

Episode 157 - Dr. Joanne Cacciatore and Kara Thieleman: Witness to Suffering: Mindfulness and Compassion Fatigue Among Traumatic Bereavement Professionals and Volunteers

[00:00:08] Welcome to in social work. The podcast series of the University at Buffalo School of Social Work at www.insocialwork.org. We're glad you could join us today. The purpose of social work is to engage practitioners and researchers and lifelong learning and to promote research to practice and practice to research. We're so sure. Hello and welcome to in social work. I'm Charles Syms the host for this episode. Compassion fatigue has been the subject of considerable concern in the social work profession the provision of service to people who are experiencing a highly stressful situation or set of circumstances can take a significant emotional toll on those providing assistance. However few experiences are more stress in bulking than the loss of a child in this episode. Dr. Joanne Cacciatore and Kara Thieleman discuss their research with the professionals and volunteers that provide service to parents who have experienced a child's death. Joanne Cacciatore Ph.D. is an associate professor at the Arizona State University School of Social Work where she studies all aspects of traumatic grief. She has written extensively and presented nationally and internationally on her work. She is also the founder of the international nonprofit group the Miss Foundation which aids families whose children have died or are dying. Dr. Cacciatore received her doctorate in Children Youth and Family from the University of Nebraska Lincoln and her Masters of Social Work and a bachelor's degree in psychology from Arizona State University. Kara Thieleman is a third year doctoral student at Arizona State University School of Social Work.

[00:02:14] She received a Bachelor of Arts degree in psychology and anthropology from Lewis and Clark College in Portland Oregon and her Masters of Social Work with a specialization in adult health and mental health from Arizona State University. Ms Thielman has experience as a grief counselor for bereaved parents and families and as a Hospice social worker. Her research interests include traumatic loss grief death and dying. And mindfulness based approaches as a practice framework for clinicians and as an intervention for clients in this discussion Dr. Cacciatore and Ms Thieleman review the findings of their research some of which you might find surprising. They identify and suggest the use of mindfulness as an important skill for social workers practicing in the area of traumatic bereavement. They also describe a framework for self care for those working in those challenging settings Additionally Dr. Cacciatore suggests the need for professional human service and medical training programs of all types be more deliberate in their training on trauma and death. Dr. Cacciatore and Ms Thielman were interviewed in August of 2014 by Nurit Fischer Shemer a doctoral student at the University at Buffalo School of Social Work Hello I'm Nurit Fischer Shemer Ph.D. student in the University at Buffalo School of Social Work. Here with me to talk about mindfulness and compassion fatigue among traumatic braverment volunteers and professionals are PHD students student Kara Thieleman and Dr. Joanne Cacciatore from the Arizona State University's School of Social Work. Thankyou for joining us today. The first question I wanted to ask you is if you can tell me a little bit about the background of this study and the theoretical framework. Sure. How about if I talk about the background of this study. And then you can address that theoretical framework. Sure.

[00:04:34] So the background of the study was born from my area of research and practice. And I work with primarily parents who have experienced the death of a child at any age and from any cars from birth to grown adult children who have died. We noticed that we have a lot of volunteers in the organization that provides support to these families. And we wanted to study the effects of their involvement because not only were the great majority of them bereaved parents themselves but they were also either professionals or para professionals and had been working with us for an extended

period of time in providing aid to other parents. So we wondered what are the effects. After looking at some of the research on for example Red Cross volunteers and other volunteers who work in what we would call high emotional risk jobs either as a volunteer or as a professional where you have high attrition rates because of the deep intense psychological effects of such work. And so Kara I got there talking about the possibility of spreading the population and seeing basically how they were doing emotionally and in their own lives. And if in fact working or volunteering in this specific area put them at risk for adverse psychological and social outcomes. OK. And regarding the tourist tical framework Kara. Yes. Well Dr. Cacciatore touched on some of that the idea that exposure to the traumatic experiences of others can cause things like secondary traumatic stress and burnout and volunteers and professionals who work with those populations.

