

# Revisiting empathic engagement: Countering Compassion Fatigue with Exquisite Empathy

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*It is recognized that those working in end-of-life care are at risk for Compassion Fatigue and Burnout. While being seen as valuable clinical assets, emotional openness and empathic availability are frequently characterized as a liability to the clinician and a more distant professional demeanor as being protective. Recent research, however, challenges these assumptions and suggests that there is a particular form of empathic engagement that can be both protective and replenishing. This has been called “Exquisite Empathy”<sup>1</sup>. In this chapter the concept of Exquisite Empathy will be explored. We will examine, how, by participating in a program designed to enhance clinician self-awareness, it is possible to practice empathic engagement in a way that is mutually regenerative for patient and clinician. It is proposed that self-awareness based empathic engagement allows clinicians to be simultaneously heartfelt and protected in their clinical encounters.*

## *Introduction*

I would like to start this chapter by sharing my personal story as a clinician faced with the challenge of finding a model of self-care that allowed me to be emotionally protected in work situations and at the same time present for my patients, without getting hardened or burned out. For a long time I had felt a silent dissonance underlying my experience as a therapist, as a leader of groups for people with AIDS, and as a physician. My training emphasized the need to keep strict boundaries and distance; that becoming too close and too “loving” with patients would make me “less professional” as a clinician. I was also taught that less distant behavior would take a personal toll and leave me depleted and worn-out. My own heart as well as my Buddhist training in Loving Kindness and compassion told me otherwise and led me to doubt these commonly held assumptions. I shared these conflicting feelings with my co-author Michael Kearney, a palliative care physician, in the context of our planning to do some teaching together about professional relationships and empathy to groups of clinicians working in end-of-life care.

One evening, the discussion took a new turn. After a meditation group I had been leading ended, a man called Richard Harrison introduced himself to me. Richard was a clinical psychologist from the University of Vancouver, Canada, now working in the University of California in Santa Barbara. In the discussion that followed I learned that he had made a curious discovery in his dissertation research. One of his findings was that, under certain favorable conditions, a group of exemplary trauma therapists, all of whom had worked for a long time in their field, did not feel, as might have been expected, depleted and re-traumatized by their work with abused patients. Rather they

described how they felt replenished by doing meaningful and heartfelt work. Richard and his colleague Westwood identified a number of protective practices that appeared to explain this. One of these was a certain type of empathic engagement, which they called “Exquisite Empathy”. These findings challenged the prevailing wisdom that being empathic makes the clinician more vulnerable in the therapeutic encounter<sup>2</sup>. Among other protective practices identified by Richard and his colleague were that these therapists had developed ways of countering isolation, embracing complexity and holistic self-care. What particularly caught my attention was that a common theme underlying all these practices appeared to be clinician self-awareness.

Interestingly, at just this time I was invited to participate as a co-author on an article on the self-care of physicians working in end-of-life care. Recognizing the unique contribution that Richard’s findings brought to this discussion I suggested that he might also come on board as co-author, which he did. The article was published in the Journal of the American Medical Association in March 2009<sup>3</sup>.

Even though Richard Harrison’s findings are only valid for a relatively small study population, they seem to speak to a larger philosophical, socio-political, and ethical conundrum; the tendency for clinicians to categorize, objectify and therefore separate themselves from their patients, which appears to be embedded in wider cultural, philosophical and economic principles of our society. My own view, based on 20 years of clinical practice, is that, rather than being protective, a standoffish and distant professional demeanor may actually be damaging for both the patient and the clinician. Perhaps, rather than finding protection in distancing, what we need both individually and

collectively, in this social climate that seems to be becoming colder, with fear seeping in through the cracks of our social and political fabric, is a new way of relating. Is it possible to find a way of being open, loving and sensitized in our relations with others, while at the same time being protected? If so, such a new way of relating would have to strike a delicate balance between caring for ourselves and being open to the world we encounter.

