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To cite this article: Ashley Martin-Cuellar, David T. Lardier Jr. & David J. Atencio (2021) Therapist mindfulness and subjective vitality: the role of psychological wellbeing and compassion satisfaction, Journal of Mental Health, 30:1, 113-120, DOI: [10.1080/09638237.2019.1644491](https://doi.org/10.1080/09638237.2019.1644491)

To link to this article: <https://doi.org/10.1080/09638237.2019.1644491>



Published online: 31 Jul 2019.



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Therapist mindfulness and subjective vitality: the role of psychological wellbeing and compassion satisfaction

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ABSTRACT

Background: Mindfulness and vitality are related constructs in the literature; however, mindfulness and vitality have not been fully examined in the literature, specifically with mental health therapists.

Aims: This study aimed to investigate the relationship between mindfulness and vitality among a sample of licensed mental health clinicians. Compassion satisfaction (CS) and psychological wellbeing are further explored as mechanisms by which a therapist may experience vitality and the impact mindfulness may have on these mechanisms.

Methods: Mediation analyses were utilized to understand the relationship between mindfulness and vitality and the indirect paths of psychological wellbeing and CS.

Results: Results indicate that therapists with greater mindfulness report more vitality, higher overall psychological wellbeing and higher CS. As expected, the relationship between mindfulness and vitality was mediated by psychological wellbeing and CS. Results support the existing research on the relationship between mindfulness and vitality.

Conclusions: Understanding the importance of psychological wellbeing and CS has implications for addressing the high incidences of the negative impact of therapeutic work.

ARTICLE HISTORY

Received 29 December 2018

Revised 6 April 2019

Accepted 13 June 2019

Published online 24 July 2019

KEYWORDS

Vitality; mindfulness; psychological wellbeing; compassion satisfaction

Introduction

Therapists tend to report positive feelings associated with their clinical work; yet, the extant research has largely highlighted the negative effects of working with clients (Lawson, 2007; Rosenberg & Pace, 2006). A glance at more recent literature signifies a shift toward the exploration of positive aspects of human experiences and adds a new perspective to view the counseling profession (Martin-Cuellar, Atencio, Kelly, & Lardier, 2018; Seligman & Csikszentmihalyi, 2000). Understanding the mechanisms by which clinicians derive fulfillment from their practice is an understudied area of inquiry in the counseling practice and burnout literature. This study aims to, therefore, examine the mechanisms related to clinicians' subjective perceptions of vitality, and more specifically, the relationship between mindfulness and vitality through psychological wellbeing and compassion satisfaction (CS).

Vitality is defined as the energy available to oneself (Ryan & Deci, 2008) and the positive feeling of being alive and feeling energetic (Ryan & Frederick, 1997). Mindfulness is self-attunement – i.e. the state of paying attention and being aware in the present moment (Brown & Ryan, 2003). While there is evidence to suggest a relationship between mindfulness and vitality (Brown & Ryan, 2003; Carlson & Brown, 2005), both research and practice have neglected the

influence of factors that may be impacting the relationship between a therapist's mindfulness and experience with vitality. Focusing on additional psychological factors such as psychological wellbeing – i.e. a multifaceted process of self-realization (Ryff, 2014) – and CS – i.e. the positive feelings derived from their compassionate work – (Stamm, 2002) may lead to a greater understanding of what enhances a clinician's experience with subjective perceptions of vitality and their positive experiences in the profession.

Mindfulness and vitality

Mindfulness is both the experience of being connected with the self in the present moment and being able to modulate and orient one's thoughts to the present (Kabat-Zinn, 1994). Mindfulness is also more broadly defined as a way of being through conscious awareness (Brown & Ryan, 2003) that empowers us to deconstruct aspects of our own selves (Singh, Lancioni, Wahler, Winton, & Singh, 2008). Kabat-Zinn (2009) emphasized specifically that mindfulness is a practice of “authentic embodiment of presencing” (p. X). The extant research has shown mindfulness to impact overall wellbeing (Brown & Ryan, 2003) and through present awareness, perceptions on stress and negative experiences are influenced (Neff & Vonk, 2009). As a result,

mindfulness decreases negative emotions (Goodman & Schorling, 2012; Hofmann, Sawyer, Witt, & Oh, 2010; McGarrigle & Walsh, 2011), serving as a catalyst for clinician wellness by operating as a mechanism of growth in compassion fatigue resilience (Figley & Figley, 2017).

Recent studies have shown that mindfulness-based practice serves as a protective factor for a variety of negative emotions such as anxiety and depression (Desrosiers, Vine, Klemanski, & Nolen-Hoeksema, 2013). Mindfulness has also been associated with CS (Decker, Brown, Ong, & Stiney-Ziskind, 2015; Thomas & Otis, 2010) and as a moderator for clinicians with a history of trauma in experiences with CS (Martin-Cuellar et al., 2018). These studies suggest that when clinicians are more mindful, they can better attune themselves, or connect with their inner experiences (Epstein, Siegel, & Silberman, 2008; McGarrigle & Walsh, 2011), and adjust to their moment-by-moment needs – i.e. both in and out of sessions (Shapiro, Carlson, Astin, & Freedman, 2006).

