Clin Soc Work J (2017) 45:10–21
DOI 10.1007/s10615-016-0582-5

ORIGINAL PAPER

The Presence of Compassion in Therapy

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Published online: 13 February 2016

Abstract The article examines the uniqueness of compassion as a healing element in current therapeutic processes. It aims to distinguish compassion from concepts such as pity, consolation, sympathy, and empathy, which have been attributed to it in the past. Despite their linkage, the emotional component in compassion is perceived as dominant in contrast to the applied cognitive ingredient in empathy. The essence of compassion in this article has been examined along three major directions: the definitions of compassion in therapy, in a concrete and applicable manner; the perception of compassion as an intersubjective concept of therapist–client relationships, and the absence of compassion components from therapeutic relationships, known as a "compassion fatigue" process, and its implications. The implementation of compassion in therapy is illustrated through two case studies, each from a different life stage—a male in his seventies and a young woman in her thirties—each being treated according to a different theoretical approach: narrative and psychosocial. The essential presence of compassion and self-compassion in the fabric of the therapeutic relationship, as reflected in both illustrations, turns a spotlight onto the innovative dynamics of therapist–client relationships. The reciprocal component that evolves produces legitimacy to experience self-compassion, and the discovery of compassion on the part of the therapist enables the client to develop self-compassion.

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Keywords Compassion · Self-compassion · Compassion fatigue · Therapeutic relationships

Introduction

"Our sorrows and wounds are healed only when we touch them with compassion." Buddha.

Compassion is an ancient concept. The word derives from the Latin word "compati," which means "suffer with," in other words, the compassionate person participates in the suffering of the other—the object of compassion (Cohen, in Sagi 2010). Compassion is an important religious motif, and appears in the sacred texts of Judaism, Christianity, and Islam, as well as in Eastern belief systems such as Buddhism.

The concept of compassion has resonated through philosophical discussions of previous centuries, in the works of Spinoza, Kant, Schopenhauer, and others, giving rise to a number of questions, such as the following: Is there a connection between compassion and pity; compassion and empathy; compassion and ethics? Is the source of compassion either emotional or cognitive? Is compassion expressed only in relation to the other, or can it involve the individual's attitude to the self? What is the nature of the relationship between the compassionate individual and his/her object? We will discuss these questions later on in the article.

Compassion is not a new concept in the therapeutic context. Nonetheless, its place in professional psychotherapy literature is unclear (Singer and Lamm 2009; Clark 2010; Gerdes 2011; Geller 2006) and it has been shunted to the sidelines. We believe that one reason for this is the tendency to equate compassion with other concepts such as pity, consolation, and sympathy. The lack of distinction

between compassion and pity undermines the essence of compassion, which is based on the perception that suffering is the lot of all of humanity. The recognition of this egalitarian element is related to the way in which the compassionate individual perceives the object of the compassion. Adversely, pity contains elements of judgment and blame toward its object, expressed through patronization (Gerdes 2011; Geller 2006).

When discussing compassion in therapy, we cannot ignore the fact that therapeutic relationships are non-egalitarian by nature, because of the lack of equality between the therapist's and client's roles. Nevertheless, both ethically and practically, there is no place in the therapeutic relationship for the therapist to either patronize or pity the client. (We will elaborate on this issue later on.) Two additional concepts included in the range of interpersonal relationships—sympathy and consolation—are not necessarily present in the professional therapeutic jargon (Gerdes 2011).

Hepworth and Larsen (1990, p. 192) recommended that novice therapists, who lack experience and professional tools, should avoid overuse of sympathy and consolation, as these might, to some extent, reduce the client's motivation for change, and simultaneously damage the therapist's credibility in the eyes of the client.

In this article, we will examine the uniqueness of compassion as a healing component in therapeutic work. We will observe the causes that have led compassion, as a concept, to be shunted to the margins, and to the factors that have restored compassion to its rightful place in theory and in practice. In addition, we will explore the perceptions of compassion, self-compassion, and compassion fatigue, and how these three concepts are linked in the current era. We will also examine the extent to which the destructive implications of compassion fatigue for therapists and their therapeutic work increases the importance of compassion and self-compassion in therapy.

We will examine and illustrate these concepts by presenting two therapeutic cases, which emphasize the place of compassion and self-compassion in the therapeutic context. In Case no. 1, we will describe a therapy administered according to the narrative approach, in which the compassionate and containing therapist assists the client to develop self-compassion, enabling him to connect to his experience of mourning and to attain new meaning in his current stage of life. In Case no. 2, we will illustrate a therapy administered according to the psychosocial approach, in which the therapist has difficulty feeling compassionate and containing toward the client and is on the verge of compassion fatigue. Thanks to the presence of compassion in the supervision, he is able to develop insights into his situation and to develop self-compassion and subsequently compassion for the client.

Compassion in Therapy in the Professional Literature and Its Implementation in Practice

In recent years, compassion has become more visible in the therapeutic context, thanks to current constructivist perceptions, which are undermining sacred cows. One of the prominent messages of these essentially pluralistic perceptions is that there is no single truth, but that many and varied truths exist. These post-modern perceptions developed in parallel to disciplines such as philosophy, philology, psychology, social work, sociology, anthropology, and physiology. The pluralistic approach allowed the therapeutic field to rely on Buddhist philosophy, in which compassion toward the other and the self is highly prominent.

Postmodern philosophies drawing on Foucault, Derida, and Wittgenstein have had a tremendous influence on present-day therapists, including narrative therapists such as White, Epston, De Shazer, Freedman, and Combs (De Shazer 1994; Freedman and Combs 1996; White and Epston 1990). Later in this article, we will expand on the narrative view and in the first case study, will present a narrative therapy interweaved with compassion and self-compassion.

