Chapter 8

Self-Compassion

This chapter reflects on the nature and importance of self-compassion. Occasionally, terms such as 'self-care' or 'self-compassion' are misunderstood as looking after oneself in a selfish or self-absorbed way. Sometimes, these concepts conjure up images of bubble baths, comforting oneself with ice cream or chocolate, or pursuing 'self-care' in a purely 'selfish' way. This is especially true in the caring professions, where there is often a sense that if we do not put other people first at all times, we are not good team members or we are too self-absorbed.

Self-care is, however, far from selfish. Without self-care, there can be no other care. The familiar safety announcement on airplanes applies in medicine: 'Please ensure you put on your own life jacket before looking after the life jackets of others, including children.' This means using self-compassion to replenish our sense of compassion for others and to renew our vocational enthusiasm. An empty, depleted, exhausted healthcare provider cannot care for other people in a meaningful, complete, or compassionate way. We cannot pour from an empty cup.

When we are exhausted or worn out, we make mistakes. We cannot recall information that is usually at the tip of our tongues. Staff who work lengthy shifts in hospitals or elsewhere take longer to perform tasks towards the end of their shifts, compared to the start. The work is also less precise, less focused, and less compassionate. Too often in these situations, we simply see the task at hand (e.g., suturing, prescribing) and not the person who is sick, injured, or worried. This is especially true when our own basic needs (e.g., food, rest, sleep, relationships) have not been met or have been set to one side owing to the pressures of work.

Against this backdrop, this chapter explores the concept of self-compassion, the idea of moral injury, and ways of navigating complex healthcare roles with self-awareness, kindness, and greater compassion. The chapter starts by examining the concept of self-compassion, especially in healthcare settings. It then explores the idea of 'moral injury', which stems from situations in which a person has to make choices that go against their core values and can corrode compassion. The chapter then outlines how to manage the risk of moral injury in these situations, how to boost self-care for staff in clinical settings, and the importance of self-compassion when managing or living with difficult experiences and situations, especially on a recurring basis.

What Is Self-Compassion?

Self-compassion refers to the ability to act in a compassionate way towards ourselves when we are suffering. It involves recognising our suffering, being moved by it, and offering kindness and understanding towards ourselves. Human beings can be our own worst

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enemies and our own toughest critics. When we make mistakes, we berate ourselves with a severity that we would not apply to other people. When we are exhausted, we punish ourselves harshly and relentlessly. We forgive others, but not ourselves.

Pause to reflect for a moment. If your child or your close friend made a mistake, would you speak to them in a harsh, judgemental way? Or would you say something along the lines of: 'You made a mistake. That's human. Everyone makes mistakes. The important thing is to be kind to yourself, learn from the mistake, and move on'? Self-compassion involves turning that kind voice towards ourselves. This can be easier said than done. In many cultures and settings, we tend to be harsh and critical towards ourselves, and can see kindness as a form of weakness.

The journey to being a person with greater compassion, a person who thrives in the demanding world of healthcare, can only start with self-compassion. No matter what area of health we work in, we have moments, hours, days when everything is difficult. It feels like nothing will ever change. It feels like the health system is working against us and against our patients, rather than striving to help and heal. It feels as if there is no compassion anywhere, and certainly none for us.

In addition, we struggle to accept that we make mistakes. Clinical practice is complex, so, intellectually, we understand that a certain amount of error is inevitable. We know this. Even so, we still blame ourselves for every near miss, every minor omission, every mistake. We do not expect perfection from other people, but we demand it of ourselves.

Even when we do our best and make no mistakes, many patients will still suffer, and some will die. We work in environments where hard choices have to be made: If I give the last remaining bed in the intensive care unit to this patient, it means another patient will not access that level of care. If I take this trauma patient into theatre, my time, energy, and resources are tied up here and cannot be used elsewhere. If I give my last emergency out-patient appointment to this patient and another urgent case is referred, I need to either arrange alternative care, revise my original decision, or somehow ration healthcare resources in a way that is fair.

This might be simply impossible to do. Moreover, I might never know if I have done it well. I might only reflect on this decision if there is a dramatic adverse event, such as a patient death. I am unlikely to congratulate myself on a good decision if all is well, because there will be no dramatic event to trigger my reflections. Most likely, I will never know if I made the correct decision in a given situation. I will simply move on to the next patient, the next scenario, the next impossible choice. This is the nature of modern healthcare, in which clinicians are continually placed in situations that require rationing decisions, often described as 'clinical judgement' but more properly described as 'clinical judgement *and* implicit rationing of healthcare resources owing to limits on services'. We continually face impossible choices.

