Chapter 3

What Compassion Is Not

Compassion in Words

The literature about values in healthcare contains many terms which are sometimes used interchangeably with each other. These words include 'compassion', 'sympathy', 'empathy', 'kindness', 'communication skills', and various other terms which are intended to denote a caring, understanding attitude towards healthcare provision. Searching the literature for papers about compassion yields a large number of publications which do not focus on compassion, but on one or more of these other terms and concepts.

Most commonly, the term 'empathy' is mistakenly used to denote 'compassion', even though the two words mean different things and affect different pathways within the brain (Klimecki et al., 2014). Empathy is the quality of experiencing the suffering of another person, whereas compassion also includes the motivation to act (see Chapter 2: 'Background to Compassionate Healthcare'). Our current understanding of the neuroscience of the two constructs suggests that empathy activates the pain circuits of the brain and compassion activates reward circuits (Goldberg, 2020). This suggests that an excess of empathy can lead to burnout, but compassion can enhance resilience and feelings of fulfilment. It also suggests that the concepts are meaningfully different from each other, albeit that they are also related in certain ways.

Confusion between these various terms adds significantly to the apparent heterogeneity of research in this area and raises the worrying possibility that some writing on this topic uses these terms without differentiating between them. With this in mind, this chapter starts by exploring terms which are often used interchangeably with 'compassion', such as 'sympathy', 'empathy', 'kindness', and 'communication skills'. The chapter then focuses on two of the so-called 'near enemies' of compassion (pity and 'horrified anxiety'), before echoing the main argument of this book, that compassionate healthcare requires an all-of-system approach, rather than isolated changes, paper exercises, or tinkering around the edges. Reflecting on terminology can help greatly with this process.

Sympathy

It is useful to examine some of the terms which are commonly used interchangeably with compassion in order to clarify meanings for the remainder of our discussion in subsequent chapters and focus our thoughts on what is special about compassion. Terms such as 'sympathy', 'empathy', 'kindness', and 'communication skills' all reflect pro-social feelings, attitudes, and behaviours which have close links with compassion, but are nonetheless significantly different from compassion in various ways.

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Words and definitions matter a great deal in this field because there can be a perception that compassion is a 'soft' concept that is potentially associated with weakness (Gilbert et al., 2019). The opposite is true, as we will see when we explore compassion more clearly in this chapter, investigate its transformative power in subsequent chapters, and examine how it operates throughout the remainder of this book. For now, let us start with the commonly used term 'sympathy' and explore how it differs from compassion.

The word 'sympathy' refers to feelings of sorrow or pity for the misfortune of someone else. It is an expression of care and understanding for somebody else's suffering. The word finds its roots in the Greek terms 'sym', which means 'together with', and 'pathos', which means 'feeling'. Many dictionaries use compassion and empathy as synonyms for sympathy, but while sympathy means that one is moved by the thoughts and feelings of another person, one maintains an emotional distance. Compassion, in contrast, includes both an awareness of the suffering of oneself or another person *and* the motivation to act in order to relieve that pain.

Empathy

The commitment to the alleviation of suffering which is associated with compassion is also what sets compassion apart from empathy. 'Empathy' can be defined as the ability to understand another person's thoughts and feelings in a situation from their point of view rather than our own. It is the capacity to share someone else's experiences or feelings by imagining what it would be like to be in that person's situation. The word 'empathy' comes from the Greek words 'em', which means 'in', and 'pathos', which means 'feeling'.

The key difference between empathy and compassion is that the person experiencing empathy is 'in' the emotion. They are taking on the emotion of somebody else as if they were feeling it themselves. This difference is important, because empathy activates different brain pathways than those activated by compassion, pathways related to the experience of pain (de Vignemont and Singer, 2006; Klimecki et al., 2014). Compassion, by way of contrast, activates reward circuits (Goldberg, 2020). We will explore this further in Chapter 6, which examines 'Neuroscience and Compassion'.

