

Limited research has considered the joint role of mindfulness and self-compassion on clinician effectiveness and wellbeing. The concept of self-compassion is a Buddhist practice that has been receiving increased research over the past decade (Neff, 2003b). Within a Western framework, compassion is typically thought of as an emotion or attitude directed towards others, however, the Buddhist definition of compassion includes compassion directed to all beings, which includes oneself (Siegel & Germer, 2012). Neff (2003a, 2003b) introduced self-compassion within a Western context as an alternative conception of one's self-attitude. Neff (2003b) defined self-compassion as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (pp. 86-87). Self-compassion includes three components and three opposing concepts: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Self-kindness is being warm and understanding towards oneself (e.g., loving towards emotional pain) rather than judgmental (e.g., disproving and judgmental of flaws and inadequacies; Neff, 2003b). Neff (2003b) states that common humanity involves recognizing that we all suffer and that it is part of the shared human experience (e.g., seeing failing as part of the human condition), as opposed to feeling in isolation (e.g., feeling that other people have it easier). Mindfulness is recognizing your thoughts and emotion (e.g., keeping emotions in balance) without over-

identifying with them (e.g., obsessing and fixating on what is wrong). Similar to mindfulness, self-compassion has also been examined as a single construct and multifaceted construct within the literature.

Due to the relative novelty of the conceptualization of self-compassion and the potential overlap and confusion with other constructs, it is important to describe what self-compassion is not. Particularly from a Western standpoint individuals commonly confuse self-compassion with self-pity, self-indulgence, and self-esteem (Neff & Dahm, 2015). When individuals experience self-pity they are individually immersed in their problems and neglect the interconnectedness with others (i.e., common humanity), while self-compassion recognizes the related connection amongst self and others with greater perspective (Neff, 2012). Another belief is that self-compassion is not motivating; yet, self-compassion actually enhanced intrinsic motivation (Neff, 2012). Self-compassion differs from self-esteem in that it is not focused on positive judgments and results in greater emotional resilience and stability compared to self-esteem (Neff, 2011).

Origins and Development of Self-Compassion

Similar to compassion, self-compassion originates from attachment and affiliation systems. Individuals who are raised in secure, validating, and caring environments tend to exhibit a more compassionate manner, whereas, individuals who are raised in insecure and stressful environments may find it difficult to engage in self-soothing behavior (Neff & Dahm, 2015). In addition, critical mothers, dysfunctional families, and insecure attachment patterns contribute to lower levels of self and other compassion (Neff & McGehee, 2010). Self-compassion may also vary by personality traits, as self-compassion was negatively

associated with neuroticism and positively associated with agreeableness, extroversion, and conscientiousness (Neff, Rude, & Kirkpatrick, 2007). In regards to age differences, Neff and Vonk (2009) examined the differences between self-compassion and self-esteem and found that self-compassion increased marginally with age, while Neff and McGehee (2010) examined self-compassion in adolescents and young adults and found that there were no significant differences between those age groups. Yet, Neff (2011) speculated that individuals become more self-compassionate as they age particularly since self-compassion was associated with reflective wisdom (Neff, Rude, & Kirkpatrick, 2007). In addition, women tend to be less self-compassionate compared to men (Yarnell, Stafford, Neff, Reilly, Knox, and Mullarkey, 2015). Although there are differences in self-compassion due to life experiences, gender, personality and potentially age, self-compassion is a practice that individuals can also learn to cultivate and develop (Neff & Germer, 2013).

Self-Compassion and Psychotherapy

Self-compassion is cited as a mechanism of change in psychotherapy (Germer, 2012; Neff, 2012) and associated with positive psychological health, such as increased wellbeing, resiliency, happiness, optimism, conflict resolution, and emotional intelligence (MacBeth & Gumley, 2012; Yarnell & Neff, 2013); while, negatively associated with anxiety, depression, and other negative emotions (Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Neff, Hsieh, & Dejitterat, 2005). Neff and colleagues examined the effect of lessening clients' self-criticism and increasing compassion for themselves over a month period. Clients' self-compassion increased and was associated with reductions in self-criticism, depression, rumination, thought suppression, and anxiety (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007).

All models of psychotherapy are conducted by therapists in a compassionate way; yet, some treatment methods more explicitly focus on the cultivation of clients' self-compassion, otherwise known as compassion oriented therapy (Germer, 2012). Compassion-oriented therapy includes compassion-informed psychotherapy, assisting clients in developing compassion through the therapeutic relationship, or compassion-based psychotherapy, explicitly teaching compassion exercises (Germer, 2012). Paul Gilbert developed an empirically supported compassion-oriented approach, known as Compassion Focused Therapy ([CFT]; Gilbert, 2010). CFT is an integration of evolutionary psychology, social psychology, and neuroscience; and was developed for individuals who have mental health concerns linked to shame and self-criticism (Gilbert, 2010). CFT draws from the affect regulation systems (i.e., drive, threat, contentment), with particular focus on the contentment and soothing system in order to restore balance amongst the systems (Gilbert, 2010). The central aspect of CFT is to help clients stimulate affiliative emotions in order to produce compassionate emotional experiences and change the emotional tone of clients' thoughts (Gilbert, 2010)

In compassion-based psychotherapy, clients learn various formal and informal techniques/practices to evoke compassionate mind states. The following compassionate training programs are available that assist with the development of compassion: Mindful Self-Compassion Training ([MSC]: Neff & Germer, 2012), Compassionate Mind Training ([CMT]: Gilbert, 2009), Compassion-Cultivation Training Program ([CCT]: Jinpa, 2010), and Emory Compassion Meditation Protocol (Negi, 2013). Compassionate Mind Training led to reduction in depression, self-attacking, shame, and feelings of inferiority in a sample of

hospital patients (Gilbert & Procter, 2006). Mindful Self-Compassion Training increased participants' self-compassion, mindfulness, compassion for others, and life satisfaction, whereas, it led to decreases in depression, anxiety, stress, and the impact of trauma (Neff & Germer, 2012). Compassion-Cultivation Training Program led to decreases in fear of compassion for others, from self, and for self, as well as increases in self-compassion for a community sample of adults (Jazaieri et al., 2013). Preliminary findings indicated that participants who engaged in compassion meditation (the Emory Meditation Protocol) exhibited reductions in immune and behavioral responses to stress (Pace et al., 2009).

In comparison, compassion-informed psychotherapy utilizes the therapeutic relationship to transmit self-compassion to clients (Germer, 2012). Germer argued that a warm healing therapeutic relationship is the most common approach to teaching and nurturing client's self-compassion, which can be conveyed through verbal and nonverbal language between clinician and client. Therefore, it is important for mental health providers to foster compassion for self and others in order to provide a healing relationship to aid clients in developing compassion for themselves and their experienced suffering. In sum, literature supports the benefit of self-compassion on psychological health and the importance of promoting self-compassion within a psychotherapy context.

Self-Compassion, Stress, and the Counseling Profession

Self-compassion has been identified as a coping mechanism following negative life events, as it buffers emotional distress after an experienced stressor and was negatively correlated with stress (Allen & Leary, 2010; Neff, Kirkpatrick, & Rude, 2007). For example, self-compassionate individuals are less likely to catastrophize events (Allen & Leary, 2010).

Specifically, self-compassion involves positive cognitive restructuring, where more self-compassionate individuals are more apt to incorporate optimism, acceptance, and a positive reinterpretation (Allen & Leary, 2010; Neff et al., 2005). This suggests that highly self-compassionate individuals view negative events in less dire terms and are less likely to focus on negative emotions (Neff et al., 2005), which may contribute to the fostering of individuals' stress tolerance following negative events.

Leary and colleagues (2007) examined how self-compassion moderated individuals' reactions to various distressing events. Self-compassion buffered against individuals' negative emotions, as more self-compassionate individuals were able to reduce the impact of the negative event and were less judgmental and harshly evaluative towards themselves (Leary et al., 2007), thus facilitating coping. In addition, self-compassion lessened the impact of self-rumination and stress and increased the relationship between self-reflection and stress (Samaie & Farahani, 2011). These findings speak to the importance of self-compassion in contributing to individuals' ability to cope against stress.

Studies suggest that mental health professionals exhibit more problem-focused coping (e.g., social support, sports and exercise) than emotion-focused coping (e.g., acceptance, personal counseling) (McCann et al., 2013; Zeidner, Hadar, Matthews, & Roberts, 2013); however, it is difficult to engage in problem-focused coping while on the job. Therefore, it is important to consider how to boost professionals' access to and incorporation of emotion-focused coping mechanisms. According to Neff (2003a) self-compassion is a form of emotional regulation and can be viewed as an emotional coping strategy. In an academic context, self-compassion was positively associated with emotional-focused coping strategies

(e.g., positive reinterpretation and growth, acceptance) and negatively associated with avoidance-oriented strategies (e.g., denial and disengagement) (Neff et al., 2005), while emotional forms of coping were related to positive psychological outcomes (Stanton, Kirk, Cameron, & Danoff-Burg, 2000). Due to the self-care deficit of mental health professionals, specifically those in training, this suggests that self-compassion could act as a potential coping mechanism in combating compassion fatigue, facilitating a resilient practitioner, and promoting compassion satisfaction. Therefore, these results point to the importance of fostering a self-compassionate atmosphere and attitude in mental health professionals.

Only recently has self-compassion been examined as a protective factor in health care professionals' wellbeing and ability to provide effective care (e.g., Beaumont, Durkin, & Hollins Martin, 2015; Gustin, & Wagner, 2013; Heffernan, Quinn, Griffin, McNulty, & Fitzpatrick, 2010; Mills, Wand, & Fraser, 2014; Olson, Kemper, 2014; Olson, Kemper, & Mahan, 2015; Şenyuva, Kaya, Işık, & Bodur, 2014). Most of these studies have focused on nurses and medical trainees. Furthermore, Raab (2014) conducted a review of literature among health care professionals and concluded that developing mindfulness and self-compassion in health care professionals is a promising intervention to reduce stress and improve care to patients and clients.

In particular, self-compassion was associated with clinician resiliency, wellbeing and confidence in providing calm, compassionate, care and inversely associated with perceived stress and burnout among medical trainees (Olson & Kemper, 2014; Olson et al., 2015). In nurses and student nurses, self-compassion is a source of offering compassionate care (Gustin & Wagner, 2013) and associated with emotional intelligence (Heffernan et al., 2010;

Senyuva, 2013). Gustin and Wagner (2013) conducted a qualitative study through a teacher-learning project in order to examine participants “understanding of self-compassion as a source of compassionate care” (p. 2). Participants identified the necessity to be present with oneself and others, the need to respect patients’ vulnerability and to not be judgmental, to be aware of what is unspoken and validate other’s suffering, and to accept compassion. They metaphorically identified this as the “The Butterfly Effect of Caring,” which addressed the mutuality of compassion and caring.

In addition, self-compassion moderated the relationship between Korean cyber students’ psychological wellbeing and academic burnout (Kyeong, 2013). In a sample of student midwives self-compassion was positively correlated with compassion satisfaction and negatively associated with burnout (Beaumont, Durkin, Martin, & Carson, 2015). Furthermore, when examining self-judgment and self-kindness (two components of self-compassion), self-judgment was positively correlated with compassion fatigue and burnout, while, self-kindness was negatively associated with burnout (Beaumont et al., 2015). Self-compassion was also positively associated with clergy satisfaction and negatively associated with clergy emotional exhaustion (Barnard & Curry, 2012). In light of these findings, self-compassion appears to be a valuable mechanism to impact health care providers’ wellbeing and reduce the experience of compassion fatigue and encourage compassion satisfaction.

For these reasons, self-compassion is likely to play a role in clinicians’ ability to cope with stress and combat against the effect of developing compassion fatigue and promote compassion satisfaction. To date, only three studies have examined self-compassion as it relates to self-care and compassion -fatigue and -satisfaction in counselors (Kane, 2010;

Patsiopoulos & Buchanan, 2011; Ringenbach, 2009). Kane (2010) used a grounded theory approach to assess how mindfulness and self-compassion impacted counselors' clinical work. Self-compassion increased clinicians' compassion for others, attunement to clients' self-judgment, and ability to model self-compassion for clients. In addition, self-compassion increased clinicians' patience and resiliency as a therapist. Factors that decreased self-compassion included: inability to be fallible and perfectionism, feeling undeserving, being controlling, and feeling entitled (Kane, 2010). Overall, this points to the benefit of self-compassion, as it improved wellness and clinical skills for mental health professionals.

Patsiopoulos and Buchanan (2011) conducted a narrative study to examine how counselors utilize self-compassion in their counseling practice through their stance in sessions, their relational interactions in the workplace, and their incorporation of balance through self-care. Self-compassion was associated with increased wellbeing and job satisfaction and prevention of burnout (Patsiopoulos & Buchanan, 2011). Some participants cited self-care as an aspect of self-compassion, while others indicated that they dovetailed into one another. Self-care strategies were shown to be performable without attention to self-compassion; however, self-compassion was cited as an attitude that translates into self-care. When working with clients, self-compassion helped participants to develop appropriate boundaries, set realistic expectations, attend to both client and counselor needs, and engage in more effective self-care (Patsiopoulos & Buchanan, 2011). This study supports that self-compassion aids in the prevention of burnout (component of compassion fatigue), fosters clinical skills, and supports mental health providers' self-care.

In addition, Ringenbach (2009) examined the relationship between meditation practice, self-compassion, compassion fatigue, and burnout in counselors. Ringenbach employed a between-subjects design to compare counselors who meditated versus counselors who did not practice meditation. Counselors who practiced meditation had higher self-compassion and lower burnout than those who did not practice meditation. Self-compassion was negatively associated with compassion fatigue and burnout and positively associated with compassion satisfaction in both meditating and non-meditating counselors. Ringenbach's research is the only known quantitative study to look at self-compassion and compassion –fatigue and –satisfaction in counselors. Ringenbach's findings further support the benefit of self-compassion and its relationship to compassion –fatigue and –satisfaction and the need for continued exploration of this relationship.

Ample research posits that mindfulness contributes to clinician wellbeing and self-care, yet there is sparser research that supports the role of self-compassion. Collectively, these three studies provide support for further investigation of the role of self-compassion in fostering clinician resiliency against stress and compassion fatigue; particularly since there is only one known study (Ringenbach, 2009) that examines the relationship between mental health providers' self-compassion and compassion fatigue and satisfaction. Yet, is unclear how the various facets of mindfulness and self-compassion relate to compassion fatigue and satisfaction, how the impact of perceived stress may vary as a function of clinicians' level of mindfulness and self-compassion, and the differential and unique effects of mindfulness and self-compassion within this relationship.

Comparison Between Mindfulness and Self-Compassion

Operationally and conceptually, self-compassion and mindfulness have similarities, as mindfulness is a core component and sub-construct of self-compassion. Both mindfulness and self-compassion entail turning towards and accepting painful experiences as a means of decreasing the process of reactivity in response to those experiences (Neff & Dahm, 2015). However, there are noteworthy distinctions between these two concepts. Neff and Dahm indicated that the mindfulness component of self-compassion, assuming a balanced awareness of one's negative thoughts and feelings, is more narrow in scope compared to the more general form of mindfulness, which focuses on paying attention to any experience (i.e., positive, negative, or neutral). Therefore, it is possible to be mindful without demonstrating self-compassion, whereas self-compassion entails a component of mindfulness. Self-compassion is also wider in scope than mindfulness because it involves self-kindness and common humanity. Although they are intrinsic parts of mindfulness, self-kindness and common humanity may or may not arise when one is being mindful of painful experiences (Neff & Dahm, 2015). Additionally, conceptually, mindfulness is an approach used to relate to an internal experience, whereas self-compassion relates to the experience of suffering (Germer, 2009; Neff & Dahm, 2015). Mindfulness creates awareness without judgment or resistance, while self-compassion includes non-judgmental awareness accompanied with feelings of care and concern for one's experience with a motivation to soothe and comfort oneself (Neff & Dahm, 2015). Comparisons between the physiological systems of mindfulness and self-compassion are minimal; however, it is likely that self-compassion may tap into different physiological systems than mindfulness (Gilbert & Choden, 2014).

