

**‘Being kinder to myself’: Using Compassion Focused Therapy  
and Compassionate Mind Training to help individuals in the  
helping professions cultivate compassion**

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## **Abbreviations**

BABCP: British Association for Behavioural and Cognitive Psychotherapies

CBT: Cognitive Behavioural Therapy

CFT: Compassion Focused Therapy

CMT: Compassionate Mind Training

DSM: Diagnostic and Statistical Manual of Mental Disorders

EMDR: Eye Movement Desensitisation and Reprocessing

FSP: Fire Service personnel

SRB: Soothing rhythm breathing

TF-CBT: Trauma-Focused Cognitive Behavioural Therapy

TPS: Threat Protection System

UKCP: The UK Council for Psychotherapy

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## **Declaration**

This thesis includes a portfolio of publications that have been published in peer-reviewed journals. This thesis also includes a range of published works, a research report, and a book, which act as supplementary evidence. The published works can be found in Appendix 1. The extent of the author's original contribution is listed in Appendix 2, which is verified by the collaborating authors in Appendix 3.

**Date 3<sup>rd</sup> March 2017**

## **Abstract**

Self-critical judgement, low levels of self-compassion, symptoms of stress, compassion fatigue, trauma and burnout can all have a negative impact on individuals who work in the helping professions. Continued absence of strategies that promote self-care, puts individuals in the helping professions at risk of experiencing such symptoms, which can impact on performance and compassion levels. This highlights the importance of developing, creating and testing interventions that promote self-care.

This portfolio of ten published works and eight supporting publications offers a unique contribution to knowledge by adapting and using Compassion Focused Therapy and Compassionate Mind Training, with populations who work in the helping professions (e.g. Fire Service personnel, student midwives, student nurses, student counsellors, student cognitive behavioural psychotherapists and healthcare educators). This population may experience trauma-related symptoms as a result of bearing witness to suffering. Teaching programmes were devised and tested and results from empirical studies in this portfolio of works suggest that CFT/CMT increased levels of self-compassion and reduced self-critical judgement. Interventions aimed at cultivating compassion for one's own suffering were incorporated into psychotherapy to help individuals who experience primary trauma and into Higher Education programmes, to help students who may experience low levels of self-compassion, high levels of self-critical judgement and/or trauma-related symptoms.

Collectively the publications provide a body of knowledge, which suggest that incorporating CFT/CMT into psychotherapy and healthcare

practitioner training may help individuals 'be kinder to self' in times of suffering. Helping individuals in the helping professions respond to their own suffering with compassion may build resilience and equip them with the tools needed to face the demands of practice and training. Whilst suffering cannot be prevented, interventions that focus on the cultivation of compassion can be employed to encourage healing.

This Portfolio of Published Works offers a unique contribution to knowledge, bridging a gap between practice and theory by offering tested, practical ways of enhancing compassion in populations that may suffer, as a result of bearing witness to trauma.

## Articles included in the Portfolio of Published Works

Throughout the portfolio the papers included in the submission will be cited in bold (e.g. **Beaumont & Hollins Martin, 2013**) to help distinguish these papers from other citations. The research papers listed below can be found in Appendix 1.

- (1) Beaumont, E., & Hollins-Martin, C. J. (2015). A narrative review. How effective is Compassion Focused Therapy? *Counselling Psychology Review*, 30(1), 21-32.
- (2) Beaumont, E., Durkin, M., McAndrew, S., & Martin, C. (2016). Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel suffering with trauma-related symptoms. *The Cognitive Behaviour Therapist*, vol. 9, e34, 1-13.  
doi:10.1017/S1754470X16000209
- (3) Beaumont, E., Hickey, A., McAndrew, S., Goldman, S., & Warne, T. (2016). Minding the gaps: Exploring the effectiveness of a voluntary sector mental health counselling service. *Journal of Counselling and Psychotherapy Research*, 16(4), 298–306.
- (4) Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J. (2016a). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery*, 34, 239–244.
- (5) Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J. (2016b). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists. *Journal of Counselling and Psychotherapy Research*, 16(1), 15-23.
- (6) Durkin, M., Beaumont, E., Hollins-Martin, C. J., & Carson, J. (2016). A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among UK community nurses. *Nurse Education Today*, 46 109–114.
- (7) Beaumont, E., Irons, C., Rayner, G., & Dagnall, N. (2016). Does Compassion Focused Therapy Training for Healthcare Educators and Providers increase self-compassion, and reduce self-persecution and self-criticism? *Journal of Continuing Education in the Health Professions*, 36(1), 4-10.

- (8) Beaumont, E., & Hollins Martin, C. (2016). A proposal to support student therapists to develop compassion for self and others through Compassionate Mind Training. *The Arts in Psychotherapy, 50*, 111-118.
- (9) Beaumont, E., & Hollins Martin, C. (2016). Heightening levels of compassion towards self and others through use of Compassionate Mind Training. *British Journal of Midwifery, 24*(11), 3-12.
- (10) Beaumont, E., Rayner, G., Durkin, M., & Bowling, G. (in press). The effects of Compassionate Mind Training on student psychotherapists. *Journal of Mental Health Training, Education and Practice*.

## Supporting articles/book included in the Portfolio of Published Works

In addition to the 10 papers fundamental to this portfolio, there are also a number of supporting papers, conference presentations, and a book that helped develop knowledge and understanding of the concepts covered in this thesis. In order to help identify the supporting works they are cited throughout the thesis in bold italics (e.g. ***Beaumont, 2016***). The supporting works are listed below.

- (11) Irons, C., & Beaumont, E. (2017). *The Compassionate Mind Workbook. A step-by-step guide to developing your Compassionate Self*. London: Little, Brown Publishers.
- (12) Beaumont, E. (2016). Building Resilience by Cultivating Compassion. *Healthcare Counselling and Psychotherapy Journal*, 16(3), 22-27.
- (13) McAndrew, S., Hickey, A., & Beaumont, E. (2015). The Impact of N. Staffs MIND's Adult Counselling Service on the Mental Health of their Clients: A Research Report. University of Salford: ISBN: 978-1-987842-76-4.
- (14) Beaumont, E. (2014). Healing the wounds of trauma, shame and grief: A case study. *Healthcare Counselling and Psychotherapy Journal*, 14(2), 15-19.
- (15) Beaumont, E., & Hollins Martin, C.J. (2013). Using Compassionate Mind Training as a Resource in EMDR: A Case Study. *Journal of EMDR Practice and Research*, 7(4), 186 -199. Ten citations.
- (16) Beaumont, E. (2012). Compassionate Mind Training: 'Self-soothing after trauma'. *Healthcare Counselling and Psychotherapy Journal*, 12(3), 18-22.
- (17) Beaumont, E., Galpin, A., & Jenkins, P. (2012). 'Being kinder to myself': A prospective comparative study, exploring post-trauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training *Counselling Psychology Review*, Vol. (27), 31-43. Forty citations.
- (18) Beaumont, E. (2010). A comparative study exploring therapy outcome measures of two groups: One group received Cognitive Behaviour

Therapy following a traumatic incident and the second group received Cognitive Behaviour Therapy and Compassionate Mind Training following a traumatic incident. Salford: University of Salford (Master's Thesis).

### **Supporting conference presentations**

Beaumont, E., Hollins Martin, C.J., Durkin, M., & Carson, J. (2017). Compassion and its relationship to mental well-being and professional quality of life (accepted paper). Research Theme: Midwives: making a difference through professionalism. International Confederation of Midwives (ICM) 31<sup>st</sup> Triennial Congress. Toronto, Canada (Toronto, 18<sup>th</sup>-22<sup>nd</sup> June 2017).

Beaumont, E., & Rayner, G. (2016). A pilot study examining the effects of Compassionate Mind Training on student psychotherapists (poster presentation). Research Theme: Compassion: Integrating Body Mind & Culture. The Compassionate Mind Foundation's 5<sup>th</sup> International Conference. (Manchester, 19<sup>th</sup>-21<sup>st</sup> October 2016).

Rayner, G., & Beaumont, E. (2016). The effects of Compassionate Mind Training on student psychotherapists: A focus group exploration (poster presentation). Research Theme: Compassion: Integrating Body Mind & Culture. The Compassionate Mind Foundation's 5<sup>th</sup> International Conference. (Manchester, 19<sup>th</sup>-21<sup>st</sup> October 2016).

Beaumont, E., Durkin, M., Hollins Martin., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout, and well-being in trainee counsellors and trainee cognitive behavioural psychotherapists (poster presentation). Research Theme: Compassion: Integrating Body Mind & Culture. The Compassionate Mind Foundation's 5<sup>th</sup> International Conference. (Manchester, 19<sup>th</sup>-21<sup>st</sup> October 2016).

Beaumont, E., Hickey, A., McAndrew, S., Goldman, S., & Warne, T. (2016). Easy like Sunday Morning: A service user perspective of compassionate counselling (paper presentation). 5<sup>th</sup> European Conference on Mental Health Prague (Prague, 14<sup>th</sup>-16<sup>th</sup> September 2016).

Beaumont, E. (2016). Healing the wounds of trauma: Can Compassionate Mind Training help protect healthcare practitioners from secondary trauma? (paper presentation). Making Research Count Conference (University of Salford, 24<sup>th</sup> May 2016).

Rayner, G., & Beaumont, E., & Irons, C. (2015). The effects of Compassion Focused Therapy training on a group of lecturers and practitioners in Higher Education: Focus group (poster presentation). Research Theme: The Relational Contexts of Compassion Focused Therapy. The Compassionate Mind Foundation's 4<sup>th</sup> International Conference (Manchester, 22<sup>nd</sup>-23<sup>rd</sup> October 2015).

Beaumont, E., & Rayner, G., & Irons, C. (2015). Cultivating Compassionate Healthcare: The effects of Compassion Focused Therapy training on a group of lecturers and practitioners in Higher Education (poster presentation). Research Theme: The Relational Contexts of Compassion Focused Therapy. The Compassionate Mind Foundation's 4<sup>th</sup> International Conference (Manchester, 22<sup>nd</sup> -23<sup>rd</sup> October 2015).

Beaumont, E. (2015). Healing the wounds of trauma using Compassionate Mind Training (paper presentation). The National Association for Rural Mental Health 41<sup>st</sup> Annual Conference. Honolulu, United States (Honolulu, 30<sup>th</sup> July-2<sup>nd</sup> August 2015).

Beaumont, E. (2015). The cost of caring: Compassionate Mind Training for Healthcare Professionals (paper presentation). Annual Conference for Counselling and Psychotherapy Placement Providers (University of Salford, 30<sup>th</sup> June 2015).

Beaumont, E., & Durkin, M. (2014). Who cares? We do: What do we know about compassion in the caring professions (paper presentation). CBT Symposium (University of Salford, 18<sup>th</sup> June 2014).

Beaumont, E. (2014). Compassion Focused Therapy for trauma, shame, guilt and blame (paper presentation). Conference for Healthcare Professionals and Placement Providers (University of Salford, 8<sup>th</sup> July 2014).

Beaumont, E. (2012). 'Being kinder to myself': A prospective comparative study, exploring post-trauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training (poster presentation). Research Theme: Clinical Applications of Compassion Focused Therapy. The Compassionate Mind Foundation's 1<sup>st</sup> Annual Conference (Manchester, 5<sup>th</sup>-7<sup>th</sup> October 2012).

## **Introduction**

This Portfolio of Published Works examines the impact Compassionate Mind Training (CMT) and Compassion Focused Therapy (CFT) has on individuals working in the helping professions. The published works presented in this thesis, investigates the potential benefits of introducing interventions aimed at cultivating compassion into healthcare training programmes and into psychotherapy for individuals who bear witness to the traumas of others.

This thesis is split into five sections. Section one discusses the detrimental effects that bearing witness to trauma can have on individuals working in the helping professions (Fire Service personnel, student counsellors, student psychotherapists, student midwives, student nurses, and healthcare educators and providers), and introduces the reader to current debates regarding the cultivation of compassion in healthcare. Section two addresses the gaps in literature, outlines the aims and objectives of this body of works, and lists the articles under scrutiny. Section three offers a critique of the presented publications. Papers one, two and three focus on compassion in clinical settings, whilst papers four through to ten focus on compassion within Higher Education. Section four focuses on methodology, limitations, ethical considerations and personal reflection. Finally, section five examines the key thesis outcomes and offers recommendations for practice and future research.

## **Section One: Background**

In this section, debates regarding compassion deficits, blocks to compassion, practitioner training demands and factors associated with bearing witness to trauma will be discussed.

Many definitions regarding the notion of compassion originate from Aristotelian virtue and theories of justice, Christian philosophy, and Buddhist traditions (Van der Cingel, 2011). According to the Oxford English Dictionary, the word 'compassion' stems from the Latin word 'compati' meaning 'to suffer with'. There is consensus within literature that compassion includes feeling for a person who is suffering and being motivated to behave in a way that helps them, encompassed in a desire to alleviate suffering (e.g., Gilbert, 2010; Lazarus, 1991).

Discussions within the fields of philosophy, sociology, psychology, and religion, regarding the meaning of compassion span 2000 years, with much debate focusing on the theoretical nature of compassion (Kanov et al., 2004). Whilst philosophical, theoretical disputes and religious views surrounding compassion are important issues to consider, the focus of this thesis is to examine the benefits of cultivating compassion.

The subject of compassion in health and social care (Care Quality Commission, 2011; Crawford, Brown, Kvangarsnes & Gilbert, 2014; Crawford, Gilbert, Gilbert, Gale & Harvey, 2013) has been deliberated, with much of this literature focusing on blocks, deficits, and lack of compassion. In recent years however, researchers and psychotherapists (**Beaumont, Durkin, McAndrew & Martin, 2016; Beaumont & Hollins Martin, 2015; Beaumont, Galpin &**

**Jenkins, 2012;** Gilbert & Irons, 2004; Gilbert & Proctor, 2006; Goss & Allan, 2010; Mayhew & Gilbert, 2008), have begun to contemplate whether individuals suffering with high levels of self-criticism would benefit from developing self-compassion, through learning to access their emotion regulation systems (Gilbert, 2009; 2010; 2014), and by learning to challenge self-criticism in a non-judgemental way.

The potential benefits of cultivating compassion will now be examined, with the initial focus on exploring whether an intervention, which was initially developed for individuals in clinical populations, can be adapted and used to help individuals in the helping professions.

### **Compassionate Mind Training/Compassion Focused Therapy**

Compassionate Mind Training (CMT) and Compassion Focused Therapy (CFT) were developed by Paul Gilbert (2005; 2009; 2010; 2014) to help people suffering with low mood, high levels of shame and self-criticism. Gilbert's theory suggests that individuals can be helped to train their mind to improve well-being, by learning to cope with emotional discomfort through cultivating compassion. CMT refers to the interventions used to cultivate compassion and CFT involves the process of therapy.

Cultivating a compassionate mind includes having a caring motivation to face suffering, tolerate distress and take action to help alleviate suffering (Gilbert, 2009). CFT incorporates elements of attachment and evolutionary theory, with the latter focusing on the evolution of the mammalian affiliative system (Gilbert, 2010). The model suggests that human beings have three

affect regulation systems (see Figure 1), which evolved for different functions and which regulate emotion (Gilbert, 2010; 2014; Goss & Allen, 2014):

- (1) The threat and protection system (TPS)
- (2) The drive, resource seeking, incentive focused and excitement system
- (3) The soothing/affiliative and safeness system

**Figure 1:** Three types of affect regulation system. From Gilbert (2009). *The Compassionate Mind*. With kind permission from Constable Robinson.



The TPS alerts and directs attention to aspects that an individual perceives as threatening, which prompts the body into action. The drive, resource seeking, incentive focused and excitement system, evolved to motivate animals to find food, shelter, and to seek out sexual partners. This system is linked to doing, achieving, wanting, avoiding rejection and consuming activities. The soothing/affiliative and safeness system is related to social connection,

affection, and kindness and is responsible for reducing threat responses to feared stimuli and for activating feelings of safety, bonding and trust. When distressed, being in receipt of compassion generates security, increases feelings of safeness, and helps regulate the TPS in response to threat.

The aim of CFT and CMT is to balance the three systems by building the soothing/affiliative and safeness system. Individuals are taught how the three systems impact upon one another. Compassionate skills, the attributes of compassion and interventions aimed at increasing levels of compassion are outlined in *Table 1*.

**Table 1:** The key attributes of compassion, skills of compassion and interventions designed to increase levels of compassion (**Beaumont & Hollins Martin, 2016a**). Reprinted with kind permission from *The Arts in Psychotherapy*.

<p><b>Gilbert’s (2009) first psychology of compassion (compassionate attributes)</b></p> <p><i>Care for well-being:</i> Caring for oneself and other people with a desire and a caring motivation to notice and turn toward suffering, with a wish to alleviate distress and stimulate well-being.</p> <p><i>Sensitivity to distress:</i> Developing self-awareness and being attentive to one’s own suffering (through physical and emotional clues) and other people’s distress.</p> <p><i>Sympathy:</i> Acknowledging and feeling emotionally moved by past and present experiences of suffering and distress.</p> <p><i>Distress tolerance:</i> Turning toward suffering and learning to tolerate difficult emotions with an open hearted acceptance and kindness.</p> <p><i>Empathy:</i> A desire and a motivation to learn, understand and discover the reasons we and other people behave, think and feel in various situations.</p> <p><i>Non-judgement:</i> Individuals are taught techniques that aim to help them learn to notice and let go of self-attacking and self-criticism without judgement.</p>
<p><b>Gilbert’s (2009) second psychology of compassion (compassionate skills)</b></p>

*Attention:* Linked to mindfulness. Focusing on the present moment without judgement or criticism.

*Reasoning:* Training the mind to think and reason in helpful ways. For example, asking oneself 'how can I think in a way that will help me in this situation'.

*Behaviour:* Behaving in ways that help the individual move through suffering, toward their life goals with a caring motivation. This can be difficult and requires courage because it may involve facing fears, or refraining from using unhelpful safety behaviours.

*Sensory:* Learning to stimulate the affect regulation system using breathing exercises, vocal tones, and body postures.

*Feeling:* Noticing and responding to emotions using compassion.

*Imagery:* Using memory and imagery exercises that aim to stimulate the soothing/affiliative and safeness system.

### **Gilbert's (2009) Compassionate Mind Training (interventions include)**

*Mindfulness and focused attention:* Learning how to notice that our attention can be directed by us.

*Soothing rhythm breathing (SRB):* Exploration of breathing methods that have been found to be connected with heart rate variability, positive health outcomes and frontal cortex activity (Gilbert, 2014). SRB can help to regulate the threat system.

*Creating a safe place:* Creating a place in the mind that provides affiliative feelings.

*Compassion focused imagery:* Using imagery exercises to stimulate the soothing system and manage distress. When anxious or worried, individuals may imagine negative, critical, or scary images that tend to add to distress.

*Compassion as a flow:* Exercises designed to increase levels of compassion for self and others are explored.

*Developing the compassionate self:* Using acting skills and imagery techniques to create and develop a compassionate ideal self.

*Developing an ideal compassionate other:* Using imagery techniques to create an image of an ideal compassionate other (an image that offers compassion).

*Our different parts:* Exploration of the different emotional parts (e.g. angry, anxious, and critical). Using a compassionate mind to relate to our different parts.

*Engaging with self-criticism using the compassionate self:* The compassionate self will direct compassionate behaviour, thoughts, and feelings to the critical self.

Gilbert (2009; 2010) suggests that compassion flows in three ways; (1) we can experience compassion from other people, (2) we can direct compassion to other people, and (3) we can direct compassion towards ourselves. Compassion focused interventions aim to increase awareness and understanding of internal and external threats.

Adapting Gilbert's theory for use in both clinical and non-clinical samples for individuals who may suffer as a result of bearing witness to trauma, has potential. For example, cultivating compassion may help those who experience trauma first hand (Lee, 2012), and help individuals working in the helping professions who bear witness to suffering and as a result may be at risk of developing symptoms associated with secondary trauma, vicarious trauma/compassion fatigue and/or burnout. Experiencing symptoms of primary or secondary trauma can impact negatively on an individual's ability to perform at work, because the individual may become disillusioned, feel isolated, or may distance themselves emotionally from other people (Figley, 1995; Freudenberger, 1974; Thomas & Wilson, 2003).

According to Kadambi and Ennis (2004) secondary traumatic stress is different from burnout, in that its core symptoms (e.g., flashbacks, intrusive thoughts, nightmares and hyperarousal), are similar to the symptoms experienced by individuals suffering following a primary trauma. *Table 2* offers a brief overview of the terms associated with what Sabo (2006) terms the 'cost of caring'.

**Table 2:** Terms associated with the ‘cost of caring’.

<b>Primary trauma</b>	Physical, emotional, behavioural, and/or psychological suffering experienced by individuals or groups in response to exposure to traumatic events.
<b>Secondary Traumatic Stress/Indirect trauma</b>	Trauma symptoms are experienced following an empathic relationship with an individual or group of people who have experienced trauma, or a series of traumatic events. Physical, emotional, behavioural, and/or psychological symptoms are experienced following <i>indirect</i> exposure to traumatic events (Baird & Kracen, 2006). Secondary trauma can happen suddenly.
<b>Compassion fatigue/Vicarious trauma</b>	Trauma symptoms are experienced as a result of cumulative helping relationships and occur when an individual strongly identifies with clients/patients who have been affected by direct exposure to traumatic events (McCann & Pearlman, 1990). A natural consequence of caring for a person who has experienced trauma (Figley, 1995).
<b>Burnout</b>	A state of exhaustion following sustained physiological, emotional, and/or psychological stress. This can be detrimental to individuals who are continually exposed to primary or secondary trauma (Maslach, 2003).

Whilst therapeutic models and government guidance propose specific treatment interventions for mental health needs, there is a scarcity of research, which focuses on how we can help individuals in the helping professions cultivate compassion for their own suffering (Barnett, Baker, Elman & Schoener, 2007; **Beaumont, 2016; Beaumont & Hollins Martin, 2016a, 2016b; Beaumont, Irons, Rayner & Dagnall, 2016; Beaumont, Rayner, Durkin & Bowling, in press; Boellinghaus, Jones & Hutton, 2012; Patsiopoulos & Buchanan, 2011**). This is important because cultivating self-compassion may help individuals exposed to primary and secondary trauma who report feelings of shame, self-criticism and guilt (Jonsson & Segesten,

2004; Lee, Scragg & Turner, 2001; Leskela, Dieperink & Thras, 2002), particularly if they have failed in their attempt to rescue or help the victim (**Beaumont, Durkin, McAndrew & Martin, 2016; Beaumont et al., 2012;** Jonsson & Segesten, 2004).

The DSM 5 (APA, 2013) acknowledges the complexity of trauma and recognises that emotions, such as shame, guilt, and fear can contribute to the development and maintenance of Post-Traumatic Stress Disorder (PTSD) (Badour, Resnick & Kilpatrick, 2015). These emotions can inhibit recovery (Balcom, Call & Pearlman, 2000) and can lead to self-criticism and self-blame if the individual feels no compassion for themselves (**Beaumont, Durkin, McAndrew & Martin, 2016; Beaumont et al., 2012;** Harman & Lee, 2010; Lee, 2009; Lee et al., 2001).

### **Psychotherapy for individuals who experience primary trauma**

No one therapeutic intervention is a panacea for all. Individuals, who report low levels of self-compassion, high levels of self-criticism, and feelings of shame, may benefit from using a range of therapeutic interventions that cultivate compassion. Currently, Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are the recommended first line treatments for trauma (National Collaborating Centre for Mental Health, 2005). However, some individuals who have received CBT report that they understand the logic of the approach yet do not feel better (**Beaumont et al., 2012; Beaumont & Hollins Martin, 2013;** Gilbert, 2010; Leahy, 2001). A common critique of trauma-focused therapies is the high levels of attrition. For example, literature suggests that between 20% and 35%

of clients drop out of therapy when interventions include in vivo exposure to traumatic memories (Foa et al., 2005; Resick, Nishith, Weaver, Astin & Feuer, 2002). Debates regarding the impact and importance of the therapeutic relationship within psychotherapy and the value of tailoring therapy to meet the needs of individuals (**Beaumont & Hollins Martin, 2013**; Joseph & Murphy, 2013) continue. For example, questions surrounding whether it is the interventions utilised within the CBT framework that instigate the majority of pre-post change or the therapeutic relationship itself (**Beaumont, Durkin, McAndrew & Martin, 2016**; **Beaumont et al., 2012**; **Beaumont & Hollins Martin, 2013**; **2015**; Gilbert & Leahy, 2007; Leahy, 2008; Leaviss & Uttley, 2015).

Cooper (2008) proposes that only 15% of client improvement is due to the theoretical model used by the practitioner. This view is echoed by other researchers who suggest that other factors play a pivotal role in recovery, for example, empathy, therapist congruence, acceptance and the therapeutic alliance (Gilbert & Leahy, 2007; Grant & Townend, 2010; Joseph & Murphy, 2013; Leahy, 2008; Murphy & Cramer, 2014; Murphy, Cramer & Joseph, 2012; Norcross, 2002).

Recognising that cultivating self-compassion may help trauma survivors respond to suffering with compassion and a caring motivation, **Beaumont et al. (2012)**, collected pre and post-therapy data from clients referred for psychotherapy with trauma-related symptoms. Two groups were compared, one group received CBT-only and a second group received CBT combined with CMT. Participants in both treatment groups experienced statistically significant reductions post-therapy in symptoms of anxiety

[ $F(1,30)=151.187, p\leq 0.001$ ], depression [ $F(1, 30)=223.935, p\leq 0.001$ ], avoidance [ $F(1,30)=293.596, p\leq 0.001$ ], hyper-arousal [ $F(1,30)=262.657, p\leq 0.001$ ] and intrusive thoughts [ $F(1,30)=272.846, p\leq 0.001$ ]. The main effect comparing the two types of intervention was significant, suggesting that the combined group developed more self-compassion post-therapy [ $F(1,30)=4.657, p\leq 0.05$ ].

Critics of CBT suggest that there are high dropout rates and relapse rates for some trauma-focused therapies (Foa et al., 2005; Resick et al., 2002). However, attrition rates were low in this study, with 33 out of 36 completing therapy. **Beaumont et al. (2012)** was the first study published to investigate whether CFT/CMT may be a useful adjunct to CBT for individuals suffering with trauma-related symptoms and low levels of self-compassion. **Beaumont et al. (2012)** therefore addressed a gap in current literature making a new contribution within the field of CFT/CMT. This inaugural paper opened up further discussions about the importance of cultivating self-compassion in clinical populations, for individuals suffering psychological distress following a traumatic incident. However, individuals in the study also recovered post-therapy in the CBT-only group. One psychotherapist administered the treatment interventions in both groups and whilst this was sufficient for this preliminary study, one could argue that it was the therapeutic relationship that instigated change. Research demonstrates that when the quality of the relationship is good, the outcome of the counselling is positive (Hodgetts & Wright, 2007; Horvath, 2013; Joseph & Murphy, 2013; Liotti, 2007; Mooney, Gibbons, Gallop, Mack & Crits-Christoph, 2014; Murphy & Cramer, 2014).

Hiraoka et al. (2015) cite **Beaumont et al. (2012)** and echo the view that it is important to study links between self-compassion and trauma. Hiraoka et al. (2015) state that the findings from **Beaumont et al. (2012)** are important because they indicate that compassion can be modified by using targeted interventions. Since **Beaumont et al. (2012)**, other authors have reported on the impact CFT had on individuals in trauma populations. For example, Ashworth, Gracey and Gilbert (2014), examined the impact CFT had on an individual with traumatic brain injury, and CMT has been used as an addition to CBT with a seventeen year-old girl who was sexually assaulted at the age of thirteen (Bowyer, Wallis & Lee, 2014). Both Ashworth et al. (2014) and Bowyer et al. (2014), suggest that both individuals in their study found benefit from incorporating exercises into psychotherapy that aimed to cultivate self-compassion, thereby supporting the work of **Beaumont et al. (2012)**.

**Beaumont and Hollins Martin (2013)** explored whether CMT could be integrated into EMDR and by doing so, be used as a resource for treating an individual suffering with psychological and somatic symptoms of trauma. The client was referred with trauma-related symptoms for a course of CBT; however, he struggled to engage with behavioural interventions, such as, exposure. Therefore, EMDR was used as a therapeutic intervention, which proved to be effective in treating his unexplained symptoms. The client initially responded well to CMT, which focused on responding to self-criticism and self-attacks with compassion, and therefore CMT was used as a resource in EMDR therapy. Although this was the first paper to incorporate CMT into EMDR, the research design does not allow us to determine to what extent both therapeutic interventions contributed to the clients' recovery. For

example, although we can hypothesise that increasing self-compassion alleviated trauma-related symptoms and enabled the individual to confront painful memories, it is difficult to ascertain whether this would have happened with EMDR therapy alone. **Beaumont and Hollins Martin (2013)** propose that a multiple baseline case study be conducted to examine the individual contributions of CMT and EMDR. Nonetheless, the paper highlights the value of working collaboratively with clients to meet their individual needs and the research design does enable researchers to evaluate the contribution of the therapeutic alliance. In this instance, the psychotherapist employed a second treatment strategy after the client struggled to engage with exposure therapy. The success with the second intervention could suggest that CMT with EMDR provided a larger treatment effect than that derived from a positive client–therapist alliance.

Following, and citing **Beaumont and Hollins Martin, (2013)**, Kennedy (2014) discusses the potential benefit of incorporating CFT/CMT into the processing phases of EMDR to help individuals address self-critical blocks. Kirby (2016) cites **Beaumont and Hollins Martin (2013)** as evidence underpinning the potential value of CFT and Kolts (2016), refers to this positive outcome study, in his book '*CFT Made Simple*'. Issues surrounding compassion in the healthcare professions will now be explored.

### **Compassion in healthcare**

The National Health Service (NHS), which is the UK's leading healthcare provider, adopts compassion as one of its six values (Cummings & Bennett, 2012). The Department of Health (DoH, 2008) states that:

*“Compassion is a ‘core value’ of the National Health Service and that all patients must be treated by staff with compassion, dignity and respect” (p. 5).*

NHS trusts are constantly under pressure to work within financial constraints in a target driven culture (Thorlby, Smith, Williams & Dayan, 2014), thus potentially breeding a competitive rather than compassionate mindset. In recent years, there has been debate regarding the privatisation of the NHS, with some service users and politicians proposing that privatisation may lead to a positive change and enable compassionate care to thrive (Iacobucci, 2014). However, marketisation of the NHS will not necessarily make a difference, especially when we consider the failures (e.g. inadequate leadership skills and concerns surrounding patient safety) in care at the first privately run NHS hospital, Hinchingsbrooke.

A report on the UK National Health Service (NHS) by Lord Francis QC revealed that certain hospital failings were in part due to staff failing to act with compassion. As a result, Francis (2013) suggested that there is a need to develop more compassionate care among healthcare staff. For example, the investigation into Mid-Staffordshire suggested that:

*“Staff treated patients and those close to them with what appeared to be callous indifference” (Francis, 2013, p.13).*

Although there are reports akin to this, which also highlight failings in care, there is an absence of research, which aims to examine and understand *why* there may be a compassion deficit and a paucity of research exploring ways of helping healthcare practitioners (including student practitioners) cultivate compassion. De Zulueta (2013) argues that the Francis Report did not discuss the challenges and fears that healthcare professionals encounter when working with vulnerable individuals. Of course, organisations

responsible for healthcare need to select employees that have the required skills and a compassionate motivation to care for others, which researchers suggest is often evident at the beginning of such a career (Maben, Cornwell & Sweeney, 2010). Murphy, Jones, Edwards, James, and Mayer (2009) support this observation, reporting a significant difference between first and third year student nurses' compassion levels, with lower scores reported in the third year.

Healthcare education has come under scrutiny recently, with concerns surrounding the impact that education, placement and organisational demands have on student practitioners' (**Beaumont, 2016; Beaumont & Hollins Martin, 2016a; 2016b**; Bray, O'Brian, Kirton, Zuairu & Christiansen, 2014; Crawford et al., 2014). The Willis Commission (2012) suggested that:

*“Nurses and their organisations must stand up to be counted, to restore professional pride and provide leadership and solutions to the challenges of poor care and a decline in public confidence” (p.6).*

The Commission (Willis Commission, 2012), went on to recommend that nursing education programmes should have high quality recruitment campaigns to ensure that the best range of applicants are selected and that organisations, should provide evidence on the correlations between entry criteria, selection processes, course outcomes and attrition rates. The Francis Report (2013) supported this view, recommending that potential employees should be engaged on the basis that they have the appropriate values, attitudes, and behaviours that underpin compassionate care provision. Nonetheless, employing staff based upon the results of a 'compassion aptitude test' does not ensure that the employee has compassion levels that can be sustained over time in stressful, traumatic, and potentially hostile

environments (Sturgeon, 2010). Without helping individuals cultivate and maintain compassion levels, the danger is that a 'compassion aptitude test' will become an added pressure. In other words, there is the risk that it could become a tick-box exercise that is used to audit and evaluate practitioners' communication skills (Sturgeon, 2010). Though such reports are well intentioned and needed, they appear to demonstrate a lack of understanding surrounding the facilitators and inhibitors of compassion and may fail to explore methods, which aim to help individuals cultivate compassion.

Whilst the Francis Report (2013) documented cases where healthcare professionals failed to provide compassionate care, the report did not acknowledge the emotional challenges that individuals in the helping professions have to face when caring for vulnerable, sick, traumatised and dying patients (De Zulueta, 2013). Helping those who experience suffering can be rewarding, but also has the potential to emotionally challenge and overwhelm caregivers, which can lead to emotional overload and personal distress (Singer & Klimecki, 2014).

A further potential contributing factor to the compassion deficit witnessed in Mid-Staffordshire is that staff experienced a culture of fear.

Francis (2013) reports:

*"A culture of fear in which staff did not feel able to report concerns....and a culture of bullying, which prevented people from doing their jobs properly" (p.10).*

Blaming and shaming individuals for a lack of compassion creates a shame-based, punishing, and potentially bullying culture, which is detrimental to learning (Collins, Block, Arnold & Christakis, 2009; Harris, 2004). Working in such conditions can create self-loathing, a lack of confidence in one's abilities

(Harris, 2004) and can activate our threat-focused system, which reduces our attention because our bodies respond by operating in survival mode (Gilbert, 2010). 'Inattention blindness' (Mack & Rock, 1998) interferes with compassionate capacities and can lead to symptoms of stress, compassion fatigue, or burnout. This occurs when one fails to notice the distress experienced by others because of prior obligations and attentional overload (Chabris, Weinberger, Fontaine & Simons, 2011; Drew, Vö & Wolfe, 2013; Greig, Higham & Nobre, 2014).

Rather than focusing on creating environments that ensure compliance and obedience (Khatri, Brown & Hicks, 2009), which foster a blaming, shaming and punishing culture, an alternative method, which is supported by psychological theories such as attachment theory (Bowlby, 1969) and Gilbert's evolutionary model (2009; 2010; 2014), is to provide the necessary conditions for compassion to flourish. Nurturing working relationships and building staff trust promotes learning, which can have an impact on employee self-esteem (Harris, 2004).

Individuals working in the caring professions face a set of unique challenges. For example, student midwives may witness loss or traumatic childbirth (**Beaumont & Hollins Martin, 2016b**). Student counsellors and psychotherapists may work with suicidal clients, or clients who self-harm, which can also present personal and professional challenges (Reeves & Dryden, 2008; Reeves, Bowl, Wheeler & Guthrie, 2004). As a result of such challenges students may question their ability, experience fear or anxiety, feel incompetent and overwhelmed (Reeves & Mintz, 2001; Wheeler, Bowl & Reeves, 2004), or harshly judge themselves particularly if they feel they have

failed in their attempt to help their client/patient (**Beaumont, Durkin, McAndrew & Martin, 2016**).

Creating conditions in which practitioners feel safe, valued, accepted, and cared for will reduce threat-based fear. Providing a secure-base (Bowlby, 1969), by helping practitioners to engage with their own suffering in times of stress, may foster compassionate care-giving and promote altruistic behaviour (**Beaumont, 2016; Beaumont & Hollins Martin, 2016a, 2016b; Beaumont, Hickey, McAndrew, Goldman & Warne, 2016; Mikulincer, Shaver, Gillath & Nitzberg, 2005**).

Rescue workers including Fire Service personnel (FSP) are also exposed to trauma in their line of duty and according to Fullerton, McCarroll, Ursano and Wright (1992), have a higher risk of experiencing psychological suffering because they identify with the individuals who have been exposed to traumatic incidents. In addition to potentially developing symptoms of trauma as a result of their work, FSP may also face organisational pressures (**Beaumont, Durkin, McAndrew & Martin, 2016**). For example, individuals may experience stress-related symptoms as a result of changing shift patterns, long working hours, bullying, job politics, poor leadership and/or sleep deprivation, all of which can impact on quality of life. Educating emergency service providers about the importance of cultivating compassion in organisations could equip subsequent generations with the psychological strategies needed to face the demands of trauma work.

Listening to oneself is essential maintenance work for leaders, practitioners and educators and according to Harris (2007), “*ensures that the individual is emotionally fit for purpose*” (p139). One way that may help

individuals in the helping professions cultivate and maintain compassion is to introduce them to techniques and interventions that promote self-care. This is the approach promoted within this thesis (**Beaumont, 2016; Beaumont & Hollins Martin 2016a, 2016b; Beaumont et al., in press**) and is timely, as recent research suggests that self-practice and self-reflection are forms of experiential learning and could potentially be significant in thwarting burnout and secondary trauma (Bell, Dixon & Kolts, 2016). Debates surrounding the 'cost of caring' (Sabo, 2006) will now be examined.

### **The cost of caring**

Figley (1995) suggests that the effects of secondary trauma can have the same detrimental effect on the observer as the person-experiencing trauma. Compassion fatigue and secondary traumatic stress has been identified in doctors (Benson & Macgrath, 2005; Joinson, 1992; Pfifferling & Gilley, 2000), nurses (Sabo, 2006), student psychotherapists (Barnett et al., 2007), and midwives (Leinweber & Rowe, 2010).

Research exploring concepts such as secondary traumatic stress, compassion fatigue, and vicarious trauma has been hindered by a lack of conceptual clarity (Collins & Long, 2003; Stamm, 2010). For example, Figley (2002) argues that the term compassion fatigue is a user friendly term for secondary traumatic stress disorder, whereas Jenkins and Baird (2002) suggest that burnout and secondary traumatic stress are comparable in that they:

*“Result from exposure to emotionally engaging clients via interpersonally demanding jobs, and represent debilitation that can obstruct providers’ services” (p. 423).*

All terms however, do outline the detrimental impact that working in the helping professions can have on practitioners.

Bearing witness to suffering can become overwhelming over time and if not managed can profoundly impact upon a caregiver's ability to engage with the distress of another (Tomova, von Dawans, Heinrichs, Silani & Lamm, 2014). This has been shown in rescue workers, who have a higher prevalence of PTSD compared with the general public (Berger et al., 2012; Skogstad et al., 2013). Whilst engaged in stressful situations, it can be easy for individuals to neglect their own emotional and psychological needs, which can lead to self-criticism, feelings of shame, low levels of self-compassion, and symptoms of compassion fatigue or burnout.

Over recent years there has been growing recognition that self-compassion may promote therapist well-being (Barnett, et al., 2007; **Beaumont, 2016; Beaumont & Hollins Martin, 2016a**; Mahoney, 2005; Rimes & Wingrove, 2011), mitigate the negative effects of job-related stress (Patsiopoulos & Buchanan, 2011), and help individuals who experience shame-based trauma memories (Lee, 2009). Educators employed in the helping professions can be seen as the gatekeepers to their profession and have responsibility for ensuring that healthcare students are fit to practise (Reeves, 2012). Hence, teaching skills to individuals who bear witness to suffering that enhance compassion for oneself and other people becomes important, because it could help build resilience. That is, it is salient to create what Sabo (2011) calls 'a compassionate presence'.

## Summary of Section One

In this section current debates regarding compassion deficits, blocks to compassion, practitioner training demands and factors associated with bearing witness to trauma have been examined. All of these factors and debates are important, but they do leave an identified gap in the literature. For example, much of the research to date focuses on; (1) what compassion is, (2) why individuals in the helping professions experience symptoms of trauma, stress, compassion fatigue, and burnout, (3) whether compassion deficits are as a result of organisational demands, and (4) why some practitioners become disillusioned and report that they want to leave practice (Maben et al., 2010). However, there is a dearth of literature examining ‘*how*’ compassion can be cultivated within the helping professions and for ‘*whom*’ training would benefit. In the next section, these gaps in the literature will be explored in more detail. CFT/CMT, which was initially designed to help clinical populations, will be adapted and used to examine the impact it has on individuals working in the helping professions.

## **Section Two: Rationale, thesis aim and objectives, and published works**

In this section the rationale for the works will be outlined, the aim and objectives of this body of works identified, and the published works will be presented.

Developing self-compassion and responding to ‘the bully within’ (self-criticism), through ‘being kinder to oneself’ (**Beaumont et al., 2012**), may function as a remedy to self-criticism and serve as an adaptive way of self-relating if trauma symptoms are experienced. Hence, nurturing compassion is a potential antidote to self-criticism and may play a role in helping individuals reduce the distress they experience as a result of bearing witness to the suffering of others. Cultivating compassion does not mean ‘just being kind to ourselves when we have a bad day’. It means having a caring motivation to notice and turn toward suffering, and involves actively facing situations that cause distress (**Beaumont & Hollins Martin, 2016a, 2016b**; Gilbert, 2009; 2010; 2014; **Irons & Beaumont, 2017**). Examining ‘how’ and ‘whether’ compassion can be cultivated may be of value for both clinicians, organisations who employ blue-light workers (**Beaumont, Durkin, McAndrew & Martin, 2016**), educators, and society as a whole, as a means of potentially improving well-being.

In spite of research that has explored issues surrounding compassion fatigue and/or secondary trauma (Benson & Macgrath, 2005; Davies & Coldridge, 2015; Farber & Heifetz, 1982; Figley, 1995; Joinson, 1992; Leinweber & Rowe, 2010; McCann & Pearlman, 1990; Pfifferling & Gilley, 2000; Sabo, 2006; Thomas & Wilson, 2003), there is a dearth of research about how healthcare educators can prepare students for clinical reality (Ting,

Sanders, Jacobson & Power, 2006), and there are very few studies that have explored how healthcare practitioners can employ self-compassion (Boellinghaus, Jones & Hutton, 2012; Patsiopoulos & Buchanan, 2011).

Barnett et al. (2007) echo this view and suggest that student psychotherapists should be taught self-management techniques that help prepare them for the emotional demands of clinical practice.

Addressing gaps in the literature, this body of works examines whether CFT and CMT can help individuals in the helping professions cultivate compassion and reduce self-critical judgement. To achieve this, Gilbert's model (2009; 2010) of CFT and CMT was used.

Alternative interventions that focus on cultivating compassion could have been examined. For example, Compassion Cultivation Training (Jazaieri et al., 2013), Cultivating Emotional Balance (Kemeny et al., 2012), or the Mindful Self-Compassion Programme (Neff & Germer, 2013) could have been used to measure pre and post change. However, CFT is the only psychotherapy model and has potential to be adapted for use in educational and organisational settings (Kirby, 2016; Welford & Langmead, 2015).

In the next section the aim and objectives of the thesis will be explained and the author's contribution of articles examined.

### **Aim and Objectives**

The aim of this thesis was to examine the impact CFT/CMT has on populations who work in the helping professions, who as a result of their work, bear witness to suffering and may then experience trauma-related symptoms.

**The key objectives were to:**

1. Examine the effectiveness and impact of CFT/CMT.
2. Examine the impact that counselling and psychotherapy has on service users who report they have experienced compassionate care.
3. Examine relationships between self-compassion, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout.
4. Develop and test an educational model to help individuals training for a career in the helping professions, cultivate self-compassion and reduce self-critical judgement.

## Contribution of included articles

The candidate has made a unique and independent contribution in each of the papers under scrutiny. Information regarding the ten papers can be found in *Table 3*.

