Chapter 12

Understanding and Cultivating Compassion in Clinical Settings

The A.B.I.D.E. Compassion Model

Joan
Halifax

Compassion is an emergent property

It arises out of the interaction of non-compassionate processes

Compassion in action is relational, mutual, reciprocal and asymmetrical

Understanding and Cultivating Compassion in Clinical Settings

Compassion should be the basis of medical care[1]. And yet, in Western medicine, too often clinicians suffer from a deficit of compassion. Curing without caring causes not only patients to suffer, but clinicians and family members as well. This chapter brings into focus three perspectives related to compassion in relation to training clinicians in compassionate end-of-life care. The chapter begins with an exploration of types of compassion relevant for clinicians and others. It also unpacks a heuristic model of compassion that makes it possible for clinicians to see how to work with those faculties that foster compassion[2]. These three perspectives are the bases of the professional training program developed at the Upaya Institute, where hundreds of clinicians have been educated in compassion-based ethics, communication and contemplative interventions[3].

Compassion is often associated with religion. It is also believed to be, at times, the cause of distress in those who experience it[4]. And yet, recent research suggests that, on the contrary, compassion might be a source of hardiness, resilience and well-being[5]. It is, as well, an important feature of socialization essential to our individual and collective well-being[6], [7], [8].

Neuroscience research on compassion is in its early stages. For example, small numbers of meditation adepts have participated in neuroscience research so scientists can map the neural substrates of compassion[9],[10]. Other research projects have involved explorations of immune response[11].

Compassion seems to be an important mental, psychophysical and social feature in our human experience, and there appears to be a deficit of it in our society, including in our medical system, which is why the research on compassion has become more concerted in the past several years[12] (see also for more detail about the science underlying compassion chapters 13 to 19). As someone in the compassion training field, I felt it was important to understand the components of compassion, then develop a simple intervention that primes compassion, particularly for clinicians. This intervention is called G.RA.C.E. and is currently used by physicians, nurses, social workers, psychologists and chaplains in various fields of patient care (see more details to this program in Box VI).

In the spring of 2011, I spent several months at the Library of Congress as a Distinguished Visiting Scholar writing a journal article on a heuristic model of compassion[2]. I did not feel that compassion had been sufficiently examined in order for adequate training approaches in the end-of-life care field to be developed. For many decades, I have been engaged in an exploration of compassion by examining the literature on compassion; analyzing my own experience as a meditation practitioner; receiving teachings on compassion from Buddhist adepts; being present for the profound suffering encountered in the end-of-life care field and in the prison system; studying the results of neuroscience and social psychology research in the areas of empathy, altruism and compassion; and training caregivers and patients in approaches to compassion. These combined experiences led me to question how we define compassion in our culture. This work encouraged me to explore the effectiveness of how we train others in compassion and to develop a compassion intervention for those in the healthcare field.

Categories of Compassion

Several years ago, I began to parse compassion into various categories. Compassion did not seem very nuanced from the Western perspective (see Harrington[13] and Halifax[14]), and there appeared to be more categories of compassion than is usually thought the case. I realized that this would be relevant to clinicians, particularly those who worked on palliative care teams, where team bonding is essential and the in-group is strong. As well, from the conceptual and ethical perspective, clinicians who work in the end-of-life care field have a unique relationship to conceptually-based compassion in giving care to those who are gravely ill.

I want to acknowledge the insights of His Holiness the Dalai Lama and Buddhist scholar John Dunne in assisting in clarifying various categories of compassion. There seem to be two large categories of compassion: referential or biased compassion, i.e., compassion with an object; and non-referential or unbiased compassion, i.e., compassion that is objectless and pervasive[14]. Both of these types of compassion are important for clinicians to actualize in clinician/patient interactions.

Referential or Biased Compassion Includes Various Subtypes:

Referential compassion is subdivided into different subtypes, which can also be distinguished in compassion for in-group or out-group members. The different types of referential as well as non-referential compassion are summarized below.

Biologically based compassion: Parent/child bond, family bond, sexual bond
Attached compassion: Bonded in-group: medical team, combatants, neighbors
Compassion through identification: Having suffered in a particular way and identifying with the suffering of one who has had a similar experience of suffering
Reasoned compassion: Ethically based compassion: compassion perceived as a moral imperative
Conceptually based compassion: Compassion that arises as a result of having insight into the nature of interdependence and that all beings want happiness.

