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Mindfulness and Self-Compassion: Mitigating Compassion Fatigue

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Mindfulness and Self-Compassion:
Mitigating Compassion Fatigue

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Abstract

Research on the inherently stressful nature of working with those who are suffering, traumatized and dying, including the potential for developing secondary trauma, stress and burn/out is growing. For example, Joan Halifax (2011), Christopher Germer (2011), and Charles Figley are a few of the researchers studying compassion fatigue. As a result, there is also increasing research conducted on various solutions to mitigate the distress of caregivers. The findings show how mindfulness can actually build resilience and alleviate compassion fatigue.

This review focuses on the literature that makes significant contributions to the field of mindfulness, compassion, self-compassion, and compassion fatigue/empathic distress. This literature is discussed along with techniques that are useful both in the clinical settings and for individuals experiencing caregiver distress. Figley (2002, 1998), Halifax (2011), Lynch and Lobo (2012), explore compassion fatigue in both the professional caregiver and non-professional caregivers such as family members. The studies demonstrate that cultivation of compassion is needed for oneself in mitigating compassion fatigue.

The Introduction defines the concept of compassion. In what follows it, I discuss the growing research on the devastating effects of caregiving distress and its possible causes. The terms compassion fatigue/empathic distress, are sometimes used interchangeably; however, not all researches agree on their definitions. It should be noted that more recent research, and in particular the mindfulness researchers, who argue that it is empathic distress and the lack of self-compassion that is the cause of caregiver distress. Following the paper, I offer a syllabus for an eight-week course on mindfulness practices aimed at mitigating compassion fatigue.

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Introduction

The impetus for writing this paper comes from a personal loss and devastating grief along with the desire to find a way out of my own personal distress. Compassion fatigue struck me in the spring of 2011. Months of around the clock care for my husband, mixing drugs, changing tubing and dressings, plus worrying about the right dosage of medication were taking their toll on me. I was starting to develop an emotional fatigue that I had never experienced before.

The prevalence of compassion fatigue has become a major issue in the field of health today. As we witness more and more violence and death vicariously as caregivers, we pay a price. Compassion fatigue/empathic distress, burn-out, secondary trauma, and PTSD, are all by-products of bearing witness to the sufferings of the people around us. Whatever names you call these forms of distress, they all have similar consequences.

According to Halifax (2011) compassion is not valued in the world, and there is actually a deficit of compassion, in medicine as in the general public. This deficit causes distress to our caregivers (Joan Halifax, 2011, p. 5). When called upon either by choice or by necessity to become a caregiver, having compassion and empathy are necessities. However, empathy without the proper self-care can take its toll on the caregiver. Knowing when to take a break and take care of yourself also then becomes a necessity.

This paper is an exploration into the phenomena, consequences and treatments of compassion fatigue. The research discussed explores the many names given to caregiver distress, the people who may be affected by this distress and how they deal with it. The paper will also examine why some people are more resilient and able to bounce back from the debilitating effects of such distress.

The distress of being with a trauma victim, caring for the aged, sick -- and long hours without respite and self-care -- can leave long lasting psychological effects. The paper looks at how the resilient caregiver handles the stress of caregiving, and is able to develop a sense of compassion satisfaction in the work they do. The qualities and practices that can strengthen and build resilience will be presented. The research explains how these qualities and practices can enhance a person's well being.

I explore the programs that outline treatments for compassion fatigue, including both traditional and less traditional methods such as mindfulness and yoga. Another topic of discussion will be the similarities of the programs, and how some of the techniques overlap. Based on the current research, I will propose a program using mindfulness and yoga as practices to mitigate the stressors of bearing witness to pain and suffering.

The central premise of this paper is that becoming more compassionate towards oneself transforms distress and builds resilience. The literature reviewed here discusses the inverse relationship between increasing resilience and decreasing compassion fatigue. We can either fall victim to the negative effects of stress or we can mitigate it with the proper practices and transform it into compassion satisfaction.

*Love and compassion are necessities,
not luxuries,
Without them humanity cannot survive.*

Dalai Lama (as cited in Halifax, 2011, p. 9)

Compassion/Empathy

What is compassion? According to the dictionary, compassion is "a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire

to alleviate the suffering” (Merriam-Webster online Dictionary, 2015). Joan Halifax (2011) in her talk on *The Edge States of Compassion* describes compassion as a feeling of being “along side” another’s pain (p. 9). Germer (2011) has described compassion as an energizing “feeling of being loved, or being highly connected, a broader sense of oneself as a human being” (Annual Conference, 2011).

Jazaieri, McGonigal and Jinpa et al. (2013) explain that, compassion is a “multidimensional construct” (p. 1), made up of four important elements:

1. An awareness of suffering (cognitive component)
 2. Sympathetic concern related to being emotionally moved by suffering (affective component)
 3. A wish to see the relief of that suffering (intentional component)
 4. A responsiveness or readiness to help relieve that suffering (motivational component)
- (p. 1)

Halifax (2011) explains that compassion is a combination of “affective, cognitive and motivational components” (p. 9). She makes a clear distinction between empathy and compassion. She defines empathy as a “step in a process of emotional and somatic responses leading towards feelings of empathic concern and compassion” (p. 9). She explains that empathy is a shared feeling of the suffering and internalizing the feelings of another’s pain as if they were one’s own. Compassion on the other hand is a “feeling alongside the sufferer’s affective state and aspiring to relieve that suffering” (Halifax, 2011, p. 9).

Empathy, the ability to identify with another’s pain, can create distress in the caregiver by bringing up a caregiver’s own unresolved pain. This unresolved pain, may have an accumulative affect on the caregiver, creating an even more stressful situation. The source of distress is our

inability to distance ourselves from the patient's pain suffered and from our investment in the health outcome for this patient (Stebnicki, 2007). It is an attachment to the outcome, according to Halifax (2011), that can "destroy the capacity of a caregiver to be fully present to the whole catastrophe" (p. 9).

Caregivers are called upon to have unwavering compassion in the face of suffering. Maintaining emotional separation from this suffering is important. Jackie Thomas (2011), in her dissertation on compassion fatigue, explains how emotional separation and mindfulness, working in tandem, mitigate compassion fatigue. To exercise emotional separation requires inner strength.

The concept of emotional separation assumes that one is able to accept the outcome without over-identifying with the patient. The Buddha taught that in order to be with the suffering and fully open your heart, while staying strong, "it takes a strong back and a soft front" (Halifax, 2011, p. 6). Thus, it takes tremendous amounts of strength to hold up your back in the midst of certain conditions, to allow yourself to fully "open to the world as it is, while having an undefended heart" (Halifax, 2011, p. 6).

Recent research (Germer, 2011, Halifax, 2011) tells us that compassion is an innate quality in everyone but that its expression needs to be nurtured. According to Halifax (2011), nurturing should be part of a caregiver's self care. Halifax (2011) suggested, based on the current research, that a person with compassion feels another person's pain more, but is also able to return to their "baseline sooner"(p. 6); she defined baseline as a neutral state of being for a given person. However, when a situation becomes overwhelming for the caregiver, he/she can feel there is no more to give: the "question then becomes what to do" (Halifax, 2011, p. 6). Charles Figley (2009) explains that even though people with more empathy seem to be drawn to

the caregiving role, they tend to be more at risk for compassion stress (p.1). This happens because many caregivers cannot create emotion separation between themselves and their patients' pain.

Figley (2002) explained that the driving force behind working with the suffering is “empathy” (p. 1). Thomas (2011) believes that being able to empathize is a crucial quality of the caregiver; however, it can leave them “vulnerable for the development of secondary stress disorders” (p. 7). This stress has many labels: Compassion Fatigue, Vicarious Trauma, Secondary Trauma Stress Disorder, Empathic Distress, and Burnout.

