Self-Compassion:

A Concept Analysis

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Abstract

This concept analysis uses a modification of the evolutionary method (Rodgers, 1989) to identify the antecedent, attributes, and consequences of self-compassion. The antecedent to self-compassion is suffering, experienced in six possible realms: an event, a situation, an emotional response, a psychological state, spiritual alienation, or a physical response to illness or pain. Suffering has three dimensions: intrapersonal, interpersonal, and contextual. Suffering manifests as a pattern of decreased self-care, decreased ability to relate to others, and diminished autonomy. The attributes of self-compassion are self-kindness, mindfulness, commonality, and wisdom. The consequences of self-compassion are the opposite of the antecedent: self-compassion manifests as a pattern of increased self-care capacity, compassion for others, and increased relatedness, autonomy, and sense of self. Ideal, borderline and contrary cases of self-compassion provide examples of the concept. The article concludes with a discussion of implications of the concept of self-compassion for nursing practice and research.

Keywords: *self-compassion; suffering; wisdom; self-kindness; mindfulness; common humanity*

In the Buddhist tradition, the Bodhisattva is a Buddha who gives up nirvana, or the ultimate happiness, in order to save human beings from the four states of suffering: birth, old age, sickness, and death (Florida, 2002; Ladner, 2004). The first life saved from suffering is the Bodhisattva's own, and this act of self-compassion results in actions that alleviate the suffering of others, replacing it with happiness (Habito, 2002). Although it appears to be paradoxical, the Bodhisattva's self-compassion sustains the compassion that saves others from suffering. The most compassionate act of the Bodhisattva is to practice self-compassion (Kornfield, 2002).

Thus, the Buddhist concept of compassion consists of four Sanskrit words. The first, *Karuna*, means to suspend transitory happiness to attain the ultimate happiness. An alternative translation of *Karuna* is "a trembling or quivering in the heart in response to another's pain" (Yao, 2008b). The second word, *Prajna*, means wisdom to understand the meaning of suffering (Florida, 2002). The third Sanskrit word, *Maitri*, means conscious good will toward others (Rinpoche, 1994; Wada & Park, 2009). The last word, *Upaya*, refers to the skillful means necessary to cultivate a compassionate state of mind. The skillful means are loving kindness for all sentient beings, compassion for the unhappiness of others, joy for the happiness, and good fortune of others and equanimity (Florida, 2002). From a Buddhist perspective, self-compassion is a response to personal suffering with wisdom, loving-kindness, and mindfulness that extends beyond the self to all others who are suffering.

The etymology of the English word *compassion* is the Aramaic *racham*, from Biblical times, meaning "to love, pity, and be merciful" (Burnell, 2009). The English version is derived from the Latin, *com*, meaning "together with," and *pati* meaning, "to suffer with" (Burnell, 2009). From a Western perspective, self-compassion is one's ability to love and have mercy on oneself when suffering.

