Mindfulness, Compassion Fatigue, and Compassion Satisfaction among Social Work Interns

James T. Decker, Jodi L. Constantine Brown, Jacqueline Ong, and Crystal A. Stiney-Ziskind

This exploratory study examined the relationship between mindfulness, an evidence-based practice model, and the risk for compassion fatigue and potential for compassion satisfaction among master's level social work student interns. MSW student interns (N=111) completed the Professional Quality of Life Scale (Stamm, 2010) and the Five Facets of Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer & Toney, 2006) to examine the effects of mindfulness as it relates to compassion fatigue and compassion satisfaction. Data revealed that greater levels of mindfulness positively correlated with greater potential for compassion satisfaction ($r = .46$, $p < .00$) while lower levels of mindfulness increased a student's risk for compassion fatigue ($r = -.53$, $p < .00$). Results suggest that mindfulness may be an important variable in mitigating compassion fatigue and increasing compassion satisfaction for helping professionals.

Many social workers are motivated to enter their chosen profession due to compassion for others and an "altruistic desire to improve individual and societal conditions" (Radey & Figley, 2007, p. 207). However, the cost of that compassion may be high. Stebnicki (2007) shared that an ancient Native American teaching holds that "each time you heal someone, you give away a piece of yourself until, at some point, you will require healing" (p. 317).

This paper explores the relationship between compassion fatigue, compassion satisfaction, and mindfulness. The paper begins with a brief introduction of spirituality that includes an overview of mindfulness. Following the definitions of key concepts, previous literature about compassion fatigue, compassion satisfaction, and mindfulness is reviewed in depth. Methods for the current study are described, followed by results, discussion, and implications for Christians in social work.

Social Work & Christianity, Vol. 42, No. 1 (2015), 28-42
Journal of the North American Association of Christians in Social Work

Spirituality, Mindfulness, Compassion Fatigue and Compassion Satisfaction

Social workers are at high risk for compassion fatigue, and many empirical studies have shown that religiosity or spirituality is an important personal coping skill for managing stressful life events, such as health problems and grief over loss or death (McCormick, Holder, Wetsel, & Cawthon, 2001; Sowell, Moneyham, Hennessy, Guillory, Demi, & Seals, 2000). The presence of these attributes in people relates positively to their psychological well-being and health (Kendler, Liu, Gardner, McCullough, Larson & Prescott, 2003; Yoon & Lee, 2004). Researchers have indicated that specific religious or spiritual factors such as forgiveness, religious support networks, or transpersonal experiences are associated with life satisfaction, depression, emotional distress, happiness, or physical health (Bono, Mcullough, & Root, 2008; Ellison, 1983; Lee, Besthorn, Bolin, & Jun, 2012).

Numerous definitions of spirituality exist (see Holloway & Moss, 2010) and a universal definition of the term "spirituality" has yet to be accepted (Gilham, 2012). According to Griffith and Griffith (2002), "spirituality is a commitment to choose, as the primary context for understanding and acting, one's relatedness with all that is" (p. 15). The focus is on relationships between the self and other people, the environment, heritage and traditions, ancestors, and a "Higher Power, or God" (Griffith & Griffith, 2002, p. 15). Spirituality places relationships at the center of awareness, whether they are relationships with the world, other people, God, or other nonmaterial beings (Griffith & Griffith, 2002, p. 16).

Practicing spirituality takes myriad forms including, but not limited to, prayer, meditation, breathing exercises, giving back, and mindfulness. The origin of mindfulness comes from Buddhist practice and philosophy; however, the experience of mindfulness can be found in many cultural, spiritual, and religious customs. Interest from social work into the benefits of mindfulness has grown considerably in the last ten years. Mindfulness, as it relates to social work practice, can be defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding moment to moment" (Germer, Siegel & Fulton, 2005, pp. 6-7). Mindfulness in relation to psychotherapy includes the components of awareness, present experience, and acceptance (Germer et al., 2005).

Previous studies have shown the benefits of mindfulness as an intervention for caring professionals which suggests a positive relationship with compassion satisfaction (Baker, 2003; Bush, 2009; Christopher & Maris, 2010; Figley, 2002), but mindfulness training, like many spiritual or religious activities, is not readily available to social workers. The purpose of this study is to explore the relationship between mindfulness, compassion fatigue, and compassion satisfaction in MSW interns who have had no particular exposure to mindfulness.

