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**Article** *in* Journal of Humanistic Psychology · September 2020

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# The Influence of Compassion Meditation on the Psychotherapist's Empathy and Clinical Practice: A Phenomenological Analysis

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**Abstract**

Mindfulness and compassion meditation practices have repeatedly been shown to have a positive impact on empathy and prosocial behavior. This study examines the perceived influence of compassion meditation on the psychotherapist's empathy and clinical practice, beyond benefits already gained from a practice of mindfulness meditation. Three psychotherapists, who had already been practicing regular mindfulness meditation, engaged in compassion meditation training over a 4-week period. Repeated semistructured interviews were conducted before and after the 4-week period, as well as 1 month later. Phenomenological analysis of the interview data showed a perceived influence of compassion meditation on four main aspects labelled as follows: (a) The therapist's relation to self, (b) Experiencing empathy, (c) Living a therapeutic relationship, and (d) Integrating change.

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Challenges and other stumbling blocks on these practices on compassion were also addressed by participants. These findings provide evidence for the inclusion of compassion meditation training in psychotherapy training curricula, as well as in burnout-prevention workshops.

**Keywords**
compassion, mindfulness, empathy, clinical practice, therapeutic relationship, psychotherapy training

Strong evidence supports the fact that empathy is an essential component to the therapeutic alliance across theories and required in the psychotherapeutic or counselling process (Peller & Rocco, 2003). For Rogers (1992/1957), empathy, or the capacity to "sense the client's private world as if it was your own, but without ever losing the 'as if' quality" (p. 829), is a necessary condition for change and the basis of the therapeutic relationship (or psychological contract), along with congruence and unconditional positive regard. Empathy was extensively researched in the 1970s and 1980s, and then scientific interest slowly decreased. Scientific attention for empathy was recently rekindled as progress in neuroscience made it possible to observe the development and functioning of the neural structures associated with empathy (Elliott et al., 2011). Empathy involves perspective taking, self-consciousness, and emotional regulation (Couthino et al., 2014; Decety & Jackson, 2006). This capacity requires openness, acceptance, and presence from moment to moment, in order to establish empathic rapport, communicative attunement or an understanding of the whole person (Bohart et al., 2002).

By definition, empathy is distinct from compassion in that it does not inherently imply the desire to help or alleviate the suffering of the other. While the terms are related, compassion includes not only the perception of suffering, but caring and a desire to help (Siegel & Germer, 2012). Neff (2003) defined self-compassion as having three components: (a) being mindful of one's thoughts and feelings, (b) connecting with others and being conscious of our shared humanity, and (c) adopting an attitude of self-kindness, rather than being judgmental. Quite evidently, both empathy and compassion rely on awareness of a person's suffering. Mindfulness, defined as an awareness of the present moment, without judgment (Kabat-Zinn, 2005), facilitates both empathy and compassion.

Accordingly, over the past three decades, there has been a growing interest in mindfulness meditation's impact on neural structures associated with empathy (Davidson, 2012; Weng et al., 2013), and on the therapeutic relationship (Bien, 2008; Hick, 2008; Siegel, 2010). Such mental training appears

to many scientists and clinicians to be a promising way to develop a therapist's presence and acceptance during the therapeutic encounter. Numerous studies confirm that mindfulness practice is beneficial to the therapist's counselling skills (Buser et al., 2012), therapeutic presence (Padilla, 2010), the therapist's acceptance of self and others (Campbell & Christopher, 2012), and the therapist's self-care (Christopher et al., 2011; Shapiro et al., 2007). Mindfulness meditation thus appears to have a positive effect on the therapeutic relationship, this being one of a number of common factors that are related to psychotherapy outcomes (Lambert & Barley, 2002; Lambert & Ogles, 2014; Lambert & Simon, 2008; Norcross, 2002).

Amid growing interest in mindfulness meditation and its many applications in psychotherapy, interest in related compassion meditation practices has also increased (Hofmann et al., 2011). Meditation practices are a family of attention and emotion regulation practices. Some practices concentrate on the development of focused attention to stabilize the mind. Other practices, often taught when the mind is stabilized, aim at developing an open awareness, and the ability to attend to whatever arises in the present moment, with acceptance; such open awareness characterizes mindfulness. Other practices focus on developing specific qualities or virtues through guided meditation; loving-kindness and compassion meditations fall under this third category (Lutz et al., 2008). In Buddhist psychology, the practice of loving-kindness and the practice of compassion meditation are closely related. Along with joy and equanimity, these highly regarded values are known as the "Four Immeasurable Minds" (Bien, 2008; Salzberg, 1995). Loving-kindness meditation (*Metta)* involves the cultivation of positive emotions toward oneself and others, wishing for all to be safe, healthy and happy. In compassion meditation (*Karuna*), the person first focuses on the suffering of self and others, thus evoking empathy and a sense of caring, and then concentrates on the aspiration that these people may be free from suffering.

