In Conversation with Compassion and Care

Editor's Note

This is the second set of a series of essays examining the role of compassion and care through the lens of different professional and personal perspectives. These essays are a poignant reminder that true compassion is visceral and deep in its emotion. There is depth in the experiences shared in these essays; some intimate, some heart-breaking. Collectively, these works highlight an essential need for self-compassion and compassion to one another with the aim of sharing knowledge and changing lives; we add these narratives to the reservoir that has gone so far. All the people involved with careif, Trustees, International Advisors, Patrons, Friends, Supporters, etc give their time as volunteers. If you want to be part of this careif experience or indeed contribute your own testimony on Compassion and Care; **email us at enquiries@careif.org**

Dr. Yasmin Khatib

CAREIF Advisor for International Women's Affairs and Compassion and Care

November 2014

Centre for **A**pplied **R**esearch &**E**valuation
International **F**oundation

National Office:
The Centre for Psychiatry
Barts and The London School of Medicine and Dentistry
Queen Mary University of London
Old Anatomy Building
Charterhouse Square
London EC1M 6BQ

Tel 020 7882 6118
Fax 020 7882 5728
Email: enquiries@careif.org
Website: http://www.careif.org
Twitter: @careif
Find us on Facebook

share knowledge change lives

REGISTERED OFFICE:
MHA MACINTYRE HUDSON CORNWALLIS HOUSE, PUDDING LANE, MAIDSTONE, KENT ME14 1NH
REGISTERED NO. 06231733 ENGLAND CHARITY NO. 1121374

Trauma and Compassion fatigue in mental health professionals

Dr Walid Khalid Abdul-Hamid, Consultant Psychiatrist, Chelmsford, Essex CM2 0QH.

"It is very important for mental health workers to give themselves the time and the space to recover from trauma"

I spent the year 2013 on sabbatical leave from my work as a consultant psychiatrist at the Adult Chelmsford Community Mental Health Team. I have decided then to follow the Oxfam Chinese proverb*; 'give a man a fish you feed him for a day, teach him how to fish and you feed him for life*'. I spent the year in the Middle East – where I originally come from. Initially I worked for a short period at a refugee camp; I then decided to work with the British charity, The Humanitarian Assistance Programme (HAP) in the UK and Ireland to teach mental health workers and professionals in the Middle East some of the techniques of trauma therapy Eye Movement Desensitisation and Reprocessing (EMDR). This in turn made me meet many of the mental health professionals who see, hear and treat trauma victims everyday which made me realised the significance of what is called Compassion Fatigue or secondary traumatisation. I have since collected information on the subject to try to help all mental health professionals cope while treating trauma.

Trauma can cause disturbance in the function of the body and mind that could be disabling. Trauma can cause varied psychological disorders, from temporary acute stress reaction to anxiety, depression, somatic or body function disturbances to the more severe Post Traumatic Stress Disorder (PTSD) and dissociative disorders. PTSD symptoms have been defined by different clinical classification systems to include defined clusters of symptoms including the re-experiencing of trauma in the form of thoughts, images or emotions, social withdrawal and numbing of emotions, and increased arousal, irritability and insomnia. To illustrate the disabling effects of severe trauma exposure, I will give a case history that I heard first hand from a mental health worker in Aleppo, Syria. A civil defence officer in Aleppo bravely saved three of five children from a burning building that was bombarded by

Syrian regime's air force. He was considered by the community as a hero but he was completely destroyed by the trauma of not being able to save two additional children from the flat whilst it was burning. He withdrew from the community and stopped going to work, became aggressive to his family, resulting in alienating himself from the only remaining social support he had. He was tortured by the images of the dead children day and night to the degree that he could not sleep any more.