Vitality represents the energy that a clinician can harness or regulate for their purposeful actions in and out of sessions (Ryan & Deci, 2008). Vitality has been considered as *health of spirit* (Ryan & Frederick, 1997) and therefore is one aspect that reflects wellbeing (Ryan, Bernstein, & Brown, 2010). Wellness, or wellbeing, however, differs from vitality in that wellness is anchored in full human functioning and not simply the absence of any form of psychopathology; it is not just the experience of happiness (Ryan & Deci, 2017). Subjective vitality is a source of energy for adaptive self-system functioning (Nix, Ryan, Manly, & Deci, 1999) and one may not be able to possess vitality if they do not possess wellbeing (Ryan & Deci, 2017). Finding one's *health of spirit* may be difficult for some clinicians struggling with feelings of depletion and compassion fatigue from frequent contact with emotional and difficult client situations (Figley, 2002). Further, Ryan and Frederick (1997) described vitality as a specific psychological experience of possessing enthusiasm and sustaining energy. Vitality is, therefore, the energy available to the self, and the energy one feels (Ryan & Deci, 2008) and can depend on a variety of situations and clinicians' perspectives about those situations (Ryan & Frederick, 1997). The perspective, or meaning, attached to a situation can impact a clinician's energy and capacity to maintain energy (Ryan & Frederick, 1997); thus, conflicts and demands impacting the self may threaten self-regulation and actualization, which can diminish vitality (Ryan, Deci, & Grolnick, 1995).

As compassionate healers, clinicians are at risk for diminished vitality as a result of both their daily experiences, which may not be within their control, and the consistent focus required to engage in sessions with clients. Mindfulness is one possibility or pathway for sustainable wellness, and thus vitality, for clinicians. Two possible theories describe how this may occur: (1) through *mindful attunement* clinicians may have less judgment toward the self and/or situation and, therefore, encounter less negative associations with challenging events; (2) as a *coping mechanism* mindfulness may serve as a coping skill when situations present themselves as challenging (Weinstein, Brown, &

Ryan, 2009). The extant research has shown that vitality may result from being mindful (Canby, Cameron, Calhoun, & Buchanan, 2015). To be more specific, subjective vitality is defined as one's *conscious* experience of possessing energy and aliveness (Ryan & Frederick, 1997). The critical word here being *conscious*. In order to have a conscious experience, one must be present, attuned, mindful. While mindfulness, as a technique and practice, has been more prevalent in the counseling literature (Brown, Marquis & Guiffreda, 2013), research is needed that examines the connection between mindfulness and vitality specifically with mental health clinicians.

Psychological well-being and compassion satisfaction

The emergence of positive psychology has illuminated the importance of and interest in positive psychological processes and the enhancement of wellbeing (Seligman & Csikszentmihalyi, 2000). Psychological wellbeing is a complex construct and does not just refer to the absence of mental illness, but the degree of optimal psychological functioning (Ryan & Deci, 2001). The World Health Organization defines mental wellness as, “a state of well-being in which the individual realizes their own abilities, able to cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2018, para. 3). This definition parallels the definition of eudaimonic wellbeing, or the ability to know yourself and to become what you are (Ryff, 2014). This definition is also consistent with Aristotle's description of eudaimonia: wellbeing is not just feeling good or satisfying particular appetites but striving to achieve the best that is within us (Huta & Waterman, 2014).

Ryff (2014) most recently defined psychological wellbeing as a multidimensional process of self-realization and proposed six dimensions that construct psychological wellbeing: *purpose in life, autonomy, personal growth, environmental mastery, positive relationships* and *self-acceptance*. Wellness and wellbeing are the foundation of the therapy profession, both in the pursuit of wellness for the client, but more pointedly, the pursuit of wellness for the clinician. Yet, clinicians may find that pursuing wellness can be difficult, especially when buttressed with the depth of traumatic stories shared with them (Craig & Sprang, 2010; McKim & Smith-Adcock, 2014). Clinicians that are consistently exposed to client trauma experiences may be impaired and unable to care for clients, as well as being at an increased risk for vicarious trauma (Sadler-Gerhardt & Stevenson, 2012). Research does, however, demonstrate that clinician wellness serves as a protective factor against vicarious trauma for clinicians working with traumatized clients (Foreman, 2018). By increasing clinician wellness and wellbeing, clinicians should show a decrease in compassion fatigue and increase in CS (Lawson & Myers, 2011).

Compassion can be defined as a caring response, a turning toward rather than an avoidance of pain, to the suffering and misfortunes of others that acknowledges the shared humanity of being imperfect (Neff & Seppala, 2016).

