Article

Mindfulness as a Moderator of Clinician History of Trauma on Compassion Satisfaction

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Abstract

Compassion satisfaction is an understudied phenomenon in the counseling literature. The impact of a clinician's history of trauma on compassion satisfaction and potential protective factors that may enhance feelings of compassion satisfaction is equally understudied. This study aimed to address models of mindfulness as a protective factor for the associations between a clinician's history of trauma and their experience with compassion satisfaction. The sample consisted of licensed clinicians ($N = 113$) reporting on their past history of trauma, dispositional mindfulness, and compassion satisfaction. Results indicated that mindfulness moderated the association between a clinician's history of trauma and compassion satisfaction. Findings also show mindfulness to be significant in supporting a clinician's experience with compassion satisfaction, overall. Therefore, mindfulness should be further considered as an important safeguard for clinicians to consider in order to continue to enjoy their work. Implications are considered for clinicians, counseling training programs, and agency employers.

Keywords

mindfulness, therapist trauma, compassion satisfaction

In recent years, there has been an increasing awareness of the negative consequences of mental health clinicians' trauma on their ability to work *with* and *for* their clients (e.g., Hensel, Ruiz, Finney, & Dewa, 2015; Venart, Vassos, & Pitcher-Heft, 2007). Much of the literature exploring clinician wellness has focused on the effect of trauma on a clinician's experience with secondary traumatic stress or vicarious trauma (Craig & Sprang, 2010a, 2010b; Figley, 1995; 2002; McKim & Smith-Adcock, 2013) and other negative outcomes related to clinician stress. There has been less exploration on the impact of a clinician's history of trauma on their compassion satisfaction, defined as the fulfillment derived from the empathetic attunement of working with clients (Stamm, 2005, 2010). Clinicians who have experienced trauma are susceptible to the negative impact of therapeutic work. Clinicians also experience aspects of working with people and oftentimes share that traumatic or negative experiences were a catalyst for becoming a clinician (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011). Therefore, it is imperative to understand the mechanisms that enrich and encourage the sustaining aspects of being a mental health clinician (Radey & Figley, 2007), especially for clinicians with a history of trauma.

Clinicians who have experienced trauma, defined as a stressful, negative, or adverse event from their past, may struggle with counselor–client emotional boundaries (Bush, 2009) and internalize their client's emotions and feelings, consequently, developing negative mental health symptoms such as depression or anxiety (Canfield, 2005; Figley, 2002; Killian, 2008). A clinician's personal trauma may in fact increase their experiences with vicarious trauma or secondary traumatic stress (Hensel et al., 2015) through the over identification of client's experiences and making client experiences part of their own experience. Overtime, the overidentification may impact clinician burnout, depression, and professional impairment (Siebert, Siebert, & Taylor-McLaughlin, 2007), all symptoms of compassion fatigue, which is contrary to the feelings of compassion satisfaction (Figley, 2002).

To our knowledge, there is a dearth of research that has documented the impact a clinician's personal history of trauma has on compassion satisfaction; to date, only two known studies have been found that examined this relationship (Killian, 2008; Thomas & Otis, 2010). Although compassion satisfaction was not their primary focus, the relationship between

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trauma and compassion satisfaction did not show significance in either study. One line of research suggests that clinicians gravitate toward the mental health profession because of their own personal traumatic histories (Esaki & Larkin, 2013), and further exploration into the effects of a clinician's personal history of trauma and the satisfaction derived from therapeutic work would be a meaningful area of inquiry. Understanding protective mechanisms by which a clinician may experience compassion satisfaction, rather than the negative experiences of compassion fatigue, requires further inquiry.

