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Pepperdine University
Graduate School of Education and Psychology

MINDFULNESS TRAINING AND DEVELOPING CLINICIANS' COMPASSION
SATISFACTION

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology
by
Priscilla Morrison
August 2017
Susan R. Hall, Ph.D., J.D. – Dissertation Chairperson

This clinical dissertation, written by

Priscilla Morrison

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

Developing clinicians experience many unique stressors during graduate training and must learn to balance these stressors in addition to a heavy academic workload and other personal demands. These circumstances might put developing clinicians at risk for burnout and/or secondary traumatic stress as well as experiencing low levels of compassion satisfaction. Mindfulness training during this time may be helpful in promoting compassion satisfaction and preventing some of the effects of burnout and/or secondary traumatic stress. In order to better understand the relationship between mindfulness training in graduate school and the compassion satisfaction of developing clinicians, a quantitative examination was conducted with 13 graduate students in a clinical psychology master's program. Quantitative data analysis was conducted to determine any differences in levels of compassion satisfaction before and after engaging in mindfulness training. Compassion satisfaction scores were in the average range at both time points; therefore, no significant difference was found when comparing compassion satisfaction scores before mindfulness training and after engagement in mindfulness training. Limitations regarding research design and characteristics of the selected sample may have contributed to null results. Recommendations for future directions include utilizing a study design with a control group and investigating the relationship between demographic factors, previous engagement in mindfulness/contemplative practices, and compassion satisfaction.

Keywords: compassion satisfaction, mindfulness, training, students

Introduction

Clinical work is difficult and challenging, especially for developing clinicians (Bonifas & Napoli, 2014; Cushway, 1992; El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). In addition to working with clients for the first time, therapists-in-training are immersed in meeting the demands of their graduate school curriculum and navigating various personal life stressors, all of which may impact developing clinicians' daily functioning (Bonifas & Napoli; Cushway, 1992). Many of these individuals may be new to learning clinical skills, a process that is unique and different from learning other types of information (Fuks, Boudreau, & Cassell, 2009; Iwata & Gill, 2013; Lin & Huang, 2014; Pica, 1998).

As a result of their efforts, developing clinicians can experience compassion satisfaction, which has been defined as the pleasure one derives from being able to act in a professional role well (Stamm, 2010). Promoting adaptive habits and positive ways of coping with clinically-related challenges early in graduate training may be critical in increasing compassion satisfaction and sustaining a sense of meaning from clinical work (Stamm, 2010). With a high level of compassion satisfaction, one may also have positive experiences while working and feel satisfaction with one's career choice (Stamm, 2010).

Because developing clinicians likely want to be successful and have positive experiences related to their clinical training and academic work (Nelson, Dell'Oliver, Koch, & Buckler, 2001), mindfulness training may be helpful in promoting progress toward these goals (e.g., developing compassion satisfaction) and coping with difficulties in clinical training. There is a growing realization of the necessity of teaching mindfulness and other self-care practices to

developing clinicians because of the prevalent stress and difficulties in completing psychological and other types of training programs (Bonifas & Napoli, 2014; Myers et al., 2012).

As a result, several programs have already implemented mindfulness as part of their training curriculum (e.g., Bonifas & Napoli, 2014; Christopher et al., 2011; Shapiro, Warren Brown, & Biegel, 2007; Tarrasch, 2015). The goal of these programs is to help students incorporate mindfulness into their daily self-care routines (Bonifas & Napoli, 2014). These programs have found increases in positive affect, self-compassion, self-care, quality of sleep, acceptance, and awareness of thoughts, feelings, and behaviors and decreases in stress, negative affect, rumination, and anxiety (Bonifas & Napoli, 2014; Christopher et al., 2011; Felton, Coates, & Christopher, 2013; Hemanth & Fisher, 2014; McCollum & Gehart, 2010; Rimes & Wingrove, 2010; Shapiro et al., 2007; Tarrasch, 2015). In addition, one program in particular with social work students found that although students' perceived stress level did not change, they did report increased quality of life (Bonifas & Napoli, 2014).

Although a few studies have examined whether mindfulness or contemplative practices is related to compassion satisfaction in the field of social work (Decker, Brown, Ong, & Stiney-Ziskind, 2015 [Five-Facet Mindfulness Questionnaire with social work interns]; Gregory, 2015 [yoga with social workers]; Thomas & Otis, 2010 [Five-Facet Mindfulness Questionnaire, Interpersonal Reactivity Index, and Maintenance of Emotional Separation with social workers]), no research was located on this topic with psychology student therapists. The proposed study, therefore, sought to investigate mindfulness and contemplative practices and compassion satisfaction in developing clinicians.

To set the stage for the present study, this literature review first discusses the few extant studies on compassion satisfaction and mindfulness in populations closely related to psychology

student clinicians. It is followed by a brief review of the literature on the association between compassion satisfaction, burnout, and secondary traumatic stress (see Appendix A for a more detailed review of the studies presented in these sections). Although increasing compassion satisfaction could be a way to prevent the occurrence of burnout and secondary traumatic stress, this association has not yet been discussed in the literature. Research appears needed to evaluate compassion satisfaction as a potential preventative approach to addressing burnout and secondary traumatic stress along with ways to increase compassion satisfaction in helping professionals.

Compassion Satisfaction and Mindfulness

The Professional Quality of Life Scale (ProQOL) Version 5 includes a compassion satisfaction subscale, the only current measure to evaluate compassion satisfaction. Three studies were located that investigated compassion satisfaction and mindfulness in populations similar to psychology graduate students; no studies were located with our specific population of interest. All three studies were conducted in the field of social work, and participants were either professionals working in the field or social work interns (Decker et al., 2015; Gregory, 2015; Thomas & Otis, 2010). Results revealed greater levels of mindfulness were positively correlated with a greater potential for compassion satisfaction, and lower levels of mindfulness increased risk for compassion fatigue (Decker et al., 2015). In addition, those who engaged in mindfulness practice in their personal lives and emotional separation in the workplace reported experiencing higher levels of compassion satisfaction than those who did not implement these practices (Thomas & Otis, 2010). Furthermore, not engaging in mindfulness practice was found to decrease compassion satisfaction, and engagement in mindfulness practice was found to halt the

decrease in compassion satisfaction, maintaining similar levels of compassion satisfaction over time (Gregory, 2015).

Limitations of these studies included lack of a comparison group in two studies (Decker et al., 2015; Thomas & Otis, 2010) as well as a fairly limited sample size. In addition, the majority of participants in these studies identified as female (Decker et al., 2015; Gregory, 2015; Thomas & Otis, 2010). Furthermore, two of the studies utilized self-report measures to assess for mindfulness and did not record an amount or frequency of mindfulness practice (Decker et al., 2015; Thomas & Otis, 2010). Finally, for the purposes of the present study, a limitation of these three studies was that they involved participants in the field of social work rather than developing clinicians in the field of psychology (Decker et al., 2015; Gregory, 2015; Thomas & Otis, 2010).

Regarding the Professional Quality of Life 5 scale, it has been revised over the years and appears to measure its construct. However, there may be components of compassion satisfaction that are not represented in the items of the questionnaire. In addition, there are no other measures of compassion satisfaction with which to compare. More research is needed to determine how different people may experience the constructs being measured.

Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Burnout and secondary traumatic stress are common in the helping professions in a variety of settings (Gockel, 2010; Ray, Wong, White, & Heaslip, 2013; Rossi et al., 2012) and are areas of risk for developing clinicians (Craig & Sprang, 2010; Figley, 2002; Gallavan & Newman, 2013; Newsome et al., 2012; Ray et al., 2013; Rossi et al., 2012; Sprang, Clark, & Whitt-Woosley, 2007; Stamm, 2010). Burnout is the experience of feelings of hopelessness and problems dealing with work and doing one's job effectively while secondary traumatic stress is

the experiencing of symptoms of stress as a result of exposure to others' traumatic material while engaging in helping work (Stamm, 2010). Burnout and secondary traumatic stress greatly impact professional quality of life and can prevent individuals from enjoying the positive aspects of their job (Sprang et al., 2007) or the experience of meaning and compassion satisfaction (Mason, 2013).

Theoretically, the detrimental effects of burnout and secondary traumatic stress may deter students from continuing to pursue clinical work before they finish their graduate studies. If graduate students' compassion satisfaction is also being impacted by the stress of the program itself, programs should provide ways of coping, other resources, and contact information for community organizations that provide programming to help alleviate stress (Gockel, 2010). These resources may be provided at the beginning of training programs in order to encourage utilization of different coping skills and involvement in appropriate community organizations as ways of preventing stress. In addition, if students are beginning to experience burnout and secondary traumatic stress during their programs, this information may be provided again in order to encourage utilization of these resources. Such strategies may allow students to continue not only to grow and develop as clinicians but gain a better sense of pleasure from the work they are completing. Promoting compassion satisfaction early in one's career appears to be a promising approach to complement existing efforts to decrease burnout and secondary traumatic stress that students report feeling.

A review of the literature conducted for this dissertation revealed the goal of most studies and theoretical writings on these topics encouraged reduction of burnout and secondary traumatic stress, rather than increasing compassion satisfaction. One potential reason may be that these

constructs appear to only have been linked through the use of the ProQOL and by its creator who coined the term compassion satisfaction (Stamm, 2010).

