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Focused Practice:
Exploring the Relationship Between Mindfulness and Empathy
Among Clinical Social Workers

by

Shannon Savageau, LSW

MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Abstract

This research project explores the impact of mindfulness on the practice of clinical social work as it pertains to building the skill of empathy. Mindfulness, in practice, varies from clinician to clinician; however, mindfulness in general involves having an expanded sense of awareness and attunement to the greater experience of the client. As such, current research (as discussed in the literature review) supports that those clinicians who practice mindfulness develop an increased compassion for self and others and thus are more empathic than those who do not practice mindfulness. This research is important to the field of clinical social work because of the implications for future education to include mindfulness training as part of developing the skill of using empathy with clients. Data collected for this research comes from 121 clinical social workers registered with the Minnesota Board of Social Work (MBOSW) and is based on their responses to the Interpersonal Reactivity Index (IRI) and a seven-question survey. The results of this study point to a relationship between mindfulness and empathy among clinical social workers, indicating that further research exploring this relationship should be done to support these findings.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

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MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table of Contents

Title Page.....	1
Abstract.....	2
Acknowledgements.....	3
Table of Contents.....	4
List of Tables and Figures	7
Introduction.....	9
Literature Review.....	11
Mindfulness.....	11
The concept of mindfulness.....	11
Mindfulness practice.....	13
Benefits of mindfulness.....	15
Mindfulness in clinical social work practice.....	16
Mindfulness in therapeutic relationships.....	17
Mindfulness, self-care, and therapeutic relationships.....	19
Negative implications for mindfulness.....	20
Empathy.....	21
Concept of empathy.....	22
The Social Work-Empathy Connection.....	27
Empathy in clinical social work practice.....	27
Making the Social Work-Empathy-Mindfulness Connection.....	30
Connection between social work, empathy, and mindfulness.....	30
Empathy and Social Work Education.....	33

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Social work education and empathy training.....	33
Educational Policy 2.1.10(a)—Engagement.....	33
Teaching empathy.....	34
Humanistic Conceptual Framework.....	35
Humanistic social work.....	35
Humanistic movement and its impacts.....	37
Methods.....	38
Study Purpose and Design.....	38
Sub-Research Questions.....	39
Study Variables and Data Collection Instruments.....	39
Sampling Method and Data Collection Process.....	40
Measures for Protection of Human Subjects.....	41
Data Analysis.....	41
Descriptive statistics.....	41
Research questions.....	42
Strengths and Limitations of Design.....	45
Findings.....	46
Descriptive Statistics.....	46
Research Questions.....	50
Discussion.....	63
Research Purpose.....	63
Relevance to Literature Review.....	65
Relationships between mindfulness, empathy, social work and quantitative data	65

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Points of consideration regarding research results67

Implications for the Field of Social Work.....68

 Social work practice.....68

 Social work education.....69

Strengths and Limitations of Design.....70

 Strengths.....70

 Limitations.....71

Recommendations for Further Research.....72

Conclusion.....73

Appendices.....76

 Appendix A – Interpersonal Reactivity Index.....76

 Appendix B – Seven Question Survey.....79

References.....80

MINDFULNESS, EMPATHY, AND SOCIAL WORK

List of Table and Figures

Figure 1. <i>Years Practicing Mindfulness Bar Chart</i>	48
Figure 2. <i>Composite IRI Scores Bar Chart</i>	49
Table 1. <i>Group Statistics for Empathy and Mindfulness Practice T-test</i>	51
Table 2. <i>Empathy and Mindfulness Practice T-test</i>	51
Table 3. <i>Descriptive Statistics for the Relationship Between the Degree of Mindfulness Practice and Empathy</i>	52
Table 4. <i>Relationship Between Degree of Mindfulness Practice and Empathy</i>	53
Figure 3. <i>Scatterplot of Relationship Between Degree of Mindfulness Practice & Empathy</i>	53
Table 5. <i>Descriptive Statistics for the Relationship Between Length of Mindfulness Practice and Levels of Empathy</i>	55
Figure 4. <i>Relationship Between Length of Mindfulness Practice and Empathy</i>	55
Table 6. <i>Group Statistics for Participation in Mindfulness Training and Empathy</i>	57
Table 7. <i>Participation in Mindfulness Training and Empathy T-test</i>	57
Table 8. <i>Descriptive Statistics for the Relationship Between Level of Mindfulness Training and Level of Empathy</i>	59
Table 9. <i>Relationship Between Level of Mindfulness Training and Empathy</i>	59
Figure 5. <i>Scatterplot of Relationship Between Level of Mindfulness Training and Empathy</i>	60
Table 10. <i>Group Statistics for Type of Social Work Practiced and Empathy with the T-test</i>	61
Table 11. <i>Type of Social Work Practiced and Level of Empathy with the T-test</i>	62

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Figure 6. *Responses to Open-Ended Question Regarding Dev. of Empathy*

Skills.....63

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Introduction

The concept of empathic social work is not a new one. In 1923 Sigmund Freud wrote extensively about the need for clinicians to connect with their clients on a deeper, more spiritual level so that they might truly understand their clients and be of assistance to them as they seek to improve their mental health (Raines, 1990; Reevy, 2010).

Relatively newer than the concept of empathic clinical work, however, is the concept of “mindfulness” within clinical work; mindfulness is defined by Jon Kabat-Zinn, the innovator behind applying mindfulness to clinical therapy, as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (Siegel, Germer and Olendzki, 2009, p. 19). It is this possibility, that there is a thread that ties social work, empathy, and mindfulness strongly together, that excites practitioners and researchers alike as more is learned about the concept of mindfulness becoming embedded within the clinical world (Shapiro and Carlson, 2009).

Although there has been a significant amount of research done on the impact of empathy within therapeutic relationships (Reevy, 2010), because empathy is in large part innate, little has been done to find effective teaching methods for professional instruction within the field of social work (Eisenberg, 2000). At this time, despite the strong connection between effective social work and empathy, there is no specific training, curriculum, or extensive research supporting how empathy should be taught to social workers (Erera, 1997). There could be a number of reasons for this lack of structured learning. One hypothesis is that it is difficult to quantify or measure empathy, which is why some shy away from attempting to teach it (Gerdes and Segal, 2011). Another

MINDFULNESS, EMPATHY, AND SOCIAL WORK

reason is that social workers tend to be more naturally empathetic, perhaps a strong reason for pursuing their chosen profession. Researching the degree to which social workers are more empathic than other professionals, or developing additional training programs, therefore may seem unnecessary (Holm, 2002). And finally, there are very few empathy training programs currently in existence, making it difficult to compare and contrast the effectiveness of various curriculums (Erera, 1997).

Mindfulness, a practice that has been in existence for centuries, but has only been brought to the forefront of clinical work within the past forty years, is a concept that many social workers are embracing as a means to develop more authentic and impactful work with clients (Siegel, Germer and Olendzki, 2009). It is this practice of mindfulness that has been lauded as a meaningful way to teach empathy to practitioners (Shapiro and Carlson, 2009). Developed in 1979 by Kabat-Zinn at the University of Massachusetts Medical Center as he worked with patients with chronic pain, Mindfulness-Based Stress Reduction (MBSR) seeks to teach practitioners to recognize the space between the moment when something stressful or painful happens, and their reaction to it (Baum, 2010). The choice to observe, acknowledge, and consider those moments and feelings of discomfort, rather than immediately react to or judge them, is the essence of what mindfulness is (Baum, 2010).

Researchers are beginning to discover how this observant, rather than reactive, state of body and mind is building skills of empathy, self-compassion, emotional regulation, and stress reduction within its practitioners (Shapiro and Carlson, 2009). Research fully supporting the connection between mindfulness and increased levels of empathy among practitioners, however, is not fully conclusive at this time. Studies with

MINDFULNESS, EMPATHY, AND SOCIAL WORK

conflicting results have neither been able to prove or disprove the direct link between elevated levels of empathy among social work professionals who practice mindfulness and those who do not (Beddoe and Murphy, 2004; Birnie, Speca, and Carlson, 2010). This research project will seek to further explore the relationship between mindfulness and empathy among clinical social workers.

Literature Review

Mindfulness

Although synonymous with phrases like “listening carefully” or “focusing on,” being mindful indicates a greater depth of consciousness and awareness than its dictionary counterparts. Difficult for some to conceptualize, mindfulness can be simplified to mean the way we relate to situations and other people. With the intention of alleviating suffering and bringing about greater change, mindfulness allows its practitioners greater perspective on events that happen throughout the day, as well as helping understand their connectedness to the universe at large (Siegel, Germer and Olendzki, 2009).

The concept of mindfulness.

As stated earlier, mindfulness is not a new concept. This ability of a person to be fully conscious and aware during the day-to-day moments of life dates back over 2500 years in Buddhist psychology (Siegel, Germer and Olendzki, 2009). The term *mindfulness* was originally used in ancient Buddhist texts as the Pali word, *sati*, which refers to “*awareness, attention, and remembering*” (Siegel, Germer and Olendzki, 2009, p. 18). *Sati* can be likened to a mirror in which the person practicing it can see what their suffering looks like, and even more deeply, know how it is felt. It is said that by

MINDFULNESS, EMPATHY, AND SOCIAL WORK

practicing sati, wisdom and insight are gained, and anguish is alleviated (Siegel, Germer and Olendzki, 2009). By viewing suffering from a different angle, without trying to ignore or rein it in, one is able to regulate emotions more naturally. While becoming increasingly aware of emotions and paying closer attention to them, the mind is able to remember this process and mindfulness comes more naturally and living becomes more intentional (Siegel, Germer and Olendzki, 2009).

Contrary to popular belief, mindfulness is not simply increased attentiveness to an experience, improved focus on one thought, or the tuning out of worldly distractions (Siegel, Germer, and Olendzki, 2009); “it is a manner of being aware, an attitude of mind toward experience, and a mode of awareness that is paradoxically both intimately close and objectively removed” (Olendzki, 2009, p. 42). Mindfulness is often best explained by defining its opposite, mindlessness, which is: “having a blank mind, becoming emotionless, withdrawing from life, seeking bliss, escaping pain” (Siegel, Germer, and Olendzki, 2009, p. 22). Mindfulness, then, means to have a greater sense of awareness and understanding of the “big picture” (Siegel, Germer, and Olendzki, 2009, p. 42).

It is through mindfulness that we are able to train our minds to behave in a way that helps us work through and learn from suffering, bringing us closer to living lives of fulfillment (Siegel, Germer, and Olendzki, 2009). Mindfulness helps us to recognize when “skills such as alertness, concentration, and lovingkindness” are necessary in order to thrive (Siegel, Germer, and Olendzki, 2009, p. 18). By teaching the brain to become more alert and aware of suffering, acute negative feelings associated with this pain, such as anger or jealousy or self-loathing, are brought to the surface and addressed (Siegel, Germer, and Olendzki, 2009). Through mindfulness, practitioners are not only able to

MINDFULNESS, EMPATHY, AND SOCIAL WORK

become alert to their pain and aware of its root, but additionally, they learn to accept these feelings without judgment. “Awareness without acceptance can be like looking at a scary scene under a bright floodlight. Sometimes we need softer light—like a candle—to approach difficult experiences” (Siegel, Germer, and Olendzki, 2009, p. 19). That soft light means that one is being kind and gentle with himself, and as the intensity of pain may increase, so an even softer light might be needed to examine this suffering (Siegel, Germer, and Olendzki, 2009).

Mindfulness practice.

There are those that when asked to consider what they think mindfulness “looks” like, conjure up images of ancient Buddhist monks sitting crossed-legged meditating. This image, although not far from the root of mindfulness, is not entirely accurate today. Mindfulness has evolved over time and there are now many ways to “train the brain” to become more alert and aware (Siegel, Germer, and Olendzki, 2009). Mindfulness originated with the Buddha over 2,500 years ago when he decided to renounce his title of prince at the age of 29 in order to live a life of physical, emotional, and mental hardship. At the age of 36, he experienced a “breakthrough of understanding that profoundly reordered his mind” (Siegel, Germer, and Olendzki, 2009, p. 30). For the next 45 years the Buddha wandered from place to place without the usual human need for “attachment, aversion, or delusion,” leaving behind his experience of becoming “enlightened” for the world to learn from (Siegel, Germer, and Olendzki, 2009, p. 30). It is this enlightenment that became the foundation of mindfulness (Siegel, Germer, and Olendzki, 2009).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Meditation.

As it was for the Buddha, one of the most common forms of cultivating mindfulness is through meditation. The most used word for meditation in the classical languages of Buddhism (Sanskrit and Pali) is *samādhi*. When broken down, *sam* refers to the mind, *dha* to the act of placing something, and *a* is the object, therefore, literally meaning placing an object on the mind (Siegel, Germer, and Olendzki, 2009, p. 37.) The word most commonly associated with meditation is *ekaggatā*, which, when broken down, means one-pointedness (Siegel, Germer, and Olendzki, 2009, p. 38). Meditation, then, is about focusing the mind to be entirely and cohesively focused on one object or subject or intention. When the mind wanders (which it usually always does) the meditator, without punishment or judgment, simply brings his mind back to its intended thought (Siegel, Germer, and Olendzki, 2009). If through practice the brain is able to be trained to sustain singlemindedness, it is said the person has reached *jhana* (Pali), or more commonly known, *zen* (Siegel, Germer, and Olendzki, 2009, p. 40).