The second type of compassion is *non-referential or unbiased compassion*, also called *universal compassion*. This category came to my attention through Tibetan Buddhist teachings on compassion offered by His Holiness the Dalai Lama. It is compassion without an object, where compassion pervades the mind of the experiencer as a way of being.

Non-Referential or Unbiased Compassion:

Universal compassion: Pervasive compassion that is not directed towards an object

A.B.I.D.E. Model of Compassion

Compassion has been defined as “the emotion one experiences when feeling concern for another’s suffering and desiring to enhance that person’s welfare”[15] (see chapter 10 for broad definitions of compassion). Compassion is believed to have two main aspects: the affective feeling of caring for one who is suffering, and the motivation to relieve that suffering[16]. This definition is frequently used and represents a narrow definition of compassion. However, it might not take into account, for example, the experience of non-referential compassion. Moreover, the A.B.I.D.E. model assumes that compassion is a process that is contingent and emergent. It is often inter-relational and mutual, reciprocal and asymmetrical. Also, compassion is possibly not a discrete feature but an emergent and contingent process that is context sensitive and dependent on other mental features. This view of compassion can have important consequences in the clinical setting (for more detail

see Box VI) in relation to the G.R.A.C.E. intervention that is designed for compassion-based clinician/patient interactions.

Training others in the cultivation of compassion, particularly clinicians working in the end-of-life care field, necessitates that we clarify what we mean by compassion, what the sub-components of compassion are, what the processes that nourish and enhance compassion are and, in the case of clinicians, what sustains compassion in giving care to those who are suffering from a catastrophic illness or injury.