The ability to be compassionate and to remain compassionate, as opposed to experiencing compassion fatigue (Figley, 2002), is a central component of a clinician's daily work. Clinicians continually listen to stressful, traumatic and upsetting situations that can impact their emotional well-being and their ability to demonstrate compassion. A clinician must engage with these raw narratives in an empathetic and attuned way, potentially leading to a vulnerability for countertransference (Sharpless & Barber, 2015; Tishby & Wiseman, 2015). Countertransference is the triggered reaction(s) of a clinician upon hearing about a client's experiences and may alter a clinician's objective perceptions as a result (Sharpless & Barber, 2015). A clinician's perceptions (impaired or clear) can impact their CS (Chaverri, Praetorius, & Ruiz, 2018; Wagaman, Geiger, Shockley, & Segal, 2015), and thus, their propensity to perceive a sense of subjective vitality (Ryan & Frederick, 1997).

Despite the negative impact that working with clients with stressful and traumatic situations can have on therapists (Hensel, Ruiz, Finney, & Dewa, 2015), clinicians often report satisfaction related to the care, empathy and help they provide to their clients (Chaverri et al., 2018; Wagaman et al., 2015). Compassion satisfaction is a subjective assessment of providing compassion to others (Stamm, 2010). Further, CS is the fulfillment clinicians report from the empathetic attunement of working with clients in addition to the positive feelings associated with caring and helping (Stamm, 2010) and a result of a clinician's sense of achievement, motivation and enjoyment from emotionally demanding work (Chaverri et al., 2018; Wagaman et al., 2015). Feeling satisfied with one's caregiving work is related to viewing one's job as a "calling" (Conrad & Kellar-Guenther, 2006) and fulfillment from that calling. Studies on CS have identified mindfulness specifically having an impact on a clinician's proneness to experiencing CS (Decker et al., 2015; Martin-Cuellar et al., 2018), as mindfulness provides an awareness about the self in the present. Having a mindful presence has shown to decrease negative perceptions which impact wellbeing and mental health (McGarrigle & Walsh, 2011; Schomaker & Ricard, 2015).

Psychological well-being and compassion satisfaction on the relationship between mindfulness and vitality

Therapists experiencing vicarious trauma is a significant area of research. Recent studies have sought to understand how clinicians remain healthy and energetic in their work (Pack, 2014). Both mindfulness and vitality have been associated with wellbeing (McGarrigle & Walsh, 2011) and CS (Martin-Cuellar et al., 2018), as well as negatively associated with compassion fatigue (Martin-Cuellar, 2017). Whether we consider Self-Determination Theory (Ryan & Deci, 2017), the field of Positive Psychology (Seligman & Csikszentmihalyi, 2000) or the Ego Depletion Model (Baumeister, 2014), it is reasonable to conclude that mindfulness conceptually impacts clinician wellbeing. More specifically, through the lens of the Ego Depletion Model (Baumeister, Bratslavsky, Muraven, & Tice, 1998), clinicians who are able to non-judgmentally attune to

their emotions (mindfulness), may be less depleted and subsequently able to preserve psychological energy by exerting less effort involved in consistently modulating reactions in sessions with clients.

Perspective is everything. Perspective affords an opportunity to view situations differently. For instance, if a clinician is in a stressful situation, they may view the environment as draining or taking from their internal resources. Both positive and negative perceptions can influence satisfaction levels. Therefore, how a clinician experiences themselves, the environment and the self in relation to the environment, may impact satisfaction with the care and service provided (CS). Taken together, present minded attention (mindfulness) may impact the perceived meaning behind a situation or potential perspective shift (based on a person's wellbeing), determining the strength of vitality, or energy, experienced.

Purpose and research hypotheses

The purpose of this study is to explore those processes by which mental health clinicians experience vitality. The current evidence suggests that mindfulness and vitality are related; however, there is still a lack of clarity as to how mindfulness may impact a clinician's experience with vitality. The purpose is to therefore examine the mediating effects of theoretically, conceptually and empirically related variables to mindfulness and vitality. We hypothesized that:

H1: A direct relationship will be present between mindfulness and vitality; however, this relationship will only account for a proportion of the variability in vitality.

H2: Psychological wellbeing and compassion satisfaction will mediate the relationship between mindfulness and vitality.

If supported as mediators, psychological wellbeing and CS would provide two important and interesting explanations as to how a therapist may work toward vitality.

Methods

Participants

Upon approval from the university IRB (# 18116), participants were recruited by email through local and national agencies and professional association listservs. The recruitment email requested recipients forward the email with the online survey link to others that may be interested. Participants provided consent before participation. Participants were 113 clinicians, with the majority living and practicing within the United States (91%). Participants were largely female (77%), between 24 and 76 years of age ($M = 44.06$, $SD = 13.83$), and non-Hispanic white (69%). Nearly half (47%) of the participants were Licensed Marriage and Family Therapists, with the remaining participants being Licensed Mental Health Counselors, Licensed Professional Clinical Counselors and Licensed Social Workers. Over 40% of the participants reported they were in private practice. Participants collectively, had an average of 11 years of practice experience and worked 36 hours per week.