This trend may also have occurred as an effort to help clinicians who are currently experiencing these effects. For example, a case illustration of a counseling psychology doctoral student addressed both compassion fatigue and secondary traumatization, yet did not focus on increasing compassion satisfaction (Figley, 2002). Also, Najjar et al.'s (2009) meta-analysis of 57 studies using versions of the ProQOL with individuals who cared for cancer patients, the Compassion Satisfaction Fatigue (CSF) test (an earlier version of the ProQOL) or the Compassion Fatigue-Short-Scale (derived from the ProQOL but with only compassion fatigue and burnout scales), offered many suggestions to address concerns about compassion fatigue, but did not mention taking steps to increase compassion satisfaction.

What appears to be needed in the field of clinical/counseling psychology, therefore, is more attention to prevention efforts or investing resources to promote compassion satisfaction in clinicians who may not be experiencing compassion fatigue, burnout, and secondary traumatic stress. This work appears to be helpful in the medical field. For instance, a study with oncology social workers found high levels of compassion satisfaction may mitigate stress and burnout (Joubert, Hocking, & Hampson, 2013). In other studies with social workers and nurses, compassion satisfaction was found to have a positive relationship with positive emotions and an inverse relationship to stress associated with burnout and compassion fatigue (Burtson & Stichler, 2010; Mizuno, Kinefuchi, Kimura, & Tsuda, 2013; Simon, Pryce, Roff, & Klemmack, 2005).

In the mental health field, a few studies were located that described compassion satisfaction and its associations with other factors, only one of which involved trainee therapists

(Beaumont, Durkin, Hollins Martin, & Carson, 2016). Regarding the study with trainees, Beaumont et al. (2016) found high levels of compassion satisfaction were significantly associated with high levels of well-being and compassion for others in a sample of 54 student counselors who were in their last year of graduate training. This study also found high levels of compassion satisfaction were significantly associated with low levels of burnout and compassion fatigue (Beaumont et al., 2016). High ratings of compassion satisfaction have also been associated with decreased psychological distress in a sample of Italian community mental health professionals (Rossi et al., 2012), positive experiences of work in professionals in correctional facilities (Gallavan & Newman, 2013), and the utilization of evidence-based practices in a sample of trauma treatment therapists (Craig & Sprang, 2010).

Also, more experienced therapists endorsed higher levels of compassion satisfaction on the ProQOL than beginning therapists (Craig & Sprang, 2010). These findings further emphasize the potential importance of promoting compassion satisfaction in developing therapists who are just beginning to enter the field, as they may feel less compassion satisfaction because of lack of experience in working with clients.

Based on the emerging literature on compassion satisfaction, this author hypothesized that developing clinicians may be more likely to learn necessary clinical skills, perform effective therapy, and enjoy their work if they have a higher level of compassion satisfaction. More research on compassion satisfaction appears needed to explore how different individuals experience this phenomenon, what contextual variables may interact with compassion satisfaction, and if the existing scale captures the variability of this experience or whether other ways of assessment should be developed.

Summary and Hypothesis for Investigation

In summary, the literature suggests burnout and secondary traumatic stress are common in the helping professions, especially in the early years of practice (Ackerly et al., 1988; Gockel, 2010; Hesse, 2002; Jones, 2002; Maslach, Schaufeli, & Leiter, 2001; Vredenburgh, Carlozzi, & Stein, 1999), and may be decreased by increasing compassion satisfaction. However, there appears to be less attention to compassion satisfaction in the literature and its relationship with mindfulness and prevention of burnout and secondary traumatic stress. Increasing compassion satisfaction could be a way to prevent the occurrence of these latter experiences. Research appears needed to evaluate compassion satisfaction as a potential preventative approach to addressing burnout and secondary traumatic stress along with ways to increase compassion satisfaction. Only one study was located that investigated compassion satisfaction in student therapists, and results indicated high levels of compassion satisfaction were significantly associated with low levels of burnout and compassion fatigue (Beaumont et al., 2016).

There have also not been any studies looking at compassion satisfaction conducted with psychology student therapists engaging in mindfulness practices. The few existing studies on compassion satisfaction and mindfulness were conducted within the field of social work, and only one study implemented engagement in mindfulness practices (Gregory, 2015). The proposed study aimed to address the gaps in the literature by investigating mindfulness and contemplative practices and compassion satisfaction in developing clinicians.

In order to gain an understanding of the relationship between mindfulness training and compassion satisfaction, a quantitative examination was conducted utilizing the Professional Quality of Life Scale (ProQOL) Version 5 (Stamm, 2010), which measures compassion satisfaction, burnout, and secondary traumatic stress, with developing clinicians in a psychology

graduate training program. The hypothesis of this study was that scores on the compassion satisfaction subscale would significantly increase from baseline before mindfulness training to after mindfulness training.

Method

Participants

Participant data screening and selection. After receiving full approval from the Institutional Review Board (IRB), archival data from a broader research project exploring the use of mindfulness and contemplative practices with master's psychology/counseling students was screened and selected for this study. To provide some background on the first wave of this longitudinal project accessed for this study, different mindfulness groups were offered to all 86 students in a clinical psychology master's program with an emphasis in marriage and family therapy at a private university in Southern California during the fall 2013 and spring 2014 semesters. In addition, all of these students were invited to complete a packet of self-report questionnaires, including a demographic form, the INSPIRIT_R (Kass, Friedman, Lesserman, Zuttermeister, & Benson, 1991), the Perceived Stress Scale (Cohen, 1983), the Mindful Attention Awareness Scale (Brown & Ryan, 2003), the Compassion Scale (Neff, 2003), the Self-Compassion Scale (Neff, 2003), and the Professional Quality of Life 5 scale (Stamm, 2010), before the beginning of the mindfulness groups in September 2013, after the fall groups in December 2013, after the spring group in June 2014, and at other regular intervals until graduation. Students were also invited to participate in an interview regarding their experience in the mindfulness training groups after the fall 2013 semester. In fall 2013, one group was facilitated by an adjunct professor who used a modified version of Mindfulness Based Stress Reduction (see Appendix C). The other group was facilitated by a graduate student, and participants engaged in contemplative practices such as mindful walking, body scans, guided meditations, silent meditation, awareness of breathing, and awareness of bodily

sensations/thoughts/feelings. In spring 2014, the mindfulness group offered a drop-in policy and provided students the opportunity to engage in similar practices with the adjunct professor.

The first step in the screening process for the present study was to identify the individuals who had participated in either the fall mindfulness groups and/or the spring mindfulness group. After those students were identified ($n = 16$), the next step was to evaluate the status of their Professional Quality of Life 5 questionnaires and whether all the items of the compassion satisfaction scale had been completed. If this scale was not completed in full, the individual was not included in the study (three students were excluded from the study for this reason). Thus, the data used for this study was collected in September 2013 and June 2014.

Participant data. Participants included thirteen graduate students enrolled in a Master's of Clinical Psychology program with an emphasis in Marriage and Family Therapy at a private university in Southern California. The majority of students were in their first year of the program ($n = 9$; 69.2%) with only a few students in their second year ($n = 4$; 30.8%). Of these participants, ten were females (76.9 %) and three were males (23.1%). The participants included seven Caucasian participants (53.9%), one African American participant (7.7%), four biracial participants (30.8%), and one participant who identified with three or more ethnicities (7.7%). Participant age range spanned from 21 to 30 years of age ($M = 23.92$, $SD = 2.5$). Most of the participants, nine to be exact, were single (69.2%), one was engaged (7.7%), two were in long-term relationships (15.4%), and one was married (7.7%). None of the participants had children. Two of the participants lived alone (15.4%), four lived with one other person (30.8%), six had four people in the home (46.1%), and one person had five people in the home (7.7%; see Table 1).

Regarding religious identification, seven participants identified as religious (53.9%), four participants reported not being religious (30.8%), and two participants did not answer the question (15.4%). Specifically, five participants identified as Christian (38.4%), one identified as spiritual in energy (7.7%), one identified with two religious groups (7.7%), three identified as agnostic (23.1%), and one identified with no religious group (7.7%; see Table 1).

In evaluating length of time spent engaging in different mindfulness and contemplative practices, descriptive information is provided about their practices before the groups began and after engagement in a mindfulness group. Nine participants reported previously engaging in some type of practice (69.2%) before starting the mindfulness groups, and four participants said they had never engaged in mindfulness and contemplative practices before participating in the mindfulness group (30.8%). Regarding specific types of practices, eight participants had never engaged in prayer (61.5%), one person had practiced praying for five years (7.7%), one participant had practiced praying for fifteen years (7.7%), two participants had practiced praying for twenty years (15.4%), and one participant did not answer the question (7.7%). None of the participants had engaged in centering prayer. Regarding meditation, eight participants had never engaged in meditation (61.5%), one participant had practiced meditation for six months (7.7%), two participants had practiced meditation for one year (15.4%), one participant had practiced meditation for nine years (7.7%), and one participant had practiced meditation for ten years (7.7%). Seven participants had never practiced yoga (53.8%), one participant had been practicing yoga for six months (7.7%), two participants had been practicing yoga for one year (15.4%), one participant had been practicing yoga for four years (7.7%), one participant had been practicing yoga for six years (7.7%), and one participant had been practicing yoga for ten years (7.7%). Nine participants had never engaged in mindful walking (69.2%), one participant had

engaged in mindful walking for six months (7.7%), two participants had engaged in mindful walking for one year (15.4%), and one participant had engaged in mindful walking for five years (7.7%; see Tables 2 and 3).