### *Burnout*

Burnout may result from stresses that arise from the clinician's interaction with their work environment, or from the mismatch between corporate values and those of the individual<sup>4</sup>. As one medical oncologist put it, "The stuff that burns me out has nothing to do with loss ... It's fighting with insurance companies ..." (Kearney et al., 2009, p.1156). Other examples of the "stuff" of Burnout might include too much work, too many long days, having to attend to too many people in too short of time, too little time to recuperate, and too little support from others. Clinicians suffering from Burnout might experience overwhelming physical and emotional exhaustion, feelings of cynicism and detachment from their job, coupled with and a sense of ineffectiveness and a lack of accomplishment<sup>5</sup>. Other symptoms of Burnout that have been reported include poor judgment, over-identification or over-involvement, boundary violations, perfectionism and rigidity, interpersonal conflicts, addictive behaviors, frequent illnesses that include headaches and gastrointestinal disturbances and immune system impairment (Maslach et al., 2001). Clinicians who burn out may even question the meaning of their lives and their prior religious beliefs<sup>6</sup>.

### *Compassion fatigue*

In contrast to burnout, “Compassion Fatigue” evolves specifically from the relationship between the clinician and the patient (Figley, 1995, p7). Compassion Fatigue is also described as Secondary Traumatic Stress Disorder, the hypothesis being that clinicians can be traumatized by getting too close to their patients’ suffering (Figley, 1995). In the process, a clinician’s own unresolved trauma-material and unconscious unresolved childhood conflicts can be stimulated<sup>7</sup>. The symptoms of Compassion Fatigue include those of Post Traumatic Stress Disorder (PTSD) such as increased arousal, irritability and hyper-vigilance, difficulty concentrating, re-experiencing memories of difficult clinical situations, avoidance of similar ones, intrusive thoughts, sleep problems including nightmares, social withdrawal and even numbness or disassociation<sup>8, 9</sup>.

In a view that has broad acceptance, the caregiver’s empathy level with the traumatized individual plays a significant role in this transmission (Figley, 1995) and<sup>10</sup>. The implication here seems to be that we may be better off not giving too much, and keeping ourselves well-protected behind strict professional boundaries. Yet, we also observe the increased isolation, alienation, emotional drying up, disenchantment and lack of enthusiasm in many clinicians. Even caring work can become drained of meaning, and begin to feel more like a business, beset with management-challenges, just like all other professions. Could it be that emotional distancing as the primary strategy of professional self-protection is, in fact, actually exacerbating the very problem it is intended to help?

## *Exquisite Empathy*

The concept of Exquisite Empathy offers another possibility. It suggests that it may be possible to give more of ourselves in our clinical encounters, if we do this in the right way, and that this could be enriching and healing for both patients and clinicians. In their paper, Harrison and Westwood report that “most of the clinicians described how intimate empathic engagement with clients sustains them in their work” (Harrison and Westwood, 2009, p.13) They continue “When therapists maintain clarity about interpersonal boundaries, when they are able to get very close without fusing or confusing the patient’s story, experiences, and perspectives with their own, this exquisite kind of empathic attunement is nourishing for therapist and client alike, in part because the therapists recognize it is beneficial to the clients. ... Participants who engaged in Exquisite Empathy describe having been invigorated rather than depleted by their intimate professional connections with traumatized clients” (Harrison and Westwood, 2009, p.213). I believe that Harrison and Westwood’s findings are relevant in a wide variety of clinical contexts. Indeed, one could postulate that the concept of Exquisite Empathy is relevant beyond the clinical setting for many of our human interactions.

Exquisite Empathy is described as empathic engagement that is, “discerning, highly present, sensitively attuned, well-boundaried and heartfelt” (Harrison, 2009, p.213). This is a quality of relationship that one can develop towards oneself, towards others, and towards the world. The concept of Exquisite Empathy could be seen as a contemporary, psychological re-visiting of Martin Buber’s idea of an “I-Thou” relationship.<sup>11</sup>

### *The practice of Exquisite Empathy*

We need to consider how to develop, over time, the skills that will enable us to practice Exquisite Empathy in the present moment. Comparable to learning to meditate or play the violin, the successful practice of Exquisite Empathy is made possible and enhanced by developing a very particular skill set. The practice of Exquisite Empathy is facilitated by clinician self-awareness (Harrison and Westwood, 2009). Clinician self-awareness, in our definition, involves four overlapping and complementary practices: the practice of self-knowledge; the practice of self-empathy; the practice of preparing the mind through Mindfulness practice; and the practice of contemplative awareness.

