

Caring for caregivers:**Enhancing compassion satisfaction and minimizing fatigue,
secondary traumatic stress, and other adverse impacts of caregiving****Introduction**

Many caregivers are drawn to the healing professions as a way of expressing their compassion for others. In the course of their work, healing professionals often experience *compassion satisfaction*, a sense of purpose and fulfillment. Chaplains, medical professionals, and mental health workers can experience visceral benefits as well as purpose. In their work, they may engage with “a myriad of adversities that others only witness through the protective lens of television or film... Optimal stress, which can produce exhilaration, high motivation, mental alertness, high energy, and sharp perceptions, is the ideal” (Craig 2010). In other words, the challenges of caregiving can be intensely rewarding in the moment and in the big picture.

That benefits accrue to caregiver as well as those cared for is a premise of this paper. In a hospital setting, for example, a patient may be supported by a chaplain’s presence and skillful listening. The chaplain may benefit as well, perhaps through heightened perception in the moment, and a deeper appreciation for life upon later reflection. While I was introduced to this paradigm, *mutual benefit*, in Buddhist chaplaincy training, it is not unique to chaplains or Buddhists. Caregivers in many professions have described receiving similar benefits and satisfaction from their work (Tedeschi 2005). Mutual benefit and compassion satisfaction are two ways of describing the positive aspects of caregiving.

Unfortunately, all too many caregivers experience adverse impacts from their work, particularly from working with traumatized people. Unlike compassion satisfaction, the adverse

impacts of caregiving are widely researched. Many studies indicate that they are also widespread. The costs of caregiving have been analyzed through a number of models. These different models have resulted in a confusing constellation of names including *burnout*, *vicarious trauma*, *secondary traumatic stress*, and the sometimes contentious term *compassion fatigue*. Evidence is overwhelming that these negative effects are quite real, and can be debilitating if unaddressed.

Unfortunately, the scientific research regarding positive and negative effects of caregiving is very unbalanced. The prevalence and import of adverse impacts is obscured by two things: the overlapping and contradictory terms describing them, and a lack of balanced research. For example, very few studies examine *post traumatic growth*, a transformative shift some people experience in the wake of primary or secondary trauma. This is perhaps in part due to the importance of proving adverse impacts are significant, when caregivers and researchers are faced with organizational ignorance or cultural minimization (Mathieu 2011).

To summarize, the scientific picture on adverse impacts of caregiving is often bleak. Furthermore, research done on the negative effects of caregiving is often confusing due to overlapping and contradictory terminology. The combination of negative and unclear information may have a negative impact on some of the very caregivers researchers are trying to help, as lack of a balanced picture may obscure their ability to fully understand how to ameliorate adverse impacts and cultivate positive outcomes such as posttraumatic growth and compassion satisfaction.

I offer this paper as a balancing voice and resource for caregivers of all kinds. These pages are intended to empower healing professionals, especially chaplains, to prevent or treat

adverse impacts and increase the personal benefits caregiving yields. I begin by framing healing professional wellness and education as ethical issues. In the following pages, I touch on the terms describing positive and negative effects of caregiving. This supports the following sections which describe the causes and conditions contributing to adverse impacts. The final sections of this paper are dedicated to discussion of treatment and prevention. These sections discuss what we know about attitudes and behaviors that help prevent or ameliorate adverse impacts. I also introduce cutting-edge research on two practices, lovingkindness meditation and self-compassion cultivation, that directly address many causes and symptoms caregivers experience.

I. Education and self-care are ethical issues

The Hippocratic Oath, *primum non nocere*, or, “first do no harm,” has guided healers for centuries. Charles Figley, a specialist in compassion fatigue, suggests adding a second clause for caregivers – “First do no SELF harm!” (Figley n.d.). His quip highlights a crucial understanding for healing professionals: In addition to being a key preventative and treatment for adverse impacts, self-care is an ethical imperative. The Green Cross, an organization serving the traumatized, puts the issue more bluntly, stating that “sufficient self-care prevents harming those we serve” (Green Cross n.d.). Their statement is supported by a 2007 study which found “a correlation between compassion fatigue and ethical violations” (Gentry & Figley 2007, qtd in Figley n.d.). In other words, when healing professionals suffer adverse impacts, those they serve are at greater risk.

Education can help prevent or ameliorate this. Unfortunately, chaplains and other clergy do not appear to be well informed (Hendron 2012, 228; Kruger 2009). A 2009 survey found that

while *two thirds* of chaplains responding had experienced symptoms, only roughly 10% of the them knew how to name—or dare we say *frame* -- their experience (Kruger 2010). In an article on secondary traumatization in the clergy, Hendron et al advocate that “there is an almost ethical and moral obligation upon researchers to examine the effects of ...[working with trauma] upon the clergy”, adding that “The lack of literature suggests that clergy are not sufficiently aware of, prepared for or managing this natural but potentially harmful aspect of their role” (228).

This matters because lack of awareness and preparation may well exacerbate caregivers’ experience of adverse impacts, in part due to unrealistic expectations inexperienced caregivers bring to their work (W. & Sprang 2007). Education, then, is important for caregivers, personally and ethically. So to learn more, lets take a look at how researchers have defined adverse impacts and positive effects caregivers experience.

II. The Compound Phenomena of labels, models, and syndromes

Burnout

UC Berkeley Professor Christina Maslach describes burnout as “a syndrome of emotional exhaustion, depersonalization¹, and reduced personal accomplishment...characterized by cynicism, psychological distress, feelings of dissatisfaction, impaired interpersonal functioning, emotional numbing, and physiological problems.”² The Maslach Burnout Inventory measures emotional exhaustion, depersonalization, and sense of personal accomplishment as individual factors or “subscales” (Mind Garden n.d.).

¹ A sense of unreality, including “a feeling of observing yourself from outside your body. Feelings of depersonalization can be very disturbing and may feel like you’re losing your grip on reality or living in a dream” (Mayo Clinic n.d.).

² Maslach 1984; Fothergill 2004; qtd in Sprang et al. 2011, 260

Compassion Fatigue

The sometimes contentious term *compassion fatigue* is used to describe symptoms “such as exhaustion, frustration, anger and depression typical of burnout,” and “a negative feeling driven by fear and work-related trauma” (ProQOL 2008-2012). The phrase compassion fatigue is used in many different ways by scientists. While researchers such as Figley characterize compassion fatigue as a serious, full-blown syndrome, the term is also used as a catchall phrase by many scientists for less deleterious symptoms. In many studies, it is used synonymously with *Secondary Traumatic Stress* and *Vicarious Trauma*. Some researchers suggest a more accurate term to be *Empathy Burnout* (Ekman 1012).