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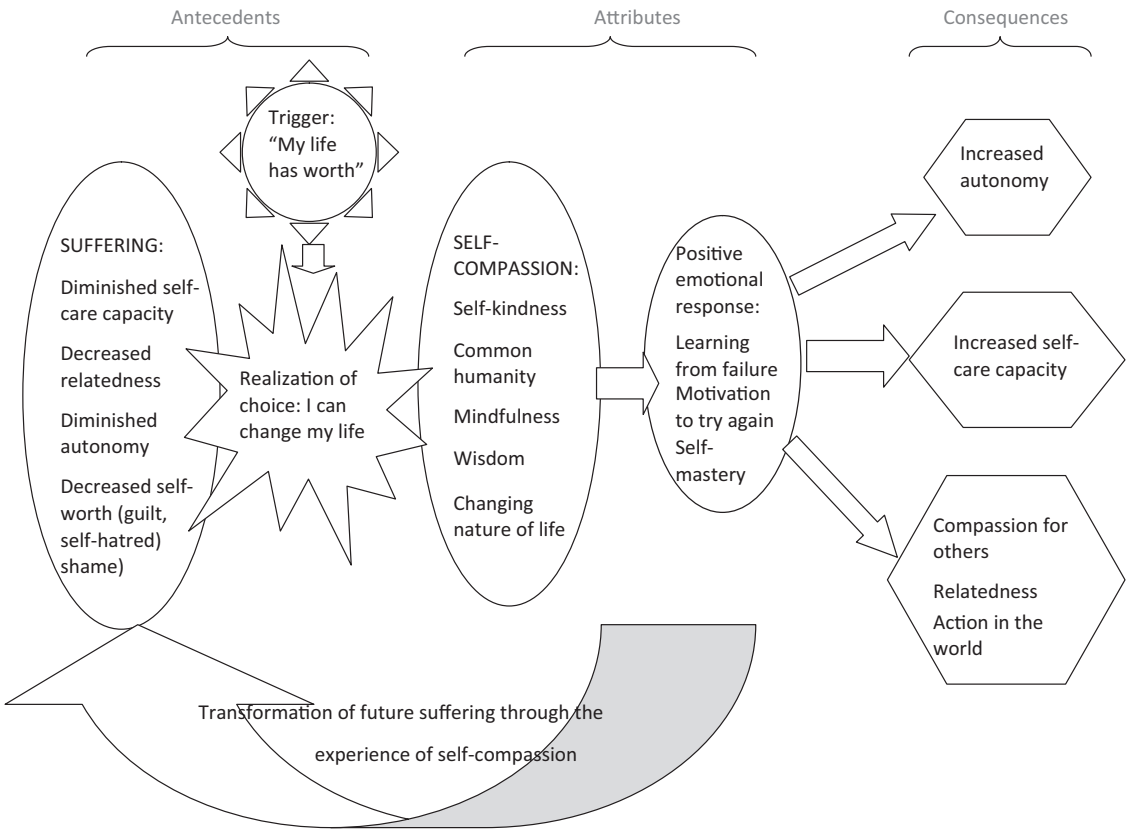

Figure 1. Conceptual Model of Self-Compassion.

The discipline of psychology has applied the concept of compassion to the understanding of people's emotional states, postulating that the development of self-compassion may be beneficial in alleviating depression and other psychological conditions (Leary, Tate, Allen, Adams, & Hancock, 2007; K. Neff, 2003; K. D. Neff, Kirkpatrick, & Rude, 2007; K. D. Neff, Rude, & Kirkpatrick, 2007; K. D. Neff & Vonk, 2009; Thompson & Waltz, 2008). The limited number of nursing research studies on self-compassion use the concept as defined by the discipline of psychology (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010). The concept of self-compassion as it applies to nursing science and practice is not well developed. The purpose of this conceptual analysis is to clarify and synthesize the meaning of self-compassion as it applies to nursing. This concept analysis uses a modification of the evolutionary approach to identify the attributes, antecedents, and consequences of the concept of self-compassion (Rodgers, 2000). Instead of an exemplar, cases from clinical nursing practice illustrate the concept of self-compassion (see Figure 1).

Realm of Data Selection

A review of the literature from 1979 to 2010 using the terms *self-compassion* and *compassion* in CINAHL, MEDLINE, PubMed, Psych Info, Philosopher's Index, ALTA Religion database, and SocIndex, limited to articles in English or translated into English, was conducted. The search retrieved 74 articles: 51 in psychology, 8 in religion, 3 in nursing, 2 in philosophy, 9 in sociology, and 1 in management. Although self-compassion as a motivating factor in human behavior is a relatively new area of research in the social sciences, Buddhist philosophy has explored the concept of self-compassion for centuries. For this reason, Buddhist sutras translated into English and scholarly Buddhist texts are important source materials on self-compassion. A nursing text on the

nature of suffering was also an important resource because nursing as a profession concerns itself with understanding and alleviating suffering.

Attributes of Self-Compassion

The attributes of self-compassion include self-kindness, awareness of common humanity, mindfulness, and wisdom (Leary et al., 2007; K. Neff, 2003; K. D. Neff et al., 2007; K. D. Neff & Vonk, 2009; Shepard & Cardon, 2009; Thompson & Waltz, 2008). Self-kindness is the act of treating oneself kindly in the face of suffering. Self-kindness allows an objective analysis of suffering, extending caring and understanding toward the self rather than self-criticism (Leary et al., 2007; K. Neff, 2003; K. D. Neff et al., 2007; Shepard & Cardon, 2009; Thompson & Waltz, 2008). Self-kindness functions as a "reciprocal golden rule," one treats *oneself* with the compassion usually reserved for others. Self-kindness is the ability to accept one's flaws, releasing regrets, disappointments, and illusions about the way "things could have been" (Ladner, 2004; Underwood, 2005). Self-kindness includes self-forgiveness and the willingness to take responsibility for actions that may have resulted in suffering without assuming penance, guilt, or punishment for the behavior (van der Cingel, 2009).