*In that moment I wanted nothing
more than to possess her suffering,
to make her feel less heavy. (Poindexter, n. d.)*

Compassion Fatigue

Compassion fatigue as described by Germer (2009), is a consequence of over extending oneself. He continues to say that it isn't compassion that is fatiguing, but it is our attachment to the outcome that is fatiguing...“we wear ourselves out when we're attached to the outcome” (p. 182). Compassion fatigue as a construct was first introduced by Charles Figley in 1995. Radey and Figley (2007) explained that, “as our hearts go out to our clients through our sustained compassion, our hearts can give out from fatigue” (p. 207). Our capacity to bear witness to the suffering of others can then become compromised (Radey & Figley, 2007, p. 207).

Compassion fatigue, secondary traumatic stress, or vicarious trauma, and empathic distress, are the terms used to describe the relationship between a caregiver and the secondary distress or trauma felt by them. Distress develops when the caregiver feels the other person's pain as though it was her own. This can lead to an emotional exhaustion. Halifax (2011)

explains that this exhaustion happens when caregivers do not develop the proper boundaries and emotional separation between the caregiver and patient. In fact, without proper training, most people fail to separate themselves emotionally from those they care for. As Germer (2011) states, everyone who bear witness to suffering can be at risk for compassion fatigue.

Drawing on neuroscience evidence, Germer (2011) points to ‘mirror neurons,’ recently identified as those that are active when a person/animal witnesses an action performed by a member of their species. This explains the human ability to have a “somatic sensory motor resonance” (Annual conference, Germer, 2011) toward another person. Furthermore, research on “mirror” neurons suggests that “embodied simulation” (Thomas, 2011, p. 4) impacts a caregiver in a way that is similar to the experience of a client or patient being cared for, and who’s suffering a caregiver witnesses. The most vulnerable and at a higher risk for developing compassion fatigue are younger people and women. Halifax (2011) believes that the reason why younger caregivers and women are more impacted is related to the fact that young people have less life experience dealing with tragedy and women are more likely to be forced into the role of a caregiver. However, all caregivers that reach their “edge state” (Halifax, 2011, p. 1) in which they are unable to self-regulate are at risk. An example of not self-regulating would be falling into a deep depression and not being able to bounce back.

Compassion fatigue prevalence in caregiving is as frequent as 40-80% (McCray et al. 2006). Halifax (2011) noted that 76% of medical resident respondents reported symptoms of emotional exhaustion and burnout (p. 6). While the professional caregivers vulnerability to compassion fatigue is well known, there is growing research on the vulnerability of the family caregiver as well (Lynch & Lobo, 2012).

As medical cost rise, there is increasing pressure for the family member to care for their families' "chronic and acute health conditions that previously were treated in hospitals" (Lynch & Lobo, 2012, p. 1). In their research on compassion fatigue among family caregivers, Lynch and Lobo (2012) drew on the parallels "between the role of healthcare providers and family caregivers" (p. 1). Figley (2002) stated, "Empathy and emotional energy are the driving forces" which need to be present in a caregiver (p. 1). Compassion fatigue is then the "change in empathetic ability of the caregiver in reaction to the continual overwhelming stress of caregiving" (Lynch & Lobo, 2012, p. 2129). Lynch and Lobo's (2012) research shows that compassion fatigue "can occur in any caregiving relationship in which empathy occurs while caring for another" (p. 2131). Family members have no respite, when being with their ailing loved one 24/7, the "overexposure and stress" (Lynch & Lobo, 2012, p. 2131) from this situation is what can cause compassion fatigue.

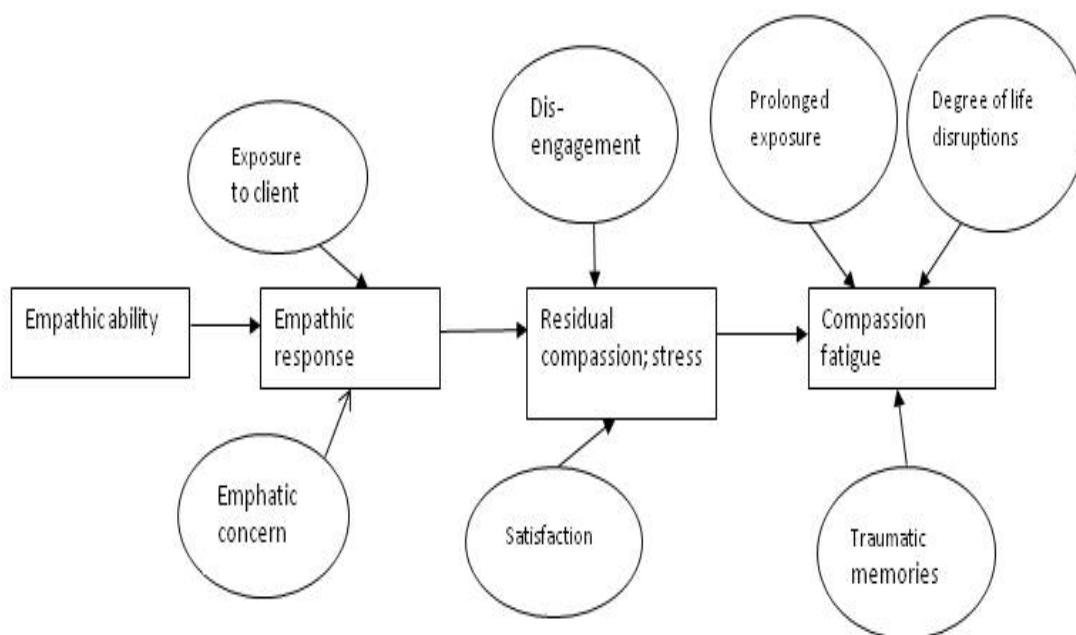
Day (2014) conducted a study among daughters taking care of a parent with dementia. She used interviews with twelve participants. She then came up with four identifiable themes endorsed by these participants: "uncertainty, doubt, attachment, and strain" (Day, 2014, p. 2). Because this group of caregivers lacked support and self-care behaviors, she felt compelled to study compassion fatigue among family caregivers (Day, 2014, p. 2). According to Bridge, Radey, and Figley (2007), to prevent compassion fatigue, one first has to "recognize the signs and symptoms of its emergence" (p.156). In looking at the practices used by the professional caregivers, Day (2014) proposed that the same practices could be used by the family caregiver.

Warning Signs for Compassion Fatigue

In Figley's (2002) early studies, a distinction between burnout and compassion fatigue was made, arguing that compassion fatigue, unlike burnout, was treatable, if recognized. He

postulated that burnout was more of an institutional long-term stress, and the only way of treating it might be to change jobs or careers. Burnout is an end state of compassion fatigue. Therefore, it is important to identify the warning signs so that compassion fatigue, by itself a serious condition, did not turn into burn-out. Thus, it is important to know what the warning signs of compassion fatigue are, how we measure them, and what are its accompanying disorders?

Figley's (2002) early "causal model" (p. 1436) introduced eleven predictors of compassion fatigue. This model relies on the "assumption that empathy and emotional energy are the driving forces in effectively working with the suffering" (Figley, 2002, p.1436). His eleven factors are: "Empathic Ability, Empathic Concern, Exposure to the Client, Empathic Response, Compassion Stress, Sense of Achievement, Disengagement, Prolonged Exposure, Traumatic Recollections and Life Disruption" (Figley, 2002, p.1436) (see Figure 1). This model both predicts compassion fatigue and can also be used to understand how to mitigate exposure to stressors (Figley, 2002, p. 1438).