**Table 3:** Details of the papers and the contributions made

Study	Study Objectives	Contribution Made	Thesis Objectives
<p><b>Paper 1:</b>  <b>Beaumont, E., &amp; Hollins-Martin, C. J. (2015).</b> A narrative review. How effective is Compassion Focused Therapy?</p>	<p>To present a synopsis of studies to assist therapists' understanding of how CFT/CMT has been used within the therapeutic arena and where further developments are required.</p>	<p>Identified gaps in knowledge and led to scholarly debate regarding the current state of play of CFT/CMT.</p> <p>Provides evidence to suggest the benefits of using CFT/CMT to create a more affiliative orientation to one-self and others.</p> <p>Further research examining the effectiveness of using CFT/CMT as a stand-alone therapy was recommended.</p>	<p>Examine the effectiveness and impact of CFT/CMT  <b>(Objective 1).</b></p>
<p><b>Paper 2:</b>  <b>Beaumont, E., Durkin, M., McAndrew, S., &amp; Martin, C. (2016).</b> Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel (FSP) suffering with trauma-related symptoms.</p>	<p>To examine the impact CFT had when used as an adjunct to TF-CBT in a sample of FSP who reported trauma-related symptoms.</p> <p>To examine whether an increase in self-compassion reduces trauma-related symptoms.</p>	<p>This was the first research paper published, which examines whether CFT could be a useful adjunct to TF-CBT for individuals referred for psychotherapy, with low levels of self-compassion, low mood and trauma-related symptoms.</p>	<p>Examine the effectiveness and impact of CFT/CMT  <b>(Objective 1).</b></p>
<p><b>Paper 3:</b>  <b>Beaumont, E., Hickey, A., McAndrew, S.,</b></p>	<p>To identify how service users experienced one-to-one therapy.</p>	<p>This paper highlights the importance of experiencing compassion within the therapeutic arena and</p>	<p>Examine the impact that counselling and psychotherapy</p>

<p><b>Goldman, S., &amp; Warne, T. (2016).</b> Minding the gaps: Using narrative accounts to explore people's experiences of using North Staffs MIND's Adult Counselling Service (A report and paper).</p>	<p>To explore whether or not therapy enabled the person to have a better quality of life and, if so how.</p> <p>To identify if one-to-one therapy impacted on other areas of service users' life.</p>	<p>provides preliminary data, which suggests that positive therapy outcomes may lead to altruistic behaviour.</p>	<p>has on service users who report they have experienced compassionate care. <b>(Objective 2).</b></p>
<p><b>Paper 4: Beaumont, E., Durkin, M., Hollins-Martin, C. J., &amp; Carson, J. (2016a).</b> Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey.</p>	<p>To examine self-compassion, self-kindness, self-judgement and their effects upon compassion for others, well-being, compassion fatigue, and burnout in student midwives.</p>	<p>This study suggests that concerns regarding the well-being of some student midwives are warranted. Students who scored high on self-judgement had lower levels of compassion for self and others and reported higher levels of burnout and compassion fatigue.</p> <p>As a result of this study, a training programme was designed aimed at helping student midwives develop self-compassion and empathy for their own suffering.</p>	<p>Examine relationships between self-compassion, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout <b>(Objective 3).</b></p>
<p><b>Paper 5: Beaumont, E., Durkin, M., Hollins-Martin, C. J., &amp; Carson, J. (2016b).</b> Measuring relationships between self-compassion, compassion fatigue, burnout, and well-being in student counsellors and student cognitive behavioural psychotherapists.</p>	<p>To examine the relationships between self-compassion, well-being, compassion fatigue and burnout in student counsellors and student cognitive behavioural psychotherapists.</p>	<p>This study provides preliminary evidence to suggest that students who report higher levels of self-compassion and well-being also report fewer symptoms of burnout and compassion fatigue. Higher self-judgement scores were correlated with symptoms of compassion fatigue and burnout.</p> <p>Students who bear witness to trauma may benefit from utilising intervention strategies whilst on clinical</p>	<p>Examine relationships between self-compassion, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout <b>(Objective 3).</b></p>

		training to help them cultivate self-compassion.	
<p><b>Paper 6: Durkin, M., Beaumont, E., Hollins-Martin, C. J., &amp; Carson, J. (2016).</b> A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life, and wellbeing among UK community nurses.</p>	To measure associations between self-compassion, compassion fatigue, well-being, and burnout in UK community nurses.	<p>The first study to examine relationships between self-compassion, compassion satisfaction, compassion fatigue, burnout, compassion for others, and well-being in UK community nurses.</p> <p>Building student nurses' resilience and self-compassion through teaching CMT could have profound benefits in terms of reducing stress and trauma-related symptoms.</p>	Examine relationships between self-compassion, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout <b>(Objective 3)</b> .
<p><b>Paper 7: Beaumont, E., Irons, C., Rayner, G., &amp; Dagnall, N. (2016).</b> Compassion Focused Therapy Training for Healthcare Educators and Providers: Does this increase self-compassion, and reduce self-persecution and self-criticism?</p>	To investigate the outcome on healthcare educators and practitioners level of self-critical judgement, self-compassion and self-persecution pre, and post CFT training.	<p>This is the first study to examine the impact compassion training had on healthcare practitioners and educators. Overall results suggest that self-compassion levels increased and self-critical judgement levels reduced post training.</p> <p>The paper also suggests that there are some concerns regarding healthcare educators and practitioners levels of self-compassion and self-critical judgement.</p>	Examine the effectiveness and impact of CFT/CMT <b>(Objective 1)</b> .
<p><b>Paper 8: Beaumont, E., &amp; Hollins Martin, C. J. (2016).</b> A proposal to support student therapists to develop compassion for self and others through Compassionate Mind Training.</p>	To present a 6-step education strategy that aims to teach student therapists about CMT. The training programme has the potential to increase compassion levels and to reduce self-critical judgement.	<p>This paper presents a 6-step creative education strategy that can be included into therapist training programmes.</p> <p>The Compassionate Mind Training Model for Healthcare Practitioners and Educators is presented offering interventions which aim to cultivate compassion.</p>	Develop and test an educational model to help individuals training for a career in the helping professions, cultivate self-compassion and reduce

			self-critical judgement <b>(Objective 4).</b>
<p><b>Paper 9:</b> <b>Beaumont, E., &amp; Hollins Martin, C. J. (2016).</b> Heightening levels of compassion towards self and others through use of Compassionate Mind Training.</p>	<p>To outline an education strategy for student midwives that has the potential to impact upon the levels of compassion that the individual can show both to themselves and to others in times of suffering.</p>	<p>Midwives bear witness to the traumas of others, which makes considering an intervention that aims to cultivate compassion important.</p> <p>This paper offers an education strategy that has potential to help student midwives who may experience symptoms of secondary trauma, self-criticism, or low levels of self-compassion whilst training.</p>	<p>Develop and test an educational model to help individuals training for a career in the helping professions, cultivate self-compassion and reduce self-critical judgement <b>(Objective 4).</b></p>
<p><b>Paper 10:</b> <b>Beaumont, E., Rayner, G., Durkin, M., &amp; Bowling, G. (in press).</b> The effects of Compassionate Mind Training (CMT) on student psychotherapists.</p>	<p>To examine the impact CMT has on students enrolled on a Cognitive Behavioural Psychotherapy programme.</p> <p>To explore whether CMT increases levels of self-compassion, compassion for others and dispositional empathy.</p>	<p>The findings from this preliminary study suggest the potential benefits of training students in compassion focused practices.</p> <p>Incorporating CMT into practitioner training instigated significant changes in students' levels of self-compassion and self-critical judgement.</p>	<p>Examine the effectiveness and impact of CFT/CMT <b>(Objective 1).</b></p> <p>Develop and test an educational model to help individuals training for a career in the helping professions, cultivate self-compassion and reduce self-critical judgement <b>(Objective 4).</b></p>

## Summary of Section Two

In this section, the rationale for the work has been outlined, the aims and objectives of this body of works identified and the Portfolio of Published Works

presented. In the subsequent section, a critique of the presented papers will be offered.

## **Section Three: Critique of the presented publications**

### **Section overview**

In this section, a critique of the papers is presented and the thesis objectives examined.

The first two studies (**Beaumont & Hollins Martin, 2015; Beaumont, Durkin, McAndrew & Martin, 2016**), use quantitative analysis to examine the impact CFT/CMT has on individuals in clinical populations (Objective 1), whilst paper three (**Beaumont, Hickey et al., 2016**), uses a narrative case study approach to examine the impact counselling had on service users (Objective 2). Papers four, five and six (**Beaumont, Durkin, Hollins Martin & Carson, 2016a & 2016b; Durkin, Beaumont, Hollins Martin & Carson, 2016**), examine the relationships between self-compassion, self-kindness, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout (Objective 3). Paper seven (**Beaumont, Irons et al., 2016**) examines the effectiveness of CFT using a sample of healthcare educators (Objective 1), and papers eight, nine and ten (**Beaumont & Hollins Martin, 2016a, 2016b; Beaumont et al., in press**), develop and test an educational model, which has potential to help individuals training for a career in the helping professions cultivate self-compassion (Objectives 1 and 4). The papers can be found in Appendix 1.

**Paper 1: Beaumont, E., & Hollins Martin, C.J. (2015). How effective is Compassion-Focused Therapy (CFT)?** *Counselling Psychology Review*, Vol. 30(1), 21-32.

### **Study overview**

This narrative review summarises findings of research that has shown successful use of CFT/CMT to improve psychological outcomes in clinical populations. Twelve studies were identified which report post-therapy data for participants in group therapy and individual therapy. The review contributes to knowledge by appraising the current state of play regarding CFT/CMT, which is useful when developing a theoretical framework (Kirkevold, 1997).

### **Contribution and critique of the Beaumont and Hollins Martin (2015) study**

**Beaumont & Hollins Martin (2015)** provides an overview of the development of CFT/CMT and both analyses and summarises a variety of studies, thereby offering a value that no single study alone can do. Healthcare professionals and educators are required to keep up to date with policies and practices in their field (Baumeister & Leary, 1997; Corrie, Hurton & Lane, 2008). Therefore this narrative review plays a key role in continuing professional development because it offers a summary of prior research, which can be used as a resource by practitioners and educators.

Although compiling and writing reviews is time-consuming for researchers (Manchikanti, 2008), they do enable learning, play a valuable role in education, and are time efficient for readers, quite simply because they provide a synopsis of what has happened to date regarding the topic of interest (Badget, O'Keefe, & Henderson, 1997). The **Beaumont and Hollins Martin (2015)** review provides a trustworthy story, through aiming to identify

and critically analyse current research. The review has been used to inform psychotherapy students and the therapeutic community about CFT/CMT and the impact it has had to date in clinical settings (Objective 1).

A review was needed on the topic of CFT and CMT to identify gaps in knowledge and to detect areas that have the potential for further research. For example, this review raises questions about what elements of CFT/CMT are most effective, what are the best measures to use in CFT/CMT, and how effective is CFT/CMT when used as a standalone therapy. This review addressed a gap in the literature by providing a broad picture regarding CFT/CMT to date and led to scholarly debate because the findings were presented at a conference, and in learning environments where critical discussion is encouraged.

**Beaumont and Hollins Martin (2015)** did not use a 'risk of bias tool' to assess potential issues surrounding bias. Failings in the design and analysis of studies can result in an intervention being either overestimated or underestimated. For example, the Cochrane Collaboration's tool for assessing bias (Higgins et al., 2011) could have been used to assess issues surrounding selection bias and reporting bias. This would be recommended for future reviews.

**Paper 2: Beaumont, E., Durkin, M., McAndrew, S., & Martin, C. (2016)**  
Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel suffering with trauma-related symptoms. *Cognitive Behaviour Therapist* vol. 9. doi:10.1017/S1754470X16000209

### **Study overview**

This pre-post outcome study, examines therapeutic interventions for two groups of FSP who as a result of experiencing primary trauma or secondary trauma, reported symptoms of trauma, low mood, anxiety and low levels of self-compassion. One group of FSP received Trauma-Focused Cognitive Behaviour Therapy (TF-CBT) and the second group received TF-CBT, which included CFT. This pilot study makes a unique contribution to knowledge by examining the impact CFT has when used as a therapeutic intervention for FSP. The paper debates whether using CFT as an adjunct to TF-CBT to cultivate self-compassion, can enhance the use of TF-CBT for FSP.

### **Contribution and critique of the Beaumont, Durkin, McAndrew and Martin (2016) study**

This study contributes to the body of trauma knowledge by introducing academics and researchers to issues surrounding FSP, who as a result of their job may experience trauma symptoms, low levels of self-compassion and experience negative emotions such as shame and guilt. The study examines the impact CFT has on FSP (Objective 1) and provides preliminary evidence to suggest that FSP may benefit from therapeutic interventions aimed at cultivating self-compassion.

Emotions, such as shame, guilt, and disgust may occur in addition to fear in trauma populations, which can inhibit recovery, if the individual feels no compassion for themselves (Balcom et al., 2000). This is important because

cultivating compassion for one's own suffering may be achieved by incorporating interventions into psychotherapy, which activate the soothing/affiliative and safeness system.

This is the first study to examine the impact of incorporating CFT into a TF-CBT programme using a sample of FSP. There is a growing body of evidence within the therapeutic community, which suggests that developing feelings of compassion can aid mental well-being. Learning to self-soothe in response to threat, shame and self-critical judgement may help FSP who bear witness to suffering. Using CFT as an adjunct to TF-CBT may therefore enhance the use of CBT for FSP.

Whilst this paper opens this discussion and provides some preliminary evidence to suggest that FSP may benefit from therapeutic interventions aimed at cultivating self-compassion, there are limitations to consider. Participants were allocated to a therapy group depending on the type of trauma they experienced, as opposed to being allocated after baseline scores were collected. Flaws of this nature can be an issue in research (Clark & Mulligan, 2011; McLeod, 2011). However, proof of concept was demonstrated in principle and the authors propose that a full-scale adequately powered and with sufficient sample size Randomised Control Trial be carried out, to address the limitations inherent in this preliminary investigation.

A further consideration is that a positive therapeutic outcome may have occurred as a result of the therapeutic alliance. One psychotherapist administered the treatment interventions in both groups, and whilst this was sufficient for this preliminary study, the therapeutic relationship could have

been a contributing factor that instigated change scores on the psychometric scales.

Consideration also needs to be given to potential 'dosage' issues. For example, participants in the combined group received a different dose of TF-CBT in comparison to the TF-CBT only group. A possible solution is that a uniform structure of therapy be delivered by a variety of psychotherapists, which can achieve high implementation fidelity.

**Paper 3: Beaumont, E., Hickey, A., McAndrew, S., Goldman, S., & Warne, T. (2016).** Minding the gaps: Using narrative accounts to explore people's experiences of using North Staffs MIND's Adult Counselling Service. *Journal of Counselling and Psychotherapy Research*, 16(4), 298-306.

### **Study overview**

This study reports on a narrative case study research project, which aimed to examine the impact counselling and psychotherapy had on the lives of service users who attended MIND, which is a voluntary service. Themes were identified, with one theme 'love is in the air', promoting the idea, that being in receipt of compassion may increase levels of altruistic behaviour, and compassion for other peoples' suffering. This is relevant within this body of published works, because it examines the impact that counselling and psychotherapy has on service users who feel they have received compassionate care (Objective 2). **Beaumont, Hickey et al. (2016)**, propose that being in receipt of compassion from others increases service users ability to provide support to other people and may help them to develop a sensitivity to suffering, which augments the work of Gilbert (2009; 2010). Three participants commented:

*"Her involvement made me want to do something, made me want to give something back and consequently now I do various tasks, voluntarily, trying to sustain this service for other people"* (Brian).

*"Because she helped me so much, it makes me think that I want to do that for other people"* (Melanie)

*"I thought this company have offered me this woman. She has given her time up to see me and they have opened the door to me.....I'm still here now, I do raffles and raise money for them"* (Sandra)

Participants also spoke about their experiences of the organisation with one participant reporting:

*“There’s just something brilliant about this place. The whole place is just, it’s a nice place to be when you’re fighting a big battle. You can be a lot more vulnerable than you think, and this place, I truly believe it saved my life” (Jack).*

The quotations from Brian, Melanie, Sandra, and Jack have resonance with elements of CFT, demonstrate the flow of compassion, and highlight the importance of compassion in organisations.

### **Contribution and critique of the Beaumont, Hickey et al. (2016) study**

The service user movement is viewed by many as being the way forward in helping to develop a contemporary agenda within healthcare (Chambers & Hickey, 2012). The literature, however, indicates that there are still gaps in which the client's view of voluntary services needs to be heard (Duncan & Miller, 2000; Lambert, 2007; **McAndrew, Hickey & Beaumont, 2015**).

In light of this assertion, this study contributes to existing knowledge by providing a narrative case study regarding service user experiences of a voluntary mental health service. Post-therapy, some service users reported an increase in altruistic behaviour, thus demonstrating the notion of compassion as a flow. That is, some participants reported the desire to return as volunteers to the charity, which exhibits character traits of humanity and compassion.

Narrative case studies can help inform practitioners and policymakers and can be empowering for service users. In the current climate, examining how service users feel when they have experienced compassionate care is important, especially when there are debates regarding the deficits, blocks, and lack of compassion in healthcare settings (**Beaumont, Irons et al., 2016**; Care Quality Commission, 2011; Crawford et al., 2014). By highlighting good

practice based on service user evidence, leaders within organisations such as the NHS, the voluntary sector, and education, can learn to create the conditions needed for healing to flourish (Crawford et al., 2014; Harris, 2007).

From the evidence collected in this study, it appears that therapeutic interventions were tailor-made to meet the person's needs using a pluralistic approach, rather than a particular model of therapy. Whilst tailoring therapy to meet the needs of the individual could be viewed as a strength of the research (McLeod, 2011), this study does not report findings regarding the specific treatment interventions used in therapy. It is therefore difficult to ascertain which interventions aided recovery. For example, the counsellors and psychotherapists could have used cognitive restructuring, behavioural activation, Socratic questioning or compassion focused interventions. Further research examining the process of therapeutic change is warranted.

**Paper 4: Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J. (2016a)** Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery*, 34, 239-244.

### **Study overview**

**Beaumont et al. (2016a)** was the first study to measure relationships between compassion for others, self-compassion, self-kindness, self-judgement, professional quality of life, well-being, burnout, and compassion fatigue (Objective 3), in a sample of midwifery students.

Student midwives who reported high levels of self-compassion and well-being reported fewer symptoms of compassion fatigue and burnout. This study addresses the significant gap in the literature noted in sections one and two, with results promoting the idea that there could be some concerns about student burnout, self-judgement, self-compassion, and symptoms of compassion fatigue in this participant group. For example, just over half of the sample reported above average scores for burnout. This is important considering that in a recent NHS survey (2014), out of 203,000 staff who participated, almost forty percent reported suffering from stress related issues, which significantly impacted on their well-being.

### **Contribution and critique of the Beaumont et al. (2016a) study**

**Beaumont et al. (2016a)** is a salient paper because the results indicate that student midwives who reported higher scores on the self-judgement sub-scale also reported lower levels of self-compassion, compassion for others and higher levels of burnout and compassion fatigue. This paper makes a noteworthy impact within the field of midwifery, because it led to discussions about how we can best prepare student midwives for the demands of

midwifery practice (**Beaumont & Hollins Martin, 2016b**). Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski and Smith-MacDonald (2017) cite **Beaumont et al. (2016a)** in their meta-narrative review suggesting that this paper is a seminal paper that makes a core contribution to the literature on compassion fatigue.

Whilst compassion can be viewed as a virtue and is extremely beneficial to those in need, paradoxically, if compassion is not given to oneself in times of suffering, this can impact negatively on well-being (Figely, 1995; Michalec, Diefenbeck, & Mahoney, 2013; Yang, Hargreaves & Bostrom, 2014). This paper suggests that developing, creating, and cultivating environments that foster compassionate care for one's self and others, may play a significant role in helping trainee midwives cope with the stressors of the job and their education programme. This view is supported by the Nursing and Midwifery Council (NMC, 2015), who suggest that an important component of healthcare provision is to cultivate environments that nurture compassionate care.

**Beaumont et al. (2016a)** has been referenced in midwifery and nursing literature in excess of 14 times to date (24<sup>th</sup> February 2017), by researchers who endorse the view that student midwives be introduced to interventions whilst training, which aim to help them manage work-related distress and that they be given education regarding the symptoms of compassion fatigue and burnout. Incorporating exercises into midwifery training programmes, which focus on self-care, could help students respond to self-judgement with compassion and arm them with the knowledge needed so that they are able to recognise ill health in themselves and colleagues. This

is important because recent research suggests that some midwives do not feel supported at work and report that they have experienced shame and fear when disclosing psychological distress to colleagues (Pezaro, 2016; Young, Smythe & Couper, 2015). **Beaumont et al. (2016a)** suggest that CMT may help furnish student midwives with strategies, which help them respond to their own suffering with self-compassion when faced with workplace stressors and traumas.

In response to **Beaumont et al. (2016a)**, the development of the Compassionate Mind Training Model for Healthcare Practitioners and Educators' (**Beaumont, 2016; Beaumont & Hollins Martin, 2016a; 2016b**), was devised. This education strategy will be incorporated into practitioner training to help students prepare for the emotional demands of clinical practice (Objective 4).

**Beaumont et al. (2016a)** addresses a potential gap in the literature, suggesting that incorporating CMT into a midwifery training programme, could help prepare students for the demands of practice and education. However, further research is needed to explore 'why' students felt the way they did. For example, unhealthy relationships or behaviours conducted inside or outside of the academic or workplace setting could have increased student's vulnerability to stress related symptoms. Furthermore, whilst the sample size (n=103) in **Beaumont et al. (2016a)** was suitable for the purpose of a feasibility study, further studies may be needed to validate these findings through increasing participant numbers. The authors suggest that this can be achieved by collaborating with agencies across the UK.

**Paper 5: Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J. (2016b).** Measuring relationships between self-compassion, compassion fatigue, burnout, and well-being in student counsellors and student cognitive behavioural psychotherapists. *Journal of Counselling and Psychotherapy Research*, 16(1), 15-23.

### **Study overview**

**Beaumont et al (2016b)** was the first study to measure associations between self-compassion, compassion fatigue, well-being, and burnout in student counsellors and student cognitive behavioural psychotherapists (Objective 3). The findings indicate a statistically significant positive relationship between self-kindness, self-compassion, and increased well-being. Conversely, self-judgement was associated with a self-reported increase in symptoms associated with compassion fatigue and burnout and low levels of well-being.

**Beaumont et al. (2016b)** propose that student therapists may benefit from using interventions aimed at cultivating compassion and suggest that CMT be adapted, and incorporated into a practitioner training programme and its effectiveness measured using multiple research methods.

### **Contribution and critique of the Beaumont et al. (2016b) study**

This study has initiated discussions regarding the importance of practitioner self-care and the implications of caring for others, but not 'practising what you preach'. Although the findings from **Beaumont et al. (2016b)** indicate relationships between variables, they do not demonstrate cause and effect. However, the aim of the research was to examine whether associations between the variables existed. As a result of the correlations found in this study, an education model was designed (**Beaumont, 2016; Beaumont & Hollins Martin, 2016a**) that can be incorporated into psychotherapy training. The intervention was tested by collecting pre and post CMT data (**Beaumont**

**et al., in press)** to examine if the training increased levels of compassion and reduced self-critical judgement (Objective 4), thus addressing a gap in the literature.

**Beaumont et al. (2016b)** made an impact within the counselling and psychotherapy community. For example, as a result of this paper, the researcher has been invited to provide a variety of workshops on the topic of trauma, stress, burnout, and compassion, for counselling and psychotherapy practitioners. Results were presented at a conference, and the author is consulting with staff within Greater Manchester Fire and Rescue Service and Greater Manchester Police, to discuss how best we can serve trainees in their organisations who may experience trauma-related symptoms.

**Paper 6: Durkin, M., Beaumont, E., Hollins-Martin, C. J., & Carson, J. (2016).** A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life, and well-being among UK community nurses. *Nurse Education Today*, 46, 119-114.

### **Study overview**

**Durkin et al. (2016)** explored the relationships between self-compassion, self-judgement, self-kindness, compassion for others, professional quality of life and well-being in a sample of community nurses (Objective 3). A cross sectional sample of registered adult community nurses (n=37) studying for a postgraduate diploma took part in this study. The paper suggests there may be concerns with the well-being of some of the nurses in the sample. Nurses in the sample who judged themselves harshly reported that this affected their emotional well-being, self-compassion levels, and compassion for others.

### **Contribution and critique of the Durkin et al. (2016) study**

This pilot study has initiated discussions within the wider community regarding the importance of practitioner self-care and argues that even moderate levels of self-compassion may be linked to reduced levels of burnout. As a result of this paper, the research team have been asked to disseminate the findings to healthcare educators in the North West and provide workshops to nursing students.

**Durkin et al. (2016)** propose that student nurses may benefit from being introduced to interventions that cultivate self-compassion. The findings merit further investigation, because the paper adds to the growing body of literature that considers self-compassion to be a healthy attribute for nurses to develop (Cornwell, Donaldson & Smith, 2014). Incorporating CMT into training

is one potential solution, which could help student nurses sustain levels of compassion for both self and others (Objective 4).

This paper initiates a debate that community nurses may benefit from cultivating compassion and that compassion for others may be linked to compassion satisfaction. This is important when we consider relating the findings to a wider audience. For example, further evidence suggests that concerns over the well-being of nursing and midwifery staff exists in the UK. In a recent survey of NHS staff (NHS, 2014) almost forty percent reported having experienced job related stress.

The small sample size (n=37) makes it difficult to generalise findings to other areas of the UK, and to allied nursing specialists. Nevertheless, the purpose of this pilot study was to investigate whether there is a potential need to equip student community nurses with interventions that aim to cultivate compassion. Hence, further research, which investigates whether CMT can be incorporated into training to help students in their quest to become a community nurse, was recommended.

**Paper 7: Beaumont, E., Irons, C., Rayner, G., & Dagnall, N. (2016).** Compassion Focused Therapy Training for Healthcare Educators and Providers: Does this increase self-compassion, and reduce self-persecution and self-criticism? *Journal of Continuing Education in the Health Professions*, 36(1), 4-10.

### **Study overview**

**Beaumont, Irons et al. (2016)** was the first study that measured whether a three day workshop on CFT/CMT would instigate changes in levels of self-compassion, self-critical judgement, self-persecution and self-correction, in a sample of healthcare providers and educators. This is an important area of work, because earlier studies have found that practising compassion can lead to higher levels of compassion for others, sensitivity to suffering, motivation to help, and altruism (Breines & Chen, 2012; Condon, Desbordes, Miller & DeSteno, 2013; Wallmark, Safarzadeh, Daukantaitė & Maddux, 2013). The potential benefit of training healthcare practitioners in compassion focused practices is evidenced in this paper (Objective 1). In order to explore the impact compassion training had on healthcare educators and providers, a pre and post-training design was used.

### **Contribution and critique of the Beaumont, Irons et al. (2016) study**

This study was the first of its kind to focus on exploring the impact CFT had on healthcare educators and providers' levels of self-compassion, self-persecution, and self-critical judgement. The study recognises that CFT/CMT may be of benefit to healthcare practitioners. Recently researchers have examined factors that have a negative impact and can block compassionate care. For example, workload, time demands, staff absences, symptoms of burnout, stress and compassion fatigue, have been found to impact negatively

on the provision of compassionate care (Crawford et al., 2014; Figley, 2002; Francis, 2010). This unique study identified a shortage of published literature that has examined how healthcare professionals can be helped to cultivate and maintain compassion.

A limitation of this study is that quantitative data was not collected to measure levels of compassion for others. For example, the Compassion for Others Scale (Pommier, 2011), could have been used to collect pre and post data. However a pragmatic approach was taken, whereby qualitative data was collected via a focus group post-training (this paper is currently under review), to examine the impact the training had on compassion levels.

Future research, measuring compassion levels over a longitudinal period, using larger sample sizes, a control group and where training is off campus is warranted, to examine whether CFT/CMT can help educators and practitioners sustain levels of compassion. This is important especially as emerging research suggests that the cultivation of self-compassion may improve levels of compassion shown to others (Gustin & Wagner, 2013; Heffernan, Quinn-Griffin, McNulty & Fitzpatrick, 2010).

The results from **Beaumont, Irons et al. (2016)** suggest that self-compassion increased and self-critical judgement reduced post-training, however, there were no statistical significant differences in self-correction and self-persecution scores post-training. This may suggest that a 3-day training programme that aims to teach interventions that cultivate compassion is not enough to instigate statistically significant changes in self-persecution and self-correction scores. The findings also suggest that there may be inter-professional differences between healthcare groups. For example, self-

persecution scores increased post-training in the nurses and midwives group. This is potentially important because it suggests that for some participants, practising exercises, which aim to cultivate compassion, may bring them into contact with self-criticism and distress in the short term. Post-training scores may have increased because participants started to become more aware of something that pre-training they were disconnected from.

Results of this preliminary study suggest the potential benefits of training healthcare educators and potentially healthcare students in compassion-based approaches (Objective 4). The findings also indicate differences in self-reported levels of self-critical judgement, self-persecution, self-correction, and self-compassion amongst this sample of healthcare educators. This may link to differences in professional training, the nature of professionals' work related stress, or differences in the level of support received from colleagues, managers, supervisors or peers. Future studies, using a larger sample size could explore these findings in detail, and if replicated, investigate what might account for these differences.

**Paper 8: Beaumont, E., & Hollins Martin, C., J. (2016a).** A proposal to support student therapists to develop compassion for self and others through Compassionate Mind Training. *The Arts in Psychotherapy*, 50, 111-118.

### **Study overview**

As a result of the findings from the earlier studies, **Beaumont and Hollins Martin (2016a)** offer an outline of an intervention strategy for student counsellors and student psychotherapists, which incorporate compassion-based interventions into an education programme (Objective 4). **Beaumont and Hollins Martin (2016a)** offers a unique contribution because it is the first published paper which aims to adapt and use an intervention that has been found helpful in clinical populations, with student therapists. Organisational, academic, placement, supervision, and personal demands can impact on student well-being (Reeves, 2012). **Beaumont and Hollins Martin (2016a)** offer a creative training programme that has potential to help student therapists face such demands. Additionally, the paper discusses issues surrounding job related-stress, burnout, empathic distress fatigue (Klimecki & Singer, 2012) and compassion fatigue, all of which can result from witnessing the trauma stories of others (Figey, 2002). Given that the curricula for counselling and psychotherapy training programmes are demanding, this is pertinent. However, practising interventions aimed at enhancing practitioner levels of self-care may be time consuming and therefore may not be seen as a priority by educators or practitioners (Christopher, Christopher, Dunnagan & Schure, 2006). This view is echoed by Sapienza and Bugental (2000) who state:

*“Many of us have never really learned how to take the time to care and to nourish ourselves having been trained to believe this would be selfish or that there is no time for this when there is so much else to*

*handle. Nor have most psychologists taken the time to develop compassion for themselves, and compassion for their own wounds” (p.459).*

**Beaumont and Hollins Martin (2016a)** recognise that there may be a potential gap in some psychotherapy/counselling training programmes, where ‘practising what you preach’ by ‘being kinder to oneself’ may take a back seat in the minds of students. This paper outlines an education strategy, which has potential to help students take care of themselves, which in turn may help them as they strive to provide better care for their clients.

### **Contribution and critique of the Beaumont and Hollins Martin (2016a) study**

Therapist self-practice and self-reflection is essential (Bell et al., 2016; Bennett-Levy, Thwaites, Haarhoff & Perry, 2015), given the distinctive demands faced by student therapists (**Beaumont, 2016**). To date no research study exists that examine whether incorporating CMT into psychotherapy training, enhances self-care, increases levels of compassion, and reduces self-critical judgement.

**Beaumont and Hollins Martin (2016a)** put forward a framework, to adapt CMT and introduce it into therapist training as a potential means of increasing compassion for self and others. This paper coincides with the publication of a study by Bell et al. (2016), who adapted a CFT intervention to examine whether introducing CBT students to the notion of an ‘internal supervisor,’ supports them on their CBT journey. A similar concept was used by **Beaumont et al. (in press)**, although the term ‘internal compassionate CBT coach’ was used. The findings from **Beaumont et al. (in press)** and Bell et al. (2016) suggest that using an ‘internal supervisor/internal compassionate

CBT coach' helped students reflect on their training, personal life and client work. This augments the work of **Beaumont and Hollins Martin (2016a)** who suggest that incorporating interventions aimed at cultivating compassion into training, has the potential to fill a gap in counselling and psychotherapy training programmes where, personal therapy is not a requirement of the course. One could also argue that increasing levels of self-compassion could reduce self-critical judgement and help student therapists, who are enrolled on training courses, where personal therapy and experiential learning is a requirement of the course.

The strength of this paper is that it explores a variety of issues that have potential to impact negatively on student therapists. For example, working with suicidal clients can present students with professional challenges (Reeves, et al., 2004). **Beaumont and Hollins Martin (2016a)** discuss the idiosyncratic demands that are unique to students aiming for a career in the caring professions, and present a creative intervention strategy that has potential to enrich student experience, increase well-being, and importantly address a gap in the literature. Patsiopoulos and Buchanan (2011) asked counsellors in their study *“what’s so important about having self-compassion?”* One participant replied *“three words: avoidance of burnout”* (p.305). **Beaumont and Hollins Martin (2016a)** address this need by proposing that CMT be incorporated into a training programme to examine if it enhances levels of self-compassion, compassion for others and reduces self-critical judgement (Objective 4).

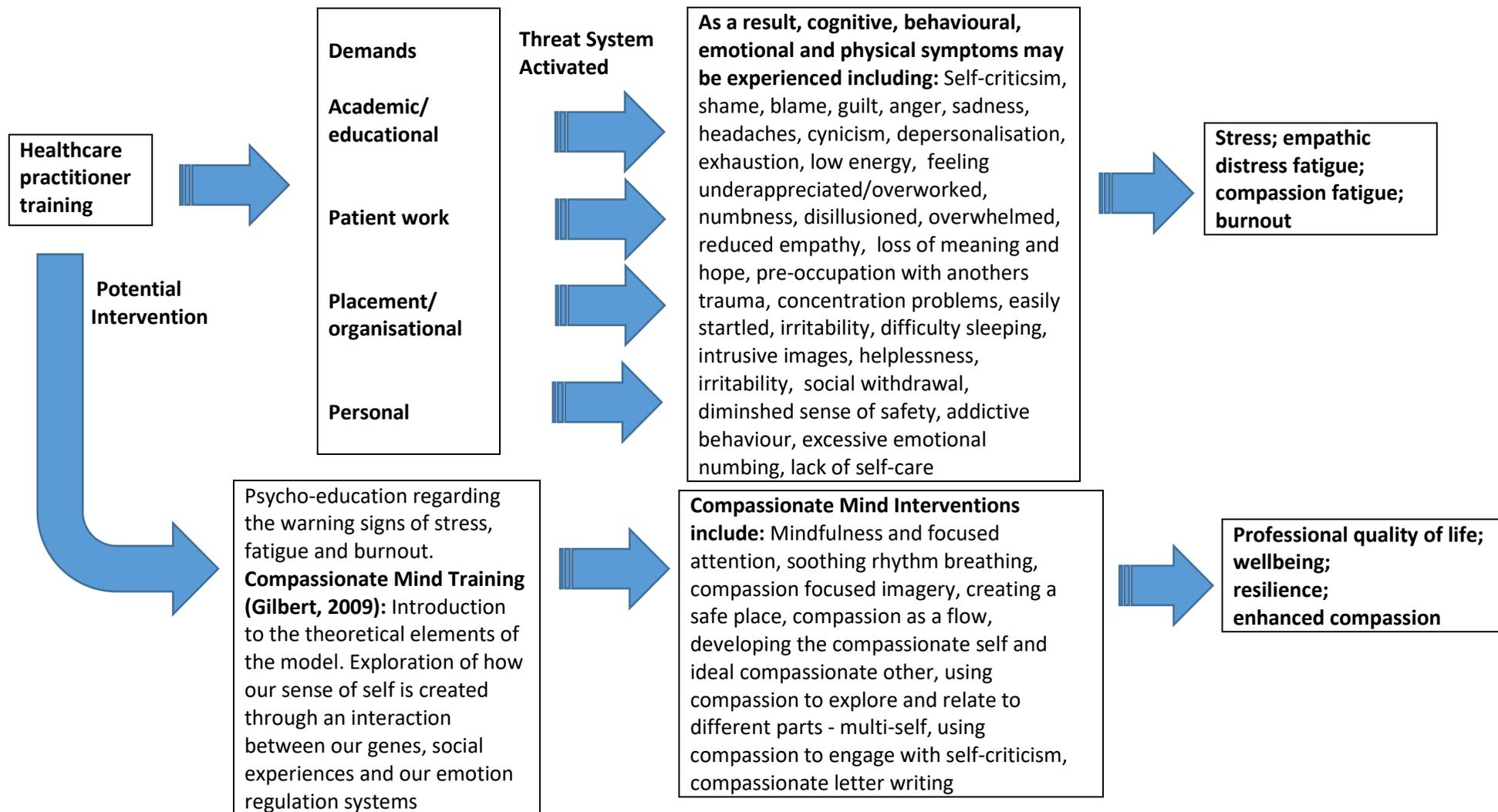
It could be argued that introducing CMT interventions into existing teaching curricula would be difficult, especially as the aim of counselling and

psychotherapy programmes is to equip student practitioners with the competencies needed to become an effective therapist. Nonetheless, therapist self-care and cultivating compassion for one's own suffering could be viewed as a competency of being an effective therapist. This is important quite simply, because it may enhance the therapeutic relationship, encourage self-practice and self-reflection, provide students with an understanding of the process of therapy and enrich student knowledge regarding therapeutic interventions (**Beaumont, 2016**; Bennet-Levy et al., 2015).

**Beaumont and Hollins Martin (2016a)** offer an overview of how academic, patient, organisational, and personal demands can influence practitioners. Discussed within are the detrimental effects that stress, compassion fatigue and burnout can have on therapists, and whether compassion can be taught to negate the deleterious impact of self-criticism. *Figure 2* (reprinted with kind permission from Healthcare Counselling and Psychotherapy Journal), presents The Compassionate Mind Training Model for Healthcare Practitioners and Educators.

**Beaumont and Hollins Martin (2016a)** offer a six-step framework, which can be incorporated into counselling and psychotherapy training programmes. Worksheets, including guided meditations and experiential exercises that have been created and designed for '*The Compassionate Mind Workbook*' (**Irons & Beaumont, 2017**) can be incorporated into the education strategy (Appendix 6 lists the contents of the workbook).

**Figure 2:** Compassionate Mind Training Model for Healthcare Practitioners and Educators (*Beaumont, 2016*).



**Paper 9: Beaumont, E., & Hollins Martin C., J. (2016b).** Heightening levels of compassion toward self and others through use of Compassionate Mind Training. *British Journal of Midwifery*, 24(11), p3-12.

### **Study overview**

**Beaumont and Hollins Martin (2016b)** propose an education strategy for student midwives, which has the potential to have a positive impact upon compassion levels (Objective 4). This paper is similar to **Beaumont and Hollins Martin (2016a)** but focuses on a training programme for student midwives, which is part of this research strategy and thesis journey.

Stress experienced from continual exposure to traumatic events may lead to emotional difficulties and a reduction in compassion. Introducing student midwives to interventions, which aim to promote compassion has potential to help furnish midwifery students with strategies that may help them respond to self-critical judgement using a compassionate mind.

### **Contribution and critique of the Beaumont and Hollins Martin (2016b) study**

Klimecki and Singer (2012) propose that compassion fatigue/empathic distress fatigue may be prevented by using exercises that stimulate the neural pathways linked with compassion, empathic concern, positive feelings, and altruistic behaviour. Therefore, examining interventions that aim to promote self-care and cultivate self-compassion warrants consideration. *Table 4* outlines the CMT implementation strategy, which is discussed in the **Beaumont and Hollins Martin (2016b)** paper.

The Nursing and Midwifery Council (NMC) recognises the importance of working in environments that foster compassionate care (NMC, 2015),

which makes considering an intervention that develops compassion relevant. In place of blaming individuals for their lack of compassionate care, instead **Beaumont and Hollins Martin (2016b)** propose that CMT has potential to help student midwives cultivate compassion and build resilience. In the current climate, it is timely and appropriate for educators to explore concepts of compassion in greater depth. This paper discusses a variety of topics relevant to midwifery education, including organisational, academic and placement demands, which are important concepts for midwifery educators to consider. It should be noted that organisational issues, such as workplace bullying and shift work could also impact negatively on student midwives. These factors can make introducing CMT into midwifery education programmes complex. In response and to identify related factors, **Beaumont and Hollins Martin (2016b)** suggest that training could be conducted using a pilot study and its effectiveness measured using a multiple method research design. It is judicious and appropriate for midwifery educators to examine whether CMT can help student midwives cultivate compassion.

**Table 4:** Compassionate Mind Training Implementation Strategy for Student Midwives

Session number	Outline of the additions to the programme based on Gilbert's (2009, 2014) model
<p>1. Psycho-education: Key elements of CMT</p> <p><i>Introduced in year 1 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ A variety of definitions of compassion will be explored</li> <li>▪ Students will be introduced to the core theoretical elements of the CMT model</li> <li>▪ Students will be introduction to the 3 circles model (threat, drive and soothing)</li> <li>▪ Discussion regarding 'our tricky brain'. E.g., we are all prone to rumination and self-criticism</li> <li>▪ Students will be introduced to the two psychologies of compassion</li> </ul>
<p>2. Psycho-education &amp; developing the compassionate self</p> <p><i>Introduced in year 1 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ Discussions regarding bearing witness to trauma, self-care and the symptoms associated with stress/burnout/empathic distress fatigue/compassion fatigue will take place</li> <li>▪ Students will be introduced to exercises that aim to develop the compassionate self by recalling memories of times when they have offered compassion to others and received compassion from others</li> </ul>
<p>3. Formulation: Understanding yourself</p> <p><i>Introduced in year 2 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ Discussions regarding how our life history and early experiences shape who we are</li> <li>▪ Students will reflect on the potential strategies that they have used to protect themselves as a result of their life experiences</li> <li>▪ Exploration regarding the qualities of compassion and an introduction to the fears, barriers and blocks to compassion will take place</li> </ul>
<p>4. Cultivating and building compassionate capacities</p> <p><i>Introduced in year 2 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ Students will be introduced to Mindfulness and Focused Attention</li> <li>▪ Students will be introduced to SRB and safe place exercises</li> <li>▪ Imagery exercises will be used to stimulate the self-soothing system</li> <li>▪ Students will create an ideal compassionate self, compassionate other or compassionate team</li> <li>▪ Students will be introduced to exercises which demonstrate the 3 flows of compassion</li> </ul>
<p>5. Building compassionate capacity using behavioural practices</p> <p><i>Introduced in year 3 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ Discussions regarding how we can direct compassion to our 'inner critic' with a focus on behaviour change and internal dialogue will take place</li> <li>▪ Students will be introduced to the concept of method acting – 'experiencing their best compassionate self'</li> <li>▪ Students will practise compassionate assertiveness using role play scenarios</li> <li>▪ Experiencing acts of kindness - both for self and others</li> </ul>
<p>6. Using the compassionate mind to engage with difficulties</p> <p><i>Introduced in year 3 of the curriculum</i></p>	<ul style="list-style-type: none"> <li>▪ Students will be introduced to interventions (e.g., chair work) which engage the angry-self, sad-self and anxious-self</li> <li>▪ Students will examine and discuss ways of coping with potential setbacks</li> </ul>

**Paper 10: Beaumont, E., Rayner, G., Durkin, M & Bowling, G. (in press).**  
The effects of Compassionate Mind Training on student psychotherapists.  
Journal of Mental Health Training, Education and Practice.

### **Study overview**

**Beaumont et al. (in press)** examine whether CMT increases self-compassion, compassion for others and dispositional empathy and reduces self-critical judgement in a sample of student cognitive behavioural psychotherapists (CBP's) (Objectives 1 and 4).

A multiple method study was used whereby data was collected in two phases. The results from the quantitative analysis are reported in this paper and a second paper is currently under review, which examines the qualitative findings collected via a focus group post-training. Quantitative data were collected using the Self-Compassion Scale (Neff, 2003), Interpersonal Reactivity Index (IRI) (Davis, 1980) and the Compassion for Others Scale (Pommier, 2011).

A variety of interventions aimed at increasing levels of compassion and reducing self-critical judgement were used to examine the impact CMT had on students. For example, students were asked to reflect on the differences between self-critical language and self-compassionate language and were introduced to imagery techniques and compassionate letter writing. Students also used an 'internal compassionate CBT coach' to help them reflect on their training. *Table 5* offers an outline of some of the interventions used by

**Beaumont et al. (in press).**

Student counsellors and psychotherapists bear witness to the suffering of others and aim to help ease the emotional distress experienced by their clients/patients. In this context, self-care is imperative, especially as listening

to the trauma stories of others may lead to heightened levels of self-critical judgement. **Beaumont et al. (in press)** discuss potential supervision issues, for example, students who feel judged by their supervisors may experience a threat response, which leaves them feeling incompetent. This in turn may lead to non-disclosure during supervision, with student's fearfulness causing them to conceal their perceived inadequacies. **Beaumont et al. (in press)** suggests that CMT has potential to encourage self-acceptance, equip students with the tools needed to manage distress and help students cultivate compassion. Developing such skills may help students gain more value from supervision and psychotherapy training.