The researcher compared participant data about mindfulness practices before the fall groups began with how they described their mindfulness practices in summer 2014 after participation in one or more of the mindfulness groups. Of those participants who did not report mindfulness/contemplative practices on the fall 2013 surveys, two participants indicated an apparently new practice of prayer (15.4%); two participants indicated an apparently new practice of centering prayer (15.4%); three participants reported what appeared to be new practices of meditation (23.1%); two participants reported an apparently new practice of yoga (15.4%); and three participants indicated an apparently new practice of mindful walking (23.1%). Regarding participants who reported mindfulness practices before the mindfulness groups began, when they were assessed in summer 2014, two participants (out of the five total) continued to endorse practicing meditation (15.4%), two (out of the six total) participants continued endorsing practicing yoga (15.4%), and three (out of the four total) participants still reported continued practice of mindful walking (23.1%). In other words, three participants no longer reported meditation practice (23.1%), four participants no longer reported practicing yoga (30.8%), and one participant no longer reported practicing mindful walking (7.7%). None of the four students who initially reported engaging in prayer said they did so when assessed in spring 2014. (See Table 4). In order to track this information over time, self-reported data was compared using individuals' code numbers, comparing each participant's reports of their practice over time. However, when reviewing these results, it is important to consider that variability in recall may

have influenced self-reports; participants may not have accurately reported their previous engagement in mindfulness/contemplative practices.

At the time of the first survey administration, five participants had provided psychotherapy previously (38.5%) and eight participants had never provided psychotherapy or counseling services (61.5%); these results are fairly consistent with their status in the program as there were nine students who were in the first year of the program. Specifically, one participant had provided psychotherapy or counseling services for six months (7.7%), two participants had provided psychotherapy or counseling services for seven months (15.4%), one participant had provided psychotherapy or counseling services for nine months (7.7%), and one participant had provided psychotherapy or counseling services for three years (7.7%). Regarding theoretical orientation, two participants reported utilizing or wanting to utilize cognitive behavioral therapy (15.4%), one participant reported psychodynamic (7.7%), one participant reported humanistic (7.7%), one participant reported eclectic (7.7%), two participants reported two different theoretical orientations (15.4%), one participant reported three or more different theoretical orientations (7.7%), four participants reported not knowing yet (30.8%), and one participant did not answer the question (7.7%; see Table 5).

Regarding engagement in personal psychotherapy before the mindfulness groups began, six participants had previously received psychotherapy services (46.1%), six participants had never engaged in their own personal psychotherapy (46.1%), and one participant did not answer the question (7.7%). Specifically, one participant had engaged in personal psychotherapy for one month (7.7%), one participant had engaged in personal psychotherapy for two months (7.7%), one participant had engaged in personal psychotherapy for three months (7.7%), one participant had engaged in personal psychotherapy for two years (7.7%), one participant had engaged in

personal psychotherapy for seven years (7.7%), and one participant had engaged in personal psychotherapy for ten years (7.7%; see Table 6).

Human subjects/ethical considerations. In order to maintain and protect the confidentiality of the participants of this study, the researchers took steps in order to ensure the rights of the participants were not violated. Each participant chose a research identification number to ensure the protection of his or her confidentiality and rights. Only the participants knew their identification numbers, ensuring their privacy and confidentiality were maintained. Also, an Institutional Review Board (IRB) course was required to be completed in order to indicate that those who were handling the confidential information would do so in an ethical and confidential manner.

Instrumentation

Demographic questionnaire. The demographics form was developed by the primary investigators of the broader research program. It inquired about each participant's gender, ethnicity, and age as well as religious/spiritual identification, relationship status, number of children, number of occupants in household, previous engagement in mindfulness or contemplative practices, year in the program, length of time providing psychotherapy or counseling services, theoretical orientation, and length of time engaging in personal psychotherapy (Appendix D).

Professional Quality of Life 5 questionnaire. The Professional Quality of Life 5 scale (Stamm, 2010) is a 30-item questionnaire in which each item is answered on a five-point likert scale, one meaning "never" and five meaning "very often." Sample items include, "I am happy, I feel connected to others, and I jump or am startled by unexpected sounds" (Stamm, 2010).

Items that compose the compassion satisfaction scale are items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 (Appendix E). Instructions for the survey are as follows:

When you [help] people, 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 [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

Respondents may substitute appropriate words for their profession in the brackets that say help or helper. For participants in the current study, current work situation referred to their role as a graduate student, which involves both clinical and academic work. Thus, the ProQOL (Stamm, 2010) instructions were modified slightly to fit the students' situation:

When you *help or counsel* people you have direct contact with their lives. As you may have found, your compassion for those you *help or provide therapy to* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a therapist in training. Consider each of the following questions about you and your current work situation as a pre-practicum graduate student or trainee therapist in practicum [noted as *helper* in the survey below]. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

The Professional Quality of Life 5 questionnaire has been refined multiple times over the years to improve its psychometric properties (Stamm, 2010). The fifth edition of this survey was normed on 1,187 individuals (Stamm, 2010). There is no other information provided in the manual on sample characteristics. The three scales of the Professional Quality of Life 5 questionnaire measure separate constructs. Analysis of data from the normative sample indicated that the compassion satisfaction scale has an alpha scale reliability of 0.88; the burnout scale (previously called the compassion fatigue scale) has an alpha scale reliability of 0.75; and the secondary traumatic stress scale (previously called the secondary traumatization scale) has an alpha scale reliability of 0.81 (Stamm, 2010). The burnout and secondary traumatic stress scales have a shared variance of 34% ($r = 0.58$), given that both measure negative affect and distress

common to these conditions (Stamm, 2010). The manual differentiates the two scales because the secondary traumatic stress scale accounts for fear. In addition to being used with mental health professionals and those in training (Beaumont et al., 2016; Craig & Sprang, 2010; Rossi et al., 2012), the Professional Quality of Life 5 questionnaire has also been used in studies with professionals in health care (Burtson & Stichler, 2010; Mason, 2013; Mizuno et al., 2013) and social work (Joubert et al., 2013; Simon et al., 2005; Thomas & Otis, 2010). Given that the measure has been used with those in training (Beaumont et al., 2016; Decker et al. 2015), its use with therapists-in-training in the present study appears consistent and a standard use of the measure.

As noted, there have been multiple changes to the Professional Quality of Life 5 questionnaire (Stamm, 2010). An early version of the Professional Quality of Life questionnaire, the Compassion Satisfaction and Fatigue Test, is no longer supported due to known psychometric problems (Stamm, 2010). Most recently, changes from the fourth to the fifth edition include different wording for the instructions, a change from a zero to five rating scale to a one to five rating scale, and different wording for some of the measure's items (Stamm, 2010). Of note, none of the wording was changed for the items that comprise the compassion satisfaction scale (Stamm, 2010). No other measures were located on compassion satisfaction.

Analysis

A pre-experimental research design was used. The participants were given pre- and post-measures of the Professional Quality of Life Scale Version 5, and there was not a control group. Quantitative data analysis procedures were utilized using Statistical Package for the Social Sciences (SPSS) software. First, the data was screened and selected to be included in the current study. The data was then inputted into SPSS. The data analyses were conducted in four steps:

demographic analyses, descriptive analyses, analyses of reliability, and main analyses. The demographic analyses demonstrated the age, gender, and ethnicity of each group. Descriptive analyses demonstrated the central tendency and spread of the data. Reliability analyses demonstrated how well the compassion satisfaction scale reflects the construct of compassion satisfaction. To test the relationship between mindfulness training and compassion satisfaction, a paired sample t-test was conducted [main analysis]. Data from baseline, or pre-mindfulness training, was compared to data from post-mindfulness training to see if there was a statistically significant increase in compassion satisfaction as measured by the compassion satisfaction scale of the Professional Quality of Life 5 questionnaire.

Results

The hypothesis of the study was that scores on the compassion satisfaction subscale would significantly increase from baseline before mindfulness training to after mindfulness training. To test this hypothesis, the mean scores on the compassion satisfaction scale of the Professional Quality of Life 5 questionnaire before mindfulness training (September 2013) and after mindfulness training (June 2014) were compared using a paired samples t-test. Mean t-scores for the pre-mindfulness training group were 55.31 ($SD = 7.22$). Mean t-scores for the post-mindfulness training group decreased slightly to 53.69 ($SD = 6.66$). Both scores were in the average range (Stamm, 2010). Results from the paired samples t-test indicate these scores were not statistically significantly different from each other; $t(12) = 1.106, p = 0.291$.

Regarding reliability, Cronbach's alpha was 0.847 for the pre-mindfulness group and 0.772 for the post-mindfulness group, indicating good and acceptable reliability (Cortina, 1993). This is similar to the Cronbach's alpha for the normative sample, which was 0.88 (Stamm, 2010), as well as the Cronbach's alpha for Thomas and Otis's (2010) study, which was 0.91. Reliability data was not reported in the two other comparable studies with social workers (Decker et al., 2015; Gregory, 2015).