Compassion satisfaction

While the benefits of caregiving have been known for centuries, compassion satisfaction is a fairly new scientific term. Researchers Beth Hudnall Stamm and Charles Figley added it to an instrument measuring compassion fatigue, creating the *Professional Quality of Life Scale*. Their innovation exemplifies a current research trend in which scientists have begun tracking beneficial emotions, practices, and frames of mind. In the study of people, this is vitally important -- until experiences can be described or measured, they do not appear in scientific research. It follows that if only adverse impacts of caregiving are studied, results will likely emphasize negative findings. Measuring “what is going right” allows scientists to explore the causes and conditions for beneficial outcomes and experiences as well as difficulties. Compassion satisfaction refers to any of the positive effects of caregiving, from greater purpose in life to simply appreciating supportive coworkers and a job well done.

Models based on trauma

There is strong scientific evidence linking contact hours with the traumatized and caregivers' experience of adverse impacts. Perhaps because of this correlation, some researchers use terminology and models emphasizing the secondary or vicarious transmission of trauma.

Secondary Traumatic Stress

While *Secondary Traumatic Stress* (STS) is comparatively rare in the overall population, it impacts many helping professionals (Stamm 1999). STS may result from exposure to other people's trauma at work. Its symptoms "are usually rapid in onset and associated with a particular event." The symptoms can be short-term, transient, and quite intense. People report forgetting important things, "feeling trapped, on edge, exhausted, overwhelmed, and infected by others' trauma." Some experience fear, upsetting or intrusive images, and avoiding objects or situations associated with an upsetting event. Caregivers may also experience preoccupation with a patient, or an "inability to separate one's private life and his or her life as a helper" (17). This model evolved from the study of PTSD, and some of the symptoms are very similar. However, "it cannot be overemphasized that *these issues are a natural consequence of trauma work and not necessarily pathological in nature.*"³

Vicarious Trauma

Trauma expert Laurie Pearlman describes her personal experience of *vicarious trauma* as "a funk...that didn't pass. Violent imagery was intruding on my consciousness when I wanted to have fun. A deep sense of sorrow pervaded my days, and my clients' stories ran around in my mind at night". Subsequent extensive discussions of countertransference reactions with colleagues at the Traumatic Stress Institute, inspired further research (1999), based on a model of

³ Figley, 1995; Larsen & Stamm, 2008; Stamm, 1999; qtd in Stamm 2010. *Emphasis added.*

therapists' internal experiences.⁴ The phrase *Vicarious traumatization* "describes the impact of repeated empathic engagement with trauma survivors" (W. & Sprang 2007, 260).

PTG

Post traumatic growth refers to the positive transformations some people experience by working through trauma (Harris 2010). Scientific research on this phenomenon is still in its infancy. I found one small pilot survey collecting data on *secondary* post traumatic growth in mental health professionals.⁵ Preliminary research is promising: it suggests difficulties experienced when supporting the traumatized may not be all bad. For some people, the very process of working through trauma inspires a deepening of appreciation for life, a broader perspective, self-awareness, patience, and compassion (Tedeschi 2005).

Looking Beneath the Labels

In her 2010 manual on professional quality of life, BH Stamm describes the use of the three terms for adverse impacts as "a taxonomical conundrum". All three are used interchangeably, and "represent three converging lines of evidence that produced three different construct names." (Stamm 2010, 9). Indeed, I encountered many papers examining adverse impacts without carefully defining the terms above. The lack of clear and consistent language and models in this field has real-world results. Readers and scientists alike do not have a clear picture of the difficulties being measured, especially when comparing studies with each other. Some researchers therefore ignore the differences in models altogether, and examine the experiential symptoms and their contributing factors. In writing this paper, I have also chosen to

⁴ 1990a&b, qtd in Sprang 2007, 260 This model includes the experiences of safety, trust, power, esteem, intimacy, interdependence, and control. See McCann and Pearlman, "Vicarious traumatization: A framework for understanding the psychological effects of working with victims." *Journal of Traumatic Stress*, 1990. (3), 131 -149.

⁵ Tedeschi, et al., "Vicarious Posttraumatic Growth in Psychotherapy", *Journal of Humanistic Psychology*, 2005. 239-263.

ignore these conceptual differences whenever possible. My emphasis is on common themes that have emerged among many studies. Where data exists, I list treatments or prevention possibilities specific to individual symptoms. That said, when quoting others' research, I do use the author's preferred terminology. During discussion, I refer to adverse impacts together as such, or use a term invented for this paper, *Caregiving Fatigue*.

III. Causes and conditions: prevalence, risks, and risk factors

How Prevalent are adverse impacts?

How prevalent is caregiving fatigue? Approximately two thirds of 304 American chaplains surveyed in 2009 reported having experienced Compassion Fatigue or STS at some point in their careers. The intensity and duration of symptoms varied, ranging from several weeks to over two years (Kruger 2010). A 2005 report “commissioned by the U.S. Army Surgeon General found that 33% of Behavioral Health (BH) personnel and Unit Ministry Teams (UMT), which includes chaplains, reported ‘high or very high’ burnout,” at that time. Army physicians fared worse; 37% reported burnout. (Duerr 2009). A study of Canadian Military chaplains “found that 52% of chaplains were at medium to high risk for anxiety or depressive disorders” (Mathieu 2011). In these three reports, prevalence of adverse impacts is high. Perhaps due in part to the unclear language discussed earlier, however, reports of prevalence vary widely.

For example, three smaller studies suggest lower rates of adverse impacts. A 2012 study found “a low level of Compassion Fatigue and Burnout” among 69 Army chaplains in its abstract (D. Stewart 2012). Airforce Chaplains reported rates of adverse impacts at 7.7%, noting

that “counseling stress exposure predicted compassion fatigue and posttraumatic growth”.⁶ A study of 66 male and female Rabbis working as chaplains concluded, "Although compassion fatigue and burnout were low among the survey participants, both measures were considerably higher among women... also among chaplains who were divorced, and increased with the number of hours per week for chaplains spent working with trauma victims and their families" (Taylor 2006, qtd in Duerr 2009).

To recap, a significant portion of chaplains experience adverse impacts during the course of their careers. There are varying time horizons and questions asked in the few extant studies of chaplains, which makes it difficult to assess how prevalent caregiving fatigue is among spiritual caregivers. We can, however, hazard to guess based on data about incidence among other healing professionals. As Franciose Matthieu summarizes in *The Compassion Fatigue Workbook*, “Depending on the studies, between 40% and 85% of helping professionals were found to have compassion fatigue and/ or high rates of traumatic symptoms” (2011, k.l. 793-797).

Who is at Risk for adverse impacts?