#### *Self knowledge*

Following the Delphic imperative to, “Know thyself!” self-knowledge prepares the ground for clinician self-awareness. This includes becoming familiar with one’s family history, one’s cultural, racial and religious history, as well as one’s individual talents and challenges. Having deep insight into our background allows us to work through emotional challenges so that these will not get repressed or projected onto others. This also includes knowledge about our emotional lives, why and when we shut down, of our capacity for openness, and especially, of our places of emotional reactivity.

It may be helpful for the clinician to engage in psychotherapy with a skilled psychotherapist. Within a secure and confidential therapeutic container, the patient finds the security to open up and to explore. Psychotherapy increases the patient’s awareness, enables her/him to recognize habitual patterns of reaction, and opens the possibility of

choosing other possible responses to a given situation. It helps her/him to better manage distress and discomfort and encourages clear thinking on how to improve communication and relationships.

Within the psychotherapeutic relationship unconscious processes can be made conscious, and distressing emotions associated with painful family histories can be worked through. In this way the unconscious phenomena of “transference” and “counter-transference” can be recognized and named, bringing greater insight to both patient and clinician. Transference is characterized by the unconscious redirection of feelings from one person to another, for example, from patient to clinician. Transference can be seen as a re-emergence of emotions, which originate in repressed experiences especially those from childhood. Then the clinician appearing in the patient’s life can be substituted for the original object of repressed impulses. For example, it was difficult for a female patient, Sarah, who had been deeply traumatized by her father, to see her male doctor as a benign figure and allow his help, as her fear lead her to *transfer* unconscious feelings of mistrust of her father onto her doctor.

Counter-transference, in contrast, addresses unconscious feelings that might arise in the clinician, stimulated through contact with the patient. Counter-transference could be seen as the inappropriate repetition in the present of a relationship that was important in a person's past. For example, a doctor, who had a complaining, self-important and always sickly mother, and who was unaware that he was repressing feelings of frustration towards her, might have trouble feeling true empathy for certain female patients, especially those, who have some resemblance to his mother. Awareness of his



unconscious feelings and addressing them with a therapist, might allow the therapeutic relationship to be freer, healthier and much more rewarding.

Clinical supervision, where the clinician meets regularly with another professional who possesses greater training and experience to discuss casework and professional issues, and ongoing continuing education, which helps the clinician to stay current with newly emerging treatment approaches and to deepen her/his understanding about cultural, sexual, political and spiritual issues, are also ways of increasing clinician self-awareness.

### *Self empathy*

Self-empathy is a form of self-knowledge that involves being aware of the state of one's own heart. This may include noticing the degree to which we are open to affection from others and when we shut down. Self-empathy also includes noticing how critical we are ourselves, and how hard it is to accept our imperfections and mistakes with an attitude of warmth and self-acceptance, and a commitment to find a way to end that suffering in ourselves. Self-empathy is not just about self-care. It also affects the quality of our empathic connection to others, "Self-empathy opens the way to interpersonal empathy."<sup>12</sup>

Certain practices from the Buddhist tradition are particularly helpful in developing self-empathy. Self-empathy is enhanced by deliberately adopting a self-compassionate attitude towards ourselves while practicing Mindfulness Meditation. Sharon Salzberg writes, "The heart of compassion is known in Buddhist teaching as the quivering of the heart in response to pain or suffering."<sup>13</sup> Metta or Loving-Kindness Meditation is an explicit practice of opening the heart with empathy and compassion. This practice is an

effective way of balancing the presence and wisdom developed through Mindfulness Meditation. In his writings, psychologist and Buddhist teacher Jack Kornfield suggests, that one needs to feel tenderness, mercy for all that arises within ourselves that is painful, confused, shameful, or frightened. He writes, "Compassion for our own fear and shame opens us to others."<sup>14</sup> He continues, "Love is our true nature, but as we have seen, it is covered over by a protective layer of fear. Even though this love is innate, the Buddhist path also uses systemic trainings to cultivate this love. They strengthen our capacity for love, compassion, joy, and peace." (Kornfield, 2008, p.386)