This situation carries substantial risks, not least because, in these circumstances, treatment decisions about individual patients are shaped by three factors, only one of which is related to the patient themselves: (a) the patient's clinical needs, as assessed by the clinician; (b) other patients' clinical needs, as assessed by the clinician; and (c) resources available for all patients, as determined by service providers. As a result, while most patients and families believe clinical decisions are based solely on the patient's needs, this is not the case. This dilemma has many consequences, including placing healthcare professionals in situations where they are at risk of what is increasingly termed 'moral injury'.

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Moral Injury

Moral injury is a term used to describe when a person has to make choices that go against their core values (Dean et al., 2019). The term was originally used in the military for situations in which a person is faced with decisions or behaviours that are inconsistent with their beliefs, such as killing innocent people in the course of a military operation. On returning from such operations, evidence-based psychological treatments for post-traumatic stress disorder do not necessarily help in relation to this kind of issue. Indeed, re-living the experience might cause more distress because it can heighten the cognitive dissonance experienced when the person recalls the actions that conflicted with their values or beliefs in the first place. Particular care is needed in these situations, along with peer support.

Following moral injury, useful interventions can include facing up to what happened and making amends for it in some way, or campaigning to try to ensure that other people will not face similar, often impossible dilemmas in the future. This process can involve acceptance of the experience, honest acknowledgement of the limited options at the time, and integration of the experience in the full context of a person's life and work. We can sometimes overestimate our options, especially in retrospect, when we repeatedly re-live decisions that we made in particular contexts, often under significant pressure. We are harsh judges of our own past actions.

There are many different varieties of moral injury, ranging from moral injury resulting from a single large decision on the one hand, to a sustained pattern of smaller but still conflictual decisions on a day-to-day basis on the other hand. The latter can lead to a slow, almost imperceptible accumulation of moral distress, resulting in moral injury that might come as a surprise when it eventually manifests, but has been developing over weeks, months, or even years. Both patterns of moral injury present cause for concern and both merit close attention.

By way of example of the first kind of moral injury, if a person is a member of a jury in a trial, and if the death penalty is the consequence of a 'guilty' verdict, it is likely that a jury member who opposes capital punishment will become distressed or even traumatised at their potential role in sending a person to their death.[1] During such proceedings, there can be a realisation of the common humanity of the perpetrator and the conditions that led to their committing the offence and being in the court room. This realisation can co-exist with deep sympathy for the victim and their bereaved family, and profound revulsion at the nature of the offence. Even so, there can be feelings ranging from ambivalence to outright opposition to the likely death sentence, resulting in moral injury for the juror when trying to reach an accurate verdict, despite its consequences. Later, it can help the juror to face up to such a decision clearly, acknowledge their limited options at the time, seek forgiveness or resolution if necessary, and campaign to ensure that others are not placed in a similar position in the future (e.g., work towards the abolition of capital punishment).

In healthcare, difficult, conflictual decisions can be less dramatic and less clearly drawn, but cumulative moral injury can nonetheless occur. In a chronic, recurrent way, healthcare professionals can repeatedly face decisions that challenge their core desire to help every patient equally and optimally. This is especially common in large healthcare delivery

[1] For a discussion of some of these matters, see: www.ted.com/talks/lindy_lou_isonhood_a_juror_s_reflections_on_the_death_penalty (last accessed 2 June 2024).

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systems that simply do not have the capacity to treat everyone equally or in a timely, optimal way. This can result in waiting lists, complicated or conflicted triage decisions, and – ultimately – clinical choices that are implicitly shaped by service limitations among other factors (albeit sometimes subconsciously so).

There can also be single, large decisions that risk moral injury in healthcare, but the most common situation is that many small decisions have a cumulative effect that results in moral injury in the longer term. Either way, healthcare providers routinely run the risk of moral injury owing to conflictual decisions, inadequate resources, outsized expectations, and working conditions that are commonly not conducive to good decision-making: long hours, sleep deprivation, inadequate personal support, and a lack of compassion for staff.

