REVIEW ARTICLE

Interventions to enhance culturally informed kindness, empathy and compassion in mental health professionals: rapid review

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Aims and method Kindness, empathy and compassion are fundamental to effective mental healthcare and are associated with reduced emotional strain and greater professional satisfaction among practitioners. However, most interventions designed to foster these virtues have not sufficiently addressed cultural adaptation, despite its critical role in ensuring care that is relevant and inclusive for diverse populations.

This rapid review aimed to synthesise evidence on empathy-, kindness- and compassion-focused training interventions in mental health and healthcare settings, with particular attention to cultural adaptation, facilitator characteristics and outcome measurement.

A rapid review was conducted to identify culturally informed interventions designed to enhance kindness, empathy and compassion among mental health professionals. Searches were performed in PubMed/MEDLINE and PsycINFO for studies published between 2014 and 2025 using key terms related to 'mental health professionals', 'empathy', 'compassion' and 'kindness'. This review was prospectively registered on the Open Science Framework (OSF; DOI: https://doi.org/10.17605/OSF.IO/U6H32).

Results The initial search identified 690 records. Following title, abstract and full-text screening, four studies met all inclusion criteria. The interventions were: (a) a 90 min empathy workshop (USA); (b) a 14-session, cross-cultural, competence course (Sweden); (c) an 8-session, trauma-focused cognitive–behavioural therapy (CBT) programme (Ukraine); and (d) a 4-day emotionally focused therapy externship (6 Spanish-speaking countries). All interventions reported positive outcomes. Significant increases in empathic awareness were observed in the USA ($p = 0.019$), with qualitative improvements in empathy reported in Sweden. In Ukraine, 69% of participants rated the programme as 'very' or 'extremely helpful', and 92% reported professional benefit. The Spanish-speaking cohort demonstrated significant gains in perspective-taking ($p < 0.001$) and empathic concern ($p < 0.001$).

Clinical implications Culturally informed approaches to enhancing kindness, empathy and compassion show promising outcomes among mental health professionals. These findings highlight the importance of integrating cultural responsiveness into virtue-based interventions to foster inclusive, intelligent kindness in global mental health practice.

Keywords Culturally informed kindness; empathy; compassion; mental health professionals; intelligent kindness.

Kindness, empathy and compassion are widely recognised as essential qualities in mental healthcare, because they shape therapeutic relationships and improve patient outcomes.[1–3] Empathy is similarly associated with improved recovery outcomes and therapeutic alliance.[1] For clinicians themselves, these qualities are linked to reduced emotional strain and greater professional reward, offering some protection against burnout.[2]

Empathy, compassion and kindness are related but distinct constructs. Empathy involves the ability to perceive and understand another person's emotional state and is directly linked to alliance and communication. Compassion extends

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beyond understanding to include a motivational component and is often examined alongside self-compassion, which involves directing the same attitudes inwards.[3–5] Kindness is broader still, referring to deliberate prosocial actions that demonstrate care and respect for others, and in healthcare it is increasingly conceptualised in action-oriented terms, sometimes described as 'intelligent kindness'.[6] Intelligent kindness emphasises not only empathic understanding but also the deliberate, action-oriented application of kindness within healthcare.[7]

Despite their importance, mental health professionals face significant challenges in maintaining empathy and compassion due to high levels of stress and burnout.[2] Evidence shows that compassion-based programmes can foster resilience, enhance positive affect and improve overall well-being.[8,9] However, most existing interventions have not fully addressed cultural adaptation, despite its importance in ensuring that mental healthcare is relevant and inclusive for diverse populations.

The aim of this rapid review was to explore the available evidence on culturally informed interventions designed to enhance kindness, empathy and compassion among mental health professionals.

Methods

Study design

We conducted a rapid review to synthesise evidence on culturally informed interventions intended to enhance kindness, empathy or compassion among mental health professionals.[10] The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement and was further informed by Cochrane Rapid Review Guidance, which provides practical recommendations for maintaining transparency, methodological rigour and efficiency in rapid evidence syntheses. Interventions were defined as either initiatives, projects, structured programmes, tools or validated frameworks in this domain. The review focused on mental health professionals across psychiatrists, psychologists, nurses and allied health workers in the mental health field.

Protocol and registration

This rapid review was prospectively registered on OSF (DOI: https://doi.org/10.17605/OSF.IO/U6H32) on 14 August 2025.[11]

Eligibility criteria

Eligible studies were either original quantitative, qualitative or mixed-methods investigations (including cohort, case–control, cross-sectional, randomised controlled trials and non-randomised designs) published in English between January 2014 and August 2025. Populations were mental health professionals (psychiatrists, psychologists, therapists, psychiatric nurses and allied health staff). Interventions were culturally informed initiatives, programmes, tools or validated frameworks aiming to enhance kindness, empathy or compassion towards colleagues and/or patients. Eligibility outcomes included measures of kindness, empathy, compassion, therapeutic alliance, job satisfaction (professional well-being), patient satisfaction, cultural safety, team cohesion and collegial trust. We excluded studies of non-mental health populations, review articles, editorials and non-English publications.