The purpose of Metta meditation is to actively cultivate kindness and compassion for oneself and others through mindful and heartfelt repetition of certain phrases that are traditionally used. We begin by directing love and kindness towards ourselves:

- May I be filled with love and kindness
- May I be safe and live my life with ease
- May I be well in body, heart, mind, and soul
- May I be peaceful and truly happy

There are ways you can expand on this meditation. You can send your good wishes to your family, friends, neighbors, or to people you feel neutral about. You can also apply this meditation to people you find challenging, for example towards those to whom you feel an aversion. You may extend your well-wishing to all beings, humans and animals. Be gentle and patient with yourself as you do this. You may choose to dedicate this practice, for example, to the expansion of your heart and the heart of the world.

When practicing Metta or Loving-Kindness meditation, one needs to be careful, so that the practice stays authentic and truthful, and one does not fall into wishful thinking. Therefore, three steps are recommended. The first involves setting the intention to wish ourselves or another well. The next step involves our slowly and silently repeating those phrases of well-wishing towards ourselves and others described above, while infusing our words with feelings of good-will. This may prove to be difficult if not impossible, especially for individuals who have had neglectful or traumatic pasts, or are so hurt in their sense of self, that wishing themselves or others well turns out to be impossible. As a third step we can notice this is so and realize that we can choose to accept that is what true for us at this time.

Another Tibetan Buddhist meditation practice, “Tonglen”, describes a way of connecting with suffering, our own and that of others that can lead to a deepening sense of compassion. The practice of Tonglen can lead to a transformation in our relationship to suffering, such that we are no longer so fearful of it, and to our needing to have a less defended heart.

The practice of Tonglen begins by bringing mindful attention to another who is suffering. As we come to sense this person, our inhalation is infused with the wish to take away all the pain and fear of that person. As we exhale we send the suffering patient happiness, health or whatever might relieve their suffering. In practicing Tonglen we may notice that we are inhibited by our own fear, resistance, anger or personal worries. In this case it may be helpful to extend the practice to ourselves. As we become aware of

our particular suffering, we may keep in mind others who at this moment are having similar experiences. Then our breathing in becomes an act of well-wishing not just for ourselves but for all the people who are caught in similar experiences of suffering, and our exhalation an act of sending out relief to both ourselves and others. The practice of Tonglen reverses the usual logic of avoiding suffering and seeking pleasure, helping us to move beyond self-preoccupation to a more compassionate and inclusive perspective.

A final meditation practice from the Buddhist tradition that may be helpful in developing self-empathy is the practice of “Shen-Pa”, as described by Pema Chodron<sup>15</sup>. In Shen-Pa Meditation, one learns how to experience and hold the physical sensations accompanying strong emotions or thoughts. An underlying premise to this practice is that tactile sensations precede thoughts and emotions. Therefore, as we learn to recognize, face and experience uncomfortable physical sensations, for example a tightness around the heart, and to simultaneously refrain from avoiding or fighting this, or of dissociating from it, we may begin to develop a relationship with the painful complex of which the physical sensation is a somatic expression, become intimate with it, and overcome our fear of it.