It is not difficult to understand how a person can become burnt out when operating from an empathic perspective all the time. The purely empathic position involves imagining what it is like to be in someone else's situation and experiencing their pain, but without the emotional distance required to sustain this position, and without the commitment to act that can discharge or sublimate these emotions in compassionate actions.

Empathy is a competence and it can be a necessary precursor of compassion, but it lacks the volitional or motivational aspect of compassion, where the suffering of others is recognised *and* action is inspired. With compassion, we are motivated to alleviate the suffering of ourselves or another person, to act on feelings of sympathy or empathy, and to move forward in a positive, therapeutic way.

Empathy can be used skilfully or unskilfully, depending on the motivation of the actors and the situation that presents itself. As we have seen, empathy can be a necessary foundation for subsequent compassion and compassionate acts. There is also an evolutionary advantage to having empathy with others. Woodruff and Stevens suggest that animal expressions of pre-empathy, such as mimicry of birds or the contagion of a howling wolf within a pack, have a survival value in promoting cohesion within the group, selecting mates, and evolutionary fitness (Woodruff and Stevens, 2018). These all lead to pro-social

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behaviours supporting species preservation. Compassion might originate with a brief flash of empathy, and this can be modulated by 'higher' brain functions or frontal cortical pathways to develop into a compassionate response.

From an evolutionary perspective, it is likely that compassion evolved from certain aspects of caring behaviour over the course of human history, especially caring behaviours that are linked with rescuing behaviour and rescuing psychology. Rescuing differs from protection and attachment, not least because rescuing behaviour can appear more reputationally rewarding than steady protection, secure attachment, or quiet empathy. In healthcare settings, rescuing can sometimes take precedence over other forms of caring, especially in emergency circumstances. As a result, care-compassion motivations can have different textures and likely different evolutionary underpinnings in different contexts, but they still share the same core motivation to address suffering in its specific context.

Against this background, it is useful that recent decades have seen significant research interest in compassion (Mascaro et al., 2020), as well as emotion, regulation, and issues relating to moral development (Eisenberg, 2000). For healthcare professionals, it is especially helpful to recall that sympathy comprises our personal reactions to events, often rooted in our own experiences and projections, as much as events themselves. For example, a clinician might feel sad that a patient is dying and might be reminded of a bereavement in their own life which caused great sadness at the time, but their current patient might be primarily experiencing fear rather than sadness. In this situation, it is useful for the clinician to remember that their feelings of sympathy might chiefly reflect their own personal reactions and personal distress. Such feelings might be usefully combined with awareness and tolerance of different responses in the patient, as well as an awareness of the need for compassion. Sympathy and empathy are important competencies for engagement, but they, alone, are not compassion (Gilbert, 2013; Gilbert, 2020). Motivation is essential for compassionate acts, along with active commitment to helping goals (Poulin, 2017).

Kindness

Having considered 'sympathy' and 'empathy' as they relate to, and differ from, compassion, what about 'kindness' and 'communication skills'? How do these concepts connect with compassion? And how can these attitudes, approaches, skills, and behaviours work together for the advancement of health and healthcare?

The term 'kindness' finds its roots in the old English word 'kin', which means treating other people like family. The concept of kindness is also related to constructs such as benevolence and pro-social emotions such as sympathy and empathy. It evolves from the need for humans to be interdependent and to work together for the betterment of all (Phillips and Taylor, 2009).

While they are both inter-related aspects of pro-social behaviour, kindness and compassion can be clearly differentiated from each other. Gilbert and colleagues, using examples to elicit meaning, showed that people were able to distinguish between the two terms (Gilbert et al., 2019). They found that people attribute higher levels of negative emotions (such as sadness, anxiety, anger, and disgust) to scenarios based on compassion, and higher levels of joy to scenarios based on kindness. There are different emotions associated with each state.