Research indicates that the strength of the trauma and the repeated cumulative exposure to trauma can cause post traumatic disorders, which can cause physical and neuro-chemical changes in the brain. It has been found that traumatic reaction can also happen as a result of emotional contagion, which means that an individual observing, or listening to a story of another person's experience, can also experience similar emotional responses. Interesting, the American psychologist, Charles Figely, described the concept of Compassion Fatigue or secondary traumatisation in his book 'Compassion Fatigue: coping with secondary traumatic stress disorder' published in 1995. CF can be a common problem amongst mental health professionals treating trauma victims.

I believe that people who volunteer to work in areas of danger may have a 'rescue personality'. This personality is characterised by being: introverted, action seeking, a perfectionist in terms of performance, not very social, tendency to taking risks, find it difficult to say no, and though highly dedicated to helping others, they can get bored very quickly. The 'rescue personality' was found to be particularly susceptible to compassion fatigue and ultimately to PTSD. It may therefore be beneficial for persons carrying out an assignment in a trauma affected area to not work alone and follow through self-awareness and careful monitoring of their thoughts and emotions, preferably through supervision of trusted colleagues. During the delivery of a humanitarian aid, the mental health worker needs to be aware of their own physical needs and be aware that they have adequate social and professional support and contact with supervisors to seek advice when needed.

By taking notice of one's own emotions and being mindful of thoughts, one can increase their psychological awareness of their own state.

More specifically these psychological awareness types could be classified into:

1. Emotional Intelligence (EI): This is the capacity of an individual to experience, understand, communicate, and manage his/her feelings and those of others. It includes major emotional skills such as self-awareness and management of social relationships. As mentioned above, trauma can occur due to emotional contagion. This is clearly an important issue for people undertaking an assignment in a disaster zone or an area of conflict. The level of EI may predict how individuals respond to traumatic experience and therefore increasing levels of psychological awareness may be one avenue worth pursuing in increasing EI.

2. Cognitive awareness: It is very important for people exposed to trauma to be able to develop the habit of reframing the traumatic situations i.e. reflect on what has happened and remind oneself of any positives that can still apply to a situation. This is easier said than done, given that the fear of stigma in the health professionals' community may cause a person to be in the predicament of being unable to cope. However, by focussing on aspects and steps that one can control, this may alleviate the effects of trauma.

After the assignment with trauma victims, it is very important for mental health workers to give themselves the time and the space to recover. They should follow their intuition on what they want to talk about in regard to the traumas they have witnessed or treated and to whom. They should make sure that they seek professional psychological or psychiatric help in the following situation:

1. If they experienced any risk that they might harm themselves.
2. If they feel so depressed that they are unable to get on with their daily life.
3. If they suffer from outbursts of anger that affect their relationship with family and friends or put them at risk with others.
4. If any trauma reaction described above continue unchanged for several weeks.

Early intervention can help reduce the severity and disability associated with post trauma problems. The first line treatment of PTSD and other post trauma problems is psychological

(i.e. talking therapies). However, in some cases medication might be needed to help people sleep better or to treat associated depression or anxiety. Furthermore, knowledge and awareness of trauma and its consequences help in the prevention of post trauma problems.

Note: This is a short summary of a larger and referenced document that is in preparation and titled 'Self-care while working with trauma victims in the Middle East'.

Further information on Compassion Fatigue can be read on Charles Figely's website:

http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html

Walid Khalid Abdul-Hamid, MRCPsych, PhD, Honorary Senior Lecturer, Centre for Psychiatry, Barts and the London School of Medicine and Dentistry, Queen Mary University of London; Visiting Fellow at the Veterans and Families Institute, Anglia Ruskin University; Consultant Psychiatrist, Chelmsford CMHT, C&E Centre, New London Road, Chelmsford, Essex CM2 0QH.

Compassion and Care

Rachael Featherstone RMN, BSC (Hons) Mental Health Work, THORN.Primary Care Mental Health Specialist.MCCH Society, Kent.

Compassionate Care – A Nurse's View

Compassion …"A deep awareness of the suffering of another,

coupled with the wish to relieve it"

I am so pleased to be able to contribute to this topic. Compassion in nursing has been an area of interest for me for many years now.

