



The Effect of Patient Self-Advocacy on Patient Satisfaction: Exploring Self-Compassion as a Mediator

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The purpose of this study was to examine the role of self-compassion as a predictor and mediator of the relationship between patient self-advocacy and patient satisfaction in health care. A sample of 522 patients completed a questionnaire that asked for their perceptions of their own self-compassion, patient self-advocacy behaviors, including illness education, assertiveness, and mindful nonadherence, and patient satisfaction. This study found that both patient self-advocacy and self-compassion were positive predictors of patient satisfaction. More specifically, patients' illness education and assertiveness positively influenced patients' satisfaction with their physician. Self-compassion was also shown to be a mediator between patient self-advocacy and patient satisfaction. The implications of these findings and future directions are also discussed.

Keywords: Self-Compassion; Patient Self-Advocacy; Patient Satisfaction

The Centers for Disease Control and Prevention (Centers for Disease Control, 2010, 2016) report that up to 51% of American adults are currently living with at least one chronic illness, such as HIV, cancer, stroke, diabetes, and depression. These chronic illnesses lead to negative outcomes, such as enhanced hospital bills and increased mortality rates (CDC 2016; Ward & Schiller, 2013). Patients with prolonged illnesses are more likely to visit and interact with their primary care physician to manage their own health concerns (Greene & Hibbard, 2012). Patients with illnesses tend to experience negative attitudes toward themselves by engaging in the self-blame process for their illness, and this leads to negative

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cognitive and emotional health care experiences (Halding, Heggdal, & Wahl, 2011). Current research has been examining the role of self-compassion in patients in health care. Patients with self-compassion, for instance, tend to treat themselves with kindness and mindfulness, which helps them cope with their illnesses (Pinto-Gouveia, Duarte, Matos, & Fraguas, 2014; Sirois, Molnar, & Hirsch, 2015). Self-compassion interventions have been implemented to help patients alleviate their perceived pain through meditations, yoga, and visualization techniques (Costa & Pinto-Gouveia, 2010; Wren *et al.*, 2012). However, not all patients display high self-compassion when going through an illness, and this may impact their own satisfaction with their prescribed care (Allen & Leary, 2010).

Thus far, a growing problem in health care has been patient dissatisfaction. Unfortunately, patient dissatisfaction is a health concern that has been affecting physicians, managers, and administrators in several health care facilities (Schaad, Bourquin, Bornet, Currat, Saraga, Panase, & Stiefel, 2015). When patients are dissatisfied with their received care, they tend to switch primary care physicians or seek alternative medical care (Harris, 2003), which may result in poor health care delivery. On the other hand, patients who are satisfied with their physicians tend to maintain the same physician in recurrent visits over time to manage their illnesses (Harris, 2003; Kafetsios, Hantzara, Anagnostopoulos, & Niakas, 2016). One construct that has been examined to improve physician-patient interactions has been patient self-advocacy, which enables patients to confidently search for health-related information regarding their medical condition, verbally assert themselves in physician-patient interactions, and practice mindful nonadherence when they openly disagree with a prescribed treatment (Brashers, Haas, & Neidig, 1999). Engaging in patient self-advocacy is advantageous for the patients receiving medical advice or care because patients with self-advocacy skills are able to approach physicians with more confidence, adaptability, and with less uncertainty (Brashers & Klinge, 1992). Patients who engage in patient self-advocacy behaviors often report being satisfied with their health care physician in the health care delivery process (Hinshaw & Atwood, 1982; O'Connell, Young, & Twigg, 1999). To date, correlational cross-sectional studies have examined self-compassion with patient self-advocacy and patient satisfaction (Eide, Graugaard, Holgersen, & Finset, 2003; O'Connell *et al.*, 1999); however, no previous study has explored the mediating role of self-compassion on patient self-advocacy and patient satisfaction.

Thus, the purpose of this study is trifold: (a) whether the three characteristics of patient self-advocacy positively predict patient satisfaction; (b) whether self-compassion serves as a positive predictor of patient satisfaction; and (c) whether self-compassion serves as a mediator of the relationship between patient self-advocacy and patient satisfaction.

