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Working with compassion : the impact of loving kindness meditation on compassion satisfaction and compassion fatigue among social workers and other mental health workers

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ABSTRACT

Loving kindness meditation is a practice that involves actively cultivating compassion and intentionally directing compassion towards one's self and towards others. Compassion fatigue refers to burnout and secondary traumatic stress that may result from caregiving, while compassion satisfaction refers to the enjoyment and sense of fulfillment that may come from caregiving. This mixed-methods study explored the impact of one week of a daily ten minute loving kindness meditation practice on mental health clinicians' levels of compassion satisfaction and compassion fatigue. Eleven participants committed to a daily ten minute loving kindness meditation practice for one week during which they worked with psychotherapy clients. Participants took a pre-test and post-test to measure their levels of compassion satisfaction and compassion fatigue before and after the intervention. Study results indicate that one week of a daily ten minute loving kindness meditation practice yields a statistically significant decrease in compassion fatigue, and has no statistically significant impact compassion satisfaction. While the results of this study are not generalizable due to the small sample size, these findings provide a reference point for future studies.

WORKING WITH COMPASSION: THE IMPACT OF LOVING KINDNESS MEDITATION ON COMPASSION SATISFACTION AND COMPASSION FATIGUE AMONG SOCIAL WORKERS AND OTHER MENTAL HEALTH WORKERS

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To the many teachers, known and unknown, who have shared mindfulness and compassion practices and who have contributed to making these practices accessible to all people: thank you. May you be happy and may you be free.

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CHAPTER 1

Introduction

In this research study, I explore the ways in which a practice from the Buddhist tradition – *metta* meditation, also called loving kindness meditation (LKM) – may benefit the field and practice of social work. The practice of LKM, which has its origins in the *metta sutta* of early Buddhist scriptures (Karaniya Metta Sutta, Sn 1.8), involves intentionally cultivating compassion for one's self, for others, and for all sentient beings. Buddhist monk and teacher Thich Nhat Hanh (2014) writes, "*metta* meditation is a practice of cultivating understanding, love, and compassion by looking deeply, first for ourselves and then for others. Once we love and take care of ourselves, we can be much more helpful to others" (p. 104). While there has been much research on mindfulness and LKM in recent years, few, if any, studies explore the impact of LKM practice on the experience of compassion satisfaction and compassion fatigue among social workers and other mental health workers.

Purpose of Study

Being an effective social worker requires compassion. At the same time, many social workers struggle to work with compassion in a sustainable way. Burnout and secondary traumatic stress are common occupational hazards among social workers, activists, and other caring professionals. Compassion fatigue can be detrimental to one's wellbeing and impede

one's ability to care for others, while compassion satisfaction can have a positive impact on personal wellbeing and quality of care for others. The current study was a quasi-experimental, correlational, mixed-methods study designed to answer the research question: "Does a daily loving kindness meditation (LKM) practice impact measures of compassion fatigue and compassion satisfaction among social workers and other mental health professionals over the course of one week?" This research question is important because one's levels of compassion fatigue and compassion satisfaction are directly related to one's ability to be of service. How clinicians do their work matters. How clinicians cultivate and use compassion matters. This is an exploration into one specific practice that may support clinicians to work skillfully with compassion.

The current study used a daily ten-minute LKM intervention for seven days that was designed to induce changes in attitudes and behaviors that would, to a certain extent, be consistent with the expected long-term effects of sustained LKM practice. Specifically, I examined whether a brief LKM intervention impacted compassion fatigue and compassion satisfaction among social workers and other mental health professionals.

Definition of Terms

Several concepts are used consistently throughout this research study. For the purposes of this study, they are defined as follows:

Loving Kindness Meditation. Loving Kindness Meditation (LKM) is a type of mindfulness practice with origins in early Buddhist scriptures. LKM involves cultivating compassion and directing it towards one's self, others, and all sentient beings.

Mindfulness. Mindfulness has roots in several spiritual traditions and has received increased attention from the western scientific community in recent years. Jon Kabat-Zinn defined mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4).

Compassion Fatigue. Compassion fatigue (CF) is a combination of burnout and secondary traumatic stress that is characterized by emotional, physical, psychological, and spiritual deficiency and exhaustion. CF often occurs among caregivers, and particularly among those who work with clients who have experienced trauma or who require intensive care and treatment. CF may lead to the provider experiencing negative attitudes towards the self and towards others, including towards clients. A caregiver experiencing compassion fatigue may feel helpless and traumatized by the work or the work environment. CF frequently results in physical and emotional pain and suffering (Figley, 1995). It is "…the natural, predictable, treatable, and preventable unwanted consequence of working with suffering people" (Figley, 1999, p. 4).

Compassion Satisfaction. Compassion satisfaction (CS) refers to the satisfaction one derives from the work of helping others (Stamm, 2002) and may be measured by the Compassion Fatigue and Satisfaction Test (Stamm, 2005).

Secondary Traumatic Stress. Secondary traumatic stress is an element of compassion fatigue. It is a possible result of secondary exposure to people who have experienced traumatic or stressful events (Stamm, 2010).

Burnout. Burnout is an occupationally-based syndrome of emotional exhaustion, depersonalization, and diminished personal accomplishment (Maslach, Jackson & Leiter, 1996). It is an element of compassion fatigue, and is often associated with feelings of hopelessness and inability to perform job duties effectively (Stamm, 2010).

Limitations

A major limitation of this study was its sample size. With a study sample of 11, and without a control and comparison group, this study's results cannot be generalized to a larger population as currently presented. A second limitation of the study is the duration of the LKM intervention. Without follow-up with the study participants, it is difficult to determine whether the short-term benefits of this intervention remained over a long-term period of time.

CHAPTER II

Literature Review

Introduction

This literature review examines existing research on compassion fatigue and compassion satisfaction, provides an overview of loving kindness meditation, identifies gaps in the literature, and identifies implications for this research study.

