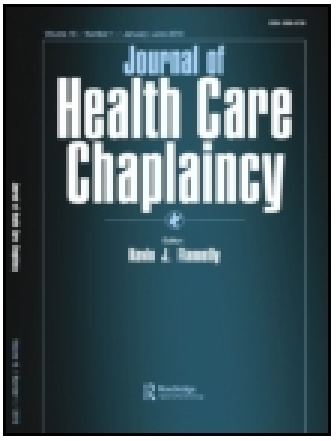

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Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature

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Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature

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The relationship between mindfulness and self-compassion is explored in the health care literature, with a corollary emphasis on reducing stress in health care workers and providing compassionate patient care. Health care professionals are particularly vulnerable to stress overload and compassion fatigue due to an emotionally exhausting environment. Compassion fatigue among caregivers in turn has been associated with less effective delivery of care. Having compassion for others entails self-compassion. In Kristin Neff's research, self-compassion includes self-kindness, a sense of common humanity, and mindfulness. Both mindfulness and self-compassion involve promoting an attitude of curiosity and nonjudgment towards one's experiences. Research suggests that mindfulness interventions, particularly those with an added lovingkindness component, have the potential to increase self-compassion among health care workers. Enhancing focus on developing self-compassion using MBSR and other mindfulness interventions for health care workers holds promise for reducing perceived stress and increasing effectiveness of clinical care.

KEYWORDS clinician self-care, health care professionals' well-being, mindfulness, mindfulness-based stress reduction, self-compassion

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INTRODUCTION

Those who work in the field of health care know that being able to "bear with the suffering of others" is essential (Figley, 2002a, 2002b). Care is one component of compassion (Wollenburg, 2004), and the action of caring has the potential to alleviate an individual's suffering (Kret, 2011). Thus, it is not insignificant that patients in the United States are reporting decreasing satisfaction with nursing care in hospitals (Heffernan et al., 2010). Moreover, the problem is not limited to the United States. A survey of ICU nurses and physicians in Europe and Israel indicates that one fourth of those surveyed report inappropriate care (Hand, 2011).

At the same time, there is a surge of interest in the well-being of those same doctors, nurses, psychologists and other health care providers who provide treatment. Stress has been shown to reduce clinicians' attention and concentration, detract from decision-making skills, diminish effective communication, as well as contribute to various physical health problems including fatigue, insomnia, heart disease, depression, and obesity (Enochs & Etzback, 2004; Miller, Stiff, & Ellis, 1988; Spickard, Gabbe, & Christensen, 2002). Workers in the health care sector are particularly vulnerable to stress overload and burnout (Harris, 2001; Moore & Cooper, 1996; Sharkey & Sharples, 2003; Wall et al., 1997). Moore and Cooper (1996) suggest that mental health workers, in particular, are subject to high levels of stress due to working in an emotionally draining workplace. Staff burnout has been associated with decreased patient satisfaction and suboptimal patient care and longer recovery times as reported by patients (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Shanafelt, Bradley, Wipf, & Back, 2002; Shapiro, Carlson, Astin, & Freedman, 2006; Shapiro, Astin, Bishop, & Cordova, 2005).

These observations point to the necessity of examining stress in the field of health care. As the consequences of burnout can be serious for the individuals concerned, their coworkers, and their clients (Jackson & Maslach, 1982; Jackson, Schwab, & Schuler, 1986), learning to be sensitive and to cope with stress are essential skills for health care workers. Moreover, compassion is pivotal to continuing to providing quality care for those in need (Adams, Boscarino, & Figley, 2006; Figley, 1995, 2002a, 2002b; Kret, 2011). Learning to be sensitive, nonjudgmental, and respectful toward oneself in turn facilitates the ability to be sensitive, nonjudgmental, and respectful toward others (Gustin & Wagner, 2013; Gilbert, 2005).

