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Investigating the relationship between the perception of common humanity and compassion in healthcare workers

Deborah Jane Ling

Bachelor of Social Work

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Department of Social Work

Faculty of Medicine, Nursing and Health Sciences

Monash University

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This thesis includes one original paper published in a peer reviewed journal and four submitted publications. The core theme of the thesis is investigating the relationship between the perception of common humanity and compassion in healthcare workers. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the Department of Social Work, Monash University under the supervision of Dr Melissa Petrakis and Professor John Olver.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapter Two and Chapter Four my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status *(published, in press, accepted or returned for revision, submitted)*	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*
Chapter Two	Compassion: A conceptual analysis and critical review	Submitted	100%. Concept, reviewed literature, prepared and revised manuscript	
Chapter Four	Investigating how viewing common humanity impacts compassion: A novel approach	In press	75%. Reviewed literature, prepared and revised data collection instruments, collected data, coded data, conducted analyses, prepared and revised manuscript	1. Professor John Olver input into manuscript (15%) 2. Dr Melissa Petrakis input into manuscript (10%)
Chapter Four	The use of common humanity scenarios to promote compassion in healthcare workers	Returned for revision	80%. Reviewed literature, prepared data collection instruments, coded data, conducted analyses, prepared and revised manuscript	1. Dr Melissa Petrakis input into manuscript (10%) 2. Professor John Olver input into manuscript (10%)
Chapter Four	Outcomes from a compassion training intervention for health care workers	Published	75%. Reviewed literature, collected data, coded data, conducted analyses, prepared and revised manuscript	1. Dr Melissa Petrakis input into manuscript (15%) 2. Professor John Olver input into manuscript (10%)
Chapter Four	An outline of a Compassion eLearn for healthcare workers	Submitted	80%. Reviewed literature, prepared and revised manuscript.	1. Professor John Olver input into manuscript (10%) 2. Dr Melissa Petrakis input into manuscript (10%)

I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis. Additionally, English spelling (American/British) and referencing styles vary across the submitted or published papers due to specific journal requirements.

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Student signature: **Date: 29/06/2019**

Main Supervisor signature: **Date: 29/06/2019**

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Abstract

Compassion is universally acknowledged as a virtue. It is defined as a sense of concern in response to another's suffering combined with a desire to alleviate the suffering of the other. Compassion is the basis of care and concern for others and is a core value in healthcare. Compassion has only recently become the subject of research studies. Neuroscience research is now showing that compassion is a positive state of mind, leads to feelings of warmth, concern, reward and affiliation, promotes helping behaviours towards others and can be trained. There have been several compassion training courses developed which are now being delivered in hospitals, schools and workplaces. However, there is a lack of consensus regarding definitions of compassion and its core mechanisms are not well understood.

There is an absence of studies that have attempted to isolate the core components of compassion. Several researchers have hypothesised that the perception of common humanity is the foundation of compassion. Common humanity involves recognising that all humans share the same basic needs. Human vulnerabilities and frailties are common to all. The perspective of common humanity appears to be a prerequisite for unbiased compassion. Someone who holds the perspective of common humanity has compassion towards any other person, not just their close others. To date, there has been no empirical research to investigate this.

The literature review in the current study revealed that there is a lack of clarity regarding what compassion is and how it comes into being. The Sequential-Relational Model of Compassion was developed though this PhD research to explain the compassion process and the relevance of common humanity. The study employed a mixed methods approach to investigate the relationship between the perception of common humanity and compassion in

healthcare workers. Structured surveys were used to collect both quantitative and qualitative data. The study incorporated two components. First, a pre/post intervention study was undertaken to investigate how viewing common humanity scenarios impacts on healthcare workers' level of compassion. Seventy-five healthcare workers viewed a common humanity scenario and completed pre- and post-test validated scales on perspective taking, common humanity and compassion. The quantitative data was analysed using descriptive statistics, nonparametric statistics, bivariate analysis and multivariate analysis. The qualitative data was analysed using thematic analysis. The results showed that compassion was significantly increased by viewing common humanity scenarios. There was evidence to suggest that perspective taking influences compassion, mediated by common humanity. Second, a compassion training session focusing on common humanity was trialled and evaluated. One hundred healthcare workers attended the compassion training session and provided feedback that the session helped them cultivate compassion. A Compassion eLearn, based on the compassion training outline, was subsequently designed so that the compassion training could be taken to scale.

This study provides quantitative and qualitative evidence to support the notion that the perception of common humanity is the foundation of compassion. This has important implications for future compassion research, the design of compassion training interventions for healthcare workers and the development of scales to measure compassion.

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Chapter 1. Introduction

1.1 Background to the study

Compassion is universally acknowledged as a virtue. Compassion is innate: humans have an inbuilt drive to respond to distress in their offspring, without which humanity would not survive. The ability to have care and concern for others is essential for thriving societies (Clark 1997; Crocker & Canevello 2008; Wuthnow 1990). A widely cited definition of compassion is 'the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help' (Goetz, Keltner & Simon-Thomas 2010, p.351). In historical records of the West, compassion is mentioned as far back as Aristotle in Ancient Greece around 350BC. In Eastern records, compassion is a central feature of Buddhist texts dating back 2,500 years. In recent times there has been the development of the worldwide Charter for Compassion. In 2009, a global Charter for Compassion was created which urged the people of the world to 'do unto others as you would have done unto you' (Charter for Compassion 2009). One hundred and fifty thousand people from 180 countries contributed to the development of the Charter for Compassion with the final product being crafted by a Council of Conscience, composed of leading thinkers and activists. To date, over 450 cities around the world have affirmed and initiated compassionate activities in their community. The Charter for Compassion (2009) states in its opening paragraph:

> *The principle of compassion lies at the heart of all religious, ethical and spiritual traditions, calling us always to treat all others as we wish to be treated ourselves. Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there, and to honour the inviolable sanctity of every single human being, treating everybody, without exception, with absolute justice, equity and respect.*

Compassion has only become the topic of research over the last two decades. Much of this recent research interest has been driven by findings from neuroscience. Research has revealed that compassion is a positive state of mind and associated with feelings of reward and affiliation (Klimecki, Leiberg, Lamm & Singer 2013; Preckel, Kanske & Singer 2018; Singer & Klimecki 2014). Compassion has been shown to improve wellbeing (Fredrickson, Cohn, Coffey, Pek & Finkel 2013), increase caring behaviour (Keltner, Kogan, Piff & Saturn 2014; Mayseless 2015) and increase social connectedness (Hoffman 2011; Kanov, Maitlis, Worline, Dutton, Frost, & Lilius 2004; Shonin, Van Gordon, Compare, Zangeneh & Griffiths 2015). Compassion has been shown to reduce the desire for punishment and revenge (Condon & DeSteno 2011). Compassion has been associated with increased altruism towards strangers (Preston 2013; Weng, Fox, Shackman, Stodola, Caldwell, Olson, Rogers & Davidson 2013). There is research that suggests that compassion has a positive impact on those who witness it and receive it (Dutton, Lillius & Kanov 2007). A number of studies have indicated that compassion can be trained (Klimecki, Leiberg, Ricard & Singer 2013; Leiberg, Klimecki & Singer 2011; Weng et al. 2013).

However, there is debate in the literature regarding definitions of compassion. The Oxford English Dictionary says the word 'compassion' comes from the Latin 'compati' which means to 'suffer with'. The Dalai Lama, perhaps the most prominent champion of compassion in the world today, defines compassion as an openness to the suffering of others with a commitment to relieve it (Lama & Thupten 1995). Compassion is commonly acknowledged to be complex (Cassell 2009; Jinpa 2016). There is a wide range of terms that are used to define compassion, for example Kanov et al. (2004) propose that compassion involves noticing, feeling and responding. Gilbert (2010) suggests compassion involves sensitivity, sympathy, empathy, motivation/caring, distress tolerance and non-judgement. Pommier (2010) suggests

compassion involves mindfulness, common humanity and kindness. Martins et al. (2013) propose that compassion involves generosity, hospitality, objectivity, sensitivity and tolerance. Conceptualisations of compassion in the literature are numerous and multifaceted. There have been a number of compassion training interventions developed which involve an equally wide array of competencies including empathy, sympathy, distress tolerance, mentalising, mindfulness, yoga, loving kindness meditation, common humanity, breath training, acting simulations, working on self-criticism (Kirby 2016). There is a notable absence of empirical studies that provide evidence for a connection between these competencies and compassion. There are urgent calls for greater conceptual clarity regarding compassion (Kirby 2016; Ledoux 2015; Sinclair, Norris, McConnell, Chochinov, Hack, Hagen, McClement & Bouchal 2016). Without an agreed upon definition and clear understanding of what compassion is and how it comes into being, it is difficult to research compassion, measure compassion and evaluate the effectiveness of compassion training interventions (Strauss, Taylor, Gu, Kuyken, Baer, Jones & Cavanagh 2016).

Compassion is also often used interchangeably with a range of related terms such as pity, empathy and sympathy (Sinclair et al. 2016; Strauss et al. 2016). Pity involves a condescending view of the other (Von Dietze & Orb 2000) and pity lacks a sense of respect for the other. Empathy involves being affected by and sharing another's emotion (Gilbert 2010). It is important to note that one can have empathy towards any emotion of another, both positive and negative. Compassion, on the other hand, is exclusively directed to another's suffering. Empathy does not incorporate a wish for the other's suffering to be relieved. Although empathy is often described as a prosocial emotion, it is possible for empathy to be used for immoral gain, for example a con artist capitalising on someone's vulnerable feelings. Sympathy involves feeling kindly towards someone who is suffering (Ricard 2015) but does

not involve a desire to alleviate their suffering. Given the subtle nuances between some of these related terms and the ease with which they can be confused, it is not surprising that the research literature on compassion can lack clarity and contain misunderstandings. The core mechanisms of compassion are currently poorly understood (Goetz & Simon-Thomas 2017; Skwara, King & Saron 2017). More research needs to be undertaken to gain greater understanding of how compassion comes into being. Historically, there has been much more research and training into empathy.

Neuroscience research is now showing that the neural pathways for empathy and compassion are different. Empathy can lead to two different pathways, one of which is empathic concern. Empathic concern is similar to compassion in that it is focused on the other and is a positive state of mind for the giver. On the other hand, compassion goes a step further than empathic concern by wishing for the other's suffering to be relieved. Empathy's second pathway is empathic distress, where one overidentifies with the suffering of the other or imagines oneself experiencing their pain, which is a negative self-focused reaction (Eisenberg 2002). Empathic distress stimulates neural circuitry related to pain (Klimecki & Singer 2012). Compassion, however, is now understood to be protective for the giver against burnout. The term 'compassion fatigue' is now being proposed to actually be 'empathic distress fatigue' (Klimecki & Singer 2012).

Empathy has been widely mentioned in the research literature for decades and tends to be the main focus of training for the helping professions. The recent findings from neuroscience are revealing that care needs to be taken to distinguish between empathy and compassion. It is important for healthcare workers to understand that empathy can unwittingly turn into a response which is negative for them. This is one of the reasons why

compassion training is so important – it is crucial to ensure healthcare workers understand what compassion is, how it differs from empathy, and to be careful about accidentally developing empathic distress.

Compassion is a core value of hospitals and the helping professions. Compassion is embedded in the codes of practice for professions such as social work, nursing and medicine. In an ideal world, healthcare workers would have compassion for every patient they see. A number of research institutes have been established over the last two decades to investigate the neural correlates of compassion, its antecedents and methods for developing compassion. These research institutes include the Centre for Compassion and Altruism Research and Education at Stanford University, Greater Good Science Centre at University of California, Center for Healthy Minds at University of Wisconsin-Madison and the Center for Contemplative Science and Compassion-Based Ethics at Emory University. Several compassion training courses have been developed including Compassion Cultivation Training by Stanford University and Cognitively Based Compassion Training developed by Emory University. These courses have been delivered in a wide range of settings including hospitals, universities and workplaces.

Research and training in compassion is held back by the lack of agreement amongst researchers regarding its conceptual specificity and core mechanisms. Several researchers suggest that the perception of common humanity is the foundation of compassion (Blum 1980, Cassell 2009; Feldman & Kuyken 2011; Jinpa 2016; Nussbaum 1996; Van Der Cingel 2009; Von Diteze & Orb 2000). This is an important area where there has been no empirical research undertaken to examine the relationship between the perception of common humanity and compassion. People commonly have compassion towards their loved ones

which is a biased form of compassion. It only includes others who have a close relationship to the person. Evolutionary approaches suggest that compassion enables caregivers to respond to suffering in their offspring and ensure the offspring survive (Bowlby 1969; Mikulincer & Shaver 2003). Compassion towards strangers or those who have no relationship towards oneself is called 'universal compassion'. Some people demonstrate considerable universal compassion towards strangers, sometimes at high personal cost to themselves. Universal compassion is poorly understood in the research literature and is the focus of this study. For clarity's sake, the term compassion will be understood to mean 'universal compassion' in this study as that is the context in which compassion is most commonly used. It is important for the new field of compassion research to gain an understanding of the underlying mechanisms of compassion and how these can be enhanced.

The perception of common humanity offers a coherent explanation for why some people help strangers in need. Common humanity recognises the basic similarity between self and others. Every single person wishes for happiness and does not wish to suffer (Jinpa 2016; Ricard 2015), yet all humans are subject to birth, ageing, sickness and death. Common humanity acknowledges the universality of suffering (Feldman & Kuyken 2011; Strauss et al. 2016). Pommier (2010) suggests that the perception of common humanity involves realising that all humans suffer and one could find oneself in the position of the sufferer if one were less fortunate. The perspective of perceived similarity, sharing a common humanity, diminishes in-group/out-group distinctions (Galinksy & Moskowitz 2000; Penner, Dovidio, Piliavin & Schroeder 2005; Sturmer, Snyder, Kropp & Siem 2006). There have been studies that suggest people have a positive bias towards their perceived in-group (Chiao & Mather 2010; Ruckmann, Bodden, Jansen, Kircher, Dodel & Rief 2015; Tajfel & Turner 1986). There are also studies suggesting in-group boundaries can be altered (Oveis, Horberg & Keltner 2010;

Valdesolo & DeSteno 2011). The perception of common humanity strengthens one's identification with all other humans, everyone becomes the in-group. Identifying with the other, seeing them as the same as oneself in terms of human frailty and vulnerability, leads to a valuing of the other.

1.2 Significance of the current study

Compassion is increasingly recognised as important in all spheres of society and it is now frequently mentioned in relation to healthcare, education, leadership and politics. Compassion training programs are being delivered in hospitals, schools and organisations. Developing a greater understanding of what compassion is and the factors which enable it to come into being is a pressing priority given compassion is considered the foundation of healthcare (Lown, Dunne, Muncer & Chadwick 2017; Shea & Lionis 2017).

Healthcare workers are confronted with patients who are suffering on a daily basis. Clearly it is not always easy to be compassionate to others. The topic of compassion in healthcare has been debated around the world for decades, particularly when there have been distressing examples where compassion has been absent. There has been much discussion pertaining to how to increase compassion in healthcare and support healthcare workers to sustain a compassionate stance towards their patients (Post, Ng, Fischel, Bennet, Bily, Chandran, Joyce, Locicero, McGovern, McKeefrey & Rodriguez 2014; Sinclair et al. 2016). Approaches that help healthcare workers cultivate and maintain compassion are needed and there is much interest in the potential of compassion training courses (Skwara, King & Saron 2017).

Healthcare workers are expected to treat all patients with compassion, irrespective of the reason the patient is in hospital. The patient may have contributed to a car accident through

drunk driving and become injured or may be the innocent victim of a car accident. Healthcare workers do not discriminate against patients based on a judgement of whether the patient is deserving of care or not. Compassion offers warmth, concern and care to whoever suffers. The inclusiveness of compassion is one of the reasons it holds an elevated status as a virtue. Compassion respects the dignity of all persons and taps into the noble sentiments of the United Nations Universal Declaration of Human Rights (1948) which states, 'All humans are born free and equal in dignity and rights.'

Healthcare is a demanding environment to work in (West & Chowla 2017). There is evidence to suggest that many healthcare professionals suffer from burnout and stress (Kim & Lee 2009; McHugh, Kutney-Lee, Cimiotti, Sloane & Aiken 2011; Prins, Gazendam-Donofrio, Tubben, Van der Heijden, Van de Wiel & Hoekstra-Weebers 2007). In the UK, the NHS was rocked by devastating failures of humanity in its healthcare system (Francis 2013). Some patients were not given basic care including toileting, nutrition, dignity and pain relief (Shea & Lionis 2017). The question of how to foster compassionate mental states and behaviours is critically important (Condon & DeSteno 2017).

There are many external factors that will have a significant influence on a person's ability to have compassion. Excessive workloads, poor processes and unsupportive management can impair compassion in the workplace (Fernando, Arroll & Consedine 2016; Lown, McIntosh, Gaines, McGuinn & Hatem 2016). These external factors are not the focus of this study. This study is concentrating on internal perspectives that the individual holds when they view another who is suffering. Since the perception of common humanity has been proposed to be fundamental to compassion, it is important to explore what the relationship is between the perception of common humanity and compassion in healthcare workers. If the perception of

common humanity is a prerequisite for compassion for others, then it is crucial that healthcare workers are provided with training in how to enhance this perspective. If healthcare workers can be provided with techniques which enhance compassion, the workers themselves benefit as compassion is a positive state of mind. Several studies have shown that compassion leads to an increase in prosocial behaviours such as caring, helping others, increased social connectedness etc. (Bierhoff 2015; Brown & Brown 2015; Penner et al. 2005). If healthcare worker compassion is boosted, it enables workers to be more caring and responsive to patients. Everyone benefits including the healthcare worker, the patient and the healthcare organisation.

1.3 Relevance to social work

The social work profession has a profound respect for all persons by virtue of their basic humanity. Radey and Figley (2007, p.207) say, 'In the most basic sense, clinical social workers are guided by compassion for humanity and an altruistic desire to improve individual and societal conditions'. Morley and Ife (2002) suggest that social work is based on sharing a common humanity and that the value of humanity holds a central place in social work. The Australian Association of Social Workers (AASW) Code of Ethics (2010) states that its values include a 'belief in the equal worth of all human beings' and 'respect for others, including compassion, fairness, equity and justice'. Social work has a belief in the potential for positive change and transformation. Bisman (2004) states that social work's primary focus is caring. It is a profession dedicated to the service of humanity. The notion of respect for all persons is an integral part of social work ethics (Gray & Stofberg 2000). Social work's emphasis on respect for all humans stands side by side with the noble virtue of compassion. Compassion is a virtue precisely because it honours the dignity of all human beings, not just some. An

important point to note is that respect for the person does not mean one has to condone what they do (Adams, Dominelli & Payne 2009). One can still respect the humanity of another but accept that justice is required. For example, a social worker working with prisoners acknowledges the prisoner has committed a crime but works with them to assist with their rehabilitation and integration back into society. Social work is a profession that believes in people's potential, capacity to change and the possibility of transformation. Social workers can be found working with both the victims of crime and with the perpetrators of crime.

Social work's foundational perspectives of person-in-environment and systems theory acknowledge that there are many complex factors coming into play in any situation. Social work, like the perspective of common humanity, holds that people are not defined by their 'problem'. Canda and Furman (2010, p.20) say that the client 'should never be reduced to a pathology or deficit label or negative expectations that come along with it. To define a person or situation only in terms of problems, defects, barriers, or deficiencies is to dehumanise…'. Once separation and differences are emphasized, people can become objectified, labelled and stereotyped ending up in full blown dehumanisation (Bilson 2006; Jinpa 2016). The focus on common humanity and respect for all persons ensures that society treats all its members in a fair and just manner.

Having compassion does not mean that one is always able to alleviate the suffering of the other. Sometimes a compassionate action may be empowering the other to make good choices. In many instances, one may feel compassion for others where there is very little one can do in a practical sense, such as for those suffering from war on the other side of the world. One can still have compassion without necessarily being able to benefit the recipient (Jinpa 2016). Inability to change the other's situation is not a failure of compassion: it is a reflection

of the messy, complex nature of real life. There are not always quick, effective solutions for all problems. Concepts such as the perception of common humanity and compassion hold a central place in social work theory and practice. Social work research aims to contribute to the betterment of humanity.

1.4 Research aim

The aim of this thesis including published works is to investigate the relationship between the perception of common humanity and compassion in healthcare workers.

1.5 Study questions

The main research question is:

What is the relationship between the perception of common humanity and compassion in healthcare workers?

Subsidiary questions are:

1. What is compassion and how does it come into being?

2. How does viewing common humanity scenarios impact on healthcare workers' level of compassion?

3. Does education on common humanity influence compassion in healthcare workers?

4. How can compassion training for healthcare workers be taken to scale?

1.6 Research methodology

The literature review incorporated a critical review to explore the first subsidiary research question of what compassion is and how it comes into being. A mixed methods approach was utilised to examine the relationship between the perception of common humanity and

compassion in healthcare workers. Few studies have attempted to explore the mechanisms of change in compassion (Skwara, King & Saron 2017). No studies have undertaken an empirical investigation of the relationship between the perception of common humanity and compassion. One part of this study involved conducting a pre/post intervention investigating whether viewing common humanity scenarios had an impact on compassion in healthcare workers. This part of the study addressed subsidiary research question two. Given the infancy of compassion research and the lack of clarity regarding what compassion is, the study also collected qualitative comments from the healthcare workers regarding their viewpoints on compassion. A compassion training session focusing on common humanity was also trialled and evaluated. This part of the study explored the third subsidiary research question. A Compassion eLearn was developed out of the content of the compassion training session and this addressed the fourth subsidiary research question.

1.7 Thesis including published works

This thesis is structured to include published works as well as articles submitted for publication.

1.8 Thesis outline

This thesis includes five chapters. The first chapter is the Introduction. The second chapter is the Literature Review which reviews the literature in relation to common humanity and compassion. The Literature Review also includes Article One, 'Compassion: A Conceptual Analysis and Critical Review' which has been submitted to *Clinical Social Work Journal*. The third chapter outlines the Methodology. The fourth chapter contains the Results and is comprised of four articles. Article Two, 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach' presents the quantitative research

component. This article has been accepted for publication in the *British Journal of Social Work*, and is currently in press. Article Three, 'The Use of Common Humanity Scenarios to Promote Compassion in Healthcare Workers' details the qualitative research component. It has been submitted to *Australian Social Work* and has been returned for revision after undergoing blind peer review. Article Four is 'Outcomes from a Compassion Training Intervention for Health Care Workers'. This article was published in a special edition of *Czech and Slovak Social Work* journal focusing on social work in health care in August 2018. It outlines the evaluation of the compassion training session provided to healthcare workers which was conducted as part of the research. Article five, 'An Outline of a Compassion eLearn for Healthcare Workers', describes a Compassion eLearn which was developed based on the compassion training content. This article has been submitted to *Health and Social Work*. The fifth chapter contains the Discussion and Conclusion.

Chapter 2. Literature Review

2.1 Compassion

An examination of the current literature on compassion reveals an interesting picture. On the one hand, there appears to be almost unanimous agreement with the definition of compassion used in Goetz et al.'s (2010, p.351) widely cited review, where compassion is defined as 'a feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help'. Thupten Jinpa (2016, p.xx), who developed the Stanford Compassion Cultivation Training describes compassion as 'a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved'. Lazarus (1991, p.289) defined compassion as 'being moved by another's suffering and wanting to help'. The majority of definitions agree that compassion is a response to *another's* suffering (Blum 1980; Nussbaum 1996; Von Dietze & Orb 2000; Kanov, Maitlis, Worline, Dutton, Frost & Lilius 2004; Cassell 2009; Feldman & Kuyken 2011; Strauss et al. 2016) and this is the context in which compassion is most well-known. For example, in hospitals where compassion is commonly stated as a core value, the meaning of compassion is the care that staff give to patients. The Charter for Compassion, a global movement to promote compassion, speaks of compassion as something that 'impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there' (Charter for Compassion 2009).

There are some definitions of compassion which diverge from the above definitions in significant ways. Gilbert (2016) defines compassion as 'a sensitivity to suffering in self and others with a commitment to try and alleviate and prevent it'. The introduction of the 'self' into the definition of compassion raises problems. If we are focusing on our own suffering, at

that moment we are not focusing on the other. In an emergency where someone has life-threatening injuries, there is a major difference in attending to the immediate needs of the severely injured person or focusing on one's own distress. In fact, the difference between concern for the other or concern for oneself can lead to a life or death situation for someone who is severely unwell. Batson (2017) makes the point that with compassion, the ultimate goal is the welfare of the other. Apart from Gilbert (2016), there do not appear to be other researchers arguing a case that compassion involves a focus on the self in the definition. Compassion focused therapy (Gilbert 2009) is a growing area of interest in psychotherapy but it appears to focus entirely on the self. This interpretation of what compassion is runs counter to the consensus view that compassion is a response to the suffering of another. It is important for these conceptual issues to be clarified. The confusion about who is the target of compassion, self or other, is taken further with the concept of 'self-compassion' which was popularized by Kristin Neff (2003). If one accepts the consensus definition that compassion is a response to another's suffering, then the term 'self-compassion' seems to be an oxymoron, a logically impossible term. Perhaps a more logically coherent term than 'self-compassion' is 'self-care' or 'self-acceptance'. The fact that the word 'self' has to be placed in front of compassion to create the term 'self-compassion' suggests that compassion is not focused on the self.

Another common term which is being contested is 'compassion fatigue'. The concept of compassion fatigue was popularized in the 1990's (Figley 1995, Joinson 1992). It has been suggested that the term lacks conceptual clarity (Ledoux 2015) and is actually describing burnout. Neuroscience research has revealed that compassion is a positive state of mind and that it is actually empathic distress that leads to burnout (Klimecki & Singer 2012). It is important to be clear about what is actually the topic of investigation.

Other terms that have been mentioned with compassion are mindfulness and kindness. Pommier (2010) suggests that compassion includes mindfulness, common humanity and kindness. A commonly used definition of mindfulness is paying attention to the present moment in a non-judgemental way (Kabat-Zinn 1982). One could suggest that mindfulness is a prerequisite for any task that requires attention, not just compassion. There have been a number of conferences with the title 'Mindfulness and Compassion'. There can be no doubt that mindfulness aids compassion but there are also numerous conferences themes such as 'Mindfulness and Leadership', 'Mindfulness and Education', 'Mindfulness in the Workplace' etc. Mindfulness, it appears, can be applied to any number of activities and it seems challenging to suggest that mindfulness is an inherent part of compassion. A similar line of argument can be used for kindness. Kindness can be used in many situations. One may be kind to someone who has no suffering whatsoever.

One of the challenges in compassion research at present is that a wide range of attributes have been proposed as being fundamental to compassion, but upon deeper investigation, one finds that they are not essential components of compassion. Neither mindfulness nor kindness are necessary or sufficient conditions for compassion to come into existence.

Article One 'Compassion: a conceptual analysis and critical review' is the next part of the literature review regarding conceptualisations of compassion and examines how compassion comes into being.

2.2 Preamble to Article One

The first article in the thesis is a conceptual analysis and critical review of the available literature on compassion.

The article addresses the first subsidiary research question, 'What is compassion and how does it come into being?'.

Title: Compassion: A conceptual analysis and critical review

Author: Ling, D.

Journal: *Clinical Social Work Journal*

Publisher: Springer

Status: Submitted, under review

This article was also presented at the following conferences:

Social Work, Education and Social Development Conference, Dublin, Ireland, 4-7 July, 2018.

International Symposium for Contemplative Research, Arizona, USA, 9 November, 2018.