Although measures of self-compassion and mindfulness are correlated with one another due to the inherent overlap aforementioned, the benefits of self-compassion and mindfulness may differ. Studies that have focused on mindfulness in the context of stress management interventions for health care professionals have examined how mindfulness increases self-compassion (e.g., Irving et al., 2009; Raab, 2014; Shapiro et al., 2005; Shapiro et al., 2007). Although mindfulness-based programs do not explicitly teach self-compassion, Shapiro et al. (2005) suggested that Mindfulness Based Stress Reduction may lead to increases in self-compassion, which may then lead to decreases in perceived stress; while others suggest that mindfulness and self-compassion independently mediate the relationship between mindfulness-based programs and psychological health (e.g., Baer, Lykins & Peters, 2012). A limited number of studies have examined the relationship of self-compassion and mindfulness simultaneously on psychological health (e.g., Baer, Lykins, & Peters, 2012; Neff, in preparation; Van Dam, Sheppard, Forsyth, & Earleywine, 2011, Hollis-Walker & Colosimo, 2011; Keng et al., 2012; Woodruff, Glass, Arnkoff, Crowley, Hindman, Hirschorn, 2013). Therefore, it is valuable to consider mindfulness and self-compassion as separate, but related psychological mechanisms.

Baer et al. (2012) conducted a cross-sectional study on the relationship between meditation experience, mindfulness, self-compassion, and psychological wellbeing in a sample of adults enrolled in a Mindfulness Based Stress Reduction program at the University of Massachusetts Medical School. The researchers concluded that although mindfulness and self-compassion shared some variance, they served as unique predictors of psychological health and noted that total self-compassion might serve as a better predictor of wellbeing than

total mindfulness (Baer et al., 2012). Therefore, self-compassion may be a stronger predictor of psychological health than mindfulness alone (Hollis-Walker & Colosimo, 2011; Neff & Dahm, 2015; Neff, in preparation; Van Dam et al., 2011; Woodruff et al., 2013) and mediated changes in the effects of mindfulness based stress reduction program and worry, above and beyond mindfulness (Keng et al., 2012).

Neff (in preparation; cited in Neff & Dahm, 2015) examined the associations of self-compassion and mindfulness on anxiety, depression, happiness, and life satisfaction. In the community sample mindfulness was more predictive of anxiety and self-compassion was more predictive of depression, whereas in the sample of individuals who practice Buddhist meditation anxiety was more strongly predicted by self-compassion. In both the community and meditation samples, self-compassion was the only significant predictor of depression, happiness, and life-satisfaction. Van Dam et al. (2011) found that self-compassion accounted for more unique variance (between 10 and 27%) in anxiety and depression than did mindfulness (between 1 and 3%) and argued that self-compassion in itself, is an important predictor of psychological health and may have advantages over mindfulness as a predictor and indicator; thus, supporting the unique effects of formulating a compassionate orientation towards oneself as opposed to creating attention and awareness to the present moment (i.e., mindfulness). Neff and Dahm (2015) indicated that further research is needed to examine the differences and beneficial aspects between mindfulness and self-compassion. This suggests the need for additional examination of the similarities and differences in the effect of self-compassion and mindfulness on mental health clinicians' stress, compassion fatigue, and compassion satisfaction.

Purpose Statement

High stress can be impactful on mental health providers' health and effectiveness (Shapiro et al., 2000). Mental health clinicians have an increased propensity to become secondarily affected by the suffering of their client(s) and develop compassion fatigue (Figley, 2002; Stamm, 2010). Barnett et al. (2007) recommended the importance of clinicians offering self-empathy, self-compassion, and self-acceptance as an ethical imperative for self-care, which may contribute to the prevention of compassion fatigue and promote resiliency and compassion satisfaction. It is important for mental health providers to be responsible to themselves in the present moment, as many clinicians do not engage in preventative self-care activities in order to care for and nourish themselves (Sapienza & Bugental, 2000). Self-compassion and mindfulness may aid in coping with experienced job stressors and contribute to the development of clinicians' resiliency by combating against compassion fatigue and buffering against the effects of perceived stress.

Overall, research suggests that self-compassion and mindfulness are associated with positive psychological health and negatively associated with anxiety, stress, and other negative emotions (Keng et al., 2011; MacBeth & Gumley, 2012; Neff, Kirkpatrick, & Rude, 2007). The effectiveness of mindfulness based programs on mental health professionals' wellbeing, stress management and effectiveness is well established (e.g., Christopher & Maris, 2010; Irving et al., 2009; Raab, 2014; Shapiro et al.; Shapiro et al., 2007); however only three known studies (i.e., Kane, 2010; Patsiopoulos & Buchanan, 2011; Ringenbach, 2009) have looked at how mental health professionals employ self-compassion and its contributions to clinicians' wellbeing and practice. Therefore, self-compassion and

mindfulness may contribute to mental health care providers' wellness and act as forms of coping and self-care in buffering against compassion fatigue and perceived stress, while influencing the development of compassion satisfaction. The purpose of this study was to explore the role of composite mindfulness and self-compassion and their individual subscales, through a stress buffering framework, as psychological factors that may function as coping resources by decreasing the effect of stress for mental health providers.

Further, the study that follows also uniquely considered age, gender, experience, theoretical orientation, and social support as possible covariates. As noted, mindfulness and self-compassion may vary by age (Brown & Ryan, 2003; Neff, 2003b), while compassion fatigue and compassion satisfaction may differ by both age and experience (Craig & Sprang, 2010). Self-care can be a particular struggle in graduate school, and beginning trainees may experience different and more pronounced stressors than experienced professionals and may be more susceptible to occupational stress (Doran, 2014).

In addition, women are less self-compassionate and experience greater stress compared to men, which suggests a need to examine gender differences (Matud, 2004; Yarnell et al., 2015). Theoretical orientation is included as a possible covariate since mindfulness and self-compassion are included in several counseling theories (e.g., Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Therapy, and Compassion Focused Therapy). Therefore, self-compassion and mindfulness may vary by clinicians' theoretical orientation.

Lastly, social support was considered as a covariate. Social support is a commonly known moderator of stress within the stress-buffering framework and this study is guided by

the stress-buffering model, which was first conceptualized utilizing social support as a stress buffer (Cobb, 1976). In addition, problem-focused coping strategies, like social support, are highly utilized coping mechanisms for health professionals (McCann et al., 2013), therefore, it is important to consider the unique impact of mindfulness and self-compassion above and beyond social support.

This study would advance the stress buffering literature by introducing self-compassion as a buffering agent and expanding the application of the mindfulness stress-buffering framework, proposed by Creswell and Lindsay (2014). This will also further illuminate the distinctions between components of self-compassion and mindfulness, a recommended area of further research by Neff and Dahm (2015). In doing so, this study sought to contribute to improvements in the stress management and psychological wellbeing of mental health professionals. The results of the study may aid in determining if professional development/continued education trainings and counseling oriented training programs could benefit from incorporating training on mindfulness and self-compassion practices in order to establish an atmosphere and practice of self-kindness and present awareness as a means to reduce stress and improve coping abilities.

CHAPTER 2

A COMPARISON OF THE STRESS BUFFERING ROLES OF SELF-COMPASSION AND MINDFULNESS ON MENTAL HEALTH PROFESSIONALS COMPASSION – FATIGUE AND –SATISFACTION

For mental health professionals, the act of extending compassion and empathy within therapeutic encounters yields a “cost of caring” for mental health professionals (Figley, 2002, p. 1436). This indirect exposure to clients’ suffering may cause the professional clinician to become secondarily affected by the suffering of their client(s), which can result in the condition of compassion fatigue and significantly impact a clinician’s psychological wellbeing and professional self (Figley, 2002; Stamm, 2010). Shapiro et al. (2000) noted that high stress impacted mental health providers’ efficacy and effectiveness, such that stress led to decreases in concentration, attention, decision-making skills, and adversely impacted the therapeutic relationship. Therefore, wellness efforts are essential to combat the adverse reactions clinicians’ experience, professionally and personally, due to stress or compassion fatigue. Regrettably, many professionals are not taking preventative and corrective responses to care for and nourish themselves and struggle with restraints to their own self-care (Barnett et al., 2007; Sapienza & Bugental, 2000).

Mindfulness and self-compassion are two practices that may contribute to mental health providers’ wellness and protect against the adverse effects of stress. Mindfulness entails relating to one’s present moment experience with a stance of curiousness, openness, and nonjudgmental acceptance (Bishop et al., 2004). Self-compassion involves treating oneself with understanding and concern in response to experienced suffering with a desire to alleviate one’s suffering; and includes self-kindness, common humanity, and mindfulness

(Neff, 2003b). Therefore, through a stress-buffering framework, the current study responds to a call for initiatives and techniques to promote mental health care providers stress resiliency and management by considering mindfulness and self-compassion as psychological buffering mechanisms on the relationship between perceived stress, compassion fatigue and compassion satisfaction in mental health professionals.

Compassion-Fatigue and -Satisfaction

Mental health professionals' vulnerability to physical and psychological consequences while working with traumatized or suffering client(s) are referred to by differing terms, such as, but not limited to, compassion fatigue, vicarious traumatization, and secondary traumatic stress. These terms refer to similar conditions and are frequently used interchangeably in the literature and field (Craig & Spang, 2010; Stamm, 2010). More recently, compassion fatigue has been proposed as alternative terms, such as attachment fatigue or empathic distress fatigue (Germer, 2012; Klimecki & Singer, 2011). Since there is a lack of unanimity on these comparable terms, these conditions will be broadly referred to as compassion fatigue, as measured by the Professional Quality of Life Scale (ProQOL V; Stamm, 2010), which identifies compassion fatigue interchangeably with secondary traumatic stress (Stamm, 2005).

Stamm (2010) defined secondary traumatic stress as exposure to a significant other who has experienced a stressful or traumatic event. In contrast, mental health clinicians also experience pleasure from the success and efficacy of their work, known as compassion satisfaction, which may protect against compassion fatigue (Stamm, 2010). Compassion satisfaction has been narrowly considered in studies that focused on compassion

fatigue/secondary traumatic stress; therefore, the current study hopes to expand research on the application of clinician resiliency to promoting compassion satisfaction. Therefore, in order to support clinicians' compassion satisfaction and diminish the development of compassion fatigue it is essential to incorporate and foster on-the-job wellness practices.

Self-care practices have been identified as an ethical imperative in combating against stress and compassion fatigue; nevertheless, many professionals struggle with incorporating self-care strategies (Baker, 2003; Barnett et al., 2007). Shapiro et al. (2000) noted that self-care and stress management interventions are effective at reducing professionals' stress, yet, there is a lack of preparation within the field and in graduate training programs on the importance of self-care and self-care practices. In addition, self-care is typically presented as an off-the-job practice rather than an individual responsibility (Christopher & Maris, 2010). Furthermore, Craig and Sprang (2010) posited that trainees' may experience different and more pronounced stressors than experienced professionals; thus, increasing their susceptibility to stress and compassion fatigue. Martin (2009) acknowledged that early career psychologists experience mixed messages regarding the integration of self-care practices within their training. This suggests that the current status of self-care practices and training within the field is problematic; thus, it is important to consider additional self-care practices that can be introduced to trainees and experienced clinicians in order to promote more effective stress management.

Self-Compassion and Mindfulness as Stress Buffers

The stress-buffering model posits that there are certain resources that alleviate the negative health influences of stressful events ("Stress Buffering Model," 2008). These

buffering resources may lessen mental health professionals' response to the traumatic suffering of their client(s) and aid in their ability to cope. The stress-buffering model has traditionally considered external resources (i.e., social support); however, it is important to expand this framework by continuing examination on the role of internal resources within the stress-buffering model, such as mindfulness (Creswell & Lindsay, 2014) and self-compassion.

The current study considers mindfulness and self-compassion as two psychological constructs that may buffer the association between perceived stress and compassion fatigue and promote satisfaction. Limited research has examined the joint role of mindfulness and self-compassion on mental health providers' wellbeing. Research that does exist suggests that the benefits of self-compassion and mindfulness on psychological health may differ (e.g., Baer et al., 2012, Van Dam et al., 2011), therefore suggesting the need to examine the specific facets of self-compassion and mindfulness on mental health providers' stress, compassion –fatigue and –satisfaction.

Mindfulness

Mindfulness originated in the Buddhist tradition and has been integrated into Western medicine and psychology. Mindfulness itself can be practiced and fostered through formal meditational practice, informal practice, or non-meditation based exercises (Hick, 2008). There is a discrepancy in a consensual definition, since mindfulness can be understood as a psychological trait or process, a cultivating practice, or a state/mode (Germer, 2013). However, a common understanding is that mindfulness involves a non-judgmental, present, awareness of ones' thoughts, emotions, and sensations (Kabat-Zinn, 1994). For the purposes

of this study mindfulness will be conceptualized as a multifaceted construct, in accordance with the Five Facet Mindfulness Questionnaire [FFMQ], which includes Observing, Describing, Acting with Awareness, Nonjudging of Inner Experience, and Nonreactivity to Inner Experience. Many cognitive and behavioral therapies address the importance of mindfulness (e.g., Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Therapy), while other forms of therapy may use mindfulness as an intervention or to strengthen the therapeutic relationship (Germer, 2013).

A majority of the research on mindfulness focuses on its application to client conditions and psychological wellbeing. Overall, studies on mindfulness and psychological health demonstrated that mindfulness leads to positive psychological effects, improved emotional and behavioral regulation, and reductions in negative psychological symptoms (Keng et al., 2011). Research on mindfulness' application to clinician wellbeing and effectiveness is emerging. For example, mindfulness contributed to mental health professionals' clinical skills (e.g., attentiveness, presence, comfort, empathy) and self-efficacy and decreased clinicians' stress and anxiety (Davis & Hayes, 2011). Similarly, Hick (2008) noted that mindfulness facilitated a more attuned awareness, empathy, and presence within the therapeutic relationship. Furthermore, mindfulness increased clinicians' ability to attend to and manage their internal experience by facilitating greater attentiveness, patience, openness, and self-awareness (Kane, 2010). Collectively, this reveals the benefit mindfulness has on clinicians' effectiveness and the therapeutic relationship.

More specifically, mindfulness-based stress reduction programs (MBSR), which train individuals how to be mindful through various formal and informal practices, are effective at

reducing stress, negative affect, rumination, and anxiety in health professionals, while increasing self-compassion and positive affect (Dorian & Killebrew, 2014; Irving et al., 2009; Shapiro et al., 2007). Shapiro et al. (2005) acknowledged that through MBSR participants indicated they were able to more effectively manage their negative emotions. Christopher and Maris (2010) taught a self-care and mindfulness course to counselor trainees, which positively impacted the students' self-awareness and clinical work. This points to the effectiveness of mindfulness at reducing clinical providers' stress. Therefore, as mindfulness continues to emerge as an evidenced based approach to alleviate stress, further research is needed to address the relationship of mindfulness to compassion -fatigue and -satisfaction within mental health professionals and also consider how mindfulness is comparable to and differs from self-compassion.

Self-Compassion

Self-compassion, within a Western framework, is conceptualized as a way of relating to oneself, with an awareness and openness to one's suffering, with a desire to alleviate it (Neff, 2003b). Neff (2003b) proposed that self-compassion is composed of six factors: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Self-kindness refers to extending warmth and understanding to oneself, whereas, self-judgment entails extending negative feelings towards the self (Neff, 2003b). Common humanity denotes recognizing the shared human experience of human suffering while isolation refers to feeling alone, as if you are the only one suffering (Neff, 2003b). A sense of mindfulness allows for a balanced and nonjudgmental state of awareness rather than over identifying with one's thoughts and emotions (Neff, 2003b). It is important to recognize

the commonality and differences between the practice of mindfulness and mindfulness as a component of self-compassion. Noteworthy is the distinction that mindfulness as a factor of self-compassion is smaller in scope, such that it is an awareness of ones' experience while suffering, as opposed to the broader mindfulness that is focused on being attentive to positive, negative, or neutral experiences (Neff & Dahm, 2015).

Through correlational studies, mood inductions, behavioral observations, and short-term interventions, research overall supports that self-compassion positively impacts physical and psychological wellbeing (Neff & Dahm, 2015). Greater self-compassion aided in reducing anxiety, depression, rumination, and self-criticism (Neff, Kirkpatrick, & Rude, 2007; MacBeth & Gumley, 2012). Self-compassion also lessened the impact of negative emotions and emotional distress in response to negative life events (Allen & Leary, 2010; Leary et al., 2007), therefore suggesting that self-compassion facilitates coping and resiliency to stress. At the same time, self-compassion is associated with positive psychological strengths, such as happiness, positive affect, life satisfaction, motivation and emotional intelligence (MacBeth & Gumley, 2012; Neff, Rude, & Kirkpatrick, 2007; Yarnell & Neff, 2013).