Compassion Fatigue & Compassion Satisfaction

In the helping professions, caring for others can be an occupational hazard. Figley (2002) writes, "…the very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others" (p. 1434). The terms vicarious traumatization, secondary traumatic stress, and compassion fatigue have been introduced by different authors to describe similar phenomena (Figley, 1995, 1999, 2002; McCann & Pearlman, 1990). Bride, Radey, & Figley (2007) explain that "…all three terms refer to the negative impact of clinical work with traumatized clients" (p. 156). Adams, Figley, and

Boscarino (2006) explain that "compassion fatigue contains secondary trauma and job burnout" (p. 108). Thus, while there is some overlap in the use of these terms, this research study uses the term compassion fatigue (CF), which Figley (1999) describes as "…the natural, predictable, treatable, and preventable unwanted consequence of working with suffering people" (p. 4). In addition, Figley (2002) notes, "…compassion fatigue is highly treatable once workers recognize it and act accordingly" (p. 1436). The Compassion Fatigue Self Test (Figley, 1995; Stamm & Figley, 1999; Stamm, 2002) is a measure used to determine whether a person is experiencing CF.

On the opposite end of the compassion spectrum, compassion satisfaction (CS) is a measure of the satisfaction one derives from the work of helping others (Stamm, 2002). Citing Stamm's contributions on the subject, Bride, Radey, & Figley (2007) explain, "there is some positive aspect of trauma work that sustains and nourishes clinicians. Many clinicians are motivated by a sense of satisfaction derived from helping others—an experience labeled compassion satisfaction (Stamm, 2002). The relationship between compassion fatigue and compassion satisfaction is not yet clear, although Stamm (2002) suggested that there is a balance between the two experiences. That is, a clinician may experience both compassion fatigue and compassion satisfaction simultaneously, though as compassion fatigue increases it may overwhelm the clinician's ability to experience compassion satisfaction" (2007, p. 156). Overall, the literature on CF and CS emphasizes the emotional burden of working in the helping professions and the need for mental health practitioners and trainees to practice self care and have proper support during training and while working with clients so as to maximize experiences of CS and minimize experiences of CF.

Loving Kindness Meditation

If a social worker's emotional health depends in part upon the worker's ability to minimize CF and maximize CS, loving kindness meditation (LKM) may be an ideal treatment for social workers experiencing CF because it involves the intentional cultivation and direction of compassion itself. LKM, or *metta*, is a specific form of mindfulness meditation that emphasizes cultivating thoughts of loving kindness and directing those thoughts towards one's self and towards other people. Thich Nhat Hanh (2014) writes, "*metta* meditation is a practice of cultivating understanding, love, and compassion by looking deeply, first for ourselves and then for others. Once we love and take care of ourselves, we can be much more helpful to others" (p. 104). Salzberg (1995) writes, "*Metta* – the sense of love that is not bound to desire, that does not have to pretend that things are other than the way they are – overcomes the illusion of separateness, of not being part of a whole. Thereby *metta* overcomes all of the states that accompany this fundamental error of separateness – fear, alienation, loneliness, and despair – all of the feelings of fragmentation. In place of these, the genuine realization of connectedness brings unification, confidence, and safety" (p. 21).

Many studies have demonstrated the efficacy of mindfulness-based interventions such as mindfulness-based stress reduction (MBSR) to improve the mental health of health workers and trainees (Cohen-Katz, Wiley, Capuano, Baker, Kimmel, & Shapiro, 2005; Rosenzweig, Reibel, & Greeson, 2003; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007; Shapiro, Schwartz, & Bonner, 1998), but fewer studies have explored the impact of mindfulness practices that cultivate and channel compassion, such as LKM, among mental health workers and

trainees. The general literature on LKM indicates that LKM can have beneficial results, including increased social connectedness (Hutcherson, Seppala, & Gross, 2008), increased positive emotions and personal resources (Fredrickson, Coffey, Pek, Cohn, & Finkel, 2008), and improved immune and neuroendocrine response (Pace, Negi, Adame, Cole, Sivilli, Brown, Issa, & Raison, 2008). A 2008 study using functional magnetic resonance imaging (fMRI) showed that long-time practitioners of LKM have increased activation in areas of the brain linked to empathy (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). Most recently, a meta-analysis of 24 empirical studies on LKM found that LKM practice increases positive emotions, but calls for additional research to understand the active components of the LKM interventions, to compare different psychological operations that occur as a result of LKM, and to explore the applicability of LKM among clinical populations (Zeng, X, Chiu, C. P. K., Wang, R., Oei, T.P.S., & Leung, F.Y.K., 2015).

While there is a growing body of general research on LKM, fewer studies focus on the potential benefits of LKM specifically among mental health workers and others in the helping professions. In an empirical study, Pidgeon, Ford, and Klaassen (2013) explored the usefulness of LKM in enhancing resilience among human service professionals. Using a randomized control trial, they found that "significant improvements were observed over time for the retreat group for mindfulness and self-compassion at one and four months and for resilience at four-months" (2013, p. 1). The study indicates that LKM may be "a promising method of increasing resilience, mindfulness and self-compassion in human services professionals" (2013, p. 1). While this study looked at resilience, the increases in self-compassion may indicate potential benefits for decreasing CF. Notably, an empirical study of LKM practice among psychological therapists in training found that LKM can be an emotionally intense experience and can cause strong feelings

to surface in practitioners (Boellinghaus, Jones, & Hutton, 2013). Boellinghaus (2013) and her colleagues recommend that individuals who have recently experienced trauma or significant loss should not practice LKM, and that even those in good health can benefit from having additional support, such as therapy, to process feelings that may arise from LKM. Even so, Boellinghaus (2013) and her colleagues found benefits among LKM practitioners, including increased self-awareness, compassion for self and others, and therapeutic presence and skills (p. 267). Collectively, the literature suggests that LKM may greatly benefit practitioners in the helping professions, but more research may be useful in clarifying the specific benefits, drawbacks, and challenges of using this practice effectively and safely (Boellinghaus, et al., 2013; Fredrickson et al., 2008; Pidgeon, et al., 2013).