*Figure 1: The dynamic relationship between initial empathic ability, possible intervening factors, both positive and negative, and compassion fatigue. Adopted from Figley's 2002 model. Figley, C.R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice*, Vol. 58(11), 1433-1441. doi: 10.1002/jclp.10090*

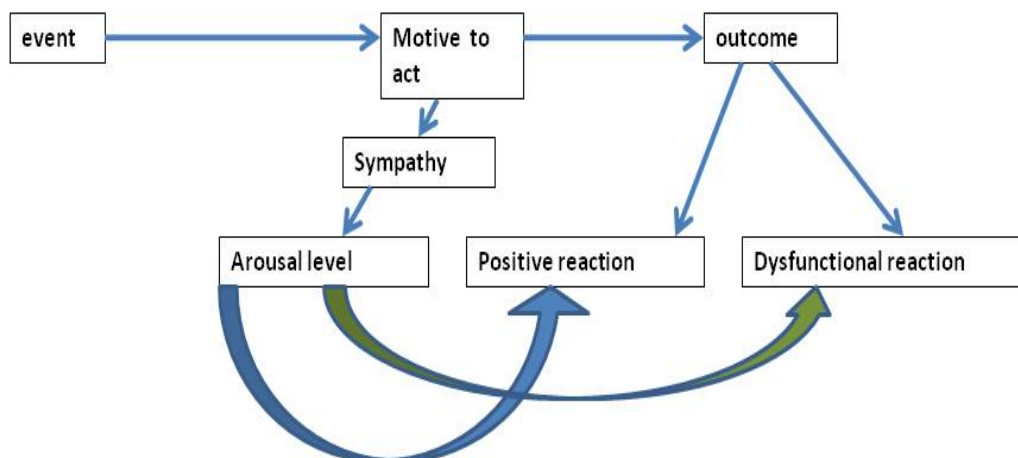
Figley's (2002) model shows that the first condition for showing compassion is the capacity for empathy. The capacity for empathy triggers a response, which is followed by a reaction to how this need for response is met. If the satisfaction from that response is not achieved or if the associated stress triggers the clinician's own traumatic memories, then compassion fatigue can follow (p. 1437) (see Figure 1).

Bride, Radey, and Figley (2007) reviewed the different measurement practices used to assess compassion fatigue. The most widely used tools are: (*CFST*), *Compassion Satisfaction and Fatigue Test (CSFT)*, and *Compassion Fatigue Scale (CFS)* (p. 156). The *CFST* instrument is the most commonly used to assess both compassion fatigue and burn/out. *CFST* has a set of questions, 23 to assess compassion fatigue, and 17 to assess burn/out. The questions ask how frequent certain characteristics present themselves (Bride, Radey & Figley, 2007, p. 156). In 1996 and then in 2005, Stamm, and Figley revised the *CFST* and introduced the *Professional Quality of Life Scale (ProQol)* (p. 159). In addition to compassion fatigue the *ProQol* scale also measures the quality of compassion satisfaction, that sense of fulfillment one receives from helping others. Compassion satisfaction is now becoming an indicator for resilience and in turn leads to flourishing (Bride, Radey & Figley, 2007, p. 159).

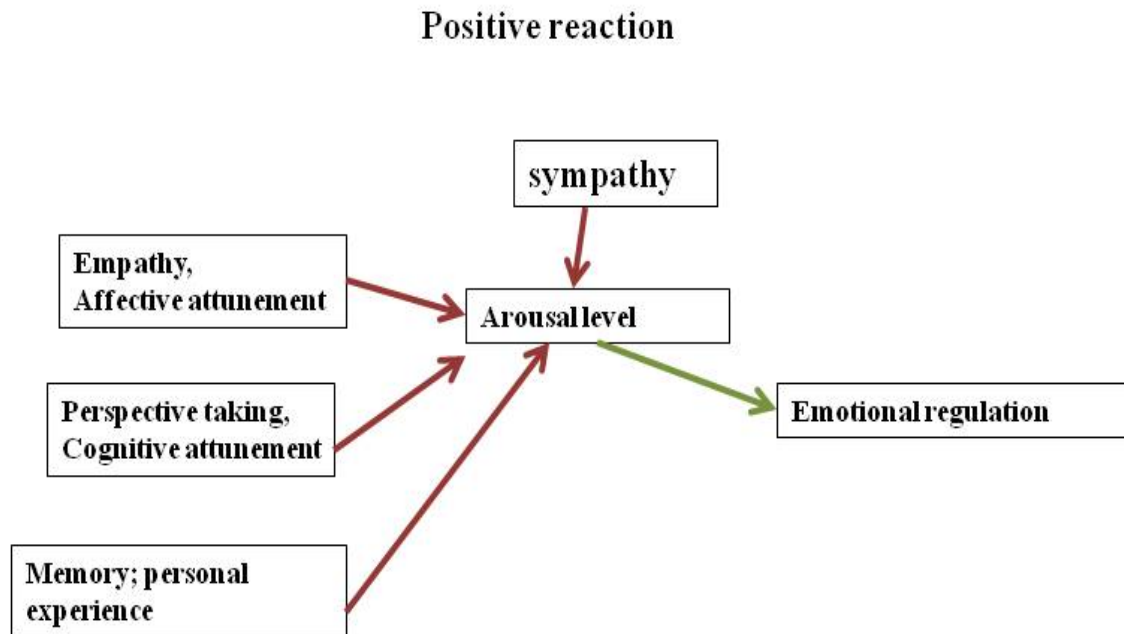
Radey and Figley (2007) cited Fedrickson and Losada's study and found that when individuals do not flourish and lack resilience, they tend to live a life that is "hollow or empty" (p. 678). Figley (1995) described four apparent factors that are draining to the caregiver. These factors are: "poor self-care, previous unresolved trauma, inability or refusal to control work stressors, and a lack of satisfaction with their work" (p. 1).

Compassion Fatigue or Empathic Distress

The very compassion that some feel leads to fatigue could actually be the tool that could protect us from this trauma. Is it then actually empathic distress and not compassion fatigue that is causing this suffering? Halifax (2011) thinks so. To this point, Halifax (2011) discussed research describing a person with compassion who feels another person's pain more, but is also able to return to their "baseline sooner" than a person without the same level of compassion (p. 9). She called this "resilience," and continued to explain, "many people think compassion drains us, but it is something that enlivens us" (Halifax, 2011, p. 9). So what is compassion fatigue in relation to compassion? Halifax (2011) postulates, "that is it not empathy fatigue?" (p. 9). She came up with a modified algorithm on personal distress based on social psychologist's Nancy Eisenberg's research (Figure 2,3,4). In the model, an event triggers a motive to act which results in an outcome (see Figure 2). The type of an outcome, either positive or dysfunctional is determined by a host of factors that are illustrated in Figures 3 and 4 (Halifax, 2011, p. 10).



*Figure 2: The overview of the model offered by Halifax where a distressful event leads to a motive to act and to possible outcomes. The outcomes can be positive or negative depending on a number of factors. Adopted from Halifax (2011) Modified Algorithm. Halifax, J. (2011). Inside compassion: The edge states of compassion. *Neuroscience*.*



*Figure 3: The successful modulation of arousal level leads to emotion regulation and capacity for compassion. Red arrows indicate modulatory influences: sympathy modulates the level of arousal. The level of arousal is modulated by empathy, perspective taking and memory/personal experience. Adopted from Halifax's 2011 Modified Algorithm. Halifax, J. (2011). Inside compassion: The edge states of compassion. *Neuroscience*.*