This article explores self-compassion in the context of mindfulness. Mindfulness courses are increasingly being taught in health care settings and training programs as a means of reducing stress and promoting well-being among health care workers (Irving, Dobkin, & Park, 2009). Moreover, research on the psychological benefits of self-compassion is growing (Germer & Neff, 2013; Barnard & Curry, 2011). While studies to date have

not measured the effects of mindfulness and self-compassion interventions on patient care, this article is a call to do so. In what follows, the nature of compassion, self-compassion, and self-compassion in the context of mindfulness-based stress reduction programs for health care professionals are discussed. The potential significance of health care professionals' mindfulness programs for clinical care is also explored.

Compassion, Compassion Fatigue, and Self-Compassion

Compassion is a deep awareness of others' suffering and the wish to alleviate it. Webster's dictionary elucidates that compassion is "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (1996, p. 416). The word "compassion" is derived from the Latin words "pati" and "cum," which together mean "to suffer with" (McNeill, Morrison, & Nouwen, 1982). Morse, Bottorff, Anderson, O'Brien, and Solberg (1992) state: "The compassionate caregiver echoes the sufferer's sentiment and shares in the suffering. In sharing in the other's suffering, the caregiver expresses compassion that strengthens and comforts the sufferer" (p. 814).

Figley (2002b) suggests that the most effective therapists are those who utilize and expresses empathy and compassion. In sharing the client's suffering, the caregiver expresses compassion that in turn strengthens and comforts the sufferer (Morse et al., 1992). Compassion, observes Kret (2011), is intrinsic to nursing practice. Figley (2002b) states: "...we cannot avoid our compassion and empathy. They provide the tools required in the art of human service. To see the world as our clients see it enable us to calibrate our services to fit them and to adjust our services to fit how they are proceeding" (p. 1434).

While it is vital that caregivers continue to work with empathy and compassion, there is an obvious cost to this work. The concept of compassion fatigue first emerged with the work of Charles Figley, who defined it as "the formal caregiver's reduced capacity or interest in being empathic or 'bearing the suffering of clients' and is 'the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person'" (Figley, 1995, p. 7). Compassion fatigue, a function of bearing witness to suffering of others, is a form of secondary traumatic stress, associated with the "cost of caring" (Figley, 2002a). It is one form of burnout.

Ironically, while empathic ability allows one to notice the pain of others, this ability also is linked to the susceptibility to compassion fatigue. Self-compassion, in turn, has seen much attention in recent years as a means of resiliency against stress, burnout, and emotional exhaustion. While deeply rooted in Buddhist teachings (Davidson & Harrington, 2002), the construct of a Western psychological view of self-compassion can be traced largely to the work of Paul Gilbert (2005, 2009), Kristin Neff (2003a, 2003b), and

Christopher Germer (2009). Gilbert (2009) describes it as "a basic kindness, with a deep awareness of the suffering of oneself and others" (p. xiii). Neff (2003a) further explains that having self-compassion builds resiliency against depression and anxiety, while increasing life satisfaction, optimism, social connectedness, and happiness. Thus, self-compassion warrants a more detailed examination.

Neff (2003a) suggests a three-faceted structure to self-compassion, each of which counters various negative effects: *self-kindness, common humanity,* and *mindfulness*. *Self-kindness* reduces "self-criticism, self-condemnation, blaming and rumination, which are common notions of depression" (Beck, Rush, Shaw, & Emery, 1979). *Common humanity* is the realization that as individuals we are part of a greater human community that is suffering as well, reducing a sense of isolation (Van Dam, Sheppard, Forsyth, & Earleywine, 2011) and increasing general well-being (Neff, 2003a). *Mindfulness* counters over-identification (Neff, 2003b), reducing excessive fixations on negative thoughts (Hayes, Strosahl, & Wilson, 1999).

The mechanisms of self-compassion lay in their mitigation of worry and rumination (Raes, 2010). Anxious worrying spirals into catastrophic thinking (Watkins, 2008), while brooding and ruminating deepen feelings of sadness by focusing on past events (Raes). These upward and downward cycles then perpetuate unproductive repetitive thinking that can turn a mild state of depression or anxiety into a more severe form (Segal et al., 2006; Raes, 2010).