2.3 Article One: Compassion: a conceptual analysis and critical review

Abstract

Background: Compassion is attracting increased research interest yet there is not agreement regarding a definition. This needs to be resolved for future research into compassion to have rigour.

Aims: To conduct a conceptual analysis and critical review of existing literature on compassion to gain clarity regarding what it is as a construct and how it comes into being.

Methods: The literature on compassion was searched across 25 years from January 1992 to May 2017 and included searches of two electronic databases CINAHL and PubMed, references from articles, grey literature and Google Scholar. Inclusion criteria were articles in English that focused on defining compassion and its core components. Excluded were articles about related concepts such as empathy, self-compassion, compassion fatigue and compassion focused therapy.

Results: Five central themes emerged: (i) a consensus that compassion is a concern regarding the suffering of another and a desire to alleviate that suffering, (ii) compassion is a virtue and arises in response to an identification with a common humanity, (iii) compassion is focused on the other, (iv) compassion does not include action and (v) compassion is a process of appraisals. The Sequential-Relational Model of Compassion is presented to capture the core component of compassion as being the perception of common humanity.

Conclusions: Care needs to be taken to ensure that compassion research and interventions are focusing on compassion and not some other response. The Sequential-Relational Model

of Compassion is offered to explain the process of compassion. Further research is required to empirically test this model.

Introduction

Compassion is the subject of considerable research interest around the world (Kirby 2016; McCaffrey & McConnell 2015; Strauss et al. 2016). Major research institutions include The Centre for Compassion and Altruism Research and Education at Stanford University, Greater Good Science Center at University of Berkeley and Center for Investigating Healthy Minds at University of Wisconsin-Madison. There is research into the neural correlates of compassion, the effects of compassion on the brain and behaviour, the development of compassion training programs and scales to measure compassion. The Charter for Compassion is a global movement to promote compassion worldwide. The UK has implemented a 'Compassion in Practice' policy to develop compassionate practice amongst healthcare staff (Cummings & Bennett 2012). Compassion is a value that is commonly cited by hospitals, schools and charitable organisations. However, what is striking when looking at the literature is that there is not consistency in the research community regarding many of the fundamental aspects of compassion. There is considerable debate around definition, what the essential components of compassion are and how it comes into being. Sinclair et al. (2016 p.14) state:

> *First, there is the need to reset the empirical foundation of compassion research by establishing its conceptual specificity, thereby providing a scientific base to conduct future research on the topic that is marked by validity and rigor.*

There have been several literature reviews undertaken in the last two years and all the authors call for more clarity around definition (Ledoux 2015; McCaffrey & McConnell 2015; Strauss et al. 2016). It is hoped that this critical review will highlight which aspects of current definitions of compassion have solid foundations and which aspects need further evaluation.

Aims

The aim of this critical review is to examine the conceptual and research literature on compassion to explore themes, competing schools of thought and gaps in order to gain a clearer idea of what compassion is and how it operates in practice.

Methods

A critical review was chosen as an appropriate approach since the conceptualisations of compassion in the research literature lack consensus and there appear to be important areas that need clarification. In particular, the critical review provides an opportunity to evaluate what is useful and to attempt to resolve competing schools of thought (Grant & Booth 2009).

The literature on compassion was searched across 25 years from 1992 – 2017 using electronic databases CINAHL and PubMed which were searched in April and May 2017 using the following search terms 'compassion definition', 'compassion model', 'compassion concept', 'compassion construct', 'compassion measures' and 'compassion scale'. Boolean operators were used to explore combinations of the above wordings. The searches identified 1121 articles. Bibliographies were searched for relevant citations. Google Scholar and grey literature were also searched. Inclusion criteria were articles in English that focused on defining compassion and its core components. Excluded were articles about related concepts such as empathy, self-compassion, compassion fatigue and compassion focused therapy. Items were selected for their conceptual contribution to the current understanding of compassion. The literature search resulted in a selection of 24 articles (Table 1) which captured an overview of thinking about compassion across a range of disciplines. Four books, one book chapter and one government agency report were also included for their viewpoints.

Table 2.1 Critical Review Sources

Author	Title	Date	Country	Type of Source
Atkins & Parker	Understanding individual compassion in organisations: The role of appraisals and psychological flexibility	2011	Australia	Conceptual Paper
Batson	These things called empathy: eight related but distinct phenomena	2009	UK	Conceptual Paper
Batson	The altruism question: Toward a social-psychological answer	2014	UK	Book
Batson et al	Perspective taking: Imagining how another feels versus imaging how you would feel	1997	UK	Conceptual Paper
Cummings & Bennett	Compassion in practice: Nursing, midwifery and care staff. Our vision and strategy	2012	UK	Government Agency Report
Dewar et al	Valuing compassion through definition and measurement	2011	UK	Conceptual Paper
Dutton et al	Compassion at work	2014	USA	Conceptual Paper
Eisenberg	Empathy-related emotional responses, altruism, and their socialization	2002	USA	Book chapter
Ellsworth & Scherer	Appraisal processes in emotion	2003	USA	Conceptual Paper
Feldman & Kuyken	Compassion in the landscape of suffering	2011	UK	Conceptual Paper
Fernando & Consedine	Beyond compassion fatigue: The transactional model of physician compassion	2014	NZ	Conceptual Paper
Gilbert	The compassionate mind: A new approach to life's challenges	2010	UK	Book
Goetz et al	Compassion: An evolutionary analysis and empirical review	2010	USA	Conceptual Paper
Gu et al	An empirical examination of the factor structure of compassion	2017	UK	Research Study
Jinpa	A fearless heart: How the courage to be compassionate can transform our lives	2016	USA	Book
Kanov et al	Compassion in organizational life	2004	USA	Conceptual Paper
Kirby	Compassion interventions: The programmes, the evidence, and implications for research and practice	2016	Australia	Conceptual Paper
Ledoux	Understanding compassion fatigue: understanding compassion	2015	Canada	Conceptual Paper
Lown	A social neuroscience-informed model for teaching and practising compassion in health care	2016	USA	Conceptual Paper
Martins et al	The development and evaluation of a compassion scale	2013	USA	Research Study
McCaffrey & McConnell	Compassion: a critical review of peer-reviewed nursing literature	2015	Canada	Conceptual Paper
Monroe	The heart of altruism: Perceptions of a common humanity	1996	USA	Book
Perez-Bret et al	Definition of compassion in healthcare: a systematic literature review	2016	Spain	Conceptual Paper
Pommier	The compassion scale	2010	USA	Research Study
Ricard	Altruism: The power of compassion to change yourself and the world	2015	France	Book
Schantz	Compassion: a concept analysis	2007	USA	Conceptual Paper
Sinclair et al	Compassion: a scoping review of the healthcare literature	2016	Canada	Conceptual Paper
Strauss et al	What is compassion and how can we measure it? A review of definitions and measures	2016	UK	Conceptual Paper
Van Der Cingel	Compassion and professional care: exploring the domain	2009	Netherlands	Conceptual Paper
Von Dietze & Orb	Compassionate care: a moral dimension of nursing	2000	Australia	Conceptual Paper

Discussion

Compassion is a response to the suffering of another and a desire to alleviate their suffering

There is widespread agreement that compassion is a response to the suffering of another and a desire to alleviate their suffering (Goetz, Keltner & Simon-Thomas 2010; McCaffrey & McConnell 2015; Strauss et al. 2016; Von Dietze & Orb 2000). In their comprehensive and widely cited review on compassion, Goetz, Keltner and Simon-Thomas (2010) define compassion as a 'feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help'. The idea of being moved by another's suffering and wanting to help is widespread amongst authors (Gilbert 2010; Schantz 2007). Jinpa (2016) who helped develop the Stanford University Compassion Cultivation Training course defines compassion as 'a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved' (p. xx). Importantly, Jinpa's definition highlights that it is not just any feeling that arises when one is confronted with another's suffering, but a specific feeling, that is, a sense of concern. Compassion is considered a virtue and is often one of the core values for hospitals, schools and charitable organisations. Compassion has a celebrated status due to its inclusion of all human beings. This noble aspect to compassion appears to result from its focus on common humanity which will be explored later in this review.

The consensus around compassion being a concern regarding the suffering of another and the desire to alleviate their suffering is the crucial foundation for gaining improved uniformity for definitions of compassion. Despite agreement regarding what compassion is, the research community diverges into various conceptualisations of compassion, which in some cases, do not conform with the central definition. An overview of the literature reveals

that there are important areas regarding compassion where there are significant differences of opinion. For example, some authors suggest compassion involves self-reference aspects (Gilbert 2010; Strauss et al. 2016) which appears to be a contradiction if compassion is defined as something that occurs purely in response to focusing on another. Other definitions grapple with whether compassion inherently involves action or not (McCaffrey & McConnell 2015), however the core definition says compassion is a 'desire' or 'wish' for the other's suffering to be relieved. A desire or wish may be the precursor to action but is not an action in itself. Finally, some explanations of compassion include components such as mindfulness (Pommier 2010) or generosity (Martins et al. 2013) which do not specifically relate to the suffering of another. They may be triggers for some individuals to have compassion but there are not clear arguments presented as to how aspects such as these constitute fundamental components of compassion. These competing ideas regarding compassion are explored in this review. It is critical for the research community to gain consistency on the essential components of compassion to improve the rigour and effectiveness of future research (Kirby 2016; Strauss et al. 2016).

Compassion is a virtue because it focuses on common humanity

Compassion is upheld as a virtue. It is enshrined in codes of practice for professions such as social work, nursing and medicine. The International Federation of Social Workers (2017) states that one of the overarching principles of social work is 'respect for the inherent worth and dignity of all people'. Social work's ethical principles are built on international conventions such as The Universal Declaration of Human Rights (1948) which states 'All human beings are born free and equal in dignity and rights.' These noble sentiments hold important clues as to the fundamental nature of compassion. Compassion honours the other person's dignity as a

fellow human being (Jinpa 2016). It is this emphasis on the common humanity of all that provides compassion with its elevated status. Schools, hospitals and charities have compassion as a value because they are caring for all others irrespective of race, religion, gender etc. Judgment of the deservingness of the recipient does not come into the equation for compassion; all human beings are considered equally valuable. For example, when hospital staff treat a patient injured in a car accident, the patient receives the same care regardless of whether they caused the accident or were the victim of it. It is easy to understand when a mother may have compassion for her child but it is harder to explain when someone has compassion for a complete stranger. It is only through the recognition of common humanity, viewing all others at the level of their shared humanity, that compassion and valuing all others can be understood. Real compassion has no boundaries (Ricard 2015).

Compassion recognises the universality of human suffering (Feldman & Kuyken 2011; Strauss et al. 2016), and that all humans share the desire for happiness and wish to be free from suffering (Jinpa 2016; Ricard 2015). Pommier (2010) suggests that this perception of common humanity involves realizing that all humans suffer and one could find oneself in the position of the sufferer if one were less fortunate. One has a level of identification with the person suffering and recognises human vulnerability as a general phenomenon (Van Der Cingel 2009; Von Dietze & Orb 2000). The perspective of perceived similarity leads to concern for the other. This perspective is derived through focusing on the basic sameness of self and others through common humanity, as Jinpa (2016) states 'just like me, other people want happiness and do not want suffering' (p. 158). Notions of 'in-group' and 'out-group' or differentiation between people is removed, we are all part of the same humanity (Von Dietze & Orb 2000). The perception of common humanity is therefore proposed as being the essential foundation of compassion.

Related terms and differences

One of the challenges in compassion research is that many terms are used interchangeably with compassion such as pity, sympathy and empathy (Goetz, Keltner & Simon-Thomas 2010; Perez-Bret, Altisent & Rocafort 2016; Sinclair et al. 2016; Strauss et al. 2016). There are differences between them and it is important that the distinctions are clear. Pity is perhaps the term most commonly confused with compassion. When examining pity, there is an inequality between the giver and receiver. The person offering the pity has a condescending view to the other (Perez-Bret, Altisent & Rocafort 2016; Von Dietze & Orb 2000) and distances themselves from the object of their concern (Jinpa 2016). Ricard (2015) quotes Jean-Jacques Rousseau, 'The rich man has little compassion for the poor man, since he can't imagine himself poor.' Pity does not occupy a hallowed status in international conventions. One could not imagine a Charter for Pity gaining worldwide popularity. On the other hand, the perception of common humanity, which is hypothesised as being the key element of compassion, connects one with the other who is suffering: there is a sense of identification at the level of shared humanity.

Empathy is also often used interchangeably with compassion. The state of empathy encompasses one being affected by and sharing another's emotions (Gilbert 2010). It is important to note that one can feel empathy with another over anything; it does not have to be suffering. The distinction is made that compassion takes a step further than empathy, compassion is not just a feeling with the person who is suffering but involves a desire to see the person's suffering alleviated (Kanov et al. 2004). Similarly with sympathy, one may have an affinity with another and feel kindly to them (Ricard 2015). Sympathy does not involve the further step of wishing for the other's suffering to be alleviated.

The literature on compassion contains many definitions of compassion which involve a wide range of characteristics. For example, compassion has been suggested to involve mindfulness and kindness (Pommier 2010) or generosity and hospitality (Martins et al. 2013). These characteristics are not a specific response to the suffering of another, one may feel kindness or generosity to another for a variety of reasons. An examination of the scales that have been developed to measure compassion and compassion training programs that have been designed reveals that there is an equally wide array of elements that are hypothesised as defining compassion. Kirby (2016 p.18), in his review of compassion interventions states:

> *Different compassion approaches define compassion differently, and there is variation regarding what competencies are targeted (e.g., empathy, sympathy, distress tolerance, mentalizing, mindfulness, yoga, LKM, common humanity, breath training, acting simulations, working on self-criticism).*

It is questionable whether yoga or breath training are intrinsic elements of compassion. There appears to be confusion between things that may help some people develop compassion versus the fundamental components of compassion. It is important to keep the basic definition of compassion foremost in mind, that compassion is a concerned response to another's suffering and a desire to alleviate that suffering. Any conceptualisations of compassion must directly relate to this core definition. Otherwise there is the risk that some compassion training programs are not focusing on compassion but placing their focus on competencies that do not have a direct relation to the development of compassion. The implications of compassion being poorly understood have important ramifications for other related areas. For example, the topic of compassion fatigue has had significantly more research in recent years (Fernando & Consedine 2014) yet it appears the tools used to measure compassion fatigue do not capture the construct of compassion (Ledoux 2015). Ledoux suggests that what is considered compassion fatigue in the research literature fits

more closely with burnout or stress. Without understanding compassion clearly, important related areas of research run the risk of going down misleading pathways.

Compassion is focused on the other, it does not contain self-reference elements

Although it has been stated that compassion arises from focusing on another's suffering (Eisenberg 2002; Ricard 2015; Von Dietze & Orb 2000), some definitions of compassion hold it to contain components that are focused on the self such as distress tolerance (Gilbert 2010; Strauss et al. 2016). Given that compassion has been expressly defined as focusing on an 'other', it is difficult to see how it can contain elements that focus on the self at the same time. If someone is focusing on their own distress, then it appears they are no longer focusing on the other. It is, of course, possible for a person to shift between the two states—focusing on the other and focusing on the self—but care needs to be taken not to treat two different responses as if they were part of one response. Distress being evoked by seeing someone else's distress is 'personal distress' (Batson 2009). Batson emphasises that this state does not involve distress *for* the other or *as* the other but involves feeling distressed *by* the other. Eisenberg (2002) calls this a 'self-focused, aversive emotional reaction to another's emotion or condition' (p.135). Batson (2009) notes personal distress has also been described as 'empathic distress' by Hoffman (1981). The opposite of 'personal distress' or 'empathic distress' is 'empathic concern' which leads to compassion (Batson 2009).

To illustrate the difference between 'empathic concern' and 'empathic distress', consider the possible different reactions of an ambulance officer and a distressed onlooker to a car accident. Both the ambulance officer and the distressed onlooker are aware of the suffering of the car accident victims as the precipitating event. The ambulance officer works to alleviate their suffering and undertakes the necessary tasks in such an emergency. The distressed

onlooker, however, has been overtaken by personal distress and must walk away to compose themselves. The onlooker is now focused on their own discomfort and is not focusing on the alleviation of the suffering of the accident victim. This difference is explained by the perspective one takes, *imagining how another would feel* (leads to empathy) versus *imagining how you would feel to experience the suffering* leads to empathy and distress (Batson, Early & Salvarani 1997). It is enough to become aware of the other's suffering, one does not have to suffer oneself (Ricard 2015).

A recent empirical examination of the factor structure of compassion by Gu et al. (2017) has found that 'tolerating uncomfortable feelings aroused by distress' does not seem to be a core aspect of compassion. This makes sense if personal feelings of distress are a separate phenomenon from a sense of concern for the other and a desire to alleviate the other's suffering. Compassion is focused on another, it is not about oneself. Ricard (2015) makes the point that compassion is not distorted by confusion between the emotions felt by the other and our own emotions. It is difficult to imagine a hospital having one of their primary values containing the words 'distress tolerance' as that association loses the elevated status compassion has as a virtue. It is a virtue precisely because it is focused on the other, their suffering and a desire to bring an end to their suffering.

Compassion does not intrinsically involve action

Some conceptualisations of compassion struggle with the notion of whether or not action is embedded in the definition (McCaffrey & McConnell 2015). There are definitions of compassion where authors have incorporated the idea of action e.g. the awareness of suffering is 'coupled with a wish and effort to relieve it' (Gilbert 2010) or saying that compassion is a 'motivation to act/acting to alleviate suffering' (Strauss et al. 2016). This

seems to be combining both wish and action into one thing whereas the wish or motivation *precedes* the action. Compassion may lead to action (Jinpa 2016) but it is not a given. Once again, if the basic definition of compassion is kept in mind, then it involves the desire or wish to alleviate the other's suffering. It does not intrinsically involve action. McCaffrey and McConnell (2015) note that authors attend to this by attaching the word compassion to other terms such as 'compassionate care' or 'compassionate practice'. Compassion is a necessary precursor to taking action that alleviates suffering although it is possible to have compassion arise and not take any action that has a benefit to the other. The lack of action does not mean that compassion was absent. Acting compassionately does not necessarily follow from compassionate feelings (Kanov et al. 2004). An example of another emotion with or without action would be 'envy'. The emotion exists regardless of whether action follows from it. For example, Person A may envy Person B's bag and steal it from Person B. However, Person C may also have envy for Person B's bag but they do not engage in the action of stealing. Both Person A and Person C had envy, but it led to different actions from them.

Compassion involves a process of appraisals

People's level of compassion for others can vary widely and individuals are not always able to respond compassionately (Atkins & Parker 2011). Compassion is an individual's subjective response to another person's situation. Goetz, Keltner and Simon-Thomas (2010) cite the appraisal work of Ellsworth and Scherer (2003) on emotions as the result of people's perceptions of their circumstances. Appraisal approaches hold that thinking and feeling are inextricably interrelated. One has to value the other to feel concern for them (Ricard 2015). The perspective one adopts to understand another's experience will impact on the activation of compassion (Lown 2016). This was exemplified by the work of Monroe (1996) who

interviewed people who rescued Jewish people in Nazi-occupied Europe. One rescuer commented 'A human being who is lying on the floor and is bleeding, you go and do something.' Monroe found that the most notable characteristic of the rescuers was that they all saw themselves as people strongly bound to others through a common humanity.

No study has yet established the entire appraisal pattern associated with compassion (Goetz, Keltner & Simon-Thomas 2010). Clearly, certain thoughts are associated with a compassionate response and other thoughts with the lack of such a response. In any given situation there are reasons why people choose whether or not to act compassionately (Von Dietze & Orb 2000). A model of compassion which can capture the necessary appraisals would be helpful and is proposed in the next section.

The Sequential-Relational Model of Compassion

There are many elements that influence whether one has compassion for another or not. From the simple act of noticing the other, through to recognising that they are suffering and then responding to the fact of their suffering. The work of Fernando and Consedine (2014) in developing the Transactional Model of Physician Compassion suggests that there is a dynamic interplay of physician, patient, clinical and institutional factors. The Sequential-Relational Model of Compassion is proposed as a model which incorporates the premise that the perception of common humanity is the central process of compassion whilst accommodating the view that many other aspects have an influence on the arising of compassion. The model builds on the work of Strauss et al. (2016), Fernando and Consedine (2014) and Goetz, Keltner and Simon-Thomas (2010). Strauss et al. (2016) did an extensive review of current definitions of compassion and proposed a five-element model of compassion. The work of Fernando and Consedine (2014) acknowledges that there are features internal to the person and external to

them that influence whether they will have compassion in a particular circumstance. As mentioned previously, Goetz, Keltner and Simon-Thomas (2010) suggest that compassion involves a process of appraisals. It is important to incorporate the appraisal process into a model of compassion to demonstrate that there are many points where the compassion process can fail.

The comprehensive review of definitions conducted by (Strauss et al. 2016) resulted in their development of a compassion definition consisting of five elements: (i) recognising suffering, (ii) understanding the universality of human suffering, (iii) feeling for the person suffering, (iv) tolerating uncomfortable feelings and (v) motivation to act/acting to alleviate suffering. Taking into account the investigation of compassion at the conceptual level in this critical review and the suggestion that compassion is focused on the other and does not contain self-reference aspects, the second element of the Strauss definition, tolerating uncomfortable feelings, is omitted. Because compassion is a motivation or a desire for suffering to be alleviated, the notion of 'acting to alleviate suffering' which is included in their fifth element is also not included. The universality of suffering originates from the perception of common humanity; by understanding that all humans at the level of their shared humanity are the same, one understands that all humans suffer at times (Pommier 2010). Hence, the perception of common humanity is placed as the key appraisal for compassion, not the universality of suffering. Common humanity includes wider elements than the universality of suffering, such as the notion that all humans are equally valuable. As mentioned earlier in this review, the notion of equality and the inherent dignity of all human beings is what gives compassion its status as a virtue.

Compassion is a relational process (Dewar, Pullin & Tocheris 2011; Kanov et al. 2004). It involves interaction and feedback at several key points. The Sequential-Relational Model of Compassion highlights the successive steps needed, including the specific appraisals, which are necessary and sufficient to give rise to compassion. The perception of common humanity is the vital appraisal which is necessary for compassion to arise.

The Sequential-Relational Model of Compassion involves a six-step process:

1. Person's openness to notice the other (dependent on context, external and internal factors)

2. Is the other suffering? (appraisal)

3. Do I empathise? (appraisal)

4. Common humanity/ 'Just like me' (appraisal)

5. No one wants to suffer, including me or this person (core belief)

6. Wish for that suffering to be alleviated (motivation)

Figure 2.1 Sequential-Relational Model of Compassion

| Notice the person to whom compassion is directed | ⟷ | Dependent on context, external and internal factors |

Yes

| Is the other suffering? (Appraisal) | ⟷ | No universal standard for assessing suffering |

Yes

| Do I empathise with them? (Appraisal) | ⟷ | Subjective component |

Empathic Concern (continue to next step)   Empathic Distress (leading to self-focus)

Yes   →   Exit the process

| Common Humanity 'Just like me' (Appraisal) | ⟷ | Subjective component |

Yes

| No one wants to suffer, including me or this person (Belief) | ⟷ | Core belief regarding universality of suffering |

Yes

| I wish for their suffering to be alleviated (Motivation) | ⟷ | Motivation of wishing the suffering of the other to be alleviated |

Yes

COMPASSION

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Further explanation of the six steps:

1. *Person's openness to notice the other (dependent on context, external and internal factors)*

There are myriad reasons why someone may or may not notice someone. For instance, when a person is running late for an important appointment, their focus tends to narrow to getting to that appointment on time. Fernando and Consedine (2014) suggest that when the workload is high and time pressured, physicians have less ability to be compassionate to others. This is arguably true of everybody, not just physicians.

2. *Is the other suffering? (appraisal)*

The appraisal as to whether another is suffering or not is subjective. Some people consider that asylum seekers who risk life threatening journeys in leaking boats are suffering whereas others see this behaviour as a lifestyle choice. It seems unattainable to delineate standards across all cultures, genders and situations to gain consensus over what constitutes suffering or not. Compassion, however, does not exist without noticing the suffering of another (Dutton, Workman & Hardin 2014).

3. *Do I empathise? (appraisal)*

Empathy depends on a person's ability to recognise and relate with someone else's feeling (Gilbert 2010). There appears to be a complex array of factors that impact whether someone will empathise with another. There is considerable variation between people as to whether they feel empathy for another or not. Empathic distress does not necessarily lead to concern for the other (Ricard 2015). However, empathic concern for another does lead one on to compassion (Batson 2009).

4. Perception of common humanity (appraisal)

The recognition of common humanity or perceived similarity, that all people suffer at times and that the person who is suffering is 'just like me' (another human being like me) or 'it could be me' appears to be a key appraisal in the development of compassion (Jinpa 2016). This recognition of common humanity prevents negative judgements (e.g. that the person is not 'deserving' of help).

5. No one wants to suffer, including me or this person (core belief)

The core belief 'no one wants to suffer' touches on the universality of human suffering and it requires the understanding that no one, including oneself wants to suffer (Ricard 2015). The importance of recognising pain and the universality of pain in human experience is emphasised (Feldman & Kuyken 2011).

6. Wish for that suffering to be alleviated (motivation)

The final step in the Sequential - Relational Model of Compassion is the motivation for the suffering of the other to be alleviated. This is the natural consequence of the preceding 5 steps of the model. It is important to note that action does not have to be taken, it is the *wish* that is important (Ricard 2015).

Conclusion

This conceptual analysis and critical review has examined a range of current thinking on compassion. It is apparent that despite broad agreement on a baseline definition, the conceptualisations of compassion are varied, divergent and at times, contradictory. This urgently needs to be addressed for research on compassion to move forward in beneficial ways. This review has proposed that the perception of common humanity is the core

component of compassion as it encompasses the inherent worth and dignity of all humans and the universality of suffering, i.e. all humans suffer at times and therefore one can feel compassion for anyone on this basis. The perception of common humanity explains compassion's elevated status as a virtue; it makes no judgments regarding who is or is not deserving of compassion. This review suggests that compassion is focused on the other, does not contain self-reference elements and does not intrinsically involve action. These areas need clarification from the research community. The Sequential-Relational Model of Compassion is hypothesised as a model which captures the core appraisals of compassion and illustrates the complex nature of this construct. There needs to be further empirical research to test this model and determine its efficacy in providing a congruent definition of the compassion process.

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2.4 Theoretical Perspectives

2.4.1 Role of perspective taking

The ability to take the perspective of another is considered a critical ingredient of social functioning (Galinksy & Moskowitz 2000). Perspective taking is imagining how another would feel. It requires the ability to differentiate between self and other. Perspective taking is necessary for human relationships. At the most basic level, a caregiver must be able to understand when a baby is tired or hungry and respond accordingly. In relation to compassion, a person must first recognise that the other is suffering. Care needs to be taken when considering the perspective of someone who is suffering. Batson, Early and Salvarani (1997) clarify that *imagining how another feels* and *imagining how you would feel in their place* are two different perspectives. Imagining how another feels can lead to empathic concern and compassion. One understands that another is suffering and wishes for their suffering to be relieved. However, imagining how you would feel to experience the same pain can lead to empathic distress.