Increasingly over the last decade, loving-kindness and compassion meditations are being taught within interventions that focus on the cultivation of compassion. A number of these are empirically supported, according to an overview and synthesis of currently available compassion-based interventions (see Kirby, 2016). For example, compassion-focused therapy (Gilbert, 2012) is particularly intended for individuals with high levels of self-criticism and shame. Through a series of exercises (e.g., safe space imagery), compassion-focused therapy provides guidance for the creation of one's own ideal compassionate-self. Results from a recent meta-analysis of Kirby et al. (2017) found that compassion-based interventions can significantly reduce suffering-based outcomes of depression, anxiety, and psychological distress ($N = 21$ studies; 1,285 participants). It appears that just a few minutes of

loving-kindness meditation can increase positive attitudes toward others (Hutcherson et al., 2008) and that short-term compassion training can lead to increases in prosocial behaviors (Leiberg et al., 2011). Furthermore, Galante, Bekkers and Gallacher, (2014) produced a systematic review and quantitative meta-analysis of the effects of loving-kindness meditation and compassion meditation on health and well-being ($N = 22$ studies; 1,747 participants). Compassion meditation was shown to be moderately effective for increasing mindfulness, compassion, and self-compassion. In addition, two weeks of training in compassion meditation was associated with altruistic behavior and shown to alter neural responses to suffering (Weng et al., 2013).

Through such studies, loving-kindness and compassion meditations have been shown to have many beneficial impacts for the general population as well as for health care professionals. In a qualitative study of Boellinghaus et al. (2013), 11 trainee therapists who had previously attended a mindfulness-based cognitive therapy course and who took part in a six-session loving-kindness course were interviewed about their experience. Participants reported that loving-kindness meditation had increased their self-awareness and compassion for self and others. They reported that this type of meditation had been beneficial for their self-care and clinical work, enhancing their therapeutic presence and skills. A quantitative study of 198 psychologists and trainee psychologists found that self-compassion significantly negatively predicted emotional stress symptoms via a reduction in emotion regulation difficulties (Finlay-Jones et al., 2015). In other words, these findings suggest that individuals who are more self-compassionate are less vulnerable to difficulties controlling impulsive behavior when experiencing stress, are more able to accept difficult emotions, and are more prompt to use appropriate emotion-regulation strategies. It has also been shown that compassion meditation training increases empathic accuracy (Mascaro et al., 2013b) and that preexisting neurobiological profiles differentially predispose individuals to engage with disparate meditation techniques (Mascaro et al., 2013a). This would suggest that more empathic individuals, such as psychotherapists, may be able to engage more fully with compassion meditation.

There is growing interest in what compassion meditation practices might contribute to the psychotherapist's development of essential therapeutic skills such as empathy or compassion (see Bibeau et al., 2016, for a review; Bennett-Levy & Finlay-Jones, 2018), but little is known about how compassion meditation affects the psychotherapist and his clinical practice. In other words, what does compassion meditation really change in psychotherapists' empathetic experience and clinical practice beyond the benefits already gained from mindfulness meditation? Consequently, the purpose of the present study is to better understand the perceived influence of compassion meditation on

psychotherapists' empathy and clinical practice, through a description, from a lifeworld perspective, of the experience of seasoned psychotherapists. To our knowledge, much of the existing research has focused either on student counselors or novice meditator*s*. A qualitative design was deemed appropriate to study the impact of compassion meditation on psychotherapists' empathy. According to Patton (2002), this type of design allows one to study a phenomenon as it naturally happens. It offers flexibility in the study process to better understand the phenomenon as it fluctuates and changes. A qualitative design, and more specifically a phenomenological analysis, is also particularly useful when one wishes to gain insight regarding a subjective phenomenon, like empathy and compassion, from the participants' perspective and experience (Paillé & Mucchielli, 2012). A qualitative design *also* allows the researcher to select participants on the basis of the richness and pertinence of the information they can provide, rather than relying on aleatory selection (Patton, 2002).

## Method

### *Participants*

Recruitment of participants was initiated through a letter of invitation, sent via the research support services of The Order of Psychologists of Quebec (l'Ordre des psychologues du Québec), to all registered psychologists in the Gatineau (Quebec) area. This first invitation yielded but a few candidates, among whom only one met all the inclusion criteria for the study. A snowball procedure was then used to contact potential candidates. Participants were required to be registered psychologists in Quebec, in order to establish a minimal common training background, and to have at least 5 years of experience in psychotherapy and a minimum of one year of mindfulness meditation experience. The principal researcher (Marc Bibeau [MB]) inquired into participants' regular meditation practices during the first telephone contact, to ensure that their practice did not already include loving-kindness or compassion meditation.