Compassion Fatigue

Working with suffering individuals is an unavoidable component of being in a care-giving profession. For social workers, the use of empathy is a necessary part of the work that is done, while at the same time it creates greater risk to the professional for what is known as compassion fatigue. This term, first introduced by Joinson (1992), describes the gradual lessening of compassion among care-giving professionals who work with traumatized individuals. Figley (1995) referred to this as "the cost of caring" (p. 103), and it can exact a spiritual cost that reduces one's capacity or interest in "bearing the suffering of others" (Figley, 2002, p. 434). Symptoms of compassion fatigue emerge suddenly and without warning and can include emotional and physical exhaustion, a tendency to withdraw, and high levels of stress (Gough, 2007). Irritability, helplessness, a sense of isolation, depression, and confusion are all common symptoms among those suffering from compassion fatigue (Bush, 2009; Huggard, 2003). After a period of time, compassion fatigue may produce distrust, negativism, and inflexibility, ultimately isolating social workers from helping their clients in a personal way (Decker, Bailey, & Westergaad, 2002).

Compassion fatigue is often used interchangeably with other terms such as vicarious traumatization, secondary traumatic stress, and burnout, defined as a breakdown of the psychological defense that workers use to adapt to and cope with intense job related stressors (Kreisher, 2002). As compassion fatigue develops, workers might feel emotionally exhausted or fatigued, withdraw emotionally from clients, and perceive a diminution of their achievements or accomplishments (Kreisher, 2002). Stress also may lead to increased burnout (Spickard, Gabbe, & Christensen, 2002), demarcated as a syndrome of depersonalization, emotional exhaustion and a sense of low personal accomplishment. Shanafelt, Bradley, Wipf, and Back (2002) found that burnout was significantly associated with suboptimal self-reported patient care.

Previous literature reveals that mental health professionals are at an extremely high risk for burnout and compassion fatigue (Christopher & Maris, 2010). As the clinician engages the client there is often indirect exposure to client trauma, which naturally creates the risk of "significant emotional, cognitive and behavioral changes in the clinician" (Bride, Radey, & Figley, 2007, p.160). Factors that may increase the chance for being "at risk" for compassion fatigue include prolonged exposure to suffering, our ability to empathize, our response to the client, our sense of satisfaction (self-efficacy; self-esteem), our own traumatic memories, and our own life demands (Figley, 1995). It has also been noted that idealistic, highly motivated, and highly empathic helpers are at greater risk for burnout due to the lack of clear boundaries as to what their role consists of and the disappointment that arises if they feel they are not moving toward their care goals or are ineffec-

tive in changing the environment to do so (Bush, 2009). There is also direct evidence suggesting that staff who are exposed to more frequent and more challenging behaviors are at increased risk of stress, burnout and mental health problems (Rose, Horne, Rose & Hastings, 2004).

Age has been positively correlated with burnout among younger helpers, possibly due to their lack of preparation, role ambiguity, heavy caseloads, and changing environments (Bush, 2009). Younger people in general also tend to be more idealistic, which may factor into their vulnerability as well. Some of the most common origins of compassion fatigue are linked to large caseloads, limited supervision or lack of good supervision, and the disappointment and frustration that takes over when our expectation of ourselves as helpers is vastly different from the reality of what we are able to do (Bush, 2009; Figley, 1995).

Compassion Satisfaction

Stamm (2002) encourages an equal emphasis on compassion satisfaction when discussing the effects of compassion fatigue, as compassion satisfaction is an important component of the whole. Compassion satisfaction is the enjoyment obtained from the work that one does. Positive connections between helping others, including colleagues, and a mental health professionals' feelings about their overall contribution to society through their work add to their overall sense of satisfaction. Put simply, if compassion fatigue is the "bad stuff" that comes from helping others, compassion satisfaction is the "good stuff" (Stamm, 2010, pp. 12-13).

Much of the literature reveals the costs of being compassionate or empathic (e.g. Figley, 2002; Walsh, 2009). Some of those costs include recurrent bouts of the flu, gastrointestinal problems, headaches, fatigue, insomnia, substance abuse, poor self-esteem, withdrawal behavior, difficulty in interpersonal relationships, rigid adherence to rules, inability to concentrate, and intolerance toward and tendency to blame clients for problems (Arches, 1991; Bush, 2009; Figley 2002; Hill, 1991; Walsh, 2009). The harmful effects of compassion fatigue tremendously affect counseling professionals' and counseling students' capacity for attention, concentration, and decision-making, thus lessening their overall effectiveness and success (Christopher & Maris, 2010), and providing additional evidence for the importance of enhancing the experience of compassion satisfaction felt by social workers.