2.4.2 Other-focus versus self-focus

Empathic distress is focused on the self and is a negative aversive reaction to another's suffering (Batson 2009; Eisenberg 2002; Hoffman 1981). Neuroscience research has found that the neural pathways for empathic concern and empathic distress are distinct from each other (Decety & Lamm 2006; Klimecki & Singer 2012). It is likely that the confusion between how one perceives another is feeling, versus one's own feelings, has resulted in some researchers (e.g. Gilbert 2010; Strauss et al. 2016) to propose that compassion involves distress tolerance. Distress tolerance is the ability to experience and withstand negative emotional states (Simons & Gaher 2005). It should be noted that compassion is an other-

focused emotion, it is not about oneself (Blum 1980; Dutton et al. 2005; Goetz 2010; Nussbaum 1996). A reason for the confusion amongst some researchers may be that it is not uncommon for some people to fall into personal distress when they witness another person's suffering. It is understandable that the distinction between other-focus and self-focus has led to a lack of clarity regarding compassion. Batson (2017) suggests that a way to understand the crucial difference between self-focus and other-focus is to reflect on whose welfare is the ultimate goal. In compassion, it is the welfare of the other that is the goal. This is why compassion is considered a virtue and held in such esteem. Looking after oneself is different to looking after another. It is possible to derive self-benefits from helping others, but the self-benefits are not the ultimate goal of compassion, they are secondary (Batson 2017). Self-care is important but it is hard to imagine a Charter for Self-care gaining worldwide recognition from luminaries around the world, whereas a Charter for Compassion has gained much support.

Another area where there is confusion between self-focus and other-focus is regarding the terminology of areas related to compassion. The term 'self-compassion' has been popularized by Kristen Neff (2003). She defines it as (p.87), 'being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness'. Neff's statement that (p.87), 'being compassionate towards oneself does not entail being self-centered' appears somewhat problematic. Self-compassion, by definition, seems to be a self-centred focus. However, Neff's conceptualisation that self-compassion involves recognising one's common humanity with others which includes understanding that oneself and others share the same vulnerabilities and highlighting that compassion does not make distinctions of the deservingness of the

recipient are aspects that are in broad agreement with many conceptualisations of compassion.

The term self-compassion was absent in literature until Neff conceptualised it. Thupten Jinpa, the Dalai Lama's principal English translator for the last thirty years and founder of the Stanford Compassion Cultivation Training program, contends that the term 'self-compassion' is not found in Buddhist literature but that the term self-caring is used instead (Shonin & Van Gordon 2016). More accurate terms for self-compassion may be self-kindness, self-care or self-acceptance. Self-compassion is focused on the self, it is not explicitly focused on the welfare of the other. This lack of clarity regarding constructs is problematic in the field of compassion research. There has been the suggestion that one cannot have compassion for others without having self-compassion (Gilbert 2010). Jinpa, on the other hand, suggests that self-compassion is not a necessary condition to have compassion for others (Shonin & Van Gordon 2016). There is unlikely to be disagreement that those who have good self-care are more available to others, not just for compassion but for a wide variety of necessary functions such as caring for others, being a parent, going to work, driving a car etc. However, care has to be taken to reinforce that compassion is other-focused. Van der Cingel (2009, p.128) has written about the relationship of compassion to nursing and makes the point, 'Compassion is not about simply imagining how it would be if something may happen to you. Compassion is not about one's own life after all: it is the other person's life that is at stake'.

People who are overly self-focused have been found to be *less* likely to engage in prosocial behaviour (Gibbons & Wickland 1982). Mikulincer & Shaver (2017) highlight that emotional over-involvement and self-related worries can interfere with caregiving. As shown in the Sequential-Relational Model of Compassion (see p.33), the entry point into the compassion process is noticing the person who is suffering. If one is focused on oneself, one

may not be aware of the other. One of the most famous studies to illustrate this point was the Good Samaritan experiment conducted by Darley and Batson (1973). Seminary students were instructed to hurry to an important appointment, on the way passing a person who seemed to be sick. Those who were in more of a hurry did not stop to offer assistance. In healthcare, there are many situations where it is imperative that the healthcare worker is paying attention to the needs of the other rather than focusing on themselves such as during delicate surgical procedures or when administering drugs. If the person keeps their attention on how the other is feeling, they are not focused on themselves and hence do not feel personally distressed. For example, a cardiac surgeon performing heart surgery understands their patient is sick and in pain. However, the surgeon keeps their attention on the patient, not on themself. The surgeon is motivated to alleviate the suffering of their patient. It is possible to switch perspectives rapidly, which is why some people may shift between empathic concern and empathic distress. Decety and Lamm (2006, p. 7) state 'Imagining oneself to be in a painful and potentially dangerous situation thus triggers a stronger fearful and/or aversive response than imagining someone else to be in the same situation'.

Being aware of one's own reactions and thoughts is necessary in many circumstances. It may involve anything from being aware of one's stress levels to checking one's physical safety. In relation to compassion, Atkins and Parker (2012) suggest that compassion involves an assessment of one's capacity to help the other. However, compassion is widely understood to be a wish or desire for the other's suffering to be alleviated (Goetz et al. 2010; Strauss et al. 2016). This wish *precedes* any consideration of what action may be taken. Compassion comes first, then the individual decides what action they may take. Terms such as 'compassionate care' or 'compassionate action' highlight that compassion is not in itself an action (McCaffrey & McConnell 2015). A person may still have compassion but recognise that they can offer no

practical help towards the other. An example of this may be someone having compassion for starving children on the other side of the world. They may or may not decide to undertake an action (such as donate money). Even in the case of someone who has no resources to assist, their lack of practical action does not mean that compassion did not arise. Jinpa (2016) points out that compassion may or may not lead to an action.

Compassion is protective against personal distress as the giver is focused on how the other feels, not themselves. This would explain why there are many healthcare workers who spend years caring for others and are able to maintain positive mental and emotional wellbeing. A notable example is Mother Theresa, who spent her life amongst the poor and sick but found peace and fulfilment in her work. There are many healthcare workers in palliative care who find their job satisfying and meaningful, they understand their patients are at the end of life. The healthcare workers focus on helping the dying person and their family through this inevitable life stage. The positive emotions associated with compassion come from focusing on the other. Not all people experience personal distress in the face of another's suffering. The ability to identify with the other and focus on them, not oneself, is critical to the arising of compassion (Cassell 2009; Feldman & Kuyken 2011; Jinpa 2016; Nussbaum 1996). It is important to educate healthcare workers regarding the difference between self-focus and other-focus, as compassion is something that can help them avoid burnout and emotional distress.

2.4.3 Perceived similarity

There is significant past work showing that compassion and altruism are more readily directed towards similar others (Burnstein, Crandall & Kitayama 1994; Krebs 1975; Preston & de Waal 2002; Sturmer et al. 2006). Members of an in-group prefer other in-group members to out-

group members (Chiao & Mather 1020; Ruckmann et al. 2015; Tajfel & Turner 1986). Research has shown that perceived similarity can be based on something quite trivial. Some followers of sporting clubs are well known for having a strong sense of affiliation. Valdesolo and DeSteno (2010) conducted research which showed that participants who were tapping in synchrony reported feelings of greater similarity with their tapping partner and showed greater compassion for their partner than for participants who were not tapping in synchrony. Circumstances and preferences in life can alter. Just as a follower of a sporting club can change the team they barrack for, people can change whom they view as similar to themselves or not.

A number of studies have found that in-group categories can be adjusted depending on arbitrary categories such as eye colour (Byrnes & Kiger 1990), assigned role (Haney et al. 1972) and mutual experience (Sherif 1961). Perceived similarity is clearly important in terms of the promotion of compassion. It should be noted that perceived similarity, by itself, is limited in relation to the fostering of compassion, due to having to find a basis from which someone can feel they are similar to someone else. There are endless combinations of eye colours, sporting teams, race, religion etc., it is impossible to cover all combinations. There are always in-groups and out-groups, however, the perception of common humanity is the group identification that supersedes all other combinations.

2.4.4 Perception of common humanity

The perception of common humanity is the most useful prosocial perspective to hold. Everyone, by virtue of their shared humanity, becomes part of the in-group. It is an enduring basis on which to perceive similarity with others and transcends all other categories such as gender, race, religion etc. The perception of common humanity promotes caring, respect and kindness to all others. It is not surprising that the perception of common humanity has been

proposed by many to be the foundation of compassion (Blum 1980; Cassell 2009; Feldman & Kuyken 2011; Jinpa 2016; Ladner 2004; Nussbaum 1996). The perception of common humanity emphasises group membership by all of humanity. It also involves a recognition that all humans are fundamentally the same in their desire for happiness and wish to avoid suffering. Jinpa (2016, p.159) considers the phrase, 'Just like me, other people want happiness and do not want suffering' to be a fundamental truth. This phrase is incorporated into the Stanford Compassion Cultivation Training program and is often used in other compassion training programs. Common humanity acknowledges the universality of suffering in life (Van Der Cingel 2009; Von Dietze & Orb 2000). Everyone experiences ageing, sickness and death. The understanding that no one wants to suffer, neither oneself nor the other, creates a connection between oneself and all other humans. Healthcare workers often have a heightened sense of the fragility of health as they work with people on a daily basis whose lives have been changed in an instant by a car accident, stroke, heart attack, cancer diagnosis or similar.

Compassion fundamentally requires an identification with the other, a sense of connection (Cassell 2009; Jinpa 2016). Common humanity is the perspective that enables someone to connect with any other person irrespective of differences of race, gender, political orientation or religion. Pain and suffering can unite people and bring connection (Jinpa 2016). After the tragic events of the 9/11 terrorist attacks on the World Trade Center in 2001, people who volunteered their help in the aftermath spoke about the camaraderie and sense of identity they had with others (Steffen & Fothergill 2009). The perception of common humanity helps clarify the role of the self in compassion. Those who hold this perspective of shared humanity acknowledge that no one, *including themselves*, wants to suffer. Thus, when confronted with another's suffering, they recognise the other person's humanity and share a

sense of identification with them (Blum 1980, Jinpa 2016; Ricard 2015). Perhaps the most tangible outcome of the perception of common humanity on the world stage has been the formation of the United Nations in 1945 after the horrors of millions of deaths in two world wars. The United Nations Universal Declaration of Human Rights was adopted in 1948 and it emphasised the inherent dignity, equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world (United Nations 1948).

Compassion and common humanity are foundational concepts in Buddhist literature. There is a range of Buddhist practices that are designed to enhance the connection between oneself and others such as loving kindness meditations, exchanging self and other and developing equanimity (Chodron 2001; Jinpa 2016; Ricard 2015). The aim of these practices appears to be designed to heighten one's sense of identification, care and concern with all other beings.

The concept of interdependence is also an important aspect of the perception of common humanity. Recognising that many others have helped one get to where one is today is crucial in developing a sense of interconnectedness. Each one of us is in an endless exchange of give and take with many others. The Cognitively Based Compassion Training course developed by Emory University emphasises that humans exist in interdependence with others (Ozawa & Negi 2013). To survive, each of us had caregivers who looked after us for years. Apart from caregivers, almost everything else we need comes from the efforts of others, whether that is teachers who provide us with an education or the food we eat and the houses we live in. Even just to live in modern society, one is reliant on technology and conveniences that have been developed by the efforts of countless others. The fact that humans cannot exist in isolation and their lives are intertwined with a wide variety of others is often overlooked. There are

many others who have assisted one in some way or another at different points in life. Focusing on interdependence helps one to view all others as an important part of a bigger picture.

Healthcare workers are required to extend their care and concern to every patient they encounter. The perception of common humanity enables a sense of identification with all others, a recognition that everyone has the same vulnerabilities and the same desire for happiness.

2.4.5 Valuing the welfare of the other

When we value the welfare of another, we are concerned about them (Jinpa 2016; Ricard 2015). It is easy to understand that people would be concerned about their close family or friends. It is natural for people to wish that those they are close to are happy and do not suffer. Batson et al. (2007) suggest that perspective taking on its own is limited in relation to compassion and that valuing the other's welfare is more important. They point out that one can adopt another's perspective but have no concern for the other's welfare. In fact, perspective taking can be used for antisocial purposes, it is not inherently prosocial. Someone who wishes to do harm to another may use perspective taking to take advantage of another. The perception of common humanity, where one recognises and values the other as equal to oneself, enables one to have compassion towards all others. Compassion is the precursor to acts of altruism (Ricard 2015).

2.5 Compassion in healthcare

There have been suggestions that that there is a crisis in healthcare due to a lack of compassion (Kneafsey, Brown, Sein, Chamley & Parsons 2016; Trzeciak, Roberts & Mazzarelli 2017). In the UK, the NHS was rocked by devastating failures of humanity in its healthcare system (Francis 2013). There were reports of some patients being denied basic care including

toileting, nutrition and pain relief (Shea & Lionis 2017). There have been numerous examples around the world which illustrate a deficit of compassion in healthcare. An American survey of 800 hospitalised patients found that almost half reported that the health care system did not provide compassionate care (Lown et al. 2011). A Swedish study found that among patients who needed emergency care, the most enduring memory five years on was the lack of compassion from the health care workers (Doohan & Saveman 2015). Haque and Waytz (2012) contend that dehumanization in medicine is endemic. Clearly, any training or education that helps foster compassion and concern would be beneficial.

Healthcare is a demanding environment in which to work (West & Chowla 2017). Individual healthcare workers are responsible for the way they treat and interact with patients. However, the healthcare organisation itself includes many challenges. Hospitals are often busy environments which require workers to juggle a range of competing demands including high workloads and significant administrative duties. Constant exposure to people's suffering can be challenging, particularly if a healthcare worker experiences empathic distress. Other factors that can be challenging are working conditions, e.g. working long hours in an understaffed clinic can to lead to diminished compassion (Fernando & Consedine 2016). Being in a hurry has long been known to reduce helping behaviours (Batson et al. 1978). On the other hand, everyone benefits when compassionate care is at the forefront – the staff themselves benefit from the positive effects of compassion, patients benefit from a compassionate environment and the healthcare organisation benefits when staff and patients are satisfied (Post et al. 2014).

It is not surprising that there are urgent calls to find effective and practical interventions to help enhance healthcare worker compassion (Patel, Pelletier-Bui, Smith, Roberts,

Kilgannon, Trzeciak & Roberts 2018; Seppala, Hutcherson, Nguyen, Doty & Gross 2014; Skwara et al. 2017). The perception of common humanity has been hypothesised by several authors to be the core component of compassion. It provides the foundation to view anyone as the same as oneself, that is, a fellow human being who also wishes for happiness and does not wish to suffer. The mechanisms that lead to compassion are currently unclear in the research literature. Exploring the impact of the perception of common humanity on healthcare worker compassion is beneficial in gaining clarity regarding the facilitators of compassion.

2.6 Compassion training

There have been a number of compassion training interventions developed over the last two decades. The two most studied ones are Compassion Cultivation Training (Jinpa 2010) and Cognitively-Based Compassion Training (Ozawa-de Silva et al. 2012). Both of these are eight-week courses. A longer-term compassion training intervention is The ReSource Project which took place over one year (Singer et al. 2016). Other compassion training interventions are Cultivating Emotional Balance (Kemeny et al. 2012) and compassion and loving-kindness approaches (Fredrickson et al. 2008; Hofman et al. 2011). There have also been shorter term compassion training interventions which have been developed (Leiberg et al. 2011; Weng et al. 2013). Compassion training often consists of multiple components and can include meditation practice, didactic instruction and individual reflection. One of the challenges is that there is an absence of studies which control for these components, so it is unclear which components might contribute to increased compassion (Skwara et al. 2017).

2.7 Significance of the literature

This literature review has highlighted the pressing need for greater clarity regarding an understanding of what compassion is. This has significant implications for healthcare workers

who are required to generate compassion on a daily basis for their numerous patients. Unless healthcare workers are clear about what compassion actually is, they may instead be offering pity to their patients or falling accidentally into empathic distress. Compassion connects with many prosocial behaviours such as kindness and caring, but at its heart, compassion is a concerned response to another's suffering and a desire to relieve the other's suffering (Blum 1980; Nussbaum 1996; Goetz et al. 2010). A person is able to have compassion for all others when the person recognises the common humanity that everyone shares and the inherent sameness between themselves and others (Jinpa 2016; Ricard 2015). Compassion recognises suffering as a universal phenomenon (Feldman & Kuyken 2011; Van Der Cingel 2009; Von Dietze & Orb 2000).

Human life is frail: there are countless difficulties that can befall anyone, and everyone experiences ageing, sickness and death at some point. The literature review has revealed that the perception of common humanity appears to be a fundamental component of compassion. Thus, this research study has chosen to explore the relationship between the perception of common humanity and compassion in healthcare workers.

Compassion is considered to be necessary for a functioning and flourishing society (Condon & DeSteno 2017; Crocker & Canevello 2008). Healthcare workers are at the front line of caring for the sick, injured and elderly. It is beneficial if strategies can be found that assist healthcare workers to cultivate and maintain compassion. The healthcare worker benefits from the positive states of mind associated with compassion and is protected from empathic distress and burnout; the patients benefit from being in an environment where the attitude is one of care, respect and kindness to all.

2.8 Theoretical framework

This literature review has outlined the complexity of researching compassion. There are a number of theoretical perspectives that need to be considered, such as perspective taking, other-focus versus self-focus, perceived similarity, valuing the welfare of the other and the perception of common humanity. A fundamental concept behind this research is the fact that people can have significantly different viewpoints towards others. One person may have complete hostility towards another, based solely on the other person's racial group whereas a second person may see the same person as someone's son or daughter and skin colour is irrelevant. The idea that people's emotions are the result of their own perception of their specific circumstances is the central foundation of appraisal theories of emotion (Lazarus 1991; Ellsworth & Sherer 2003). Depending on how people perceive and interpret an event, they can have different emotional responses. Empathy can fail under certain circumstances such as when there is conflict (Brewer 1999; Hein et al. 2010) or when interacting with dissimilar others (Chiao & Mathur 2010; Mitchell et al. 2006; Singer et al. 2006; Xu et al. 2009). People can change their appraisals of others from a negative perspective to a positive perspective and vice versa. This ability to reappraise a situation is important in changing perceptions of perceived similarity and in-group/out-group distinctions (Decety & Lamm 2006; Dahl, Lutz & Davidson 2015).

It should be noted that the topic of perception, in particular the fragility of the boundary between the self and other, has had extensive treatment in Western psychodynamic literature dating back to the founding forefathers Freud and Jung. Buddhist philosophy also considers the boundary between self and other to be complex and considers accurate perception to be a complicated topic (Ricard 2015). However, to undertake empirical research, particularly

using scales and verifiable measurement, it is necessary to assume that people are aware of the distinction between themselves and others and can perceive this.

Van der Cingel (2009) highlights that specific thoughts are needed to have specific emotions. For example, suffering can evoke other emotions in people such as fright or disgust. In the case of atrocities in war, a torturer may even be pleased if the victim is suffering. The work of Monroe (1998) has highlighted the significance of the perception of common humanity. People who have a sense that themselves and all others are bound by a shared humanity are motivated to help others, even at risk to their own lives. The importance of this universal viewpoint has been emphasized by Fogelman (1994), Hoffman (1989) and Oliner et al. (1992). It is important for more research to be undertaken that sheds light on the appraisals that lead to compassion. Healthcare organisations request that healthcare workers be kind, caring, connect to the patient etc., but unless the healthcare worker genuinely feels a connection to the patient and values the patient, the patient is unlikely to feel they were on the receiving end of compassion. It is the motivation, the thinking behind the action that is important. An act alone, such as smiling, may or may not be a prosocial connection. It is the perspective of the person behind the smile that counts. The specific appraisals that influence compassion have not been catalogued to date and are not well understood (Goetz & Simon-Thomas 2017). The Sequential-Relational Model of Compassion (see p.33) is proposed to outline the appraisals needed to lead to compassion. Once a person has judged that another is suffering, if they hold the perspective of common humanity, 'just like me, this person wishes to be happy and not to suffer', and by doing so, value the welfare of the other as a priority, then the natural response is to wish the other to be free from suffering.

This research is also underpinned by social learning theory. Social learning theory proposes that people can learn from others' behaviours and attitudes and that there is an interplay between cognitive, behavioural and environmental influences (Bandura 1971; Wenger 1999). Social learning theory sits comfortably with social work's foundational perspective of person-in-environment, as social work recognises that there is a complex range of factors, both individual to the person and externally in the environment that can influence thoughts and behaviour (Dominelli 2004). Social work has a profound belief in the ability of people to undergo positive change (Bisman 2004). Accordingly, this research study employed common humanity scenarios to determine if they influenced healthcare workers' perceptions and viewpoints in relation to compassion.

2.9 Summary and conclusions

Compassion is widely held to be a concerned response to the suffering of another combined with a desire to alleviate the other's suffering (Goetz et al. 2010; Strauss et al. 2016). However, there is confusion in the literature between compassion and other related constructs such as pity and empathy. There also appears to be some confusion regarding the point that if compassion is a concern about *another's* suffering, then it is does not involve focus on one's *own* distress (Batson 2017). There are various perspectives which have been proposed as being important for compassion to arise including empathy, perspective taking, perceived similarity, valuing the welfare of the other and the perception of common humanity. Taken alone, perspective taking, empathy and perceived similarity are insufficient to guarantee that compassion will be the outcome. It is possible to hold the perspective of the other but have no concern for them; one can have empathy which leads to empathic distress and perceived similarity falls down if one cannot find something with which leads to a sense of sameness.

The perception of common humanity leads to a valuing of all others and has been proposed as the foundation of compassion (Blum 1980; Cassell 2009; Feldman & Kuyken 2011; Jinpa 2016; Ladner 2004; Nussbaum 1996). Based on the available literature, the Sequential-Relational Model of Compassion has been developed to outline the compassion process and explain the relevance of the perception of common humanity in this process (see p.33).

Chapter 3. Methodology

3.1 Research context

The study was carried out at Epworth HealthCare in Richmond, Victoria, Australia. Epworth HealthCare is Victoria's largest not-for-profit private health care organisation, includes 8 hospitals and 4 health clinics and employs 6,870 staff. Compassion is one of its stated core values. Their other core values are Integrity, Respect, Community, Excellence and Accountability (Epworth HealthCare, 2012). Epworth HealthCare management were supportive of the research study being undertaken with their healthcare workers. Epworth HealthCare promoted the pre/post intervention section of the study to the entire workforce. This part of the study is detailed in the Results Chapter as Article Two 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach' and Article Three 'The use of common humanity scenarios to promote compassion in healthcare workers'.

The research study involved inviting healthcare workers throughout Epworth HealthCare to attend a compassion training session facilitated by the researcher and to complete pre-test/post-test surveys on perspective taking, common humanity and compassion after viewing a common humanity scenario presented at the beginning of the compassion training session. After the compassion training session, the healthcare workers were requested to complete an online survey to evaluate the session.

Epworth HealthCare management had requested that the pre/post intervention be situated as part of a compassion training session, so that the healthcare workers could benefit from training as part of their participation in the research. The overall compassion training

session was evaluated and this is presented in the Results Chapter as Article Four 'Outcomes from a compassion training intervention for healthcare workers'. Providing a compassion training session and evaluating it, in addition to undertaking the pre-test/post-test surveys, added an extra dimension to the research study with the opportunity to gather a broader range of data. As a direct result of the positive evaluation of the compassion training session, Epworth HealthCare management subsequently requested the researcher to develop a compassion eLearn so that the entire organisation workforce could access the training. The development and content of the compassion eLearn is outlined in Article Five 'An Outline of a Compassion eLearn for Healthcare Workers'

3.2 Ontology and epistemology

There are varying ontological and epistemological positions regarding the nature of reality and how it can be known. These have important implications regarding research approaches. Ontology is concerned with what one believes constitutes social reality (Blaikie & Priest 2019). Two significant ontological positions when examining social reality are objectivism and constructivism. Objectivism regards social phenomena as having an external existence separate from the mind of the researcher. Constructivism, on the other hand, considers social phenomena and their meanings to be produced through social interaction (Bryman 2016). Epistemology is the science of knowing (Rubin & Babbie 2016). Objectivism and constructivism relate to two contrasting epistemological positions respectively – positivism and interpretivism (Grix 2002). Positivists believe an external reality exists that can be measured. They typically employ quantitative research methods that allow them to quantify data, often using closed-ended information (Creswell & Clark 2017). Interpretivists focus on the subjective meaning-making aspects of people's experiences, commonly utilising open-ended

information. They may use in-depth interviews or other sources of information to understand someone's experience. Interpretivists undertake qualitative research methods.

There has traditionally been a divide between the worldview of quantitative and qualitative approaches. Critics of quantitative approaches suggest that the use of categories may not reflect a full understanding of the problem to be researched given that the voices of research participants are not directly heard (Grinnell & Unrau 2014). Quantitative supporters highlight the objective stance taken in research as a strength, yet the quantitative researcher has necessarily made a range of subjective decisions including what to study, choosing tests and items for measurement, drawing conclusions based on the collected data and deciding which aspects of the research to report and emphasise. Despite the claims of quantitative approaches as being objective, it is impossible to carry out fully objective and value-free research (Johnson & Onwuegbuzie 2004). Critics of qualitative research maintain that the knowledge produced may not be generalisable to other people and therefore of limited utility. Qualitative research is seen as more easily influenced by the researcher's personal biases. Administrators and commissioners of programs tend to place lower credibility on qualitative research (Johnson & Onwuegbuzie 2004). All research approaches have strengths and weaknesses.

The divide between quantitative and qualitative approaches has been bridged over the last two decades by mixed methods research. Mixed methods research combines both quantitative and qualitative approaches to obtain a more comprehensive understanding of research questions (Tashakkori & Teddlie 1998; Johnson & Onwuebguzie 2004; Cresswell & Clark 2007). Cresswell and Clark (2007, p.8) state:

> *The combination of quantitative and qualitative approaches provides a better understanding of research problems than either approach alone.*

This study uses a mixed methods approach to explore how the perception of common humanity influences compassion in healthcare workers. The central tenet of mixed methods is pragmatism. Mixed methods research takes a pragmatic stance and recognises that both quantitative and qualitative research are important and useful (Tasakkori & Teddlie 2003; Johnson & Onwuegbuzie 2004; Maudsley 2011). Pragmatism is interested in generating knowledge around what works (Goldkuhl 2012) and views both objective and subjective information as being beneficial. Mixed methods research is considered the 'third wave' that moves past the quantitative versus qualitative debate by offering a practical alternative (Johnson and Onwuegbuzie 2004). Pragmatism rejects an either/or approach to paradigm selection and recommends pluralism (Johnson & Onwuebguzie 2004). Pragmatism contends that epistemological and methodological pluralism allows for more effective research. Such mixed methods research can produce more comprehensive findings that are ready to put into practice in the real world (Azorin & Cameron 2010). Pragmatism considers that combining quantitative and qualitative approaches is useful, rather than a quantitative versus qualitative mindset (Maudsley, 2011). Mixed methods research is an approach that 'combines the strengths of quantitative and qualitative research for the purpose of obtaining a richer and deeper understanding' (Zhang & Cresswell 2013, p.51). Grinnell & Unrau (2014, p.107) state:

> *Mixed methods research provides more evidence for studying a research problem than either the quantitative or qualitative approach alone.*

Pragmatism has been a defining feature of the social work tradition (Borden 2013). Social work has eclecticism as a fundamental approach to practice, for example, social workers recognise multiple explanatory systems and theoretical perspectives. Social workers are found in a wide range of sectors and undertake a diverse range of tasks (Marsh & Bunn 2018). Practical action

and a desire for change are what frequently motivate social work researchers (Flynn & McDermott 2016). Social workers interact with individuals, families, communities and organisations to promote social change, social justice and the empowerment of people. Many social problems are complicated, and the solutions must encompass a range of approaches in order to make a useful contribution. Healthcare is an area with many complexities and mixed methods research can be a useful tool in the search for solutions to complex problems (O'Cathian, Murphy & Nicholl 2007; Wisdom, Cavaleri, Onwuegbuzie & Green 2012). Another important factor in the bigger picture of achieving change is that qualitative research struggles for funding and mainstream medical acceptance (Sandelowski 2008; Pope & Mays 2009). Healthcare administrators are operating in tight budgeting environments and have a preference for data and quantitative evidence when it comes to allocating money towards new services or programs (Maudsley 2011).