The first participant dropped out after a week of compassion meditation training for personal reasons. The next three candidates who met the selection criteria were included in the study. Two women and one man enrolled in the study. Each participant had over 20 years of experience as a psychotherapist and over 8 years of experience in mindfulness meditation.

### *Compassion Meditation Training*

Participants were provided with an MP3 recording of a guided compassion meditation procedure and were asked to practice at least three to four times

per week for 4 weeks. Since it was felt that participation in the study already represented quite a commitment, it was decided not to ask participants to put aside their regular meditation practice altogether. It was rather proposed that they alternate between their regular daily practice and the compassion meditation. However, participants were free to practice more often. Two of the participants chose to practice the compassion meditation daily, and one added compassion meditation to his daily routine.

The guided meditation provided to participants was borrowed from the Weng et al. (2013) study. The script of this guided compassion meditation had graciously been made available via the website of the Center for Healthy Minds (https://centerhealthyminds.org/). The original script was 30 minutes long. It was translated into French by the principal researcher (MB) and was shortened to a 20-minute version, as it was felt that this change might encourage participants' compliance, without interfering with the quality of the meditation. This guided compassion meditation unfolds through six stages. First, loving-kindness is directed toward a loved one. Then, as one imagines that the loved one is suffering, compassion is directed toward this person. Then, compassion is directed toward the self, as one imagines oneself in a difficult situation. Next, compassion is directed toward a neutral person who experiences suffering. Next, compassion is directed toward a person with whom one's relationship is difficult and who also experiences suffering. Finally, compassion is directed toward all beings.

Participants were asked to meditate with a second version of the compassion meditation at the beginning of the second week of training. This modified version was introduced to sustain participants' motivation and to hone in on particularities that might hold more meaning for psychotherapists; it was inspired by Morgan and Morgan's (2005) who recommended exercises to cultivate empathy. In this version a neutral client and a difficult client replace the neutral person and the difficult person. During Weeks 3 and 4, participants were invited to choose whichever version they preferred.

## *Data Collection*

To better understand, the perceived influence of compassion meditation on the psychotherapist's empathetic experience and clinical practice and ensure validity of the data (Whittemore et al., 2001), data were collected through a variety of sources such as semistructured interviews, a meditation journal and correspondence by emails with the researcher during the week. Participants were interviewed three times by the principal researcher (MB) at their consultation office: once before any compassion training, again within a week of completion of the 4 weeks of compassion training, and a third 4 weeks later.

The initial interview questions related to the participant's psychotherapeutic approach, their meditation background and their regular practice. Following interviews focused mainly on the impact of compassion practice on empathy (e.g., definition of empathy, how exactly empathy was felt during a therapy session, and how it contributed to the therapy) but participants tended to report their experiences inside and outside the therapy room. To anchor the interview in the participant's lifeworld, participants were invited to talk about a specific case that they felt to be representative of their experience. Questions were also asked about what participants felt when confronted with a client's suffering, and how they responded to these feelings. Participants were also asked whether compassion had influenced their feelings and actions in therapy, and if so, in what ways. The interviewes made room for more specific questions, based on data collected during preceding interviews and via the participant's meditation journal. Difficulties that participants might have experienced during the training were also addressed. Interviews lasted between 30 and 45 minutes, excluding social talk at the beginning and end of each interview. Interviews were digitally audio recorded and were later transcribed by a research assistant.

## *Data Analysis*

The main researcher (MB) performed the analysis of the data by following the steps identified by Paillé and Mucchielli's (2012) and Giorgi and Giorgi (2003) for a phenomenological analysis. First, MB attended attentively to the phenomenon being studied by reading and rereading transcriptions of the recorded interviews of each participant to get the gist of them. Second, units of meaning from the transcripts were extracted by marking off relevant passages based on the research question. Third, the meanings in data were made explicit via an interpretive process that involves the identification of aspects of the experience (or "themes") and the assignment of a thematic label (see also Smith & Osborn, 2003). The elaborated units were then blended into a narrative of the participant's experience throughout the entire study. The narrative was then emailed to the participant, and the participant was asked to validate their narrative. Participants were invited to feel free to comment or even rewrite any portion of the narrative. The three participants agreed entirely with the narratives. One participant commented that the narrative enhanced her own understanding of her experience, while at the same time accurately capturing it in every respect. Another participant commented that he felt totally at ease with the narrative and was moved by the way it presented his experience. Fourth and last, the narratives were then further analyzed to identify psychological invariants or common constituent elements across the three narratives

that would capture the underlying essence of the phenomenon being studied (Deschamps, 1993; Giorgi & Giorgi, 2003; Paillé & Mucchielli, 2012). Several structures were discussed with the co-researchers (Frédérick Dionne, Jeannette Leblanc) to come up with a final structure comprising various aspects and dimensions of the phenomenon being studied.