Limited research has placed emphasis on protective mechanisms, such as *mindfulness*—that is, the state of being present through attention and awareness—that could offset the negative relationship between trauma and compassion satisfaction. Although mindfulness is a continuously growing area of study, mindfulness has been considered as more of a treatment (Godfrin & Van Heeringen, 2010; Hofmann, Sawyer, Witt, & Oh, 2010), opposed to a psychological state (Brown, Kasser, Ruan, Linley, & Orzech, 2009). The existing literature associates mindfulness with concentration and attention (Brown, Ryan & Creswell, 2007), as an important protective factor against general work-related outcomes (Dane, 2011; Glomb, Duffy, Bono, & Yang, 2011), and as an important component in a clinician's ability to attune one's self to adjust and cope in the moment with difficult and traumatic experiences (Shapiro, Carlson, Astin, & Freeman, 2006). Even though mindfulness appears to be an important self-care strategy for mental health workers (McGarrigle & Walsh, 2011; Shapiro, Brown, & Biegel, 2007), the influence of mindfulness in augmenting a clinician's compassion satisfaction and buffering against a history of trauma has received limited attention.

The purpose of the present study was to investigate whether state mindfulness moderates or buffers the relationship between a clinician's trauma history and compassion satisfaction. There are a variety of defenses (i.e., physical activity, journaling, family support, personal counseling, among others) clinicians possess that may be impactful and prompt compassion satisfaction, and mindfulness is but one. This study examines the role mindfulness plays as a protective factor for counselors with a history of personal trauma and the impact on compassion satisfaction.

Literature Review

The Influence of Trauma and Mindfulness on Compassion Satisfaction

Trauma plays a critical role in influencing a clinician's experiences with clients and the narratives brought to the session. Trauma is context-specific and takes different forms among people based on their experiences. The literature on trauma and its impact is broad, and the description or definition does not fully capture the experiences of those exposed (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Trauma can refer to a range of maltreatment and include anything negative in a person's life that has a substantial impact in their life (D'Andrea et al., 2012). For the current study, the definition of trauma is taken from the Early Childhood Trauma Questionnaire and is defined as any event that a clinician may have experienced in their past (before the age of 17 and within the past 3 years) that they deem is traumatic including issues of abuse or neglect, sexual abuse, divorce, or other family issues (Pennebaker & Susman, 2013). Traumatic experiences have the potential to impact present experiences, especially when triggered through the therapeutic relationship. The process of triggered emotions could lead to compassion fatigue (Figley, 2002), rather than compassion satisfaction.

Compassion satisfaction is described as the positive feelings a clinician encounters relative to the care and help they provide to their clients (Stamm, 2005). Compassion satisfaction is implicated in not only a clinician viewing one's job as a "calling" (Conrad & Kellar-Guenther, 2006) but also a clinician's sense of achievement, motivation, and enjoyment from emotionally demanding work (Wagaman, Geiger, Shockley, & Segal, 2015). Clinicians who experience personal trauma tend to have lower perceived levels of compassion satisfaction and are more prone to burnout, as well as secondary traumatic stress (I. Thompson, Amatea, & Thompson, 2014). Through this, trauma can negatively affect a clinician in both work and their development as a competent and confident clinician (Thomas & Otis, 2010).

Despite the negative impact trauma can have on a clinician's lived experiences and clinical work, there are several protective factors that clinicians employ to improve the quality of their treatment. These protective factors include, but are not limited to, having specialized training in trauma work (Sprang, Clark, & Whitt-Woosley, 2007), increasing one's personal sense of empathy (Wagaman et al., 2015), and developing a deeper state of mindfulness (Thieleman & Cacciatore, 2014). Few studies have examined, specifically, the relationship between mindfulness and compassion satisfaction. Those studies that are present show that mindfulness is worth further understanding as a component of compassion satisfaction (Decker, Brown, Ong, & Stiney-Zinkind, 2015; Gregory, 2015). Being present in the moment and having a conscious state of mind has shown to impact overall well-being (Brown & Ryan, 2003). Paying attention to the present moment influences perspective on stress and negative experiences (Neff & Vonk, 2009; Shapiro et al., 2007). Although not directly investigated, based on evidence from prior research, mindfulness may be impactful in reducing the detrimental impact of a clinician's personal trauma on their experience with compassion satisfaction (Thieleman & Cacciatore, 2014).