There are many ways of conducting mixed methods research, one where the quantitative and qualitative data is collected at the same time, another where they are collected sequentially, and one set of data informs the other (Zhang & Cresswell 2013). Greene et al. (1989) outline five major rationales for conducting mixed methods research: a) triangulation (seeking convergence and corroboration of results from different methods and designs studying the same phenomenon); b) complementarity (seeking elaboration, enhancement and clarification of results from one method with results from the other method); c) initiation (discovering paradoxes and contradictions that lead to a re-framing of the research question); d) development (using the findings from one method to help inform the other method); e) expansion (seeking to expand the breadth and range of research using different methods for different inquiry components). Mixed methods research is not without its weaknesses. It can be difficult for a single researcher to carry out both quantitative and qualitative research, it

can be time consuming, expensive and places a greater requirement on the researcher to learn about multiple methods (Johnson & Onwuegbuzie 2004).

3.3 Research level and approach

Social work research can serve many purposes. Rubin and Babbie (2016) outline the following common research purposes: exploration (seeking to gain an initial familiarity with a topic); description (describing situations and events); explanation (explaining particular aspects of a topic); evaluation (evaluating policies, programs and interventions); constructing instrument measurements (developing and testing measurement instruments). Many social work studies contain elements of several of these purposes (Rubin & Babbie 2016) and may not fall neatly into a prescribed category (Grinnell & Unrau 2014).

In addressing the research question, this study fits within a descriptive level design as it seeks to describe the relationship between the perception of common humanity on compassion in healthcare workers. Descriptive studies include goals such as describing processes, mechanisms or relationships and clarifying steps (Neuman 2014). Descriptive studies may use either quantitative or qualitative research methods (Grinnell & Unrau 2014). The literature review identified that the perception of common humanity has been proposed by several researchers as the core component of compassion (Von Dietze & Orb 2000; Feldman & Kuyken 2011; Jinpa 2016; Ling, Olver & Petrakis 2018). The study undertook to research this proposal using both quantitative and qualitative data to provide the basis for developing a greater understanding of the relationship between the perception of common humanity and compassion.

3.4 Methodological design

The research employed several complementary components to investigate the relationship between the perception of common humanity and compassion in healthcare workers. A conceptual analysis and critical review was undertaken to explore the first subsidiary research question, 'What is compassion and how does it come into being?'. A pre-test/post-test experimental design was used to examine the second subsidiary research question, 'How does viewing common humanity scenarios impact on healthcare workers' level of compassion?'. A compassion training session was conducted to examine the third subsidiary research question, 'Does education on common humanity influence compassion in healthcare workers?'. A compassion eLearn was developed to address the fourth subsidiary research question, 'How can compassion training for healthcare workers be taken to scale?'.

The pre-test/post-test experiment was conducted at the start of the compassion training session where healthcare workers were asked to view a common humanity scenario. Two different common humanity scenarios were used, one was called the Lifeguard video and the other was called the Danish TV Ad. The researcher chose to use two different videos as one of the videos, the Lifeguard video, contained emotive material showing men, women and children who were refugees in distress. The other video, the Danish TV Ad, had a more light-hearted approach to people's human issues. The researcher wanted to ensure that any biases, both positive and negative, that some respondents might have to refugees did not overly affect the results. The Lifeguard video contained footage of an Australian lifeguard speaking about his reasons for volunteering to rescue Syrian refugees escaping the civil war by boat in the Mediterranean Sea (Charter for Compassion Australia 2016). The theme of honouring humanity dominates the lifeguard's story. He talks about 'as a lifeguard, you help people

irrespective of race, religion, creed. You don't look at them as a label or agenda. You look at them as human' and 'when I was on the ground in Greece, what I saw were humans. I didn't see a label, I didn't see the word "refugee", I didn't see the word "asylum seeker". What I saw were 2 arms, 2 legs, a beating heart, open eyes'. The Danish TV Ad also pursues a strong theme of common human bonds but chose to approach it in a different way. A varied group of Danish people are initially grouped according to superficial categories (TV2 Danmark 2017). The voiceover states 'It's easy to put people in boxes. There's us. And there's them'. People are put in groups such as 'the high earners', 'those we trust', 'those we avoid' etc. The groups start to change in response to an interviewer's question and regroup based on questions which emphasise common human experiences such as 'those who are stepparents', 'those who are lonely', 'those who have been bullied'. The final scene of the TV ad shows the participants connecting with a wide range of others who were not in their original groups with the voice over saying, 'So maybe there's more that brings us together than we think'.

The healthcare workers were randomly assigned to two groups, each group watching only one common humanity scenario. The pre-test surveys were completed prior to watching the common humanity scenario, the post-test surveys immediately after watching the common humanity scenario. Then both groups of healthcare workers were brought together to attend the compassion training session (see Figure 3.1).

The compassion training session contained the following content: (i) information defining compassion, (ii) research from neuroscience demonstrating that compassion is a positive mind state and different from empathy, (iii) scenarios emphasising common humanity and (iv) a slogan for healthcare workers, 'Just like me, this person wishes to be happy and not to suffer', to help the workers hold a compassionate stance towards their patients. The compassion

training session was evaluated by a cross-sectional survey design emailed to participants immediately after the training via a survey monkey link.
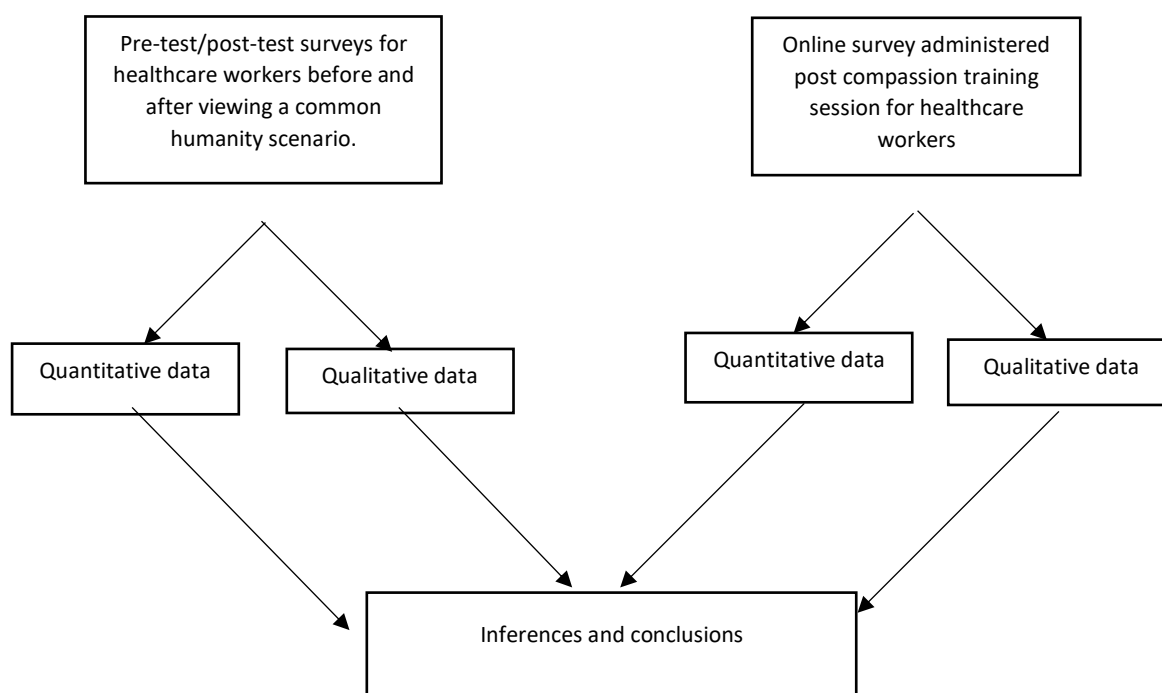
Figure 3.1 Mixed methods research overview.

The common humanity scenarios included either the Lifeguard video or the Danish TV Ad which had comprised the pre/post intervention. Then there were three additional real-life common humanity scenarios that were described to all the healthcare workers. The first scenario was where an American prison guard had a heart attack and collapsed while supervising prisoners who were doing gardening duty at a cemetery in the community (BBC News 2017). The prisoners removed the guard's bullet proof vest, performed CPR, put aside his gun and used his mobile phone to call the ambulance. When asked afterwards why they did this, they said 'it wasn't the case of him being the prison guard and us the prisoners. It was just "man down" and you go and help'. The second scenario involved homeless men who rushed to help victims of a bomb attack. The bomb attack had occurred at a concert where

there were women and children attending. One of the homeless men said afterwards, 'Just because I'm homeless, it doesn't mean I haven't got a heart and I'm not human still' (Smith 2017). The third scenario involved a father of two from Harlem named Wes Autrey. Autrey was waiting on the subway platform with his two young daughters when a fellow commuter, Cameron Hollopeter, collapsed and fell onto the train tracks just as an oncoming train approached (Buckley 2007). Autrey realised the train would not be able to stop in time so he leapt down onto the tracks, positioned Hollopeter safely in the middle of the train tracks and lay on top of him to keep him still. Afterwards, Autrey said 'I've always been about helping people, this guy was going to die unless someone helped him'.

3.5 Study sample

The study was conducted at Epworth HealthCare, Victoria's largest not-for-profit private health care organisation which has 6,870 staff.

3.5.1 Recruitment

Healthcare workers across the organisation were invited to participate in the research study and attend a compassion training session which was part of an overall 'Mindfulness and Compassion' education session. Emails promoting the research study and compassion training session were sent to all staff (Appendix 1). At the beginning of the 'Mindfulness and Compassion' education session, the researcher explained the research study to the audience (Appendix 2), its purpose and that the pre-test/post-test section would be conducted prior to the 'Mindfulness and Compassion' education session for healthcare workers who were willing to participate (Appendix 3). The healthcare workers were then randomly allocated to two groups to complete the pre-test/post-test surveys after watching a common humanity scenario. After the pre-test/post-test section was concluded, the researcher then delivered a

one-hour compassion training session to all healthcare workers. Then a different presenter delivered a one-hour mindfulness training session. An online survey was sent to all attendees immediately after the session ended (Appendix 4).

3.5.2 Sample size

One hundred workers attended the Mindfulness and Compassion session, eighty in person and twenty via remote viewing link from various Epworth HealthCare sites. Seventy-five healthcare workers participated in the pre-test/post-test surveys. Healthcare workers were randomly assigned to two groups to watch a different common humanity scenario. Forty-one healthcare workers were in the Lifeguard group and watched an interview of a lifeguard talking about his experiences rescuing Syrian refugees in the Mediterranean. Thirty-four healthcare workers were in the Danish TV Ad group and watched a Danish TV advertisement called 'All that we share'.

The online survey that evaluated the compassion training session was emailed to all the healthcare workers who attended the compassion training. Twenty-two healthcare workers responded.
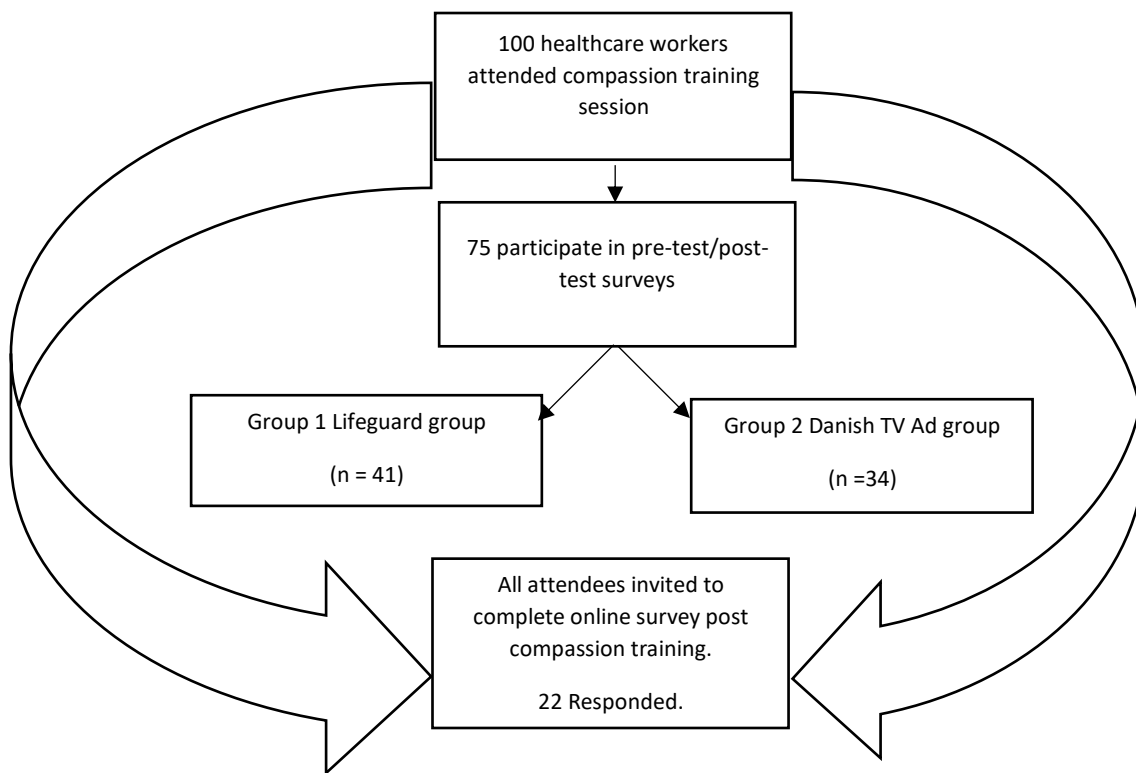
Figure 3.2 Sample size.

3.6 Data collection

The data collection method was structured surveys which obtained both quantitative data and qualitative data gathered from healthcare workers. Surveys are useful research methods because the characteristics of populations can be described. A probability sample in combination with a standardised questionnaire can offer the possibility of making refined descriptive assertions about a population group (Rubin & Babbie 2016).

This research study used a combination of:

a) Structured surveys pre-test and post-test (Appendix 3)

b) Online survey (Appendix 4)

3.6.1 Structured surveys

The structured pre-test/post-test survey was developed in consultation with the researcher's supervisors and the Monash University Statistical Consulting Service. The structured survey included demographic information including gender, age range and profession, three validated scales and one additional common humanity questions scale. The validated scales were:

(i) Perspective taking subscale from the Interpersonal Reactivity Index by Davis (1980).

(ii) Common humanity subscale from The Compassion Scale by Pommier (2010).

(iii) Santa Clara Brief Compassion Scale by Hwang, Plante & Lackey (2008).

The additional common humanity questions scale contained six new items which were trialled to capture common humanity. The content of the scales is described in Article Two 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach'.

The online survey to evaluate the compassion training session was developed by the researcher in consultation with the researcher's supervisors. The online survey contained open-ended questions as well as forced-choice questions. The online survey asked respondents: (i) to rate the Mindfulness and Compassion education session (5 point Likert scale from 'poor' to 'excellent'); (ii) to choose topics or ideas from the compassion training session they found useful (from a total choice of 4 topics); (iii) an open ended question asking them for an idea or strategy from the session that may help them have more compassion and (iv) how important it is to them to have access to information that can boost compassion (5 point Likert scale option from 'very unimportant' to 'very important'). The mindfulness

segment of the Mindfulness and Compassion session also asked the same questions but in relation to mindfulness (see Appendix 4 for details). One of the advantages of online surveys is the ease with which they can be emailed out. A criticism of online surveys concerns the representativeness of the sample (Grinnell & Unrau, 2014). It is possible that healthcare workers who did not find the compassion training useful did not complete the evaluation. Therefore, the results of the online survey may be skewed positively.

3.7 Data analysis

The mixed methods approach results in quantitative and qualitative data. The quantitative data was analysed using descriptive statistics, nonparametric tests, bivariate analysis and multivariate analysis. The qualitative data was analysed using thematic analysis. The results from the quantitative and qualitative analyses were then merged during interpretation.

3.7.1 Quantitative data analysis

All quantitative data from the pre-test/post-test survey was entered into IBM SPSS Statistics 25 software (http://www.spss.com) for analysis. Descriptive statistics including means and standard deviations of all variables were calculated. Nonparametric tests were conducted to test differences between groups (Mann-Whitney U test) and differences between pre-test and post-test scores (Wilcoxon Signed-Rank Test). Kendall's tau b was performed to determine relationships between perspective taking, common humanity and compassion. A mediation analysis was performed to investigate the hypothesis that the relationship between perspective taking and compassion is mediated by common humanity. Cronbach's alpha was calculated to measure the internal consistency of the additional common humanity questions which had been trialled. Results can be viewed in Article Two 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach'.

Significance was set at p < .05 (two-tailed) unless otherwise stated. Effect sizes were reported for the Wilcoxon Signed-Rank Test. A value of less than .3 represents a small effect, .3 to .5 represents a moderate effect, and .5 and above represents a large effect size (Pallant 2013).

3.7.2 Qualitative data analysis

The qualitative data from the pre-test/post-test survey and the online survey was analysed using thematic analysis. Thematic analysis brings together core themes and patterns in the data which relate to the research question (Flynn & McDermott 2016). The data was analysed by multiple readings of the transcripts. The transcripts were coded by hand into initial groupings and themes. The initial themes were checked to ensure the groupings were consistent and coherent. Results of the qualitative data from the pre-test/post-test survey can be viewed in Article Three, 'The Use of Common Humanity Scenarios to Promote Compassion in Healthcare Workers'. Results of the qualitative data from the online survey can be viewed in Article Four, 'Outcomes from a Compassion Training Intervention for Health Care Workers'.

3.8 Research ethics

Ethics approvals were obtained from the Monash University Human Research Ethics Committee (MUHREC) and the Epworth Human Research Ethics Committee (see Appendices 5-7 for ethics approval letters).

3.9 Limitations

There were some limitations associated with the study's methodology and associated methods. The flyer to promote the research intervention advertised a mindfulness and compassion session. Although the research segment and compassion training session was

conducted first, completely independent of the mindfulness presentation, it is possible some healthcare workers were more interested in mindfulness than compassion. Efforts to take this into consideration were made by ensuring the post training session survey separated out questions on compassion and mindfulness (Appendix 4). Other limitations included: (i) quantitative data for the pre-test/post-test common humanity intervention was collected at two time points only; (ii) two different common humanity scenarios were used; (iii) sample size to trial the additional common humanity questions was small; (iv) online survey to evaluate the compassion training session was a once-off data collection and had a low response rate.

Regarding (i), the use of additional time points for the pre-test/post-test common humanity intervention would be beneficial to see if the effect on healthcare workers' level of compassion would hold over a longer period of time.

In relation to (ii), the two common humanity scenarios represented common humanity in different ways, the lifeguard scenario being more emotive and showing people in distress whereas the Danish TV Ad was a constructed scenario and had a light-hearted tone. It is possible that these differences influenced the results in more substantive ways than the statistical analysis revealed. Article Three, 'The Use of Common Humanity Scenarios to Promote Compassion in Healthcare Workers' explored the different themes from each common humanity scenario. Further empirical studies would be useful to see if differences in how common humanity is presented have different effects on healthcare workers' level of compassion.

Concerning (iii), the sample size to trial the additional common humanity questions was 75. The decision was made to undertake a preliminary analysis of these questions despite the

fact that sample sizes of approximately 300 are preferred when trialling items for scale development (DeVellis 2016). There has been virtually no work on developing a scale for common humanity and it is hoped that the results from this study are a beginning contribution in this area for future research. It would be useful to replicate the study with a larger sample size.

Finally, in relation to (iv), the online survey to evaluate the compassion training was administered at one time point with most of the respondents replying within three days of the training session. Only 22 healthcare workers responded which is 22% of the total number of healthcare workers who attended the training session. It is unclear why the response rate was so low, although healthcare workers tend to be busy with patient contacts and a high administrative load. It would be useful for further studies to see if they can obtain a higher response rate, as well as surveying the healthcare workers at an additional time point to see if the training effects hold over time.

3.10 Chapter summary and conclusions

The Methodology Chapter has provided an outline and justification of the research design, study sample, data collection methods and data analysis. The mixed methods approach enables both quantitative and qualitative data to be collected to provide evidence to answer the research question. A pragmatic approach was applied where data from the pre-test/post-test study was collected alongside data from the online survey which evaluated the compassion training session. The breadth of the study and use of different research methods has resulted in a rich array of data to describe the impact of the perception of common humanity scenarios and training on compassion in healthcare workers. As the literature review highlighted, the relationship between the perception of common humanity and compassion

in healthcare workers is an area where there has been no empirical research undertaken. As such, this research study is important as a first step in opening up inquiry into this relationship.

The Results Chapter will present four research publications, three have been submitted for publication and one published article, which present the study findings.

Chapter 4. Results

The Results Chapter contains four academic articles which deliver the research findings. The four articles are:

Article Two: 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach' (p.75).

Article Three: 'The use of common humanity scenarios to promote compassion in healthcare workers' (p.103).

Article Four: 'Outcomes from a compassion training intervention for health care workers' (p.119).

Article Five: 'An outline of a Compassion eLearn for healthcare workers' (p.130).

4.1 Preamble to Article Two

The second article in the thesis outlines the quantitative results from the pre/post intervention at Epworth HealthCare. Healthcare workers watched common humanity scenarios and completed pre- and post-test validated surveys on perspective taking, common humanity and compassion. The data was analysed using descriptive statistics, nonparametric tests, bivariate analysis and multivariate analysis.

The article addresses the second subsidiary research question, 'How does viewing common humanity scenarios impact on healthcare workers' level of compassion?'.

Title: Investigating how viewing common humanity scenarios impacts compassion: A novel approach

Authors: Ling, D., Olver, J. and Petrakis, M.

Journal: *British Journal of Social Work*

Publisher: Oxford University Press

Status: In press

This article was also presented at the following conference:

Epworth HealthCare Innovations in Rehabilitation and Mental Health Conference, Melbourne, October 27, 2018.

4.2 Article Two: Investigating how viewing common humanity scenarios impacts compassion: A novel approach

Abstract

Compassion is a core value in healthcare. It enables healthcare workers to respond with care and kindness to all patients. The perception of common humanity has been proposed as the central mechanism of compassion. There have been no empirical studies examining the connection between common humanity and compassion. The present study aimed to investigate the impact of viewing common humanity scenarios on compassion. Seventy-five healthcare workers participated and were randomly allocated to two groups. The healthcare workers viewed different common humanity scenarios and completed pre- and post-test validated scales on perspective taking, common humanity and compassion. The authors investigated whether compassion increased after viewing the common humanity scenarios. A mediation analysis was performed to examine if perspective taking influences compassion, mediated by common humanity. Some new common humanity items were also trialled to help develop a common humanity scale. The results demonstrated that healthcare workers' level of compassion increased after viewing the common humanity scenarios. There was some evidence that perspective taking influences compassion mediated by common humanity. Common humanity appears to be a collection of constructs captured by a number of subscales. This study has important implications for supporting healthcare workers to develop and sustain compassion.

Keywords: Values, health, job satisfaction, human rights, professional practice

Introduction

Compassion is fundamental to quality healthcare (Sinclair *et al*., 2018). It is embedded in the codes of practice for professions such as social work, nursing and medicine. A widely accepted definition of compassion is that it is 'the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help' (Goetz *et al*. 2010, p.351). Jinpa (2016) further highlights that compassion is a sense of concern, not just any feeling, that arises when we are confronted with another's suffering. Compassion is associated with prosocial behaviours towards others (Preston, 2013). Compassion is considered a virtue across cultures. In the West, records show Aristotle speaking about compassion in 350 BC. In the East, Buddhist texts which are 2,000 years old mention compassion. Compassion holds an elevated status due to its inclusivity, care and concern for others. Social workers are working with people on a daily basis who may be suffering. Radey and Figley (2007, p.207) say, 'in the most basic sense, clinical social workers are guided by compassion for humanity and an altruistic desire to improve individual and societal conditions. Compassion, a desire to alleviate the suffering of the other, is at the core of what social work does. Compassion is essential, not just for social workers, but for a range of helping professions.

The importance of compassion has been recognised globally and has influenced government policy. The UK implemented a three-year Compassion in Practice policy in 2013 to improve care in the National Health Service (Cummings and Bennet, 2012). Major research institutes such as the Stanford Centre for Compassion and Altruism Research and Education and Max Planck Institute for Human Cognitive and Brain Sciences are conducting research into compassion. Recent findings have revealed that compassion is a positive state of mind and can be trained (Klimecki *et al*., 2012). It has been found that compassion leads to feelings of

affiliation, reward and prosocial behaviour (Batson, 2011; Goetz *et al.*, 2010). Compassion has also been associated with reduced conflict and aggression (Crocker and Canevello, 2008; Condon and DeSteno, 2017).

Compassion is an innate aspect of human nature. Evolutionary theory suggests compassion arises from the need to raise and protect offspring (Goetz *et al.*, 2010). Compassion enables caregivers to look after the young, sick and elderly. However, the mechanisms underlying compassion are unclear (Goetz and Simon-Thomas, 2017). Why is it that some have compassion for complete strangers and others do not? Understanding the underlying motivation that leads to compassion is crucial (Batson, 2017), as is the question of how to foster compassionate states (Condon and DeSteno, 2017).

Compassion requires one to take the perspective of another. One has to be aware that the other is suffering. It is important to clarify that one does not have to feel exactly the same discomfort as the person who is suffering in order to have compassion. Healthcare workers can have compassion for their patients without needing to feel their patients' physical pain. Compassion is based on feeling *for* the other, not feeling *as* the other. Taking the perspective of the other involves imagining how they would feel, not how you yourself would feel in their situation (Batson, 2011). The role that empathy plays has led to some confusion in the research literature (Batson, 2017). Empathy, having an understanding of how the other is feeling, is required to have compassion. Empathy can lead to *empathic concern* (positive state of mind) or *empathic distress* (negative state of mind) (Klimecki and Singer, 2012). Empathic distress or personal distress is when one becomes distressed by the other's suffering; it is an aversive self-focused negative reaction (Eisenberg, 2002). Compassion is other-focused; that is, it is always wishing to improve the welfare of another.

The perception of common humanity

People commonly have compassion for their family and friends - a biased form of compassion. Compassion shown towards strangers or those who have no close relationship to one is a universal form of compassion. Universal compassion is elevated as a virtue and is the context in which compassion is most commonly used. The Charter for Compassion is a worldwide movement that urges the people of the world to embrace compassion in daily life. The Charter states (2009):

> *Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there, and to honour the inviolable sanctity of every single human being, treating everybody, without exception, with absolute justice, equity and respect.*

Hospitals have compassion as a stated core value, stating that all patients will be treated with care and concern. The development and enhancement of universal compassion is the focus of this paper, and for clarity's sake, will be called compassion from here on.