### *Declaration of Researcher Bias*

Since a qualitative study relies primarily on the researcher's capacity to take participants' perspective and share their worldview, it is inevitable that interpretation of the data may be influenced by certain biases. Staying aware of these biases throughout the research process provides a measure of protection against undue influence of these biases and contributes to the validity of the whole endeavor. To remain mindfully aware of potential biases, MB noted his reflections about the study's guided compassion meditation in a journal, and he kept track of his thoughts and insights in a diary throughout every phase of the study.

## Results

Phenomenological analysis of the participants' narratives highlighted the perceived influence of compassion meditation on four main aspects labelled as follows: (a) The therapist's relation to self, (b) Experiencing empathy, (c) Living a therapeutic relationship, and (d) Integrating change. Each of these aspects is further defined through one or more dimensions that will be described below. Challenges and stumbles encountered by participants throughout this study constitute another important aspect of their experience with compassion meditation that will also be addressed.

### *The Therapist's Relation to Self*

One major aspect of the psychotherapists' experience that seemed to benefit from this meditation involved the relationship with themselves. Since dimensions pertaining to this aspect of the therapists' experience were so pervasive throughout the narratives, the therapists' relation to themselves was regarded as the first main aspect to be considered. Self-compassion and performance pressure are two dimensions of this aspect of the therapists' experience.

*Self-Compassion.* Each participant reported that the compassion meditation had an influence on their level of self-compassion. In fact, throughout the three narratives, self-compassion appeared to be the foundation of all other impacts and benefits of compassion meditation on participants:

Anna: Compassion meditation helped me develop more tenderness toward myself and more compassion toward my own suffering when I get caught in my own patterns as I try to help others through their suffering.

Bill: Through this meditation, I have come to see very clearly that it all starts with ourselves and that we are all interrelated; being more indulgent toward myself makes it easier to be so with others.

*Performance Pressure.* Participants also reported that throughout this meditation practice, they came to feel less pressure to perform or to offer a quick fix that would alleviate their client's suffering. Anna expressed this the most explicitly:

> Through these four weeks of compassion meditation, I have realized how much pressure I felt coming from the clients, from my professional organization, and from myself. [ . . . ] I feel that when I am under this pressure I somehow tend to impose a solution to my clients, without even realizing that I am doing so [ . . . ]. Compassion meditation freed me from this pressure and I came to accept myself as I am, human and imperfect, and to simply do my best.

## *Experiencing Empathy*

Participants talked about their personal definition of empathy, how they felt it, and how it contributed to their work in therapy. Though they did not explicitly refer to these dimensions in their formal definition of empathy, our three participants underlined the impact that compassion meditation had on their quality of presence, acceptance, and tolerance for suffering, as well as noting that even subtle changes within these dimensions of empathetic experience allowed them in turn to feel more empathetic. As participants discussed these matters, similarities and differences between empathy and compassion were also highlighted, revealing more about the experience of compassion.

*Quality of Presence.* Participants noted that the practice of compassion meditation had an influence on the quality of their presence with clients. Being more present allowed them to better accompany the client's exploration and comprehension process with empathy:

Anna: I'd say that compassion meditation and the changes I made in my professional practice in its wake helped me to be more present and more available to my clients, both emotionally and intellectually; I dare say more empathetic.

*Acceptance of the Other.* Participants also reported that this type of meditation influenced their capacity to welcome and to accept the client as a person beyond the presenting symptom and the suffering:

> Clara: As I welcome the client with compassion for his whole being, it becomes an invitation and even some kind of modelling for him to develop such compassion for the parts of himself that are rejected.

The concept of equanimity was particularly important for our second participant, and it was decided to include it within this dimension. Equanimity is defined as the "capacity to accept whatever comes undisturbed" (Bien, 2008, p. 45).

> Bill: While it was initially difficult for me to reconcile the practice of compassion with the equanimity I strive to achieve, I realize now that equanimity is much more elusive than I thought and that these two states of mind are linked and mutually reinforcing. . . . All in all, I feel that compassion meditation strengthened my equanimity.