**Table 5:** Compassionate Mind Training additions to the Post Graduate Diploma in Cognitive Behavioural Psychotherapy

Training Overview	Compassionate Mind Training (based on Gilbert's 2009; 2014 model)
Psycho-education and the flow of compassion.	<ul style="list-style-type: none"> <li>▪ Definition of compassion</li> <li>▪ Student therapists were introduced to the core theoretical elements of Gilbert's (2009; 2014) theory</li> <li>▪ Students were introduced to the 3 circles model (threat, drive and soothing)</li> <li>▪ Discussions took place regarding 'our tricky brain'. E.g., we are all prone to rumination and self-criticism</li> <li>▪ Students were introduced to Mindfulness, SRB and the three flows of compassion</li> </ul>
Psycho-education. Trauma and self-care. Creating a compassionate self.	<ul style="list-style-type: none"> <li>▪ Discussions regarding self-care and the symptoms associated with stress/burnout/empathic distress fatigue/compassion fatigue took place</li> <li>▪ Students created a safe place – a place in the mind that produces affiliative feelings</li> <li>▪ Using memory and imagery to cultivate compassion. Students were introduced to the concept of method acting</li> <li>▪ The qualities of compassion were explored and discussions regarding fears and blocks to compassion took place</li> </ul>
Formulation. Developing the skills of compassion.	<ul style="list-style-type: none"> <li>▪ Students reflected on how early experiences impact upon how they view themselves</li> <li>▪ Timeline exercise – students offered compassion to the younger learner</li> <li>▪ Students were introduced to the skills of compassion and spent time writing compassionate letters - focusing on psychotherapy practice and learning on the programme</li> </ul>
Using compassion to engage with self-criticism.	<ul style="list-style-type: none"> <li>▪ Discussions took place regarding the functions of self-criticism. Self-correction vs self-persecution and the impact of shame</li> <li>▪ Students created an 'internal compassionate CBT coach' and used this to enhance compassionate thoughts in relation to psychotherapy practice and learning on the programme</li> </ul>
CFT within the therapeutic arena.	<ul style="list-style-type: none"> <li>▪ Discussions surrounding the potential benefits of using CFT as an adjunct to CBT took place</li> <li>▪ Research evidence surrounding CFT was examined</li> <li>▪ Students spent time reflecting on self-compassionate language vs self-critical - 'the bully within'</li> </ul>
Engaging with difficulties using a compassionate mind-set.	<ul style="list-style-type: none"> <li>▪ Challenges to compassion were examined (e.g., examining thoughts such as, "I'm not good enough to do CBT")</li> <li>▪ Discussions and exercises were used to examine how the compassionate mind can be used to engage with the angry-self, sad-self, critical-self and anxious-self</li> <li>▪ Students created cue cards with compassionate statements on and read the statements to a partner, mirror or camera phone</li> <li>▪ Reflecting compassionately on practice. Students used their 'internal compassionate CBT coach' to set homework tasks that aimed to increase self-compassion, self-practice and self-reflection</li> </ul>

### **Contribution and critique of the Beaumont et al. (in press) study**

**Beaumont et al. (in press)** addresses a gap in the literature with few studies having investigated how psychotherapists employ self-compassion (Patsiopoulou & Buchanan, 2011), and is unique because it is the first study to examine the impact CMT has on student psychotherapists.

Self-care is viewed as a critical component in the prevention of harm to clients and is an ethical imperative for psychological practitioners (Barnett et al., 2007).

**Beaumont et al. (in press)** adapted and incorporated CMT into practitioner training, thus encouraging student therapists to focus on self-care, self-acceptance and self-practice. This is important because Gilbert and Choden (2013) suggest that individuals may experience symptoms of stress if they have high levels of compassion for others but lack self-compassion.

Self-compassion increased post-training and self-critical judgement reduced post training. Compassion for others increased post-training but scores did not reach statistical significance. Scores possibly did not reach statistical significance, due to either the small sample size, or the high scores reported by participants at the pre intervention stage. This is important because one would expect high levels of compassion for others in students wanting a career in counselling and psychotherapy.

**Beaumont et al. (in press)** do not report findings from a control group and therefore the results from this study make it difficult to establish whether the CBT programme alone would help students develop compassion and reduce self-critical judgement. However, this preliminary study provides evidence to suggest that students found benefit from CMT. Hence, further exploration of these factors is recommended using a larger sample size, a control group and whereby data can be

collected over a longitudinal period, to examine the impact of CMT on well-being long term.

### **Summary of Section Three**

Existing literature focuses on *'whether'* and *'why'* there may be a need to cultivate compassion and a need for utilising self-care strategies in the helping professions, but there is an absence of literature examining *'how'* and *'what'* can be done to help cultivate compassion within caregiving populations, and also for *'whom'* training would benefit. Building on existing knowledge and considering this gap in existing literature, this body of works addresses these issues and seeks to move the field of compassion forward by examining the impact CFT/CMT has on individuals working in the helping professions, thus bridging a gap between theory and practice.

Collectively, this body of works makes a unique contribution to knowledge by creating and testing an education strategy, which may help individuals cultivate compassion. This is achieved by examining how educators and clinicians can help individuals cultivate compassion and build resilience via self-reflection and self-practice. This is also accomplished by demonstrating that CFT/CMT can be used as an adjunct to therapy and can be adapted and incorporated into Higher Education training programmes, for individuals embarking on a career in the helping professions.

Paper one (**Beaumont & Hollins Martin, 2015**) offers an overview of the current state of knowledge to date regarding CFT/CMT. This narrative review examines the effectiveness of CFT/CMT and discusses the impact that CFT/CMT had on individuals in clinical populations (**Objective 1**).

The evidence in paper two (**Beaumont, Durkin, McAndrew & Martin, 2016**), demonstrates that adding CFT to TF-CBT has comparable outcomes to TF-CBT in a sample of FSP. The paper provides some preliminary evidence to suggest that FSP may benefit from therapeutic interventions aimed at cultivating self-compassion, as there was a statistical significant difference in self-compassion levels post-therapy in the combined group (**Objective 1**).

Paper three (**Beaumont, Hickey et al. 2016**), uses a qualitative narrative case study approach to examine the impact that counselling had on service users (**Objective 2**). Results demonstrate a flow of compassion, highlighting the impact receiving compassionate care had on service users' desire to show compassion for others, with many keen to 'give back' to the service that helped them manage their own suffering.

This body of works suggests that concerns in existing literature surrounding work-related stress, burnout, compassion fatigue, well-being, professional quality of life, levels of self-compassion, and self-critical judgement are warranted in populations that provide care for others (**Objective 3**). This is evidenced in papers four, five and six (**Beaumont et al., 2016a, 2016b; Durkin, et al., 2016**).

Paper seven (**Beaumont, Irons et al., 2016**), examines the impact compassion training had on healthcare educators and providers' levels of self-compassion, self-critical judgement, self-persecution, and self-correction, pre and post-training (**Objective 1**). Self-compassion scores increased post-training and self-critical judgement reduced post-training in all groups.

Papers eight and nine (**Beaumont & Hollins Martin 2016a, 2016b**), discuss the idiosyncratic demands that students pursuing a career in the helping professions face and suggest that CMT can be incorporated into practitioner training, to promote

self-care and help students build resilience. The Compassionate Mind Training Model for Healthcare Educators was designed and tested to address concerns surrounding practitioner well-being (**Objectives 1 and 4**). Paper ten (**Beaumont et al. in press**) reports the findings from a study that introduced CMT to a sample of student CBP's. Self-compassion levels increased post-training and self-critical judgement reduced post-training, suggesting that students found benefit from CMT. Practical exercises from '*The Compassionate Mind Workbook*' (**Irons & Beaumont, 2017**) were used in the study providing example templates for educators, clinicians, and students.

In section four, ethical considerations and methodological issues will be examined.

## **Section 4: Ethical considerations, methodological issues, and limitations**

In this next section, ethical considerations, methodological issues, and thesis limitations will be discussed.

### **Ethical considerations**

Although psychotherapists make informed decisions in the best interests of their clients, they need to ensure that their theoretical work has been applied and tested by research and need to exercise reasonable care within the therapeutic arena that meets professional standards (Bond, 2010). Ethical issues considered in this body of work consisted of the following; to have respect for autonomy, protect and preserve confidentiality, have an ethical commitment to doing good (beneficence), to act in the best interest of individuals, to commit to safeguard the welfare of participants by storing data securely and to avoid harm (Beauchamp & Childress, 2008). An example that demonstrates an ethical commitment to doing good and avoiding harm was achieved within the FSP study (**Beaumont, Durkin, McAndrew & Martin, 2016**). For example, a decision was made when designing the study to add the “new” intervention (CFT) to CBT rather than providing CFT as a standalone therapy. CBT and EMDR practitioners are well placed to satisfy the ethical principle of doing good in relation to PTSD, because the National Collaborating Centre for Mental Health (2005) recommends CBT or EMDR as first-line therapies for trauma. Withholding first-line trauma treatments from clients in this instance could have violated the ethical commitment to doing good and avoiding harm. Furthermore, within the same study, to protect client anonymity, qualitative data that had been collected from FSP (and provided evidence regarding CFT), was not reported

because the findings could potentially have revealed the identity of some participants. FSP had been referred for psychotherapy following a tragic incident where a fire-fighter had lost his life, thus reporting the qualitative findings from this study would not have been in their best interest.

Respect for autonomy involves respecting an individual's rights to be self-governing (Bond & Dryden, 2012). This was achieved by putting clients in charge of making decisions that relate to them.

Bond and Dryden (2012) suggest that:

*“One of the basic ways of demonstrating respect for autonomy is to be attentive to seeking the clients consent to the term on which therapy is being offered” (p.402).*

Psychotherapists aim to protect client autonomy by ensuring that clients are informed about who their psychotherapist is accountable to and what type of information may be disclosed about them. Clients were given this information prior to commencement of therapy.

The author worked in collaboration with her clients, created appropriate expectations (Bond & Dryden, 2012), refined assessments and formulations (Corrie & Lane, 2011) and focused on building good therapeutic relationships. Additionally, the author received clinical supervision and attended professional development courses, which helps protect clients from harm, helps practitioners to keep up to date with new psychotherapy developments, and is a requirement of professional bodies such as, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) (Corrie et al., 2008).

Ethical approval (Appendix 4) was sought and granted for all research studies **(Beaumont et al., 2016a, 2016b; Beaumont, Hickey et al., 2016; Beaumont, Durkin, McAndrew & Martin, 2016; Beaumont, Irons et al., 2016; Beaumont et**

**al., in press; Durkin et al., 2016).** Greater Manchester Fire and Rescue Service provided approval for the research project involving their employees (Appendix 5). Ethical approval was not needed for the theoretical papers (**Beaumont & Hollins Martin, 2015; Beaumont & Hollins Martin, 2016a, 2016b).**

The author was aware of potential ethical issues surrounding dual role relationships in working with some participants (**Beaumont et al., 2016a, 2016b; Beaumont et al., in press; Durkin et al., 2016).** For example, there was an interrelationship between being a member of the research team and pedagogue. To manage this potential dual role, the author did not collect data directly from students she taught. This helps promote student autonomy and protect student identity (Aycock & Currie, 2013). This is also important because students may agree to take part in research projects to please or help the pedagogue, or may respond to questions in a way that they think is desired, which can undermine the validity of the findings (Perrier, Etchegary, Palarchio & Snelgrove, 2009).

Dual roles that are not managed ethically can lead to unethical practice and ruptures in relationships. Whilst some researchers suggest that dual role relationships, such as, practitioner and researcher can be managed (Etherington, 2000; Fleet, Burton, Reeves & DasGupta, 2016), others suggest that there is a potential for conflict when practitioners hold dual roles (Gabriel, 2005; McLeod, 2006). For example, the duty of the researcher is to collect data and contribute to knowledge, whereas, the role of the educator or therapist is to act in the best interest of the individual in their care, protect them from harm and enhance their well-being. It is for this reason that the author acknowledged the interrelationships between self as educator, researcher and clinician and had minimal involvement with data collection.

For confidentiality reasons individuals who completed pre and post questionnaires wrote a pseudonym on their questionnaires to protect their anonymity and were asked to make a note of their pseudonym in case they wanted to request that their data be withdrawn from the study. This also allowed the researcher(s) to match post-questionnaires with pre-questionnaires. Questionnaires, which could not be matched were destroyed. To protect against a breach of confidentiality, all documentation was stored in a locked filing cabinet. Data collected was coded and information, which was stored on a computer, was password protected.

Once the aim and purpose of the research had been explained and individuals had made an informed decision to participate, informed consent was gained from participants prior to data collection. This is essential, as researchers should have respect for autonomy, and enable individuals to make reasoned informed choices (Beauchamp & Childress, 2008; Bowling, 2002; Jenkins, 2007; Johnson & Long, 2007). Individuals were given information regarding the research, were given the opportunity to ask questions and were reminded that their participation in the research was voluntary.

Participants were debriefed after each focus group, interview or questionnaire completion and were given the opportunity to ask questions. All participants were informed that they could have access to research findings and that they could withdraw their data. Participants who agreed to attend focus groups at the end of training and participants, who consented to meet for face-to-face interviews, agreed that the sessions could be recorded and transcribed verbatim. Participants understood that their personal details would not be revealed to people outside the project. Once the data had been transcribed, recordings were destroyed and the anonymised transcripts kept on password protected computers belonging only to the

research team. In line with the Data Protection Act (1998) and the protocol used within the School of Nursing, Midwifery, Social Work & Social Sciences at the University of Salford, data will be kept for 3 years. All participants were assured that the collection and use of data would only be used for the purpose for which consent had been given.

BABCP ethical guidelines (2010) were adhered to and the author received monthly supervision from a clinical supervisor throughout the projects. All participants in the studies were informed at the beginning and end of the research that they could have access to research findings. In addition, participants were informed that they had the right to contact the supervisor in the event of any query (there was no take up).

### **Methodology and limitations**

A critique and discussion of each individual paper has been presented in section three. In this section methodological issues, rationale for data collection, research limitations, and personal reflection will be discussed.

Whilst there has been an increase in interest in new therapeutic interventions, such as CFT, there remains a gap between practice and research (McLeod, 2011). From a practitioner's viewpoint, one of the difficulties is that researchers and clinicians often have differing priorities and opposing paradigms. For example, research using large-scale studies provide evidence regarding which therapeutic interventions works for the 'average client' (McLeod, 2011). However, such studies risk generating league tables of therapies rather than considering processes of change and individual differences (Dryden, 2007). The Department of Health (DoH, 2005) states:

*“Research should attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods”* (pg. 10).

However, if research is conducted using large samples and Randomised Control Trials (RCTs) alone, then opportunities for debate and discussion regarding single case study methods, or service user reports may be missed. Margison et al. (2000) suggest that in comparison to RCTs, the therapeutic alliance is the best predictor of outcome. RCTs in counselling and psychotherapy face problems due to their poor success in predicting outcomes at an individual level, when data has been summarised at the level of group average scores (Margison et al., 2000). Pilot studies and case studies, reporting the views of students, educators, healthcare workers, and service users are therefore essential and add to the debate regarding how practitioners and educators can best serve the people in their care. For example, ‘practice based evidence’ provides a voice recognising that service users have first-hand knowledge of what works for them, what needs to be changed and why (Ryan & Morgan, 2004).

Barkham and Margison (2007) suggests that practitioners may find it difficult to see the relevance of large-scale research findings when thinking about their own practice, and instead are more likely to want to understand why there is, or is not an improvement post-therapy. However, outside these criticisms if experimental research is not undertaken, therapeutic approaches will not be supported by fund-holders. This in the long run will be detrimental to the psychotherapeutic profession (Hill & Brettle, 2006). Both outcome and process research is essential within education and psychotherapy because both introduce new debates, examine new theories, and have potential to offer a tool kit of educational and psychotherapeutic interventions for practitioners.

A strength of this body of works is that it embarks on a journey of discovery through using a variety of research methods in a sample population comprising of individuals working in the helping professions. For example, quantitative and qualitative data were collected in multiple method pilot studies, a narrative review, and case study research.

### **Pragmatic paradigm**

Pragmatism as a philosophy originates from the work of Charles Sanders Pierce, who proposed that pragmatism was a theory of meaning that has application in the real world (Murphy, 1990). Pragmatists believe that the method is not as important as the problem and that researchers should use pluralistic approaches to understand the problem and search for meaningful solutions (Cherryholmes, 1992; Murphy, 1990; Patton, 1990; Rossman & Wilson, 1985). According to Creswell (2003), *“pragmatist researchers focus on the 'what' and 'how' of the research problem”* (p.11) and provide a philosophical framework for mixed methods research (Somekh & Lewin, 2005; Tashakkori & Teddlie, 2003). Pragmatic researchers choose data collection and analysis of methods that provide insights into the research question. Pragmatists tend to reject the scientific notion that ‘truth’ about real world issues can be understood by scientific methods alone (Mertens, 2005; Robson, 2011; Tashakkori & Teddlie, 2003).

A pragmatic approach was used throughout this body of works, whereby the researcher was not committed to any one system of philosophy and had freedom of choice, choosing methods and procedures that provided the best understanding of the research problem (Bryman, 2008; Mertens, 2005; Patton, 1990). The research question is deemed to be more important than either the method used *“or the*

*paradigm that underlies the method*" (Teddlie & Tashakkori, 2003, p. 20). This view is echoed by Erzberger and Kelle (2003), who relegate ontological and epistemological debates to the side-lines and instead argue that:

*"The selection of adequate methods should not be made mainly on the basis of sympathies toward a certain methodological camp or school. Methods are tools for the answering of research questions and not vice versa"* (p. 482).

'Truth' is what works at the time and pragmatic researchers are therefore open to using both quantitative and qualitative methods. Scientific enquiry is viewed as a process where procedures and norms are evaluated and revised in light of new experience. In this body of works, a pragmatic approach was taken when considering appropriate ways to examine if concerns in current literature regarding the well-being of student practitioners are warranted. Correlational data suggested that there were relationships between self-critical judgement, burnout and compassion fatigue. The next step in the research process was to adapt and test an intervention that aimed to cultivate compassion for self and others and test whether it improved well-being. Cherryholmes (1992) states that:

*"Pragmatic research is driven by anticipated consequences. Pragmatic choices about what to research and how to go about it are conditioned by where we want to go in the broadest sense"* (p13).

Many counsellors and psychotherapists are interested in research projects that have a pragmatic value. For example, asking themselves, does this piece of work have the potential to make a difference?

Both qualitative and quantitative methods are of value to pragmatic researchers, clinicians and educators, because they offer research options (McLeod, 2010). Findings from studies that have recruited large samples can be augmented by qualitative methods, which provide subjective information that quantitative methods lack. Many psychotherapists also value a pluralistic approach to psychotherapy,

believing that as human beings, individuals may need different psychotherapeutic interventions at different times in their lives.

### **Rationale for data collection**

The quantitative studies presented in the body of work (**Beaumont, Durkin, McAndrew & Martin, 2016; Beaumont et al., 2016a, 2016b; Durkin, Beaumont et al., 2016**), utilised self-report questionnaires to measure variables. In this situation, an advantage of using a quantitative approach to collect data was ease of completion with anonymity easily maintained. This quantitative method aimed to be objective, theoretical, and empirical. Nonetheless, quantitative methods have limitations, for example, participants may respond to questions, which do not reflect their precise behaviour or emotions (Crowne & Marlowe, 1964) but instead, aim to please the experimenter. However, data collected quantitatively is of value especially when collating data from large sample sizes that can be generalised to similar populations.

In contrast to quantitative data, qualitative methods offer rich, detailed subjective data regarding 'lived experiences', which can complement quantitative methods such as RCTs (Cooper & Reeves, 2012), because they fill gaps missed by collecting statistics alone (Creswell, 2003). Case studies are widely used across the social sciences and have become one of the most popular ways to do qualitative analysis (Stake, 2005; Yin, 2003, 2006), because they allow researchers to examine meaningful characteristics of real-life events (Yin, 2006). Case studies aim to highlight issues that have been neglected within research literature (McLeod, 2010) and have an important role in hypotheses testing and building theory (Hartley, 2004; Stiles, 2003; Yin, 2003, 2006). Few narrative case studies within psychotherapy

have been carried out, therefore having little impact on counselling and psychotherapy theory building and research (McLeod, 2010). Despite this, there is evidence that narrative case studies play an important role within psychotherapy. For example, collating accounts of service user views demonstrate 'insider knowledge' (McLeod, 2010), with clients sharing their knowledge about how they overcome their condition.

Narrative case study data was collected to collate service users' views of their experiences of therapy (**Beaumont, Hickey et al., 2016; McAndrew, Hickey & Beaumont, 2016**), and a quantitative case study approach was used to generate knowledge and debate regarding the value of using CMT as an adjunct to EMDR (**Beaumont & Hollins Martin, 2013**). Throughout the history of psychotherapy, case study research has provided information to clinicians regarding new treatment approaches. For example, Freud's (1901; 1910) work on the early development of psychoanalysis. Wolpe (1958) reported case study research to establish the credibility of behaviourism and more recently, Shapiro (1989) used case reports to demonstrate the effectiveness of EMDR. Researchers may argue that case study material is unscientific and the findings not transferable to a wider population. However, in recent years systematic methods of case study research have been developed including theory-building case studies (Stiles, 2005; 2007), pragmatic case studies (Fishman, 1999), and narrative case studies (Etherington, 2000; McLeod, 2010).

Widdowson (2011) argues that well-constructed case studies can be used as evidence for outcome change in therapy and that RCTs do not account for the complexity of therapy. Within the field of practitioner education, examining data from case studies is crucial because it encourages scholarly debate, provides educators

with opportunities to discuss case material in depth using a systematic approach, and offers students an opportunity to examine the process of change.

Cooper and McLeod (2011) argue that policy makers have little interest in qualitative methodologies and suggest that qualitative studies within the field of counselling will only be viewed as supplementary to quantitative studies, such as RCTs. McGrath and Johnson (2003) propose that qualitative methods are inferior and argue that the counselling and psychotherapy profession is ruled by policy makers who value evidence based practice, with RCT evidence viewed as gold standard. Whilst health care provision is often commissioned on the basis of evidence based practice, where most interventions fit within a quantitative framework, this does not mean that qualitative methods are inferior.

**Beaumont, Hickey et al., (2016)** collected qualitative data from service users. This type of data analysis is essential because the views of service users can be used to help empower others and can inform practice (Hollway & Jefferson, 2000). Narrative accounts facilitate the story, allowing the voices of individual experiences to be heard and the points emphasised represent the choices made by the person telling the story, which adds to the richness of the data (Hollway & Jefferson, 2000; **McAndrew et al., 2016**; Polkinghorn, 1988).

Two multiple method studies (Bryman, 2008; Morse, 2003) were conducted during the course of this thesis (**Beaumont, Irons et al., 2016**; **Beaumont et al., in press**), which was deemed a useful approach because it captures the best of both quantitative and qualitative approaches. Although this approach can be time consuming because researchers need to collect and analyse both quantitative and open-ended qualitative data, it is advantageous and was the best way to understand the research problem (Bryman, 2008).

There is ongoing debate regarding the correct terminology for multiple method research, which can be misleading for researchers, educators, and clinicians.

Robson (2011) and Harvey and Land (2017) for example, argue that multiple method research is sometimes referred to as mixed methods research, combined or blended research, multi-strategy research or mixed strategy research. On the other hand, Morse (2003) suggests that there is a distinction between multiple method and mixed methods. According to Morse, mixed methods research should aim to integrate two or more sets of data into a comprehensive whole, whereas multiple method research should be used in one project, reported separately and then the results triangulated to form a complete whole.

**Beaumont, Irons et al. (2016)** used quantitative analysis to examine changes in levels of self-compassion, self-critical judgement, self-correction and self-persecution in a sample of healthcare educators and providers. A follow up focus group examined what impact compassion training had on staff and their work with both clients and students. This was therefore a multiple method approach and presented the research team with the opportunity to collect and collate data in a way that worked to address the research questions, in line with a pragmatic philosophy.

**Beaumont et al. (in press)** also used a multiple method design, collecting quantitative data to examine the impact CMT had pre and post-training on levels of self-compassion, empathy, self-critical judgement and compassion for others. A follow up focus group examined how the training influenced students' study, their lives, and their practice. Using a pluralistic approach suited the author who enjoys the structure offered by quantitative research and the flexibility of qualitative investigation. Adopting a multiple method approach enabled the researcher(s) to collect data in a way that best works to address the research questions. **Beaumont**

**et al. (in press)** used a staged design involving two separate phases. Firstly, quantitative data was collected pre and post training, potentially aiming to generalise the findings to a wider population. Following on, qualitative data was collected via a focus group one month post training, with the aim of developing a comprehensive view of subjective experience. This approach captures both statistical data and valuable information regarding subjective experience.

Gorard (2004) suggests that using various methods in research is a *"key element in the improvement of social science, including education research"* (p.7), and argues that this type of research often has greater impact for two reasons; (1) because statistics and figures can be influential to policy-makers, and (2) because subjective stories may be easily remembered and used for illustrative purposes. Additionally, Gorard (2004) argues that such an approach to data collection *"creates researchers with an increased ability to make appropriate criticisms of all types of research"* (p. 7). The author's opinion represents a pragmatic view and echoes the views of Creswell (2003) and Thomas (2003), who suggest that both qualitative and quantitative methods can be complementary and that researchers should select the most suitable method/s for each study. A strength of choosing to use a multiple method design is that the data can be collected at different stages of research (Bryman, 2008). Quantitative data was collected pre and post CMT training in papers seven (**Beaumont, Irons et al., 2016**) and ten (**Beaumont et al., in press**), and qualitative data was collected via focus groups a month after training.

Incorporating different methods into research projects helps practitioners in their role as educators, because it ensures that student practitioners examine, reflect and debate the pros and cons of different methods and philosophical approaches, in order to consider 'the best fit' for them. The research reported in this body of work

also contributes to a wider audience (e.g., general public and organisations responsible for compassionate care), by providing a variety of outcome data, regarding interventions that may be used to help people in the helping professions cultivate compassion. Additionally, this Portfolio of Published Works contributes to a wider population by incorporating interventions into a self-help book (***Irons & Beaumont, 2017***), which offers a step-by-step guide to creating a compassionate self. As the use and effectiveness of compassion training are currently debated, this work is important.

A limitation of this body of works is that despite setting out to use an approach that should be generalisable, the small sample sizes in some of the studies make it difficult to generalise the findings to a wider population. Additionally, all of the work took place within the North West of England, which makes it difficult to generalise findings to other locations. This is especially pertinent because the North of England tends to have higher poverty, crime rates, and incidence of trauma compared to other parts of the United Kingdom, which can influence the well-being of those who provide care for others. Further research using larger sample sizes, blue-light workers from around the United Kingdom, and multiple institutions could be conducted to examine whether a similar pattern exists elsewhere. In contrast, a strength of the body of this work is the collaborative nature of the research. This has been achieved by adopting a team approach, where organisations have supported this work at a macro level and educators and fellow practitioners have assisted in the organisation and delivery of an education programme that informs practice and encourages self-care at a micro level. Findings have been illuminating and working with other healthcare professionals and researchers has been challenging but rewarding. As a result, this has enriched the research reported in this thesis. Whilst

this series of papers reflect research partnerships with various collaborators, the author has undertaken the majority of the work and is the main contributor (see Appendices 2 and 3).

## Reflections

The research presented in this thesis was completed over a seven-year period and therefore personal reflection on this period is warranted.

Etherington (2004) argues that even the most objective researcher brings themselves, their personal knowledge and history into the research mix. Reflexivity is therefore essential, because it helps researchers to challenge and identify their assumptions. I use a reflective log to journal my personal and professional development, which is seen as good practice within the psychotherapeutic community, because it helps identify areas for self-development. Finlay and Gough (2003) argue that researchers are not detached experts, but instead are a “*central figure who actively constructs the collection, selection and interpretation of data*” (pg. 5). Practitioners are morally required to question and debate (Martin, 2006), examine new data and theories, in addition to reflecting on their own strengths and areas for development with peers, colleagues, and supervisors.

As a practitioner, I welcome debate regarding new developments in the therapeutic and research arena, viewing this as an essential part of an educator’s role. My first degree is in psychology and the teaching on that programme was very quantitatively biased. As I started on this research journey, I felt more at ease collecting quantitative data and the earlier studies in this Portfolio of Published Works reflect this (**Beaumont et al., 2016a, 2016b; Durkin et al., 2016**). However, the studies presented in this thesis do demonstrate development of research and

writing skills over the period of time. Critique, scholarly discussions, and knowledge of different research methods improved throughout the body of work and as a result, I have developed into a more rounded researcher. For example, recent research projects focused on collecting multiple method data (**Beaumont, Irons et al., 2016; Beaumont et al., in press**), and service user views (**Beaumont, Hickey et al., 2016**).

Working as part of a research team, taking a pragmatic approach also stimulated scholarly debate. A pragmatic approach was taken for the **Beaumont et al. (2016a, 2016b)** and **Durkin et al. (2016)** projects. For example, the research team wanted to examine relationships between variables in order to investigate whether concerns regarding the well-being of students pursuing a career in the helping professions are necessary. The findings suggest concerns in current literature are warranted and therefore an education strategy was designed (**Beaumont & Hollins Martin, 2016a, 2016b**) and tested (**Beaumont et al., in press**), to examine whether self-compassion can be cultivated. This led to the writing of a self-help book, which provides strategies that can help assist the flow of compassion (**Irons & Beaumont, 2017**).

A potential bias that warrants consideration is allegiance bias, which was a term first coined by Luborsky, Singer and Luborsky (1975). Luborsky et al. (1975) proposed that results from intervention studies could potentially be distorted or contaminated by researchers theoretical or treatment preferences. This is an important albeit controversial topic, which according to Leykin and DeRubeis (2009), should not be embraced, or dismissed without considering how this can be measured in research. Wilson, Wilfley, Agras and Bryson (2011) suggest that a potential solution to this problem lies in balancing allegiances. Within this body of

works, I have worked with a variety of researchers and clinicians from a variety of backgrounds, potentially protecting against unconscious allegiance bias. Luborsky et al. (1999) propose that allegiance bias is evident when researchers compare their preferred treatment to a less effective treatment. This was not the case in this body of works because CFT was used as an adjunct to psychotherapies, which are first-line trauma treatments, as evidenced by the National Collaborating Centre for Mental Health (2005).

Embarking on doing a PhD by Published Works has been a rollercoaster ride at times. Opening up emails to find a paper has been returned for major revisions, to opening an email the following week to say a paper has been accepted, brings with it a variety of emotions, which triggered my own threat system. It has certainly reminded me to practise what I preach, by compassionately responding to my own self-criticism! I have learnt to be tenacious, to not take the peer review process personally and have embraced the review procedure. I have been grateful to reviewers who have given their time freely and as a result of their feedback publications have improved.

As a result of my publications and as my reputation as a researcher has grown, I have provided reviews for journals. This, whilst time consuming has been very rewarding and has enhanced my learning. Working with other researchers and experts in their field has been illuminating also. I have learnt to be proactive, trust in my own abilities and trust in the research process. I have struggled on a number of occasions only to remind myself 'I am where I am meant to be'.

Initially, I set out to measure the impact and effectiveness of CFT/CMT in clinical settings for individuals referred with symptoms of trauma. I hit a roadblock after my first three publications (**Beaumont et al., 2012; Beaumont & Hollins**

**Martin, 2013; Beaumont & Hollins Martin, 2015**), because the next step I had initially wanted to take was to examine the effectiveness of CFT/CMT as a standalone trauma therapy. However, I decided that it would not be in my client's best interest if I withheld recommended first-line trauma therapies, such as CBT and EMDR just because I was interested in examining the impact CFT had as a standalone therapy. Whilst I spent time reflecting on this roadblock, I reminded myself of the deficits and blocks to compassion in education, and my own journey as practitioner and educator, which also link with this work.

My first teaching job was as a psychology teacher. Many of the students I taught had struggles at home and some were asylum seekers. For some students, English was their second language, which presented an extra obstacle for them. In target driven cultures, the needs of the minority can be overlooked. Students may enjoy a subject, but if they fail to meet target grades, they may be asked to leave the course, which may impact on their well-being.

As an educator, researcher and practitioner, I want to make a difference, I aim to create opportunities in learning environments that encourage personal growth, and I believe that educators should examine innovative interventions, which may enhance student learning and student well-being. Creating learning environments where learning is journey focused rather than solely target focused is essential to me. I decided to leave the job because I wanted to create environments where every student felt heard, valued, and understood. Whilst this is the aim of all educators, it can be difficult for practitioners working in organisations that are purely target focused (Thorlby, Smith, Williams & Dayan, 2014), because this can create a competitive and potentially bullying environment, where both students and educators survive rather than thrive (Harris & Biddulph, 2000).

Compassionate pedagogy can help create a secure base for students, address imbalance in learning environments and aid intellectual growth (Goldstein, 1999). As an educator and clinician, I challenge students to consider how they would behave, hear, work with, and respond to others when at their compassionate best (the best version of themselves).

Encouraging students to identify any fears and blocks to learning can also encourage self-reflection and promote self-care. For example, students may have had bad experiences at school or college, which may prevent them fully engaging with their peers, lecturers, supervisors or clients. Helping students to bring self-compassion to past painful memories relating to education may help them overcome these hurdles, and heal the suffering that they experienced as a younger learner.

Whilst working in Higher Education a student (who has given my permission to write about this), spoke to me about the struggles she was having with her psychotherapy training. She had used an intervention with a client, which was not relevant to them and was struggling to stop a vicious cycle of rumination. This in turn had led to self-criticism, doubt and a reluctance to speak about her struggle with peers because she felt ashamed, "I should be better than this," she said to me. This was not a life or death situation, she had made a mistake, which she could rectify as long as she had a good therapeutic relationship with her client (Cooper, 2008). As a result, she learnt a valuable lesson, that the therapeutic alliance is a key ingredient to recovery. I reminded her of a quote from Westbrook, Kennerley and Kirk (2007)

*"If you forget to ask a particular question you can always come back to it later, whereas if you fail to respond with warmth and humanity to your clients, they may not come back at all!" (p.5)*

The student was struggling with incorporating self-care strategies in to her life, she was stuck in a cycle of self-critical rumination and lacked compassion for the

suffering she was experiencing. This experience led me to question how other student healthcare professionals cope with the demands of practice and education, and whether the idiosyncratic demands this student group face, impacts on their own compassion levels and self-care.

Using CMT in psychotherapy training to help students create affiliative feelings may enhance learning. This kind of pedagogy can help students be more mindful of the present moment, leaving space to connect with themselves, their peers and lecturers. For example, **Beaumont et al. (in press)** introduced students to reflective exercises and loving kindness meditations at the beginning and end of classes, thus promoting self-care and potentially increasing compassion for others.

As I reflected on issues surrounding compassion and self-criticism in education, I also reflected on my experiences as a psychotherapist. Following a string of tragic incidents involving Greater Manchester Fire and Rescue Service I received a number of trauma referrals. As a practitioner, I have spent a great deal of time listening to many trauma stories. Whilst I received support from supervision, led a healthy lifestyle, and had plenty of support around me, I had started to feel nervous when traveling in the car. Many of the individuals I was working with therapeutically were not traumatised by incidents of fire, but by coping with nightmares and flashbacks as a result of witnessing horrific road traffic accidents. This realisation started a chain reaction as I reflected on the impact of trauma, self-criticism, self-compassion, and shame in the helping professions as a whole. Was I feeling symptoms of secondary trauma? After speaking to a variety of healthcare care professionals and students, I volunteered to do a couple of classes on compassion fatigue, burnout, and well-being for an intake of student nurses. Many students nodded their heads in agreement, as I discussed issues surrounding compassion

fatigue, symptoms of stress and burnout. In an open discussion in class, some students reported feeling overwhelmed or not good enough, reporting that they were struggling to juggle a variety of roles and demands. This felt like a gift to me as a clinician, educator, and researcher and propelled me to examine these concepts in further detail, so that I could hopefully make a difference. This is evidenced in this body of works as I worked on a variety of projects with other clinicians, educators, and researchers to examine whether CFT/CMT can improve the well-being of individuals working in the helping professions.

### **Summary of Section Four**

In this section ethical considerations, methodological issues, personal reflections, compassionate pedagogy, and limitations of the studies have been examined. In this body of works, data was collected using a variety of methods, which can be considered a strength of this thesis.

Incorporating different methodologies into research projects helps practitioners in their role as educators, because it ensures that student practitioners examine, reflect and debate the pros and cons of different methods and philosophical approaches, in order to consider 'the best fit' for them. The research reported in this body of works also contributes to a wider audience because it provides outcome data regarding interventions that may help people cultivate compassion for their own suffering. As the use and effectiveness of compassion training are currently debated, this body of research provides information to individuals and a wider audience (e.g. organisations responsible for compassionate care), offering interventions that have the potential to cultivate compassion.

## **Section Five: Key thesis outcomes and recommendations for practice and future research**

In this final section, the thesis objectives are revisited and recommendations for further research are examined.

### **The key objectives were to:**

1. Examine the effectiveness and impact of CFT/CMT.
2. Examine the impact that counselling and psychotherapy has on service users who report they have experienced compassionate care.
3. Examine relationships between self-compassion, compassion for others, well-being, professional quality of life, self-critical judgement, compassion fatigue and burnout.
4. Develop and test an educational model to help individuals training for a career in the helping professions, cultivate self-compassion, and reduce self-critical judgement.

### **Outcomes**

The thesis demonstrates that the following key outcomes have been achieved through this Portfolio of Published Works. The effectiveness and impact CFT/CMT has on individuals in clinical populations, has been examined and measured **(Objective 1)** in papers one and two **(Beaumont & Hollins-Martin, 2015; Beaumont, Durkin, McAndrew & Martin, 2016)**. The findings suggest that CFT/CMT can be integrated into psychotherapeutic frameworks. Results suggest that using CFT/CMT, as an adjunct to therapy was as effective as treatment as usual

and had a positive impact on self-compassion levels. Although the findings provide promising support for the utility of CFT/CMT, further research is needed to examine the individual contribution that CFT/CMT makes to recovery. The impact counselling and psychotherapy has on service users (**Objective 2**), was reported in paper three (**Beaumont, Hickey et al., 2016**). The findings suggest that some service users had a desire to give something back post-therapy, demonstrating altruistic behaviour and increased levels of compassion for others. In studies involving a sample of healthcare students (**Beaumont et al., 2016a, 2016b; Durkin, et al., 2016**), statistical analysis was applied to examine relationships between self-compassion, self-judgement, compassion fatigue, compassion for others, burnout, professional quality of life and well-being, with findings being presented in papers four, five and six (**Objective 3**). The results suggest that concerns in existing literature surrounding ‘the cost of caring’ are warranted. The impact compassion training had, on healthcare educators and providers’ levels of self-compassion, self-critical judgement, self-persecution and self-correction (**Beaumont, Irons et al., 2016**), was examined in paper seven (**Objective 1**). There was no significant statistical difference in self-correction and self-persecution levels post-training. However, self-compassion levels increased and self-critical judgement reduced post-training, which suggests that the training was beneficial and impacted on well-being. An educational model that incorporates CMT into practitioner training to help students cultivate compassion and manage the idiosyncratic demands of client/patient work was created and tested (**Beaumont, & Hollins Martin, 2016a, 2016b; Beaumont et al., in press**), in papers eight, nine and ten (**Objectives 1 and 4**). The intervention was tested by collecting pre and post data and demonstrated that incorporating CFT/CMT

into training may be useful in helping students face client, organisational, personal, academic and placement demands.

In meeting the study objectives through the development and publication of the ten focused papers presented in this thesis, a unique contribution to current literature has been established. This portfolio includes the first published study that examined the impact CFT has on FSP, which contributes to existing trauma literature. The portfolio provides evidence to suggest that concerns in existing literature regarding healthcare professional's well-being are warranted and presents an education programme, which can be incorporated into practitioner training, thus making a unique contribution to current literature. This portfolio of works bridges a gap between practice and theory by offering tested, practical ways of enhancing compassion in populations that may suffer as a result of bearing witness to trauma. In light of this burgeoning evidence base, I would make the following recommendations for future research and practice.

### **Recommendations for future research and practice**

As a result of the findings in this Portfolio of Published Works, the following recommendations for future research are made:-

- Further research is needed using a larger sample size and adequately powered randomised controlled trial, to examine the individual contribution CFT/CMT makes to recovery in FSP experiencing trauma-related symptoms, such as those commonly associated with PTSD.
- A randomised control trial with an adequately powered sample, adhering to the CONSORT guidelines (Schulz, Altman & Moher, 2010) should be

conducted within the UK to compare CFT to alternative models of psychotherapy for trauma.

- Longitudinal research (whereby quantitative, qualitative and follow-up data is collected over a period of time), is recommended to examine the impact CFT/CMT has on individuals in the helping professions throughout their careers.
- Further research should be conducted to examine if CFT/CMT can help individuals in the helping professions sustain levels of compassion, and provide a defensive barrier against compassion fatigue and burnout.

As a result of the findings in this Portfolio of Published Works, the following recommendations for practice are made:-

- A disorder specific CFT therapy manual should be written that provides a guide to practitioners who want to incorporate CFT/CMT into their client/patient work.
- Interventions from '*The Compassionate Mind Workbook*' (**Irons & Beaumont, 2017**), could be adapted and introduced into contexts such as educational settings and organisational workplaces.
- CMT should be introduced into Higher Education to help individuals embarking on a career in the helping professions respond to self-critical judgement with compassion.
- A questionnaire that enables practitioners to examine the individual contributions of CFT/CMT should be created to help researchers and clinicians examine what elements of CFT/CMT are most helpful and for whom. The author has created an example questionnaire (see Appendix 7).

## Conclusions

This thesis has examined the impact CFT/CMT has on populations who work in the helping professions. To achieve this, Paul Gilbert's (2009; 2010) model of CFT and CMT was adapted. In doing this, I was able to address identified gaps in the literature and thus create this unique body of works.

Midwives, FSP, nurses, counsellors, and psychotherapists bear witness to the trauma stories of others. If not managed, this may result in symptoms of stress, compassion fatigue, burnout, and higher levels of shame and self-critical judgement, which could impact on client/patient care, student experience, and student/staff retention rates. Given the difficulties that individuals in the helping professions face in their jobs, and the deleterious impact that self-criticism can have, it is essential that educators and healthcare providers examine evidence-based solutions. This portfolio of evidence offers a unique contribution to knowledge, by providing research evidence regarding the impact CFT/CMT has on individuals in the helping professions, thus providing a first step toward an evidence-based solution. Collectively, the publications in this thesis suggest that incorporating CFT/CMT into psychotherapy and healthcare practitioner training may be useful in helping individuals respond to suffering with compassion.

In essence, CFT/CMT has potential to help individuals cultivate compassion and reduce self-critical judgement, which in turn may help them face the demands of practice. A Compassionate Mind Training Model for Healthcare Educators was designed and tested (**Beaumont, 2016; Beaumont & Hollins Martin, 2016a, 2016b; Beaumont et al., in press**), providing evidence that CMT can be incorporated into practitioner training to help students face clinical, organisational, personal, academic, and placement demands. Exercises from *The Compassionate*

*Mind Workbook* (Irons & Beaumont, 2017) were used in the training, which provides templates for educators and clinicians to follow. Post-training, students reported that they found benefit from using interventions that aimed to cultivate compassion and that the exercises encouraged self-reflection and self-practice.

The work presented in this thesis has been reinforced with oral and poster presentations delivered at international and national conferences, which support the efficacy of this Portfolio of Published Works. During this process, the researcher disseminated ideas and theories to other practitioners and demonstrated her ability to converse with experts and researchers within the mental health arena.

Disseminating research can influence the wider community, has led to scholarly conversations with other professionals and has opened doors to further research collaborations, which can be pursued at post-doctoral level. The papers included in this thesis also demonstrate understanding of the wider issues faced within education and mental health settings and the author's ability to integrate theory into educational practice. This body of works is richly reinforced by supporting publications and highlights the author's ability to organise, plan, collaborate, design, and execute research outputs. Experts in the field who have agreed to publish the papers in peer-reviewed journals have assessed each paper.

A variety of methodologies have been used in this body of works, which have demonstrated knowledge of different research approaches. This portfolio of research presents credible evidence regarding the potential benefits of CFT/CMT and offers practical ways practitioners and educators can enhance well-being in populations who bear witness to suffering. In terms of psychotherapy, developing affiliative functioning using the interventions outlined in this thesis may help individuals who

struggle to respond to interventions, which focus exclusively on thoughts, behavioural experiments or unconscious conflicts.

Fostering environments that harness compassion provides a remedy to self-critical judgement. Whilst suffering cannot be prevented, responding to suffering by adopting the stance of 'being kinder to myself', nurtures healing and impacts on well-being at a personal, professional and societal level. To date much of the literature regarding compassionate care is theoretical, whereas the unique contribution of this thesis is to provide tested, practical ways of enhancing or cultivating compassion in populations that may suffer from the 'cost of caring' for others.

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**Appendix 1**

**Papers included in the**

**Portfolio of Published Works**

# A narrative review exploring the effectiveness of Compassion-Focused Therapy

Elaine Beaumont & Caroline J. Hollins Martin

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**Content & Focus:** *This narrative review summarises findings of research that has shown use of Compassion-Focused Therapy (CFT) to improve psychological outcomes in clinical populations. This article reviews the research studies that have utilised CFT to treat clients experiencing a variety of mental health issues. The paper begins offering an overview of CFT theory and compassionate mind interventions. A literature search was conducted which included book chapters and articles that discussed compassion focused therapy. Twelve studies were identified which showed significant psychological improvements in clients with diagnosed trauma symptoms, brain injury, eating disorders, personality disorders, schizophrenia-spectrum disorder, chronic mental health problems and psychosis, both within groups and during one-to-one therapy. Within the context of the reviewed studies, CFT has shown itself to be an effective therapeutic intervention when combined with approaches such as Cognitive Behavioural Therapy (CBT).*

**Conclusion:** *The research design of the majority of the studies examined precluded determining the extent of individual contributions that CFT made towards client recovery. Further research that uses more rigorous approaches are required to evaluate more effectively the role CFT plays in clients' therapeutic recovery.*

**Keywords:** *Compassion-Focused Therapy (CFT); Compassionate Mind Training (CMT); Self-compassion; clinical outcome measure; narrative review.*

## Compassion-Focused Therapy

OVER THE LAST DECADE there has been an increase in the amount of research that has explored the benefits of cultivating compassion (Germer & Siegel, 2012; Gilbert, 2010, 2009, 2000; Hutcherson, Seppala & Gross 2008; Leary et al., 2007; Lutz et al., 2008; Neff & Vonk, 2009; Neff, Hsieh & Dejjitterat, 2005; Rein, Atkinson & McCraty 1995). With the evidence-base in mind, this paper intends to look at what the literature says about Compassion-Focused Therapy (CFT) and its ability as a therapeutic intervention to enhance psychological outcomes in clinical populations.

