

# Chapter 10

## Whole Person Self-Care: Self-Care from the Inside Out

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**Keywords** Self-care • Burnout • Compassion fatigue • Empathic engagement • Exquisite empathy • Wounded healer • Soul and role • Clinician self-awareness • Mindfulness meditation

A discussion of self-care normally begins by focusing on topics such as stress, ways of protecting ourselves from the traumas of the workplace, and encouragement to find sources of self-renewal outside of work. We would like to start with a different focus, one that is offered by Tibetan Buddhist teacher Chögyam Trungpa when he writes the following:

We are in touch with basic health all the time. Although the usual dictionary definition of *health* is, roughly speaking, “free from sickness,” we should look at health as something more than that. According to the Buddhist tradition, people inherently possess Buddha-nature; that is, they are basically and intrinsically good. From this point of view, health is intrinsic. That is, health comes first: sickness is secondary. Health *is*. So, being healthy is being fundamentally wholesome, with body and mind synchronized in a state of being which is indestructible and good. This attitude is not recommended exclusively for patients but also for the helpers and doctors. It can be adopted mutually because this intrinsic basic goodness is always present in any interaction of one human being with another [1].

What if self-care is not so much about stress management and damage limitation as about finding ways of remembering and staying connected in the workplace with the wholeness that is already there? And what might self-care look like if it is true, as psychoanalyst Michael Balint puts it, that “we are the medicine” [2]? If, as Balint suggests, we are the most powerful medicine we will ever give our patients, then who we are as persons matters as much as how knowledgeable and skilled we are as professionals. The quality of our lives affects the quality of our patients’ lives. As clinicians, therefore, the question “what is the quality of my life?” has both personal and professional consequences. At a personal level, it speaks to the

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possibilities of being happy, of flourishing, of growing in our work. Professionally, it speaks to our quality of presence and to our resilience and effectiveness as clinicians.

If there is such a thing as “Whole Person Self-Care” what might it look like in clinical practice and in our secular lives? In this chapter, we explore this question by sharing stories, reflections, and ideas. We tell one of our own personal stories as illustrative of the two syndromes of clinician stress, Compassion Fatigue and Burnout, and reflect on this against the backdrop of two universal stories: that of the Wounded Healer and that of the Rainmaker of Kiao-chau. And we present a model of self-care based on clinician self-awareness, which, we suggest, offers a positive, whole person approach to self-care.

## **The Story Then**

In the summer of 1980, having decided that “Hospice Medicine,” as it was then called, was what I (MK) wanted to specialize in, I began working at St Christopher’s Hospice in London. This gave me the opportunity to work alongside and learn from some of the pioneers of the modern hospice movement, including Dame Cicely Saunders, Professor John Hinton, and Dr Colin Murray Parkes. I felt lucky to be doing something that was congruent with my soul, with who I was, and to have such wonderful teachers and colleagues. While I learnt a lot professionally during my time at St Christopher’s, I believe I learnt even more at a personal level. There was one particular event that proved a turning point in this regard.

I had just completed my first 3 months at St Christopher’s. I looked forward to coming to work each day and happily gave my patients and their families my all. While there were obvious limits to what I could offer in terms of my clinical and communication skills, I tried to make up for this by being as openhearted as possible. Listening attentively, taking it all in, the pain, the fear, the joy, the tenderness, the regrets, the sadness, and leaving work each day feeling simultaneously depleted and enriched. As I walked those couple of hundred yards between the hospice and the apartment where I was living with my wife and our baby daughter, I felt like I was walking in a silent landscape that had been blasted by a hurricane, flattened by a tsunami. Yet I simultaneously felt centered and, in some curious way, fulfilled.

On this particular morning, I was to attend a family meeting with the husband and children of a young woman with a glioblastoma who was very close to death. Elizabeth, the social worker, the patient’s nurse, Alison, and I, were to meet with the patient Julia’s husband John, and their three children John, aged 7, Matt, aged 5, and Rosie who was 3.

By then, Julia was very weak, drowsy, and at times confused – evidence, we felt, that death was imminent. When Elizabeth had met previously with John, he had told her that he had spoken to the children about their mum being “very ill” but not

that she was dying. He had said that he wanted to protect them as much as possible for as long as possible. Nonetheless, he had gratefully accepted Elizabeth's offer of a family meeting to help him talk to the children about this as he realized it could not wait any longer.