Anyone whose work involves hearing stories of others’ trauma or working directly with traumatized people may experience adverse impacts. As Matheiu writes, “the data collected during the past 15 years are highly consistent: many helpers across the various helping fields (teachers, physicians, nurses, social workers, animal shelter workers, paramedics, psychologists, shelter workers, prison therapists, judges, police officers, chaplains, etc.) are showing clear signs of compassion fatigue and vicarious trauma” (2011, kl 787-790). While there are certainly

⁶ Levy 2011. Norms for various demographic factors are included in the *ProQOL Concise Manual, 2nd Edition*. BH Stamm. http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf.

different specific stressors in these professions, all of these professionals encounter populations with potentially high rates of trauma.

Risk factors

Indeed, working with traumatized people is highly correlated with caregiving fatigue symptoms. Strong evidence suggests other key factors: unresolved personal trauma, lack of education about risks, lack of work-life boundary, and inadequate interpersonal support.

Studies have repeatedly found significant links between caregiver contact hours with traumatized people and risk of adverse impacts.⁷ The *kind* of trauma caregivers are exposed to matters. One study of military chaplains found they experienced more stress *hearing about* difficulties from patients than when directly exposed to combat related physical trauma (Greer 2009).

Military chaplains may be a special case, however, there is strong evidence that hearing about certain kind of trauma is difficult for everyone. For example, mental health "workers with high caseloads of survivors of violent or human-induced trauma (especially against children) seemed to be a greater risk..."⁸ Exposure to people who habitually harm themselves or others, or those at imminent risk for self-harm is also particularly problematic (Craig 2010). Regardless of the kind of trauma involved, "Most studies come to the same conclusions...the more trauma you have on your caseload, the more likely you are to develop vicarious trauma" (Mathieu 2011, kl 790-793).

⁷ Craig 2010; Duerr 2008, Lawson and Myers 2011; Mathieu 2011; Sprang 2007; Stamm 2010.

⁸ Sprang 2007, also see Creamer & Liddle 2005; Cunningham 2003

Exposure to traumatized patients remains a significant risk “even when controlling for...prior [caregiver] trauma exposure” (Craig 2010). However, healing professionals who have personally experienced trauma do bear increased risk regardless of caseload. A report synthesizing ten years of research studies concludes there is “reasonable evidence that a personal history of trauma exposure increases the likelihood of compassion fatigue.”⁹ There are other occupational risk factors, too. Authority styles minimizing worker self-determination, chain of command, size of organization, role conflicts and ambiguities, and rank of the worker contribute to burnout among crisis workers (Hartsaugh & Myers, qtd in Duerr 2009). Lack of time and ability to process being with others’ trauma, lack of clarity or boundaries between roles, and not having peers also compound a caregiver’s chances of developing adverse effects (W. & Sprang 2007).

Given this data, it is not too surprising that workers in rural areas have been shown to be at greater risk. Rural caregivers tend to work in organizations with fewer resources. They face a higher probability of supporting others outside of the scope of their training. In addition, due to the size of their communities, rural healing professionals also have less opportunity to distance themselves from potential community stresses, (Mathieu 2011, Kindle Location 1471) and may have fewer peers with whom to talk things over.

Outside of work, there are personal risk factors to consider. Poor life-work boundaries are both a risk and a warning sign. Lack of close friendships and not asking for help are well-known contributors to Caregiving Fatigue. Being divorced is also implicated as a risk factor for STS (Adams et al 2008, qtd in Craig 2010). Several studies suggest that youth and inexperience

⁹ Baird & Kracen 2006 qtd in Craig 2010.

correlate with lower compassion satisfaction at work. Young, inexperienced women have been shown to be at greater risk for adverse impacts than others.¹⁰ Being female does not necessarily mean a caregiver will experience adverse impacts.

Women, however, have also been shown to experience greater post traumatic *growth* in meta-analyses of self-reported PTG (Vishnevsky 2010). A study of mostly female counselors found they experienced high compassion satisfaction and low rates of compassion fatigue when compared to other caregivers. The authors posit this is potentially due to the high priority the counselors placed on self-care (Lawson 2011). To me, it appears this emphasis may be in part a result of the counselling field's orientation towards wellness and prevention.

Caregivers who are not educated about adverse impacts are likely to be at greater risk for developing it (Hendron 2012), which may be part of why education is a key part of every treatment regimen I found.¹¹ Education alone, however, is not an adequate preventative (Kruger 2010). The scientific studies I reviewed did not fully agree about every risk factor for caregiving fatigue. In discussing risks, I have focused on overall common themes that emerged, and caution readers to keep an open mind when comparing risk factors to their own situations. No one risk factor is destiny.

Considerations for chaplains and other clergy

Many of the risk factors for adverse impacts are related to occupational stress. While all healing professionals share some stressors, chaplains and other clergy occupy a distinctive role in the caregiving community. Some stressors are related to this role. Retired Chaplain Michael

¹⁰ W. & Sprang 2007, Craig 2010, Taylor 2006 qtd in Duerr 2008.

¹¹ Duerr 2009; Gentry n.d.; Green Cross n.d.; Greer 2009.

Stuart describes how in many institutions, chaplains are considered “‘non-essential employees,’ which means they are among the first to experience the effects of cutbacks. Other stressors include insufficient resources, disrespect, lack of pay, lack of security, [and] perceived lack of opportunity...” (Stuart 2012). Another study suggests that excessive workload and “being at the beck and call” of others (Hendron 2012, 227) are common stress factors.

In 1997, BH Stamm proposed that “clergy could potentially be exposed to a great deal of traumatic material due to the very nature of their work”. While research specific to caregiving fatigue among clergy – and chaplains -- is sparse, additional studies support this idea. A 2001 study of American pastors encountering trauma in their jobs found that levels of clergy burnout were comparable with those of mental health professionals. In the same study, 57% of clergy scored in the moderate to high range for emotional exhaustion, one of the three components of burnout (Hendron 2012, 226).

Dual role pressures may stress even the most grounded and healthy spiritual care providers, “If clergy are being accessed as both counselors and mental health workers then logic dictates that they may be susceptible to similar impacts normally seen within these professions” (Hendron, 226). Several studies suggest that clergy are increasingly “being identified as an important counseling and mental health resource” in some communities (Wang et al. 2003 qtd in Hendron 2012, 224)¹², particularly rural and underserved areas.

As a result, chaplains and clergy in underserved areas are on the front line of encountering mental health issues – including trauma (Hendron, 226). Chaplains in large urban institutions have a more constrained role, as large institutions employ mental health professionals. These chaplains are less likely to be tapped as first-line mental health care.

¹² Hendron also references Abernethy 2002; Lounta and Hargie 1997.

Unlike mental health workers, chaplains do not belong to a professional community requiring regular supervision or peer meetings, as is built into the system for psychologists. Chaplains do learn a similar model of peer and supervisory support during Clinical Pastoral Education (CPE). For many chaplains, though, formal support ends with their clinical training.