Search strategy

A systematic search was conducted in PubMed/MEDLINE and PsycINFO in August 2025. Search terms included 'mental health professionals', 'psychiatrists', 'psychologists', 'therapists', 'psychiatric nurses' and 'allied health professionals', combined with terms related to 'empathy', 'compassion' and 'kindness'. This comprehensive strategy enabled the identification of both explicitly cultural and implicitly humanistic interventions aimed at enhancing culturally responsive mental healthcare.

Study selection and data extraction

Screening followed the 2020 PRISMA statement.[12,13] One reviewer screened titles, abstracts and full texts against eligibility criteria; a second member verified data extraction for included records. Screening and record management were undertaken using the Rayyan systematic review web application (Rayyan Systems Inc., Cambridge, Massachusetts; https://www.rayyan.ai/).[14] Data were extracted into a Microsoft Excel template (version 16.112 (26070718), macOS; Microsoft Corporation, Redmond, Washington, USA; https://www.microsoft.com/microsoft-365/excel) by one reviewer and cross-checked by a second. Any discrepancies between reviewers were resolved through discussion and, where consensus could not be reached, a third reviewer was consulted. Screening and subsequent data extraction commenced on 15 August 2025.

Data items

Extracted data included study characteristics (country, setting, design, sample size, demographics), intervention description (materials, procedures, providers, mode, location, tailoring), implementation information (structure or dose, frequency, session length, fidelity where reported), outcomes and instruments and details of cultural adaptation features.

Intervention description and cultural adaptation frameworks

Data extraction was conducted using Microsoft Excel and tailored based on two validated frameworks: the Template for Intervention Description and Replication (TIDieR) checklist was utilised to improve the completeness of intervention reporting in research.[15] This incorporates variables related to the intervention applied, including the materials used, dissemination format, provider and participant characteristics and strategies used to measure adherence to the process. The Bernal and Sáez-Santiago Ecological Validity Model (EVM) was also integrated due to its emphasis on cultural adaptation of interventions in research. Although originally developed for adapting psychological interventions for patients, its eight

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dimensions were modified to suit this review's professional training context. Modified EVM domains included culturally appropriate language, diversity among professionals, cultural knowledge, context and methodology. Outcomes related to kindness, compassion, empathy, job satisfaction, cultural safety, collegial trust and team dynamics were also extracted. Demographic data included sample size, mean age, gender distribution and study design.

Outcomes and measures

Primary domains were kindness (other-directed), empathy and compassion (other-directed). Secondary outcomes included therapeutic alliance, job satisfaction (professional well-being), patient satisfaction, cultural safety, team cohesion and collegial trust. Instruments were catalogued and classified by respondent type (self-report, observer-rated or patient-reported). Qualitative findings, including focus group data, were summarised thematically. Risk of bias assessment was not incorporated, consistent with the rapid review format.

Data analysis

A narrative synthesis was undertaken in accordance with Synthesis Without Meta-analysis (SWiM) guidance.[16] Meta-analysis was not attempted due to the heterogeneity of designs/measures and incomplete dispersion reporting. For each prespecified outcome, inferential statistical results were prioritised where available; otherwise, descriptive changes in means, proportions or qualitative themes were reported. Where multiple measures existed within the same outcome domain, findings were summarised narratively rather than pooled. Qualitative insights were used to contextualise quantitative results. Implementation features were summarised via TIDieR, and cultural adaptation assessed using EVM. No data transformation or imputation was performed.

EVM coding rules

Each EVM item was coded as either 'Yes', 'Partially', 'No' or 'Not Applicable (N/A)' using pre-specified thresholds. 'Yes' indicated sufficient detail, demonstrating that the element was fully addressed (e.g. translated or bilingual materials, simultaneous interpretation or culturally specific content such as a Ukraine war-context course using local idioms). 'Partially' was applied when the element was acknowledged but superficially described (e.g. language translation without deeper adaptation or facilitator matching). 'No' indicated that the element was unaddressed. 'N/A' was reserved only when the element did not apply to the intervention format and was not used for missing data.

Results

Study selection

The initial database search yielded 556 records in PubMed and 134 in PsycINFO, resulting in 690 records. Following the removal of duplicates ($n = 80$), a total of 610 unique records were screened for eligible title and abstracts. Of these, 544 articles were excluded on the basis of either wrong study design, incorrect study outcomes or non-English studies. The final screening stage yielded 66 articles for full-text assessment. Following further screening and exclusion of irrelevant studies, four studies met all prespecified inclusion criteria and were included in the final rapid review (Fig. 1).