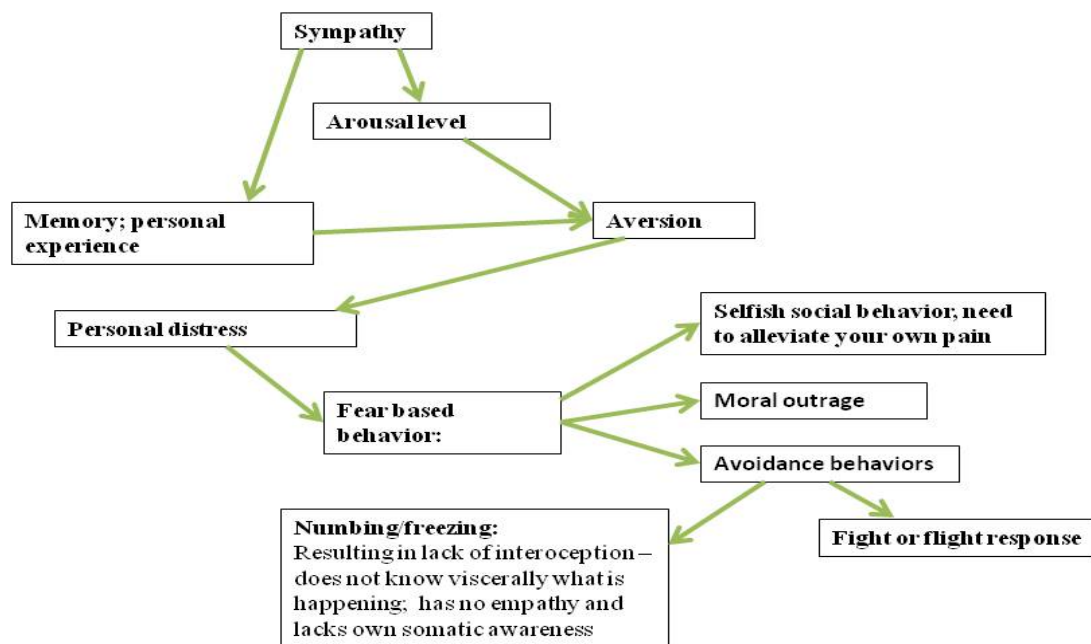
Dysfunctional reaction (in the absence of self-regulating components):

Figure 4: Dysfunctional reaction to distress in the absence of self-regulation. Adopted from Halifax's 2011 Modified Algorithm. Halifax, J.(2011). Inside compassion. Neuroscience

So what might be some protective factors against compassion fatigue? How does the caregiver who is more resilient perceive the same stress differently? Can we learn from them and develop the same qualities? Can learning these practices that build resilience transform distress and create a difference for future distress for the caregiver?

Resilience

Resilience is being able to competently function in spite of adversity (Cicchetti & Blender, 2006). Resilience is being able to bounce back or to recover quickly from a trauma. In his paper “Why Resilience” Ryan Santos (2015) discusses how in the process of dealing with disruptive events and trauma an individual can be left with more adaptive skills than before the

event took place (p. 3). Resilience is what makes it possible. Santos (2015), cited Higgins and Wolin's description of resilience is a "process of self-righting or growth"(p. 3) while in the face of adversity.

Given the same caregiving hardships and adversities, what makes some people better able to adjust and grow? A review of the research will show some of the qualities and coping skills these particular caregivers possess. The following studies and neuroscience research discuss the affect that adapting and changing in the face of distress can change our neural connections in a direction of more positive outcomes.

Studies on Resiliency

Looking at the research on cultivating resilience in caregiving, there are certain qualities that can be developed. Figley's manual on the symptoms of compassion fatigue outlines all the symptoms of "secondary stress, burnout, and compassion fatigue among caregivers" (as cited by Gentry, 2002, p. 11). In his dissertation on *Compassion Fatigue*, Gentry (2002) discusses this manual, and drawing from it, developed the *Certified Compassion Fatigue Specialist Training (CCFT)* program (p. 12). In the 17-hour training part of (*CCFT*), Gentry (2002) postulated that this program would be as effective as an intervention as well as a predictor of compassion fatigue (p. 13). In the course of this training, Gentry (2002) observed certain qualities of participants that might lead to "positive treatment outcomes and enhanced resiliency" (p. 14). He then came up with seven practices that would help when treating caregiver distress (Gentry, 2002).

Building Resilience

The seven practices of importance are:

1. Intentionality, which is the intentional acknowledgment of noticing feelings, making a connection

2. Anxiety management, not isolating oneself from support of colleagues and friends
3. Self-soothing, techniques, such as meditation, yoga, and exercise
4. Self-care, which can be linked to self-management, knowing when to take care of yourself, and knowing what will have a positive effect
5. Self-management, to the degree the caregiver is able to maintain (relaxed muscles)
6. Narration, many researchers believe that being able to tell your story, writing it down can give voice to it, and thereby ease the distressing feelings.
7. Reprocessing, looking at the situation differently (Gentry, 2002, p. 14)

In my own personal distress after the loss of my husband I found “narration” to be a turning point in my grief. When I started to put down how I felt on paper, I felt an emotional release. Gentry (2002) discusses the importance of “reprocessing” and “self management” in managing ones negative thoughts and distorted beliefs, and the importance of understanding what is really happening. In a mindful meditation practice, there is a way of looking at one’s situation from a non-judgmental way that can enable the caregiver to step back and reframe exactly what is actually happening. With these practices in mind I look to other studies that resonate.

Intention.

Potter et al. (2013) study on compassion fatigue and resiliency in oncology nurses, used the (*ProQOL*) IV scale and the “*Impact of Event Scale A, Revised (IES-R)*, the *Nursing Job Satisfaction Scale*” to measure the nurses resilience (para 5). The authors conducted a five-week program on “compassion fatigue resiliency”. The nurses were then re-evaluated using the

ProQOL IV scale again, and the results showed a decline in compassion fatigue scores. The subjects' scores continued to decline after six months of careful monitoring (Potter et al., 2013, para 5). The significance of this study lies in showing that “working by intention reduces reactivity in the workplace and makes communication more intentional and, therefore, effective” (Potter et al., 2013, para 9).

Narration.

Narration seemed to play a significant role in building resilience in a study done by Randall, Baldwin, McKenzie-Mohr, McKim and Furlong (2015). In comparing how older adults narrate their life, they recruited one hundred and sixteen older adults, and used “*the Connor Davidson Resilience Scale*” (Randall et al., 2015, p. 157). They conducted interviews with these participants that scored the highest on the questionnaire. The researchers found that it was not that resilient older adults didn't have adversity in their lives, but that they framed their experiences differently than the low scorers. In their narratives the high scorers presented themselves as survivors and showed the willingness to tell their stories. Randall et al. (2015) found that the low scorers had “negative or unresolved memories of their childhood” (p. 157). The authors also found that “they displayed a tendency to engage in obsessive more than integrative reminiscence” (p. 157). The study confirmed the need and “relevance for narrative care,” and the importance of a person in distress to tell his/her story (p.155).

The next four preventative strategies fall into a category of self-regulation. One of the theories of self-regulation is the “Hedonic Treadmill Theory.” The theory assumes that no matter what the emotional state we are in, we automatically adapt back to a neutral point. Germer (2009) explains that if one stays on the “hedonic treadmill too long, it can lead to

exhaustion and disease” (p. 13). The Hedonic Treadmill theory does not capture phenomena that seem to accompany compassion fatigue.

Internal Self-Regulation in Different Theoretical Perspectives

As our life situations get more stressful, our bodies “react to psychological threats the same way they react to physical threats, and a sense of constant danger raises our overall stress level” (Germer, 2009, p. 13), which in turn can lead to a host of both psychological as well as physical ailments. If the theory of constant neutrality (Hedonic Theory) to which an organism can revert back to a homeostatic state were accurate, then our emotions would also reset to a so-called neutral set-point. However, in the case of constant psychological stress, this is not the case. Among researchers that dispute this theory are Diener, Lucas and Scollon (2009).

Diener et al. (2009) suggested three revisions to the hedonic theory:

1. Non-neutral set points. People are happier than neutral and individual personality traits may predispose individuals to experience different levels of well-being.
2. Individual set-points may be due to genetically mediated personality traits.
3. Multiple set-points. A set-point is not a single entity, with a single baseline, but is based on separate well-being variables. These variables can move in different directions over time. Both positive and negative emotions might both decline in tandem or life satisfaction might move upward while positive emotions decrease. (pp. 306-307)

These points illustrate the fact that different people may experience different set points and that some of these set points may be more adaptive than others. The exact nature of a set point is likely under the influence of several complex variables but also is subject to change.

This also illustrates the argument that as a caregiver faces extreme distress over a period of time, the set point may change and reset downward toward chronic depression. However, it is also the possibility of change that makes therapeutic interventions possible. In another study negating the hedonic treadmill theory Mochon, Norton and Ariely (2007) concluded that small shifts in life changes have more lasting effects on a person's well being than sudden changes (p. 633).