All three children knelt at the low table in the middle of the family meeting room, drawing with waxed crayons on large pieces of white paper. "Why don't you draw your family?" Elizabeth had suggested. Matt began to draw a house with his dad and the children standing by the front door, his mum standing alone and by herself at the extreme left-hand side of the paper. John drew his mum upstairs in bed, his dad and brother and sister down in the kitchen, and himself walking down the stairs. Rosie started drawing a round figure whose arms were wrapped around a tiny little figure on her belly. "That's me and mummy," she said.

Ever so gently, Elizabeth told them that we had asked them to come in today because we wanted to talk with them about their mum. She said she would really like to hear from them about how they thought their mum was doing.

After a short silence, Matt spoke. "I know mummy is dying. I have not wanted to talk about it because I did not want to upset daddy." The others did not look up from their drawing. It seemed that these words came as no surprise to them, or perhaps in Rosie's case that she did not understand what they meant. Turning to me, Elizabeth said, "Perhaps Dr Michael can tell us all just how your mum is doing these days."

I don't remember what words I used. What I do recall is the way the two boys paused as I began to speak and turned to look in my direction, still leaning on the table, crayons in their hands, faces wide-open in expectation. Rosie, meanwhile, continued to draw. I began to speak because I knew I had to, not because I knew what to say. I fumbled to find the kindest words I could to say the impossible.

As I finished speaking, I was aware that John was sobbing quietly. The children had all returned to their drawing. Then, Matt looked up and asked, "Do you mean that mummy will never come home again?" I replied that I was terribly sorry to say that I did not think so. At that, Rosie left her drawing, walked over to her dad and put her arms around him. The boys followed, one at a time.

Meanwhile, I continued to sit, as did my colleagues, witness to this family held in a single embrace of grief. I felt part of it and yet separate. I had wanted so badly to say something that would make the children feel better, yet my words had just inflicted more pain. My heart ached. I felt a failure.

The following day, I came to work in a fog. This sensation lingered through the day and I noticed that I could not easily concentrate. I was aware of a sense of dread in my chest and I became more and more apprehensive. Then, as I sat listening to a colleague talking about a patient, a strong sense of *déjà vu* wafted from nowhere into my consciousness. It immediately captured my complete attention. I felt panicked, "What was this?" "What did it mean?" "Was I having a nervous breakdown?" In the midst of this whirlwind of images, feelings, and questions, I was suddenly aware that my colleague was still speaking to me, now with a look of concern on her face. I felt disorientated and confused. I could not make sense

of what she was talking about. Then, the rumbling sense of dread in my chest swelled to a wave that seemed to crash right through me. I excused myself and left the office bumping into Tom West, the then Medical Director of St Christopher's, who was walking down the corridor. I asked if I could speak with him. He led me to his office.

Tom listened attentively as I described how I was feeling. "You sound exhausted," he said, "You have been here three months now and you have not had a break. You've thrown yourself into the work and you're doing a great job, but I think you may not have learned yet that you also need to take care of yourself. Two suggestions: One that you take this Friday off. Make it a long weekend and go away somewhere nice with your family. Second, I can recommend someone you could meet and talk with from time to time. I have been doing this myself for years and I would not have survived in this work without it."

My head was still reeling, but I felt relieved. I heard Tom saying that he understood what I was talking about and, more importantly to me at that moment, that he did not think I was crazy to be feeling this way.

Early the following week, I met with a counselor, whom I immediately liked. We agreed to meet on a weekly basis for the coming 3 months. Little did I then realize that I was experiencing an acute case of what I would later understand to be "Compassion Fatigue." And little did I realize that I was on the threshold of what PW Martin calls "An Experiment in Depth" [3], that I was unwittingly heeding Jung's advice "to dive, not drown."

## Compassion Fatigue

The term "Compassion Fatigue" (CF) is used to describe a syndrome of clinician stress that evolves from *the relationship between the clinician and the patient* [4]. Compassion Fatigue is also known as Secondary Traumatic Stress Disorder, the hypothesis being that clinicians may be vicariously traumatized by their patients' suffering [4]. In the process, a clinician's own unresolved trauma material and unconscious unresolved childhood conflicts may be stimulated [5].

The symptoms of CF include those of Post-Traumatic Stress Disorder (PTSD): hyperarousal, reexperiencing, and avoidance. Chronic CF may lead to burnout, the other and better-known syndrome of clinician stress, which is discussed below, and "symptoms of burnout may be the final common pathway of continual exposure to traumatic material that cannot be assimilated or worked through" [6].