The Influence of Trauma on Compassion Satisfaction

In all realms of life, individuals are a product of their history. Past experiences, and more specifically, traumatic experiences, impact future actions in many ways (Perry, 1997, 2009). Clinicians are not immune to the impact of trauma. A clinician's trauma—both past and present—may have an impact on their

ability to regulate emotions and feelings that may manifest during and after therapeutic encounters (Dagan, Ben-Porat, & Itzhaky, 2016; Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). Several studies point to the effect of a clinician's personal history of trauma on their clinical work and subsequent emotional distress (e.g., Hensel et al., 2015; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006). For instance, clinicians with a personal history of trauma may struggle with boundaries, making client problems their own (Bush, 2009), and clinicians may, themselves, show symptoms of anxiety, depression, and Post-traumatic stress disorder (Bride, Radey, & Figley, 2007; Figley, 2002; McCann & Pearlman, 1990); therefore, having a significant impact on the therapeutic relationship (Lawson, Venart, Hazler, & Kottler, 2007).

Although limited, recent studies have examined clinicians' personal histories of trauma (e.g., Esaki & Larkin, 2013; Hensel et al., 2015). These investigations highlight that personal trauma is an important aspect of awareness for clinicians treating clients and the possibility for one's past to increase the possibility for developing compassion fatigue (Nelson-Gardell & Harris, 2003; VanDeusen & Way, 2006; A. Williams, Helm, & Clemens, 2012). Clinicians with a history of trauma are at further risk of countertransference, or the emotions brought up and experienced by the clinician as a result of the therapeutic encounter (Lawson & Myers, 2011; Tishby & Wiseman, 2014), which compounds the effect of being exposed to a client's traumatic narratives (Stebnicki, 2007; A. Williams et al., 2012). This risk may be exacerbated by the motivation and inclination by aspiring clinicians to become practitioners to help others as a result of past experiences (Black, Jeffreys, & Hartley, 1993; Lyter, 2008). When clinicians were asked about the impact of their personal history of trauma on their experiences as a practitioner with clients, clinicians reported positive experiences and changes within themselves (Jenkins et al., 2011), meaning that there are resiliency factors and protective factors within clinicians that incite the positive reactions in managing past trauma and working with clients.

Taken together, these studies emphasize the importance the role a clinician's trauma plays in their susceptibility of developing compassion fatigue symptoms as a response to their client's trauma. Further investigation into what promotes the contrary, compassion satisfaction, is imperative. Research supports our contention that trauma has a negative influence on a clinician's compassion satisfaction; however, this negative effect may be buffered by a clinician who is mindful.

The Influence of Mindfulness on Compassion Satisfaction

Pervasive sources of stress are endemic to therapeutic practice, and because of the frequent encounters with tragic and difficult client narratives, clinicians are susceptible to compassion fatigue (Figley, 1995, 2002), if they are not attuned to their inner experience (Brown & Ryan, 2003; Davis & Hayes, 2011). This self-attunement can also be described as *mindfulness*—that is, a process in which an individual connects with the self in the present moment (Brown & Ryan, 2003; Kabat-Zinn, 1994). Being mindful allows a clinician to connect with their inner experience(s) (Epstein, Siegel, & Silberman, 2008; Ludwig & Kabat-Zinn, 2008; McGarrigle & Walsh, 2011). The ability to connect with one's inner experience and increase awareness about feelings and emotions prompts the self to regulate and engage in activities or actions that are self-preserving (Brown & Ryan, 2003; Davis & Hayes, 2011; McGarrigle & Walsh, 2011).