A scant area of research focuses on the application of self-compassion to health care professionals' wellbeing and efficacy. This research is primarily centered on nurses and medical trainees (e.g., Gustin, & Wagner, 2013; Heffernan et al., 2010; Olson et al., 2013; Senyuva et al., 2014). There is an even narrower emphasis on the relationship of compassion fatigue and self-compassion for mental health care providers. Only three known studies examine the application of self-compassion to mental health providers' clinical work (Kane,

2010; Patsiopoulos & Buchanan, 2011; Ringenbach, 2009). Through qualitative analysis, Kane (2010) and Patsiopoulos and Buchanan (2011) postulated that self-compassion reduced burnout and improved clinical skills, resiliency, job satisfaction, and self-care. Ringenbach (2009) conducted a quantitative study to assess the relationship between meditation practice, self-compassion, and compassion fatigue. Composite self-compassion was negatively associated with compassion fatigue and burnout, while positively associated with compassion satisfaction (Ringenbach, 2009). These three studies support the application and utilization of self-compassion by mental health professionals to aid in their self-care and stress management; and point to the need for further investigation of these constructs, which the current study seeks to examine by exploring the various facets of mindfulness and self-compassion within the association between stress and compassion fatigue and compassion satisfaction.

The Current Study

Mindfulness, being aware of one's present experience, and self-compassion, treating oneself kindly, are two ways of relating to one's experience that have emerged as constructs that positively impact individuals' psychological health and are growing in their integration into mental health treatment (Davis & Hayes, 2011; Keng et al., 2011; MacBeth & Gumley, 2012; Neff, Kirkpatrick, & Rude, 2007). The application of mindfulness and self-compassion to psychotherapy clients is established (mindfulness more so than self-compassion), yet research on the effects of mindfulness and self-compassion for mental health professionals is in its infancy. The current study advanced this area of research by examining the relationships between mental health professionals' perceived stress, compassion fatigue, and

compassion satisfaction, while considering the moderating effects of mindfulness and self-compassion on these relationships. Both composite and subscale factors of mindfulness and self-compassion are considered since researchers have endorsed the importance of further understanding the distinctions between features of mindfulness and self-compassion, while also positing that multifaceted constructs should be examined at the subscale level, therefore, allowing for the maximization of the overall construct as total scores may obscure the relationships that are present (Neff & Dahm, 2015; Smith, Fischer, Fister, 2003). This facilitates further understanding of the associations and distinctions between mindfulness and self-compassion for mental health professionals.

Furthermore, age and gender will also be considered as covariates. Self-compassion may differ by age and gender (Neff 2003b; Yarnell et al., 2015), and there is also evidence to suggest that meditation and acting in awareness (a component of mindfulness) was associated with age (Brown & Ryan, 2003). In addition, compassion fatigue and compassion satisfaction may vary by age and gender, as younger professionals experienced higher levels of burnout and older health providers endorsed higher levels of compassion satisfaction (Craig & Sprang, 2010), while women exhibited higher levels of compassion fatigue and chronic stress (Matud, 2004; Sprang, Clark, Whitt-Woosley, 2007). Additionally, social support will be considered as a covariate, as social support is heavily studied within the stress literature, one of the most commonly reported self-care strategies, and ameliorates individuals' responses to stress; therefore, in order to advance research on the stress-buffering framework and factors that influence individuals' responses to stress, it is important to control for social support. Provider experience and theoretical orientation, which was

previously described, will also be explored since stress level may vary by experience, while, mindfulness, compassion, and self-compassion are considered and utilized within various forms of therapy.

The current study was exploratory in nature and contributes to the gap in research on the application of mindfulness and self-compassion to stress, compassion fatigue, and compassion satisfaction. Examination of these constructs advances the mindfulness stress-buffering framework proposed by Creswell and Lindsay (2014), while also introducing self-compassion as a buffering agent within this theoretical framework, since this is the only known study that has considered self-compassion within the stress-buffering model. Furthermore, this study responds to the ethical need within the field to promote self-care management techniques and considers self-compassion and mindfulness as two practices that may facilitate mental health providers' wellness and clinical skills. Findings may shed light on how these practices may differ among personal (i.e., age, gender, sexual orientation, etc.) or professional (i.e., training, experience, accreditation, background, etc.) characteristics of mental health providers and whether clinicians may benefit from receiving training of mindfulness and self-compassion in order to reduce stress and improve coping strategies.

Hypotheses

Specifically, this study sought to address four central research questions and two hypotheses among a sample of mental health professionals:

1. Mindfulness and self-compassion will be positively correlated with one another, positively correlated with compassion satisfaction, and negatively correlated with compassion fatigue.

2. Mindfulness and self-compassion will account for independent variance in compassion fatigue and compassion satisfaction.

Research Questions

1. What are the differential associations between composite self-compassion and mindfulness on compassion fatigue and compassion satisfaction?
2. Do composite self-compassion and composite mindfulness moderate the association between perceived stress and compassion fatigue and compassion satisfaction?
3. What are the differential associations between self-compassion subscales (i.e., self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification) and mindfulness subscales (i.e., observing, describing, acting with awareness, nonjudging, and nonreactivity) on compassion fatigue and compassion satisfaction?
4. Do self-compassion subscales and mindfulness subscales moderate the association between perceived stress on compassion fatigue and compassion satisfaction?

Methodology

Participants and Sampling Procedures

Given the exploratory nature of the current study a broad sample of mental health professionals was targeted. Eligibility criteria for participating in the study included (1) being either currently enrolled in a graduate training program that teaches psychotherapy/counseling, or a licensed practicing clinician who currently conducts psychotherapy/counseling; (2) if in training, having completed at least one semester of practicum experience; and (3) seeing clients in a counseling/therapeutic capacity. This study

relied on a convenience sample of mental health professionals, who were recruited through online psychology, clinical, and counseling oriented LISTSERVS, such as those for APA's Division 12 (Society of Clinical Psychology), 17 (Society of Counseling Psychology), and 29 (Society for the Advancement of Psychotherapy), as well as through e-mail contact with accredited and unaccredited counseling and clinical psychology programs, university counseling centers, and other psychological associations around the country.

The current study included 309 experienced and in-training mental health professionals (M age = 35.45; SD 12.41). In total, there were 142 experienced mental health professionals (M age = 43.71; SD = 13.20) and 167 in training to become licensed mental health professionals (M age = 28.44; SD = 5.41). Experienced clinicians included mental health professionals who had finished their respective training programs and either obtained licensure or who were not licensed, but currently pursuing licensure when they completed the current study (n = 22). The sample included 248 women (80.3%), 57 men (18.4%), and 4 non-binary persons (1.2%). In terms of sexual orientation, 257 participants (83.2%) identified as heterosexual, 20 as bisexual (6.5%), 9 as lesbian (2.9%), 10 as gay (3.2%), 6 as pansexual (1.9%), 4 as queer (1.3%), and 3 preferred not to answer (1%). A majority of the sample identified as White/European American (n = 254; 82.2%), followed by Hispanic/Latino/a (n = 15; 4.9%), Asian/South Asian/Pacific Islander (n = 9; 2.9%), Multiracial (n = 8; 2.6%), Black/African American (n = 7; 2.3%), Biracial (n = 7; 2.3%), Native American/American Indian (n = 3; 1%), and Arab/Middle Eastern (n = 2; .6%). Five participants (n = 1.6%) additionally identified as international (i.e., not native to the United States and U.S. culture). The religious affiliations of the sample were: No Religious

Affiliation (n = 67; 21.7%), Catholic (n = 52; 16.8%) Christian-Non-Denominational (n = 44; 14.2%), Agnostic (n = 40; 12.9%), Atheist (n = 26; 8.4%) Protestant (n = 32; 10.4%), Jewish (n = 19; 6.1%), Buddhist (n = 9; 2.9%), Hindu (n = 5; 1.6%), Muslim (n = 4; 1.3%), Fundamental/Evangelical Christian (n = 3; 1%), and Other (n = 8; 2.6%). Participants also responded to specific questions regarding their training, experience, and academic program, responses to which are summarized in Table 1.

Procedures

Study data were collected and managed using REDCap electronic data capture tools hosted at the Center for Health Insights of the University of Missouri–Kansas City (UMKC) (Harris, Taylor, Thielke, Payne, Gonzalez, & Conde, 2009). REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources. There was a minimal risk that security through RedCap would be breached; however, no identifying information was associated with survey measure responses.

Participation was entirely voluntary and there was a minimal risk that the survey may have invoked negative reactions (e.g., sadness, anxiety) for some participants, as they reflected on their current stress and the negative effects of working with clients. Participants received a general description of the study and the potential risks and inconveniences. They completed the study on their own personal computer at a time and location of their choosing.

Within the survey, participants first endorsed an informed consent page (see Appendix B) and were then directed to complete the online survey. Although there was no time limit for completion of the survey itself, it was anticipated to take participants approximately 20 minutes to complete. Following the completion of the survey, participants were given the opportunity to submit their contact information in a separate questionnaire in order to register for a chance to receive one of ten \$25.00 gift cards to Amazon.com. Participants supplied their e-mail address to be notified if they won the gift card drawing. Since this questionnaire was separate there was no way to link participants' survey responses to their e-mail address.

Measures

The following measures were included in the online survey: Demographic Questionnaire; Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet & Farley, 1988); The Cohen Perceived Stress Scale (Cohen et al., 1983); The Five-Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006); The Self-Compassion Scale (SCS; Neff, 2003a); and the Professional Quality of Life Scale (ProQOL; Stamm, 2010).

Demographic variables. Personal characteristics and information about participants' training, experience and program was assessed and considered as demographic variables. This included, age, gender, sexual orientation, race, and religion/spirituality, training/experience as a mental health trainee/professional, whether participant was in training, their professional training background, highest degree received (i.e., bachelor, masters, doctorate), program accreditation status, and theoretical orientation. See Appendix C for the demographic questionnaire, as well as Table 1 for further demographic information.

Social support. Social support operated as a covariate, as measured by the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), a 12-item questionnaire measuring social support from family, friends, and significant other (See Appendix D). The MSPSS produces a total score and three subscales, with four items per subscale each with response answers ranging from 1 (*very strongly disagree*) to 7 (*very strongly agree*). The total score is the mean of all of 12 items. The composite social support was used as a covariate since social support is one of the most commonly moderated factors of perceived stress.

Zimet, Powell, Farley, Werkman, and Berkoff (1990) conducted a confirmatory factor analysis, which produced three factors with factor loadings ranging between .87 and .88 for friends, .74 and .85 for family, and .72 to .88 for significant other. This three-factor model was further supported by Clara, Cox, Enns, Murray, and Torgrudc (2003) in college students (GFI = .95; CFI = .97; RMSEA = .07) and a psychiatric outpatient sample (GFI = .90; CFI = .97; RMSEA = .08), as was a single model of Global social support for college students (GFI = .95; CFI = .97; RMSEA = .07) and a psychiatric outpatient sample (GFI = .94; CFI = .97; RMSEA = .07), respectively. Zimet et al. (1990) demonstrated that the alpha coefficients for global social support ranged from .84 to .92 for three different samples (pregnant women, adolescents, and pediatric residents). Clara et al. (2003) reported Cronbach alphas for the subscales with both a psychiatric and university sample: Friends (.94 psychiatric, .93 university), Family (.92 psychiatric, .92 university), and Significant-Other (.94 psychiatric; .93 university); however, they did not report an alpha for the full scale. The MSPSS also demonstrated appropriate construct validity, as evidenced by significantly negative

correlations with depression and anxiety.

The current study utilized a single global social support score, which produced a Cronbach's Alpha of .94. Social support in the current sample was positively and significantly correlated with compassion satisfaction ($r = .20; p < .001$) and total self-compassion ($r = .15; p = .01$), and negatively and significantly correlated with compassion fatigue ($r = -.12; p < .05$) and stress ($r = -.14; p = .02$). Since the MSPSS was not validated with mental health clinicians or clinicians in training, principal axis factoring was conducted to determine whether the structure underlying a global factor was like that of previous studies. The results confirmed a single global MSPSS score. Three factors were also extracted to compare the structure to that found in prior studies; loadings ranged from .70 to .84.

Perceived stress. Cohen's Perceived Stress scale (PSS-10; Cohen et al., 1983) was used to assess participants' appraisal of stress within the last month (See Appendix E). This state stress scale consists of 10 items that ask about the frequency of stressful events within the last month. Responses are rated on a Likert scale from 0 (*never*) to 4 (*very often*), with higher total scores indicating greater perceived stress. The total score is calculated by the sum of all items. The Perceived Stress scale has been utilized in previous studies examining self-compassion and mindfulness (e.g., Baer, Carmody, & Hunsinger, 2012; Neff & Germer, 2012). The PSS-10 has adequate reliability, with coefficient alphas ranging between .84 to .86 in two college samples and a community sample, and predictive validity, as demonstrated by significant and positive correlations with impact of life events ($r = .35; r = .24$) and depressive symptomatology ($r = .76; r = .65$) in two college samples (Cohen, 1983).

Furthermore, the PSS demonstrated appropriate convergent validity as evidenced by high correlations with anxiety and depression (Roberti, Harrington, & Storch, 2006). This was further confirmed within the current sample, as the PSS produced a Cronbach's alpha of .88 for a single global factor score.

Mindfulness. The Five-Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006) was used to assess mindfulness (See Appendix G). The FFMQ is a 39-item, five-factor instrument that originated from factor analyses of five other dispositional mindfulness measures (e.g., The Mindful Attention Awareness Scale [MAAS], Brown & Ryan, 2003; The Freiburg Mindfulness Inventory [FMI], Walach, Buchheld, Buttenmüller, Kleinknecht, & Schmidt, 2006; The Kentucky Inventory of Mindfulness Skills [KIMS], Baer, Smith, & Allen, 2004; The Cognitive and Affective Mindfulness Scale [CAMS], Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007; and the Mindfulness Questionnaire [MQ], Chadwick, Hember, Symes, Peters, Kuipers, & Dagnan, 2008). Both the total score and five subscales were utilized within the current study. The five subscales are Observing (8 items), Describing (8 items), Acting with Awareness (8 items), Nonjudging (8 items), and Nonreactivity (7 items). Responses were rated on a Likert scale from 1 (*never or rarely true*) to 5 (*very often or always true*). Several items were reverse coded and then the sum of the scores were used to establish the subscales and total score.

All inter-correlations, with the exception of observing with nonjudging ($r = -.07$) were significant, ranging between $r = .15$ to $r = .34$ (Baer et al., 2006). Christopher, Neuser, Michael, and Baitmangalkar (2012) reported significant inter-correlations from $r = .27$ to $r = .55$ for meditators, and significant inter-correlations from $r = .34$ to $r = .51$ for non-

meditators, along with a non-significant correlation between observing with nonjudging subscales ($r = 0.14$). In a sample of social work interns, compassion fatigue was significantly and negatively correlated with mindfulness ($r = -.53$), describing ($r = -.36$), acting with awareness ($r = -.42$), non-judgmental ($r = -.35$), and non-reactive ($r = -.43$), while compassion satisfaction was significantly and positively correlated with mindfulness ($r = .46$), acting with awareness ($r = .35$), non-judgmental ($r = .30$), and non-reactive ($r = .34$) (Decker et al., 2015). The five subscales demonstrated internal consistency ranging from .75 to .91 and a full-scale alpha of .96 (Baer et al., 2006; Baer et al., 2008). The FFMQ also demonstrated both convergent and discriminant validity, as evidenced by the subscales correlations with constructs such as emotional intelligence, openness to experience, psychological symptoms, thought suppression, difficulties with emotional regulation, etc. (Baer et al., 2006).

Scores from the current sample of experienced and in training mental health professionals resulted in a full-scale Cronbach's alpha of .79 and subscales ranging between .85 and .94 (see Table 2). The correlations between the five factors ranged from $r = .33$ to $r = .78$ (see Table 3). These correlations were higher than those reported by Baer et al. (2008), which were between $r = .32$ to $r = .56$. Principle factor analysis confirmed the five-factor structure of the FFMQ for the current sample, with factor loadings ranging from .47 to .89, except for one item on the observing subscale, which had a factor loading of .17 and loaded higher on the describing and non-reactive factors (see Table 4).