*Tolerance for Suffering.* As the preceding dimension of the empathetic experience dealt with acceptance of the client's whole being, this dimension refers to acceptance of the client's suffering. It is no easy undertaking to stay with the client through his ordeal, providing a secure holding environment for him to explore, understand, and finally come through his suffering. In the long run, mental health professionals are prone to burnout or empathy fatigue (Boellinghaus et al., 2013). According to our three participants, compassion meditation enhanced their capacity to tolerate their clients' pain and to accept it with calmness and serenity.

> Bill: Through these four weeks, compassion meditation helped me to get closer to the roots of my client's suffering, without getting caught in a defensive reaction to this suffering . . .
> Clara: Compassion allows for a greater acceptance of suffering which I see more now as part of human nature. Because of this greater acceptance of suffering I feel less urgency to decrease or silence it. I note that I feel less turmoil inside of me as I face the client's suffering.

Changes in the way participants experience empathy were brought about through changes already mentioned above, regarding their quality of presence, acceptance of the client, and tolerance of the client's suffering. Participants also indicated that they felt more empathetic through an

increase in their sensitivity, as well as a reduction in sympathy and emotional contagion:

> Bill: Compassion meditation allowed me to increase my empathetic position and reduce my sympathetic position . . . I feel that compassion meditation has strengthened my capacity to take the necessary step back so as not to feel attacked by the client's anger and to see it more as an expression of his suffering . . . I would say that my desire for the client to be free from his suffering is now more authentically turned toward the client's well-being . . .
>
> Clara: I can feel that this meditation consolidated something that was already developing within myself through experience and maturity. Compassion meditation cultivates a kind intention toward the client and it allows me to welcome the client's inner experience and to contain it within something much larger and kinder.
>
> Anna: Before I started to meditate on compassion, I often had the impression that I synchronized myself with the client's emotional state. As much as it gave me cues as to what the client might be feeling, I also needed to take care not to be engulfed in these feelings. As I became more self-compassionate, I also became more able to remain present with the client's suffering without making it my own.

*Experiencing Compassion.* Although there can be some confusing overlap between empathy and compassion, participants were keenly aware of the differences between the two concepts and their complementarity. The participants described the meeting points of these two concepts in surprisingly similar ways:

> Anna: The similarity between empathy and compassion lies in the perception and understanding of another person's suffering. The difference lies in what you do with it.
>
> Bill: As I said, for me empathy remains the capacity to see and feel what the other person is feeling, to remain present and to tolerate his suffering; compassion meditation has now added a softer dimension to this: the wish that the other may free himself from this suffering. And this wish is now more authentically turned toward the other's well-being.
>
> Clara: For me, empathy remains the capacity to step into someone else's shoes and to feel what this person may be going through. However, it doesn't necessarily involve feeling compassionate toward this person. This is a very important distinction that influences the therapeutic endeavour. As empathy allows us to feel and understand a client's

anger or his sadness, compassion introduces a benevolent intention to welcome the person who bears these difficult emotions with something that can ease her suffering.

## *Living a Therapeutic Relationship*

Participants also discussed the influence of compassion meditation on altruistic love and therapeutic intentions.

*Altruistic Love.* Both Bill and Clara explicitly pointed to compassion meditation's impact on a very particular dimension of the therapeutic relationship that can be described as altruistic love:

Clara: When a client expresses her contempt, empathy helps me to hear the suffering underneath the contempt, and compassion helps me love this person within a larger dimension than the contempt.

Bill: Compassion's impact is almost like a quantum leap, I don't know why but I think it is love. Honestly, I think this is due to the love dimension it introduces and on which we concentrate during the meditation.

*Therapeutic Intentions.* Since each participant reported that compassion meditation influenced one aspect or another of her therapeutic intervention, it was decided to include all of these impacts under the umbrella of therapeutic intentions. Included in this dimension are comments bearing on the therapeutic intention itself, the therapeutic stance, therapeutic interventions, and techniques. Though each participant mentioned changes regarding some of these aspects, Clara talked about it at length:

> For me, it is the therapist's responsibility to remain aware of her intentions. Techniques, as good as they may be, have little therapeutic impact unless they take place in a relationship that is anchored in the explicit intention to mend something with much kindness and humility; compassion meditation allows one to cultivate this intention and to remain mindfully aware of it throughout the therapeutic encounter . . .

The modified version of the compassion meditation, which invited participants to offer compassion to neutral or difficult clients, added an interesting dimension to the exercise: it helped the psychotherapist prepare herself for sessions with difficult clients:

Bill: I feel more able to let an opening arise in the therapy session where suffering can reveal itself. It allows the client to be more in touch with

different dimensions of his suffering and it allows me to make better use of my reflexive competency, so that together we can elaborate more deeply the meaning of this suffering for the client.