Mochon et al. (2007) studied the use of exercise, yoga and religion to determine their effects on the well being of caregivers. They concluded that it is the cumulative effect of life changes that create lasting effects (Mochon et al., 2007, p. 633). They also found that it wasn't the amount and time spent, but the consistency of the activity that had a lasting effect on the subjects' well being (Mochon et al., 2007, p. 633). These studies give hope to those caregivers wanting to improve their own well-being.

In the book *Whole Person Self-Care: Self-Care from the Inside Out* (Kearney & Weininger, 2011), the authors propose yet a different way of looking at self-care. They stress not just looking at managing the stress in your life, but point to the need of connecting with the wholeness of self and workplace. The authors suggest that the most powerful medicine comes from within an individual...we are "the most powerful medicine we will ever give our patients" (Kearney & Weininger, 2011, p. 109). This mindset of taking care of oneself begins to influence the environment in which an individual works. An approach used in this study is mindfulness.

We can make our minds so like still water that beings gather about us, that they may see, it may be, their own images, and so live for a moment with a clearer, perhaps even with a fiercer life because of our quiet. (William Butler Yeats)

Mindfulness

The Buddha in his teachings gave us the four noble truths: there is pain, sickness, old age, and death. He explained that no one escapes these facts; however, there is a way out of suffering. The way out was to follow a path that he laid out, and one of the tools he described was mindfulness.

Mindfulness comes out of the Buddhist philosophy. Mindfulness or '*Sati*' in Pali denotes "awareness, attention, and remembering" (Siegel, Germer, & Olendzki, 2008, p. 3). Mindfulness has also been described as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment" (Kabat-Zinn, 2003, p. 145).

To test the hypothesis that mindfulness is useful in mitigating compassion fatigue, Decker, Brown, Ong, and Stiney-Ziskind (2015) conducted a study that included 111 masters level social work students. The average age of participants was 32 years, with 92.5% female. The authors used the Professional Quality of Life Scale (ProQOL) (Stamm, 2010) along with the Five Facets of Mindfulness Questionnaire (FFMQ), which are self-report questionnaires (pp. 34–35).

The results of Decker et al. (2015) revealed "a positive correlation between mindfulness and compassion fatigue, suggesting that mindfulness may be a protective factor for those in helping professions" (p. 36). The importance of these findings was even more significant given that the participants were young inexperienced caregivers. This group of caregivers was previously noted to be at higher risk for developing compassion fatigue (Decker, Brown, Ong, & Stiney-Ziskind, 2015, p. 36).

Compassion Satisfaction

Compassion satisfaction has been described as the pleasure one receives from working from helping others in need, the positive connections made with them along with a feeling of contributing to society's well being (Decker et al., 2015). If compassion fatigue is the negative consequence of caregiving, compassion satisfaction is then the positive effect that can come out of the same circumstance (p. 31). How can one create a situation of flourishing? How does one find compassion satisfaction in caregiving? Some suggestions on increasing compassion satisfaction include stress management, reflective practices, relaxation techniques, exercise, and self-forgiveness and compassion (Decker et al., 2015, pp.31-32). These practices can create positive feelings.

Positivity-Negativity Ratio

The positivity-negativity ratio is “the ratio of pleasant feelings (or positive affect) to unpleasant ones (or negative affect) over a given period of time” (Radey & Figley, 2007, p. 210). This ratio is an important tool for measuring compassion satisfaction. Along with compassion satisfaction this tool is also a good predictor if a person is flourishing. Radey & Figley (2007) looked at self-care, as having either a positive or negative effect in ratio to each other. They also examined the issue of compassion satisfaction in a population of clinicians, which builds upon Frederickson's “broaden-and-build theory” (as cited by Radey & Figley, 2007, p. 208). They looked at increasing a clinician's compassion satisfaction, which they believed would lead to a “sense of flourishing” (p. 208). The study suggested three positive attributes, which were described as: feeling grateful, an upbeat disposition, and expressing appreciation. In contrast, the negative attributes were: feeling contemptuous, an irritable disposition, and expressing

disdain (Radey & Figley, 2007). The study concluded that there needed to be a “3 positive to 1 negative attribute ratio” to flourish (Radey, Figley, 2007, p. 210).

This model suggests three “interrelated” steps in achieving a favorable positivity-negativity ratio: The first step is to increase affect by “keeping a positive attitude;” the second step is to increase “resources to manage stress, including compassion stress”(Radey & Figley, 2007, p. 210) (Figure 5). The third step in this model is self-care that might not only include exercise and yoga but also inspirational practices that enhance happiness in life (Radey & Figley, 2007, p. 210) (Figure 5). The favorable positivity/negativity ratio will lead to compassion satisfaction while a failure to achieve it will lead to compassion fatigue.

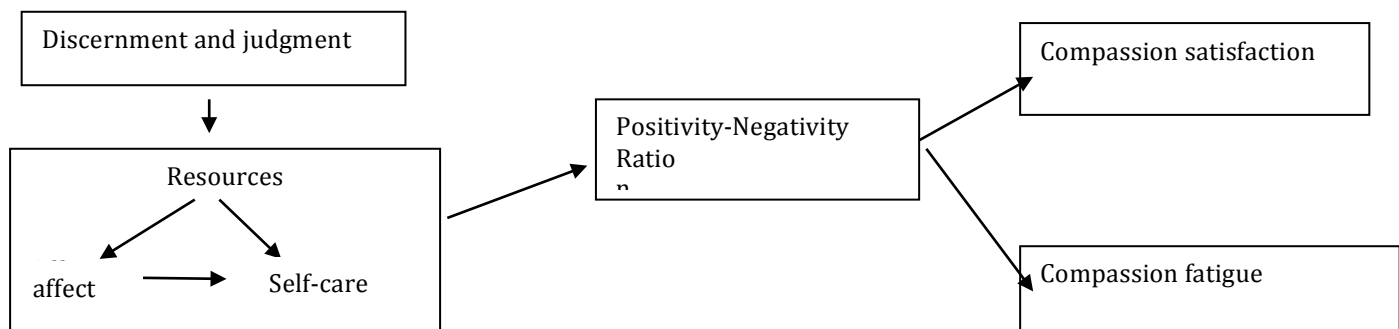


Figure 5: Radey and Figley (2007) model for compassion satisfaction/compassion fatigue, positivity/negativity ratio. Radey, M., Figley, C.R. (2007). The social psychology of compassion. *Clinical Social Work Journal*. 35:207-214.

Diehl, Hay, and Berg (2011) conducted another study on the ratio “between positive and negative affect and flourishing mental health across adulthood” (p. 10). The authors wanted to test the hypothesis of whether age differences and psychological issues were affected by the critical 2.9 to 1 ratio “critical value” (p. 10) (the ratios tend to vary across studies). They confirmed that healthy mental status was more than the absence of mental illness (Diehl et al., 2011, p. 10). The authors suggested that mental health should be put on a continuum that included: “flourishing, moderately mentally healthy, and languishing states” (p. 10), and that a

state of well being below a ratio of 2.9 to 1, was in the languishing state (Diehl et al., 2011, p. 10). In addition, the authors' concluded that, "the positivity-negativity ratio differed with age such that younger adults had the lowest mean positivity-negativity ratios" (Diehl et al., 2011, p. 10).

If compassion satisfaction is so crucial to the state of well-being, can compassion training raise the positivity ratio? Can a person be trained to have more compassion? The research reviewed below suggests that in fact this is an attainable goal.

Before you know kindness as the deepest thing inside,

You must know sorrow as the other deepest thing.

You must wake up with sorrow.

You must speak to it till your voice

Catches the thread of all sorrows

And you see the size of the cloth.