More specific to the concept of mindfulness, the Pali words for mindfulness meditation are *vipassana bhavana*, which roughly mean becoming more insightful or “insight meditation” or “mindfulness meditation” (Siegel, Germer, and Olendzki, 2009, p. 27). Somewhat different than meditation with the intention of emptying one’s mind or focusing it solely on one object, mindfulness meditation’s purpose is to gain a deeper understanding of human emotion, suffering, and greater connectedness with others. Throughout the course of this meditation, a practitioner may choose to flow through several different practices, *sati* (mindfulness), *metta* (lovingkindness), *samatha*

MINDFULNESS, EMPATHY, AND SOCIAL WORK

(concentration), or *vipassana* (mindfulness or insight), as needed (Siegel, Germer, and Olendzki, 2009, p. 28).

Benefits of mindfulness.

With gentle concepts like lovingkindness and insight as focal points of mindfulness, it is no surprise that there are many benefits of a regular mindfulness practice. Research is abundant in support of the positive physical, emotional, and professional effects mindfulness have on those in the helping professions (Gockel, 2010; Schure, Christopher and Christopher, 2008; Shapiro, Brown, and Biegel, 2007; Shapiro and Carlson, 2009). In a study of graduate level counseling students, participants who took part in Mindfulness-Based Stress Reduction (MBSR) classes during their training reported a reduction in perceived stress, feelings of anxiety, rumination, and negative affect, while improving positive affect, self-compassion, and regulation of emotional states compared to the control group who did not take the MBSR course (Shapiro, Brown, and Biegel, 2007). Other researchers concurred through similar studies, citing evidence that supported other benefits of a regular mindfulness practice as perceived improvement of quality of life; health-related quality of life (i.e. reduction in rates and symptoms of cancer, eating disorders, chronic pain, fibromyalgia); general health; sleep quality and immune function; and decreases in psychological distress (Gockel, 2010; Schure, Campbell and Christopher, 2012). And finally, in a controlled study, those who were instructed in MBSR over an eight-week period demonstrated greater left-sided brain activity than those who did not, supporting the theory that those who practice mindfulness have improved physical health (Davidson, et al., 2003).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Research also supported that meditation, as part of a mindfulness practice, can produce positive outcomes in terms of mental health and well-being among its practitioners (Birnbaum and Birnbaum, 2008; Brenner and Homonoff, 2004; Williams, Richardson, Moore, Eubanks-Gambrel, and Keeling, 2010). Increased awareness (being present, suspending reactions and theories, confidence about uncertainty), acceptance (restraining from judgment, more empathetic, acknowledging suffering), and responsibility (recognizing what needs to be done in situations and doing it) are all identified as outcomes of meditation (Brenner and Homonoff, 2004; Birnbaum and Birnbaum, 2008). Meditators also reported greater feelings of relaxation on a daily basis: feeling calmer, less stressed, and less impacted by the behavior of others (Williams, et al., 2010).

Mindfulness in clinical social work practice.

In light of all the aforementioned known benefits of a regular mindfulness practice, mindfulness used within the context of clinical work in the fields of social work and psychology is increasing rapidly. In a recent survey of psychotherapists in the United States (Simon, 2007), 41.4 percent of those surveyed said they do “mindfulness therapy” at least some of the time during work with clients. While cognitive behavioral therapy continues to be the most commonly used therapeutic approach (68.8 percent), psychoanalytic therapy is now third (35.4 percent) behind mindfulness (Siegel, Germer, and Olendzki, 2009, p. 24). Theories as to why mindfulness has gained such popularity are abundant and vary, from clients needing a more “acceptance-based” therapy to the increase of practicing therapists whose practices evolved during the 1960s and 70s, for some a time of heightened spirituality (Siegel, Germer, and Olendzki, 2009).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

While mindfulness is becoming a more common practice for clinical social workers and psychologists alike, what a mindful practice actually looks like varies from clinician to clinician. For some practitioners, utilizing mindfulness in clinical work actually means teaching clients principles and practices of mindfulness and meditation in an attempt to help clients meet ongoing mental health needs. For others, a mindful practice simply means embracing a mindful state of mind while working with clients (Fulton, 2009). In this sense, mindful practice can be considered on a continuum; at one end of the scale the client will be fully aware of the concept of mindfulness within the context of therapeutic work, whereas at the other end, mindfulness is an “invisible” presence in the room during time with clients (Fulton, 2009, p. 408). To get an even greater visual sense of the presence of mindfulness in practice, it may be helpful to consider two overlapping circles, one circle representing mindfulness, the other therapeutic practice. It is at the discretion of the practitioner to determine how much these two circles overlap, and therefore how mindfulness is enmeshed into their therapeutic work (Fulton, 2009, p. 409).

Mindfulness in therapeutic relationships.

Regardless of a clinician’s motivation for practice or theoretical orientation, generally speaking, therapists put great importance on being able to empathize with a client (Siegel, Germer, and Olendzki, 2009). So it is then, that the concept of mindfulness has emerged as a potentially helpful tool in the field of social work, to calm the body and mind in an effort to bring awareness to the present moment (Shapiro and Carlson, 2009). Schure, Christopher, and Christopher (2008) described mindfulness as “the ability to attend to thoughts and emotions as they arise and to be fully conscious of

MINDFULNESS, EMPATHY, AND SOCIAL WORK

the present-moment experience” (p. 47). Mindfulness’ focus on being present in the moment allows its practitioners to experience difficult feelings and circumstances in a different way. Rather than flee from the accompanying discomfort of negative feelings, people who practice mindfulness instead acknowledge this discomfort and re-frame it in a more productive way (Gockel, 2010).

In addition to increasing tolerance of uncomfortable feelings, mindfulness also allows its practitioners to accept their imperfections, recognizing the impossibility of responding perfectly all the time, and therefore not condemning or shaming themselves in response to it (Shapiro and Carlson, 2009). At this time, mindfulness’ meaning and practice are evolving to fit a more Western lifestyle and way of thinking, from strictly being about “awareness, attention, and remembering,” to include *nonjudgment*, *acceptance*, and *compassion*” (Siegel, Germer, and Olendzki, 2009, p. 19).

For a clinician to be able to carry these qualities into their work with clients is to ensure the client feels heard and understood, without judgment, yet with compassion. The word *compassion*, coming from the Latin roots *com pati*, which means to “suffer with,” enables a practitioner to suffer with a client, rather than just have an understanding of their suffering (Seigel, Germer, and Olendzki, 2009, p. 19). It is this sense of compassion, derived from practicing mindfulness, which allows a practitioner to be self-compassionate as well, demonstrating kindness, a sense of common humanity, and mindful acceptance for oneself, in addition to others (Gilbert and Tirsch, 2009). The soothing quality of learning self-acceptance and self-compassion allows a practitioner to calm himself to the point that he is able to easily connect to and empathize with others (Gilbert and Tirsch, 2009).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Mindfulness, self-care, and therapeutic relationships.

In the spirit of self-compassion, Shapiro (2009) was told by a supervisor, “The heart pumps blood to itself first, before pumping blood to the rest of the body. If it didn’t, it would die, and then the rest of the body would die. The art of caring for others is learning how to first care for yourself. Remember this.” (p. 108). Research supports that social work practice, viewed through the lens of mindfulness and meditation, begins and ends with the concept of being kind and loving to oneself. To be able to work with clients in a gentle and non-judgmental way, social workers must first treat themselves with gentleness and self-acceptance. The ways in which we view ourselves are manifested in the ways in which we view one another (Gockel, 2010; Shapiro and Carlson, 2009). If we are harsh and critical with ourselves, how can we be kind and gentle with others? Mindfulness is also a way of exploring one’s own pain and suffering, why it’s happening and how it can be healed. In doing so, practitioners open themselves up to helping others do the same (Shapiro and Carlson, 2009).

As it pertains to social workers’ work with clients, and guided by the principle that we are best able to help others when we have first helped ourselves, there are many positive impacts that the aforementioned self-care techniques also have upon social work practice. Mindfulness allows its practitioners to be in the present moment with clients. Rather than focusing on future implications or what should be said or advised next, practitioners look no further than what is presently being shared (Shapiro and Carlson, 2009). Mindfulness’ focus on the present also allows clinicians to be more cognizant of client growth and to be able to recognize moments of greatness. By concentrating energy

MINDFULNESS, EMPATHY, AND SOCIAL WORK

on growth and accomplishment, however big or small, the general feel of treatment becomes more positive for both client and clinician (Shapiro and Carlson, 2009).

Research supports that mindfulness has been beneficial to other helping professionals as well as to social workers (Schure, Christopher and Christopher, 2008; Shapiro and Carlson, 2009). A study of nurses who practiced mindfulness reported improved feelings of relaxation and calmness, self-acceptance, self-compassion, self-awareness, self-care, and self-reliance. They also reported decreased physical pain and improved sleep, better relationships, and improved communication in relationships (being more present, empathic, and less reactive) than before they began their practice (Shapiro and Carlson, 2009). As a result of similar studies supporting this same theory, there has been an increase in focus on teaching mindfulness and self-care to college students for future use as professional nurses, doctors, therapists, and counselors in order to increase instances of empathy, coping skills, and adaptability, and decrease instances of anxiety and depression in their work (Schure, Christopher and Christopher, 2008; Shapiro and Carlson, 2009).

Negative implications for mindfulness.

Mindfulness, meditation, and yoga (a combination of these three practices are largely interwoven and used under the mindfulness umbrella) are often viewed as Eastern spiritual practices. Because not everyone is comfortable practicing Eastern-based techniques due to their divergence or absence of spiritual beliefs, clinicians may personally be hesitant to embrace this practice and even less inclined to share these skills with clients (Brenner and Homonoff, 2004). The connection between mind-body practice at a more spiritual level, therefore, is not a comfortable practice for all clinicians and

MINDFULNESS, EMPATHY, AND SOCIAL WORK

could produce significant reservations if it were a requirement of formal clinical work (Campbell and Christopher, 2012).

Another point of consideration that mindfulness brings up is the need for properly trained staff to teach quality mindfulness curriculum. Without professional safeguards ensuring proper instruction, one risks misrepresentation of concepts of the practice and as such it may not be taught thoroughly or embraced heartily by students. This misrepresentation may perpetuate the myth of mindfulness being a “bandwagon theory” (Campbell and Christopher, 2012). When done correctly, mindfulness instruction is an all-encompassing training. Students gain exposure to their own pain and suffering, as well as joy and happiness, and learn how these raw emotions connect them to one another, gaining greater self-compassion and empathy (Campbell and Christopher, 2012; Stew 2011).

Empathy

Mindfulness calls its practitioners to be in tune with their own thoughts and feelings in the moment, as well as the thoughts and feelings of others whom they are with (Shapiro, Brown, and Biegel, 2007; Shapiro and Carlson, 2009). This ability to be attuned to others is often referred to as empathy. Different than sympathy, which indicates an “otherness” to someone else’s painful experience, empathy indicates feeling what another person is feeling (Eisenberg, 2000, p. 179). Also different than compassion, which refers to strong feelings for a person or situation and thus taking action to alleviate the suffering, empathy is truly understanding what another person is saying, both cognitively and emotionally (Birnie, Speca, and Carlson, 2010; Gerhart, 2012).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Concept of empathy.

The word empathy is derived from the Greek word *empathia*, which means “feeling into, finding or searching one’s way into, or experiencing another” (Bruneau, 2009, p. 337). Because the suffix *path* indicates “emotion, passion, or suffering” in Greek, one can truly grasp that when the word was created, it genuinely meant to imbibe another person’s pain (Bruneau, 2009, p. 337).

The concept of empathy has evolved since the time the word was birthed during early Greek ages. During the 1950s and 1960s, empathy was simply used in reference to understanding the mental state of another person. Today, empathy in the field of helping professions implies a much deeper connection between two people, an “emotional reaction to the comprehension of another’s emotional state” (Eisenberg, 2000, p. 179). Empathy has become a powerful interpersonal communication tool because when it is practiced correctly, it can be as powerful as “projecting oneself onto another person” in an effort for them to truly understand complex human emotion (Rohr, 2011, p. 5).

However deep its roots in the Greek language or depth of understanding it implies, there are many modern-day definitions of what it means to be empathetic. The *Social Work Dictionary* defined empathy as “the act of perceiving, understanding, experiencing, and responding to the emotional state and ideas of another person” (Gerdes and Segal, 2011, p. 141). Reevy (2010) described empathy in the *Encyclopedia of Emotion, Volume 1* as “feeling the inner experience of another person, particularly the person's emotions” (p. 235). And to complement those definitions, the *Encyclopedia of Communication Theory* said empathy means to “feel into another person’s biological processes, perceptions, emotional states, and their kinds and forms of consciousness in

MINDFULNESS, EMPATHY, AND SOCIAL WORK

order to assess their feelings” (Bruneau, 2009, p. 336). Clearly each of these definitions are very similar to one another, each a beautiful variation of the same concept of genuinely understanding another person.