It is good for clinicians to be aware of these factors, to acknowledge the risk of moral distress and moral injury, and to articulate their patients' needs clearly, even if service limitations mean that not all of these needs will be met. This level of insight and awareness can be unsettling, so it is essential that clinicians recognise their limitations as individuals within a broader healthcare system. We cannot fix everything.

It also helps to recognise that we are not alone in these dilemmas. All healthcare professionals face similar decisions and familiar conflicts. All run risks of moral injury. Acknowledging this common humanity is an important first step towards preventing, resolving, and overcoming moral injury, and building health systems that are based on compassion for all, including staff.

Mindful Self-Compassion

Acknowledging the nature and risks of moral injury is an important step towards greater self-compassion for healthcare staff. There are also many other aspects to self-compassion, and these are explored throughout the rest of this chapter and this book, with particular reference to the work of Kristin Neff (Neff, 2011; Neff, 2021) and the idea of mindful self-compassion (Germer and Neff, 2019). These are key concepts and ideas that have generated essential strategies for building and sustaining self-compassion, especially in difficult, stressful environments.

In general terms, Neff and colleagues conceptualise self-compassion as a balance between increased positive and reduced negative self-responding to personal struggle (Neff et al., 2018). This involves three key elements: (a) being supportive to oneself, rather than harsh and judgemental; (b) recognising that difficulties constitute a normal part of a human life, rather than feeling isolated from others as a result of one's experiences; and (c) keeping personal suffering in rational awareness, rather than becoming fully absorbed by one's problems (Neff, 2003a; Neff, 2003b).

Research on self-compassion indicates that self-compassion is positively associated with psychological well-being, cognitive well-being, and positive affective well-being (Zessin et al., 2015), and negatively associated with symptoms of psychopathology; that is to say, the more self-compassion, the less anxiety, stress, and depression (MacBeth and Gumley, 2012). Self-compassion is also a trait that sustains people in the act of caring for others and is a positive psychological characteristic in stressful work settings, including healthcare.

Self-compassion is a quality that is amenable to change (Germer and Neff, 2019). Educational interventions and therapies have been developed to increase self-compassion, with strong evidence of efficacy (Kirby et al., 2017). In 2019, Wilson and colleagues performed 'a systematic review and meta-analysis' of the 'effectiveness of self-compassion

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related therapies' (Wilson et al., 2019). This research group identified 22 randomised controlled trials that met inclusion criteria, and showed that self-compassion related therapies were effective in improving self-compassion, and were at least as useful as other interventions:

> Results indicated that self-compassion-related therapies produced greater improvements in all three outcomes examined: self-compassion (g = 0.52, 95% CIs [0.32, 0.71]), anxiety (g = 0.46, 95% CIs [0.25, 0.66]) and depressive symptoms (g = 0.40, 95% CIs [0.23, 0.57]). However, when analysis was restricted to studies that compared self-compassion-related therapies to active control conditions, change scores were not significantly different between the intervention and control groups for any of the outcomes . . . There was some evidence that self-compassion-related therapies brought about greater improvements in the negative than the positive subscales of the Self-Compassion Scale, although a statistical comparison was not possible . . . Overall, this review presents evidence that third-wave therapies bring about improvements in self-compassion and psychopathology, although not over and beyond other interventions. (Wilson et al., 2019; p. 979)

Against this background, it is clear that therapies which focus on self-compassion are effective in boosting self-compassion, that continued accumulation of evidence will help delineate their precise effects more clearly, and – most importantly – that self-compassion is amenable to change and improvement over time. These are enormously positive, helpful, and hopeful findings from this growing literature, especially for healthcare providers who sometimes struggle with moral injury or struggle to make the compassion that motivates them evident in their clinical practice.

Understanding Self-Compassion

There are many myths and misunderstandings about self-compassion. As Neff points out, self-compassion is not self-pity, weakness, complacency (which might reduce motivation), narcissism, or selfishness (Neff, 2015). Each of these concepts differs significantly from self-compassion. Self-pity, for example, is often overlaid with guilt, shame, and recrimination, along with over-identification with being a victim and an excessive sense of injustice, unfairness, or righteous indignation. Self-pity turns the attention inwards, triggers rumination focused on the self, and contracts our world. Self-compassion, by contrast, identifies us with common humanity, broadens our attention and awareness, and acknowledges that life has difficulties which everyone goes through. It's not me; it's *us* and it's *the world*.