For the pre-mindfulness group, skewness was -0.486 ($SE = 0.616$) and kurtosis was -1.188 ($SE = 1.191$), indicating the data was slightly left-skewed and not leptokurtic, but the departure from a normal distribution is not extreme (Bulmer, 1979). For the post-mindfulness group, skewness is 0.340 ($SE = 0.616$) and kurtosis is -1.006 ($SE = 1.191$), indicating the data was slightly skewed to the right and also not leptokurtic. In addition, the post-mindfulness group departure from a normal distribution is also not extreme (Bulmer, 1979).

Discussion

The current study adds to the existing literature on the Professional Quality of Life 5 questionnaire by focusing on compassion satisfaction, an element of the ProQOL 5 that is often overlooked or at times seen as secondary to the effects of burnout and secondary traumatic stress. Moreover, of the literature on the ProQOL 5, less is known about the professional quality of life of individuals who are still in training in graduate school settings. In fact, only one other study was located that examined compassion satisfaction with trainee therapists (Beaumont et al., 2016).

Exploring new ways of promoting compassion satisfaction, such as mindfulness, and implementing these practices may help decrease or prevent burnout and secondary traumatic stress, which may be of particular interest to graduate training programs as educators strive to teach future clinicians not only clinical skills but also ways to engage in effective self-care strategies. The current study is one of four total studies evaluating mindfulness and compassion satisfaction.

Thus, providing information about compassion satisfaction in a sample of trainee therapists appears to be a valuable contribution to the literature and graduate training programs. The present study provided information about compassion satisfaction using the only known measure of this construct, the ProQOL (Stamm, 2010). In the present study, the mean compassion satisfaction score on the ProQOL at pre-test was 55.31 ($SD = 7.22$), and at post-test was 53.69 ($SD = 6.66$), both in the average range and suggesting expected levels of compassion satisfaction. To place this finding in context, means are compared to the few related studies with similar samples.

Of the three studies investigating compassion satisfaction and mindfulness with social workers, only one was located that provided mean compassion scores for the ProQOL 5. Gregory (2015) did not explicitly report means while Thomas and Otis (2010) utilized an older version of the ProQOL, the ProQOL R-IV. Compared to Decker et al.'s (2015) study mentioned previously with social work interns, these scores were higher than the majority of scores from their participants. Sixty-six percent of their participants scored t-scores of 43 or lower, and only two participants scored a t-score of 50 (Decker et al., 2015). Differences in characteristics of the samples include sample size ($n = 111$ vs. $n = 13$), nature of social work versus clinical psychology training, and years of clinical experience. Decker et al. (2015) required participants to have at least one year of clinical experience while the majority of participants in the current study were first year students who had no previous experience providing psychotherapy. Another difference between the current study and Decker et al.'s (2015) study is Decker et al. (2015) did not utilize a mindfulness intervention, only a self-report measure of mindfulness administered at one time point.

Years of experience may be a major factor to consider given comparable findings with other samples of clinical/counseling students and professionals; other studies with developing clinicians utilized samples who were toward the end of their graduate school training (Beaumont et al., 2016; Decker et al., 2015). In the current study's sample, the majority of students had never provided clinical services before engagement in the mindfulness training groups. In Beaumont et al.'s (2016) study with 54 student counselors who were in their last year of graduate school training [mindfulness was not a variable in that study], results revealed a mean compassion satisfaction score of 41.0 ($SD = 4.5$), similar to the majority of participants in Decker et al.'s (2015) study; both lower than the present study's mean scores. Additionally,

Craig and Sprang (2010) noted trauma treatment therapists with more experience reported higher levels of compassion satisfaction on the ProQOL than beginning therapists. Since this study used a previous version of the ProQOL, which did not use t-scores, only raw scores, it is difficult to directly compare their scores to the present study given how the ProQOL is currently scored. Notwithstanding, 46% of their participants scored at least one standard deviation above the average. In contrast, in a sample of staff working in Italian community-based mental health services, compassion satisfaction scores for the most experienced professionals were almost one standard deviation below the average (Rossi et al., 2012).

Contrary to the study's hypothesis that compassion satisfaction would increase after mindfulness group participation, results revealed a slight, non-statistically significant decrease in scores after engagement in the mindfulness groups. A decrease in scores could have occurred for a variety of reasons, including being further along in a graduate program, similar to some of the studies mentioned previously (Beaumont et al., 2016; Decker et al., 2015). Also, although participants in this study engaged in a mindfulness group, attendance at these groups does not necessarily translate to incorporation of mindfulness or contemplative practices in one's personal life. There was no assessment in the present study of students' self-reported level of mindfulness as utilized in Decker et al. (2015) and Thomas and Otis (2010), although this information was collected in the broader research project database. With that said, however, descriptive data was collected about students' self-reported engagement in different mindfulness/contemplative practices before and after the groups. This data revealed previous engagement in a variety of different practices, such as prayer, meditation, yoga, and mindful walking. After engagement in the mindfulness groups, some participants began new practices, some continued previous practices, and some no longer reported engaging in mindfulness/contemplative practices.

Considering a previous study in the field of social work suggesting engagement in mindfulness practice may halt the decrease of compassion satisfaction (Gregory, 2015), results of this study could be viewed in this manner. The decrease in compassion satisfaction from pre-mindfulness training to post-mindfulness training was insignificant, suggesting similar levels of compassion satisfaction at both time points. According to Gregory (2015), providing helping professionals with self-care resources impacts not only the clinicians but also their clients and the organizations for which they work. Without it, decreases in compassion satisfaction may impact the quality of clinical services provided as well as one's likelihood to continue working at a particular agency or with a challenging population (Gregory, 2015).

In order to further understand the results of the current study, methodological limitations are considered next. The insignificant difference also allows for opportunities for future research, which is valuable in research like this in its exploratory stage.

Limitations

Regarding data analysis limitations, using a t-test allows one to make conclusions about means, but not about individuals. Therefore, the results of this study may not be generalizable to the majority of developing therapists. Also, a t-test does not account for other variables that may affect variance, such as various demographic factors (e.g., gender, age), previous engagement in mindfulness/contemplative practices, and experience of the groups. Regarding demographic factors, the general homogeneity of the participants selected for the study included that the majority of students were single, Caucasian females ranging from 21 to 30 years of age ($M = 23.92$, $SD = 2.5$). Although this is a limitation, comparable studies showed similar demographics. More specifically, Gregory (2015) also had a predominantly Caucasian female sample. Although Decker et al. (2015) and Thomas and Otis (2010) did not report ethnicity of

their samples, they had predominantly female samples as well. Compared to the samples in these studies, the sample of the current study is notably younger in age. The mean age of Decker et al.'s (2015) sample was 32.17 ($SD = 8.23$), Gregory's (2015) sample was 44.73 ($SD = 14.4$), and Thomas and Otis's (2010) sample was 50.34 ($SD = 10.85$). In the current study, there was more variability in regards to religious identification and the number of individuals living in one's household. Although no research was located considering the role of household members, a dissertation study found no relationship between religiosity and compassion satisfaction (Gillespie, 2014).

In addition, previous engagement in mindfulness/contemplative practices may have influenced students' experiences in the available groups and influenced self-reports of compassion satisfaction as well. Students' previous experiences engaging in mindfulness/contemplative practices may have influenced their ability to actively engage in the exercises and benefit from the training offered. Experience with mindfulness/contemplative practices may also have influenced participants' pre-mindfulness group self-reports of compassion satisfaction. If some participants had consistently engaged in mindfulness/contemplative practices before beginning the formal mindfulness training groups, their self-reported compassion satisfaction at that time may have been higher than would be expected for individuals who had no previous experience engaging in mindfulness/contemplative practices. There was no research located evaluating previous engagement in mindfulness/contemplative practices before receiving a mindfulness intervention and compassion satisfaction.

It should also be noted that the data from those that participated in the mindfulness groups was not compared to individuals who did not participate, another potential limitation to

the results. In addition, there was no control group, which limits the ability to attribute a difference, or in the case of this study a halting of a significant decrease in compassion satisfaction, to engagement in the mindfulness/contemplative practices.

Regarding the time points used to evaluate compassion satisfaction, the pre-mindfulness and post-mindfulness time points were the same for every participant, fall 2013 and summer 2014. However, some students elected to participate in one mindfulness group while others participated in two. Therefore, the amount of structured group mindfulness practice varied within the sample. Given the small sample size and other variables to consider, such as length of time in the graduate program and providing clinical services, it was decided to use a consistent post-mindfulness time point. These differences can greatly influence ratings of compassion satisfaction, posing another limitation to this study. A comparable study with social workers noted variance as well as participants did not attend the same number of mindfulness sessions (Gregory, 2015).

Another factor to consider is facilitator differences of the two different groups offered in fall 2013. The leaders had different levels of experience, possibly influencing experience in the groups as well as self-reported compassion satisfaction. Although some programs, such as mindfulness-based stress reduction, have suggested standards for teachers and instructors (Kabat-Zinn et al., 2016), one study investigating mindfulness-based cognitive therapy and depression found teacher competence was not significantly associated with treatment adherence or outcomes (Huijbers et al., 2017). Another study revealed an interesting finding regarding the background of mindfulness teachers. Waelde, Thompson, Robinson, & Iwanicki (2016) found trauma therapists who were trained in mindfulness and meditation by a mental health professional were more likely to integrate mindfulness and meditation in their clinical work.