Self-compassion. The Self-Compassion Scale (SCS; Neff, 2003a) was used to assess individuals' level of self-compassion (see Appendix F). This scale is a 26 item, six-factor

measure that assesses individuals' overall self-compassion and components of self-compassion: Self-Kindness (5 items), Self-Judgment (5 items), Common Humanity (4 items), Isolation (4 items), Mindfulness (4 items), and Over-Identification (4 items). Items asked how individuals perceived their response towards themselves during difficult times on a Likert scale ranging from 1 (*almost never*) to 5 (*almost always*). Total self-compassion is calculated by reverse coding the negative subscale items and then calculating a total mean score, while the subscales are calculated using the mean of the subscale items (Neff, 2003a). Both the total self-compassion score and its subscales were utilized for this study. The subscales consisted of four to five items each. Neff (2003a) confirmed the fit of the 26-item, six factor scale (NNFI = .90; CFI = .91), with the following factor loadings: self-kindness (.71-.77), self-judgment (.65-.80), common humanity (.57-.79), isolation (.63-.75), mindfulness (.62-.80), and over-identification (.65-.71) (Neff, 2003a).

Neff (2003a) reported the inter-correlations between factors: self-kindness and self-judgment ($r = -.81$), common humanity and isolation ($r = -.50$), and mindfulness and over-identification ($r = -.77$). Although the subscales have high correlations they are considered as separate subscales within the literature (e.g., Baer et al., 2012; Heffernan et al., 2010; Van Dam et al., 2011). Further, Neff (2003a) reported that the SCS exhibited convergent and discriminant validity, as self-compassion was negatively correlated with self-criticism ($r = -.65$) and narcissism ($r = -.08$), moderately correlated with self-esteem ($r = .59$), self-acceptance ($r = .62$), and self-determination ($r = .43$), and positively correlated with a sense of connection ($r = .41$). Good test-retest validity was obtained, ranging from .80 to .88 for the subscales and .93 for the total score (Neff, 2003a). The internal consistency for the full

scale was alpha .92, while the subscale coefficients ranged from alpha .77 to .81 (Neff, 2003a).

Similarly, within the current sample, the full scale produced an alpha of .90 and the subscales ranged from .76 to .89 (see Table 2). The correlations amongst the six factors within the current sample ranged from -.32 to .77 (see Table 3). Similar to Neff (2003a), three separate factor analyses (i.e., self-kindness and self-judgment variables, common humanity and isolation variables, and mindfulness and over-identification variables) were conducted to assess the six-factor structure with the current sample of mental health professionals and trainees. Factor loadings ranged between .42 and .90 for each subscale (see Table 5).

Compassion fatigue and compassion satisfaction. The fifth version of the Professional Quality of Life Scale (ProQOL-V; Stamm, 2005; Stamm, 2010) was used to assess compassion fatigue and compassion satisfaction (see Appendix H). The ProQOL is a revision of the Compassion Fatigue Self-Test (CFST or CSF) developed by Figley (1995) and is cited as the most commonly used measure that examines “the positive and negative effects of working with people who have experienced extremely stressful events” (Stamm, 2010, p. 12). Stamm (2005, 2010) indicated that unlike the original CSF, the ProQOL addressed the distinction between burnout and secondary/vicarious trauma and included the concept of compassion satisfaction.

Previous versions on the ProQOL consider compassion fatigue and secondary traumatic stress interchangeably, whereas the current fifth version considers compassion fatigue as a multi-dimensional component of secondary traumatic stress and burnout.

Although studies support the three-factor structure, Stamm (2010) reported that burnout and secondary traumatic stress have a shared variance of 34%, which reflects the overlap and common distress experienced in both conditions. However, more recent research utilizing the ProQOL –V, continue to identify the secondary traumatic stress subscale as compassion fatigue (e.g., Beaumont et al., 2015; Decker et al., 2015; Hunsaker, Chen, Maughan, & Heaston, 2014) or broadly acknowledge compassion fatigue as opposed to making a distinction between secondary traumatic stress and burnout (e.g., Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). Therefore, due to the lack of consensual definition and interchangeable nature of secondary traumatic stress and compassion fatigue, the current study considered the secondary traumatic stress scale as compassion fatigue and excluded the burnout subscale.

The ProQOL –V contains 30-items that assess Burnout (e.g., “I feel trapped by my job as a helper”), Secondary Traumatic Stress (e.g., “I find it difficult to separate my personal life from my life as a helper”), and Compassion Satisfaction (e.g., “I get satisfaction from being able to help people”). Stamm (2005) indicated that these three scales, each consisting of ten items, are separate constructs and do not produce a composite score. Only the secondary traumatic stress and compassion satisfaction subscales were used, which resulted in a 20-item scale. Responses were assessed on a Likert scale ranging from 1 (*never*) to 5 (*very often*). Subscale items are summed together to produce total scores for compassion satisfaction and compassion fatigue. Stamm gave consent for researchers to substitute the appropriate target group for the term *help* or *helper*. Therefore, for the current study *mental health practitioner* was substituted for *helper*. Prior research has used the ProQOL –V with mental health practitioners, yet it is unclear whether the words were adjusted to fit the

sample, therefore, reliability and validity evidence for the word changes is unidentified.

Stamm (2010) reported good construct validity and indicated that the multi-trait, multi-method approach provided evidence of convergent and discriminant validity (Stamm, 2005); however, available data supporting the validity of the ProQOL are limited. Craig and Sprang (2010) conducted an exploratory factor analysis on the ProQOL –III, which did not support the 30-item scale, but confirmed a 24-item three-factor structure of burnout, compassion fatigue, and compassion satisfaction. Due to the lack of validity evidence principle axis factoring was conducted to assess the three-factor structure of the ProQOL. Similarly, with the current sample, the 30-item three factor scale was not confirmed. When forced to three factors, items appeared to load differently than what was proposed by Stamm (2005, 2010). Since the current study only used the Compassion Satisfaction and Compassion Fatigue scales, factor analysis was conducted excluding the Burnout items, which produced two factors with factor loadings ranging from .34 to .83 (see Table 6), and an inter-correlation of -.28. These two subscales were retained due to appropriate factor loadings in conjunction with the reputability of the ProQOL. The ProQOL has demonstrated adequate reliability with Cronbach’s alpha levels of .88 for compassion satisfaction, and .81 for secondary traumatic stress (Stamm, 2010). The current sample of experienced and in training mental health professions produced an alpha of .84 for compassion satisfaction and .90 for compassion fatigue, (see Table 2).

Results

Analysis of the data was completed using IBM SPSS version 22. Preliminary data screening was run and confirmed that the assumptions of normality, linearity, homogeneity

of variance, and multicollinearity were met in order to perform multiple linear regression analysis. Normality and homogeneity of variance were confirmed by examination of residual plots. Linearity was tested and established with scatter plots and histograms. Univariate and bivariate outliers were identified and deleted: one on compassion satisfaction and one on compassion fatigue. Pearson correlational analysis were run to assess the bivariate associations between stress, mindfulness, self-compassion, compassion fatigue, and compassion satisfaction to ensure that they are not strongly correlated ($r > .80$; see Table 3). Tolerance and variance inflation factor (VIF) statistics, which address the impact of collinearity, illustrated that all variables fell within an acceptable range.

Missing values analysis was performed. The sample initially included 396 participants; however, 18 cases were removed since those participants did not endorse seeing clients in a counseling/therapeutic capacity and another 60 were removed due to total incompleteness of the independent, dependent, and or moderator measures. Missing Value Analysis was performed on the data. Little's MCR test confirmed that the remaining incomplete data for the independent, dependent, and moderator variables were missing completely at random and expectation maximization was utilized to impute missing values. Social support was not missing at random and Listwise deletion was utilized since only 2.8% of the data were missing, resulting in nine participants removed and an N of 309 participants.

As previously noted, compassion fatigue, compassion satisfaction, self-compassion, and stress may vary by age and gender (Brown & Ryan, 2003; Craig & Sprang, 2010; Matud, 2004; Neff 2003b; Sprang, Clark, and Whitt-Woosley, 2007; Yarnell et al., 2015), while mindfulness and self-compassion are embedded within several counseling theories.

Therefore, correlations were assessed amongst age, gender, theoretical orientation and the predictor and outcome variables to determine whether there was a significant relationship. Age was the only demographic variable that was significantly correlated with the independent and dependent variables, and was considered a covariate within the study. There was a positive correlation between age and compassion satisfaction ($r = .25; p < .001$), mindfulness ($r = .40; p < .001$), and self-compassion ($r = .41; p < .001$), respectively. Social support was also considered as a covariate within the current study, as there was a positive correlation between social support and compassion satisfaction ($r = .20; p < .001$), while a negative correlation with compassion fatigue ($r = -.12; p < .05$) and stress ($r = -.14; p = .02$).

T-tests were conducted to assess whether there were any significant differences between trainees and experienced mental health professionals. Experienced clinicians appeared to exhibit significantly higher levels of nonjudging ($p = .01$), self-kindness ($p = .02$), and compassion fatigue ($p = .03$) compared to trainees, whereas, trainees exhibited greater levels of isolation ($p = .03$) compared to experienced clinicians. There were not any significant differences between trainees and experienced clinicians on compassion satisfaction, composite mindfulness and self-compassion, and the other subscales of mindfulness and self-compassion. As a result, participant's status as a trainee or experienced mental health professional was not controlled for within the analysis.

Correlational Analysis

Hypothesis one was supported and ascertained through Pearson correlational analysis (see Table 3). Mindfulness and self-compassion were significantly and positively correlated with one another ($r = .69, p \leq .01$), positively correlated with compassion satisfaction ($r =$

.43, $p \leq .01$; .41, $p \leq .01$) and negatively correlated with compassion fatigue ($r = -.30, p \leq .01$; $-.26, p \leq .01$), respectively. These correlation coefficients represent a moderate to large effect size. Perceived stress was also significantly correlated with compassion fatigue ($r = .39, p < .001$) and compassion satisfaction ($r = -.39, p < .001$), signifying a moderate effect size.

Regression Analysis with Composite Scales

Hypothesis two and research question one and two were addressed through multiple linear regression analyses. Two separate models were examined: one with compassion fatigue as the outcome and a second with compassion satisfaction as the outcome. For each model variables were entered in four blocks. In Step 1, I examined the variance explained by, and differential association of, composite mindfulness and self-compassion to compassion fatigue and compassion satisfaction (i.e., hypothesis two and research question one) by adding mindfulness and self-compassion as predictors into the model. Perceived stress was added in Step 2, and in Step 3, product terms to represent interactions between perceived stress and composite self-compassion and composite mindfulness were created and added to the model. These interaction terms were entered to assess how the association between perceived stress and compassion satisfaction or compassion fatigue was moderated by mindfulness and self-compassion (i.e., research question two). Lastly, in Step 4, control variables (i.e., age and social support) were added to describe how these associations change as a function of personal characteristics. See both Table 9 and 10 for a depiction of this analysis.

Compassion fatigue. Mindfulness significantly and negatively predicted compassion fatigue within the model, while perceived stress level and age significantly and positively predicted compassion fatigue. However, self-compassion was not predictive of compassion fatigue within the model. In addition, there was not an interaction effect between mindfulness and stress, nor was there one between self-compassion and stress on compassion fatigue (see Table 9).

Compassion satisfaction. In comparison, composite mindfulness positively predicted compassion satisfaction, while there was not a significant effect for composite self-compassion on compassion satisfaction. Stress significantly and negatively predicted compassion satisfaction, while social support significantly and positively contributed to the promotion of compassion satisfaction. There was a significant interaction effect between stress and composite mindfulness, such that higher mindfulness resulted in a stronger negative association between stress and compassion satisfaction (see Table 10 and Figure 1). In addition, the highest level of compassion satisfaction was found at high mindfulness and low stress. In contrast, the lowest level of compassion satisfaction was found at low mindfulness and high stress.

To further ascertain this relationship and the significance of the moderation a simple slopes test was conducted at different levels of mindfulness (i.e., low, average, and high). Since variables were centered for the analysis the following values of the moderator were considered as low, average, and high mindfulness: -20, 0, and 20. There was a statistically significant negative association between stress and compassion satisfaction at average ($p < .001$) and high ($p < .001$) levels of mindfulness, but not at low levels of mindfulness ($p >$

.05). Collectively, this demonstrates that mindfulness enhanced the relationship between stress and compassion satisfaction, particularly at average and high levels of mindfulness.

Regression Analysis with Subscales

Similarly, two regression models were run to assess the association of self-compassion and mindfulness subscales on each outcome (i.e., research question three). Given the exploratory nature of the study, the subscales were entered through stepwise regression, to determine which factors should be retained in the models. For compassion satisfaction, the mindfulness subscale of self-compassion and the observing and describing subscales of mindfulness were retained. For compassion fatigue, the nonjudging, awareness, observing, and describing subscales of mindfulness were retained. To test the interaction effect of mindfulness and self-compassion subscales (i.e., research question four), the subscales that were found to be significant main effect predictors on compassion fatigue and compassion satisfaction were examined. Interaction terms between these particular scales with perceived stress were created. Correspondingly, to assess the facets of self-compassion and mindfulness, variables were entered in four blocks: Step 1, aforementioned significant mindfulness and self-compassion subscales; Step 2: perceived stress; Step 3: interaction of perceived stress on the mindfulness and self-compassion subscale, respectively; and Step 4, control variables (age and social support), in order to examine the unique contributions of covariates. See Table 11 and 12 for hierarchical regression analysis of subscales of mindfulness and self-compassion for compassion fatigue and compassion satisfaction.

The results demonstrated that the mindfulness subscale of self-compassion, and the observing and describing subscales of mindfulness, positively predicted compassion

satisfaction. To contrast, the nonjudging, acting with awareness, and describing subscales of mindfulness negatively predicted compassion fatigue, and the observing subscale of mindfulness was positively associated with compassion fatigue. There was a significant interaction between stress and observing on compassion fatigue, such that the association between stress and compassion fatigue was lower at higher levels of observing. There was also a significant interaction between stress and describing on compassion fatigue. Specifically, the positive association between stress and compassion fatigue was lower at lower levels of observing. Simple slope analyses were conducted to further clarify these relationships. There was a statistically significant and positive slope between stress and compassion fatigue at low (-5.80) and average (0) describing, $p < .001$, but not at high levels of describing (5.80), $p = .059$. There was also a statistically significant positive slope between stress and compassion fatigue at average (0) and high (5.68) observing $p < .001$, but not at low (-5.68) observing, $p = .06$. Refer to tables 9 thru 12 and Figure 2 and 3 to further assess the variance and significance of the composite and subscale models on compassion fatigue and compassion satisfaction.

Discussion

This is the first known study to examine the moderating effects of mindfulness and self-compassion on compassion fatigue and compassion satisfaction with mental health professionals. The results point to the benefit of training and utilization of mindfulness and self-compassion practices for mental health professionals, both experienced and in training. Hypothesis one was supported: mindfulness and self-compassion were positively correlated with one another, positively correlated with compassion satisfaction, and negatively

correlated with compassion fatigue. The inverse relationship between mindfulness and compassion fatigue, as well as the positive relationship between mindfulness and compassion satisfaction, is consistent with previous research suggesting that mindfulness aids in preventing compassion fatigue (Christophor & Maris, 2010; Shapiro et al., 2007; Thieleman & Cacciatore, 2014), decreasing stress levels and reducing reactivity to stressful or negative situations (Cahn & Polich, 2006; Davis & Hayes, 2011). Self-compassion was negatively associated with stress and compassion fatigue and positively associated with compassion satisfaction, which is consistent with Ringenbach's (2009) findings; therefore, demonstrating that mental health professionals who engage in self-compassion are more likely to experience greater levels of compassion satisfaction and less likely to experience higher levels of compassion fatigue compared to their less self-compassionate counterparts.

Composite Mindfulness

Mindfulness negatively predicted compassion fatigue and enhanced the relationship between stress and compassion satisfaction. Compassion satisfaction was highest among participants who endorsed high mindfulness irrespective of stress level. Consistent with prior research, this points to the negative impact of stress on compassion satisfaction, but also to the benefit of promoting mindfulness, as those with higher mindfulness reported greater compassion satisfaction regardless of stress level. This demonstrates that mindfulness appeared to safeguard against the negative implications of stress on mental health professionals' compassion satisfaction.