Gilbert (2009) explains that children raised in a stable, nurturing environment learn to be compassionate and gradually to regulate their own emotions; on the other hand, children reared in an excessively negative environment readily develop self-criticism, shame, and guilt. Individuals with a strong, early history of maltreatment (Vetesse, Dyer, Li, & Wekerle, 2011) can develop emotional dysregulation, self-criticism, and greater susceptibility to stress. Moreover, highly self-critical individuals set up expectations for themselves that, when they fail, perpetuate feelings of worthlessness, shame, and guilt (Shapira & Mongrain, 2010; Blatt, 1974).

To counter self-criticism and shame, self-compassion interventions encourage qualities that reduce negative thoughts (Vetesse et al., 2011), that is, self-kindness, mindfulness, and common humanity. Self-compassion interventions target defensive reactions, seeking to acknowledge them, accept them, to then reduce shameful feelings that may arise (Gilbert & Procter, 2006).

Currently, self-compassion is taught in a variety of ways. Compassionate mind training (CMT), which "seeks to alter a person's whole orientation to self and relationships" (Gilbert & Procter, 2006, p. 359) utilizes reframing, compassionate imagery, and focus. Therapeutic letter writing, which involves positive visualizations of future events and goal-setting techniques, also has been used as an intervention (Shapira & Mongrain, 2010). Compassionate meditations have been utilized successfully as well (Hofman, Grossman, & Hinton, 2011), with findings of increased immune responses (as measured by plasma concentrations of interleukin) and decreased stress responses

(as measured by decreased cortisol levels) as positive health benefits (Pace et al., 2008). Self-compassion strategies focus on nurturing feelings of warmth and safety, presence, and interconnectedness (Gilbert & Procter, 2006). Loving-kindness meditation, for example, an exercise where one directs compassionate images and thoughts toward oneself and others (Shapiro, Brown, & Biegel, 2007; Hofman et al., 2011), helps to enhance positive emotions through the cultivation of *metta*, or lovingkindness, while remaining attentive to the present-moment.

Interestingly, while self-compassion has been a core part of Buddhist traditions for centuries (Neff, Rude, & Kirkpatrick, 2007), only recently has the concept been introduced into Western psychology. As a psychological construct, self-compassion has been successfully tested using Neff's (2003a) 26-item Self-Compassion Scale, which measures six aspects of compassion: self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Utilizing a 5-point Likert scale, it has shown to demonstrate concurrent validity, convergent validity, discriminant validity, and test-retest reliability (Neff et al., 2007).

Self-Compassion and Compassion for Others

Compassion for another may emanate from compassion for self. In a recent Swedish study (Gustin & Wagner, 2013), for example, researchers examined the "butterfly effect of caring," that is, the development of a compassionate self—the ability to be sensitive, nonjudgmental and respectful toward oneself—as a contributing factor to a compassionate stance toward others. The aim of Gustin and Wagner's study was to explore participants' understanding of self-compassion as a source to compassionate care. Based on principles for experiential and reflective learning, the project made use of Watson's Theory of Human Caring (2008), with special emphasis on 5 processes: 1) cultivating lovingkindness and equanimity towards self and others, 2) being authentically present, 3) cultivation of one's own spiritual practice, 4) developing and sustaining a helping-trusting caring relationship, and 5) being present and supportive of positive and negative feeling. The study findings highlighted the specific character of compassion: "... compassion appears to diminish both a hierarchical attitude and a view of the one cared for as someone just like the caregiver. Rather it enables the caregiver to apprehend the suffering other as someone different from the caregiver, yet related to the caregiver in a shared humanity" (p. 180). Moreover, findings suggest that the willingness to "give a little extra"—a symbolic act bridging the caregiver's responsive connection to the suffering other–requires self-compassion and the ability to care for oneself.