Study characteristics and intervention structure

The 4 studies collectively involved 715 mental health professionals (Table 1). Two studies reported participant demographics. Lewis et al (US agency staff; $n = 166$) reported a mean age of 42.26 years (s.d. 12.82), with 28 men and 125 women.[17] Rodríguez-González et al (Spanish-speaking emotionally focused therapy (EFT) cohort; baseline $n = 207$) reported a mean age of 42.32 years (s.d. 11.14), with 33 men and 174 women.[18]

McDonald et al (Sweden; $n = 248$) did not report demographic variables but described professional composition (psychologists/psychotherapists 30.6%, nurses 21.3%, social workers 15.7%, medical doctors/students 6.0% and other roles in smaller proportions).[19] Pollio et al (Ukraine; $n = 52$) did not collect demographic data.[20]

Ethnicity was reported in 2 studies: explicitly in Lewis et al, where 133 participants identified as White (80.1%), 10 as mixed (6.0%), 2 as Indigenous (1.2%) and 2 as Asian/Asian American (1.2%), with the remaining 19 (11.4%) selecting other categories or not responding;[17] and categorically in Rodríguez-González et al (Hispanic/Latino/Latin American; White/Caucasian).[18] McDonald et al[19] and Pollio et al[20] did not report ethnicity.

Occupational information was comprehensively reported in McDonald et al (Table 1).[19] Lewis et al reported that 49.4% of participants were in clinical roles and 19.3% in administrative or clerical positions.[17] Trainer or facilitator gender was not consistently reported across studies.

Four culturally informed training interventions were included (Table 2). The first was a 90 min, in-person, decolonising empathy workshop for community mental health staff in the USA.[17] The second was a 14-session, in-person, 'Comprehensive cross-cultural competence training' course delivered over 12 weeks for providers working with refugees and asylum-seekers at a transcultural training centre in Sweden.[19] The third was an eight-session, virtual trauma-focused CBT (TF-CBT) PRACTICE (the TF-CBT acronym for 'Psychoeducation and Parenting skills, Relaxation, Affect expression and modulation, Cognitive coping, Trauma narration and processing, In vivo mastery, Conjoint parent–child sessions, and Enhancing safety and future development', as described by Pollio et al[20]) skills course delivered weekly to Ukrainian therapists during the ongoing conflict.[20] The fourth was a 4-day, intensive (28 h total), EFT externship for Spanish-speaking clinicians conducted across Argentina, Costa Rica, Guatemala, Mexico, Panama and Spain.[18]

Study designs comprised one single-group, pre–post evaluation,[17] two mixed-methods evaluations[19,20] and one longitudinal cohort study with 6-month follow-up.[18] Three interventions were delivered in-person[17–19] and one online.[20] Baseline sample sizes ranged from 52 to 249 mental health professionals. All interventions aimed to enhance providers'

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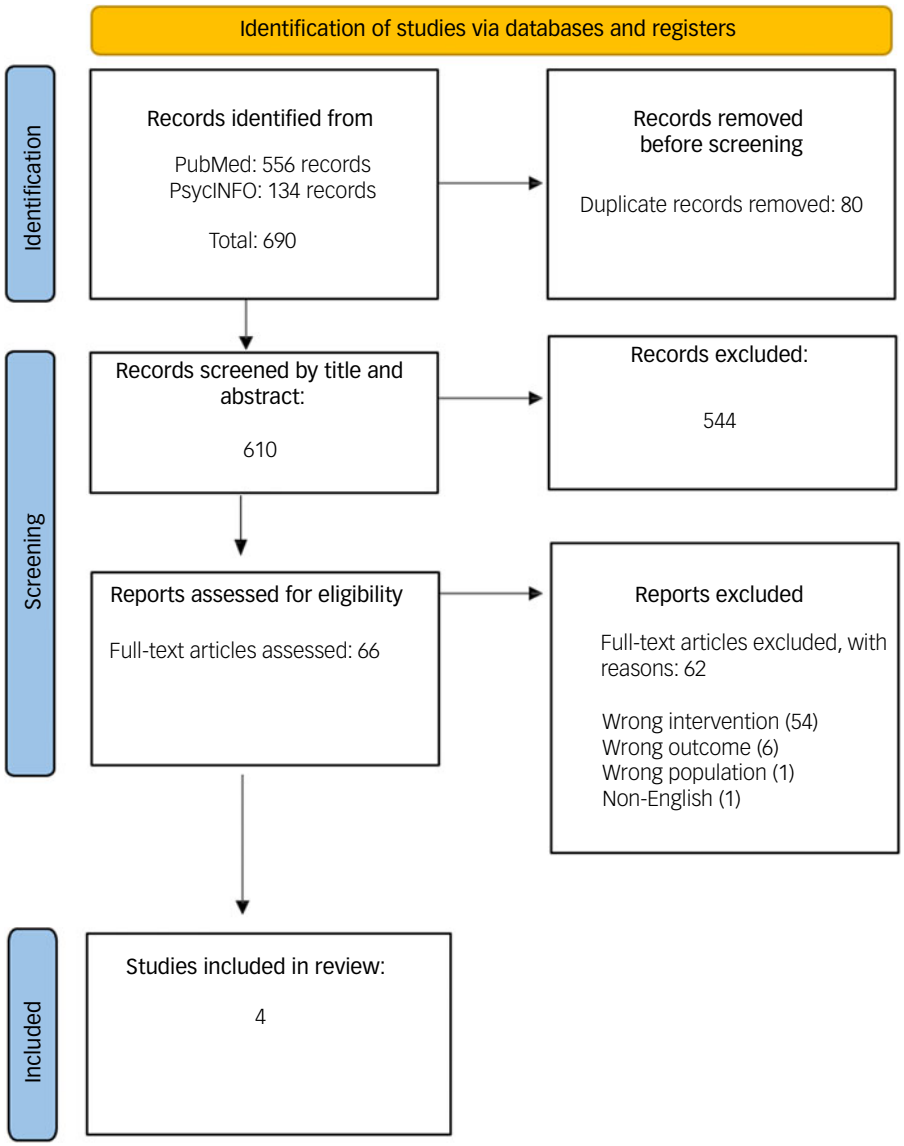

Fig. 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 flow diagram, including searches of databases.

interpersonal skills (such as empathy or cultural sensitivity) through training workshops or courses.