A review of the literature reveals many suggestions on how to improve and increase compassion satisfaction, including stress management (Figley & Bride, 2009), concentrative practices, and relaxation techniques (Brown, Marquis, & Guiffrida, 2013), and the general panacea for self-care, which includes exercise, rest and good diet. Several articles call for reflection and inner awareness, the practice of "responsible selfishness," the balance of giving what we give to others to ourselves, and forgiveness (Bush, 2009;

Hill, 1991; Walsh, 2009). Figley's (2002) article explores how the practice of mindfulness may be the best option for enhancing compassion satisfaction and avoiding compassion fatigue in a profession where empathy is acknowledged to be a double-edged sword.

Mindfulness

Mindfulness originates from Zen Buddhism and historically Eastern practices, although its access can be as simple as a heightened awareness of one's thoughts, body, and emotions as one moves through the ordinary tasks of the day. Its non-judgmental approach frees the practitioner to explore unpleasant experiences and possibly allows the unconscious mind to reframe the experience with deeper insight (Epstein, 1999). When mindfulness has been employed by psychotherapists, it has also shown to be a useful tool for improving patient outcomes, which suggests that it could be helpful in training therapists (Grepmair, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007). Mindfulness can potentially advance competence in social work practice by serving as a protective factor for the practitioner, the patient and/or the case outcome.

Much of the growing interest in mindfulness is in large part due to the work of Jon Kabat-Zinn (1990), who developed an eight-week intervention program, mindfulness-based stress reduction (MBSR), and researched its effects on those suffering from chronic illnesses. Kabat-Zinn (1990) defined mindfulness as "paying attention in a particular way; on purpose, in the present moment, and non-judgmentally" (p.14). Similar to other religious and spiritual practices, the purpose of mindfulness, a personal, internal state of being, is to help one recognize habitual, ingrained thinking patterns and other behaviors (Stahl & Goldstein, 2010).

Mindfulness-based stress reduction (MBSR) is a structured group program that employs mindfulness meditation to alleviate suffering associated with physical, psychosomatic and psychiatric disorders (Grossman, Niemann, Schmidt, & Walach, 2004). MBSR is an educationally based program focusing on training in the Eastern contemplative practice of mindfulness. Mindfulness is a form of meditation originally derived from the Theravada tradition of Buddhism (Hanh, 1976). The 2,500-year-old practice known as Vipassana was developed as a means to cultivate greater awareness and insight (Goldstein, 1976). *Mindfulness* is often translated as "to see with discernment" (Shapiro, Astin, Bishop, & Cordova, 2005 p. 165).

Previous research found mindfulness significantly increased positive affect, self-compassion (Shapiro, Brown, & Biegel, 2007), global functioning, and overall well-being (Christopher & Maris, 2010; Grepmair, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007), and decreased anxiety, depression, and stress (Christopher & Maris, 2010; Grepmair et al., 2007; Shapiro, Brown, & Biegel, 2007). A qualitative study by Christopher and Maris (2010) imple-

mented a 15-week course for student self-care loosely based on Kabat-Zinn's MBSR training. The students reported the positive ways in which mindfulness practices influenced their clinical work, including being more comfortable with silence, being less enchanted by the story, and having the capacity to be more attentive. They also disclosed that when they experienced feelings such as anxiety, confusion, or irritation, they had the grace to view this affect objectively with less pressure to behave differently or change the situation. The benefits of mindfulness from Kabat-Zinn's work legitimized the value of mindfulness as an evidence-based practice model in the health care arena.

As mindfulness emerges as an evidence-based approach to mitigate compassion fatigue, there is an increasing amount of literature on the use of mindfulness in certain healthcare populations such as cancer-care providers (Najjar, Davis, Beck-Coon, & Doebbeling, 2009), physicians (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013), trauma responders (Chopko & Schwartz, 2009), and counselors (Schure, Christopher, & Christopher, 2008). A limited amount of research directly addresses the relationship between mindfulness and compassion fatigue in social workers. Such studies support mindfulness as an effective tool to bring about flexibility, adaptability and empowerment in the social worker while at same time reducing negative patterns of avoidance, panic, and anxiety (Berceli & Napoli, 2006). Research supports that as a state of mindfulness sets in, people sleep better, feel better, cope better, and have a renewed enthusiasm for life and work (Stahl & Goldstein, 2010). In general, mindfulness can play a significant role in improving or increasing psychological and physical well-being (Shapiro, Brown, & Biegel, 2007).