[00:06:29] We also wanted to look at mindfulness though because there's been a lot of research on the positive effects of mindfulness for instance and many studies have shown that it improves psychological well-being and improves emotional regulation. And so we were interested in seeing if mindfulness was related to compassion fatigue and compassion satisfaction and we had some ideas about what we might find there. Can you elaborate a little bit about compassion fatigue and the two aspects that it comprises. Yes so compassion fatigue is defined as a reduced capacity for empathy toward clients resulting from repeated exposure to their trauma. And so it's not to encompass two aspects secondary trauma also known as vicarious trauma and burnout secondary trauma. It includes many of the symptoms that we see in the post-traumatic stress disorder diagnosis those symptoms of hyper arousal intrusion avoidance. And on the other hand burnout has more to do with experiencing intense interpersonal situations where there is high distress and high emotional demands. And it's often expressed more as emotional exhaustion not some of the trauma symptoms but just the sense of not really being connected to what you're doing anymore and just being exhausted with what you're doing. Did you find a lot of similarities between the PTSD symptoms in clients and the compassion fatigue in the service providers that you were working with. We didn't measure anything. The client so I went there specifically the same and we used a different measure. To me is the professional quality of life scale. It has a subscale for burnout and for secondary traumatic stress. Some of the items are the same. So for instance it asks whether you are startled by unexpected sounds and that's something similar to hyper arousal and a PTSD diagnosis is very interesting. What is the relevance of your study to social work and other health professionals.

[00:08:47] Well I'm happy to address that part of the most salient issue in my opinion and mental health services and even community care to families specifically families who have experienced traumatic grief is that oftentimes providers are not getting the pedagogical training they need to prepare them for working with this population out in the field. This is a very unique and very vulnerable subset in not only academic research but also in clinical practice. And given that we actually know as a whole we actually know very very little very few graduate students when they graduate are prepared to deal with this population. So part of what we saw as incredibly important is OK so once they go out into the field if they're not prepared to deal with this how could this potentially affect them. And can mindfulness and additional training specific to this area help to prepare them for this work. So the model that they were trained with that these particular providers and volunteers were trained with is a mindfulness based framework that I proposed back in 2010 and it's called attend. And it basically multifaceted and it includes attunement to the client and to self and to the relationship. So approaching the client mindfully approaching the self mindfully and the therapeutic relationship mindfully trust therapeutic touch so touch being an important factor. Oftentimes egalitarianism nuance and then Deaf Education and deaf education goes two ways from the provider to the client and also continuing education for provider. It's important for the providers to continue to learn and grow because we never know all there is to know about this experience.

[00:10:56] And in fact the egalitarian aspect of the model encourages humility and encourages providers to allow the client system to be the teacher allow the client system to guide the

therapeutic relationship in a sense. Does that make sense. Yes definitely. And I know you were talking about the nuance and also the DETA advocacy including death dying in grief which is also a very unique and personal depending on the circumstances of each person. So I think that model it's very very interesting and very good for the population you're working with. I wish more people were using it and actually reading your work about the chairman and the founder of the Ms Foundation and all the work you've been doing there. It really has a lot of growth in the future to do I think in this area in this specific research for token. What were you hoping to discover through the study and what major questions or hypotheses were you addressing. Well I'll get the first part of that question and care can talk about the hypotheses. So I think from our perspective we were really just overall curious Kara and I are both longtime practitioners of mindfulness and I'm a regular meditator and I believe Kara is too. And so one of the things that I knew from my own personal experiences I've been doing this work for 18 years and just people will come up to me and go How do you do that work. Don't you get burned out. Isn't it awful don't you have nightmares. And the reality is that I haven't been adversely affected by my work.

[00:12:41] Conversely my work has made my heart and my life bigger not smaller and it has added to my life not taken away from my life. And so Karen and I were really curious if that was the case for other people who worked in the organization and who volunteered for us and the clinicians as well if in fact they would have experienced the same things because anecdotally I can tell you what really got me curious was about maybe it was six years ago I had three interns through the school of social work and they didn't want to leave the internship. When the year ended they were all very upset and didn't want to leave the internship. And they said one of them came to me and said You ruined me. I don't feel like I can do anything else. Nothing else feels rewarding to me. So I got to thinking and care and I got to talking about this and I thought Is there something about this model and working in this way with this population that creates a deeper sense of connection and kind of profound life satisfaction for people because that's what I experienced and I was hearing it from other people too. And so we started talking about it. And we know that mindfulness practice has helped both of us and we know what the literature says about mindfulness practice and we said maybe this is part of it maybe this is part of it let's look at it. So I'll let Kara talk about kind of the hypotheses and how we came to those. So let me just cover briefly the instruments that we used.