The current literature review regarding the concept of compassion in the therapeutic professions, such as psychology, social work, and psychiatry, indicates three main directions: definitions of compassion and compassion in therapy, compassion in therapist–client relationships, and compassion fatigue, discussing the following aspects: (a) Attempting to define compassion in therapy, out of a tendency to characterize compassion as a tangible and concrete concept (Elizur 2006; Eshel 2009; Cosley et al. 2010); (b) Turning the spotlight onto compassion in the intersubjective sense, as a meaningful element in therapeutic relationships, regarding a range of aspects: compassion toward the client (Eshel 2009), the client's self-compassion (Barkan 2010), and the therapist imparting tools to the client for the development of self-compassion (Gilbert 2010; Neff 2003a), and (c) Identifying therapeutic situations in which compassion is absent, originating in compassion fatigue. If not treated, this might lead to burnout in the therapist (Figley 2002a, b; Radey and Figley 2007).

Definitions and Perceptions: Compassion and Compassion in Therapy

Several prominent components that constitute a connecting thread in the written definitions of the concept of compassion can be identified in philosophical works and the professional literature in the therapeutic field: (a) "The

awareness of the suffering of others"… connection to the suffering other, when "our heart goes out to" those who touch us, the willingness to assist the sufferer, the development of sensitivity to one's own and others' suffering (The Dalai Lama, according to Buddhism, in Gilbert 2010; Lazarus 1991; Goetz et al. 2010). Dutton et al. (2006) and Miller (2007) see the discernment of the client's suffering as one of the main measures of compassion. (b) Empathetic understanding of another person's situation (Piper, in Sagi 2012, p. 21) and expressing empathy toward the client's pain (Dutton et al. 2006; Miller 2007). (c) Identification with the suffering of others (Gilbert 2010). (d) Engagement in action: through identification with others' suffering, one mobilizes to act for their well-being (Piper, in Sagi 2012, p. 21). (e) An additional main measure of compassion is the action taken to relieve the client's suffering (Dutton et al. 2006; Miller 2007).

The three main measures of compassion—discerning the client's suffering, empathizing with the client's pain, and taking action to relieve the client's suffering—and the cognitive, emotional, and applicable components of compassion—are expressed in the definitions of compassion in the therapeutic world, with variable emphases.

Compassion is perceived as an emotional element that motivates action for the physical and mental well-being of vulnerable others in distress. In addition, it enables the development and strengthening of this close relationship (Cosley et al. 2010).

> Compassion is not a sharing of another person's emotional state…but an emotion of its own… In compassion, the emotion is felt and shaped… by feeling personal distress at the suffering of another and wanting to ameliorate it. The core relational theme for compassion, therefore, is being moved by another's suffering and wanting to help (Lazarus 1991, p. 289).

Compassion is also associated with feelings of condolence, pity, sympathy, empathy and commiseration all of which are synonymous with one another and are connected to altruism (Radey and Figley 2007; Schantz 2007; Gerdes 2011).

It is conspicuous from these writings that compassion was previously perceived as associated with pity. The absence of a distinction between these two concepts led to a certain confusion in relating to the concept of compassion in the therapeutic language. This issue was discussed in the philosophy field by Kant and his followers, who did not distinguish between compassion and pity. Kant assumed that compassion/pity create hierarchical rather than egalitarian relationships (Sagi 2010).

In his writings, Nietzsche (1895/1954) changed the noble attitude to "pity" that had been accepted up to that time. He perceived this emotion to evoke negative judgment toward those to which the pity was directed, "Pity makes suffering contagious" ("pitiful"), p. 572. It seems reasonable to assume that this stance contributes to the separation between "pity" and "compassion."

The concept of compassion today is influenced by postmodern and Buddhist perceptions, which recognize that all human beings are exposed to the same possibilities of suffering (Gilbert 2010). From this point of view, the difference between compassion and pity can be identified, when compassion involves participation in suffering and the wish to assist, whereas pity involves the wish to release the self from the others' suffering for the sake of self-protection. Pity is accompanied by negative judgment and by holding the sufferers responsible for their situation. Compassion, however, involves the determination to assist the sufferer patiently and tolerantly for as long as necessary (Zweig, in Sagi 2012).

In the psychotherapy field, this issue was researched by Geller (2006), who examined therapists' stances toward the concept of pity and found that they perceived it as a negative emotion. This perception of pity is in keeping with the approach among the general population. Gerdes (2011) took a similar stance, perceiving therapists' expressions of pity toward clients as destructive. Neff (2003a, b), who explored psychological functioning and its connection to the concept of compassion and self-compassion, indicates an essential difference between pity and compassion. The sense of pity toward another is characterized by extreme isolation and distancing: ("thank goodness it's your problem not mine").

Regarding compassion toward another, there is a sense of connection to and awareness of suffering as the human lot. At the same time, with self-pity, individuals are immersed in their own suffering and problems and forget that others are suffering from similar problems. Contrary to this, with self-compassion, individuals allow themselves "… To see the related experience of self and other without this type of distortion or disconnection" (Neff 2003a, p. 88; Goldstein and Kornfield 1987).

We believe that such compassion is present in the ethical jargon of the social work profession, as the value of prioritizing the client's needs over the needs of the therapist.

