Chapter 7

Resilience and Compassion

So far in this book, we have examined definitions of compassion (Chapter 1: 'What Is Compassion?') and the 'Background to Compassionate Healthcare' (Chapter 2). We then explored 'What Compassion Is Not' (Chapter 3) and the relationship between 'Medical Professionalism and Compassion' (Chapter 4). Chapter 5 examined 'Compassion in Healthcare' in further detail, while Chapter 6 entered the field of 'Neuroscience and Compassion', noting recent developments in this area and suggesting directions for the future.

The current chapter moves our discussion forward by examining the relationship between 'Resilience and Compassion'. This will be followed by chapters focusing on 'Self-Compassion' (Chapter 8) and 'Compassion-Based Therapies' (Chapter 9). Part II of the book then presents practical approaches to compassionate care on a day-to-day basis in clinical settings.

For now, the present chapter considers definitions of resilience and its relevance in healthcare, especially during the Covid-19 pandemic of the early 2020s. The chapter then considers the concepts of 'compassion fatigue' and 'burnout', and outlines barriers to, and facilitators of, compassionate care. The chapter concludes by examining the roles of mindfulness and meditation in navigating some of the challenges outlined. But, first, what is 'resilience', and why does it matter?

Resilience

Resilience is 'the ability to cope with adversity and to adapt to major life events' (Jeamjitvibool et al., 2022; p. 2). Resilience changes over time, 'varies widely from person to person and depends on environmental as well as personal factors' (p. 2). Working in healthcare can bring particular challenges to resilience: dealing with difficult clinical situations on a daily basis, managing the anxieties of patients and families, and working in large systems of care which can often prove stressful or dysfunctional in certain respects. Providing healthcare is deeply rewarding, but, often, it is not easy.

As a result of these factors, a significant amount of resilience can be necessary in order to navigate the challenges of caring. These matters come into sharp focus at times of crisis or emergency, so it is unsurprising that the Covid-19 pandemic of the early 2020s prompted a number of studies of resilience in healthcare. This research looked at not only resilience itself, but also its relationship with other variables, especially as the global public health emergency intensified and various pressures were brought to bear on healthcare professionals around the world (Kelly, 2023).

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Liu and colleagues studied 'resilience and anxiety among healthcare workers' during the pandemic (Liu et al., 2022). They defined resilience as 'the capacity that allows people to successfully adapt and face adversity, traumatic and stressful events' (p. 2). This research group performed a 'cross-sectional study among 390 healthcare workers in Jiangsu Province, China':

> The prevalence of anxiety among Chinese healthcare workers during the spread of the SARS-CoV-2 Delta variant was 41.8%. Male, unmarried, childless and younger subjects reported higher levels of anxiety. Positive coping partially mediated the effect of resilience on anxiety among healthcare workers and the indirect effect was stronger with the increase of general self-efficacy. (Liu et al., 2022; p. 1)

These researchers concluded that 'positive coping could be one of the pathways through which resilience affects anxiety' (p. 7). Clearly, levels of resilience were significantly related to levels of anxiety at this time, and various coping mechanisms were relevant to how this relationship operated in practice.

In a similar vein, Jeamjitvibool and colleagues performed 'a systematic review and meta-analysis' of 'the association between resilience and psychological distress' during the pandemic (Jeamjitvibool et al., 2022). This group included thirty-three studies in their review:

> Based on the meta-analysis, we found a moderate negative relationship between resilience and psychological distress across populations during the COVID-19 pandemic (pooled r = −0.42; 95% CI: −0.45 to −0.38; $p < 0.001$). In other words, during the pandemic, the higher an individual's resilience, the lower the psychological distress. The results indicate that resilience is essential in promoting a person's positive mental health and reducing negative consequences. (Jeamjitvibool et al., 2022; p. 11)

These researchers concluded that 'psychosocial support is needed to improve resilience and the ability to cope with psychological distress during the COVID-19 pandemic and in future disease outbreaks. On the whole, this study's findings emphasize the need to develop specific interventions to enhance resilience in these populations' (p. 13).

Overall, these studies showed that, during the pandemic, resilience was negatively associated with psychological distress (Jeamjitvibool et al., 2022), and 'positive coping' was relevant to the relationship between resilience and anxiety in healthcare workers (Liu et al., 2022; p. 1). Compassion can play a key role in positive coping by combining an awareness of distress in our patients with a resolution to alleviate that distress, as best as possible, even in times of enormous challenge, such as the Covid-19 pandemic.