There are several theories for the mechanism of transmission of traumatic stress from one individual to another. Useful information may be gained by focusing on the nature and practice of empathy [7]. Figley has hypothesized that the caregiver's empathy level with the traumatized individual plays a significant role in this transmission [4]. The concept of "Vicarious Traumatization" (VT) is very similar to that of CF and is defined as "the cumulative transformative effects upon therapists resulting from empathic engagement with traumatized clients" [6].

## Exquisite Empathy

Recent research calls into question existing assumptions about the presumed causal relationship between caregiver empathy and VT. In a phenomenological study, Harrison and Westwood [8] looked at a group of peer-nominated, exemplary mental health therapists who were thriving in their work with traumatized clients. They identified a variety of protective practices that enhance caregiver's professional satisfaction and help prevent or mitigate VT. Of particular interest to us here, they noted that trauma therapists who engaged in a form of empathic engagement they called *exquisite empathy* were "invigorated rather than depleted by their intimate professional connections with traumatized clients" [8]. Harrison and Westwood define exquisite empathy as "highly present, sensitively attuned, well-boundaried and heartfelt empathic engagement" [8] and note that "moment-by-moment embodied awareness of self and surroundings helps therapists develop the kind of interpersonal presence and clarity crucial to the practice of exquisite empathy" [8].

## The Wounded Healer

Judith Lewis Herman summarizes the recovery from trauma as follows: "The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the individual and the creation of new connections" [9]. For me, the process of recovery from the CF I experienced during my early months at St Christopher's Hospice began with the counseling I started at that time. Within the secure container of that therapeutic relationship, I was committing myself to what I now understand to be a life-long process of self-knowledge and to the realization that my true power as a clinician is found, paradoxically, in an acceptance of my limits and, at times, my powerlessness in the face of another's suffering.

The image of the wounded healer is ancient and universal, dating back to the shamanic healers of early tribal cultures. A shaman is an individual who has been initiated into an underworld of suffering by a wounding or illness and returned with knowledge and wisdom gleaned from that experience to serve their tribe. In Western culture, the image of the wounded healer is found in the Greek mythological figure of Chiron:

Chiron was a centaur, half-human and half-horse. Being a demi-god he did not die when he was wounded in the leg by a poisoned arrow. Rather, he lived on with a painful unhealable wound. Day after day, he limped around the slopes of Mount Pelion searching for herbs anything that might ease his pain and cure his wound. While he became knowledgeable in healing plants and herbs he was unable to heal himself. He was, however, able to heal others. Those suffering all manner of ailments came to him from far and wide. Each received a remedy that helped. Furthermore, Chiron's understanding and compassion touched something within them. As they walked away they knew that a deeper healing had also taken place.

## **“Know Thyself!” – The Dynamics of the Wounded Healer Relationship**

The psychodynamics of the wounded healer have important implications for clinician self-care. They give an insight into the power dynamics of the therapeutic relationship and contrast two kinds of clinical encounter, one that is a liability to the clinician and another that is potentially protective and restorative.

In his book, “Power in the Helping Professions,” depth psychologist Adolf Guggenbühl Craig [10] describes the archetype of the wounded healer as a universal, unconscious psychological structure, which is “dyadic,” meaning that it encompasses both a wounded part and a healer part. As an archetype, it exists in what depth psychologist Carl G. Jung calls the “Collective Unconscious” of all, clinicians and patients alike, where it remains in a latent state until it is activated by specific external circumstances.

Since clinicians are expected to be problem solvers, they tend to exclusively identify with the “healer” part of the wounded healer archetype, repressing the “wounded” part in their unconscious. With patients, on the contrary, the opposite is the case. They tend to identify exclusively with the “wounded” part of the archetype and repress the “healer” part. A therapeutic relationship based on this dynamic is one that holds the clinician as the sole active therapeutic agent and the patient as the passive recipient of treatment. While a therapeutic alliance based on this premise can and often does have a successful outcome, it also has significant implications for clinician self-care. In such a relationship, empathy is flowing in one direction only, from clinician to patient, while simultaneously the clinician is receptive to information about the patient’s problems and associated distress. Within this dynamic, which Guggenbühl Craig [10] calls “the power dynamic,” empathy is a potential liability, a one-way street that can lead to vicarious traumatization, CF, and emotional depletion of the clinician. This may be extremely stressful for the clinician and trigger survival reactions of fight, flight or freeze, which may be seen in overtreatment, abandonment, or emotional numbing or disassociation.