Compassion-Focused Therapy was initially developed to help people with chronic and complex mental health problems linked to high levels of shame and self-criticism (Gilbert, 2009). According to

Gilbert (2009), CFT has been designed to increase awareness and understanding of human innate automatic reactions to threats within the environment, with the underpinning principle to motivate the client to care for their own well-being, increase sensitivity to their personal needs, and develop warmth and understanding for self. Over recent years there has been an increase in the use of third-wave CBT approaches, such as mindfulness (Segal et al., 2001), Compassion-Focused Therapy (Gilbert, 2005) and acceptance and commitment therapy (Pierson & Hayes, 2007).

At present there is a growing body of evidence within the health care community that suggests that developing feelings of compassion for self and others can have a profound impact on physiology, mental health and well-being (Harman & Lee, 2010;

Gilbert & Irons, 2004; Gilbert et al., 2006). For example, CFT has been shown to increase immune system effectiveness (Klimecki et al., 2012; Lutz et al., 2008), lower blood-pressure and cortisol release (Cosley et al., 2010), reduce paranoid ideation (Lincoln et al., 2012), moderate negative emotions associated with Cluster C personality disorders (Schanche et al., 2011), and improve general psychological well-being (Neff & Germer, 2012).

In contrast to other therapeutic approaches, CFT employs self-soothing techniques, and individuals benefit from these which are designed to develop empathy, compassion and loving kindness (Gilbert & Irons, 2004; Harman & Lee, 2010; Neff et al., 2007) towards themselves. CFT processes are informed by the evolutionary model and psycho-education and seek to depersonalise and de-shame by helping the client understand how their brain regulates emotion. The theoretical background of this approach draws on evidence from neuropsychology, attachment theory, evolutionary psychology, social psychology and Buddhism, and aims to help the individual self-soothe and develop acceptance and empathy for their suffering (Gilbert, 2009). Once the client stops condemning and blaming themselves for their symptoms, thinking and feelings, they are freer to progress towards taking responsibility and learning to cope.

Cognitive Behavioural principles are incorporated into therapy, for example, at commencement of therapy the therapist conducts an assessment and develops a case formulation and treatment plan in collaboration with the client. Psycho-education is essential and the role behaviour, physiology, cognitions and emotions play are examined and the basic evolutionary model that underpins CFT is explored to help the client understand how their body is responding to perceived threat. Socratic dialogue, guided discovery, exploration of goals and homework activities are incorporated into CFT

sessions, and are designed to help the client become their 'own therapist'. In addition, setback plans are formulated that involve asking questions such as:

- What kind of situation could 'set you back'?
- How could your compassionate-self deal with a set back?

Individuals are encouraged to employ self-soothing techniques, with the therapist focused on identifying strengths, positive attributes and good coping strategies (Gilbert & Irons, 2004; Gilbert et al., 2006). The CFT process involves the therapist listening warmly and acknowledging and validating clients' emotions and personal meanings (Gilbert, 2009; Gilbert & Irons, 2004; Lee, 2009b). Whereas CFT describes the process and theory of applying the model to therapy, compassionate mind training (CMT) is an element of CFT which focuses on activating the self-soothing system by using a variety of interventions.

Therapeutic interventions may include compassionate letter writing, building a compassionate image, examining compassionate behaviour and exploring compassionate ways of thinking. In addition, mindfulness techniques may be incorporated to help the client focus on what the brain is sensing 'in the now', instead of ruminating on past events (Segal et al., 2001).

### **Purpose of the review**

CFT is a new and flourishing style of therapy, which is currently not widely available in the UK or the extended international market. To increase awareness of the worth of CFT, the objective of this paper was to present a synopsis of studies to assist therapists' understandings of how CFT has been successfully used and where developments in the body of research are required. The research questions asked included: (1) Is CFT an effective therapeutic intervention; and (2) What are the benefits of using CFT as an adjunct to psychotherapy and CBT?

## **Method**

A review of the literature was undertaken to identify and summarise relevant research observations of the effectiveness of CFT either standalone or as an adjunct to other therapies. Narrative reviews are an essential part of scientific enquiry because they combine results from a variety of studies, therefore giving them a value that no single study can have (Baumeister & Leary, 1997). This method of review was considered suitable because it provides a historical account of the development of a theory, offers an overview of research in a particular area, and as such is a valuable method of pulling together what is known about a particular phenomenon in the broader sense, such as for a grant proposal or as a resource to therapists (Baumeister & Leary, 1997). Narrative reviews, therefore, can be a valuable building technique and can tell a trustworthy story, aiming to identify and critically analyse research (Popay et al., 2006).

Our purpose was to simply inform the field about what is already known about CFT and its ability to treat clinical populations. Having justified the choice of method, the ultimate aim of this review was to produce a paper to educate therapists about the state of knowledge on the topic of CFT and its ability to improve clients' situation.

## **Ethical considerations**

Published data were used in preparation of this manuscript, hence no ethical approval was required (Hollins-Martin & Martin, 2013).

## **Results/Findings**

The review was conducted between January and May 2014. All titles, abstracts and full-text of studies identified were screened for potential inclusion. Primary research directly related to CFT therapy and its outcomes were examined. Papers required to be published in English and as CFT is a relatively new concept any studies that had been published before 2014 were included. Studies which focused on non-clinical samples and/or student populations were

excluded, because the objective was to explore the effectiveness of CFT as a therapy to treat clinical populations.

## **Search strategy**

Data bases explored included MEDLINE, PsychINFO, CINAHL, Cochrane Database and Google scholar. Key words and search terms included were:

- Compassionate Mind Training;
- Compassion-Focused Therapy;
- Self-Compassion.

The authors wanted to include both qualitative and quantitative methods and so a strict hierarchy of evidence was not applied.

The initial review identified 885 papers, but after closer examination was reduced to 13. Studies were excluded because they did not focus on examining CFT therapy outcomes with a clinical population. Studies that did not incorporate compassionate mind interventions as per Gilbert's model were also excluded. For example, research papers which focused on non-clinical samples, compassion fatigue or student populations were excluded from this review. Finally a further study was excluded (Gilbert & Irons 2004) as this was a pilot study which aimed to explore how individuals experience self-criticism on a daily basis, as opposed to examining CFT as a treatment intervention.

To view a summary of the 12 studies reviewed, see Table 1 overleaf.

Participants in the studies presented with (a) mental health problems (2 studies), (b) psychosis (3 studies), (c) trauma symptoms (4 studies), (d) eating disorders (1 study), and (e) personality disorders (1 study), and (f) CFT-group approach for acute inpatients (1 study). A summary of the literature that addressed use of CFT with participants experiencing mental health problems follows.

### **(a) CFT and its effectiveness at treating individuals with mental health problems**

Two of the 12 studies support the effectiveness of CFT at treating clients with chronic mental health problems (Gilbert & Proctor, 2006; Judge et al., 2012).

Table 1 : Summary of the findings from studies using CFT as a therapeutic intervention.

Study	Country	Research method/design	Number	Participant information	Treatment type and length	Measures	General findings
Gilbert & Proctor (2006)	UK	Pre-post study. 2-month follow-up. Quantitative. Self-monitoring diary.	6	Individuals attending a day hospital with chronic mental health problems (39 to 51 years old).	12 (2 hour) sessions of group CMT. Individuals were supported within a CBT programme.	Weekly diaries HADS, FSCS, FSCRS, OAS, SCS, SBS, SRV.	CMT reduced self-criticism, shame, sense of inferiority and depression and anxiety. Increased self-compassion and reassurance.
Judge et al. (2012)	UK	Pre- and post- measures. Weekly diary.	27 clients in 5 groups	Group CFT in a heterogeneous group of clients presenting with severe mental health difficulties. TAU from CMHT.	12 to 14 sessions of group CFT (2 hours).	Weekly diaries, BDI, BAI, FSCR, FSCS, ISS, OAS, SBS, SCS.	Significant reductions were found for depression, anxiety, stress self-criticism, shame, submissive behaviour, and social comparison post-intervention.
Mayhew & Gilbert (2008)	UK	Case Series. Quantitative. Weekly diary. 6-month follow-up.	3	CMT for people who hear malevolent voices.	12 1 hour weekly sessions plus TAU from Community Mental Health teams.	Weekly diaries, BAVQ, VRQ, SeCS, SCL-90, FSCRS, FSCS.	CMT appeared to have a major effect on participants' hostile voices, transforming them into becoming more reassuring, less persecutory and less malevolent.
Braehler et al. (2012)	UK	Prospective, RCT. Mixed method design. Pre-post study.	40	Individuals with a schizophrenia-spectrum disorder	16 sessions of group therapy. CFT plus treatment as usual (TAU N=22) or TAU (N=18).	BDI-11, PANAS, FORSE, PBIO-R, CGI-1, NRSS	Group CFT was associated with greater observed clinical improvement and an increase in compassion and reduction in feelings of shame.
Laitthwaite et al. (2009)	UK	Pre-, mid-, post- and 6-week follow-up. Quantitative.	18 male	Patients with psychosis residing in a maximum-security hospital.	3 groups over 10 weeks (twice per week).	SCS, OAS, SeCS, BDI, RSE, SIP-AD, PANSS	An improvement in depression, self-esteem, and rating of self-compared with others, and a reduction in shame, and general psychopathology. Significant changes were not found on the SCS, SeCS or the SIP-AD.
Ashworth et al. (2011)	UK	Case Study. Quantitative.	1	23-year-old woman - traumatic brain injury 3 years prior to attending rehabilitation.	Integration of CFT into a CBT programme (6 sessions of CBT and 18 sessions of CFT).	BAI-11, BDI, SCQ STAXI-AI	CBT was of limited effectiveness. CFT useful and showed positive change - helping the client develop feelings of warmth and kindness.

Table 1: Summary of the findings from studies using CFT as a therapeutic intervention (continued).

Beaumont et al. (2012)	UK	Comparative Study. Pre-post study.	32	Trauma victims.	12 sessions. 16 participants received CBT therapy only and 16 received CBT and CMT.	HADS, SeCS, IES-R	Significant reductions in anxiety, depression and trauma symptoms post-therapy. No significant difference between treatment groups. Significant higher SeCS scores in the CBT/CMT group post-therapy. CMT may be a useful addition for clients suffering with trauma symptoms.
Bowyer et al. (2014)	UK	Quantitative. Case Study. Quantitative. Pre-post study.	1	17-year-old - PTSD.	Trauma-focused CBT. 14 sessions x 1 hour and 4 sessions x 1.5 hours.	PDS, BDI, OAS, FSCRS	CFT enhanced TF-CBT. Reductions in PTSD, shame, self-attacking and depressive symptoms.
Beaumont & Hollins-Martin (2013)	UK	Case Study. Pre-, post- and 9-month follow-up.	1	58-year-old man - signature-signing phobia and trauma.	CMT and EMDR - 8 sessions.	HADS, SeCS, IES-R	Compassion-focused EMDR resulted in an elimination of the client's signature-signing phobia and a reduction in trauma-related symptoms. Effects were maintained at follow-up.
Gale et al. (2012)	UK	Quantitative. Pre-post study.	139 (101 sets of scores)	Individuals with eating disorders.	CFT was introduced into a CBT 2 step programme. Step 1=2 hours per week for 4 weeks (psycho-education). Step 2=20 sessions over 16 weeks.	EDE-Q, SEDS, CORE-OM	Significant improvements on all subscales. Individuals diagnosed with bulimia nervosa particularly benefited from the programme.
Lucre & Corten (2012)	UK	Mixed method. Pre-post scores. 12-month follow-up.	8	Individuals diagnosed with personality disorders with previous experience of therapy.	16 weeks of CFT-group therapy.	SCS, FSCRS, SBS, OAS, DASS21, CORE	CFT delivered in a routine psychotherapy department for PD was beneficial. Improvements were maintained at 12-month follow-up.
Heriot-Maitland et al. (2014)	UK	Pre-post study. Semi-structured interview.	57 sets of scores	Inpatients in acute mental health setting.	22 sessions over a 6 month period. Group CFT.	Likert Scale (level of distress and calmness).	A significant decrease in distress ratings and significant increase in calmness ratings.

BAI=Becks Anxiety Inventory, BAVO=Belief About Voices Questionnaire, BDI-II=Becks Depression Inventory, CGI-I=The Clinical Global Impression-Improvement Scale, CORE-OM=Clinical Outcomes in Routine Evaluation, DASS21=Depression Anxiety and Stress Scale, EDE-Q=Eating Disorders Examination Questionnaire, FORSE=Fear of Recurrence Scale, FSCRS=Forms of Self-Criticizing/Attacking and Self-Reassuring Scale, FSCS=Functions of the Self-Criticizing/Attaching Scale, HADS=Hospital Anxiety and Depression Scale, IES-R=Impact of Events Scale Revised, ISS=Internalized Shame Scale, NIBSS=Narrative Recovery Style Scale, OAS=Other as Shamer Scale, PANAS=Positive and Negative Affect Scale, PANSS=Positive and Negative Syndrome Scale, PBIO-R=Personal Beliefs about Illness Questionnaire-Revised, PDS=Post Traumatic Diagnostic Scale, RSE=Rosenberg Self-Esteem measure, SBS=Submissive Behaviour Scale, SCL-90-r=a symptom inventory, SeCS=Social Comparison Scale, SCS=Self-Compassion Scale, SEDS=Stirling Eating Disorders Scale, SIP-AD=Self-Image Profile for Adults, SRV=Social Rank Variables, STAXI-AI=State Trait Anger Expression Inventory, VRO=Voice Rank Scale.

(1) Gilbert and Proctor (2006) used a group-therapy approach to help individuals experiencing high-shame and self-criticism. Participants' received 12 two-hour CFT sessions supported within a CBT programme. A weekly diary was also completed to assess participants' self-attacking and self-soothing behaviours. Post-therapy, a significant reduction in depression ( $p < 0.03$ ), anxiety ( $p < 0.03$ ), self-criticism ( $p < 0.03$ ), shame ( $p < 0.03$ ), inferiority and submissive behaviour ( $p < 0.05$ ) were found. Also recorded in the diaries was discourse that relates to an increase in feelings of self-warmth, reassurance for self and self-care. There was no significant change in self-correcting and self-attacking scores. One limitation of the Gilbert and Proctor (2006) study was the small participant group ( $N=6$ ). However, this study presents as a pilot, with room for repetition and validation in similar contexts.

(2) Judge et al. (2012) found significant reductions post CFT therapy in symptoms of depression, anxiety, stress, self-criticism, shame, submissive behaviour and social comparison in individuals ( $N=27$ ) attending group therapy (seven groups with an average of ( $N=5$ ) per group). The analyses revealed significant improvements in scores for all of the study variables with the exception of the self-correction sub-scale. The authors propose that self-correction could possibly be seen as a positive, preventing people from becoming too arrogant or as a way of helping maintain their standards. CFT had a significant impact at reducing depression, anxiety, and internal and external shame in clients' experiencing chronic mental health problems. Additional qualitative data supported that CFT was easily understood, helpful and well-tolerated by clients.

#### **(b) CFT and its effectiveness at treating people with psychosis**

Three of the 12 studies support the effectiveness of CFT at treating clients with psychosis (Mayhew & Gilbert, 2008; Laithwaite et al., 2009; Braehler et al., 2012).

(3) Mayhew and Gilbert (2008) present individual case-studies that explore three clients' with auditory hallucinations and their acceptance of CFT. Between sessions clients recorded auditory hallucinations, and their critical and compassionate thoughts towards self. CFT focused on helping them develop empathy for fear and distress felt, and also to develop tolerance and compassion for their fears through generating warmth and self-acceptance in response to their self-critical thoughts. Results recorded a decrease in depression, psychoticism, anxiety, paranoia, Obsessive-Compulsive Disorder (OCD) and interpersonal sensitivity. In response to CFT therapy, all three participants' auditory hallucinations became less malevolent, less persecuting and more reassuring. A surprising finding from this study was that two participants' self-compassion and self-criticism scores as measured by the Self-Compassion Scale (Neff 2003) did not reflect their diary sheet scores. All participants rated themselves as highly self-compassionate at commencement of therapy but later reported that they had not understood 'self-compassion' until they started to engage in CMT.

(4) Braehler et al. (2012) conducted a Randomised Clinical Trial (RCT) that compared outcomes of a CFT group ( $N=22$ ) and a Treatment As Usual (TAU) group ( $N=18$ ) in clients diagnosed with schizophrenia-spectrum disorder. Therapy focused on reducing symptoms of shame and self-criticism and developing self-compassion. Post 16-weekly sessions, the CFT group showed greater observed clinical improvements ( $p < 0.001$ ). A significant increase in compassion ( $p = 0.015$ ) was associated with significant reductions in depression ( $p = 0.001$ ), and a decrease in perceived social marginalization ( $p = 0.002$ ). When treatment scores were compared at the end of therapy there was a significant increase in compassion ( $p = 0.02$ ) compared to non-significant small effects in TAU. Although further studies are required to validate these findings, using CFT as a therapeutic intervention

with individuals with schizophrenia-spectrum disorder has shown to be an effective and safe form of therapy.

(5) Laithwaite et al. (2009) evaluated a 10-week CFT programme that included ( $N=19$ ) clients diagnosed with psychosis who were residing in a high security setting. By the end of the programme significant improvements in social comparison ( $p<0.05$ ), self-esteem ( $p<0.01$ ), shame ( $p<0.05$ ), and depression ( $p<0.05$ ) were achieved. Significant differences in self-compassion and self-concept were not found, leading the authors to conclude that the self-report of compassion could be different for individuals who have lacked the experience of compassion from others during critical periods of their development. Further replication of this study could involve a waiting list control group and a larger sample size.

#### **(c) CFT and its effectiveness at treating symptoms of trauma**

Four of the 12 studies supported effectiveness of CFT at treating clients with symptoms of trauma (Ashworth et al., 2012; Beaumont et al., 2012; Bowyer et al., 2014; Beaumont & Hollins Martin, 2013).

(6) Ashworth et al. (2011) reported that CBT had limited effect on Jenny who had experienced traumatic brain injury. In contrast to CBT, CFT helped reduce depression and anxiety, improve validation of 'self', increase acceptance of difficulties, raise self-esteem, and reduce anger. Ratings of beliefs relating to key cognitions also improved. The cognition 'I am worthless' fell to 10 per cent from 100 per cent by the end of therapy. It is important to note that Jenny was treated in the context of a holistic rehabilitation program. Therefore, it cannot be assumed that the clinical changes observed are due only to CFT interventions. However, developing a portfolio of case studies would work towards validating the findings of this single-case report (Fishman, 2005).

(7) Beaumont et al. (2012) compared outcomes of clients with trauma-related

symptoms between a group that received CMT and CBT ( $N=16$ ), and a CBT only group ( $N=16$ ). Participants in both treatment groups experienced statistically significant reductions post-therapy in symptoms of anxiety ( $p<0.001$ ), depression ( $p<0.001$ ), avoidance ( $p<0.001$ ), hyper-arousal ( $p<0.001$ ) and intrusive thoughts ( $p<0.001$ ). However, there was no significant difference between treatment groups. Participants in the CBT/CMT condition developed statistically significant higher self-compassion scores post-therapy than the CBT-only group. The main effect comparing the two types of treatment was significant [ $F(1,30)=4.657, p\leq.05$ ] suggesting higher levels of self-compassion post-therapy in the CBT/CMT group..

(8) Bowyer et al. (2014) used CMT to enhance trauma-focused CBT with a 17-year-old girl who was sexually assaulted at the age of 13. Post-therapy, there was an increase in self-reassurance, with reduced PTSD, depression, self-attacking behaviours and shame. Again, assembling an anthology of case-reports with similar findings will help validate use of CMT adjacent to trauma-focused CBT.

(9) Beaumont and Hollins Martin (2013) propose that CMT can be used as a resource in Eye Movement Desensitization and Reprocessing (EMDR). In the Beaumont and Hollins Martin (2013) single-case report, EMDR was used to treat a 58-year-old man who presented with psychological distress and somatic symptoms post-trauma. EMDR combined with CMT facilitated recall of forgotten memories about the client's sister's traumatic death, with emotions of shame and grief creating insight into how past events linked to a current signature-signing phobia. The combined EMDR/CMT approach was implemented to reduce threat of rejection, self-criticism, and self-attack (Wheatley et al., 2007). This client responded well to strategies used to increase self-compassion and tackle the 'critic within.' Eight sessions of compassion-focused EMDR eliminated the client's signature signing

phobia, reduced his anxiety and trauma related symptoms, and elevated his mood and self-compassion. These effects maintained at 9-month follow-up. A multiple baseline case study could be used in future research to examine the individual contributions of CMT and EMDR.

**(d) CFT and its effectiveness at treating individuals with eating disorders**

One of the 12 studies supported effectiveness of CFT for treating clients with eating disorders (Gale et al., 2012).

(10) Gale et al. (2012) measured outcomes between 2002-2009 from integrating CFT into a standard CBT programme for clients with eating disorders ( $N=139$ ).

In total, 73 per cent of clients with bulimia nervosa, 21 per cent with anorexia nervosa, and 30 per cent with atypical eating disorders reported significant improvements in their eating disorders by end of treatment. The results of the study suggest that individuals with eating disorders can benefit from a compassion-focused approach. However, due to issues surrounding missing data only 99 people who completed the programme had pre- and post-scores at the end of treatment.

**(e) CFT and its effectiveness at treating individuals with personality disorders**

One of the 12 studies supported effectiveness of CFT for treating clients with personality disorders (Lucre & Corten, 2012).

(11) Lucre and Corten (2012) measured the responses of clients with diagnosed personality disorders ( $N=8$ ) who had completed a 16-week course of CFT informed by CBT. A significant reduction in depression ( $p<0.05$ ), stress ( $p<0.05$ ), shame ( $p<0.05$ ), social comparison ( $p<0.01$ ), self-hatred ( $p<0.01$ ), and an increase in self-reassurance, well-being and social functioning ( $p<0.01$ ) were reported. Qualitative feedback informed that participants found CFT helpful, with benefits upheld at one-year follow-up. A limitation of this study is that it

is difficult to identify the specific aspects of the CFT programme that accounted for the significant changes in the self-report measures. However, improvements were maintained at one-year follow-up.

**(e) CFT and its effectiveness at treating individuals in acute in-patient settings**

One of the 12 studies supported effectiveness of CFT for treating clients in acute in-patient settings (Heriot-Maitland et al., 2014).

(12) Heriot-Maitland et al. (2014) assessed the impact of 22 CFT group sessions delivered over a six-month period to patients ( $N=82$ ) in an acute unit. Participants rated their pre- and post-session levels of distress and calmness on a six-point Likert scale, which produced 57 datasets. Results found a significant reduction in levels of distress ( $p=0.005$ ) and a significant increase in overall calmness post-session ( $p=0.05$ ) particularly within a session which focused on imagery ( $p=0.019$ ). Qualitative data themes produced were labelled 'understanding compassion', 'experience of positive affect' and feelings of a 'common humanity'. A limitation of this pilot study is that it did not use standardised outcome measures. However, comments from the individuals in the group offered rich data regarding client experience of therapy.

**Discussion**

Strengths and limitations of the studies examined and identified areas for future research follow. First, the research questions were supported by the findings of this narrative review. CFT has shown itself in the context of the reviewed studies to be an effective therapeutic intervention. Also, analysis has demonstrated benefits of using CFT as an adjunct to psychotherapy and CBT. In essence, the evidence examined supports that people referred for psychological intervention may benefit from developing self-compassion.

Three of the studies examined were case studies (Ashworth, 2011; Beaumont et al.,

2012; Bowyer et al., 2014), one was a case series (Mayhew & Gilbert, 2008), and a further three had 'sample sizes' of ( $N=20$ ) or under (Gilbert & Proctor, 2006; Laithwaite et al., 2009; Lucre & Corten, 2012). Yet, because of small samples and lack of rigour from tight control groups, generalisation of findings to the wider population becomes problematic. Also there is ambiguity about whether or not changes in self-compassion were in fact due to the CFT therapy alone. Due to therapy being combined with EMDR or CBT in some of the studies cited, it is advised that further research examines stand-alone CFT in clinical contexts.

Also, without a treatment control group (Braehler et al 2012), it is difficult to determine if individuals improved as a direct result of the CFT or because of external factors (Corney & Simpson, 2005), such as personality type, social support, relapse prevention, relapse indication issues and/or individual resilience. Increasing sample sizes and taking a gold standard RCT approach is essential to further validate effectiveness of the CFT technique (McLeod, 2010). To our knowledge effect sizes quantifying the difference between groups and the effectiveness of the treatment intervention was not reported in all of the studies reviewed. Reporting effect sizes in research is valuable for quantifying the effectiveness of the interventions examined (Huberty, 2002).

Triangulating quantitative data with qualitative approaches also helps identify palatability of CFT at an individual level. For example, Laithwaite et al., (2009) reported that some clients struggled with compassionate imagery tasks. In contrast, Hariot-Maitland et al. (2014) reported that their imagery sessions were particularly well-received by inpatients, and that they received the lowest attrition rate (25 per cent) of all the therapeutic interventions used. These conflicting results, support that some individuals appreciate CFT imagery exercises, whilst others do not. Consequently, rich detailed qualitative data is essential if therapists are to understand why particular

aspects of CFT works and with whom.

Other aspects that require exploration include, mismatches between clients' diary reports and their self-compassion scores. For example, Mayhew and Gilbert (2008) report that self-compassion scores in their study did not mirror participants' diary sheet scores. Also, some clients' rated themselves as highly self-compassionate, and later in therapy reported that they did not understand what the term meant. This highlights the importance of clearly defining the term 'compassion' and assessing client comprehension throughout therapy and before CFT commences. In addition, for the evidence-base to develop, it is important to gather follow-up data to ascertain longevity of scores.

A variety of measures and questionnaires were used in the 12 studies (refer to table 1) including:

- Functions of the Self-Criticizing/Attacking Scale (Gilbert et al., 2004)
- Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (Gilbert et al., 2004)
- Self-Compassion Scale-Short Form (Raes et al., 2010)
- Self-Compassion Scale (Neff, 2003)
- Other as Shamer Scale (Goss et al., 1994)
- Submissive Behaviour Scale (Allan & Gilbert, 1997)
- Social Comparison Scale (Allan & Gilbert, 1995).

A further question for researchers to consider is what outcomes measures are appropriate for future CFT research?

## **Conclusion**

Counselling psychology welcomes the opportunity to integrate new developments within existing therapeutic approaches and it is essential that new treatment options be examined so that we as a counselling and psychotherapy profession provide therapy that meets the needs of clients referred for psychological intervention.

This review has shown benefits of using CFT to create a more affiliated orientation to ones-self and others. However, further

research evidence in this area is needed in order to ensure that we as a therapeutic community offer the best treatment for those individuals referred to us for psychotherapy. To date there is not enough evidence to suggest that CFT is as effective as other psychotherapeutic interventions.

The CFT model is advantageous because it can be integrated into a CBT program or incorporated into other psychotherapeutic frameworks. In conclusion, data provides promising support for the utility of CFT, with research already conducted an encouraging starting point for exploring structured, time limited, compassion-focused interventions for clients diagnosed with clinical conditions.

In terms of future research, there are a number of research questions that remain unanswered. For example:

1. What elements of CFT are the most effective, why and to whom?
2. What are the best measures of CFT?
3. How effective is CFT when used as a therapeutic intervention on its own?

In addition to examining symptom reduction, further research is required to examine improvements in quality of life, changes in

individual resilience and social functioning. Introducing control groups, using larger sample sizes, implementing long-term follow-up and independent rating of changes in outcomes would also improve rigour. Also needed are qualitative studies that explore what is helpful during delivery of CFT to enrich and develop skills of therapists from the 'compassionate mind community'.

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## Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service personnel suffering with trauma-related symptoms

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**Abstract.** Individuals working for the emergency services often bear witness to distressing events. This outcome study examines therapeutic interventions for Fire Service personnel (FSP) experiencing symptoms of trauma, depression, anxiety and low levels of self-compassion. This study aims to investigate the effectiveness of using Compassion-Focused Therapy (CFT) as an adjunct to Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) in reducing symptoms of trauma, anxiety and depression and increasing self-compassion. A convenience sample ( $n = 17$ ) of participants, referred for therapy following a traumatic incident, were allocated to receive 12 sessions of either TF-CBT or TF-CBT coupled with CFT. The study employed a repeated-measures design. Data were gathered pre- and post-therapy, using three questionnaires: (1) Hospital Anxiety and Depression Scale; (2) Impact of Events Scale-R; (3) Self-Compassion Scale – Short Form. TF-CBT combined with CFT was more effective than TF-CBT alone on measures of self-compassion. Significant reductions in symptoms of depression, anxiety, hyperarousal, intrusion and avoidance and a significant increase in self-compassion occurred in both groups post-therapy. The study provides some preliminary evidence to suggest that FSP may benefit from therapeutic interventions aimed at cultivating self-compassion. Further research is warranted using a larger sample size and adequately powered randomized controlled trial, to detect statistically significant differences and to negate the risk of confound due to low numbers resulting in significant differences between groups at baseline. Using CFT as an adjunct to TF-CBT may help FSP, who bear witness to the distress of others, cultivate compassion for their own suffering.

**Key words:** Compassion-Focused Therapy, Compassionate Mind Training, Fire Brigade, Fire Service personnel, self-compassion, trauma-focused CBT

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## Introduction

Emergency work while rewarding, for many can also be a hazardous occupation, with staff often facing traumatizing situations, long working hours and shift work. Personnel working for the emergency services either bear witness to distressing events, memories, sights, smells and/or sounds *or* are vicariously exposed to trauma. Individuals who respond to disasters and threats of terror may be more at risk of developing psychological, social and physical reactions (Fullerton *et al.* 1992; Harris *et al.* 2002), with shame, fear and guilt being common reactions (Lee, 2009).

One of the psychological sequelae of exposure to trauma for emergency-service personnel is post-traumatic stress disorder (PTSD). The lifetime prevalence of PTSD is estimated to be 6.8% (Kessler *et al.* 2005); however, for emergency personnel, such as firefighters, the chance of developing PTSD has been estimated to range from 8% to 24.5% (Wagner *et al.* 1998; Haslam & Mallon, 2003; Del Ben *et al.* 2006).

More recently, a systematic review undertaken by Berger *et al.* (2012) and an in-depth review carried out by Skogstad *et al.* (2013), demonstrated the importance of preventive work and a thorough follow-up of employees after a critical event. Berger *et al.* (2012) aimed to estimate the worldwide pooled current prevalence of PTSD in rescue workers and concluded they have a much higher prevalence of PTSD than the general public. The authors suggest that there is a need for pre-employment strategies which aim to select the most resilient individuals for rescue work, and a need to implement preventative and educational measures through which resilience can be built.

PTSD symptoms can include hyperarousal, intrusive thoughts, fear, avoidance of feared situations, flashbacks and nightmares. The DSM-5 (APA, 2013) now recognizes that negative emotions, in addition to fear, may play a role in PTSD (Badour *et al.* 2015). For example, shame, guilt and self-focused disgust may contribute to the development and maintenance of PTSD. Individuals exposed to traumatic events may report feelings of shame, self-criticism and guilt (Lee *et al.* 2001; Leskela *et al.* 2002; Jonsson & Segesten, 2004), particularly if they have failed in their attempt to rescue or help the victim (Jonsson & Segesten, 2004).

## Evidence regarding therapeutic approaches in addressing trauma

Trauma-focused CBT (TF-CBT) therapies, for example, Prolonged Exposure (Foa *et al.* 2005), Cognitive Processing Therapy (Resick & Schnicke, 1993) and Cognitive Therapy for PTSD (Ehlers & Clark, 2000; Ehlers *et al.* 2005), are effective in the treatment of PTSD (Bradley *et al.* 2005; Bisson *et al.* 2007) and are currently recommended as first-line treatments for this condition (NICE, 2005).

All TF-CBT treatment programmes require the individual to confront trauma memories. Research, however, has highlighted high drop-out rates of between 20% and 35% with trauma-focused PTSD therapies that include exposure to trauma memories (Resick *et al.* 2002; Foa *et al.* 2005). Moreover, between a third and a half of individuals receiving empirically supported treatments for PTSD do not fully respond to treatment (Bradley *et al.* 2005). Regardless of the above, other studies have demonstrated the effectiveness of TF-CBT and its acceptability to those who experience PTSD (Ehlers *et al.* 2005; Smith *et al.* 2007). The present study was specifically designed to explore the impact of introducing Compassion-Focused Therapy (CFT) into a highly effective version of TF-CBT (Ehlers *et al.* 2005).

Ehlers & Clark's (2000) cognitive model of PTSD suggests that individuals with PTSD perceive a serious current threat which includes: excessively negative appraisals of the trauma and/or its sequelae, negative self-appraisals, for example, 'I could have prevented this', and characteristics of trauma memories that lead to re-experiencing symptoms, such as flashbacks. Therapy aims to modify negative appraisals, correct autobiographical memories that lead to disturbance and remove maladaptive behavioural and cognitive coping strategies (Ehlers *et al.* 2005).

Ehlers & Clarke (2000) suggest idiosyncratic appraisals can maintain the sense of current threat, and associated distress underlying PTSD symptoms. This can include guilt from appraisals/ruminations about one's perceived actions or failings, and/or shame about how one reacted during or after the trauma and what such reactions mean about them as a person and in the views of others. For example, negative ruminations about how colleagues may perceive them. This is relevant to the present study as emergency personnel are exposed to critical incidents on a regular basis and may be more susceptible to feelings of guilt and shame (Jonsson & Segesten, 2004), especially if they feel that they have failed in their attempt to help or rescue. Within this population stakes are high and the risk of making a mistake may ignite a threat response and a fear that colleagues will reject them, which makes considering an intervention that develops self-compassion and compassion for others relevant. Shame can make the individual feel inferior, socially unattractive and powerless (Harman & Lee, 2010), which can lead to self-criticism, isolation and self-blame. Therefore, for some individuals PTSD symptoms may be maintained by shame rather than fear (Lee *et al.* 2001), because individuals may persistently re-shame themselves, maintaining a sense of ongoing current threat (Lee, 2009).

Thompson & Waltz (2008) found that students ( $n = 210$ ), who had experienced a traumatic event were more self-judgemental and self-critical. The researchers suggest that trauma survivors may benefit from incorporating techniques into treatment, which will help them address self-criticism, shame and increase affiliative feelings. Fire Service personnel (FSP) face life-and-death situations and therefore integrating compassion-based approaches into TF-CBT, may help FSP create self-supportive voices in response to shame and self-criticism and may help them cultivate compassion for the suffering they have experienced (Leahy, 2001; Gilbert, 2010).

## CFT

CFT describes the process and theory of Gilbert's (2000, 2010) model and was developed specifically to help individuals who experienced high levels of self-criticism and shame (Gilbert, 2000, 2010). Compassionate Mind Training (CMT) is an element of CFT, which focuses on activating the self-soothing system using a variety of compassion-focused interventions. Gilbert's model of CFT suggests that compassion is a flow; we can feel compassion from other people, we can direct compassion to other people and we can direct compassion towards ourselves (Gilbert, 2010). The model incorporates elements of attachment and evolutionary theory, the latter focusing on the evolution of the mammalian affiliative system (Gilbert, 2010). Interventions aim to increase awareness and understanding of human reactions to internal and external threats. Hence, the idea of incorporating an intervention into TF-CBT to enhance self-compassion could improve FSP's capacity to manage distress through reducing levels of self-criticism, self-blame and shame.

To achieve this, compassion-focused interventions are used which focus on helping individuals to employ self-soothing techniques and create affiliative feelings towards themselves and others (Gilbert & Irons, 2004; Gilbert & Proctor, 2006; Gilbert, 2010). Recent research suggests compassion-focused practice can be beneficial for a range of client groups (Beaumont & Hollins Martin, 2015). Particularly, assisting individuals with enduring mental health problems (Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008; Braehler *et al.* 2012), eating disorders (Gale *et al.* 2014), social anxiety (Boersma *et al.* 2015), alcohol dependency (Brooks *et al.* 2012) and help with trauma symptom reduction (Beaumont *et al.* 2012; Beaumont & Hollins Martin, 2013; Bowyer *et al.* 2014).

Bowyer *et al.* (2014) used CMT as an intervention to enhance TF-CBT with a 17-year-old girl, who had suffered sexual assault at the age of 13. Results indicated a significant increase in self-reassurance and reduction in trauma, depression, shame and self-attacking symptoms post-therapy. Likewise, Beaumont *et al.* (2012) found that individuals ( $n = 32$ ) developed more self-compassion post-therapy when CMT was used as a therapeutic intervention.

Further evidence from case study research suggests that CFT may be a useful resource in eye movement desensitization and reprocessing (EMDR; Beaumont & Hollins Martin, 2013). Beaumont & Hollins Martin (2013) present a case report of a 58-year-old man who presented with psychological and somatic symptoms following a traumatic incident. The individual had struggled to engage with cognitive behavioural interventions and therefore a combined treatment approach was employed to help increase levels of compassion and tackle the 'bully within'. Thus, the application of a compassion-focused EMDR approach produced a post-therapy reduction in trauma-related symptoms and an elevation in mood and self-compassion. However, the limitation of a case study involving one person raises ambiguity about whether or not adding CFT to EMDR actually added benefit over and above standard EMDR.

Compassion-focused interventions examine the interaction and link between three human affect regulation systems: (1) threat and protection system, (2) seeking and acquiring system, and (3) soothing and contentment system. Therapy aims to help restore balance between the affect regulation systems, with individuals learning to access their self-soothing system in response to threat. Responding to self-criticism by accessing the contentment/self-soothing system therefore helps individuals develop self-compassion in response to their traumatic experience. Within therapy, individuals learn through a variety of interventions, to cultivate a compassionate mind and learn to develop understanding for the suffering they feel (Gilbert, 2010). Learning to help individuals manage self-criticism, develop a motivation for change and incorporate self-soothing techniques into daily life, plays an important role in therapy. Within therapy individuals learn the key skills required to develop compassionate attributes which include, being motivated to care for and alleviate distress (care for wellbeing), having a sensitivity to distress, responding to suffering with empathy, learning to tolerate difficult emotions (distress tolerance) and responding to distress with non-judgement (Gilbert, 2010). Therapeutic interventions focus on the skills of compassion which include, compassionate reasoning, compassionate behaviour, compassionate imagery, compassionate feeling and compassionate sensation (Gilbert, 2010).

### **Rationale for the study**

Early research findings suggests that psychotherapists may find benefit from incorporating CFT into a CBT approach. This is the first study that has investigated CFT as a therapeutic

intervention for FSP. The study aimed to explore the effectiveness of using CFT as an adjunct to TF-CBT (Ehlers *et al.* 2005) in reducing symptoms of trauma, anxiety and depression and increasing self-compassion.

## Method

The study used a 2×2 mixed-group design with repeated measures on the second factor (data collected from FSP pre-therapy and post-therapy).

### *Participants*

Seventeen participants referred for therapy with symptoms of trauma took part in this study. A Fire Service in England referred participants for therapy. FSP were allocated to one of the two groups prior to the start of therapy. One group ( $n = 8$ ) received TF-CBT (treatment as usual) for up to 12 weeks and the second group ( $n = 9$ ) received a combination of TF-CBT and CFT for up to 12 weeks. The initial and final sessions lasted 90 min, with all other sessions lasting 60 min. In the TF-CBT group, seven of the eight participants attended 12 sessions of psychotherapy and one participant attended 11 sessions. In the combined group seven participants completed 12 sessions of therapy, one completed 11 sessions and one completed nine sessions. Individuals who received fewer sessions did so because they were ready to be discharged. The sample in the TF-CBT group consisted of six males and two females with a mean age of 41.3 (range 27–55) years and the combined group consisted of six males and three females with a mean age of 43.2 (range 25–54) years.

### *Procedure*

Following the cognitive model of PTSD (Ehlers *et al.* 2005), all individuals received TF-CBT from an EMDR Europe-Approved and BABCP-accredited cognitive behavioural psychotherapist (E.B.). In addition, those in the combined therapy group were taught to use interventions that help provide a supportive and affiliative response to suffering. Psycho-education was used in both groups. In the combined group individuals were introduced both to TF-CBT psycho-education and to the CFT model. The combined group were given explanations regarding how the human brain has evolved to respond to threat and Gilbert's (2009) three-circle model was introduced and diagrams presented explaining the model (see Gilbert, 2014 for an overview of the model). Individual formulations were conducted for all participants in both groups. For example, in the combined group compassion-focused formulations were introduced to explain how early life experiences impact on the development of the threat system, how humans cope with threat and how following trauma the coping strategies utilized may be unhelpful and lead to unintended consequences. Compassion-focused thought records were used in the combined group with a focus on creating encouraging thoughts using warmth and a compassionate tone. Individuals in both conditions wrote accounts of the trauma and focused on 'hotspots'. However, individuals in the combined group also spent time focusing on compassionate letter writing by connecting with a compassionate self (a compassionate self that understands, supports and validates unconditionally). Table 1 provides examples of some of the interventions used in both conditions.

**Table 1.** *Some of the treatment interventions incorporated into both conditions*

Trauma-focused CBT (Ehlers et al. 2005)	Compassion-focused therapy (Gilbert, 2010)
Identifying relevant appraisals, memory characteristics and triggers	Developing sympathy, acceptance and insight into one's own difficulties through self-reflection and mindfulness
Identifying behavioural and cognitive strategies that maintain PTSD	Learning to notice and experience physiological and psychological reactions with compassion, empathy and kindness
Examining 'hotspots'	Developing breathing techniques – e.g. soothing rhythm breathing
Socratic questioning	Creating an imaginary safe place in the mind's eye that provides a sense of calm and peace
Identifying an alternative new appraisal – e.g. by adding it to a written account or by using imaginal reliving	Imagining and using acting skills to experience a compassionate self
Revisiting the scene of the trauma to: (1) obtain evidence that helps explain why or how an event occurred. This is helpful for FSP who have appraisals such as 'I could have prevented this from happening' and (2) focusing on what was different between 'then' and 'now'	Experiencing compassion as a flow which can flow in three ways: (1) from other people to oneself, (2) from oneself to other people and (3) from and to self
Reclaiming work – reintroducing social and behavioural activities that have been avoided or given up following the trauma	Using thought records to explore the role played by self-critical rumination
Develop a narrative account – starting before the trauma and ending after the individual is safe again. Events are placed in the past	Learning to respond compassionately to the 'bully within'
Cognitive restructuring – focusing on the personal meanings of the trauma and its sequelae	Thinking about and responding to the anxious, sad, angry and critical self
Examination of maintaining strategies – rumination, hypervigilance and/or safety behaviours	Compassionate letter writing which focuses on being kind, supportive and nurturing as opposed to being self-critical
	Creating a 'step by step' approach to cope with trauma symptoms such as avoidance

PTSD, Post-traumatic stress disorder; FSP, Fire Service personnel.

### Measures

*The Hospital Anxiety and Depression Scale (Snaith & Zigmond, 1994).* This 14-item questionnaire measures symptoms of anxiety and depression. The scale is easy to administer and is a useful tool to measure symptoms of change over time.

*The Impact of Events Scale – Revised (IES-R) (Horowitz et al. 1979; Weiss & Marmar, 1996).* This questionnaire measures symptoms of trauma and consists of 22 items, which measure avoidance, intrusion and hyperarousal.

*The Self-Compassion Scale – Short Form (SCS-SF; Raes et al. 2011).* This 12-item questionnaire uses a Likert scale of 1 (almost never) to 5 (almost always) to measure 'how I typically act toward myself in difficult times'. The SCS-SF is an alternative to the 26-item questionnaire (Neff, 2003).

All three scales are reliable measuring tools, having high internal validity (Snaith & Zigmond 1994; Weiss & Marmar, 1996; Neff, 2003).

**Table 2.** Pre- and post-therapy mean scores and standard deviations for the CBT-only group and the CBT+CFT group

	Therapy type					
	CBT group ( <i>n</i> = 8)			CBT+CFT group ( <i>n</i> = 9)		
	Pre	Post	Difference	Pre	Post	Difference
<b>HADS</b>						
Anxiety	10.3 (2.7)	4.4 (1.9)	6.0 (2.6)	14.8 (4.5)	5.3 (1.1)	9.5 (4.7)
Depression	10.6 (3.5)	4.9 (2.0)	5.7 (3.0)	15.9 (3.3)	5.9 (1.4)	10.0 (2.6)
<b>IES-R</b>						
Avoidance	19.7 (6.2)	7.7 (3.4)	12.0 (4.4)	22.1 (5.0)	5.0 (3.5)	17.1 (6.3)
Hyperarousal	15.4 (5.1)	5.1 (3.3)	10.3 (2.9)	13.2 (5.6)	3.4 (2.9)	9.8 (4.4)
Intrusion	20.9 (5.0)	7.4 (3.9)	13.5 (5.2)	23.0 (5.9)	6.9 (4.6)	16.1 (5.9)
Total IES	56.0 (7.5)	20.2 (6.4)	35.8 (7.7)	54.0 (15.3)	15.3 (9.1)	38.7 (13.0)
SCS-SF	1.9 (0.5)	3.1 (0.4)	1.3 (0.7)	2.2 (0.8)	3.9 (0.6)	1.7 (0.9)

Values given are mean (S.D.).

HADS, Hospital Anxiety and Depression Scale; IES-R, Impact of Events Scale – Revised; SCS-SF, Self-Compassion Scale – Short Form.