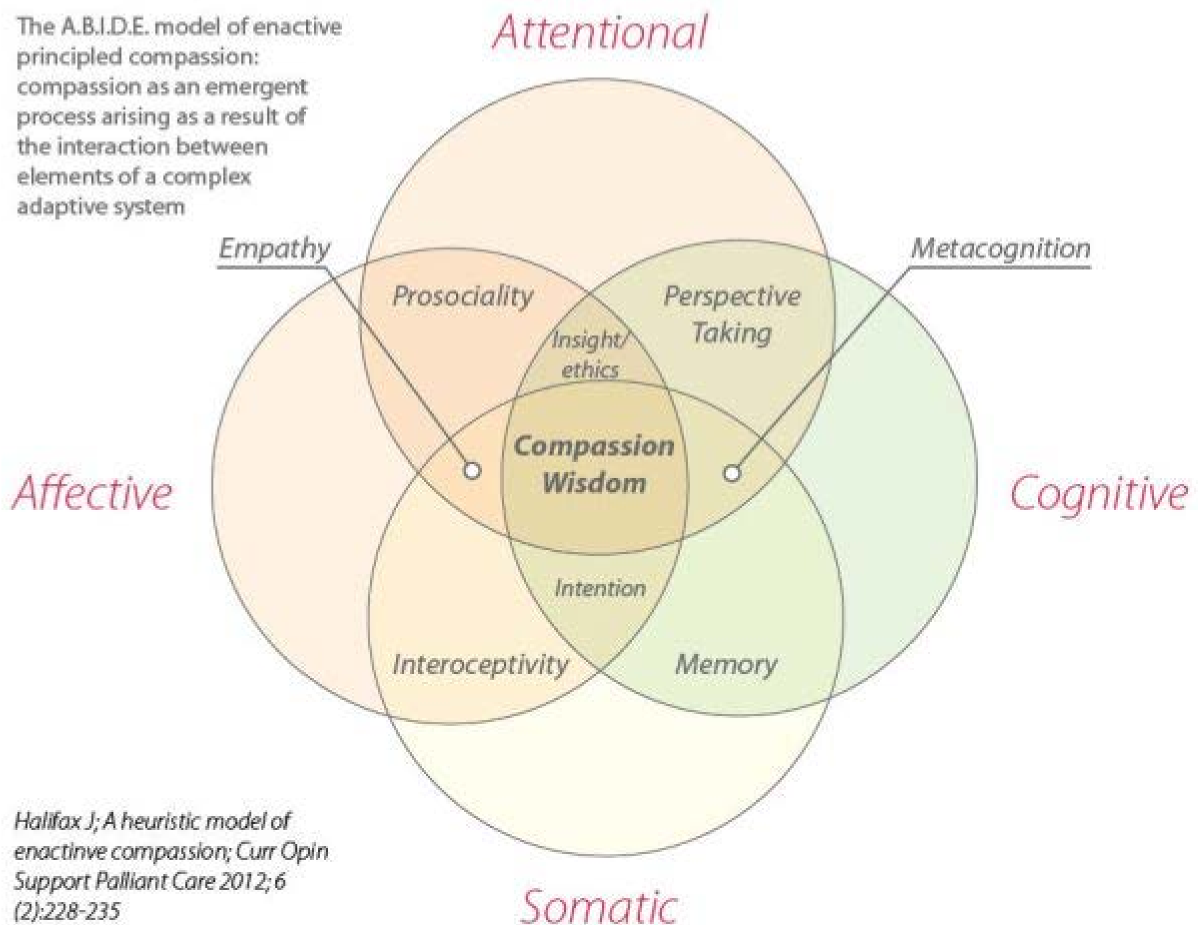

Figure 1: The A.B.I.D.E. Model

In the present model and in line with other views (see also chapter 8 and chapter 9), compassion is an emergent process arising out of the interaction of non-compassion processes.

The A.B.I.D.E. model is thus divided into three interdependent experiential areas that prime compassion: the A/A Axis, giving rise to attentional and affective balance; the I/I Axis, reflecting the cognitive domain and relating to the cultivation of intention and insight that support discernment; and the E/E Axis, or embodied and engaged processes that support engaged responses to the presence of suffering, and foster ethical grounding, eudaemonia and equanimity. These axes are non-linear and co-emergent.

The A/A Axis and Attentional Balance

The A/A Axis encompasses the subjective experiences of attention and affect; these domains support mental balance. The first part of the A/A Axis is attention. Attention forms the stable base of compassion; it is both biased by and contingent on affect and context[17]. William James, the nineteenth century psychologist, wrote that “Everyone knows what attention is. It is the taking

possession by the mind, in clear and vivid form, of one out of what seem several simultaneously possible objects or trains of thought. Focalization, concentration of consciousness are of its essence. It implies withdrawal from some things in order to deal effectively with others"[18].

Attention entails the allocation of mental processing resources to an object. Attention can be focused, selective, sustained, alternating, dispersed or divided. It can also be panoramic, where the attentional ground is inclusive, reflective and non-judgmental.

One cannot quite imagine compassion being present without attention being stable, whether attention is focused or panoramic. In order to recognize suffering in others or oneself, one must have cultivated attentional balance, where attention is at least focused and sustained or panoramic and inclusive. The ability to perceive in an unfiltered way the nature of suffering and also one's own responses to suffering requires attentional balance. Stable attention is sustaining, vivid and effortless; it is non-judgmental, non-reactive, not contracting in relation to unpleasant phenomena and not clinging to a desired outcome. Attention also makes it possible for cognitive processing to be grounded; cognitive control is needed for attention to be balanced, so that the attentional field is not disturbed by assumptions, judgment and reactivity.

Balanced attention can make accessible an unambiguous perception of reality, and in the case of compassion, an unbiased perception of suffering. Recent research has shown that the attentional training that entails a component of mindfulness meditation results in decreased susceptibility to the effects of emotionally arousing events upon task performance. This suggests that attentional balance enhances one's ability to perceive reality non-judgmentally, including the reality of suffering[19]. This ability is essential for compassion to be present when caring for those who are suffering from catastrophic illness and when giving compassion-based attention to family members and colleagues who are distressed around issues related to suffering, dying and death.