In parallel with this, it is important to note that while a certain amount of resilience is helpful and even essential, resilience depends on not only the personal characteristics of each healthcare worker, but also the conditions in which they work. Relevant factors include the structure and function of teams, models of organisation, quality of leadership, provision of resources, and various other factors. These matters have an enormous influence on individual experiences, attitudes, and behaviour, and on the levels of resilience that are required and accessible in the workplace.

An over-emphasis on personal resilience, and a lack of attention to structural stressors, creates a danger that practitioners might be left feeling personally responsible for, to blame for, or even guilty about systemic shortcomings in services. Staff might also feel guilty about the limits of their own 'resilience' or about fluctuations in their levels of compassion as

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circumstances around them change. Many of these matters are decisively shaped by context and environment, rather than individual skills. It is important to recognise the existence of these limits to personal resilience in order to maintain a realistic sense of what each individual can reasonably achieve and to minimise 'compassion fatigue', which we will consider next.

Compassion Fatigue

'Compassion fatigue' refers to the cost of caring for others or for their emotional pain that can lead to vicarious or secondary trauma and can make it harder to provide patient care. Compassion fatigue differs from 'burnout', which is a psychological syndrome resulting in emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment. Burnout results from stress and can occur in any area of life. Compassion fatigue, on the other hand, is unique to caring professions and can develop more rapidly than burnout. It is a natural but preventable consequence of working with people who suffer (Figley, 1995).

Baqeas and colleagues note that 'compassion fatigue is a term used to describe the exhaustion that results from prolonged exposure to compassion stress among those who work in a caring profession' (Baqeas et al., 2021; p. 1). Sweileh writes that, while 'burnout and compassion fatigue are closely related concepts', 'burnout is thought to develop from occupational stress while compassion fatigue results from being in a caregiver role leading to inability to get engaged in a caring relation' (Sweileh, 2020; p. 1).

The Global Compassion Coalition highlights the difference between burnout and compassion fatigue, noting that burnout is a state of advanced exhaustion (Global Compassion Coalition, 2023). Compassion fatigue, on the other hand, does not simply result from using up a finite amount of compassion, because being compassionate can fuel further compassion, rather than diminish it. As a result, apparent 'compassion fatigue' is more likely to result from system-level factors such as poor resourcing of services, staff feeling undervalued, or insufficient compassion for staff themselves, rather than individual staff members using up a finite personal supply of compassion as they care for their patients.

Evidence from social neuroscience suggests that it is empathy that fatigues, rather than compassion (Klimecki et al., 2014). By looking at the neurophysiological differences between empathy and compassion, we can see the behavioural responses and understand clearly why empathy can result in fatigue, stress, and burnout, while compassion can prove protective and contribute to resilience. Against this background, Klimecki and Singer suggest that the term 'compassion fatigue' should be replaced by 'empathic distress fatigue' (Klimecki and Singer, 2012; p. 368). This makes sense.

From the evolutionary perspective, the foundations for compassion include that it should be universal and should include distinct experiential and physiologic processes that motivate relevant behaviour (Goetz et al., 2010). There should also be compassion-related appraisals, informed by the idea that sensitivity to suffering is constrained by the costs and benefits of responding to suffering in this way. This aspect of compassion has significant implications in healthcare, where appraisals of the costs and benefits of responding can feel futile if staff are obligated to act anyway, regardless of any appraisals of the costs and benefits of compassionate care. On occasion, such costs might seem to outweigh the benefits, and this can lead to distress, anger, and fatigue, which are often compounded by feelings of powerlessness to respond adequately to suffering in a given situation.

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If empathy is the precursor to compassion, but an excess of empathy or an exclusive reliance on empathy can lead to burnout or 'compassion fatigue', then strengthening and training the areas of the brain associated with compassion might improve resilience and enhance engagement and joy in work, especially among healthcare workers.