### *Integrating Change*

Four weeks after the most intensive part of the study in which participants were asked to practice compassion meditation at least every other day, all three participants had integrated the compassion meditation into their regular meditation routine with the intention to stick to it. All three also reported that the changes this meditation brought to their personal and professional life were now well integrated.

Clara: I am more aware of the compassionate space within myself and I pay particular attention to it as I prepare myself for work, going through my day's schedule. I take a moment to meditate on compassion before meeting a difficult client, both for the client's well-being and for my own.

### *Challenges and Other Stumbling Blocks*

As they described their experiences with the practice of compassion meditation, each of the participants mentioned their own stumbling blocks: fatigue, difficulty with the pace of the procedure, difficulty visualizing, and conceptual difficulty regarding the wish for others to be free from suffering. Not too surprisingly, the biggest challenge for some consisted in cultivating self-compassion. Here is an example:

Bill: I had some difficulty visualizing that these people be free from their suffering. For me, visualizing means that I strive to see it literally, and it wasn't realistic; it felt like wishful thinking. Moreover, I felt some contradiction between the wish for others to be free from their suffering, and the equanimity I strive to cultivate through my mindfulness practice, the necessary acceptance of what is . . . In the beginning, I have to admit that I felt some resistance inside of me when it came to offering compassion to myself. I told myself, "I don't deserve this."

## Discussion

The objective of this study was to better understand the perceived influence of compassion meditation on the psychotherapist's empathy and clinical

practice, through a description, from a lifeworld perspective, of the experiences of seasoned psychotherapists. The three participants in our study generously explained how compassion meditation had influenced their empathy and psychotherapeutic experience, which they reported being through a heightened quality of presence, greater acceptance of their clients' whole being, and more tolerance for the suffering exhibited by their clients. Compassion meditation, they said, helped them be more sensitive and yet, less prone to emotional contagion. Still one of the most important changes they felt in these 4 weeks of compassion meditation was the effect on their self-compassion. Throughout their narratives, self-compassion appears as the foundational rock of their compassion for others, the key factor that allowed them to be present, more accepting, and more tolerant toward the suffering of their clients, as well as more empathetic.

In many respects, the narratives of the participants in this study echo what participants in another study reported about the influence of loving-kindness meditation on their level of presence, awareness, and compassion toward self and others (Boellinghaus et al., 2013), although the latter study was conducted among novice therapists. The participant narratives in this study also resonate with Neff's (2003) three components of self-compassion (mindfulness, self-kindness, and common humanity). In Bill's words:

> I came to realize that (mindfulness) starts with ourselves; being more patient and indulgent with myself (self-kindness), it is easier to be more patient and indulgent with my clients [ . . . ]. We all wish to be happy and to be free from suffering [common humanity]; I can recognize myself in the other as he struggles through his own ordeal, even though his ways to escape suffering are different than mine.

According to Gilbert (2009), compassion is made up of many interacting elements: the necessary attributes to help one engage with pain and suffering, and the necessary skills to alleviate and prevent suffering. The six attributes of compassion are empathy, sympathy, sensitivity, motivation/care for the well-being of others, nonjudgment and distress tolerance (see also Gilbert & Choden, 2014, for in-depth descriptions of these six attributes). As can be seen in the preceding section, it is striking to read the participants' narratives and to realize that they unknowingly, yet very explicitly, spoke at length about these six attributes and reflected on the ways that compassion meditation brought subtle changes to all these aspects of their relationships with their clients. These results tend to support Gilbert's (2009) model of the compassionate mind.

The participants in this study each had several years of mindfulness meditation experience, and each of them acknowledged that compassion meditation

helped them regulate their own emotions during therapy, supporting the results obtained in a quantitative study by Finlay-Jones et al. (2015). Compassion meditation also helped them to remain aware of the resonance of their clients' distress within themselves and to use this resonance empathically as information regarding their clients' experience. Still the three participants reported that compassion meditation had improved their emotional regulation, and that it allowed them not only to remain present but also to get even closer to the roots of their clients' suffering. These results are congruent with the notion that mindfulness serves as a context for cultivating compassion (Tirch, 2010), the latter building on the former's benefits. The perceived influence of compassion meditation on the therapists themselves, on their empathetic experience, and on their therapeutic relationships matches closely with the perceived impact that loving-kindness meditation had on therapists in training in the study by Boellinghaus et al. (2013). One participant admitted at the end of the study that she now finds more pleasure in practising psychotherapy than she had in years.