Several authors and researchers have proposed that the perception of common humanity is the foundation of compassion (Blum, 1980; Nussbaum, 1996; Von Dietze and Orb, 2000; Cassell, 2009; Jinpa, 2016; Ling *et al*., 2018). Compassion has only become the topic of research interest in the last two decades. However, it should be noted that the perception of common humanity was proposed as central to compassion by Blum (1980) almost forty years ago. Blum suggested that compassion involves a sense of shared humanity and regarding the other as a fellow human being. Blum has been widely cited in the literature and the notion of common humanity has been raised frequently in the literature. This study is the first empirical study to investigate this idea. Common humanity recognises the similarity between self and others. All humans have the same basic needs and wish to be happy. Every single person is

subject to ageing, sickness and death. Common humanity eliminates the sense of the 'other' (Ledoux, 2015). Everyone becomes part of the in-group, so there is no basis upon which to ignore or diminish the suffering of the other. When seeing others who have misfortune, one understands that it could happen to oneself (Pommier, 2010). One identifies with the person suffering and recognises human vulnerability as a general phenomenon (Von Dietze and Orb, 2000; Van Der Cingel, 2009). Common humanity recognises that humans are the same in their desire for happiness and aversion to discomfort, 'Just like me, this person wishes to be happy and not to suffer' (Jinpa, 2016, p. 159). There has been significant research on the impact of perceived similarity leading to empathic concern and/or compassion (Penner *et al*., 2005; Cikara *et al*., 2011; Valdesolo and DeSteno, 2011). Perceived similarity diminishes in-group/out-group distinctions and brings everyone into the in-group (Galinksy and Moskowitz, 2000; Penner *et al*., 2005). Common humanity is the perspective that enables one to view all others as similar to oneself. Compassion involves a sense of connection and identification with someone; a deep regard and honouring of the other who is in distress (Nussbaum, 1996; Cassell, 2009; Jinpa, 2016).

Taking the perspective of another – being able to imagine how they might be thinking and feeling – is not, in itself, enough to engender empathic concern or compassion (Batson, 2011). Both empathic concern and compassion are focused on the other, but compassion takes a step further than empathic concern, and wishes for the other to be free from suffering. It is possible to understand that another is suffering but not care that they suffer. One also has to value the welfare of the other for compassion to arise (Batson, 2011; Ricard, 2015; Lown, 2016). Evolutionary theory suggests that it is adaptive for adults to place high value on the wellbeing of their offspring (Goetz *et al*., 2010). Healthcare professionals and emergency service workers are expected to provide care and compassion to strangers every day as part

of their work. It is the basis of a well-functioning society to look after others. Examples of people helping others at some sacrifice to themselves happen quite frequently (Penner *et al*., 2005). The perception of common humanity is a perspective that offers an explanation as to why some people have compassion towards complete strangers. It is important to gain a better understanding of what leads to unbiased universal compassion, particularly in healthcare where healthcare workers are caring for people who are strangers. The circumstance of people helping strangers is evident in day to day life. It is not uncommon to even hear of instances where someone risks their life to help others whom they do not know. A notable example of this was people in Nazi occupied Europe who risked their lives to save Jewish people. When the rescuers were asked why they did this, all of the rescuers spoke about valuing the other based purely on a sense of shared humanity (Monroe, 1998).

There has been little empirical research on common humanity (Greenaway *et al*., 2010; McFarland *et al*., 2013) and no empirical research investigating the connection between common humanity and compassion. There is an absence of studies that separate out the underlying mechanisms of compassion (Davis, 2017; Skwara *et al*., 2017). Understanding the impact of common humanity on compassion is, therefore, of prime importance for three reasons. First, there is a lack of consensus regarding definitions of compassion (Ledoux, 2015; McCaffrey and McConnell, 2015; Strauss *et al*., 2016, Kirby, 2017; Sinclair *et al*., 2016). If, as several researchers propose, common humanity is found to be a core component of compassion, it will shed important light on a key underlying mechanism of compassion. The concept of common humanity has not been included into most current definitions of compassion. An exception is Pommier's (2010) conceptualisation of compassion. However, if common humanity is central to compassion, as has been theorized by several authors and

researchers, then future research into compassion will be strengthened by including the perception of common humanity into definitions.

Secondly, there is a strong need to understand which components of compassion training are most influential (Condon and DeSteno, 2017; Kirby, 2017). There is currently a range of compassion training interventions that have been developed. The range of competencies targeted by different compassion training interventions is broad, including empathy, sympathy, distress tolerance, mentalizing, mindfulness, yoga, loving kindness meditation, common humanity, breath training, acting simulations and working on self-criticism (Kirby, 2017). It is questionable whether all of these competencies lead to the development of compassion. Consequently, some compassion training programs run the risk of incorporating elements which do not promote compassion. Care needs to be taken to ensure that compassion training interventions are training compassion and not some other competencies.

Thirdly, existing compassion scales are not robust (Sinclair *et al*., 2016; Strauss *et al*., 2016). Gaining greater clarity regarding the core components of compassion and its underlying mechanisms will assist in the development of compassion scales which have validity and rigour. There is also a lack of common humanity scales available which makes common humanity difficult to study. The development of valid and reliable common humanity scales would aid efforts to conduct research on its influence.

Healthcare workers are exposed to suffering on a daily basis. Research has shown that the neural pathways for compassion are positive (Klimecki *et al*., 2012). Compassion is a wish for the other's suffering to be alleviated. Compassion provides the motivation to engage in prosocial actions. Whether one is actually able to achieve the goal of the other being freed from suffering does not negate the positivity of the giver holding a compassionate stance

(Jinpa, 2016). The important point is that teaching healthcare workers how to enhance the strength and frequency of compassion is good for the giver and the receiver. Even if the receiver's plight is not substantially improved, being on the receiving end of care and kindness is much more preferable than being dismissed and ignored. Those who are compassionate create supportive interpersonal environments for themselves and others (Crocker and Canevello, 2008). Training in compassion can assist healthcare workers to avoid emotional burnout which has now been associated with empathic distress fatigue (Klimecki and Singer, 2012). Klimecki and Singer (2012) suggest that the term 'compassion fatigue' is a misnomer and it is actually 'empathic distress fatigue'. It is only recently that neuroscience has revealed the important distinctions between empathy and compassion. There are serious implications for healthcare workers if they experience empathic distress on a regular basis instead of compassion. Therefore, it is beneficial to discover ways to help healthcare workers develop and sustain a compassionate stance in their daily work. Compassion research is in its infancy. The evidence base for compassion in healthcare needs further exploration (Sinclair *et al.*, 2016). There is a scarcity of empirical studies that attempt to shed light on the underlying mechanisms of compassion. It is hoped that this study will contribute to the existing knowledge base on compassion.

The present study

The purpose of the study was to investigate whether viewing material on common humanity had an impact on healthcare workers' level of compassion. We examined whether measures of common humanity and compassion increased after viewing common humanity material. The relationship between perspective taking, common humanity and compassion was explored via a mediation analysis to see if common humanity mediates the impact of

perspective taking on compassion. Scales that capture common humanity are almost non-existent so although the study sample size was insufficient for a full-scale validation, the decision was made to trial some additional common humanity questions to see if they could be a preliminary step in assisting with the development of a robust common humanity scale.

We propose:

Hypothesis 1: Viewing material on common humanity will increase healthcare workers' level of the perception of common humanity

Hypothesis 2: Viewing material on common humanity will increase healthcare workers' level of compassion.

Methods

Sampling and procedure

The study was conducted in October 2017 at Epworth HealthCare in Victoria, Australia. Epworth HealthCare staff numbers in 2017 were approximately 6,800. Ethics approval was obtained to conduct the study. The study was promoted organisation wide. Healthcare workers were informed that participation in the study was anonymous, participation was voluntary, and they could withdraw at any time. Healthcare workers gave verbal consent to participate in the study. One hundred healthcare workers attended a compassion training session conducted by the lead author. Eighty of the healthcare workers attended in person and twenty attended via remote video link. Seventy-five healthcare workers participated in the study. The study was conducted immediately prior to the compassion training session. Healthcare workers completed the pre-test surveys prior to the intervention. Then they were randomly assigned to two different groups to view different common humanity scenarios.

Due to the difficulty in getting large numbers of healthcare workers to interrupt their clinical work to attend a research study and stay for its duration, a decision was made to provide both groups with the opportunity to view a common humanity scenario as opposed to using a control group who do not receive the intervention. The healthcare workers then completed the post-test surveys immediately after viewing the scenario. One group was shown a seven-minute interview with a lifeguard who volunteered in the Mediterranean to rescue Syrian refugees escaping the Syrian war by boat (Charter for Compassion Australia, 2017). The lifeguard speaks about his motivation to volunteer being that 'these are people in need and lifeguards go to help where the need is'. The second group were shown a three-minute Danish TV advertisement called 'All That We Share' (TV2 Danmark, 2017). This shows different groups of people discovering that they have more in common than they initially realise. Two different scenarios were selected to capture common humanity, however since the lifeguard interview contained more emotive material and there was the possibility that material on refugees may confound the results since there are polarized views on this issue, the decision was made to also show the Danish TV Ad as a comparison. Respondents were asked to indicate their age range, gender and occupation.

Measures

Perspective Taking

The perspective taking subscale from the Interpersonal Reactivity Index developed by Davis (1980) was used. The Interpersonal Reactivity Index is a widely used measure. The perspective taking subscale consists of seven items: (1) 'Before criticizing somebody I try to imagine how I would feel in their place', (2) 'If I'm sure I'm right about something I don't waste much time listening to other people's arguments', (3) 'I sometimes try to understand my friends better

by imagining how things look from their perspective', (4) 'I believe that there are two sides to every question and try to look at them both', (5) 'I sometimes find it difficult to see things from the 'other guy's' point of view', (6) 'I try to look at everybody's side of a disagreement before I make a decision', (7) 'When I'm upset at someone, I usually try to 'put myself in his shoes' for a while'. Respondents were asked to rate how well these statements described them on a five-point scale ranging from 1 (Does not describe me well) to 5 (Describes me very well). Items 2 and 5 were reverse scored. The internal consistency of this subscale has a Cronbach's alpha of 0.75.

Common Humanity

Common humanity was measured using the common humanity subscale from The Compassion Scale by Pommier (2010). The four items in this scale included: (1) 'Everyone feels down sometimes, it's part of being human', (2) 'It's important to recognize that all people have weaknesses and no one's perfect', (3)'Despite my differences with others, I know that everyone feels pain just like me', (4) 'Suffering is just a part of the common human experience'. The response category ranged from 1 (Almost never) to 5 (Almost always). The internal consistency of this subscale has a Cronbach's alpha of 0.75.

Compassion

The scale used to measure compassion was the Santa Clara Brief Compassion Scale by Hwang *et al*., (2008). The Santa Clara Brief Compassion Scale is a brief validated version of Sprecher and Fehr's (2005) Compassionate Love Scale which has been used widely. The five items included: (1) 'When I hear about someone (a stranger) going through a difficult time, I feel a great deal of compassion for him or her', (2) 'I tend to feel compassion for people, even though I do not know them', (3) 'One of the activities that provides me with the most meaning to my

life is helping others in the world when they need help', (4) 'I would rather engage in actions that help others, even though they are strangers, than engage in actions that would help me', (5) 'I often have tender feelings toward people (strangers) when they seem to be in need'. The response category ranged from 1 (Not at all true of me) to 7 (Very true of me). The internal consistency of this scale has a Cronbach's alpha of 0.90.

Additional Questions on common humanity

Since there are virtually no scales to measure common humanity, six additional common humanity questions were trialled with the aim to progress efforts in the future development of a suitable scale. The items included: (1) ' No one wants suffering', (2) 'People all around the world want happiness', (3) 'Myself and others are the same in our basic human needs', (4) 'When I think of the similarities between me and others, I feel more compassion for others', (5) 'People bring it on themselves when something bad happens to them', (6) 'There are many factors that go into someone suffering misfortune'. The response scale was 1 (Disagree strongly) to 5 (Agree strongly). Item number 5 was reverse scored.

Statistical Analysis

Descriptive statistics including means and standard deviations of all variables were calculated. Mann-Whitney U test was conducted to determine if there were differences between the Lifeguard group and the Danish TV group. Wilcoxon signed-rank test was conducted to investigate if there was a median difference between the pre-test and post-test results on perspective taking, common humanity and compassion after the viewing the Lifeguard interview or the Danish TV advertisement. Kendall's tau b was performed to determine the relationships between perspective taking, common humanity and compassion. A mediation analysis was performed to investigate the hypothesis that the relationship between

perspective taking and compassion is mediated by common humanity. Cronbach's alpha was calculated to measure the internal consistency of the additional common humanity questions trialled. The significance level was set at p = 0.05. Statistical analyses were performed using SPSS version 25.

Results

Table 4.1 lists the demographic information, means and standard deviations on each measure pre- and post-test. The means on all 4 scales – perspective taking, common humanity, compassion and additional common humanity questions – increased after viewing the common humanity material.

Table 4.1 Participant characteristics

Variables	Values, mean±SD or n (%)	Variables	Values, mean ±SD or n (%)
Lifeguard group (n=41)		**Danish TV group (n=34)**	
Sex, n (%)		Sex, n (%)	
Male	4 (9.7)	Male	3 (8.8)
Female	37 (90.3)	Female	31 (91.2)
Age Range, n (%)		Age Range, n (%)	
18-24	-	18-24	1 (2.9)
25-34	16 (39.0)	25-34	11 (32.4)
35-44	12 (29.3)	35-44	6 (17.6)
45-54	5 (12.2)	45-54	10 (29.5)
55-64	7 (17.1)	55-64	3 (8.8)
65-75	1 (2.4)	65-75	3 (8.8)
Profession, n (%)		Profession, n (%)	
Nursing	13 (31.7)	Nursing	10 (29.4)
Medical	2 (4.8)	Medical	1 (2.9)
Social Work	3 (7.3)	Social Work	4 (11.8)
Occupational Therapist	6 (14.6)	Occupational Therapist	2 (5.9)
Physiotherapist	-	Physiotherapist	-
Psychologist	4 (9.7)	Psychologist	5 (14.7)
Speech Pathologist	-	Speech Pathologist	-
Dietician	-	Dietician	1 (2.9)
Pastoral Care	3 (7.3)	Pastoral Care	1 (2.9)
Allied Health	1 (2.4)	Allied Health	3 (8.8)
Management	4 (9.7)	Management	4 (11.8)
Administration	3 (7.3)	Administration	1 (2.9)
Other	2 (4.8)	Other	2 (5.8)
Measures (mean ± SD)		Measures (mean ± SD)	
Perspective taking (pre)	3.87 (.53)	Perspective taking (pre)	3.83 (.67)
Perspective taking (post)	4.15 (.43)	Perspective taking (post)	4.16 (.39)
Common Humanity (pre)	4.38 (.54)	Common Humanity (pre)	4.40 (.49)
Common Humanity (post)	4.43 (.54)	Common Humanity (post)	4.61 (.45)
Compassion (pre)	5.67 (.87)	Compassion (pre)	5.68 (.84)
Compassion (post)	5.98 (.81)	Compassion (post)	5.93 (.87)
Additional CH qns (pre)	4.37 (.40)	Additional CH qns (pre)	4.42 (.38)
Additional CH qns (post)	4.50 (.41)	Additional CH qns (post)	4.60 (.33)

Mann-Whitney U test was used to determine if there were differences between the Lifeguard group and the Danish TV group on the perspective taking, compassion, common humanity and additional common humanity scales. The distribution of all scores in both the Lifeguard and the Danish TV group pre- and post-test were similar as assessed by a visual inspection. The difference between median scores on all scales pre- and post-test was not statistically significant. Table 4.2 shows these results. The Mann-Whitney U test results suggest the Lifeguard group and Danish TV ad group were comparable.

Table 4. 2 Mann-Whitney U test results

Scale	U	Z	p
Perspective taking (Pre)	696.0	.01	.991
Perspective taking (Post)	712.0	.16	.872
Common Humanity (Pre)	713.5	.18	.858
Common Humanity (Post)	820.5	1.35	.176
Compassion (Pre)	692.0	-.05	.957
Compassion (Post)	680.5	-.18	.860
Additional CH qns (Pre)	732.5	.38	.703
Additional CH qns (Post)	796.5	-.18	.860

Wilcoxon signed-rank tests were conducted to investigate whether there was a median difference on perspective taking, common humanity, compassion and additional common humanity questions before and after watching the common humanity videos. Table 4.3 summarises these results. There were statistically significant increases in all the medians except in the Lifeguard group where common humanity median (4.50) did not change, $Z =$ 1.05, p = 0.293. These findings support the hypothesis that viewing material on common humanity would increase healthcare workers' level of compassion. The hypothesis that viewing material on common humanity would increase healthcare workers' level of common humanity was supported in the Danish TV group but not the Lifeguard group.

Table 4.3 Wilcoxon Signed-Rank test results

Scale	Difference	Median (Pre, Post)	Z	Sig (2-tailed)	Effect size
Lifeguard group					
Perspective taking	.14	3.86,4.14	3.83	.001	0.59
Common Humanity	0	4.50, 4.50	1.05	.293	0.16
Compassion	.20	5.60, 6.0	3.51	.001	0.55
Additional CH qns	0	4.50, 4.67	2.39	.017	0.37
Danish TV group					
Perspective taking	.28	3.86, 4.14	3.29	.001	0.57
Common Humanity	.25	4.50, 4.75	2.59	.009	0.44
Compassion	.20	5.60, 6.0	3.23	.001	0.55
Additional CH qns	.17	4.50, 4.67	3.27	.001	0.56

The strength and direction of the association between perspective taking, common humanity and compassion was investigated by calculating Kendall's tau b. Table 4.4 shows the pre-test results. Table 4.5 shows the post-test results.

Table 4.4 Kendall's tau b for main study variables (N=75) pre-test

Scale	Perspective taking	Common Humanity	Compassion	Additional CH
Perspective taking		.08	.16	.06
Common Humanity	.08		.15	.09
Compassion	.16	.15		.23*
Additional CH	.06	.09	.23*	

* = statistically significant at $p < .01$ level

Table 4. 5 Kendall's tau b for main study variables (N=75) post-test

Scale	Perspective taking	Common Humanity	Compassion	Additional CH
Perspective taking		.09	.34*	.31*
Common Humanity	.09		.16	.09
Compassion	.34*	.16		.27*
Additional CH	.31*	.09	.27*	

* = statistically significant at $p < .01$ level

Mediation analysis is useful in explaining the process by which one variable affects another (Hayes, 2013). Often this process is not just a straightforward effect of one independent variable impacting on a dependent variable but involves a mediating variable which transmits the effect of one variable to another (MacKinnon *et al*., 2007). A mediation analysis was

conducted on the post-test results to explore the hypothesis that perspective taking influences compassion mediated by common humanity. There were two different scales used to capture common humanity: Pommier Common Humanity scale (CH) and the Additional Questions Common Humanity scale (AQ). The requirements for mediation analysis are stated by Baron and Kenny (1986). These include a regression analysis to demonstrate that the independent variable (perspective taking) significantly affects the dependent variable (compassion) and that the independent variable (perspective taking) also significantly affects the mediating variable (common humanity). Common humanity, as represented by the Pommier Common Humanity scale did not satisfy the requirements for mediation, as the regression analysis showed that the impact of the perspective taking on common humanity was not significant, see Figure 4.1. However, mediation was found to occur using the Additional Questions Common Humanity scale, see Figure 4.2. The results from the mediation analysis for the Additional Questions Common Humanity scale including path coefficients, indirect effects and 90% bias-corrected confidence intervals predicting compassion scores, are shown in Table 4.6.

Figure 4.1 Mediation analysis path diagram (using Pommier Common Humanity subscale)
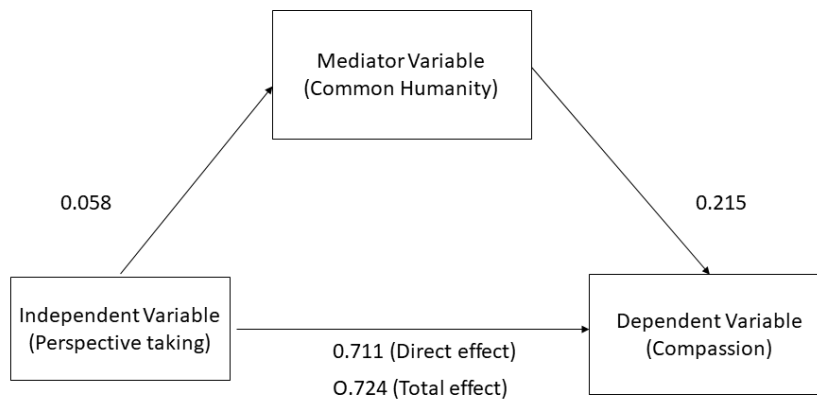
Regression analysis showed that the independent variable, perspective taking, was not a significant predictor of the mediator, common humanity (CH scale), b = 0.058, SE = 0.142, p = 0.685 and that common humanity was a not significant predictor of compassion, b = 0.215, SE = 0.179, p = 0.233. These results do not support the mediational hypothesis. Perspective taking was a significant predictor of compassion after controlling for the mediator, common humanity, b = 0.724, SE = 0.218, p = 0.001. Approximately 13% of the variance in compassion was accounted for by the predictors (R^2 = 0.131). The indirect effect was tested using a bootstrap estimation approach with 5000 samples (Hayes, 2013). These results indicated that the indirect coefficient was not significant, b = 0.013, SE = 0.047, 95% CI = -0.059, 0.142.

Figure 4.2 Mediation analysis path diagram (Additional Questions Common Humanity scale)
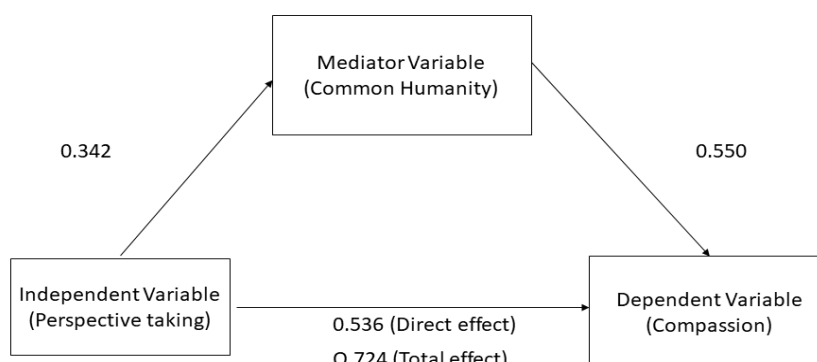
When the mediation analysis was repeated using common humanity (as measured by the Additional Questions Common Humanity scale) as mediator, the results indicated that perspective taking was a significant predictor of common humanity, b = 0.342, SE = 0.098, p = 0.001 and that common humanity was a significant predictor of compassion, b = 0.550, SE = 0.254, p = 0.034. These results support the mediational hypothesis. Perspective taking was still a predictor of compassion after controlling for the mediator, common humanity, b = 0.536, SE = 0.229, p = 0.023. These results suggest partial mediation. Approximately 18% of the variance in compassion was accounted for by the predictors (R^2 = 0.184). The indirect effect was tested using a bootstrap estimation approach with 5000 samples (Hayes 2013). These results indicated that the indirect coefficient was significant, b = 0.188, SE = 0.107, 90% CI = 0.024,0.369.

Table 4.6 Path coefficients, indirect effects, and 90% bias-corrected confidence internal predicting compassion (N=75)

Path	Effect	BootLLCI	BootULCI	SE	t	P-value
Total effect (c)	0.724	0.360	1.087	0.218	3.318	0.001
Direct effect (c')	0.536	0.153	0.919	0.229	2.331	0.023
a path	0.342	0.178	0.505	0.098	3.485	0.001
b path	0.550	0.127	0.973	0.254	2.167	0.034

Abbreviations: BootLLCI, bootstrapping lower limit confidence interval; BootULCI, bootstrapping upper limit confidence interval; SE, standard error.

Cronbach's alphas were calculated to determine the reliability of the common humanity scales post-test. Cronbach's alpha is a measure of the internal consistency of the scale. The four item Pommier Common Humanity subscale (CH) had a Cronbach's alpha was 0.703. The first four questions only of the Additional Questions Common Humanity scale (AQ) were used to calculate the Cronbach's alpha as question (5) 'People bring it on themselves when something bad happens to them' and question (6) 'There are many factors that go into someone suffering misfortune' were not directly capturing common humanity. The AQ scale Cronbach's alpha was 0.627. When the two scales were combined, Cronbach's alpha was 0.692.

Discussion

Results of this study suggest that the perception of common humanity is central to the arising of compassion. Showing healthcare workers common humanity scenarios increased their levels of compassion. In both the lifeguard and Danish TV group, the increase in levels of compassion after the intervention was statistically significant. Showing healthcare workers common humanity scenarios also increased their level of perception of common humanity, although it was only statistically significant in the Danish TV group. The findings support the suggestion that the perception of common humanity is a prerequisite for compassion. Given that compassion research is still in its early days, future work on conceptualisations of compassion may want to incorporate the concept of common humanity. Perspective taking and compassion were positively correlated as were perspective taking and common humanity. The mediation analysis found perspective taking influenced compassion mediated by common humanity when the Additional Questions Common Humanity scale was used. There was no mediation when the Pommier Common Humanity subscale was used. This suggests that the

Additional Questions Common Humanity scale and the Pommier Common Humanity subscale are capturing different aspects of common humanity.

The results from the calculation of Cronbach's alpha for the Pommier Common Humanity scale and the Additional Questions Common Humanity scale also suggest that the construct of common humanity may be a collection of subscales. The internal consistency of both the Pommier Common Humanity subscale (0.703) and the Additional Questions Common Humanity scale (0.627) was marginally acceptable. When the two common humanity scales were combined, the Cronbach's alpha was 0.693. Cronbach's alpha of 0.7 or above is considered desirable, a Cronbach's alpha closer to 1 indicates that all the items are measuring the same thing (DeVellis, 2016). Further work will be required to tease out what are the components of common humanity. It is important for reliable and valid scales representing common humanity to be developed to enable research on the connection between it and compassion. Since it appears that common humanity is fundamental to compassion, the construct of common humanity would be useful if it was incorporated into compassion scales. There are serious issues with existing compassion scales having poor validity and reliability (Strauss *et al*., 2016; Sinclair *et al*., 2016; Gu *et al*., 2017). This reflects the lack of clarity regarding what are the core components of compassion. These findings provide support for further research examining the relationship between common humanity and compassion. If the results from this research are verified in future empirical studies, then it confirms that compassion training programs need to focus on training people in the perception of common humanity. Currently there are a wide range of competencies that are targeted in compassion training programs. This is problematic as it is unclear whether compassion is actually being targeted (Kirby, 2017).

There were a number of limitations with this research. The differences between the two common humanity scenarios were not explored. Although they both represented common humanity, the lifeguard scenario was more emotive as it showed men, women and children in distress, whereas the Danish TV ad had a lighter tone to its focus on common humanity. Both groups showed an increase in compassion after viewing the scenarios but only the Danish TV group had an increase on the level of perception of common humanity. This was an unexpected result and it is unclear what the factors were that led to only one group experiencing a statistically significant increase in common humanity.

There was no control group in this study. Future studies may choose to replicate the study with a control group. Data was collected pre- and post-intervention only. Surveying respondents at additional time points would be useful to explore if the results hold over time. The mediation analysis showed perspective taking to influence compassion mediated by common humanity when the Additional Common Humanity questions were used. There was no mediation using the Pommier Common Humanity scale questions. This result provides some limited support for mediation but this would need to be explored in future studies. Sample sizes were relatively small; it would be preferable to do further studies with larger sample sizes. The calculation for Cronbach's alpha was based on the sample size of seventy-five. DeVellis (2016) suggests a sample size of approximately 300 is ideal for assessing reliability of a scale. However, the decision was made to calculate Cronbach's alpha for the Additional Common Humanity questions to provide a tentative indication of fit of the trial questions given there has been very little empirical work done in this area to date. It is hoped that other researchers will pursue further work clarifying the components of common humanity, given the suggestion that common humanity is critical to compassion. Further studies would need to aim at larger sample sizes to be robust.