A story from the Lotus Sutra clarifies the concept of common humanity. A woman who lost her son went to the Buddha for consolation. The Buddha gave the woman a mustard seed with instructions to plant it at a home where no occupant had experienced suffering. After searching for some time, the woman realized that all the occupants in all the homes had experienced suffering. Realizing this, the woman was able to stop mourning and take up the daily tasks of living (Watson, 1993). In reality, all human beings have the same opportunity to experience suffering (Ferrell & Coyle, 2008; Florida, 2002; Habito, 2002). Yet the tendency of humans is to think that suffering is a solitary experience (van der Cingel, 2009). This illusion of separateness intensifies the experience of suffering. Common humanity consists of seeing one's experience as part of humanity rather than seeing oneself as separate and provides a sense of belonging that replaces feelings of isolation (K. D. Neff et al., 2007; K. D. Neff & Vonk, 2009; Shepard & Cardon, 2009; Thompson & Waltz, 2008). A person with self-compassion recognizes that self and others coexist in a mutually interdependent manner; at the same time, there is an appreciation of one's unique self (Vieten, Amorok,& Schlitz, 2006; Wada & Park, 2009).

Mindfulness is a balanced frame of mind that avoids overidentification with the state of suffering or pleasure. This allows detachment from negative emotional states and the realization of the impermanence of all emotions (Ladner, 2004; Shepard & Cardon, 2009; Wada & Park, 2009). Mindfulness is not an analysis of past events to label or categorize emotions but an opportunity to see life in the present rather than the past or the future (Gnaratana, 2002; Rinpoche, 1994). Mindfulness allows one to witness the experience of suffering objectively. Rather than intensifying, mindfulness transforms suffering into an opportunity for spiritual and psychological growth (Rinpoche, 1994; Wada & Park, 2009). This transformation results in an alignment of emotional and rational processes.

There are several aspects of wisdom attributed to self-compassion. Discriminating wisdom is the ability to evaluate one's behavior, understanding the positive and negative factors that influence one's actions (Neff, Hsieh, & Dejitterat, 2005; Shepard & Cardon, 2009). Reflective wisdom is the ability to see events realistically and develop insight into personal behaviors that may contribute to suffering (K. D. Neff et al., 2007). Affective wisdom is the development of a nonjudgmental attitude and the realization that a judgmental attitude results in a disconnection from one's self and others (Ferrell & Coyle, 2008; K. D. Neff et al., 2007).

Wisdom acknowledges the internal experience of suffering: the inability to accept loss, rumination about what is or might be, the illusion that life will always be the same, and the illusion that we are isolated and separated from others when events occur that result in suffering (Wada & Park, 2009; Yao, 2008a). Wisdom results in skillful actions, which are behaviors arising from insights that transform suffering into understanding and acceptance (Florida, 2002; Yao, 2008b). Skillful actions also include giving up harmful behaviors, feelings, and thoughts that perpetuate suffering.

Self-compassion is not a condition exemplified by self-pity, self-centeredness, or self-esteem (Ladner, 2004; K. D. Neff et al., 2007; van der Cingel, 2009; Wada & Park, 2009). Self-pity reflects engrossment in one's own suffering, whereas self-compassion acknowledges that other people have

similar problems (K. D. Neff et al., 2007; van der Cingel, 2009; Wada & Park, 2009). The need to view oneself as better than others characterizes self-centeredness; with self-compassion, comparisons between self and others are not needed (Ladner, 2004; Shepard & Cardon, 2009). Self-esteem requires the accomplishment of goals external to the self; self-compassion seeks self-mastery over behavior and action (K. D. Neff et al., 2007; Shepard & Cardon, 2009).

In the discipline of nursing, self-compassion is a state of being consisting of self-kindness, mindfulness, wisdom, and commonality that transforms suffering and results in actions that improve the individual's health and well-being as well as the health and well-being of others. Self-compassion acknowledges that suffering exists and is visible because something of value, such as health or well-being has been lost (Leary et al., 2007; K. D. Neff et al., 2007; K. D. Neff & Vonk, 2009; Wada & Park, 2009). This acknowledgment of suffering means that the person has made a choice not to deny suffering. Instead, the person chooses to alleviate suffering by treating himself or herself with kindness as opposed to harsh judgment. This suspension of judgment recognizes the impermanent nature of suffering. The realization that the situation will change prevents an overinvestment of self in suffering. This objectivity results in mindfulness, or the alignment of the mental, emotional, and psychological states of the person. Mindfulness promotes the development of wisdom, which acknowledges the distorted perception of external events as the internal cause of suffering. Wisdom leads to behaviors that result in well-being, thereby modifying the experience of suffering. Once a person can put suffering into perspective, there is the realization that suffering is common to all people. The realization of the commonality of suffering promotes a willingness to assist others who are suffering.

Antecedents of Self-Compassion

The major antecedent to self-compassion is suffering (Florida, 2002; Habito, 2002; Ladner, 2004). Suffering has been described as "what cannot be put into words but is screaming to be disclosed" (Ferrell & Coyle, 2008, p. 27). Although the experience of suffering is universal, suffering is also uniquely individual. To list all the permutations of suffering is beyond the scope of this concept analysis. Suffering is an experience characterized by a loss of control that creates insecurity and a feeling of being trapped in the circumstances of suffering (Ferrell & Coyle, 2008; Wada & Park, 2009). The loss may be evident only in the mind of the suffering person, but it still results in feelings of sadness, despair, loneliness, or anguish (Ferrell & Coyle, 2008). Nonacknowledgment that suffering is a part of life increases the nature and intensity of suffering (Habito, 2002; Rinpoche, 1994; Thompson & Waltz, 2008).

The six realms of suffering are "states of being" or "life worlds" permeated by suffering and experienced as an event, a situation, an emotional reaction, a psychological condition, spiritual alienation, or a physical response to illness or pain. Examples of events that comprise suffering are loss, death, and abandonment. Situations of suffering include conflict and victimization because of torment, hatred, or anger. Emotional reactions that result in suffering include anxiety, fear, regret, or guilt (Ladner, 2004). Mental illness is a form of psychological suffering. Inability to cope or loss of autonomy also results in psychological suffering. Spiritual suffering is a result of the individual's feelings of isolation from loved ones, the community, and the person's higher power (Ladner, 2004; Wada & Park, 2009). Loss of personal meaning is another form of spiritual suffering (Ferrell & Coyle, 2008). Physical suffering results from disease, pain, and illness. Physical pain may be associated with the realms of psychological, social, and spiritual distress, but pain is not synonymous with suffering (Ferrell & Coyle, 2008).

People usually experience suffering in more than one realm simultaneously (Ferrell & Coyle, 2008; Florida, 2002; Ladner, 2004; Thompson & Waltz, 2008). Suffering in one realm, for example, spiritual suffering, may result in an inability to pay attention to physical needs. Neglect of physical needs may result in illness, hospitalization, and the separation from loved ones or loss of autonomy.

There are three dimensions of suffering. The first dimension of suffering is intrapersonal, or within the person. This includes feelings of emptiness, feelings of incompleteness, a lack of a sense of self, the inability to recognize that one is suffering, an unwillingness to examine painful experiences, an acute awareness of the consequences of painful experiences, resistance to loss, or harsh judgment of oneself (Ferrell & Coyle, 2008; Ladner, 2004). The

second dimension of suffering is interrelational. This is suffering that occurs because of relationships among people. Interrelational suffering includes lack of boundaries between the self and others, overdependence on the opinion of others, failure to achieve a goal set by the self or an authority, conflict with another person, or the need to control what cannot be controlled (Ferrell & Coyle, 2008; Ladner, 2004; Shepard & Cardon, 2009). The third dimension of suffering is contextual and arises between the person and environment or community. This is suffering that may arise from a toxic environment, being disconnected from people or places of comfort, or the perception of differences between the individual and the larger community (Ferrell & Coyle, 2008). The three dimensions of suffering can occur simultaneously, although one dimension may appear more dominant.

Suffering manifests as a pattern of diminished self-care capacity, decreased relatedness to others, decreased autonomy, and a perception of decreased self-worth that occurs in an environment that appears to support these conditions. This pattern of suffering will continue until a trigger event occurs. The trigger event is an occurrence that results in the person's realization that life has worth (Habito, 2002; Ladner, 2004; Watson, 1993). With this realization, the person understands that there is a choice. The realization that one has choice or that one's life has worth may in itself be a trigger event. Rather than continuing along the path of suffering, the person chooses to embrace all aspects of the experience, viewing suffering with compassion, and breaking the cycle of negativity but not disconnecting from the source of suffering (Gnaratana, 2002; Rinpoche, 1994). Once a person becomes aware of choice in the midst of suffering, the person becomes actively involved in making the changes needed for a more fulfilling and productive life. The person begins to desire well-being (Shepard & Cardon, 2009; Thompson & Waltz, 2008).

Consequences of Self-Compassion

Self-compassion leads to a positive emotional response that consists of increased autonomy, increased self-care capacity, and compassion for others. Increased autonomy includes self-mastery developed through the practice of mindfulness. The second consequence of self-compassion is increased self-care capacity because of the lessons learned as a person attempts to transform suffering. The third consequence of self-compassion is increased relatedness, as evidenced by actions in the world and community to help other people.

Identification of Cases of Self-Compassion

As self-compassion is an evolving process, and human beings are unique and complex, it is important that nurses develop an understanding of the varied permutations of self-compassion encountered while caring for human beings. Although a nurse may encounter an ideal case of self-compassion, the nurse is more likely to encounter borderline and contrary cases of self-compassion. People on the borderline of self-compassion may one day acquire the missing attribute(s) and become self-compassionate. People appearing to be contrary cases of self-compassion may one day experience a triggering event that results in self-compassion. With those permutations in mind, this article presents an ideal case, a borderline case, and a contrary rather than an exemplar.

Ideal Case

Mr. James is a 63-year-old African American man who grew up in an orphanage in a rural area of the southern United States. Mr. James left the orphanage at the age of 16 years without employable skills and unable to read or write; he turned to criminal activities in order to survive, resulting in incarceration for many years. Mr. James contracted human immunodeficiency virus/acquired immunodeficiency disorder syndrome (HIV/AIDS) from intravenous drug use. Now, Mr. James attends an Adult Day Health Care (ADHC) program for people with HIV where he receives his health care from a nurse practitioner (NP) and attends Narcotics Anonymous (NA) meetings three times a week. Mr. James has been drug free for many years and is adherent to his HIV medication regimen.

Mr. James lives in a single-room occupancy hotel (SRO), where, he says, people die from drug overdoses all the time, and "the management does not pay any attention until the bodies start to smell." Mr. James feels he should help the other

people in the SRO stop using drugs "because that is not the way you solve your problem and it is killing them." Mr. James credits the "chairs with getting him clean" and explains that before and after every meeting at NA, he sets up and takes down the chairs. This task has taught him a lot about self-discipline and taking care of himself.

Recently, Mr. James experienced the death of his son and his brother within a month of each other. Although Mr. James spoke freely of his feelings of grief and loss to the NP as well as his peers in the ADHC and NA, he began to visit the clinic several times a week with various nonspecific physical complaints. Examination and laboratory tests could not determine a cause for his complaints. On one visit, Mr. James arrived at the clinic unkempt and disheveled, demanding transport via ambulance to the emergency room (ER). When the NP could not find a reason to transfer him to the ER, Mr. James left the office angry and upset.

Weeks later, well dressed and groomed, Mr. James returned to the clinic because the ER doctor told him that if the NP listened to him during his time of grief, Mr. James should listen to the NP. Mr. James realized that nothing physical was wrong with him and that he was suffering from grief, which he described as "Giving up on life, there is no cure. What do you need a cure for if you've given up?" Now, Mr. James said, he had to

> face the world wherever he was at and fight to come out of the box. Once you face it, it is going be all right, you don't run from the box. You treat yourself better, you feel better. You got to promise yourself—let nothing rob you of your joy.

Mr. James said he accepted that he could not change the fact that his son and brother had died or that he had an incurable disease, but that he could heal his grief. Mr. James described his experience as "looking in the mirror and going backwards in order to go forward." Mr. James summed it up his journey through grief in the most profound way: "You got a *roam-map* where you come from, and you got to look at it to see where you are now." Mr. James decided to help another occupant of the SRO with his drug addiction and offered his services as the person's NA sponsor. He returned to the ADHC program and the meditative task of setting up the chairs for NA meetings.

The deaths of his son and brother resulted in isolation and caused Mr. James's suffering, the antecedent event. The ER visit was a triggering event that activated Mr. James's self-compassion, allowing Mr. James to verbalize his grief, evidencing self-kindness. Looking in the mirror, using his life experience to understand his present condition, and recognition that he once had the same problem as the other people in the SRO are expressions of mindfulness, wisdom, and commonality. This resulted in self-care (well groomed), increased autonomy and self-mastery (honoring the promise he made to himself), and compassion for others (wanting to help the SRO occupant).

Borderline Case

Mr. Robb has lived with HIV/AIDS for 25 years. He is an active drug user and has a history of selling his medications to buy illicit drugs. Although he is a long-term survivor, he has become increasingly ill, due to a very high viral load and very low CD4 count. In the past 6 months, he has had two hospital admissions. Between the first and second hospitalization, an old friend contacted Mr. Robb, offered support, and shared his experience of living with HIV/AIDS. Mr. Robb realized that his tendency to isolate himself from others was contributing to his feelings of anxiety, causing him to ruminate about his health and increase his drug use to avoid unpleasant emotions. Mr. Robb explained,

> I saw myself as the star, the co-star, the director, the cameraman, and the audience in my own little drama. I did not realize that other people were feeling the same things, too. Once I realized other people experienced the same thing, everything changed. I didn't feel alone anymore.

Mr. Robb decided to start psychotherapy, join NA, and reconnect with his sister. After the second hospitalization, Mr. Robb continued these activities, as well as attending health care appointments and adhering to his medication regimen.

On a recent clinic visit, Mr. Robb discussed how his feelings had changed: "I loaded off the things I was carrying. . . . I was bringing a lot of baggage on this journey of life. Life is already hard, and

I didn't need this baggage." Mr. Robb realized that the fight was

> with no one else but myself and the people who loved me were still there. . . . I am part of a universe which honestly, I have no choice but to be a part of, but my purpose here will manifest itself. . . . People were all around me, and they cared, and I didn't see it, but now I do.

Although Mr. Robb appreciates the support he receives from others, active drug use prevents him from helping another person at this time.

The visit of an old friend was a triggering event that resulted in Mr. Robb's experience of commonality with others as evidenced by his reconnecting with a sister and NA. Exhibiting wisdom, Mr. James identified the emotional burden of self-involvement that resulted in suffering, and in an act of self-kindness, Mr. Robb was able to let go of that particular bit of internal baggage. Although starting psychotherapy and attending health care appointments indicates Mr. Robb possesses self-care and autonomy, he is not ready to take compassionate actions for others.

Contrary Case

When Ms. Davina thought she was going to die from AIDS, she realized,

> I was not where I wanted to be and not who I wanted to be and I wanted to live. I realized everything I was doing was going to lead to my death not my life . . . it became important to be true to my real self.

Ms. Davina said that she had hidden her "real self" so completely in drugs and casual sexual encounters that she almost forgot her name. Afraid of confronting death, Ms. Davina started taking her medications faithfully.

Ms. Davina acknowledges the inevitability of death, but feels that "if she stays in touch with her own inner wisdom, she will be alright." She also accepts herself as she is, saying, "I believe I have the answer to the problem inside me. More than help, I want confirmation of my solutions. I am ready to work for my life." Ms. Davina's life is now "stable with glitches." Drugs and casual sex are no longer the responses to life's challenges; instead, Ms. Davina "starts from the heart then goes to the head, if they are conflicted, there's a problem. I try to get them on the same track; my heart takes me there." However, Ms. Davina remains separate from others, believing "I have everything I need, I do not have to deal with other people, that's BS" and "reefer [marijuana] saved my life, and saves other people's lives also because it keeps me from doing them harm."

Taking medications, striving for a stable life, bringing heart and mind in alignment, acknowledging one's true self, and looking internally for answers all indicate that Ms. Davina is developing self-kindness, autonomy, mindfulness, and wisdom. On the other hand, Ms. Davina's remark that she does not want to deal with other people indicates a lack of commonality with others; the use of marijuana to control the impulse to harm others indicates a lack of compassion for self and others.

Implications of Self-Compassion for Clinical Practice

That humans suffer and seek ways to overcome suffering is an insufficient justification for a nursing concept of self-compassion. To be useful for nursing, self-compassion must meet the following criteria: (a) What patient need does self-compassion meet? (b) How would self-compassion guide nursing actions? (c) How does the concept of self-compassion enhance clinical outcomes?

The concept of self-compassion meets the person's need to have her or his suffering understood and alleviated. All people suffer according to the nature of their illnesses but share common characteristics that define that suffering. By understanding both the common and unique attributes of suffering, the nurse can support the person and respond to behavior that reflects feelings of isolation, diminished self-care capacity, or lack of autonomy. This supportive response may be the triggering event that causes a person to overcome suffering, see the value in life, and begin to heal.

Nursing interventions and care plans derived from the concept of self-compassion guide the nurse's actions in caring for the patient who is suffering. Interventions based on self-compassion include mindfulness exercises, loving-kindness meditations or affirmations that speak to the shared experience of suffering, connections to other loving beings, or recognition of the impermanence of suffering.

Through therapeutic touch or the therapeutic use of touching, the nurse and the patient experience mutuality and connectedness, attributes of self-compassion.

Reduced suffering has the potential to improve health outcomes. An attribute of self-compassion is self-mastery, the ability to learn from failure and willingness to try again without self-recrimination. This attribute results in increased self-care capacity and autonomy, potentially increasing treatment adherence. Common humanity allows a person to seek out others experiencing similar problems and establish mutual support, which counteracts the obstacles associated with treatment adherence.

In nursing practice, self-compassion is often confused with caring. *Self-compassion* is a noun, or state of being which provides an understanding of suffering beyond the definition of illness, disease, and pain. *Caring* is a verb, or the nursing actions that arise from this understanding. The common humanity that nurses experience with patients leads to the development of self-compassion in both, improving the effectiveness of the healing relationship. When the nurse is able to identify triggers in the patient's life that lead to self-compassion rather than further suffering, caring nursing actions can support the patient's move beyond suffering and illness toward health and well-being.

Implications of Self-Compassion for Nursing Research

Self-compassion has implications for both qualitative and quantitative research in nursing. For quantitative studies, an operational definition of the concept of self-compassion is required for empirical testing of the attributes of the concept. The Self-Compassion Scale, a psychological research instrument, attempts to measure self-kindness, commonality, and mindfulness using a Likert-type scale (K. D. Neff, 2003). Correlational descriptive studies using the Self-Compassion Scale with instruments measuring autonomy and self-care may provide information about the strength of the relationship between the attributes and consequences of self-compassion.

Interventional studies are useful to identify if mindfulness exercises, therapeutic touch, or affirmations implemented by nurses increase any of the attributes or consequences of self-compassion. Interventional studies are also useful to identify the relationship among physiological status, self-compassion as a state of being, and mindfulness interventions. Studies comparing the effects of self-compassion interventions on variables such as cortisol levels, CD4 levels, blood pressure, reported health status, reported stress levels, or adherence to medication regimens would also increase nursing knowledge with regard to the concept of self-compassion.

Phenomenological research exploring the lived experience of self-compassion in particular groups of people may identify other common themes in the lived experience of self-compassion and suffering. Phenomenological studies may also identify additional antecedents, attributes, or consequences of self-compassion not found in the literature to date. This information could lead to the development of nursing theories founded on the concept of self-compassion.

A hermeneutic study of literature on suffering and self-compassion would provide new understanding of self-compassion. Although this concept analysis focused on defining a nursing concept of self-compassion through the literature of Buddhism and the experiences of people with HIV/AIDS, an exploration of self-compassion in the literature of Christianity, Judaism, Hinduism, or Islam and the experiences of people with other chronic diseases may identify different antecedents, attributes, or consequences of self-compassion.

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