All interventions sought to enhance culturally responsive professional capabilities, with an emphasis on empathy. The decolonising workshop drew on multicultural counselling competencies, cultural humility and decolonising frameworks to improve knowledge and empathic practice with Indigenous clients. The Swedish course aimed to build providers' capacity to meet refugee mental health needs by addressing culture, trauma and interpreter-mediated care. The Ukrainian TF-CBT course by Pollio et al targeted increased use of PRACTICE coping skills, reduced burnout and secondary traumatic stress, greater TF-CBT competency and confidence and increased empathy for clients' experiences. The EFT externship by Rodríguez-González et al aimed to evaluate EFT training effectiveness for Spanish-speaking therapists while maintaining core attachment-based and experiential principles.

Materials included translated slides and handouts with simultaneous interpretation;[20] bilingual training materials and standard EFT externship manuals;[18] case vignettes and module content on culture, trauma and interpreter work;[19] and a decolonising lesson plan-based workshop.[17]

Teaching modalities combined didactic teaching with interactive methods: brief reflective exercises and group dialogue;[17] multi-module classroom teaching with case discussions and practice;[19] weekly skills teaching and between-session practice aligned with PRACTICE components;[20] and lectures, demonstrations/role-plays and supervised practice according to the EFT externship format.[18] Settings included a community mental health agency, a regional transcultural training centre, a nationwide web-based platform and

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Table 1 Characteristics of included studies, participants and providers

Title	First author	Study design	Country	Age of participants (mean)	s.d.	Total participants	Number of male participants	Number of female participants	Ethnicity of participants	Occupation of participants	Number of male providers	Number of female providers
Effects of a decolonizing training on mental health professionals' indigenous knowledge and beliefs and ethnocultural empathy	Lewis et al (2023)[17]	Single arm pre/post intervention	USA	42.26	12.82	166	28	125	White/ Caucasian, Mixed, Other, 'East Asian: Chinese, Japanese, Korean, Mongolian'	49.4% reporting a clinical position in mental health, 19.3% reporting an administrative/clerical position, and the rest distributed among human resources, information technology, maintenance and 'other' positions	0	3
Cross-cultural training program on mental health care for refugees – a mixed method evaluation	McDonald et al (2021)[19]	Mixed method	Sweden	N/A	N/A	248	N/A	N/A	N/A	Medical doctors/students (6.0%), social worker (15.7%), psychologist/ psychotherapist (30.6%), nurses (21.3%), auxiliary/ psychiatric nurse aide (8.5%), occupational therapist (2%), physiotherapist (1.6%), midwife (1.6%), management (2.8%), administrative staff (2.8%), missing (5.6%)	N/A	N/A
Engaging Ukrainian TF-CBT therapists in a PRACTICE skills course to support their wellbeing	Pollio et al (2025)[20]	Mixed method	Ukraine	N/A	N/A	52	N/A	N/A	N/A	Therapists	N/A	N/A
Short-term and long-term effects of training in EFT: a multinational study in Spanish-speaking countries	Rodrıguez-Gonzalez et al (2019)[18]	Longitudinal study	Argentina, Costa Rica, Guatemala, Mexico, Panama, Spain	42.32	11.14	249, but 207 participated in the pre-intervention survey	33	174	White/ Caucasian, Hispanic/ Latino/Latin American	Psychotherapists and clinicians	N/A	N/A

Country for Rodríguez-González et al refers to six Spanish-speaking sites (Argentina, Costa Rica, Guatemala, Mexico, Panama, Spain). EFT, Emotionally Focused Therapy; TF-CBT, Trauma-Focused Cognitive Behavioral Therapy; PRACTICE, Psychoeducation and Parenting skills, Relaxation, Affect expression and modulation, Cognitive coping, Trauma narration and processing, In vivo mastery, Conjoint parent–child sessions, and Enhancing safety and future development[20]; N/A, data not reported.