[00:14:16] This was an online survey that was distributed to all of the volunteers and everyone at that foundation and then they had the option of whether or not to take it. So the first instrument we use is the mindful attention awareness scale. It's a very short scale that assesses mindful attention awareness which is thought to be a key component of mindfulness and thought to be especially related to emotional regulation and so higher scores on this scale represents a higher level of mindfulness. So that's one matter. The second one we used is called the professional quality of life scale and it actually has three subscale. So as I mentioned we looked at secondary traumatic stress and burnout but there's also a compassion satisfaction scale which is basically something that results when you have a positive experience of being able to help others. It's kind of the counterpoint to secondary traumatic stress and burnout. It's the sense of feeling connected and enjoying what you're doing. So those are the two measures that we used to and we specifically we expected that we would find that there was a positive correlation between mindfulness and compassion satisfaction that people were more mindful they would be deriving great satisfaction from their role working with people who had experienced trauma in this form. We also hypothesized that mindfulness would be inversely related to secondary traumatic stress and burnout so that if mindfulness goes up the risk of burnout and secondary traumatic stress go down and vice versa. Low levels of mindfulness would be associated with higher levels of secondary traumatic stress and burnout. So those are basically our predictions going in although we had another hypothesis that we weren't fully able to test due to the small sample size but we expected that there would be differences between those individuals who had a personal history of trauma.

[00:16:24] As Dr. catch mentioned most volunteers and practitioners working with this agency have had a traumatic loss most commonly the death of a child. But some of them haven't had that experience. And so you're interested in seeing if the two groups differed from each other in that way as well. Well we were unable to test it because there were so few who hadn't experienced the death of a child. Yes. I mean who reported what we could find but we put a strong caveat in there that there were only I think seven people who hadn't experienced the deaths of a child and so we were very hesitant to draw any substantial conclusions from that. We did find that there were no differences which was really interesting because prior research suggests that a personal history of a traumatic event can increase your risk of these adverse outcomes. And we didn't find them in this study. Right. Which is really important. If you think about it. So what your research suggests in a sense is that people who have experienced trauma people with a history of interpersonal trauma are at an increased risk of burnout when working with trauma. And yet this study seemed to show just the opposite. Right. We didn't have enough data and power to run any kind of quantitative analyses. But there are preliminary data that suggests it is certainly worthy of further and deeper exploration. If you would have to take a guess or just suggest an idea why is that. So what would you say. Can I just offer a clarification. We didn't actually run an independent means test.

[00:18:07] So we did run some statistics on it and we did report those but we we're very cautious in drawing any conclusions interpreting. Yes yes. Why that is. Well I have some theories as to why that is and maybe those theories might echo mine. But Mindfulness is about several things but in this population the way I see mindfulness working most often is in cultivating very deep self awareness of our own emotional states and experiences as well as building what they call affect tolerance or a tolerance for what the our culture would call negative motions. I tend not to label them that way. I feel like their necessary emotions but in a sense Mindfulness helps us to endure what would otherwise be the unendurable and in so doing when you once you build up asset tolerance then you don't experience the kind of pushback the kind of emotional resistance to adverse experiences to experiences that cause you for example to feel emotional pain to feel sadness. Not only that I mean I'll take it a step further and say these experiences tend to connect said a deeply deeply human level. When we are able to sit with someone else in their suffering turn our hearts outward toward that person go into that dark abyss with them bear witness to their suffering. We feel deeply connected to them and there's something we get back from that so not only is it those affect helped protect us but it gives us the ability to open the door to deeper human connection and that deeper human connection that deeper sense of belonging benefits not only the receiver but the giver. Does that make sense. Yes.