Demonstrating empathy.

Unlike other emotions that are obvious to observe (such as happiness, frustration, or sadness), empathy is far more subtle in its appearance. Empathy can be a gentle touch in a poignant moment, a tender voice in response to agonizing words, or a mirrored look of pain while embracing human suffering. Being truly empathetic may elicit feelings of distress for the person doing the empathizing as they whole-heartedly feel what the other person is feeling, including feelings of anxiety and discomfort (Eisenberg, 2000).

Reevy (2010) hypothesizes that there are five ways in which people demonstrate empathy. The first three are described as “primitive,” meaning they happen automatically, and include mimicry (copying someone else’s facial expressions and body movements), conditioning (feeling and showing the same emotions as someone else), and direct association (recalling when a similar situation happened to themselves). The last two are learned and require some practice. They include verbally mediated association (by reading or hearing something, one can visualize and feel the situation), and perspective taking (putting oneself in another person’s shoes) (Reevy, 2010, p. 235).

Additionally, Bruneau (2009) describes the three types of empathy as interactive (focused on the present, in the moment, connection between two people), reflective (fully understanding a situation that happened in the past), and projective (being able to accurately predict what a future could be based on cognitive and emotional insights). These outward demonstrations of human understanding through both verbal and

MINDFULNESS, EMPATHY, AND SOCIAL WORK

nonverbal communication help to “develop trust, predictability, friendlier and more open communication between people” (Bruneau, 2009, p. 336).

Learning empathy.

As briefly mentioned above, some qualities of empathy can be learned while others are innate. Most attachment theorists support the idea that empathy can be learned as early as infancy as mothers’ feelings are projected onto babies during development. For example, if a baby is distressed and a calm, soothing caregiver gently holds and talks to the baby, the baby’s feelings of distress will subside as the baby is comforted. Conversely, if a distressed baby is attempted to be soothed by a distressed caregiver who presents with a frantic, anxious approach, the baby will continue to feel distressed as its emotional needs are not able to be met (Eisenberg, 2000). In this example, the baby is able to sense the caregiver’s emotions and responds accordingly.

In addition to being born with innate empathetic skills, there are additional skills that can be taught and learned. One such program for teaching empathy is called the Empathy Training Program (ETP). It is based on a cognitive model and enables participants to not just hear and reflect what another person is feeling and experiencing, but also to feel it by coming up with hypotheses about why the other person is feeling this way. The concept of this curriculum is to encourage participants to go beyond their own experience and try to delve into the experience of another person. However helpful, this training program is rarely used when training clinicians (Erera, 1997). Experts in the helping professions have determined that other strategies such as the use of psychodrama, Gestalt techniques, role playing, and imitative play have also been helpful in teaching people to be more empathetic (Segal et. al, 2011).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Perhaps less structured than ETP or any of the other strategies mentioned above, meditation, taught independently or through MBSR (Jon Kabat-Zinn), seems to impact individuals' levels of empathy. Meditation has been demonstrated to be helpful in reducing stress, increasing self-compassion, and learning to dis-identify with one's criticism of oneself. As a result, those who meditate become less stressed and ultimately focus inward, thus being able to relate to others better because the focus is less on them, and more on the deeper connection between all people (Shapiro and Izett, 2008). As a whole, the concept of mindfulness can be applied to any of these curriculums or techniques as a foundation for building empathy with its non-judgmental focus on the present moment.

Empathy in therapeutic relationships.

Because empathy allows for the connection between two people, it is a skill critical in many professions. Empathy has been shown to be an effective tool for doctors, nurses, therapists, social workers, politicians, lawyers, authors, activists, or any other person who can use the experiences of others to help them meet a need (Reevy, 2010). Beginning with Freud and moving forward through the years to psychologists such as Carl Jung and Carl Rogers, empathy has been perceived to play a critical role in clinical settings in building therapeutic relationships with clients (Raines, 1990; Reevy, 2010). Freud (1923) was noted for encouraging psychologists to "clear their minds" in an attempt to let the client's unconscious interact with theirs. Almost like telepathy, Freud believed that when a clinician was able to be perfectly in tune with a client, he could give the best insight during his work with the client because he understood the client's situation most clearly (Rohr, 2011).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Because of the back and forth, giving and receiving of thoughts and emotions, empathy can sometimes be perceived as “play” between client and clinician. The clinician’s role when viewing this phenomenon through the lens of play is to be in a constant state of “reading” the client and responding appropriately, a give and take, much like a game of tennis or volleyball. The difference is, of course, that the ending point does not have a winner or loser, but instead two people who have moved to a new place of understanding together (Saari, 1994). Much like a sport, clinicians must follow their instincts as they engage in empathetic work with clients. If the client is stuck on an experience that the clinician just cannot grasp, it is up to the clinician to continue volleying questions and responses with the client until they come to a place of understanding. It is only then that forward motion could be made that would provide insight which may be helpful to the client (Rohr, 2011).

Many times this insight and forward motion is made with clients who have experienced significant trauma. In situations such as those, when clinicians are able to be “attuned” to clients, they enter into a state of “resonance” with them (Gerhart, 2012, p. 65). This resonance enables clients to feel the original feelings they experienced during their trauma, but this time with another person who is vicariously experiencing those emotions with a sense of calm and safety and peace, thus making re-living the experience much easier (Gerhart, 2012). There are those who are far too guarded to allow themselves to be this emotionally vulnerable (due to trauma, anger, mistrust, or negativity); but for the most part, it is a natural human emotion to want to feel understood (Bruneau, 2009).

As evidenced in the example of working through trauma, being present as a clinician in a therapeutic setting is more than listening and offering solutions. It means

MINDFULNESS, EMPATHY, AND SOCIAL WORK

being wholly immersed in the therapeutic process, entwined in the clients' struggles from an incredibly human perspective. Clinicians must make the leap from "doing to being" (Campbell and Christopher, 2012, p. 213; Stew, 2011). The concept of *being* rather than *doing* is often referred to as therapeutic presence and requires clinicians to be equal parts "empathic, compassionate, charismatic, spiritual, transpersonally communicative, responsive, optimistic, and expert" (Gerhart, 2012, p. 60). In relationship to this concept of therapeutic presence, Carl Rogers (1957) states:

"The therapist should be, within the confines of this relationship, a congruent, genuine, integrated person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly."(Campbell and Christopher, 2012, p. 213).

Most clinicians would agree, therefore, that the relationship between client and therapist seems to be one of the primary determining factors for client success, apart from client motivation (Campbell and Christopher, 2012). This seems to hold true across conceptual frameworks, as approaches including psychoanalysis, relational, intersubjective, cognitive-behavioral, crisis intervention, humanistic, existential, human behavior, and attachment-oriented have all stressed the importance of "presence" (King and Holosko, 2011; Shemmings, 2011). As such, it would seem critical that all clinicians have a foundational empathetic skill set in order to engage in best practice in a professional clinical setting.

The Social Work-Empathy Connection

Empathy in clinical social work practice.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Empathy is a critical component of social work, but it is often difficult to teach or explain because it is in large part innate and a fully automatic response (Eisenberg, 2000). As such, Gerdes and Segal (2009) have developed a rubric for a social work model of empathy based on research supporting several components of effective empathic skills. In their research, they have found that the three most important skills are affective response, cognitive processing, and conscious decision making. They defined affective response as an “involuntary, physiological reaction to another’s emotions and actions” that is demonstrated through mirroring, mimicry, and conditioning (Gerdes and Segal, 2009, p. 120). Cognitive response, the second component of their theory, defined as “voluntary mental thought processes used to interpret one’s affective response; enables one to take the other person’s perspective,” is done by practicing self-awareness, mental flexibility, role taking, emotional regulation, labeling, judgment, and self-agency (Gerdes and Segal, 2009, p. 120). And finally, the third component they described was conscious decision-making, meaning “voluntary choices for action made in response to cognitive processing” (Gerdes and Segal, 2009, p. 120). Key parts of this component are empathetic action, social empathy, morality, and altruism (Gerdes and Segal, 2009).

The concept of empathy, while somewhat straightforward, is also quite complex upon dissection. The ability to cognitively understand another person’s situation is quite different than actually putting oneself in another person’s position and experiencing the feelings and emotions tied to that situation. This transference of self to other is empathy (Gerdes and Segal, 2011). And being able to identify what another person is feeling, while recognizing that another person’s feelings are not their own, is what makes an effective clinical social worker because the level of insight is that much greater (Gerdes

MINDFULNESS, EMPATHY, AND SOCIAL WORK

and Segal, 2011). Social workers honing their empathic skills must remember that while it can be practiced, it also needs to happen organically; by forcing oneself to be empathetic, one loses the ability to do so (Raines, 1990). “If the client looks away, stops talking, or changes the topic, then it is likely the empathic response was incorrect in its timing or administration. It is a rare client who can challenge the worker and declare him or her wrong” (Raines, 1990, p. 68).

Clinical risks of demonstrating empathy.

As with most things in life, too much or too little empathy can be detrimental to both client and clinician (Raines, 1990). With empathy, there is a risk for social workers to become too much of an observer when not being empathetic enough while working with clients (inhibition of empathy). Conversely, there is also a risk of over-relating to a client and becoming overly emotional, and thus ineffective, to a client’s story (Raines, 1990). Researchers of late have put a more cognitive and neutral spin on being empathetic in an effort to safeguard against becoming overly involved emotionally with clients. This over-involvement can be seen in ways such as projection of clinicians’ feelings, fantasy, or projective distortion, psychoses, and over-identification with clients (Rohr, 2011).

Finding this balance is critical for clinicians to be effective. Additionally, social workers must be mindful of the difference between counter-transference and empathy (Raines, 1990). While empathy is helpful to client-clinician relationships because it helps clinicians understand clients, counter-transference can be harmful in that it insinuates an entanglement of feelings about not just clients’ situations, but also for the clients themselves (Raines, 1990). As such, appropriate empathy must be “mature” and

MINDFULNESS, EMPATHY, AND SOCIAL WORK

altruistic, and not confused with other positive feelings clinicians may get from work with a client (Raines, 1990, p. 68). Empathy must also be done with cultural competence and not for the wrong reasons, such as self gratification or an ego boost (Raines, 1990). Social workers must also be aware that empathy is not always positive (in the cases of violence, war, learned abuse, etc.). Working with a client who has become overly empathetic to a cause that promotes hate, suffering, or injustice is a risk of being empathetic and can be challenging to some social workers. Again, it requires the practitioner to make the fine distinction of being empathetic to the client's cause, but not overly empathetic (Gerdes and Segal, 2009).

Making the Social Work-Empathy-Mindfulness Connection

Connection between social work, empathy, and mindfulness.

Research supports that the practice of mindfulness helps build feelings of empathy in its practitioners and empathy is a necessary skill in the field of social work (Shapiro and Carlson, 2009; Campbell and Christopher, 2012). In a study of counseling students, mindfulness was a predictor of empathy, self-efficacy, and clinician attention; those students who had a foundation in mindfulness reported increased levels of those three skills (Campbell and Christopher, 2012; Turner, 2009). Additional research supports that mindfulness training can increase therapeutic responsiveness while decreasing reactivity and defensiveness. The decrease in reactivity and defensiveness can be attributed to mindfulness' focus on being in the moment without judging it (Campbell and Christopher, 2012).

Being able to maintain a non-judgmental position when working with clients is essential to therapeutic rapport (Gerdes and Segal, 2011). While it allows for clinicians

MINDFULNESS, EMPATHY, AND SOCIAL WORK

to be more moderate in their reactions, it also allows clinicians to feel less pressured to help clients make immediate changes, instead allowing for a slower change process to happen. Mindfulness focuses on the concept of self-compassion, which means not judging oneself, recognizing the humanity of all people, and the interconnectedness between all people's experiences. It encourages a person to see the big picture and the suffering every person endures. This shared sense of experience is what helps build empathy in a clinician (Birnie, Speca, and Carlson, 2010). Mindfulness also enables a clinician to have a good concept of "self-other," allowing the clinician to be in tune with, yet separate from, the client and thus allowing the practitioner to self-observe and not pass judgment, just acknowledge feelings (Gerdes and Segal, 2011).

Evidence for mindfulness as supporting empathy.

While research is sparse in supporting the theory that those who have been trained in mindfulness are truly more empathic than those who have not been, research does support that there are connections between mindfulness practice and positive clinical social work skills. Clients who have a more empathetic treatment experience are more likely to be successful in therapy (Shapiro and Izett, 2008). Meditation, taught independently or through MBSR, appears to influence clinician levels of empathy by reducing stress, increasing self-compassion, and learning to separate oneself from one's subjective experience. Those who meditate become less stressed and therefore focused inwardly, thus being able to better relate to others (Shapiro and Izett, 2008).

Influence of mindfulness and empathy on brain function and mental illness.