As discussed, other literature suggests that compassion for others is closely linked to self-compassion and the ability to self-care (Figley, 2002a, 2002b; Kret, 2011; Gilbert, 2005). Thus, developing self-compassion may

be vital for prevention of compassion fatigue and promotion of compassionate care (Gustin & Wagner, 2013). Gilbert (2005) explains: "... meeting one's own needs for relief, empathic understanding, and support is an important prerequisite for continuing to serve as an attachment figure for needy others" (p. 140).

Heffernan et al. (2010) suggest that examining nurses' self-compassion is a significant nursing issue, because without ability for self-compassion, nurses may be ill-prepared to show compassion to those for whom they care. It stands to reason that the same assessment can be made of other health care professionals. Over 200 journal articles and dissertations on self-compassion have been published since 2003, when the first two articles defining and measuring self-compassion were published (Germer & Neff, 2013; Neff, 2003a, 2003b). One of the most consistent research findings is a link between greater self-compassion and less psychopathology (Barnard & Curry, 2011). MacBeth and Gumley (2012), for example, found a large effect size when comparing the link between self-compassion and depression, anxiety, and stress across 20 studies. Moreover, self compassion has also been shown to improve interpersonal functioning. It is linked to such traits as more empathic concern, altruism, perspective-taking, and forgiveness of others (Neff & Pommier, 2013).

Mindfulness

Because both mindfulness and self-compassion have deep spiritual roots, and because both confer significant mental health benefits, the connection between the two is of increasing interest. Mindfulness usually is defined in terms of bringing one's complete attention to what is happening in the present moment in a nonjudgmental way (Brown & Ryan, 2003; Kabat-Zinn, 1990; Linehan, 1993a; Marlatt & Kristeller, 1999). For Kabat-Zinn (1993), mindfulness as a form of cultivating awareness has the aim of "helping people live each moment of their lives—even the painful ones—as fully as possible" (Kabat-Zinn, 1993, p. 260). Mindfulness, or nonjudgmental awareness of the present moment, creates a spaciousness in one's experience that enables greater awareness of and acceptance of "what is."

In recent decades, traditional Buddhist mindfulness practices have been adapted for secular use in health care settings; among them dialectical behavior therapy, (DBT; Linehan, 1993a, 1993b), mindfulness-based stress reduction (MBSR: Kabat-Zinn, 1982, 1990), mindfulness-based cognitive therapy (MBCT: Segal, Williams, & Teasdale, 2002), acceptance and commitment therapy (ACT: Hayes et al., 1999), and relapse prevention for substance abuse (MBRP: Bowen et al., 2009; Witkiewitz & Bowen, 2010; see also Marlatt & Gordon, 1985; Parks, Anderson, & Marlatt, 2001). Research increasingly supports the use of mindfulness-based interventions for a wide range of

populations and disorders (Baer, 2003; Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004; Robins & Chapman, 2004).

Epstein (1999) explains that mindfulness informs all types of professionally relevant knowledge, "including propositional facts, personal experiences, processes, and know-how, each of which may be tacit or explicit" (p. 833). In contrast, *mindlessness* may account for some deviations from professionalism and errors in judgment and technique. Epstein advocates that mindfulness, as a link between relationship-centered care and evidence-based medicine, be considered a characteristic of good clinical practice. Mindfulness is an extension of the concept of a reflective practice. Mindfulness is attending to the ordinary, the obvious, the present. For example, one becomes interested not only in a patient's disease but in how he or she lives in the world with it. The underlying philosophy is based on the interdependence of action, cognition, memory and emotion. Epstein states, "The goals of mindful practice are to become more aware of one's own mental processes, listen more attentively, become flexible, and recognize bias and judgments, and thereby act with principles and compassion" (p. 835).