[00:20:10] Yes very much so you're saying that mindfulness not only immune for some of the traumatic events ours and others but it also works on some of the coping mechanisms that we develop during the years for ourselves and for clients. It does. So in other words how I like to say it to my clients when I'm working with clients is I like to say you know on a scale of 1 to 10 what's your grief been like this week how intense has your grief been and what they say to me my grief is at a nine this week in intensity. OK so let's talk about coping. How have you been able to cope with your grief. If they say I'm coping and an eight nine ten. OK. All right. So they're coping with whatever intense emotions happen to manifest. Conversely if I talked to another client and they say my grief is at a five and I say how's your coping my coping as a one. OK so they're noticing a greater disparity between their intense emotion and their ability to tolerate and cope with that intense emotion. Well the same thing goes for providers because as providers we're human beings with emotions too and especially when you're working in the realm of child death which is a particularly unique and difficult population recognized in the literature and in clinical practice providers who have their own children at home for example might be talking to someone who lost a 3 year old to cancer and they may have their own 3 year old at home. So what does that bring up for them. Naturally it brings up fears and concerns and maybe even terror.

[00:21:59] Well the cultivation of self awareness helps us to cope with that because we become aware and because we can turn toward the emotion that we're feeling usually fear and then the asset tolerance helps us to cope. So we may be having a reaction to this particular client story of an 8 but if our coping is innate then it doesn't interfere with the therapeutic relationship. And now we don't put ourselves at risk. This is a hypothesis of course and we'd have to test this. But it doesn't put us at risk for vicarious trauma for diminished life satisfaction for increased anxiety. All of those kind of what we would call negative psychological outcomes. So the mindfulness is a powerful tool here for the service providers and I wonder if you think that there's any way that we can also teach the clients for a long term to use mindfulness. I will tell you that that's exactly what the model is. So the model is about modeling mindfulness for the client and when the client is ready. Because this is very important. People have to be ready for this type of practice when the client is ready. Then you start cultivating that mindfulness practice and helping them to integrate it. We don't use mindfulness to circumvent grief. We don't use mindfulness as a bypass around grief. We use mindfulness as a way to turn toward grief and walk in grief. And that's really a different paradigm I think than predominant culture today. The idea is to eliminate grief ameliorate grief overcome grief make grief the way this is a model of integration because when we don't integrate we fragment you know fragmenting.

[00:23:41] Certainly can work at certain times in your life when you need to fragment but this is a particular time when integration can be really important and can help promote post-traumatic growth. So when clients are ready if they want to start a sit practice we'll teach them a sit practice. So you might spend half of your session doing narrative mindfulness based narrative therapy and then you might do the other half of a session teaching meditation or teaching mindful walking or other mindfulness practices. And then there are also accompanying I don't want to call them homework assignments but practice is that they can take home with them and work with us through the week between meetings between sessions. And all of those things help the client to cultivate their own mindfulness practice which is unique to them. Know to mindfulness practices are like this is unique to them. This is in a sense the anti protocol model. This is deeply deeply individualized based on the client the circumstances the history of the Hamas their personal preferences their religious beliefs and practices or lack of their family system. Everything is individualized. So it's part of what you call the nuance in that model right. Absolutely correct. You know what I think the work is amazing. The only concern I have that it's with our healthcare system today and the definitions that we have to and required to give in order to the billing system and so on. About what is the diagnoses what is going on with our client. How long are we going to be treating him and so on.

[00:25:30] Your approach is so much holistic and so much attending the human being that I wish there will be more room in our system to accept individualized work. Yes we agree don't we. Kara we wish the same thing. Do you find that challenging. Would you like to talk about that a little bit about where can you take all these wonderful things and actually integrate them in our system. Well I Kara and I have published a couple of papers critiquing the move the Diagnostic and Statistical Manual five move to remove the bereavement exclusion which makes it possible for a person to be diagnosed with a serious mental illness as early as two weeks after the death of a child for example. And so we've published a couple of articles critiquing that here do you want to talk a little bit about what our position was there and then I'm happy to address how we can navigate that system. Sure. Well basically when we looked at them we did what we did is look at other studies that have evaluated the bereavement exclusion. They've tried to determine you know is this a useful construct should we keep it. Should we remove it and the best studies all supported keeping the bereavement exclusion that it did help draw a line between individuals who were experiencing grief that may be very intense but who are not going to have perhaps long term psychological problems related to it from individuals who are more likely to go on to have repeated episodes of depression and more severe impairment. So the empirical evidence suggested that keeping the bereavement exclusion

was a good idea and even that expanding it might be an even better idea because it used to allow two months since DSM 4.