### *Preparing the Mind*

For the purpose of teaching the practice of Exquisite Empathy we differentiate three aspects of training the mind: focused-awareness, mindful-self awareness and dual-awareness. *Mindfulness Meditation* practice can be used to cultivate these three cognitive skills, which are synergistic with one another. Jon Kabbatt-Zinn, whose

teachings derive from the Theravaden Buddhist tradition, describes Mindfulness Meditation as a process of developing careful attention to minute shifts in body, mind, emotions, and environs while holding a kind, non-judgmental attitude towards self and others.<sup>16</sup>

*Focused awareness* is the platform from which we prepare the mind and is taken here to mean the stabilization and direction of attention. Alan Wallace, coming from the Tibetan Buddhist tradition, writes, “From a Buddhist perspective, the untrained mind is afflicted with attention deficits and hyperactivity; it is dysfunctional. Like a wild elephant, the untamed mind can inflict enormous damage on ourselves and those around us.”<sup>17</sup> He describes the first stage of gathering the mind as directed attention. “The sign of having reached the stage is simply being able to place your mind on your chosen object of meditation for even a second or two.” (Wallace, 2006, p.14) Wallace emphasizes the importance of deep relaxation, stabilization of the mind and an attitude of vividness in his method of teaching mindfulness of breathing. The core-practice is simply described: “Mindfulness of breathing means settling your awareness on the sensations involved in breathing, continually returning your attention whenever your mind wanders” (Wallace, 2006, p. 6-7) While the breath is the primary touchstone, we learn to simultaneously notice and name whatever thoughts, feelings and sensations may arise. This practice, which Wallace describes as settling the mind in its natural state, enables us, over time, to allow the activities and manifestations of the mind go by without grasping them.

*Mindful self-awareness* arises naturally from focused awareness and is described as a “non-judging, respectful awareness” that enables us to witness the stream of our thoughts,

physical symptoms and feelings and, at the same time, to notice when we are reacting, comparing and evaluating. Through mindful self-awareness we learn to be with ourselves with kindness and without commentary or judgment.

Kornfield proposes using the tools of recognition, acceptance, investigation and non-identification (R-A-I-N) to develop mindful self-awareness. *Recognition* refers to “the willingness to see what is so.” (Kornfield, 2008, p.102). Recognition of physical sensations precedes recognition of thoughts and feelings e.g. a sensation of tightness around the heart or the sensation of a tight knot in the stomach precedes the thought that we are scared or upset. “*Acceptance* allows us to relax and open to the facts before us” (Kornfield, 2008, p.102). Without acceptance and self-compassion the sudden awareness of our internal process including the multitude of sensations, feelings, thoughts could be overwhelming and discouraging. Through *investigation* we can become aware of, “what is happening within our body, we can notice what feelings are part of this journey and look into the mind and see what thoughts and images are associated with this experience” (Kornfield, 2008, p. 104). As we investigate our experience without analysis, investigation or judgment, we can learn to respect and even befriend them. *Non-identification* means to stop taking our experience so personally. When we are less attached to our experience as “me or mine” we are freer allow what is. “Without identification we can respectfully care for ourselves and others yet we are no longer bound by the fears and illusions of the small sense of self” (Kornfield, 2008, p. 106). Non-identification may allow us to recognize the impermanent and universal nature of experience.

Developing mindful self-awareness through the practice of mindfulness meditation allows us to carry the skill of being present and introspective into the rest of our lives. We can then apply being mindfully present to moments of challenge, including interactions with patients, clients, neighbors or relatives. Having a regular practice of mindfulness meditation allows us to carry the skill of being present and introspective into the rest of our lives

*Dual awareness* is a cognitive stance that permits the clinician to simultaneously attend to and monitor the needs of the patient and/or the work environment and his or her own subjective experience. In other words, it is the ability to be simultaneously aware of one's inner and outer experience without reactivity, or at least with the ability to be conscious of one's reactivity. In practice it means being able to notice our thoughts, feelings, body sensations, triggers and reactions, while simultaneously holding our outer experience, including how we experience the person in front of us, without being drawn into or overwhelmed by that experience unwillingly.