### Data analysis

To examine outcome measures comparing the efficacy for both conditions, analysis of covariance (ANCOVA) was performed for each outcome measure using post-therapy scores as the dependent variable, group as the independent variable and pre-therapy scores as the covariate. Partial eta squared ( $\eta^2$ ) was calculated as a measure of the effect size. Data were analysed using SPSS v. 20 (IBM Corp., USA).

### Results

Table 2 reveals the mean and standard deviation scores for both groups pre- and post-therapy. The mean scores suggest a greater improvement in the combined group for symptoms of anxiety, depression, avoidance, intrusion and self-compassion. However, as both groups started with different pre-therapy scores ANCOVA was implemented to control for any possible differences in post-therapy scores and reduce the chance of within-group error variance. When analysing outcomes between groups where differences in the independent variable at the pre-intervention stage could affect the dependent variable outcome ANCOVA is recommended, as it can control for such differences (Lord, 1967). Tests of normality and skewness across clinical variables were within acceptable limits. Data were tested for homogeneity of regression and linear relationships. Scores for anxiety and hyperarousal violated the assumptions and therefore were excluded from the analysis. All other variables met the assumptions to proceed with ANCOVA.

After controlling for pre-test scores there was a significant effect of the between-groups factor for self-compassion ( $F_{1,14} = 7.014, p = 0.05, \eta^2 = 0.334$ ). This suggests that TF-CBT combined with CFT was more effective than TF-CBT alone in increasing self-compassion among this present sample of firefighters.

Although not statistically significant, results from the ANCOVA revealed a trend towards greater reduction in estimated marginal means in the TF-CBT+CFT group for scores of depression (TF-CBT: mean = 5.6, S.D. = 0.60; TF-CBT+CFT: mean = 5.1, S.D. = 0.56), intrusion (TF-CBT: mean = 7.6, S.D. = 1.4; TF-CBT+CFT: mean = 6.6, S.D. = 1.3), avoidance (TF-CBT: mean = 7.3, S.D. = 1.0; TF-CBT+CFT: mean = 5.3, S.D. = 0.96) and the total IES-R (TF-CBT: mean = 19.9, S.D. = 2.6; TF-CBT+CFT: mean = 15.5, S.D. = 2.5). The estimated marginal means scores control for the effect of the covariate for pre-intervention measures by providing an estimate for adjusted means (Field, 2013). This gives an overall average for the pre-stage scores on all independent variables to further control for extreme differences in pre-therapy scores between the two groups. We must stress that, as the results did not achieve statistical significance, they are reported here only as an indicator of a possible trend warranting further study.

## Discussion

The results indicate a statistically significant reduction in symptoms of hyperarousal, avoidance, intrusion, depression and anxiety post-therapy and a significant increase in self-compassion for both groups, with effect sizes high. Analysis of the comparative efficacy of both treatment groups indicates that the combined group was more effective for increasing self-compassion. Indeed, a large effect size was observed in the combined group post-therapy. Both the TF-CBT alone group, and the CFT adjunct group, showed large and statistically significant improvements post-therapy in intrusion, avoidance and hyperarousal symptoms, as well as in anxiety and depression. Analysis of comparative efficacy of the treatment groups found that CFT as an adjunct to TF-CBT improved self-compassion more than TF-CBT alone. However, in this study, adding CFT to TF-CBT did not improve outcomes in trauma-related or depression symptoms. There was, however, some evidence of a non-significant trend favouring the combined CFT group, suggesting a larger study with greater power may be worthwhile in order to clarify the findings.

The present findings are consistent with the results of Thompson & Waltz (2008), who suggest that incorporating techniques into therapy that help create affiliative feelings, may benefit individuals suffering with symptoms of trauma, develop self-compassion. The results are in keeping with the findings of previous studies suggesting that when CFT is incorporated into psychotherapy it can be effective in helping individuals who experience mental health problems (Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008; Beaumont *et al.* 2012; Braehler *et al.* 2012; Brooks *et al.* 2012; Beaumont & Hollins Martin, 2013, 2015; Bowyer *et al.* 2014; Gale *et al.* 2014; Boersma *et al.* 2015).

A strength of the study was that participants in both groups completed therapy which is consistent with the findings of Ehlers *et al.* (2005). TF-CBT, as a stand-alone therapy, was shown to be acceptable for those experiencing trauma-related symptoms, although as highlighted the absolute therapeutic value of adding CFT for such symptoms has not been demonstrated in the present study. Nevertheless the findings suggest that CFT may be a helpful intervention, that can be integrated into traditional treatments for symptoms of PTSD and that FSP may benefit from utilizing techniques that help them to develop inner caring and compassion for the suffering they have experienced.

## Limitations

Within this preliminary study there were a number of methodological challenges. First, participants in the TF-CBT group started their therapeutic journey with fewer symptoms of depression, anxiety, avoidance and intrusion, and this could be viewed as a methodological flaw. This highlights the problems of allocating participants into two separate groups prior to collecting baseline measures, as both groups can start with different pre-intervention scores. A statistical strategy to address this in the current study was to use ANCOVA within the analysis plan. However, a more erudite solution to this fundamental problem is to conduct an adequately powered randomized controlled trial (RCT), with sufficient sample size to detect statistically significant differences between groups and to negate the risk of confound due to low numbers resulting in significant differences between groups at baseline. An RCT as suggested, would require robust randomization procedures and consider carefully the role of blinding procedures within the study paradigm. A further limitation is that this study did not encompass a 'no treatment' comparison group. However, we did have a 'treatment as usual group'. The sample size was adequate for this preliminary pilot and feasibility study; however, the small sample size limits generalizability and may have also occluded potentially meaningful effects of the intervention as highlighted earlier by non-statistically significant improvements in some of the subscale scores. Another limitation is that it is difficult to determine which aspects of TF-CBT and CFT led to the improvements. Consideration also needs to be given to potential 'dosage' issues because the therapeutic interventions in both conditions varied, which meant that participants in the combined group received a different dose of TF-CBT than the TF-CBT group. This issue would need to be addressed in larger scale study, particularly if data is collected from a variety of psychotherapists. A potential solution is that a more uniform structure of therapy be delivered and a framework followed that can achieve high implementation fidelity as this may be the best way of replicating success. Carroll *et al.* (2007) developed one such framework, which the authors suggest enables better evaluation of intervention outcomes, improves the credibility and validity of the research and may protect against intervention variation. This should be considered in future research studies.

## Further research

The addition, of a qualitative arm of inquiry to understand the client's experience of the intervention might illuminate a greater understanding of the impact of CFT at an individual level. This would also help clinicians to evaluate CFT as a stand-alone therapy. Follow-up data is essential for future research as this would help researchers to examine the impact cultivating self-compassion has on relapse rates. Further research investigating the impact CFT has on self-criticism, and the negative coping associated with emergency-service personnel's experience of trauma (Cicognani *et al.* 2009), would be beneficial to the Fire Service and the therapeutic community.

## Conclusion

This study aimed to compare outcome measures from two groups of FSP referred with trauma-related symptoms and low levels of self-compassion. The results indicated that TF-CBT significantly reduced symptoms of trauma whether or not combined with CFT. Adding CFT

had no statistically significant effect on trauma-related symptoms or depression, but did improve self-compassion relative to TF-CBT alone. Nevertheless, the study provides some preliminary evidence to suggest that FSP may benefit from therapeutic interventions aimed at cultivating self-compassion. A full-scale adequately powered and with sufficient sample size RCT is recommended to address the limitations inherent in the current preliminary pilot investigation. However, proof of concept would seem to have been demonstrated to a significant degree in the current study thus providing support and justification for such an RCT.

This the first study to examine the effectiveness of incorporating CFT into a TF-CBT programme using a sample FSP. There is a growing body of evidence within the therapeutic community, which suggests that developing feelings of compassion can aid mental wellbeing. CFT can lead to higher levels of self-compassion and a sensitivity to suffering. Learning to self-soothe in response to threat, shame and self-criticism may help FSP who bear witness to suffering on a daily basis. Using CFT as an adjunct to TF-CBT may enhance the use of CBT for FSP. This inaugural paper opens this discussion.

### Summary

- Compassion-focused interventions focus on helping individuals to employ self-soothing techniques and create affiliative feelings towards themselves and others.
- TF-CBT combined with CFT was more effective than TF-CBT alone on measures of self-compassion.
- CFT as an adjunct to TF-CBT may be a useful intervention for FSP.

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### Ethical standards

The University College Research Ethics Committee gave ethical approval. The researchers adhered to the Ethical Principles and Code of Professional Conduct (2009) throughout this study and followed the Ethical Guidelines of the British Association for Behavioural and Cognitive Psychotherapies. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, and its most recent revision.

### Declaration of Interest

The authors have no conflict of interest with respect to this publication.

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### Learning objectives

- (1) To understand that CFT was developed specifically to help individuals who experienced high levels of self-criticism and shame.
- (2) To increase knowledge of the number of challenges Fire Service personnel (FSP) face in their day-to-day work, which may lead to symptoms of shame, guilt, blame and self-criticism.
- (3) To recognize that incorporating compassion-focused interventions into TF-CBT may enable FSP to employ self-soothing techniques and create affiliative feelings toward themselves and others.
- (4) To identify the interaction and link between three human affect regulation systems: (i) threat and protection system, (ii) seeking and acquiring system and, (iii) soothing and contentment system.
- (5) To consider that no one therapy is panacea for all. Incorporating interventions that aim to cultivate compassion for self and others into psychotherapy may help individuals who bear witness to the suffering of others and as a result may develop symptoms of PTSD.

## ORIGINAL ARTICLE

# Minding the gaps: Using narrative accounts to explore people's experiences of using North Staffs MIND's Adult Counselling Service

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## Abstract

*Introduction:* In the UK, almost 50% of illness diagnosed among working age adults is mental distress, with depression and chronic anxiety cited as the two most prevalent psychological illnesses. However, only 24% of those who experience anxiety and depression, consistent with diagnoses, receive National Health Service (NHS) interventions. Effective mental health care is predicated on understanding the lived experiences of those using services in order to provide sensitively attuned therapy. An understanding of the process of counselling and what makes it effective will only be achieved through hearing the voices of service users. However, with regard to counselling, the literature foregrounding the perspectives of those using services remains sparse. *Method:* This study reports on a qualitative research project, the aim of which was to explore the experiences of people who have used North Staffs MIND's Adult Counselling Service in order to elicit the strengths of and/or opportunities for improving the service. Twelve participants, five males and seven females, were interviewed on a one-to-one basis and six themes were identified; Mindful of the Gap; Easing Like Sunday Morning; Magic Moments; Love is in the Air; Lighting up a Future and Following up the Changes; Spreading the Word. *Results:* Findings suggest the participants in this study found the service beneficial, with therapeutic interventions being tailor-made to meet the person's needs, and one which ensures a safe environment and compassionate care for those in distress.

**Keywords:** counselling, mental health, narrative research

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## Introduction

In the UK, almost 50% of illness diagnosed among working age adults can be attributed to mental distress (London School of Economic (LSE), 2012). Depression and chronic anxiety are the two most prevalent mental illnesses in the UK, accounting for approximately £12 billion a year in lost revenue (Layard et al., 2006). In 2012, 11.6 per 100,000 of the population completed suicide, equating to 5,981 deaths in those 15 years old and above (Office of National Statistics (ONS), 2014). Although recognition is given regarding the differences between

mild and major depression, the latter has a high association with suicide (MIND, 2013). While targets for 2015-16 require the NHS to provide therapy through the Improving Access to Psychological Therapies (IAPT) programme, for 75% of people within six weeks of referral and 95% of people within 18 weeks, only 24% of those experiencing anxiety and depression receive intervention (DoH, 2015). Voluntary sector mental health services often address gaps in statutory provision for those who experience psychological distress.

Effective mental health care is predicated on understanding the lived experiences of those using

services to provide sensitively attuned therapy (McAndrew, Chambers, Nolan, Thomas & Watts, 2014). Twenty years ago, the Mental Health Foundation (1997) suggested people who require mental health services need: somewhere to feel safe and accepted; a place where there is someone to talk to when distressed; help to manage feelings; and support from someone who is willing to listen. While contemporary mental health providers are orientated towards improving outcomes for those who use services, these are not always person centred. For example, service users accessing therapeutic interventions via IAPT are likely to be referred for cognitive behaviour therapy with little or no negotiation. It is only through hearing their voices that an understanding of the process of counselling and how it works will be achieved (McAndrew et al., 2014). However, with regard to counselling, the evidence-based literature foregrounding the perspectives of those using services remains sparse (McAndrew et al., 2014). This study reports on a project exploring the narrative accounts of those who have used North Staffs MIND's Adult Counselling Service.

### Reviewing the literature

Service user involvement is not a new phenomenon. Over the past 25 years, service user involvement in clinical settings, professional education and health and social care research has continuously gathered momentum, becoming an implicit part of good practice for a range of statutory and nonstatutory organisations. The service user movement has been particularly proactive within mental health, often being seen as the way forward in helping to develop a contemporary agenda within health and social care (Chambers & Hickey, 2012,). In keeping with this ethos, a review of the literature undertaken for this study focused only on those papers including a service user perspective.

To identify such papers, a rapid review of the literature was undertaken, allowing for a quick sifting out of inappropriate research and to establish an overview of available evidence. Terms used to describe service users (for example, clients, consumers) and therapy (counselling, psychotherapy, therapeutic engagement) were combined to search databases including, MEDLINE (R), PsychINFO, PsycARTICLES Full Text and PsycEXTRA, CINAHL and ASSIA and inclusion criteria was also used to capture relevant studies. This included papers: (1) written from the client's perspective; (2) in the English language and (3) published from 1990

(approximate time of the start of the service user movement) to present. A synopsis of the findings of the rapid review is offered below.

Since 1990, one systematic review has been published (Hodgetts and Wright, 2007), which focused on client perspectives and identified five core issues: helpful aspects of therapy; therapist advice and problem solving; client's understandings/expectations of approach; reflexive aspects, such as self-disclosure; and processes developed from 'bottom-up' enquiry. These core issues reaffirmed that clients who experience their therapist as personable, caring and competent, are likely to have a more favourable outcome (Hodgetts & Wright, 2007).

In addition to the above review, the literature suggests for service users two important areas when engaging therapeutically: the characteristics and skills of the counsellor and the therapeutic environment.

### Counsellor characteristics and skills

The strength of the therapeutic relationship can determine the outcome of therapy, with the therapeutic alliance playing a central role in ensuring success (Bamling & King, 2001; Bachelor, 2013). A consensus of evidence suggests the quality of the relationship impacts on the counselling being perceived as positive (Hodgetts & Wright, 2007; Horvath, 2013; Oliveira, Sousa & Pires, 2012; Mooney, Gibbons, Gallop, Mack & Crits-Christoph, 2014). However, it is the counsellor's 'being' that appears to be of fundamental importance in the creation of the therapeutic relationship (Mearns, Thorne & McLeod, 2013) and therefore, as a person, how he or she relates to the client is a vital factor influencing therapeutic outcome.

Clients value a collaborative relationship, especially when the therapist sees the person rather than a diagnosis (Glass & Arnkoff, 2000). A non-judgemental attitude has been found to considerably enhance the therapeutic alliance (Hilsenroth & Cromer, 2007). Clients also value therapists' ability to deal with difficult and strong emotions, while showing a willingness to explore sensitive situations and provide comfort (Glass & Arnkoff, 2000; Oliveira et al., 2012). Likewise, knowing that the counsellor remains compassionate, constant and reliable offers the client reassurance that it is safe to work at an emotional depth that might otherwise be avoided (Mearns & Cooper, 2005).

In terms of counsellor skills, the most helpful elements appear to be a therapist who listens and

shows understanding (Glass & Arnkoff, 2000; Duncan & Miller, 2000; Clarke, Rees & Hardy, 2004; Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake, 2009; Gostas, Wiberg, Neander & Kjekkin, 2012; Jones, Latchford & Tober, 2016). From the available evidence being listened to conveys the idea that the therapist is paying attention to the client, reinforcing to the client that they are being heard.

### A counselling environment

To facilitate disclosure, clients need to have a safe space to talk and express themselves, with flexibility within the sessions to meet their individual needs (Gallagher, Tracey & Millar, 2005; Omylinska-Thurston & Cooper, 2014; Simonsen & Cooper, 2015). Clients attribute greater value to having the opportunity to share emotions in a safe environment that promotes self-reflection and self-knowledge (Lilliengren & Werbart, 2005). Many clients experience freedom and relief when being able to talk openly, without censoring, and without fear of upsetting the recipient (Lambert, 2007). Having the temporal space also appears to be important. McManus, Peerbhoy, Larkin and Clark (2010) identified having time to consolidate gains as an important aspect of counselling, while Cape, Whittington, Buszewicz, Wallace and Underwood (2010) caution that results are poorer for time limited therapies in primary care compared with therapies of longer duration. Also, for some, the actual time in session and the frequency of sessions are aspects of therapy clients would prefer to change (Glass & Arnkoff, 2000; Barkham & Mellor-Clark, 2003; von Below & Werbart, 2012).

While the above are facilitative aspects of therapy, it is the client, as an active agent of change, who is primarily responsible for changes that take place during the therapeutic encounter (Cooper, 2008), thus largely determining therapeutic outcome (Miller, Hubble & Duncan, 2008). In the light of the above, and within the context of this voluntary organisation, therapy and therapist might most usefully be evaluated by the client, with such knowledge being harnessed to ensure we learn what makes counselling effective for those who are experiencing psychological distress.

## Rationale

### The organisation

North Staffs MIND's Adult Counselling Service provides counselling to adults who experience mental

health problems. In 2012/13, the Adult Counselling target for ongoing sessions offered was 7,200. The total number of new clients within this period was 1,246, of which 1,127 were offered ongoing appointments. The service is provided by paid staff and qualified volunteers, with sessional staff being called upon when the budget allows. During 2012/13, the average waiting time between assessment and ongoing counselling was approximately 10 weeks, with those considered to be a priority starting counselling within four weeks of their initial appointment. Of those attending the service; 53% were female and 47% male, 97% were white British, age distribution: 18–25, 20%; 26–35, 29%; 36–45, 24%; 46–65, 25%; 65+, 2%. In a sample of 200 people attending for counselling, 86.5% were identified as experiencing anxiety and 78.5% depression, with 19.5% having suicidal ideation (McAndrew et al., 2014). While such statistical information is useful to assess the level of service being offered, North Staffs MIND wanted more in-depth knowledge regarding the impact of the service on the lives of those who had used it, in order to provide greater insight and understanding of the value of the service at both a personal and community level. Therefore, North Staffs MIND commissioned the University of Salford to undertake the study as independent researchers. The aim of the study was to explore the experiences of people who have used North Staffs MIND's Adult Counselling Service in order to elicit the strengths of and opportunities for improving the service.

## Methodology

This qualitative research project collected data from service users, enabling the researchers to focus on understanding issues pertinent to individuals and the organisation. Narrative accounts can be used to challenge a theory, and this approach is ideal for in-depth understanding of an individual's experience against the backdrop of an organisation (Creswell, Hanson, Plano & Morales, 2007). Through hearing the individual's account of their lived experience in the context of their social world, an understanding can be gained of how each person locates him- or herself in relation to their internal and external worlds (Mason, 1996), in this instance their experience of having received counselling within North Staffs MIND's Adult Counselling Service. Ethical approval was granted via the Research, Engagement and Innovation Panel, University of Salford, ref HSCR 15/38.

## Recruitment

A purposive sample was used to ensure potential participants met the inclusion criteria. The inclusion criteria required participants to be aged 18 and above, referred between 2012/13 and having completed their counselling within the previous 12 months. It was agreed with the organisation that, within the given timeframe of the project, the researchers would aim to recruit approximately 1% of the total new referrals for 2012/13, equating to 10-12 people who had made use of the service. Potential participants were recruited via the organisation's database. All those meeting the inclusion criteria were sent a letter of invitation asking if they would be interested in participating in the research. The same invitation appeared on North Staffs MIND's website. Those who responded positively were sent a participant information sheet providing more detailed information and were asked to contact the researchers directly if they wished to discuss any of the information further before making their decision.

## Participants

Twelve people participated, five males and seven females. All were white British, with an age range of 33 – 57 years (mean = 44.8 years). All participants had experience of intervention from NHS services, either through admission to hospital and community care, being treated for depression, anxiety and/or suicide intent. The demographic characteristics of those participating were reflective of the clients seen at North Staffs MIND's Adult Counselling Service (see above). Prior to participating, all participants were asked to sign a consent form before being interviewed.

## Data collection

Narrative interviewing was the main approach for data collection. Narrative offers the participant a topic area and an open forum to tell their story in their own way without researcher restriction (Riessman, 2008). Interviews were carried out by members of the research team, all of whom have a background in counselling and psychotherapy and one who is also a mental health professional. All researchers were employed as lecturers at the University of Salford and had no connection with North Staffs MIND. Interviews started using an opening gambit of 'please just tell me about your experiences of your counselling'. Where the participant found the open

nature of this challenging a structured first question was asked: 'what aspects of the counselling do you think enabled you to talk about things that were worrying you?' Data were collected via face-to-face interviews at a venue agreed between the participant and the researcher. Interviews were audio-taped and lasted around one hour, the shortest interview lasting 50 minutes and the longest 65 minutes. At the end of each interview, there was a short, off-the-record, debriefing opportunity.

## Data analysis

Audio tapes were transcribed and the researchers initially analysed each transcript for story content. Following this, individually each researcher looked across transcripts to identify uniqueness and/or commonalities within the analysed stories. This allowed for individual stories regarding the experience of the counselling service to be told, as well as identifying common themes that can be used to harness what has worked well for those using the service and where improvements might be made. Once transcripts were considered by each researcher, a meeting was arranged to discuss their individual analysis and to negotiate themes believed to best represent the collective findings. While there was consistency across all 12 narratives, at an individual level there were some nuances differentiating participant stories. Individual stories were reported in the final report (McAndrew, Hickey & Beaumont, 2015). However, for the purpose of this study, the themes identified across all 12 transcripts that are presented.

## Findings and discussion

The findings presented represent the six common themes identified across the 12 narratives: '*Mindful of the Gap*'; '*Easing Like Sunday Morning*'; '*Magic Moments*'; '*Love is in the Air*'; '*Lighting up a Future*' and '*Following up the Changes: Spreading the Word*'. The names of the participants included in the next section are pseudonyms.

### 'Mindful of the Gap'

It appeared from the data the organisation was filling an important gap evident within current NHS mental health care. A number of the participants talked of their previous involvement with NHS mental health services, whether through admission/s to hospital and/or community care and the inadequacy of the interventions offered.

The second time I struggled with my life, the NHS system, in my opinion, was struggling even more and they offered me a telephone service, for want of a better word, like they would ring you up at a set time. Now, that system I found totally inadequate. (Chris)

Likewise, the inflexibility of NHS services was concerning;

I didn't find CBT anything like my counselling. I couldn't sort of divulge a lot of the things like what had happened because all I could think of was, you've only got her [therapist] until March. (Sandra)

In some instances, participants attending for therapy sessions via statutory services were directed towards this voluntary counselling service by their therapist, as this was seen as a way of extending psychotherapeutic support. However, being referred to this organisation appeared to be a positive experience for all the participants, as it offered something more than they had previously experienced. Brian reiterates what was said when he first met his counsellor;

I am going to help you and we are going to fix this and I [counsellor] am not going until it is done and that is kind of how it felt. And that was very unusual for me to experience, because in the past it has always been, as I said earlier, a quick fix or a short term course. (Brian)

A major difference in the way voluntary and statutory services approach mental health is the former adopt a humanising approach, rather than medicalising or pathologising problems, the latter approach often being called into question over a number of years (Szasz, 1961; Szasz, 1991; Kleinman, 2008; McAndrew et al., 2014). The humanising approach is evident within the ethos of this organisation and is demonstrated through interactions and encounters both within therapeutic relationships and contextually in its buildings, people and range of opportunities for support. The ethos of the organisation is linked to the second theme, 'Easing Like Sunday Morning', whereby participants talked of a more general, whole organisationally contextual approach, promoting a sense of inclusion and security, a place where they felt at ease to talk about their distress.

### 'Easing Like Sunday Morning'

Participants identified aspects of the counselling service that contributed to it being a '*fantastic*'

organisation and included: the actual building/s providing a place of '*sanctuary*', flexibility in counselling arrangements, '*the welcome*' and not least '*all the people working there*'.

Every person in this building from the girls downstairs in the office, I don't know, maybe it's just me, but you always seem to get this reassurance, calmness. No matter what you say it won't be laughed at, or frowned at, or shock somebody. (Jack)

I don't know where they get it from but that calmness and that trust thing. Like they've got all the time in the world for you. (Julie)

Being able to instill calmness and trust and reassure the client of their importance are key elements of therapy (Rogers, 1951). Kindness, consistency, empathy, unconditional positive regard, reliability and compassion appear to feature strongly among all those working at this counselling service. For the participants, the development of such compassionate qualities was facilitated by an organisation that not only understands the importance of compassionate care, but demonstrates it on a daily basis through the beliefs and values of the team as a whole.

### 'Magic Moments'

With regard to the third theme, all participants used various superlatives when describing their counsellor. A couple of participants had experienced a counsellor they were not able to relate to, but this was attended to during the early stages of therapy. The theme of 'Magic Moments' encompasses both the personal characteristics and skills demonstrated by the counsellor, enabling the participants to feel they were being listened to and valued. Personal characteristics encompassed: the counsellor's way of being with the service user; how he or she was able to gain and sustain trust and hope; and the way in which caring was demonstrated. The skills identified included: active listening; hearing what was being said; empathising and facilitating service users to see the bigger picture and enabling new perspectives to be considered. When the researchers came together to discuss their individual findings across all 12 transcripts there was agreement about there being counsellor 'magic', the bringing together all of these important facets which led to a valued service. This theme elicited most comments from the participants, all of which were interrelated and appeared important to participants and therefore it was decided to keep it

as a theme but to subdivide into 6 sections: (1) Telling the story: Hearing the narrative (2) Comfort and understanding (3) It wouldn't be make-believe (4) There for me (5) Learning for and about me (6) A bumpy ride. The six quotes below, respectively, represent each subtheme, demonstrating their importance in each participant's healing process.

Just that sense of someone does want to know and does want to listen and does want to help you, and you can feel that, and that makes a difference. (Julie)

I just trust her. She didn't belittle me. I just feel comfortable. I just feel... I don't feel trapped. I don't feel I've got to. It's all my choice if I want to tell not. But I told her my secrets. (Lynn)

And the second you know someone believes you it's like a problem shared is a problem halved. He believes me. He knows my mind is broke. And that was just priceless. (Jack)

I saw it as her really wanting me to succeed. Not just from a point that it was her job, but from a point that she valued me as a person and, wanted to help me and wanted me to succeed. She stuck by me. (Brian)

She learned me how to cry and get rid of some of these feelings I'd got inside of me, which was all new. And at 50 odd it's hard to take in. (Sandra)

He was really nice. He made you feel that you weren't nuts. He sort of got what I would say, the daft thinking and he would be like on your side, but helping you to realise that it wasn't quite normal. (Liz)

It was clear from the overarching theme and subthemes that the participants within the study believed their needs had been met within the context of the counselling they received from the organisation.

### **'Love is in the Air'**

The fourth theme, 'Love is in the Air', relates to participants' gaining a sense of altruism, something that could be considered a by-product of counselling: developing compassion for other people's suffering. The majority of participants talked about what they had got from counselling and how they wanted to give something back, through not wanting more sessions and/or by volunteering.

I just said to myself don't be greedy, somebody else needs your spot. (Sandra)

Her involvement made me want to do something, made me want to give something back. Consequently now I do various tasks, voluntarily, to sustain this service for other people. (Brian)

From the gestures highlighted above, it appears the participants learnt to care for themselves by cultivating compassion for their suffering and that of other people. Recent research has focused on the role compassion plays in mental health care (Gilbert & Procter, 2006; Beaumont & Hollins Martin, 2015) and suggests that cultivating compassion can play an important role within the therapeutic arena. Developing self-compassion can lead to higher levels of compassion for others and a motivation to help other people (Wallmark, Safarzadeh, Daukantaitė & Maddux, 2013). The accounts of the participants in this study reiterate this, with the notion of '*giving something back*' post-therapy being evident among the group.

### **'Lighting up a Future'**

'Lighting up a Future' appeared to be the result of the above experiences. Participants talked of '*hope*' and also recognised how their counselling journey had enabled them to move from a position of powerlessness to one of being able to '*take control of their life*'. Recent research has articulated the relationship between taking control and gaining a sense of autonomy, both of which play a pivotal role in interpersonal empowerment (Hickey, 2013).

And I know they'll put me on the list to see somebody. So that's what's amazing. They've given me something to help me to survive and trust in people. (Sandra)

All of the participants in the study came away from therapy having moved on and feeling more positive about their future. Believing in self, others and the organisation impacted positively on those who participated in the study. The positivity instilled through the organisation led to participant satisfaction and, in the light of this, they were able to offer only a few suggestions for change.

### **'Following up the Changes: Spreading the Word'**

The final theme encompassed the fear and apprehension often experienced when counselling was

coming to an end. The data suggest that the end of counselling was negotiated between counsellor and client, but some expressed apprehension as to whether or not they would manage without their regular sessions of counselling. Some of the participants suggested a more stepped ending to the counselling, believing this may act as a safety net.

I felt like, completely lost when I came out of the last one, I didn't know what I was going to do. It would have been nice if I could have paid to carry on because you have got like a bond with them. Or if you could have say a one-off every three months. (Liz)

For some participants, the final few sessions of their counselling were spread out and this appeared to be an acceptable approach to bringing counselling to an end. However, others suggested a 'drop-in' facility, as this would provide a 'safety net';

If I had my way I would come here once a month. I would just sit down with a counsellor and have a good chat for 30 minutes and I believe it just... I don't know. It just tidies the garden up all the time (previously used an analogy of his mental state being akin to too many leaves on the lawn). (Jack).

In addition to the above regarding potential changes, some unease was voiced in relation to the gender mix between client and counsellor, with all three comments relating to a female client with a male counsellor. While all three women were positive about their counselling experience, Sandra and Jan managed to change counsellors and Pauline trusted and liked her male counsellor, but felt unable to discuss one aspect of her problem. The gender mix may well be worth further consideration and how it might be addressed in the light of personal preference.

The composite story, with its six themes, offers the collective voice of the 12 participants giving context to their shared positive experience of the service. The theme of 'Lighting up a Future' goes some way to explain why adult counselling at this organisation is beneficial, while 'Easing Like Sunday Morning' and 'Magic Moments' foreground the characteristics which made it a positive experience for those with mental health problems. With regard to 'Being Mindful of the Gap' this introduced the notion of how participants used it as a benchmark for other organisations offering therapy, by comparing their experiences. Such positive experiences were reflected in their collective altruism, 'Love is in the Air'. Likewise, 'Following up the Changes: Spreading the Word' demonstrated an acknowledgement on the

part of the participants that certain changes would further improve the service, while at the same time reiterating their appreciation of the quality of service provided. While some of the results echo previous findings, others, such as the organisation being at one, that is the same nurturing and compassionate nature being consistently demonstrated by all staff working there, offer further understanding of what makes this specific therapeutic milieu such a positive experience for those it provides therapy for.

### Limitations

There were limitations of this study, the main one being that only participants that had a positive experience of therapy took part in the study. This is a common problem when participants are self selecting and could lead to findings that may not represent the experiences of other service users. Likewise, while using narrative produces rich data, findings are limited to the specific context in which they were generated. It is anticipated that North Staffs MIND will use data from this study to complement the quantitative data they collected prior to this study, giving them a fuller picture of the impact of the adult counselling service they offer.

### Conclusion

Despite the limitations, it would appear for the participants in this study that this voluntary sector counselling service is providing interventions that service users find more appropriate than those available within NHS provision. The evidence presented offers insight and understanding as to how this counselling service has played a significant role in enabling those with psychological problems to get back on track and move towards building a better future. This paper suggests this mental health counselling service provides compassionate care within a safe environment for those in distress. It is as a result of this provision that service users report such a positive impact on their psychological wellbeing post-therapy.

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## Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey

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### ABSTRACT

**Background:** compassion fatigue and burnout can impact on the performance of midwives, with this quantitative paper exploring the relationship between self-compassion, burnout, compassion fatigue, self-judgement, self-kindness, compassion for others, professional quality of life and well-being of student midwives.

**Method:** a quantitative survey measured relationships using questionnaires: (1) Professional Quality of Life Scale; (2) Self-Compassion Scale; (3) Short Warwick and Edinburgh Mental Well-being Scale; (4) Compassion For Others Scale.

**Participants:** a purposive and convenience sample of student midwives ( $n=103$ ) studying at university participated in the study.

**Results:** just over half of the sample reported above average scores for burnout. The results indicate that student midwives who report higher scores on the self-judgement sub-scale are less compassionate towards both themselves and others, have reduced well-being, and report greater burnout and compassion fatigue. Student midwives who report high on measures of self-compassion and well-being report less compassion fatigue and burnout.

**Conclusion:** student midwives may find benefit from 'being kinder to self' in times of suffering, which could potentially help them to prepare for the emotional demands of practice and study.

**Implications:** developing, creating and cultivating environments that foster compassionate care for self and others may play a significant role in helping midwives face the rigours of education and clinical practice during their degree programme.

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### Introduction

The journey to become a midwife involves demanding workloads, challenging placements, and witnessing of traumatic events, with subsequent stress sometimes affecting compassion fatigue and burnout. Examples include, working with women who

experience perinatal bereavement (Hollins Martin and Forrest, 2013; Hollins Martin et al., 2013, 2014), those who relinquish their baby for adoption (Mander, 2000), or traumatic birth (Leinweber and Rowe, 2010; Mollart, 2013; Sheen et al., 2014). In acknowledgement of such stressors, the British Medical Association (BMA, 2011) and the Nursing and Midwifery Council (NMC, 2015) recommend that a key element of health provision is to cultivate an environment that fosters compassionate care.

In an effort to explore this topic, a literature search was undertaken to find out what was already known about compassion in midwifery practice. A narrative review provided an

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overview which informed that some worries in relation to compassion and midwives in fact exist. Brettle and Grant's (2004) search strategy guidelines were followed, with key words including: compassion, midwives, midwifery, stress, compassion fatigue, burnout, and self-compassion. Databases explored included MEDLINE (R), PsychINFO, PsycARTICLES Full Text and PsycEXTRA and CINAHL. As the authors wished to include both quantitative and qualitative methods, a strict hierarchy of evidence was not applied. The motivation was simply to capture a wide variety of literature relevant to the area of interest. What follows is an appraisal of aspects of compassion to underpin the value of conducting the study.

### Compassion

Religious scholars perceive that compassion involves being charitable towards others (Barad, 2007). In contrast, the psychological sciences view compassion as recognising own or another's distress, and making an attempt to alleviate it (Gilbert, 2009). Empathy, distress tolerance, and kindness are key attributes of compassion, with self-compassion associated with reduced self-criticism, blame and worry (Neff, 2003; Gilbert et al., 2004; Gilbert and Procter, 2006). Self-compassion has its roots in Buddhist teachings, with research substantiating its link with psychological well-being (e.g., Neff, 2003; Neff et al., 2005; Leary et al., 2007; Hutcherson et al., 2008; Lutz et al., 2008; Gilbert, 2009; Kelly et al., 2009; 2010; Beaumont et al., 2012; Germer and Siegel, 2012; Beaumont and Hollins Martin, 2013, 2015). Mindfulness, empathy and loving kindness are factors that cultivate self-compassion and promote self-care and well-being (Raab, 2014).

Much debate has surrounded difficulties with health care professionals delivering compassionate care in health care settings (Care Quality Commission, 2011; Brown et al., 2013; Crawford et al., 2013, 2014). High levels of self-compassion and compassion for others has been linked with lower levels of compassion fatigue and burnout (Figley, 2002; Beaumont et al., in press). Additionally, higher levels of self-compassion post-therapy has been linked to reduced trauma symptoms (Beaumont et al., 2012; 2013), improved mood (Gilbert and Procter, 2006), and a reduction in symptoms of psychosis (Mayhew and Gilbert, 2008; Braehler et al., 2012). Self-compassion exercises have been shown to reduce cortisol levels and increase heart-rate variability, which are linked with an ability to self-soothe when stressed (Rockliff, et al., 2008). Individuals who score:

- High on self-compassion are equally kind to others (Neff, 2003)
- Low on self-compassion are kinder to others than self (Neff, 2003; Neff and Germer, 2012)

As such, self-compassionate midwives are more likely to present with greater empathy for a childbearing woman's suffering through their appreciation of shared unity of pain (Şenyuva et al., 2014). A positive correlation between self-compassion and emotional intelligence was identified in nurses ( $n=135$ ) (Heffernan et al., 2010), with an absence of self-compassion rendering carers less able to convey authentic compassion towards patients. Although participant numbers in the Heffernan et al. (2010) study are small, results indicate the worth of further exploration, particularly into the area of compassion fatigue and burnout in midwives.

### Compassion fatigue and burnout

Compassion fatigue is personal suffering that results from stress experienced through working with trauma (secondary traumatic stress) (Figley, 1995), or the reality of practice being mismatched to beliefs about care (Blomberg and Sahlberg-Blom,

2007). Compassion fatigue has been diagnosed in doctors (Joinson, 1992; Pffferling and Gilley, 2000; Benson and Macgrath, 2005), nurses (Sabo, 2006), and midwives (Leinweber and Rowe, 2010). Experiencing, high levels of empathic relationships with child-bearing women can place midwives/student midwives at risk of secondary traumatic stress (Leinweber and Rowe, 2010; Davies and Coldridge, 2015). Symptoms of compassion fatigue include (Figley, 1995):

- Lack of empathy/sympathy
- Irritability/anger
- Hyper-arousal
- Intrusive thoughts,
- Anxiety
- Increased alcohol consumption
- Trepidation of working with some patients

Women are more at risk of developing compassion fatigue than men (Sprang et al., 2007).

In contrast to compassion fatigue, burnout is the physical and emotional exhaustion that occurs in practitioners from working in stressful environments (Figley, 1995). Maslach and Leiter (1997; 2008) propose three dimensions of burnout, which include: (1) exhaustion, (2) cynicism, and (3) inefficacy. In relation to exhaustion, out of ( $n=56$ ) midwives, 60.7% were found to be experiencing high levels of exhaustion and 30.3% burnout (Mollart et al., 2013). A further study reported that 56% of nurses working in acute medicine, and 20% in Accident and Emergency reported emotional exhaustion (Gillespie and Melby, 2003a, 2003b). The authors conclude that regular encounters of work related stress may cause nurses to lose their ability to respond empathically to their patients. One limitation of these studies is the small participant numbers. Nonetheless, they indicate a problem worthy of further exploration. Using a larger sample size, Bakker et al. (1996) reported an association between increased workload and burnout in Dutch midwives ( $n=200$ ), concluding that implementation of policies to reduce burnout should be employed.

Together, burnout and compassion fatigue reduce attention, concentration, ability to communicate, and they contribute towards development of heart disease, mental health problems, and obesity (Miller et al., 1988; Spickard et al., 2002). Also, exposure to continual change, cutbacks, increased workloads, and pressure to meet NHS targets augment pre-existing stress in midwives (Todd et al., 1998; Kirkham, 2007; Iles, 2011), with workplace settings, personal trauma, and role type all influencing potential for the midwife to develop compassion fatigue and burnout (Ray et al., 2013; Sheen et al., 2014). Continuous exposure to distressing situations and lack of control can increase student midwives susceptibility to developing compassion fatigue and burnout (Abendorth and Flannery, 2006), with Yoshida and Sandall (2013) arguing that effective team-work, managerial support, job control and job satisfaction are key factors in relation to predicting burnout in midwives (Yoshida and Sandall, 2013). When faced with stressors, some student midwives smoke to excess, consume more alcohol, or comfort eat, whilst others implement positive approaches towards health, such as implementing mindfulness, writing diaries, or seeking help (Davies and Coldridge, 2015).

Clearly, a combination of factors can lead to compassion fatigue and burnout in student midwives, with point made that when a student midwife's threat system is in a persistent state of activation, compassion may be hindered (Gilbert, 2009). A compounding problem is that compassion fatigue and burnout are strongly associated with anxiety and depression in nurses (Hegney et al., 2013), with mental well-being a significant predictor of staff turnover (Brunetto et al., 2013). In essence, the optimal aim of

midwifery lecturing staff and clinical mentors is for student midwives to be high on compassion and low on burnout and fatigue.

### Rationale

Evidence has shown that working in stressful environments can cause student midwives to overlook their own emotional and psychological needs. In addition, student midwives are set stressful challenges by higher education institutions (Robotham and Julian, 2006), which have potential to impact upon academic performance and mental health (Figley, 1995; Andrews and Wilding, 2004). The literature review has highlighted a lack of research that has explored the impact of secondary traumatic stress and burnout in midwives, with little known about relationships between self-compassion, compassion for others, and quality of professional life in student midwives. In response, the aim of the present study was to examine self-compassion, self-kindness, self-judgement and their effects upon compassion for others, well-being, compassion fatigue and burnout in student midwives.

### Methodology

A quantitative survey investigated the relationship between self-compassion, professional quality of life, compassion for others and well-being in trainee midwives using 4 validated questionnaires. A quantitative survey was selected because it is an effective and systematic method that can engage a sizable population (Polit and Hungler, 1999). Surveying can provide a snapshot of the target population to establish a baseline from which the researcher can compare results (Field, 2013).

### Recruitment

Student midwife recruitment was from classes engaged in face-to-face education in the university classroom. MD and CJHM provided information and facilitated data collection. An information sheet and consent form was given to each student, followed by a brief presentation and question/answer session. Students were offered the opportunity to opt out at any time during the process with no expectation of an explanation or penalties implied, in keeping with the principles of Johnson and Long (2007). Only one student midwife opted out, voluntarily explaining that she felt completely exhausted and had been caught in traffic in attempts to make the lecture on time. Participants were given a contact number in the event that they wanted to know their scores, and counselling was offered by an accredited psychotherapist (EB), with no uptake.

### Participants

A purposive and convenient sample of student midwives ( $n=103$ ) from a university in the north-west of England (UK) participated in this study. All participants were female and aged between 19–56 years; ( $n=54$ ) were in second year, and ( $n=49$ ) in third year of their midwifery degree programme.

### Ethical considerations

Ethics approval was afforded by the University Ethics Committee, in line with the British Psychological Society guidelines of appropriate ethical practice. To limit fear of identification, participants were afforded complete anonymity, with questionnaires tagged with a number.

### Data collection

A quantitative survey was conducted using the subsequent 4 validated scales:

#### Compassion-for-Others-Scale

The *Compassion-for-Others-Scale* (Pommier, 2011) consists of 24-items (e.g., Q=When people cry in front of me I usually don't feel anything at all), and is subdivided into 6 subscales; (1) kindness, (2) indifference, (3) common humanity, (4) separation, (5) mindfulness, and (6) disengagement. Participants respond to items on a 1–5 Likert scale (1=almost never & 5=almost always), with indifference, separation, and disengagement items reverse-scored. Cronbach alpha's for overall scale=0.9, with kindness=0.77, indifference=0.68, common humanity=0.7, separation=0.64, mindfulness=0.67, and disengagement=0.57. Content, convergent and discriminant validity of the *Compassion-for-Others-Scale* is supported in USA populations (Pommier, 2011).

#### Self-Compassion-Scale-Long-Version

The *Self-Compassion-Scale-Long-Version* (Neff, 2003) consists of 26-items that measure typical action towards self during difficult times (e.g., Q=I'm disapproving and judgemental about my own flaws and inadequacies, and Q=I try to be loving towards myself when I feel emotional pain). The scale consists of 6 subscales: (1) self-kindness, (2) self-judgement, (3) mindfulness, (4) common humanity, (5) isolation, and (6) over identification, with items scored on a Likert scale (1=almost never & 5=almost always). Cronbach's alpha's for the overall scale=0.93, with kindness=0.88, self-judgement=0.88, common humanity=0.80, isolation=0.85, mindfulness=0.85, and over-identification=0.88 (Neff et al., 2007).

#### Professional-Quality-of-Life (ProQOL) scale

The *ProQOL* scale (Stamm, 2009) consists of 30-items that measure positive and negative aspects of working with trauma in the workplace (e.g., Q=I feel connected to others), and consists of 3 subscales: (1) compassion satisfaction, (2) compassion fatigue/secondary traumatic stress and, and (3) burnout. The *ProQOL* consists of 30-items scored in relation to the preceding 30 days using a Likert scale (1=never & 5=very often). Cronbach's alpha's for the overall scale=0.88, with burnout=0.75, and compassion fatigue/secondary traumatic stress=0.81. The *ProQOL* scale has been effectively validated in > 200 papers (Stamm, 2010).

#### Short-Warwick-and-Edinburgh-Mental-Well-Being-Scale (sWEMWBS)

The *sWEMWBS* is a 7-item short version of the 14-item *Warwick-and-Edinburgh Mental-Well-being Scale*, which is used to access participants perceptions of well-being over the preceding 2 weeks (e.g., I've been feeling optimistic about the future). Items are scored on a Likert scale (1=none of the time & 5=all of the time). Cronbach's alpha's for the overall scale=0.8, and the *sWEMWBS* has been validated for use in UK populations (Tennant et al., 2009).

### Findings

Data for the mean and standard deviation scores for the 4 questionnaires are presented in Table 1.