Research on mindfulness suggests that mindfulness-based strategies are important in the development of competent practitioners (Christopher & Maris, 2010; Greason & Cashwell, 2009). Mindfulness training with clinicians has been found to significantly decrease clinicians' negative emotions and feelings, as well as reduce clinicians' experiences of stress, negative affect, rumination, and anxiety (McGarrigle & Walsh, 2011; Schomaker & Ricard, 2015; Shapiro et al., 2007). Mindfulness has also been attributed to augmenting a clinician's "presence" within the counseling session (Dunn, Callahan, Swift, & Ivanovic, 2013); and in such a scenario, clients were more likely to perceive their clinicians as effective (Dunn et al., 2013). Mindfulness has also been linked with a clinician's ability to know when they need to take time away or engage in "self-care," which may serve as a buffer to the experience of compassion fatigue (Figley, 1995; Thieleman & Cacciatore, 2014; Valent, 2002) and may heighten feelings of compassion satisfaction (Thomas & Otis, 2010). For instance, Thomas and Otis (2010) explored the impact of mindfulness on compassion satisfaction and found that mindfulness significantly impacted compassion satisfaction, with higher mindfulness scores correlating with higher levels of compassion satisfaction. They also found that mindfulness was negatively associated with burnout (Thomas & Otis, 2010) further suggesting that mindfulness is important not only for increasing compassion satisfaction, but for impacting the inverse as well. Thieleman and Cacciatore (2014) similarly found that there was a strong positive relationship between mindfulness and compassion satisfaction for clinicians who worked with traumatized clients. Likewise, Decker and colleagues (2015) found that mindfulness positively correlated with compassion satisfaction with social work interns. Although research may be limited for clinicians specifically, there is general support for the overall positive effect mindfulness has on decreasing negative emotions and feelings (Godfrin & Van Heeringen, 2010; Goodman & Schorling, 2012; Grossman, Niemann, Schmidt, & Walach, 2004; Hofmann et al., 2010; King et al., 2013; McGarrigle & Walsh, 2011; Shapiro et al., 2007; Smith et al., 2011; Teasdale et al., 2000) and could thus be a catalyst for a clinician's experience with compassion satisfaction in the same way, further serving as a protective factor for therapists with a trauma history.

Moderating Role of Mindfulness

Mindfulness can be an important buffer in the lives of counselors who have a history of trauma. Studies demonstrate that mindfulness performs as a buffer or moderator to stress and

symptoms of trauma (e.g., Nitzan-Assayag, Aderka, & Bernstein, 2015; Smith et al., 2011; R. W. Thompson, Arnkoff, & Glass, 2011). For instance, as mindfulness increases, one is able to better regulate their emotions and have deeper self-insight (Davis & Hayes, 2011). Counselors benefit from having a mindful practice. Buser, Buser, Peterson, and Seraydarian (2012) specifically measured the impact on counselors implementing specific counseling skills and found that those counselors in mindfulness groups were better able to effectively implement counseling skills in session (e.g., open-ended questions, nonverbal attending, reflecting feelings among others, as observed by researchers). Another study explored the impact of mindfulness with emotional exhaustion and job satisfaction and found that mindful counselors were able to more adequately deal with job-related stress (Hülsheger, Alberts, Feinholdt, & Lang, 2013). More recently, Hanley, Garland, and Tedeschi (2017) found that mindfulness may also assist clinicians in being better able to manage their own personal histories of trauma, as mindfulness supports more positive posttraumatic outcomes and encourages posttraumatic growth. It is reasonable to conclude from these few studies that mindfulness is an important protective mechanism in general and we predict likewise that mindfulness in this study will serve as a protective factor between clinician history of trauma and compassion satisfaction.

The Current Study

In the present study, the impact of mindfulness on a clinician's experience of compassion satisfaction was examined. Additionally, clinician's mindfulness was examined as a moderator between their personal history of trauma and their experience of compassion satisfaction. Based on the reviewed literature, it was hypothesized that:

Hypothesis 1: Trauma would negatively impact compassion satisfaction.

Hypothesis 2: Mindfulness would show a positive relationship with compassion satisfaction.

Hypothesis 3: Mindfulness would moderate the relationship between past and recent trauma and compassion satisfaction.