Research has demonstrated that there may be a link between increased brain function and mindfulness. fMRI's ["functional magnetic resonance imaging" is a special

MINDFULNESS, EMPATHY, AND SOCIAL WORK

scan done to measure neural functioning in the brain and spinal cord, a variation of the typical MRI (Devlin, 2008)] done on meditators have found that when people are doing a loving-kindness meditation, the front region of the brain, which controls compassion and empathy, is especially active. This supports current brain research about mirror neurons, compassion, and empathy in both humans and primates (Birnbaum, 2009). Recently researchers have discovered that certain brain cells in monkeys, which are also present in humans, control the ability to demonstrate empathy. They are called mirror neurons (Asian News, 2012). Mirror neurons allow people to virtually feel the activities or feelings of another person. When someone is being empathetic and says, “I feel your pain,” if their mirror neurons are firing, they truly do feel a version of another person’s pain (Gerdes and Segal, 2011, p. 243). In relation to clinical social work, if a clinician is able to truly practice empathy, they are able to experience a version of their client’s suffering because of neurological functioning (Turner, 2009).

As mentioned earlier, it is in infancy when humans first begin developing innate empathetic abilities, thus using the mirror neuron-laden part of the brain that causes a person to be empathetic (Eisenberg, 2000). We are innately able to read the feelings and emotions of others because of brain development as babies, literally mirroring what we see parents and caregivers do (Gerdes and Segal, 2011). In addition to being hardwired in a particular way, our brains are also able to change with instruction. Neuroplasticity refers to the ability to change the physiology of the brain in order to change qualities about the person, such as learning to become more empathetic, which is helpful to parents, social workers, and people living with mental illness (Gerdes and Segal, 2011).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Empathy and Social Work Education

Social work education and empathy training.

However difficult it is to quantify or teach, empathy is a critical quality to have in the field of social work (Shapiro and Carlson, 2009). “Lack of empathy underlies the worst things human beings can do to one another; high empathy underlies the best. Social work can almost be seen as an organized manifestation of empathy--to such an extent that social work educators and practitioners sometimes take it for granted” (Segal et.al, 2011, p. 109). Empathy-building curriculums such as ETP and MBSR help develop empathy-related skills. These skills can be easily quantified in terms of paraphrasing, appropriate self-disclosure, and articulation of feelings (Segal et.al, 2011).

Empathy training and the Council on Social Work Education.

Because of a strong belief in the need for clinicians to have an empathetic practice, the Council on Social Work Education (CSWE) speaks directly to the need for clinicians to enter the field versed in empathy. Their educational policy related to this skill is as follows:

Educational Policy 2.1.10(a)—Engagement

Social workers must: substantively and affectively prepare for action with individuals, families, groups, organizations, and communities; use empathy and other interpersonal skills; and develop a mutually agreed-on focus of work and desired outcomes. (CSWE, 2008, p. 6-7).

And yet, despite its importance, diversity and ethics get more attention in articles in an online search of pertinent social work issues. Additionally a search of text books found that none taught how to develop empathy, although most referred to it as important

MINDFULNESS, EMPATHY, AND SOCIAL WORK

in terms of “empathy, warmth, and genuineness” (Segal et.al, 2011, p. 111). While there is a demand for students to be instructed on empathy as part of their training, there is no specific way in which this should be taught; there is a need to further define and develop teaching to instruct students on empathy (Segal et. al, 2011).

Teaching empathy.

Those social work programs that do include instruction on empathy typically focus on learning to become active listeners and effective communicators. While this is helpful, it widely ignores the need to perceive and truly understand the world of another (Erera, 1997). Tools for building empathy may be useful to social work students and practitioners as they consider various opportunities within the field (King and Holosko, 2011). While empathy training programs may not improve empathic scores in research settings, they do increase important skills, which validate the need for more increased, structured training (Erera, 1997).

“Mindfulness is a skill that can help students increase empathy and prevent compassion fatigue and burnout. It means it is time to consider including mindfulness techniques and practices as a prominent, perhaps even mandatory, component of the social work practice curriculum” (Segal et. al, 2011, p. 118). Mindfulness practice is also a helpful tool in social work supervision. New social workers become more self-reflective and less judgmental of themselves as they practice being loving-kind to themselves (Birnbaum, 2009). There are, however, inherent challenges to practicing mindfulness and becoming mindful. It takes discipline to practice meditation each day (a component of mindfulness), as well as becoming increasingly mindful of mundane daily activities such as eating or driving. The feasibility of students, busy with coursework,

MINDFULNESS, EMPATHY, AND SOCIAL WORK

internships, and other daily demands, may prevent such instruction from being impactful (Stew, 2011).

Association between mindfulness and empathy among clinical social workers.

There is conflicting evidence tying the concept of mindfulness to an increased sense of empathy among practitioners. One study of medical students by Shapiro in 1998 reported more empathic feelings in participants, while neither a 2004 study of nurses by Beddoe and Murphy or a 2005 study of health care professionals by Galatino were able to demonstrate that same finding (Beddoe and Murphy, 2004; Birnie, Speca, and Carlson, 2010). In their 2010 study, Galatino's participants who completed a course in mindfulness did not report an increase in empathic feelings as reported on the IRI (Interpersonal Reactivity Index), but did report an increase in feelings that contribute to feelings of empathy (Birnie, Speca, and Carlson, 2010). Researchers continue to speculate if these inconclusive findings are due in part to already high levels of empathy innately in the general social worker population.

Humanistic Conceptual Framework

Humanistic social work.

Humanistic conceptual theories, such as person-centered, Gestalt, or existential theories, center on the relationship between clinician and client (Miller et al., 2011). They focus on the interpersonal skills of the clinician to guide the work through “acceptance, honesty, genuineness, and a warmth that the client can sense” (Miller et al., 2011, p. 1). Social work practiced through this lens requires the clinician to be genuine in representing who they are and what their role with the client will be with emphasis on the human relationship between the two (Miller et al., 2011). The concept of humanistic

MINDFULNESS, EMPATHY, AND SOCIAL WORK

social work is based on the beliefs that all people are human, and that those human experiences are central to growth and progress (Payne, 2011).

From a humanistic perspective of social work, a social worker's job is to walk with his or her clients on their journeys as they explore their suffering and continue to move forward. Social workers must focus on the person as a whole and not at the negative aspects of any individual or community in isolation. Humanistic social work also focuses on the client as both subject and object. As subject, the client focuses on himself to heal, but as object, the client focuses on his relationship with or in connection to others (Payne, 2011). In summary, "Humanistic and transpersonal psychologies and therapies bring to humanistic social work the idea of seeking to promote personal growth and self-actualization through our shared human experience" (Payne, 2011, p. 16).

More specifically, according to Rice and Greenberg (1992) there are four concepts to the humanistic approach. The first is that it is phenomenological, meaning it is discovery-oriented with the client viewed as the expert on his or her own experience. Core beliefs about this concept are that the client knows himself best and is the "owner of his own truth" (p. 111). The second is the actualizing tendency involving growth, self-determination, and choice. This concept means that clients want to focus on moving forward and creating their future, rather than focusing on events of the past. The third concept is fostering the construction of new meaning, which essentially means experiencing what you're feeling. And finally, the last concept is that humanistic social work is person-centered. This means that there is a true therapeutic relationship between client and clinician and that this relationship teaches the client a new way to be in a relationship and relate to another person (Rice and Greenberg, 1992).

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Humanistic movement and its impacts.

Through the process of humanistic social work, “the client must feel the real or authentic presence of the counselor who possesses and conveys honest empathy, warmth, and unconditional positive regard in the relationship” (Miller et al., 2011). Carl Rogers first coined the term “unconditional positive regard” when referring to the acceptance of a person without negative judgment of their basic worth (Miller et al., 2011). Rogers first fathered the concept of client-centered work with his focus on “I-Thou,” the idea that it was beneficial for clinicians to experience what their clients were experiencing in order to foster therapeutic success. Frederick Perls was the brain behind Gestalt Therapy, with its focus on interconnectedness, the concept that we are all part of a greater system. Additionally, there were many other psychologists throughout the 1940s and 50s who contributed to the existential movement, which focuses on the relationship one has with himself and the therapist’s ability to empathize with the client (Rice and Greenberg, 1992; Reevy, 2010).

Person-centered approach to clinical social work.

According to Miller (2011), “Person-centered counseling involves concepts stemming from terms such as congruence, non-possessive warmth, empathy, and unconditional positive regard.” By focusing positive energy and emotion on the clients and their goals, clients will be more inclined to make healthier decisions, creating a new and improved environment (therapeutically) in which to grow and thrive (Miller et al., 2011). The clients’ goals, therefore, are central to the focus of the therapy. The client is empowered to set his own goals and the therapist simply acts as a supportive figure on the client’s journey (Miller et al., 2011). To be an effective clinician in the context of

MINDFULNESS, EMPATHY, AND SOCIAL WORK

person-centered social work, clinicians must demonstrate empathy, unconditional positive regard, and genuineness (Rice and Greenberg, 1992).

Because of its focus on the human experience, the concept of mindfulness, as it pertains to work with clients in a clinical setting, is best viewed through the lens of humanistic social work. The notions of mindfulness and humanism seem to complement one another well in terms of their foundations in the fundamentals of humanity; the need for a sincere human connection between two people, an authenticity within relationships, a desire to feel understood by another person (Miller et al., 2011; Shapiro and Carlson, 2009). Humanism prescribes to these ideas and mindfulness provides the vehicle in which to meet these human desires.

Methods

Study Purpose and Design

The purpose of this quantitative study was to discover if there was a relationship between the degree of empathy experienced by clinical social workers and mindfulness practice. Using a cross-sectional research design, primary analysis was applied to the responses of a random sampling of licensed clinical social workers in the state of Minnesota to the Interpersonal Reactivity Index (IRI) (Davis, 1980, 1983) and a seven-question survey. The IRI is a self-proctored tool that measures the overall empathy level of a person, as well as breaks down empathy into four sub-categories. The short informational survey of seven open-ended, closed-ended, and Likert scale questions was administered to ascertain respondents' training in and practice of mindfulness, type of social work practiced, and opinion regarding empathy training. By learning the degree of self-reported empathy levels of clinical social workers in conjunction with their degree of

MINDFULNESS, EMPATHY, AND SOCIAL WORK

knowledgeability of the concept of mindfulness, this research was able to assess the connection between mindfulness and empathy among clinical social workers.

Sub-Research Questions

In conjunction with this research question, also seeking to be answered were the following research questions: (1) Does mindfulness practice impact the level of empathy reported among clinical social workers? (2) Do clinical social workers who practice mindfulness more often demonstrate greater levels of empathy than those who do not? (3) Do clinical social workers who have practiced mindfulness for a longer period of time demonstrate greater levels of empathy than those who have practiced for a shorter period of time? (4) Does having been formally trained in mindfulness increase levels of empathy among clinical social workers? (5) Do clinical social workers who have had more mindfulness training demonstrate higher levels of empathy? (6) Does the type of social work a clinician practices impact levels of empathy? (7) Do clinical social workers who attribute mindfulness training to their ability to exhibit empathy report higher levels of empathy?

Study Variables and Data Collection Instruments

In this study, which attempted to answer the question, “What is the association between mindfulness and empathy among clinical social workers?”, the dependent variable was the level of empathy reported, and the independent variable was the reported practice of mindfulness. Empathy was measured using the Interpersonal Reactivity Index (IRI) (Appendix A). The IRI is “a measure of dispositional empathy that takes as its starting point the notion that empathy consists of a set of separate but related constructs” which was developed by Mark Hanson in 1980 (Sanfilippo, 2012, p.1). These constructs

MINDFULNESS, EMPATHY, AND SOCIAL WORK

are quantified to measure the ability of a respondent to demonstrate perspective taking (PT), empathetic concern (EC), personal distress (PD), and the ability to imagine oneself experiencing the situation of someone else (fantasy scale, FS) (Sanfilippo, 2012).

The seven-question questionnaire (Appendix B), developed by the author of this research project as a supplement to the IRI for purposes of this research study, was comprised of both closed- and open-ended questions. The questions gathered nominal, ordinal, and ratio information designed to supplement questions on the IRI. Questions on this survey measured the independent variable of mindfulness. The questions measured whether respondents had mindfulness training and if so, the extent to which they were trained. They also determined if respondents practiced mindfulness and if so, the degree to which they practiced. Additionally, questions measured potential extraneous variables such as identifying how long a respondent had practiced mindfulness, the type of social work the respondent practiced, and their opinion about ways in which they have learned to practice empathy. The information gathered from this questionnaire was compared with the respondent's IRI scores in order to make the connection between mindfulness training and impact on levels of empathy.

Sampling Method and Data Collection Process

The population surveyed for this research project consisted of a random sample of 121 clinical social workers registered with the Minnesota Board of Social Work (MBOSW). A list of 500 Licensed Independent Clinical Social Workers (LICSW) and their contact information was purchased from the MBOSW. An email explaining the purpose of the study, as well as a link to the Qualtrics website containing the IRI survey and follow-up seven-question questionnaire, was sent to the list of clinical social workers.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Potential participants were advised in the introductory email that their participation was voluntary and all participants would remain anonymous. Participating social workers completed the survey and questionnaire online and submitted it within two weeks of the initial email. Data was collected and analyzed using the Qualtrics and SPSS operating systems.