Kindness is simply well-wishing towards others and can take the form of actions of body, speech, and mind that go towards assisting others to flourish. Kindness and compassion are

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therefore different processes, with different competencies and emotional overlays. Compassion can involve kindness, but kindness does not have to be in response to suffering:

> Compassion may often involve kindness, but kindness does not need to include suffering and compassion. Another core theme relating to suffering and compassion is the degree of suffering arising from the cost of helping. In other words, to what extent do we suffer as a result of trying to help others, be it sacrificing and giving up something important to us or actually being prepared to experience pain, as in the case of providing bone marrow or a kidney for a cancer victim. Indeed, the whole concept of altruism is based on the idea that caring and helping carry a cost and it's the cost that determines the degree to which it is an altruistic act (Preston, 2013). While simple definitions (like those above) are useful starting points, if we only stop with the simple definitions these subtleties and complexities are lost. (Gilbert et al., 2019; p. 2262)

Cultivation of kindness and cultivation of compassion also differ from each other, with cultivation of compassion specifically requiring engagement with suffering, both in oneself and in others. This is a further difference between the concepts, albeit that they still remain related within the broader framework of caring and pro-social behaviours.

Consistent with this, and as discussed in Chapter 1 ('What Is Compassion?'), loving-kindness or benevolence (*mettā*) and compassion (*karuṇā*) are two of the Brahma Viharas or 'four immeasurables' in Buddhist tradition (Wallace, 2010; Feldman, 2017). They form part of a set of virtues, states of being, or divine abodes that enlightened people dwell in and act spontaneously from. The Brahma Viharas also include empathetic joy (*muditā*), and equanimity (*upekkhā*). In this tradition, cultivation of states such as loving-kindness and compassion involve separate and distinct foci of meditative training and contemplation, underpinning the idea that the two concepts are related in various ways, but are also distinct in others (Dalai Lama, 2002).

Communication Skills

Communication skills are a competency which is essential for good medical practice and delivery of effective healthcare. A great number of studies and interventions for clinical staff converge on considerations of communication techniques and their impact on care. Zhou and colleagues, for example, performed 'a systematic scoping review of approaches to teaching and assessing empathy in medicine' (Zhou et al., 2021). They found that a range of approaches were used in research, practice, and education, with many focusing on communication techniques in various different ways:

> Group discussions on personal experiences and/or simulated scenarios including role play and simulated patients facilitate analysis of empathy and shared experiences. Role play has been found to boost participants' confidence in communication. The use of the arts and humanities including poetry and literature, drawings and paintings, reflective writing, cultural studies and history, film, photography, and comics have also shown to increase self-awareness and reflection.
>
> The topics introduced in the 'teaching' of empathy vary significantly. They include mindfulness, communication and interpersonal skills, and the arts and humanities. Teachings in mindfulness involve meditation and mindful listening whilst communication skills include active listening, use of open-ended questions, and improving communication among healthcare staff. Arts based curricula include teachings such as principles of art therapy, art analysis, and social and cultural studies.

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> Critically, empathy was nurtured by facilitating understanding of the concept of empathy, underscoring the differences between empathy and sympathy, its importance and its role in clinical practice. (Zhou et al., 2021; pp. 5–6) (citations omitted)

More recently, Byrne and colleagues published 'an umbrella review' of 'the current state of empathy, compassion and person-centred communication training in healthcare' (Byrne et al., 2024). They identified twenty-five reviews to consider on this theme. Their conclusions also accorded significance to 'empathic communication':

> For policy and practice, we advise the inclusion of empathic communication into the curriculum; longitudinal and sequenced learning; debriefing, targeted feedback, enabling self-reflection, deliberate practice, experiential learning; improving motivation by teaching the benefits of empathy and teaching sustainable empathy. Future research should involve patients in training and research and study the effect of targeting interventions at healthcare practitioners and patients. (Byrne et al., 2024; p. 1)

This group's 'key recommendations' include 'systemic changes to enable organisational culture supporting clinical empathy', and 'incorporation of empathy, compassion and person-centred communication training into the curriculum; longitudinal training', along with 'future research' into 'longitudinal interventions with long-term follow-up of outcomes (participant attitudes, behaviour and patient outcomes), combining qualitative information from students' portfolios and objective measures' (Byrne et al., 2024; p. 9).