Gaps in the Literature

While many studies point towards various benefits of LKM in the general population, more research is needed to explore the impact of LKM among mental health workers and trainees. In addition, more research is needed to determine the minimum dosage or length of practice necessary to achieve desired results with LKM. While various studies measure impact over weeks or months or years of practice, fewer studies explore the benefits that may be gained from short-term practice periods. Additional research to understand the benefits and drawbacks of very short-term practice periods could be of use, as a shorter time commitment to the practice might increase the accessibility of this practice among individuals who for various reasons may not choose to or be able to dedicate as much time to the practice.

Overall, the literature does not explore systemic oppression as a potential cause of CF or attempt to consider the material with an intersectional lens. In general, the literature reviewed does not explore differences among rates of CF by social identities such as race, ethnicity, gender, ability, sexual orientation, age, geographic location, or socio-economic status. Similarly, some of the existing empirical studies of LKM lack diversity among participants, particularly racial and ethnic diversity (Boellinghaus, et al., 2013; Pidgeon, et al., 2013). By omission, the literature may miss important and useful information regarding the prevalence of CF among oppressed groups or the benefits or drawbacks of using LKM with members of oppressed groups. In addition, the lack of diversity among participants in LKM studies indicates a need for increased justice in study design and participation.

Implications for Proposed Study

Individuals experiencing CF will likely not be as effective at supporting their clients (Figley, 2002, p. 1434), and may be at greater risk of leaving the social work profession entirely (Bride, 2007; Figley, 1999). Given the prevalence of CF among individuals in the helping professions, and given the fact that these conditions can hinder a person's abilities to effectively serve their clients, it is critical to identify effective tools that social workers can use to treat and prevent CF. With knowledge of specific practices to decrease CF, social workers can take steps to buffer themselves from this occupational hazard. Increasing the knowledge base around treating CF has the potential to strengthen the field of social work as a whole. This research study seeks to add to the body of knowledge that can strengthen the ability of social workers as individuals to support their own wellbeing, and, by extension, that of their clients. With

healthier, more satisfied social workers, more social workers may stay in the field longer, and ultimately decrease rates of attrition. Consequently, the field of social work will have increased beneficial impact and longevity.

To explore the benefits of LKM over a short period of time, this intervention was limited to a daily ten-minute practice, for seven days. To increase justice in study design and to learn more about how LKM may impact individuals with a variety of social identities, I conducted this study remotely and conducted outreach to a diverse group of potential participants. While this study offered many potential benefits for participants and for the field of social work, steps were taken to minimize risk to participants. These steps included ensuring that participants had appropriate support systems in place, such as individual psychotherapy to process feelings that surfaced from the LKM practice, and ensuring confidentiality.

CHAPTER III

Methodology

Research Purpose and Design

While the negative impacts of compassion fatigue (CF) have been well documented (Bride, 2007; Figley, 1995, 1999, 2002, 2008) and the potential benefits of loving kindness meditation (LKM) among helping professionals have been explored (Boellinghaus, 2011, 2013; Pidgeon, et al., 2013), there remains insufficient research on the potential for LKM to impact CF or CS, or even research to determine whether a correlation exists among these variables. Research on LKM alone shows few studies that measure short-term impact over the course of one week. Additionally, the limited studies that were conducted fail to include diverse participants from different social identities. Hence, conducting research on the impact of LKM on CF and CS over a short period of time, with a more diverse population, expands existing literature on this topic.

The current study was designed to answer the research question: "Does a daily loving kindness meditation practice impact measures of compassion fatigue and compassion satisfaction among social workers and other mental health professionals over the course of one week?" This was a quasi-experimental, correlational, mixed-methods study. Data collection occurred over the

course of seven days, with two points of quantitative collection (pre-test and post-test) in addition to qualitative collection after the seven days, which included additional written questions and interviews with participants. All participants provided written consent (see appendix A). The independent variable was the daily, guided, ten-minute LKM practice, which was provided via an mp3 audio file (Appendix B provides a transcript of this intervention). The dependent variables were the rates of CF and CS. First, participants were given the most recent version of the ProQoL Scale (Stamm, 2005; see Appendix C) to determine pre-test levels of CF and CS before the seven-day intervention. The ProQoL Scale measures CF and CS using Likert-scale questions to capture dimensions of CS and the two components of CF, burnout and secondary traumatic stress. Questions on the ProQoL Scale include "I feel worn out because of my work as a [helper]," and "I get satisfaction from being able to [help] people." Upon completion of the pre-test, participants were given an audio file of a ten-minute guided LKM practice. They were asked to complete the ten-minute practice, on their own, daily, for a seven-day period. Participants were invited to choose any consecutive seven-day period between January 11, 2016 and February 5, 2016, while they were actively meeting regularly with clients. Following the seven-day period, participants were asked to complete the ProQoL Scale again to determine levels of CF and CS following the intervention. In addition, participants were asked to report on how closely they followed the daily practice over the course of the seven days, to report on the nature of their work with clients, and to answer a set of demographic questions (see Appendix D). Five participants were randomly selected upon completion of the intervention to be interviewed about their experiences (see Appendix E for interview questions).

The strengths of this design were that the scope of the research was limited to one intervention and one measure, and that the mixed-methods nature of the study gathered not only

a quantitative measure of change in CS and CF, but also qualitative data about the participants' experiences with the LKM practice.

Sample

For this study, I limited participation to actively practicing mental health professionals engaged in direct work with clients. Participants could be at any level of experience, from trainees to experienced clinicians, and could be social workers, psychologists, mental health counselors, or other licensed psychotherapy professionals or students working towards a degree in the mental health field. There were no geographical restrictions as the study was conducted remotely. Participants were required to have a good command of English, have the ability to listen to an audio recording, and have access to the Internet. Participants were required to be working directly with clients during the week they selected to participate in the study. Participants were not required to have any previous meditation experience, nor were participants excluded if they already had experience with LKM or other forms of meditation.