Method

Participants

Participants were recruited via e-mail through local and national marriage and family therapy agencies and professional association listservs (e.g., National Council on Family Relations, American Counseling Association). Additionally, the recruitment e-mail requested that recipients forward the e-mail with the online survey link to others who may be interested. In accordance with institutional review board ethics committee standards, participants were provided informed consent and digitally signed before participating in the survey. Those participants who agreed to participate were able to continue to the online survey.

Table 1. Descriptive Statistics and Correlations Among Primary Study Variables.

Variable	1	2	3	4
1. Past trauma	—			
2. Recent trauma	.30**	—		
3. Mindfulness	−.01	−.23**	—	
4. Compassion satisfaction	−.04	.05	.38**	—
M	2.11	1.87	3.94	40.79
SD	1.53	1.20	0.954	5.57
α			.90	.90

*$p < .05$. **$p < .01$. ***$p < .001$.

The sample of clinicians ($N = 113$) lived and practiced 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%), with the next largest demographic group identifying as Hispanic/Latina(o) (16%). 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 that they were in private practice. Participants collectively had an average of 11 years of practice experience and worked 36 hr per week.

Procedure

Participants were provided a 140-question survey in an online survey format. Participants were asked to respond to questions that assessed attention and awareness, professional quality of life, and well-being. Prior studies that have compared online survey formats to written formats have shown minimal differences in participants' responses to questions (Beck, Guignard, & Legleye, 2014). In fact, some have reported that responses on more sensitive questions, such as trauma, observe less social desirability bias (Wang et al., 2005). This study focused specifically on mindfulness and compassion satisfaction. Descriptive statistics, associated α levels (Cronbach's α), and a correlation matrix of main analytic variables are found in Table 1.

Measures

Childhood trauma. Participants completed The Childhood Trauma Questionnaire (Pennebaker & Susman, 2013). This questionnaire uses two separate measures, a Past Traumatic Events Scale (i.e., traumatic experience before the age of 17) and a Recent Traumatic Events Scale (i.e., traumatic experience within the last 3 years). The instrument includes 13 questions, with 6 questions designated to *past traumatic events* and 7 questions designated to *recent traumatic events* (sample items: Prior to the age of 17, did you experience a death of a very close friend or family member? Within the last 3 years, did

you experience a death of a very close friend or family member?). Evidence of validation of this questionnaire was found through correlational studies (Nickel et al., 2011; Whitelock, Lamb, & Rentfrow, 2013). Participants reported an average of 2.11 ($SD = 1.53$) traumatic experiences prior to 17 years of age and an average of 1.87 ($SD = 1.20$) traumatic experiences within the past 3 years.

Professional Quality of Life (ProQOL) Scale. The ProQOL Scale was used to measure *compassion satisfaction*. The original measure included 30 questions that assessed burnout, secondary traumatic stress, and compassion satisfaction, which are assessed using 5-point Likert-type 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, 2002, 2010). For the current study, the Compassion Satisfaction Scale included 10 items (sample items: I get satisfaction from being able to help people, I feel invigorated after working with those I help, and I like my work as a helper). These 10 items were summed to reflect higher composite scores of compassion satisfaction (Cronbach's $\alpha = .90$). Participants in this study reported an average score of 40.79 ($SD = 5.57$) for compassion satisfaction.

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 6-point Likert-type scale, from *almost always* (1) to *almost never* (6; Brown & Ryan, 2003). Studies have shown this scale to be psychometrically sound and have a Cronbach's αs ranging from .81 ((Brown & Ryan, 2003) to .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 ($SD = 0.95$).

Data Analysis Strategy

Preliminary Data Analyses

Preliminary analyses were run using SPSS v.23.0. 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, α-level reliabilities (Cronbach's α), and a bivariate correlation matrix were examined (see Table 1). Univariate skew and kurtosis were within normal distribution ranges, and there were no observed issues of multicollinearity, based on the designated parameter ranges for variance inflation factor (= <10) and tolerance (>0.2; Field, 2013).