Table 2 Intervention characteristics and measurement instruments, organised by TIDieR items, for the four included training programs

First author	Intervention name	Number of sessions	Duration of intervention (per session)	Frequency of session	Rationale/Why	Primary frame-works/model	Materials	Procedures	Providers	Mode of delivery	Location	Tailoring	Scales
Lewis et al (2023)[17]	Decolonising training	1	90 min	1 session only	To increase knowledge, empathy, and empathetic practice towards indigenous clients	Multicultural counselling competencies,[43] cultural humility,[44,45] and a decolonising framework[43]	Presentation	Self-reflection and self-critique in groups	Therapists and Tribal citizens	In-person	Mental health agency	Indigenous group	Indigenous Knowledge and Beliefs Scale, Ethnocultural Empathy
McDonald et al (2021)[19]	Comprehensive Cross-Cultural Competence Training	14 across 12 weeks	13 sessions (12 full-day training interventions and 2 half-day interventions)	N/A	To build and improve knowledge as well as the capacity of psychiatry care providers in Region Stockholm to address mental health needs of refugees, asylum seekers and undocumented migrants, both adults and minors	Literature review and prior training experience	Presentation	Lectures, discussions, reflecting, asking questions, sharing experiences, and case presentations in large groups	Psychiatrists, psychologists, nurses and social workers	In-person	Transcultural centre (training centre)	Refugees, asylum seekers, and undocumented migrants	Pre- and post-structured questionnaires
Pollio et al (2025)[20]	PRACTICE	8 across 8 weeks	75 min	1 per week	Increased PRACTICE coping skills usage, decreased burnout and Secondary Traumatic Stress, increased feelings of TF-CBT competency/ confidence, and increased empathy for clients' experiences when implementing the skills	Psychoeducation/ Parenting, Relaxation, Affect expression and modulation, Cognitive coping, Trauma narration and processing, In vivo mastery, Conjoint parent–child sessions, and Enhancing safety and future development	Slides, worksheets, and reminder emails translated in Ukrainian	Practicing with clients individually during the same course period, group activities, assignment review	International TF-CBT trainers and consultants, in collaboration with the TF-CBT developers	Virtual	Web-based	Tailored to Ukrainian culture	Pre and post scales including the practice activity scale-revised[33], the Professional Quality of Life Scale 5 (ProQOL;[46] attendance data, qualitative responses
Rodrıguez-Gonzalez et al (2019)[18]	EFT	4 days (28 h)	1 day (7 h)	4 days non-stop	Improve the cross-cultural effectiveness of EFT externship training in a sample of Spanish-speaking therapists	Attachment theory	Didactic presentations, live sessions	Experiential learning, behavioural role-plays, and watching videotaped sessions	EFT certified trainers	In-person	N/A	Training was adapted to Spanish-speaking therapists	EFT knowledge and competency scale, interpersonal reactivity index, self-compassion scale, experiences in close relationships-revised scale

TIDieR, Template for Intervention Description and Replication; EFT, Emotionally Focused Therapy; TF-CBT, Trauma-Focused Cognitive Behavioral Therapy; N/A, data not reported.

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Table 3 Ecological Validity Model (EVM) mapping of cultural adaptation features across the four included interventions

First author	Language	Persons	Metaphors	Content	Concepts	Goals	Methods	Context
Lewis et al (2023)[17]	English	Partially	No	Yes	No	Yes	Yes	Yes
McDonald et al (2021)[19]	Swedish	No	N/A	Yes	No	Yes	Yes	Yes
Pollio et al (2025)[20]	English with Ukrainian interpreters as needed	Partially	Yes	Yes	No	Yes	Yes	Yes
Rodrıguez-Gonzalez et al (2019)[18]	Spanish and English	Yes	N/A	No	No	Yes	No	No

Columns indicate EVM dimensions. N/A, data not reported.

in-person externships conducted across six Spanish-speaking sites in Argentina, Costa Rica, Guatemala, Mexico, Panama and Spain. Three interventions were delivered in person;[17–19] that of Pollio et al was delivered fully online as a synchronous virtual course.[20]

Facilitator backgrounds varied. The decolonising workshop was developed by Indigenous authors in the study; facilitator cultural background was not reported. The Swedish course by McDonald et al was delivered by health professionals at a transcultural training centre; cultural matching to refugee backgrounds was not indicated. Pollio et al's Ukrainian TF-CBT course was delivered by international TF-CBT trainers and consultants, with simultaneous interpretation; some sessions involved local co-facilitation. Rodríguez-González et al's EFT externship was led by bilingual certified EFT trainers.

Cultural adaptation: EVM mapping

Each intervention was mapped to the eight EVM dimensions to characterise cultural adaptation: language (use of participants' first or working language); persons (cultural background of facilitators); metaphors (incorporation of culturally specific symbols or sayings); content (integration of cultural history and relevant examples); concepts (adaptation of theoretical constructs); goals (alignment with cultural priorities); methods (culturally appropriate delivery techniques); and context (acknowledgment of sociopolitical factors). All four studies reported at least one EVM-aligned element, although the breadth and emphasis varied by setting and target population (Table 3).

Language: training was delivered in English to largely non-Indigenous staff,[17] in Swedish,[19] with English sessions and simultaneous Ukrainian interpretation plus translated materials,[20] and in Spanish with some bilingual materials.[18]

Persons: cultural matching of facilitators was not reported in Lewis et al (authors were Indigenous, facilitator background not specified).[17] In McDonald et al, trainers were health professionals with no reported refugee background.[19] Partial matching occurred in Pollio et al through a mix of international and local co-facilitators.[20] In Rodríguez-González et al, bilingual certified EFT trainers delivered the externship.[18]

Metaphors: only Pollio et al[20] reported the use of culturally specific metaphors incorporating local sayings and examples.