Previous research has identified various suggestions for mitigating or preventing compassion fatigue, including religion. However, little research exists on the use of informal spiritual practices. The purpose of this exploratory study was to examine the relationship between levels of mindfulness with potential for compassion satisfaction and risk for compassion fatigue among masters of social work students. This study explored the correlation between mindfulness and risk for compassion fatigue, positing that higher levels of mindfulness positively correlate with a greater potential for compassion satisfaction and that lower levels of mindfulness positively correlate with greater risk for compassion fatigue.

Method

Participants

Participants were recruited from masters of social work students at a campus of the California State University system. Due to survey questions assessing professional quality of life related to working with traumatized clients, participation was limited to those who reported having at least one

year of clinical experience. Of the 140 people who initially opened the online survey, 12 did not fill in any information resulting in N = 128. Of the remaining 128 participants who filled in some portion of the survey, 17 did not complete the survey in its entirety: 4 with 85% of the survey remaining; 4 with 70% of the survey remaining; 1 with 55% of the survey remaining; 4 with 35% of the survey remaining; and 4 with 16% of the survey remaining. We compared distribution curves and conducted bivariate analyses with and without the missing cases. Finding no difference in the normality distribution of the variables, all subsequent analyses were performed using the remaining 111 participants.

The final sample consisted of 111 participants ranging in age from 22–61 (*M*=32.17, *SD*=8.23). Of the 107 participants who reported their gender, 92.5% (n=99) were female. Practice experience ranged from 1 year to more than 10 years (direct clinical practice (n=109): *M*=3.34, *SD*=2.42; administrative experience (n=104): *M*=3.94, *SD*=3.41; and volunteer experience (n=102): *M*=4.68, *SD*=2.69) with volunteer experience more prevalent than either direct clinical practice or administrative experience. Participation in the study was voluntary and anonymous. This study was approved by the California State University Institutional Review Board.

Measures

The Professional Quality of Life Scale (Stamm, 2010), commonly referred to as the ProQOL, is a 30-item self-report measure that assesses risk for compassion fatigue, level of compassion satisfaction, and risk of burnout. The measure has been in use since 1995. There have been several revisions and the ProQOL 5 (2010) is the current version. Participants are at higher risk for compassion fatigue if they have higher scores on the compassion fatigue subscale. Furthermore, high scores on the compassion satisfaction subscale (*M*=50, *SD*=10) reveal a greater satisfaction with self-efficacy. Higher scores on the burnout portion of the questionnaire (*M*=50, *SD*=10), such as symptoms of helplessness and hopelessness, reveal a greater risk for burnout. Compassion satisfaction and burnout subscales show good reliability (.75-.88) and have been used in numerous previous research studies (Figley, 1995; Figley & Stamm 1996; Stamm, 2002).

The Five Facets of Mindfulness Questionnaire (FFMQ) was created by Baer et al, (2006) following an analytic study of five mindfulness questionnaires that were developed independently. The FFMQ is a 39-item self-report questionnaire that measures five facets related to mindfulness, including non-reactivity and non-judgment of inner experiences, observation, acting with awareness, and description. The FFMQ uses a five-point range of scaling from “very often or always true” to “never or very rarely

true" and "demonstrated adequate to internal consistency, with alpha coefficients ranging from .75 to .91" (Baer, Smith, Lykins, Button, Krietemeyer, Sauer…Williams, 2008, p. 330). Baer et al. (2008) report that correlations between the FFMQ and other mindfulness measures are high, suggesting the usefulness of the FFMQ as a solitary measure of mindfulness.

Results

Preliminary analyses were conducted to check for violation of the assumptions of normality, linearity, and homoscedasticity as well as further examine outliers and missing data. Univariate analyses revealed normal distributions, no extreme outliers, and randomly missing data comprising less than 5% of the sample. Scatter plots revealed linear relationships between variables of interest.