Recruitment Procedures

I used nonprobability sampling for this study, including availability sampling and snowball sampling. My outreach methods included posting to social media (Facebook, Instagram, LinkedIn, Twitter), emailing my professional colleagues, and sending email announcements to various professional networks of social workers and other mental health professionals, primarily in New York and the San Francisco Bay Area.

Informed Consent & Confidentiality

Participants were informed that LKM may bring up intense emotions, and were advised to have their own form of support, such as therapy, to work with any difficult emotions arising as a result of the practice. Participants were informed that while the researcher would take all possible precautions to safeguard identifying information, should any information regarding their levels of compassion fatigue become known, their professional reputations may be at risk. Participants were informed that potential benefits of LKM include increased feelings of connectedness, empathy, and happiness, and decreased levels of anxiety, sadness, and/or compassion fatigue. Participants were informed and reminded that participation in the study was completely voluntary, and that they were able to opt out of the study at any time prior to the date of analysis that was shared with them. Participation was confidential. Participants' identifying information was disguised by assigning a number to each participant, labeling all participant data with that participant's number, and keeping identifying participant information, such as consent forms, in separate locked files.

Sample Characteristics

This study had 21 total participants. Of these, 11 completed the study. Of these, 1 participant identified as Asian American, 1 identified as Black, 8 identified as Caucasian or white, and 1 participant declined to identify race. In addition, 9 participants identified as female, 1 as male, and 2 identified as gender queer (one participant identified as both female and gender queer). The ages of participants ranged from 25 to 55, and 1 participant did not indicate age. Participants included current graduate students as well as clinicians working in the field, and had between 2 and 25 years of experience as psychotherapists, with the average being 9 years of

work experience. Participants worked in community agencies, inpatient and outpatient centers, college and university counseling centers, VA medical centers, and in private practice.

Data Analysis

This study yielded both quantitative and qualitative data. The primary quantitative data included the pre-test and post-test results of the ProQoL Scale. The pre-tests and post-tests were individually scored for CS and the two components of CF, Burnout, and Secondary Traumatic Stress. These scores were then put into an Excel file and the data was analyzed using a t-test to determine whether there were any statistically significant differences between the scores on the pre-tests and post-tests. Marjorie Postal, Research Analyst at Smith College, performed the quantitative data analysis. The primary qualitative data came from the additional questions gathered following the intervention, and the interviews of participants. The researcher conducted and transcribed the interviews. Then, the transcribed interviews were coded for themes among the participants' responses. The qualitative data provided a more nuanced understanding of the participants' identities and contexts, and the participants' experiences of the LKM meditation and their perceptions of how the practice impacted their levels of CS and CF.

Limitations

The limitations of this study design were that the study only had 21 participants, and of these, only 11 completed the study, leaving the study with 11 participants. Availability sampling and snowball sampling did not provide a thoroughly diverse sample of participants based on race or

gender identity. The participant sample size did not allow generalizable results for the general population, but findings can serve as a point of reference for future studies. Lastly, as there was no control or comparison group, this study did not measure efficacy. Chapter IV, the following chapter, discusses this study's findings.

CHAPTER IV

Findings

This chapter presents the results of my data analysis to the research question, "Does a daily loving kindness meditation (LKM) practice impact levels of compassion satisfaction (CS) and compassion fatigue (CF) among social workers and other mental health professionals over the course of one week?" The first section of this chapter describes the study's demographic information. Section II, quantitative findings, provides descriptive statistics derived from analysis of each variable related to the three hypotheses generated for this study; and Section III provides qualitative findings generated by participant interview responses. Overall, this study found that there was a statistically significant decrease in CF among participants, and no statistically significant change among levels of CS.

Demographic Information

A total of eleven (11) participants participated in this research study. Of these, 1 participant identified as Asian American, 1 identified as Black, 8 identified as Caucasian or white, and 1 participant declined to identify race. In addition, 9 participants identified as female, 1 as male, and 2 identified as gender queer (one participant identified as both female and gender queer). The ages of participants ranged from 25 to 55, and 1 participant did not indicate age. Participants included current graduate students as well as clinicians working in the field, and had between 2 and 25 years of experience as psychotherapists, with the average being 9 years of

experience. Participants worked in community agencies, inpatient and outpatient centers, college and university counseling centers, VA medical centers, and in private practice.

Quantitative Findings

This study found a statistically significant decrease in compassion fatigue (CF) among participants. Specifically, the study found a statistically significant decrease in the two components of CF, Secondary Traumatic Stress (STS) and Burnout (B). There was no statistically significant change in levels of Compassion Satisfaction (CS). A paired t-test was used to compare the pre-test (PRE) and post-test (POST) scores of all three subscales: CS, STS, and B. Data was examined using SPSS Statistics for frequency, mean, median and mode. Data were then analyzed for correlations using Pearson's correlation. The results of the paired t-test showed that while there was no significant difference in CS, there was a significant difference in STS and B. There was a significant difference in burnout ($t(10)=2.604$, $p=026$, two-tailed). The mean burnout score of the pre-tests was higher ($m=24.09$) than the mean burnout score of the post-tests ($m=22.27$). There was a significant difference in STS ($t(10)=3.022$, $p=013$, two-tailed). The mean secondary score of the pre-tests was higher ($m=23.55$) than the mean secondary score of the post-tests ($m=20.73$). Below, each of these three hypotheses is explored in depth.

Hypothesis 1:

> Daily LKM practice increases levels of compassion satisfaction (CS) among social workers and other mental health professionals.

Findings:

Mean T-test score for CompassionPRE was 37.818 and for CompassionPOST, it was 38.909 (Table 1). The Pair 1 correlation for CompassionPRE and CompassionPOST was .419 at the .199 level of significance (Table 2). The 2-tailed significance was .315. These data show no observed differences between CompassionPRE and CompassionPOST testing. Therefore, there is no significant difference in CompassionPRE and CompassionPOST for participants in this study. Hence, Hypothesis 1 is not accepted as evidenced by the following tables.