According to Guggenbühl Craig [10], there is another possibility, what he calls “the wounded healer dynamic.” Here, while the clinician continues to do all that can be done to solve the patients’ problems and alleviate their suffering, he or she does so with an awareness that he or she is not omnipotent, that there are limits to what he or she can do. In other words, the clinician begins to allow into consciousness the “wounded” part of the archetype, which up until now has been repressed in the unconscious. The clinician also realizes that patients have within themselves innate capacities to heal physically, psychologically, and spiritually. In other words, the clinician understands that patients also carry within themselves the “healer” part of the wounded healer archetype, and he or she then strives to find a way to awaken this innate potential in the patient.

What this looks like in clinical practice becomes clear by considering some of the insoluble issues a clinician may encounter. Let us consider, as an example, an actively dying patient in profound existential anguish who says to his clinician,

“promise me you won’t let me die.” As the clinician realizes and begins to accept that he or she is “wounded,” in the sense that he or she cannot give this patient what he is asking for, the previously repressed wounded part of the archetype comes into consciousness, and a process of psychological integration begins to take place. The clinician may experience this as a mix of emotions, for example, feelings of frustration and failure, as well as feelings of relief and self-compassion.

Further implications of the dynamics of the wounded healer for clinician self-care are understood by considering the impact this process has for the patient. A clinician who chooses to stay empathically present in the therapeutic relationship, despite being unable to solve the patient’s problem, encourages the patient to stay with his or her experience of suffering. As the patient does so, he or she may begin to realize that, like it or not, “this is how it is.” With this, a subtle yet significant shift may occur in his or her experience. He or she may notice more spaciousness within their suffering, and, possibly, a lessening of its intensity, and articulate this with a phrase such as “the pain is still there, but I can live with it now.” What is happening here is that the patient is experiencing the reality of his or her own “inner healer.” He or she has also now become a wounded healer. In contrast to the earlier power dynamic, the empathic flow is now moving in both directions, clinician to patient and patient to clinician; and, as each realizes that the other is wounded, and human, both may experience the transformative power of profound human connection.

To live as a wounded healer necessitates a high degree of self-knowledge on the part of the clinician; we need to know ourselves well enough to recognize that we have reached that place of powerlessness, to prevent ourselves reacting impulsively, and to consciously respond in the most appropriate way, including the possibility of calling “time-out,” or choosing to remain compassionately present without acting, despite possibly painful feelings of failure or impotence. For the clinician, the rewards of the path of the wounded healer include finding healing and meaning within his or her empathic connection with patients.

## **The Story a Year Ago**

By this time last year, I had been in the field of end-of-life care for 29 years. I was working as a physician with a hospital and community-based palliative care service, and with a community and inpatient hospice program in Santa Barbara, CA. While I was truly grateful to be working with good people in good palliative care and hospice programs, I had become aware that I was no longer happy in my work. I noticed that I was not excited, as I had been in my early days in hospice and palliative care, to go to work each morning. In fact, I was feeling emotionally and physically pretty run down much of the time. I no longer had that inner “hum,” that inner “knowing” that was there in the past, and that came from sensing that I was in and doing the right work. Instead, I had a pervasive feeling that I was not doing what I really wanted to do and was doing too much of what I did not want to do anymore. I realized that I was burnt out.

As I reflected on how this might have happened, and talked about it with my clinical supervisor, I came to see that this was probably at least in part due to the 29 years of almost daily exposure to profound human suffering that came from working in end-of-life care; burnout as a result of chronic vicarious traumatization and compassion fatigue, in other words. However, I concluded that this was neither the only nor possibly the main reason. When Harrison and Westwood [8] described exquisite empathy in the way they did, they described something that I was familiar with. I could relate to the protective and renewing power of this way of being with others in their suffering. Indeed, when I did an inventory of those aspects of my work that were most meaningful and replenishing for me, I identified just such occasions of being with another in a mutuality of suffering and healing, wounded healers together.

I concluded that the other significant contributor to these feelings of burnout was a growing mismatch between who I was, or had become, and the role and tasks I was expected, needed to, and was paid to perform in my work every day. Burnout as a result of the slow grinding down that comes from being “a square peg in a round hole,” in other words. I knew that long-term sustainability in our work is dependent on there being at least a “good-enough” fit between our calling and our responsibilities. I realized that I needed to pay attention to this and that I would need to make some changes. I asked myself how much of this was about inner, subjective change; if I didn’t have much flexibility in *what* I was doing at that time, were there changes in *how* I was doing what I was doing that could make a difference? And how much was it about needing to try to change external, objective circumstances so that what I was doing in my work, whether in my current or some other work setting, would be more aligned with who I was?