MBSR

A Mindfulness-Based Stress Reduction (MBSR) program was initially developed and implemented in 1979 by Jon Kabat-Zinn (1990) at the University of Massachusetts Medical Center. Spanning 8 weeks, MBSR programs consist of weekly 2.5 hour-long classes and one "day of silence" between the 6th and 7th weeks. Participants learn various types of meditation practices, which they apply in class and at home to routine activities such as eating, driving, walking, and interacting with others. MBSR interventions are designed to teach participants to become more aware of and relate differently to thoughts, feelings, and body sensations, assisting them with cultivating a nonjudging yet discerning observation of the stimuli that enter their field of awareness, moment by moment (Shapiro et al., 2005). As the practitioner learns to let go of ruminations about the past and fears about the future, he/she learns to see habitual reactions to stress and to cultivate healthier, more adaptive ways of responding. While the goal of MBSR is to be present to whatever one's experience is at the moment, training in mindfulness attempts to increase awareness of thoughts, emotions, and maladaptive patterns of mind that render one more vulnerable to stress (Shapiro et al., 2005).

As stated, the goal of MBSR is nonjudgmental, moment-to-moment awareness, with the potential to help practitioners become less vulnerable to stress (Shapiro et al., 2005). In the field of counseling, Christopher, Christopher, Dunnagan, and Schure (2006) suggest that mindfulness can help counselors become less reactive to stress-related events such as when clients

are in crisis or are discussing painful emotions; instead, counselors can become more present and connect more intimately with themselves, their clients, and their supervisors.

Krasner et al. (2009) conducted a single-group cohort study evaluating the effect of a mindfulness and self-awareness curriculum on primary care physicians' burnout, empathy, and mood. Participants engaged in an intensive mindfulness program involving a 52-hour curriculum administered over one year; the curriculum included training in appreciative inquiry, narrative medicine, and mindful meditation. Results demonstrated increases in mindfulness skills and orientation. Correlated with improvements in mindfulness were durable improvements in burnout, mood disturbance, and empathy, suggesting that enhancing physicians' attention to their own experience concomitantly increases their orientation toward patients and reduces their distress.

Other studies of mindfulness for clinicians showed promising results, such as Irving et al.'s (2009) review of empirical studies of MBSR for health care professionals. Overall benefits of the 10 mindfulness studies reviewed included lower levels of perceived stress, decreased ruminative thoughts, and increased ratings of self-compassion.

Self-Compassion in the Context of Mindfulness

Enhancing a self-compassion focus in MBSR training is a prominent research agenda, in that both mindfulness and self-compassion involve promoting an attitude of nonjudgment towards one's experiences. Despite the conceptual overlap, however, most research on their psychological correlates and effects has been conducted independently. As an exception, the study of Keng, Smoski, Robins, Ekblad, and Brantley (2012) examined the independent roles of mindfulness and self-compassion in mediating the effects of MBSR. Results indicated that changes in mindfulness independently mediated the effects of MBSR on difficulties in emotion regulation, controlling for changes in self-compassion, whereas changes in self-compassion mediated the effects of the intervention on worry, controlling for changes in mindfulness. Both variables mediated the effects of MBSR on fear of emotion. The study findings highlight the importance of changes in both self-compassion and mindfulness as mediators of the effects of the intervention, and suggest that unique processes in MBSR are responsible for specific outcomes. The results indicate that enhancing focus on developing self-compassion in MBSR, or other mindfulness-based interventions, may bring about direct benefit in terms of reducing maladaptive cognitive coping tendencies and increasing the willingness to accept and experience emotions.

Two previous research studies utilizing Neff's Self-Compassion Scale (2003a) in an MBSR intervention for health care professionals warrant discussion. In the study conducted by Shapiro at al. (2005) in the United States,

38 health care professionals aged 18–65 were randomly assigned to either a MBSR group ($n = 18$) or waitlist control group ($n = 20$). The MBSR intervention was modeled after the aforementioned manualized treatment program developed by Kabat-Zinn (1982). In addition, a guided loving-kindness meditation was taught, in an attempt to help health care professionals develop greater compassion for themselves, their coworkers, and their patients. Significant between-group differences were observed on the Self-Compassion Scale ($p = .004$). Compared with the control group, the intervention (MBSR) group demonstrated a significant increase in self-compassion (22% vs. 3%). In the MBSR group, 90% of the participants demonstrated increases in self-compassion.