Conclusion

The suggestion that the perception of common humanity is the central component of compassion is promising. It opens up fruitful avenues for cultivating and sustaining compassionate approaches if this association can be verified empirically. This study revealed that exposure to common humanity scenarios appears to boost compassion and that common humanity is a specific perspective that is required in order to arrive at compassion. To date, this is the first study to examine the relationship between common humanity and compassion amongst healthcare workers. This research provides direction for more in-depth research on the connection between common humanity and compassion. Subsequent research may incorporate longitudinal designs to confirm the long-term impact of common humanity on compassion. There is an urgent need for scale development to validate scales for common humanity and compassion. It is hoped that further research in this area can shed light on the mechanisms of compassion and the connection between common humanity and compassion.

Compassion training using common humanity material may support healthcare workers to maintain a compassionate stance in their daily work caring for patients. Healthcare workers themselves benefit from the positive emotions that are associated with compassion; the patients benefit by being in an atmosphere that promotes dignity, care and kindness.

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4.3 Preamble to Article Three

The third article in the thesis describes the qualitative results from the pre/post intervention at Epworth HealthCare where healthcare workers watched common humanity scenarios and completed structured surveys. A thematic analysis was undertaken.

The third article, along with article two, addresses the second subsidiary research question, 'How does viewing common humanity scenarios impact on healthcare workers' level of compassion?'.

Title: The use of common humanity scenarios to promote compassion in healthcare workers

Authors: Ling, D., Petrakis, M. and Olver, J.

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4.4 Article Three: The Use of Common Humanity Scenarios to Promote Compassion in Healthcare Workers

Abstract

The importance of compassion in healthcare is universally acknowledged. However, the factors that enhance compassion are not well understood. This study examined the use of common humanity scenarios to promote compassion in healthcare workers. Healthcare workers were shown common humanity scenarios and then asked to reflect on their feelings towards others. Thematic analysis was used to identify themes. Four main themes emerged: a) common bonds; b) people have the same needs; c) no one wants to suffer; d) seeing strangers helping others is motivating. Healthcare workers reported feelings of care, concern and compassion after viewing common humanity scenarios.

Implications

- Viewing common humanity scenarios appears to support and enhance the development of compassion in healthcare workers. Using common humanity scenarios may be a useful compassion training strategy.

- Compassion is a core value in healthcare and the helping professions, yet little is known regarding the factors that lead to the arising of compassion. This research offers an effective technique for enhancing compassion.

Compassion in health care has been a topic of interest for decades. It is a core value in society and is universally recognised as fundamental to human flourishing (Condon & DeSteno, 2017; Goetz et al., 2010). Compassion is defined as a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved (Jinpa, 2016). Instances when compassion has been absent in healthcare have led to much discussion

and debate. Internationally, there is the recognition that there is a crisis in healthcare due to a lack of compassion (Sinclair et al., 2017; Trzeciak et al., 2017). The UK NHS was rocked by devastating failures of humanity in its healthcare system (Francis, 2013). Basic care, hygiene and pain relief were neglected to be given to patients in some hospitals. Attempts to improve the healthcare system in the UK were made by implementing a 3 year 'Compassion in Practice' policy (Cummings & Bennett, 2012).

Increased research on compassion

Compassion has been the focus of increased research interest in the last decade. Neuroscience has revealed that compassion is a positive state of mind and can be trained (Klimecki & Singer, 2012). Several researchers have suggested that the perception of common humanity is the foundation of compassion (Feldman & Kuyken, 2011; Jinpa, 2016; Ling et al., 2018; Von Dietze & Orb, 2000). Common humanity involves the recognition that all humans are the same in their basic needs and desire to avoid suffering. Common humanity also acknowledges the universality of suffering as part of the human condition (Pommier, 2010; Strauss et al., 2016). Anyone can become sick or suffer a misfortune. There has been substantial research that has found that perceived similarity promotes compassion (Batson, 2011; Cialdini et al., 1997; Cikara et al., 2011; Oveis et al., 2010; Penner et al., 2005; Valdesolo & DeSteno, 2011). Perceived similarity creates a sense of connection with the other and diminishes in-group/out-group distinctions (Galinksy & Moskowitz, 2000; Sturmer et al, 2006). When people view others as similar to themselves, they are more positive and helpful to others. The strength of the perception of common humanity is that all humans become the in-group. This perspective leads a person to treat all others with respect and dignity by virtue of a shared humanity.

Perspective-taking

Perspective taking is a critical ingredient in proper social functioning (Galinksy & Moskowitz; 2000). People are more interested in the perspective of those they care about or where they have a level of identification with the other person. An important point is that perspectives can be altered. People can change their views on others and view them more favourably, that is, bring the 'out-group' into the 'in-group' (Penner et al., 2004). There are many examples of people putting aside their differences and focusing on working together in a cooperative manner. These can be in both small and large matters. The United Nations is an example this at the level of world peace. The United Nations was established post World War Two to maintain international peace, cooperation and harmony. It now comprises of 193 member states, some of whom were previously at war with each other (United Nations, 2019). These countries have put aside their differences and chosen to move forward in peaceful and cooperative ways. The perspective of common humanity is one way of achieving a sense of inclusion with all others. Familiarity can also help diminish differences and promote increased understanding of shared human values. As people get to know each other better, they realise that people want the same things – happiness, health, safety and basic needs met.

Striking examples of the power of the perspective of common humanity are when people risk their lives to save a stranger in distress. In 2005, Wesley Autrey, was standing on a train platform with his 2 young daughters aged 5 and 6. A young man standing beside him became unwell and collapsed, falling onto the train tracks as the incoming train pulled into the station. Autrey leapt onto the tracks and placed the young man in a safe position on the tracks. Autrey then lay on top of the young man to ensure he did not move and let the train roll over the top of both of them. They both survived and Autrey was hailed as a hero. When he was asked he

took such a risk he said, 'I don't feel I did something spectacular; I just saw someone who needed help.' (New York Times, 2007).

Empathic concern vs empathic distress

Healthcare workers are required to bring compassion into their work on a daily basis. There are numerous pressures working in health care and many factors that can interrupt the compassion process (Fernando et al., 2016; Shea & Lionis, 2017). One of these factors is when healthcare workers inadvertently become distressed by the other's suffering. This is called 'empathic distress'. The difference between 'empathic concern' which is similar to compassion and 'empathic distress' is significant. Empathic distress or personal distress is a negative, self-focused aversive reaction to another's suffering (Eisenberg, 2002). In empathic distress, one becomes distressed by the other's suffering. This can happen by imagining how one would feel in the other's situation, that is, imagining what their pain and discomfort would be like. Another avenue to empathic distress is where a worker does not want to acknowledge the other's distress at any level because the worker feels they do not have the capacity to respond appropriately. Healthcare workers who have burnout often have a diminshed capacity for acknowledging another's pain. When a worker is caught up in empathic distress or burnout, the main goal is for the worker to alleviate their own distress. By contrast, the goal of empathic concern, or compassion, is the alleviation of the other's suffering. Klimecki & Singer (2012) suggest that the term 'compassion fatigue' is incorrect and it is actually 'empathic distress' fatigue.

The distinction between empathy and compassion is important to emphasize in healthcare worker training. Unfortunately, many healthcare workers have been trained to have empathy but not necessarily compassion. This may have inadvertently opened them up

to empathic distress fatigue. Research findings are that compassion is a positive state of mind. The *wish* for the other to be free from suffering is protective against empathic distress. Compassion leads to feelings of affiliation, care and reward. Strategies that support healthcare workers to maintain a compassionate stance in their work are beneficial for everyone. The healthcare worker maintains a positive state of mind and caring disposition; the patient benefits from the worker's compassion. Despite the universal agreement that compassion in healthcare is essential, there is a lack of practical approaches to embed compassion in healthcare delivery and culture (Frampton et al., 2013).

This study describes the responses of healthcare workers when they were shown two common humanity scenarios. Researchers often use videos and stories to promote understanding of out-group members (Weisz & Zaki, 2017). Utilising common humanity scenarios as a compassion training exercise is also time efficient and cost effective (Cook et al., 2008). Healthcare workers often have busy workloads and are not always able to attend lengthy training sessions. Healthcare organisations operate under increasingly tight financial constraints, therefore showing common humanity scenarios uses minimal resources and is easily accessible.

Methods

Healthcare workers at Epworth HealthCare, a large not-for-profit health group in Victoria, Australia were invited to take part in the research study. Ethics approval was obtained to conduct the study. Participation was anonymous and voluntary. Seventy-five healthcare workers participated in the study and were randomly assigned to two groups. One group watched a 7-minute interview of a Lifeguard speaking about his experience rescuing Syrian

refugees in the Mediterranean (Charter for Compassion Australia, 2016). The other group watched a 3-minute Danish TV ad called 'All That We Share' (TV 2 Danmark, 2017).

The Lifeguard group had forty-one participants, 90% were female. The age range was from twenty-five to seventy-five with a median age in the thirty-five to forty-four age group. The occupational breakdown was nursing (31%), medical (5%), social work (7%), occupational therapy (15%), psychology (10%), pastoral care (7%), allied health (2%), management (10%), administration (7%) and other (5%). The Danish TV ad group had thirty-four participants, 91% were female. The occupational breakdown was nursing (29%), medical (3%), social work (12%), occupational therapy (6%), psychology (15%), dietetics (3%), pastoral care (3%), allied health (9%), management (12%), administration (3%) and other (5%). The age range was from twenty-five to seventy-five with a median age in the thirty-five to forty-four age group.

Lifeguard Interview

The two scenarios both represented common humanity but had different content. The Lifeguard interview shows an Australian lifeguard talking about his experiences helping Syrian refugees who are trying to escape the civil war in Syria and flee by boat to Greece. The lifeguard speaks about seeing the Syrian refugee crisis unfolding on the news. He says he was particularly moved by the photo of Alan Kurdi, a 3-year-old Syrian boy whose drowned body was washed up on the beach. The photo went viral around the world. The lifeguard reflected that Alan was found without a life jacket and he realised that the other people in the boat who didn't have life jackets, including Alan's mother and brother, also drowned. The Lifeguard interview showed men, women and children in distress in leaky boats. The lifeguard also described two significant experiences he had while rescuing the Syrian refugees. One was where a mother tried to hand her baby to him across the open sea because she was so worried

about the boat sinking. Another situation was where a man who had never driven a boat before was driving a boat with eighty Syrian refugees, including his wife, to safety. The lifeguard described how the man's motivation was purely to create a better life for his wife. The lifeguard mentioned overt common humanity perspectives such as 'as a lifeguard you help people irrespective of race, religion, creed' and 'when I was on the ground in Lesbos, what I saw were humans. I didn't see a label, I didn't see the word refugee. I didn't see the word asylum seeker. What I saw was two arms, two legs, a beating heart, open eyes and the biggest humanitarian crisis of our generation'.

Danish TV Ad

The Danish TV ad 'All that we share' was made to promote the Danish TV2 channel. The ad shows 80 people from all walks of life standing in groups that initially reflect certain stereotypes – nurses in uniform, migrants, people who appear anti-social. The ad opens with the phrase 'It's easy to put people in boxes. There's 'us' and there's 'them'. The people in the groups are then asked a range of questions which transcend stereotypes such as 'Who in this room was the class clown?', 'Who are stepparents?'. After each question, the people who answer the question in the affirmative come to the front so everyone can see who answered yes. The questions range into common human emotions such as 'Who is broken hearted?', 'Who is lonely?'. What quickly becomes apparent is that the stereotypes dissolve as anyone can relate to being lonely etc. The ad ends with the comment 'so maybe there's more that brings us together than we think' and the tagline 'All that we share'. After watching the scenarios, the health care workers were asked to write down what effect watching the video had on their perception of common humanity and compassion and to give reasons for their answers.

Data was analysed by multiple readings of the transcripts. The transcripts were coded by hand into initial groupings of themes. The initial themes were checked to ensure the groupings were consistent and coherent.

Results

There were four main themes that emerged: a) how much people have in common despite superficial differences; b) people have the same needs; c) no one wants to suffer; d) seeing strangers helping others is motivating.

a) Common bonds

The theme of common bonds was very strong in the Danish TV group responses. Examples include comments such as 'realising how much you have in common with people you believed you have nothing in common with', 'deep down we have common bonds with others' and 'felt closer to others despite differences'. It is not surprising that these comments dominated the Danish TV ad group since the ad specifically focused on the similarities that people have once you move beyond superficial differences.

b) People have the same needs

The Lifeguard group showed footage of ordinary men, women and children risking their lives to escape war and find a safe home. The Lifeguard group responses focused more explicitly on basic human needs. Examples of comments were 'everyone wants the same things such as freedom, safety, food, shelter, water, love', 'we all have the same needs' and 'all humans have similar needs regardless of their backgrounds, community status etc'.

c) No one wants to suffer

The Lifeguard video showed people clearly suffering. Men, women and children had to face a dangerous journey across the sea in unsafe boats and often without life jackets. Some of them did not survive the trip. Several of the group comments highlighted that no one wants to suffer: 'Life is not easy and no one wants to suffer', 'everyone wants happiness and no one wants suffering'.

d) Seeing strangers helping others is motivating

Several of the Lifeguard group responses mentioned that it was motivating to observe people helping others. Examples of comments were: 'So touched to see people in such suffering and also help from total strangers' and 'There are some amazing souls doing their bit for the world. Makes me want to do more myself'. Role modelling is an important teaching strategy (Cruess et al., 2008). The fact that the lifeguard video showed real life footage made a difference. Several respondents spoke about it heightening their awareness of the Syrian refugee crisis: 'Visualising others suffering makes it more of a reality', 'made me more aware of putting myself in their shoes', 'The examples and video increased my understanding of the experiences of the refugees'.

Discussion

Showing the common humanity scenarios to healthcare workers highlighted the importance of perspective taking – being able to take the perspective of another and understand what they are feeling. Several comments from the Lifeguard group suggested that seeing the reality of the Syrian refugee crisis made an impact. 'Seeing the little boy dead, seeing the desperation. We hear it, but seeing it makes a stronger impact for me' and 'It gave me specific examples to relate to'. This relates to the 'identifiable victim effect' where it was found that people give

more when the victim is identifiable as opposed to a faceless silhouette (Genevsky et al., 2013). Although the Danish TV ad did not focus on suffering as explicitly as the Lifeguard video, the Danish TV ad also role modelled groups of people interacting with each other and moving beyond stereotypes. It appears that there is a benefit in seeing others displaying prosocial attitudes.

Perceived similarity brings out people's natural capacity for compassion (Cialdini et al., 1997). The opposite of perceived similarity is differentiation into 'us' and 'them'. This can lead to objectification, generalization of the other through stereotyping and dehumanisation (Jinpa, 2016). Unfortunately, the history of war attests to the power of people categorising others as 'out-groups', providing rationales for violence. Compassion has been found to reduce aggression and the drive for punishment (Condon & DeSteno, 2017). Societies that foster cooperation have less conflict than those that utilise punishment. Compassion, which necessarily focuses on the welfare of the other, leads to a different response than punishment and revenge.

It is also crucial to value the welfare of the other. Without this, one can be aware another is suffering but not care. This is apparently what happened in the UK NHS hospitals where there was a failure of compassion and regard for the humanity of the patients. The perception of common humanity facilitates the valuing of others: one realises that 'we are all in this together'. The ecosystem perspective recognises that the interconnections between people helps foster a sense of closeness and shared responsibility (Crocker & Canevello, 2008). It is valuable for people to reflect on how they themselves have been the recipient of many other people's kindness and compassion. Every single person needs dedicated caregivers to ensure their basic needs are met as a baby and young child. Apart from direct care needs, people's

basic living requirements – housing, food, water etc. – are provided through the efforts of others. Individualistic societies do not foster enough awareness of the fact that life is dependent on interactions with a wide range of others. Anyone who has been a patient in hospital comes to understand how important the small things are such as having a healthcare professional spend a few moments to allay fears and uncertainties, a smile and a kind word.

Conclusion

There is clearly a need to promote compassion in healthcare. Showing common humanity scenarios to healthcare workers elicited positive responses focusing on care, connection and concern for others. There were strong themes around recognising common bonds, understanding that people have the same basic needs and no one wishes to suffer. Seeing positive role models in both common humanity scenarios was useful. The promising results from this study suggest that it is beneficial for common humanity scenarios to be used as a compassion training approach. More research into this area would be useful to provide further evidence that showing common humanity scenarios does impact positively on healthcare worker compassion. There is a great need to support and promote healthcare worker compassion, not just for the patients but also for the wellbeing of the workers themselves.

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4.5 Preamble to Article Four

The fourth article in the thesis outlines the content and evaluation of the compassion training session focusing on common humanity which was conducted at Epworth HealthCare.

This article addresses the third subsidiary research question, 'Does education on common humanity influence compassion in healthcare workers?'.

Title: Outcomes from a compassion training intervention for health care workers

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University of Queensland Compassion Symposium, Brisbane, Australia, September 8, 2018.

Australia21 Mindfulness, Empathy and Compassion Conference, Melbourne, Australia, November 23, 2018.

4.6 Article Four: Outcomes from a compassion training intervention for health care workers

Outcomes from a Compassion Training Intervention for Health Care Workers

Debbie Ling, John Olver, Melissa Petrakis

Debbie Ling[1] is a senior clinician social worker, meditation and mindfulness teacher, teaching associate in the Department of Social Work, Monash University and part of the Epworth Monash Rehabilitation Medicine Unit. Debbie is a member of the Australia21 Mindful Futures Network Advisory Group. Debbie is a member of the Australian Compassion Council, Charter for Compassion Australia. She is completing a PhD on compassion at Monash University.

Professor John Olver[2] is currently Director of Rehabilitation, Mental Health and Chronic Pain Clinical Institute and the Director - Smorgon Chair of Rehabilitation Medicine - Monash University. His main areas of clinical and research interests in Rehabilitation Medicine are managing people with traumatic brain injury and stroke.

Dr. Melissa Petrakis[3] is Senior Lecturer at Monash University, Department of Social Work, Faculty of Medicine, Nursing and Health Sciences. She has worked in mental health services for over 20 years, the first decade as a clinician and the second as a practice-based researcher (PBR), engaged in health services research on the implementation of evidence-based practice (EBP). For the last 10 years she has been Chief Investigator of a longitudinal cohort study into evidence-based public mental health early psychosis treatment with St Vincent's Hospital (Melbourne).

Abstract

OBJECTIVES: To investigate how compassion training may help support health care workers do their jobs well, maintaining positive states of mind without being overloaded by empathic distress. THEORETICAL BASE: Recent findings from neuroscience suggest that compassion is a positive mind state and can be trained. Compassion is found to be different from empathy which, unlike compassion, can lead to empathic distress and burnout. This finding has led to the development of a range of compassion training programs. METHODS: A single session compassion training intervention including: (i) information defining compassion, (ii) research information from neuroscience demonstrating that compassion is a positive mind state and different from to empathy, (iii) scenarios emphasising common humanity and (iv) a slogan for health care workers to use to help them hold a compassionate stance towards their patients. OUTCOMES: The compassion training intervention was delivered to 100 health care workers at a major inner city private healthcare organisation in Australia in October 2017. A survey

[1] Contact: Debbie Ling, PhD Candidate, Department of Social Work, Faculty of Medicine, Nursing and Health Sciences, Monash University, Australia; debbie.ling@monash.edu

[2] Contact: John Olver, FAFRM (RACP), Monash University, Australia; john.olver@monash.edu

[3] Contact: Melissa Petrakis, PhD., Department of Social Work, Faculty of Medicine, Nursing and Health Sciences, Monash University, Australia; melissa.petrakis@monash.edu

administered post-training session indicates that the health care workers found the compassion training useful and further training would be beneficial. SOCIAL WORK IMPLICATIONS: As a result of the positive findings from this research, a web-based compassion training module is being developed for all staff at the healthcare organisation.

Keywords

INTRODUCTION

Research into compassion

Compassion is not new, and has been mentioned for centuries. It appears to be an innate part of being human. Children as young as 18 months old exhibit natural helping behaviours towards others (Warneken, Tomasello, 2006). Humans cannot survive without compassion. Compassion enables the caregiver to be able to recognise when their offspring is suffering and be motivated to alleviate that suffering. Even animals have this capacity towards their offspring. Compassion is widely regarded as a virtue in all cultures and is essential for a society that flourishes and extends care and concern for one another. One has to value the other to feel concern for them (Ricard, 2015). A widely held definition of compassion is that it is a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved (Jinpa, 2016). Until recently there has been little scientific research into compassion. That is now changing with the evidence from functional magnetic resonance imaging research over the last two decades that mental training has positive effects.

There is now considerable research interest in training people in positive mind states such as compassion. There has been significant worldwide research into compassion over the last two decades (McCaffrey, McConnell, 2015; Strauss et al., 2016; Kirby, 2017;). Major research institutes that are investigating compassion include The Center for Compassion and Altruism Research and Education at Stanford University, Greater Good Science Center at the University of Berkeley, Center for Investigating Healthy Minds at the University of Wisconsin-Madison and the Max Planck Institute for Human Cognitive and Brain Sciences. Compassion training programs have been developed including the Stanford University Compassion Cultivation Training program and the Emory University Cognitively Based Compassion Training. These compassion training programs are being delivered to health care workers, school teachers and children. It is early days in compassion research and these compassion training programs require evaluation regarding their effectiveness. Compassion is a complex phenomenon. It is important to have a clearer understanding of the factors which support the emergence of compassion and those which are barriers to compassion. Compassion training programs may play an important role in helping people cultivate and maintain more compassionate stances towards others.

Compassion and empathy have important differences

One of the key findings in compassion research has been by Klimecki and Singer (2012) who found that compassion is other-focused, a positive mind state and can be trained. This highlights an important distinction between compassion and empathy which are often confused with one another. Empathy is an important core skill for relating to others and understanding how they feel. Empathy encompasses being affected by and sharing another's emotions (Gilbert, 2010). Compassion, on the other hand, is always centred on another's suffering (Schantz, 2007; Goetz, Keltner, Simon-Thomas, 2010). One can have empathy for any emotion that another is feeling, including positive emotions such as joy and happiness. In fact, empathy which leads to an overidentification with another's suffering has a downside.

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Neuroscience suggests there are two types of empathy: first there is one which is empathic concern or compassion. Compassion, or empathic concern, has positive neural pathways, leading to feelings of warmth, concern, reward and affiliation (Stickle, 2016). Even if the suffering of the other is very great, if one can have compassion towards them, the neural pathways are positive. One *wishes* for the other to be free from suffering: it is a positive mindset. One does not have to be successful in freeing the other from suffering; it is the wish that is important. Compassion is the motivation that prompts acts of altruism. The second type of empathy is focused on the self and can lead to empathic distress; it registers in neural networks related to pain (Klimecki, Singer, 2012). In the second type of empathy, the person overidentifies with the suffering of another and becomes overwhelmed by their own feelings of distress.

An example of the difference between the two types of empathy is shown by a situation where an ambulance officer and a distressed onlooker arrive at a car accident scene at the same time. Both the ambulance officer and the distressed onlooker are aware there are injured people. The ambulance officer has empathic concern or compassion: he wishes to alleviate the suffering of the injured people and leaps into action as he is trained to do. The distressed onlooker sees the injured people's injuries, *imagines what it would be like to feel their pain* and becomes faint and has to walk off. The distressed onlooker is now overwhelmed by their own feelings of distress: they are no longer focusing on the injured people. At this point, the compassion process has ended, since compassion is defined as a concern in response to the suffering of another. The perspective one takes is key, *imagining how another would feel* (can lead to empathic concern) versus *imagining how you would feel to experience the suffering* (leads to empathic distress) (Batson, Early, Salvarani, 1997). For example, a surgeon can operate on a patient's broken arm to alleviate their suffering. The surgeon does not have to feel the same pain as the patient who has the broken arm. In the case of compassion, it is sufficient to become aware that another is suffering; one does not have to suffer oneself (Ricard, 2015).

The second type of empathy, empathic distress, bears no relation to compassion because one is no longer concerned with the suffering of the other. One has become concerned about one's own suffering. Compassion is always about the other, it is not about oneself. Several authors have spoken about this distinction of other-focus versus self-focus. Eisenberg (2002:135) calls the empathic distress response of the distressed onlooker a 'self-focused, aversive emotional reaction to another's emotion or condition'. Batson (2009) says that 'personal distress' or 'empathic distress' is the opposite of 'empathic concern'. Distress over one's own suffering is a valid experience, but it cannot be called compassion. Some definitions of compassion hold it to contain elements that are focused on the self, for example distress tolerance (Gilbert, 2010; Strauss et al., 2016). Compassion does not contain self-reference items. Compassion is a virtue because it is a selfless concern for another who is suffering.

Klimecki and Singer (2012) suggest that the term 'compassion fatigue' is a misnomer and it should be called 'empathic distress fatigue' instead. Compassion has been shown by neuroscience to be a positive state of mind. Ledoux (2015) says that an examination of the literature on compassion fatigue shows that compassion fatigue does not match with the definition of compassion. Ledoux (2015) suggests that what is called 'compassion fatigue' is really burnout or overloaded workloads, not compassion. Compassion research needs greater clarity regarding definitions of what constitutes compassion and the differences between compassion and empathy. It is important to distinguish between concern for others, which makes compassion noble and a virtue, and concern for self. This is not to say that concern for self is unimportant, but once one's attention is taken off the other, it changes the situation completely. Hospitals do not promote their core values as 'we make sure we are feeling good'; they always promote their core values as 'we care for you'. Sinclair et al. (2016:14) say 'there is the need to reset the empirical foundation of compassion research by establishing its conceptual specificity, thereby providing a scientific base to conduct future research on the topic that is marked by validity and rigor'.

Compassion and common humanity as core values for health care workers

Compassion is a core value of hospitals and enshrined in the codes of practice of professions such as social work, nursing and medicine. The National Association of Social Workers Code of Ethics (1996) emphasises that social work practice is founded on respecting basic human needs and recognising the dignity and worth of the person. Several authors suggest that the perception of common humanity is the foundation of compassion (Von Dietze, Orb, 2000; Jinpa, 2016). Compassion recognises the universality of human suffering (Feldman, Kuyken, 2011; Strauss et al., 2016). All humans share the desire for happiness and the wish to be free from suffering (Ricard, 2015). The social work profession is founded on the principles of common humanity, respect for all persons and human rights. Radley and Figley (2007:207) state, 'In the most basic sense, clinical social workers are guided by compassion for humanity and an altruistic desire to improve individual and societal conditions'. Morley and Ife (2002) suggest that social work is based on sharing a common humanity and that the value of humanity is central. These values of compassion and common humanity are shared by all helping professions; their ethical principles are built on international conventions such as the United Nations Universal Declaration of Human Rights (1948) which states 'All human beings are born free and equal in dignity and rights'. An example of this is staff working in accident and emergency departments. They treat all inpatients, irrespective of whether the patient caused the accident or was an innocent victim. Hospitals do not make judgements as to who is worthy of admission and who is not; the only criterion is whether the patient needs medical attention and care.

The reality is that providing compassionate care on a day in day out basis is not always easy. Compassion is a complex multidimensional construct (Jinpa, 2016). There are many factors that can easily disrupt compassion such as excessive workloads or viewing the other through a biased lens that emphasises difference instead of similarity. When one can recognise that all humans share the same basic needs, one is able to feel compassion towards any other person. Common humanity recognises the universality of suffering (Feldman, Kuyken, 2011; Strauss et al., 2016). All people struggle with experiences of suffering, injustice, mortality and death (Canda, Furman, 2010). All humans share the desire for happiness and wish to be free from suffering (Ricard, 2015; Jinpa, 2016). Social workers know that difficult circumstances can come upon anyone. Furthermore, Gray and Stofberg (2000) make the point that even if one brings suffering upon themselves, it is still suffering nevertheless.