This is an important consideration for two reasons: first, isolation is a known risk factor. Second, Chaplains are listening professionals as well as spiritual caregivers. They may frequently find themselves in situations where the outcome for those they serve is unclear. Particularly among professionals working with traumatized populations, repeated lack of observable positive outcomes may contribute to losing a sense of personal efficacy. Loss of perceived self-efficacy is in of itself a risk factor for burnout (Gentry n.d.; Mathieu 2011), potentially compounded by lack of time and peer support to process difficult experiences.

Stressors for chaplains or clergy serving congregations reflect their integration with their communities. Clergy self-report stressors such as idealization of them and their role, at times feeding their striving to sustain a perfect image. Some clergy reported isolation, feelings of failure, and reluctance to discuss difficulties openly in order to “keep up appearances.” Work-life boundaries presented challenges too, including intrusive congregation members, a sense of “living in a glass house”, being pressured to have an exemplary family life and children, and feeling obligated to respond to unreasonable congregational expectations.¹³

To summarize, a precise understanding of how many caregivers suffer adverse impacts to caregiving is obscured by a lack of clear language and methodology. Overall, however, the rate of incidence is high. The sparse research about adverse impacts on chaplains indicates that spiritual caregivers are not immune.

¹³ Darling et al. 2006, 441; Grosch 2000, qtd in Hendron 2012; Hendron 2012.

The most significant risk factors for all healing professionals include contact hours with traumatized people, unresolved personal trauma, lack of time to process, lack of close relationships, poor personal or professional boundaries, and lack of work-life balance. For chaplains and clergy, general risk factors may be exacerbated by either idealization or disrespect based on their role, needing to act outside the scope of their training, insufficient resources, lack of work security, excessive workload, and social isolation.

IV. Breaking the Chain of Suffering: Treatment

Basic principles in treating adverse impacts

These risks perhaps implicate treatment possibilities. In the *Compassion Fatigue Workbook*, Fraciose Mathieu highlights the “key strategies ...found to reduce compassion fatigue and vicarious trauma.” They are: “strong social support both at home and at work, increased self-awareness, good self-care, better work/ life balance, job satisfaction, rebalancing caseload and workload reduction, and limiting trauma inputs (2011, Kindle Location 1723).

Empirical examinations of prayer and spirituality

Many caregivers, particularly chaplains, consider spirituality to be central to their work lives. Despite this, few scientific studies examine the potential influence of spirituality on compassion satisfaction, post traumatic growth, or caregiving fatigue. In one study, maintaining a spiritual outlook was examined in relationship to counseling students, finding that “as spirituality decreases the likelihood of compassion fatigue increases” (Simpson 2006). The author cites another study concluding that “A greater awareness now exists in education and

health services that if a person's spiritual needs fail to be addressed, a person's emotional well-being is put at risk" (Morgan, 2004, p. 8 qtd in Simpson 2006).

In many religious traditions, prayer is a vital and important aspect of spiritual outlook. A recent rigorous study indicates that prayer can be helpful in coping with trauma and other adverse experiences. The authors examined several kinds of prayer by "coping function", specific intentions or beneficial psychological impacts within the mind of the person praying. One function, "Calm/Focus", includes "meditation and reflection" (Harris 2010, 34). This type of prayer is also correlated with positive mental effects after trauma (Harris et al., 2002; Harris et al., 2005 qtd in Tedeschi 2010).

Thus far, Calming Prayer's effectiveness as a coping mechanism appears to vary with the type of trauma to which people are exposed. People experiencing (or exposed to) physical trauma and difficulties were more likely to report mental benefits after Calming Prayer. Those who prayed after experiencing interpersonally based trauma reported much weaker Post Traumatic Growth (Harris 2010, 34). This may well be significant for caregivers – as I discussed in the "risk factors" section, statistically, healing professionals bear greater risks for adverse impacts when working with populations suffering interpersonal violence or those experiencing actual or probable self-inflicted harm.

These studies examine primary trauma, and thus do not address caregivers' issues directly. I think this area begs further examination, however, as there is a close relationship between Calm/Focused Prayer and empirically validated meditation techniques for reducing caregiving fatigue symptoms.

Established Treatment Protocols

Accelerated Recovery Program

A five session protocol, the Accelerated Recovery Program (ARP), was developed in 1997. ARP's efficacy "has been validated through multiple studies" (Gentry 37-61, in Greer 2009). In addition to clinically and statistically significant symptomatic improvement, study results indicated a "significant increase in Compassion Satisfaction."¹⁴ ARP includes a number of elements (see Table 2). It integrates Narrative Therapy, Trauma Therapy, and Eye Movement Desensitization Reprocessing (EMDR)¹⁵.

In addition to psychotherapeutic interventions, the program emphasizes education, including presenting Stress Resiliency Research. ARP also stresses interpersonal support, physical exercise, and a positive mental attitude. Patients are encouraged to develop an "internal locus of control", which includes cultivating non-reactivity to thoughts and other people. Personal practices, are introduced, including Hypnotherapy and Anxiety Management Skills (Gentry n.d.). ARP is used primarily in US Government Agencies (Gentry n.d.).

Outside of the government, several organizations offer continuing education for professional caregivers, including the Green Cross, TRAINi (Trauma Research, Education, and Training Institute), and the Figley Institute. While education is fundamental, it is not sufficient treatment (Greer 2009; Hendron 2012). Discussion and processing with peers, a therapist, or spiritual counselor is also necessary, in part to normalize or de-pathologize the experience.¹⁶

¹⁴ Figley 1995; Figley & Stamm 1996, qtd in Greer 2009.

¹⁵ EMDR is an evidence-based practice used by psychologists to help patients integrate trauma through eye movements.

¹⁶ Gentry n.d.; Mathieu 2011; Sprang & Woolsey 2007

Direct psychotherapeutic modalities are also very important (SAMHSA n.d.; Simpson 2006).

For many healing professionals, workload and lifestyle shifts are also necessary (Mathieu 2011, k.l. 1737).

MBSR and Mindfulness of Breathing

Mindfulness-based Stress Reduction (MBSR) is an extensively studied and validated eight week protocol for addressing mental and physical stress-related symptoms. Its scope is broader than ARP; MBSR was designed to help people experiencing any number of physical or psychological conditions. The MBSR protocol incorporates didactic education, body-scans, Hatha yoga or other movement, interpersonal support, and meditation practices. The program is based on the premise that increasing mindful awareness helps participants reduce stress by lessening emotional reactivity and acceptance of the present moment. In addition to the elements above, the MBSR protocol includes two formal meditation practices we will revisit in detail later: mindfulness of breathing and loving-kindness meditation.