[00:27:30] But in DSM 3 it allowed up to a year. And there was actually some good evidence that moving it back to a year would be a better indicator of whether or not someone is truly depressed or experiencing grief. So it was also that when that many of the studies on depression are conducted with one type of population namely elderly bereaved spouses and that their experience and their grief trajectory is not necessarily the same as for someone who has lost a child or for someone who has lost a spouse in a very violent manner and that you can't just superimpose the trend that you see in one population to every bereaved person. So we had a further concern that even with the bereavement exclusion then allowing for eight weeks and DSM 4 that it wasn't adequate for some populations particularly for parents who lost a child. So now what do we do about that. Because it is a difficult position for providers to be in. So if a provider wanted to adopt the A10 model what he or she could do is for example use the ICD 10. If they must use a code for billing that's what some writers I know are doing other providers are going to a sliding scale system so that they're bypassing insurance altogether. There are many providers who find with whom I've spoken who find that sometimes people are very quite happy to pay their copayment basically as full payment. What would otherwise be a copayment as full payment. And so in that way they don't have to use a diagnostic coding system.

[00:29:18] The reality is because of the work I do I know a lot of clinicians and many of my friends are clinicians and one of my good friends who has a clinician said to me as the DSM 5 was impressed with the bereavement exclusion taken out by the way let me go on the record and saying I'm not happy with the DSM 4 either I'm not happy with eight weeks I don't think eight weeks is appropriate. I do agree with the evidence in the field test that one year you experience less risk of false positives. Having said that the DSM 4 was enacted long before I could engage in any vociferous not positioned to that change. So what ends up happening is these providers in a sense have decided that they agree with this position. The position of many many who critique the DSM 5 move and said you know grief is not mental illness and have chosen to bypass that and just go with a sliding scale system that allows people to make a payment and it's in a sense grief therapy or grief counseling and there are people on a sliding scale who might be able to pay twenty five dollars for an hour session which is usually actually less than many copayments nowadays. And then there are people who could pay 60 or 100 or 150 dollars or maybe more. I don't know.

[00:30:37] I don't get into that kind of detail with providers who use our particular model but I can tell you that one of my colleagues as I was saying earlier when this change was about to be made she said yeah I know it's not real but isn't it a noble lie and that is to diagnose someone with a major depressive disorder so that they can get the services paid for and that to me seems like a gross ethical breach to offer up a noble lie just so the insurance company will pay for services. I don't know why that would not be problematic ethically for any of us. So we're saying that someone has major depressive disorder and we knowingly know if we knowingly assign that code as a noble lie. That seems like now practice to me. Yes it's malpractice but the system doesn't give you another option. This is true and that's why I would love to see social workers organize and say no we need another system a person centred system not a medical centred system not a pathology centred system we need a more humane system. At the very least with this population and because of my area of expertise I don't go beyond that but I have colleagues who would say we need a more humane system for all. And so we have to ask ourselves what are we doing. Are we causing more harm and if we're causing more harm and if we're doing things that are unethical then it's time to stop then it's time to stop. And so again a lot of our clinicians are doing things like going to a sliding scale ability to pay or using the ICD and just using adjustment disorder as a diagnostic code rather than something like major depressive disorder or bipolar. I mean grief is bipolar one day you feel like you're okay you know you're like okay I can get through this day and the next day you're

you can't get out of bed that's normal grief that's that looks like that's what it feels like that's not bipolar disorder.

[00:32:37] So it gets very very sticky and any time you have a science where you could put the same person in front of four different clinicians and come up with four different diagnoses then you have to question the soundness of the process right. Yes and have more mindful and holistic approach to each individual absolutely and much more humane because this particular framework is a humane framework. We're about working with this family in their circumstance in their time and treating them with civic love and compassion and it works. It's working. We're seeing the benefits of it with these populations. Does that mean they don't have grief. No. Does it mean they don't have anxiety. No. It's normal to have anxiety if you've lost a child in a car accident. What would be abnormal is not to be fearful when your other children get in the car. That's the abnormality it's not having fear it's not having fear. We've made that which is normal abnormal. So what do you think the implications of your findings and of all of that to other helping professions not only social workers because social workers are a certain population which we all belong to the older other people grieving families and parents are working with the doctors even the lawyers sometimes and all the other helping circle that they're surrounded with. Can I clarify a few things or just provide additional information that I think supports everything that you said and I do want to add that not everyone in the sample was a social worker. So we did have people from various backgrounds.