Then it is only kindness that makes sense anymore,

Only kindness that raises its head

From the crowd of the world to say

It is I you have been looking for, (Naomi Shilab Nye)

Compassion, Self-Compassion, Self-Regulation and Mindfulness

Halifax (2011) reflected on this issue by quoting Buddha, 'Compassion is not part of mindfulness training, it is mindfulness training' (p. 5). This paper proposes that if self-compassion and mindfulness enhance compassion, then in turn it may lead to a greater sense of well-being. An example of this can be seen in the following article on palliative caregiving.

In the *Journal of Palliative Medicine*, Roger Cole (1997) wrote how his practice of mindfulness and meditation has enhanced his life, along with finding more compassion in his caregiving. He believes that regular meditation is a way to “balance introversion, self-awareness and surrender with responsiveness to the suffering of others” (p. 411). Cole (1997) believes meditation is a “practical tool for self-management” (p. 411). He also explained that the practice of meditation brings inner peace. This inner peace is not only a form of self-regulation, but can also bring a peaceful presence into our caregiving (p. 411).

Mindfulness and Self-Regulation

Another important aspect of mindfulness is self-regulation. Self-regulation, or emotional regulation, is important in being able to bounce back from emotional distress. Mindfulness, more than the behavioral approach of reframing the distressful situation, has been shown to be a more effective regulation strategy (Murakami, et al., 2014, p. 1).

The importance of self-regulation cannot be underestimated: without self-regulation, a caregiver’s distress can spiral into complete freeze mode (Halifax, 2011, see Figure 4). When in a freeze mode, people experience a lack of interoception where there is no visceral feeling in the body. As a consequence, the caregiver goes into empathic distress and lacks empathy.

Mindfulness, Interoception, and Proprioception

Mindfulness tools that ease distress were examined in a study by Kogler, Jurgen, Monika, Domenico and Johannes (2013): they employed a questionnaire to determine the types of practices that were helpful. The authors found two main categories of practices that were helpful in easing distress: social support, and self-regulation (Kogler et al., 2013). Practices offered by mindfulness were helpful because of their focus on the present and positive outlook toward the

future: the participants felt that these practices helped with self-regulation. Mindfulness was also found to be useful in eliminating rumination of negative thoughts (Kogler et al., 2013).

Ruminating on negative thoughts can be felt in the body. Mindfulness helps cultivate an enhanced awareness of how we are feeling both internally and externally. Having this awareness enhances our ability to self-regulate in times of distress. Empathic distress and/or compassion fatigue can leave the caregiver in a state of panic, or over-arousal with exaggerated physical symptoms (Mehling et al., 2012, p. 1). Mindfulness of the body brings attention to the physiological body, which includes proprioceptive and interoceptive awareness (p. 2).

Proprioceptive awareness is knowing where your body is in space. It “refers to the conscious perception of joint angles and muscle tension, of movement, posture, and balance” (Mehling et al., 2012, p.3). Interoceptive awareness is the perception of internal sensations of the body. It is the awareness of the heart beating, “respiration, satiety, and the autonomic nervous system sensations related to emotions” (p. 3). Having a non-judgmental awareness of these sensations, as an effect of mindfulness practices, is what can help the caregiver self-regulate in times of distress.

In a study conducted by Mehling et al. (2012), the authors discuss a need to look at a more “multidimensional view of body awareness” (p. 3) which discriminates between “thinking about physical symptoms (interpreting, appraising, and eventually ruminating with fearful hyper-vigilance) and a state of perceptual presence within the body, often labeled as mindfulness” (p. 3). This ability to observe the emotional reaction felt in the body in a non-judgmental way can bring about a whole new awareness and understanding of what is really happening.

Using what they called “The Multidimensional Assessment of Interoceptive Awareness (MAIA),” Mehling et al. (2012) used yoga, tai chi, Feldenkrais, mindful meditation, Alexander

technique, breath therapy and massage to determine their usefulness (p. 1). In studying novice and experienced practitioners, they concluded that, "... mere awareness of how body sensations correspond to emotional states, without the ability to use awareness of those sensations to reduce distress, could increase anxiety" (Mehing, et al., 2012, p. 26). In a mindful yoga practice there is an opportunity to work on these sensations felt in the body to reduce anxiety. The body can be used as a grounding mechanism through the standing postures to help soothe the agitation of anxiety.

Self-Compassion

There is research that is linking mindfulness and self-compassion with a greater sense of well-being (Barnar & Curry, 2011). Kristen Neff has defined self-compassion as showing ourselves the same compassion we would show a friend (as cited by Barnard & Curry, 2011, p. 1). It is "a basic kindness, with a deep awareness of the suffering of oneself and others" (Germer & Gilbert, 2009, p. xiii).

Germer (2009) in his book *The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions*, describes the three constructs that make up self-compassion: Self-kindness, common humanity and mindfulness. He then describes each one and contrasts it with its opposite. Self-kindness is defined as treating oneself with care and understanding, not with harsh judgment. Common humanity is understood as seeing one's own experience as part of a larger human experience and understanding that life is imperfect rather than isolating oneself and thinking you are alone. Mindfulness is defined as allowing one to "be" with painful experiences as they are, and turning towards suffering in a non-judgmental balanced way rather than over-identifying with the suffering (Germer, 2009, p. 37).

Self-compassion can increase a person's resilience to self-criticism, isolation and rumination (Banard & Curry, 2011; Decker et al., 2015; Raab, 2014). For example, Raab (2014) found that "to counter self-criticism and shame, self-compassion interventions encourage qualities that reduce negative thoughts" (Raab, 2014, p. 98). He discusses research that was done by Gustin and Wagner (2013) in their work with self-compassion (Raab, 2014, p. 98).

Butterfly effect.

Andy Andrews' (2009) book *The Butterfly Effect: How your Life Matters*, explains how this effect has become *The Law of Sensitive Dependence Upon Initial Conditions* (p. 1). This law states that when a butterfly flaps its wings in one part of the country, it affects another part of the country (p. 8). Andrews states that "this principle has proven to be a force encompassing more than mere butterfly wings" (p. 8). Rabb (2014) examined Gustin and Wagner's "butterfly effect of caring" (p. 99), whereby they wanted to understand the relationship between self-compassion and empathy as a practice towards compassionate care (p. 99). Using the "Theory of Human Caring" the authors examined the five processes involved:

1. Cultivating loving kindness and equanimity towards self
2. Cultivating the same loving kindness towards others
3. Being authentically present, cultivation of one's own spiritual practice,
4. Developing and sustaining a helping-trusting caring relationship,
5. Being present and supportive of positive and negative feeling" (Rabb, 2014, p. 98).

There was a direct relationship between the "caregiver's responsive connection to the suffering other and self-compassion and the ability to care for oneself" (cited by Rabb, 2014, p.99).

Self-regulation and neuroplasticity.

One of the issues in compassion fatigue is not being able to self-regulate. Lutz et al. (2008), Klimecki et al. (2013), Fox et al. (2013) conducted brain imaging (fMRI) studies showing that the “the voluntary generation of compassion” and self-compassion effect our internal regulatory responses which can be trained and that this training can have lasting neurological effects (Fox et al., 2013, p. 3).

To test the hypothesis that compassion can actually be trained, Fox et al. (2013) used compassion meditation as a tool to increase both compassion for others and self, while instructing the subjects to play a game of “dictator” and “victim” (p. 1). The “dictator” had all the wealth and the “victims” were treated poorly and not compensated fairly. The authors found that in the compassion group, as opposed to the cognitive group, there was a more altruistic willingness “to help someone who was treated unfairly” (Fox et al., 2013, p.3). As the compassion group became “more sensitive to other people’s suffering, they learned to regulate their emotions” (Fox et al., 2013, p. 3).

In another study in which the participants were instructed in compassion meditation, Weng et al. (2013) found “compassion training also increased activity in both the inferior parietal cortex, and dorsolateral prefrontal cortex: these two brain regions are involved in emotion regulation and positive emotions” (p. 1). These studies confirmed that short-term compassion training leads to “changes in neural responses to suffering, along with increasing altruistic behavior” (Weng et al., 2013, p. 1).