Measurement

Criterion measure

Subjective Vitality Scale (SVS). The SVS was used to assess clinicians' subjective feelings of being alive and energetic (Ryan & Frederick, 1997). This seven-item scale assesses clinicians' state of feeling energy using a six-point Likert scale from *not at all true* (1) to *always true* (5) (Ryan & Frederick, 1997). Studies have shown this scale to be psychometrically sound (Cronbach's $\alpha=.84$) and have shown good psychometric properties including internal consistency and convergent validity (Ryan & Frederick, 1997). Responses were summed to reflect high composite scores of subjective vitality (Cronbach's $\alpha=.89$). Clinicians in this study reported an average vitality score of 4.35 ($SD=1.29$).

Predictor measures

Mindfulness Attention and Awareness Scale (MAAS). The MAAS was used to assess clinicians' state of being present in the moment. This 15-item scale assesses clinicians state of being present in the moment using a six-point Likert scale from *almost always* (1) to *almost never* (6) (Brown & Ryan, 2003). Studies have shown this to scale to be psychometrically sound and have Cronbach's alphas ranging from 0.81 (Brown & Ryan, 2003) to 0.88 (Van Dam, Earleywine, & Borders, 2010). MAAS scores also showed both convergent and discriminate validity. Convergent validity was shown to have positive correlations, with scores of self-regulation and divergent validity with scores of social anxiety (Brown & Ryan, 2003; MacKillop & Anderson, 2007). Responses were summed to reflect higher composite scores of mindfulness (Cronbach's $\alpha=.90$). Participants in this study reported an average mindfulness score of 3.94 ($SD=0.95$).

The Ryff Scales of Psychological Wellbeing Scale (RPWS). The RPWS was used to measure psychological wellbeing. The RPWS has 42 questions with a total of six subscales: self-acceptance, purpose in life, physical health, autonomy, feelings of positive relations with others and environmental mastery. Both the overall scores of the main scale and the scores of the subscales showed high reliability, with Cronbach's alpha for all subscales and the overall scale $>.80$. Convergent validity was shown with positive correlations with other scores of measures of wellbeing and discriminant validity was shown through negative correlations with scores that do not show wellbeing (Ryff, 1989). Responses were summed to reflect higher composite scores of PW (Cronbach's $\alpha=.92$). Participants in this study reported an average PW score of 196.84 ($SD=24.18$).

Professional Quality of Life Scale (ProQOL). The ProQOL was used to measure CS. The original measure included 30 questions that assessed burnout, secondary traumatic stress and CS, which are assessed using five-point Likert scale, from *never* (1) to *very often* (5). The psychometric properties have been widely researched and have shown both high internal consistency and convergent validity (Stamm, 2010). For the current study, just the CS scale was used which included 10-items. These 10-items were summed to reflect

Table 1. Correlations among study variables.

	1	2	3	4
1. Vitality	–			
2. Mindfulness	0.60**	–		
3. Psychological wellbeing	0.70**	0.58**	–	
4. Compassion satisfaction	0.59**	0.38**	0.61**	–
<i>M</i>	4.35	3.94	196.84	40.79
<i>SD</i>	1.29	0.95	24.18	5.57
α	0.89	0.90	0.92	0.90

** $p < 0.01$.

higher composite scores of CS (Cronbach's $\alpha=.90$). Participants in this study reported an average score of 40.79 ($SD=5.57$) for CS.

Data analysis plan

Preliminary analyses were conducted using SPSS (v. 23.0, SPSS Inc., Chicago, IL). During preliminary analyses, missing data were assessed. The largest amount of missing data present for any item was less than 5%, with no evident patterns observed. Items were imputed at the scale level, which is an appropriate method imputing missing data (Plumpton, Morris, Hughes, & White, 2016). Ten multiple imputations (MIs) iterations were used, with complete blocks resulting (McGinniss & Harel, 2016). Following MI, normality, descriptive statistics, alpha level reliabilities (Cronbach's α) and a bivariate correlation matrix were examined (see Table 1).

Main analytic procedures were carried out using the PROCESS macro (Hayes, 2012) in SPSS (v.23.0, SPSS Inc., Chicago, IL) to examine the multiple mediator model (see Figure 1), or the mediating effect of psychological wellbeing and CS between mindfulness and vitality. PROCESS uses a regression-based analytic approach. For continuous variables, PROCESS uses OLS (ordinary least squares) regression to estimate unstandardized coefficients, standard errors, t - and p values and confidence intervals (CIs). In addition, PROCESS generates both direct effects (c') and indirect effects (ab) (Hayes, 2012; Hayes & Preacher, 2014). In the current study, the indirect effects were tested using 10,000 bootstrap resamples and a bias-corrected 95% bootstrap CI. Studies have indicated that bias-corrected bootstrap CIs provide more accurate intervals for small samples (Efron & Tibshirani, 1994) and skewed distributions of the indirect effect estimates (Mallinckrodt, Abraham, Wei, & Russell, 2006). Bias-corrected bootstrap CIs also improve the power of the test of the indirect effect (Shrout & Bolger, 2002). Indirect effects are statistically significant when zero is not located within the 95% CI range. Variables were standardized using z -score standardization before analyzing. Standardized regression results are presented.