Two of the three participants in this study, though long-time practitioners of mindfulness meditation, appeared unaware of their own suffering before they began to meditate on compassion. Anna and Clara each demonstrate an example of empathy fatigue (Ricard, 2013). By the end of the study, both testified that being more self-compassionate naturally led to the implementation of self-care strategies that in turn helped them remain present with their clients' suffering without feeling engulfed by it. Similarly to the benefits of mindfulness meditation on therapists' self-care, well documented in the past decade (e.g., Christopher et al., 2011), the potential of compassion meditation and self-compassion for preventing therapist burnout and empathy fatigue is now gaining empirical support (Boellinghaus et al., 2013; Finlay-Jones et al., 2015) and is further validated by the experience of these two participants.

For therapists to engage in self-care, they must pay appropriate attention to their own emotional wounds. As has often been reported in the literature, compassion meditation can sometimes backfire, that is, have the reverse of the desired or expected effect (Boellinghaus et al., 2013; Germer, 2009; Gilbert et al., 2010). Although none of the three participants who completed this study encountered such difficulty, the very first participant who enrolled in the study dropped out after a week and confided that the compassion meditation training had opened old wounds that he had thought were long past and forgotten. He thus decided to drop the study and to address the issue through psychotherapy. This example underlines the need to remain aware of potential adverse effects when offering these exercises and highlights the necessity for some people of combining psychotherapy and compassion meditation.

Participants in this study explicitly mentioned that compassion meditation introduced a loving dimension to the therapeutic relationship. According

to Ricard (2013): "[when altruistic love passes through the prism of empathy, it becomes compassion]" (p. 69, our translation). Participants in this study expressed the relationship between empathy, compassion and love in similar terms. As one participant explained, empathy helps the therapist hear the suffering underneath the outward display of emotion, and compassion helps the therapist love this person within a larger dimension than the symptoms they present. Compassion thus seems to allow for rehabilitation of the notion of love in psychotherapy. Therapists are often uncomfortable with the notion of love in therapy, as inappropriate forms of love in the therapeutic context often creates further suffering for individuals who are already wounded. Yet avoiding the topic of love, whether for scientific or ethical reasons, or plainly out of embarrassment, can make things worse. As Firman and Gila (2010) point out:

> If altruistic love is in fact central to psychotherapy and therapists do not realize this, the tremendous power of this love can be confused with other types of love such as romantic love, friendship, or parental love. That is, therapists unaware they are experiencing altruistic love may be led into romance, friendship, or parenting with their clients—all violations of the therapeutic relationship. (p. 6)

Calls for the recognition of a form of love that has evidence-based healing properties are regularly heard from clinicians and scientists alike (see Fehr et al., 2009). Some clinicians explicitly propose a psychotherapy of love (Firman & Gila, 2010), while others invite psychotherapists to develop the courage to love (Gilligan, 1997; Tenney, 2013; Tsai et al., 2013).

## Study Limitations and Recommendations for Future Studies

A qualitative design was used in this study because it was felt that psychotherapists' empathy might be near the ceiling on empathy scales and, as Walsh (2008) mentioned, psychotherapists may not be that good in judging their own empathy. So the study focused on the lifeworld perspective of seasoned psychotherapists who also had significant mindfulness meditation experience to study the impact of compassion meditation on psychotherapists' experience of empathy. That being said, the limitations of this study are bound by these methodological choices. This study explored the experience of only three participants. Even if transferability seems adequate considering the similarities between the findings reported here and those found in similar studies (Boellinghaus et al., 2013; Patsiopoulos & Buchanan, 2011), results from this study are not generalizable.

A second limitation comes from the fact that the three participants in this study happen to share a humanistic approach, possibly due to the snowball recruitment that resulted in selecting participants who may know each other to a certain extent, or participants who share common professional interests and attend the same workshops. This raises questions about the impact compassion meditation might have on psychotherapists using a different approach. For example, would compassion meditation have the same impact on the way therapists practicing cognitive behavioral therapy experience empathy? Although compassion meditation and mindfulness in general appear to have transtheoretical benefits, a wider qualitative study including psychotherapists from different theoretical backgrounds would provide a better view of the impact of compassion meditation on psychotherapists' empathy. The same thing could be said about the fact that the three participants in this study also happened to be older than 50 years, and had more than 20 years of experience. Considering that "more experience as a therapist may pose an obstacle to empathy" (Walsh, 2008, p. 74), future research examining the lifeworld perspective of younger or less experienced psychotherapists would further our understanding of the impact of compassion meditation on psychotherapists' empathy.