One of the leading researchers in the field of neural plasticity is Tania Singer. Klimecki, Leiberg, Ricard and Singer (2013) conducted studies on brain plasticity using compassion and empathy training. In their 2013 study on the positive effect of compassion training, they used

disturbing videos to create distress among the participants. They concluded that, “deliberate cultivation of compassion offers a new coping strategy that fosters positive affect even when confronted with the distress of others” (Klimecki et al. 2013, p. 1). Knowing that empathy is an important quality to have when caring for others, Klimecki et al., (2013) wanted to test compassion and empathy training on a French Tibetan monk named Matthieu Ricard. In this test, Ricard and a group of novices were trained in empathy and then were instructed in a compassion meditation (p. 1).

The areas of the brain that were negatively affected by distressing videos were the “anterior insula and anterior mid-cingulate cortex, which are the areas associated with empathy for pain” (Klimecki et al., 2013, p. 13). Even though empathy is an important quality for the caregiver, intense sharing of the other’s pain without the ability to self-regulate can cause empathic distress and decreased helping behavior (Klimecki et al., 2013, p.13). Importantly, when participants were given compassion training, it reversed the negative effects. Thus, the authors concluded that training in compassion could be a new coping practice that would decrease “empathic distress and strengthen resilience” (Klimecki et al., 2013, p. 13).

The sun has entered me. The sun has entered me together with the cloud and the river. I myself have entered the sun with the cloud and the river. There has not been a moment when we do not interpenetrate. (Thich Nhat Hanh)

Common Humanity and Connectedness

Common humanity concept proposes that we are not alone in our suffering (Germer, 2009). It is the ability of the caregiver to not feel isolated or alone in their distress. As compassionate caregivers want to do everything possible for their patient or loved one, the

outcome is sometimes not what is planned. “The main threat to the happiness of caregivers is attachment to the outcome of their labor” (Germer, 2009, p. 196). Thich Nhat Hanh (1998) describes in his book *Interbeing* how we are all connected. He explains that it is in our interconnectedness that we share in each other’s joys and sorrows and that how we treat ourselves affects the whole of humanity (Thich Nhat Hanh, 1998, p. 1). This was also concluded in Raab’s (2014) study on “butterfly effect on caring” that caring for oneself has a direct effect on caring for another (p. 1).

Gustin and Wagner (2012) conducted a study of clinical nursing teachers. They met with the nurses for twelve hours to understand the nurses’ comprehension of compassion in the context of caregiving. Gustin and Wagner (2012) wanted to address the idea of “interdependency” in health care (p. 1). What they found was that the “development of a compassionate self and the ability to be sensitive, non-judgmental and respectful towards oneself, contributes to a compassionate approach towards others” (p. 1). They concluded that

Compassionate care was not only something the caregiver does, but is a way of becoming and belonging together with another person. It is where both are mutually engaged and where the caregiver compassionately is able to acknowledge both self and ‘other’s’ vulnerability and dignity. (Gustin & Wagner, 2012, p. 1)

If a compassionate caregiver is able to radiate his/her warmth towards their patient, then there exists this shared connection felt by both clinician and patient.

Hospice and Mindfulness

The caregivers of hospice are encouraged to become a compassionate healing presence for their patients. “While suffering may be inevitable in a modern society that fears death, it is also a source of compassion for those who work within its shadow” (John, 2004, p. 14). Miller

(2001), in his book *The Art of Being a Healing Presence*, tells us that in order to become a healing presence, one needs to be really present to yourself. One begins to notice the relationship between you and your patient. When one is completely present, one stays awake to each unfolding moment (Miller, 2001, p. 15).

Common Humanity, Mindfulness, and End-of-life care

Common humanity is the feeling that one is not alone in one's distress. Mindfulness is the non-judgmental awareness of knowing one is not alone in their distress. Mindfulness may be an opportunity to view end-of-life care in a different way. Providing end of life care can take its toll on the caregiver. Watching life slip away over and over again has its consequences. Thus, it may seem odd to observe, based on both my research and personal experience, that end-of-life caregivers and hospice volunteers seem to have more compassion satisfaction in their work than their counterparts in other fields of caregiving.

What do some palliative care professionals do for self-care? Bruce and Davies (2014) conducted a study with hospice caregivers using mindful meditation at a Zen hospice facility. What they found was that an awareness of openness increased the more the caregivers meditated. They described this openness as a space that allowed the meditators/hospice caregivers to develop an acceptance for what was happening; this acceptance created a sense of calm between the patient and the caregiver (Bruce & Davies, 2014, p. 1).

Common humanity, and interconnectedness in end of life care.

Breiddal (2011) looking at research with palliative caregivers and the reasons why some thrive discovered some important qualities they possess. She describes strategies that might help the caregiver in “cultivating a sense of empowerment and growth, while at the same time

assisting them to better care for their clients” (p. 1). She concludes that “when self-care is a way of being rather than doing, the environment becomes one where growth is possible and palliative caregiving and receiving become one” (Breiddal, 2011, p. 1).

In hospice work one can see the interplay of common humanity and interconnectedness. The caregivers go into this work knowing the outcome and share in the end journey of their patients. My own personal experience after working in hospice has been one of interconnectedness and compassion satisfaction, as one works alongside another person bearing witness to their final journey. In asking co-workers how they feel about what they do, they all seem to respond similarly, saying, “it has changed my life, I look at life differently now, and I receive more than I give” (personal communications, June, 2015).

Summary

In summary, the research has shown that while caregiver distress such as compassion fatigue/empathic distress is widespread not only in the professional caregiver but also in the general public, there are therapeutic practices available to help mitigate the symptoms of this distress. For the professional caregivers, a test to evaluate if they have compassion fatigue/empathic distress or complete burn/out is available. Researchers such as Halifax (2011), Thomas (2011), and Germer (2011) have shown how effective self-care such as mindfulness, exercise, and yoga, along with proper emotional separation have led to self-regulation, enhanced compassion, and compassion satisfaction. Germer (2011) and Neff’s (2003a) research has also shown that mindfulness practices such as self-compassion can be measured. They also point out how an increase in a caregivers’ sense of self-compassion increases their resilience .

We must hold ourselves open to the truth as the flower holds

Itself open to the sun (Sangharakshita, 1999).

In mindfulness training one begins to look at life differently, and reframe distress in a way that is not so disturbing. When in distress, as Germer (2009) points out, we can sometimes “find ourselves in the crowd of thoughts and feelings that swirl in our heads” (p. 37). Meditation allows one the opportunity to stand back and take stock of oneself and to just observe with non-judgmental awareness. Mindfulness training allows one the space to be with another’s suffering, and also the space to separate one’s own feelings from that of their patient’s. Being compassionate with yourself is an effective balm for all the names you call your distress, compassion fatigue, empathic distress, vicarious distress, PTSD. In his book *Being Mindful, Easing Suffering: Reflections on Palliative Care*, Christopher Johns (2004) explains that “The idea that suffering and caring are opportunities for growth, to care for another person in the most significant sense, is to help him/her grow and actualize him/her self” (p. 15).

The importance of self-care is obvious but not easy. As a caregiver, taking care of yourself is reflected in the type of care you give to your patient, parent, child, friend, or spouse. As John (2004) in his work with hospice states, “It is who you are as a person, your feelings, frustrations, concerns and compassion that dominate the way you see and respond to the world,” and this in turn “determines how effective a practitioner you will be” (p. 7).

From the evidence of the effectiveness of mindfulness, self-compassion, and yoga, I will introduce a course using these practices in the mitigation of compassion fatigue/empathic distress. The first foundation of mindfulness is the body and breath. The mindful practice of yoga teaches awareness of the body where, through movement, tension is released. In my own practice and working with distressed individuals, I have found mindfulness and yoga practiced together to be of great benefit.