Mean levels for the five facets of mindfulness fell within an average to high score range for the majority of participants (see Table 1). Scoring for the compassion satisfaction section of the ProQOL measure revealed that the majority of the participants in this sample scored quite low on the compassion satisfaction scale: 66% (n=71) scored 43 or lower whereas typically 25% score below 43 (Stamm, 2010). Only two of the respondents in this sample scored 50, compared to the average score of 50 using alpha score reliability .88. Although this sample is not showing compassion satisfaction scores similar to other samples, neither are they showing burnout. Burnout scores ranged from 12-35, (M=22.0, SD=4.8) compared to the average score of 50 using alpha reliability .75 (Stamm, 2010). Low burnout scores translate to a low risk for compassion fatigue. Mean levels of risk for compassion fatigue and potential for compassion satisfaction were also similar to other studies that utilized the ProQOL among helping professionals (Bride, Robinson, Yegidis & Figley 2004; Stamm, 2002).

Table 1: Mean, Standard Deviation, Range, and Potential Range for Mindfulness Facets

Mindfulness Facet	M	SD	Range	Potential Range
Observe (n = 105)	27.4	5.2	12-39	8-40
Describe (n = 104)	29	4.7	17-39	8-40
Act Aware (n = 106)	27.6	5.3	14-40	8-40
Non Judging (n = 105)	27.8	5.5	13-40	8-40
Non Reacting (n = 104)	22.9	3.5	13-33	7-35

The relationship between compassion satisfaction, compassion fatigue, (as measured by the (ProQOL) and mindfulness (and measured by the FFMQ) was investigated using Pearson product-moment correlation

coefficient. There was a moderate, positive correlation between compassion satisfaction and mindfulness, r=.46, n=92, p<.00 with high levels of compassion satisfaction associated with higher levels of mindfulness. There was a strong, negative relationship between compassion fatigue and mindfulness, r=-.53, n=91, p<.00 with high levels of compassion fatigue associated with lower levels of mindfulness. In addition to reporting the correlations between compassion satisfaction, fatigue, and overall mindfulness, Table 2 details correlations between compassion satisfaction, fatigue, and the five separate components of mindfulness.

Table 2: Pearson Product-moment Correlations between Measures of Compassion and Mindfulness

Scale	1	2	3	4	5	6	7	8
1. Compassion Satisfaction	-	-.60*	.46*	.18	.18	.35*	.30*	.34*
2. Compassion Fatigue		-	-.53*	-.12	-.36*	-.42*	-.35*	-.43*
3. Mindfulness			-	.53*	.71*	.74*	.66*	.55*
4. Observe				-	.35*	.08	-.03	.11
5. Describe					-	.37*	.22**	.24**
6. Act Aware						-	.44*	.30*
7. Non-Judgmental							-	.26*
8. Non-Reactive								-

* p<.001 (2-tailed); ** p<.05 (2-tailed)

Discussion

In keeping with previous research, results of these data revealed a positive correlation between mindfulness and compassion satisfaction and a negative correlation between mindfulness and compassion fatigue, suggesting that mindfulness may be a protective factor for those in helping professions. The sample for this study is relevant because it consists of primarily younger, inexperienced helpers, which previous research has shown are at greater risk for compassion fatigue (Bush, 2009). Social workers who engage appropriate spiritual interventions such as mindfulness may find greater satisfaction, increased ability to handle professional stressors, and ultimately remain working in a human service field longer than those who do not maintain spiritual self-care practices.

We did not conduct an intervention study, and therefore can make no statements about the effects of practicing mindfulness vs. not using mindfulness in relation to compassion fatigue or satisfaction. However, previous intervention studies (e.g. Kabat-Zinn, 1990) have established mindfulness as a useful tool for health services practitioners, and the consistency of our results with previous research supports the validity of the findings. Using

the FFMQ to measure mindfulness in a sample of MSW interns who have not necessarily previously been exposed to mindfulness practice allows us to explore possible effects of everyday mindfulness practices such as acknowledging feelings without getting lost in them.

Previous research has focused on examining mindfulness as a formal intervention, instructing participants in specific practices, or following an 8-week intervention. We did not instruct participants in mindfulness practices, instead relying on self-report via the FFMQ to identify mindfulness practices or beliefs. Results suggest that mindfulness may be useful even when not practiced formally, akin to the way many use spiritual or religious practices. One does not need to attend church to be religious, just as one does not need to understand the facets of mindfulness to have awareness.