## Burnout

Burnout (BO) results from stresses that arise *between the clinician and his or her work environment*. The syndrome of BO may present as overwhelming exhaustion – emotional and physical – as feelings of cynicism and detachment from the job, and/or as a sense of ineffectiveness and lack of personal accomplishment [11, 12]. BO results from frustration, powerlessness, and inability to achieve work goals [13].

Other symptoms of BO may be apparent at an individual or at a team level. For example, an individual may experience poor judgment, overidentification or overinvolvement, boundary violations, perfectionism and rigidity, interpersonal conflicts, addictive behaviors, frequent illnesses that include headaches and gastrointestinal disturbances, and immune system impairment [14]. A team that is experiencing BO may have chronically low morale, poor job retention, impaired job performance, and frequent staff conflict [15].

Maslach et al. [14] suggest that a “mismatch” between the individual and the organization may lead to BO. They identify six areas of worklife, namely, workload,

control, reward, community, fairness, and values, and postulate that BO arises when there are chronic mismatches between individuals and their work settings in some or all of these areas. On the contrary, the better the match or fit between the individual and their work environment, the greater will be their job engagement and satisfaction.

## The Rainmaker

There is story of a Rainmaker of Kiao-chau that was told to Carl Jung by his friend, Richard Wilhelm. Wilhelm, a Christian minister, Sinologist, and the author who introduced the West to the *I Ching* [16] witnessed this incident during his time in China. Jung was very taken by the story. His students describe how he told them never to teach a seminar without including the story of the rainmaker [17]. Here is Jung's own version of the story [18]:

There was a great drought where Wilhelm lived; for months, there had not been a drop of rain and the situation became catastrophic. The Catholics made processions, the Protestants made prayers, and the Chinese burned joss sticks and shot off guns to frighten away the demons of the drought, but with no result.

Finally, the Chinese said, "We will fetch the rain-maker." And from another province, a dried-up old man appeared. The only thing he asked for was a quiet little house somewhere, and there he locked himself in for three days.

On the fourth day, the clouds gathered and there was a great snowstorm at the time of the year when no snow was expected, an unusual amount, and the town was so full of rumors about the wonderful rainmaker that Wilhelm went to ask the man how he did it. In true European fashion, he said: "They call you the rain-maker, will you tell me how you made the snow?"

And the little Chinese man said: "I did not make the snow, I am not responsible."

"But what have you done these three days?" Wilhelm asked.

"Oh, I can explain that. I come from another country where things are in order. Here they are out of order, they are not as they should be by the ordinance of heaven. Therefore the whole country is not in Tao, and I also am not in the natural order of things because I am in a disordered country. So I had to wait three days until I was back in Tao and then, naturally, ... the rain came."

## Becoming Rainmakers

The story of the rainmaker could be read as a story of burnout, in this case, the parched lands, dying animals, and suffering humans in a drought-ridden part of China, which had not seen replenishing rains for some time. It tells of how burnout is a consequence of being "out of Tao," that is, of being disconnected from our deepest selves, which, the story implies are contiguous with the rhythms of the natural world, and how *the primary move* in addressing burnout is to do whatever it is we need to do to "come into Tao," for "then, naturally, the rain comes."

“To be in Tao” brings healing to ourselves and to the other (in this case the drought-ridden land and its peoples). And yet we note that the rainmaker did not “do” this, in the sense of willing and acting to make it happen in a causal way. Rather, the resolution of the drought, the weather’s once again coming “into order,” was in some mysterious, noncausal way related to the inner work he did, his own coming into Tao, for “healing begets healing begets healing ...” [19]. This story suggests that if we want to achieve healing in our own lives, including the healing of burnout, and if we want to be healers to others, we, like the rainmaker, must first come into balance, into order, “into Tao.”

## Soul and Role

Educator and author Parker Palmer offers a helpful way of thinking about how we might do this when he speaks of the importance of aligning “soul and role” [20]. Writing of the sense of calling or vocation in our work, Palmer observes, “Vocation does not mean a goal that I pursue. It means a calling that I hear. Before I can tell my life what I want to do with it, I must listen to my life telling me who I am. I must listen for the truths and values at the heart of my own identity, not the standards by which I *must* live – but the standards by which I cannot help but live if I am living my own life” [21].