An important point to note is that respect for the person does not mean one has to condone what they do (Adams, Dominelli, Payne 2009). One can still respect the humanity of another but accept that justice is required. For example, a social worker working with prisoners acknowledges the prisoner has committed a crime but works with them to assist with their rehabilitation and integration back into society. Unfortunately, it is common for blame to be focused on the person as a 'bad person' rather than focusing on their negative actions. Social work is a profession that believes in people's potential, capacity to change and the possibility of transformation. Social workers can be found working both with the victims of crime and with the perpetrators of crime. Jinpa (2016) points out that stereotyping and biases can led to exclusion, objectification and in the worst cases, dehumanisation and genocide.

The opposite of this is when people risk their own lives to save strangers. Monroe (1998) interviewed people who rescued Jewish people in Nazi-occupied Europe. The critical element was the perspective that people held. Monroe (1998:206) says for others to help strangers they had a 'particular perspective…in which all living beings are entitled to a certain humane treatment merely by virtue of being alive…deeply felt recognition that all share common characteristics and are entitled to certain rights, merely by virtue of our common humanity.' Compassion depends on our identification with the person we are concerned about (Jinpa, 2016). Compassion training, with its emphasis on common humanity, has an important role to play for health care workers.

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METHODS

Compassion training intervention

The health care organisation in the current study is the largest not-for-profit private health care group in Victoria, Australia. Victoria has a population of approximately 6 million people. The health care organisation comprises 8 hospitals and 4 specialist centres. The health care organisation employs 7,770 staff and holds compassion as one of its 6 core values, alongside respect, integrity, excellence, community and accountability. The decision was made to trial a single session compassion training intervention to gauge staff interest and gather feedback from them regarding the effectiveness of this approach. Health care workers usually have multiple demands on their time and a heavy workload. They may not be able to attend a 6-week program of compassion training whereas a single session training program with a low time commitment may be more readily accessed.

The compassion training intervention was promoted across the health care organisation and 100 health care workers attended. Eighty health care workers attended in person and another twenty watched the training session via remote video link. The compassion training intervention was of one hour duration and was presented by the lead author of this paper. After the session the health care workers were emailed a survey to complete to provide feedback on the session. The compassion training intervention included: (i) information defining compassion, (ii) information from neuroscience research indicating that compassion is a positive mind state and different to empathy, (iii) scenarios emphasising common humanity and (iv) a slogan for health care workers to use to help them hold a compassionate stance towards their patients. These will be examined in more detail below.

(i) Information defining compassion

Health care workers were given education on the difference between compassion, pity, empathy and sympathy. These terms are often used interchangeably in compassion research (Goetz, Keltner, Simon-Thomas, 2010; Sinclair et al., 2016). They are not the same. Pity involves the giver having a condescending view towards the receiver (Von Dietze, Orb, 2000; Perez-Bret et al., 2016). Empathy involves one being affected by and sharing another's emotions (Gilbert, 2010). Empathy is not specific to suffering in the way that compassion is. Sympathy involves feeling kindly to another but not necessarily wishing their suffering is alleviated (Ricard, 2015). Compassion involves feeling concern in response to another's suffering and wishing them to be free from that suffering.

(ii) Research information from neuroscience indicating that compassion is a positive mind state and different from to empathy

Health care workers were shown recent research findings which indicate that compassion and empathy use different neural pathways (Klimecki et al., 2013). Compassion is now shown to be a positive mind state leading to feelings of warmth, concern, reward and affiliation (Stickle 2016). Excessive empathic resonance where one is overwhelmed by empathic distress can lead to burnout, whereas compassion is a positive mind state (Klimecki et al., 2012).

(iii) Scenarios emphasising common humanity

The perception of common humanity has been proposed as fundamental to being able to cultivate compassion for all others. Health care workers were shown a number of scenarios (4 real life and 1 constructed) where common humanity was emphasised. The scenarios were:

(a) A Danish television advertisement called 'All that we share'. The people in the TV advertisement were initially grouped under headings 'those who wear suits', 'those who save lives', 'those who exercise' and then gradually the groupings were changed into common human experiences such

as 'those who are lonely', 'those who are step parents, 'those who have been bullied'. The final message was that people have much more in common than they realise when they get beyond superficial differences.

(b) Footage of an Australian lifeguard talking about why he volunteered to rescue men, women and children who were fleeing the war in Syria on fragile inflatable boats in the Mediterranean which often sank. He said 'As a lifeguard, you help people irrespective of race, religion or creed. You don't look at them as a label or agenda. You look at them as human.'

(c) Prison inmates who saved the life of their prison guard who had a heart attack. They used his mobile phone to call an ambulance and removed his gun and bullet proof vest to help him breathe more freely. One of the prisoners said in an interview afterwards 'It wasn't the case of us being the prisoners and him being the prison guard. It was just 'man down' and you go and help.'

(d) Homeless men who rushed to help victims of a bomb attack. In an interview after the event, one of the homeless men said 'I might be homeless and living on the streets but I still have feelings. I saw women and children screaming and bleeding and I went to help.'

(e) Father of two young children who leapt onto train tracks in front of an oncoming train and lay down on top of a man who had fallen onto the train tracks and was having an epileptic fit. The train ran over the top of them both and they both survived unharmed. The father, who was from Harlem said, 'I've always been about helping people, this guy was going to die unless someone helped him.'

(iv) Slogan for health care workers to assist in holding a compassionate stance

The Compassion Cultivation Training (CCT) course developed by Stanford University Center for Compassion and Altruism Research and Education uses the slogan 'Just like me, this person wishes to be happy and to be free from suffering'. People can use this slogan to adopt an attitude towards anyone they meet, even people who may be exhibiting challenging behaviours. The slogan helps promote the sense of common humanity and the commonality of basic needs.

RESULTS

Twenty-two health care workers responded to the survey link. Their response rates were as follows (Table 1).

Table 1: Health care worker responses regarding compassion training

Statement	Response rate (N=22)
Was it useful to have information on the neuroscience behind compassion?	16 respondents said yes (73%)
Was it useful to have information on compassion being a positive mind state whereas too much empathy can lead to burnout	22 respondents said yes (100%)
Was the slogan 'Just like me, this person wants happiness and does not want suffering' useful?	18 respondents said yes (82%)
Was it useful to view video material on common humanity?	18 respondents said yes (82%)

Health care workers were asked 'How important is it to you to have access to information that can boost compassion?' A total of 81% said 'Very Important' and 19% said 'Somewhat Important'. Health care workers were asked for an idea or strategy from the training session that might help them have more compassion. Responses included:

'That all of us just want to be loved and live happily'
'Put yourself in their place'
'Find the commonality between myself and another'
'To remember 'they are just like me' with same hopes and fears'
'Try to imagine other's perspective, we are all human'
'Looking at common human traits'
'Reflecting on others' feelings and others' points of view'

DISCUSSION

The results from the compassion training intervention demonstrated that the health care workers found several aspects of the intervention helpful. Although only 22% of the health care workers who attended the compassion training session filled in the post intervention survey, they rated the usefulness of the segments very highly. In particular the health care workers found information on compassion being a positive mind state and too much empathy leading to burnout being important. The slogan 'Just like me this person wants happiness and does not want to suffer' and the video material on common humanity was rated as useful by 82% of the respondents. It appears that the slogan and common humanity material are helpful in reducing 'in-group'/out-group' differentiation: everyone becomes the 'in-group', sharing a common humanity. Von Dietze and Orb (2000) consider this to be essential for the development of compassion.

It is important to note that no research has been conducted to investigate whether the perception of common humanity impacts on people's levels of compassion. As noted in the introduction, several authors have suggested that the perception of common humanity appears to be the core component of compassion (Feldman, Kuyken, 2011; Jinpa, 2016; Strauss et al., 2016). Pommier (2010) suggests that the perception of common humanity involves realising that one could find oneself in the position of the sufferer if one were less fortunate. One has a level of identification with the person suffering and recognises human vulnerability as a general phenomenon (Van Der Cingel, 2009). The perspective of perceived similarity leads to concern for the other. More research urgently needs to be undertaken to test this notion because if it is found to be correct, then future compassion training interventions will be made more effective by incorporating the perception of common humanity into their core training.

These results, combined with the strong interest from the staff at the health care organisation, have led to the health care organisation management deciding that it will benefit staff to have access to the compassion training material as a permanent web based module. This will be developed, trialled and evaluated over the next 2 years.

Limitations
There were several limitations to the study:
1. Data was not collected on respondent demographics. This would be helpful to ascertain whether there are differences between sex, age and professional discipline.
2. The survey was administered at one time point only, emailed to health care workers the day after the compassion training intervention. Most completed the survey within the first 3 days after the session. It would be interesting to see what the results might be at 3, 6 and 12 months mark.
3. There was a fairly low response rate at 22% and it appears this cohort found the compassion training very useful. It is unclear how the 78% who did not respond found the training.
4. Five scenarios that emphasised common humanity were used (4 real life and 1 constructed). It is not clear whether some scenarios were more effective than others. It would be helpful to gather feedback on each scenario to see if the health care workers found some scenarios easier to relate to than others.

CONCLUSION

The reasons for developing and promoting compassion training programs for health care workers are compelling. Compassion is a positive mind state; it helps health care workers maintain a caring and concerned attitude towards every patient they work with and protects the health care workers against empathic distress and burnout. The compassion training intervention held at the health care organisation attracted significant interest from staff and the results indicate that the health care workers found the content useful. Health care workers were particularly interested in learning about the difference between compassion and empathy. The health care workers also found viewing material on common humanity and being given the slogan 'Just like me, this person wants happiness and does not wish to suffer' helpful. The perception of common humanity is an area where very little research has been conducted to date. More research needs to be done investigating the perception of common humanity as it appears to be fundamental to people's ability to have compassion for others. It is recommended that further research be conducted on compassion training interventions to gain clarity regarding which components of the training are most useful and whether the training effect is constant and holds over a longer time.

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4.7 Preamble to Article Five

The fifth article in the thesis outlines the Compassion eLearn which was developed based on the content of the compassion training session, due to the feedback from staff that the compassion training was useful in assisting them to develop and sustain compassion.

Epworth HealthCare requested the researcher to build a Compassion eLearn so that the compassion training could be taken to scale. Epworth HealthCare currently has 6,870 staff.

The fifth article addresses the fourth subsidiary research question, 'How can compassion training be taken to scale?'.

Title: An outline of a Compassion eLearn for healthcare workers

Authors: Ling, D., Olver, J. and Petrakis, M.

Journal: *Health and Social Work*

Publisher: Oxford University Press

Status: Submitted, under review

4.8 Article Five: An Outline of a Compassion eLearn

ABSTRACT

Compassion is a core value in health care. It is the basis of caregiving interactions and is an essential component of societies that provide care and concern towards one another. Health care workers are expected to have compassion for all patients. Patients clearly benefit when health care workers are kind, attentive and caring. It can be challenging for health care workers to generate compassion for every single person they interact with and there are many factors that can inhibit compassion. Research is showing that compassion is a positive state of mind and can be trained. There has been an increased interest in how to support health care workers to cultivate and sustain compassion. This paper outlines a compassion eLearn that has been developed for health care workers. The eLearn includes: what compassion is; how it differs from pity, empathy, sympathy; the difference between empathic concern and empathic distress; how compassion is a positive mind state; strategies to promote compassion; how to manage when compassion is difficult or being challenged. It is proposed that a compassion eLearn is a cost effective and accessible compassion training approach for health care workers.

KEY WORDS: compassion; eLearn; training; health care

BACKGROUND

Compassion is the foundation of health care. It is a sense of concern that arises when confronted with another's suffering and the motivation to see that suffering relieved (Jinpa, 2016). Compassion is an innate human emotion; it enables caregivers to respond to and care for the young, sick and elderly. Neuroscience findings have shown compassion to be positive

state of mind (Klimecki, Leiberg, Lamm & Singer, 2012), and associated with feelings of affiliation, reward and prosocial behaviour (Skwara, King & Saron, 2017). Compassion has also been shown to reduce aggression, punishment and revenge (Condon & DeSteno, 2011). Although compassion is not new, scientific understanding regarding its core mechanisms is still in its infancy (Goetz, Keltner & Simon-Thomas, 2010). There are compelling reasons to help health care workers cultivate compassion, not only from a moral point of view but from a pragmatic one. Compassion is beneficial for the giver and the receiver; it leads to the creation of supportive interpersonal environments (Crocker & Canevello, 2008). Health care workers are required to generate compassion on a daily basis. Yet internationally, it is recognised that there is a crisis in health care due to a lack of compassion (Trzeciak, Roberts & Mazzarelli, 2017). Training interventions that support health care workers to develop and sustain compassion are urgently needed.

Research is delineating the difference between compassion and empathy. Empathy is where one is affected by and shares another's emotion (Gilbert, 2010). One can have empathy towards any feelings that another has, both positive and negative, whereas compassion is always in response to another's suffering. Empathy towards another's suffering can go down two different pathways. One pathway, *empathic concern,* is similar to compassion. It is an other-focused emotion and is associated with feelings of concern and affiliation. The goal of empathic concern is another's wellbeing. The other pathway, *empathic distress*, is where one becomes distressed by the other's suffering. Empathic distress or personal distress is an aversive self-focused reaction (Eisenberg, 2002). The goal of empathic distress is one's own wellbeing. The term 'compassion fatigue' is now considered to be incorrect; it is actually 'empathic distress fatigue' (Klimecki & Singer, 2012). It is important to remember that compassion is feeling *for* the other, not feeling *as* the other (Batson, 2017). A doctor can

understand a patient has extreme physical pain and have strong compassion for the patient without the doctor feeling the same physical pain as the patient. These new understandings regarding different ways of reacting to the presence of another's suffering have important implications for health care. Most health care workers have been trained to have empathy rather than compassion and may unintentionally open themselves to empathic distress which can lead to burnout.

The compassion eLearn was developed for a major health care organisation in Melbourne, Australia. The eLearn focused on the perception of common humanity as a facilitator of compassion. The perception of common humanity has been proposed as the core mechanism of compassion by several researchers (Feldman & Kuyken, 2011; Jinpa, 2016; Ling, Olver & Petrakis, 2018). The perception of common humanity views all humans as deserving of care and compassion. Everyone is equal in their desire for happiness and their wish to avoid suffering. Common humanity also acknowledges the universality of suffering as part of the human condition (Strauss, Taylor, Gu, Kuyken, Baer, Jones & Cavanagh, 2016; Van Der Cingel, 2009). Anyone can become ill or suffer a misfortune. Strengthening health care workers' perception of common humanity is highly beneficial since their work requires them to care for every patient.

The decision to design a compassion eLearn was the result of positive health care worker feedback following a face-to-face one-hour compassion training session (Ling et al., 2018). The compassion training was provided to 100 health care workers at the health care organisation in Melbourne, Australia in October 2017. Health care workers rated the training as useful, in particular learning about the difference between compassion and empathy and being given a common humanity slogan to use in their work, 'Just like me, this person wishes to be happy

and not to suffer'. Health care management requested that a compassion eLearn be developed to provide all health care workers with access to the training. The advantages of eLearning are accessibility, cost-effectiveness and learner satisfaction (Ruiz, Minter & Leipzig, 2006).

COMPASSION ELEARN DESCRIPTION

The eLearn covered the key points from the compassion training session that had been held at the health care organisation including: what compassion is; how it differs from pity, empathy, sympathy; the difference between empathic concern and empathic distress; how compassion is a positive mind state; strategies to promote compassion; how to manage when compassion is difficult or being challenged. Figure 4.3 shows the compassion process flowchart which was included in the eLearn.
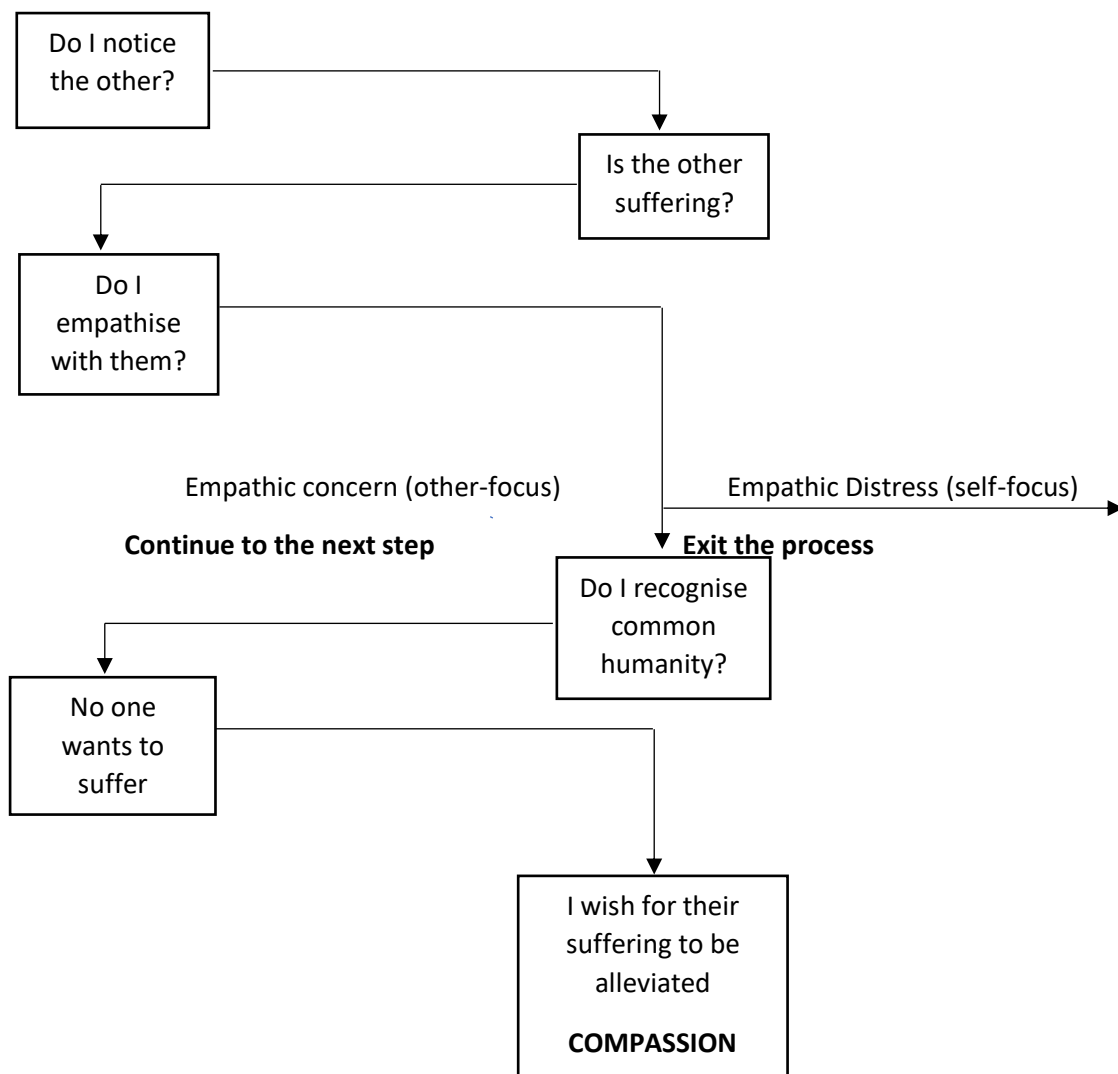
Figure 4.3 The Compassion Process

The eLearn emphasises a range of strategies to enhance and sustain health care worker compassion, particularly if they are confronted by challenging behaviours from patients such as people who are angry or upset. It is easier to respond with compassion when one understands that being unwell and frightened is difficult for anyone. The slogan, 'This person is someone's mother, father, son, daughter' is provided to health care workers as another way of reminding them of their common humanity. Everyone is special to someone and anyone can be vulnerable, anxious and scared about their health. The compassion eLearn had a range

of graphics embedded in it such as pictures of generic figures helping the young, sick and elderly; figures tending to those in need; groups of people collaboratively helping each other. The graphics were an additional way of reinforcing that compassion is an innate prosocial act that happens naturally in society. Figure 4.4 shows an example of the graphics in the eLearn. The content in the eLearn is outlined in Table 4.7.

What is Compassion?

DEFINITION: Compassion is a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved.

Compassion is a virtue in all cultures.

Compassion is innate, it enables society to flourish and care for the young, the sick and the elderly. Even young children and animals show care and concern towards others.

Figure 4.4 Example of Compassion eLearn slide

Table 4.7 Compassion eLearn content
_____
1. What is Compassion
a) Definition: Compassion is a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved.
b) Compassion is a virtue in all cultures. It is innate, enabling society to flourish and care for the young, sick and elderly. Even young children and animals show care and compassion towards others.
c) Compassion views all humans, by virtue of their common humanity, as deserving of care, dignity and kindness. Compassion taps into the sentiments of the Universal Declaration of Human Rights (1948) 'All Humans are born free and equal in dignity and rights'.
d) Compassion often gets mixed up with terms such as pity, empathy and sympathy. It is not the same.
(i) Pity is looking down on the other, it lacks a sense of equality with the other.
(ii) Empathy is a resonance with how another is feeling (positive or negative feelings).
(iii) Sympathy is feeling sorry for another but not taking the further step of wishing their suffering to end.

Compassion is an identification with the humanity of ALL others and a wish to alleviate their suffering. Compassion includes the recognition that 'Just like me, this person wishes to be happy and not to suffer'. Compassion understands that all humans have the same basic needs.

2) Compassion is a Positive State of Mind
a) Neuroscience research has found that compassion is a positive mind state and can be trained.
b) Compassion leads to feelings of warmth, concern, reward and affiliation.
c) Compassion is the wish for the other's suffering to be alleviated. It is good for the giver and the receiver. Even if one is not able to be fully prevent another's suffering, the arising of compassion triggers positive neural pathways in the brain.
d) Compassion decreases stress and improves the wellbeing of the giver.

3) The Difference between Compassion and Empathy
a) Empathy has two types: one is positive and the other is negative. Empathic concern is similar to compassion; it is focused on the other and is a positive state of mind. Empathic distress is where one over identifies with the suffering of another; it leads to a painful self-focused reaction. Empathic distress is focused on the self and triggers negative neural pathways. It can lead to burnout.
b) Remember, focus your care and concern on the other. Compassion is always a positive mind state and will help you avoid burnout.

4) Strategies to Promote Compassion
a) Notice the common humanity you share with the person in front of you.
b) Think common humanity phrases such as 'Just like me, this person wishes to be happy and not to suffer' and 'This person is someone's mother, father, son, daughter'.
c) Diminish in-group/out-group categories. When we view the other as 'different' it is easy to develop negative judgement and a critical attitude towards them. When we view the other as 'similar' to us, we feel positive and helpful towards them.
d) Focusing on common humanity brings everyone into the in-group. It helps one hold a compassionate attitude towards anyone - colleagues, patients, strangers.

5) When Compassion is Hard
a) Compassion is easily disrupted if our attention becomes distracted elsewhere or if someone is cross with us.
b) When someone is upset or angry it is helpful to remember: 1. They are upset due to reasons which are valid to them. 2. Being sick and in hospital is difficult and frightening for everyone.
c) Compassion becomes easier when you remember that it is actually fear that is the cause of people getting angry.

6) Choosing a Win-Win Option
a) If we think 'how dare you speak to me like that!' or 'you are not nice' – we feel unhappy in ourselves. It does not improve the situation for us or the other person.
b) If we focus on the other person's suffering and we wish them to be in a better place, it brings us peace, contentment and a sense of meaning.

7) Acknowledging the Universality of Suffering
a) When we identify with the universality of suffering and remember – 'Yes, I know what it's like to be afraid and alone' – then we don't judge the other and we feel compassion for them.
b) Focusing on helping the other makes us feel better and so do they. Everyone benefits.

8) Recognising Interdependence
a) The perspective we hold is key. Recognising our deep interdependence with others also helps increase compassion. We have connections to many others, both near and far.
b) Each and every one of us had caregivers look after us for years in our infancy.
c) Then we had teachers who taught us how to read and write.
d) We eat food grown on farms in far off places.
e) Remembering all these connections reminds us that everyone is important.

9) Every Moment Matters
a) Many factors create any single event. Every action is important.
b) Even small things like a smile or kind word help ease another's suffering.

10) Quick Quiz
a) Compassion involves looking down upon another who is suffering. TRUE or FALSE?
Answer – This is a FALSE statement. Compassion involves viewing all others as equal.
b) Compassion is a positive mind state, it leads to feelings of warmth, concern, reward and affiliation. TRUE or FALSE?
Answer – This is a TRUE statement. Compassion triggers positive neural pathways associated with warmth, concern, reward and affiliation. Compassion also lowers stress and improves the wellbeing of the giver.

11) Brief Summary
a) Compassion is innate. We all have it inside us but we can increase it through thinking in certain ways.
b) Compassion is a positive mind state and protects against empathic distress and burnout. Compassion and empathy are not the same. Too much empathy can lead to empathic distress.
c) The perception of common humanity is the key to compassion – focus on the common ground you have with others. Use the slogan, 'Just like me, this person wishes to be happy and not to suffer'.
d) Every action, big or small, makes a difference.

12) Compassion Quotes
a) 'If you want others to be happy, practice compassion. If you want to be happy, practice compassion' – Dalai Lama
b) 'Compassion is the basis of all morality' – Arthur Schopenhauer
c) 'Simplicity, patience, compassion. These three are your greatest treasures' – Lao Tzu
d) 'The purpose of human life is to serve, and to show compassion and the will to help others' – Albert Schweitzer
_____

Heavy workloads can prevent compassion as the health care worker may be struggling to get through all the tasks they are required to do. There are factors, both internal and external to the worker that can impact on compassion (Fernando & Consedine, 2016). The compassion eLearn is focusing exclusively on factors internal to the health care worker. Health care management needs to carefully consider external factors such as workload, organisational culture and physical environment, to name a few.

FUTURE DIRECTIONS

A compassion eLearn is a cost effective and accessible training approach to help health care workers develop and sustain compassion in their work. Holding perspectives such as the perception of common humanity facilitate compassionate responses towards all others. When health care workers can easily cultivate compassion, everyone benefits; the health care workers maintain positive states of mind and the patients are on the receiving end of care and kindness. Focusing in on common humanity – that everyone wishes to be happy and to avoid suffering – can help health care worker wellbeing. Future research to investigate the impact of a compassion eLearn will be useful.

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Chapter 5. Discussion and Conclusion

5.1 Study overview

This study investigated the relationship between the perception of common humanity and compassion in healthcare workers.

The research question was:

What is the relationship between the perception of common humanity and compassion in healthcare workers?

 Subsidiary questions addressed:

1. What is compassion and how does it come into being?

2. How does viewing common humanity scenarios impact on healthcare workers' level of compassion?

3. Does education on common humanity influence compassion in healthcare workers?

4. How can compassion training for healthcare workers be taken to scale?

5.2 Overview of research key findings

This section will now detail the key findings of the study in relation to the research questions.

The overarching research question was:

What is the relationship between the perception of common humanity and compassion in healthcare workers?