Griffith and Griffith (2002) state that "religion…provides methods for attending spirituality, most often in terms of a relationship with the God of that religion" (p. 76). However, spirituality is not always a function of religion, as some people believe it to be. According to Zeckhausen (2001), spirituality involves a deepening connection to oneself or to others, to God or a higher power, or to nature. It often produces a deep sense of peace and satisfaction that may facilitate physical healing. Spirituality may evolve over time, or it may come unexpectedly, triggered by a spectacular scene in nature, an intimate moment between a parent and child, a sudden and unexplained healing or a response to an outstanding artistic performance. Spiritual experiences are unique and deeply personal (Walsh, 2009).

Limitations and Future Research

Results of this study must be interpreted with caution given the limitations inherent in the design and sample. The anonymous nature of the data collection process resulted in an inability to assess the potential role of gender in the findings, since the sample did not include enough males. Previous research is mixed regarding the nature of gender differences in spirituality with researchers suggesting that women are more spiritual than men (Mahalik & Lagan, 2001) and other studies finding no difference in spirituality by gender (Simpson, Cloud, Newman, & Fuqua, 2008). It is unclear whether or how findings in the current study would have been different had the sample included an equal number of men and women.

The exploratory nature of the current study and the fairly limited sample size made it unfeasible to control for extraneous or confounding variables. Future mindfulness and compassion fatigue research should include multi-disciplinary mental health professionals as well as consider relevant information that contributes to compassion fatigue such as prolonged exposure to traumatized individuals, support in placement, and relevant personal home life information. A pre-test/post-test with an 8-week mindfulness-based stress reduction intervention specifically focused on

care-giving professionals who rate high on a compassion fatigue scale would also be a worthwhile endeavor to add to the growing body of mindfulness literature. Research shows that while institutions have recognized a need for providing counseling students with tools for self-care, very few actually provide courses in self-care and stress management (Christopher & Maris, 2010). Introducing mindfulness into core social work curriculum as a tool to use with clients, as well as a form of self-care, is a worthwhile endeavor. Upon implementation of these types of courses, future studies should include program evaluations of the classes to determine their efficacy.

Implications for Christians in Social Work

Christian social workers draw upon their faith for strength and compassion in their work and, according to Canda and Furman (2010), recognize "that many of the people we serve draw upon spirituality, by whatever names they call it, to help them thrive [and] to succeed at challenges" (p. 3). The importance of practitioners identifying spiritual strength in themselves and their clients should not be overlooked. Increasing social workers' experience with the positive effects of compassion satisfaction, whether through the use of mindfulness or other means, may act as a protective factor against compassion fatigue. In turn, greater compassion satisfaction on the part of social workers may result in a greater ability to assist clients.

Practitioners recognizing the strength spirituality brings clients may also result in a greater ability to engage with and effectively help clients. Christian social workers are well positioned to understand the importance of spirituality and religion to their clients, and should use that understanding to 'meet clients where they are' throughout the treatment relationship.

The results of this study suggest that MSW interns are using mindfulness practices despite not having formal training to do so. Christian educators might consider exploring the value of including mindfulness and other contemplative practices in the training of social work students as a means of broadening protective factors against compassion fatigue.

Conclusion

Different self-care approaches practiced by helping professionals are essential to help reduce stress levels and be more effective and compassionate when helping clients. Sympathy and empathy are relevant to the social work field; hence it is essential for social workers to practice self-compassion for their well-being (Shapiro et al, 2007) as well as that of their clients. Overall, social work mental health professionals' level of mindfulness may be related to risk for compassion fatigue as well as potential for compassion satisfaction.

Results from this exploratory study reveal a correlation between mindfulness and compassion satisfaction/fatigue, suggesting that mindfulness, whether formally "taught or caught" improves the well-being of social work interns. In general, mindfulness could be an effective spiritual practice and protective factor for social work practitioners and educators. ❖

References

Arches, J. (1991). Social structure, burnout, and job satisfaction. *Social Work, 36*(3), 202-206.

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.

Baer, R. A., Smith, G. T., Lykins, E., Button, D., Krietemeyer, J., Sauer, S., Walsh, E., Duggan, D., Mark, J., & Williams, G. (2008). Construct validity of the five facet mindfulness questionnaire in meditating and nonmeditating samples. *Assessment*, 15(3), 329-342. DOI: 10.1177/1073191107313003.

Baker, D. C. (2003). Studies of the inner life: The impact of spirituality on quality of life. *Quality of Life Research, 12*, 51-57.

Berceli, D., & Napoli, M. (2006). A proposal for a mindfulness-based trauma prevention program for social work professionals. *Complementary Health Practice Review*, *11*(3), 153-165.