Measures for Protection of Human Subjects

Measures were taken to protect the rights of the human subjects participating in this research. No identifying information was gathered or used in this research project. Participants were informed of the purpose of this research, the accessibility of information gathered during and after the research process, and the methods that data were kept throughout the duration of the research project prior to participation. Participants were advised that this research project was in compliance with current St. Catherine University Institutional Review Board standards. Participants were advised to contact the IRB or this researcher with any questions or concerns.

Data Analysis

Descriptive Statistics

Descriptive statistics were run on all variables to provide an understanding of this data set. A measure of central tendency and dispersion, and histogram, were used to demonstrate respondent scores of the IRI. General data analysis was used to demonstrate descriptive qualities of the respondents of this project. These descriptors include mindfulness practice (question three of the seven-question survey [1.Do you practice mindfulness?]), length of time practicing mindfulness (question five [5. If you practice mindfulness, how many years have you practiced it?]), mindfulness training (question

MINDFULNESS, EMPATHY, AND SOCIAL WORK

one [1. Have you participated in mindfulness training]) and type of social work practiced (question six [6. What type of social work do you practice?]).

Finally, a qualitative description and bar chart of participant responses was used to demonstrate answers to question seven of the seven-question survey (7. How have you developed empathetic skills with clients throughout the course of your career?).

Research Questions

Does mindfulness practice (independent variable) impact the level of empathy reported (dependent variable) among clinical social workers? This study was interested in the relationship between mindfulness and empathy among social workers. A t-test was used to test the hypothesis that those social workers who practice mindfulness have higher levels of empathy than those who do not. Levels of empathy were measured by composite scores of the IRI and mindfulness practice was measured using responses from question three of the seven-question survey.

Do clinical social workers who practice mindfulness more often (independent variable) demonstrate greater levels of empathy (dependent variable) than those who do not? This study was interested in the relationship between the degree of practice of mindfulness and levels of empathy among social workers. A correlation scatterplot was used to test the hypothesis that those social workers who practice more mindfulness have higher levels of empathy than those who practice less or not at all, thus indicating a positive correlation. Levels of empathy were measured by composite scores of the IRI and the degree of mindfulness practice will be measured by question four of the seven-question survey.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Do clinical social workers who have practiced mindfulness for a longer period of time (independent variable) demonstrate greater empathy (dependent variable) who have practiced for a shorter period of time? This study was interested in the relationship between the length of time practicing mindfulness and levels of empathy among social workers. A correlation scatterplot was used to test the hypothesis that those who have practiced mindfulness longer report having higher levels of empathy than those who have practiced less time or not at all, thus indicating a positive correlation. Levels of empathy were measured by composite scores of the IRI and the length of mindfulness practice will be measured by question five of the seven-question survey.

Does having been formally trained in mindfulness (independent variable) increase levels of empathy among social workers (dependent variable)? This study was interested in the relationship between mindfulness training and levels of empathy among social workers. A t-test was used to test the hypothesis that social workers who have had mindfulness training report higher levels of empathy than those who have not. Levels of empathy were measured by composite scores of the IRI and mindfulness training was measured using responses from question one of the seven-question survey.

Do clinical social workers who have had more mindfulness training (independent variable) demonstrate higher levels of empathy (dependent variable)? This study was interested in the relationship between the degree of training in mindfulness and the levels of empathy among social workers. A correlation scatterplot was used to test the hypothesis that those social workers with more training in mindfulness report higher levels of empathy, thus indicating a positive correlation. Levels of empathy were

MINDFULNESS, EMPATHY, AND SOCIAL WORK

measured by composite scores of the IRI and the degree of training in mindfulness was measured by question two of the seven-question survey.

Does the type of social work a clinician practices (independent variable) increase levels of empathy (dependent variable) among clinical social workers? This study was interested in the relationship between type of social work practice and mindfulness practice among social workers. A t-test was used to test the hypothesis that social workers who spend more than 50% of their time doing clinical social work report higher levels of mindfulness practice than those who practice clinical social work 50% of the time. Type of social work practice will be measured by question six of the seven-question survey and mindfulness practice will be measured using responses from question three of the seven-question survey.

Do clinical social workers who attribute mindfulness training to their ability to exhibit empathy (independent variable) report higher levels of empathy (dependent variable)? This study was interested in the relationship between mindfulness and levels of empathy among social workers. A qualitative analysis was used to test the hypothesis that social workers who report that mindfulness training has helped them develop empathy skills demonstrate higher levels of empathy than those who report other ways they have developed empathy. Levels of empathy were measured by composite scores of the IRI and mindfulness training as a means for developing empathy was categorized and measured in question seven of the seven-question survey.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Strengths and Limitations of Design

Strengths

There were several strengths of this research design. Because of the proposed size of the random sample of social workers surveyed, there was an increased likelihood of participation among social workers contacted. Additionally, the survey and questionnaire were anonymous and relatively short, with an approximate completion time of less than five minutes, which may have also contributed to the likelihood of participation in this study. With high numbers of participants, the validity of the data collected is high. Finally, the tool used to measure levels of empathy (IRI) among participants was a reliable tool which reflects accurate levels of empathy. Comparing these scores to data collected through the seven-question survey using Qualtrics, provided relatively accurate reflections of the connections between mindfulness and empathy among clinical social workers surveyed.

Limitations

The survey was only distributed to clinical social workers in the state of Minnesota and thus the results of the survey are limited in generalizability to this population of people. Additionally, this research project ran the risk of having a limited number of respondents due to respondent interest in the subject matter, which may also mean that only those social workers with experience in mindfulness responded, thus skewing the data to be unrepresentative of those without training or experience in mindfulness.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Findings

The purpose of this research project was to explore the connection between mindfulness and empathy among clinical social workers. This research project sought to answer the following research questions: Does mindfulness practice impact the level of empathy reported among clinical social workers? Do clinical social workers who practice mindfulness more often demonstrate greater levels of empathy than those who do not? Do clinical social workers who have practiced mindfulness for a longer period of time demonstrate greater empathy than those who have practiced mindfulness for a shorter period of time? Does having been formally trained in mindfulness increase levels of empathy among clinical social workers? Do clinical social workers who have had more mindfulness training demonstrate higher levels of empathy? Does the type of social work a clinician practices increase levels of empathy among clinical social workers? And do clinical social workers who attribute mindfulness training to their ability to exhibit empathy report higher levels of empathy? These questions will be explored in the descriptive statistic, research question analysis, discussion, and implications for practice and further research sections that follow.

Descriptive statistics.

Descriptive statistics were run on all variables to provide an understanding of this data set. These descriptors included participation in mindfulness practice, years of practice of mindfulness, participation in mindfulness training, type of social work practiced, and composite Interpersonal Reactivity Index (IRI) scores. Narrative descriptions and bar charts were used to demonstrate descriptive qualities of the

MINDFULNESS, EMPATHY, AND SOCIAL WORK

respondents of this project. A measure of central tendency and dispersion, and histogram, were used to demonstrate respondent scores of the IRI.

Descriptive qualities of respondents.

Mindfulness practice.

This study was interested in whether or not clinical social workers practiced mindfulness. To measure this, respondents were asked to answer the question: Do you practice mindfulness? This nominal variable measured the respondents' mindfulness practice. The findings of this study revealed that 92 respondents (76.7 percent) report that they practice mindfulness and 28 respondents (23.3% percent) report that they do not practice mindfulness. These findings show that the majority of the sample practices mindfulness.

Years spent practicing mindfulness.

Respondents who answered that they practiced mindfulness, were then asked to answer the following question: How many years have you practiced mindfulness? This nominal variable measured the number of years participants have been practicing mindfulness. Answers to this question were divided into five-year increments (i.e. 0-5 years, 6-10 years, etc.), with the first column indicating no answer given (this column included those that answered 'no' to the question "Do you practice mindfulness?"). The findings of this study in Figure 1 show that the majority of participants who practice mindfulness have spent less than ten years doing so.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Figure 1. *Years Practicing Mindfulness Bar Chart*

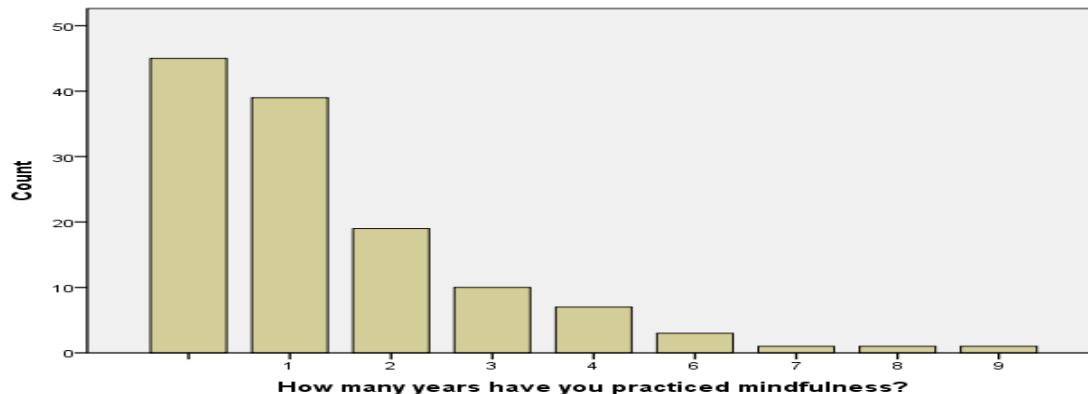


Figure 1. Years Practicing Mindfulness

No value entered = (blank), 0-5 = 1, 6-10 = 2, 11-15 = 3, 16-20 = 4, 21-25 = 5, 26-30 = 6, 31-35 = 7, 36-40 = 8, 41-45 = 9, 46-50 = 10

Mindfulness training.

The study was interested in whether the respondents had participated in formal mindfulness training. To measure this, the survey asked the respondents: Have you participated in formal mindfulness training? This nominal variable measured the respondents' level of mindfulness training. The findings of this study revealed that 53 respondents (44.5 percent) report having participated in formal mindfulness training and 66 respondents (55.5 percent) report not having participated in such training. These findings demonstrate that the sample is divided almost evenly between those who have training in mindfulness and those who do not.

Work practiced.

The study was interested in what type of social work participants practiced (clinical or not clinical). To measure this, the survey asked the respondents: What type of social work do you practice? This nominal variable measured respondents' clinical practice. The response options were "less than 50 percent clinical work" and "more than 50 percent clinical work." The findings of this study revealed that 29 respondents (24.6 percent) reported doing less than 50 percent clinical work and 89 respondents (75.4

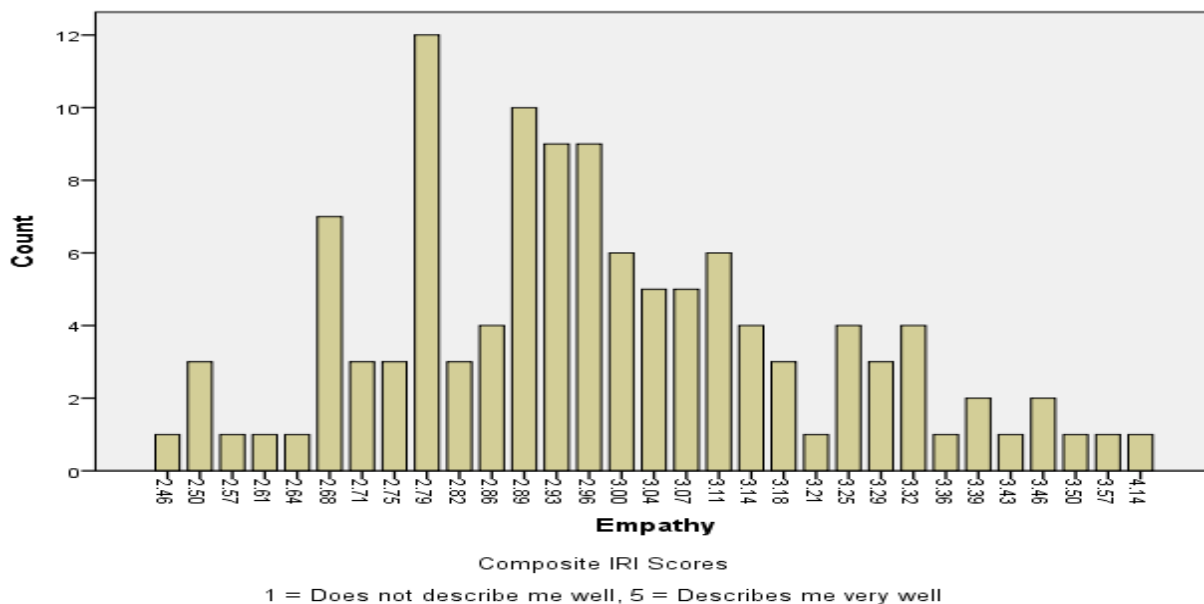
MINDFULNESS, EMPATHY, AND SOCIAL WORK

percent) reported doing more than 50 percent clinical work. These findings demonstrate that the majority of the sample practices more clinical work than non-clinical work.