Table 2. Predicting Compassion Satisfaction.

Predictor Variables	β	*SE*	R^2	ΔR^2
Past trauma				
Block 1			.09	.09**
Past Trauma	−.03	.33		
Mindfulness	.30**	.53		
Block 2			.10	.01
Past trauma	−.04	.33		
Mindfulness	.32**	.53		
Past Trauma × Mindfulness	−.09	.33		
Recent Trauma				
Block 1			.11	.11**
Recent trauma	.05	.42		
Mindfulness	.34**	.54		
Block 2			.15	.04*
Recent trauma	.01	.23		
Mindfulness	.39***	.54		
Recent Trauma × Mindfulness	−.22*	.37		

Note. $N = 113$.
*$p < .05$. **$p < .01$. ***$p < .001$.

Main Analytic Procedures

Main analytic procedures were carried out using SPSS v.23.0. Multiple linear regression analyses were used to assess the direct influence of past and recent trauma on compassion satisfaction, as well as the effect of mindfulness on compassion satisfaction (Block 1). Block 2 then incorporated the moderating effect of mindfulness on past and recent trauma on compassion satisfaction. *Gender*, *age*, and *years in practice* were assessed as potential controls, given the relationship prior studies have shown these covariates to have with the main analytic variables (Craig & Sprang, 2010a; Killian, 2008; Thomas & Otis, 2010). No significant relationships were found with main analytic variables. Therefore, no control variables were found during subsequent analyses. Once main analyses were completed, significant interaction effects were plotted using Preacher's online utility (Preacher, Curran, & Bouer, 2006).

Results

Descriptive statistics and bivariate correlations for the variables used in the analyses are reported in Table 1. Prior to conducting tests of the hypotheses, we computed descriptive statistics on measures of traumatic events, mindfulness, and compassion satisfaction. Correlations were observed between recent trauma and past trauma, as well as between recent trauma and mindfulness, and mindfulness and compassion satisfaction (all correlations were at $p < .01$).

Main Analyses

See Table 2 for standardized regression results. Significant results ranged from moderate (.05 to .09) to strong (>.10; Field,

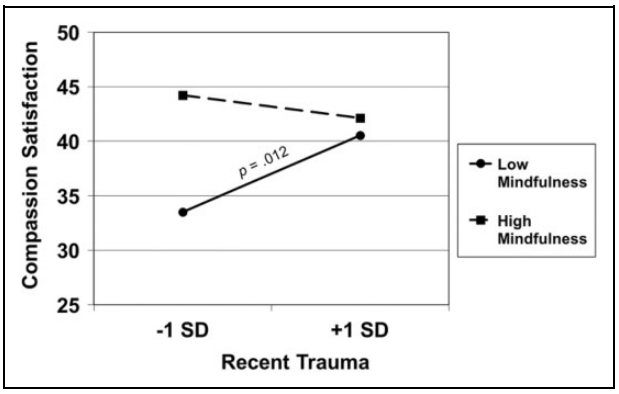

Figure 1. Recent trauma and mindfulness in relation to compassion satisfaction.

2013). Separate block analyses were conducted for both past and recent traumas on compassion satisfaction, when moderated by mindfulness. Our first goal was to examine the direct effects of past trauma on compassion satisfaction, moderated by mindfulness. Results indicate that past trauma has no effect on compassion satisfaction ($\beta = -.03$, $p = .71$); however, mindfulness positively predicted compassion satisfaction ($\beta = .30$, $p = .001$). In Block 2, past trauma continued to have no effect on compassion satisfaction, with mindfulness holding constant ($\beta = .32$, $p = .001$). There were no moderation effects present.