Palmer suggests that vocation is an expression of soul, which “wants to keep us rooted in the ground of our own being” [20]. The consequences of a disconnection between soul and role is what Palmer calls a “divided life” leading to psychological pain that we “try to numb ... with an anesthetic of choice, be it substance abuse, overwork, consumerism, or mindless media noise” [20]. While a disconnection between the calling of our core or deepest selves and what we do in our work may lead to burnout, a realignment of soul and role may lead to an experience of joy and flourishing. And our personal choice to realign our lives in such a way may have more than purely personal consequences because our individual soul is contiguous with a wider and deeper web of connectedness. As I attend to my soul, I am simultaneously tending *Anima Mundi*, the soul of the world, and my act of personal responsibility becomes one of service. As Palmer puts it, “As we [align soul and role], we will not only find the joy that every human being seeks – we will also find our path to authentic service in the world. True vocation joins self and service, as Frederick Buechner asserts when he defines vocation as “the place where our deep gladness meets the world’s deep need” [21, 22].

## Healing Connections and Meaning-Based Coping

In a phenomenological study, Mount and his colleagues interviewed 21 patients with life-threatening illness who were experiencing either existential anguish or, conversely, integrity and wholeness, in an attempt to identify “inner life” and existential contributors to suffering and subjective well-being in advanced illness [23]. In their

discussion of their findings, they state: “A sense of meaning was evident in those able to find a sense of well-being and wholeness in facing serious illness, while a sense of meaninglessness was common to those experiencing suffering and anguish. Meaning-based coping was associated with a capacity to form bonds of connection, what we came to call healing connections in response to the evident revitalization, sense of security, and equanimity that accompanied them” [23]. Mount et al. [23] identify these healing connections as being in one of four areas: “Connection with self, others, the phenomenal world experienced through the five senses, and with God or ultimate meaning, however conceived by that person,” and continue, “The experience of healing connections, in large part, characterized the striking difference between those with ‘positive’ and ‘negative’ coping patterns.”

The implications of these findings in the prevention and mitigation of both BO and CF are evident. Healing connections bring a sense of meaning, which allows us to not only survive but also thrive in our work. Exquisite empathy offers a roadmap on how this might be possible in even the most challenging of circumstances. As Harrison and Westwood put it, “exquisite empathy ... affords clinicians opportunity to ethically benefit from ‘healing connections’ [23] with clients, without sacrificing clients’ needs to their own. In this sense, exquisite empathy may constitute a form of mutual, reciprocal, healing connection, in which clients and clinicians alike benefit from the latter’s caring, well-boundaried, ethical attunement to the client” [8].

How each of us establishes healing connections is a highly individual process. The four domains identified by Mount et al. offer us a useful framework to consider some possibilities:

1. *Within the Individual*: Meditation, Reflective writing, Dream work
2. *With Others*: Quality time with significant others, Humor
3. *With the Phenomenal World*: Exercise, Yoga, Massage, Nature, Music
4. *With Ultimate Meaning*: Spiritual and religious practice, Creative expression

## Developing Clinician Self-Awareness

We suggest that clinician self-awareness is the key to a whole person approach to self-care. Clinician self-awareness can mitigate CF and BO. Clinician self-awareness can enable us to practice exquisite empathy, to make choices that align soul and role, and to establish healing connections. We identify four overlapping and complementary aspects of clinician self-awareness: self-knowledge, self-empathy, preparing the mind through the practice of mindfulness, and contemplative awareness.

*Self-knowledge* lays the foundation for clinical awareness. This means becoming familiar with our family history, our cultural, racial, and religious history, as well as our individual strengths and limitations. Having an insight into our background allows us to work through emotional challenges so that these will not get repressed or projected onto others. This allows us to recognize “Transference”

(the unconscious redirection of feelings from one person to another, for example, from patient to clinician) and “Countertransference” (the clinician’s unconscious projection onto the patient and/or his or her reaction to the patient) [24], enabling the clinician to engage in the therapeutic encounter with more awareness and less reactivity. Some possible ways for the clinician to increase self-knowledge include counseling or psychotherapy, peer-group or individual clinical supervision, and reflective writing.

*Self-empathy* is an essential complement to self-knowledge. As we become more familiar with ourselves through the practice of self-knowledge, we may not like what we see and become self-critical and judgmental. Self-empathy includes noticing how hard it is for us to accept our imperfections and mistakes with an attitude of warmth and self-acceptance while simultaneously being committed to finding a way to become more forgiving and compassionate toward ourselves. Certain practices from the Buddhist tradition are especially helpful in developing self-empathy. Metta or Loving-Kindness Meditation is an explicit practice of opening the heart with empathy and compassion towards oneself and others [25].