Content: Lewis et al[17] provided the most extensive adaptation, integrating Indigenous history, colonisation and reflective exercises grounded in decolonising frameworks. McDonald et al[19] emphasised refugee experiences and interpreter-mediated care. Pollio et al contextualised examples within Ukrainian culture and wartime realities. Rodríguez-González et al[18] retained standard EFT content with language adjustments.

Concepts: core theoretical constructs were preserved across studies. Lewis et al[17] used standard empathy constructs; McDonald et al[19] and Pollio et al[20] followed established CBT and TF-CBT models; Rodríguez-González et al maintained core EFT principles.[18]

Goals: each intervention aligned its objectives with cultural priorities – improving care for Indigenous populations,[17] for refugees,[18] supporting war-affected therapists[20] and expanding EFT training in Spanish-speaking regions.[18]

Methods: delivery techniques reflected cultural considerations where described. Lewis et al employed self-reflection and group dialogue.[17] McDonald et al used interactive discussion and narrative approaches.[19] Pollio et al incorporated collective activities, peer support and pragmatic coping strategies.[20] Rodríguez-González et al followed standard EFT pedagogy with lectures, demonstrations, role-plays and supervised practice.[18]

Context: sociopolitical context was explicitly acknowledged in three studies. Lewis et al addressed historical trauma and colonisation;[17] McDonald et al incorporated interpreter use and acculturation challenges;[19] and Pollio et al recognised the shared trauma of ongoing war.[20] Rodríguez-González et al focused primarily on language adaptation without explicit attention to broader sociocultural context.[18]

Study-level outcomes

All four studies assessed empathy, with some also examining self-focused outcomes such as burnout or self-compassion (Table 4). Notably, kindness and compassion (towards patients or colleagues) were not directly measured in any study, despite their potential relevance to the study outcomes, nor were patient-rated outcomes (patient satisfaction or therapeutic alliance).

All four studies reported positive changes in empathy, although the nature and strength of the evidence varied.

(a) McDonald et al (Sweden): quantitative analysis did not find a significant pre–post change in knowledge scores regarding refugee mental health, but qualitative feedback suggested improved empathy and professional confidence in refugee care.[19]
(b) Rodríguez-González et al (Spanish-speaking countries): significant post-training increases were observed in

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Table 4 Study-level outcomes for kindness and empathy across the four included interventions

First author	Impact on kindness	Impact on empathy	Impact on compassion	Impact on therapeutic alliance	Impact on Job satisfaction	Impact on patient satisfaction	Impact on cultural safety	Impact on team cohesion	Impact on collegial trust
Lewis et al (2023)[17]	N/A	A paired samples *t*-test of the four subscales revealed a significant increase on the Empathetic Awareness subscale from pre- ($M = 4.57$, s.d. = 0.98) to post-test ($M = 4.70$, s.d. = 0.98); $t(132) = 2.37$, $p = 0.019$, with a small-to-moderate effect size of 0.041. Job category had significant between-group differences on ethnocultural empathy (F (6, 143) = 2.62, $p = 0.019$).	N/A	N/A	N/A	N/A	N/A	N/A	N/A
McDonald et al (2021)[19]	N/A	From the focus group, one informant emphasised that the training in general, and some of the lectures in particular, also stimulated empathy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pollio et al (2025)[20]	N/A	All participants responded that course participation helped them to at least somewhat increase their empathy for the therapy-related benefits and challenges their clients may experience with 69.2% reporting the course was 'very much' or 'extremely' helpful in this regard ($M = 3.85$, s.d. = 0.69).	N/A	N/A	Most of the participants who completed the post-course survey ($n = 12$, 92.3%) reported they benefited from their participation in the course in their professional life.	N/A	N/A	Professional benefits listed in qualitative responses ($n = 7$, 53.9%) included the improvement of the professional atmosphere (ID 7) and better relationship with colleagues (ID 1).	Participants also shared their feelings about the support from/connection with other therapists and how these were impacted by the course.
Rodríguez-Gonzalez et al (2019)[18]	N/A	Participants showed significant positive linear growth in both IRI-PT, b1j = 0.60, $p < 0.001$, and in IRI-EC, b1j = 1.31, $p < 0.001$.	Self-compassion scores (assessed via the Self-Compassion Scale) increased significantly post training. However, the study did not assess compassion toward clients.	N/A	N/A	N/A	N/A	N/A	N/A

SEE, Scale of Ethnocultural Empathy; IRI-PT, Interpersonal Reactivity Index, Perspective Taking; IRI-EC, Interpersonal Reactivity Index, Empathic Concern; N/A, data not reported. Percentages in Pollio et al (2025) refer to participants who completed the post-course survey.