There is a large and growing body of evidence documenting MBSR's beneficial effects, including two meta-analytic reviews.¹⁷ Its efficacy has been repeatedly demonstrated in healthcare professionals and trainees.¹⁸ In her prospectus, *Meditation and Mindfulness Practices to Support Military Care Providers*, Maia Duerr concludes that "findings ... indicate that meditative and contemplative practices can aid in relieving the acute symptoms of compassion

¹⁷ Shapiro et al. cite Baer, R.A. "Mindfulness Training as a Clinical Intervention: a Conceptual and Empirical Review." *Clinical Psychology: Science and Practice*, 10, 2003, 125-143 and Grossman, Niemann, Schmidt, & Walach. "Mindfulness-based Stress Reduction and Health Benefits: a Meta-Analysis." *Journal of psychosomatic research*, 57, 2004, 35-43.

¹⁸ Shapiro 2007, 106. Shapiro cites four studies, including: Cohen-Katz, Wiley, Capuano, Baker, Kimmel, & Shapiro, S. "The effects of mindfulness-based stress reduction on nurse stress and burnout, Part II: A quantitative and qualitative study." *Holistic Nursing Practice*, 19, 2005. 26 –35; Rosenzweig, Reibel, & Greeson. "Mindfulness-based stress reduction lowers psychological distress in medical students." *Teaching and Learning in Medicine*, 15, 2003. 88 –92.

fatigue and burnout, including depression and anxiety, and physiological symptoms such as insomnia and a weakened immune system".¹⁹ As we have seen, all of these symptoms are hallmarks of adverse impacts (Mathieu 2011). This means MBSR directly addresses some of the primary symptoms of caregiving fatigue.

Indeed, researchers have more recently begun to study MBSR's efficacy in treating compassion fatigue. In one study, clinical nurses reported decreased symptoms of adverse impacts, and being "calmer and more grounded during their rounds and interactions with patients and colleagues" (Mathieu 2011, k.l. 2639; Cohen-Katz et al. qtd in Matthieu 2011). Another study of therapists in training found MBSR participants to experience an increase in mindful attention and awareness, which "predicted a drop in rumination, trait anxiety, and perceived stress." Participants also self-reported a lessening of negative affect and more transient states of anxiety (Shapiro 2007, 110). This is significant because anxiety is a primary symptom of caregiving fatigue. The finding that rumination decreases is also significant: rumination is strongly correlated with negative affect (ie depressive or contracted mindstates and moods), another primary symptom. Despite promising findings about psychological benefit, I do not mean to suggest that MBSR is an appropriate replacement for therapeutic support and interventions. The therapists in the study above, for example, utilized MBSR in conjunction with therapeutic supervision, not as a replacement for it.

To summarize, MBSR has a well validated track record of lessening all kinds of physical and psychological stress related problems, including those associated with caregiving fatigue.

¹⁹ 2009, 27. Studies cited include Shapiro et al. 1998; Marcus et al. 2003; and Roth & Creaser 1997.

Furthermore, while there are not yet many studies specifically examining MBSR as an intervention for adverse impacts, preliminary results of the studies available are very promising.

V. Prevention

Strategies for prevention of caregiving fatigue fall into several interlinked domains, including organizational, interpersonal, educational, lifestyle, and personal. The following is a list of the top preventative strategies recommended by experts in the field:

Prevention of Adverse Impacts
<p><i>Personal and Lifestyle Factors</i></p> <ul style="list-style-type: none"> Practicing self-validated care-giving²⁰ Cultivating a calm, non-anxious, presence Intentionality vs. reactivity Addressing and resolving any personal trauma Orienting to intense experiences as challenges rather than threats Maintaining work/life balance and other healthy boundaries Self-care, including <ul style="list-style-type: none"> • aerobic exercise • mind-body practices (yoga and meditation) <p><i>Interpersonal Factors</i></p> <ul style="list-style-type: none"> Supportive clinical supervision and/or spiritual direction Open and mutually supportive peer discussion groups about cases Connection and appreciative social support at and outside of work

²⁰ Figley defines self-validated caregiving as the “ability to give yourself acknowledgement and validation for the work you do” (C. Figley n.d.).

Educational Factors

For chaplains, completion of clinical pastoral education (CPE)
For psychologists, training in evidence-based practices for trauma
Continuing education about best practices and self-care

Workplace factors

While my emphasis here is on personal wellness and prevention strategies, organizational policies and workplace culture are key influences on caregiver health and wellness. For example, limiting contact hours with traumatized or high risk people is the most clearly understood strategy for protecting caregivers from adverse impacts. Different researchers report ways to accomplish this, including balancing caregivers' caseloads with a variety of people, splitting jobs between contact hours and administrative tasks, or even working part-time (Mathieu 2011). All of these strategies require flexible organizational policies as well as a workplace culture that acknowledges the existence of adverse impacts and the importance of caregiver health. Within workplace culture, supportive supervisory relationships and relationships with immediate peers mitigates emotional stress for healing professionals (Barkin 2012). In terms of boundaries, caregivers who are able to negotiate some control over when and how they did their work generally experience less burnout and general emotional stress (Mathieu 2011, k.l. 1479). In short, workplace policy and culture play an important role in whether and how healing professionals are able to engage in important preventative strategies for caregiving fatigue.

Lifestyle and life balance

Workplace policy and culture also influences caregivers' ability to maintain life balance. This domain of wellness is crucial to consider: Healing professionals overwhelmingly cite healthy boundaries between work and personal life as foundational to their resilience and well-being (Kruger 2010; Lawson 2011; Sprang et al. 2007). In addition to work-life balance, the basics of a healthy lifestyle are important. Cardiovascular exercise is known to help with mood regulation. Adequate sleep is important not just for physical health, but also for the mind to integrate emotionally intense experiences that caregivers may encounter. Recent findings indicate that a low-glycemic, whole foods diet can help people maintain stable moods (Bowles 2010), and that eating adequate probiotics may minimize emotional reactivity (Costandi 2012).

Interpersonal Relationships

A range of studies and large amounts of anecdotal evidence indicate that strong interpersonal relationships result in greater life satisfaction and lessened experience of adverse impacts.²¹ High-quality relationships in which both parties are comfortable speaking honestly and openly are especially important. Many healing professionals indicate that quality time spent with a partner and/or family, talking to close friends, and being with supportive peers (both on and off the job) are fundamental sources of rejuvenation.

Personal prevention factors: perspective, practices, and cultivated resilience

There are a few powerful personal factors that enhance compassion satisfaction and posttraumatic growth. They are also correlated with reduced experience or intensity of the caregiving fatigue symptoms (Table 1). Important overall factors include cultivating an overall

²¹ Duerr 2009; Kruger 2010; Lawson 2011; Mathieu 2011.

sense of purpose, resolving your own past trauma, and learning how to frame and orient to intense experiences as challenges rather than threats. Development of these factors is in turn greatly supported by mindful awareness and intentionally cultivating a sense of satisfaction and other positive emotions. Development of these personal factors and attributes has been shown to be an intentional process, one that can be greatly supported by a commitment to considered personal choices and mature cognitive-emotional skills (W. & Sprang 2007).