The results from this study suggest that the perception of common humanity is an essential prerequisite for compassion in healthcare workers. This was demonstrated by several aspects

of the study. The critical review of the literature highlighted that the perception of common humanity is the specific perspective that leads to compassion. Perspective taking, perceived similarity and empathy alone were insufficient to guarantee that compassion would arise. The pre/post intervention component of this study demonstrated that showing common humanity scenarios to healthcare workers led to a statistically significant increase in self-reported levels of compassion. A thematic analysis of the qualitative comments by the healthcare workers indicated that viewing the common humanity scenarios led them to feeling a greater sense of connection to others due to recognising shared basic needs. This sense of understanding that all others are similar to oneself incorporates a stance where any other human is considered valuable, purely by virtue of their basic humanity. The perception of common humanity appears to be the specific perspective that results in one having care and concern for any other person. The key findings from the study will now be summarised below in response to each subsidiary research question.

Subsidiary questions addressed:

1. What is compassion and how does it come into being?

Compassion is defined as a concerned response to the suffering of another and a desire to alleviate the suffering of the other. The Sequential-Relational Model of Compassion (see p. 33) was developed from the available literature by the researcher to illustrate how compassion comes into being. There are six steps a person must progress through to arrive at compassion: (1) notice the other person; (2) decide whether the other is suffering; (3) empathise with the other; (4) have the perception of common humanity; (5) understand that no one wants to suffer and (6) wish for the suffering of the other to be alleviated. The Sequential-Relational Model highlights the subjective nature of the appraisals made regarding

whether another is suffering or not and whether one has empathy or not. Not everyone interprets a situation in the same way, however specific appraisals are necessary to result in compassion. The Sequential-Relational Model of Compassion shows clearly that a person must keep their concern focused on the other in order to progress to compassion. If a person becomes distressed themselves and turns their attention away from the other, this becomes empathic distress which is a negative, self-focused reaction. Empathic distress, rather than the so called 'compassion fatigue', has now been proposed as leading to burnout (Klimecki & Singer 2012).

The perception of common humanity is at the core of the Sequential-Relational Model of Compassion. This perspective enables a person to identify, connect with and value any other person, irrespective of the particular nature of their suffering. The perception of common humanity instils in a person the strong wish that the other's suffering is relieved. This occurs as one views the other as similar to oneself, because of the understanding that all humans have the wish to be happy and to be free from suffering (Jinpa 2016; Ricard 2015).

2. How does viewing common humanity scenarios impact on healthcare workers' level of compassion?

A pre/post intervention was undertaken in which healthcare workers were asked to view a common humanity scenario. The healthcare workers completed validated scales on perspective taking, common humanity and compassion prior to viewing the common humanity scenario and again immediately afterwards. As described in the Results Chapter Article Two, 'Investigating how viewing common humanity scenarios impacts compassion: A novel approach', the results showed statistically significant increases in compassion in healthcare workers after viewing common humanity scenarios as calculated using the

Wilcoxon Signed-Rank test. A mediation analysis provided some evidence that perspective taking influences compassion mediated by common humanity. These results seem to support the proposal by a number of authors and researchers that the perception of common humanity is the central to compassion (Blum 1980; Nussbaum 1996; Von Dietze & Orb 2000; Cassell 2009; Feldman & Kuyken 2011; Jinpa 2016; Ling et al. 2018).

Healthcare workers also provided qualitative comments in response to viewing the common humanity scenarios. The Results Chapter Article Three, 'The use of common humanity scenarios to promote compassion in healthcare workers', outlines these findings. A thematic analysis of the comments from the healthcare workers indicated that viewing common humanity scenarios appeared to strengthen healthcare workers' sense of common humanity with others. There were strong connections to the themes of (1) common bonds; (2) people have the same needs; (3) no one wants to suffer and (4) seeing strangers helping others is motivating. Examples of some of the comments the healthcare workers made were 'realising how much you have in common with people you believed you have nothing in common with', 'seeing how all others are really similar at heart', 'life is not easy and no one wants to suffer' and 'made me more aware of putting myself in their shoes'.

3. Does education on common humanity influence compassion in healthcare workers?

The healthcare workers also attended a compassion training session, facilitated by the researcher, immediately after completing the pre/post intervention. The compassion training session and evaluation by the healthcare workers is detailed in the Results Chapter Article Four, 'Outcomes from a compassion training intervention for health care workers'. The healthcare workers were provided with (i) information defining compassion; (ii) research information from neuroscience indicating that compassion is a positive mind state and

different to empathy; (iii) scenarios emphasising common humanity and (iv) a slogan for healthcare workers to help them hold a compassionate stance towards their patients. The healthcare workers completed an evaluation after the compassion training session. Feedback from the healthcare workers indicated that they found the content of the compassion training session useful, in particular, discovering that compassion is a positive mind state and differs from empathy. The healthcare workers said it was important to them to understand that empathy can turn into empathic distress which can lead to burnout whereas compassion, keeping one's focus and concern on the other, is always a positive state of mind. The healthcare workers said that viewing information on common humanity and being given a common humanity slogan, 'Just like me, this person wishes to be happy and to avoid suffering' was beneficial in enhancing compassion.

4. How can compassion training for healthcare workers be taken to scale?

Epworth HealthCare is Australia's largest, private not-for-profit healthcare organisation with a staff of approximately 6,870 (Epworth HealthCare 2012). Epworth HealthCare was the partner organisation in this study and has compassion as one of its stated core values. The significant results from the pre/post intervention in support of the perception of common humanity as a pathway to compassion and the strong interest from healthcare workers to attend the compassion training session prompted Epworth HealthCare to request the researcher to take the compassion training to scale. The researcher developed a Compassion eLearn based on content from the original compassion training. The content of the Compassion eLearn is detailed in the Results Chapter Article Five, 'An outline of a Compassion eLearn'. The Compassion eLearn is a translational research outcome from this study. The Compassion eLearn will be trialled in the Epworth Rehabilitation and Mental Health Division

with a view to rolling it out across the organisation. To the best knowledge of the researcher, it is a world first for a healthcare organisation to have a Compassion eLearn focusing on common humanity.

There are suggestions that compassion in healthcare is in crisis (Kneafsey et al. 2016; Lown et al. 2011; Trzeciak et al. 2017). Accessible compassion training for staff is one approach to address this crisis. An eLearn is a low-cost efficient means to provide education and training (Ruiz et al. 2016). Making compassion training available to large numbers of healthcare staff is vital if healthcare wishes to operate from a position that understands and promotes humanity in healthcare.

5.3 Overview of research approach

This research chose to focus on healthcare workers at Epworth HealthCare. A variety of healthcare workers were involved in the study, however further research will be required to see if the results are replicated in other groups of healthcare workers. The study employed a mixed methods approach and generated both quantitative and qualitative data to help investigate the research question. The use of common humanity scenarios as a compassion training tool to heighten staff awareness of their connection with all others appears to have been effective. Furthermore, it is a low cost and readily accessible option for other healthcare organisations to utilise.

It would also be useful to replicate this study with groups outside of healthcare since compassion is a universal value and not the exclusive domain of healthcare workers.

5.4 Implications

This research provides quantitative and qualitative evidence to support the hypothesis that the perception of common humanity is the foundation of compassion. This has significant implications for healthcare where compassion is a core value in hospitals and the helping professions. Healthcare exists to alleviate the suffering of others. Furthermore, compassion is considered important in areas beyond healthcare, for example in schools, in parenting, in governments. It is common these days to hear about the need for compassion in education, leadership, politics and world affairs. Compassion is a widely held virtue around the world.

It is relatively easy to provide education on common humanity. The perception of common humanity has been shown to be necessary for compassion. This study utilised video scenarios and real-life examples to represent common humanity. The development of the Compassion eLearn demonstrates that it is possible to create compassion resources that can be easily accessed by large numbers of people.

Given the lack of clarity regarding what compassion is and how it comes into being, it is hoped that the Sequential-Relational Model of Compassion, which is an outcome of this research, will assist future researchers in the development of compassion training programs and compassion scales. The Sequential-Relational Model of Compassion highlights that it is imperative to focus on the perception of common humanity.

5.5 Limitations

There were several limitations to this study. Regarding the presentation of findings, the thesis inclusive of published works (or works submitted for publication) places requirements on each article to be a standalone work. Articles had constraints placed on them depending upon the requirements of specific journals, word count and emphasis. There were several ideas and

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themes which were repeated in each article to ensure the audience had an understanding of what compassion is, how it differs from empathy and why the perception of common humanity has been proposed as the foundation of compassion.

In terms of theoretical framework, the researcher adopted the view that the boundary between self and other is clearly defined. However, as noted in the literature review, psychodynamic literature and aspects of Buddhist philosophy suggest the boundary between self and other to be more complex, fragile and containing significant overlap.

In terms of the research intervention conducted at Epworth HealthCare, the limitations of the study have been discussed in the results papers, however they will be mentioned briefly here. The sample was one hundred healthcare workers attending the compassion training session and of those, seventy-five participated in the pre/post intervention. This is a limited sample and further research is needed to see if the results are replicated. The pre/post intervention study only collected data at two time points. It would be useful for further studies to collect data at a third and fourth time point to determine if the effect is constant over a longer time period. Two different common humanity scenarios were used, one more emotive than the other. Further research would need to be undertaken to ascertain whether there are certain types of common humanity scenarios that have a greater impact on compassion so that they would be more effective in training compassion.

5.6 Future research directions

The results of this study are promising, providing evidence that the perception of common humanity appears to be the foundation of compassion. The perception of common humanity strengthens connection and identification with others which leads to a sense of care and concern towards others (Cassell 2009; Jinpa 2016). There is an important need for further

research to investigate the relationship between the perception of common humanity and compassion to verify if these findings can be replicated with other studies and different populations. It would be useful to explore the impact of different common humanity scenarios to see if some are more effective than others. It would also be interesting to determine if simple reminders to staff about common humanity such as 'everyone wishes to be happy and not to suffer' or 'everyone is someone's mother, father, son, daughter' would help reinforce and heighten their sense of connectedness with others.

More studies are needed to refine a definition of common humanity. Further research is required to provide support for the findings in this research that the perception of common humanity increases compassion in healthcare workers. Research that measures both healthcare worker self-report on compassion and patients' report of receiving more compassionate care is vital. Scale development is an area which urgently needs attention to ensure the validity and rigour of future research (Sinclair et al. 2016; Strauss et al. 2016). There has been some work on compassion scales over the last few years but it has been held back by the lack of consensus regarding conceptualisations of compassion. Additionally, the development of a more rigorous scale to measure common humanity is also necessary. Compassion training interventions need to incorporate a focus on the perception of common humanity.

This study focused exclusively on healthcare workers' attitudes and perspectives which is clearly an essential starting point. Without healthcare workers feeling genuine care and concern for others, there cannot be the expectation of compassionate care. Healthcare organisations, however, need to make changes at a number of levels to become compassionate organisations (Lown et al. 2011; Post et al. 2014). Workloads, the built

environment, management style and staff communication to patients are all areas that are vital to creating a compassionate organisation (Fernando et al. 2016). It would be preferable for all staff in a healthcare organisation to undergo compassion training, not just the frontline healthcare workers. Healthcare executive and management also need to have a strong sense of common humanity and compassion to make decisions which will benefit both staff and patients. There is undoubtedly pressure to cut costs and maintain profits, but it must be remembered that healthcare fundamentally exists to serve others and alleviate suffering. Healthcare organisations cannot provide an acceptable level of service without compassion.

5.7 Concluding comment

Compassion has become the topic of research over the last two decades. It is now known that compassion increases the wellbeing of the giver, prevents empathic distress and burnout, leads to increased helping behaviours and motivates action to alleviate the suffering of others. The perception of common humanity has been proposed to be fundamental to compassion. This study has now provided empirical evidence to support this claim. While these results cannot be generalisable to all populations, the results provide support that the perception of common humanity is a critical perspective to hold to be able to value all others and care about alleviating their suffering. It is hoped that compassion researchers further explore these findings with some urgency as providing compassion training, emphasising common humanity, may be an effective way of cultivating and enhancing compassion.

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Appendices

Appendix 1. Study flier

Appendix 2. Study explanatory statement

Appendix 3. Participant survey

Appendix 4. Post compassion training survey questions

Appendix 5. Ethics approval from Epworth HealthCare Human Research Ethics Committee

Appendix 6. Epworth HealthCare Governance Authorisation Granted

Appendix 7. Ethics registration with Monash University Human Research Ethics Committee

APPENDIX 1: Study flyer

Epworth Rehabilitation
"Mindfulness and Compassion"
Education Session

FRIDAY OCTOBER 20, 10am-12noon

AUDITORIUM – EPWORTH RICHMOND

Epworth Rehabilitation invites you to attend a special session looking at the intersection of mindfulness and compassion for healthcare workers. The session will include:

- Information on some of the latest research on mindfulness and compassion
- Techniques for enhancing mindfulness and compassion in the workplace
- Strategies for preventing burnout

Presented by A/Professor Craig Hassed (Monash University) and Debbie Ling (Epworth Social Worker & PhD Candidate, Monash University).

A/Professor Craig Hassed is an International Expert on Mindfulness. Debbie Ling is a Senior Clinician Social Worker at Epworth Rehabilitation and conducting her PhD research on compassion. Debbie will invite participation from audience members via a short survey for those who are interested in contributing to the research.

Numbers limited. Morning tea provided.

RSVP Debbie.Ling@epworth.org.au or Mob: 0418 118 853 by Thursday 12 October.

APPENDIX 2: Study explanatory statement

Compassion Research study
PLAIN LANGUAGE STATEMENT

Debbie Ling (PhD candidate, Monash University)
Supervisors: Professor John Olver (Epworth HealthCare), Dr Melissa Petrakis (Social Work Department, Monash University)

Explanation of the study
This study is investigating the impact of viewing material on common humanity on healthcare workers' level of compassion. A hypothesis is that the perception of common humanity may be a core component of compassion for others. Participants' responses on the surveys will be analysed using a statistical data package to see if there is an effect from viewing the material.

Why this research is useful
The results will be helpful in providing the research community with clarity over the core component of compassion. This is beneficial for future research on compassion and in the design of future compassion training programs.

Further Information
Please contact Debbie Ling from the Epworth Rehabilitation social work department on Debbie.Ling@epworth.org.au or Mob: 0418 118 853

Complaints contact person
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

HREC contact person: Helen Christensen
Reviewing HREC name: Epworth HealthCare Human Research Ethics Committee (EC00217)
HREC Executive Officer: Kyle Heffernan
Telephone: 03 9426 8806
Email: HREC@epworth.org.au

Compassion Research Study (V2, 13/July/17)

APPENDIX 3: Participant survey

Compassion Research study

Debbie Ling (PhD candidate, Monash University)
Supervisors: Professor John Olver (Epworth), Dr Melissa Petrakis (social work department, Monash University)
E: Debbie.Ling@epworth.org.au Mob: 0418 118 853

You are invited to participate in a brief research study on compassion. It will involve watching a short video and filling in some survey questions prior to and immediately after watching the video. It will take about 10 minutes. The survey information is completely anonymous. If you are agreeable to take part, please continue by filling in the questions below. If you have any questions about this research, you are welcome to contact Debbie Ling for further information.

Thank you for taking part.

Please tick the correct response:

Gender: Male__   Female__

Age: 18-24____
                   25-34____
                   35-44____
                   45-54____
                   55-64____
                   65-75____

Profession: ___Nursing
                   ___Medical
                   ___Social work
                   ___Occupational Therapist
                   ___Physiotherapist
                   ___Psychologist
                   ___Speech Pathologist
                   ___Dietician
                   ___Pastoral Care
                   ___Allied Health
                   ___Management
                   ___Administration
                   ___Other (please state): _____

Please answer the questions on the next 2 pages BEFORE watching the video.

1

Compassion Research Study Form (v2, 13/July/17)

INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

___ Before criticizing somebody, I try to imagine how I would feel if I were in their place.

___ If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

___ I sometimes try to understand my friends better by imagining how things look from their perspective.

___ I believe that there are two sides to every question and try to look at them both.

___ I sometimes find it difficult to see things from the "other guy's" point of view.

___ I try to look at everybody's side of a disagreement before I make a decision.

___ When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

Compassion Scale HOW I TYPICALLY ACT TOWARDS OTHERS

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				Almost Always
1	2	3	4	5

___ 1. I don't feel emotionally connected to people in pain.

___ 2. I feel detached from others when they tell me their tales of woe.

___ 3. When I see someone feeling down, I feel like I can't relate to them.

___ 4. Everyone feels down sometimes, it is part of being human.

___ 5. It's important to recognize that all people have weaknesses and no one's perfect.

___ 6. Despite my differences with others, I know that everyone feels pain just like me.

___ 7. Suffering is just a part of the common human experience.

___ 8. I can't really connect with other people when they're suffering.

2

Santa Clara Brief Compassion Scale

Please answer the below questions honestly and quickly using the scale below:

1	2	3	4	5	6	7
Not at all true of me						Very true of me

___1. When I hear about about someone (a stranger) going through a difficult time, I feel a great deal of compassion for him or her.

___2. I tend to feel compassion for people, even though I do not know them.

___3. One of the activities that provide me with the most meaning to my life is helping others in the world when they need help.

___4. I would rather engage in actions that help others, even though they are strangers, than engage in actions that would help me.

___5. I often have tender feelings toward people (strangers) when they seem to be in need.

Additional Questions

Please answer the following questions using the scale below:

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree or Disagree	Agree Somewhat	Agree Strongly

___ 1. No one wants suffering

___ 2. People all around the world want happiness

___ 3. Myself and others are the same in our basic human needs

___ 4. When I think of the similarities between me and others, I feel more compassion for others

___ 5. People bring it on themselves when something bad happens to them

___ 6. There are many factors that go into someone suffering misfortune

3

Please pause at this point and watch the video.

**After watching the video, please complete the rest of the survey
questions on pages 5-7. Thank you.**

Please answer all of the following questions AFTER watching the video, taking into account what your responses are now.

INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT				DESCRIBES ME
DESCRIBE ME				VERY WELL
WELL				

___ Before criticizing somebody, I try to imagine how I would feel if I were in their place.

___ If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

___ I sometimes try to understand my friends better by imagining how things look from their perspective.

___ I believe that there are two sides to every question and try to look at them both.

___ I sometimes find it difficult to see things from the "other guy's" point of view.

___ I try to look at everybody's side of a disagreement before I make a decision.

___ When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

Compassion Scale

HOW I TYPICALLY ACT TOWARDS OTHERS

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				Almost Always
1	2	3	4	5

___ 1. I don't feel emotionally connected to people in pain.

___ 2. I feel detached from others when they tell me their tales of woe.

___ 3. When I see someone feeling down, I feel like I can't relate to them.

___ 4. Everyone feels down sometimes, it is part of being human.

___ 5. It's important to recognize that all people have weaknesses and no one's perfect.

___ 6. Despite my differences with others, I know that everyone feels pain just like me.

___ 7. Suffering is just a part of the common human experience.

___ 8. I can't really connect with other people when they're suffering.

Santa Clara Brief Compassion Scale

Please answer the below questions honestly and quickly using the scale below:

1	2	3	4	5	6	7
Not at all true of me						Very true of me

___1. When I hear about about someone (a stranger) going through a difficult time, I feel a great deal of compassion for him or her.

___2. I tend to feel compassion for people, even though I do not know them.

___3. One of the activities that provide me with the most meaning to my life is helping others in the world when they need help.

___4. I would rather engage in actions that help others, even though they are strangers, than engage in actions that would help me.

___5. I often have tender feelings toward people (strangers) when they seem to be in need.

6

Additional Questions

Please answer the following questions using the scale below:

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree or Disagree	Agree Somewhat	Agree Strongly

___ 1. No one wants suffering

___ 2. People all around the world want happiness

___ 3. Myself and others are the same in our basic human needs

___ 4. When I think of the similarities between me and others, I feel more compassion for others

___ 5. People bring it on themselves when something bad happens to them

___ 6. There are many factors that go into someone suffering misfortune

After watching the video, please write about:

1. What effect did it have on your perception of common humanity with others?

2. If there was a shift in your perception of common humanity with others, what were the reasons for this?

3. If there was no shift in your perception of common humanity with others, what were the reasons for this?

4. What impact did watching the video have on your level of compassion for others? Please give reasons.

Thank you for participating in this research.

Compassion Research Study Form (v2, 13/July/17)

'Mindfulness and Compassion' Education Session Evaluation

1. Overall how would you rate the 'Mindfulness and Compassion' session?

   Excellent ❑
   Very good ❑
   Good ❑
   Fair ❑
   Poor ❑

2. What did you find useful about the 'Mindfulness and Compassion' session?

3. What topics or ideas from the session did you find useful? (please tick all that apply)

   Information on the neuroscience behind compassion ❑

   Information on the neuroscience behind mindfulness ❑

   Compassion is a positive mind state whereas too much empathy can lead to burnout ❑

   Strategy to support compassion is to hold the perspective 'just like me, this person wants happiness and does not want suffering' ❑

   Viewing video material on common humanity ❑

   Strategy to support mindfulness – seeing that multi-tasking when talking blocks communication ❑

   Men and women's brains respond differently to stress ❑

   Default brain network (wandering brain is associated with stress) ❑

   Attentive brain is associated with the brain being quiet and efficient ❑

4. What is one idea or strategy from the session that may help you be more mindful?

5. What is one idea or strategy from the session that may help you have more compassion?

6. How important is to you to have access to information that can boost mindfulness?

   Very important ❑
   Somewhat important ❑
   Neither important or not important ❑
   Somewhat unimportant ❑
   Very unimportant ❑

7. How important is it to you to have access to information that can boost compassion?

Very important ❑
Somewhat important ❑
Neither important or not important ❑
Somewhat unimportant ❑
Very unimportant ❑

8. Do you have any other comments or feedback about the session?

Epworth HealthCare
Ethical Approval Granted

Ms Deborah Ling
Rehabilitation, Mental Health and Chronic Pain
Epworth Rehabilitation
Social Worker

24/07/2017

Dear Ms Deborah Ling,

Research Project:	How does viewing material on common humanity impact on healthcare workers' level of compassion?
Reference Number:	EH2017-242

Thank you for submitting the above research project for ethical review. This project was considered at the **Low Risk Sub-Committee** meeting held on **11/07/2017**.

I am pleased to advise you that the Committee has granted ethical approval of this research project.

Documents:

Approved:
-Study Protocol V1 26June2017
-Data Collection Tool V2 13July2017
-Plain Language Statement V2 13July2017

Noted:
-Ethics Application form dated 26 June 2017
-Principal Investigators ethics submission & authorisation checklist signed & dated 04 June 2017
-Response to queries correspondence
-Researcher CV Ms Ling
-Researcher CV Professor Olver
-Researcher CV Dr Petrakis

To ensure compliance with the National Statement on Ethical Conduct in Human Research (2007), Guidelines for Good Clinical Research Practice (GCRP) in Australia, and in line with Epworth HealthCare's HREC policy, it is the Principal Investigator's responsibility and a condition of ethical approval, to ensure that:

- The reviewing committee is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.

- The reviewing committee is notified of all Serious Adverse Events (SAEs) or Serious Unexpected Adverse Reactions (SUSARs).
- Proposed amendments to the research protocol or conduct of the research that may affect the ethical acceptability of the project are submitted to the reviewing committee (including any relevant attachments).
- Proposed changes to the personnel involved in the research project are submitted to the reviewing committee.
- The reviewing committee must be provided with an annual progress report for the research project on the anniversary of ethical approval.
- The reviewing committee must also be provided with a comprehensive final report upon completion of the research project.
- The reviewing committee must be notified, giving reasons if the research project is discontinued at the site before the expected date of completion.

If applicable, you will be sent a Certificate of Approval, which notes the terms and conditions of this approval. You are requested to acknowledge these terms and conditions by signing the duplicate copy and returning it to me as soon as possible.

If any presentations or publications arise from this research project, please ensure that Epworth HealthCare receives appropriate recognition and copies of presentations and publications are provided to the Research Ethics Officer for Committee review and file inclusion.

The Epworth Human Research Ethics Committee and Low Risk Sub-Committee are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) in addition to adherence to the Guidelines of Good Clinical Practice and the Australian Code for the Responsible Conduct of Research.

The above named research project may not begin at Epworth HealthCare until both Ethics approval and Research Governance Authorisation are granted.

If you have any questions regarding this letter, please contact the Research Ethics Officer: Telephone (03) 9426 8806 Email HREC@Epworth.org.au.

Yours Sincerely,

Victoria McMorran
Acting Research Ethics Coordinator
Research Development and Governance
Telephone: (03) 9426 8806
Email: HREC@Epworth.org.au

Epworth HealthCare Ethics Committee, Mailbox #4, 89 Bridge Road, Richmond, VIC 3121
Phone: (03) 9426 8806   HREC@Epworth.org.au

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Epworth HealthCare
Governance Authorisation Granted

Ms Deborah Ling
Rehabilitation, Mental Health and Chronic Pain
Epworth Rehabilitation
Social Worker

24/07/2017

Dear Ms Deborah Ling,

Research Project:	How does viewing material on common humanity impact on healthcare workers' level of compassion?
Reference Number:	EH2017-242

Thank you for submitting the above named research project for Research Governance review at Epworth HealthCare. I can confirm that the valid submission was received on **24/07/2017**.

I am pleased to inform you that **Governance Authorisation** has been granted for this project to be conducted at Epworth HealthCare.

The following conditions apply to the research project at this site. These conditions may be additional to those imposed by the Committee that granted ethics approval.

1. The principal investigator will immediately report anything to the Research Governance Officer that might warrant review of authorisation of the project in the specified format, including:

   a. any serious or unexpected adverse event at this site.
   b. unforeseen events that might affect continued ethics acceptability or governance of the project.

2. The research governance officer will be notified if the project is discontinued at this site before the expected date of completion, and why.

3. The principal investigator will provide progress reports to the Research Governance Officer, in the specified format, and provide a comprehensive final report at the completion of the project. Note that annual reports are due on the anniversary of ethical approval date.

4. Where Epworth is the Sponsor of the research project, the principal investigator will comply with any additional requests from the Research Development and Governance Department or the ethics committee.

If any matters arise concerning the conduct of the research at your site, please ensure you contact the Research Development and Governance Department: Telephone (03) 9936 8205 Email Research@Epworth.org.au

Research Development and Governance, Mailbox #21, 89 Bridge Road, Richmond, VIC 3121
Phone: (03) 9936 8205 Research@Epworth.org.au

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Yours Sincerely,

Gerlinda Amor
Research Governance Officer
Research Development and Governance
Epworth HealthCare
Telephone: (03) 9936 8205
Email: Research@Epworth.org.au

Research Development and Governance, Mailbox #21, 89 Bridge Road, Richmond, VIC 3121
Phone: (03) 9936 8205 Research@Epworth.org.au

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APPENDIX 7: Ethics Registration Monash University Human Research Ethics Committee

Monash University Human Research Ethics Committee

Confirmation of Registration

Project Number: 10542

Project Title: How does viewing material on common humanity impact on healthcare workers' level of compassion?

Chief Investigator: Dr Melissa Petrakis

Expiry Date: 21/08/2022

Terms:

1. Registration is valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. This notification does not constitute an HREC approval. It is the responsibility of the Chief Investigator to ensure that approval from the primary HREC continues for the duration of the research.
3. End of project: You should notify MUHREC at the conclusion of the project or if the project is discontinued before the expected date of completion.
4. Retention and storage of data: The Chief Investigator is responsible for the storage and retention of the original data pertaining to this project in accordance with the *Australian Code for the Responsible Conduct of Research*.

Thank you for your assistance.

Professor Nip Thomson

Chair, MUHREC

CC: Ms Deborah Ling, Professor John Olver