Scores on the *Compassion-for-Others-Scale* (3.86) were closer to the 'almost always' range (5), which according to Pommier (2011) can be considered a high score. The total mean score on the *Self-Compassion Scale* was within the moderate range (2.89), with self-

kindness (2.61), and self-judgement (3.34) scores, also considered to be within moderate range (Neff, 2003).

Percentage scores as measured by the ProQOL scale (compassion satisfaction, compassion fatigue, and burnout) are presented in Table 2. For the present sample of student midwives, well-being was within the average range for UK populations (24.6) (Evans et al., 2015).

Further analysis using Pearson's correlations indicates that over half the sample had a burnout score of average or above, with 40% reporting similar scores for compassion fatigue. In response, we explored the impact of these scores relative to the other measures. To view correlational analysis between scores for each measure see Table 3.

Self-judgement was significantly negatively correlated with compassion for others ( $r = -.216$ ), and well-being ( $r = -.373$ ). A positive relationship was observed between self-judgement scores and compassion fatigue ( $r = .233$ ) and burnout ( $r = .283$ ). This result suggests that when student midwives judge themselves harshly they also become less compassionate to self and others. In addition, they experience reduced well-being, and report greater burnout and compassion fatigue.

**Table 1**  
Mean and Standard Deviation scores for each scale.

Questionnaire	N	Mean	S.D
CFOS	103	3.86	.73
SCS	103	2.89	.67
SJSs	103	3.34	.85
SKSs	103	2.61	.91
CS	103	41.6	4.6
CF/STS	103	21.8	5.1
BO	103	22.9	4.8
sWEMWBS	103	24.6	4.2

CFOS=Compassion for others scale. SCS=Self-Compassion Scale. CS=Compassion satisfaction, CF/STS=Compassion fatigue/secondary traumatic stress, BO=burnout, sWEMWBS=The Short Warwick and Edinburgh Mental Well-being Scale. SJSs=Self-judgement subscale, SKSs=Self-kindness subscale.

**Table 2**  
Frequency of scores categorised as being low, average or high, on measures of compassion satisfaction, compassion fatigue and burnout.

ProQOL subscale	Low (22 and below)	Average (23–41)	High (42 and above)
Compassion satisfaction	N/A	44.6%	56.4%
Compassion fatigue	60.45	39.6%	N/A
Burnout	49.5%	50.5%	N/A

**Table 3**  
Pearson's correlational scores for self-compassion, self-judgement and self-kindness in relation to burnout, compassion fatigue, compassion satisfaction, well-being and compassion for others.

	Compassion for others	Compassion satisfaction	Burnout	Compassion fatigue	Self-kindness	Self-judgement	Self-compassion	Well-being
Compassion for others	1	.166	-.135	-.225*	.186	-.216*	.132	.172
Compassion satisfaction	.166	1	-.593**	-.412**	.125	-.170	.201*	.469**
Burnout	-.135	-.593**	1	.550**	-.203*	.283**	-.312**	-.530**
Compassion fatigue	-.225*	-.412**	.550**	1	-.130	.233*	-.192	-.213*
Self-kindness	.186	.125	-.203*	-.130	1	-.570**	.581**	.408**
Self-judgement	-.216*	-.170	.283**	.233*	-.570**	1	-.607**	-.373**
Self-compassion	.132	.201*	-.312**	-.192	.581**	-.607**	1	.382**
Well-being	.172	.469**	-.530**	-.213*	.408**	-.373**	.382**	1

\*\*  $p < 0.01$  level (2-tailed).  
\*  $p < 0.05$  level (2-tailed).

Conversely, self-kindness was found to be associated with less burnout ( $r = -.203$ ) and greater well-being ( $r = .408$ ), and self-compassion scores were associated with low burnout ( $r = -.312$ ), increased well-being ( $r = .382$ ) and compassion satisfaction ( $r = .201$ ). Compassion satisfaction scores positively correlated with scores on well-being ( $r = .469$ ) and self-compassion ( $r = .201$ ), and inversely with burnout ( $r = -.593$ ) and compassion fatigue ( $r = -.412$ ).

These results suggest that student midwives who report greater compassion satisfaction, encounter better well-being, greater self-compassion, fewer symptoms of burnout, and experience less compassion fatigue.

Self-judgement scores were divided into two categories (High versus Low), specifically to investigate if any difference could be found between ProQOL measures, compassion, and well-being. To view comparison scores between high and low self-judgement in relation to all other scales (see Table 4).

Results indicate significant statistical differences, indicating that when self-judgement scores are high, student midwives report less compassion for others, increased burnout, and lower personal well-being. No significant difference was found between measures of compassion fatigue and compassion satisfaction.

**Discussion**

Results show that high self-judgement is significantly negatively correlated with compassion for others, self-kindness, and well-being. In addition, a positive relationship was observed between self-judgement scores and compassion fatigue and burnout. These results reinforce the idea that when student midwives judge themselves unsympathetically, they become less compassionate to self and others, which results in reduced well-being, greater burnout and compassion fatigue. This set of results

**Table 4**  
Independent samples *t*-test results for high versus low self-judgement scores in comparison to compassion for others, compassion satisfaction, compassion fatigue, burnout and well-being.

Scale	Low self-judgement	High self-judgement	t	p-Value
Compassion for others	4.2 (.94)	3.6 (.69)	2.23	.05
Compassion satisfaction	42.4 (5.1)	40.6 (4.6)	1.27	ns
Compassion fatigue	20.0 (5.2)	23.2 (5.9)	-1.81	ns
Burnout	20.6 (4.4)	24.2 (5.4)	-2.27	.05
Well-being	27.4 (3.7)	23.2 (4.7)	3.08	.01

is in keeping with the findings of Mollart et al. (2013) who found that 40% of midwives reported average or above average burnout scores. Likewise, Yoshida and Sandall (2013) found that over 50% of midwives report significantly high levels of burnout, which supports that it is not only prevalent during midwifery training, but also post-registration. Moreover, our participants reported above average scores for compassion fatigue.

A surprising finding was the high levels of self-judgement amongst student midwives. One explanation could be that student midwives feel pressurised by a system that places more emphasis on hospital targets, and less on childbearing women's individualised needs (Kirkham, 2007). Gilbert (1997) proposes that self-blaming and self-criticism arise from efforts to improve self or prevent mistakes. Considering that midwives work in life threatening situations and operate in highly pressurised environments, they may become more self-attacking and self-punishing in their judgements of self-performance in attempts to improve standards and/or prevent errors (Gilbert, 2002). A hazardous environment can foster fear that ignites the endocrine 'threat system', which potentially could be deactivated by teaching self-soothing strategies to restore harmony and compassion for self and others (Iles, 2011).

In conjunction, high mean self-judgement scores may reduce levels of self-compassion in response to threat, because fear of outcomes overrides self-compassion and compassion for others. This idea is reinforced by the self-kindness and compassion scores, which were found to be associated with less burnout, greater well-being, and compassion satisfaction. Compassion satisfaction scores positively correlated with scores on well-being and self-compassion, and inversely for burnout and compassion fatigue. Student midwives who enjoy their work reported greater well-being, higher levels of self-compassion, lower levels of burnout, and compassion fatigue.

#### *Developing a culture of compassion*

Developing self-compassion by learning to self-soothe in times of stress could potentially reduce risk of compassion fatigue and burnout, at the same time as increasing personal well-being (Boellinghaus et al., 2012). This idea is in keeping with Leary et al. (2007) who identified that individuals who demonstrate self-compassion when suffering are less likely to experience stress or develop mental health problems. In addition, individuals with high emotional resilience are less concerned about failure and demonstrate more effective coping strategies in troubled times (Neely et al., 2009).

Including compassionate mind training, mindfulness practice and/or stress reduction programmes into student midwifery curriculum could potentially help student midwives develop self-compassion, empathy for their own suffering, and build resilience, which is an area that requires further study. Davies and Coldridge (2015) reported that students felt there was lack of training on subjects such as stress and how to cope in traumatic situations. Introducing self-care strategies that attempt to cultivate a compassionate mind and challenge negative self-talk may also help student midwives cope with placement demands. Benefits accrued from developing a compassionate mind are well documented (see Leaviss and Uttley, 2014; Beaumont and Hollins-Martin, 2015).

The merits of developing self-compassion to reduce stress and develop coping strategies during midwifery programmes could potentially prepare student midwives to manage stressors, promote self-care, improve compassionate care offered to others, and reduce self-criticism in both the workplace and at home. Such action could work towards improving quality of life, and help create compassionate environments for students and practitioners (Crawford et al., 2014).

#### *Limitations*

There are a number of limitations of this study. First, although students were on placement in a variety of clinical settings, the data collected was gathered from only one institution. Second, gathering survey data at longitudinal points (e.g., start, beginning & end of training) would have provided richer information about direction of changes across time. Third, triangulating findings with a qualitative component would have enriched findings in terms of subjective experience. Fourth, participants may have chosen to answer questions on the questionnaires in a particular way to please the experimenter in keeping with the 'social desirability bias' (Clifford, 1997).

A further potential weakness is that the researcher had to rely upon the participant concentrating on each question, being motivated, and in the right frame of mind to answer honestly (McLeod, 2001). Finally, participants may have engaged in other activities, which incidentally increased their self-compassion, well-being and resilience to stress and burnout.

#### **Conclusion**

This is an inaugural study which reports that student midwives who score high on self-judgement have:

- Lower levels of compassion for self
- Lower levels of compassion for others
- Lower levels of well-being
- Increased levels of burnout
- Increased levels of compassion fatigue

As the numbers in this study were relatively small, there is opportunity to conduct a larger study that involves student midwives from multiple universities across the UK. Midwifery lecturers have a duty of care to explore this topic further, and if consistency in findings are reported, they could consider the possibility of utilising strategies to help equip students with the necessary tools to combat compassion fatigue and burnout.

#### **Conflict of interest**

There was no conflict of interest

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## ORIGINAL ARTICLE

# Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey

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A video abstract of this article can be viewed at: <https://vimeo.com/150762974>

## Abstract

*Background:* Prolonged deficiency in self-care strategies puts counsellors and psychotherapists at risk of burnout and compassion fatigue. *Aim:* To measure associations between self-compassion, compassion fatigue, well-being and burnout in student counsellors and student cognitive behavioural psychotherapists. *Method:* A quantitative survey using four validated data collection instruments: (1) Professional Quality of Life Scale; (2) Self-Compassion Scale; (3) short Warwick and Edinburgh Mental Well-being Scale; (4) Compassion For Others scale, was used to measure relationships between self-compassion, compassion fatigue, well-being and burnout. *Participants:* A mixed sample of student counsellors and student cognitive behavioural psychotherapists ( $n = 54$ ) in their final year of study. *Results:* This preliminary study shows that student counsellors and student cognitive behavioural psychotherapists who reported high on measures of self-compassion and well-being also reported less compassion fatigue and burnout. *Implications for practice:* Compassion fatigue and burnout are found in many modern-day, highly stressful healthcare professions. The practice of self-compassion could help student practitioners manage these symptoms and subsequently improve their professional quality of life.

**Keywords:** burnout, compassion fatigue, counsellors, cognitive behavioural psychotherapists, self-compassion, well-being

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## Introduction

Compassion and empathy are necessary tools for therapists and healthcare professionals to effectively treat their clients (Figley, 2002a). However, working with these psychological tools can bring costs for counselling practitioners (Figley, 1995). Whilst compassionate care is essential for clients, it also plays a significant role in the development of counsellor and psychotherapist self-care (Raab, 2014). If

healthcare professionals have the ability to offer care and compassion to themselves in times of suffering, they will also be better prepared to show compassion towards the individuals they care for (Heffernan et al. 2010).

## Self-compassion

The psychological sciences view compassion as recognising one's own or another's distress and

making an attempt to alleviate it (Gilbert, 2009). Developing self-compassion has been shown, in the literature, to have many benefits (Boellinghaus, Jones & Hutton, 2012). Recent research suggests that there is a link between self-compassion and psychological well-being (Germer & Siegel, 2012; Gilbert, 2000, 2009, 2010; Hutcherson, Seppala & Gross, 2008; Lutz, Brefczynski-Lewis, Johnstone & Davidson, 2008; Neff, 2003; Neff, Hsieh & Dejitterat, 2005; Neff & Vonk, 2009). For example, individuals that possess self-compassionate qualities and do not judge themselves too harshly are less likely to suffer with mental health issues (Neff, Kirkpatrick & Rude, 2007), are more likely to cope with symptoms of stress (Leary, Tate, Adams, Allen & Hancock, 2007), have greater emotional resilience (Gilbert & Procter, 2006), are less afraid of failure, employ effective coping strategies when distressed (Neely, Schallert, Mohammed, Roberts & Chen, 2009) and are at less risk of compassion fatigue and burnout (Thompson, Amatea & Thompson, 2014).

A literature review by Raab (2014) identified mindfulness, empathy and loving kindness as factors that cultivate self-compassion. Developing a compassionate mind may thwart compassion fatigue (Figley, 2002a,b; Gilbert, 2005) and help to reduce mental health problems (Gilbert & Procter, 2006; Judge, Cleghorn, McEwan & Gilbert, 2012), psychosis (Braehler et al., 2012; Laithwaite et al., 2009; Mayhew & Gilbert, 2008), symptoms of trauma (Ashworth, Gracey & Gilbert, 2012; Beaumont, Galpin & Jenkins, 2012; Beaumont & Hollins Martin, 2013; Bowyer, Wallis & Lee, 2014), eating disorders (Gale, Gilbert, Read & Goss, 2012) and personality disorders (Lucre & Corten, 2013).

### Compassion fatigue and burnout

Personal and professional factors can cause compassion fatigue in counsellors and psychotherapists (Zeidner et al., 2013), with mental health workers most at risk (Moore & Cooper, 1996) and higher prevalence in therapists working closely with trauma (Sodeke-Gregson, Holttum & Billings, 2013).

Stamm (2009) suggests that three factors contribute to the health of the practitioner: compassion satisfaction, secondary traumatic stress/compassion fatigue and burnout. When compassion satisfaction is high and both burnout and compassion fatigue low, it is considered the optimal balance for professionals. Adams and Riggs (2008) found, in a sample of trainee

therapists, that trauma symptoms were associated with a personal history of trauma, defence style and level of experience. Burnout in practitioners has been associated with patient dissatisfaction and longer recovery times (Vahey, Aiken, Sloane, Clarke & Vargas, 2004).

Figley (1995) introduced the notion of compassion fatigue suggesting that it occurs as a result of knowing about a traumatising event that a person has suffered. Figley (1995) claims that compassion fatigue is the 'cost of caring' (p. 7) and psychotherapists' prolonged deficiency in self-care strategies puts them at risk of burnout and compassion fatigue (Jackson, Schwab & Schuler, 1986). Burnout and compassion fatigue have been shown to reduce attention and concentration, affect communication, and can lead to heart and/or mental health problems (Miller, Stiff & Ellis, 1988; Spickard, Gabbe & Christensen, 2002). Consequently, it may be important for counsellors and psychotherapists to develop techniques that desensitise and educate them about compassion fatigue (Figley, 2002b).

Self-care strategies such as Compassionate Mind Training (CMT) (Gilbert, 2009) and Mindfulness-Based Stress Reduction (MBSR) (Christopher & Maris, 2010) can be taught and may prevent burnout and compassion fatigue. Thieleman and Cacciatore (2014) found a positive association between mindfulness and compassion satisfaction, and an inverse correlation between mindfulness and compassion fatigue amongst bereavement specialists.

Given that it is possible to develop self-compassion (Gilbert, Baldwin, Irons, Baccus & Palmer, 2006; Harman & Lee, 2010; Neff et al., 2007), by challenging self-criticism and self-judgement and teaching self-soothing techniques (Gilbert, 1997; Gilbert, Clarke, Hemel, Miles & Irons, 2004; Gilbert & Irons, 2004; Harman & Lee, 2010; Neff et al., 2007), lecturers can improve care offered to student counsellors and student psychotherapists which may in turn reduce levels of counsellor burnout (Brewin, 2006).

### Rationale

Acknowledging the need emphasised within the literature to teach self-care strategies to student counsellors and psychotherapists, we wanted to augment the literature by taking a different approach: that is, to support the need for self-care strategies through exploring relationships between self-compassion, well-being, compassion fatigue and burnout, using validated scales.

The research question asked was as follows: What are the relationships between self-compassion, well-being, compassion fatigue and burnout in student counsellors and student cognitive behavioural psychotherapists?

## Method

A quantitative survey using four validated data collection instruments was implemented to measure relationships between (1) self-compassion, (2) compassion fatigue, (3) well-being and (4) burnout.

## Participants

Participants were a mixed sample of student cognitive behavioural psychotherapists (CBP) and person-centred counsellors ( $n = 54$ ) in their final year of study. No inclusion or exclusion criteria were applied.

## Data collection instruments

Four data collection instruments were used to measure participants' self-compassion, compassion fatigue, well-being and levels of burnout.

### *The Professional Quality of Life (ProQOL) scale*

The *Professional Quality of Life* (ProQOL) scale (Stamm, 2009) consists of 30 items divided into three subscales: (1) compassion satisfaction, (2) compassion fatigue and (3) secondary traumatic stress and burnout, and has been validated by Stamm (2009). Item responses relate to thoughts about statements over the last 30 days, which are recorded on a Likert scale ranging from 1 to 5 (1 = never; 2 = rarely; 3 = sometimes; 4 = often, 5 = very often). Sample items include 'I feel connected to others' and 'I feel overwhelmed because my workload seems endless'.

### *The Self-Compassion Scale*

The *Self-Compassion Scale* (long version) (Neff, 2003) consists of 26 items divided into six subscales: (1) self-kindness, (2) self-judgement, (3) mindfulness, (4) common humanity, (5) isolation and (6) over identification, and has been validated by Neff (2003). Items are scored using a Likert scale ranging from 1 (almost never) to 5 (almost always). Sample items include 'I'm disapproving and judgemental about my own flaws and inadequacies' and 'I try to be loving towards myself when I feel emotional pain'.

### *The short Warwick and Edinburgh Mental Well-being Scale (sWEMWBS)*

The *short Warwick and Edinburgh Mental Well-being Scale* (sWEMWBS) is a shorter version of the 14-item *Warwick and Edinburgh Mental Well-being Scale* (Tennant et al., 2009), and has been validated by Tennant et al. (2009). The short version consists of seven positively worded items that enquire about well-being over the prior two weeks. Items are scored using a Likert scale ranging from 1 to 5 (none of the time = 1, rarely = 2, some of the time = 3, often = 4 and all of the time = 5). A sample item is 'I've been feeling optimistic about the future'.

### *Compassion For Others (CFO) scale*

The *Compassion For Others* (CFO) scale (Pommier, 2011) consists of 24 items divided into six subscales: (1) kindness, (2) indifference, (3) common humanity, (4) separation, (5) mindfulness and (6) disengagement, and has been validated by Pommier (2011). Item responses are recorded on a Likert scale ranging from 1 (almost never) to 5 (almost always), with reverse scoring applied to the indifference, separation and disengagement subscales. A sample item is 'when people cry in front of me I usually don't feel anything at all'.

## Procedure

The four scales, an information sheet and a consent form were placed in packs and issued at commencement of university-based teaching sessions. Student counsellors and student cognitive behavioural psychotherapists were asked to participate in the research, with assurance of no consequences in terms of course progression. Descriptive statistics were calculated, and the data were analysed using the statistical package SPSS 20.

## Ethical considerations

Ethical approval was obtained from the University Ethics Committee. The first author (EB) was aware of her dual role with some of the participants as both a researcher and lecturer on counselling and psychotherapy programmes. To minimise any potential negative implications, data were therefore collected by the second author (MD) who also gave an overview of the project as he did not lecture on counselling or psychotherapy courses.

Informed consent was obtained from all participants, and anonymity and confidentiality were assured. Students were informed that they had the right to withdraw their data at any stage. The whole process of administration and data collection took around 30 minutes.

**Table I:** Mean and standard deviation scores for compassion for others, self-compassion, compassion satisfaction, compassion fatigue, burnout and well-being

Questionnaire	<i>n</i>	Mean	S.D.
CFOS	54	4.2	0.5
SCS	54	3.1	0.6
CS	54	41.0	4.5
CF/STS	54	21.0	5.2
BO	54	21.6	5.7
sWEMWBS	54	25.4	4.3

CFOS, compassion for others scale; SCS, self-compassion scale; CS, compassion satisfaction; CF/STS, compassion fatigue/secondary traumatic stress; BO, burnout; sWEMWBS, the short Warwick and Edinburgh mental well-being scale.

## Results

Mean and standard deviation scores for all measures are shown in Table I.

Results show a mean score of 4.2 for compassion for others, which is considered high by Pommier (2011). However, self-compassion was 3.1, indicating a moderate score (Neff, 2003). Compassion satisfaction was high with a mean score of 41, and results also reveal low scores for compassion fatigue (21.0) and burnout (21.6) (Stamm, 2009) (see Table I). Well-being was in line with the UK national average.

Pearson's correlations between self-compassion, burnout, compassion fatigue, compassion satisfaction, well-being and compassion for others are shown in Table II.

The correlation analysis reveals a significant negative relationship between self-compassion and burnout ( $r = -.486$ ), and self-compassion and compassion fatigue ( $r = -.350$ ). Also, self-compassion correlates positively with well-being ( $r = .439$ ). No significant relationship between self-compassion and compassion for others was found. Students who

**Table II:** Pearson's correlations between self-compassion, burnout, compassion fatigue, compassion satisfaction, well-being and compassion for others

	Self-compassion	Burnout	Compassion fatigue	Compassion satisfaction	Well-being	Compassion for others
Self-compassion	1	-.486**	-.350*	.055	.439**	.061
Burnout	-.486**	1	.580**	-.376**	-.555**	-.289*
Compassion fatigue	-.350*	.580**	1	-.418**	-.415**	-.319*
Compassion satisfaction	.055	-.376**	-.418**	1	.336*	.341*
Well-being	.439**	-.555**	-.415**	.336*	1	.318*
Compassion for others	.061	-.289*	-.319*	.341*	.318*	1

\* $p < 0.05$  level (2-tailed).

\*\* $p < 0.01$  level (2-tailed).

**Table III:** Pearson's correlations for associations between self-kindness, self-judgement, compassion for others, compassion satisfaction, compassion fatigue, burnout and well-being

	Compassion for others	Compassion satisfaction	Burnout	Compassion fatigue	Well-being	Self-kindness	Self-judgement
Compassion for others	1	.341*	-.289*	-.319*	.318*	.142	-.059
Compassion satisfaction	.341*	1	-.376**	-.418**	.336*	.051	-.045
Burnout	-.289*	-.376**	1	.580**	-.555**	-.442**	.545**
Compassion fatigue	-.319*	-.418*	.580**	1	-.415**	-.221	.511*
Well-being	.318*	.336*	-.555**	-.415**	1	.352*	-.364**
Self-kindness	.142	.051	-.442**	-.221	.352*	1	-.592**
Self-judgement	-.059	-.045	.545**	.511*	-.364**	-.592**	1

\* $p < 0.05$  level (2-tailed).

\*\* $p < 0.01$  level (2-tailed).

**Table IV:** The mean difference on all measures for students categorised as having low/high levels of self-compassion

Scale	Low self-compassion	High self-compassion	<i>t</i>	<i>p</i> -value
Compassion for others	4.3 (0.4)	4.3 (.51)	0.039	ns
Compassion satisfaction	42.1 (2.9)	42.0 (4.8)	-0.082	ns
Compassion fatigue	21.8 (4.1)	17.4 (4.0)	2.48	<.05
Burnout	26.8 (8.0)	18.3 (4.0)	3.41	<.001
Well-being	22.1 (4.5)	27.8 (1.8)	-4.37	<.001

reported greater compassion for others scored less on burnout ( $r = -.289$ ) and compassion fatigue ( $r = -.319$ ). In addition, those with high compassion for others reported higher well-being ( $r = .318$ ) and compassion satisfaction ( $r = .341$ ).

Pearson correlations between self-kindness, self-judgement, compassion for others, compassion satisfaction, compassion fatigue, burnout and well-being are shown in Table III.

No significant association was found between self-kindness and self-judgement and compassion for others or compassion satisfaction. In contrast, both positive and negative associations on measures of compassion fatigue, burnout and well-being were found. Self-kindness correlated positively with well-being ( $r = .352$ ) and was inversely related to burnout ( $r = -.442$ ). Self-judgement correlated negatively with well-being ( $r = -.364$ ) and more positively with compassion fatigue ( $r = .511$ ) and burnout ( $r = .545$ ). These findings indicate a significant relationship between student therapists who are kinder to themselves and increased well-being, with fewer reporting burnout. Conversely, self-judgement was associated with increased compassion fatigue and burnout, and low levels of well-being.

Further analysis was conducted using independent samples *t*-test, with split scores (high versus low) for self-compassion (see Table IV).

Results show that having greater self-compassion is associated with reduced compassion fatigue ( $M = 17.4$ ,  $S.D. = 4.0$ )  $t(21) = 2.48$ ,  $p \leq .05$ ; burnout ( $M = 18.3$ ,  $S.D. = 4.0$ )  $t(21) = 3.41$ ,  $p \leq .001$ ; and higher well-being ( $M = 27.8$ ,  $S.D. = 1.8$ )  $t(21) = -4.37$ ,  $p \leq .001$ . These results support data from the correlation analysis, with those higher on self-compassion experiencing less burnout, compassion fatigue and greater well-being.

## Discussion

Results indicate that student counsellors and student psychotherapists who score high on measures of self-compassion experience improved well-being and compassion satisfaction, and report lower compassion fatigue and burnout. We also found that positive scores of self-kindness corresponded with increased well-being and less burnout. Scores on the measure of self-judgement were inversely correlated with well-being and positively with compassion fatigue and burnout. Furthermore, those in the high self-compassion group showed less compassion fatigue and burnout, as well as greater well-being than those in the low cohort.

The results inform us that student counsellors and student cognitive behavioural psychotherapists with higher levels of self-compassion experience greater well-being and reduced burnout, in keeping with literature that reports on the benefits of cultivating a compassionate self (see Beaumont & Hollins Martin, 2015 and Leaviss & Uttley, 2014).

The literature also reports the negating effects of the internal self-critic on general well-being (Gilbert, 2006; Neff et al., 2007), with participants in our sample scoring high on the self-judgement subscale also experiencing more compassion fatigue and burnout. Classically, compassion fatigue occurs in counsellors when levels of compassion in the workplace become eroded due to secondary trauma and/or discovering that the imagined role differs from reality (Blomberg & Sahlberg-Blom, 2007; Figley, 1995). Compassion satisfaction and self-care have been shown to impact positively on counsellors working with trauma (Sodeke-Gregson et al., 2013), with these concepts further extended to explore whether enjoying a therapeutic alliance with clients, and being kinder to the self, initiates greater compassion, reduced burnout and/or compassion fatigue.

## Contribution and advantages

To our knowledge, this is the first study to examine the relationship between self-compassion, compassion fatigue, burnout and well-being amongst student counsellors and cognitive behavioural psychotherapists. This preliminary study shows students who report higher levels of self-compassion and well-being also report fewer symptoms of compassion fatigue and burnout.

This first small study has initiated important discussions about the potential implications for improving counselling students' ability to gain better

outcomes for themselves. Compassion fatigue and burnout are authentic experiences for individuals, with learning self-compassion strategies important for protecting students from symptoms, and by doing so improving the quality of their professional lives.

### Limitations of study

The small sample size in our study is a limitation, and replication of our study using larger numbers of students is recommended. In addition, a longitudinal component, extending data collection to the start, middle and end of courses, and possibly beyond, may have yielded more fruitful data. A qualitative component would also have complemented the current data through explaining cause, effect and the lived experience of students undergoing counselling training.

### Further research

Healthcare professionals such as counsellors and psychotherapists enter into their profession with a desire to help other people manage the difficulties of life. However, for some the trauma and stressors of life as a therapist along with the pressures of everyday life and education can lead to burnout and compassion fatigue. Further research examining this process of change for students and practitioners is recommended.

Exploring strategies to help student counsellors and psychotherapists develop compassion for one's own suffering could also be explored further. Developing compassion for oneself may promote self-care, reduce self-criticism, compassion fatigue, and burnout and equip students wanting a career within the counselling and psychotherapy professions with the necessary tools needed to face the rigours of education and patient care.

### Conclusion and recommendations

Self-care is recognised as a preventive factor for work-related stress (Figley, 2002a). There are many recommendations for developing self-care, for instance Mindfulness-Based Stress Reduction (MBSR) (Christopher & Maris, 2010) and Compassionate Mind Training (Gilbert, 2009). The current study alludes to self-compassion as having the potential to be of benefit to students' own health and general well-being.

This preliminary study shows that students who score high on measures of self-compassion and well-being report less compassion fatigue and burnout.

This could have implications for developing new approaches in counselling and psychotherapy training. When entering into a course of study where students bear witness to the devastating effects of trauma, there is a need for intervention strategies for the student. For example, students could be taught strategies to help them increase self-compassion. Following a course of MBSR training, Shapiro, Brown and Biegel (2007) found that therapists reflected greater self-kindness and acceptance towards their patients. We therefore recommend that further research examine intervention strategies that help student counsellors and psychotherapists develop self-compassion.

Compassionate Mind Training (CMT) is one such approach that could guide further research. Compassion fatigue is also referred to as secondary traumatic stress, as therapists can absorb the client's traumatic experiences (Figley, 2002b). CMT has been shown to be effective when treating primary trauma (Beaumont & Hollins Martin, 2013; Beaumont et al., 2012) and is especially useful for reducing self-judgement (Gilbert, 2006); therefore, its potential to benefit practitioners warrants further investigation. Taking this into consideration, self-care strategies could reduce symptoms of fatigue, burnout and self-criticism and increase well-being. This in turn could help students manage the stresses of education and practice, which may make them more effective counsellors and psychotherapists in the future.

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### Biographies

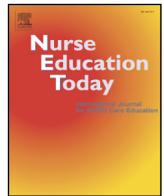
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# A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among UK community nurses

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## ABSTRACT

**Background:** Compassion fatigue and burnout can impact on performance of nurses. This paper explores the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life, and wellbeing among community nurses.

**Aim:** To measure associations between self-compassion, compassion fatigue, wellbeing, and burnout in community nurses.

**Method:** Quantitative data were collected using standardised psychometric questionnaires: (1) Professional Quality of Life Scale; (2) Self-Compassion Scale; (3) short Warwick Edinburgh Mental Wellbeing Scale; (4) Compassion For Others Scale, used to measure relationships between self-compassion, compassion fatigue, wellbeing, and burnout.

**Participants:** A cross sectional sample of registered community nurses ( $n = 37$ ) studying for a postgraduate diploma at a University in the North of England took part in this study.

**Results:** Results show that community nurses who score high on measures of self-compassion and wellbeing, also report less burnout. Greater compassion satisfaction was also positively associated with compassion for others, and wellbeing, whilst also being negatively correlated with burnout.

**Conclusion:** High levels of self-compassion were linked with lower levels of burnout. Furthermore when community nurses have greater compassion satisfaction they also report more compassion for others, increased wellbeing, and less burnout. The implications of this are discussed alongside suggestions for the promotion of greater compassion.

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## 1. Background

A recent report on the UK National Health Service (NHS) by Lord Francis QC, revealed that certain hospital failings were in part due to staff not acting with compassion, which led to his recommendation to develop more compassionate care among healthcare staff, with a specific focus on nurse training (Francis, 2013). Compassion is an integral part of any healthcare profession, and forms the basis of the Royal College of Nursing's (2010) and Nursing and Midwifery Council's (2008) guidelines for good practice in the UK, and also the American and Canadian professional nursing bodies (American Nurses Association, 2010;

Canadian Nurses Association, 2008). Providing compassionate care is also highlighted as a necessary skill for district nurses (Queens Nursing Institute, 2014).

## 2. Compassion in Nursing

Nurses generally start their careers wanting to make a difference to the lives of the people they treat. However, over time some staff become disillusioned with their role, which leaves them frustrated, burned out, and wanting to leave practice (Maben et al., 2010). For district nurses, having the ability to visit people in their homes and provide care for them brings a shared experience of suffering and accompanied compassion (Öhman and Söderberg, 2004). Bjerknes and Bjork (2012), suggest that nurses enter their profession with enthusiasm and empathy for patients. However, once they have settled in to their new roles, they sometimes find themselves faced with a variety of organizational difficulties

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which impede their performance. Examples of this include staff shortages, which can lead to additional work demands, long hours, less support, and poorer working conditions. Nurse education has come under scrutiny in recent years, with concerns centered on the impact this can have on students' ability to be compassionate (Bray et al., 2014; Crawford et al., 2014). For example, Murphy et al. (2009) observed a significant difference between first and third year student nurses' compassion, with lower scores reported in the third year. It has been argued that contemporary nurse education can erode a person's ability to exhibit compassion, whilst burnout can lead to feelings of depersonalization (Straughair, 2012a, 2012b). Hence, an absence of compassion in some parts of the NHS in the UK may be related to deficits in nurse education, particularly in relation to stress related subjects.

### 3. Compassion Fatigue and Burnout

Joinson (1992) first coined the term compassion fatigue, when she noted that an increasing number of nurses were reporting feelings of exhaustion as a direct consequence of working with patients. Building on this, Figley (1995) introduced his own notion of 'compassion fatigue' when talking about these effects with healthcare workers, further suggesting that 'compassion fatigue' occurs as a result of hearing about a traumatizing event that a person has experienced. 'Compassion fatigue' is a secondary form of traumatic stress, which Figley terms the 'cost of caring' (Figley, 2002). Durkin et al. (2013), reported high levels of 'compassion fatigue' and lower levels of 'burnout' in student nurses, compared with assistant practitioners. Causal factors were considered to include heavy workloads, lack of support, and long working hours. A study by Rout (2000), discovered that out of a sample of ( $n = 79$ ) NHS employed district nurses, the greatest predictors of stress included lack of communication between colleagues, extra work demands, feeling dissatisfied and problematic patients. Similarly, Beaumont et al. (2015a) discovered that more than half of a sample of student midwives ( $n = 103$ ) reported average levels of burnout. Burnout is commonly reported by nurses, with many describing experiences of feeling stressed as a direct consequence of stressors within their demanding role. Hegney et al. (2014) identified in a sample of 132 nurses, that compassion fatigue and burnout are strongly related to anxiety and depression. Burnout can affect a person's ability to display compassion, and has been related to feelings of emotional strain, reduced job satisfaction, and lack of support provision from managers and the organization (Farquharson et al., 2013; Young Hee and Jong Kyung, 2012). Michalec et al. (2013), highlights the risks of burnout amongst undergraduate students transitioning into full time employment.

In addition, the UK National Health Service (NHS), with its constant organizational changes, cutbacks, and target driven approach, may inhibit staff from expressing compassion through fear of the unknown and job insecurity (Iles, 2011). When we consider these factors from the perspective of Gilbert's theory of a compassionate mind, in many circumstances the threat system of a student nurse could be in a constant state of activation, which hinders their ability to feel compassion (Gilbert, 2009). However, having a compassionate presence has been shown to negate stress and improve wellbeing among nurses (Sabo, 2011).

### 4. Compassion Satisfaction and Wellbeing

Compassion satisfaction is the positive feeling associated with knowing that the professional has in some way helped another. According to Stamm (2009), when compassion satisfaction is high, and both burnout and compassion fatigue are low, the professional's quality of life is improved. Professional quality of life is the balance between compassion satisfaction, burnout, and compassion fatigue. When there is equilibrium in a person's professional quality of life, they will experience more flourishing in practice (Stamm, 2009). Todaro-Franceschi (2013), reported that although nurses are taught to understand what constitutes 'quality of life', they can lose their own

self-care in their daily working life. Nurses are required to work long hours and are expected to tend simultaneously to multiple patients, whilst consistently providing continuous compassion (Gershon, 2013). In stressful situations, such as a hospital environment, nurses often neglect their personal emotional and psychological needs. To compound these claims, nurses connect with their patients and families through the concept of empathy (Şenyuva et al., 2014), which can be impeded by compassion fatigue and burnout.

Work related stress can also affect the wellbeing of nurses. In a recent NHS staff survey (National Health Service Staff Survey, 2013), out of 67,261 registered general nursing and midwifery staff, 41% reported having experienced stress related issues that significantly impacted upon their personal wellbeing. Wellbeing has shown to be a significant predictor of high nursing staff turnover (Brunetto et al., 2013). This leads one to question what can be implemented to improve nurses' ability to provide and sustain high levels of compassion across time to their patients.

There is an increasing amount of evidence that promotes the idea that developing compassion for one's own suffering can alleviate stress, burnout, and increase resilience (Neff, 2003; Gilbert, 2009; Neff and Germer, 2013).

Curtis (2014), suggests that for nurses to continue delivering compassionate care, they must first receive education about compassion and be taught self-management techniques that prepare them for the emotional demands of clinical practice. Zeller and Levin (2013), recommend that 'mindfulness' should be taught to alleviate stress levels, with interventions for compassion fatigue delivered in education programs (Aycock and Boyle, 2009). In essence, higher education institutions must teach the concept of 'compassion' and practical applications to develop it into nursing programs.

### 5. Self-compassion

There has been an expansion of the amount of research that has explored the role self-compassion plays (Beaumont and Hollins Martin, 2015; Gilbert, 2009; Hutcherson et al., 2008), especially in relation to the education of health care professionals (Cornwell et al., 2014). For example, Beaumont et al. (2015b), found a significant association between high levels of 'self-compassion' and fewer symptoms of 'burnout' in trainee psychotherapists.

Several studies have explored relationships between compassion and nursing. For example, Gustin and Wagner (2013), discovered that cultivating self-compassion in clinical nurse teachers improved compassion for others. Jafari et al. (2012) found that a positive attitude towards the nursing role, job satisfaction, and feelings of hope, were related to lower levels of stress among a sample of Iranian nurses. Şenyuva et al. (2014), found that compassion can help nurses understand patient suffering through recognition of a shared unity of pain. Heffernan et al. (2010), reported a positive correlation between self-compassion and emotional intelligence in a sample of 135 nurses. Heffernan et al. (2010), further suggest that without self-compassion nurses would be unable to deliver authentic compassion for others.

Neff and Pommier (2013), propose that self-compassion can improve interpersonal functioning and is linked to qualities such as empathy and altruism. These studies support the idea that examining self-compassion among student nurses is important, and that this may be a way forward for developing compassion and stress reduction techniques.

To our knowledge, ours is the first study to examine relationships between self-compassion, compassion satisfaction, compassion fatigue, burnout, compassion for others, and wellbeing in community nurses.

### 6. Methodology

This study was a cross sectional questionnaire survey. Quantitative data were collected from a total of ( $n = 37$ ) registered community nurses studying at a University in the North of England. All participants had clinical experience and were full-time students studying for a 1 year

post-graduate diploma in community specialist practice. The sample included 34 females and 3 males, aged 23–56 (mean age 36). Other demographic data were excluded to retain focus on relationships between the measures themselves.

## 7. Procedure

At the start of their lecture a group of community nursing students were invited to participate in the survey, resulting in a small convenience sample of 37 community nursing students. Informed consent was provided by all students present.

## 8. Ethical Considerations

Approval was granted by the University Ethics Committee in line with the British Psychological Society guidelines on ethical practice (The British Psychological Society, 2014). Participants were informed that data would be stored securely and anonymously for a year before being destroyed.

## 9. Data Collection and Selection of Research Instruments

Data were collected using 4 psychometric instruments. A questionnaire-based method was selected because it is a standardized, effective, and economical way of collecting data.

### (1). Compassion for Others (CFO) Scale (Pommier, 2011).

The CFO Scale measures how people typically act towards others and includes statements such as “when people cry in front of me I usually don't feel anything at all”. Each item connects to six subscales; kindness, indifference, common humanity, separation, mindfulness, and disengagement. Participants indicate how they behave in relation to the individual items using a scoring scale from 1–5 where 1 equals ‘almost never’ and 5 ‘almost always’. Indifference, separation, and disengagement items are reverse scored. Total score for compassion is calculated using the mean for each subscale, before computing the overall mean from the scores. When examining subscales separately, reverse-coding is not used. Cronbach's alphas for this measure are high, with overall compassion (0.90), kindness (0.77), indifference (0.68), common humanity (0.70), separation (0.64), mindfulness (0.67), and disengagement (0.57). The scale's validity was established from data collected with student populations in the USA, and may not be directly comparable to British community nurses.

### (2). The Professional Quality of Life (ProQOL) Scale (Stamm, 2009).

This 30-item scale measures positive and negative aspects of working with trauma. There are 10 statements for each of the 3 subscales; compassion satisfaction, compassion fatigue/secondary traumatic stress, and burnout. Each item is scored using a Likert scale ranging from 1 (never) to 5 (very often) relative to the last 30 days. A sample item is “I feel connected to others”. Internal reliability is good with Cronbach's alphas for compassion satisfaction (0.88), burnout (0.75), and compassion fatigue/secondary traumatic stress (0.81). Scale validity was calculated from data from over 200,000 participants across the globe (Stamm, 2009).

### (3). The Self-Compassion Scale (SCS)-Long Version (Neff, 2003).

This instrument measures how people typically act towards themselves during times of great difficulty. It includes 6 subscales: self-kindness, self-judgement, mindfulness, common humanity, isolation, and over identification. Statements such as “I try to be loving towards myself when I feel emotional pain” are scored on a scale of 1 (almost never) to 5 (almost always). This scale has a high internal reliability, with Cronbach's alphas for overall self-compassion (0.93), kindness (0.88), self-judgement (0.88),

common humanity (0.80), isolation (0.85), mindfulness (0.85), and over-identification subscale (0.88). The SCS has been validated in both the UK and internationally.

### (4). The Short Warwick Edinburgh Mental Well-being Scale (sWEMWBS).

The sWEMWBS consists of 7 positively worded items that relate to respondents feelings over the prior fortnight. For example, “I've been feeling optimistic about the future”. Responses range from 1 (none of the time) to 5 (all of the time). Internal reliability is high, with a Cronbach's alpha of (0.83) (Tennant et al., 2009). Scale validity has been established with data collected in the UK and globally.

## 10. Statistical Analyses

Data were analyzed using SPSS version 20. Descriptive statistics were calculated before inferential analyses using a Spearman's Rho correlation and Mann Whitney Independent *U* test from divided scores of ‘high’ versus ‘low’ on all measures which relate to self-compassion. The rationale behind test use was to investigate the relationship between each variable, and to explore differences in ‘high’ versus ‘low’ levels of self-compassion among community nurses. Data were not normally distributed, therefore non-parametric tests were conducted.

## 11. Results

To view mean and standard deviation scores for the 4 questionnaires (see Table 1).

Results indicate that compassion scores (mean = 4.1) were higher than the original sample of USA psychology students (mean = 3.86) used by Pommier (2011), when developing the measure. Self-compassion scores were low (mean = 2.8), with mean scores of 3 and 3.5 considered moderate levels of self-compassion (Neff, 2003). Compassion satisfaction scores were high (mean = 39.3), and scores for burnout (mean = 22) and compassion fatigue (mean = 21) low, with this considered the desired balance for professional quality of life (Stamm, 2009). Wellbeing scores were slightly higher than the national average for general populations (mean = 25.1) (Evans et al., 2015).

The significance level for examining differences between groups was set at  $\alpha = 0.05$ . To view the calculated relationships between variables using a Spearman's rho correlation (see Table 2).

A statistically significant negative relationship between self-compassion and burnout was found ( $r = -0.369$ ). Self-kindness was also significant and again inversely related to burnout ( $r = -0.351$ ). Compassion satisfaction was found to be positively associated with compassion ( $r = 0.330$ ), wellbeing ( $r = 0.410$ ), and negatively with burnout ( $r = -0.370$ ). Although non-significant, self-judgement was found to be positively associated with both compassion fatigue and burnout.

Mean scores for ‘high’ and ‘low’ levels of self-compassion, burnout, compassion fatigue, compassion satisfaction, and wellbeing were

**Table 1**

Mean, standard deviation and range on scores for each measure.

Nurses				
Questionnaire	N	Mean	S.D	Range
CFOS	37	4.1	0.59	3–5
SCS	36	2.8	0.53	2–4
CS	37	39.3	6.3	19–48
CF/STS	37	21	5.1	10–30
BO	37	22	5.0	16–36
sWEMWBS	36	25.2	3.1	18–32

CFOS = compassion for others scale, SCS = Self-Compassion Scale, CS = compassion satisfaction, CF/STS = compassion fatigue/secondary traumatic stress, BO= burnout, sWEMWBS = The Short Warwick and Edinburgh Mental Well-being Scale.

**Table 2**  
Spearman's rho correlations for self-compassion, self-judgement and self-kindness in relation to burnout, compassion fatigue, compassion satisfaction, wellbeing and compassion for others.

	Compassion for others	Compassion satisfaction	Burnout	Compassion fatigue	Self-kindness	Self-judgement	Self-compassion	Wellbeing
Compassion for others	1	0.330*	0.041	0.187	0.027	0.128	−0.191	0.073
Compassion satisfaction	0.330*	1	−0.370*	0.053	0.056	0.061	0.080	0.410*
Burnout	0.041	−0.370*	1	0.499**	−0.351*	0.315	−0.369*	−0.550**
Compassion fatigue	0.187	0.053	0.499**	1	−0.011	0.163	−0.182	−0.292
Self-kindness	0.027	0.056	−0.351*	−0.011	1	−0.329*	0.626**	0.136
Self-judgement	0.128	0.061	0.315	0.163	−0.329*	1	−0.675**	−0.086
Self-compassion	−0.191	0.080	−0.369*	−0.182	0.626**	−0.675**	1	0.118
Wellbeing	0.073	0.410*	−0.550**	−0.292	0.136	−0.086	0.118	1

\*\*  $p < 0.01$  level (2-tailed).