I always set out to work in psychiatry to provide care, compassion and understanding, but it seems I have become more proficient in ways of expressing this in the last few years, indicated by the feedback I have received from service users and carers. This is a hopeful indicator to me, that if people hold the desire to be a positive influence within care, then they can be taught how to use their personal skills more effectively. There was a time where I believed if you didn't have it you couldn't be taught it, but I think differently now.

Part of this ability I believe comes from life experience, feeling those bad times. Alongside this, a confidence to be able to give a little of yourself, without fear of losing professional status or being reprimanded. We are told by our peers; not to give personal information; to maintain boundaries; not to be affected by the people with whom we work and if we do so then this is a sign of our weakness, and we are being taken by a fool at best or being unprofessional at worst. I consider these instructions influential in the lack of compassion displayed within care, where our personal strengths are highlighted as a professional weakness.

I also hold the treatment of the organisation towards its staff partially responsible for care staffs' inability to more consistently display compassion. Staff are put in situations whereby they have too higher caseload to be able to work in a therapeutic way. They work on wards that are short staffed or with people who are unable to do the tasks or provide the peer support required. Managerial structures put into place to safeguard these things are written but not adhered to, so when something goes wrong the individual is used as a scapegoat to move responsibility away from the organisation. Staff are told they will be disciplined if training is not completed, yet are not given the time to attend. Our success is judged on dates of care plans rather than the quality of our engagement to devise them. And the last straw….staff must provide their own tea bag and cup!

Almost immediately I have seen nursing students hit by this stark reality, and they are fearful from the start. More recently staff have been moved from one job and location to another, with a choice of "job or no job". Encompassed by this fear and restriction of authoritarian management we still expect individuals to be confident, compassionate, to stand alone and make the right decisions or challenge the organisational structure. These reasons I hold predominantly accountable for the lack of compassion within the organisation for which I have previously worked.

Examples of compassion from my practice vary in the extent of work required. Particular cases that stay in my mind include: a lady who wrote to thank me for the most simple action of giving a smile and an introduction of my name and role on the ward; a man who wrote to thank me for playing music whilst administering an injection he didn't want; holding the hands of a man who was acutely distressed to stop him punching himself and showing faith and confidence that he wouldn't punch me; taking time to clean blood from the nails of a man who had tried to end his life; and sharing personal experiences to enable the person sitting opposite me to do the same.

I have come to understand the role of power in psychiatry as influential in our ability to show compassion. The relationship between the psychiatrist/nurse and service user is by its very nature unbalanced (Repper and Perkins 2009). One person discloses their thoughts, feelings, hopes and fears whilst the other remains largely unseen, often resulting in the

person feeling vulnerable and exposed (Watkins, 2008;Repper and Perkins, 2009). The nurse may use her power to enhance these feelings, by maintaining such a social distance as to be detrimental to the therapeutic relationship. Conversely, a confident and skilled practitioner may use her power to empower the service user, enabling them to recognise their inner strength and capacity for self-healing, without concern for the loss of power to herself (Oudshoorn, 2005; Watkins, 2008).

I believe it is possible to empower service users, if as professionals, we have embedded within us a way of being, that is compassionate, loving, empathic and accepting. These personal values are reflective of the person centred model of helping, developed by Carl Rogers. A need to be compassionate towards ourselves, to have an acceptance of essential goodness, a forgiveness of our transgressions and an openness to being something more is essential in the delivery of compassion to others. It is through this way of being, which when reflected within recovery relationships allows it to be internalised by another (Watkins 2008).

***Details have been changed to ensure confidentiality**.

Case Study – Nigel*

I began working with Nigel on his second admission under the Mental Health Act (1983 amended 2007). He had a diagnosis of paranoid schizophrenia, which he strongly disagreed with. He would not discuss any element of his mental health, but was agreeable to talking about other things and this was the basis on which our relationship formed. He refused all medications and was forcibly medicated on the ward. Following his discharge he refused contact with all services. His parents felt unable to cope and I offered to work with them and try to engage with Nigel.