Clearly, communication is a key area in need of improvement in healthcare and clinical education. However, while verbal and non-verbal communication skills are important components of receptivity to another person's suffering, and can prompt or indicate compassionate behaviour, they are just one component of compassionate healthcare, just one competency, and are not sufficient in themselves to sustain compassionate responses. Communication skills have been described as central to compassionate leadership and developing a compassionate healthcare culture, but more is needed for true compassion, including but not limited to effective communication techniques (West and Chowla, 2017).

Attending to other people's non-verbal cues and active listening are sometimes described as micro-skills which can be taught in curricula for healthcare and behavioural sciences, and can facilitate skilful, compassionate approaches to patients (Schairer et al., 2022). Sometimes described as 'relational communication' (Sinclair et al., 2018; p. 8), this is just one component of compassion. One-stop-shop courses which focus on communication skills for frontline staff are sometimes rolled out across health systems, with reports of high levels of customer satisfaction from course participants. Too often, however, the focus is solely on communication techniques and there is no evaluation of outcomes from the perspective of the end user; that is to say, patients and their families.

By contrast, NHS Wales has led from the top down by seeking to generate a culture of compassionate healthcare, with clearly stated goals, measurables, and objectives.[1] This involves developing a 'compassionate leadership' approach which 'includes the four pillars of compassionate leadership': 'effective leadership', 'inclusive leadership', 'collective leadership', and 'systems leadership'. This initiative in Wales reflects a recognition of the need for a holistic, top-down approach to compassionate healthcare, rather than ticking a 'communication skills' box on a checklist for staff training. Compassionate healthcare

[1] See: https://nhswalesleadershipportal.heiw.wales/the-four-pillars-of-compassionate-leadership (accessed 5 April 2024).

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requires an all-of-system approach, rather than isolated changes, paper exercises, or tinkering around the edges.

Empathy, kindness, and communication skills are each important, but they are not in themselves the same as compassion. Used wisely, they can be helpful and even essential, but more is needed in order to promote and sustain compassion, especially across complex, high-stress, multi-actor settings such as healthcare systems.

The 'Near Enemies' of Compassion

We may be trying to cultivate compassion, but, at times, emotions can arise that may be mistaken for compassion and can have negative effects. Two of these emotions, pity and 'horrified anxiety', can arise in the place of compassion and can be recognised by negative emotional effects that become evident in the body. Feeling pity for someone, sometimes described as sentimental pity, involves a sense of being outside or detached. Sometimes, we can view someone's suffering in a way that attaches a value judgement; for example, that this person is 'not like us', they are 'different', we are not in the same situation as them, or they are 'separate' from us in some additional way.

In healthcare settings, listening to a person's story of suffering and responding with this kind of sentimental pity can inadvertently devalue what the person is going through. It does not have the quality of motivation that compassion has, or necessarily the desire to alleviate their suffering or relieve their pain. Similarly with empathy, responding to another person's pain in an empathic way identifies with the pain, whereas recognising their suffering *and* feeling motivated to act in a compassionate way allows an appropriate, compassionate response to develop.

Self-pity, by contrast, can be overlaid with guilt, shame, and recrimination, and there can be over-identification with being a victim, along with a (sometimes justified) sense of injustice and unfairness, or even righteous indignation. There is sometimes a sense that we can cognitively or intellectually understand our own suffering, but that intellectual understanding is divorced from having kindness or sympathy towards ourselves for having had that experience. Having self-compassion is different to self-pity, as we will explore in Chapter 8 of this book which is devoted to 'Self-Compassion'.

The other so-called 'near enemy' of compassion, in addition to self-pity, is sometimes known as 'horrified anxiety' and can also occur in healthcare settings. It is helpful to be aware of this possibility.

'Horrified anxiety' is an emotion that arises when we are confronted by suffering, and we allow it to overwhelm us. We over-identify with suffering in a way that leads to a state of physiological stress. This feeling can arise quite frequently in modern life where world events are enacted in front of our eyes through on-the-spot television reporting and social media. At times, it can be hard not to feel both horrified by, and anxious about, the state of the world.