The highest level of compassion satisfaction was for those who endorsed low perceived stress and high mindfulness. Therefore, mindfulness promoted compassion

satisfaction most dramatically when stress level was low. Since mindfulness is associated with higher levels of emotional intelligence (Brown & Ryan, 2003; Schutte & Malouff, 2011) and aids in emotion regulation (Keng et al., 2011), it then may facilitate greater awareness and satisfaction with mental health professionals' experiences and emotional states particularly in times of low stress.

Surprisingly, these findings contradict the mindfulness stress buffering framework proposed by Creswell and Lindsay (2014), as mindfulness increased the effect of stress on compassion satisfaction. There was a stronger negative relationship between compassion satisfaction and stress at average and high levels of mindfulness. It is possible that a buffering effect was not found since compassion satisfaction was a positive outcome. Literature on the stress buffering model typically examines resources that aid to lessen negative effects (e.g., agents that reduce the effect of stress on a disease, physiological outcome, negative health behaviors, etc.). Creswell and Lindsay (2014) primarily addressed the negative health outcomes within their mindfulness stress buffering account. Bergin and Pekenham (2016) utilized a stress-buffering framework and did not find a moderating effect of the mindfulness subscales on six psychological well-being outcomes (i.e., autonomy, environmental mastery, personal growth, positive relationships, purpose in life, and self-acceptance). However, they did find a buffering effect for the observing subscale of mindfulness on life satisfaction, which contrasts the current study's findings. Notable is that this is only one subscale of mindfulness that had a buffering effect on life satisfaction. Perhaps the stress-buffering model applies differently to positive outcomes, like compassion satisfaction, thus producing an enhancing relationship like the current study found between

stress and compassion satisfaction.

Furthermore, few studies examine the less positive implications of mindfulness, and most studies demonstrate that mindfulness reduces the effects of stress, which contradicts the results of this study. It is widely known that we tend to avoid, deny, or suppress negative or unwanted thoughts, feelings, and sensations. Since mindfulness involves awareness and acceptance (as opposed to suppression and avoidance), perhaps then the act of engaging in greater levels of mindfulness for clinicians creates an emotional awareness and or shift in perception about their stress levels and professional work that strengthens the relationship between stress and compassion satisfaction.

The relationship between perceived stress and compassion satisfaction varied by participants' level of mindfulness, however, there was not a significant interaction between composite mindfulness and perceived stress on compassion fatigue. The results provide support for an inverse relationship between mindfulness and compassion fatigue, such that the relationship between perceived stress and compassion fatigue is the same for low, average, and high levels of mindfulness. This supports the importance for the use and practice of mindfulness for mental health professionals, yet does not support a moderating effect for mindfulness on mental health professionals' perceived stress and compassion fatigue. Given that mindfulness moderated the relationship between perceived stress and compassion satisfaction, we would presume it to moderate the relationship between perceived stress and compassion fatigue, as well; however, this was not the case. This may be a result of the competing subscale interactions (i.e., observing subscale x stress and describing subscale x stress), since the describing subscale resulted in a weaker association

with compassion fatigue and the observing subscale resulted in a stronger association with compassion fatigue; therefore, pulling the interaction in different directions.

Composite Self-Compassion

To contrast, although self-compassion was positively correlated with mindfulness and compassion satisfaction, and negatively correlated with compassion fatigue there was not a main effect for self-compassion on compassion fatigue and compassion satisfaction. There was also no interaction effect between self-compassion and stress on compassion fatigue or compassion satisfaction. Therefore, self-compassion does not reduce or promote the impact of stress on the development of compassion satisfaction and fatigue, respectively.

Although mindfulness and self-compassion are two different constructs, they do share conceptual and operational overlap particularly related to the awareness and acceptance of experiences. Due to the conceptual overlap and research suggesting that mindfulness increases self-compassion (e.g., Irving et al., 2009; Raab, 2014; Shapiro et al., 2005; Shapiro et al., 2007), this study demonstrated that composite self-compassion does not uniquely contribute above and beyond what mindfulness accounts for in the relationship between perceived stress and compassion fatigue and satisfaction. Although the results suggest that there was a relationship between mindfulness, self-compassion, compassion fatigue, and compassion satisfaction without accounting for control variables (see bivariate correlations; Table 3); there were not significant relationships between self-compassion and compassion fatigue and self-compassion and compassion satisfaction, when accounting for mindfulness (see semi partial correlations; Table 9 and 10). However, it is also possible that self-compassion may mediate the observed interaction between mindfulness and the association

of stress to outcome variables, thus a possible mediated moderation, as studies have demonstrated that mindfulness increased self-compassion (e.g., Irving et al., 2009; Raab, 2014; Shapiro et al., 2005; Shapiro et al., 2007), self-compassion partially mediated the relationship between mindfulness and psychological wellbeing (Walker & Colosimo, 2011), and self-compassion mediated the relationship between mindfulness-based stress reduction and worry (Keng et al., 2012).

Furthermore, a lack of both a main and interaction effect could be because self-compassion entails attending to the experiencer and being free from their suffering, whereas mindfulness involves an awareness of the internal and external experience itself (Germer, 2009; Neff & Dahm, 2015). Therefore, it is possible that for mental health professionals and trainees it is more advantageous to attend to the experience as a mental health professional and their clients/patients, as opposed to themselves as the experiencer, in managing the effects of perceived stress on compassion fatigue and satisfaction. This is not to discredit the importance of mental health professionals practicing self-compassion, but rather suggest that mindfulness of the experience may be more advantageous than extending self-compassion to the experiencer in reducing compassion fatigue and promoting compassion satisfaction.

Subscales: Mindfulness and Self-Compassion

When examining the relationship between mindfulness and self-compassion subscales on compassion fatigue, the self-compassion subscales were not included in the model, as well as the non-reactivity (i.e., allowing thoughts to come and go) component of overall mindfulness. Specifically, the self-compassion subscales were not predictive of compassion fatigue, which is consistent with the composite model, which did not support a main effect

for self-compassion on compassion fatigue or compassion satisfaction. With regards to the subscales of mindfulness, acting with awareness, maintaining a nonjudgmental stance, and describing negatively predicted compassion fatigue, whereas observing positively predicted compassion fatigue. In contrast, the mindfulness subscale of self-compassion and the observing and describing subscales of mindfulness positively predicted compassion satisfaction. Noteworthy is that non-reactivity to one's inner experience, allowing thoughts and feelings to come and go without over-identifying with them, was not associated with compassion fatigue or compassion satisfaction.

Furthermore, there was not an interaction effect between stress and mindfulness subscales nor stress and self-compassion subscales within the compassion satisfaction model. However, there was an interaction between the describing subscale and stress on compassion fatigue, as well as the observing subscale and stress on compassion fatigue. Describing one's experience resulted in a weaker association between perceived stress and compassion fatigue, which supports the mindfulness stress buffering framework, as describing buffered the relationship between stress and compassion fatigue. High describing decreased the effect of stress on compassion fatigue. Observing one's sensations, emotions, and cognitions resulted in a stronger association of stress and compassion fatigue.

This suggests that there may be differences in the effect of observing versus describing one's experience on perceived stress and compassion fatigue. Describing one's experience may be more helpful in recognizing thoughts, feelings, and sensations as opposed to solely observing (i.e., noticing) the experience. This is further confirmed by Lieberman et al. (2007) who found that labeling affect (i.e., describing one's emotions), compared to other

forms of encoding (like observing), resulted in less amygdala activity, and therefore, aided in reducing participant's emotional reactivity. As well as Niles, Craske, Lieberman, and Hur (2015) who demonstrated that labeling one's affect when engaging in exposure public speaking exercises resulted in a reduction in participant's physiological arousal. Lieberman, Inagaki, Tabibnia, and Crockett (2011) proposed that affect labeling may in fact serve as a form of emotion regulation. This points to the neurological benefit of describing/labeling one's experience in managing affective responses compared to just observing the experience.

Previous research has demonstrated differing and at times less positive effects of the observing subscale compared to other mindfulness subscales. Bergin and Pakenham (2016) found that observing was associated with anxiety, yet they also found a buffering effect for observing on depression and life satisfaction. While Baer et al. (2008) found that observing was correlated with maladaptive constructs like dissociation and thought suppression. Baer et al. (2008) demonstrated that the effects of observing varied by meditation experience, such that observing was correlated with more adaptive constructs and characteristics in experienced meditators. They posited that more experienced meditators were less judgmental and reactive in response to observing their inner stimuli and were more likely to label their experience. Although over half of the current study's sample reported that they practiced a form of mindfulness-meditation it is unknown whether they would be considered experienced meditators. For the current sample, perhaps the act of observing one's experiences and reactions at higher levels of stress leads to greater awareness and acknowledgement of one's level of stress and compassion fatigue, and may produce a maladaptive reaction, which in turn may increase their own experience of compassion

fatigue.

Collectively, these findings allude to the unique benefits and roles of multiple components of mindfulness, not just the act of observing, since solely focusing on observing could make mental health clinicians more susceptible to stress. As noted, the non-reactivity subscale was not significant in either model. This does not suggest that non-reactivity is not effective at managing mental health professionals or trainees stress and susceptibility to compassion fatigue, but could indicate that non-reactivity is most effective in combination with other aspects of mindfulness or the benefits of non-reactivity are better captured in other component subscales of mindfulness. This sheds light on the importance of practicing the facets of mindfulness together in order to promote compassion satisfaction and protect against compassion fatigue.

When examining the subscales of self-compassion, mindfulness, assuming a balance awareness of one's negative thoughts and feelings (Neff & Dahm, 2015), was the most prominent component of self-compassion that predicted mental health professionals compassion satisfaction. Interestingly, this sample exhibited the highest mean on the mindfulness subscale of self-compassion compared to other self-compassion subscales. This may be because the sample has greater exposure and experience with aspects of mindfulness compared to other components of self-compassion, as over half of the sample reported that they practiced a form of mindfulness-meditation and or have attended one or more sessions, workshops, and or classes on mindfulness. Additionally, 20% of the sample reported that they use mindfulness, a theory that incorporates mindfulness or a mindfulness based program within their approach to counseling.

In addition, although the subscale of mindfulness in the self-compassion scale is narrower in scope compared to the more general form of mindfulness (Neff & Dahm, 2015), there is operational and conceptual overlap. As aforementioned, both mindfulness and self-compassion are correlated with higher levels of emotional intelligence (Brown & Ryan, 2003; Heffernan et al., 2010; Schutte & Malouff, 2011), which suggests that aspects of mindfulness and self-compassion may facilitate greater awareness of one's emotional states. Furthermore, mental health professionals exhibit greater emotional intelligence when compared to non-mental health professionals (Martin et al., 2004), therefore, it is assumed that emotional intelligence and perspective taking may be more inherent in mental health professionals. It then comes as little surprise that the sample of mental health professionals exhibited higher levels of mindfulness compared to other aspects of self-compassion.

Control Variables: Social Support and Age

When examining the control variables, social support did predict lower levels of compassion fatigue within the subscale compassion fatigue model, but not the composite model. Interestingly, age was not a significant predictor within the composite and subscale compassion satisfaction models, as higher social support predicted greater compassion satisfaction. Overall, this points to the benefit of social support in promoting compassion satisfaction, as well as combating compassion fatigue particularly when self-compassion is not present. When self-compassion is present, it appears that age, as opposed to one's level of social support, has a greater contribution to one's level of compassion fatigue. The fact that both social support and components of mindfulness and self-compassion were significant within the model, shed light on the importance of fostering both problem-focused coping

mechanisms (i.e., social support) and emotion-focused coping (e.g., mindfulness and self-compassion), as well as on and off the job wellness practices.

Additionally, age was a significant predictor of compassion fatigue within the composite mindfulness and self-compassion models, but not the subscale model. This suggests that increased age and experience may contribute to greater levels of compassion fatigue. As expected, social support, which aids in stress management and is common moderator within the stress buffering model, promoted compassion satisfaction and combated against compassion fatigue for both experienced professionals and trainees. This is consistent with the literature that social support buffers against stress (Cosley et al., 2010).

Differences in Mental Health Professionals and Trainees

Given that mindfulness and self-compassion are self-care practices that aid in managing stress and compassion fatigue, that experienced and in training mental health professionals have differential stressors, and both struggle with conflicts and restraints to their own self-care it was imperative to examine the unique differences between these two groups on the variables assessed within this study. Experienced and in training mental health professionals would both greatly benefit from the direct teaching and incorporation of these practices within training programs and professional development opportunities; however, they may benefit differently given their age, professional development, and varied stressors. Therefore, it is helpful to examine how these two groups differ on compassion fatigue, compassion satisfaction, mindfulness, and self-compassion in order to provide insight on ways to tailor these practices and/or training opportunities for licensed mental health professionals and those in training.

It comes as little surprise that experienced clinicians, whose mean age was higher than the sample of trainees, demonstrated higher levels of nonjudging (mindfulness) and self-kindness (self-compassion), as self-compassion and mindfulness vary by age and are both learned skills that can be fostered (Bishop et al., 2004; Brown & Ryan, 2003; Neff, 2003b; Neff & Vonk, 2009). Trainees may experience less kindness and greater isolation and judgment towards themselves, due to the stress, competition, and the evaluative nature present in graduate school. They also may be combatting feelings of anxiety and questioning self-efficacy that could in turn contribute to greater levels of isolation and judgment (Skovholt & Rønnestad, 2003). This speaks to the importance of fostering greater self-kindness and nonjudgment within mental health related graduate programs, as these are also skills clinicians can help their clients/patients foster.

In contrast, experienced clinicians within this sample exhibited greater levels of compassion fatigue, which could be attributed to heavier caseloads, more severe clientele and presenting concerns (including more work with abuse and trauma survivors), and greater time and years of practice. It is possible the longer work history of experienced clinicians, coupled with greater contact with trauma survivors, may make those who have been in the field longer more susceptible to compassion fatigue. It is assumed that trainees endorsed less compassion fatigue as they are just beginning their careers as mental health professionals and may have less client contact compared to their experienced counterparts. There were no differences between experienced clinicians and trainees on levels of compassion satisfaction, which contradicts Craig and Sprang (2010) who found that experienced clinicians reported higher compassion satisfaction; however, their sample involved clinicians who

predominately worked with traumatized clients. In addition, mental health professionals who have their own history of victimization may be at an increased risk of experiencing compassion fatigue, particularly if they work with or are exposed to clients who have abuse/trauma histories.

The current study did not examine differences between discipline or type of degree. In a comparison of clinical psychology graduate programs there were no differences in participant's stress levels across Ph.D., Psy.D. and Masters programs (Myers et al. 2012). Myers et al. posited that despite the programmatic differences, graduate students across degree programs exhibit similar levels of stress. Notable is that this finding is for clinical psychology programs and may not generalize to other disciplines. It is possible that specific program variables (e.g., funding, size, student to faculty ratio, emphasis on self-care, research/clinical focus, etc.) may impact mental health professionals stress, compassion fatigue, and self-care, which may then account for differences across disciplines and degrees. In addition, the characteristics and interests across disciplines may also impact a program's focus on wellness and incorporation of mindfulness and self-compassion practices. Historically, in relation to counseling and clinical psychology, which most the current sample endorsed, counseling psychology has exhibited a greater focus on professional issues and training compared to clinical psychology (Norcross, Sayette, Mayne, Karg & Turkson, 1998), which may impact student's awareness and approach to self-care and the incorporation of wellness practices like mindfulness and self-compassion. Further research is warranted to determine differences in stress, compassion fatigue and satisfaction, and the impact of mindfulness and self-compassion across discipline and degree program.

Implications

The current study encourages opportunities for mental health professionals, trainees, and training programs to either offer or attend classes or workshops that address/integrate self-care, mindfulness and self-compassion practices in order to aid mental health professionals in managing stress, reducing compassion fatigue, and promoting compassion satisfaction. Given the results, it appears more advantageous to focus more on training in mindfulness, as opposed to self-compassion, to promote compassion satisfaction.