Patient Self-Advocacy and Patient Satisfaction

Patient self-advocacy is defined as “representing one’s own interests within the health care decision-making process” (Wright, Frey, & Sopory, 2007, p. 36). Patients with self-advocacy may seek health information and may interact effectively with their health care providers, and as a result, report patient satisfaction with their physician and their health care experience (Adams & Drake, 2006). Patients who advocate for

their own behalf in doctor-patient interactions may also report patient satisfaction with their physician (Hinshaw & Atwood, 1982; O'Connell *et al.*, 1999). Patient self-advocacy has three characteristics, including increased illness education, assertiveness with a doctor, and mindful nonadherence (Brashers *et al.*, 1999), and these three characteristics may influence patients' satisfaction.

Illness education refers to patients who seek knowledge that is relevant to their health care condition to participate in their own health care decisions (Brashers *et al.*, 1999). For example, a patient may research his or her own condition through WebMD or through a medical Web site to learn more about his or her own symptoms and treatments. A study by Williams, Weinman, and Dale (1998) found a positive relationship between information-seeking behavior about illness resources and patient satisfaction. Correspondingly, another patient-physician study found a positive correlation between patients' ability to educate themselves about their own illness upon a doctor consultation and their perceived patient satisfaction levels (Eide *et al.*, 2003). In addition, an acute cancer study by Wright and Frey (2008) found that patients' willingness to engage in information-seeking behaviors to learn about their illness to improve their health positively predicted their satisfaction with the quality of care at a cancer center. Because of these findings this study investigates whether illness education predicts patient satisfaction.

Assertiveness, on the other hand, refers to patients' confidence in initiating health care topics with their health care provider. For instance, patients may ask direct questions about their treatments to their health care providers (Brashers *et al.*, 1999). Previously, a few studies demonstrated the relationship between patients' communicative behaviors, such as engaging in conversation, asking questions, and listening actively, and patients' perceived satisfaction with their health care physicians (Roberts & Aruguete, 2000; Roter & Hall, 1993; Wanzer, Booth-Butterfield, & Gruber, 2004). A study by Van Dulmen (2002) found that patients' instrumental communicative strategies, such as asking for advice and clarifying an illness, served as a predictor of patient satisfaction. Similarly, another study by Koermer and Kilbane (2008) found that communicating with one's physician had an effect on patients' perceived satisfaction. Given the findings of these studies, patients' assertiveness in the patient self-advocacy process may positively relate to patients' perceived satisfaction.

Mindful nonadherence refers to challenging the treatments offered by health care physicians if they do not suit their needs, or if the treatments are inadequate (Brashers *et al.*, 1999). A patient who receives inadequate treatment, for instance, may request to explore other treatment alternatives to better suit his or her individual needs. Previously, patient nonadherence was perceived to be a negative patient behavior and disruptive to the patient-doctor relationship (Svarstad, 1976). However, mindful nonadherence can benefit patients because by challenging the treatments or medications prescribed by their physicians, this may lead to better treatment options, which can enhance patients' satisfaction with flexible physicians (Donovan & Blake, 1992). In addition, when patients engage in mindful nonadherence, the recovery rates may improve, which can also improve patients' satisfaction with the health care process (Heszen-Klemens & Lapinska, 1984). Thus, it is expected that patients' mindful nonadherence will positively relate to patient satisfaction. Given that the previous research has found evidence that sex, income level, and frequency of physician visits impact patient satisfaction (Shah & Baba, 2016;

Teunissen, Rotink, & Lagro-Janssen, 2016), this study will control for these demographic variables to determine if the three characteristics of patient self-advocacy positively relate to patients' satisfaction. Thus, the following hypothesis is posed.

- H1: After controlling for sex, income level, and frequency of physician visits, patient self-advocacy (a. illness education, b. assertiveness, and c. mindful-noncompliance) will have a positive effect on patient satisfaction.