\*  $p < 0.05$  level (2-tailed).

examined. Results found there to be no significant difference between groups (see Table 3).

## 12. Discussion

Results suggest that community nurses who are more self-compassionate are less likely to suffer from symptoms of burnout. In addition, community nurses who feel a greater sense of satisfaction from their work show greater compassion, more positive wellbeing, and are less prone to burnout. The high scores for compassion satisfaction are supported by the work of Maben et al. (2010), who found that nurses at the beginning of their careers want to provide high quality evidence-based care. However, two years on these nurses reported feelings of frustration and burnout. Michalec et al. (2013), call this the “quiet before the storm”, with self-judgement increasing a tendency towards burnout. Such evidence supports the idea that teaching community nurses the skills of self-compassion could potentially reduce negative thoughts and emotions. Such self-care techniques could potentially help prevent compassion fatigue and burnout.

Our results promote the idea that experiencing symptoms of compassion fatigue and burnout may be related to self-judgement in community nurses. Nurses who judge themselves harshly may feel consumed with critical self-talk, shame and guilt, which in turn impacts upon their emotional wellbeing. Overall scores for compassion were higher than Pommier's (2011), original sample of undergraduate students. However, two restrictions of our study are that we do not have access to the Pommier (2011) data, and our sample of community nurses is relatively small. Nonetheless, our findings are indicative of a possible larger problem and potentially explain recent criticisms of nursing staff highlighted in the Francis Report (Francis, 2013).

Our data have shown that when compassion satisfaction and self-compassion are high, the community nurses in our study showed greater compassion, experienced a better quality of life, increased wellbeing, and greater resilience towards occupational stress. Those who were self-critical tend to experience greater stress. In essence, whilst engaged in stressful situations it can be easy for nurses to neglect their own emotional and psychological needs, which makes them prone to compassion fatigue and burnout. Hence, more of a sense of enjoyment from providing care to patients could be developed through teaching

**Table 3**  
Mann Whitney Independent  $U$  test results for all variables in relation to nursing students classified as having high or low self-compassion.

Scale	Hi or low self-compassion		
	$U$	$z$	$p^*$
Compassion for others	14.0	24.0	4.92
Compassion satisfaction	13.0	58.0	4.27
Compassion fatigue	10.0	20.0	2.15
Burnout	8.0	18.0	1.21
Wellbeing	15.0	60.0	6.40

\*  $p < 0.05$ .

self-compassion skills. This would create what Sabo (2011), calls ‘a compassionate presence’.

## 13. Contribution to the Literature

There are several contributions that can be taken from this study.

- (1). We are the first research team to examine relationships between compassion, self-compassion, compassion fatigue, quality of life, burnout, and wellbeing in registered community nurses. However, it should be noted that we used a small convenience sample of community nurses.
- (2). Teaching techniques for self-care might reduce levels of compassion fatigue and burnout in community nurses. Building students' resilience and self-compassion through teaching techniques might have benefits in terms of reducing compassion fatigue and burnout. This is a matter for further research.
- (3). Developing community nurses' compassion satisfaction could increase compassion for others, and improve their personal wellbeing. When a nurse's wellbeing is high, they are said to become more engaged with their work (Brunetto et al., 2013).
- (4). Those who were dissatisfied with their role tended to score lower on measures of compassion. Findings show that self-compassion did not correlate positively with compassion for others, instead they were related to reduced burnout scores.

## 14. Implications for Community Nurses

Findings suggest that developing self-compassion may prove beneficial for registered community nurses. Our study has shown that even moderate levels of self-compassion may be linked to reduced levels of burnout. This finding in itself merits further investigation. Our paper adds to the growing body of literature that considers self-compassion to be a healthy attribute for nurses to have (Cornwell et al., 2014). If community nurses can be taught to recognise how they interact with patients, they will be able to develop greater compassion satisfaction. This in turn can lead to an increase in compassion for others.

## 15. Limitations

Questionnaires were collected from participants at the beginning of their post graduate diploma in community nursing. If questionnaires were given at the start and end of training, this would have provided pre-training and post-training data. It is difficult to generalize the findings of this study to other community nurses, both within and outside of the university.

Participant numbers were quite small. An additional investigation involving a larger sample, and including allied nursing specialisms would provide more information. In addition, only quantitative data was collected. A qualitative approach may have offered richer and more detailed data regarding the subjective experiences of the participating community nurses. Further factors may have influenced the

scores from this survey. For example, participants from different backgrounds may have strong trait resilience that could have altered results. In addition to the data collected, we could have measured resilience, coping strategies, cultural, and ethnic differences.

## 16. Further Research

Developing greater self-care could help individuals cope with everyday stressors. Previous studies have noted that compassion declines as nurse's progress through education (Murphy et al., 2009). Further research could include collecting pre, post and follow-up data to help develop a more longitudinal picture. Examining the role played by organisations for community nurses could also be illuminating. For example, organisational stress can inhibit compassion, especially when people feel under financial threat or threats of job loss (Crawford et al., 2014). Similarly, staff shortages can impact on staff, especially if staff members do not feel supported by managers.

Further research could also investigate interventions that may promote self-care in community nurses. Compassionate Mind Training (CMT) is perhaps one intervention that could help community nurses to develop compassion for their own suffering and the suffering of others. CMT draws on evidence from neuropsychology, attachment theory, evolutionary psychology, and social psychology, and its aim is to cultivate a compassionate mind. Within a therapeutic context, compassionate mind training is endorsed as a technique that helps increase feelings of care and compassion, through reducing self-criticism, guilt, and shame (see Beaumont and Hollins Martin, 2015 and Leaviss and Uttley, 2014, for a review). Furthermore, developing self-compassion has been found to increase compassion for others (Heffernan et al., 2010) and impact positively on wellbeing (Yarnell and Neff, 2013).

## 17. Summary and Conclusions

To conclude, the results suggest community nurses who report higher levels of self-compassion are less likely to suffer with burnout. Furthermore, community nurses who report a greater sense of satisfaction from their work also experience more compassion and less burnout. In light of recent documented cases where nurses failed to provide compassionate care, if students were to be taught strategies to improve their ability to self-care and provide compassionate care, then this in turn could impact positively on patients. Further research is recommended to investigate if community nurses, when armed with the tools to develop a compassionate mind, are fit to face the demands of their profession. It is hypothesized that such strategies will reduce the onset of burnout and lead to a more compassionate workforce.

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# Does Compassion-Focused Therapy Training for Health Care Educators and Providers Increase Self-Compassion and Reduce Self-Persecution and Self-Criticism?

Elaine Beaumont, MSc; Chris Irons, PhD; Gillian Rayner, PhD; Neil Dagnall, PhD

**Introduction:** There is a growing body of evidence within the health care community suggesting that developing feelings of compassion can profoundly affect physical and psychological health. This is an important area of work, and initial research with nonprofessional groups has found that practicing compassion through a variety of experiential practices and meditations can lead to higher levels of compassion for others, sensitivity to suffering, motivation to help, and altruism. This study examines outcome measures after a 3-day introductory workshop on compassion-focused therapy provided to health care providers and educators. The aim of the research is to explore whether the training would increase self-compassion and reduce self-criticism and self-persecution.

**Methods:** A total of 28 participants who were classified into three groups “nurses and midwives,” “counselors/psychotherapists,” and “other health care providers” completed the Self-Compassion Scale and Functions of Self-Criticizing and Self-Attacking Scale before and after training.

**Results:** Results reveal an overall statistically significant increase in self-compassion and statistically significant reduction in self-critical judgment after training. There was no statistically significant reduction in self-persecution or self-correction scores after training.

**Discussion:** Developing self-compassion and compassionately responding to our own “self-critic” may lead the way forward in the development of more compassionate care among health care professionals. Training people in compassion-based exercises may bring changes in levels of self-compassion and self-critical judgment. The findings are exciting in that they suggest the potential benefits of training health care providers and educators in compassion-focused practices.

**Keywords:** workplace learning, profession-other, human factors, self-compassion, compassion-focused therapy, health care educator and provider, compassionate mind training

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Compassion is one of the essential tools that health care workers need to work effectively with the individuals they treat.<sup>1</sup> Compassion has been defined in various ways, but a common definition is that it involves “a basic kindness, with a deep awareness of the suffering of oneself and of living things, coupled with a wish and effort to relieve it.”<sup>2(xiii)</sup> Compassion may involve a variety of attributes (eg, empathy,

distress tolerance, being nonjudgmental, and sympathy) and links to motivational systems associated to caring for and being cared for.<sup>3</sup> Recently, there has been much debate about compassion in health and social care<sup>4-7</sup> and after recent scandals within the National Health Service, much of the literature has focused on the blocks, deficits, and lack of compassion in health and social care settings.

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## Blocks to Compassionate Health Care

Recently, factors that may negatively affect health and social care professionals' compassionate capacity have been explored. These include a variety of factors linked to the working environment, such as high workload, time demands, and paperwork.<sup>7,8</sup> Research has also suggested that within this context, various intrapersonal factors may also block compassionate care, including experiences of vicarious trauma, compassion fatigue, stress, and burnout.<sup>1,9</sup> We now know, for example, that at the beginning of their careers, nurses are often motivated to provide high quality, patient-centered, and evidenced-based care. However, Maben et al.<sup>10</sup> found that just 2 years after starting their nursing career, many reported feelings of frustration, and exhibited evidence of burnout. This in turn, led to disillusionment, role changes, and in some cases staff opting to leave the profession. Similarly, Bjerknes and Bjørk<sup>11</sup> found that newly

qualified nurses tended to enter the nursing profession with empathy for their patients and enthusiasm toward the organization and their new role. However, once ensconced into their new role they often found themselves faced with organizational and professional obstacles that hindered their performance.

### Can We Cultivate More Compassionate Health Care?

At present, there is a growing body of evidence within the health care community that suggests that developing feelings of compassion can have a profound impact on mental health<sup>12,13</sup> and has also been shown to increase immune system effectiveness,<sup>14,15</sup> lower blood pressure and cortisol release,<sup>16</sup> and improve general psychological well-being.<sup>17</sup> There have been a variety of studies that have looked at cultivating more compassionate “organizations”<sup>18</sup> while other researchers have focused on how we could train and cultivate compassion as individuals. This is an important area of work, and initial research with nonprofessional groups has found that practicing compassion through a variety of experiential practices and meditations can lead to higher levels of compassion for others, sensitivity to and motivation to help suffering, and altruism.<sup>19–21</sup>

Researchers have also been interested in how self-compassion, and cultivating compassion for oneself, may have an important impact on our ability to be compassionate toward others. Gustin and Wagner<sup>22</sup> found that the cultivation of self-compassion in clinical nursing teachers improved the compassion they exhibited to other people. Heffernan et al.<sup>23</sup> discovered a positive correlation between emotional intelligence and self-compassion, with both factors leading to increased compassion for others among a sample of nurses.

Another related area of recent study has been the exploration of factors associated with lower levels of self-compassion. One emerging factor that seems to play an important role in this aspect is self-criticism. For example, self-criticism has been found to be strongly related to lower levels of self-compassion,<sup>24</sup> and that practicing compassion is associated with a reduction in self-criticism.<sup>13</sup> Moreover, being critical with ourselves has been found to be associated with a variety of negative correlates, including higher levels of stress and symptoms of mental illness.<sup>25</sup> Gilbert et al.<sup>24</sup> suggest that individuals may criticize themselves because they have thoughts of inadequacy, inferiority, disgust, and/or hatred toward themselves. The functions of self-criticism include correcting or improving oneself, to hurt or punish oneself, to prevent future mistakes, to maintain a certain standard, or to elicit sympathy from others.<sup>24</sup>

Given the results of this research, it seems helpful to consider whether compassion—and self-compassion—can be trained or cultivated in staff. This research is relevant to our study because self-attacking tends to be activated when individuals think that they have failed in a particular task. An alternative and psychologically healthier response could perhaps be taught. For example, another response to failure could be to learn to self-support or develop compassion for one’s pain and suffering.<sup>24,26</sup>

### Compassion-Focused Therapy and Self-Compassion

Self-compassion has its roots in Buddhist teachings but during the recent years it has been linked to psychological well-being. This has led to an increase in research exploring the benefits of cultivating compassion.<sup>3,15,27–32</sup> Compassionate mind training (CMT) and compassion-focused therapy (CFT) were specifi-

cally developed by Professor Paul Gilbert with and for individuals who experience self-criticism and shame. The model offers an evolutionary and neuroscience-based approach that explores how the evolution of affiliative emotions can regulate threat processing. Key principles of CFT are to motivate individuals to care for their well-being, to become sensitive to personal needs and distress, and to extend warmth and understanding toward themselves.<sup>3</sup> CFT involves developing key compassionate attributes and the skills of compassion.<sup>2</sup> Compassionate attributes include:

1. Developing a caring motivation and wish to alleviate distress (care for well-being)
2. Learning to recognize our own and other people’s distress (sensitivity to distress)
3. Being emotionally moved by feelings of distress (sympathy)
4. Using the compassionate mind to tolerate difficult emotions by moving toward suffering rather than avoid suffering (distress tolerance)
5. Seeing the world through the eyes of another and learning to understand why we feel the way we do (empathy)
6. Individuals are taught techniques that aim to help them become more aware of and let go of self-attacking and self-criticism (nonjudgmental attitude).

Individuals are encouraged to reflect on the key attributes of compassion and practice the skills needed to develop them. For example, skill training includes learning to direct attention in a compassionate way, behave, think, reason, and respond to emotions in a compassionate way and use imagery to cultivate a compassionate mind. Individuals are taught to use self-soothing actions, adaptive coping strategies, courage, and acts of kindness.<sup>24,33,34</sup> Research within therapeutic practice demonstrates that developing compassion for oneself and others can be beneficial for individuals experiencing chronic mental health problems,<sup>29,35</sup> psychosis,<sup>36–38</sup> trauma,<sup>27,39–41</sup> and eating disorders.<sup>42</sup> The study by Gilbert<sup>3</sup> entails a comprehensive overview of the origins and nature of CFT.

### Rationale for This Study

Increasing self-compassion and reducing self-criticism and self-persecution may protect health care professionals (HCPs) from compassion fatigue and burnout,<sup>1,43–45</sup> in addition to improving physical and psychological health.<sup>12–17</sup> Given the current pressures within health care settings, the literature highlighting frequent reductions in compassionate care as professionals move through their careers, and research emphasizing the important role played by self-compassion and self-criticism, this study was designed to measure whether attendance at a training course in CFT (as part of a Continuing Professional Development [CPD] programme) may increase levels of self-compassion of the attendees while lowering their self-reported self-criticism.

CPD is essential for those working within health care professions because it helps ensure that professional standards of care are maintained. Keeping up to date with health care developments and therapeutic approaches helps practitioners acquire new skills, reflect on practice, and remain a competent practitioner. CPD can help the clinician to identify and challenge their own assumptions and reflect on their own needs as HCPs.<sup>46</sup> For these reasons, we introduced CFT as a CPD event to the staff team.

To the best of our knowledge, this is the first study to investigate the outcome of a brief 3-day introduction to CFT on HCPs' level of self-criticism and self-compassion.

## METHODOLOGY

### Participants

Participants were HCPs working at a university in the United Kingdom. Forty-four people attended the workshop and 28 completed pre and postquestionnaires were obtained. The sample consisted of 11 nurses and midwives, 10 therapists (counselors and cognitive behavioral psychotherapists) and seven HCPs. The HCPs included smoking cessation workers, health care improvement practitioners and lecturers in health care.

### Data Collection

Data were collected before the start of the workshop, at the end of training and at a follow-up focus group 1 month later.

### Quantitative Element

Two measures were given to participants before and after training.

*Self-Compassion Scale–Short Form (SCS-SF).* The SCS-SF is a 12-item questionnaire.<sup>47</sup> The scale consists of six subscales (self-kindness, self-judgment, mindfulness, common humanity, isolation, and overidentification) and examines how individuals act toward themselves while experiencing difficulties. Recent research suggests that the scale measures two separate factors, self-compassion and self-critical judgment,<sup>48</sup> we therefore collapsed items to give a measure of two subscales. Self-compassion scores were calculated by collating data from the self-kindness, common humanity, and mindfulness subscales. Self-critical judgment scores were calculated by collating data from the subscales isolation, self-judgment and overidentification.<sup>48</sup> This scale has a near perfect correlation with the long-scale questionnaire when examining total scores.<sup>47</sup>

*Functions of Self-Criticizing and Self-Attacking Scale (FSCS).* This scale measures the functions of self-criticism.<sup>24</sup> This scale examines why people think they self-criticize and self-attack. Factor analysis suggests two very different functions for being self-critical, which are as follows:

1. To try and improve oneself and to stop oneself from making mistakes. Questions include “to make sure I keep my standards up” and “to stop me being lazy.”
2. The other involves expressing anger and wanting to harm oneself. Questions include “to destroy a part of me” and “to harm part of myself.”

This is a 21-item scale measuring both of these factors. The responses are given on a 5-point scale (ranging from 0 = not at all like me, to 4 = extremely like me). Cronbach alphas were 0.92 for correcting and persecuting, respectively. Statistical analyses used SPSS release 20 for Windows (IBM SPSS, Chicago, IL).

### Qualitative Element

Participants were given the opportunity when completing posttraining questionnaires, to answer the following questions:

1. What have you found most useful from the 3-day training course?
2. Will you use any of the interventions with your students or clients or patients?

Participants were informed that they would be invited at a later date to attend a focus group to discuss the workshop. The results collected through the focus group will be examined in a second article.

### Procedure and Study Design

Participants were offered a place on a 3-day workshop titled “An Introduction to Compassion Focused Therapy.” Training was provided by one of us (C.I.), a board member of the Compassionate Mind Foundation ([www.compassionatemind.co.uk](http://www.compassionatemind.co.uk)) and an experienced trainer and practitioner in CFT. The workshop has been developed for attendees to use in their clinical practice, although as part of the workshop, attendees are encouraged to consider the model in relation to themselves and their students.

### Overview of the Workshop

Participants were introduced to core theoretical elements of CFT, including the evolved nature of our minds; how our sense of self is created through an interaction between our genes and our social experiences; and our emotion regulation systems (threat, drive, and soothing); and the nature of shame, self-criticism and compassion. Participants also explored the evolution, definition, and qualities of compassion, along with the practice of a variety of experiential exercises designed to cultivate different aspects of compassion (TABLE 1).

Ethical approval was given by the College Research Governance and Ethics Committee.

## RESULTS

Following participation in the 3-day training changes between premeasures and postmeasures across occupation groups were assessed by a series of 2 (time: pre versus post: within)  $\times$  3 (occupation: nurses and midwives versus therapists versus HCPs: between) mixed analysis of variance (ANOVA). Each subscale was analyzed independently.

Multivariate ANOVA was not appropriate. To use multivariate ANOVA, dependent variables are required to be conceptually related and moderately correlated. Specifically, Maxwell<sup>49</sup> recommends that correlations should be in the range of 0.3 to 0.7. Consideration of dependent variable intercorrelations revealed that correlations between self-critical judgment and self-correction,  $r = 0.29$ ,  $df = 26$ ,  $P = .07$ ; self-compassion and self-correction,  $r = -0.20$ ,  $df = 26$ ,  $P = .15$ , failed to reach the required level. Additionally, Levene's test for equality of variance revealed nonhomogeneity of between-group variance for pre and posttraining intervention measures of self-correction before,  $F = 4.28$ ,  $df = 2, 25$ ,  $P = .025$ ; after,  $F = 3.80$ ,  $df = 2, 24$ ,  $P = .036$ . Given these data limitations, an ANOVA was performed on each dependent variable (SCS: self-critical judgment and self-compassion; FSCS: self-correction and self-persecution). Means (M) and standard deviations (SD) are shown in TABLE 2.

It was predicted that posttraining scores on SCS and FSCS subscales would improve compared to the pretraining scores.

**TABLE 1.**  
**Some of the Experiential Exercises That Were Examined and Practiced in the 3-day Workshop**

Mindfulness and focused attention	Mindfulness: learning how to pay attention in the present moment without judging or criticizing
Soothing rhythm breathing	Teaching breathing methods that have been found to be associated with heart rate variability, positive health outcomes and facilitation of frontal cortex activity
Compassion-focused imagery	Use of imagery to help manage life's struggles (imagining the compassionate self-dealing with a problem)
Creating a safe place	Creating a place in the mind that provides a feeling of safety and calm
Compassion as a flow	Compassion can flow in three ways, from others to us, from us to other people and from and to ourselves
Developing the compassionate self	Using method acting and imagery techniques to create and develop a compassionate ideal self which may be used to direct compassion to others, and to oneself
Developing our ideal compassionate other	Using imagery techniques, participants create an image of an ideal compassionate other, and learn to experience compassion from this image
Using compassionate self to explore and relate to different parts of ourselves (multiself)	Participants explore different emotional parts of themselves (eg, angry, anxious, sad) to a recent distressing incident, and then use their compassionate mind to relate to these different parts, and the incident itself
Using compassion to engage with self-criticism	From the developed compassionate part of self, participants direct compassion (eg, empathy, distress tolerance, care) to their self-critical parts
Compassionate Letter writing	Compassionate letter writing helps to engage with difficulties and problems by focusing on being kind, supportive, and nurturing, as opposed to being self-critical

To reduce the probability of type I errors, posthoc interaction comparisons were restricted to pretraining versus posttraining differences by using related t tests on each level/occupation type. Application of Bonferroni corrections for multiple comparisons produced an alpha level of 0.017. Information about effect sizes accompanies statistical analysis and is indicated by partial eta-squared ( $\eta_p^2$ ) within ANOVA and Cohen's *d* when t tests were calculated. A partial eta-squared value of between 0.01 and 0.06 reflects a small effect size, 0.06 to 0.13 represents a medium effect size, and a value of 0.14 or higher indicates a large effect.<sup>50</sup> Cohen's<sup>51</sup> *d* classifies effect sizes as small (0.2), medium (0.5), and large (0.8) when interpreting the effect of an intervention.

**Self-Compassion Scale**

**Self-Critical Judgment**

A significant main effect was observed for time,  $F(1, 25) = 19.48, P < .001, \eta_p^2 = 0.44$ . Posttraining ( $M = 15.61, SD = 4.57$ ) self-critical judgment scores were lower than pretraining ( $M = 18.11, SD = 5.09$ ) scores. The occupation main effect was significant,  $F(2, 25) = 18.00, P < .001, \eta_p^2 = 0.59$ . These main effects were qualified by the significant time  $\times$  occupation interaction,  $F(2, 25) = 3.96, P = .032, \eta_p^2 = 0.24$ .

Simple main effect analysis revealed differences between pre and posttraining ratings for therapists ( $M = 13.60, SD = 3.17$  versus  $M = 11.40, SD = 3.20$ ),  $t = 3.60, df = 9, P = .006, d = 0.69$ , and HCPs ( $M = 23.43, SD = 4.20$  versus  $M = 18.00, SD = 2.45$ ),  $t = 2.52, df = 6, P = .046, d = 1.92$ . Self-critical judgment for therapists and HCPs reduced after training. The HCP score after applying the Bonferroni correction was above the corrected level of significance. However, scores suggested a trend toward improvement as indicated by the large effect size.<sup>50</sup> Pre and posttraining scores for nurses and midwives did not differ significantly ( $M = 18.81, SD = 3.13$  versus  $M = 17.91, SD = 4.01$ ),  $t = 1.34, df = 10, P = .211, d = 0.25$ .

**Self-Compassion**

A significant main effect was observed for time,  $F(1, 25) = 15.76, P = .001, \eta_p^2 = 0.39$ . Posttraining ( $M = 20.75, SD = 3.21$ ) self-compassion scores were higher than their pretraining ( $M = 18.36, SD = 4.44$ ) scores. No main effect was found for occupation,  $F(2, 25) = 0.71, P = .501, \eta_p^2 = 0.05$ . The time  $\times$  occupation interaction was not significant,  $F(2, 25) = 1.90, P = .170, \eta_p^2 = 0.13$ .

**TABLE 2.**  
**Pre and Posttraining Occupation Mean and Standard Deviations on the SCS and FSCS**

Scale	Occupation										Overall (n=28)					
	Nurses and Midwives (n = 11)				Therapists (n = 10)				HCP (n = 7)				Pre		Post	
	Pre		Post		Pre		Post		Pre		Post		M	SD	M	SD
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
SCS																
Self-Judgement	18.81	3.13	17.91	4.01	13.60	3.17	11.40	3.20	23.43	4.20	18.00	2.45	18.11	5.09	15.61	4.57
Self-Compassion	19.27	4.83	20.46	3.39	19.00	3.77	21.30	3.62	16.00	5.16	20.43	2.57	18.36	4.44	20.75	3.21
FSCS																
Self-Persecution	4.73	4.63	7.00	5.06	3.50	5.70	2.40	4.17	11.14	7.93	8.29	4.99	5.89	6.52	5.68	5.22
Self-Correction	24.64	13.13	23.45	13.25	15.70	9.32	13.70	6.73	26.86	4.45	28.71	7.02	22.00	11.00	21.29	11.34

FSCS indicates Functions of Self-Criticizing and Self-Attacking Scale; SCS, Self-Compassion Scale.

## Functions of Self-Criticizing and Self-Attacking Scale

### Self-Correction

No significant main effect was observed for time,  $F(1, 25) = 0.10, P = .756, \eta_p^2 = 0.00$ . Posttraining ( $M = 21.29, SD = 11.34$ ) and pretraining ( $M = 22.00, SD = 11.00$ ) scores did not differ. The occupation main effect was significant,  $F(2, 25) = 4.58, P = .020, \eta_p^2 = 0.27$ . Posthoc comparisons using independent Bonferroni corrected independent t tests found HCP ( $M = 27.79, SD = 3.63$ ) self-correction scores to be higher than those of therapists, ( $M = 14.70, SD = 7.10$ ),  $t = 4.45, df = 15, P < .001, d = 2.34$ . Differences between nurses and midwives ( $M = 24.05, SD = 12.95$ ) and HCPs ( $M = 27.79, SD = 3.63$ ),  $t = -0.90, df = 12.31, P = .38, d = 0.38$  and nurses and midwives ( $M = 24.05, SD = 12.95$ ), and therapists ( $M = 14.70, SD = 7.10$ ),  $t = 2.08, df = 15.79, P = .055, d = 0.93$  were not significant. While significance testing indicated no significant difference between the nurses and midwives versus therapist groups, a large effect size was present. This suggested that a significant difference would be observable with a relatively modest increase in sample size. The time  $\times$  occupation interaction was not significant,  $F(2, 25) = 0.61, P = .550, \eta_p^2 = 0.05$ .

### Self-Persecution

No significant main effect was observed for time,  $F(1, 25) = 0.33, P = .570, \eta_p^2 = 0.01$ . Posttraining ( $M = 5.68, SD = 5.22$ ) and pretraining ( $M = 5.89, SD = 6.52$ ) scores did not differ. The occupation main effect was significant,  $F(2, 25) = 4.19, P = .027, \eta_p^2 = 0.25$ . Posthoc comparisons using independent Bonferroni corrected t tests found that HCPs ( $M = 15.29, SD = 9.19$ ) had higher self-persecution scores than therapists ( $M = 4.70, SD = 7.66$ ),  $t = -2.59, df = 15, P = .021, d = 1.38$ . However, this difference was above the Bonferroni corrected significance level. Differences between nurses and midwives ( $M = 8.23, SD = 6.26$ ) and HCPs ( $M = 15.29, SD = 9.19$ ),  $t = -1.95, df = 16, P = .069, d = 1.00$  and nurses and midwives ( $M = 8.23, SD = 6.26$ ) and therapists ( $M = 4.70, SD = 7.66$ ),  $t = 1.16, df = 19, P = .260, d = 0.53$  were not significant. Consideration of the observed effect sizes revealed large effect sizes<sup>50</sup> for the HCPs versus therapists and nurses and midwives versus HCPs comparisons indicated that modest increases in sample size would produce significant differences. The time  $\times$  occupation interaction was not significant,  $F(2, 25) = 2.43, P = .109, \eta_p^2 = 0.16$ .

An introductory, 3-day CFT training workshop had beneficial effects on SCS ratings. Compared with the pretraining ratings, the posttraining ratings for self-critical judgment decreased for therapists and HCPs and self-compassion ratings increased.

The workshop had no statistical significant effect on FSCS subscales (self-correction and self-persecution).

## DISCUSSION

There is an increasing focus within health care about the importance of compassionate care, and an awareness of blocks or inhibitors to this. This study looked at whether, as part of a training workshop, teaching health care and academic professionals about CFT, there may be associated increases in participant's levels of self-compassion, and reductions in levels of self-criticism. Self-compassion scores increased posttraining in all groups and self-critical judgment (as measured using a composite of item scores on the SCS) reduced posttraining in all groups.

Our finding that in the total sample there were pre to post CFT training changes in the scores on the SCS suggests that training people in compassion-based exercises may bring about changes in their self-reported levels of compassion and judgment, even when this is in the context of training in an approach for one's clients/work. This supports other research that has found that training in compassion-based experiential exercises may bring changes in levels of self-reported compassion.<sup>52</sup> Given that this was a brief training programme, and that the experiential exercises that participants engaged with were part of a broader programme of learning, these findings are exciting in that they suggest the potential benefits of training health care staff in compassion.

Although we found very small reductions in two specific forms of self-criticism—self-correction and self-persecution—these did not reach statistical significance. It is interesting that while we identified statistical significance in changes in self-compassion, this did not translate to changes in self-criticism. There may be a number of reasons for this; this was a preliminary study with a small sample size, with statistical analysis suggesting that a significant difference may be observed on self-correction and self-persecution scores with a relatively modest increase in sample size. However, it may be that affecting change in levels of self-criticism may take longer than was given in this study. Moreover, given that the introductory workshop taught participants compassion-based exercises, it spent longer teaching participants about the theory and practice of CFT. Given this, it may not be surprising that levels of self-criticism did not reduce.

Although sample size numbers were small, there seemed to be some interdisciplinary variation in change scores. Looking at the three different professional groups, we found an interesting pattern of change pre to posttraining. On the two subscales of the SCS, all groups showed an increase in scores linked to self-compassion, and a reduction in items measuring self-critical judgement. Interestingly, the “other HCPs” group also showed a small (nonsignificant) increase in self-criticism (self-correction) scores. One explanation which was discussed in the training itself is that we may have multiple ways of relating to ourselves (eg, self-critically, self-compassionately) and therefore it may be easy, in the early stages of exposure to this work, to tone up one's capacity for self-compassion, but this does not mean that our level of self-criticism reduces accordingly. This study did not set out to test the impact of changes in levels of self-compassion on self-criticism (ie, in a linear, causal manner), but it may be interesting in the future to see whether change in one, or both, is salient in facilitating change in other related processes (eg, stress, burnout, compassion fatigue, depression, and so forth).

Although it is difficult to make clear inferences because of low numbers in each professional subgroup, the different patterns of average scores across the measures in each group is intriguing. Self-persecution scores increased posttraining in the nurses and midwives group only. For some people, practicing compassion exercises can bring them in contact with their self-criticism and personal distress in a way that may, in the short term, increase their self-reported scores as they become more aware of something that previously they were disconnected from. Counselors and psychotherapists seem to have lower levels of self-criticism and higher self-compassion, whereas the “other HCPs” group had the highest pretraining levels of self-criticism and lowest pretraining level of self-compassion. It is unclear whether these

findings are an accurate reflection of interprofessional differences, but if they are, these may link to a variety of factors, including the content/nature of differences in professional training; the nature of professionals' day-to-day job stress; or the level of support/supervision provided. It may be helpful for future studies to explore these findings in greater detail, and if replicated, investigate further what might account for such differences.

Training was only conducted for a 3-day period and the results suggest that this may not be enough time to instigate change in self-criticism and self-persecution for all participants.

## LIMITATIONS

There are a number of limitations to the study. First, this was a small study which used only two questionnaires. Second, the training took place on the university campus, which meant participants may have been distracted by students and work commitments during break times. Moreover, some staff had to leave sections of the workshop to deal with work-related issues. Third, although we took measures of self-compassion, we did not record if participants' level of "other" compassion increased, or if participants' ability to experience support and compassion from others changed after training. Fourth, although the workshop includes many compassion-based exercises, it also includes participants having to engage (potentially) difficult memories, emotions, and thoughts, including working directly with recognizing the nature and function of their own self-criticism. Actively engaging in experiential exercises that linked to shame memories and self-criticism may have reduced the potential for some participants to benefit from the compassion exercises themselves. One participant disclosed on the posttraining questionnaires "I will practice the exercises (CFT) myself when I notice shame. . . I didn't realize I had such feelings until I started to reflect over the 3 days." Another commented, "The training was a reminder of the nature and role of shame in maintaining distress and a reminder about the importance of self-compassion."

Despite the limitations, participants reported that the model was easy to understand. Participants reported that they valued the experience of coming together as a staff group to discuss the CFT model and to examine interventions that could potentially help them develop compassion for themselves and others.

## FURTHER RESEARCH

Future studies would benefit from larger sample sizes, and not only might this be helpful to detect overall effects on attendance at compassion training but it would also elucidate whether there are interdisciplinary differences between levels of self-criticism and self-compassion. We would also be keen to explore whether any potential benefits gained from attendance at similar trainings are maintained, and whether continued practice of compassion-focused exercises is linked to this.

There is growing evidence that compassion-based approaches can positively affect clinical and student populations. It is essential that HCPs deliver compassionate care especially because research suggests that there is an increase in compassion fatigue and burnout.<sup>1,45</sup> With research suggesting that more HCPs want to leave their profession because of stress-related issues<sup>53</sup> policy makers and organizational factors should be examined in further research. Interestingly, one participant

commented after training that the training helped them feel valued by the organization, "the training helped me to feel valued by the organization and has been academically satisfying. I want to know more and study more about this topic." With another participant reflecting, "the techniques will empower me and help me to relate and be with others. Getting a chance to spend time with colleagues and getting to know them was beneficial."

## SUMMARY AND CONCLUSIONS

This study provides some initial data on the impact on health professional's level of self-compassion and self-criticism after a 3-day introductory CFT training course. Results suggest some intriguing findings, and trends in places toward pre to post increases in self-compassion, and reductions in self-criticism. Given the difficulties that health professionals face in their jobs, and the potentially deleterious impact of self-criticism on their ability to maintain compassionate care for others, it may be that training staff on having compassion for their own suffering may be helpful in developing greater self-care and emotional resilience. It is therefore essential that health care educators and providers explore these concepts in more depth.

CPD helps to ensure effective patient and student care. Education regarding the impact that self-compassion and self-criticism plays within health care populations may help HCPs be "kinder to themselves" in times of distress, which in turn may help them foster compassionate environments. Nursing, midwifery, and psychotherapy professions have evolved during the past 30 years, cultivating a compassionate mind and compassionate working environments may lead the way forward in the development of more compassionate care among HCPs.<sup>5,7,18</sup>

### Lessons for Practice

- Training health care professionals in compassion-based exercises may bring changes in levels of self-compassion and self-critical judgment.
- Cultivating compassion for oneself may have an impact on our ability to be compassionate to others.
- Practicing compassion may be associated with a reduction in self-criticism.
- Self-attacking tends to be activated when individuals think that they have failed in a particular task. An alternative response could be taught by learning to self-support and develop compassion for one's pain and distress.
- Developing a compassionate mind by responding to our own "self-critic" may lead to more compassionate care among health care professionals.

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## Research article

# A proposal to support student therapists to develop compassion for self and others through Compassionate Mind Training



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## ABSTRACT

**Purpose:** Student therapists can experience incidents in practice interactions that are emotionally rewarding but sometimes highly challenging. In responding to distressing events, they may experience empathic distress fatigue, compassion fatigue, stress, burnout, and self-criticism, which in turn can alter their ability to provide compassion to both self and others, and can create persistent self-criticism and negative rumination. A creative framework designed to teach student therapists about Compassion Focused Therapy (CFT) to underpin the worth of Compassionate Mind Training (CMT), is a training process designed to increase levels of compassion.

**Expected learning outcomes:** On completion of teaching the 6-step study framework, student therapists will understand variables that influence compassion delivered to both self and others. They will understand how the compassionate mind model works, and consider how cultivating compassion can moderate self-critical dialogue. They will gain understanding of the 3 flows of compassion, examine how low levels of compassion can lead to empathic distress fatigue, compassion fatigue, burnout and self-criticism, and explore how emotions, such as shame and self-critical thinking impact upon well-being.

**Practical implications:** The suggested programme will develop the ability in student therapists to 'be kinder to self' in times of stress, hence building their resilience. It is recommended that post-delivery of a well prepared teaching plan that addresses the 6-step study framework, that the lecturing team evaluate the effectiveness of the training.

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## Introduction

Students embarking on a career as a counsellor or psychotherapist are likely to experience traumatic incidents whilst engaged in clinical training, which can be emotionally demanding and stressful. In response, student therapists may experience emotional fallout, symptoms of empathic distress fatigue, stress, burnout, compassion fatigue, and/or self-criticism, which has the potential to impact upon levels of compassion shown towards self and others (Beaumont, Durkin, Hollins Martin, & Carson, 2015; Figley, 1995, 2002). Within this context, teaching self-care strategies and interventions aimed at increasing levels of compassion becomes imperative. Teaching student therapists about Compassion Focused Therapy (CFT) and Compassionate Mind Training

(CMT) may help equip them with the interventions needed to cultivate compassion for distress. This form of self-care is designed to increase the quality of life of therapists, increase levels of self-compassion and compassion for others, and reduce risk of emotional fallout (Beaumont et al., 2015). Christopher, Christopher, Dunnagan, & Schure (2006) argues that, due to the demands of the curricula of clinical training, "self-care is typically presented to the student as an individual responsibility" (p. 496). Nonetheless, over recent years there has been growing recognition that incorporating interventions (e.g., mindfulness & loving kindness meditations) into clinical training programmes may help students to be mindful of their own well-being (Rimes & Wingrove, 2011).

The Dalai Lama (2003) suggests that before individuals can develop genuine compassion for others they first have to be able to commit to care for their own well-being. This view is echoed by Shapiro (2008) who argues that the human heart needs to first pump blood to itself. The value of practicing self-compassion to promote therapists continued well-being has been recognised in the literature by Barnett, Baker, Elman, & Schoener (2007)

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and Mahoney (2005). However and surprisingly, few studies have examined the process of teaching student therapists strategies for self-care (Patsiopoulos & Buchanan, 2011). Addressing this gap in student therapists training, this paper explores an intervention that has potential to enhance and enrich the lives of therapists, through teaching self-care strategies that incorporate creative methods to increase levels of compassion towards self and others.

### Clinical training challenges

Student life can be stressful, due to juggling study with work commitments, financial pressures, and personal responsibilities (Leathwood & O'Connell, 2003; Rückert, 2015; Scanlon et al., 2010; Neely, Schallert, Mohammed, Roberts, & Chen, 2009). Whilst many students face similar challenges (Scanlon, Rowling, & Weber, 2007), those engaged in clinical training programmes face further distinctive challenges that test both their knowledge and capability (De Stefano, Atkins, Noble, & Heath, 2012). By the very nature of the job, student therapists work with clients experiencing high levels of distress, possible suicidal ideation, with possible fixations of self-injury. Such disclosures require timely response, ethical and legal consideration, and are surrounded by rules around confidentiality and disclosure (De Stefano et al., 2012). In addition, placements that engage individuals with mental health problems can augment these emotional challenges (Moore & Cooper, 1996). Furthermore, student therapists are required by many clinical training programmes to engage in personal therapy. This can add stress for student therapists, because they are required to reflect on their own history, present circumstances and attachment styles (Edwards, 2013). This in itself can 'ignite a threat response' (Gilbert, 2009), leaving the individual without a 'secure base' (Bowly, 1969).

Rizq and Target (2010) examined the role of attachment status in student counselling psychologists ( $n=12$ ). Results suggest that 'insecurely-attached' participants experienced personal therapy differently (e.g., they were more reluctant to attend therapy sessions) and were more concerned, less trusting, more fearful and suspicious, than students with a 'secure' or 'earned-secure' attachment style. The authors argue that more research should be conducted to examine if the attachment status of the student therapist influences patient work. Obegi and Berant (2008) suggest that therapist attachment styles may impact on the client-therapist relationship, arguing that therapists with a 'secure' attachment are more likely to create a secure therapeutic environment. Indeed, this notion is echoed by Farber and Metzger (2008) who propose that therapists with a 'insecure' attachment may not be as well-equipped to heal ruptures in the therapeutic relationship as therapists with a 'secure' attachment style. This makes consideration of incorporating Compassionate Mind Training (CMT), as an intervention rooted in various sciences, including neurophysiological research, attachment theory, developmental and social psychology, into counselling and psychotherapy training potentially important.

A further point to consider is that although personal therapy can help students to develop personal insights (Edwards, 2013), it also has demands. For example, student therapists have to pay for psychotherapy, which adds expense and potentially may heighten anxiety and rumination. Furthermore, just as in clinical populations, student therapists are required to be ready to engage wholeheartedly in the therapeutic process, "otherwise an opportunity for personal growth will be missed" (Edwards, 2013, p. 224). Introducing the idea of 'lifework' into counselling and psychotherapy training programmes may help educators equip students with some of the tools needed to manage the difficulties of clinical training. Cultivating compassionate environments may therefore help create a 'secure base' for students, and also help them develop a

caring motivation for change. This in turn may increase confidence, and remind students that they are 'in the same boat' as other students (e.g., that all human beings have moments of stress, suffering, and anxiety). We are all part of one humanity (Neff, 2003a) and becoming a competent therapist can be dependent on the 'lifework' students engage in, whether that is personal therapy and/or introducing activities into life that promote self-care and boost levels of self-compassion. Working toward a shared goal may increase the quality of care given to others. Indeed, there is often a strong bond between student therapists and counselling and psychotherapy teams (Edwards, 2013), which can enable development. However, for some students the group experience may not necessarily be positive (Edwards, 2013). For example, some students may feel isolated or 'not good enough' and so compare themselves unfavourably to other students in the cohort, which also makes considering an intervention that aims to cultivate self-compassion important.

In essence, student therapists may experience anxiety that is considered part of their journey towards developing a psychotherapeutic identity (Jacobsson, Lindgren, Hau, 2012). Like other healthcare professionals, this places them at particular risk of stress and burnout (Boellinghaus, Jones, Hutton, 2012; Moore & Cooper, 1996; Rønnestad & Skovholt, 2003). Surveys by Boellinghaus et al. (2012) and Brooks, Holtum, and Lavender (2002), propose that between 25 and 41% of student therapists report struggles with low self-esteem, depression, and work adjustment. Kim and Sunwoo (2012) reported that play therapists and likewise Gam, Kim and Jeon (2016) reported that art therapists, had low levels of burnout when they were proactive in using stress coping strategies (e.g., social support, self-efficacy, and supervision) to manage perceived stress. This evidence reinforces the need for student therapists to develop self-care strategies, which is characterised in this paper as developing the ability to demonstrate compassion toward self and others. Self-care strategies include building self-awareness, self-regulation and the ability to balance one's own needs with others (Boellinghaus et al., 2012).

Providing self-care is an ethical imperative for psychological practitioners (Barnett et al., 2007), with therapists possessing a duty to take action when their own physical or mental health is harming their fitness to practice. Therapists' self-care is a critical element in preventing harm to clients during a therapeutic intervention (Barnett et al., 2007). Considering this expressed need, designing a training model that focuses on personal and professional aspects of self-care across the life span could be integrated into psychotherapy training programmes.

A further challenge for student therapists is the impact that clinical supervision has on their professional and personal development. Liddle (1986) promotes the idea that although clinical supervision is about support provision, it can provoke anxiety. Such provocation can also ignite the student therapists' 'threat system', which may result in self-criticism, embarrassment, shame, or fear of negative reactions from supervisors. Such responses can lead to negative thinking patterns, avoidance, and fear of disclosing thoughts during a supervision session, in attempts to conceal self-perceived flaws. Hence, teaching student therapists strategies that facilitate disclosure during their supervisory sessions may reduce the student therapists fear of being appraised harshly (Liddle, 1986). Self-compassionate individuals feel confident in admitting their mistakes, modify unproductive behaviours, and take on new challenges (Neff, 2009). As such, practices that encourage self-acceptance and cultivate a compassionate mind could help student therapists' gain more from their clinical supervision, placement experiences and clinical training.

Part of the role of educators is to search for meaningful solutions to problems encountered. Lecturers and clinical supervisors engaged in clinical training face a distinctive number of idiosyncratic difficulties. For example, in addition to having a

role as educator, lecturers are also gatekeepers for the profession (Edwards, 2014), aiming to provide high quality of care to students at the same time as being mindful of ethical obligations to the counselling and psychotherapy profession. Students will graduate and become the therapists of tomorrow, thus treating patients that will test their limits. As such, introducing exercises into clinical training programmes that cultivate compassion for self and others could help the students of today cope with the demands of therapeutic work.

### Self-compassion and self-criticism

Student therapists in the initial stages of clinical training can experience increased anxiety, disapproving self-evaluation, and place pressure on self to excel in a mistake free environment (Rønnestad & Skovholt, 2003). Emerging research has suggested that CMT and CFT enhances well-being, improves levels of compassion, and reduces self-criticism in clinical populations (see Beaumont & Hollins Martin, 2015; Leaviss & Uttley, 2015). In response, we propose that Compassionate Mind Training be taught to student therapists.