Results

Preliminary results

Refer to Table 1 for bivariate correlations and descriptive statistics. Significant correlations were observed between all variables. Due to significant and higher correlations (i.e.

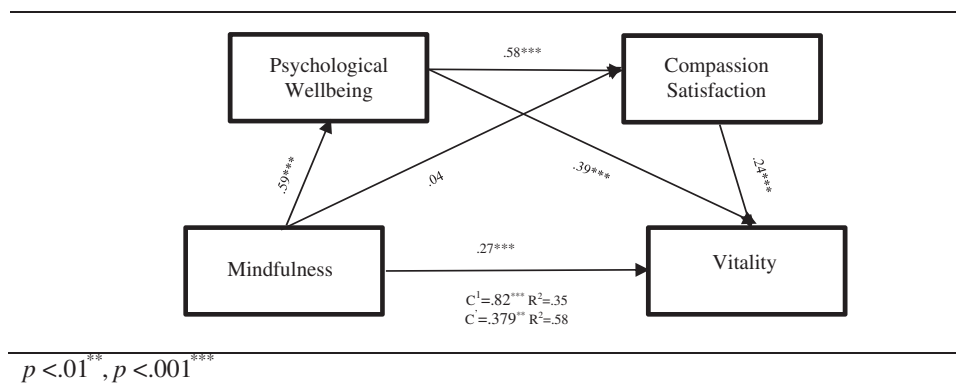


Figure 1. Standardized path diagram predicting vitality.

>0.70) between vitality and overall psychological well-being, the variance inflation factor ($VIF \leq 10$) and tolerance (>0.2) were assessed for issues related to collinearity (Field, 2013). Collinearity statistics indicated that the VIF was less than 10 and the tolerance was less than 0.2 (Field, 2013). Univariate skew and kurtosis were within normal distribution ranges.

Main analytic results

See Figure 1 for mediating model. Results presented using standardized beta weights. Results confirmed that first a significant direct effect exists between mindfulness and vitality ($B=0.59$, $p<.001$). When the mediators, psychological well-being and CS were introduced the overall goodness of fit increased ($\Delta R^2=0.26$). Two significant mediating paths resulted. These individual paths were specified as having a significant indirect influence on vitality. First, mindfulness indirectly influenced vitality via psychological wellbeing ($ab=0.23$, $SE=0.06$, bias-corrected bootstrap 95% CI [0.12, 0.36]). The decomposition of effects, relative indirect effect proportions, indicated that psychological wellbeing mediated 36% of the effect between mindfulness and vitality. The second mediating path illustrated that the relationship between mindfulness and vitality was mediated through psychological wellbeing and CS ($ab=0.10$, $SE=0.03$, bias-corrected bootstrap 95% CI [0.04, 0.16]). The decomposition of effects, relative indirect effect proportions, indicated that this indirect path mediated 14% of the effect between mindfulness and vitality. Results indicate that a moderate to strong indirect effect for the given model (Field, 2013). Interestingly, the mindfulness and CS path did not have a mediating effect alone. Nonetheless, these results imply that the relationships between mindfulness and psychological wellbeing and psychological wellbeing and CS are an important consideration for clinician's vitality.

Discussion

Further examination of the relationship between mindfulness and vitality is a needed area of inquiry for clinicians. The aim of this study was to explore psychological wellbeing and CS as mediators to the relationship between mindfulness and vitality. The two hypotheses were confirmed. We

found support for the direct effects of mindfulness on a clinician's vitality, and further, these findings describe this relationship as being influenced by psychological wellbeing and CS. Results indicated that both psychological wellbeing and CS had a significant impact on vitality. The path by which therapists experience vitality by mindfulness could be explained through the wellness obtained via a mindfulness state and the impact that wellness has on the perspective of the profession, thus impacting CS.

Additionally, psychological wellbeing alone had a significant impact on vitality. In line with previous research, mindfulness and wellbeing are interrelated with numerous studies pointing toward the positive impact of mindfulness on wellbeing (Hofmann et al., 2010; McGarrigle & Walsh, 2011; Rybak, 2013). Furthermore, through wellbeing, one may feel more energy and vigor (Ryan & Frederick, 1997; Ryan et al., 2010). Not surprisingly CS alone did not have a significant mediating effect between mindfulness and vitality. One explanation that can be drawn from this is that the presence of psychological wellbeing provides the wellness lens for clinicians to view their situations, thus impacting their levels of CS. Wellness and wellbeing may allow one to perceive positive experiences in challenging situations and view situations in a more optimistic way.

Taken together, these results imply that the relationships between mindfulness, psychological wellbeing and CS are important considerations for a clinician's vitality and worth further investigation as it relates to the health and longevity in the field of practicing clinicians. Our results add to the understanding of the relationship between mindfulness and vitality and contribute to the literature on mechanisms by which mental health therapists may experience vitality. These findings extend previous work on the significance of mindfulness in therapeutic practice (McGarrigle & Walsh, 2011; Schomaker & Ricard, 2015) and further emphasizes the importance of therapists engaging in a mindful practice.