The A/A Axis and Affective Balance

The second domain in the A/A Axis is the emotional or affective domain. For clinicians, kindness and equanimity are essential affective processes associated with compassion. Kindness is characterized by a dispositional tenderness towards others combined with genuine concern. Equanimity is a process of stability or mental balance that is characterized by mental composure and an acceptance of the present moment. These two qualities are essential for clinicians who care for the dying. Equanimity also supports empathy, another affective feature frequently associated with the priming of compassion. Empathy is affective attunement with another. Affective attunement, often associated with compassion, might or might not elicit kindness, depending on the psychological makeup of the experiencer or the capacity of the experiencer to regulate her or his arousal level and maintain equanimity[6]. In the case of the latter situation, emotion regulation and attentional and affective balance are essential. These conditions, when engaged, can lead to compassion. Recent research has indicated that affective balance, compassion and other prosocial emotions can stabilize and broaden the attentional base and allow one to be more resourceful and have the capacity to make clearer discernments and decisions. Negative emotions, such as anger and fear, seem to narrow the attentional base and color perception, making discernment challenging[20]. In addition to kindness and equanimity, altruism, empathy, sympathetic joy, gratefulness and a long list of mental processes associated with positive psychology and prosociality can be fostered. Like attention, these seem to be trainable processes of mind. These prosocial processes can be greater or lesser features associated with the emergence of compassion. Whatever affective features are engaged, balance and regulation of these faculties is essential for compassion to be primed. There is no question that affective balance, combined with attentional balance, or equanimity, is critical to clinician well-being and resilience. The end-of-life

care field is a setting where deep emotions and existential issues prevail. The stabilization and regulation of the mental continuum in the face of dying on the part of clinicians can have profoundly beneficial effects on both clinician and patient[3].

I/I Axis and Prosocial Ethical Intention and Insight

One can ask the question: how do we regulate emotional responses like empathy so compassion can be nurtured and one does not fall into reactions of avoidance, abandonment, numbness or moral outrage, responses that are not uncommon in the clinical setting where the dying are cared for? Clearly, one of the most important interventions is balanced attention and affect (A/A Axis), as well as the ability to guide the mind in accord with one's intentions and stabilize the mental continuum in order to have insight about suffering, its origins and how to transform suffering. These dimensions are characteristic of the I/I Axis, the cognitive dimension that entails intention and insight. Both intention and insight must operate in conjunction with attentional and emotional balance (A/A axis), which enhance one's ability to have access to, be aware of and have potential control of the attentional, affective and cognitive continuum. Intention and insight can also support attentional and affective balance. From the point of view of this model, the attentional, affective, cognitive and somatic domains cannot be isolated, one from the other, nor can these domains be dissociated from the social, cultural and environmental surround of the individual.

Intention

The intention to transform suffering is one of the features that distinguishes compassion from empathy. From the point of view of compassion, intention is a key process in the cultivation of this mental faculty[21]. It is based in the prosocial experience of the motivation to transform the suffering of others as well as oneself. Intention priming compassion is based in part on an ethical orientation, which is the foundation of one's motivation to not harm, do good and to help others. This moral ground is fundamental to the practice of medicine. Even if one's motivation is altruistic, it can happen that aversive reactions and actions arise out of one's conditioning. In working with dying people, aversion is not uncommon. In this case, it is essential to override habitual responses, engage in positive and realistic appraisal, and learn how to down-regulate arousal or shift away from thoughts and behaviors that are destructive, from abandoning patients, engaging in moral outrage, or simply becoming numb to the suffering of patients, families and colleagues. This is usually done through the experience of insight based in self-awareness and supported by the intention to decrease the suffering of the patient and all those associated with the patient.

Insight

The second aspect of the I/I Axis is that of insight. Insight can support a metacognitive perspective and mental pliancy, hardiness and autonomy. In this cognitive dimension, self-awareness, including access to memory, can lead to insights about the nature of reality and can foster reappraisal and down-regulation, should that be necessary, when serving those who are dying. It also primes perspective taking or cognitive attunement, which allows one to understand the mental experience of another, whether colleague, dying person or family member. In a complementary fashion, the I/I Axis can nourish insight into the distinction between another and one's self, a key feature in referential compassion, or compassion with an object[14],[22]. Another dimension that is engaged in the compassion process is the recognition of one's moral grounding, which includes the deep sense of a moral imperative in how we relate to the world, and moral sensitivity that makes it possible for one to discern moral issues[23]. These features lead to the development of moral character, the basis of compassionate care[24]. In addition to these features in the cognitive domain, insight into the truth of impermanence and interconnectedness is essential, as is the