Self-Compassion and Patient Satisfaction

Previously, studies examined the association between self-compassion and patient satisfaction in health care contexts. Neff (2003) defines self-compassion as the ability of "being touched by and open to one's own suffering, not avoiding or disconnecting from it, [and] generating the desire to alleviate one's suffering and to heal oneself with kindness" (p. 87). Self-compassion encompasses the following three dimensions: self-kindness, mindfulness, and common humanity (Neff, 2003). Multiple health care studies have shown that self-compassion is beneficial to enhance patients' ability to engage in self-kindness when suffering from a variety of illnesses or from a lack of proper self-care (Batista, Cunha, Galhardo, Couto, & Massano-Cardoso, 2015; Gilbert, 2005; Pinto-Gouveia *et al.*, 2014; Wren *et al.*, 2012). Patients with self-compassion treat themselves with kindness, which helps buffer against any negative emotions that may be experienced during the health care delivery process in patient-physician interactions (Leary, Tate, Adams, Allen, & Hancock, 2007). A study showed that patients with persistent musculoskeletal pain who engaged in self-compassion were better able to adjust to persistent pain, which enhanced their overall well-being (Wren *et al.*, 2012). Another controlled trial study adopted a self-compassion intervention and showed that patients with diabetes who engaged in self-compassion reported less depressive symptoms and distress and better mental health than those with low self-compassion (Friis, Johnson, Cutfield, & Consedine, 2016). Because self-compassion can help patients cope with anxiety and any suffering regarding their illness, patients may report being more satisfied with their health care experience (Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). Being self-compassionate about one's health issues can help patients heal from their suffering with kindness and mindfulness, which may influence their satisfaction with their health care facility and health care physicians (Gilbert, 2005, 2010). For example, cancer patients who report engaging in self-compassion toward their chronic illness report regulating their symptoms and being satisfied with their quality of life (Pinto-Gouveia *et al.*, 2014). Because studies suggest that self-compassion may be related to patient satisfaction, the following hypothesis is investigated.

- H2: After controlling for sex, income level, and frequency of physician visits, self-compassion will have a positive effect on patient satisfaction.

Self-Compassion as a Mediator of Patient Self-Advocacy and Patient Satisfaction

Prior studies suggest that self-compassion may influence patient self-advocacy and patient satisfaction. In particular, self-compassionate patients may emphasize with their own health issues, and as a result, may engage in patient self-advocacy behaviors by engaging in illness education, assertiveness, and mindful nonadherence (Brashers *et al.*, 1999). Previous studies also demonstrated that self-compassion is associated with patient satisfaction in health care settings (Gilbert, 2010; Neff *et al.*, 2007; Pollak *et al.*, 2011). Similarly, research findings have found a positive correlation between patient self-advocacy and patient satisfaction (Brashers, Basinger, Rintamaki, Caughlin, & Para, 2017; Senders, Sando, Wahbeh, Peterson, & Shinto, 2016). For example, a self-care management study found that patients who engage in self-advocacy behaviors tend to be more satisfied with their medical experience (Health Affairs, 2012). Given the role of self-compassion on patient self-advocacy and patient satisfaction, this study investigates whether self-compassion contributes to the relationship between patient self-advocacy and patient satisfaction.

H3: Self-compassion mediates the relationship between patient self-advocacy and patient satisfaction.

Method

Participants

Patient participants were recruited from a snowball sample from undergraduate and graduate business courses at a large, midwestern university. A total of 313 females and 201 males ($N = 522$) participated in an online survey using Qualtrics. The inclusion criteria included (a) having a regular primary care physician and (b) visiting a physician for a prolonged or chronic illness within a year. The average age of the participants was 38 ($SD = 13.60$; range = 18 to 99). Participants' ethnic background included 352 (68.2%) White, 40 (7.8%) African American, 43 (8.9%) Hispanic, 46 (8.9%) Asian, 3 (0.6%) Native American, 4 (0.8%) Pacific Islander, and 28 (5.4%) Other/Mixed Ethnicities. The highest level of education completed included five (1.0%) less than high school, 36 (6.9%) high school graduate/GED, 68 (13.1%) some college, 61 (11.7%) two-year college degree, 232 (44.6%) four-year college degree, 89 (17.1%) master's degree, 11 (2.1%) doctoral degree, and 18 (3.5%) professional degree (JD, MD). Of the participants, 249 (47.9%) indicated that they were currently taking prescription drugs. The average length of knowing a primary care physician included 4.16 years. Participants also indicated the number of times they visited their physician within the last year, which included one time (18.4%), two times (13.1%), three times (10.2%), four times (8.2%), five times (3.9%), six times (3.3%), and more than six times (42.1%).