The skill of dual-awareness takes a lot of practice and presence of mind, yet it can be learned through meditation practice and good instruction. Dual-awareness builds on the practices of focused-awareness and mindful self-awareness. Through focused and mindful self-awareness we attend to and witness our experience in a non-judgmental way. As we do so we may notice moments of expanded awareness, when we are aware that we are aware of the object of our focused mindfulness, or possibly that we have just been distracted by a thought. This is dual-awareness, also sometimes referred to as "meta-attention". With time and practice we can deliberately chose this cognitive stance

and use it to monitor the quality of our attention in meditation practice. As we become more experienced in “shifting gears” between focused and mindful-awareness and dual-awareness we can begin to bring our awareness to our inner and outer reality at the same time and use this skill in clinical and social contacts as a means of self-monitoring and self-awareness. Developing the skill of dual-awareness helps to prevent us from getting trapped in reactivity or self-preoccupation, or over-identified with the other in the relationship, or trapped in “tunnel vision” where we get so engaged with the other that we lose sight of the whole *gestalt* of the situation. . Dual awareness is also being used in the field of trauma therapy as a means of countering the dissociating effects of PTSD. Babette Rothchild describes how this works: “Developing or reconnecting with the ability for dual awareness enables the client to address a trauma while secure in the knowledge that the actual, present environment is trauma-free. It is an extremely useful tool for healing discrepancies between the experience and observing selves.”<sup>18</sup> In other words through dual-awareness a client can be grounded in the safety of the present moment while simultaneously attending to the unsafe content associated with the trauma event. This may also have relevance in the treatment of compassion fatigue/secondary traumatization.

### *Contemplative Awareness*

Contemplative awareness is an awareness of how we as individuals are situated in a larger field of relationships. Psychologically this is sometimes referred to as the intersubjective field. Spiritually, this could be seen as a meaningful field of interconnectedness. In various religious traditions contemplative awareness could be seen as



the experience of our relationship to the sacred. It includes becoming aware how we find meaning through our values, our spiritual ethics and our cosmology or philosophy of life.

Martin Buber's concept of "I-Thou" shows great humanism embedded and spiritual wisdom and speaks to the spiritual underpinning of relating in a heartfelt way that is rooted in contemplative awareness. In his book "I and Thou"(1970), Martin Buber distinguishes between two types of interpersonal relationships. In the first of these, which he calls the I-It relationship, we relate to others as objects or members of categories. In the other, in the I-Thou relationship, we relate with the entirety of our being to another whole person within the context of a deeper field of connectedness and with an understanding of the sacredness of the other. Buber writes, "When I confront a human being as my "Thou" and speak the basic word "I-Thou" to him, then he is no thing among things nor does he consist of things. He is no longer He or She, limited by other He's and She's, a dot in the world grid of space and time, nor a condition that can be experienced and described, a loose bundle of named qualities. Persons now appear by entering into relation to other whole persons" (Buber, 1970, p.15). For Buber an I-Thou way of relating is a sacred process.

Assuming that we are embedded not only within a deeper field not only of sacred connectedness but also of the potentially desensitizing effects of personal, collective and cultural assumptions, how can we, as clinicians, be truly present to our fellow humans? How can we as clinicians, caregivers and educators come into an "I-Thou" relationship with the people we care for and work with? Perhaps the first and necessary step is to engage in a process of re-sensitization.

## *The contribution of Buddhist Psychology*

Within a Buddhist worldview everything and everybody is ultimately interconnected, co-dependently arising and disappearing in a meaningful way. The view that we are autonomous individuals who can treat others as separate is seen as a misconception, a distortion of consciousness that leads to suffering for everyone involved. From a Buddhist perspective, therefore, the more we can be aware of our interconnectedness and live from that consciousness, the more peace and freedom we can have, experienced as kindness, generosity and compassion.

Through the practice of Mindfulness Meditation we learn to attend to physical sensations and emotions, closely noticing as they arise, dissolve, and catalyze other feelings. We also learn to track when and how emotions trigger other reactions. In this way we come to see how all the processes of the mind are part of a larger interconnected process of perception. As we persist in our practice we may come to experience and see how our individual awareness is interconnected with other wider and deeper fields of consciousness. In this philosophy we ultimately do not exist in separateness and the fate of the individual affects others and the world at large. Learning to witness this process through mindful-self-awareness can allow us to experience increased inner spaciousness and peace, and provide a possibility of living in balance within the bigger community of beings. Buddhist philosophy is not unique in having this perspective. Many of the mystical paths of the world's great religious traditions share the view of the interconnectedness of all beings and the meaning that needs to be created to find

freedom. However, the Buddhist tradition does make available a number of meditative practices that can be extremely useful in a contemporary clinical setting.