Bono, G., McCullough, M. E., & Root, L. M. (2008). Forgiveness, feeling connected to others, and well-being: Two longitudinal studies. *Personality and Social Psychology Bulletin, 34*(2), 182-195.

Bride, B., Radey, M., & Figley, C. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, *35*, 155-163.

Bride, B. E., Robinson, M. M., Yegidis B. L., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 14*(1), 27-35.

Brown, A., Marquis, A., & Guiffrida, D. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling and Development*, *91*(1), 96.

Bush, N. (2009). Compassion fatigue: Are you at risk? *Oncology Nursing Forum: Clinical Challenges, 36*(1), 24-28.

Canda, E.R. & Furman, L.D. (2010). *Spiritual diversity in social work practice: The heart of helping*. New York, NY: Oxford University Press.

Chopko, B. A., & Schwartz, R. C. (2009). The relation between mindfulness and posttraumatic growth: A study of first responders to trauma-inducing incidents. *Journal of Mental Health Counseling*, *31*(4), 363-376.

Christopher, J. C. & Maris, J. (2010). Integrating mindfulness as self-care into counseling and psychotherapy training. *Counseling and Psychology Research, 10*(2), 114-125.

Decker, J. T., Bailey, T. L., & Westergaard, N. (2002). Burnout among childcare workers. *Residential Treatment for Children and Youth, 19*(4), 61-77.

Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology, 11*(4), 330–340.

Epstein, R. (1999). Mindful practice. *Journal of the American Medical Association*, *282*(9), 833-839.

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York, NY: Brunner/Mazel.

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology/In Session*, *58*, 1433-1441.

Figley, C. , & Bride, B. (2009). Secondary trauma and military veteran caregivers. *Smith College Studies in Social Work, 79*(3), 314-329.

Figley, C. R. & Stamm B. H. (1996). Psychometric Review of Compassion Fatigue Self Test. In B.H. Stamm (Ed), *Measurement of Stress, Trauma and Adaptation* (pp. 127-130). Lutherville, MD: Sidran Press.

Fortney, L., Luchterhand, C., Zakletskaia, L., Zgierska, A., & Rakel, D. (2013). Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: A pilot study. *Annals of Family Medicine*, *11*(5), 412-420.

Germer, C. K., Siegel, R. D., & Fulton P. R. (2005). *Mindfulness and psychotherapy,* New York: Guilford Press.

Gilham, J. J. M. (2012). The ethical use of supervision to facilitate the integration of spirituality in social work practice. *Social Work & Christianity, 39*(3), 255-272.

Goldstein, J. (1976). *The experience of insight*. Boston, MA: Shambhala.

Gough, D. (2007). Empathizing or falling in the river? Avoiding and addressing compassion fatigue among service providers. *JADARA, 40*(3), 13.

Grepmair, L., Mitterlehner, F., Loew, T., Bachler, E., Rother, W., & Nickel, M. (2007). Promoting mindfulness in psychotherapists in training influences the treatment results of their patients: a randomized, double-blind, controlled study. *Psychotherapy and Psychosomatics*, *76*, 332-338.

Griffith, J. L. & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy,* New York, NY: Guilford Press.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, *57*(1), 35-43.

Hanh, T. N. (1976). *The miracle of mindfulness: A manual of meditation.* Boston, MA: Beacon Press.

Hill, H.R. (1991). Point and counterpoint: Relationships in oncology care. *Journal of Psychosocial Oncology, 9*(2), 97–112.

Holloway, M. & Moss, B. (2010). *Spirituality and social work.* New York, NY: Palgrave Macmillan.

Huggard, P. (2003). Compassion fatigue: how much can I give? *Medical Education*, *37*(2), 163-164.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 116-120.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. New York, NY: Bantam Doubleday Dell Publishing Group.

Kendler, K. S., Liu, X. Q., Gardner, C. O., McCullough, M. E., Larson, D., & Prescott, C. A. (2003). Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders. *American Journal of Psychiatry, 16*(3), 496-503.

Kreisher, K. (2002). Burn out. *Child welfare league of America*. Retrieved February 25, 2006 from www.ewla.org/articles.

Lee, K. H., Besthorn, F. H., Bolin, B. L., & Jun, J. S. (2012). Stress, spiritual, and support coping, and psychological well-being among older adults in assisted living. *Journal of Religion & Spirituality in Social Work: Social Thought, 31*(4), 328-347.