Eshel (2009, p. 50) defined compassion according to its Latin origin (which means "to suffer with") as "to suffer with-in." She made an additional connection to the root of the Latin word meaning "patient"—"pati," which is equivalent to "suffer," meaning "to be with the patient in his/her suffering." The ability to "be with" the patient is perceived as an empathic attitude. It is from here that the conceptual proximity between "compassion" and "empathy" takes shape.

The psychiatrist and post-Freudian psychoanalyst, Heinz Kohut (1913–1981), founder of the self-psychology stream, in his final book, "How Does Analysis Cure?" (2005), placed empathy at the center of the healing procedure in analysis. In an attempt to define empathy, Kohut indicated the confusion between the concepts of empathy and compassion. On the one hand, he defined empathy as the capacity to think and feel oneself into the inner life of another person, while remaining an objective observer, meaning that empathy is a scientific tool, an objective device for collecting data. On the other hand, out of the emotional experience as a therapist, Kohut felt a "wave of compassion" toward the client; compassion which, in his opinion, originated in the client's need of the therapist's direct expression of emotional understanding. Hence, Kohut's two definitions of empathy created a lack of clarity: the first defined empathy as a scientific tool for collecting data and the second defined empathy as sympathy and emotional understanding, which, for Kohut, were synonymous with compassionate understanding. Later, Kohut declared that empathy should not be identified with compassion, but that the compassionate presence exists in the empathic attitude (Kohut 2005).

Kohut's insights into the link between empathy and compassion are multifaceted and are expressed in the current professional literature. In the literature, empathy is perceived as a learned skill that is not a healing factor in itself, but a tool that assists the gathering of objective data about the client's inner world and a prerequisite for the therapist's ability to successfully provide the client with compassionate support (Kohut as cited in Ryckman 2012). On the source of the growth of compassion, Ryckman (2012) states that: "compassion grows out of our ability to accurately assess another's needs" (Ryckman 2012, p. 170). Maxwell (2008) underscores the difference between empathy and compassion: "The difference being that empathy is a skilled response, while compassion and sympathy are reactive responses" (Maxwell 2008, p. 43).

As we mentioned before, Kohut was one of many undecided voices about the similarity and difference between compassion and empathy. This indecision occurs when theoreticians and therapists translate the concepts of empathy and compassion into practice. For example, Germain and Gitterman (1996) were of the opinion that to enter into the client's life space, the therapist must have an empathic attitude including cognitive and emotional components of "delicacy, knowledge, compassion, careful planning, and skill" (Germain and Gitterman 1996). Here, similarly to Kohut, the link between empathy and compassion can be identified. As opposed to these writers, who pointed to a link between the cognitive and emotional component in relation to an empathic attitude, others defined empathy as based solely on cognitive parts, which are expressed in the ability to understand the other from the other's point of view. The emphasis here is on the ability to think with rather than for the client, and therefore, the therapist's individual point of view is irrelevant (Cormier and Cormier 1985). Understanding the client's point of view includes understanding his or her emotions, experiences, behaviors, and the interpretation that the client gives to them all (Egan 2009). Some claim that the experience of sharing emotions with the other is a kind of expression of sympathy, but not necessarily of empathy. An empathic reaction involves understanding the other's emotions and circumstances, without taking a personal stance (Hepworth and Larsen 1990).

In his definition of empathy, Rogers (1961) warns against taking a personal stance in the context of losing the "as if" dimension, in therapists' understanding of the client's world as if it was their (the therapists') own: "… accurate understanding of the [client's] world as seen from the inside. To sense the [client's] private world as if it were your own, but without losing the 'as if' quality—this is empathy" (p. 284).

The loss of the sense of "as if" impairs the therapist's capability for emotional separation and prevents flexibility in the use of empathy. Holmes et al. (2008) perceived therapists' capability for empathic flexibility to be important for their mental health. If they can adopt the stance of a neutral and dissociated observer, their emotions will lessen in intensity (Badger et al. 2008). Nevertheless, Decety and Lamm (2006) see empathy as a double-edged sword because empathy has varying levels of intensity; from high emotional arousal in the face of another's distress that might lead to the therapist's secondary traumatization, through compassion fatigue (an issue that we will address later), to emotional separation capability.

Optimal use of empathy will be made through "being with" in all stages of therapy (Egan 2009), starting with building a therapeutic rapport, which includes different and varied components, such as mutual respect, emotional support, sensitivity to the client's needs, active and passive listening, trust, responsibility, boundaries, and transparency. This relationship will include use of the self, which will be expressed through the ability to be there for the other, not in a technical manner, such as through professional skill, but from a concerned, empathic stance, and the ability to induce hope in the client (Egan 2009; Zastrow 2003). The discussion of the issue of empathy shows that the integration of cognitive and emotional elements must remain. Nevertheless, the cognitive element is the dominant one. Empathy has meaning and a place in every therapeutic situation, particularly in states of stress, crisis, and trauma, which are turbulent and emotionally charged situations.

What is compassion? Are we able to feel compassion for the client without empathy? Does the compassion itself

involve empathy? Are the components of compassion cognitive or emotional? These are not random questions. It is very difficult to isolate compassion as a concept, which is often drawn from or draws on other closely-related concepts, which have similar, identical, and even different meanings. From this short discussion dealing with empathy and compassion, it has become clear that these concepts are not identical, but nevertheless, are linked. We will not be able to feel empathy in therapy without the accompanying sense of compassion. Just as a therapeutic relationship cannot exist without empathy, neither can it exist without compassion. However, whereas the dominant component in empathy is cognitive, "an understanding of others' emotions," compassion is made up of the entire range: emotion, awareness, and action, even though, in compassion, the emotional component apparently takes precedence over the other components, as focus is placed on connecting to the suffering other.