Furthermore, mental health professionals would benefit from focusing on the various facets of mindfulness, as solely focusing on observing their experience may make them more susceptible to stress and compassion fatigue. It would also be advantageous to integrate an emphasis and training on the effects of describing one's experience, as that is the only component of mindfulness that aided in buffering the relationship between stress and compassion fatigue within the current study. Both formal and informal mindfulness practices that include a describing component are recommended in response to the current findings. Lastly, given the differences in trainees versus experienced mental health professionals, it would be important to emphasize aspects of self-kindness and common humanity with trainees.

One way to offer this training to graduate students is through providing courses that focus on self-care or integrating a greater focus on self-care and discussion of self-care within already established courses. Christopher and Maris (2010) conducted research over the course of ten years looking at the effects of integrating a self-care course specifically focused on mindfulness training called "Mind/Body Medicine and the Art of Self-Care"

within their training program. Across Christopher and colleagues' research, mindfulness and participation in a self-care course demonstrated benefits across physical, emotional, mental, and interpersonal domains. Similarly, Shapiro et al. (2007) demonstrated that participation in Mindfulness-Based Stress Reduction in a graduate course on Stress and Stress Management led to a reduction in stress and anxiety and an increase in self-compassion in a sample of counseling psychology graduate students. Taken together, these two studies provide support for the integration of mindfulness training and courses that promote self-care.

It is well known the negative impact of stress; however, until more recently, there has been limited research on the workload, stress, and wellbeing of psychology graduate students. Rummell (2015) assessed both clinical and counseling psychology graduate students' workload, health, and program satisfaction. They found that students reported spending almost 55 hours per week engaging in school related activities, 60% identified graduate school as the most stressful part of their life, and approximately half of the sample identified physical and mental health symptoms. In addition, 43.6% of the sample identified that their greatest dissatisfaction with their program was the limited emphasis placed on self-care, followed by 54.5% who identified their greatest dissatisfaction was with the amount of time for recreation. This speaks to the importance of integrating self-care practices within training programs.

This was further confirmed by Zahniser, Rupert, and Dorociak (2017), who found in a sample of clinical psychology students that graduate programs provided limited opportunities to learn about self-care. Bamonti et al. (2014) indicated that graduate students may not know best practices for self-care and suggested that students would benefit from training in self-

care. Zahniser and colleagues (2017) recommended that training programs would benefit from the incorporation of systematic instruction, active encouragement, modeling, and culture change in order to promote self-care, as students who perceived that their graduate program had a greater emphasis on self-care were more likely to engage in self-care themselves. Myers et al. (2012) proposed the importance of specifically teaching self-care behaviors as opposed to promoting a general concept of self-care. The current study, in conjunction with previous literature, proposes that mental health professionals and training programs could benefit from modeling, teaching and fostering mindfulness and self-compassion practices as specific self-care behaviors to aid in reducing stress and compassion fatigue and promoting compassion satisfaction.

Limitations and Future Directions

The exploratory nature of this study, the cross-sectional and correlational analysis, and the use of self-report measures impact the conclusions and generalizability of this study and should be interpreted with caution. This study relied on a convenience sample of experienced and in training mental health professionals from different fields; therefore, this study may not speak to the experiences of all mental health professionals, as a majority of the sample identified as woman, heterosexual, White/European American, and in or graduated from a Counseling Psychology program. However, the current sample is relatively comparable to the demographics of the psychology workforce (American Psychological Association, 2015). Since the current study did not employ an intervention, but rather relied on self-report data to assess mindfulness and self-compassion, no causal effects can be drawn about the effects of practicing mindfulness and self-compassion on compassion fatigue and

compassion satisfaction.

There were also limitations of the measurements used within the current study. The FFMQ loaded differently within the current sample, but since it has been extensively used in the mindfulness literature and reliability is satisfactory, the five-factor scale was retained. Similarly, the ProQOL did not load on three factors and the Burnout items were excluded, which draws into question the validity of the measure for the current study. Another methodological limitation was that social support was not missing at random, demonstrating that variables that were missing were due to participant's level of social support. Respondents with lower social support, were less likely to report their perceived social support, most notably on items related to support from a significant other.

Although there are several studies on the benefit of mindfulness for mental health professionals, this is one of three known studies that examined the relationship between self-compassion and compassion fatigue and satisfaction in mental health professionals, therefore, further research is needed to further clarify this relationship. In addition, this is the only known study that examined the moderating effect of both mindfulness and self-compassion on compassion fatigue and compassion satisfaction. Therefore, further research is needed to explore the unique contributions and differences among the subscales of mindfulness and self-compassion. As described previously, it is also possible that a more complex model, such as a mediated moderation, is warranted to assess these relationships. There are previous studies that have examined the effects of mindfulness (e.g., MBSR; Shapiro et al., 2007) as an intervention for mental health professionals, therefore, it would also be valuable to conduct future research on the effects of teaching self-compassion to experienced and in

training mental health professionals. Recognizing the impact of mental health professionals stress and compassion fatigue on their cliental, it would also be interesting to examine the effects of mental health professionals' trait and state mindfulness and self-compassion on their clinical practice and clients.

In conclusion, since mental health professionals, both experienced and in training, struggle with conflicts and restraints to their self-care, and training programs are limited in the self-care services they employ, it is important to provide education to mental health professionals on self-care and stress management interventions. The current study proposes that mental health professionals, both experienced and in training, could benefit from fostering mindfulness and self-compassion practices. These results suggest that incorporating mindfulness and self-compassion practices with mental health professionals may be helpful in reducing compassion fatigue and fostering compassion satisfaction.

Mindfulness and its subscales explained greater variance in the models compared to self-compassion. In particular, mindfulness enhanced the relationship between stress and compassion satisfaction, while the describing subscale of mindfulness buffered the impact of stress on compassion fatigue. Surprisingly, the observing subscale of mindfulness contributed to a more positive relationship between stress and compassion fatigue. This suggests the importance of practicing multiple components of mindfulness, not just observing on its own. Therefore, training programs and practices are encouraged to provide professional development and training on self-care practices, with more attention to emotion focused coping strategies like mindfulness and self-compassion practices.

APPENDIX A
RESEARCH ANNOUNCEMENT

Dear Mental Health Practitioners and Graduate Students,

My name is Jenny Schaafsma, and I am a doctoral student at the University of Missouri-Kansas City in Counseling Psychology. I am currently conducting a dissertation study on the impact of self-compassion and mindfulness on clinicians' wellbeing and work as a mental health professional.

In order to participate you must:

- Either currently enrolled in a training program that teaches psychotherapy or counseling OR a licensed practicing clinician who currently conducts psychotherapy/counseling
- If in training, must have completed at least one semester of practicum/clinical experiences
- See clients, patients, or students in a counseling or therapeutic capacity

The survey will take approximately 15 minutes to complete. If you choose to participate, you may have the chance to win one of ten \$25.00 gift cards to Amazon.com.

Please click on the link below if you are interested in participating:
<https://redcap.umkc.edu/surveys/?s=3RFYPK7C8M>

If you have any questions please contact Jenny Schaafsma at jenniferschaafsma@mail.umkc.edu or Dr. Carolyn Barber barberce@umkc.edu. You should contact the Office of UMKC's Social Sciences Institutional Review Board at 816-235-5927 if you have any questions, concerns or complaints about your rights as a research subject.

Thank you for taking the time to consider participating!

Sincerely,

Jenny Schaafsma, M.A.
Doctoral Candidate in Counseling Psychology
Division of Counseling and Educational Psychology
University of Missouri-Kansas City

APPENDIX B
INFORMED CONSENT

Request to Participate

As a licensed or in training mental health professional, you are being asked to take part in a research study conducted by Jennifer Schaafsma, M.A., and Dr. Carolyn Barber, through the University of Missouri-Kansas City, aimed at understanding the impact of self-compassion and mindfulness on clinicians' wellbeing and work as a mental health professional.

Eligibility and Purpose

- Either currently enrolled in a training program that teaches psychotherapy or counseling OR a licensed practicing clinician who currently conducts psychotherapy/counseling
- If in training, must have completed at least one semester of practicum/clinical experiences
- See clients, patients, or students in a counseling or therapeutic capacity

Procedures & Participation

If you agree to take part in this study, you will be involved in this study for approximately 15 minutes. Taking part in this research study is voluntary. There is no penalty for not participating and you have a right to withdraw from the current study at any time.

Risks & Inconveniences

There is a minimal risk that survey items may invoke a negative reaction; however, this risk is not anticipated. If you experience any adverse effects from participation in this study, you are encouraged to contact a colleague or seek access to a psychologist within your local area.

Benefits

There are no direct benefits to participating in this study.

Compensation

You may be selected as a winner of one of 10 \$25 Amazon gift-cards.

IRB Approval

This study has been approved by the University of Missouri-Kansas City IRB. If you have any questions, please contact the UMKC IRB at 816-235-5927 or umkcirb@umkc.edu.

Contact Persons

If you have any questions about this study or any problems arise, contact Jennifer Schaafsma (jsxc5@mail.umkc.edu) or Dr. Carolyn Barber (barberce@umkc.edu; 816-235-6151).

By electronically signing this consent form, you volunteer and consent to take part in this research study.

___ I have reviewed the informed consent and am willing to proceed.

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

1. Do you see clients, patients, or students in a counseling or psychotherapeutic capacity?
 - a. Yes
 - b. No (if not exited the survey)

2. Indicate your age: _____

3. Indicate your gender identity:
 - a. Man
 - b. Woman
 - c. Trans+
 - d. If not listed, please specify: _____

4. Indicate your sexual orientation:
 - a. Lesbian
 - b. Gay
 - c. Bisexual
 - d. Pansexual
 - e. Heterosexual
 - f. If not listed, please specify: _____

5. Which of the following ethnic/racial group(s) do you consider yourself a member of?
You can check multiple groups.
 - a. Arab/Middle Eastern
 - b. Asian/Pacific Islander
 - c. Biracial/Multiethnic
 - d. Black/African American
 - e. Caucasian/White
 - f. Hispanic/Latino/a
 - g. Multiracial/ethnic
 - h. Native American/American Indian
 - i. International (i.e., not native to the United States and U.S. culture)
 - j. If not listed, please specify: _____

6. Which of the following religious affiliations best describes you?
 - a. Protestant
 - b. Catholic
 - c. Fundamentalist/Evangelical Christian
 - d. Christian-Non-Denominational

- e. Jewish
- f. Muslim
- g. Hindu
- h. Buddhist
- i. Agnostic
- j. Atheist
- k. No Religious Affiliation
- l. If not listed, please specify: _____

7. How important is religion in your life?

- a. Not at all important
- b. Low importance
- c. Slightly important
- d. Neutral
- e. Moderately important
- f. Very important
- g. Extremely important

8. How important is spirituality in your life?

- a. Not at all important
- b. Low importance
- c. Slightly important
- d. Neutral
- e. Moderately important
- f. Very important
- g. Extremely important

9. Indicate your current academic/professional status: (*branch logic set up*)

- a. In training to become a professional clinician or mental health practitioner
- b. Completed training, yet either not licensed or are currently pursuing licensure
- c. Licensed professional clinician or mental health practitioner

10. How many years have you spent/did you spend in graduate training program(s)?

Please use decimal places when appropriate. For example, if you have been in training for two and a half years, indicate 2.5. (*ask to all, experienced and in training*)

11. During your graduate training program(s), how many years have you seen/did you see clients/patients/students in a counseling or therapeutic capacity? Please use decimal places when appropriate. For example, if you have seen clients for a year and a half, indicate 1.5. (*ask to all, experienced and in training*)

12. How many years of professional experience do you have (post-graduate work, including post doctorate positions)?
(branch logic, if participant answers b or c for question 8)
-
13. Indicate the degree you are currently seeking:*(branch logic, if participant answers a for question 8)*
- a. BA/BS
 - b. MA/MS
 - c. M. Ed.
 - d. Ed. S.
 - e. Psy.D
 - f. Ph.D
 - g. If not listed, please specify: _____
14. Indicate your highest level of professional training: *(branch logic, if participant answers b or c for question 8)*
- a. BA/BS
 - b. MA/MS
 - c. M. Ed.
 - d. Ed. S.
 - e. Psy.D
 - f. Ph.D
 - g. If not listed, please specify: _____
15. Indicate the discipline of your current degree program or highest degree earned:
- a. Mental Health Counseling
 - b. Counseling Psychology
 - c. Clinical Psychology
 - d. Community Counseling
 - e. Couples/Marriage and Family Therapy
 - f. School Psychology
 - g. School Counseling
 - h. If not listed, please specify: _____
16. What type of client/patient/student population(s) do you currently serve in a counseling or therapeutic capacity?
-
17. How many clients/patients/students do you typically see in a counseling or therapeutic capacity per week?
- a. 1-10
 - b. 11-20
 - c. 21-30

- d. 31-40
- e. 41-50
- f. 51 or more

18. Indicate the accreditation body of your current degree program or highest degree earned. If your program is currently going through the accreditation process, please indicate whose accreditation they are seeking. You may check multiple accreditation bodies, if applicable to your current degree or highest degree earned.

- a. American Psychological Association (APA)
- b. American Counseling Association (ACA)
- c. Council for Accreditation of Counseling & Related Educational Programs (CACREP)
- d. Master's in Psychology and Counseling Accreditation Council (MPCAC)
- e. Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
- f. Council for the Accreditation of Educator Preparation (CAEP)
- g. American School Counselor Association (ASCA)
- h. National Association of School Psychologists (NASP)
- i. I do not know my program's accreditation status.
- j. My program is not accredited.
- k. If not listed, please specify: _____

19. Indicate your theoretical orientation(s):

20. Do you actively practice a form of mindfulness-meditation?

- a. Yes
- b. No

21. How many professional development sessions, workshops, and/or classes on mindfulness have you attended?

- a. 0
- b. 1-3
- c. 4-6
- d. 7-9
- e. 10 or more.

APPENDIX D

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

Zimet, Dahlem, Zimet & Farley, 1988

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

1 = Very Strongly Disagree

2 = Strongly Disagree

3 = Mildly Disagree

4 = Neutral

5 = Mildly Agree

6 = Strongly Agree

7 = Very Strongly Agree

1. There is a special person who is around when I am in need.
2. There is a special person with whom I can share my joys and sorrows.
3. My family really tries to help me.
4. I get the emotional help and support I need from my family.
5. I have a special person who is a real source of comfort to me.
6. My friends really try to help me.
7. I can count on my friends when things go wrong.
8. I can talk about my problems with my family
9. I have friends with whom I can share my joys and sorrows.
10. There is a special person in my life who cares about my feelings.
11. My family is willing to help me make decisions.
12. I can talk about my problems with my friends.

APPENDIX E

COHEN'S PERCEIVED STRESS (CPSS)

Cohen, Kamarck, & Mermelstein, 1983

The following questions ask you about your feelings and thoughts during the last month. Please indicate how often you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and "stressed"?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. In the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that were outside of your control?
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

APPENDIX F

THE SELF-COMPASSION SCALE

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. Masters and dissertation students also have my permission to use and publish the Self-Compassion Scale in their theses. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.

Associate Professor Educational Psychology Dept.

University of Texas at Austin

e-mail: kneff@austin.utexas.edu

Reference: Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.

Coding Key:

Self-Kindness Items: 5, 12, 19, 23, 26

Self-Judgment Items: 1, 8, 11, 16, 21

Common Humanity Items: 3, 7, 10, 15

Isolation Items: 4, 13, 18, 25

Mindfulness Items: 9, 14, 17, 22

Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items before calculating subscale means - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a grand mean of all six subscale means. Researchers can choose to analyze their data either by using individual sub-scale scores or by using a total score.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the total score if a mean is used.)

APPENDIX G

THE FIVE-FACET MINDFULNESS QUESTIONNAIRE

Description: This instrument is based on a factor analytic study of five independently developed mindfulness questionnaires. The analysis yielded five factors that appear to represent elements of mindfulness as it is currently conceptualized. The five facets are observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. More information is available in:

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
never or very rarely true	rarely true	sometimes true	often true	very often or always true

1. When I'm walking, I deliberately notice the sensations of my body moving.
2. I'm good at finding words to describe my feelings.
3. I criticize myself for having irrational or inappropriate emotions.
4. I perceive my feelings and emotions without having to react to them.
5. When I do things, my mind wanders off and I'm easily distracted.
6. When I take a shower or bath, I stay alert to the sensations of water on my body.
7. I can easily put my beliefs, opinions, and expectations into words.
8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
9. I watch my feelings without getting lost in them.
10. I tell myself I shouldn't be feeling the way I'm feeling.
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
12. It's hard for me to find the words to describe what I'm thinking.
13. I am easily distracted.
14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
15. I pay attention to sensations, such as the wind in my hair or sun on my face.
16. I have trouble thinking of the right words to express how I feel about things.
17. I make judgments about whether my thoughts are good or bad.
18. I find it difficult to stay focused on what's happening in the present.
19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21. In difficult situations, I can pause without immediately reacting.
22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
23. It seems I am "running on automatic" without much awareness of what I'm doing.
24. When I have distressing thoughts or images, I feel calm soon after.