IRI scores.

This study was interested in the degree of empathy social workers worker rate practicing as measured by an empathetic rating tool. This nominal variable measures the respondents' composite IRI scores. The IRI measures "dispositional empathy" based on a series of questions asking respondents how would respond in different situations based on their thought and feelings (Sanfilippo, 2012, p.1). Composite scores may range from one to five, with one indicating a low degree of empathy and five indicating a high degree of empathy. This score represents the following research question: How empathetic are you? The findings of this study in Figure 2 show that the majority of participants are moderately empathetic with a mean score of 2.98.

Figure 2. *Composite IRI Scores Bar Chart*



MINDFULNESS, EMPATHY, AND SOCIAL WORK

Research questions.

Does mindfulness practice (independent variable) impact the level of empathy reported (dependent variable) among clinical social workers?

This study was interested in the relationship between mindfulness and empathy among social workers. Levels of empathy were measured by composite scores of the IRI and mindfulness practice was measured using responses (“yes” or “no”) from question three of the seven-question survey: Do you practice mindfulness? The research hypothesis for the study was: There is a relationship between mindfulness and empathy among clinical social workers. The null hypothesis for the study was: There is no relationship between mindfulness and empathy among clinical social workers.

Tables 1 and 2 show the results of the t-test comparing the mean IRI scores of the respondents (representing degree of empathy) with reported mindfulness practice. The mean IRI score of respondents who practice mindfulness was 3.0060, while the mean IRI score of respondents who do not practice mindfulness was 2.8955. The difference between these mean scale scores was 0.1105.

The Levene’s Test of Equality of Variance for the independent samples t-test is 0.457, indicating that the two variances are approximately equal. Because the variances are approximately equal, the p-value considered to evaluate for statistical significance is 0.051. This p-value is not, however, considered equal to 0.05, thus the findings of this data are not statistically significant. As a result the hypothesis is rejected, indicating that there is not a relationship between mindfulness and empathy among clinical social workers.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table 1. *Group Statistics for Empathy and Mindfulness Practice T-test***Group Statistics**

Do you practice mindfulness?	Levene's Test for Equality of Variances		t-test for Equality of Means	
	F	Sig.	t	df
Empathy Yes	.558	.457	1.973	114
No			2.242	53.900

Table 2. *Empathy and Mindfulness Practice T-test***Independent Samples Test**

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Empathy	.558	.457	1.973	114	.051	.11052	.05600	-.00042	.22145
Equal variances assumed									
Equal variances not assumed			2.242	53.900	.029	.11052	.04930	.01167	.20937

Do clinical social workers who practice mindfulness more often (independent variable) demonstrate greater levels of empathy (dependent variable) than those who do not?

This study was interested in the relationship between the degree of practice of mindfulness and levels of empathy among social workers. A correlation scatterplot was used to test the hypothesis that those social workers who practice mindfulness more often have higher levels of empathy than those who practice less or not at all, thus indicating a positive correlation. Levels of empathy were measured using composite scores of the IRI

MINDFULNESS, EMPATHY, AND SOCIAL WORK

and the degree of mindfulness practice was measured by question four of the seven-question survey: To what degree do you practice mindfulness? Answers were given on a Likert scale ranging from one to ten, with one indicating practicing mindfulness “a little” and ten indicating “it is an integral part of my day, life, and perspective on the world.”

Tables 3 and 4, and Figure 3, show the inferential statistics of the relationship between the two variables, level of empathy and degree of mindfulness practice. The calculated correlation ($r = .097$, $p = .375$) indicates a very weak, positive correlation. With the degree of chance factored into this statistic, it is assumed, then, that there is no correlation between degree of mindfulness practiced and levels of empathy.

Because the p-value ($p = .375$) is greater than 0.05, the hypothesis is rejected. Therefore, the results of this study support the null hypothesis that there is no relationship between the degree of mindfulness practiced and the level of empathy demonstrated among clinical social workers.

Table 3. *Descriptive Statistics for the Relationship Between the Degree of Mindfulness Practice and Empathy*

Descriptive Statistics

	Mean	Std. Deviation	N
Empathy	2.9792	.25721	117
To what degree do you practice mindfulness?	6.61	2.015	89

MINDFULNESS, EMPATHY, AND SOCIAL WORK

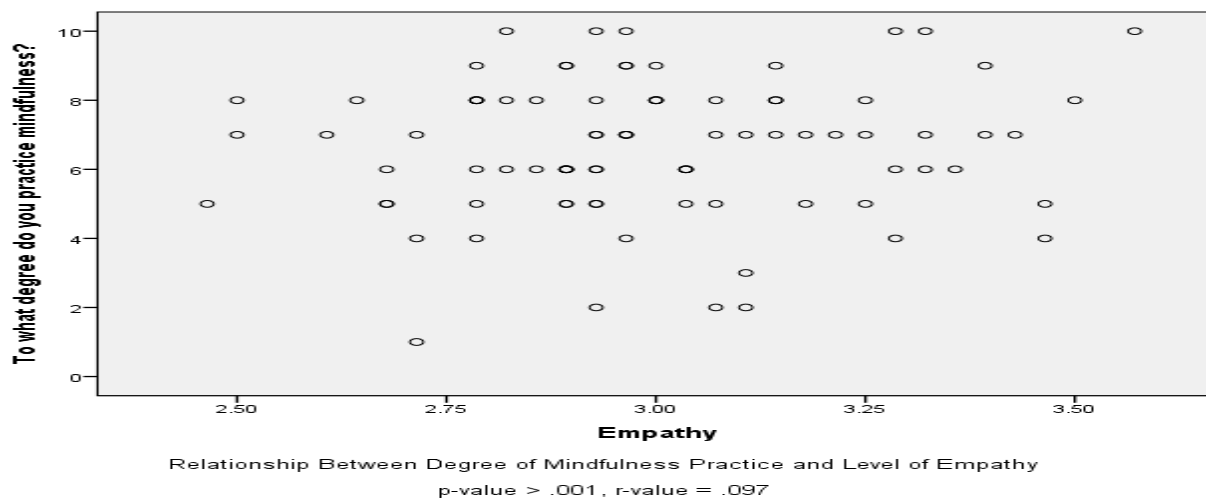
Table 4. Relationship Between Degree of Mindfulness Practice and Empathy

Correlations

		Empathy	To what degree do you practice mindfulness?
Empathy	Pearson Correlation	1	.097
	Sig. (2-tailed)		.375
	N	117	86
To what degree do you practice mindfulness?	Pearson Correlation	.097	1
	Sig. (2-tailed)	.375	
	N	86	89

Figure 3. Scatterplot of Relationship Between Degree of Mindfulness Practice and

Empathy



Do clinical social workers who have practiced mindfulness for a longer period of time (independent variable) demonstrate greater empathy (dependent variable) than those who have practiced mindfulness for a shorter period of time?

This study was interested in the relationship between the length of time practicing mindfulness and levels of empathy among social workers. An evaluation was used to test the hypothesis that those who have practiced mindfulness for a longer period of time will demonstrate having higher levels of empathy than those who have practiced mindfulness

MINDFULNESS, EMPATHY, AND SOCIAL WORK

for a shorter period of time, thus indicating a positive correlation. Levels of empathy were measured using composite scores of the IRI and the length of mindfulness practice was measured by question five of the seven-question survey: How many years have you practiced mindfulness? The question was posed as an open-ended question and respondents wrote in their length of practice. For data analysis purposes, responses were coded and re-assigned value in five-year increments.

Table 5 and Figure 4 show the results of the correlation which measure the relationship between the two variables, level of empathy and length of time practicing mindfulness. The calculated correlation ($r = .156$, $p = .094$) indicates a weak, positive correlation. Therefore, as respondents' length of time practicing mindfulness goes up, so then the level of empathy goes up as well, but not to the degree that it can be considered statistically significant.

Because the p-value ($p = 0.094$) is greater than 0.05, the hypothesis is rejected. Therefore, the results of this study support the null hypothesis that there is no relationship between the length of time practicing mindfulness and the level of empathy demonstrated among clinical social workers.

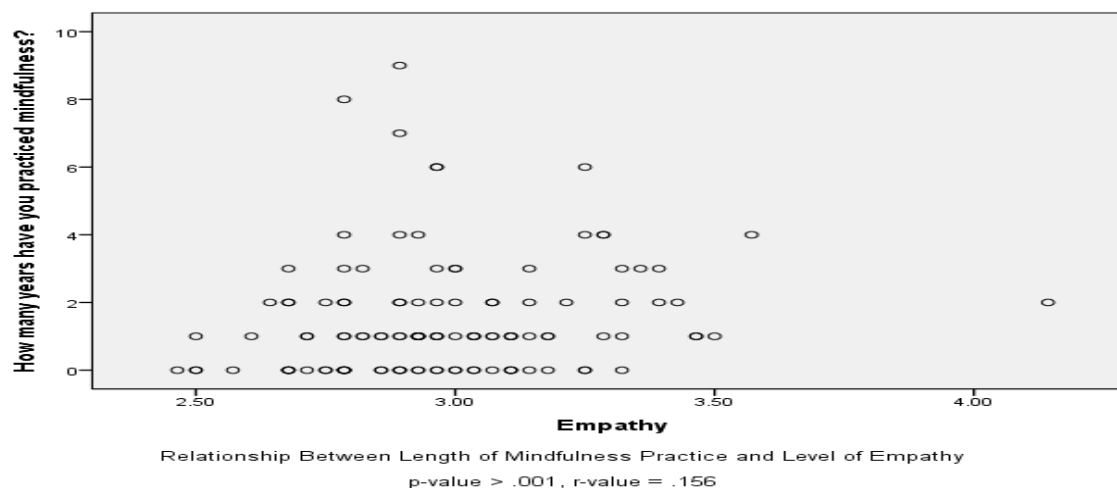
MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table 5. *Descriptive Statistics for the Relationship Between Length of Mindfulness Practice and Levels of Empathy*

Correlations

		Empathy	How many years have you practiced mindfulness?
Empathy	Pearson Correlation	1	.156
	Sig. (2-tailed)		.094
	N	117	117
How many years have you practiced mindfulness?	Pearson Correlation	.156	1
	Sig. (2-tailed)	.094	
	N	117	126

Figure 4. *Relationship Between Length of Mindfulness Practice and Empathy*

Correlations

Does having been formally trained in mindfulness (independent variable) increase levels of empathy among clinical social workers (dependent variable)?

This study was interested in the relationship between mindfulness training and levels of empathy among social workers. Levels of empathy were measured by

MINDFULNESS, EMPATHY, AND SOCIAL WORK

composite scores of the IRI and mindfulness training was measured using responses (“yes” or “no”) from question one of the seven-question survey: Have you ever participated in formal mindfulness training? The research hypothesis was: There is a relationship between mindfulness training and levels of empathy. The null hypothesis for the study was: There is no relationship between mindfulness training and levels of empathy.

Tables 6 and 7 show the results of the t-test comparing the mean IRI scores of the respondents (representing degree of empathy) with reported mindfulness training. The mean IRI score of respondents who have been trained in mindfulness was 3.0586, while the mean IRI score of respondents who have not been trained in mindfulness was 2.9187. The difference between these mean scale scores was 0.1399.

The Levene’s Test of Equality of Variance for the independent samples t-test was 0.078, indicating that the two variances are approximately equal. Because the variances are approximately equal, the p-value considered to evaluate for statistical significance is 0.004. This p-value is less than 0.05; thus the findings of this data are statistically significant. As a result the hypothesis is accepted, indicating that there is a relationship between mindfulness training and empathy among clinical social workers. Respondents who have had mindfulness training demonstrate being more empathetic than those who have not had mindfulness training.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table 6. *Group Statistics for Participation in Mindfulness Training and Empathy***Group Statistics**

Have you participated in formal mindfulness training?	N	Mean	Std. Deviation	Std. Error Mean
Empathy Yes	50	3.0586	.28697	.04058
No	65	2.9187	.21729	.02695

Table 7. *Participation in Mindfulness Training and Empathy T-test***Independent Samples Test**

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Empathy	3.169	.078	2.976	113	.004	.13989	.04701	.04676	.23302
Equal variances assumed									
Equal variances not assumed			2.871	88.563	.005	.13989	.04872	.04308	.23670

Do clinical social workers who have had more mindfulness training (independent variable) demonstrate higher levels of empathy (dependent variable)?

This study was interested in the relationship between the degree of training in mindfulness and the levels of empathy among clinical social workers. The research sought to determine if, as training in mindfulness increases, will empathy levels increase

MINDFULNESS, EMPATHY, AND SOCIAL WORK

as well? A correlation scatterplot was used to test the hypothesis that those social workers with more training in mindfulness will report having higher levels of empathy, thus indicating a positive correlation. Levels of empathy were measured using composite scores of the IRI and the degree of training in mindfulness was measured by question two of the seven-question survey: Please indicate the level of [mindfulness] training you have participated in. Respondents chose an answer on a Likert scale ranging from one to ten, with one indicating “having participated in general mindfulness education” and ten indicating “having extensive training, teaching, and experience in the field of mindfulness.”