The entire range of compassion components will be illustrated in the first case presented in this article, in which treatment was administered according to the narrative approach. Treatment according to this approach enables clients to present their internal reality to the therapist through telling their personal story—their narrative (White and Epston 1990; Monk et al. 1996; Freedman and Combs 1996). Through telling and retelling their story to another, clients learn how to know, accept, and discover themselves.

The narrative approach has several basic principles: (a) The therapist and client deconstruct and reconstruct the client's narrative through telling and retelling (Bruner 1990; White and Epston 1990). (b) The narrative approach respectfully acknowledges that clients are expertly acquainted with their own life stories, difficulties, and problems and that the therapist's expertise lies in facilitating the therapeutic process, as in the words of Freedman and Combs (1996, p. 44): "Our knowledge is of the process of therapy, not the content and meaning of people's lives." (c) The therapist avoids interpretation and leaves the interpretations and the meanings derived from them to the client (White and Epston 1990). In the words of Freedman and Combs (1996, p. 45): "The people we work with are the primary interpreters of their own experience." (d) The client shapes the reality of his/her life and its meaning through language: "We focus on how the language that we use constitutes our world and beliefs" (Freedman and Combs 1996, p. 28). De Shazer (1994, p. 53) asserts that: "Meaning comes from people's use of language," and Anderson and Goolishian (1988, p. 378) state that: "Language does not mirror nature; language creates the nature we know."

Hence, insights are created that enable a different reality in the therapist–client relationship. This is a reality in which therapists, humbly and at eye-level, allow clients to tell and reconstruct their stories through creating a thicker and richer world of subjective meanings. The narrative dealing with "thin" facts undergoes a transformation, creating a "thick" narrative, which contains additional "voices" (Geertz 1973; Freedman and Combs 1996). In the new "thickened" narrative is a web of thoughts and insights with deep meaning for the client, originating in the client's self and in his/her attributions to significant others. The client's words are accepted without evaluations or interpretations, which determine "scientific classification" (White and Epston 1990, p. 53). The renewed narrative creates a reality that has elements of healing, containment, and compassionate meaning, as described in Case no. 1: About Leon.

Using the narrative approach, the therapy with Leon (fictitious name) illustrates the attribution of healing and compassionate meaning to an emotionally turbulent and threatening state derived from mourning at an advanced stage of life.

Leon was 70 years old, and was married with three adult children and five grandchildren. He visited his family doctor 6 months after his 95-year-old father had died of a stroke. Leon told the doctor about his distress that was manifest in insomnia, loss of appetite, and drastic weight loss. After ruling out physiological causes, the doctor referred Leon to emotional therapy with the social worker at the health fund clinic.

In the first meeting with Ruhama, the social worker working with the older population, Leon reported restlessness and the inability to find his niche, having closed himself off from his environment: "I have no patience to see people; I have no energy even for my little grandchildren…" Leon reported feeling depressed and unable to function as he had previously. He claimed not to understand what was happening to him; his reactions were exaggerated and alien to him and he felt threatened. Ruhama asked about the circumstances of his father's death. Leon told her that the death had been expected, similar to his mother's death 2 years previously. He had accepted his parents' deaths as a natural part of life. At this stage, he spoke angrily of the doctor who had referred him to psychotherapy: "What, am I crazy?" He told Ruhama that all he had wanted was to attain some relief for his physical suffering with the help of medication. Nevertheless, he had agreed to attend several meetings with the social worker.

In their next meeting, Leon described himself as an active, energetic person and told Ruhama that he used to work with computers. He was involved in family life and had a good, warm relationship with his wife, children, daughters-in-law, and grandchildren. He and his wife had an active social life, and they both enjoyed hiking and other pastimes. Later, Ruhama encouraged Leon to express his

thoughts and feelings regarding the changes that he had undergone in recent months. Leon described his distress and suffering after receiving a notification from the old age home where his deceased parents used to live, demanding that he immediately empty the apartment of all their possessions. Leon tried to comprehend his emotional turmoil, and why it was aroused specifically in this context. He described himself as a practical and realistic person, and said that, had it not been for his overreaction, he would have viewed the clearing out of the old, disused objects as a simple, necessary task. This was the attitude taken by his younger brother.

Ruhama said: "Sometimes, old objects have a soul of their own. Maybe they have a story to tell about your life?"

This suggestion was followed by a few moments of silence. Leon's expression softened and he was visibly moved when he began to speak, hesitantly, about the end of an era in his life and about the previous generation that had departed this world. During this conversation, he raised questions that were troubling him: "As the eldest son, am I now on the front line? Does this mean that I'm getting old? Am I really afraid of old age? What is it about these old objects, which is so difficult for me to deal with? Have I maybe really undergone some change?"

The following dialogue developed between Leon and Ruhama:

Ruhama: "Leon, your suffering, pain, and sense of loss are with us in this room, and it's no wonder. Even though your parents' deaths were expected at their age, the death of a parent is ageless… you are asking if their departing this world is a turning point in your life. I feel that you are worried that something might be wrong with you". You are asking: "What is happening to me?"

Leon: "I'm not the sentimental type… I'm not used to this kind of talk… I ask myself… what is it about my father's work tools… his screwdrivers… his old pipe wrench… from which he wouldn't be parted even when he went into the old age home?"

Ruhama: "It would be interesting if that pipe wrench could tell a story… what would that pipe wrench tell us? Which drawers would it open?"