Self-compassion involves recognising difficult situations when they occur and acknowledging challenging emotions when they arise. It means accepting these with as much kindness as possible, allowing them to simply *be* when we cannot change them, and letting go of the feelings when they subside, rather than ruminating or clinging to them. This is not always easy, but the benefits are clear: people with higher levels of self-compassion have less anxiety and depression (Egan et al., 2022) and reduced symptom-focused rumination (Krieger et al., 2013).

Egan and colleagues make this point clearly in their 2022 'review of self-compassion as an active ingredient in the prevention and treatment of anxiety and depression in young people' (Egan et al., 2022). This study included 'qualitative consultation with young people and researchers in self-compassion':

> Previous meta-analyses have found higher self-compassion is associated with lower anxiety and depression . . . Higher self-compassion was related to lower symptoms of anxiety,

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> $r = -0.49$, 95% CI (−0.57, −0.42), and depression, $r = -0.50$, 95% CI (−0.53, −0.47). There was evidence for self-compassion interventions in decreasing anxiety and depression in young people. Consultation with young people indicated they were interested in self-compassion interventions; however, treatment should be available in a range of formats and tailored to address diversity. Self-compassion experts emphasised the importance of decreasing self-criticism as a reason why self-compassion interventions work. The importance of targeting self-criticism is supported by the preferences of young people who said they would be more likely to engage in a treatment reducing self-criticism than increasing self-kindness. (Egan et al., 2022; p. 385)

Svendsen and colleagues, in a study of 'self-compassion and its association with ruminative tendencies and vagally mediated heart rate variability in recurrent major depression' found that 'self-compassion was associated with lower ruminative tendencies' in people with major depressive disorder (MDD) (Svendsen et al., 2022; p. 1). This is important in terms of potentially reducing risk of relapse of depression:

> Rumination is recognized as a key vulnerability factor for depressive relapse, and thus an implication of the current study is that strengthening self-compassion is beneficial for individuals suffering from recurrent MDD. (Svendsen et al., 2022; p. 10)

Self-Compassion in Body and Mind

Often, there is a sense that we can and should understand our own suffering in a cognitive or intellectual way. Commonly, however, this search for intellectual understanding is divorced from developing kindness or sympathy towards ourselves. This is particularly the case among people who have experienced trauma but have not integrated the traumatic events or their bodily experiences of trauma (Van der Kolk, 2014).

Following such trauma, there is often emotional detachment which does not allow for integration. By contrast, increasing self-compassion means being emotionally moved by our traumatic experiences (past or present), taking the steps required to reduce suffering, and allowing compassionate understanding to develop. In this way, we are moved by our pain, we recognise our suffering, and we acknowledge this as part of the common human experience. Self-compassion helps us to be more honest, more courageous, more connected, and more resilient than we usually give ourselves credit for. We are stronger than we think and wiser than we know, once we open ourselves to our own emotions with kindness and compassion.

From an evolutionary perspective, much of what we experience is driven by older emotional and cognitive habits which date from earlier stages of evolution, rather than being appropriate for today (Gilbert, 2014). As a result, we commonly feel fear and anger in response to multiple stimuli, and we respond from a threat-based perspective even when this is disproportionate or inappropriate. To a degree, we cannot help how we instinctively respond, but by cultivating compassion, we can turn these instinctive responses into something more helpful. We can develop more balanced responses to negative events and apparent threats, and more nourishing ways of managing or living with the emotions and anxieties that these provoke. Most of all, we can forgive ourselves for responses we feel were unhelpful, and seek to act more appropriately next time.

Responding with greater self-compassion, rather than self-pity, recognises that our experiences are difficult but are not unique to us, and that our initial responses are very

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human, no matter how distressing they feel at the time or how unhelpful they appear in retrospect. In other words, self-compassion recognises that, no matter what happens and no matter what we do, we are not alone. Self-compassion connects us to ourselves *and* to each other *and* to the universal realities of human life.

The essential message is that, at times of difficulty and trauma, when my responses might not be ideal, I am not a terrible person. I am a person having a terrible experience. Responding to this situation involves recognising suffering (in myself as well as others), taking action to relieve this suffering (as best as possible), and maintaining a sense of self-compassion throughout the experience and in its aftermath.

This experience is not unique. I am not alone. I deserve compassion.

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