Procedure

Participants were recruited by using the snowball sampling approach in undergraduate and graduate business courses. Eligible participants were invited to participate in an

online health survey with an incentive of being included to be part of a raffle to win a \$50 gift card after obtaining Institutional Review Board approval. Upon providing their informed consent, participants were referred to a Web link via Qualtrics to complete the survey. Participants were also asked to respond to questions about their demographics, self-compassion, patient self-advocacy, and their satisfaction with their doctor.

Measures

Self-compassion

Perceived self-compassion was measured by using Raes, Pommier, Neff, and Van Gucht (2011) Self-Compassion Scale–Short Form (SCS-SF). Sample items included, “When something painful happens, I try to take a balanced view of this situation,” “When I’m going through a very hard time, I give myself the caring and tenderness I need,” and “When something upsets me, I try to keep my emotions in balance.” Participants responded to 12 items and indicated their agreement from 1 (*strongly disagree*) to 5 (*strongly agree*). The alpha reliability of this scale was .79.

Patient self-advocacy

The Patient Self-Advocacy Scale (PSAS) (Bashers, Haas, & Neidig, 1999) was used to measure patients’ self-advocacy. This 18-item instrument measures patients’ involvement in their own health care decision-making interactions (Brashers *et al.*, 1999). The 18-item measure includes the following three subscales: information seeking, assertiveness, and mindful-noncompliance. Sample items for information seeking include, “I actively seek out information on my illness” and “I research the latest treatments for my illness.” Sample items for assertiveness include, “I frequently make suggestions to my physician about my health care needs” and “I am more assertive about my health care needs than most U.S. citizens.” Sample items for mindful-noncompliance include, “If I am given a treatment by my physician that I don’t agree with, I am likely to not take it” and “Sometimes I think I have a better grasp of what I need medically than my physician does.” Participants indicate their perceived patient self-advocacy in health care settings from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores indicate a higher agreement in patients’ self-advocacy abilities. The alpha reliabilities of this study include .83 for information seeking, .73 for assertiveness, and .83 for mindful-noncompliance.

Patient satisfaction

Perceived satisfaction with one’s doctor was measured by using Hausknecht’s (1990) three-item instrument. This instrument has been previously used to measure patient satisfaction with one’s doctor with an alpha reliability of .94 (Koermer & Kilbane, 2008). The following three items were used: “I am satisfied with this doctor,” “My choice to use this doctor was a good one,” and “If I had to do it all over again, I would use this doctor.” Responses ranged from 1 (*strongly disagree*) to 5 (*strongly agree*), and higher ratings indicated higher satisfaction with one’s physician. The alpha reliability of this instrument was .94.

Demographic variables

Several demographic variables, including sex, income level, and frequency of physician visits, were controlled.

Preliminary Analysis

Correlations were examined for the variables in this study to determine the strength of the relationships (see Table 1). In addition, the tolerance statistics (TS) and variance inflation factor (VIF) were also examined in the regression analyses to uncover any possible multicollinearity issues among the independent variables. The lowest tolerance statistic was .10 and the highest variance inflation factor was .70, which showed that multicollinearity was not a main concern in this study given Mertler and Vannatta's (2013) recommendations.

Main Analysis and Results

A series of hierarchical multiple regressions were used to analyze Hypotheses 1–3 using SPSS and Hayes's PROCESS. For summaries of the multiple regression findings please see Tables 2 and 3.