Leon arrived at the next meeting in a pensive mood:

Leon: "I've been thinking a lot about our last conversation, about the extent to which I felt uncomfortable with my father's story, the sudden onset of old age, the changes he went through, the stories from long ago, the memories, but mainly his holding on to those old, rusty work tools. I remembered how easily I lost patience with him. I was even openly angry with him."

Ruhama: "And where does that take you today?"

Leon: "It's very hard for me when I remember how I criticized him. I am ashamed that I was openly scornful of something so close to his heart. I didn't realize how difficult it was for him to leave behind the life that he had before he went into the old age home… I let him feel that he and his old possessions were past it and a nuisance. How could I have done that to him?"

Ruhama: "Your words contain so much regret and pain. Now that you are clearing out your father's old things, what do you know today that you didn't know then…?"

Leon: "I didn't know that it would be difficult also for me to part with my father's old possessions… so have I also grown old and sentimental? As if I have stepped into his shoes?"

Ruhama: "If your father could hear what you are saying, what would he say?"

Leon: [a little tearful but smiling]… "He would say that the apple doesn't fall far from the tree…I really miss him."

A conversation from another meeting:

Ruhama: What do you miss about your father?

Leon: "I miss the sounds of my father coming home from work in the evening, very tired, coughing on the stairs. He was a heavy smoker… my father's voice, early in the morning, humming a tune while he shaved… his joy and the smacking of his lips when my mother baked her famous honey cake…"

Ruhama: "If your father could hear you say that you're missing him now, what would he say?"

Leon: "He might say: 'It's a shame we never talked about it back then…' or maybe: 'I didn't know I was so important to you,' or maybe 'You've turned emotional, like me'…

Ruhama: [leaning toward him] "Where do the thoughts about those internal voices take you?"

Leon: "That I am closer to him today than ever before… maybe I am a bit emotional… and it's hard for me to part with him…[with emotion in his voice]…I don't know… maybe it's too late… maybe I've missed the boat… my father isn't here anymore, how will he know how angry I am with myself and how sorry I am that I hurt him…?"

Ruhama: "If your father knew how touched you were by his suffering and how you are tormenting yourself about having hurt him, would he forgive you?"

Leon: [with hesitation in his voice]… probably, yes… [and added], he might even have been moved by it."

Ruhama: "If your father could have forgiven you, can you find some kindness for Leon, and might you be able to forgive yourself?"

At this point in the conversation, an aperture into Leon's internal, experiential world was opened. This aperture allowed him to observe his relationship with his parents

and his feelings toward them at different periods in his life, as well as memories related to objects, which, for him, represented an entire life of recollections, some pleasant and some difficult. Leon was not deterred from speaking about his fear of approaching old age. He succeeded in moderating and accepting his sensations around his apparent overreaction. He succeeded in verbally expressing his distress and in achieving understanding, acceptance, and self-compassion toward the guilt feelings, the grief, and the loss that he was experiencing (Leary et al. 2007; Neff 2003a, b; Gilbert 2010).

Ruhama acknowledged, legitimized, and made room for his suffering. She encouraged him to express, in his own words, his experience of loss and its meaning for him, as well as his ability to develop self-compassion. Ruhama's therapeutic intervention is in keeping with the following statement by Neff: "Self-compassion requires that individuals do not avoid or repress their painful feelings so that they are able to acknowledge and feel compassion for their experience in the first place" (Neff 2003a, p. 88).

Following Leon's developing insight during these conversations, the old objects were transformed into objects with meaning. From being a solely practical and concrete task, the removal of these objects had turned into an activity that framed his own life story as well as the story of his parents, his relationship with them, and his new experience regarding his selfhood.

Out of the "thin" story about old objects, a new, "thicker" story was created, containing self-compassion. The source of this self-compassion was the containing and compassionate attitude of the social worker, which enabled him to deal with his relationship with his deceased parents and with the meaning of the grief, the pain, the loss, and the threat of old age. The "old objects" served as linking objects, which symbolized for Leon the link that connected him to representations of his deceased father and their connection to parts of him (Volkan 1983; Witztum and Roman 2000).

The discussion that developed dealt with the fears and anxieties that had recently been troubling Leon. The conversation addressed questions such as the following: "What is normal for me?" "What is appropriate?" "What is abnormal?" "What does it mean to be on the front line?" Had the sense of being orphaned, even at an advanced age, left Leon's mourning without a backbone and placed him in the position that his parents had vacated with their deaths, as written about in the book by Lydia Flem (2007): *The Final Reminder: How I Emptied My Parents' House*?

Ruhama used the narrative approach, which enabled Leon to meet the "soul within the objects." She opened a window for him into his emotional world and his current experience of mourning. His anger toward the doctor who had referred him to the social worker made way for legitimate emotions of pain and sorrow, without the repressed feelings, self-criticism, shame, and pretense of "I am coping." The confirmation of his own health and normativity enabled a discussion of the meaning of the changes that he had undergone following the bereavement, as he stood on the brink of the advanced stage of life.

The therapy with Leon, who was at a juncture in his life, interwoven with experiences of loss and acute mourning, shows the extent to which the social worker's acknowledgement of his suffering, her participatory stance, and her compassionate point of view, generated Leon's self-compassion. Later, we will elaborate on the link between the sense of suffering, the compassionate attitude, and the development of self-compassion.

Compassion as an Intersubjective Concept in the Therapist–Client Relationship

We will use the psychosocial approach in therapy with Noa (fictitious name) in Case no. 2 as an example to illustrate the therapist's difficulties in responding to his client with empathy that contains compassion, which eventually brought him to the verge of compassion fatigue. The supervisor's compassionate approach helped him to develop awareness of his situation, as well as self-compassion, which enabled him to be containing, accepting, and compassionate toward the client.