Table 1. T-Test Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	CompassionPRE	37.818	11	2.9939	.9027
	CompassionPOST	38.909	11	3.3303	1.0041

Table 2. Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	CompassionPRE & CompassionPOST	11	.419	.199

Table 3. Paired Samples Test

		Paired Differences							
					95% Confidence Interval of Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	T	df	Sig. (2-tailed)
Pair 1	CompassionPRE - CompassionPOST	-1.0909	3.4192	1.0309	-3.3880	1.2061	-1.058	10	.315

Hypothesis 2:

Daily LKM practice decreases measures of burnout (feeling depleted by one's job) among social workers and other mental health professionals.

Findings:

Mean T-test score for BurnoutPRE was 24.091 and for BurnoutPOST, it was 22.273 (Table 4). The Pair 2 correlation for BurnoutPRE and BurnoutPOST was .814 at the .002 level of significance (Table 5). The 2-tailed significance was .026 (Table 6). These data show there was a significant difference in burnout (t(10)=2.604, p=026, two-tailed). The mean burnout score PRE was higher (m=24.09) than the mean burnout score POST (m=22.27). Therefore, there was a significant difference in BurnoutPRE and BurnoutPOST for participants in this study. Hence, Hypothesis 2 is accepted as evidenced by the following tables.

Table 4. T-Test Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 2	BurnoutPRE	24.091	11	3.9104	1.1790
	BurnoutPOST	22.273	11	3.6357	1.0962

Table 5. Paired Samples Correlations

		N	Correlation	Sig.
Pair 2	BurnoutPRE & BurnoutPOST	11	.814	.002

Table 6. Paired Samples Test

		Paired Differences							
					95% Confidence Interval of Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	T	df	Sig. (2-tailed)
Pair 2	BurnoutPRE – BurnoutPOST	1.8182	2.3160	.6983	.2623	3.3741	2.604	10	.026

Hypothesis 3:

Daily LKM practice decreases measures of secondary traumatic stress among social workers and other mental health professionals.

Findings:

Mean T-test score for Secondary Traumatic StressPRE was 23.545 and for Secondary Traumatic StressPOST, it was 20.727 (Table 7). The Pair 3 correlation for Secondary Traumatic StressPRE and Secondary Traumatic StressPOST was .814 at the .002 level of significance (Table 8). The 2-tailed significance was .013 (Table 9). These data show there was a significant difference in Secondary Traumatic Stress ($t(10)=3.022$, $p=013$, two-tailed). The mean Secondary Traumatic Stress score PRE was higher ($m=23.55$) than the mean Secondary Traumatic Stress score POST ($m=20.73$). Therefore, there was a significant difference in Secondary Traumatic Stress for participants in this study. Hence, Hypothesis 3 is accepted as evidenced by the following tables.

Table 7. T-Test Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 3	SecondaryPRE	23.545	11	5.1839	1.5630
	SecondaryPOST	20.727	11	4.9415	1.4899

Table 8. Paired Samples Correlations

		N	Correlation	Sig.
Pair 3	SecondaryPRE & SecondaryPOST	11	.814	.002

Table 9. Paired Samples Test

		Paired Differences							
					95% Confidence Interval of Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	T	df	Sig. (2-tailed)
Pair 3	SecondaryPRE - SecondaryPOST	2.8182	3.0925	.9324	.7406	4.8958	3.022	10	.013

Qualitative Findings

Of the eleven participants, three consented to be interviewed and were available to be interviewed at a time that was mutually convenient to the participant and the researcher. These three participants' interviews ranged between 20-40 minutes. They were asked to comment on their overall experience with the LKM practice, as well as more specific questions related to how they felt the LKM intervention impacted their feelings of compassion satisfaction and compassion fatigue. They also were asked how they felt the practice impacted their work with

clients (see Appendix E for list of interview questions). Below are the various themes that emerged in the participant interviews.

Themes

Structure and Accountability

Each participant stated that it was helpful to have a structured framework, the week of practice, and the guided audio recording as external motivators to practice. For example, one participant shared:

> … "I never had that much experience with meditation, and I took one brief class, and didn't find it that helpful, and found it hard to do, but the way this was set up for ten minutes every day, and I had made a commitment to you, made it easier for me to do, and I found it helpful right away."

Another participant shared that she kept a journal of the days she engaged in the study. She said, "I thought it was really cool…to take part in something like this, because it seems like a really important part of our self care." Reflecting on the week of practice, one participant stated, "…it really has been a gift for me."

Personalized Language and Practice

Some participants shared that they adapted the phrases of the meditation to better suit their individual needs and intentions. One participant commented, "I've changed it, to meet my

own needs…I use it as a sort of mantra." One participant shared that she adapted the sitting practice into a walking meditation practice, because she preferred walking to sitting.

LKM as a Coping Mechanism

One participant reported that she started to repeat the LKM phrases throughout her day as a way of stopping stressful thoughts. She shared, "I use it whenever I start…you know, I can get obsessively worried…and I tend to be very hard on myself…and what I do now is I start to do the loving kindness." She shared, "I do it several times a day and I find it very calming." She also reported that the practice helped her go back to sleep when she woke up in the middle of the night.

Confidence and Empowerment

Each of the participants commented on a sense of empowerment and confidence that developed as a result of the week of practice. One participant spoke of "coming into my professional self" and "having more confidence in giving psycho-education to clients." She commented, "I remember feeling like my voice is like a professional therapist voice." She shared, "I felt more empowered working with my clients…I felt stronger about myself." Another participant reported, "it made me feel more comfortable using things that I sort of already learned about deep breathing and meditation…to my clients." She shared, "I have a patient who has a history of sexual abuse and also a current trauma…and I told [the LKM practice] to her and she changed it to make her feel more empowered, and it's been beautiful and helpful for her, and wonderful for me to have another tool to help her."