It was predicted that after controlling for sex, income level, and frequency of physician visits, patient self-advocacy (H1a–H1c) would positively influence patient satisfaction. The multiple regression analysis revealed a significant model [$R^2 = .13$, $F(3, 494) = 10.86$, $p < .001$], after putting the controlling variables in the first block, and illness education, assertiveness, and mindful-noncompliance on the second block. In the first block ($R^2 = .06$), sex ($\beta = .10$, $t = 2.17$, $p < .01$, $pr^2 = .10$) and frequency of physician visits ($\beta = .21$, $t = 4.70$, $p < .001$, $pr^2 = .21$) were found to be a predictor of patient satisfaction, but the income level was not found to be a predictor ($\beta = .06$, $t = 1.43$, $p > .05$, *ns*). In the second block after accounting for the demographic variables ($R^2 = .13$), illness education ($\beta = .13$, $t = 2.45$, $p < .01$, $pr^2 = .11$) and

Table 1 Reporting Means, Standard Deviations, Alpha Reliabilities, and Correlation Matrix.

Measure	1	2	3	4	5
1. Illness Education	1				
2. Assertiveness	.55**	1			
3. Mindful-Noncompliance	.17*	.16**	1		
4. Self-Compassion	.18*	.24**	-.09*	1	
5. Patient Satisfaction	.25**	.25**	0.07	.15**	1
<i>M</i>	3.6	3.4	3.22	3.1	3.86
<i>SD</i>	0.74	0.66	0.77	0.52	0.88
α	0.83	0.73	0.83	0.79	0.94

Note. * $p < .05$, ** $p < .01$.

Table 2 Results of Hierarchical Multiple Regression Model of Patient Satisfaction.

	<i>t</i>	β	Patient Satisfaction		
			pr^2	R^2	R^2 change
Block One (Demographic Variables)				0.06***	
Sex	2.17	0.10*	0.10		
Income Level	1.43	0.06	0.06		
Frequency of Physician Visits	4.70	0.21***	0.21		
Block Two (Patient Self-Advocacy Subscales)				0.13***	0.07***
Illness Education	2.45	0.13*	0.11		
Assertiveness	3.17	0.20**	0.14		
Mindful-Noncompliance	-3.22	-0.14***	-0.14		

Note. * $p < .05$. ** $p < .01$, *** $p < .001$. β = standardized beta coefficients.

assertiveness ($\beta = .20$, $t = 3.17$, $p < .001$, $pr^2 = .14$) positively impacted patient satisfaction. However, mindful-noncompliance ($\beta = -.14$, $t = 3.22$, $p < .001$, $pr^2 = .14$) was a negative predictor of patient satisfaction. Thus, Hypothesis 1 was partially supported.

The second hypothesis predicted that after controlling for sex, income level, and frequency of physician visits, self-compassion would be positively related to patient satisfaction. The results of a multiple regression analysis revealed a significant model [$R^2 = .06$, $F(3, 494) = 10.86$, $p < .001$] after controlling for the demographic variables. In the first block ($R^2 = .06$), sex ($\beta = .17$, $t = 2.17$, $p < .01$, $pr^2 = .10$) and frequency of physician visits ($\beta = .21$, $t = 4.7$, $p < .001$, $pr^2 = .06$) were shown to be predictors of patient satisfaction. Yet income level ($\beta = .06$, $t = 1.43$, $p > .05$, *ns*) was not shown to be a predictor. In the second block ($R^2 = .10$), self-compassion ($\beta = .16$, $t = 3.72$, $p < .001$, $pr^2 = .10$) positively influenced patient satisfaction, therefore, supporting Hypothesis 2.

Table 3 Results of Hierarchical Multiple Regression Model of Patient Satisfaction.

	<i>t</i>	β	Patient Satisfaction		
			pr^2	R^2	R^2 change
Block One (Demographic Variables)				0.06***	
Sex	2.17	0.17*	0.10		
Income Level	1.43	0.06	0.06		
Frequency of Physician Visits	4.70	0.21***	0.21		
Block Two (Self-Compassion)				0.10***	0.03***
Self-Compassion	3.72	0.16***	0.10		

Note. * $p < .05$. ** $p < .01$, *** $p < .001$. β = standardized beta coefficients.