realization that all beings on some level wish to be free of suffering and want happiness. A final feature in the cognitive domain that is important is that there be no attachment to an outcome. Of course, compassion entails the aspiration to transform or end suffering. At the same time, the attachment to a particular outcome can be a cause of suffering. These two valences of 1) not having an unrealistic expectation for an outcome and 2) the dedication to supporting a beneficial outcome in relation to the experience of suffering can be viewed as the "two sides of the same coin" of intention. A clinician strives diligently to alleviate disease, pain and suffering, for example, but, at the same time, she or he has, in the best circumstances, "therapeutic humility", which leads the clinician to realize that he or she must accept the eventual course of events that may be swayed by influences beyond one's control. In sum, the I/I Axis, which has a cognitive base that is interrelated with the attentional and affective domains, has two valences: intention and insight. These interdependent valences produce mental pliancy and discernment, and can prime context-sensitive, principled compassion.

E/E Axis and Ethical Engagement and Embodiment

The E/E Axis is comprised of the somatic process associated with embodiment and engagement. The E/E Axis gives rise to three key features: ethike (moral virtue), equanimity and eudaemonia. The E/E axis is based on an enactive process where mind, body and the environment are contexts for each other and become the means for the generation of the embodied dimension of the inter-subjective, mutual, grounded and interactive processes associated with compassion. Embodiment can be said to be the source of the felt sense of another's suffering through the experience of inter-subjective resonance, wherein another's experience feels as if it is happening in the subject's own body. Embodiment is viewed as forming a fundamental base for the compassionate, interactive, enacted, engaged life. The enactive experience reveals directly and indirectly how the mind, body and environment are inter-related in a dynamic co-emergent process. Here, perception, cognition, and action or engagement give rise to the subjective experience of one's embeddedness in the world.

Engagement with and Response to Suffering

The E/E Axis is also associated with the experience of the body having a dispositional readiness for action in the environment. Here, one's bodily being and the environment are contexts for each other and the interactive basis for the generation of compassion. Compassion in action is relational, mutual, reciprocal and asymmetrical. This axis grounds inter-subjectivity in bodily action and interaction. From the base of the embodied mind, engagement with the world arises. In the case of compassion, the mind is in a state of readiness to meet the world in response to suffering. Without the world priming the mind, compassion would not arise as a non-linear, interdependent, adaptive and sense-making process. One of the mental features that arises when all these axes are activated is equanimity. Equanimity is characterized by a calm, even, balanced state of mind; it is also supported by the realization of the truth of impermanence and holding things in equal regard. This mental faculty is accompanied by eudaemonia, translated as human flourishing or happiness, another potential outcome of compassion. For the Greeks, eudaemonia correlates with the highest human good and the exercise of goodness and morality, what Buddhists call "basic goodness". A third valence is "ethike", or moral virtue, which is also present in principled compassion and reflects the outcome of intention and insight in action. Principled compassion is compassion that does no harm to self or other. Compassion is an emergent process arising out of the interaction of a number of interdependent attentional, affective, cognitive and embodied or somatic processes, all of which themselves can be trained in. There is no compassion without attentional and affective balance. Compassion is not possible without prosocial intention and insight, including insight about the distinction between self and other. And compassion is an

embodied and engaged process that can lead to a direct and transformative relationship with suffering and be enacted in the world. Since compassion seems to be an emergent process rather than a mental feature, the implication that this has regarding the trainability of compassion for clinicians is quite different from assumptions often made by those who wish to train others in compassion. One can set the field for the emergence of compassion by training in the faculties associated with the A/A Axis, I/I Axis and E/E Axis. In the last section of this paper, I propose an intervention that can support the priming of compassion for clinicians by bringing together the features described in the compassion model.