The protective potential of meditation

In my own research, I've been investigating two separate topics -- adverse impacts to caregivers, and the empirically measured effects of lovingkindness and compassion meditation. In the process, I stumbled across something interesting. Scientific studies were finding that people engaged in loving-kindness and compassion meditation experienced reductions in anxiety, rumination, and emotional reactivity -- three of the most common symptoms of caregiving fatigue. This caught my attention. Then I noticed another striking pattern. There is preliminary but growing evidence that people engaged in these practices experience enhanced wellness, happiness and other aspects of compassion satisfaction. I wondered, might there be an opportunity to explore how these positive outcomes could relate to caregiving?

As I discussed earlier, there is strong empirical evidence suggesting that MBSR is an effective treatment for many of the adverse impacts caregivers experience (see Tables 1 and 2). As it happens, researchers have begun to examine two of the formal meditation practices used in the MBSR protocol. These two practices, mindfulness meditation or mindful breathing (MB) and Loving-kindness meditation (LKM), yielded demonstrable benefits for novice practitioners in relatively short periods of time. Jon Kabat Zinn, creator of MBSR, describes self-love or self-

compassion as a particularly important aspect of lovingkindness meditation (1990, 182-184). So, lovingkindness and compassion meditation are already aspects of a well-established and effective protocol. What does science have to say about lovingkindness and compassion meditation in particular?

Lovingkindness meditation (LKM) has been the subject of a number of recent studies examining relatively short term effects of the practice. The form of lovingkindness meditation used in these studies is secular, and involves consciously cultivating kind, loving, friendly thoughts of good wishes. These intentions are often first directed at the practitioner themselves then to another person for whom the practitioner cares.

In the Buddhist practice from which this meditation is adapted, practitioners then shift these kind intentions to a series of other people, ultimately sending loving kindness to all living beings. In some studies, practitioners are taught to direct their intentions to this entire series of people. In others, a simpler version of the meditation involving fewer people is used. In one study, practitioners were instructed to imagine care for others sending *them* love and kindness. Regardless of the exact method used, the emphasis in current research is on the results of intentionally cultivating intentions and feelings of love, kindness, and friendliness.

What are the effects of cultivating love? In terms of wellness and preventive factors for caregivers, empirically correlated effects of several weeks of lovingkindness meditation are moderate but striking. For example, one study found that a single session of 15 minutes of lovingkindness meditation resulted in a short term, measurable, decrease in attentional blink (May et al. 2011). Attentional blink is the amount of time it takes the mind to cognitively recover between noticing bits of looked-for information among stream of incoming sensory data. One

reason attentional blink is important is because conscious awareness of personal responses to unpleasant events *as such* when they occur may reduce later symptoms of secondary trauma.

The benefits for practitioners engaging in 15 minutes or more of lovingkindness meditation over 9-12 weeks were moderate but compelling (Hofman 2011). Measurable effects in well-controlled, rigorously analyzed studies included greater self-reported sense of life purpose, keener mindfulness, greater resilience, enhanced sense of social connectedness, and a greater sense of overall well-being.²² Each one of these effects directly relates to known aspects of resiliency, wellness, or preventative factors (see Table 3). Lovingkindness meditation increases both the frequency and duration of positive emotions in many practitioners. This relates to a beneficial effect particular to lovingkindness meditation -- positive emotions are even more noticeable when those practicing this meditation later interact with others. To summarize, loving kindness meditation has been correlated with three experiences of interest: greater frequency of positive emotions, a stronger tendency to want to engage with other people, and enhanced satisfaction and positive emotions while interacting. Practitioners of lovingkindness also report reduced interpersonal reactivity. Not surprisingly, the same practitioners report a greater sense of satisfaction in relationships overall.²³ All of these findings suggest that lovingkindness meditation may well be a strong support for caregivers wishing to develop and maintain more satisfying interpersonal relationships, a key factor in enhancing compassion satisfaction, reducing social isolation, and preventing adverse effects (Myers 2011).

Because self-kindness or compassion can be considered one aspect of lovingkindness meditation, the two practices are often undertaken together. They are also often studied together,

²² Fredrickson 2008; Hofman 2011; Hutcherson 2008.

²³ *Ibid.*

although recently some studies have focused on compassion cultivation specifically. In my literature review, I honed in on cultivation of *self*-compassion, which appears to be particularly beneficial to caregivers. For example, studies suggest people practicing self-compassion experience enhanced coping abilities, emotional resilience, and psychological well-being in the face of difficult circumstances (Krakovsky 2012; Neff 2007). Practitioners of several weeks of self-compassion report a greater sense of life satisfaction, greater presence with others, enhanced resiliency, and broadened cognition.

Self-compassion is predicated on “framing personal experience in the light of common human experience”, which decreases tendencies towards over-identification. Over-identification is a process in which your sense of self becomes conflated with the emotional reactions of another, often resulting in emotional exaggeration that can become overwhelming (K. Neff 2004). Lessening over-identification is important for caregivers because it may result in a healing professional “taking on” others’ emotional difficulties or trauma, a well-documented phenomenon I’ve seen and experienced in my own chaplaincy work. Neff’s research and my personal experience suggest that self compassion may help caregivers maintain an internal sense of psychological integrity and healthy boundaries when working with high risk and traumatized populations.

In addition to these benefits, self-compassion meditation has been correlated with increased interest in learning, a greater sense of personal initiative, and decreased emotional reactivity (Neff et al. 2007). Specifically, self-compassion, like mindfulness meditation, is correlated with a lessening of self-centered, negatively biased thinking (Feldman 2010; Neff 2004), a process known as decentering. This result highlights one apparent difference between

current findings on self-compassion and lovingkindness meditation. While lovingkindness meditation has many beneficial effects, thus far it is not strongly correlated with decentering. Lovingkindness meditation, however, has been shown to decrease interpersonal reactivity (as opposed to internal emotional reactivity to thoughts). Indeed, studies of lovingkindness suggest people experience an enhanced tendency to seek out and enjoy social contact and satisfaction in relationships. Practitioners of self-compassion meditation, on the other hand, specifically report a deepening of meaningful relationships. While terminology among these studies tend to be very consistent, it is possible that these varying results may be due to semantic differences in research questions, as opposed to differences in results of specific meditation. To my knowledge, research directly comparing these practices has not yet been published.