25. I tell myself that I shouldn't be thinking the way I'm thinking.
26. I notice the smells and aromas of things.
27. Even when I'm feeling terribly upset, I can find a way to put it into words.
28. I rush through activities without being really attentive to them.
29. When I have distressing thoughts or images I am able just to notice them without reacting.
30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
32. My natural tendency is to put my experiences into words.
33. When I have distressing thoughts or images, I just notice them and let them go.
34. I do jobs or tasks automatically without being aware of what I'm doing.
35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.
36. I pay attention to how my emotions affect my thoughts and behavior.
37. I can usually describe how I feel at the moment in considerable detail.
38. I find myself doing things without paying attention.
39. I disapprove of myself when I have irrational ideas.

Scoring Information:

Observe items: 1, 6, 11, 15, 20, 26, 31, 36

Describe items: 2, 7, 12R, 16R, 22R, 27, 32, 37

Act with Awareness items: 5R, 8R, 13R, 18R, 23R, 28R, 34R, 38R

Nonjudge items: 3R, 10R, 14R, 17R, 25R, 30R, 35R, 39R

Nonreact items: 4, 9, 19, 21, 24, 29, 33

Reference:

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27- 45.

APPENDIX H

PROQOL-V (Stamm, 2010)

Professional Quality of Life Scale (ProQOL) *Compassion Satisfaction and Compassion Fatigue* (*ProQOL*) Version 5 (2009)

When you *help people through counseling and psychotherapy* you have direct contact with their lives. As you may have found, your compassion for those you [*help*] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [*mental health practitioner*]. Consider each of the following questions about you and your *work as a mental health practitioner*. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I [*help*].
3. I get satisfaction from being able to [*help*] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [*help*].
7. I find it difficult to separate my personal life from my life as a [*mental health practitioner*].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [*help*].
9. I think that I might have been affected by the traumatic stress of those I [*help*].
10. I feel trapped by my job as a [*mental health practitioner*].
11. Because of my [*helping*], I have felt "on edge" about various things.
12. I like my work as a [*mental health practitioner*].
13. I feel depressed because of the traumatic experiences of the people I [*help*].
14. I feel as though I am experiencing the trauma of someone I have [*helped*].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [*counseling and psychotherapy*] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [*mental health practitioner*].
20. I have happy thoughts and feelings about those I [*help*] and how I could help them.

21. I feel overwhelmed because my case [*work*] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [*help*].
24. I am proud of what I can do to [*help*].
25. As a result of my [*helping*], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [*mental health practitioner*].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Copy Right Information: © B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. /www. isu. edu/~bhstamm or www. proqol. org. The ProQOL measure may be freely copied and used as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for / [helper] / if that is not the best term. For example, if you are working with teachers, replace / [helper] /with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group. Additionally you are granted permission to convert the ProQOL into other formats such as a computerized or taped version for the visually impaired.

Note: Burnout data will be collected for future research but will not be analyzed in this study.

Compassion Satisfaction Items: 3, 6,12, 16, 18, 20, 22, 24, 27, 30

Burnout Items: 1R, 4R, 8, 10, 15R, 17, 19, 21, 26, 29

Compassion Fatigue/Secondary Traumatic Stress Items: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28

Table 1
Training and Experience

Training, and Experience Characteristics	N (%)
Discipline (current degree program or highest degree earned)	
Counseling Psychology	129 (41.7%)
Clinical Psychology	85 (27.5%)
Mental Health Counseling	49 (15.9%)
Couples/Marriage and Family Therapy	11 (3.6%)
Community Counseling	13 (4.2%)
Social Work	14 (4.5%)
School Psychology	2 (.6%)
School Counseling	2 (.6%)
Educational Psychologist	1 (.3%)
Counselor Education and Supervision	1 (.3%)
Degree Pursuing (those in training; N = 167)	
Ph.D	109 (35.3%)
Psy.D	34 (11%)
MA/MS	24 (7.8%)
Accreditation Body (current degree program or highest degree earned; option to select multiple)	
American Psychological Association	200 (64.7%)
American Counseling Association	19 (6.1%)
Council for Accreditation of Counseling and Related Educational Programs	48 (15.5%)
Commission on Accreditation for Marriage and Family Therapy Education	8 (2.6%)
Master's in Psychology and Counseling Accreditation Council	5 (1.6%)
National Association of School Psychologists	2 (.6%)
Council on Social Work Education	9 (2.5%)
National Association of Social Workers	7 (2.2%)
Did not know program's accreditation status	16 (5.2%)
Program was not accredited	6 (1.9%)
Other	7 (1.8%)
Theoretical Orientations	
Eclectic/Integrative	185 (59.9%)
Cognitive/Behavioral/CBT/Third-wave CBT	72 (23.3%)
Humanistic/Existential	12 (3.9%)
Psychoanalytic/dynamic	11 (3.6%)
Interpersonal	6 (1.9%)
Other (e.g., feminist, constructivist, pluralistic, narrative)	11 (3.6%)
Participants did not disclose their theoretical orientation	12 (3.9%)
Number of clients per week	
1 to 10	151 (48.9%)
11 to 20	94 (29.1%)
21 to 30	54 (17.5%)
31 or more	13 (4.2%)

Client/Patient/Student Population	
Students/University Counseling Center	82 (26.5%)
All ages	65 (21%)
Young Adults/Adults	37 (12%)
Children/Adolescents	23 (7.4%)
Children/Adolescents/Families	12 (3.9%)
Offenders, Court Mandated Individuals, or in Forensics	9 (2.9%)
Multiple Settings (e.g., counseling center and hospital, counseling center and community mental health or private practice, VA and private practice)	25 (8.1%)
Specific Presenting Concerns	10 (3.2%)
Mindfulness Experience	
Practice a form of mindfulness-meditation	156 (50.5%)
Attended one or more sessions, workshops, and or classes on mindfulness	260 (84.1%)
Use mindfulness, a theory that incorporates mindfulness or a mindfulness based program within their approach to counseling (within qualitative theoretical orientation response)	55 (17.8%)

Table 2
Descriptive Statistics and Reliability Analysis

	Cronbach's Alpha	Total (trainees and experienced) Mean (S.D.)	In Training Mean (S.D.)	Experienced Mean (S.D.)
Perceived Stress	.88	14.18 (5.99)	15.35 (6.05)	12.81 (5.66)
Social Support	.94	5.80 (1.04)	5.79 (1.03)	5.81 (1.06)
Total Self-Compassion	.90	3.59 (.69)	3.38 (.65)	3.84 (.65)
Self-Kindness	.87	3.40 (.83)	3.21 (.75)	3.63 (.87)*
Self-Judgment	.89	2.42 (.91)	2.65 (.91)	2.16 (.83)
Common Humanity	.78	3.46 (.82)	3.25 (.79)	3.72 (.78)
Isolation	.84	2.29 (.93)	2.53 (.95)*	2.01 (.84)
Mindfulness	.76	3.72 (.70)	3.54 (.66)	3.94 (.69)
Overidentification	.80	2.32 (.84)	2.55 (.83)	2.06 (.77)
Total Mindfulness	.79	140.38 (20.92)	134.43 (19.27)	147.37 (20.68)
Observing	.85	27.14 (5.68)	25.55 (5.11)	29.01 (5.75)
Describing	.92	31.75 (5.81)	31.05 (5.79)	32.57 (5.74)
Awareness	.88	27.19 (5.73)	26.09 (5.71)	28.48 (5.50)
Nonjudging	.94	31.14 (6.63)	29.74 (7.00)	32.79 (5.76)**
Nonreactivity	.86	23.16 (4.47)	22.01 (4.09)	24.52 (4.53)
Compassion Fatigue	.90	18.19 (5.35)	17.51 (4.72)	18.99 (5.92)*
Compassion Satisfaction	.84	41.95 (5.34)	41.51 (5.39)	42.47 (5.24)

*Significant differences between trainees and experienced clinicians; $p \leq .05$

**Significant differences between trainees and experienced clinicians; $p \leq .001$

Table 3
Bivariate Correlations

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Stress	—															
2. Compassion Fatigue	.39*	—														
3. Compassion Satisfaction	-.39*	-.25*	—													
4. Self-Kindness	-.49*	-.19*	.39*	—												
5. Self-Judgment	.58*	.28*	-.29*	-.69*	—											
6. Common Humanity	-.36*	-.06	.29*	.53*	-.32*	—										
7. Isolation	.52*	.26*	-.34*	-.56*	.72*	-.42*	—									
8. Subscale Mindfulness	-.56*	-.20*	.44*	.75*	-.56*	-.63*	-.57*	—								
9. Over-identified	.64*	.27*	-.29*	-.58*	.77*	-.46*	.75*	-.63*	—							
10. Self- Compassion	-.64*	-.26*	.41*	.83*	-.85*	.69*	-.83*	.83*	-.86*	—						
11. Observing	-.26*	-.01	.33*	.37*	-.25*	.38*	-.26*	.43*	-.31*	.40*	—					
12. Describing	-.29*	-.25*	.33*	.43*	-.34*	.27*	-.32*	.46*	-.32*	.43*	.33*	—				
13. Awareness	-.48*	-.29*	.29*	.41*	-.45*	.31*	-.41*	.46*	-.51*	.53*	.44*	.42*	—			
14. Non-reactivity	-.56*	-.17*	.37*	.63*	-.53*	.52*	-.51*	.71*	-.62*	.71*	.47*	.37*	.53*	—		
15. Non-judging	-.57*	-.35*	.30*	.62*	-.66*	.36*	-.58*	.58*	-.64*	.71*	.34*	.39*	.47*	.61*	—	
16. Composite Mindfulness	-.58*	-.30*	.43*	.66*	-.61*	.49*	-.57*	.71*	-.65*	.69*	.69*	.68*	.77*	.78*	.77*	—

* $p \leq .01$

Table 4
Factor Loadings for Five Mindfulness Subscale Factors

Item	Loading
Nonjudging Subscale	
I criticize myself for having irrational or inappropriate emotions.	.61
I tell myself I shouldn't be feeling the way I'm feeling.	.76
I believe some of my thoughts are abnormal or bad and I shouldn't think that way.	.84
I make judgments about whether my thoughts are good or bad.	.82
I tell myself that I shouldn't be thinking the way I'm thinking.	.89
I think some of my emotions are bad or inappropriate and I shouldn't feel them.	.84
When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.	.77
I disapprove of myself when I have irrational ideas.	.79
Describe Subscale	
I'm good at finding words to describe my feelings.	.86
I can easily put my beliefs, opinions, and expectations into words.	.78
It's hard for me to find the words to describe what I'm thinking.	.70
I have trouble thinking of the right words to express how I feel about things.	.73
When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.	.57
Even when I'm feeling terribly upset, I can find a way to put it into words.	.75
My natural tendency is to put my experiences into words.	.82
I can usually describe how I feel at the moment in considerable detail.	.87
Awareness Subscale	
When I do things, my mind wanders off and I'm easily distracted.	.72
I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.	.73
I am easily distracted.	.73
I find it difficult to stay focused on what's happening in the present.	.63
It seems I am "running on automatic" without much awareness of what I'm doing.	.67
I rush through activities without being really attentive to them.	.78
I do jobs or tasks automatically without being aware of what I'm doing.	.73
I find myself doing things without paying attention.	.88
Observe Subscale	
When I'm walking, I deliberately notice the sensations of my body moving.	.55
When I take a shower or bath, I stay alert to the sensations of water on my body.	.70

I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.	.47
I pay attention to sensations, such as the wind in my hair or sun on my face.	.80
I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.	.79
I notice the smells and aromas of things.	.65
I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.	.72
I pay attention to how my emotions affect my thoughts and behavior.	.17
Nonreact Subscale	
I perceive my feelings and emotions without having to react to them.	.55
I watch my feelings without getting lost in them.	.66
When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it.	.64
In difficult situations, I can pause without immediately reacting.	.58
When I have distressing thoughts or images, I feel calm soon after.	.55
When I have distressing thoughts or images I am able just to notice them without reacting.	.90
When I have distressing thoughts or images, I just notice them and let them go.	.64

Table 5
Factor Loadings for the Six Self-Compassion Subscales

Item	Loading
Self-Kindness	
I try to be loving towards myself when I'm feeling emotional pain.	.77
When I'm going through a hard time, I give myself the caring and tenderness I need.	.78
I'm kind to myself when I experiencing suffering.	.90
I'm tolerant of my own flaws and inadequacies.	.37
I try to be understanding and patient towards those aspects of my personality I don't	.76
Self-Judgment	
I'm disapproving and judgmental about my own flaws and inadequacies.	.79
When times are really difficult, I tend to be tough on myself.	.78
I'm intolerant and impatient towards those aspects of my personality I don't like.	.74
When I see aspects of myself that I don't like, I get down on myself.	.85
I can be a bit cold-hearted towards myself when I'm experiencing suffering.	.55
Common Humanity	
When things are going badly for me, I see the difficulties as part of life that everyone	.49
When I'm down and out, I remind myself that there are lots of other people in the world	.76
When I feel inadequate in some way, I try to remind myself that feelings of inadequacy	.81
I try to see my failings as part of the human condition.	.56
Isolation	
When I think about my inadequacies, it tends to make me feel more separate and cut	.65
When I'm feeling down I tend to feel like most people are probably happier than I am.	.90
When I'm really struggling, I tend to feel like other people must be having an easier	.79
When I fail at something that's important to me, I tend to feel alone in my failure.	.66
Mindfulness	
When something upsets me I try to keep my emotions in balance.	.57
When something painful happens I try to take a balanced view of the situation.	.71
When I fail at something important to me I try to keep things in perspective.	.83
When I'm feeling down I try to approach my feelings with curiosity and openness.	.57
Over-Identification	
When I'm feeling down I tend to obsess and fixate on everything that's wrong.	.61
When I fail at something important to me I become consumed by feelings of	.42
When something upsets me I get carried away with my feelings.	.78
When something painful happens I tend to blow the incident out of proportion.	.77

Table 6
Factor Loadings for PROQOL subscales

Item	Loading
Compassion Satisfaction	
I get satisfaction from being able to <i>[help]</i> people.	.70
I feel invigorated after working with those I <i>[help]</i> .	.63
I like my work as a <i>[mental health practitioner]</i> .	.77
I am pleased with how I am able to keep up with <i>[counseling and psychotherapy]</i>	.51
My work makes me feel satisfied.	.75
I have happy thoughts and feelings about those I <i>[help]</i> and how I could help them.	.76
I believe I can make a difference through my work.	.74
I am proud of what I can do to <i>[help]</i> .	.77
I have thoughts that I am a "success" as a <i>[mental health practitioner]</i> .	.66
I am happy that I chose to do this work.	.75
Compassion Fatigue	
I am preoccupied with more than one person I <i>[help]</i> .	.42
I jump or am startled by unexpected sounds.	.34
I find it difficult to separate my personal life from my life as a <i>[mental health</i>	.57
I think that I might have been affected by the traumatic stress of those I <i>[help]</i> .	.75
Because of my <i>[helping]</i> , I have felt "on edge" about various things.	.72
I feel depressed because of the traumatic experiences of the people I <i>[help]</i> .	.71
I feel as though I am experiencing the trauma of someone I have <i>[helped]</i> .	.83
I avoid certain activities or situations because they remind me of frightening experiences	.64
As a result of my <i>[helping]</i> , I have intrusive, frightening thoughts.	.79
I can't recall important parts of my work with trauma victims.	.43

Table 7
Inter-correlations of Mindfulness Factors

	Nonjudge	Describe	Awareness	Observe	Nonreact
Nonjudge	–				
Describe	.39	–			
Awareness	.49	.45	–		
Observe	.30	.26	.42	–	
Nonreact	.61	.39	.55	.46	–