However, therapists who were trained in mindfulness and meditation by a spiritual teacher were more likely to teach clients to implement mindfulness and meditation in their daily lives between sessions and to report more personal practice of mindfulness and meditation than those who were taught by a mental health professional (Waelde et al., 2016).

Another limitation of this study concerns the characteristics of the sample. There was a small sample size, and the students were not randomly selected. These factors influence external validity or generalizability and decrease the likelihood that the selected participants represented the broader population of all clinical psychology graduate students. However, the only other study that could be located that has looked at compassion satisfaction and mindfulness training was conducted in the field of social work and similarly used a small sample ($n = 11$; Gregory, 2015), which appears appropriate for exploratory work.

Regarding the sample of the current study, another limitation is the data only represent a subset of helping professionals. Participants were graduate students in a psychology program at a small, private, and Christian university, which influences how generalizable the findings are to other developing clinicians in other size universities, training facilities without as many financial resources, and programs without an affiliation to a religious organization.

Additionally, there was variation in participant adherence to the mindfulness groups. Conflicts could have arose and therefore prevented all students from participating consistently in the groups. Regarding attendance, students may also have felt pressured to engage in the mindfulness training groups to be perceived in a positive light by their professors and program administrators, which may have influenced their ability to fully engage in the mindfulness practices. No current research exists that investigates what would be a sufficient amount and consistency of mindfulness training and at-home practice to see a reasonable impact on

compassion satisfaction. For mindfulness-based stress reduction, one study noted the correlation between mean effect size for psychological distress and number of in-class hours was nonsignificant for both clinical and nonclinical samples (Carmody & Baer, 2009). Since other literature has suggested few significant associations between amount of meditation practice and positive outcomes (Zeng, Chio, Oei, Leung, & Liu, 2017), more research is warranted in this area generally and specifically pertaining to compassion satisfaction.

When utilizing specific self-report measures, in this case the ProQOL 5, it is important to consider the items used and the constructs for which they are intended to measure. The ProQOL 5 has been revised over the years, and it appears to measure its constructs. However, there may be components of compassion satisfaction that are not represented in the items of the questionnaire, and no other measures of compassion satisfaction were located to which to compare it. Utilizing the ProQOL 5 could have limited the types of information obtained from participants, potentially missing out on other aspects about compassion satisfaction the participants may have wanted to share about their experiences. Although qualitative measures such as a post-group participation interview were conducted, they were not utilized in this study and did not focus specifically on the construct of compassion satisfaction. Using specific self-report measures also limited the present study from exploring new avenues of information or analyzing data from a different perspective, such as looking at progress in development of clinical skills. However, of note, supervisor evaluations were gathered in the broader research program.

A final limitation of using the ProQOL 5 was the need to modify the instructions to fit the current sample. Since students were asked to consider their role as a helper, although many professional roles are interchangeable with this term (such as practicum trainees), it is not known

whether the role of a pre-practicum trainee felt congruent with helper to the students or if the experiences are comparable as the majority of individuals in the current sample were in this latter group; they never provided clinical services at the master's level before engagement in the mindfulness groups.

Future Research

Although the results of this study did not demonstrate any significant changes on the compassion satisfaction scale of the Professional Quality of Life 5 questionnaire from pre-mindfulness training to post-mindfulness training, the outline of this study lays the groundwork for future research in this area. A larger study with more participants, a control group, and random selection to groups may yield information regarding factors that may influence compassion satisfaction and mindfulness training with developing clinicians, specifically in graduate psychology programs. Demographic factors such as gender, age or ethnicity as well as religiosity/spirituality and previous engagement in mindfulness/contemplative practices may be related to compassion satisfaction and mindfulness training and could be examined through use of an analysis of covariance. More research is needed in order to understand how different cultural factors and contexts are related to compassion satisfaction. In addition, facilitator differences may also be related to experiences of mindfulness training and/or levels of compassion satisfaction and may be further explored by comparing compassion satisfaction of participants based on who facilitated their mindfulness training.

Future questions to be explored may include investigating the length of time or amount of mindfulness or other types of practices necessary to produce a noticeable difference in compassion satisfaction since individuals may define mindfulness/contemplative practices differently. Since the limited literature in this area presents contrasting views on the suggested

amount of meditation practice or engagement in a mindfulness-based stress reduction training course as related to positive outcomes (Carmody & Baer, 2007; Zeng et al., 2017), more research is needed to investigate this area of interest. For example, one study may utilize a control group along with two or three different groups participating in the same type of mindfulness practice but for varying lengths of time. In order to ensure relatively equal participation in the groups, only data from participants who attended the majority of group sessions would be used for analysis. In addition, individuals could be grouped together based on previous engagement in mindfulness/contemplative practices. A repeated measures analysis of variance may be used to determine if there are any significant changes in compassion satisfaction over time. This study design would provide information regarding any significant differences in compassion satisfaction related to varying lengths of time of engagement in mindfulness/contemplative practices as well as previous experience with mindfulness/contemplative practices. In addition, as noted in the previous paragraph, different moderating variables may be explored, such as demographic factors or previous engagement and level of experience with mindfulness/contemplative practices.

One way to make mindfulness training groups more accessible is to increase the frequency of times groups meet or incorporate a drop-in policy for attendance. To test the hypothesis that mindfulness may result in a maintenance of or increase in compassion satisfaction, one study may investigate compassion satisfaction based on frequency of engagement in structured group mindfulness practice by separating participants into different groups depending on their frequency of attendance. Eliciting information from students about various factors that are related to their frequency of engagement in a formal mindfulness group and incorporating qualitative research such as participant interviews may elucidate any variation

in frequency of practice among students. Such research could have the potential to inform students about self-care strategies that may prove beneficial and meet the specific needs of graduate psychology students in training.

Regarding engagement in mindfulness practice outside of a structured group, decreasing the length of time of suggested practice between group meetings may increase the likelihood of students incorporating mindfulness in their personal lives. A study with college students investigated length of time of mindfulness meditation by prescribing either ten or twenty minutes of daily meditation for two weeks, and results revealed no difference in adherence between the groups; however, the participants who engaged in twenty minutes of daily meditation experienced an increase in self-compassion (Berghoff, Wheelless, Ritzert, Wooley, & Forsyth, 2017). Although this study investigated self-compassion and not compassion satisfaction, it provides information suggesting that one may not need to engage in lengthy mindfulness/contemplative practices in order to experience positive benefit. If only twenty minutes of mindfulness meditation results in a difference, busy graduate students may be more likely to engage in this type of practice.

Another way to provide formal mindfulness training in an accessible way is to present training in a different format. One study provided online mindfulness modules to psychologists, social workers, physicians, nurses, dietitians, and other health professionals (Kemper, 2017). Results revealed significant improvements on the Cognitive and Affective Mindfulness Scale-Revised, the Mindful Attention Awareness Scale, and the Five Facet Mindfulness Questionnaire (Kemper, 2017). Providing developing clinicians with online mindfulness training and resources may be more appealing to some students and easier for students to access on their own time, and research is needed to explore this method of mindfulness training further.

Previous research has also suggested emotional separation and specific practices, such as yoga, as other factors that may influence compassion satisfaction (Gregory, 2015; Thomas & Otis, 2010). Another study may investigate different types of practices and compassion satisfaction over time. To evaluate emotional separation, the Maintenance of Emotional Separation scale may be utilized in conjunction with the ProQOL 5 in investigating mindfulness/contemplative practices and compassion satisfaction. To decrease burnout and secondary traumatic stress, emotional separation has been suggested as a balance to empathy (Thomas & Otis, 2010). Developing clinicians' ability to achieve this balance may be related to mindfulness/contemplative practices and compassion satisfaction and could be tested by using a factorial analysis of variance.

Future research may also explore compassion satisfaction at different time points during graduate training. Experience providing clinical services may be related to pre-mindfulness training group levels of compassion satisfaction. Such study designs could include evaluating compassion satisfaction before and after engagement in mindfulness/contemplative practices at the beginning of a graduate program, in the middle, and towards the end with individuals who have the same amount of experience providing clinical services. It would be helpful for future research to have normative data at these different time points. In addition, future study designs may also evaluate the different settings or types of populations with which developing clinicians are working. To accomplish this goal, a study could group participants based on the type of setting in which they work or by specific populations with whom they work, as working with certain populations may be more challenging than others.

Finally, future research may explore the construct of compassion satisfaction and help determine if there are better ways to measure this experience. There was only one instrument

located that measures compassion satisfaction. Information obtained from participant interviews or other qualitative ways of gathering data, such as written journal entries, may contribute to a better understanding of compassion satisfaction as well as development of new quantitative measures.