The third hypothesis posed that self-compassion mediated the relationship between patient self-advocacy and patient satisfaction. In the first step of the mediation model (see Figure 1), the regression of patient self-advocacy with patient satisfaction, without the mediator, was significant, $\beta = .14$, $t(494) = 3.17$, $p < .001$. The second step showed that the regression of patient self-advocacy on the mediator, self-compassion, was also significant, $\beta = .29$, $t(494) = 3.93$, $p = .001$. On the third step, the mediation process showed that the mediator (self-compassion), controlling for patient self-advocacy, was significant, $\beta = .22$, $t(493) = 2.98$, $p = .003$. In Step 4 of the analyses, after controlling for the mediator (self-compassion), patient self-advocacy was not a significant predictor of patient satisfaction, $\beta = .29$, $t(493) = 3.93$, *ns*. Also, a Sobel test was conducted and found support for the full mediation in the model ($Z = 2.11$, $p = .03$). Therefore, it was found that self-compassion fully mediated the relationship between patient advocacy and patient satisfaction.

Discussion

Patient Self-Advocacy as a Predictor of Patient Satisfaction

One of the purposes of this study was to investigate the characteristics of patient self-advocacy as predictors of patient satisfaction. Not only did this study find correlational support for illness education and assertiveness on patient satisfaction but this study found that illness education and assertiveness were effective predictors of patient satisfaction after controlling for sex, income level, and physician visits. This finding is consistent with previous findings that found that patient self-advocacy is a positive predictor of patient satisfaction (Senders *et al.*, 2016; Brashers *et al.*, 2017). For instance, patients who engage in illness education behaviors, such as researching their own health condition and enhancing their own knowledge about their illness, also report higher patient satisfaction levels than those who do not engage in illness education behaviors (Eide *et al.*, 2003; Wright & Frey, 2008). Because patients take

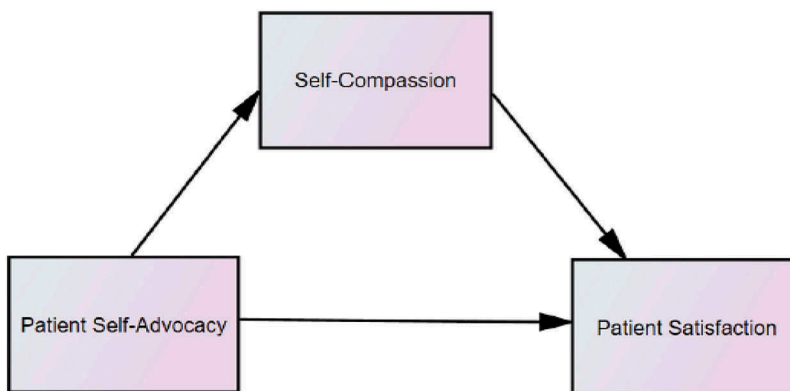


Figure 1 Tested mediation model: Effect of patient self-efficacy on patient satisfaction via self-compassion in patient adults.

ownership of their own health condition, patients who educate themselves about their illness are more informed and may feel less uncertain about their health condition, and as a result, may experience more satisfaction in making decisions with their physicians in the health care process (Brashers *et al.*, 1999).

Patient assertiveness also may positively influence patient satisfaction. For example, patients with chronic illnesses, such as multiple sclerosis and psychological distress, who engaged in patient self-advocacy through engaging in assertive communication about their stress influenced their own perceived satisfaction with their physician (Senders *et al.*, 2016). Similarly, patients diagnosed with HIV who engage in patient self-advocacy through self-assertion efforts also report being more satisfied (Brashers *et al.*, 2017). Patients with assertiveness advocate for their own needs and may feel more confident in their ability to initiate conversations by asking direct questions and listening effectively during conversations with their physicians. As a result, patients with these assertiveness skills may report more satisfaction with their physician during consultations than patients who do not assert themselves on their behalf (Brashers *et al.*, 1999; Roter & Hall, 1993; Wanzer *et al.*, 2004). Thus, patients' assertion skills in the patient self-advocacy process may positively influence patient satisfaction.