Compassionate Care: Barriers and Facilitators

Notwithstanding the centrality of compassion in good health services, there are personal, patient-related, and systemic challenges or barriers to working from a compassionate perspective at all times (Singh et al., 2018; Pavlova et al., 2024; Habib et al., 2023; Maddox and Barreto, 2022). The distinction between 'barriers' and 'challenges' is important (Singh et al., 2018). When obstacles are perceived as barriers to compassionate care, they can appear insurmountable and incapable of change. There is a sense of passivity and of an inability to make a difference. When reframed as challenges to be overcome, there can be a growing sense of agency and possibility.

In a study by Singh and colleagues, people who actively reframed barriers as challenges were nominated by their peers as being exemplary compassionate colleagues and providing a model of how to act (Singh et al., 2018). This research group also noted that personal challenges in this area can include the personal perspectives and attitudes of healthcare professionals. Care given from an egotistic perspective can prove to be a barrier, especially when there is subtle inflation of status in caregiving. In addition, some people view compassion as an innate capacity that is not amenable to education. We return to this theme in Part II of this book, which presents practical approaches to compassionate care on a day-to-day basis, and ways to enhance compassion in clinical settings.

At this point, however, it is worth noting that the motivation to act compassionately in response to suffering, and the compassionate action itself, can arise spontaneously, and might not always be the response that the healthcare provider consciously thinks is the required one (i.e., not the 'fixing' response). The spontaneous, compassionate act might be more relational than goal-directed (e.g., the kind word, active listening, really getting to know and see the other person). As healthcare providers, we may default to the idea that appropriate responses are always actions such as prescribing medication, referring to other team members, or seeking to 'fix' the problem in other direct ways. In fact, care can be seen as compassionate by patients even when there is no firm action taken or when patients do not immediately get the outcome that they want, provided the patient feels seen, heard, and cared for in an overall sense.

From a provider perspective, aids and barriers to compassionate care mirror each other. Maddox and Barreto performed an especially valuable study of 'staff perceptions of compassionate care, aids and barriers in adolescent mental health wards' (Maddox and Barreto, 2022). They found that what staff feel is key to giving compassionate care is also what staff feel they need to receive themselves in order to deliver compassionate care:

> Elements of compassionate care fell into six themes relating to individual, team and organisational factors: emotional connection, sense of being valued, attention to the whole person, understanding, good communication, and practical help/resources. Aids and barriers mirrored each other, and showed that what staff think is key to the nature of compassionate care for patients is also what they feel they need to receive to be able to show compassionate care. (Maddox and Barreto, 2022; p. 1)

These researchers concluded that their study 'suggests that staff need the same elements of compassion as those which they seek to provide':

> A greater emphasis needs to be placed on providing staff with individual, team and organisational level resources which help them to feel compassionately held within the interconnected systems in which they work, in order to be able to continue to provide high level compassionate care. Staff need to be nourished, valued and compassionately cared for in order to be able to care compassionately for the patients they look after. (Maddox and Barreto, 2022; p. 1)

The systemic challenges to providing such compassionate care can include competing system demands and time constraints (Singh et al., 2018), in addition to inadequate resources, communication issues, poor emotional connections with the broader healthcare system as a whole, and the perception and/or reality of staff not being valued for the care that they provide (Maddox and Barreto, 2022). These are themes that will likely resonate with many people who work in large healthcare systems where organisational challenges can loom large, often distracting focus from day-to-day patient care.

Meditation and Mindfulness

This chapter has, so far, considered definitions of resilience and its relevance in healthcare, especially during the Covid-19 pandemic of the early 2020s. The chapter then explored the concepts of 'compassion fatigue' and 'burnout', as well as barriers to, and facilitators of, compassionate care. This final section concludes the chapter by examining the roles of mindfulness and meditation in navigating some of the challenges outlined.

A common reaction to the suffering of another person is to feel sad, to be reactive, or to turn away. These are natural human responses. A compassionate response, however, allows professionals to hold difficult feelings while also cultivating the desire to relieve the suffering of the other person, as well as our own. Mindfulness training can help individuals to be aware of what is present, including difficult emotions, without judgement (Kelly, 2019). Meditation practice can help professionals to hold difficult thoughts, emotions, and feelings non-judgementally, while cultivating the motivation to relieve suffering and act as compassionately as possible.

Contemplative traditions have long used meditation as a training to enhance compassion, resulting in greater real-world altruistic behaviour. Specific exercises include cultivating benevolent feelings towards ourselves, towards people we like, towards people we don't know, towards people we find difficult, and, ultimately, towards all living beings. These kinds of meditation exercises can be challenging to initiate and to sustain, but they often have profound effects on habits of mind and emotion.