Mahalik, J.R. & Lagan, H.D. (2001). Examining masculine gender role conflict and stress in relation to religious orientation and spiritual well-being. *Psychology of Men & Masculinity, 2,* 24-33.

McCormick, D. P., Holder, B., Wetsel, M. A., & Cawthon, T. W. (2001). Spirituality and HIV disease: An integrated perspective. *The Journal of the Association of Nurses in AIDS Care, 12*(3), 58-65.

Najjar, N., Davis, L., Beck-Coon, K., & Doebbeling, C. (2009). Compassion fatigue: A review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology*, *14*, 267-277.

Radey, M., & Figley, C. (2007). The social psychology of compassion. *Clinical Social Work Journal*, *35*, 207-214.

Rose, D. , Horne, S. , Rose, J. , & Hastings, R. (2004). Negative emotional reactions to challenging behaviour and staff burnout: Two replication studies. *Journal of Applied Research in Intellectual Disabilities, 17*(3), 219-223.

Schure, M. B., Christopher, J. & Christopher, S. (2008) Mind–body medicine and the art of self care: Teaching mindfulness to counseling students through yoga, meditation, and qigong. *Journal of Counseling & Development, 86*(1) 46-56.

Shanafelt, T. D., Bradley, K. A., Wipf, J. E., & Back, A. L. (2002). Burnout and self-reported patient care in an internal medicine residency program. *Annals of Internal Medicine, 136,* 358–367.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordona, M., (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management, 12*(2), 165-176.

Shapiro, S., Brown, K., & Biegel, G. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, *1*(2), 105-115.

Simpson, D.B., Cloud, D.S., Newman, J.L., & Fuqua, D.R. (2008). Sex and gender differences in religiousness and spirituality. *Journal of Psychology & Theology, 36*(1), 42-52.

Sowell, R., Moneyham, L., Hennessy, M., Guillory, J., Demi, A., & Seals, B. (2000) Spiritual activities as a resistance resource for women with human immunodeficiency virus. *Nursing Research, 49*(2), 73-82.

Spickard, A., Gabbe, S., & Christensen, J. (2002). Mid-career burnout in generalist and specialist physicians. *Journal of the American Medical Association, 288,* 1447–1450.

Stahl, B. & Goldstein, E. (2010). *A mindfulness-based stress reduction workbook*. Oakland, CA: New Harbinger Publications.

Stamm, B. H. (2010). The Concise ProQOL Manual. Pocatello, ID., The ProQOL. org HTTP://www.proqol.org/ProQol test.html.

Stamm, B. H. (2002). Measuring Compassion Satisfaction as well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C. R. Figley (Ed.), *Treating compassion fatigue,* 107-119. New York, NY: Brunner Routledge.

Stebnicki, M. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation,* 10, 317-338.

Walsh, F., (2009). *Spiritual resources in family therapy*, *(2nd Ed)*. New York, NY: Guilford.

Yoon, D. P., & Lee, E. O. (2004) Religiousness/spirituality and subjective well-being among rural elderly Whites, African Americans, and Native Americans. *Journal of Human Behavior in the Social Environment, 10*(1), 191-211.

Zeckhausen, W. (2001). Balancing act: Spirituality and your practice. *Family Practice Management, 8*(5), 60.

***James T. Decker**, LCSW, Ph.D., Professor, Department of Social Work, California State University, Northridge, 18111 Nordhoff Avenue, Northridge, CA 91330. Phone: (818) 677-3710. Email: jdecker@csun.edu.*

***Jodi L. Constantine Brown**, MSW, Ph.D., Associate Chair and Director of Online and Offsite Programs, Department of Social Work, California State University, Northridge, 18111 Nordhoff Avenue, Northridge, CA 91330. Phone: (818) 677-6010. Email: Jodi.brown@csun.edu.*

***Jacqueline Ong**, MSW, Department of Social Work, California State University, Northridge, 18111 Nordhoff Avenue, Northridge, CA 91330. Email: jacquelineong360@gmail.com.*

***Crystal A. Stiney-Ziskind**, MSW, Clarity for Youth Manager, CLARE Foundation, Inc., 909 Pico Blvd., Santa Monica, CA, 90405. Phone: (310) 314-6200. Email: cstiney@clarefoundation.org.*

Keywords: mindfulness, compassion fatigue, compassion satisfaction, self-care