It is interesting that this study did not find a positive correlation between mindful nonadherence and patient satisfaction. However, this study found an inverse correlational relationship between mindful nonadherence and patient satisfaction. Previously, it was suggested that engaging in mindful nonadherence may benefit the patients' recovery through alternative treatments and it may enhance patients' satisfaction with their physician (Donovan & Blake, 1992; Heszen-Klemens & Lapinska, 1984). However, in this study, patients who engaged in mindful nonadherence, such as not taking their medications as prescribed if they found them to be threatening to their needs, or challenged their physicians' advice, reported not being satisfied with their physician. One reason for this finding might be the physicians' responses back to patients' mindful nonadherence patterns. For instance, if physicians perceive patients' mindful nonadherence as threatening or challenging, this might negatively impact interactions with this patient, and as a result, the patient may report lower satisfaction levels.

Mindful nonadherence also was shown to be a negative predictor of patient satisfaction. Those with high mindful nonadherence indicated being less satisfied with their physician. If patients engage in mindful nonadherence in the patient self-advocacy process, then this may already indicate discontent with a physician's treatments, suggestions, or advice in the recovery process of an illness. Because mindful nonadherence refers to challenging a physician to enhance one's own needs given an illness, this process may lead to patient dissatisfaction given that this is often perceived as a negative patient behavior in the patient-doctor relationship (Svarstad, 1976). Consequently, mindful nonadherence was a negative predictor of patient satisfaction. Overall, this study found support for only two

characteristics of patient self-advocacy (e.g., illness education; assertiveness) as positive predictors of patient satisfaction.

Self-Compassion as a Predictor of Patient Satisfaction

Another purpose of this study was to investigate self-compassion as a predictor of patient satisfaction. This study found a positive correlation between self-compassion and patient satisfaction, but more importantly found that self-compassion was a positive predictor of patient satisfaction after controlling for the demographic variables. Patients who engage in self-kindness, mindfulness, and common humanity in the self-compassion process report being more satisfied with their physician than those without self-compassion (Neff, 2003; Gilbert, 2005; Wren *et al.*, 2012). Studies have shown that self-compassion in patients with a variety of illnesses report being able to buffer against negative emotional patterns due to an illness and also feel more comfortable with their physicians (Leary *et al.*, 2007). For instance, cross-sectional studies have found that depressed patients who engage in self-compassion reduce their own depression symptoms and report being more adaptive to treatments, which can affect their satisfaction with health care (Krieger, Berger, & Holforth, 2016). If patients engage in self-comforting behaviors through self-compassion, they may indirectly influence their own satisfaction with the health care experience given their own ability to be aware of their own personal needs (Krieger *et al.*, 2016; Wren *et al.*, 2012; Yarnell & Neff, 2013). Future studies may need to continue to investigate the role of self-compassion as a predictor of patient satisfaction in patient-physician interactions in applied health care communication studies.

Self-Compassion as a Mediator of Patient Self-Advocacy and Patient Satisfaction

Another important finding of this study was that self-compassion served as a mediator of patient self-advocacy and patient satisfaction. While correlations demonstrated that self-compassion is positively correlated to both patient self-advocacy and patient satisfaction, this study found support for self-compassion among these constructs. The mediating role of self-compassion suggests that patients who engage in self-compassion may engage in patient self-advocacy behaviors in consultations, and as a result, this can trigger their own patient satisfaction with their physician. Previous studies highlighted the positive correlation between patient self-advocacy and patient satisfaction in health care settings (Brashers *et al.*, 2017; Health Affairs, 2012), but no previous studies specifically examined self-compassion with a mediating effect on these constructs. Yet previous studies suggested that self-compassion has a direct effect on patient self-advocacy and patient satisfaction (Gilbert, 2010; Pollak *et al.*, 2011). Patients who report engaging in high self-compassion also report engaging in patient self-advocacy behaviors (e.g., illness education, assertiveness), and as a result, feel more satisfied with their physician than patients with low self-compassion. Part of the reason for this finding is that patients who engage in self-kindness and mindfulness tend to be less self-critical of their illness or condition and may feel more

agency to engage in patient self-advocacy behaviors to ensure that their personal health care needs are fulfilled (Neff, 2003, 2011). Moreover, this can lead to an elevation in their perceived satisfaction with their physician in the health care decision-making process. Therefore, this study supports the mediation effect of self-compassion on patient self-advocacy and patient satisfaction.