[00:34:23] I just wanted to be a little bit more specific about what we did find because one piece in particular is very interesting and supports everything that Dr. teche Tory was saying. So we did find the three relationships that we hypothesized would be there. There was the typically significant relationship between mindfulness and compassion satisfaction a positive relationship and an inverse relationship between mindfulness and burnout and secondary traumatic stress. So what was kind of surprising and that I didn't necessarily expect to see was evident just from the descriptive statistics. So I mean mindfulness score for our sample was four point to five and it's slightly higher than the norms reported by the developer of the instrument which is four point two. So it's slightly higher but considering that the people who the instrument was normed on weren't necessarily working with trauma. So it is very interesting that we had such a high Meine level of mindfulness in our group suggesting that maybe something about the training the model is effective at increasing that mindfulness. And secondly we had a fairly high score for compassion satisfaction average score. It was forty two point three nine. And generally any score above 42 indicates high satisfaction. So that was very interesting that we had that and also we had relatively low scores for secondary traumatic stress and burnout twenty point six six for secondary tremendous stress and nineteen point six three for burnout. And what's interesting in this case is that any score below 22 indicates low risk. And so the mean score was low risk and when we looked at particularly who scored in the low range and who scored in the higher range the high range that indicates there could be some problems.

[00:36:26] Nobody scored in the high range in the entire sample so nobody was according to this instrument at risk for burnout or secondary traumatic stress. And in addition nobody scored in the low range for compassion satisfaction. And actually most of them 71 percent scored in the really high range. So what was really interesting was just to see where the scores fell on these instruments because it suggested that there's something about this group there's something here that is protective against these things for them. We thought that was really interesting because you wouldn't necessarily expect that normally you see a spread. Some people score in the low range. Some people score in moderate range and some people score in the high range but it was all pretty consistent. Yeah yeah that's good. Kara thank you. Yes actually the statistics are really impressive. I'm just hoping there is a way we can take it forward. OK so how do we take it forward really. I mean really mental health institutions should be training their their providers. I would say in mindfulness. But I think it has to go beyond mindfulness. I think it has to go into death and trauma because if you look at most people who are suffering with mental health diagnoses they're not it

trauma experience free so many of them have suffered different varying types of trauma to varying degrees. But it's something that everyone in the helping professions needs to be prepared to deal with needs to understand the evidence needs to understand what works what doesn't work and trained in mindfulness as well.

[00:38:06] So Kiran I also just published some research on my I teach a traumatic death education course at Arizona State University graduate level and the findings are very very interesting and may have implications for these findings and the implications of that is that the trauma and that education course for graduate students increased not only empathy but mindfulness or seemed to have a relationship to increases in empathy and mindfulness. Now this is really important because from my experience anecdotally and empirically it suggests that perhaps it's the death education piece that's really really important and often missing in pedagogical models today. So I think we need to get better at treating providers of mental health doctors nurses first responders. They need better training not only on mindfulness and deep awareness and cultivating a mindful practice but also trauma and death which I know you know I mean not you know Karen and I can kind of clear out a party. You know when we walk in people know what we do and you know we're not very popular because it's hard to talk about this stuff that makes us confront our own mortality and the mortality of those we love which is very hard to do. It's very hard to contemplate that. I get it. And yet people think that it's going to paralyze them in some way and actually what it does is it gives them the opportunity to live more fully. That's the big secret here is that studying death gives you life and understanding. Not like any other diagnosis. Death is actually part of everybody's life and the grief is part of most people's lives. It's inevitable. I mean unless you go through your life without loving you're going to grieve at some point. It's a common human experience it's nearly universal. Yes.