The process of practicing self-compassion is very similar to the first step of loving kindness, cultivating loving feelings towards oneself. The emphasis, however, is on noticing one's own suffering and intentionally cultivating a kind attitude towards one's own feelings of inadequacy, isolation, embarrassment, or other difficult emotions. Compassion meditation in general emphasizes recognizing our shared humanity with others through the common experience of suffering. Practitioners are encouraged to see their own suffering as something that can bring all people together instead of feeding feelings of isolation. This tends to cultivate a broader perspective helpful for many when navigating inevitable difficulties.

To summarize, documented effects of both of these forms of meditation are important attributes of healing professional wellness (Tables 2 & 3). In the big picture, practitioners report a greater sense of purpose and more satisfying relationships overall, which are fundamental aspects of compassion satisfaction as well as protection against social isolation.

In terms of moment to moment experience, meditational effects such as greater presence, heightened mindfulness, decentering, and reduced attentional blink all suggest very promising forms of developing caregiving best practices that can prevent or ameliorate adverse impacts while increasing healing professional efficacy.

Conclusion: Perspective is Pivotal

Meditation is not a panacea. Caregivers will encounter difficulties in the course of their work, and there are many factors in play determining the individual experience of adverse impacts, post traumatic growth, and compassion satisfaction. That said, the findings on lovingkindness and self-compassion cultivation are promising. They suggest that with careful attention and dedicated practice, there is much healing professionals can do to enhance the benefits of caregiving while lessening the risks and intensity of adverse impacts so many experience. Accurate information about risk factors, warning signs, treatment, and prevention is a tool in of itself practitioners can use to weave their own personal ways of enhancing wellness.

In the larger picture, however, personal action alone cannot address the risks healing professionals face. Given the correlation between caregiver adverse impacts and ethical violations, leaders of institutions and organizations have an important role to play in nurturing cultures and crafting policies prioritizing healing professional wellness. Much good could be done by balancing caseloads, cultivating nurturing cultures, and providing work time and resources for adequate peer support. Researchers have an opportunity, too. There is much that could be done to clarify language about adverse impacts. This would improve the quality of research on the subject. Careful language and clear research balancing adverse impacts and

benefits may actually improve outcomes for symptomatic healing professionals. Meanwhile, my hope is that the information in these pages will educate and empower caregivers, especially chaplains, to more wisely navigate the very real risks and benefits of this challenging and deeply rewarding work.

Figure 1: Warning Signs of Adverse Impacts²⁴

Anger and irritability are two key symptoms of CF.

Emotional exhaustion is a key indicator of Burnout.

Disruption of world view, especially heightened anxiety or irrational fears.

Reduced ability to feel sympathy and empathy is a very common symptom

Physical exhaustion. "Feeling exhausted when you start your day..."

Physical warning signs: increased susceptibility to illness, sleep problems, migraines, frequent headaches.

Somatization: a process of translating emotional stress into real physical symptoms.

Hypochondria is a form of anxiety and hypervigilance about potential physical ailments that we or others may have. If untreated, hypochondria can become quite severe.

Hypersensitivity or Insensitivity. Crying during sappy commercials. Insensitivity may include not knowing when sharing disturbing stories is inappropriate, such as at a family dinner.

Intrusive imagery is another symptom of vicarious trauma. This includes images from client's stories intruding on your own thoughts and daily activities.

Difficulty separating personal and professional. e.g. Taking work calls or emails at all times.

Exaggerated sense of responsibility at work. "I can't leave; people are counting on me..."²⁵

Avoiding patients, "hiding in a broom closet when you see a challenging family...delaying..."

Compromised care, including the silencing response, "...whereby we unknowingly silence our clients" because what they are sharing is too difficult for us. Includes "changing the subject...providing pat answers...boredom, using humor to change or minimize the subject, faking interest or listening, not believing clients and not being able to pay attention..."²⁶

Other behavioral and emotional signs include distancing and other problems in personal relationships, impaired ability to make decisions, cynicism and embitterment, and substance abuse or addiction.

²⁴ Adapted from Franciose Mathieu's *Compassion Fatigue Workbook*. Chapter 6, KL 1161-1372, 2012.

²⁵ Lipsky 2009, 111 qtd in Mathieu 2012

²⁶ Baranowsky 2002, qtd in Mathieu 2012

Figure 2: Direct Modalities used in the Accelerated Treatment Protocol

- Self-validation
- Anxiety management skills
- Cultivating non-reactivity to others
- "Resiliency Skills", including developing:
 - Non-reactivity to emotions and intrusive thoughts
 - Internal locus of control
 - Positive mental attitude (PMA)
 - Reframing problems as challenges
- Self-care
 - Regular Cardiovascular Exercise
 - MBSR and mindfulness meditation
 - Self-soothing
 - (Self) Hypnosis
- Connection with others
 - Resolving conflicts (internal & external)
 - Setting personal and professional goals
 - Developing a self-care plan
 - Resolution of any Primary Traumatic Stress
 - Eye Movement Desensitization Reprocessing, or EMDR
- Neurolinguistic programming, or NLP

Table 1: Symptoms of adverse impacts and empirical results of MBSR, Loving-kindness, and self-compassion meditation²⁷

Symptom	Practice method	Empirically shown result
Anxiety	Self-Compassion meditation (SCM) MBSR	Lowered anxiety, especially about perceived weaknesses/inadequacies
Disruption of world view	Self-Compassion meditation	Mild but significant increases in optimism in a few weeks. Reduction of cognitive distortions. Evokes greater equanimity.
Distress	Self-Compassion meditation	Correlated with lowered distress
Emotional numbness	Lovingkindness meditation (LKM)	Lessening of depressive symptoms
	Self-Compassion meditation	Increased ability to read and be with emotions without reactivity
	Mindfulness of breathing (MB)	Increased ability to read and be with emotions without reactivity
Hypersensitivity to emotional material	Self-Compassion meditation	Increases emotional stability
	Mindfulness of breathing	Lessens emotional reactivity
Impaired interpersonal functioning/isolation	SCM	Social connection, agreeability, and extroversion
	Lovingkindness meditation	Social connection; increased satisfaction in relationships
	Mindfulness of breathing	Enhanced "approach behavior" (willingness to connect with others)
Increased susceptibility to illness	LKM MB	Reduced susceptibility to illness
Intrusive imagery and Negative repetitive thoughts	Self-Compassion meditation Mindfulness of breathing	Lessening of negative reactions to thoughts . Ability to face painful thoughts and emotions without exaggeration or pity.
Overwhelm	Self-Compassion meditation	Increased personal initiative, increased curiosity, greater emotional stability
Reduced ability to feel sympathy/empathy	Lovingkindness meditation Self-Compassion meditation	Enhanced ability to model others' emotions neurologically, especially after sufficient practice
Sorrow and sadness	Lovingkindness meditation	lessening of depressive symptoms and increased ability to be with emotions without reacting to them

²⁷ Please see the following studies for detailed results and statistical analysis: Feldman et al. "Differential effects of mindful breathing, progressive muscle relaxation, and loving-kindness meditation on decentering and negative reactions to repetitive thoughts," *Behavior Research and Therapy* 48 (2010): 1002-1011; Fredrickson et al. "Open Hearts Build Lives: Positive Emotions, Induced Through Loving-Kindness Meditation, Build Consequential Personal Resources," *Journal of Personality and Social Psychology* 95, no 5 (2008): 1045-1062; Hoffman et al. "Loving-kindness and compassion meditation: Potential for psychological interventions," *Clinical Psychology Review* 31, (2011): 1126-1132; Hutcherson et al. "Loving-Kindness Meditation Increases Social Connectedness," *Emotion* 8, no. 5 (2008): 720-724; Neff et al. "An examination of self-compassion in relation to positive psychological functioning and personality traits," *Journal of Research in Personality* 41 (2007): 908-916.