Strengths

Several strengths are derived from this research study. First, this study examined self-compassion as a predictor of patient satisfaction and as a mediator of the relationship between patient self-advocacy and patient satisfaction among patients with chronic illness. To date, no previous study explored self-compassion as a predictor or as a mediator of patient satisfaction with one's doctor. This study can inform patient-doctor interactions about chronic illness or prolonged diseases by encouraging patients to engage in self-compassion and patient self-advocacy behaviors. The findings from this study can stimulate future self-compassion and patient self-advocacy research in health care contexts. Second, this study adopted a large sample size of patients, which represent the perceptions of patients who frequently visit their regular physicians given their chronic illnesses or diseases. Third, the alpha reliabilities of each of the instruments used in this study were adequate, or above .70.

Limitations and Future Directions

This study has several limitations that are discussed along with future directions to advance self-compassion and patient self-advocacy scholarship. First, this study used self-report instruments to obtain the perceptions of the patients, which may pose a threat to social desirability bias. To overcome this bias, future research studies may conduct dyadic research using other-report instruments focusing on patients and their physicians to cross-examine patients' perceptions. Second, this study used cross-sectional data, which limits the generalizability of the findings over time. Future studies may conduct time series analyses using longitudinal data to determine whether self-compassion remains a predictor and a mediator between patient self-advocacy and patient satisfaction. Third, while this study was derived from the findings and insights of previous scholarships, this study did not adopt a health communication theory. Future research may adopt relevant communication theories such as communication accommodation theory (CAT) (Giles, 2008), which can explain how patients accommodate their patient self-advocacy behavior about their illness in health interaction patterns. Researchers also may adopt Dillard, Sergrin, and Harden's (1989) goals-plans-action theory to determine whether patients' self-compassion tendencies trigger their own interaction goals and plans to adhere to prescribed medical behavior.

Implications and Conclusion

This study provides several practical implications and insights. First, this study found that two demographic factors, sex and frequency of physician visits, were predictors of patient satisfaction. After examining the post hoc analyses, it was found that women reported being more satisfied with their doctor than the men did. Consequently, studies should continue to control for sex in patient satisfaction research. Whether patients regularly visit their physicians given a chronic illness may influence their relationship with their physician, and as a result, this may impact their perceived satisfaction with their physician. Second, this study found that income level was not a predictor of patient satisfaction; thus, future studies may not need to use it as a control variable. Third, this study showed that self-compassion is a predictor of patients' self-advocacy behaviors, including illness education and assertiveness, which suggests that developing patients' self-compassion levels may be beneficial to improve patients' perceived quality of care. Fourth, this study found that self-compassion serves as a mediator of the relationship between patient self-advocacy and patient satisfaction. Thus, scholars and practitioners may nurture self-compassion in their patients by developing seminars, workshops, or meditations to enhance patients' awareness of their self-compassion skills to help them become effective self-advocates during important health care decisions.

To conclude, this study provides initial support that self-compassion is a mediator of the relationship between patient self-advocacy and patient satisfaction. Self-compassion served as an effective predictor of patient self-advocacy, including patients' behaviors in learning about their own illness and in their own assertiveness in interacting with their physicians about their illness concerns. Self-compassion was also an effective predictor of patient satisfaction, which shows that patients with high self-compassion toward their illness are kinder and more mindful about their condition than those with low self-compassion, and as a result, report being more satisfied with their physicians in the health care process. This study also suggests that self-compassion serves as a mediator of the relationship between patient self-advocacy and patient satisfaction, which suggests that patients with illness, especially chronic illness, should engage in the self-compassion process in health care settings. Overall, this study provides evidence that self-compassion is a relevant construct to explore as a predictor and as a mediator to understand patients' self-advocacy behaviors and patient satisfaction.

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