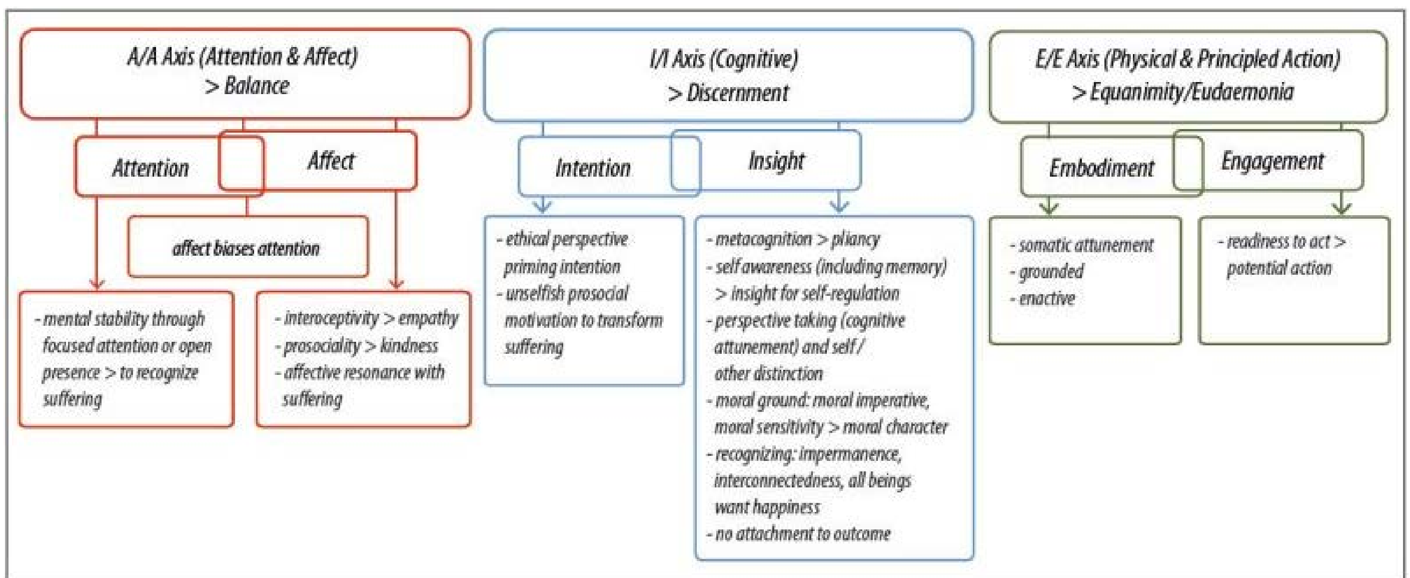

Figure 2: Summary Figure

This is a summary figure of the A.B.I.D.E. heuristic model of modes that prime and optimize principled compassion (attention is biased, contingent upon affect and context)

The mnemonic of the A.B.I.D.E. compassion model can assist clinicians in recalling the elements of the model, though it is important to recall that the model itself is non-linear, and compassion is an emergent process arising from the combination of all these faculties:

A.B.I.D.E. = Compassion:

A = Attention and Affect >

B = Balance

I = Intention and Insight >

D = Discernment

E = Embodiment and Ethical Enactment

Engagement > Equanimity/Eudaemonia

Summary

In training clinicians to care compassionately for those who are dying, Upaya’s professional training program in compassionate end-of-life care has developed a granular approach to compassion for teaching purposes. This chapter has outlined a typology of compassion, parsing compassion into two main types: referential compassion and non-referential compassion, in other words, compassion with an object and universal compassion. The chapter then goes on to outline a model of compassion that includes the interaction between attention and prosocial affect, ethical intention and insight, and embodiment and engagement.

Acknowledgements

The author acknowledges Dr. Alfred Kaszniak for his help with the neuroscience and citations, Dr. George Chrousos for his input around the Venn Diagram and discussions on compassion during her tenure at the Library of Congress; Drs. John Dunne and Evan Thompson for their insights regarding enaction and philosophical perspectives. Drs. Tony Back and Cynda Rushton for work with me on the G.R.A.C.E. intervention. And Peggy Murray for editorial contributions. Gratitude to Drs. James Billington, Head Librarian at the Library of Congress, and Carolyn Brown, Director of the Office of Scholarly Programs and John W. Kluge Center, Library of Congress, for her tenure as a Kluge Distinguished Scholar at the Library of Congress.

References

1. Halifax, J. (2008). *Being with dying: Cultivating compassion and fearlessness in the presence of death*. Boston: Shambhala.

2. Halifax, J. (2012). A heuristic model of enactive compassion. *Current Opinion in Supportive and Palliative Care, 6*(2), 228–235.