Tables 8 and 9, and Figure 5, show the inferential statistics of the relationship between the two variables, level of empathy, and degree of mindfulness training. The calculated correlation ($r = 0.093$, $p = 0.554$) indicates a very weak positive correlation. Therefore, as respondents’ degree of mindfulness training goes up, so then the level of empathy goes up as well, but not to the degree that it can be considered statistically significant.

Because the p-value ($p = 0.554$) is greater than 0 .05, the hypothesis is rejected. Therefore, the results of this study support the null hypothesis that there is no relationship between the degree of mindfulness training and the level of empathy demonstrated among clinical social workers.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table 8. *Descriptive Statistics for the Relationship Between Level of Mindfulness Training and Level of Empathy*

Descriptive Statistics

	Mean	Std. Deviation	N
Level of Mindfulness Training	5.36	2.598	44
Empathy	2.9792	.25721	117

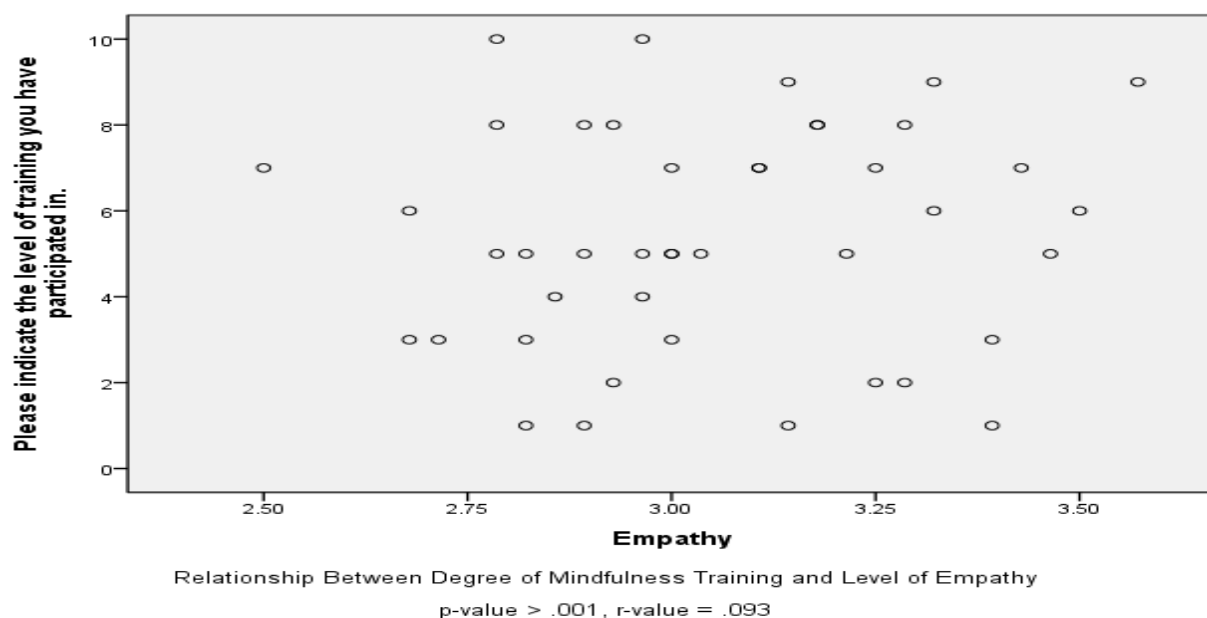
Table 9. *Relationship Between Level of Mindfulness Training and Empathy*

Correlations

		Level of Mindfulness Training	Empathy
Level of Mindfulness Training	Pearson Correlation	1	.093
	Sig. (2-tailed)		.554
	N	44	43
Empathy	Pearson Correlation	.093	1
	Sig. (2-tailed)	.554	
	N	43	117

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Figure 5. *Scatterplot of Relationship Between Level of Mindfulness Training and Empathy*



Does the type of social work a clinician practices (independent variable) increase levels of empathy (dependent variable) among clinical social workers?

This study was interested in the relationship between type of social work practiced and levels of empathy practice among social workers. Levels of empathy were measured by composite scores of the IRI and type of social work practice was measured using responses (“More than 50 percent clinical” or “Less than 50 percent clinical”) from question six of the seven-question survey: What type of social work do you practice? The research hypothesis for the study was: There is a relationship between type of practice and empathy among clinical social workers. The null hypothesis for the study was: There is no relationship between type of practice and empathy among clinical social workers.

Tables 10 and 11 show the results of the t-test comparing the mean IRI scores of the respondents (representing degree of empathy) with reported type of social work

MINDFULNESS, EMPATHY, AND SOCIAL WORK

practice. The mean IRI score of respondents who practiced less than 50 percent clinical social work was 3.0000, while the mean IRI score of respondents who practiced more than 50 percent clinical social work was 2.9809. The difference between these mean scale scores was 0.0191.

The Levene's Test of Equality of Variance for the independent samples t-test is 0.923, indicating that the two variances are approximately equal. Because the variances are approximately equal, the p-value considered to evaluate for statistical significance is 0.733. This p-value is greater than 0.05, thus the findings of this data are not statistically significant. As a result the hypothesis is rejected and the null hypothesis is accepted, indicating that there is not a relationship between type of social work practiced and empathy among clinical social workers.

Table 10. *Group Statistics for Type of Social Work Practiced and Empathy with the T-test*

Group Statistics

What type of social work do you practice?	N	Mean	Std. Deviation	Std. Error Mean
Empathy Less than 50% clinical	28	3.0000	.25882	.04891
More than 50% clinical	86	2.9809	.25630	.02764

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Table 11. *Type of Social Work Practiced and Level of Empathy with the T-test***Independent Samples Test**

	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Empathy	.009	.923	.342	112	.733	.01910	.05590	-.09165	.12986
Equal variances assumed									
Equal variances not assumed			.340	45.518	.735	.01910	.05618	-.09401	.13222

Do clinical social workers who attribute mindfulness training to their ability to exhibit empathy report higher levels of empathy?

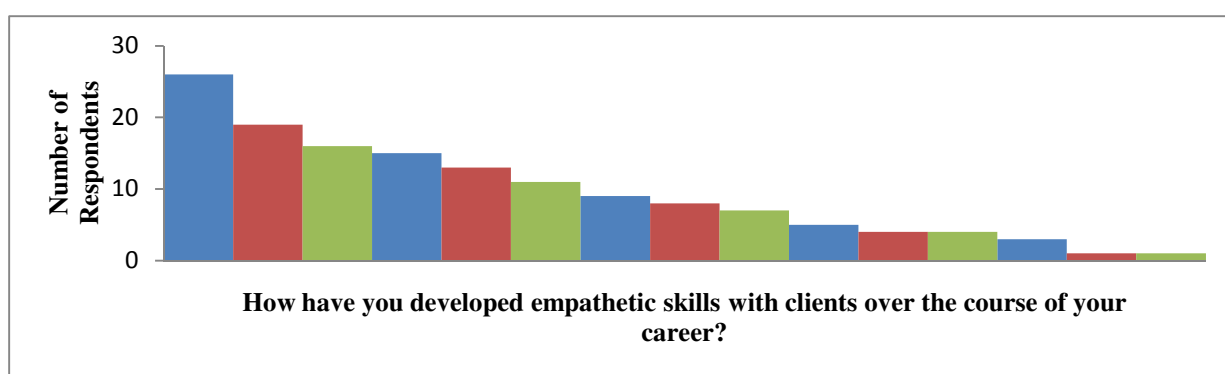
Of 121 respondents to this survey, 99 completed the final open-ended question on the seven-question survey: How have you developed empathetic skills with clients throughout the course of your career? Answers to this question were quantified and categorized to fit within one of fifteen common response categories. Many respondents listed more than one way in which they developed their empathic skills. As such, the total number of responses exceeds the number of people who answered this question.

Figure 6 shows the number of respondents per response category. The following are responses to this question and the number of respondents who listed this response. They are listed from most prevalent answer to least prevalent answer and correspond to the descending bars on the graph: listening and understanding (26), understanding /attunement (19), natural empathic ability (16), attending trainings which address the

MINDFULNESS, EMPATHY, AND SOCIAL WORK

issue of empathy (15), ongoing practice (13), life experiences (11), supervision (9), consultation (8), reading books/articles related to this topic (7), increasing awareness of issues of transference and countertransference (5), spirituality (4), mindfulness training (4), focusing on self/personal therapy (3), internships (1) and practicing existentialism (1).

Figure 6. *Responses to Open-Ended Question Regarding Development of Empathy Skills*



Discussion

Research Purpose

The purpose of this research was to discover if there was a relationship between mindfulness and empathy among clinical social workers. A review of the literature shows a relationship between these two concepts: social workers who practice mindfulness are more empathic than those who do not (Campbell and Christopher, 2012; Turner, 2009; Shapiro and Izett, 2008). This study showed mixed results as to the connection between mindfulness and empathy. Most of the sub-questions were not statistically significant, nor was the overall degree of empathy reported by respondents, in conjunction with whether or not they practice mindfulness. While overall empathy scores were higher among clinical social workers who practice mindfulness than those

MINDFULNESS, EMPATHY, AND SOCIAL WORK

who do not, there was not a margin of difference wide enough to be considered statistically significant.

Of statistical significance was the relationship between those clinical social workers who had been formally trained in mindfulness (versus those who had not) and levels of empathy. This study sought to discover if there was a relationship between formal mindfulness training and empathy. Again, based on research (Campbell and Christopher, 2012; Turner, 2009; Shapiro and Izett, 2008), the hypothesis of this research was that those who have been trained in mindfulness would be more empathic than those have not been trained. This hypothesis was supported by inferential statistics comparing participants' IRI scores with their reported participation in mindfulness training.

In addition to this project's main research question (Is there a relationship between mindfulness and empathy among clinical social workers?) demonstrating not to have statistical significance, several sub-research questions proved not to have statistically significant results as well. The three sub-questions that explored the degree to which a respondent practiced mindfulness, the length of time they practiced mindfulness, and level of training they had in mindfulness (based on Likert scale questions), all proved to be statistically insignificant.

Also statistically insignificant was the relationship between type of social work practiced (more or less than 50 percent clinical) and levels of empathy. The hypothesis of this research project was that there was a relationship between type of practice and level of empathy. Because this relationship was statistically insignificant, the null hypothesis was proven, which was that there was no relationship between these types of social work practice and level of empathy. Due to the weak relationship between

MINDFULNESS, EMPATHY, AND SOCIAL WORK

practicing and being trained in mindfulness and levels of empathy, there is not enough evidence to fully imply that there is in fact a solid relationship between mindfulness and empathy.

Also of interest in this research project was the concept of what clinical social workers attribute their development of empathy skills to. Despite the weak, yet quantifiable, relationship between mindfulness and empathy, when given the opportunity to reflect in their own words on what influenced the development of their empathetic skills, only four respondents listed their mindfulness practice as aiding in this process, while approximately ten times as many attributed their levels of empathy to their ability to listen and understand (attend and attune to) their clients. This disconnect between mindfulness and empathy as reported by respondents suggests that the sample group, despite data suggesting otherwise, does not see practicing mindfulness as a contributing factor to their development of empathy skills.

Relevance to Literature Review

Relationships between mindfulness, empathy, social work, and quantitative data.

Previous research has demonstrated that there is a relationship between mindfulness practice and both physical and emotional health (Gockel, 2010). Participants of MBSR training experienced a reduction in stress, anxiety, rumination, and negative affect, while improving their instance of positive affect, self-compassion, and regulation of emotional states (Shapiro, Brown, and Biegel, 2007). Studies on meditation specifically have demonstrated that meditators report higher levels of awareness and acceptance of life circumstances (Birnbaum and Birnbaum, 2008). The ability for those

MINDFULNESS, EMPATHY, AND SOCIAL WORK

who practice mindfulness to carry over these positive qualities to their work with clients, specifically in terms of empathy, was the focus of this research project.

In relation to social work practice and mindfulness, the ability of the practitioners to be attuned to their clients' emotions and experiences is essential for the clients to feel understood and make healthy progress in terms of clinical work (Gockel, 2010). This attunement from a clinical perspective allows the practitioner to see the client's situation from a wider-angle lens, thus enabling the clinician to help the client re-frame a situation and continue on a path forward (Gockel, 2010). The use of empathetic skills in these circumstances is an essential action on the part of the clinician, and thus the development of these empathetic skills would seem to be a critical component of social work training.

At this time, the Council on Social Work Education calls for education on the concept of "empathy and other interpersonal skills" (CSWE, 2008, p. 6-7). Future research supporting the findings of this study would assist the field in evaluating the effectiveness of mindfulness training as it pertains to teaching empathy and give educational facilities another venue for enhancing the practical skills of its clinicians. By enhancing the skills of its clinicians, the field of social work is adding to its credibility as it is viewed by colleagues and consumers alike.