In the supervision session, Nitzan, the social worker, presented his difficulties in his therapy with Noa, whom he had experienced as being "stuck" for some time.

Noa was 34 and single. She was born in Israel to parents from Eastern Europe, has two younger brothers, and was working in hi-tech. She had been in therapy for about a year. The therapeutic conversations revolved around Noa's frustrating relationship with her parents, who spared no criticism of her, and her feeling that she was a disappointment to them, as well as around her relationships with girlfriends and male partners, which usually ended after a short time.

During the therapy, Noa had been preoccupied with existential anxieties, expressed in rigid, obsessive thinking about unfounded fears of disasters and terminal illnesses that might befall her. Noa had difficulty dealing with situations over which she had no control and expected events to progress according to her own design. Recently, she had separated from a partner with whom she had hoped to develop a serious relationship. At the same time, she had been unexpectedly dismissed from her job due to administrative cuts. These events were the source of tremendous tension, hurt, frustration, anger, and pain. Noa expressed her sense of deep harm to her self-image and of undermining her emotional, personal, social, and economic security. This was manifest in sessions of intense crying

and prolonged sobbing, both at home in the presence of her parents as well as during therapy. She claimed that "no-one sees how much I am truly suffering, no-one believes me, because you can't tell; I know how to hide it; I always talk a lot, and laugh, as though everything is alright." This statement indicates that the therapist does not recognize or identify the intensity of her suffering.

The social worker presented his difficulty in containing Noa's crying. He was very honest with the supervisor: "When she starts crying and doesn't stop, I feel helpless, angry, and tense, and unable to reach out a supporting hand. I feel guilty because I'm waiting for the end of the session." He described Noa's crying as childish behavior, as a kind of tantrum, which, he believed, was derived from her fear of emptiness and loneliness; fear that flooded her and caused her suffering. Nitzan experienced Noa as demanding and exhausting, and saw her needs as a bottomless pit. He told the supervisor that he came out of the sessions with her both physically and emotionally fatigued, with emotional flooding and suffering, which prevented him from being compassionate. It sounds as though Nitzan was experiencing a state of compassion fatigue.

During the supervision sessions, Nitzan became more aware of Noa's current experience of rejection: by her family, by her ex-partner, by him as her therapist, as well as by the employer who dismissed her. The supervision focused on his sense of exhaustion as a therapist and reflected his internal struggle with the feeling of helplessness, emotional flooding, guilt, and shame because of his difficulty in assisting Noa in her suffering. Alongside the discussion of the social worker's relationship with the client, the supervisor expressed her admiration for Nitzan's honesty and genuineness and for his ability to recognize and confront his sense of failure. The supervisor identified Noa's sense of loss and drew the social worker's attention to the transference and countertransference processes in the therapy: Noa felt as though she had lost control of her life, and Nitzan, as her social worker, felt that he had lost control of the therapeutic process. Noa felt rejected by her parents and by others in her environment. She was crying over her deeply entrenched suffering that had been neither recognized nor contained over a long period of time. There was a reason why, in the transference toward him, that the social worker sensed the client's childish and demanding crying. As a therapist, Nitzan criticized himself and his suffering that was preventing him from being there for her, namely, from expressing empathy, compassion, and containment. Nevertheless, in contrast to Noa's lack of a sense of support from those around her, in the supervision process, the therapist's suffering was acknowledged and accepted, and his feelings were understood. At the same time, Nitzan became connected to his distress, which took on meaning. He reached an understanding of the transference–countertransference process through activating a defense mechanism of projective identification, which was expressed in the interaction with the client. His suffering was linked to his personal sense of loss, originating in his father's abandonment of his 9-year-old self, and his mother's turbulent emotional reaction, expressed through intense, prolonged crying, when it was he who had felt abandoned, alone, helpless, hurting, angry, and uncontained. The client's intense crying following her sense of abandonment was linked to her experience of the lack of containment by primary figures in her life, whereas the lack of the therapist's containment as a child was linked to his mother's intense crying in response to his father's abandonment.

Scattered throughout the description of Noa's therapy are themes of suffering, compassion, and self-compassion and they appear with parallel duality in the social worker and the client. As opposed to the Freudian model that perceives suffering as a feeling of guilt related to forbidden desires, Kohut, with renewed insight, interpreted human suffering as a failure to receive needed attention from the significant other, in the form of warmth, emotional support, or containment (Mitchell 2003). Noa the client and Nitzan the social worker both experienced this lack. According to Kohut, the therapist's task is to show an empathic attitude in which compassion is present (Kulka 2004). Nitzan's encounter with the "wounded healer" within him related to his ability, as a therapist, to identify with the client's pain through his own pain, his own "wound." This Jungian concept draws on the myth of Chiron, whose own wound gave him knowledge, sensitivity, and healing capability (Samuels 1985). Nitzan's ability to experience self-compassion and compassion toward the client created new insights regarding possibilities of helping Noa. At this stage of the treatment, Noa was able to express and verbalize her pain and suffering without the need for defenses such as concealing her emotions, as she says: "I know how to hide it now; I always talk a lot, and laugh, as though everything is alright."