Next, the effects of both recent trauma and mindfulness were examined on compassion satisfaction. Results indicated that while recent trauma had no effect on compassion satisfaction ($\beta = .14$, $p = .12$), mindfulness had a significant effect ($\beta = .34$, $p < .001$). In Block 2, recent trauma continued to have no effect on compassion satisfaction, with mindfulness holding constant ($\beta = .39$, $p < .001$); however, mindfulness was found to moderate and reduce the effect of recent trauma on compassion satisfaction ($\beta = -.22$, $p = .02$). Such variability (r^2) results are not uncommon (e.g., Killian, 2008; Sprang et al., 2007), when considering that a host of additional variables are likely to predict compassion satisfaction (e.g., specialized training [Sprang et al., 2007], social support, work hours, internal locus of control [Killian, 2008], as well as age and years of experience [Craig & Sprang, 2010]; see Figure 1 for moderating effect). These results indicate that mindful clinicians were more likely to experience compassion satisfaction, even in the presence of recent trauma.

Discussion

This study sought to add to the existing literature by exploring the moderating effect of mindfulness between a clinician's personal history of trauma and compassion satisfaction. Results indicated that mindfulness plays a significant role as a protective factor. This corroborates with previous research that suggests that clinicians benefit from a mindful presence, which impacts their work with clients (Christopher & Maris, 2010; Greason & Welfare, 2013). This study represents one of a handful of investigations (notable exceptions include Jenkins et al., 2011; Killian, 2008; Thomas & Otis, 2010) that have explored the impact of a clinician's trauma history and compassion satisfaction. While our findings did not show a relationship between trauma and compassion satisfaction, which is in line with the extant research (e.g., Killian, 2008; Thomas & Otis, 2010), this study did show that mindfulness both positively and directly affected compassion satisfaction and, more importantly, moderated the effect between trauma and compassion satisfaction. Being mindful and aware of the present moment may allow for clinicians to closely monitor their intra- and interpersonal experiences within a clinical session. This attentiveness to the self may be what allows for deeper understanding of oneself in relation to clients and to be proactive in the ability to care for the self and provide the self with reflexive feedback (Bruce, Manber, Shapiro, & Constantino, 2010).

Implications for Practice

This study was motivated by the desire to understand the relationship between a clinician's traumatic experiences and the degree to which this trauma may positively impact clinicians work with clients in the form of perceived compassion satisfaction. Although this study examines clinicians not only from the discipline of marriage and family therapy but also with counselors and social workers, these results can be extended to all clinicians working with families. Family sessions require a significant amount of attunement. Although other self-care and coping mechanisms may be pursued by clinicians as strategies to warrant against the negative impact of therapeutic work, mindfulness has a history of diminishing adverse effects (McGarrigle & Walsh, 2011; Schomaker & Ricard, 2015). With mindfulness serving as a protective factor in the experience of compassion satisfaction, this study encourages several implications for both practicing clinicians and clinician training programs.

Imbedded within prior research (e.g., Johnson, 2018), state mindfulness may provide a self-regulatory awareness within the context of engaging in family therapy. Being attuned to one's inner experience allows the clinician to engage with the self while engaging with the clients present. Clinicians with a history of trauma may be more susceptible to the impact of working with the complexities of families. Family sessions can prompt countertransference within the therapeutic relationship and attunement with the self may ameliorate this impact.

Aligning with previous research (e.g., Shapiro et al., 2007), counselor training programs should consider the importance of mindfulness in their clinical training programs (Campbell & Christopher, 2012; Christopher & Maris, 2010), specifically assisting and educating clinicians in developing a mindful practice for the health of the clinician, the therapeutic relationship, and the overall therapy profession. Mindfulness-based stress reduction (Kabat-Zinn, 2003; Kabat-Zinn, 2013) is one program that has been utilized by counselor training programs (Felton, Coates, & Christopher, 2015), and although there is a growing interest in using mindfulness interventions in

counseling training programs for the purposes of alleviating the negative consequences of being a clinician (Christopher & Maris, 2010; Dorian & Killebrew, 2014; Rudaz, Twohig, Ong, & Levin, 2017), many training programs still do not implement mindfulness training in their curriculum.