The statistically significant results of this research project support what the limited research available at this time reports: Mindfulness training builds empathetic skills (Campbell and Christopher, 2012; Turner, 2009; Shapiro and Izett, 2008). The insignificant results, however, do not support that increased mindfulness practice, increased length of time practicing mindfulness, or an increased amount of time being trained in mindfulness equate to clinicians becoming more empathic. Current research in

MINDFULNESS, EMPATHY, AND SOCIAL WORK

this area, exploring the degree of certain characteristics, was unavailable and therefore my hypotheses regarding these research questions were speculative, based on a personal theory that with practice and training, skills in these areas would increase.

Because the degree of mindfulness practice does not seem to impact the level of empathy demonstrated, it may be of interest to explore the breadth and depth with which empathy is practiced, rather than simply focus on its overall presence. To do this, further examination of the data collected in this research project may be looked at from a more pointed perspective. The Interpersonal Reactivity Index (IRI) can be broken down into four sub-categories, which include perspective taking (being able to see others' viewpoints), fantasy (the ability to put oneself in the situation of another), empathic concern (being compassionate and sympathetic towards others), and personal distress (having a feeling of anxiety in highly emotional situations), and may be useful upon closer examination of the relationship between mindfulness and empathy (Sanfilippo, 2012).

Points of consideration regarding research results.

It is important to consider, when evaluating this research project, that the results may be skewed simply because of the nature and motivation of the respondents who chose to participate in this project. The descriptive statistics showed that the majority of participants (76 percent) in this study practiced mindfulness. Additionally, approximately half the respondents (44 percent) have some degree of training in mindfulness. For those reasons, it may be suggested that the data may be skewed to represent a sample of clinical social workers who have a preference for mindfulness in their daily lives and/or social work practice. Therefore, those who chose not to

MINDFULNESS, EMPATHY, AND SOCIAL WORK

participate in this research (379 people) may have chosen not to because they have no interest in or knowledge about mindfulness. Further research may be helpful in determining if this 76 percent participation rate in mindfulness and 44 percent participation rate in mindfulness training is representative in other random samples of clinical social workers. Supportive research would give increased validity to the results of this research.

Another point to consider in examining this research would be that of the nature of the respondents. Because the majority of respondents practiced mindfulness, it could be assumed that the sample has an increased interest in the emotionally focused aspect of social work. In response to the open-ended question (How have you developed your empathetic skills throughout the course of your social work career?), several of the respondents indicated a natural ability to be more empathic, suggesting that just by nature they found themselves to be more sensitive to others. Also, many respondents reported their need to want to listen to and understand their clients, which in many ways speaks to their desire to be empathetic. One could make the assumption that those who want to be more empathetic would work at becoming so. The average empathy score was slightly above average, for both practitioners who practice mindfulness and those who did not, indicating that choosing this profession in and of itself may indicate that a participant has a higher than average degree of empathy skills.

Implications for the Field of Social Work

Social work practice.

Because of the weak, but significant relationship identified between mindfulness and empathy as demonstrated through data acquired through this research project, social

MINDFULNESS, EMPATHY, AND SOCIAL WORK

work professionals may have another tool accessible to them to help develop their skills of empathy. Not typically addressed using specific methods of development, empathy can be a rather abstract concept for new practitioners to develop without ongoing instruction. The development of important empathetic skills is crucial to the entire field of social work.

Although it goes without question that empathy is important to the field of social work, the way in which a practitioner should be trained to be empathetic is somewhat unfocused at this time. As such, critics of the idea of implementing mindfulness curriculum into social work instruction may question if this training is entirely necessary. Most clinicians reported in the survey that they felt they were innately empathic or were naturally drawn to improving their listening, understanding, and attunement skills. As such, developing a training that seeks to enrich, not teach per se, these natural abilities would be important to curriculum development.

Additionally, a clearer, more quantifiable description of the concept of mindfulness would be beneficial to the application of mindfulness within the field of social work. Because social workers perceive mindfulness in many different ways (i.e. prayer, meditation, yoga, being in nature, etc.) a more concise idea of what mindfulness looks like in practice, and thus how it might be taught to practitioners, would be useful to practitioners interested in pursuing this field.

Social work education.

At the present time, there is no specific curriculum that teaches social workers ways in which to develop their empathetic skills. The results of this research project, however, indicate there may be an opportunity for the field to become more proactive in

MINDFULNESS, EMPATHY, AND SOCIAL WORK

teaching future clinicians specific skills to become more empathic. The Council of Social Work Education (CSWE, 2008), states the necessity for clinicians to practice work with an empathic presence; however, they do not specify how this might be taught.

Mindfulness training offers an opportunity to do that.

In addition to developing more opportunities for research to corroborate the findings of this project, it must also be explored as to who might benefit from being trained in mindfulness. The results of this research project show that it was irrelevant whether a clinician practiced primarily clinical social work or non-clinical social work, therefore indicating that it would be of use to *all* social work practitioners, not just clinical social workers to have some training in mindfulness.

Strengths and Limitations of Design

Strengths.

One major strength of this research project was the size of the random sample of social workers surveyed. There was a relatively high rate of participation among social workers contacted (24 percent participation rate). The relatively large sample size adds validity to the findings. Additionally, the survey and questionnaire were anonymous and relatively short, with an expected completion time of less than five minutes, which may have also contributed to likelihood of participation of this study. Finally, the tool used to measure levels of empathy (IRI) among participants was a reliable tool which likely reflects accurate levels of empathy. Comparing these scores to data collected through the seven-question survey using Qualtrics, provided relatively accurate reflections of the connections between mindfulness and empathy among social workers surveyed.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Limitations.

This research project was foremost limited by the nature of its subject matter. As stated in the literature review, empathy in and of itself is difficult to measure due to its intangibility (Gerdes and Segal, 2011). The tool which this research project used to measure empathy, the IRI, while demonstrated to be reliable, also relied on the honesty and self-insightfulness of respondents in order to determine the degree to which each respondent was empathetic (Davis, 1980, 1983). Although presumably a good indicator, it cannot be entirely accurate.

Additionally, the concept of mindfulness was also difficult to define in a way that had a universal meaning for all participants. Although mindfulness was described in many ways at the beginning of the survey, one participant contacted this researcher to inquire about various forms of prayer that may also be included in the definition of mindfulness, feeling that various forms of prayer were excluded in the survey and, as such, results of the research may be negatively impacted. In that vein, measuring the degree to which clinicians implement mindfulness practice in their lives and practices is also highly subjective, thus eliciting those responses “to be taken with a grain of salt” as well.

An additional limitation of this research project was that the survey was only distributed to clinical social workers in the state of Minnesota, and thus the results of the survey can be generalized only to this population of professionals. And finally, this research project ran the risk of having a limited number of respondents based on proposed respondent interest in the subject matter, which may also mean that only those

MINDFULNESS, EMPATHY, AND SOCIAL WORK

social workers with experience in mindfulness responded, thus skewing the data to be unrepresentative of those without training or experience in mindfulness.

Recommendations for Further Research

The results of this study indicate that there is not a statistically significant relationship between mindfulness and empathy among clinical social workers, however, the statistical difference is so small that further research exploring this relationship should be done to support these findings. Ongoing research may be helpful in making more conclusive assertions.

Ongoing research projects in this field of study would also benefit from a clearer definition of the word *mindfulness*. With additional education about what this concept may look or feel like for participants, more representative data may be acquired regarding mindfulness practice among clinical social workers. Gathering more specific data about training in mindfulness, its use in clinical practice, as well as perceived benefits of this practice may also be beneficial in further research.

Using a different tool to measure empathy may also result in measurable scores that are more representative of true feelings of empathy. While the IRI has proven to be a valid measure of empathy, other tests may provide a better glimpse into this. The Likert scale used in this tool could be perceived as vague with multiple meanings for each numerical value. Should further research use the IRI, it would also be worthwhile to do further data analysis to determine if analyzing the sub-scores of this tool would demonstrate any other important themes relevant to the concepts of mindfulness and empathy.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

And finally, related specifically to the questions on the seven-question questionnaire, there are several changes that may heed more accurate findings for a similar study. These changes include a greater break down in the periods of time spent practicing mindfulness into smaller increments (by simply using five-year time spans, it is left unexamined how empathy scores may be impacted during the first few months and years of practice, which it may be assumed increase significantly as one develops a sense of mindfulness), improving the descriptions of degrees of mindfulness training (the Likert scale used in this study could be perceived as vague with multiple meanings for each numerical value), and by using close-ended answers when assessing how empathy skills were developed (by allowing open-ended responses to this question, there was room for misinterpretation on the part of this researcher; using themes from the literature review and research studies such as this one, a thorough list of applicable responses may easily be developed and utilized).

Conclusion

The work of Carl Rogers placed great emphasis on the concepts of genuineness, empathy, and unconditional positive regard when working with clients (Kahn, 1997). Rogers felt that if the majority of work done with clients was done within this framework, and that if a practitioner could exercise these skills, clients would be halfway to where they needed to be, regardless of the content of conversations (Kahn, 1997). As a clinician, Rogers' sentiments have always resonated strongly with me, which was why my interest was sparked to research the concept of empathy in conjunction with the practice of mindfulness. Like many of the participants in this research project, I, too,

MINDFULNESS, EMPATHY, AND SOCIAL WORK

acknowledge a natural inclination to be more empathic with clients, and so in that vein am always seeking ways to enhance this practice.

Like myself, many social workers today still place a great deal of emphasis on practicing empathy while working with clients. However, apart from discussing the concept of empathy and its importance to clinical work within the academic setting, there is no specific curriculum or educational model to teach this important clinical skill. While many social workers will report having an innate ability to be empathic with clients, this research project was able to support the theory that in addition to many other positive physical and emotional benefits of mindfulness, the breadth and depth of empathy can also be enriched and increased through mindfulness practice.

As evidenced by the data acquired through this research project, there is a weak, yet statistically significant, relationship between mindfulness and empathy among practitioners. This relationship opens the door to the potential for new instruction in social work education that may help shape the practice of developing effective social workers. Continuing research supporting this relationship will seek to enhance the practice of social work in the future.

Ensuring that clients feel heard and understood, in an effort to make authentic connections in a therapeutic setting, is critical to the field of social work. In that vein, in order for clinicians to show genuine concern for clients, they must first practice compassion, non-judgment, gentleness, and forgiveness with themselves. Emphasizing the care a social must give themselves will be reflected through empathy with the care they must take of their client. By continuing to explore avenues in which these skills can

MINDFULNESS, EMPATHY, AND SOCIAL WORK

be built, such as by means of teaching and practicing empathy, we are ensuring that both clients and patients are able to have a meaningful therapeutic experience.

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Appendix A

INTERPERSONAL REACTIVITY INDEX¹

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL			DESCRIBES ME VERY WELL	

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
2. I often have tender, concerned feelings for people less fortunate than me. (EC)
3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
5. I really get involved with the feelings of the characters in a novel. (FS)
6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
8. I try to look at everybody's side of a disagreement before I make a decision. (PT)
9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)

1

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MINDFULNESS, EMPATHY, AND SOCIAL WORK

10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
12. Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)
13. When I see someone get hurt, I tend to remain calm. (PD) (-)
14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)
17. Being in a tense emotional situation scares me. (PD)
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)
19. I am usually pretty effective in dealing with emergencies. (PD) (-)
20. I am often quite touched by things that I see happen. (EC)
21. I believe that there are two sides to every question and try to look at them both. (PT)
22. I would describe myself as a pretty soft-hearted person. (EC)
23. When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)
24. I tend to lose control during emergencies. (PD)
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
27. When I see someone who badly needs help in an emergency, I go to pieces. (PD)
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

MINDFULNESS, EMPATHY, AND SOCIAL WORK

NOTE: (-) denotes item to be scored in reverse fashion

PT = perspective-taking scale

FS = fantasy scale

EC = empathic concern scale

PD = personal distress scale

A = 0

B = 1

C = 2

D = 3

E = 4

Except for reverse-score items, which are scored:

A = 4

B = 3

C = 2

D = 1

E = 0

MINDFULNESS, EMPATHY, AND SOCIAL WORK

Appendix B

Seven Question Survey

Please indicate your experience and opinions by completing the following seven questions. For purposes of this study, “mindfulness” is defined as “paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally” (Jon Kabat-Zinn). Mindfulness practice may include yoga, meditation, lovingkindness, or breathing exercises.

1. Do you practice mindfulness?

YES

NO

2. If you answered yes, to what degree do you practice mindfulness?

1	2	3	4	5	6	7	8	9	10
A little.				During time spent with clients.			It is an integral part of my day, life, and social work practice.		

3. Have you ever participated in formal mindfulness training?

YES

NO

4. If you answered yes, on a scale of one to ten, please indicate the level of training you have participated in.

1	2	3	4	5	6	7	8	9	10
Have participated in general mindfulness education				Have completed a specific mindfulness training course			Have extensive training and experience in the field of mindfulness		

5. If you practice mindfulness, how many years have you practiced it?

6. What type of social work do you practice?

More than 50% Clinical

Less than 50% Clinical

7. How have you developed empathetic skills with clients throughout the course of your career?

MINDFULNESS, EMPATHY, AND SOCIAL WORK

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