Acknowledgment of the client's suffering is part of the therapist's humanity. To be connected to the suffering of others, we must acquire the ability to touch our own suffering. "For therapists to respond compassionately to clients, they need self-compassion, expressed in the ability to return to the self and to the living places within the self and within one's life, to return and to be with their clients in such difficult places" (Barkan 2010, p. 325). Compassion is the possibility of being with the suffering of the other… out of the ability to share emotions and to experience a connection without negating the difference (ibid.). Compassion contains a reciprocal dimension between therapists and clients, which enables them to cope with what cannot be coped with alone. Radey and Figley (2007) also

perceive compassion as fundamental and essential to the social worker–client relationship. Buddha's statement reflects these insights: "Our sorrows and wounds are healed only when we touch them with compassion." Self-compassion, which originates in Buddhist philosophy, is related to existentialist, humanist perceptions which, today, have been lent to the therapeutic world. This concept received research validity based on physiological findings of Gilbert's brain research (Gilbert 2009). Different researchers (Gremer 2009; Gilbert 2010; Neff 2003a, b) viewed self-compassion as a remedy to counter self-criticism. They asserted that self-compassion aids individuals who encounter their limitations. Gilbert (2010) developed a compassion focused therapy (CFT) model, tailored to people with a mental structure frequently linked to excessive emotions of shame, anxiety, and self-criticism. In this model, the therapist is focused on developing the client's self-compassion capabilities, for the client's welfare, and for formulating a more positive self-perception, which reduces anxiety and strengthens the sense of security. According to this model, therapists do not prevent clients from touching or reducing their pain, but enable them to connect to pain out of self-compassion, in a way that helps them cope with their suffering without shame and self-criticism, and without a pathological attribution.

The following words by Neff strengthen this claim: Self-compassion… "helps to motivate productive behavior…" (Neff 2003a, p. 92). "… Encouraging the development of self-compassion should benefit individuals by helping them to counter destructive self-critical tendencies…" (Neff 2003a, p. 92).

The concept of self-compassion was previously absent from professional writings (Neff 2003a). Today, a compassionate stance toward the therapist is more prominent in the therapeutic discourse, with the influence of pluralistic, postmodern, intersubjective perceptions. As mentioned, Nitzan's supervisor acknowledged his suffering as a therapist by taking a "compassionate angle" toward him, and thus helped him to develop a sense of self-compassion. In addition, the supervisor identified Nitzan's tendency to develop elements of compassion fatigue in his therapy with Noa. Therefore, the supervisor envisioned compassion as a central means of preventing compassion fatigue (McCrea and Bulanda 2008). The issue of compassion fatigue will be discussed later on.

The best-known definition of compassion is found in the writings of the Dalai Lama, who said that "compassion is the sensitivity to the suffering of self and others, with a deep wish and moral commitment to relieve the suffering." Compassion, therefore, is attentive and sensitive awareness of others and of the self, coupled with motivation to assist. Hence, self-compassion is closely related to compassion for others (Gilbert 2010).

Neff examined the components of self-compassion and identified actions that bridge between the abstract and the concrete (Neff 2003b): attentiveness and openness to self-suffering; avoidance of self-judgment; awareness and willingness to share the self-suffering experience with others, with neither shame nor a sense of isolation, and openness to the humane part within us. We encountered these stages in Nitzan's therapeutic work process. We will be able to identify the pitfalls that he encountered in the role of therapist, one by one; pitfalls that he overcame with the help of skilled supervision. The legitimacy that Nitzan received in supervision to encounter his own suffering and that of Noa, allowed Noa to express her suffering out of self-compassion, without self-criticism and the outward pretense that "everything is OK." It simultaneously allowed Nitzan the current experience of being attentive to other voices and meanings regarding Noa's crying. This crying, which he perceived as demanding and childish, resonated with current loneliness, abandonment, and loss. Nitzan's ability to connect and to accept his own suffering without judgment as well as his ability to share this experience exposed the warm, humane aspect and the compassionate therapist within him.

In light of the above, and based on the professional literature, the case presented here is consistent with the idea that therapists' ability to show compassion toward clients' suffering and to their own suffering and to help clients relate to their own suffering with compassion creates a constructive, healing therapeutic process, which removes the pathological aspect (Germer and Neff 2013; Gilbert 2010; Neff 2003a; Neff et al. 2007). In their article, Leary et al. (2007) emphasize the absence of judgmentalism in the essence of self-compassion, and consequently, see it as a preferable alternative to the concept of "self-worth," which is linked to determining "high" and "low" values. The findings of their study indicate the conspicuous advantages of self-compassion for the individual: self-compassion enables a better psychological perception of self, the absence of wearying self-criticism, and the ability to cope better with difficulties presented by reality (Leary et al. 2007).

Compassion Fatigue

Bride et al. (2007) and Stamm (2005) noted that, alongside the suffering that was caused to the therapist in his work with clients who had experienced difficult traumas, positive aspects can be found, which strengthen and nurture the therapist. These are expressed in a sense of satisfaction derived from providing help to others, defined as compassion satisfaction, which motivates therapists to continue with their work.

In addition, researchers found a positive relationship between compassion toward therapists in the workplace

and the therapists' positive emotions toward their clients) Dutton 2003; Folkman and Moskowitz 2000).

Nevertheless, when the compassion component is missing from the therapeutic relationship, the process that occurs can be described as compassion fatigue (Radey and Figley 2007; Sprang et al. 2007). A large part of the professional literature on compassion over the last 20 years has dealt with compassion fatigue. This state occurs when social workers and therapists from other related disciplines experience extensive, continuous, cumulative exposure to their clients' suffering and trauma, and extreme and chronic distress (Adams et al. 2006).