I had gained important information about Nigel and his family. Nigel's father had experienced a psychotic episode in his thirties. Whilst unwell he threw himself from a building and as a consequence was disabled. Nigel had always been the 'strong' male within

the family, his sisters and brother turned to him for advice. He was successful in his studies and gained a job in banking in London. He met a girl and they were engaged to marry. He lost all of this following his first psychotic episode. To be in control and strong; to be a leader was important to Nigel's core esteem. He saw his father's physical state as a weakness and associated this as the consequence of psychosis.

After visiting his parents at home, Nigel agreed to speak to me over a cup of tea. He spoke of his anger about his detention and enforced treatment. Through the use of guided discovery he identified purpose and exercise as his need. He stated if I wanted to help him, I could run with him. I hate running but agreed we would do a swap; I would run if he allowed me to talk about his mental health. He agreed. For me this intervention was about much more than jogging. In order to ignite and nurture hope a person needs to experience success, take control, find meaning and maintain relationships (Watkins 2008). This intervention fulfilled all of these elements for Nigel. He was a very fit person and could easily run the distance proposed, he knew this type of work was not ordinarily agreed to and devising it put him in a position of control, he tested my willingness to help him and established a secure relationship, in which he trusted and felt able to ask pertinent questions around his mental health and illness.

Our first jogging session took place on a snowy day. We ran through country fields behind his home. When running up a hill I began to struggle and Nigel held my arm and helped me up the hill, encouraging me on. I later used this as an example of how we can share strengths and knowledge to help one another. This collaboration became the ethos within which we worked.

After several sessions of jogging I asked Nigel if I could show him something I had learnt within my THORN studies. He was reluctant but agreed. I wanted to use the card sort exercise which features a variety of cards, each stating a thought, feeling or behaviour related to mental health problems. This would enable us to identify his relapse indicators and for the first time, be aware of the extent of psychotic phenomena he had experienced. I was aware disclosure would be very difficult for him and challenge the image he portrayed.

Nigel read through the cards and began laughing. He sarcastically stated “yep, yep, oh yeah I’ve definitely had that” and was picking up the majority of cards. I decided to continue with the exercise differently and return to the ethos of our relationship. I picked up a card allowing him to see the experience written on it and said “Ok, I’ve had this one; this can go on my pile, your turn”. Nigel looked at me, and then picked a card. On two occasions I picked cards which indicated some unusual experiences, Nigel responded, “I’ve had that too, can I have them on my pile?” We didn’t discuss what was written on our cards and at the end of the exercise I filed them away without deliberating them, recognising that verbal acknowledgment of these experiences may be too challenging for him at this time. Instead I used the results to devise a relapse prevention plan which I gave to Nigel in a book of our work together. He later reported having read the book and found it helpful.

This practice is far from the mainstream, in my experience. I did not document details of it within the notes of our work together as again I feared my professionalism would be called to question.

On reflection of this intervention and my response to it I considered; if I am asking another person, who does not wish to discuss his mental health, not to be embarrassed or ashamed of disclosing experiences he may have had, then I need to role model behaviour that displays trust and strength in disclosing mine. In part this submission intends to do so.

References

Mind (2011) Listening to Experience. An independent enquiry into acute mental health care.
Oudshoorn, A (2005) Power and Empowerment: critical concepts in the nurse-client relationship.
Repper J, Perkins R (2009) Social inclusion and recovery: a model for mental health care.
Roger, C (1951) Client centred therapy.
Watkins (2008) Mental health practice a guide to compassionate care.

Reshaping Our World View through Compassion

Francis Sealey is the Chairman of GlobalNet21 (21st Century Network)

"There is now an overriding need to engage with each other to both understand our world and change it".