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perspective-taking and empathic concern on the interpersonal reactivity index, sustained at 6-month follow-up. Self-compassion also improved (self-compassion scale), although attachment style did not change.[18]

(c) Lewis et al (USA): cultural knowledge increased significantly on the Indigenous knowledge and beliefs scale (mean difference 2.23, 95% CI [1.82, 2.64], $t(140) = 10.73$, $p < 0.001$, $\eta^2 = 0.45$). Overall ethnocultural empathy did not change significantly ($p = 0.176$), but the empathic awareness subscale improved (4.57 ± 0.98 to 4.70 ± 0.98; $t(132) = 2.37$, $p = 0.019$, $\eta^2 = 0.041$). No other outcomes (e.g. kindness or alliance) were assessed. Across studies, improvements were most consistent in empathy-related measures and qualitative accounts of increased cultural understanding, suggesting that culturally informed approaches may enhance empathic awareness and professional well-being even in diverse training contexts.[17]

(d) Pollio et al (Ukraine): 92% of participants reported professional benefits, including increased confidence and empathy. Among 13 therapists with matched data, coping skill use improved significantly (PRACTICE skills activity scale, $p = 0.010$). Burnout and secondary traumatic stress scores declined, but not significantly.[20]

Discussion

This rapid review of 4 studies involving 715 mental health professionals found improvements in empathy following culturally informed training interventions, although none directly measured kindness or compassion. Three studies demonstrated clear gains in empathy, two quantitatively and one qualitatively, with one showing subscale-specific improvement without overall change. Across interventions, improvements appeared related to both training duration and cultural adaptation.

Lewis et al reported a significant increase in empathic awareness on the ethnocultural empathy scale ($p = 0.019$), although total empathy scores did not change.[17] Rodríguez-González et al identified significant linear growth in the interpersonal reactivity index subscales (perspective taking and empathic concern) at 6-month follow-up.[18] Pollio et al found that 92% of Ukrainian therapists reported professional benefits and empathy gains, supported by significant improvement in coping skills ($p = 0.010$).[20] McDonald et al found qualitative evidence of enhanced empathy and professional identity among providers serving refugees.[19] Collectively, these findings suggest that structured, culturally informed training can enhance empathy, although certainty is low due to heterogeneity and small sample sizes.

The modest effect observed by Lewis et al is consistent with prior work showing limited gains from single-session interventions.[17] Meta-analytic evidence by Teding Van Berkhout and Malouff[21] found a pooled moderate effect (Hedges' $g = 0.61$); and Riess et al,[22] for example, reported a larger improvement following an 8 h empathy course. Compared with these, Lewis et al's effect ($\eta^2 = 0.041$) suggests that brief, single-exposure workshops may not allow sufficient depth for sustained empathy growth.[17] Multi-session or experiential models, such as Rodríguez-González's 4-day externship, appear more effective, probably due to repeated opportunities for reflection and interpersonal practice.[18]

McDonald et al's cross-cultural competence training provides further insight.[19] Although quantitative change was not detected, qualitative data revealed perceived gains in empathy and professional role awareness. This aligns with Lamothe et al, who found that most empathy interventions showed qualitative improvements even when standardised scales failed to capture change.[23] Such discrepancies may arise because empathy is contextually and culturally embedded; existing measures may not be sensitive to these nuances. As demonstrated in a meta-analysis by Hall et al, culturally adapted health interventions tend to produce stronger effects ($g = 0.47$ *v.* 0.15).[24] McDonald et al's findings support this view, that cultural adaptation appears to enhance provider empathy and role clarity even when numerical scales underrepresent the effect.[19]

These findings emphasise that evaluating empathy and compassion in culturally diverse contexts may require mixed-methods designs;[25–27] relying solely on self-report scales can underestimate meaningful attitudinal or relational growth.[28–30] Culturally sensitive evaluation tools are essential to capture change accurately, particularly when working across linguistic and cultural boundaries.[31,32]

Pollio et al further illustrated this point.[20] Their trauma-focused CBT programme for Ukrainian therapists produced significant gains in coping skills and self-reported empathy, along with reductions in burnout and secondary traumatic stress, although the latter were not statistically significant. Qualitative feedback indicated enhanced collegial trust and professional confidence, markers of improved relational capacity. These findings echo prior research suggesting that compassion-based or empathy-focused interventions can strengthen well-being and professional connectedness.[23,33] The small sample and brief duration may explain the non-significant quantitative outcomes; larger studies with extended follow-up may reveal more robust effects.

Duration and intensity appear critical. Pollio et al's 8-session course showed benefits for coping and empathy, and Rodríguez-González et al's 4-day externship yielded the strongest results, with substantial proportions of variance in empathy growth explained (pseudo-$R^2 = 22$–38%).[18,20] This suggests that immersive, experiential and culturally grounded models may be most effective. The significant and sustained increases in empathy and self-compassion observed by Rodríguez-González et al mirror Jazaieri et al, who found moderate effect sizes (Cohen's $d \approx 0.45$) for compassion cultivation training among healthcare workers.[34] Such parallels indicate that empathy and self-compassion are mutually reinforcing; enhancing one may promote the other and buffer against burnout.