Implications

Although research documents a variety of self-care strategies are valuable, research continues to point to mindfulness as a means for overall wellness (Ryan, Huta, & Deci, 2008). Our findings further support evidence of the value of

mindfulness and add to the existing literature to attempt to explain possible mechanisms by which mindfulness and therapist subjective vitality are related. With these findings in mind, it would be advantageous for practicing clinicians to incorporate mindfulness practice into their self-care routines. Clinicians should build a mindfulness practice into their daily routines to prevent the negative impact of therapeutic work.

Findings also have implications for prevention of clinician compassion fatigue, deemed the opposite of CS (Stamm, 2002). If counseling agencies provided mindfulness trainings and offered quiet areas where mindfulness could be practiced, this could provide a foundation of wellness needed for maintaining the psychological energy to engage with clients. Energy is not only important for the therapist, but the implications extend to clients as well. Continuing to understand mindfulness, psychological wellbeing, CS and vitality is significant for both the therapist and their practice with clients.

Limitations

Implications and findings should be considered with several limitations in mind. First, these data are cross-sectional and therefore causal associations cannot be made. Second, mediation analyses occurred cross sectionally, opposed to longitudinally. While important mediation results were identified, future research needs to replicate findings using mediation analyses longitudinally. Such analyses would help to uncover developmental processes and further unpack the temporal order of variables overtime (Kline, 2015). Third, this study explored subjective vitality which is impacted by the clinician's subjective experience, rather than by objective observations. Minimal studies have examined clinicians' subjective vitality and future research should further explore the experience of vitality by seeking to understand the mechanisms by which clinicians find sustained energy. Finally, the sample demographics (mostly White women) and modest sample size impact generalizability of these findings. Close to half of the clinicians (41%) disclosed being in private practice which may have impacted all aspects of reporting on the questionnaires. Future studies should include a larger and more diverse sample.

Disclosure statement

No potential conflict of interest was reported by the authors.

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References

- Baumeister, R. F. (2014). Self-regulation, ego depletion, and inhibition. *Neuropsychologia*, 65, 313–319. doi:10.1016/j.neuropsychologia.2014.08.012
- Baumeister, R. F., Bratslavsky, E., Muraven, M., & Tice, D. M. (1998). Ego depletion: Is the active self a limited resource?. *Journal of Personality and Social Psychology*, 74(5), 1252–1265. doi:10.1037/0022-3514.74.5.1252
- Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development*, 91, 96–104. doi:10.1002/j.1556-6676.2013.00077.x
- Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, 84(4), 822–848. doi:10.1037/0022-3514.84.4.822
- Canby, N. K., Cameron, I. M., Calhoun, A. T., & Buchanan, G. M. (2015). A brief mindfulness intervention for healthy college students and its effects on psychological distress, self-control, meta-mood, and subjective vitality. *Mindfulness*, 6(5), 1071–1081. doi:10.1007/s12671-014-0356-5
- Carlson, L. E., & Brown, K. W. (2005). Validation of the mindful attention awareness scale in a cancer population. *Journal of Psychosomatic Research*, 58(1), 29–33.
- Chaverri, J., Praetorius, R. T., & Ruiz, E. (2018). Counselor happiness: Effects of therapy work with similar trauma. *Social Work in Mental Health*, 16(4), 419–435. doi:10.1080/15332985.2017.1419535
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burn-out, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, 30, 1071–1080. doi:10.1016/j.chiabu.2006.03.009
- Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, 23, 319–339. doi:10.1080/10615800903085818
- Decker, J. T., Brown, J. L. C., Ong, J., & Stiney-Ziskind, C. A. (2015). Mindfulness, compassion fatigue, and compassion satisfaction among social work interns. *Social Work and Christianity*, 42, 28–42. doi:10.1080/03069880600942574
- Desrosiers, A., Vine, V., Klemanski, D. H., & Nolen-Hoeksema, S. (2013). Mindfulness and emotion regulation in depression and anxiety: Common and distinct mechanisms of action. *Depression and Anxiety*, 30(7), 654–661. doi:10.1002/da.22124
- Efron, B., & Tibshirani, R. J. (1994). *An introduction to the bootstrap*. New York, NY: CRC Press.
- Epstein, R. M., Siegel, D. J., & Silberman, J. (2008). Self-monitoring in clinical practice: A challenge for medical educators. *Journal of Continuing Education in the Health Professions*, 28(1), 5–13. doi:10.1002/chp.149
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Thousand Oaks, CA: Sage Publications.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, 58(11), 1433–1441. doi:10.1002/jclp.10090
- Figley, C. R., & Figley, K. R. (2017). Compassion fatigue resilience. In E. Seppala, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds.), *The Oxford handbook of compassion science* (pp. 387–398). New York, NY: Oxford University Press.
- Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling*, 40(2), 142–155. doi:10.17744/mehc.40.2.04
- Goodman, M. J., & Schorling, J. B. (2012). A mindfulness course decreases burnout and improves well-being among healthcare providers. *The International Journal of Psychiatry in Medicine*, 43(2), 119–128. doi:10.2190/PM.43.2.b
- Hayes, A. F. (2012). *PROCESS: A versatile computational tool for observed variable mediation, moderation, and conditional process modeling* [White paper]. Retrieved from <http://www.afhayes.com/public/process2012.pdf>
- Hayes, A. F., & Preacher, K. J. (2014). Statistical mediation analysis with a multi-categorical independent variable. *British Journal of Mathematical and Statistical Psychology*, 67(3), 451–470. doi:10.1111/bmsp.12028
- Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress*, 28(2), 83–91. doi:10.1002/jts.21998

- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183. doi:10.1037/a0018555
- Huta, V., & Waterman, A. S. (2014). Eudaimonia and its distinction from hedonia: Developing a classification and terminology for understanding conceptual and operational definitions. *Journal of Happiness Studies, 15*(6), 1425–1456. doi:10.1007/s10902-013-9485-0
- Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York, NY: Hyperion.
- Kabat-Zinn, J. (2009). Foreword. In S. L. Shapiro & L. E. Carlson (Eds.), *The art and science of mindfulness*. Washington, DC: American Psychological Association.
- Kline, R. B. (2015). *Principles and practice of structural equation modeling*. New York, NY: Guilford Publications.
- Lawson, G. (2007). Counselor wellness and impairment: A national survey. *The Journal of Humanistic Counseling, Education and Development, 46*(1), 20–34. doi:10.1002/j.2161-1939.2007.tb00023.x
- Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development, 89*, 163–171. doi:10.1002/j.1556-6678.2011.tb00074.x
- MacKillop, J., & Anderson, E. J. (2007). Further psychometric validation of the mindful attention awareness scale (MAAS). *Journal of Psychopathology and Behavioral Assessment, 29*(4), 289–293. doi:10.1007/s10862-007-9045-1
- Mallinckrodt, B., Abraham, W. T., Wei, M., & Russell, D. W. (2006). Advances in testing the statistical significance of mediation effects. *Journal of Counseling Psychology, 53*(3), 372–378. doi:10.1037/0022-0167.53.3.372
- Martin-Cuellar, A. (2017). When the clinician is burdened: Clinician's trauma history, resiliency and the impact on compassion fatigue (Doctoral dissertation). University of New Mexico, Albuquerque, New Mexico. Retrieved from https://digitalrepository.unm.edu/educ_ifce_etds/52
- Martin-Cuellar, A., Atencio, D. J., Kelly, R. J., & Lardier, D. T. Jr. (2018). Mindfulness as a moderator of clinician history of trauma on compassion satisfaction. *The Family Journal, 26*(3), 358–368. doi:10.1177/1066480718795123
- McGarrigle, T., & Walsh, C. A. (2011). Mindfulness, self-care, and wellness in social work: Effects of contemplative training. *Journal of Religion & Spirituality in Social Work: Social Thought, 30*, 212–233. doi:10.1080/15426432.2011.587384
- McGinniss, J., & Harel, O. (2016). Multiple imputation in three or more stages. *Journal of Statistical Planning and Inference, 176*, 33–51. doi:10.1016/j.jspi.2016.04.001
- McKim, L. L., & Smith-Adcock, S. (2014). Trauma counsellors' quality of life. *International Journal for the Advancement of Counselling, 36*(1), 58–69. doi:10.1007/s10447-013-9190-z
- Neff, K. D., & Seppala, E. (2016). Compassion, well-being, and the hypoegoic self. In K. W. Brown & M. Leary (Eds.), *Oxford handbook of hypo-egoic phenomena: Theory and research on the quiet ego*. New York: Oxford University Press.
- Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality, 77*(1), 23–50. doi:10.1111/j.1467-6494.2008.00537.x
- Nix, G. A., Ryan, R. M., Manly, J. B., & Deci, E. L. (1999). Revitalization through self-regulation: The effects of autonomous and controlled motivation on happiness and vitality. *Journal of Experimental Social Psychology, 35*(3), 266–284. doi:10.1006/jesp.1999.1382
- Pack, M. (2014). Vicarious resilience. A multilayered model of stress and trauma. *Affilia, 29*, 18–29. doi:10.1177/0886109913510088
- Plumpton, C. O., Morris, T., Hughes, D. A., & White, I. R. (2016). Multiple imputation of multiple multi-item scales when a full imputation model is infeasible. *BMC Research Notes, 9*(1), 45–60. doi:10.1186/s13104-016-1853-5
- Rosenberg, T., & Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family therapist. *Journal of Marital and Family Therapy, 32*(1), 87–99. doi:10.1111/j.1752-0606.2006.tb01590.x
- Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*(1), 141–166. doi:10.1146/annurev.psych.52.1.141
- Ryan, R. M., & Deci, E. L. (2008). From ego depletion to vitality: Theory and findings concerning the facilitation of energy available to the self. *Social and Personality Psychology Compass, 2*(2), 702–717. doi:10.1111/j.1751-9004.2008.00098.x
- Ryan, R. M., & Deci, E. L. (2017). *Self-determination theory: Basic psychological needs in motivation, development, and wellness*. New York, NY: Guilford Press.
- Ryan, R. M., & Frederick, C. (1997). On energy, personality, and health: Subjective vitality as a dynamic reflection of well-being. *Journal of Personality, 65*(3), 529–565. doi:10.1111/j.1467-6494.1997.tb00326.x
- Ryan, R. M., Bernstein, J. H., & Brown, K. W. (2010). Weekends, work, and well-being: Psychological need satisfactions and day of the week effects on mood, vitality, and physical symptoms. *Journal of Social and Clinical Psychology, 29*(1), 95–122. doi:10.1521/jscp.2010.29.1.95
- Ryan, R. M., Deci, E. L., & Grolnick, W. S. (1995). Autonomy, relatedness, and the self: Their relation to development and psychopathology. *Ariel, 128*, 618–655.
- Ryan, R. M., Huta, V., & Deci, E. L. (2008). Living well: A self-determination theory perspective on eudaimonia. *Journal of Happiness Studies, 9*(1), 139–170. doi:10.1007/s10902-006-9023-4
- Rybak, C. (2013). Nurturing positive mental health: Mindfulness for wellbeing in counseling. *International Journal for the Advancement of Counselling, 35*(2), 110–119. doi:10.1007/s10447-012-9171-7
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081. doi:10.1037/0022-3514.57.6.1069
- Ryff, C. D. (2014). Psychological well-being revisited: Advances in the science and practice of eudaimonia. *Psychotherapy and Psychosomatics, 83*(1), 10–28. doi:10.1159/000353263
- Sadler-Gerhardt, C. J., & Stevenson, D. L. (2012). When it all hits the fan: Helping counselors build resilience and avoid burnout. *Vistas, 1*, 1–8.
- Schomaker, S. A., & Ricard, R. J. (2015). Effect of a mindfulness-based intervention on counselor-client attunement. *Journal of Counseling & Development, 93*, 491–498. doi:10.1002/jcad.12047
- Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5–14. doi:10.1037/0003-066X.55.1.5
- Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology, 62*(3), 373–386. doi:10.1002/jclp.20237
- Sharpless, B. A., & Barber, J. P. (2015). Transference/countertransference. In R. L. Cautin & S. O. Lilienfeld (Eds.), *The encyclopedia of clinical psychology* (pp. 2875–2880). West Sussex: Wiley Blackwell. doi:10.1002/9781118625392.wbecp293
- Shrout, P. E., & Bolger, N. (2002). Mediation in experimental and non-experimental studies: New procedures and recommendations. *Psychological Methods, 7*(4), 422–445. doi:10.1037/1082-989X.7.4.422
- Singh, N. N., Lancioni, G. E., Wahler, R. G., Winton, A. S. W., & Singh, J. (2008). Mindfulness approaches in cognitive behavior therapy. *Behavioural and Cognitive Psychotherapy, 36*(6), 659–666. doi:10.1017/S1352465808004827
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Psychosocial stress series, no. 24. Treating compassion fatigue* (pp. 107–119). New York, NY: Brunner-Routledge.
- Stamm, B. H. (2010). *The concise ProQOL manual*. Retrieved from https://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf
- Thomas, J. T., & Otis, M. D. (2010). Intrapyschic correlates of professional quality of life: Mindfulness, empathy, and emotional