On an individual level and in a healthcare context, one way of balancing this is to recognise that the person who is suffering has many facets to their life and their personhood: they have moments of joy and love in their lives, as well as times of suffering and difficulty. They are not their disease; they are full and rounded people living full and rounded lives. It is helpful if we can bear witness to their pain and help to alleviate it, rather than adding to their suffering by obviously being in distress ourselves, getting too caught up in the situation, or responding in a disproportionate or inappropriate way that amplifies overall levels of distress. Compassion is central to this response, with its acknowledgement of suffering *and* its commitment to compassionate action to relieve it.

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Building Compassion

Despite the variety of definitions of compassion explored in Chapter 1 of this book ('What Is Compassion?'), all find their roots in the recognition of distress (our own or that of other people) and the motivation to respond to prevent or relieve that suffering.

As will become apparent in later chapters, responding compassionately involves turning towards the suffering that is in front of us, rather than turning away. The instinct to turn away comes from difficulty in facing our own pain, fear of suffering, and a need to protect ourselves. Turning towards distress, however, connects us with the person who is suffering, be it ourselves or another person. It is rooted in a sense of solidarity with other people because all people experience suffering, all people seek to act from the desire to relieve that distress, and all people strive to be happy.

Responding compassionately is not always easy. Often, healthcare professionals need to manage a wide variety of emotions including anxiety and, at times, anger towards healthcare systems that make excessive demands of them or fail to protect them. Focusing on compassion as a motivation to alleviate suffering can help to clarify distinctions between how we are sensitised to suffering in our work and how we respond to it. Engaging with suffering can be challenging, so there can be a temptation to short-circuit engagement and jump straight to action in order to avoid our own complex feelings. This is not a wise course of action and does not promote compassionate, mindful care.

Teaching clinicians how to practice compassionate care is therefore both essential and challenging. Schairer and colleagues highlight these matters in relation to medical students in no uncertain terms:

> The importance of empathic and compassionate doctor-patient relationships has become more widely appreciated in recent years. There is growing evidence that empathic and compassionate interactions can have a therapeutic effect independent of the technical treatment provided. In addition to saving lives, compassionate care has been shown to save money and lessen provider burnout. Research has shown that compassionate communications that improve health can integrate into efficient high-quality treatment. Yet, medical school curricula often emphasize the teaching of medical facts and procedures rather than the learning of 'doctoring' and how to communicate effectively with patients. Furthermore, the 'hidden curriculum' of medical schools often promotes a dehumanizing view of patients and a value system that favors technical prowess, speed, and efficiency over interpersonal skills. (Schairer et al., 2022; p. 1) (citations omitted)

One of the first steps in teaching and modelling compassionate healthcare is likely to lie in achieving as much clarity about key terms as is possible, including 'compassion' itself (see Chapter 1: 'What Is Compassion?') and terms which are often used interchangeably with 'compassion', such as 'sympathy', 'empathy', 'kindness', and 'communication skills' (explored in this chapter). It is also helpful to be aware of two of the so-called 'near enemies' of compassion, pity and 'horrified anxiety', which can arise in clinical care and might be mistaken for compassion.

Clarity about these terms can help to understand their significance, their importance in healthcare provision, and the ways in which they can support, as well as differ from, compassion. Understanding these concepts also facilitates education. As Schairer and colleagues point out, 'students remember and integrate lessons about both performative and emotional dimensions of compassion' (Schairer et al., 2022; p. 8). As a result, educational initiatives are valuable opportunities that should not be hampered by conceptual confusion or unclearness in terminology.

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Overall, compassionate healthcare requires a broad shift in mindset and an all-of-system approach, rather than isolated changes, paper exercises, or tinkering around the edges. Reflecting on terminology can help greatly with this process and help move towards more compassionate health systems for all: patients, families, and healthcare professionals alike.

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