Conclusion

In sum, developing clinicians need tools that will allow them to succeed in their graduate programs as well as have skills to cope with the stress that comes with balancing academic and clinical work. In the pursuit of training future leaders in the field, development of these skills may encourage growth and progress toward professional goals. Mindfulness training has been proposed as one way of buffering the stressors of clinical graduate programs (Shapiro et al., 2007) and positively influencing the ability of developing clinicians to learn clinical skills (Myers et al., 2012). Mindfulness may also be a useful tool in allowing developing clinicians to experience compassion satisfaction and continue to cultivate this aspect of professional quality of life throughout their clinical work (Thomas & Otis, 2010). Mindfulness may contribute to halting a decrease in compassion satisfaction, as suggested by the maintenance of compassion satisfaction scores presented in the current study and Gregory's (2015) study. Encouraging developing clinicians to maintain compassion satisfaction despite the challenges of graduate training will further promote an experience of a sense of pleasure from their clinical work, which is something that can be continued as they begin their careers.

Due to the lack of research in this area, this study lays the groundwork for future research focusing on compassion satisfaction, developing clinicians, and mindfulness training. It was only one of four total studies that examined these variables together using the only measure of compassion satisfaction currently available, and was the only one to use a sample of clinical

psychology trainees. Future research may help inform graduate program curriculum for students who are in training for clinical professions as well as encourage developing clinicians to engage in mindfulness/contemplative practices in order to promote experiences of compassion satisfaction.

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Tables

Table 1.

Demographic Factors

Variable	Total Sample <i>n</i> = 13
Year in Program	
First	9 (69.2%)
Second	4 (30.8%)
Gender	
Female	10 (76.9%)
Male	3 (23.1%)
Ethnicity	
Caucasian	7 (53.8%)
African American	1 (7.7%)
Biracial	4 (30.8%)
Three or More Ethnicities	1 (7.7%)
Religion	
Christian	5 (38.4%)
Spiritual in Energy	1 (7.7%)
Two Religious Groups	1 (7.7%)
Agnostic	3 (23.1%)
No Religious Group	1 (7.7%)
Did not Report	2 (15.4%)
	(continued)

Variable	Total Sample
	<i>n</i> = 13
Relationship Status	
Single	9 (69.2%)
Engaged	1 (7.7%)
Long-Term Relationship	2 (15.4%)
Married	1 (7.7%)
Number in Household	
1	2 (15.4%)
2	4 (30.8%)
4	6 (46.1%)
5	1 (7.7%)

Table 2.

Fall 2013 Report of Previous Mindfulness/Contemplative Practice

Previous Mindfulness/Contemplative Practice	Total Participants
	<i>n</i> = 13
Prayer	4 (30.8%)
Centering Prayer	0 (0%)
Meditation	5 (38.4%)
Yoga	6 (46.1%)
Mindful Walking	4 (30.8%)

Table 3.

Fall 2013 Report of Length of Time of Previous Mindfulness/Contemplative Practice

Type of Mindfulness/Contemplative Practice	Length of Time	Total Participants
<i>n</i> = 13		
Prayer	None	8 (61.5%)
	5 years	1 (7.7%)
	15 years	1 (7.7%)
	20 years	2 (15.4%)
	Did not Report	1 (7.7%)
Meditation	None	8 (61.5%)
	6 months	1 (7.7%)
	1 year	2 (15.4%)
	9 years	1 (7.7%)
	10 years	1 (7.7%)
Yoga	None	7 (53.8%)
	6 months	1 (7.7%)
	1 year	2 (15.4%)
	4 years	1 (7.7%)
	6 years	1 (7.7%)
	10 years	1 (7.7%)
Mindful Walking	None	9 (69.2%)
	6 months	1 (7.7%)
	1 year	2 (15.4%)
	5 years	1 (7.7%)

Table 4.

Summer 2014 Mindfulness/Contemplative Practice after Mindfulness Training

Mindfulness/Contemplative Practice	Total Participants
	<i>n</i> = 13
Began Prayer	2 (15.4%)
Began Centering Prayer	2 (15.4%)
Began Meditation	3 (23.1%)
Began Yoga	2 (15.4%)
Began Mindful Walking	3 (23.1%)
Continued Meditation	2 (15.4%)
Continued Yoga	2 (15.4%)
Continued Mindful Walking	3 (23.1%)
Stopped Prayer	4 (30.8%)
Stopped Meditation	3 (23.1%)
Stopped Yoga	4 (30.8%)
Stopped Mindful Walking	1 (7.7%)

Table 5.

Fall 2013 Report Regarding Psychotherapy Provision

Providing Psychotherapy	Total Participants
	<i>n</i> = 13
Length of Time	
None	8 (61.5%)
6 months	1 (7.7%)
7 months	2 (15.4%)
9 months	1 (7.7%)
3 years	1 (7.7%)
Theoretical Orientation	
Cognitive Behavioral Therapy	2 (15.4%)
Psychodynamic	1 (7.7%)
Humanistic	1 (7.7%)
Eclectic	1 (7.7%)
Two Different Orientations	2 (15.4%)
Three or More Different Orientations	1 (7.7%)
Do not Know Yet	4 (30.8%)
Did not Report	1 (7.7%)

Table 6.

Fall 2013 Report of Engagement in Personal Psychotherapy

Engagement in Personal Psychotherapy	Total Participants
	<i>n</i> = 13
None	6 (46.1%)
1 month	1 (7.7%)
2 months	1 (7.7%)
3 months	1 (7.7%)
2 years	1 (7.7%)
7 years	1 (7.7%)
10 years	1 (7.7%)
Did not Report	1 (7.7%)

APPENDIX A

Extended Review of the Literature

This dissertation aimed to examine mindfulness training and compassion satisfaction in developing clinicians. To provide context for this goal, this extended review of the literature summarizes and critiques the literature on clinicians and compassion satisfaction and compassion satisfaction and mindfulness. This extended review of the literature, revised since the preliminary orals, served as the basis for the final dissertation's brief literature review.

Clinicians and Compassion Satisfaction

Compassion satisfaction allows individuals to experience a sense of pleasure from their work. Promoting compassion satisfaction in professionals who work in helping fields may prevent or decrease the negative experiences of burnout and secondary traumatic stress. Six studies in the medical field will be reviewed (Burtson & Stichler, 2010; Joubert, Hocking, & Hampson, 2013; Mason, 2013; Mizuno, Kinefuchi, Kimura, & Tsuda, 2013; Prati, Pietrantonio, & Cicognani, 2010; Simon, Pryce, Roff, & Klemmack, 2005), followed by four studies involving mental health professionals. Only two of these studies involved trainees. Furthermore, mindfulness was not investigated in any of these studies, an important component of the current study, but is discussed in the subsequent section's review of research on compassion satisfaction and mindfulness.

Helping professionals in medical settings. Compassion satisfaction has been evaluated with professionals who work in a variety of medical settings. After discussing a study with Japanese nurses working in abortion and childbirth services, two studies with oncology social workers are presented; each of the three studies showed a negative association between compassion satisfaction and burnout. Then, two studies are described that looked at other factors associated with compassion satisfaction, namely self-efficacy in a sample of Italian rescue workers and meaning in a sample of trainee nurses.

In order to investigate the scales of the ProQOL and relationships with positive and negative emotions, one study evaluated nurses and self-reported stress. Japanese nurses and midwives working in abortion and childbirth services ($n = 255$) completed the ProQOL and the Japanese version of the Frankfurt Emotional Work Scale (FEWS-J; Mizuno et al., 2013). Scores on the ProQOL on compassion satisfaction, compassion fatigue, and burnout were significantly associated with self-reported stress related to the emotionally taxing professional requirements of the medical field in this specific area (Mizuno et al., 2013). More specifically, scores for negative emotions, emotional dissonance, and sensitivity requirements on the FEWS-J were significantly positively correlated with ProQOL scores for compassion fatigue (Mizuno et al., 2013). On another questionnaire regarding stress factors, “difficulty in controlling emotions during abortion care,” “thinking that the aborted fetus deserved to live,” and “difficulty in supporting patient behavior while providing abortion care” also had a significant positive relationship with ProQOL scores for compassion fatigue (Mizuno et al., 2013, p. 544). Finally, the score for positive emotions display on the FEWS-J had a significant positive relationship with ProQOL scores for compassion satisfaction, indicating that positive emotions may be associated with compassion satisfaction (Mizuno et al., 2013). Although this study demonstrates relationships of the scales of the ProQOL with positive and negative emotions with Japanese nurses and midwives, correlations from this study may not be applicable to developing clinicians. In addition, there was no control group utilized in this study, another limitation to keep in mind. In evaluating the scales of the ProQOL along with the Mueller McCloskey Satisfaction Scale, the Stress in General Scale, and the Caring Behaviors Inventory, Burtson and Stichler (2010) studied a sample of 126 medical nurses at a single academic medical center who had high stress jobs. They found compassion satisfaction and stress associated with burnout may

be inversely related (Burtson & Stichler, 2010). A statistically significant positive relationship was found between nurse caring and compassion satisfaction, and a statistically significant negative relationship between nurse caring and burnout (Burtson & Stichler, 2010). A statistically significant negative relationship was also identified with knowledge and skill and compassion fatigue (Burtson & Stichler, 2010). Burtson and Stichler (2010) conducted a hierarchical multiple regression analysis and found compassion satisfaction and nurse satisfaction with social interaction opportunities related to work was accountable for variability in nursing care. Limitations of this study include the use of a convenience sample that consisted of a disproportionate representation of nurses from the medical surgical division and the lack of inclusion of possible confounding variables that could influence responses to the self-report measures, such as variables related to patients or organizational changes. This study also did not utilize a control group or gather self-report information over time.