3. Hylton Rushton, C., Sellers, D. E., Heller, K. S., Spring B., Dossey, B. M., & Halifax, J. (2009). Impact of contemplative end-of-life training program: Being with dying. *Palliative and Supportive Care, 7*(4), 405–414.

4. Figley, C. R. (Ed.) (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Routledge.

5. Duerr, M. (2008). *The use of meditation and mindfulness practices to support military care providers: A prospectus*. Northampton: Center for Contemplative Mind in Society.

6. Eisenberg, N. (2002). Empathy-related emotional responses, altruism, and their socialization. In R. J. Davidson, & A. Harrington (Eds.), *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature* (pp. 131–164). New York: Oxford University Press.

7. Dalai Lama (2002). Understanding our fundamental nature. In R. J. Davidson, & A. Harrington (Eds.), *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature* (pp. 66–80). New York: Oxford University Press.

8. Vaish, A., & Warneken, F. (2012). Social-cognitive contributors to young children's empathic and prosocial behavior. In J. Decety (Ed.), *Empathy: From bench to bedside* (pp. 131–146). Cambridge, MA: MIT Press.

9. Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. *PLoS One, 3*(3): e11897. doi:10.1371/journal.pone.0001897

10. Lutz, A., Greischar, L. L., Perlman, D. M., & Davidson, R. J. (2009). BOLD signal in insula is differentially related to cardiac function during compassion meditation in experts vs. novices. *NeuroImage, 47*(3), 1038–1046.

11. Pace, T. W., Negi, L. T., Adame, D. D., Cole, S. P., Sivilli, T. I., Brown, T. D., Issa, M. J., & Raison, C. L. (2009). Effect of compassion meditation on neuroendocrine, innate immune and behavioral responses to psychosocial stress. *Psychoneuroendocrinology, 34*(1), 87–98.

12. Marsh, A. A. (2012). Empathy and compassion: A cognitive neuroscience perspective. In J. Decety (Ed.), *Empathy: From bench to bedside* (pp. 191–205). Cambridge, MA: MIT Press.

13. Harrington, A. (2002). A science of compassion or a compassionate science? What do we expect from a cross-cultural dialogue with Buddhism? In R. J. Davidson, & A. Harrington (Eds.), *Visions of compassion: Western scientists and Tibetan Buddhists*

examine human nature (pp.18–30). New York: Oxford University Press.

14. Halifax, J. (2011). The precious necessity of compassion. *Journal of Pain and Symptom Management, 41*(1), 146–153.

15. Leiberg, S., Klimecki, O., & Singer, T. (2011). Short-term compassion training increases prosocial behavior in a newly developed prosocial game. *PLoS One, 6*(3): e17798. doi:10.1371/journal.pone.0017798

16. Hofmann, S. G., Grossman, P., & Hinton, D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological interventions. *Clinical Psychology Review, 31*(7), 1126–1132.

17. Todd, R. M., Cunningham, W. A., Anderson, A. K., & Thompson, E. (2012). Affect-biased attention as emotion regulation. *Trends in Cognitive Sciences, 16*(7), 365–372.

18. James W. (1891). *The principles of psychology*. Cambridge, MA: Harvard University Press.

19. Ortner, C. N. M., Kilner, S. J., & Zelazo, P. D. (2007). Mindfulness meditation and reduced emotional interference on a cognitive task. *Motivation and Emotion, 31*(4), 271–283.

20. Fredrickson, B. L., & Branigan, C. (2005). Positive emotions broaden the scope of attention and thought-action repertoires. *Cognition and Emotion, 19*(3), 313–332.

21. Schmidt, S. (2004). Mindfulness and healing intention: Concepts, practice, and research evaluation. *The Journal of Alternative and Complementary Medicine, 10*(S1), S7–S14.

22. Lamm, C., Batson, C. D., & Decety, J. (2007). The neural substrate of human empathy: Effects of perspective-taking and cognitive appraisal. *Journal of Cognitive Neuroscience, 19*(1), 42–58.

23. Rushton, C. H., & Penticuff, J. H. (2007). A framework for analysis of ethical dilemmas in critical care nursing. *AACN Advanced Critical Care, 18*(3), 323–328.

24. Schopenhauer, A. (1995). *On the basis of morality*. Providence: Berghahn Books