Table 2: Some ARP treatment goals, matched with empirical effects of MBSR, Loving-kindness and Compassion meditation²⁸

ARP treatment protocol intervention	ARP stated goal	Documented effects of meditation practices ²⁹
Psychotherapy, esp Thought Field Therapy and Cognitive Behavioral Therapy (CBT)	Addressing and resolving cognitive distortions & negative self-reinforcing beliefs	Self-Compassion meditation (SCM) Lovingkindness meditation (LKM) Mindful Breathing (MB)
brief trauma treatments, potentially EMDR or CBT	Desensitization and Reprocessing of memories	
Interpersonal or self-education	Education	SCM is correlated with increased interest in learning
Therapy and peer support	Internal locus of control (sense of control over events that affect one's life)	Self-Compassion meditation
Crafting a personal mission statement	Goal orientation/Personal initiative	Self-Compassion meditation
Psychotherapy, self-soothing	Decreased emotional reactivity	Self-Compassion meditation Mindful Breathing
	Decreased interpersonal reactivity	Lovingkindness meditation
Therapy/group meetings/creation of narratives	Exploration and restructuring of narrative	
	PMA – Positive Mental Attitude	Regular MB meditation is correlated with decentering Self-Compassion meditation
	Presence with others	Self-Compassion meditation – double check
Integrated post-care plan designed by participant and teacher/therapist	Resiliency-building	Self-Compassion meditation Lovingkindness meditation

²⁸ ARP Goals and protocol interventions are listed in Gentry. "Accelerated Recovery Program for Compassion Fatigue." Tampa, n.d., <http://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=1168&context=doctoral>

²⁹ Please see the following studies for detailed results and statistical analysis: Feldman et al. "Differential effects of mindful breathing, progressive muscle relaxation, and loving-kindness meditation on decentering and negative reactions to repetitive thoughts," *Behavior Research and Therapy* 48 (2010): 1002-1011; Fredrickson et al. "Open Hearts Build Lives: Positive Emotions, Induced Through Loving-Kindness Meditation, Build Consequential Personal Resources," *Journal of Personality and Social Psychology* 95, no. 5 (2008): 1045-1062; Hoffman et al. "Loving-kindness and compassion meditation: Potential for psychological interventions," *Clinical Psychology Review* 31, (2011): 1126-1132; Hutcherson et al. "Loving-Kindness Meditation Increases Social Connectedness," *Emotion* 8, no. 5 (2008): 720-724; Neff et al. "An examination of self-compassion in relation to positive psychological functioning and personality traits," *Journal of Research in Personality* 41 (2007): 908-916; Johnson et al. "Loving-kindness meditation to enhance recovery from negative symptoms of schizophrenia," *Journal of Clinical Psychology: In Session* 65, no. 5 (2009): 499-509 [case studies].

Table 3: Aspects of wellness/prevention vs effects of MBSR, Mindful breathing, Loving-kindness, and Compassion meditation

Aspect of wellness/ preventative ³⁰	Correlated meditation practices ³¹
Attentional control	10-15 minutes of Lovingkindness meditation evokes short-term state change of reduced attentional blink Mindfulness of breathing (MB)
Broadened cognition (enhanced problem-solving, creativity, and contextual awareness)	Self-Compassion meditation (SCM) Lovingkindness meditation (LKM) Mindfulness of breathing
Decentering (less self-centered, negatively biased thinking)	
Increased positive emotions and sense of well-being	Mindfulness of breathing Self-Compassion meditation
Life purpose	Lovingkindness meditation
Life satisfaction	Self-Compassion meditation
Mindfulness	Lovingkindness meditation
Presence with others	Self-Compassion meditation– double check
Resilience/ego resilience	Lovingkindness meditation
Social connectedness/meaningful relationships	Self-Compassion meditation

³⁰ The following authors conducted or cited studies indicating these factors to be associated with overall wellness, and/or prevention or mitigation of adverse impacts: Duerr, Maia. "The Use of Meditation and Mindfulness Practices to Support Military Care Providers: A Prospectus." Northampton, MA, 2009; Feldman, Greg, Greeson, Senville. "Differential effects of mindful breathing, progressive muscle relaxation, and loving-kindness meditation on decentering and negative reactions to repetitive thoughts." *Behavior Research and Therapy* (Elsevier) 48 (2010): 1002-1011; Figley. *The Art and Science of Caring for Others without Forgetting Self-Care*. n.d. <http://www.giftfromwithin.org/html/artscien.html> (accessed July 27, 2012); Figley, Charles. "What Is Compassion Fatigue?" *A Gift From Within*. n.d. <http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html> (accessed June 11, 2012). Halifax, Joan. "A heuristic model of enactive compassion." *Supportive and Palliative Care*. 2012. www.supportiveandpalliativecare.com (accessed July 2012); Kruger, TL. *Keys to resilient practice in contemporary chaplaincy*. Dissertation, Pennsylvania: Umi, 2010.

³¹ Please see the following studies for detailed results and statistical analysis: Feldman et al. "Differential effects of mindful breathing, progressive muscle relaxation, and loving-kindness meditation on decentering and negative reactions to repetitive thoughts," *Behavior Research and Therapy* 48 (2010): 1002-1011; Fredrickson et al. "Open Hearts Build Lives: Positive Emotions, Induced Through Loving-Kindness Meditation, Build Consequential Personal Resources," *Journal of Personality and Social Psychology* 95, no 5 (2008): 1045-1062; Hoffman et al. "Loving-kindness and compassion meditation: Potential for psychological interventions," *Clinical Psychology Review* 31, (2011): 1126-1132; Hutcherson et al. "Loving-Kindness Meditation Increases Social Connectedness," *Emotion* 8, no. 5 (2008): 720-724; Neff et al. "An examination of self-compassion in relation to positive psychological functioning and personality traits," *Journal of Research in Personality* 41 (2007): 908-916.

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