[00:40:04] So when we do the research you are standing right now like looking forward and from now like what are you working on what's the next step right now. OK first I want to say I do think this can be expanded to other settings. We do need more research on the model. But what we've seen so far is very promising. And so for instance this could be used in a hospice setting. And I worked as a hospice social worker after having been trained in this model and found it immensely helpful even in that setting. And because also you do encounter trauma in a setting like hospice people tend to think that it's elderly people at the end of life kind of going peacefully. But you actually see victims of car accidents and young people and people who are you know in a vegetative state after a suicide attempt. So you do see all these things in other settings and not just hospice also but you see these kinds of things working with children in schools you know trauma in their lives and loss in their lives. So I think it is very applicable across a range of settings and that's one avenue I'd love to see more research in the future as to what we have going right now. As Dr. Cacciatore mentioned we just had an article published by guess education and the benefits for students but we're also moving ahead with research on mindfulness and bereaved parents so we are all working right now on evaluating a grief focused mindfulness retreat for bereaved parents and looking at its impact on trauma symptoms depressive symptoms anxious symptoms as well as mindfulness and self compassion.

[00:41:48] And then we're following up the quantitative piece with qualitative interviews to really understand from participants point of view what is helpful. What was some of their concerns and how they experience this kind of how some of them have integrated mindfulness into their lives as a result the retreat. And so it's really interesting project it's going to take a while to get all the data. So what we have so far is very encouraging. We'll be adding people to the sample. So right now it's a pretty small sample but we did find that compared to a comparison group. So people who didn't go to their retreat there are statistically significant changes on most of the measures. So depression anxiety trauma symptoms and increases in self compassion and mindfulness. So we'll run all the steps again when we have the larger sample. Right now it's very encouraging. Very interesting. I

think you have a lot of work to do. Yes. In our world it's so personal lives and it's hard for many people to see how the mindfulness is coming into the actual work every day. Anything else you would like to add. You know maybe just a couple words about the limitations. You know this is really interesting promising research but I don't want to overstate the findings. We included in our limitations section that this was a relatively small sample and we weren't able to fully test the differences between bereaved parents and Andri parents due to their not paying.

[00:43:26] Many parents in the group also any Tangaroa study their strong points and weak points and we don't have as much information as we would have liked about the actual time that each participant spent volunteering there could be differences between people who work full time and those who don't. But we just can't tell this from this sample. So basically we were really impressed with what we found but we could test this further before and I would love to see more data on this particular model in different populations. So what I really love is for us to be able to go in and do some training for different agencies who don't serve specifically bereaved parents or the traumatically bereaved and test this model in that population. Because I can't see how this model would not benefit all populations because of not only the benefits to the individual who they're helping but also because of the benefits to the providers I mean there's a dearth of research but it's increasing as time passes on the importance of the providers state of mind and state of heart on outcomes for patients and clients. So not just because of the effects that it had that this model has on the client but also the effects that it has on the provider and thus the relationship I call it a tripartite effect. And because of that I would like to see more data generated from within other populations. Yeah that was actually my concluding question is how do we take that for other types of trauma because it seems promising for many other traumas as well. Absolutely. And I think it has to come from administrators. I think administrators have to see the research. I think administrators have to see the cost benefit ratio here. The reality is this is a really inexpensive and very effective.

[00:45:27] Lots of bang for the buck as far as administrators are concerned. That's important to them. And so if we can get this kind of information into the hands of administrators those who make the decisions on training and practice models just let them do some research just let them do some pre posting just some simple task even just to show us facts because my guess would be that in many populations we would have an effect. Yes. OK. Thank you so much for your time. Well thank you. And Dr. Cacciatore and Kara Thieleman thank you again for participating today. Thank you. I also want to say Can I just say briefly I have the best research assistant on Earth. So Kara is awesome and it helps when you're doing this kind of work it really helps to have an amazing research assistant. She really is so stay in touch with her watch her because she's on fire. I will you. Good. OK thank you. Kara thank you. You have been listening to Dr. Joanne Cacciatore and Ms. Kara Thieleman talk about their research with those who provide care to people experiencing traumatic bereavement. We hope you have found this episode informative. I'm your host Charles Syms. Please join us again at social work Hi I'm Nancy Smyth professor and dean of the University at Buffalo School of Social Work. Thanks for listening to our podcast. We look forward to your continued support of the series.

[00:47:08] For more information about who we are as a school our history our programs and what we do we invite you to visit our Web site at www.socialwork.buffalo.edu.