Impact on Participants' Work with Clients

All participants who were interviewed reported that the practice has carried over into their work with clients. All participants who were interviewed reported that they have adapted the practice for use as a direct intervention with their own clients, or they plan to use the practice with their clients in the future. A participant commented, "I taught it to some patients, and I started to use it myself every day, and I've continued to." She said, "it's helpful to both of us, and makes me more present with them." Another participant asked the researcher if she had permission to use the audio recording with her clients, because she would like to use it with them.

Challenges: Resistance and Sitting

One participant reported experiencing resistance to getting started with the practice at the beginning of the seven-day period. She shared, "I definitely noticed resistance before the first day…then once I did it, it was easy to do it." Another participant said she preferred moving meditation to sitting meditation. This participant reported that she adapted the practice as a walking meditation practice. She shared, "I'm more comfortable in motion, so to try and sit and do deep breathing is still hard…I think it works for me, better, the way I do it, when I'm walking."

Comments about the Audio Recording

One participant commented that the audio file sounded "professional and relaxing." She shared, "I loved the quality of the recording…your voice was very calming." Another participant

reported that she would have preferred the audio recording to have lengthier silences between the spoken audio prompts.

Study Limitations

Findings from this study are telling; however, there are some limitations that cannot be overlooked. As previously mentioned, the small study population presents limitations for the study. For more extensive conclusions about compassion fatigue, burnout, and secondary traumatic stress, a larger sample size is indicated. Participant feedback strengthens this study as it speaks specifically to participants' experiences with compassion satisfaction, compassion fatigue, and secondary traumatic stress. Future research in this area should allow longer and shorter terms of measurement and increased diversity in study population, including mixed methods.

CHAPTER V

Discussion

This study supported the hypothesis that LKM practice decreases CF, and did not support the hypothesis that LKM increases CS. In this chapter, I discuss these findings, review implications for social work practice and theory, and make recommendations for future research.

Impact on CF and CS

The quantitative findings support the hypothesis that LKM decreases CF. It is promising that after engaging with the LKM practice for only ten minutes a day for one week, participants in this study showed a statistically significant decrease in CF. Given that there is limited existing literature on the relationship between LKM and CF, this is an exciting finding. Additional research to further explore this relationship is recommended.

The quantitative findings did not support the hypothesis that LKM increases CS. This is not consistent with the existing literature that indicates LKM increases positive emotional and personal resources. It is noteworthy, however, that many of the participants in this study started with moderate-to-high levels of CS, and as such the statistical possibility that they could increase CS was limited. Research among mental health workers with low levels of CS would be useful to further examine whether any relationship exists between LKM and CS.

Impact on Work with Clients

It is noteworthy that after only one week of LKM practice, all participants who were interviewed noted that they felt the practice positively impacted their interactions with clients. From the qualitative data, it appears that engaging with the practice had an impact not only on the practitioner, but also on the practitioner's clients. Several participants spoke of sharing the practice directly with clients by leading them through the meditation in sessions, but I am curious about the more subtle effects of LKM practice on the therapeutic relationship. For example, do clients working with therapists who practice LKM have different therapeutic outcomes? Do they experience healing faster? Do they report feeling more connected to their therapist? Further research could explore the more subtle effects LKM practice may have on the client-therapist relationship.

Confidence and Empowerment

This study yielded an unexpected finding in that several participants spoke of feeling increased empowerment and confidence during and after the intervention. Previous studies on LKM found increased feelings of connection, empathy, positive emotion, and personal resources, but the existing literature does not point specifically towards increased feelings of empowerment and confidence. Future studies could examine this possible relationship between LKM and feelings of empowerment and confidence.

Variations on LKM

It is important to note that LKM practice can vary in several ways. The practitioner, the teacher, the method of instruction, the duration of practice, the presence or lack of community, and other factors, may influence results. This study was conducted remotely, and the LKM instruction was given to participants via an audio recording of this researcher's voice reading a script adapted from an experienced LKM teacher (see Appendix B). As such, it is important to note that this study design added additional variables to the results, such as whether participants enjoyed the researcher's voice, whether participants felt connected to the researcher as a teacher, whether participants felt they had enough instruction and support to properly carry out the meditation practice, and the relative isolation and lack of community in practicing.

Some participants in this study personalized the LKM practice by slightly altering the phrases to suit their individual needs. One participant engaged with the practice while walking to work, rather than while sitting. One participant who made it her own through modifications showed a significant decrease in levels of CF. Thus, similar to the meta-analysis of 24 LKM studies (Zeng, X, Chiu, C. P. K., Wang, R., Oei, T.P.S., & Leung, F.Y.K., 2015), this study further begs the question: What are the active components of LKM? In many practices, participants are encouraged to make modifications and adapt practices to suit their individual needs. As such, what are the essential factors of LKM that contribute to beneficial outcomes, such as decreased levels of CF?

Implications for Social Work Practice and Theory

At the individual level, social workers can try LKM for themselves, and examine the impact it has on their experience of CF and CS and how it impacts their work with clients. At the

systemic level, agencies and other organizations may consider making a commitment to scheduling time for LKM or other supportive practices during working hours. In addition to scheduling administrative time for writing up case notes and clinical consultations, agencies and other organizations could designate time in the existing workday for clinicians to practice LKM if they find that it supports their work with clients. While implementing a change of this nature requires a shift from the capitalist mandate that all hours be billable and directly profitable, intentionally designating time for clinicians to cultivate compassion while on the job could have immense benefits over time for clinicians, clients, and communities. I do not mean to suggest that LKM should be mandatory, or that it is the only practice that can nourish and support the emotional wellbeing of social workers, or that it is more effective than other practices. LKM is one example of a practice that has potential to support social workers to be effective and sustainable in their work. While more research is needed to validate the findings of this study, if we learn that certain practices can benefit how we work, it follows that we would benefit from incorporating these practices into our work and systems. Social workers are repeatedly instructed to practice "self care," but often struggle to do so. Reframing our working models to include LKM and other "self care" practices in the context of the workday would provide individual social workers with the support of the agencies and communities in which they work. Thus, we could move from a model of isolated "self care" to a model of holistic "community care" in which the collective wellbeing of social workers is prioritized.