A third limitation of this study comes from its focus on empathy. There was actually some ambiguity in the participants' narratives: they sometimes said that their empathic capacity had not changed, and yet at other times they said that it did change. This pertains to the very nature of empathy and it's many facets: it sometimes focuses on empathic rapport, and thus involves openness and acceptance; other times it may refer to communicative attunement and the therapist's ability to be present to the client's unfolding experience; and still at other times, or at other moments in the therapy process, it may designate person empathy, as an effort to understand the whole person's history and current living context (Bohart et al., 2002). Those many facets of empathy may also be seen as (common) factors influencing the therapeutic relationship and they are also considered attributes of compassion (Gilbert, 2009). Future studies on the impact of compassion meditation may yield clearer results if they have a wider focus than the present study from the start, and bear explicitly on most of these factors and attributes, including empathy. A mixed-design study could also provide a more interesting perspective as it could supplement the therapists' narratives with measures of empathy, presence, attunement, and acceptance, as well as clients' evaluation of the same variables, and outcome measures. Would their narratives be supported by corresponding changes in their scores on validated scales measuring empathy, presence, and acceptance? Would clients perceive such reported changes? Would it have an impact on therapy outcomes?

## *Implications for Training and Clinical Practice*

This study suggests that compassion meditation may actually be a promising method to help therapists be more authentically empathetic, through a heightened quality of presence and through their unconditional acceptance of their clients' suffering. Compassion meditation appears to be one very practical way to achieve this, yet it cannot simply be made a mandatory part of the regular curriculum because such practices require a personal commitment and intrinsic motivation. Still offering compassion meditation as an optional course on a more general basis would provide official recognition of its usefulness in the "making of a therapist" (Cozolino, 2004), and demonstrate practical ways to develop or deepen therapists' quality of presence with clients, capacity for acceptance of clients, and tolerance of their suffering, all evidence-based factors crucial for a positive outcome in the therapeutic process. As Kirby (2016) puts it, "compassion as the focus of therapy offers a novel, innovative, and transdiagnostic approach for reducing psychopathology and increasing well-being" (p. 451).

Another implication has to do with the fact that compassion meditation should not be undertaken as a standalone technique. First, as a meditation practice, it builds on skills previously developed through mindfulness meditation (all of our participants had a regular mindfulness practice). Second, even when anchored in a mindfulness meditation context, compassion meditation involves concepts borrowed from Buddhist psychology that may not be sufficiently understood by many Westerners. For example, the wish for the other to be free from suffering does not mean that he will get rid of whatever made him suffer and never experience pain. It is saying that some of the difficulties encountered by some participants in this study had to do with such misunderstandings, since they were not provided with any kind of education regarding these concepts. To reap the full benefits of this meditation, it is recommended that it should always be supplemented with some education regarding the involved concepts. Two of the three participants in this study spontaneously decided to deepen their understanding of these concepts through appropriate readings after the four weeks of meditation in the study. As for the potential for objections by some who might fear that such education could give rise to conflicts regarding values, it is good to recall that compassion is a value shared by most of the world's religions, spiritual approaches and philosophies (Armstrong, 2011). The educational context surrounding compassion meditation training could thus be easily tailored to accommodate most values systems. Germer and Neff (2013), as well as Gilbert and Choden (2014), offer examples of training curricula that provide adequate context for learning self-compassion meditation.

A final implication has to do with therapists' self-care. Increasingly, therapists are encouraged to develop and make use of different self-care strategies to prevent burnout or empathy fatigue. Unfortunately, while many engage in such strategies, after a while too many drop them, ending up stressed out and fatigued, as exemplified by some of the participants in this study. Compassion meditation appears to provide a fertile ground in which to cultivate self-care strategies that may end up being more thoroughly integrated, as it invites therapists to initially recognize their own suffering and to meet it with self-compassion, making this the foundation for compassion for others. Participants in this study suggested that workshops to prevent burnout and related interventions would benefit from the inclusion of compassion meditation training.

## Conclusion

This study explored the lifeworld perspective of experienced psychotherapists who also have a regular mindfulness meditation routine as they enrolled in compassion meditation training. Participants reported that compassion meditation primarily enhanced their self-compassion. Compassion meditation changed their empathetic experience through an increase in the quality of their presence, their acceptance of the client's whole being, and their tolerance for suffering. Participants also reported that compassion meditation allowed them to experience altruistic love within the therapeutic relationship and to feel less performance pressure. Participants were thus more inclined to better care for themselves and felt that their interventions were more authentically turned toward the other's well-being. These findings also provide support for the inclusion of compassion meditation training in psychotherapy training curricula, as well as in burnout-prevention workshops.

### Acknowledgments

Gentle acknowledgments to the participants of the study.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

### Note

1. Names of the participants have been changed to preserve confidentiality.

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