*Exquisite Empathy: The practice of self-awareness in the present moment*

Clinician self-awareness makes the practice of Exquisite Empathy in the moment possible. The practice of Exquisite Empathy involves mindful self-awareness and dual-awareness in practice. It may be helpful to reflect on these different aspects of Exquisite Empathy in more detail.

*Highly present:* Through Mindfulness Meditation we learn to hold focused attention in the present moment; noticing physical sensations, emotions, thoughts and the environment we encounter, and to do so without being self-critical, judgmental, distracted or impatient. Being mindfully present to physical and mental perception in this way grounds us in the present moment and in a heightened quality of presence. The relationship with our clients will then be qualitatively different because of this degree of presence.

*Sensitively Attuned:* When the clinician has acquired self-knowledge, and through dual-awareness is mindful of both her or himself and the client in a highly present and empathic way, then the clinician is able to attune to that particular client with great sensitivity. When sensitive attunement is practiced within a cosmology of the interconnectedness and meaningfulness of life, we may notice how our lives are not separate from each other but instead are part of a much broader Gestalt. This, in turn,

may infuse the relationship with compassion and heighten the sensitivity of our attunement to the other.

*Well-boundaried:* Being “well-boundaried” does not only mean holding the necessary legal and ethical boundaries. In a broader sense it also means knowing the limits of what one can and cannot do. The Serenity Prayer used by Alcoholics Anonymous says, “May God grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference”. Making an accurate assessment of the clinical situation and accepting the limits of our clinical competence helps to create a safe container for the interaction, in which client and clinician can feel relaxed and open towards each other. Besides the obvious professional boundaries, clinicians also need to be aware of their internal limits and reserves, of what they can or cannot give.

Sometimes the most compassionate thing to do is referral to someone else who can provide what is needed. “Well-boundaried” might also mean awareness of transference feelings of the client towards the therapist as it rises in the moment of their meeting.

*Heartfelt;* Self-awareness also leads to an awareness of the state of our hearts. Most of us have habitually a shield of protection around our emotional core. Mindful self-awareness affords us a degree of emotional protection. Therefore, through mindful self-awareness we can learn to allow our shields to become more porous, our self-protection to be less rigid. While we are still protected when it is necessary, warmth can infuse the interpersonal dynamic allowing for the practice of Exquisite Empathy, and an “I-Thou” relationship with the other person.

*What does Exquisite Empathy look like at the bedside?*

Dr. X. is an internist whom I see in clinical supervision. One day he talks about the case of Jodie, a forty-two year old woman, who was known to have carcinomatosis peritonei of the cecum. Widowed five years earlier when her husband died of a malignant melanoma, she had two children and worked as a journalist. She had been brought up Roman Catholic but was no longer practicing. When the doctor and nurse visited her at her home, they found a gaunt and frightened woman who complained of severe abdominal pain, nausea and vomiting. Her family doctor had referred her to the palliative care unit for symptom management and emotional support while nearing the end of her life. Following admission her physical condition at first became a bit more stable, however, she became extremely emotionally distressed. “This is the last straw”, she said, “I feel utterly degraded...do you call this “dying with dignity?”

Over the next few days Jodie remained greatly distressed and seemed inconsolable despite constant attention from her family and the ward staff. When Dr X. set down at her bedside, she told him, “Doctor what are you going to do to help me ... I am in agony ... even the stronger pain killers you gave me made no difference ... I feel I am going crazy ... nothing helps ... I don’t want to die ... What have I done to deserve this ... promise me you won’t let me die ... Promise”.