Table 8
Inter-correlations of Self Compassion Factors

Correlation	Correlation Coefficient
Self-Kindness & Self-Judgment	-.70
Common Humanity & Isolation	-.46
Mindfulness & Over-Identification	-.73

Table 9

Hierarchical Regression Analysis with Compassion Fatigue as Dependent Variable

Steps	Variable	b (SE)	β	t	sr	R	R ²	F	ΔR^2
1						.39	.15	55.38***	.15
	Stress	.35(.05)	.40	7.44***	.40				
2						.40	.16	19.83***	.01
	Stress	.32 (.06)	.35	5.09***	.27				
	Self-Compassion	.66 (.67)	.08	.98	.05				
	Mindfulness	-.40 (.02)	-.16	-1.93	-.10				
3						.41	.16	11.87***	.001
	Stress	.31 (.06)	.35	4.90***	.26				
	Self-Compassion	.68 (.67)	.09	1.01	.05				
	Mindfulness	-.04 (.02)	-.16	-1.96*	-.10				
	Stress X Self-Compassion	-.04 (.10)	-.4	-.41	-.02				
	Stress X Mindfulness	.001 (.003)	.02	.20	.01				
4						.45	.20	10.60***	.03
	Stress	.31 (.06)	.35	4.99***	.26				
	Self-Compassion	.39 (.67)	.050	.58	.03				
	Mindfulness	-.05(.02)	-.20	-2.52*	-.13				
	Stress X Self-Compassion	-.04(.10)	-.03	-.38	-.02				
	Stress X Mindfulness	.002 (.003)	.044	.50	.03				
	Age	.08 (.03)	.19	3.28***	.17				
	Social Support	-.28 (.27)	-.05	-1.02	-.05				

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 10

Hierarchical Regression Analysis with Compassion Satisfaction as Dependent Variable

Steps	Variable	b (SE)	β	t	sr	R	R ²	F	ΔR^2
1						.38	.15	54.90***	.15
	Stress	-.35 (.05)	-.40	-7.41***	-.39				
2						.47	.22	28.97***	.07
	Stress	-.15(.06)	-.17	-2.54*	-.13				
	Self-Compassion	.92 (.64)	.12	1.43	.07				
	Mindfulness	.06 (.02)	.25	3.16**	.16				
3						.50	.25	20.28***	.03
	Stress	-.18(.06)	-.20	-2.98**	-.15				
	Self-Compassion	.77 (.64)	.10	1.21	.06				
	Mindfulness	.06 (.02)	.25	3.23***	.16				
	Stress X Self-Compassion	.117 (.10)	.10	1.22	.06				
	Stress X Mindfulness	-.01(.00)	-.24	-2.90**	-.14				
4						.52	.27	16.17***	.02
	Stress	-.17(.06)	-.19	-2.81**	-.14				
	Self-Compassion	.53 (.64)	.07	.83	.04				
	Mindfulness	.06 (.02)	.25	3.25**	.16				
	Stress X Self-Compassion	.11 (.10)	.10	1.16	.06				
	Stress X Mindfulness	-.01 (.00)	-.24	-2.81**	-.14				
	Age	.02 (.02)	.04	.71	.04				
	Social Support	.78 (.26)	.15	3.03**	.15				

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 11

Hierarchical Regression Analysis with Subscales and Compassion Fatigue as Dependent Variable

Steps	Variable	b (SE)	β	t	sr	R	R ²	F	ΔR^2
1						.44	.19	17.81***	.19
	Nonjudging	-.22 (.05)	-.27	-4.45***	-.23				
	Awareness	-.20 (.06)	-.22	-3.42***	-.18				
	Observing	.21 (.06)	.23	3.82***	.20				
	Describing	-.12 (.05)	-.13	-2.21*	-.11				
2						.48	.23	17.81***	.04
	Nonjudging	-.12 (.06)	-.16	-2.42*	-.12				
	Awareness	-.15 (.06)	-.15	-2.27*	-.12				
	Observing	.21 (.05)	.22	3.79***	.19				
	Describing	-.12 (.05)	-.13	-2.25*	-.11				
	Perceived Stress	.22 (.06)	.25	3.82***	.19				
3						.50	.25	10.86***	.02
	Nonjudging	-.12 (.06)	-.15	-2.17*	-.11				
	Awareness	-.15 (.06)	-.16	-2.41*	-.12				
	Observing	.21 (.06)	.22	3.77***	.19				
	Describing	-.10 (.05)	-.11	-1.93	-.10				
	Perceived Stress	.23 (.06)	.25	3.93***	.20				
	Stress X	-.01 (.01)	-.04	-.67	-.03				
	Nonjudging								
	Stress X Awareness	.01 (.01)	.08	1.1888	-.06				
	Stress X Observing	.01 (.01)	.10	1.62	.08				
	Stress X Describing	-.02 (.01)	-.13	-2.15*	-.11				
4						.52	.28	10.22***	.03
	Nonjudging	-.14 (.06)	-.17	-2.52*	-.13				
	Awareness	-.14 (.06)	-.15	-2.29*	-.11				
	Observing	.16 (.06)	.16	2.77**	.14				
	Describing	-.11 (.05)	-.12	-2.03*	-.10				
	Perceived Stress	.25 (.06)	.28	4.29***	.21				
	Stress X	-.00 (.01)	-.03	-.51	-.03				
	Nonjudging								
	Stress X Awareness	.01 (.01)	.07	1.11	.06				
	Stress X Observing	.02 (.01)	.14	2.21*	.11				
	Stress X Describing	-.02 (.01)	-.14	-2.30*	-.11				
	Age	.08 (.02)	.18	3.23	.16				
	Social Support	-.21 (.26)	-.04	-.80**	-.04				

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

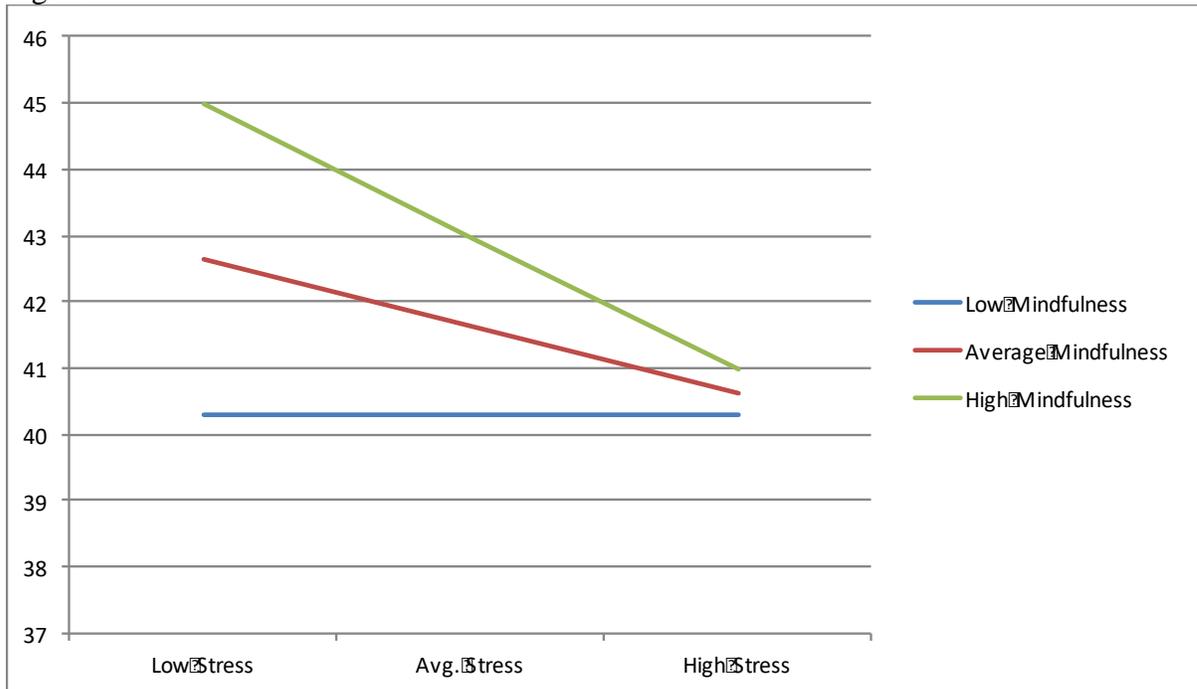
Table 12

Hierarchical Regression Analysis with Subscales and Compassion Satisfaction as Dependent Variable

Steps	Variable	b (SE)	β	t	sr	R	R ²	F	ΔR^2
1						.48	.23	30.79***	.23
	Mindfulness (Self-Compassion)	2.35 (.46)	.31	5.18***	.26				
	Observing (Mindfulness)	.14 (.05)	.15	2.70**	.14				
	Describing (Mindfulness)	.13 (.05)	.14	2.49*	.13				
2						.51	.26	26.70***	.03
	Mindfulness	1.54 (.51)	.20	3.00**	.15				
	Observing	.114 (.05)	.15	2.70**	.13				
	Describing	.12 (.05)	.14	2.40*	.12				
	Perceived Stress	-.18 (.05)	-.20	-3.37**	-.17				
3						.53	.28	16.40***	.02
	Mindfulness	1.40 (.51)	.18	2.73**	.13				
	Observing	.13 (.05)	.14	2.52*	.12				
	Describing	.13 (.05)	.14	2.50*	.12				
	Perceived Stress	-.19 (.05)	-.21	-3.43***	-.17				
	Stress X Mindfulness	.05 (.07)	.05	.73	.04				
	Stress X Observing	-.02 (.01)	-.12	-1.73	-.09				
	Stress X Describing	-.01 (.01)	-.07	-1.15	-.06				
4						.54	.30	13.86***	.02
	Mindfulness	1.19 (.52)	.16	2.30*	.11				
	Observing	.14 (.05)	.15	2.68**	.13				
	Describing	.12 (.05)	.13	2.31*	.11				
	Perceived Stress	-.18 (.05)	-.20	-3.30***	-.16				
	Stress X Mindfulness	.05 (.07)	.04	.63	.03				
	Stress X Observing	-.02 (.01)	-.12	-1.75	-.08				
	Stress X Describing	-.01 (.01)	-.06	-1.07	-.05				
	Age	.01 (.02)	.02	.38	.02				
	Social Support	.72 (.26)	.14	2.80**	.14				

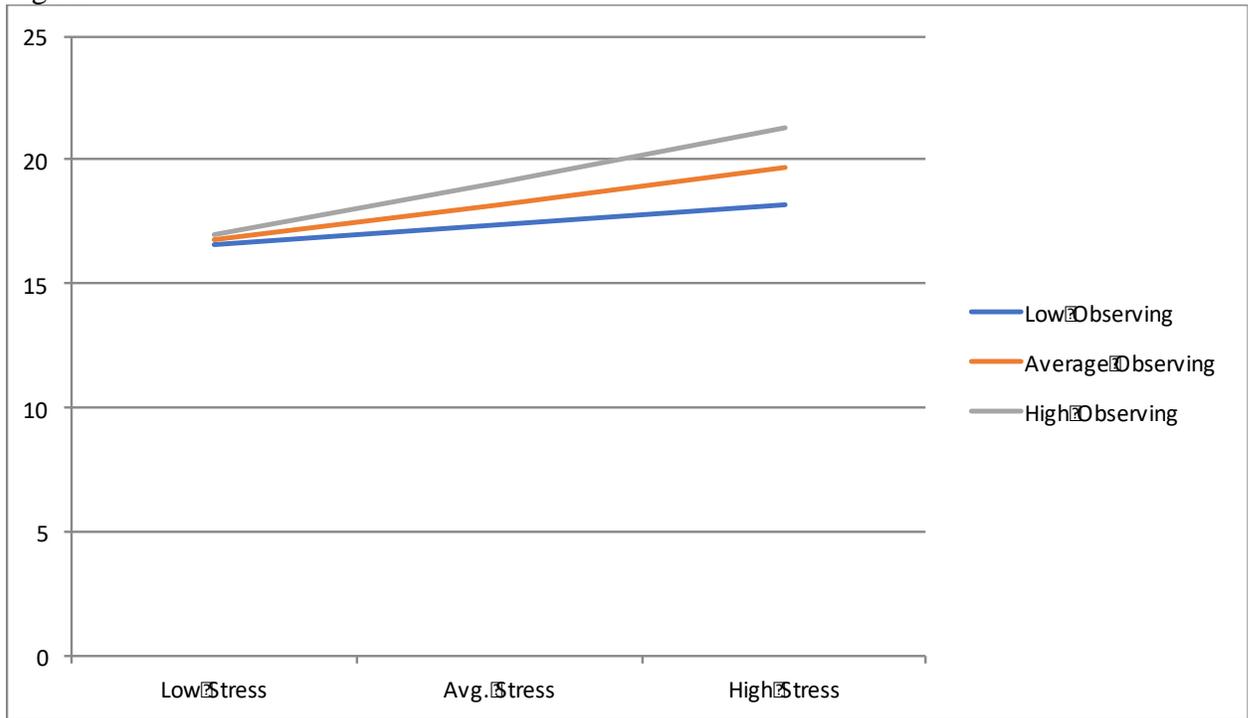
* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Figure 1



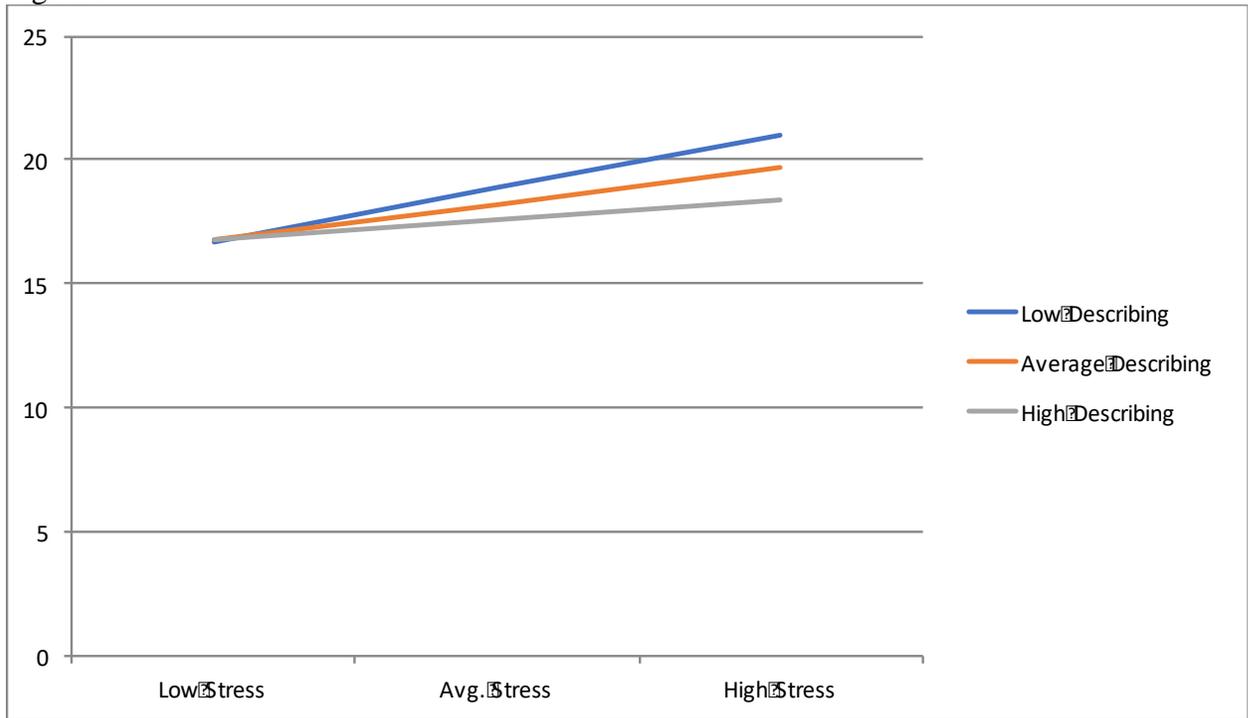
Interaction of Composite Mindfulness and Stress on Compassion Satisfaction

Figure 2



Interaction of Observing Subscale of Mindfulness and Stress on Compassion Fatigue

Figure 3



Interaction of Describing Subscale of Mindfulness and Stress on Compassion Fatigue

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