Recommendations for Future Studies

Empirical Research

It is promising that with a sample size of 11, this study found a statistically significant decrease in CF after only one week of ten minutes of daily LKM practice, but the small sample size of this study limits the conclusions we can draw from the results. Moreover, as this study did not involve a control group, it does not prove efficacy. Empirical research with more participants and a control group is recommended to validate the findings of this study.

Additional Research on Practices from the Buddhist Tradition

Given the promising findings of this study and the many others on mindfulness and LKM, additional research on other practices in the Buddhist tradition could be useful for the field of social work and others in the helping professions. For example, Tonglen is another Buddhist practice that works with compassion. Tonglen, which in Tibetan means "giving and receiving," instructs practitioners "to take on the suffering and pain of others, and give them your happiness, well-being, and peace of mind" (Sogyal Rinpoche, 2002, p. 206). This practice is related to LKM in that it involves compassion, but it also involves the instruction to "take on" the suffering of others. Additional research on Tonglen practice among social workers and their levels of compassion fatigue and compassion satisfaction would likely yield useful information for the field.

Questions and Recommendations: Study Design & Participation

Given that 11 of the 22 people who consented to participate in the study finished the study, and the other 11 people left the study, I am curious about the reasons participants stayed with or left the study. Several of the participants who completed the study and consented to be interviewed said they felt this study provided them with structure and accountability, which helped them commit to sticking with the practice. As for the individuals who left the study, I do not have data on their reasons for doing so, but I hypothesize that a combination of distance, lack of in-person support and instruction, and a lack of financial compensation may have contributed to people leaving the study prematurely.

This study was limited by time constraints, limited human resources, and limited financial resources. This study was developed and carried out by one researcher working under the guidance of one research advisor. From start to finish, this study was designed and carried out over the course of less than one year, during which time the researcher was simultaneously completing graduate coursework and working full time. There was no funding designated for this research study.

With increased time for planning and coordination, human resources, and financial resources, future studies could be designed to include more in-depth instruction in LKM. Seasoned teachers could be invited to provide in-depth instruction for participants, in person or via the Internet. Studies could be designed to allow for connectivity and community among participants, which would provide additional information about the experience of practicing in community versus in isolation. With additional funding, participants could be offered a financial incentive to complete the practice, which may attract more participants. By not offering

monetary compensation, this study attracted and maintained only those participants who were compelled to participate for personal reasons and who agreed to give their time without monetary compensation. With additional time to devote to outreach efforts, future studies could increase both sample size and diversity among participants. This study attempted to increase participant diversity by conducting outreach through professional networks in New York and California, but more robust outreach efforts are recommended for future studies.

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Appendix A: Consent Form

SMITH COLLEGE

2015-2016

Consent to Participate in a Research Study

Smith College, Northampton, MA

Title of Study: The Impacts of Loving Kindness Meditation on Compassion Fatigue and Compassion Satisfaction Among Psychotherapists

Investigators:

Name: Dianne Gallo **Dept:** SSW **Phone:** _____

Introduction

- You are being asked to be in a research study exploring the impact of loving-kindness meditation on compassion fatigue and compassion satisfaction among psychotherapists.
- You were selected as a possible participant because you are currently practicing psychotherapy and you have expressed interest in the study.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to determine whether there is any correlation between practicing loving-kindness meditation and levels of compassion fatigue and compassion satisfaction among psychotherapists.
- Ultimately, this research may be published online as a thesis, published as a paper in a research journal, presented publicly or in conference settings, and/or published as a part of a book or online for a wider audience.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: (1) commit to a daily 10-minute loving kindness meditation practice for seven (7) consecutive days; (2) complete a pre-test and post-test to measure your levels of compassion fatigue.
- A random selection of study participants will be invited to be interviewed about their experiences. Participants can choose to decline to participate in the interview. If you are invited and agree to be interviewed, you will be asked a series of questions about your experience related to the study. Interviews will be recorded.

Risks/Discomforts of Being in this Study

Practicing loving kindness meditation can bring up strong emotions. It is recommended that you have support, such as your own therapy, to process any strong feelings that arise during the course of the study. In addition, there is a potential risk to participant reputation should information about participants' levels of compassion fatigue and burnout become known to others. The following measures will be taken to ensure confidentiality of participant information: Participants will be assigned a number, and all data will be linked to that number. Participant names and corresponding numbers will be stored in a separate file. All electronic emails will be printed as hardcopy and deleted from my email box to ensure confidentiality of sender. Hardcopies will be numbered with no name identification. Consent forms and intervention data will be kept separately in a locked file or password protected with only the researcher having access. Every effort will be taken to ensure the confidentiality of participants.

- There may be other unknown risks.

Benefits of Being in the Study

- The potential benefits of participation include increased feelings of connectedness, empathy, and happiness. There may be a decrease in anxiety, sadness, and/or compassion fatigue. There may be additional unknown benefits.

Confidentiality

- The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password-protected file. We will not include any information in any report we may publish that would make it possible to identify you.

Payment

- There will be no payment for participating in the study.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the investigators of this study or Smith College. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process; additionally, you have the right to request that the interviewer not use any of your interview material.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Dianne Gallo, at dgallo@smith.edu. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant that have not been answered by the investigator, or if you

have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study investigators.

Subject's Name (print): _____

Subject's Signature: Date:

_____ _____

Investigator's Signature: _____ Date: _____

Consent for Audio or Video Recording of Interviews (optional)

If you are open to participating in an interview about your experience, please complete this section:

I agree to be [audio or video] recorded for this interview: (Please check which options apply)
____ I agree to be audio recorded only
____ I agree to be video or audio recorded
Name of Participant (print):
_____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Board (HSRB).

Appendix B: Transcription of LKM audio recording

[bell chime]

You can sit or lie down comfortably on your back
Your eyes can be open or closed, however you feel most at ease.
We begin by offering loving kindness to ourselves
By silently repeating the phrases:

May I be safe
May I be happy
May I be healthy
May I live with ease.