*Preparing the Mind* involves developing three specific cognitive skills: focused-awareness, mindful-self awareness, and dual-awareness. Mindfulness Meditation practice can be used to cultivate these three cognitive skills, which are synergistic with one another. Meditation teacher and author Jon Kabat-Zinn describes Mindfulness Meditation as a process of developing careful attention to minute shifts in body, mind, emotions, and environment while holding a kind, nonjudgmental attitude toward self and others [26]. *Focused awareness* is the platform from which we prepare the mind and is taken here to mean the stabilization and direction of attention. Tibetan Buddhist teacher and author Alan Wallace emphasizes the importance of deep relaxation, stabilization of the mind, and an attitude of vividness in his method of teaching mindfulness of breathing to focus the mind [27]. *Mindful self-awareness* arises naturally from focused awareness. It means being able to witness the stream of our thoughts, physical symptoms, and feelings without commentary, reaction, or comparison. *Dual awareness* is a cognitive stance that permits the clinician to simultaneously attend to and monitor his or her own subjective experience and the needs of the patient and/or the work environment. It is the ability to be simultaneously aware of our inner and outer experience without reactivity, or at least with the ability to be conscious of our reactivity. Dual awareness builds on the practices of focused awareness and mindful self-awareness. Through focused and mindful self-awareness, we attend to and witness our experience in a nonjudgmental way. As we do so, we may notice moments of expanded awareness, when we are aware that we are aware of the object of our focused mindfulness, or possibly that we have just been distracted by a thought. With time and practice, we can deliberately choose dual-awareness, use it to monitor the quality of our attention in meditation practice, and, in time, begin to include it in clinical and social contacts as a means of self-monitoring. This can help to prevent us from getting trapped in reactivity or self-preoccupation and allow us to respond to the patient with more flexibility and greater sensitivity.

*Contemplative Awareness* is awareness that we as individuals are situated in a larger field of relationships. Psychologically, this includes the recognition of the intersubjective field in the therapeutic encounter, and of an archetypal or universally shared dimension to our experience. Spiritually, it can be understood as the experience of our relationship to the sacred. It includes becoming aware how we find meaning through our values, our cosmology, and our philosophy of life. Practices to develop contemplative awareness will be unique to each of us as individuals. They may include some of the methods of establishing “healing connections” outlined above.

### A Proposed Self-Awareness-Based Model of Self-Care

In Fig. 10.1, a proposed Self-Awareness-Based Model of Self-care and its consequences builds on the hypothesis that clinician self-awareness enhances self-care [28] and is supported by recent empirical data [29].

In the proposed model, two adjacent, symmetrical circles represent contrasting pathways in response to occupational challenges for the clinician in his or her interactions with the work environment and the patient’s suffering. The circle to the left illustrates possible negative consequences of the clinician’s interactions. The circle to the right represents possible positive consequences of the same interactions.

The amount of self-awareness determines which route the clinician travels. When functioning with less self-awareness, clinicians are more likely to lose perspective, suffer more from stress in interactions with their work environment,

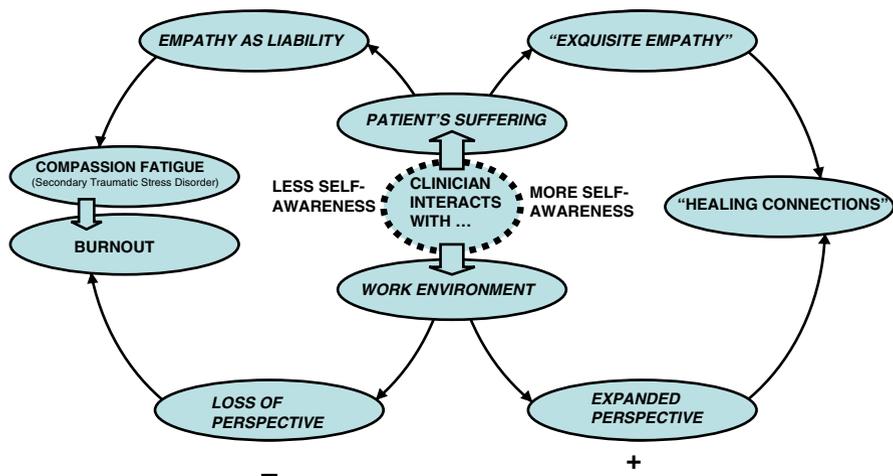


Fig. 10.1 A proposed self-awareness based model of self-care

experience empathy as a liability, and have a greater likelihood of compassion fatigue and burnout. On the contrary, clinicians functioning with greater self-awareness are more likely to have an expanded perspective, experience less stress and more satisfaction in interactions with their work environment, experience exquisite empathy in their interactions with their patients, and promote healing connections with themselves, their patients, their family, and their colleagues.

Self-care may be practiced with or without enhanced self-awareness. Methods of self-care that do not specifically increase self-awareness, such as maintaining clear professional boundaries, can offer protection at work and renewal outside of work. Self-awareness-based methods of self-care, however, offer the additional possibility of finding regeneration *within* the work environment and clinical encounters, for example, through the practice of exquisite empathy and by establishing healing connections.

## **Organizational Benefits of a Self-Awareness-Based Model of Self-Care**

The successful implementation of a self-awareness-based model of self-care depends on the choices, commitment, and practices undertaken by the individual clinician. However, unless there is also support from the organization within which that individual works, this may simply become another source of frustration and stress. While it would be nice to think our organizations would choose to support such initiatives for altruistic reasons, it is unlikely that this will happen. Organizations need to be persuaded that there are potential tangible benefits from such practices for the organization and its bottom line. These may include increased staff retention and reduced absenteeism, increased employee morale and job satisfaction, reduced employee conflicts, employees who are present, empathic, and effective, and increased patient and family satisfaction. If our organizations understand this, they will realize that an investment in encouraging and facilitating clinician self-awareness and self-care is a sound business strategy that benefits staff, clients, and the healthcare organization. They may, then, accept that this is a joint responsibility of *both* organization and employees.

## **The Story Now**

One year later, and now 30 years in end-of-life care, I continue to work full-time as a physician in palliative care and hospice. The external circumstances of my work have not changed, in part, because it is not possible for me to do so at this time. Over the past 12 months, I have continued to reflect, individually and in dialog with others, on what it means to live with the daily reality of compassion fatigue and burnout as I continue to work with my colleagues in trying to alleviate suffering and promote

healing in those we care for. I have come to certain insights that are sustaining me in work. While I realize they are personal and individual, I share them in the hope that they may have some resonance for others:

- Self-care is not a luxury. It is an ethical and clinical imperative. It affects both my sustainability as a clinician and the quality of my work.
- Clinician self-awareness is the key. It allows me to survive, maybe even to thrive, in even the most adverse of circumstances. It is like a psychophysiological process that generates the oxygen I need to breathe underwater.
- Self-care is an ongoing process that needs to become as integral a life practice as eating or sleeping.
- From time to time, I will make an inventory of those aspects of *my work* that are most meaningful and satisfying by asking myself, “Where and when am I most myself and most awake, alive, and connected in my work?” I will try to include as many of these aspects of my work as I can and, ideally, have them written into my job description at the expense of those parts of the job that are most depleting.
- From time to time, I will make an inventory of those aspects of *my life* that are most meaningful and satisfying by asking myself, “With whom, where, doing what, am I most awake, alive, and connected and most myself?” I will commit to making space and time for those relationships, activities, practices, and places that are most nourishing to me and that bring the deepest sense of healing connectedness.
- If, despite making what changes I can in and outside my work, I become increasingly burnt out, I will consider either a partial or complete job change to allow for a greater soul-role alignment when circumstances allow.

## Practicing Clinician Self-Awareness

The wholeness is already there. Our task as healers, of ourselves as well as others, is to remember this, to radically re-member this, and to do so both *inside* as well as *outside* of the workplace. This is not as easy as it sounds, but it is possible if we develop clinician self-awareness. Clinician self-awareness involves a commitment to deepening in self-knowledge, the practice of self-empathy and mindfulness, and experiencing connectedness and the sacred through the practice of contemplative awareness.

Practicing clinician self-awareness makes whole person self-care possible. Clinician self-awareness in the workplace allows us to engage in exquisite empathy with the possibility of protection from traumatization while simultaneously finding sources of nourishment and renewal in the work itself. But this alone is not enough. We also need times of retreat, times when we step back and completely away from our work and immerse ourselves in whatever is most deeply meaningful for us. Such times of retreat allow us to see our work from a different perspective, to sense the bigger picture and to discern if soul and role are in alignment. This allows us to experience healing connectedness, to rest in the source, to be in Tao, and then, naturally, it rains.

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