Despite these encouraging findings, kindness and compassion were notably absent as direct outcome measures. This reflects a wider literature gap: although empathy is routinely assessed, kindness and compassion are often implied but unmeasured.[35–37] Future studies could integrate validated measures such as the Santa Clara Brief Compassion Scale or Compassion for Others Scale to capture these constructs explicitly.[38–40] Doing so would enable a fuller understanding of how interventions influence both emotional understanding and compassionate action.

The concept of intelligent kindness provides a useful framework for interpreting these findings.[7] It extends

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beyond empathy to emphasise the deliberate, context-sensitive application of kindness in professional interactions, transforming empathic awareness into constructive, prosocial behaviour.[7] Intelligent kindness involves awareness, ethical intent and responsive action aimed at reducing suffering and promoting well-being. In clinical settings it manifests through micro-affirmations, collaborative safety planning and culturally grounded communication that fosters trust and dignity.[7,41,42]

Although none of the reviewed interventions explicitly targeted intelligent kindness, several incorporated its principles implicitly. Lewis et al's decolonising workshop invited participants to reflect on historical trauma and unconscious bias, an act of culturally intelligent awareness.[17] McDonald et al's cross-cultural course promoted perspective-taking across refugee and provider experiences,[19] whereas Pollio et al's programme fostered solidarity and mutual support among clinicians during wartime stress.[20] Rodríguez-González et al's experiential training emphasised attunement and emotional presence, foundational to compassionate practice.[18] These interventions collectively illustrate the practical relevance of intelligent kindness, even when unnamed.

Strengths and limitations

This review is, to our knowledge, the first to synthesise culturally informed interventions targeting empathy, kindness and compassion among mental health professionals. It included studies from diverse contexts, a pooled sample of 715 participants and applied systematic methods with validated frameworks, enhancing credibility.

However, only four heterogeneous studies were included, limiting generalisability and precluding meta-analysis. Kindness and compassion were not directly measured, leaving a key evidence gap. Demographic reporting was inconsistent, intervention fidelity was not systematically assessed and the rapid review design involved methodological shortcuts, including a two-database, English-language search, single-reviewer screening and no formal risk-of-bias assessment.

Overall, the review provides valuable insights into culturally informed empathy training while highlighting the need for larger, rigorous studies that directly evaluate kindness and compassion.

Future directions

Future research should assess not only empathy but also kindness and compassion using culturally validated, mixed-methods approaches. Core instruments could include the Sussex–Oxford Compassion for Others and Santa Clara Brief Compassion Scale for compassion, the Jefferson Scale of Empathy and Questionnaire of Cognitive and Affective Empathy for clinician empathy and patient-rated tools such as the CARE Measure and Working Alliance Inventory. Importantly, because most existing scales were developed in Western contexts, cross-cultural validation is essential to ensure accurate measurement across diverse populations. Longitudinal studies with multi-session interventions are needed to determine the durability of effects and optimal training dose. Outcome assessment should extend to professional well-being, burnout, collegial trust, therapeutic alliance and patient satisfaction.

Implementation research is also critical. Future studies should clarify who delivers training (clinicians, peers, community facilitators), whether follow-up or booster sessions are needed and how fidelity is monitored. Evaluations should consider scalability, cost-effectiveness and integration of culturally adapted training into routine practice across diverse settings, including in-patient, community and low- and middle-income contexts.

Clinical and policy implications

This study showcases the vital role of incorporating culturally informed practices in virtue-based interventions for mental health professionals with limited but promising outcomes across the literature. It underscores the need for more rigorous, larger-scale studies that include direct measures of intelligent kindness, empathy and compassion to prevent burnout and promote inclusive health policy advancements.

From a systems perspective, embedding intelligent kindness within professional development could enhance both clinician well-being and patient care. Compassionate, culturally informed communication strengthens therapeutic alliance, promotes equity and mitigates burnout. To achieve this, training programmes should integrate cultural humility, reflective practice and compassion-focused exercises within ongoing supervision and team development structures. Mixed-methods evaluation frameworks are recommended to capture both attitudinal shifts and behaviourally observable expressions of kindness in care.

In summary, culturally informed empathy training appears to foster meaningful professional growth among mental health providers, although current evidence is limited and heterogeneous. Empathy gains were evident across diverse contexts, but kindness and compassion remain underexplored. Integrating the principles of intelligent kindness and intentional, culturally grounded, action-oriented compassion offers a promising next step for research and clinical training. Future studies should include validated compassion measures, assess long-term outcomes and examine how culturally adaptive, kindness-based approaches can sustain professional well-being and enhance equitable mental healthcare globally.

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Data availability

Data availability is not applicable to this article because no new data were created or analysed in this study.

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Author contributions

F.A.N. led the conceptualisation, methodology design, writing of the original draft and critical revision of the manuscript. S.A.B. contributed to the conceptualisation, manuscript writing and critical review of the content. F.M.U., R.U., W.A., S.C., N.N.A. and N.K. contributed to the literature review and drafting and editing of the manuscript, as well as providing intellectual input during the revision process. All authors reviewed and approved the final version of the manuscript, and agree to be accountable for all aspects of the work.

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Transparency declaration

The lead author and manuscript guarantor affirm that the manuscript is an honest, accurate and transparent account of the study being reported, and that no important aspects of the study have been omitted.

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