- separation. *Journal of the Society for Social Work and Research*, 1(2), 83–98. doi:[10.5243/jsswr.2010.7](https://doi.org/10.5243/jsswr.2010.7)
- Tishby, O., & Wiseman, H. (2014). Types of countertransference dynamics: An exploration of their impact on the client–therapist relationship. *Psychotherapy Research*, 24(3), 360–375. doi:[10.1080/10503307.2014.893068](https://doi.org/10.1080/10503307.2014.893068)
- Van Dam, N.T., Earleywine, M., & Borders, A. (2010). Measuring mindfulness? An item response theory analysis of the Mindful Attention Awareness Scale. *Personality and Individual Differences*, 49(7), 805–810. doi:[10.1016/j.paid.2010.07.020](https://doi.org/10.1016/j.paid.2010.07.020)
- Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work*, 60(3), 201–209. doi:[10.1093/sw/swv014](https://doi.org/10.1093/sw/swv014)
- Weinstein, N., Brown, K.W., & Ryan, R.M. (2009). A multi-method examination of the effects of mindfulness on stress attribution, coping, and emotional well-being. *Journal of Research in Personality*, 43(3), 374–385. doi:[10.1016/j.jrp.2008.12.008](https://doi.org/10.1016/j.jrp.2008.12.008)
- World Health Organization. (2018). *Promotion of mental well-being*. Retrieved from http://www.searo.who.int/entity/mental_health/promotion-of-mental-well-being/en/