In talking with Dr X. in clinical supervision, he remembered this as an extremely difficult situation for him. As we reflected on the situation, we realized that he could have reacted to Jodie in one of two ways. He could have avoided being with her by referring her another physician or to other members of the interdisciplinary team (*a flight*

reaction). Alternatively, he could have medicated Jodie to point where she, and he, was out of pain (the *fight* reaction). In fact, he had done neither of these. He remembers feeling overwhelmed, numbed, and slightly dissociated but it was at this point that his training in self-awareness proved to be immensely helpful.

Through self-knowledge he was able to recognize that he was extremely stressed and that he needed to step back, which he did by saying that, while he could sense her great distress, he was going to think about what else he could do to help her, and that he would come back to see her later that day. As he reflected on this situation he became aware that it always had been very hard for him to treat women who were the same age as his mother when she had died, and that the urge to save such women was extreme. His training in self-empathy allowed him to feel compassionate towards himself as he recognized the counter-transference in his feelings towards Jodie. This allowed him to feel more gentleness towards himself concerning his inability to help Jodie.

When reflecting on the contribution of his 12 years of training in Mindfulness Meditation, he could see how this made it a bit easier for him to stay present and emotionally open with a difficult situation without becoming detached, closed down or self-critical. While sitting with Jodie in her despair, through dual awareness he was able to distinguish her panic from his own distress and to identify his need to find a way of responding that would both offer her some reassurance and allow him to step back for now.

Dr X's spiritual understanding and the contemplative awareness this provided him with helped him to see that as humans we are not meaningless specks and that our lives

are interconnected in mysterious ways we do not and perhaps cannot understand. It situated what was happening clinically in a bigger and deeper context. This allowed him to appreciate Jodie for who she was and to let her go to her journey as she entered uncharted territory and total uncertainty.

Dr X. returned to Jodie's bedside and was part of her care in her final days. The capacities of self-awareness he had developed helped him to sit and be present with her in her suffering, without dissociating, feeling overwhelmed, or over-reacting. Even though Dr. X was painfully aware of the limits of what he could do to help Jodie, she and her family commented how valuable his support was. He remembers sitting with Jodie late one afternoon, holding her hand and breathing with her. He experienced a moment of peace, and it seemed that Jodie did too.

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In finishing, my hope and intention for this chapter is that it might help clinicians to engage empathically in more human, sensitive and effective "I-thou" relationships, and that it might contribute to greater well-being, especially for those who are vulnerable.

## References

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Sometimes their empathy tanks can feel empty. Compassion Fatigue - The American Institute of Stress. "We have not been directly exposed to the trauma scene, but we hear the story [and]" Empathic connection with one's patients is essential to genetic counselor clinical practice. However, repeatedly engaging with distressed patients may cause compassion fatigue, a phenomenon characterized as feeling overwhelmed by experiencing patients' suffering. In order to extend findings of an initial qualitative study, we surveyed 222 genetic counselors about their compassion fatigue and factors that predict its occurrence. We begin by introducing compassion fatigue in caregivers as a form of pathological altruism. We move on to introduce such relevant concepts as empathy, compassion, empathic concern, and distress; we then review relevant empirical findings from social and developmental psychology and social neuroscience. Finally, we propose a new integrative model that suggests that the term compassion fatigue should be replaced by the term empathic distress fatigue to more accurately account for symptoms of withdrawal and burnout. We conclude by outlining potential ways to circumvent the downside of too much e... Compassion fatigue is a condition characterized by emotional and physical exhaustion leading to a diminished ability to empathize or feel compassion for others, often described as the negative cost of caring. It is sometimes referred to as secondary traumatic stress (STS). According to the Professional Quality of Life Scale, burnout and secondary traumatic stress are two interwoven elements of compassion fatigue. Pity, Sympathy, Compassion & Empathy. What feelings rise up within you as you see someone in need and/or in pain? The answers are what we are going to compare and contrast here. Empathy is the capability to share your feelings and understand another's emotions and feelings. It is often characterized as the ability to "put oneself into another's shoes," or in some way experience what the other person is feeling. Some other definitions of Empathy are: 1. the intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another. 2. the imaginative ascribing to an object, as a natural object or work of art, feelings or attitudes present in oneself. Compare & Contrast.