A study with oncology social workers, identified as members of the Association of Oncology Social Workers, found similar relationships among the scales of the ProQOL (Simon et al., 2005). Of all the potential participants who were sent surveys by Simon et al. (2005), 21 oncology social workers returned completed usable forms, 20 were female and 20 were Caucasian. Statistical analysis of the survey data noted compassion fatigue and burnout were inversely related to compassion satisfaction (Simon et al., 2005). Limitations of this study include a small number of participants and lack of a control group. In addition, the sample utilized was demographically heterogeneous, as participants were mostly Caucasian females.

In another exploratory study with oncology social workers, Joubert et al. (2013) suggested high levels of compassion satisfaction, measured with the third ProQOL scale, in the work environment may mitigate stress and burnout, as measured by the ProQOL and the

Traumatic Stress Institute Belief Scale. After administering these scales, Joubert et al. (2013) facilitated a focus group, learning that participants viewed compassion satisfaction as helpful in mitigating stress and burnout experienced at work. Given the very small number of participants, findings from this study must be interpreted with caution. In addition, the study did not use a control group or follow participants over time. They also utilized an older version of the ProQOL, making it difficult to compare their results with the most recent version of this measure.

Other factors have been considered as having a relationship with compassion satisfaction, burnout, and secondary traumatic stress, such as self-efficacy. A study with 451 Italian rescue workers, including firefighters, paramedics, and medical technicians, showed that self-efficacy may impact the effect of perceived stressful events on professional quality of life (Prati et al., 2010). Self-efficacy had a significant positive correlation with compassion satisfaction and significant negative correlations with compassion fatigue and burnout (Prati et al., 2010). Individuals with higher self-efficacy may have experienced less of a negative effect from stressful and traumatic events on their professional quality of life, as measured using the ProQOL, than rescue workers with self-reported lower self-efficacy. Limitations of this study include lack of a control group and demographic heterogeneity in regards to nationality.

Another factor that has been considered in relationship to compassion satisfaction, compassion fatigue, and burnout is meaning. One study evaluated meaning and compassion satisfaction with professionals-in-training in the nursing field. Mason (2013) used the ProQOL scale and the Life Purpose Questionnaire to evaluate professional quality of life and meaning in a sample of eighty nursing students. In addition to meaning being positively associated with compassion satisfaction, after evaluating correlational results, negative correlations were found

between meaning and both compassion fatigue and burnout (Mason, 2013). Because there was no comparison group in this study, it is difficult to determine what factors about this population and/or their work may have influenced this finding. In addition, this study used self-report measures and did not implement mindfulness training, an area of investigation for the current study.

Mental health professionals. Consistent with this research in medical fields, other studies have used the ProQOL with mental health professionals. Only four studies were located in a review of the literature for this dissertation, and only one with trainees. Also, all of the studies presented evaluated compassion satisfaction at one time point and did not follow participants over time. Although these studies provide information on the compassion satisfaction scale of the ProQOL, none investigated mindfulness, a component of the current study; studies that met this criteria are discussed in the next subsection.

One group of researchers (Beaumont, Durkin, Hollins Martin, & Carson, 2016) investigated compassion satisfaction, compassion fatigue, burnout, self-compassion, and well-being in student counselors. They used the Professional Quality of Life Scale, Self-Compassion Scale, short Warwick and Edinburgh Mental Well-Being Scale, and Compassion for Others Scale with 54 student counselors who were in their final year of graduate training (Beaumont et al., 2016). No other demographic information was provided regarding the sample (Beaumont et al., 2016). Pearson's correlations show high levels of compassion satisfaction are significantly associated with high levels of well-being and compassion for others and low levels of burnout and compassion fatigue (Beaumont et al., 2016). In addition, self-compassion and well-being are significantly associated with lower compassion fatigue and burnout (Beaumont et al., 2016).

Limitations of this study include a limited sample size, lack of a comparison group, and measurement at one time point instead of following participants over a length of time.

Regarding clinical experience, other research suggests more experienced therapists endorsed higher levels of compassion satisfaction on the ProQOL (Craig & Sprang, 2010) than beginning therapists. In a national sample of 532 trauma treatment therapists from 46 states and Washington, D.C., Craig and Sprang (2010) utilized the ProQOL scale and the Trauma Practices Questionnaire with licensed social workers and psychologists; 73% of whom worked in community mental health settings. Craig and Sprang's (2010) sample was 65% female with a mean age of 53.2 years (ranging from 27 to 83). Fifty-two percent of the sample had doctoral-level training, and mean clinical experience was 22.9 years ($SD = 9.28$), ranging from one to 58 years (Craig & Sprang, 2010). Although 98% of the sample reported having current clients on their caseload who were suffering from post-traumatic stress disorder, just over half (62%) of participants reported receiving specialized training in treating individuals who had experienced trauma (Craig & Sprang, 2010). Utilizing an analysis of variance and hierarchical regression models, Craig and Sprang (2010) found evidence-based practices were associated with lower compassion fatigue and burnout scores and higher compassion satisfaction scores; this relationship was not found with other types of practices. They also found younger professionals reported higher levels of burnout than older professionals, and that more experienced professionals endorsed higher levels of compassion satisfaction than beginning professionals (Craig & Sprang, 2010). These findings further emphasize the potential importance of promoting compassion satisfaction in developing therapists who are just beginning to enter the field, as they may feel less compassion satisfaction because of lack of experience in working

with clients. Limitations of this study include lack of a control group and analysis of data from one time point rather than following participants over time.

Utilizing the ProQOL in a different setting, Gallavan and Newman (2013) evaluated a sample of 101 currently practicing correctional mental health professionals in the Departments of Corrections in Wyoming, Oklahoma, Arkansas, Missouri, Alabama, and Pennsylvania; no control group was used. The sample included 45 men, 55 women, and one individual who did not report sex; the mean age of the participants was 46 years old (Gallavan & Newman, 2013). Over half of the participants ($n = 72$) were master's-level clinicians; clinical experience in a correctional setting was a mean of 8.47 years (Gallavan & Newman, 2013). Seventy percent of participants reported being married, and 53.9% of participants reported having children (Gallavan & Newman, 2013). The study investigated predictors of burnout among correctional mental health professionals by examining both positive and negative experiences of work (Gallavan & Newman, 2013). Using principal components analysis, the researchers incorporated the compassion satisfaction scale of the ProQOL into a component encompassing positive experiences of work (Gallavan & Newman, 2013). This component was related to a sense of competence, success, and satisfaction in one's work and was derived from scales on both the Maslach Burnout Inventory-Human Services Survey and the ProQOL (Gallavan & Newman, 2013). The component encompassing negative experiences of work was related to the experience of being emotionally spent, detached, and socially avoidant (Gallavan & Newman, 2013). Limitations of this study include no control group, as mentioned previously, and collection of self-report data at one time point.

In a sample of community mental health professionals in Verona, Italy, Rossi et al. (2012) used the ProQOL with a sample of 260 individuals (33.3% male and 66.7% female),

including psychiatrists, psychologists, social workers, psychiatric nurses, rehabilitation therapists, and healthcare support workers with psychological distress (measurement not reported). Participants were asked to complete the Professional Quality of Life Scale, the General Health Questionnaire, and a socio-demographic questionnaire (Rossi et al., 2012). In evaluating compassion fatigue and burnout in this study, several factors were associated with different scores on these scales. Rossi et al. (2012) found psychiatrists and social workers had the highest levels of compassion fatigue and burnout compared to other mental health professionals. In addition, being female and having experienced one negative life event in the previous year were associated with a higher level of compassion fatigue than being male and/or not having the same amount of negative life experience (Rossi et al., 2012). Rossi et al. (2012) also found that individuals scored significantly higher than their peers on the compassion fatigue and burnout scales for each additional year they had worked for the mental health department. It appears psychiatrists, social workers, being female, experiencing negative life events, and working in the field for a long period of time may have put some individuals at risk for experiencing compassion fatigue and burnout.

Regarding compassion satisfaction, study participants with psychological distress reported lower levels of compassion satisfaction on the ProQOL than professionals without psychological distress (Rossi et al., 2012). This finding further suggests that compassion satisfaction has an inverse relationship to psychological distress for clinicians and other individuals in the helping professions. Regarding the applicability of these findings to the current study, there are several limitations, such as lack of a control group and one time point of measurement.

Compassion Satisfaction and Mindfulness

Mindfulness has been incorporated in a variety of different settings due to the positive benefits experienced by diverse groups of individuals, including health care settings, mental health settings, social work, and training programs in psychology and education (Butryn et al., 2013; Christopher et al., 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Irving, Dobkin, & Park, 2009; McCollum & Gehart, 2010; McGarrigle & Walsh, 2011; Shapiro, Warren Brown, & Biegel, 2007; Tarrasch, 2015; van der Valk, van de Waerdt, Meijer, van den Hout, & de Haan, 2013). Research in medical settings suggests that mindfulness may be associated with a decrease secondary traumatization, increase a sense of personal accomplishment, less emotional exhaustion, depression, and anxiety (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013; Potter et al., 2013). Research is needed to investigate whether developing clinicians in psychology might experience these benefits as well.