GlobalNet21 was set up to attract new audiences of people to engage in the discussions around the big issues of the 21st century. At a time when the models that have guided us through the last two centuries have been found waning, then there is considerable confusion over the state of our globe and how to tackle its problems that are inclusive. There is now an overriding need to engage with each other to both understand our world and change it.

However, because the world is increasingly complex and the blue prints that once guided us through the moral maze now seem inadequate that engagement is difficult. What is needed is a process of dialogue between people, but what often happens is a conflict of entrenched positions. Whereas individuals once belonged to broad based movements and had their sense of belonging there, today there is a fragmentation of opinion and direction. Consequently there is a multitude of different opinions that people hold strongly often with a sense of self-righteousness. This may give a person a personal sense of belonging but it can treat others with different views as of little worth.

Dialogue requires compassion if it is to work and it is compassion that needs to be brought back into the public square. Somehow we have to understand our own weakness and frailty even though that means uncertainty and self-doubt. Most of us shy away from that because self-doubt causes suffering to our sense of worth. That is why compassion is so important. Compassion means "the sharing of suffering" and for dialogue to work in the public square

then we have to share our suffering that we may not be right. Once we do that, then we can begin to listen to each other and even find that those who hold views that we once felt heretical still have something valuable to say and that the views they hold (like our own) come from our own life experiences.

One of the biggest challenges of our time is to have compassion for others and that just does not mean helping each other, it also means listening to each other. We need to find time to understand why people hold the views they do and to find the commonalities with our own world view. Once we learn to do that then we often find that what we once considered irretrievable differences are not so different after all and that with effort there can be common ground. But for many it is a cultural change. The adversarial nature of British politics often has meant we see each other in opposing tribes (or political parties) and we view the other tribe with derision and often contempt even when the differences are minimal. This is often not political but based on the comfort and security that tribal existence offers us. Developing compassion is the only way to break this silo mentality down and help us to look at others notas tribal members but as human beings. If compassion does that then that is something worth working to achieve.

GlobalNet21 (21st Century Network) was set up to discuss some of the great issues of our millennium. GlobalNet21 have taken the idea of citizen discussion and tried to develop it by using social network sites as a way of getting more citizen involvement and introducing another audience to the issues of the 21st century.To date, GlobalNet21 have held many meetings (some in the House of Commons - UK Parliament) on Development, Human Trafficking, The New Media World, Education, Climate Change, Social Enterprise, conflict resolution, alienation, the impact of China on the world order and much more.

For more information about GlobalNet21, please see: www.globalnet21.org

It's What We Say and How We Say It – Language, The Media and Mental Health

Emma Gilbert is a Mental Health Nurse/Radio Producer/Development Researcher at South London and Maudsley NHS Foundation Trust, Male Street Voices and Global Radio.

"Without wanting to sound like an absolute party pooper, there is still a way to go if mental illness is to be given equal credence alongside physical ill health".

The representation and discussion of mental health in the media has seen a dramatic increase in focus over the past decade. Not only have there been nationwide campaigns run by broadsheet newspapers about reducing stigma, but much loved national treasures have made brave choices in opening up about their personal experiences of mental ill health. So much so that it has almost reached a tipping point of sorts, where the public has become so well versed in the politically correct language of what can and can't be said, I worry it continues to mask any bone fide change which is difficult to facilitate and often unpalatable to do.

Without wanting to sound like an absolute party pooper, there is still a way to go if mental illness is to be given equal credence alongside physical ill health. Having worked for years in psychiatric wards, you only have to spend a small amount of time to realise that mental ill health is so often a combination of environmental and genetic factors. Environmental being the economic and social challenges we all face day to day – the drudgery of the job centre, the stress of unpaid rent, the constant demands of consumer culture and expectations that just cannot be met. These pressures, I believe often culminate in the very real breakdown of the self, and is often why I refer to mental health as 'frontline sociology'.