In Shapiro et al. (2007), data were analyzed for 54 participants (88.9% females) recruited from a Masters level counseling program, also in the United States. The average age was 29.2 years. Similar to the Shapiro et al. (2005) study, the active treatment group ($n = 22$) received a MBSR intervention modeled after the treatment program developed by Kabat-Zinn and colleagues (Kabat-Zinn, 1982), with the addition of a guided loving-kindness meditation. A control group ($n = 32$) was given a didactic, nonexperiential Research Methods and Psychological Theory course. Neff's Self-Compassion scale (Neff, 2003a; sample alpha = .94) was used to measure self-compassion based on the aggregate of responses on the 3 subscales: self-kindness/self-judgment, common humanity/isolation, and mindfulness/overidentification. Results indicated that participants in the MBSR intervention reported a significant increase in self-compassion relative to participants in the control group, with older MBSR participants showing higher self-compassion.

In sum, MBSR may lead to significant increases in self-compassion, and increases in self-compassion may predict decreases in perceived stress (Shapiro et al., 2005). In terms of possible mechanisms, Keng et al. (2012) posit that mindfulness allows for greater clarity in developing self-compassion, whereas self-compassion "clears the way" for mindfulness by reducing attention-interfering cognitions such as negative rumination. Clearly more research focusing on self-compassion in the context of MBSR and other mindfulness-based interventions is warranted.

CONCLUSION

Due to a multiple reasons (e.g., limited resources, the nature of the work, and a "caregiver" mentality), stress, burnout, and compassion fatigue will continue to be issues facing health care workers (Irving et al., 2009). Moreover, burnout has been associated with suboptimal patient care (Shapiro et al., 2005, Shapiro et al., 2006). Research suggests that mindfulness training for healthcare professionals can function as a viable tool for promoting self-care and well-being (Irving et al.). Increases in self-compassion as a result of

MBSR programs are particularly relevant to counsellors and therapists (Shapiro et al., 2007), since compassion for both self and clients has been posited as an essential part of conducting effective therapy (Gilbert, 2005).

Therapists who lack self-compassion and who are self-critical have been found to be more critical of patients and to have poorer patient outcomes (Henry, Schacht, & Strupp, 1990). In contrast, Shapiro et al. (2007) state: The effects of mindfulness training on positive affect and self-compassion found here may help to enhance professional skills, reflected in a greater kindness towards, and acceptance of clients and patients . . . " (p. 113). The most important ingredient in building a therapeutic alliance—without which change is unlikely to occur—is "directly related to the degree to which the therapist expresses empathy and compassion" (Figley 2002a, p. 2). Szalavitz and Perry (2010) acknowledge: "If we want to be kind to others or have others respond with empathy towards us, we need to minimize unpredictable and highly tense situations and maximize our ability to deal with ordinary stress. To encourage compassionate action, we need to create conditions and emotional states conducive to it" (p. 199).

We have seen that mindfulness interventions are important for their potential to reduce stress and burnout and increase empathy and self-compassion. Coming to terms with one's shortcomings is a prerequisite for compassionate care, as a caregiver who is unable to be compassionate toward self may encounter difficulties when confronted with perceived shortcomings of his or her patients (Gustin & Wagner, 2013). In this complex world of fast-paced technology and change, it is easy to lose sight of the human factor in health care. Todaro-Franceschi (2013) states: ". . . the nurse who is heart empty, or seemingly heartless, is . . . manifesting apathy and perhaps lethargy; she will be dispassionate carer and will not feel good about herself. She feels exhausted, energy depleted, and never goes home feeling like her job has been done well. She feels disheartened, hopeless, joyless, and numb" (p. 121).

Severe stress makes one less capable of making the best choices (Szalavitz & Perry, 2010). With that in mind, MBSR and self-compassion training are recommended for healthcare workers to decrease perceived stress and burnout and to increase self-compassion and empathy for patients. These positive benefits are likely to improve clinical care outcomes, albeit more research in this area is warranted.

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