In regards to the helping professions, mindfulness has been implemented with professionals and trainees as a way to encourage self-care as well as positively influence clinical work and training (Bonifas & Napoli, 2014; Christopher et al., 2011; Felton, Coates, & Christopher, 2013; Hemanth & Fisher, 2014; McCollum & Gehart, 2010; Rimes & Wingrove, 2010; Shapiro et al., 2007; Tarrasch, 2015). In her review of the literature on mindfulness-based psychotherapies and the utility of mindfulness training for clinical practice education in the field of social work, Gockel (2010) concluded that mindfulness training may foster essential clinical skills and attitudes, increase self-care, reduce the impact of occupational stress, and prepare students to understand and use mindfulness-based interventions in practice.

Of interest to the present dissertation is the idea that mindfulness may help alleviate the negative effects of compassion fatigue and increase compassion satisfaction. Only three studies

were located in a review of the literature conducted for this study that investigated mindfulness and compassion satisfaction. All were conducted in the field of social work, and only one was with social work trainees. Each is discussed and critiqued here.

In the only study of the three with trainees, Decker, Brown, Ong, & Stiney-Ziskind (2015) looked at mindfulness, compassion fatigue, and compassion satisfaction in 111 social work interns (Decker et al., 2015). The sample consisted of master's students at a campus of the California State University system who had at least one year of clinical experience. The participants ranged in age from 22-61 ($M = 32.17$, $SD = 8.23$), and the majority of participants were female. Regarding clinical experience, reports ranged from one year to more than ten years and involved direct clinical practice ($n = 109$; $M = 3.34$, $SD = 2.42$), administrative experience ($n = 104$; $M = 3.94$, $SD = 3.41$), and volunteer experience ($n = 102$; $M = 4.68$, $SD = 2.69$). The Professional Quality of Life Questionnaire (ProQOL; Stamm, 2010) was used to assess compassion fatigue and compassion satisfaction and the Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) was used to assess mindfulness. Using a Pearson product-moment correlation coefficient, results revealed mindfulness was positively correlated with compassion satisfaction and negatively correlated with compassion fatigue (Decker et al., 2015). Limitations of the study included demographic heterogeneity, given that the majority of participants who reported their gender (92.5%) were female, a limited sample size, lack of information regarding previous experience with mindfulness/contemplative practices, no comparison group, and not following the sample over time.

The next study in the field of social work was conducted by Thomas and Otis (2010), who evaluated emotional separation in the workplace (the intentional management of internal emotional states) in a sample of 171 social workers. The Professional Quality of Life R-IV,

Five-Facet Mindfulness Questionnaire, Interpersonal Reactivity Index, and Maintenance of Emotional Separation scales were administered to study participants who had an average length of clinical experience of 21.3 years ($SD = 10.12$; Thomas & Otis, 2010). Experience ranged from five years to 53 years (Thomas & Otis, 2010). Those who reported high levels of mindfulness and implemented emotional separation in the workplace reported experiencing compassion satisfaction, measured using the ProQOL (Thomas & Otis, 2010). Results highlighted skills that mental health caregivers can use to manage their own internal emotional states in the context of their professional lives (Thomas & Otis, 2010). Limitations of this study included no comparison group or a reported amount and frequency of mindfulness practice utilized among the study participants. Also, an older version of the ProQOL was utilized, rendering results difficult to compare directly with the most recent version of the ProQOL. Furthermore, the majority of the sample was female, and working in substance abuse counseling was over-represented with almost 85% of participants reporting their longest work tenure had been in this type of setting (Thomas & Otis, 2010).

In the only study of the three to examine the use of a mindfulness program, Gregory (2015) investigated how compassion fatigue and compassion satisfaction scores were affected before and after a yoga and mindfulness program. Eleven social workers participated in this study, with five assigned to the experimental group and six assigned to the control group (Gregory, 2015). The study lasted for three weeks, and participants in the experimental group engaged in one one-hour session of yoga and mindfulness per week (Gregory, 2015). Facilitated by a certified yoga instructor in an independent yoga studio, sessions involved guidance through deep breathing exercises, yoga postures, and mindfulness activities followed by group reflection (Gregory, 2015). Participants were also instructed to practice at home between sessions

(Gregory, 2015). The ProQOL 5 was utilized to evaluate compassion satisfaction, burnout, and secondary traumatic stress, and was administered at the beginning of the study and at the end of the study, after three weeks (Gregory, 2015). A paired sample t-test was utilized to evaluate pre-test and post-test effects of the yoga and mindfulness program on compassion satisfaction, burnout, and secondary traumatic stress (Gregory, 2015). Grounded theory was used to analyze information elicited from participant interviews (Gregory, 2015).

Results indicated a significant decline in compassion satisfaction from the beginning of the study compared to the end of the study for the control group and no significant difference in compassion satisfaction for the experimental group (Gregory, 2015). Scores for burnout and secondary traumatic stress remained the same (Gregory, 2015). Gregory suggested participation in a brief yoga and mindfulness program may halt a decrease in compassion satisfaction. In addition, participants were asked about their perception of their professional relationship with their clients (Gregory, 2015). Participant perceptions of their professional relationship with clients they identified as being difficult to work with also improved (Gregory, 2015). Limitations of this study included a small sample size and no random assignment to the control group. Participants were selected to participate in the yoga and mindfulness intervention based on availability.

Overall, these studies suggested that mindfulness is positively correlated with compassion satisfaction in individuals in the field of social work (Decker et al., 2015; Gregory, 2015; Thomas & Otis, 2010). Although the nature of social work may differ from the work of developing clinicians in psychology, these studies provide a foundation for similar research to be conducted in the field of clinical psychology. In addition, Gregory (2015) suggested that engagement in mindfulness practice may halt a natural decrease in compassion satisfaction over

time. This is of particular relevance to developing clinicians because of the implications for graduate training program development. One of the facets to potentially consider in such training programs and future research is the role of emotional separation, which Thomas and Otis (2010) introduced as a factor that may be related to mindfulness and compassion satisfaction.

Summary

Developing clinicians may be more likely to learn necessary clinical skills, perform effective therapy, and enjoy their work if they have a higher level of compassion satisfaction. More research on compassion satisfaction appears needed to explore how different individuals experience this phenomenon, what contextual variables may interact with compassion satisfaction, and if the existing scale captures the variability of this experience or whether other ways of assessment should be developed.

Theoretically, the detrimental effects of burnout and secondary traumatic stress may deter students from continuing to pursue clinical work before they finish their graduate studies. If graduate students' compassion satisfaction is being impacted by the stress of the program itself, programs should provide ways of coping, other resources, and contact information for community organizations that provide programming to help alleviate stress. Such strategies may allow students to continue not only to grow and develop as clinicians but gain a better sense of pleasure from the work they are completing. Promoting compassion satisfaction early in one's career may be a better alternative than solely focusing on decreasing burnout and secondary traumatic stress after students are already feeling these effects.

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APPENDIX B

IRB Notice of Approval



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: July 06, 2016

Protocol Investigator Name: Priscilla Morrison
Protocol #: 15-08-038
Project Title: Mindfulness Training and Developing Clinicians' Compassion Satisfaction
School: Graduate School of Education and Psychology

Dear Priscilla Morrison:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

APPENDIX C

Outline of Structured Mindfulness Group

- Week 1: Guided Body Scan Meditation
- Week 2: Guided Mindful Movement
- Week 3: Guided Walking Meditation
- Week 4: Guided Mindful Eating Exercise
- Week 5: Guided Sitting Meditation of Breath
- Week 6: Guided Lovingkindness (Metta) Meditation
- Week 7: Guided Sitting Meditation of Thinking
- Week 8: Guided Choiceless Awareness Meditation

APPENDIX D

Demographic and Spiritual Beliefs Questions

Demographic Questionnaire

Assessing the development of personal qualities related to counseling practice with therapists-in-training: Exploring the role of contemplative practice.

Demographic and Spiritual Beliefs Questions

Assessing the development of personal qualities related to counseling practice with therapists-in-training - Thank you for choosing to participate in the study!

Please choose a 4-digit ID number you can remember at the end of the term: _____

Gender: _____ Age: _____

Ethnicity: _____

Religious / Spiritual identification: _____

Relationship Status: _____

Number of Children: _____

Number of Occupants in Household: _____

Please list the length of your engagement with any and all of the contemplative practices below:

_____ Prayer _____ Centering Prayer _____ Meditation

_____ Yoga _____ Mindful Walking _____ Other Practice(s) (_____)

Year in MACLP program: Please Circle: 1 or 2

How long have you provided psychotherapy or counseling services? _____
(months/years)

How would you describe your theoretical psychotherapy/counseling orientation or approach to working with clients:

List length of time (if any) spent in personal psychotherapy: _____

APPENDIX E

Professional Quality of Life Scale (ProQOL) Version 5

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

When you *[help]* people 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 *[helper]*. Consider each of the following questions about you and your current work situation. 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 *[helper]*.
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 *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
- 12. I like my work as a *[helper]*.**
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 *[helping]* 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 *[helper]*.
- 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 *[helper]*.**
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.**

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/www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Note: Bolded items comprise compassion satisfaction scale.