Having worked for years, prior to mental health nursing, within media and having felt consistent disappointment with the way in which, television especially, seeks out vulnerable people under the guise of good programming. Much has been said about the exploitative nature of programmes such as Jeremy Kyle where young researchers would ask 'what medication are you on?' as a filtering question, whereby those on medication for whatever emotional or psychological vulnerability would be seen as an excellently malleable fodder for the televised circus of relationship breakdown, financial crisis and educational impoverishment.

The problem is – how do we police the language we use and the images we see? Mental health vernacular is so very entrenched in the way we speak that it's hard not to refer to a 'manic' day or your rather eccentric friends as 'bonkers'. However we cannot underestimate the power that language has, and those that who are responsible for conveying messages still have huge milestones to overcome when it comes to deciding what passes for entertainment and what constitutes exploitation. Mr Kyle's stroke of genius is that he is not only a master of ceremonies during his 'talk' show – but he proffers his words of wisdom too. He shouts directly at contributors for one reason or another – 'Be a man!' or 'Haven't you heard of contraception? Put something on the end of it!'. And as entertaining as this may be to watch, it offers nothing in the way of sensitively examining the myriad matrix of problems faced by the people he claims he serves.

This is not to say positive change is not underway. Time to Change which is a campaign led by mental health charities Mind and Rethink, now have a media advisory service to help journalists and production companies tackle the stories of mental illness with greater sensitivity and less sensationalism. But what about behind the scenes in the fast paced world of production? This is a world where 'characters' and 'storylines' are the currency, and a savvy producer will stop at nothing to get the biggest impact and emotional fallout captured on screen. I still feel great concern when I think about the emotional aftermath left

for contributors on shows such as ‘Long lost family’ or ‘Who do you think you are?’ These are often shows where seismic life events like reuniting with a child after a twenty year absence are filmed right until the ‘big reveal’. I know all too well the company line about ‘utmost care and compassion’ taken to care for the wellbeing of contributors, but have never been overly reassured when I hear of the ‘aftercare’ offered to contributors and in fact the consideration offered to clinicians if they feel they need to speak out against the wishes of a production company.

A Guardian journalist reported back in 2008 about a particular episode of Jeremy Kyle, Live! This seems to constitute the bear baiting nature of the show but filmed live in a local area with members of the community able to rally round and throw their two pence worth in. Have we moved far from public hangings and the stocks? It seems not. This particular episode featured ‘a young, terrified-looking 18-year-old called Jamie’. He recently left his eight-month pregnant girlfriend because he suspected she had an affair and he believes her newborn daughter might not be his. Jamie speaks so quietly he is almost inaudible, whereas his pregnant girlfriend is able to project her opinions pretty clearly to the frenzied crowd.

It is only at one point during the feeding frenzy that Jamie’s step mother tries to tell Gemma about his ‘problems’, which turn out to be ‘Bipolar disorder and paranoid schizophrenia’. This is something the journalist had to find out himself, because it was glossed over completely during the filmed episode. She reveals to the journalist that she’s been repeatedly telling the research team about the extent and severity of Jamie’s illness but it has been reportedly ignored before the show went ‘live’.

The disparity between the liberal masses education of what is deemed acceptable when describing mental illness and the sensationalist nonsense factories such as Jeremy Kyle and Heat magazine, which have stories such as ‘my Bipolar hell’ nestled comfortably alongside

‘Rear of the Year’ campaigns continue to astonish me. All I know is that until you’ve seen the coalface of mental illness and breakdown and made a personal effort to understand what it might be like to lose one’s mind – what is out there to enliven understanding still has a lot to answer for. As individuals we must continue to push for greater compassion towards people who exist on the fringes, at the margins and beyond the pale of what we can understand as civilized both on our doorstep and on our TV screens.

Compassion

Neville Emslie, Ministry Development Officer at Diocese of Canterbury: Kent. UK.

"Whilst kindness is a beautiful and respectful gift to another, compassion is far more powerful and, consequently, will more likely lead to greater endeavours of mercy, reconciliation and love".