Silently repeat these phrases at a comfortable pace.

Repeat just one phrase at a time, with all of your attention gathered behind that phrase.

In these phases, the "may I" is intended not as begging, but as a blessing:

May I be safe
May I be happy
May I be healthy
May I live with ease.

[pause for 20 seconds]

If you find your attention wandering, don't worry.
Just bring your attention back to the repetition of these phrases.

May I be safe
Be happy
Be healthy
Live with ease.

[pause for 40 seconds]

Next, you can call to mind someone who's helped you.
They've been good to you, or kind to you.
Or maybe you've never met them, but they've inspired you.
Maybe it's an adult, a child, or an animal.
Someone who, when you think of them, you smile.
Offer loving kindness to them.

May you be safe
Be happy
Be healthy
Live with ease.

[pause for 20 seconds]

May you be safe
Be happy
Be healthy
Live with ease.

[pause for 40 seconds]

Next, you can call to mind someone who's hurting. Someone who's having a difficult time right now. You can offer the phases of loving kindness to them.

May you be safe
Be happy
Be healthy
Live with ease.

[pause for 40 seconds]

And if you find your attention wandering, just gently return your attention to the phrases.

[pause for 30 seconds]

Next, call to mind someone you might encounter just now and then. Perhaps a neighbor, or someone you notice as you go about your day. You may not even know their name. But you can picture them. You might not know much about them, but we can know that this person wants to be happy, just as you do. That they are vulnerable to pain and loss, just as we are. And we can wish them well.

May you be safe
Be happy
Be healthy
Live with ease.

[pause for 40 seconds]

Next, you can call to mind a person you find difficult. Someone you have trouble getting along with, or who pushes your buttons in some way. If you feel ready, you can offer the phrases of loving kindness to them.

May you be safe
Be happy
Be healthy
Live with ease.

[pause for 20 seconds]

If at any time it becomes too difficult to offer loving kindness to this person, just go back to sending loving kindness to yourself.

[pause for 20 seconds]

Finally, you can offer loving kindness to all beings everywhere, known and unknown, near and far.

May all beings be safe
May all beings be happy
May all beings be healthy
May all beings live with ease.

[pause for 40 seconds]

And, when you're ready, you can open your eyes.

[bell chime]

This meditation has been adapted from Sharon Salzberg's Loving Kindness Meditation from her book and accompanying audio CD, *Real Happiness: The Power of Meditation* (Salzberg, 2011).

Appendix C: ProQoL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	**2=Rarely**	**3=Sometimes**	**4=Often**	**5=Very Often**

___ 1. I am happy.

___ 2. I am preoccupied with more than one person I *[help]*.

___ 3. I get satisfaction from being able to *[help]* people.

___ 4. I feel connected to others.

___ 5. I jump or am startled by unexpected sounds.

___ 6. I feel invigorated after working with those I *[help]*.

___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.

___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.

___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.

___ 10. I feel trapped by my job as a *[helper]*.

___ 11. Because of my *[helping]*, I have felt "on edge" about various things.

___ 12. I like my work as a *[helper]*.

___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.

___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.

___ 15. I have beliefs that sustain me.

___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

___ 17. I am the person I always wanted to be.

___ 18. My work makes me feel satisfied.

___ 19. I feel worn out because of my work as a *[helper]*.

___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.

___ 21. I feel overwhelmed because my case [work] load seems endless.

___ 22. I believe I can make a difference through my work.

___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.

___ 24. I am proud of what I can do to *[help]*.

___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.

___ 26. I feel "bogged down" by the system.

___ 27. I have thoughts that I am a "success" as a *[helper]*.

___ 28. I can't recall important parts of my work with trauma victims.

___ 29. I am a very caring person.

___ 30. I am happy that I chose to do this work.

Appendix D: Additional Questions

Post Questions for Loving Kindness Meditation study participants

Meditation Experience

Did you complete the 10-minute meditation every day for 7 days? ___Yes ___No

If no, how many days did you practice? _____

Do you have any previous experience with any type of meditation or mindfulness practice?
___Yes ___No

If yes, please describe your previous experiences, including type of practice and length of time practicing, if applicable:

Demographic Information

Please indicate your:
Age: _____
Gender: _____
Race / Ethnicity: _____

For how many years have you been working as a therapist? _____

Please describe your current employment setting(s). (e.g., Adult outpatient mental health, home visits, working at a public high school, university counseling, hospice care, hospital, private practice, etc.):

How many hours do you work with clients per week? _____

Questions / Feedback

Do you have any questions or feedback about your experience with the loving kindness meditation practice, or about participating in this study? Please use the reverse of this page or add additional pages as necessary.

Thank you for your responses!

Appendix E: Interview Questions

Interview Questions
for participants in a research study on
Loving Kindness Meditation, Compassion Satisfaction, Burnout, and Compassion Fatigue

- Tell me about your experience of practicing loving kindness meditation (LKM). What was this experience like for you?

- Did you complete the LKM practice as directed, for 10 minutes for seven days? If not, what challenges or barriers did you face in completing the practice?

- What, if anything, did you enjoy about the LKM practice?

- What, if anything, did you find to be challenging aspects of the LKM practice?

- Did you notice any benefits from the LKM practice?

- Do you feel practicing LKM has impacted, or will impact, your ability to provide quality care for your clients?

- Do you feel practicing LKM has impacted, or will impact, your ability to care for yourself?

- Do you feel practicing LKM has impacted, or will impact, your approach to practicing psychotherapy and working with clients?

- Do you feel this practice had any impact on your levels of:
    - Compassion Satisfaction (the satisfaction you get from helping others)?
    - Burnout (feeling depleted by your job)?
    - Compassion Fatigue (feeling depleted from helping others)?

- How likely are you to continue to practice LKM after this study? Why or why not?

Appendix F: Human Subjects Review Committee Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

November 23, 2015

Dianne Gallo

Dear Dianne,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor