Chapter #2

EMPATHY: HOW MUCH IS RIGHT?
A methodology for the management of empathy in the context of healthcare

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ABSTRACT
The paper describes an innovative program "Empathy without Compassion Fatigue" for health professionals designed to enable them to manifest empathy without suffering compassion fatigue (CF). It includes four distinct parts. The first is designed to promote the creation of a motivational disposition for bounded empathy. The second is targeted to produce a cognitive mental set enabling the individual to focus on interpersonally-shared reality rather than on the subjective personal meanings. The third is designed to promote the expansion of meaning assignment of the situation in terms of meanings other than those that support empathy. The fourth is targeted to enhance the differentiation between the self and the other. The first part is based on the cognitive orientation theory, the second and third parts are based on the Kreitler Meaning System, the fourth is based on the self-identity approach. An empirical demonstration of the implementation of the program with nurses provided evidence for its feasibility and potential efficacy.

Keywords: empathy, compassion fatigue, bounded empathy, cognitive orientation, meaning.

1. INTRODUCTION

1.1. The role of empathy in the health professions

Empathy is commonly considered as an important resource for health professionals. They are expected to manifest empathy when in contact with patients so as to express how much they care, which in turn enhances the empowerment of the patients and their mobilization to invest in the recovery process (Kim, Kaplowitz, & Johnston, 2004). Health professionals of all disciplines tend to feel an obligation for the empathic ability, while patients often include empathy as a criterion for evaluating the expertise and trustworthiness of the doctors.

1.2. The problems of empathy

It has been noted that empathy is probably a limited resource. If activated a lot it may become depleted temporarily but if the depletion-restoration process is repeated often, the activation of empathy may undergo habituation and culminate in compassion fatigue (CF). CF has been found in 16% to 85% of health care workers in different contexts (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010).

CF is characterized by a gradual lessening of compassion over time. It is common among individuals working with trauma victims. The symptoms of CF are hopelessness, a decrease in experiences of pleasure, constant stress and anxiety, sleeplessness or nightmares, a pervasive negative attitude, cynicism, a decrease in productivity, difficulty to concentrate,

and feelings of incompetency and self-doubt. Symptoms of this kind may cause a decrease in the health professional's efficacy at work and eventually to limiting his or her contact with patients. CF appears to be a major constituent of burnout of healthcare professionals (Figley, 1995). Major risk factors include job overload, lack of support, excessive empathy and life demands (Sacco, Ciurznski, Harvey, & Ingersoll, 2015).

There is a great interest in conserving the health professionals' ability to continue functioning on the optimal level. One prerequisite for attaining this goal concerns the management of empathy manifestations. The issue is not limited only to preserving the health professionals' ability to manifest empathy and to reducing the conditions for CF. Manifesting high degrees of empathy may be disconcerting for at least some patients. The excessive expressions of empathy may overwhelm them, cause discomfort and make them feel obliged to their doctor to a degree they would like to avoid or feel unable to assume. Expressing a lot of empathy may be also uncomfortable or difficult for at least some health professionals, for personal reasons or because they may consider it inadequate for some patients, or because it reduces the distance between them and the patients in a manner that may interfere with their work as health professionals. As noted, eventually too frequent or too strong expressions of empathy may result in CF (Bloom, 2016).

However, reducing seriously the expressions of empathy on the part of health professionals is also not the right solution. If too little empathy is expressed toward the patient, it may reduce the cooperation of the patient with one's doctor and lower adherence with the treatment implementation. It may result in increasing the distance between the health professional and the patient to a degree that may harm the patient, cause misunderstandings in the communication about health issues between health professional and the patient, and may even cause a sense of guilt in the health professional who may feel that one's low empathy expressions contradict one's conscience as a human being and as a health professional (Haque & Waytz, 2012).

In sum, the problem of empathy seems to be broader than simply combating CF. It encompasses also the issue of regulating the manifestations of empathy in line with the requirements of the situation and the tendencies of the health professional. Hence, the required tools should help healthcare professionals to manage and control the expressions of empathy in the healthcare context.

1.3. Common means for reducing compassion fatigue

Awareness of CF and its role in promoting burnout has led doctors and other health practitioners to come up with different proposals for combatting or preventing CF. These are mostly based on common sense and personal experience. They emphasize self-care, such as getting enough sleep, regular meals, physical exercise, breaks during working time, vacations, working fewer hours, having fun and entertainment; spending time with family and friends, and getting professional help in case the listed measures provide no help (Pfifferling & Gilley, 2000). Further more specific suggestions are reducing exposure to situations in which empathy is required (e.g., by switching to research or administrative work), or focusing on self-reflection, which may help in identifying what is important for oneself and living in accordance with it. There is little if any evidence whether suggestions of this kind have been applied or their effects on CF tested. A study with health care workers in pediatric oncology found that CF was lowered by two relief-inducing actions: interacting with people (who are not colleagues or patients) and bodily activities, such as sport (Toren et al., 2016). Mindfulness is the means that has been most commonly used for reducing CF. Several studies reported positive results following participation in several mindfulness sessions (Duarte& Pinto-Gouveia, 2016). Teaching resilience had no

appreciable effect on CF (Jakel et al., 2016; Pfaff, Freeman-Gibb, Patrick, DiBiase, & Moretti, 2017). Only a minimal effect on CF was reported following participation in a formalized educational program (Klein, Riggenbach-Hays, Sollenberger, Harney, & McGarvey, 2017).

2. OBJECTIVES

The purpose of the paper is to describe a program "Empathy without CF" for enabling health professionals to manage and control the expressions of empathy to patients to the adequate degree according to their judgment. The program is designed to provide means to facilitate adjusting the degree of expressed empathy to the situation, the patient and the health professional, including guarantee for the reduction of the chances for CF. A preliminary limited empirical demonstration supporting the application of the program is presented.

3. THE PROGRAM "EMPATHY WITHOUT CF"

3.1. Some assumptions that have led to the program "Empathy without CF"

Several assumptions have led to the development of the program "Empathy without CF".

Empathy and compassion are tendencies of limited quantity and get depleted when activated, similarly to self-control (Muraven & Baumeister, 2000). Hence, these emotional tendencies need to be exercised with caution, under control. A caretaker is advised to acquire a useful and easily applied set of tools for controlling at will one's empathic responses while avoiding the danger of accumulating CF.

Individuals differ in their basic capacity to empathize and to manifest their empathy (Davis, 1983). Yet some professions, especially healthcare, require this skill. Hence it is necessary to examine the possibilities for training this skill so that it can be applied at will.

It is possible to control empathy and regulate its manifestation in line with different contextual characteristics. For example, the impact of mindfulness training on reducing CF was mediated by self compassion which acts as a factor that focuses empathy on the other (Raab, 2014). Further, the degree of empathy by therapists towards another person depends on whether that person belongs to an in-group or an out-group of the observer and whether the event that has affected that person is positive or negative (Cikara & Fiske, 2011). Studies with mental health workers showed that empathy is continuously in a state likely to be affected by contextual factors and social contingencies (Santamaria-Garcia et al., 2017).

Empathy consists not only of the experience of the empathizer but includes also behavioral manifestations of empathy. The behavioral component of empathy plays a role in determining the effects of empathy on other people, including patients. It is possible that what affects another person is not the experience of empathy by the health professional but rather the external behavioral manifestations that are identified as expressive of empathy.

The behavioral component of empathy requires dealing with both the motivational tendency for empathy and the manner of its implementation, as is evident in the program of "Empathy without CF".

3.2. Outlines of the program "Empathy without CF"

The program "Empathy without CF" developed slowly, mainly through gradual adaptations after a series of applications and demonstrations of the program in different settings.

The program includes four parts, each introducing one strategy. The first (Part A.) focuses on producing the motivation for controlled empathy; the second (Part B.) deals with creating the mental set supporting controlled empathy; the third (Part C.) is devoted to enhancing the kinds of meanings in the situation that turn one's attention to aspects other than those expressing empathy; and the fourth (Part D.) promotes focusing on the other as an entity separated from oneself. Each of the four parts is presented separately, introduced by the supporting theoretical and methodological background, and describing the means of actual intervention.

3.3. Part A. Formation of a motivational disposition for "bounded empathy"

The first part in the Empathy without CF program is the formation of a motivational disposition designed to support the emergence and manifestation of "bounded empathy". The motivational disposition is a tendency for behavior acquired and strengthened in the framework of the cognitive orientation theory, which specifies conditions and components of dispositions for behaviors and for physiological states (Kreitler & Kreitler, 1982). Dispositions of this kind need not be conscious, nor controlled by volition, and are not the product of decision making, or of rational considerations of costs and benefits. By applying Part A. of the program, the healthcare provider may acquire this motivational tendency and maybe enhance it from time to time. Once acquired it will be set in operation in the treatment situation automatically or at will.

A motivational disposition is the function of a set of specific cognitive beliefs. The beliefs include four types: beliefs about oneself (e.g., I like to understand others), beliefs about rules and norms (e.g. One should try to understand others), beliefs about goals (e.g. I would like to be able to understand others), and beliefs about reality and others (e.g., Understanding others is often difficult). The beliefs refer to specific themes that represent meanings identified as underlying the specific behavior. The themes are the result of a standard interviewing method employed with pretest subjects and based on a sequential three-step probing procedure focused on repeatedly requesting the meaning of the preceding response. The selected themes are meanings occurring in the final step in over 50% of the pretest subjects evidencing the behavior of interest and those occurring in fewer than 50% of those not manifesting that behavior. The motivational disposition may be assessed by a CO questionnaire (Kreitler, 2004).

The core of the motivational disposition consists of the themes. The themes for bounded empathy are the following: 1. Replacing actual emotions by emotional attitudes; 2. Controlling the situation; 3. Controlling oneself; 4. Guarding oneself; 5. Emphasis on manifesting expertise; 6. Adjusting the means to the needs; 7. Distinguishing between means and ends; 8. Not wasting resources; 9. Separating the inner world from the external one.

The intervention for creating the motivational disposition for bounded empathy consists in mobilizing in the subject sufficient support for the themes constituting the motivational disposition by evoking in the subject beliefs of the four types in regard to each of the themes.

Theme 1: The intervention focuses on beliefs emphasizing, for example, that evoked emotions in the health professional as well as in the patient may be distractive insofar as the goals of treatment are concerned, or on beliefs supporting emotional attitudes as a more efficient means for evoking in patients feelings similar to those supposedly evoked by actual empathy, i.e., feeling accepted, appreciated, cared about, encouraged, listened to, and

evoking concern and interest in the physician. The behaviors of the healthcare professional that evoke these feelings without emotional investment are: being attentive, asking questions, listening to the answers, being polite, making the impression of not being time pressured, giving hope. Behaviors that need to be avoided are telling about oneself and one's reactions, and imitating the patient's posture and movements.

Theme 2: The intervention for strengthening the healthcare provider's control of the situation focuses on promoting beliefs, such as control of the situation reduces the patients' anxiety, strengthens their confidence in the treatment and awareness of its goals, and encourages them to act empowered. It also enhances the doctor's ability to focus on a precise implementation of the treatment.

Theme 3: The intervention for enhancing self-control focuses on beliefs emphasizing the value of independence and autonomy, the power to attain one's goals, assuming responsibility, and the ability to plan.

Theme 4: Beliefs promoted for supporting the theme of guarding oneself are those emphasizing the importance of taking care of oneself continuously, of keeping oneself fit mentally and physically, and of the duty to guard one's special gifts and expertise as a healthcare provider.

Theme 5: The theme concerning the importance of expertise may be promoted by beliefs such as, expert healing skills are rare and difficult to acquire, patients need to benefit maximally from the particular skills of the healthcare.

Theme 6: The theme which focuses on adjusting the means to the needs, may be promoted by beliefs, such as the importance of maintaining a realistic view, flexibility and parsimony in using one's resources adequately.

Theme 7: The theme which stresses the distinction between means and ends, may be promoted by beliefs, such as control requires focusing on the goals and adapting the means to attaining them.

Theme 8: The theme which focuses on preserving the resources, may be promoted by beliefs such as the limited amount of precious resources and the need to manage carefully such resources.

Theme 9: The theme which focuses on separating the inner world from the external one, may be promoted by beliefs such as keeping one's privacy, and preventing exposure of one's possible weaknesses which may be exploited by others.

In interventions targeting the generation of a motivational disposition it is important to focus (a) on mobilizing supporting beliefs provided by the participants themselves, (b) to get support of beliefs of the four types, and (c) to strengthen support for at least half of the involved themes (Kreitler, 2004). Once acquired, the motivational disposition for bounded empathy may be strengthened further at the participant's decision, and may be evoked in any number and type situations other than healthcare.

3.4. Part B. Creation of a mental set that regulates one's internal and external emotional reactions with a focus on the interpersonally-shared mode of meaning

The mental set that promotes bounded empathy and safeguards the healthcare professional from CF is based on the meaning system approach (Kreitler, 2014). According to the meaning system theory every meaning may be stated or expressed in one of the two major modes of meaning: the interpersonally-shared mode or the personal-subjective mode. The former is used mainly in interpersonal communication, the latter for the expression of personal experiences and approaches. Meaning may be considered as consisting of meaning units defined by a referent which states to what meaning is assigned and the assigned

contents, e.g., table – a piece of furniture. The two modes of meaning differ in the nature of the bond between the referent and the assigned contents, rather than in the referents or the contents themselves. The differences are structural. The interpersonally-shared mode uses mainly the attributive relation (e.g., Love – is an emotion) and the comparative relation (e.g. Love –resembles happiness, but differs from hatred), and the personal-subjective mode of meaning expresses meanings in the illustrative-exemplifying form (e.g., Love – a mother holds her baby and kisses him) or by the use of metaphors or symbols (e.g. Love – is like the spring of life). Previous studies showed that it is possible to activate one or the other mode temporarily by cognitive means and that the activation is followed by cognitive and emotional manifestations corresponding to the different modes, e.g., better logical thinking and verbal memory in the case of interpersonally-shared mode and better recognition of emotional cues and stronger emotional empathy in the case of the personal mode (Kreitler, 1999; 2009, 2017). Hence, promoting the interpersonally-shared mode of meaning results in lowering emotional empathy.

The training of mental set creation includes the three following steps:

(1) The first step consists in learning to identify the two modes of meaning. This is done by presenting to the participants examples of both modes for identification and by requesting active production of examples in both modes.

(2) The second step consists in learning to switch between the two modes of meaning, by practicing the switch, first at the instruction of the trainer, and then by self-instruction. The latter case mimics the situation when the person activates one or another meaning mode at will.

(3) The third step consists in learning to establish the interpersonally-shared meaning by focusing intentionally on the interpersonally-shared meaning and overlooking the personal-subjective meanings in the situation of treating patients. For example, concerning a symptom described by a patient, it is recommended to focus on the general diagnosis indicated by the symptom rather than on the specific subjective meaning assigned to it by the patient.

3.5. Part C. Meaning-assignment to a present or unfolding situation in terms of meanings differing from those characterizing empathy

This part of the training is also based on the meaning system but in a different manner than the second part (see section 3.4). The meaning system includes a comprehensive set of variables characterizing different ways in which a person assigns meaning to stimuli, situations and constructs. The variables describe contents, relations, forms of expression and handling of the stimuli. A previous study showed the kind of meaning assignment tendencies characteristic of individuals scoring high on empathy scales i.e., Toronto Empathy Scale (Spreng, McKinnon, Mar, & Levine, 2009) and the Interpersonal Reactivity Index (Davis, 1983). These were primarily tendencies to focus on the active agents in a situation, cognitions, judgments and evaluations, emotions evoked in oneself or observed in others, sensory qualities, sensory experiences, impressions, examples and illustrations, metaphors, declarative statements, positive statements, nonverbal expressions mostly gestural, and focusing on inputs close to those presented. These tendencies constitute the meaning profile of empathy (Kreitler, 2014). The third part of the training consists in promoting in the individual assignment of meanings that differ from those constituting the meaning profile of empathy.

Two major goals are attained by this strategy. One goal is extending the overall meaning assignment of the individual in the given situation, and the second goal is directing the assignment of meanings to those aspects of meaning that promote reduction of empathy

rather than its evocation. The training consists in (a) identifying referents (i.e. the objects or constructs to which meaning is assigned), (b) learning about the meaning variables (i.e., the major categories of contents and kinds of relations that constitute meaning) and (c) assigning meaning values (i.e., actual meaning responses) to the different identified referents. Referents are trained for example by directing participants to name or point out specific objects in treatment situations that may be presented verbally or visually (e.g., chair, stretcher, window, doctor). Meaning variables are trained by presenting to the participants the content categories and kinds of meaning that are not related to empathy, describing each, providing examples for each and asking the participants to provide examples on their own. Relevant meaning variables are, for example, actions, functions, manner of operation, structure, materials, qualities of time, qualities of space, size and dimensions, possessions and belongingness, negative statements, conjunctive and disjunctive statements, associations, etc. Assigning meaning values to identified referents is trained by asking the participants to produce varied meaning responses (at least 3) describing selected referents in the therapeutic situation, e.g., chair – a piece of furniture, is made of wood, serves for sitting; stethoscope – a medical instrument, used for listening to sounds in the body, during patient examination.

3.6. Part D. The self-other differentiation

The fourth part of the training deals with enhancing awareness of the gap between the self and the other. This entails focusing on differences between oneself and the other person so as to emphasize the special qualities of the "other" as compared to the "self", obviously excluding derogatory evaluations (Bullock & Trombley, 1999). Different theoretical approaches to the development of self-identity focus on the role of awareness of the distinctions between the self and the other, for example, in terms of physical, social or attitudinal characteristics (Cinoğlu, & Arikan, 2012). One's self identity was found to be based on cognitions regarding features in which one shares with others or in which one differs from others (Miller, 2008; Horowitz, 2012). The gap between the former and latter cognitions may vary and could be modified by attention. A decrease in the gap may be manifested in increased altruism and empathy, while an increase in the gap is related to enhanced concern with one's own needs and self-interests (Fowler & Kam, 2007). The gap is increased when one focuses on the features whereby one differs from others (Miller & Ratner, 1998). It is likely that under these circumstances empathy is decreased.

The rationale underlying this part of the program is that empathy is a function related to the self in a double sense: first, it is a function of the self like all other emotions; and secondly, this relation is enhanced because empathy consists precisely in blurring the boundaries between self and other by emphasizing "I can feel what you feel". Accordingly, Part D of the training focuses on strengthening awareness of the gap between "I" and "the other", by promoting responses that exemplify and emphasize the differences. For example, the participants are asked to focus first on themselves, by noting different parts of their body (at least 3, e.g., their legs, chest, face), to state to oneself 3 different sensory qualities one has: e.g., my hair/face/color vision/taste… and 3 different traits one has: e.g., I am intelligent/ patient/impulsive. Further, the participant is requested to state to oneself three statements expressing differences between oneself and one's patient (for example, I differ from my patient in age/gender/profession/my patient's experiences differ from the ones I have had etc.). This part may include also statements distinguishing between "patient's feelings", "feelings I have experienced", "my feelings due to identification with the patient" and "my feelings towards the patient and in reaction/response to the patient".

3.7. Some general remarks about the program "Empathy without CF"

The program consists of a set of strategies that function as tools for controlling the manifestations and use of empathy by the healthcare professional. The program may be acquired and practiced prior to addressing patients in the healthcare context. Not all parts need to be applied each time or in a specific order. Most importantly, if practiced, the program does not need extra constant training for ensuring its utility in regard to empathy. The mere use of the program is guarantee enough that it will be kept in shape. Eventually it will be evoked automatically when the individual is confronted with stimuli for empathy. Moreover, the program may be applied also in contexts other than that of healthcare. It is general enough to be applicable in any interpersonal context which may evoke empathy. Further, the program can and should be applied for controlling empathy to different degrees, ranging from enhancing empathy to moderating its manifestations to the degree judged to be adequate by the individual. Hence, the program may be used by health practitioners for the control of their emotional behavior and the enrichment of their cognitive approach in any context in which they function.

4. EMPIRICAL DEMONSTRATION

4.1. Objectives and method

The objective of the study that will be described briefly was to demonstrate the effectiveness of the new current version of the four parts of the program "Empathy without CF". The participants were nurses who have been working in pediatric oncology wards for over 10 years. CF was assessed by the Compassion Fatigue Scale Revised (Gentry, Baranowsky, & Dunning, 2002), based on the original Figley (1995) scale, which includes 13 items each rated on a

10-point, visual, analog-type Likert-type scale (1 = *never or rarely*, 10 = *very often*) (see Adams, Boscarino, & Figley, 2008, pp. 242, 249). The subjects were divided randomly into two groups, with 8 participants in each: the experimental group got the training in line with the program of "Empathy without CF" and the control group did not get it. In the experimental group the training included all four parts of the program in the order described above (section 3), and lasted 2 hours, with about 30 minutes devoted to each part. The training was performed by two psychology students according to the guidelines. In the control group the participants were asked to discuss their work for two hours, in the presence of two psychology students. The experimental and control groups met on different times in order to prevent effects due to interactions between the subjects in the two groups. All subjects were administered the CF scale prior to the beginning of the study, and again four weeks after its termination, during which time all subjects continued their regular work. The subjects were told that they are participating in a preliminary exploration designed to examine the feasibility of a program. The hypothesis was that CF would decline in the experimental group but not in the control group.

Table 1.
Means and SDs of CF in the pre-test and post-test phases in the experimental and control subjects.

	Experimental Pre	Experimental Post	Control Pre	Control Post	T-Test
Mean	7.3	5.9	6.9	7.1	
SD	1.6	1.2	1.9	2.1	
Exp. Pre & Control Pre					$T=0.45$, p=0.66
Exp. Pre & Exp. Post					$T=1.98$, p=0.06
Control Pre & Control Post					$T=0.19$, p=0.84
Exp. Post & Control Post					$T=1.40$, p=0.18

4.2. Results and discussion

The results presented in table 1 show that the experimental and control groups did not differ in CF prior to the training, so that no selection bias can be assumed. The important result is that in the experimental group the scores of CF declined after the training, as expected. However, the change was only of borderline significance. There was no comparable change in the control group.

The two obvious reasons for the not quite significant result are first, the small sample size, and second, the highly limited time devoted to the training itself. Actually, it is surprising that the results show a tendency in the expected direction despite the short training time. Indeed, the result obtained under these unfavorable conditions is itself a kind of evidence for the power of the training program. The latter conclusion is supported also by the suggestive but not significant results obtained in a previous study which the impact of training the separate parts of the program (Kreitler, 2018). Be it as it may, the presented results suggest the feasibility of the program and its potential power even if implemented under highly curtailed temporal conditions. Future research is needed for examining the extent of improvement in reducing CF that could be attained by longer investment in the training. Further, it is likely that after a brief training, the effects of the program will be enhanced and become habitual through the mere repeated application of its tools by the health professionals themselves, without additional training by experts.

5. SUMMARY AND CONCLUSIONS

A four-tier program for attaining Empathy without CF is based on two separate theoretical approaches – the cognitive orientation theory that deals with shaping motivational dispositions and the meaning theory that deals with mental sets and meaning assignment.

Accordingly, the program includes a part that focuses on producing in the healthcare professionals a motivational disposition for bounded empathy, another part that deals with producing the adequate meaning-based mental set, a third part that focuses on expanding meaning assignment in the situation beyond the elements supporting empathy, and a fourth part that enhances the gap between the self and the other in a manner that puts checks on the evocation of empathy. Each of the four parts deals with a specific well defined aspect of the issue of empathy and has a unique contribution to the attainment of the goal. While the motivational disposition contributes to determining the goal of the behavior, the meaning-based set and meaning assignment contribute to the operational aspect by rendering the attainment of bounded empathy possible and shaping its actual manner of operation. Hence, the four parts can be applied separately at the individual's will. Further, each of the parts may be used in different degrees of completeness or intensity so as to modulate the total effect on empathy. Similarly, the different parts may be combined in different forms, so as to attain varying outputs in terms of empathy. It is possible to select one or another part on the basis of personal preference. A further advantage of the program is that it does not deal openly and directly with empathy and its weakening for reducing CF. The theoretical approaches focus the training on major underlying processes of motivation and meaning which do not mention empathy directly and hence prevent the involvement of conscious attitudes towards empathy and the evocation of responses based on social desirability or resistance.

The described possibilities of application demonstrate the wide range of potential uses of the four parts of the program in different combinations. These include the different varieties of empathic expressions, such as enhancement, regular manifestation, moderated manifestation, decreased expression, or replacement of empathy by empathy-mimetic behavior. All these forms are examples of controlled empathy. There are additional kinds of empathic expression. These and others could be non-voluntary expressions of empathy as well as controlled expressions, dependent on the choice and decision of the individual. Choices of this kind reflect to varying degrees the individual's goals, norms, self image and perceptions of context. Most importantly, acquiring the tools of the program enable the individual to regulate the expressions of empathy in the healthcare context so that they do not fall below the level necessary for satisfying the patients' needs but at the same time prevent the generation of CF and conform to the healthcare professional personal tendencies. The program is designed for use by all health care providers on all levels, including the professional ones as well as the informal and non-professional ones, all of whom had been shown to suffer from CF.

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Short biographical sketch: Professor Shulamith Kreitler was born in Tel-Aviv and got her education at Bar Ilan University in Israel, her PhD (summa cum laude) at Bern University (Switzerland) and her post doc at Yale University in the USA. She has been a professor of psychology at Harvard University, Princeton University and at Yale University in the USA as well as at Vienna University (Austria), and for over 40 years full professor of psychology at Tel-Aviv University. At present she is professor emeritus at the school of psychological sciences Tel-Aviv university. She has founded and directed the Unit of psychooncology at the Sourasky Tel-Aviv Medical Center for 20 years and works now as the head of the Psychooncology Research Center at the Sheba Medical Center at Tel-Hashomer. She has written over 300 articles in scientific journals and 16 books. Her major scientific contributions are in the domains of human motivation (the "cognitive orientation theory"), cognition (the meaning system) and health psychology. She has developed an innovative approach to studying the interactions of body and mind and clarifying the impact of psychological processes on physiological phenomena relevant for diseases, mainly cancer