Clinicians in training may not have received instruction or training on developing a mindfulness practice; therefore, clinicians should consider cultivating a mindfulness practice as a form of self-care. Self-care practices can be varied for clinicians, and clinicians should be thoughtful about intentional self-care practices that develop a mindful, introspective practice. Specifically, I. D. Williams, Richardson, Moore, Gambrel, and Keeling (2010) personally engaged in a self-care strategy and noted the impact on the experience on their well-being and work with clients. One of the researchers engaged in a mindfulness-based practice and reflected on their experience. The reflections supported the benefits of mindfulness—even meditating for just 5 min. The researcher summed up that mindfulness helped them to track clients and themselves, to not take things personally, and to connect deeply with their clients (I. D. Williams, Richardson, Moore, Gambrel, & Keeling, 2010).

Limitations and Future Research

The research and implications should be considered with the following limitations in mind. First, this study was cross-sectional in design, which impacts the causal effects of the relationship between history of trauma, mindfulness, and compassion satisfaction. Future studies should consider a longitudinal design, assessing these variables over time. Future research should also consider intervention studies, which may help to tease apart the effects of mindfulness.

Second, the modest sample size and the demographics suggests limitations in generalizability of findings. For example, a proportion of participants were in private practice (41%), whereas the remaining 59% worked at an agency, which may have impacted their reports of compassion satisfaction, reflecting the potential for clinicians in private practice to experience more autonomy and sense of personal agency within their job. With this limitation in mind, studies involving clinicians that work specifically at nonprofit agencies are needed. Additionally, the majority of the sample were women (77%), with 69% of the overall sample identifying as White. Future research should focus on casting a wider net in order to sample a larger and more diverse sample of clinicians.

A third limitation relates to the trauma questionnaire specifically. This study explored trauma through retrospective self-report assessment of personal experiences and did not include the evaluative component to allow the clinician to describe their subjective construal of whether the experience was traumatic to them. Furthermore, the trauma questionnaire used in this study addressed major and significant traumas and did not address chronic and less significant traumas occurring over time. It may be the case that these potential sources of trauma may influence one's personality and development. This study did not assess chronic trauma or accumulated trauma, and therefore, the conclusions drawn are specific to the traumas measures by the questionnaire. This study did not assess or account for specific daily lifestyle stressors, family supports, family dynamics, work-related supports, specific financial stressors, income levels, specialized training, age and years of experience, or other forms of social support (Craig & Sprang, 2010; Killian, 2008; Sprang et al., 2007), some of which have been noted in previous studies and may have explained some proportion of variance in participants' self-reported compassion satisfaction. Research that explores compounding variables that affect stress and compassion satisfaction is necessary to further understand the relationship between past trauma and its impact on compassion satisfaction.

Finally, this study explored state mindfulness and not mindfulness as a practice or the impact of a mindfulness program. Previous research has sought to understand mindfulness and its place with practicing mental health clinicians (e.g., Aggs & Bambling, 2010; Bruce et al., 2010; Dorian & Killebrew, 2014; Moore, 2008; Rothaupt & Morgan, 2007; Shapiro et al., 2007); however, additional research should explore ways that clinicians can engage in mindfulness-based strategies that can be implemented easily within their office setting and throughout their busy day (Dunn et al., 2013). Understanding what keeps clinicians from engaging in a mindfulness practice would be important.

Conclusion

Limited research has explored compassion satisfaction in the counseling literature. It was our intention to begin to fill this gap in the extant literature to initiate dialog concerning protective factors that may contribute to compassion satisfaction, specifically for clinicians with a history of personal trauma. Findings suggest that mindfulness is significant in supporting clinicians' experience with compassion satisfaction overall and is worth continued exploration in future research with clinicians. Additionally, counselor training programs and clinicians alike are encouraged to consider these findings for the well-being of clinical professionals, for the benefit and welfare of clients, and for the overall health of the profession.

Declaration of Conflicting Interests

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