Meditation can also re-shape the way our brains work and respond to events, through neuroplasticity, leading to improvements in levels of stress, symptoms of depression and anxiety, and how we relate to each other. These changes are reflected most clearly in how we think, feel, and behave, although they are also increasingly explored through neuroscience and, especially, brain imaging techniques. Research in this area confirms that meditation is not only a psychological and emotional practice, but also a physical activity with detectable impact on our bodies and our biologies (Treleaven, 2018).

Interoception is one of the lesser-known senses that helps us to notice, feel, and understand what is going on in our bodies. Having trouble with this sense can make self-regulation a challenge and can limit the biological aspects of knowing when we feel full, hungry, cold, thirsty, etc. We tend to be more immediately familiar with outward-facing senses such as hearing, sight, taste, touch, and smell. Inner senses, on the other hand, include both proprioception, which is knowing where our body is in space, and interoception, which focuses on how we feel. These inner senses merit more attention than they routinely receive, not least because interoception can be affected by various interventions, including neuromodulation of the vagus nerve, slow breathing to alter respiratory depth and rate, and other awareness processes, including mindfulness-based interventions (Weng et al., 2021).

Clearly, neuroscience has much to offer in this area both in terms of understanding how our bodies and minds work together and in terms of future research possibilities. Looking at the relevance of neuroscience in this field more broadly, and returning to the theme of compassion, Weng and colleagues, in 2020, published a paper titled 'Toward a compassionate intersectional neuroscience: increasing diversity and equity in contemplative neuroscience' (Weng et al., 2020). This research group noted that 'mindfulness and compassion meditation are thought to cultivate prosocial behavior':

> However, the lack of diverse representation within both scientific and participant populations in contemplative neuroscience may limit generalizability and translation of prior findings. To address these issues, we propose a research framework called *Intersectional Neuroscience* which adapts research procedures to be more inclusive of under-represented groups. Intersectional Neuroscience builds inclusive processes into research design using two main approaches: 1) community engagement with diverse participants, and 2) individualized multivariate neuroscience methods to accommodate neural diversity. (Weng et al., 2020; p. 1)

Using focus group and community feedback, and in collaboration with a meditation centre in the United States, this research group 'adapted functional magnetic resonance imaging (fMRI) screening and recruitment procedures to be inclusive of participants from various under-represented groups, including racial and ethnic minorities, gender and sexual minorities, people with disabilities, neuropsychiatric disorders, and/or lower income':

> This approach made the invisible processes of meditation more visible, and revealed that each meditator experienced a different pattern of fluctuation between mental states of attention to breath, mind wandering, and self-referential processing. These decoded mental states could then be quantified into metrics of internal attention during meditation: percentage time attending, number of events, and mean duration and variability of events. Using these metrics, attention profiles could be computed for each individual, showing the feasibility of using individualized brain patterns to estimate subject-level attention metrics. Participants varied in how their attention fluctuated during meditation, and in the resulting pattern of attention metrics such as percentage time attending to breath, mind wandering, or self-referential processing. (Weng et al., 2020; p. 13)

Clearly, the practice of meditation has significant effects on mental states and internal mental activity, all of which also vary from person to person, depending on a range of factors. While we usually devote limited attention to these internal events, they are nonetheless powerful ways to affect our inner lives, re-shape our thinking, and increase compassion. Weng and colleagues highlight this aspect of their work:

> For example, in breath-focused meditation (a core meditation skill that cultivates stability of attention which supports interoception and compassion), attention is focused on sensations of the breath, until distracted by other internal or external stimuli, and then attention is returned nonjudgmentally to the breath. This practice is simple but not easy. (Weng et al., 2020; p. 3)

Compassion, too, is arguably simple in certain ways, but is not always easy to sustain in practice. A certain amount of resilience helps to navigate the challenges of healthcare systems, and can also help to avoid burnout, 'compassion fatigue', and general exhaustion. If, however, a workplace requires enormous levels of resilience from staff, there is a need to examine systemic factors that increase stress, hamper healthcare delivery, and diminish compassion. Healthcare workers who experience compassion themselves are more likely to deliver compassionate care to their patients and therefore generate better clinical outcomes.

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