I was fortunate to have had the opportunity this past year to work as an intern in a hospice facility. I was also given the opportunity to put together a workshop for caregivers on compassion fatigue. From this experience and from the feedback of the participants in my classes, I have been compelled to come up with an eight-week program. I started with a one-hour workshop and realized there was just too much information to cover in that hour. For the participants that had never experienced any mindfulness practices, it was overwhelming with too many questions to be answered in one workshop. I realized I needed to break down the workshop into segments teaching different practices and allowing the participants to experience the practice at a more reasonable pace. When teaching this material in a series of eight classes – making time for reflection and questions -- the response was more positive. After working with two different groups of caregivers, the needs of the family caregiver became clear to me. This particular group had less services than the professional group did. I recommend these classes for anyone who may find himself or herself in the role of caring for a loved one, friend, or stranger.

Since the inception of this work on compassion fatigue, I have received many requests and inquiries to teach this workshop in different health care facilities. Knowing that so many of us will be put in a position of caregiving, I believe that this work is important in today's world. The pain of bearing witness to suffering will never be eliminated. However, we can be prepared in a way that eases the distress.

Introduction to the Syllabus

The following Syllabus is an eight-week session using practices that have been shown to be of benefit in distressed individuals. While the program is for anyone who feels they need such a program, I have taught this program in settings where there were both professional caregivers and family members caring for a child, or family member.

After teaching this Curriculum to various caregiver groups, many of the participants asked for recommended readings. Included in this Curriculum are optional readings. I have included mindfulness readings, self-compassion readings, and some studies pertaining to self-care, yoga, and compassion fatigue. The yoga postures selected for this practice were chosen with every body type and ability in mind. The use of yoga props and chairs are used to help facilitate and aid with the yoga postures.

SYLLABUS

COMPASSION FATIGUE AND MINDFUL WAYS OF SELF-CARE

INSTRUCTOR: Elaine Loiacono
E-mail: elaine.R.loiacono@gmail.com

COURSE DESCRIPTION:

This eight-week course meets for two hours each week. The course uses mindfulness, self-compassion, and yoga, as self-care practices in the hopes of mitigating Compassion Fatigue among caregivers.

COURSE OBJECTIVES:

1. Explore and understand the effective relationship between mindfulness, yoga, and self-compassion as self-care practices.
2. Understand the types of distress caregivers face, the warning signs, symptoms, and when to get help.
3. Understand healthy responses to caregiving, such as, proper boundaries in respecting the patient or loved one, while protecting oneself.
4. Explore the self-care practices that might help protect a caregiver.
5. Be able to assimilate mindfulness practices into their day-to-day lives.

PEDAGOGICAL APPROACH:

The class will employ various methods, including: lecture, video, discussion, experiential exercises, and feedback.

REQUIRED READINGS and HOMEWORK:

- Instructor handouts
- Yoga stretches
- Studies
- Video: Joan Halifax (2011) *Care Giving Edge States*

OPTIONAL READINGS:

Germer, C.K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York, NY: Guilford Press.

- Goldstein, J. (2013). *Mindfulness: A practical guide to awakening*. Boulder, Co: Sounds True.
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- Rothschild, B. (2006). *Help for the helper – Self-care strategies for managing burnout and stress*. New York: W.W. Norton & Company.
- Tang, Y. et al. (2009). Central and autonomic system interaction is altered by short-term meditation. *PMCID*. 106(22): 8865-8870. doi: 10.1073/pnas.0904031106

COURSE SCHEDULE AND ASSIGNMENTS:

Class #1

Objectives: To understand what a caregiver is, the distress: definitions, and warning signs of caregiver distress.

Introductions

Opening -take a moment to notice your breathing pattern.

- Syllabus overview
- Define caregiver distress-compassion fatigue vs. empathic distress, and burn/out
 1. Warning signs
 2. Self-test on Compassion Fatigue
- Define what a caregiver is – Professional, family member, friend
- Self-care exercise
 1. Letting go – exercise
 2. Chair/standing yoga stretches – taking burden off shoulders

Closing meditation

- Assignment:
 1. Find time each day for a meditation break to find your breath
 2. Read handouts and take Human Service survey

Class #2

Objectives: To understand mindfulness as paying attention in a nonjudgmental way -- intention, attention and awareness -- and how to use the body as a vehicle of mindful awareness to ease distress.

Opening – take a moment to notice your breathing pattern.

- Poem – Guest House – (Rumi)
- Mindfulness – definition
- The cultivation of mindfulness:
 1. Intention
 2. Attention
 3. Awareness
- Mindfulness of Body and Breath utilizing -- intention, attention and awareness
 1. Using the body in yoga postures – has a grounding effect on emotions
- Questions and answers

Closing meditation

- Assignment:
 1. Take home self-test on: How mindful are you?
 2. Practice 15 minutes of meditation each day.
 3. When possible practice yoga postures in hand-out

Class #3

Objectives: To understand the triangle of awareness in Mindfulness: how to use this awareness in the practice of yoga, and why it is important.

Opening – A mindful moment of attending to your breath

- Poem – Befriending ourselves – (Pema Chodron)
- Triangle of awareness –explain
 1. Emotions
 2. Body sensations
 3. Thoughts
- Using the triangle of awareness in a 15 minutes meditation
- Yoga postures – using the triangle of awareness.
 1. Talk on the domain of the body and body sensations along with the breath is known as the 1st foundation of mindfulness.
 2. Why, all emotions, all thoughts, all behavior have a substrata of physical Sensation.
 3. Explain why this is important.
- Questions and answers

Closing meditation

- Assignment:
 1. Read handouts: yoga postures, readings
 2. Meditate 15 minutes per day

Class #4

Objectives: Understand the two wings of awareness: our interconnectedness, and the importance for compassion

Opening a mindful moment

- Story of Indra's net - Interconnectedness
- How mindfulness cultivates compassion
- Describe the two wings of awareness: Mindfulness and Love
- Yoga stretches
- Questions and answers

Closing meditation

- Assignment:
 1. Read handouts
 2. Practice yoga postures
 3. Meditate 15 minutes per day

Class #5

Objectives: Understand Self-Compassion: Its three constructs and be able to practice self-compassion in meditation and yoga practice.

Opening five minute mindful moment

- Poem – St. Frances and the Sow
- Mindful self-compassion explained – Three constructs of self-compassion
 1. Self-kindness
 2. Common Humanity
 3. Mindfulness
- Self-compassion meditation for caregivers
- Yoga postures to open the heart

Closing moment of quiet to assimilate the yoga practice, meditation

- Questions and answers
- Introduce assigned reading
- Assignment:
 1. Read handouts:
 - Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 285-101.
 2. Yoga postures
 3. Meditate 15 minutes per day

Class #6

Objectives: Understand what the Positivity Ratio is: test whether you are thriving or languishing, and learn practices to cultivate thriving.

Opening meditation

- Poem – Tibetan saying – “letting ourselves be at the mercy of our thoughts”
- Questionnaire: Positivity Ratio test, are you thriving or languishing?
- Discuss questionnaire
 - Explain - creating a mindset of positivity, resiliency, optimism and compassion satisfaction, in caregiving.
- Group self-compassion exercise – in two’s –then discuss results

Closing meditation

- Assignment:
 1. Read handouts – Ratio Between Positive and Negative Affect
 2. Yoga stretches
 3. Meditate 15 minutes per day

Class #7

Objectives: To be able to construct a practice of self-care: utilize meditation and yoga in a daily routine.

Opening meditation

- Poem – words of wisdom – “Your action become your habits”- Gandhi
- Yoga stretches
- Self-Care, discussion and reflection on practices previously discussed
Yoga Stretches – mindful breathing

Closing meditation

- Assignment:
 1. Yoga stretches
 2. Meditate 15 minutes per day

Class #8

Objectives: Understand the importance of knowing when the caregiver needs help: view film and ask questions of concern.

Opening meditation

- Poem – words of wisdom – “Expanding our circle of concern” – Darwin
- Yoga stretches
- Watch video – Joan Halifax “Edge States” in caregiving
- Questions and answers
- Closing remarks

Closing meditation

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