Compassion is a word used in many quarters these days: schools, businesses, hospitals, even politicians use it when they are referring to caring for people.In the ancient world the Greek word for compassion was *splánchnon.* Originally, in the plural, the word referred to the 'inward parts' of a sacrifice, the viscera or guts of an animal, and from this the word denoted impulsive passions such as anger and desire. The opposite, *ásplanchnos*, meant cowardly, 'with no guts,' or as we would say today, 'gutless.'

In the Hebrew Bible, or Old Testament, the word is used for the 'seat of feelings' and over time it came to mean the deep, inner disposition that leads to mercy. When the Gospels were written in the second half of the 1st century CE the verb *splanchnízomai*is used of Jesus when he sees a starving crowd (Mark 6.34), and when he comes across a widow in a funeral procession burying her only son (Luke 7.13). In the parable of the prodigal son, one of the most famous stories ever told, the destitute prodigal decides to return to his father to beg to be treated as a servant, but 'while he was still far off, his father saw him and was filled with compassion; he ran and put his arms around him and kissed him' (Luke 15.20). Buddhist philosophy too considers that the basic nature of human beings is to be compassionate.

True compassion is visceral; it turns the guts with deep emotion, and so leads to merciful action. The Latin root from which the English word comes indicates the same intensity – *com* 'together' + *passio*'to suffer,' which is also understood in the death and resurrection of Jesus which is called the Passion. Modern usage tends to use 'passion' in a romantic, or even sexual way, but at heart it means the kind of love that one is willing to suffer for one's beloved.

Often these days, churches, charities, hospitals, hospices, politicians, care groups, service organisations, businesses, schools and pastoral agencies use the word 'compassion' as part of their mission statement to clients, customers and the outside world. But is their prevailing emotion for their clients 'gut-wrenching'? Whilst kindness is a beautiful and respectful gift to another, compassion is far more powerful and, consequently, will more likely lead to greater endeavours of mercy, reconciliation and love.

On the other hand, and rather sadly, a term increasingly employed in literature is 'compassion fatigue' with reference to the personal cost to professionals of caring for long periods of time with high-maintenance individuals in a non-supportive or limited-support environment or institution. The difficulty with this term lies in its fundamental definition for compassion is fatiguing, tiring and stressful. If it's not, it isn't compassion. The trouble is these days we confuse 'care' with 'compassion.'

In the Christian tradition St Paul exhorts church members to 'clothe yourselves with compassion, kindness, humility, meekness, and patience' (Colossians 3.12). The order is important, compassion is the first feature of Christian behaviour, but it is also something which one can take on, or put on, like clothes. How do you clothe yourself with compassion? The answer is found in the earlier references where Jesus sees a starving crowd, and a grieving mother, and the father sees his desperate son. We need to 'see' others in such a

way that we identify with their situation and circumstances, and this leads to life-enhancing responses. Here we refer to another word derived from Greek, *empatheia*'empathy,' which comes from *en*, 'in' + *pathos*, 'passion' or 'suffering.' Empathy is that action of truly looking at, or beholding, a person or group in need such that one's guts are gripped, compassion twists the innermost being, and so one responds in merciful action.

Interestingly modern researchers are rediscovering this ancient wisdom and applying it to modern organisations. A group of researchers in organisational psychology recently suggested that compassion is a dynamic process that may be found in individuals and collectives. The task of a high-functioning organisation is to strengthen people's feelings of connectedness through 'noticing,' 'feeling,' and 'responding.' They conclude by suggesting that members of healthy organisations create pockets of collective compassion within the organization which could potentially develop the individuals and the corporate whole.

Ancient wisdom and modern psychology concur – compassion is about truly noticing, deeply feeling, and mercifully responding.

Neville Emslie is the Ministry Development Officer at Diocese of Canterbury and a theological educator with strengths in ministry formation, theological reflection and preaching. Neville's contemplative side is greatly interested in poetry, and mystical and contemplative spirituality and Neville's activist side finds energy in cricket, rugby and exploring the natural world.