The concept of compassion fatigue was coined by Figley (1995) and was defined as secondary traumatic stress by Bride and Figley (2009), Boscarino et al. (2004), and Bride (2007). In a parallel process, therapists might develop compassion fatigue because of flooding and resonance of the high emotional intensity experienced by the posttraumatic client. Therapists' prolonged exposure to extreme incidences of their clients' distress might create a state of severe tension and evoke symptoms such as fears, sleep and eating disorders, changes in worldview, difficulties in interpersonal relationships, social isolation, and self-doubt regarding professional ability. These difficulties are explained by emotional numbing, which constitutes a defense mechanism for the therapist. This situation carries a high risk, mainly for professionals providing long-term treatment to victims of trauma and clients in deep distress. According to Figley (2002a, b), this is the price that the helping professional pays at this juncture in this role: "As our hearts go out to our clients through our sustained compassion, our hearts can give out from fatigue" (Radey and Figley 2007, p. 207).

In their study, Radey and Figley (idem), Sabin-Farrell and Turpin (2003), and Jenkins and Baird (2002) identified, unified, and highlighted active elements in the compassion fatigue process among professionals. This process is formed when therapists (social workers, psychologists, doctors, nurses, or caregivers) disregard their personal needs and are disconnected from their own suffering. When they have an unresolved trauma in their past, the system in which the therapists are working cooperates with this disregard, is neither conscious of nor deals with stress factors at work, and hence provides neither relief nor support for the worker. All these cause dissatisfaction with the job itself, which is followed by burnout and premature dropout from the profession (Bride 2007).

Strategies for coping with compassion fatigue include developing awareness, diverting attention to and understanding of the impacts of work on the therapist, conversations with colleagues with whom they can share the emotional burden, maintaining their quality of life, relinquishing the self-perception of someone who is carrying the world on their shoulders alone, and accepting professional supervision from experts in the field of trauma (Figley 1995).

In addition, research has proved that compassion-focused training programs for therapists from different disciplines, such as trauma therapists (Craig and Sprang 2010) and palliative therapists (Shih et al. 2013), significantly improve the therapists' coping ability in therapeutic work. Following this training, therapists showed elevated levels of compassion satisfaction and reduced compassion fatigue.

Conclusion

The concept of compassion has gained greater visibility in the therapeutic discourse in recent years. In this article, we examined the essence of the concept, the reason for its previous absence from the therapeutic discourse, and what has influenced its presence today. To isolate compassion as an essential component in itself in the therapeutic process, we separated the concepts of compassion, empathy, pity, and sympathy, which were previously perceived as synonymous. The two former concepts are included in the professional therapeutic jargon, whereas the latter two are not perceived as part of the therapeutic discourse. The present discussion focused mainly on the differences between compassion and empathy and between compassion and pity. The discussion on compassion and empathy revealed both differences and links between the two, whereas compassion and pity were shown to be different and without overlapping components (in light of the perceived judgmental and patronizing elements of pity). Empathy is perceived as an essential prerequisite for compassion toward the therapist and is necessarily based on learned, cognitive skill, whereas compassion is perceived as a reactive response and its emotional components dominate its other cognitive and applicable components.

The current therapeutic discourse acknowledges the uniqueness of compassion due to currently accepted pluralistic and postmodern perceptions that enable the application of theories based on Eastern philosophies, such as Buddhism. This philosophy, which gives compassion and self-compassion a very valuable place in the human context, has enabled us to look directly at the moral, ethical command that accompanies the essential presence of compassion and self-compassion in the fabric of relationships in therapy. We perceive the presence of compassion as taking a stance toward others and toward the relationship with them.

In the presence of compassion in therapy in the current era, we identified innovative aspects both in the dynamics of the therapist–client relationship, in which both sides'

experience of self-compassion is legitimized, as well as in the therapeutic intervention, which is focused on the therapist's assistance to the client in developing self-compassion. Both therapeutic cases that were presented in the article illustrated the extent to which therapists' recognition of their clients' suffering and being there with them from a compassionate angle generated their self-compassion. It can be identified how therapeutic intervention with each of the clients translated the three concepts of the sense of suffering, the compassionate attitude, and the development of self-compassion from abstract to concrete and highlighted the link between them. Each of the clients presented was at a different stage of life: a man in his seventies and a woman in her thirties. Each client was treated using a different therapeutic approach: narrative and psychosocial. In both cases, compassion and self-compassion in therapy enabled the clients to bear their suffering, to give new meaning to their situation, and to acquire tools for coping with their self and with those around them in a nurturing way.

The therapeutic models dealing with self-compassion indicate that the process has healing significance. Self-compassion enables self-acceptance, removes perpetual self-criticism and pathological aspects from the client's life, and thus enables the clients to take control and provides them with a vehicle for self-help. This concept has great significance for professional therapists and the style of their work. In the absence of compassion, a situation might be created in which the therapist will develop a state of compassion fatigue, which describes emotional and behavioral disorders in the therapist's life and might lead to burnout if not treated.

In light of the content of this article, we attribute great importance to integrating compassion in therapy issues and the development of self-compassion as an integral part of training programs for the therapeutic professions; from the initial process of acquaintance with the profession, through the bachelor's degree and introductory courses on therapeutic aspects, to advanced degree courses on therapy. When teaching the subject of compassion, we recommend addressing four different levels: theoretical, ethical, practical, and processual-developmental, as a component in constructing the student's professional personality. The formative message to impart while teaching about compassion is as follows: The absence of compassionate visibility by therapists, similar to the absence of empathy, will prevent the development of a therapist–client relationship. It will also render impossible a reciprocal constructive therapeutic process that imparts tools for creating meaningful change in the client's situation. Compassion includes a reciprocal dimension between therapists and clients, which enables them to bear what they would not be able to bear alone.

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