Self-criticism is an important concept, because it is strongly related to lower levels of self-compassion (Gilbert, Clarke, Hemel, Miles, Irons, 2004). Student therapists who are self-critical, often feel inferior, experience inadequacy, and exhibit self-antipathy. Underpinning these negative perceptions may be a desire to correct and prevent mistakes and sustain set standards, which if disappointed can lead to self-punishment (Gilbert et al., 2004). Teaching CFT/CMT is just one solution to counteract such adversities, and may be worthwhile because individuals who report high levels of self-compassion experience improved relationship functioning (Neff & Beretvas, 2013), a willingness to embrace innovation and challenge, and lower levels of self-criticism when failing at a task (Neff, Hsieh, Dejitterat, 2007). In addition, students report enhanced empathetic concern, improved perspectives, altruism, and forgiveness (Neff & Pommier, 2013).

Developing self-compassion may function as a remedy to self-criticism (Beaumont, 2016) and is an adaptive way of self-relating when experiencing feelings of inadequacy. Individuals who have unrealistic standards (Ellis, 1962) and high expectations (Beck, 1976) are prone to self-criticism. Developing self-compassion and responding to 'the bully within', through 'being kinder to oneself' in times of difficulty may help student therapists on their journey to become successful practitioners. Beaumont, Irons, Rayner, & Dagnall (2016) found that compassion focused therapy training was helpful in a sample (n=28) of healthcare educators and providers (nurses, midwives, counsellors and psychotherapists), which suggests that CMT may also benefit student therapists. The researchers found a statistically significant increase in levels of self-compassion and statistically significant reduction in self-critical judgement post training. The researchers concluded that developing self-compassion and responding to the 'inner self-critic' with compassion may help change levels of compassion and self-critical judgement. These findings augment the results of Barnard and Curry (2011) who found that teaching compassion based experiential exercises instigated changes in levels of self-reported compassion.

Links between self-compassion, compassion for others, compassion fatigue and burnout have previously been explored by Beaumont et al. (2015), who utilised a quantitative survey to measure relationships between self-compassion, compassion for others, compassion fatigue, well-being, and burnout in student counsellors and student cognitive behavioural psychotherapists (CBT) (n=54). Findings support that participants who report higher self-compassion and well-being report fewer symptoms of burnout

and compassion fatigue. In addition, self-judgement scores correlated negatively with well-being and positively with compassion fatigue and burnout. In response to these findings, this paper proposes an intervention designed to cultivate compassionate care in student therapists. Developing an intervention to cultivate self-compassion could improve student's ability to cope with distress by reducing levels of self-criticism, self-blame, and self-attack (Klimecki, Leibergh, Lamm, Singer, 2013).

Cultivating compassion involves responding to situations without judgement, with a caring motivation and understanding. Self-kindness, mindfulness, and common humanity are the three components of self-compassion according to Neff (2003a).

- 1 Self-kindness is associated with a tolerance and understanding of the apparent negative characteristics of self.
- 2 Common humanity recognises that mistakes are an integral part of the human experience.
- 3 Mindfulness involves being in the moment, without judgement when suffering is experienced.

Gilbert (2009) proposes that compassion "aims to nurture, look after, teach, guide, mentor, soothe, protect, offer feelings of acceptance and belonging – in order to help another person" (p. 193). Higher levels of self-compassion have been linked to lower levels of self-criticism and lower risk of experiencing symptoms of anxiety and depression (Luyten et al., 2007; Neff et al., 2007; Neff, 2003a). Self-compassionate people are better equipped to face painful thoughts, without avoidance or exaggeration (Neff, Hsieh, Dejitterat, 2005; Neely et al., 2009). One strategy for reducing self-criticism is presented by Breines and Chen (2012) who found that participants who wrote about their experiences of providing support to a friend following a negative event, demonstrated an increase in self-compassion. In addition, participants who recalled events where they provided support to a stranger, reported higher levels of self-compassion compared with participants who did not.

### Rationale

Some students who embark on a counselling career are self-critical, expressing thoughts akin to; 'I am not good enough', 'other people are better than me', 'what if I don't meet my targets and fail in pursuit of my dreams', and/or 'I have to be perfect and not flawed'. It is the job of educators to help student therapists reach their potential, which involves helping them to respond to self-criticism with kindness and self-compassion. Self-compassion may be the remedy to self-criticism, is necessary for self-care and is a quality needed for students entering the demanding world of therapeutic work. Student therapists may benefit from using creative methods, which aim to improve levels of compassion. This idea is echoed by Orkibi (2012) who suggests that self-care can be enhanced through use of creative interventions, and that such strategies may help students cultivate their professional identity. Therefore considering a training programme which incorporates interventions including compassionate letter writing, imagery techniques, acting skills, and art could be of value, because it may help students cope with some of the difficulties experienced in training. Other benefits of cultivating compassion include boosting immune system efficiency (Klimecki et al., 2013; Lutz, Brefczynski-Lewis, Johnstone, Davidson, 2008) and improving psychological well-being (Beaumont & Hollins Martin, 2015; Neff & Germer, 2012). Acknowledging such advantages, justifies the act of introducing CMT into a training programme, with follow-up evaluation examining the effectiveness of increasing levels of compassion.

## Cultivating a compassionate mind

Professor Paul Gilbert developed CFT and CMT (Gilbert & Procter, 2006; Gilbert, 2009) to help individuals suffering from low mood and high levels of shame and self-criticism, move towards healing. CFT describes the process and theory of the model, while CMT is just one element of CFT. Gilbert's (2009) CFT model incorporates fundamentals from evolution, attachment theory, neuroscience, social and developmental theory. The CFT approach examines how the development of affiliative emotions help regulate the threat-processing and social motivational systems, for example, how we have evolved to help other people, to care for one's family and to search for partners. The model is often referred to as the 'three circles model' (see Gilbert, 2014) and proposes that humans possess 3 emotion regulation systems:

- The threat and protection system
- The drive, resource seeking, and excitement system
- The affiliative/soothing and safeness system

### Threat and protection system

The *Threat Protection System (TPS)* directs attention to situations that a person perceives as threatening. As a result the body is called into action and the individual will respond to the perceived threat with a variety of emotions, including, anger, anxiety and disgust. It works to generate 'better safe than sorry' scenarios (Gilbert, 2009). For example, a student therapist may perceive that they are an inadequate therapist and imagine themselves failing the course, which in turn ignites the TPS.

### Drive system

The *drive system* developed to motivate animals to pay attention to particular resources, including, finding food and shelter and seeking sexual opportunities. It down-regulates negative emotions from the TPS system, and is activated upon winning a competition, passing an exam or gaining promotion (Depue & Morrone-Strupinsky, 2005). Experiencing positive emotions make it likely that the person will repeat associated behaviours.

### The content, soothing/affiliative system

The *soothing/affiliative system* is associated with physiological responses. For instance, physical calming, attachment, caring, and interpersonal connection (Depue & Morrone-Strupinsky, 2005). As such, the *soothing/affiliative system* is linked to affection, social connection, kindness, and bonding and is thought to be linked to the experience of attachment and associated with the neuropeptide oxytocin. This system may therefore play a role in helping affiliative emotions and feelings of safeness, connection, bonding, and trust. Cultivating this system may help student therapists to cope with the emotional demands of training, especially as this system is thought to help regulate the *threat and protection system*.

When faced with distressing events, being in receipt of compassion creates feelings of security. Utilising exercises that activate the *soothing/affiliative system* increases the partakers' self-compassion and regulates their threat responses. This in turn enables the person to feel safe and less distressed, with reduced associated negative thoughts helping them cultivate self-kindness and reduce self-judgement (Neff & Vonk, 2009).

## Cultivating compassion for self, experiencing compassion from others and offering compassion to others

It has been reported that therapists who provide compassion for others in the absence of self-compassion can experience increased stress in practice (Gilbert & Choden, 2013). This amplifies the need to teach student therapists skills of internal and external compassion via programmes designed to enhance and support the development of these capacities. Such programmes are based on supportive approaches that have proven valuable in helping clinical populations (Beaumont, Galpin, Jenkins, 2012; Beaumont & Hollins Martin, 2013, 2015; Gilbert & Procter, 2005; Mayhew & Gilbert, 2006). Compassion flows in 3 ways (Gilbert, 2014):

- (1) Compassion flowing out (*compassion for others*). That is, directing compassion outward towards others.
- (2) Compassion flowing in (*compassion from others*). That is, experiencing compassion from others, and receiving and accepting it.
- (3) Self-to-self compassion (*self-compassion*). That is, accepting, nurturing, directing and developing compassion within ourselves and towards ourselves.

Clinical training programmes that incorporate CMT may have potential to help student therapists regulate the emotions activated by the TPS and help students to balance academic, client, placement, organisational, supervision, and personal demands (see Fig. 1). In particular, CMT uses a variety of breathing, postural and imaginal interventions which help balance the three systems. Recalling times when participants have experienced giving and receiving compassion are also examined.

### Cultivating compassion in student therapists

Key principles of CFT/CMT include motivating participants to,

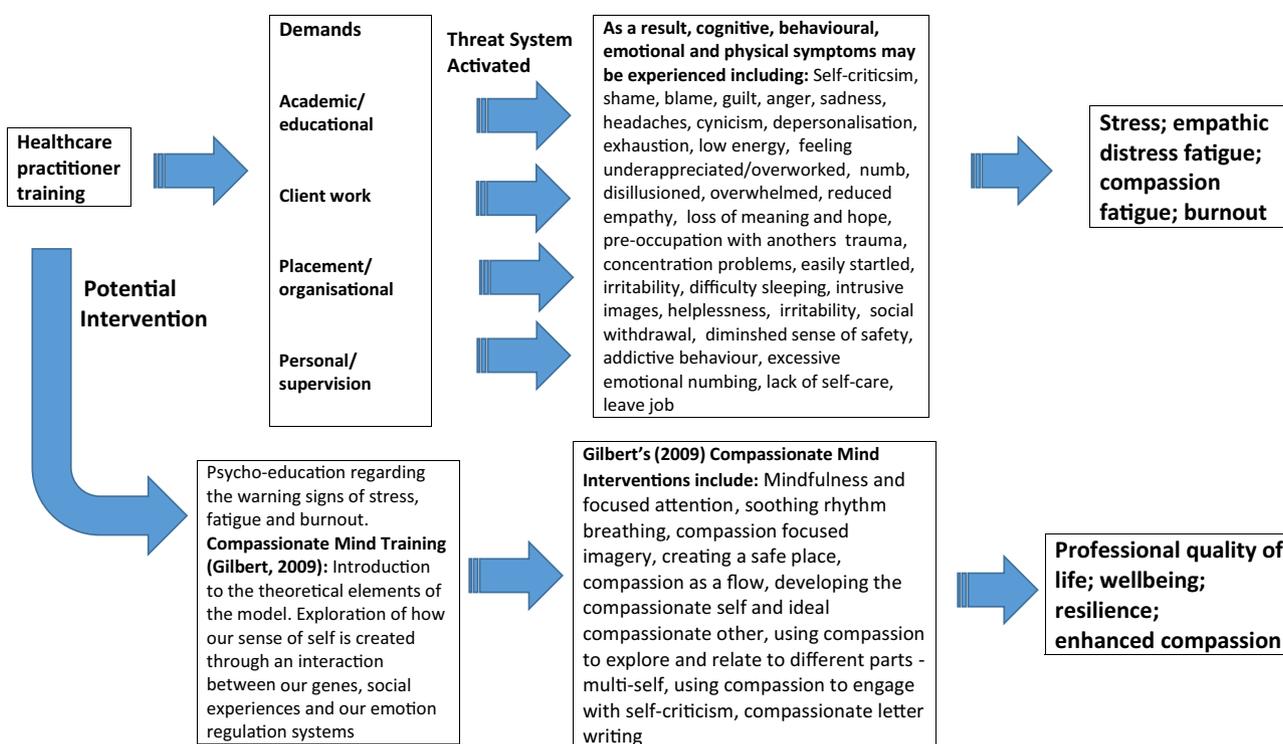
- Care for themselves and their own well-being and the well-being of others
- Become more sensitive to personal needs and distress
- Extend warmth, non-judgement and understanding towards self and others in times of suffering

Gilbert (2014) proposes two psychologies of compassion. The first involves having awareness of suffering and an ability to tolerate and engage with it. The second is action focused and aims to figure out what to do about suffering (Germer & Siegel, 2012; Gilbert, 2014). During the process, individuals learn to: (1) direct attention, (2) use imagery, and (3) act, reason, attend and respond to sensations and emotions with compassion through a variety of interventions (see Table 1).

Introducing student therapists to the core theoretical elements of Gilbert's (2009) model, involves delivering education about the evolved nature of the human mind. This includes theoretical explanations of how and why our 'sense of self' is shaped by interaction between genetics and life experience. In addition, experiential exercises which aim to cultivate compassion are taught in a step-by-step programme. What is taught to student therapists is captured in the *6-step study framework* that follows:

#### Step 1: education regarding self-care

- Students will be introduced to concepts and issues surrounding occupational stress, empathic distress fatigue, compassion fatigue/secondary traumatic stress and burnout. How symptoms



**Fig. 1.** Compassionate Mind Training Model for Healthcare Practitioners and Educators (Beaumont, 2016). Reprinted with kind permission from Healthcare Counselling and Psychotherapy Journal.

can impact on a person's ability to display compassion will be explored.

- The importance of self-care and self-soothing in times of suffering will be discussed.
- The forms and functions of self-criticism and how this impacts upon relationships, supervision and placement experiences (e.g., exploring how internal and external stressors can ignite the TPS and impact upon well-being) will be explored.
- The relationships between self-compassion, compassion for others, professional quality of life, compassion fatigue, burnout, and well-being will be examined.
- Students will be introduced to role-play scenarios that examine how to bring compassion to, and listen to one's own needs and the needs of others.
- Helpful and unhelpful coping strategies for managing stressors (e.g., academic, client, placement, organisational, supervision, and personal demands, burnout and trauma) will be explored.

#### Step 2: psycho-education about Gilbert's (2009, 2014) key elements of CFT/CMT

Student therapists will be introduced to the core theoretical elements of Gilbert's model and will explore how the emotion regulation systems works (i.e., threat, drive, and soothing). Gilbert's (2014) model proposes that we possess a 'tricky brain', with most of the internal workings of thinking 'not our fault' (e.g., we are all prone to rumination, self-criticism, and feelings of shame, which impact on well-being and compassion levels).

#### Step 3: formulation (Gilbert, 2014)

In this step discussions regarding how early in life we create coping strategies that enable us to self-soothe, drive forward, and defend against threat will be explored. These early experiences impact upon student therapist's views of self, and by doing so influ-

ence self-to-self interaction. For example, students will reflect on how they respond to themselves when they make a mistake (i.e., tone of voice employed). Time will be spent reflecting on how students have previously responded to fears and problems and how they would like their future self to respond to potential difficulties.

#### Step 4: compassionate capacities (Gilbert, 2009)

Breathing exercises and imagery techniques that create a sense of safeness and calm will be introduced and practiced. Exercises which can be helpful in times of stress such as 'safe-place' will be explored by students.

#### Step 5: using behavioural exercises to build compassionate capacities (Gilbert, 2009)

Incorporating exercises that foster wisdom and courage to counter situations, and assertiveness to challenge unhelpful behaviours (e.g., work evasion with particular clients, inhibiting challenging discussion during supervision for fear of error or being judged) will be incorporated into training. Creative interventions such as, compassionate letter writing, art, acting techniques and imagery will be used to portray self-compassion. This in turn may help student therapists reflect on their own needs in the 'here and now', understand their self-critical self and develop an understanding of their own suffering.

#### Step 6: engaging with difficulties using a compassionate mind-set (Gilbert, 2009)

Organisational demands, placement struggles, academic and personal demands and self-criticism all impact upon levels of self-compassion. Utilising exercises aimed at listening to the sad-self, angry-self, critical-self, and offering non-judgement and compas-

**Table 1**

The key attributes of compassion, skills of compassion and interventions designed to increase levels of compassion (Gilbert, 2009).

#### Gilbert's (2009) first psychology of compassion (Compassionate Attributes)

*Care for well-being:* Caring for oneself and other people with a desire and a caring motivation to notice and turn toward suffering with a wish to alleviate distress and stimulate well-being.

*Sensitivity to distress:* Developing self-awareness and being attentive to one's own suffering (through physical and emotional clues) and other people's distress.

*Sympathy:* Acknowledging and feeling emotionally moved by past and present experiences of suffering and distress.

*Distress tolerance:* Turning toward suffering and learning to tolerate difficult emotions with an open hearted acceptance and kindness.

*Empathy:* A desire to learn, understand and discover the reasons we and other people behave, think and feel in situations and environments (e.g., thinking about why we are self-critical and when we first noticed self-criticism).

*Non-judgement:* Individuals are taught techniques that aim to help them learn to notice and let go of self-attacking and self-criticism without judgement.

#### Gilbert's (2009) second psychology of compassion (Compassionate Skills)

*Attention:* Linked to mindfulness, focusing on the present moment without judgement or criticism.

*Reasoning:* Training the mind to think and reason in helpful ways (focusing on a balanced perspective, for example, asking oneself 'how can I think in a way that will help me in this situation').

*Behaviour:* Behaving in ways that help individuals move through suffering, toward their life goals. This can be difficult and requires courage because it may involve facing fears or refraining from using unhelpful safety behaviours.

*Sensory:* Learning to stimulate the affect regulation system by using breathing practices, vocal tones and body postures.

*Feeling:* Noticing and responding to emotions using compassion.

*Imagery:* Using imagery exercises that aim to stimulate the soothing affiliative system.

#### Gilbert's (2009) Compassionate Mind Training (Interventions Include)

*Mindfulness and focused attention:* Learning to notice that our attention can be directed by us.

*Soothing rhythm breathing (SRB):* Exploration of breathing methods that have been found to be connected with heart rate variability, positive health outcomes and frontal cortex activity (Gilbert, 2014). SRB can help to regulate the threat system.

*Creating a safe place:* Creating a place in the mind that provides affiliative feelings.

*Compassion focused imagery:* Using imagery exercises to stimulate the soothing systems and manage distress. When anxious or worried, individuals may imagine negative, critical or scary images that tend to add to distress.

*Compassion as a flow:* Exercises designed to increase levels of compassion for self and others would be introduced.

*Developing the compassionate self:* Using acting skills and imagery techniques to create and develop a compassionate ideal self which, may be used to cultivate compassion for others and self.

*Developing our ideal compassionate other:* Using imagery techniques to create an image of an ideal compassionate other (an image that offers compassion).

*Our different parts:* Exploration of the different emotional parts (e.g. angry, anxious and critical). Using a compassionate mind to relate to our different parts.

*Engaging with self-criticism using the compassion self:* The compassionate self will direct compassionate behaviour, thoughts and feelings to the critical self.

sion to the different selves could help students understand their own needs.

### Data collection

Compassionate Mind Training will be incorporated into a psychotherapy training programme and its effectiveness will be measured by collecting qualitative and quantitative data. Qualitative data will be collected via a focus group and through the use of creative methods. For example, students will create (using compassionate letter writing, imagery, art, acting and music) their compassionate self and self-critic before and after training. These methods have the potential to help student therapists reflect on their personal development whilst at the same time nurturing compassion. Quantitative data will be collected using the Self-Compassion Scale (Neff, 2003b), the Compassion For Others Scale (Pommier, 2011), Professional Quality of Life Scale (Stamm, 2009), The Interpersonal Reactivity Index (Davis, 1980) and the Forms and Functions of self-criticising/attacking and self-reassuring Scale (Gilbert et al., 2004).

### Learning objectives

On completion of the 6-step study framework, student therapists will be able to:

- (1) Critically explain how empathic distress fatigue, compassion fatigue, burnout, self-critical judgement, the supervisee/supervisor relationship, clinical training, and organisational pressures impact on self, colleagues, relationships and clients.
- (2) Demonstrate understanding of how the compassionate mind model works.
- (3) Consider how cultivating compassion can help diminish self-critical dialogue.

- (4) Discuss the 3 flows of compassion.
- (5) Explain how emotions, such as shame and self-critical thinking, impact upon well-being.
- (6) Consider how creative interventions could be used within clinical settings to help clients develop self-compassion and reduce self-criticism.

It is recommended that post-delivery of a well prepared teaching plan, that the lecturing team evaluates delivery and measures pre and post changes.

### Conclusion

Given that CFT/CMT has proven effective in clinical populations for treating individuals who are self-critical and report feelings of shame (Beaumont & Hollins Martin, 2013, 2015; Gilbert & Irons, 2004; Gilbert & Procter, 2006; Harman & Lee, 2010; Mayhew & Gilbert, 2008), teaching the method to student therapists could develop their ability to 'be kinder to self' in times of stress. Additionally, it could help students to build resilience and help students face a variety of idiosyncratic demands (e.g., academic, client, placement, organisational, supervision and personal demands). Providing compassionate care is considered vital for clients, and also plays a significant role in the therapists' self-care (Raab, 2014). This evidence makes the idea of cultivating compassion within student therapists important, because those capable of self-compassion may be better equipped to demonstrate compassion to clients (Beaumont et al., 2015; Heffernan, Quinn Griffin, McNulty, & Fitzpatrick, 2010). Educators are the gatekeepers of the profession and have first-hand knowledge of the stressors faced by students entering the world of clinical care. It is therefore essential that these issues are examined and meaningful solutions searched for. Creating compassionate environments may provide a 'secure base' for students which long-term could improve the quality of care student therapists give to both themselves and others.

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# Heightening levels of compassion towards self and others through use of compassionate mind training

**S**ustaining compassion across long periods of time is an essential part of a midwife's role, with stress experienced from continual exposure to traumatic events potentially resulting in emotional fallout. As a consequence, midwives may experience symptoms of empathic distress fatigue (Klimecki and Singer, 2012), compassion fatigue (Sabo, 2006), secondary trauma (Leinweber and Rowe, 2010), and burnout—all of which can have an impact on the level of compassion the individual is able to show towards him/herself and others (Figley, 1995, 2002). Introducing student midwives to interventions that aim to promote self-compassion is, therefore, vital; this may furnish them with some of the coping strategies needed to manage emotional distress. The aim of this article is to explore an intervention designed to increase student midwives' levels of compassion for themselves and reduce levels of self-criticism.

Empathic distress fatigue is the consequence of emotional, psychological, physical, spiritual and occupational exhaustion, and according to Klimecki and Singer (2012) it is the cause of burnout and compassion fatigue. Compassion fatigue was a term first coined by Joinson (1992) and is a form of burnout that can have a negative effect on health professionals who bear witness to suffering. Klimecki and Singer (2012) suggest that compassion fatigue is a result of placing the needs of other people above one's own and can lead to emotional, physical and psychological damage. Compassion fatigue may be prevented by using exercises that activate the neural pathways associated with compassion, empathic concern, positive feelings and altruistic behaviour (Klimecki and Singer, 2012).

Richards (2013) argues that health professions should expect clinicians to nurture their own wellbeing; therefore, examining interventions that aim to promote self-care and cultivate self-compassion warrants consideration. Compassion can be defined as a quality that 'aims to nurture, look after, teach, guide, mentor, soothe, protect, offer feelings of acceptance and belonging' (Gilbert,

## Abstract

**Background:** A continued absence of strategies that promote self-care puts midwives at risk of experiencing symptoms of stress, empathic distress fatigue, burnout, and compassion fatigue, all of which can affect midwives' performance and the level of compassion they show to others.

**Aims:** The objective of this paper is to outline a possible education strategy for student midwives that has the potential to affect the level of compassion that the individual can show both to him/herself and others in times of suffering.

**Suggested approach:** Compassionate mind training (CMT) has been found to be beneficial in clinical populations with individuals who report symptoms of primary trauma, low levels of self-compassion, and who are self-critical. Student midwives bear witness to the traumas of others, so it is important to consider an intervention to help student midwives who may experience symptoms of secondary trauma, self-criticism, or low levels of self-compassion while in training.

**Conclusion:** Incorporating CMT into undergraduate midwifery degree programmes may help student midwives become sensitive to their own suffering, and could potentially help them cope with emotional demands, placement anxieties and organisational pressures.

**Keywords:** Compassion, Training, Self-care, Stress, Burnout

2005: 127). These factors are important because work-related stress has been shown to have an impact on health professionals' concentration levels and ability to communicate effectively (Raab, 2014). This article explores an intervention that could potentially equip midwifery students with the psychological tools required to cope with organisational, personal, academic and placement

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### Box 1. Literature review

Brettelle and Grant's (2004) search strategy guidelines were followed. Keywords—including 'compassion', 'stress', 'compassion fatigue', 'burnout', 'midwifery education' and 'self-compassion'—were entered into Medline (R), PsychINFO, PsycARTICLES Full Text and CINAHL. Inclusion criteria used to capture relevant studies were papers published from 1995–2016 and written in English.

demands. Compassionate mind training (CMT) may enhance levels of compassion, reduce self-criticism, and help prepare student midwives to face the challenges of academic and organisational pressures, traumatic childbirth (Leinweber and Rowe, 2010; Mollart et al, 2013; Sheen et al, 2014) and stillbirth (Hollins Martin and Forrest, 2013; Hollins Martin et al, 2013; 2014).

### Background

A literature review was conducted (*Box 1*) to examine what research has already addressed in relation to self-compassion, compassion for others, empathic distress fatigue, compassion fatigue, and burnout in the health professions. From the body of literature it was identified that patient dissatisfaction (Vahey et al, 2004), insufficient training, shortage of personnel and lack of support from colleagues are all linked to staff burnout (Shanafelt et al, 2002). Continued absence of self-care strategies can put midwives at risk of burnout (Miller et al, 1988) and compassion fatigue (Figley, 2002), and can create a tendency to be more self-judgemental (Beaumont et al, 2016a). Van Mol et al (2015) conducted a systematic review to examine the literature connected to emotional suffering among health-care practitioners. The authors concluded that the true scale of emotional distress among practitioners was uncertain, with prevalence rates ranging from 7.3–40% for compassion fatigue and 0–70% for burnout. In response, they suggest that policy makers introduce practitioners to interventions that help prevent the negative consequences of emotional distress. This sentiment is echoed by Raab (2014), who conducted a literature review which concluded that further research focusing on cultivating self-compassion among health-care practitioners is warranted. Enhancing levels of self-compassion may have the potential to reduce stress-related symptoms and improve levels of compassion in student midwives.

Links between self-compassion, compassion for others, wellbeing, compassion fatigue and burnout have already been explored by Beaumont et al (2016a). In a quantitative survey, Beaumont et al (2016a) examined the relationships between wellbeing, self-compassion, compassion for others, compassion fatigue and burnout in student midwives ( $n=103$ ). The authors found that just over 50% of the sample reported scores that were above average for burnout. In addition, participants who reported higher levels of self-judgement also reported lower levels of self-compassion and compassion for others, and an increase in symptoms associated with burnout and compassion fatigue. The authors concluded that students wanting a career in midwifery may benefit from learning to be 'kinder to self' when faced with challenging circumstances. To augment these findings, studies by Mollart et al (2013) found that 60% of midwives ( $n=56$ ) reported symptoms of emotional exhaustion that were categorised as moderate to high. Yoshida and Sandall (2013) also found that 50% of practising midwives reported symptoms of burnout. In response to these findings, this article will examine the possible benefits of incorporating CMT into undergraduate midwifery education programmes.

### Organisational demands

The Nursing and Midwifery Council (NMC, 2015) recognises the importance of working in environments that foster compassionate care. Maben et al (2010) reported that some nurses felt disillusioned with their role, and experienced feelings of frustration and symptoms of burnout, within just 2 years of commencing their career. This highlights the relevance of considering an intervention that develops compassion. The working environment can affect all health professionals, with newly qualified staff sometimes facing organisational obstacles that have a negative impact on their performance (Bjerknes and Bjørk, 2012). Compassion inhibitors in the working environment include stress and workplace threats that compel individuals to focus on self-defence mechanisms, which can lead to judgement errors and, ultimately, compassion fatigue (Figley, 1995, 2002; Crawford et al, 2014). To compound such situations, bureaucratic organisations and staff shortages inhibit the capacity of staff to function compassionately (Brown et al, 2014).

Research has also been conducted to examine the stressors experienced by staff during the processes of delivering bereavement care. Peer support has been found to be one variable that

affects the midwife's experience of delivering bereavement care (Kirkham, 1999; Mander, 2006). Stress may initially manifest itself in the form of an increase in sickness absence, or through a rise in errors in the workplace. Educators, peers and team leaders must be vigilant to recognise when a student midwife is not coping well with a bereavement situation or an adverse event. Causes of stress or stressors fall into two categories: external and internal.

### External stressors

External stressors consist of physical stimuli in the person's environment, such as uncomfortable hot or cold temperatures. Alternatively, external stimuli may include an abusive colleague, or being given too much work to cope with during a given time period.

### Internal stressors

Internal stressors consist of stimuli within the person's body, such as infection, inflammation, lack of sleep, hunger or thirst. Alternatively, internal stimuli may be psychological in origin, e.g. experiencing worrying thoughts, nightmares or anxiety. The working environment is capable of producing both acute and chronic stressors. Other causes of stress and trauma at work include (Hollins Martin and Forrest, 2013; Hollins Martin et al, 2016):

- Bullying or harassment, by anyone, not necessarily one's manager
- Feeling powerless and uninvolved in determining one's own responsibilities
- Continuous unreasonable performance demands
- Lack of effective communication and conflict resolution
- Lack of job security
- Long working hours
- Excessive time away from home and family
- Office politics and conflict among staff
- A feeling that one's reward is not commensurate with one's responsibility.

When a professional recognises signs of stress and trauma in him/herself or a staff member, it is that individual's duty to do something about it. Maternity unit managers, lecturers and supervisors should take responsibility for continuing to provide support to colleagues while they gain experience in all areas of practice. Midwifery educators should consider the variety of acute stress responses that may lead to symptoms of trauma, and offer interventions to student midwives to support them with such challenges (Davies and Coldridge, 2015). Self-

‘ Developing an intervention that cultivates compassion could improve students' ability to cope with distress through reducing levels of self-critical judgement and self-attack ’

compassion has been shown to include a healthier reaction to stress (Leary et al, 2007). These factors together provide a rationale for creating a more compassionate environment for student midwives on their undergraduate training programmes.

Creating and cultivating environments that foster compassion could help student midwives cope with placement and educational demands (Beaumont, 2016). Wiklund Gustin and Wagner (2013) found that nurse lecturers who cultivated self-compassion presented with improved compassion for others. This makes the idea of developing self-compassion in student midwives a promising solution for stress reduction, and it also has the potential to increase the effectiveness of maternity care provision.

### Benefits of self-compassion

Increasing self-compassion and reducing self-criticism may work towards protecting student midwives from a variety of stress-related illnesses, including empathic distress fatigue, burnout and compassion fatigue. Klimecki et al (2013) demonstrated that compassion training led to a significant improvement in positive emotions when faced with the suffering of others. It has been found that individuals who report high self-compassion scores experience improved relationships and report lower levels of self-criticism (Neff and Beretvas, 2013), and self-compassion has been shown to include a healthier reaction to stress (Leary et al, 2007). Developing an intervention that cultivates compassion could, therefore, improve students' ability to cope with distress through reducing levels of self-critical judgement and self-attack.

The act of self-compassion includes reacting to self-suffering with a non-judgemental attitude, kindness and understanding (Neff, 2003). Neff (2003) proposes that there are three elements of self-compassion:

- Self-kindness, which is linked with patience and an understanding of oneself
- Common humanity, which recognises that all human beings make mistakes
- Mindfulness, which aims to take a non-judgemental view when a person experiences negative emotions.

### Compassionate mind training and compassion-focused therapy

CMT and compassion-focused therapy (CFT) were developed by Professor Paul Gilbert to help clinical populations who experienced high levels of self-criticism and shame reduce negative emotional responses. CFT describes the process and theory of Gilbert's (2009) model, whereas CMT refers to the specific interventions used to trigger the affiliative self-soothing system. The model offers an evolutionary and neuroscientific approach that explores how the evolution of affiliative emotions regulate threat-processing and motivational systems (e.g. to help others, improve status, care for family, or seek out partners).

### Compassion as a flow

A continuous and external flow of compassion, in the absence of self-compassion, can lead to burnout (Gilbert and Choden, 2013). Compassion is classified as flowing in three ways (Gilbert, 2014):

- Compassion for others (compassion flowing out), which involves learning to experience compassion in self, and direct compassion outward towards other people
- Compassion from others (compassion flowing in), which includes experiencing and accepting compassion from other people
- Self-compassion, which embraces cultivating and developing compassion within ourselves, and directing compassion to the many different parts of oneself.

Exercises that assist internal and external compassion have shown to be beneficial in clinical populations (Gilbert and Procter, 2006; Mayhew and Gilbert, 2008; Beaumont et al, 2012; Beaumont and Hollins Martin 2013, 2015) and, as such, could assemble part of a strategy that attempts to improve compassionate care in student midwives.

### Rationale for developing CMT for student midwives

Placement stressors, trauma, academic demands, staff absences and organisational issues can all take their toll on midwifery students (Chang et al, 2005; McNeely, 2005; Sheen et al, 2014). In

place of blaming individuals for their lack of compassionate care, we could instead offer interventions which are designed to develop greater compassion. Such activities are devised to help build emotional resilience through an individual feeling 'cared for' within an organisation. Cultivating self-compassion could help student midwives deal with distress and trauma in the workplace, with CMT using a variety of breathing, postural, and imaginal interventions. During the process, acting techniques (experiencing what it would be like to be a compassionate self), and recall of experiences of giving and receiving compassion are also examined.

### CMT implementation strategy for student midwives

Given that CMT has been found useful for helping people experiencing primary trauma, a CMT teaching programme has been designed to explore whether it can help student midwives (who bear witness to the trauma of others) develop self-compassion, build resilience and reduce self-criticism. The teaching programme devised aims to help student midwives cope with organisational, placement, personal, and academic demands through cultivating compassion (*Figure 1*).

### Data collection and ethical considerations

Data will be collected pre- and post-CMT and its effectiveness will be measured using qualitative and quantitative methods. Qualitative data will be collected via a focus group and quantitative data collected using the Self-Compassion Scale (Neff, 2003), Professional Quality of Life Scale (Stamm, 2009), Short Warwick-Edinburgh Mental Well-being Scale (Tennant et al, 2007) and the Compassion For Others Scale (Pommier, 2011). Ethical approval will be sought from the university ethics committee before the sessions are incorporated into the student midwifery curriculum.

### Implementation

*Table 1* offers an implementation strategy outlining the interventions that will be added to each year of the midwifery curriculum. Students will be offered additional support, practice and reflection sessions which they can choose to attend if they wish.

Student midwives will initially be introduced to the core theoretical elements of Gilbert's (2009) model. This approach will include exploration of the evolved nature of the human mind, how sense of self is created through an interaction between genetics and social experience, and how shame

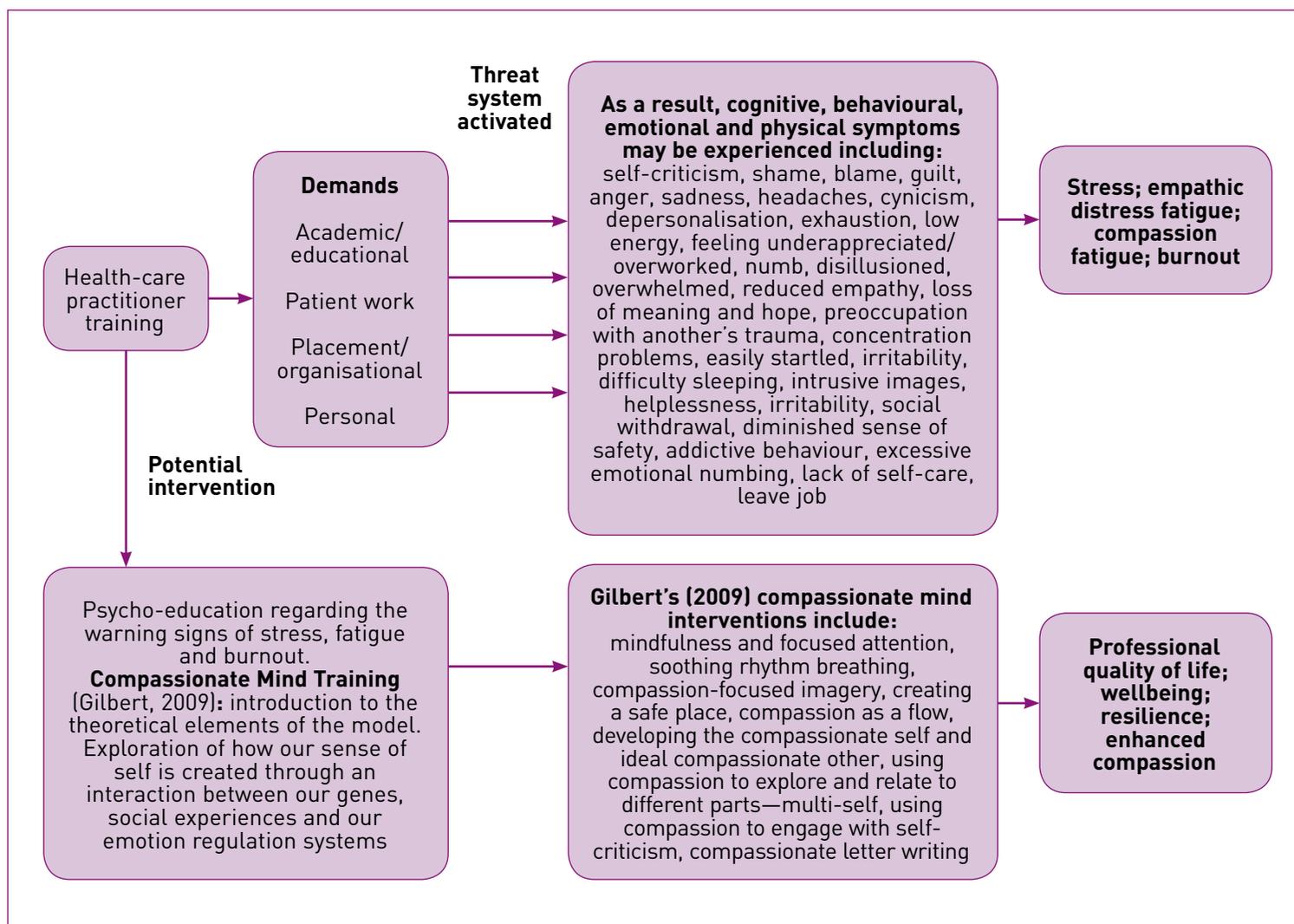


Figure 1. Compassionate mind training model for health care practitioners and educators (Beaumont, 2016). Adapted with kind permission from *Healthcare Counselling and Psychotherapy Journal*

and self-criticism can have an impact on levels of compassion. A variety of experiential exercises to cultivate distinctive aspects of compassion will be utilised, that follow a series of defined steps.

### Step 1: Psycho-education: key elements of CFT

Students will be introduced to the theoretical components of the compassionate mind model, alongside a critical exploration of how a ‘sense of self’ is created, through:

- An interaction between one’s genes and social experiences
- Emotion regulation systems (threat, drive, soothing)
- The nature, origins, and functions of shame and self-critical judgement
- Considering the ‘tricky brain’ and how ‘much of what goes on in the mind is “not our fault”’ (Gilbert, 2014: 30) because we are genetically programmed for survival. Gilbert (2014)

proposes that the brain has the capacity to be intelligent, yet is essentially flawed and vulnerable to a variety of problems that may have an impact on wellbeing (e.g. fear, arousal, rumination, self-criticism and shame).

The model proposes that humans have three systems that regulate emotion (Figure 2):

- Threat and protection system (TPS)
- Drive, resource-seeking, incentive-focused and excitement system
- Affiliative/soothing and safeness system.

#### Threat and protection system

The TPS alerts and directs attention to aspects that an individual perceives as threatening, and prompts the body into action. The TPS creates ‘better safe than sorry’ scenarios that focus on the negative. For example, the person imagines in their mind ‘worst case’ scenarios and their catastrophic consequences. Self-critical or shame-prone individuals are sensitised towards

**Table 1. Compassionate mind training (CMT) implementation strategy**

Session number	Outline of the additions to the curriculum
1. Psycho-education: Key elements of CMT (Introduced in year 1 of the curriculum)	<ul style="list-style-type: none"> <li>• A variety of definitions of compassion will be explored</li> <li>• Students will be introduced to the core theoretical elements of the CMT model</li> <li>• Students will be introduced to the three-circles model (threat, drive and soothing)</li> <li>• Discussion regarding 'our tricky brain' e.g. we are all prone to rumination and self-criticism</li> <li>• Students will be introduced to the two psychologies of compassion</li> </ul>
2. Psycho-education and developing the compassionate self (Introduced in year 1 of the curriculum)	<ul style="list-style-type: none"> <li>• Discussions regarding self-care and the symptoms associated with stress/burnout/empathic distress fatigue/compassion fatigue</li> <li>• Students will be introduced to exercises that aim to develop the compassionate self by recalling memories of times when they have offered compassion to others and received compassion from others</li> </ul>
3. Formulation: Understanding yourself (Introduced in year 2 of the curriculum)	<ul style="list-style-type: none"> <li>• Discussions regarding how our life history and early experiences shape who we are</li> <li>• Students will reflect on the potential strategies that they have used to project themselves as a result of their life experiences</li> <li>• Exploration regarding the qualities of compassion and an introduction to the fears, barriers and blocks to compassion</li> </ul>
4. Cultivating and building compassionate capacities (Introduced in year 2 of the curriculum)	<ul style="list-style-type: none"> <li>• Students will be introduced to mindfulness and focused attention</li> <li>• Students will be introduced to soothing rhythm breathing and safe place exercises</li> <li>• Imagery exercises will be used to stimulate the self-soothing system</li> <li>• Students will create an ideal compassionate self and compassionate other</li> <li>• Students will be introduced to exercises which demonstrate the three flows of compassion</li> </ul>
5. Building compassionate capacity using behavioural practices (Introduced in year 3 of the curriculum)	<ul style="list-style-type: none"> <li>• Discussions regarding how we can direct compassion to our 'inner critic' with a focus on behaviour change and internal dialogue</li> <li>• Students will be introduced to the concept of method acting—'experiencing their best compassionate self'</li> <li>• Students will practise compassionate assertiveness using role-play scenarios</li> <li>• Experiencing acts of kindness—both for self and others</li> </ul>
6. Using the compassionate mind to engage with difficulties (Introduced in year 3 of the curriculum)	<ul style="list-style-type: none"> <li>• Students will be introduced to interventions (e.g. chair work) which engage the angry-self, sad-self and anxious-self</li> <li>• Students will examine and discuss ways of coping with potential setbacks</li> </ul>

Based on model by Gilbert, 2009; 2014

having a dominating threat system (Gilbert, 2009); for example, a midwife engaged in an unexplained stillbirth who blames him/herself for the unfortunate outcome. In turn, this could cause stress to the extent that the midwife imagines being publically shamed and struck off the register.

**Drive system**

The drive system is linked to doing, wanting, achieving, avoiding rejection, and consuming activities (Depue and Morrone-Strupinsky, 2005).

It evolved to motivate animals to find food and shelter, and seek out sexual partners. The drive system down-regulates negative emotions from the threat system. That is, when a person engages their drive system (e.g. to win a competition, pass an exam, or gain an award), they experience positive emotions (e.g. excitement, joy, elation) that act as reinforcers for repeating behaviour.

**The content, soothing/affiliative system**

The soothing/affiliative system is associated with a number of physiological responses, such

as physical calming, attachment, caring and interpersonal connection (Depue and Morrone-Strupinsky, 2005). The soothing/affiliative system is associated with social connection, affection and kindness, and is responsible for reducing threat responses to feared stimuli and for activating feelings of safety, bonding and trust. In distressing events, being in receipt of compassion generates security within the group. Hence, activities that engage the soothing/affiliative system increase self-compassion and feelings of safeness, and help to regulate the affect-regulation system in response to threat (e.g. self-criticism).

In a nutshell, the aim of CMT is to balance the three systems, build the soothing/affiliative system, and understand how the three systems affect one another. Cultivating a compassionate mind involves being prepared to change, having wisdom about how to take effective action (Gilbert, 2014), and having a caring motivation to develop a variety of key attributes and skills linked to compassion. Gilbert (2009) refers to the first psychology of compassion, which involves:

- An awareness and noticing of suffering
- Turning towards suffering
- Having an ability to tolerate and engage with distress, as opposed to avoiding, denying or dissociating from suffering.

The second psychology of compassion includes acknowledging, knowing, and finding out what to do when suffering is experienced (Gilbert, 2014).

The two psychologies of compassion are action-focused and include a desire to acquire skills that attempt to alleviate suffering. For example, skills training involves the person learning to direct attention, behave, reason, and respond to feelings and sensations with compassion (Table 2).

### Step 2: Compassion in midwifery

The education provided in step 1 will be strengthened by discussions regarding symptoms of empathic distress fatigue, compassion fatigue, (secondary/vicarious trauma), burnout, and occupational stress—all of which can have an impact on the performance of midwifery staff. Discussions will include examination of how trauma experiences in the workplace (e.g. traumatic childbirth, stillbirth, lack of support) have an impact on staff wellbeing. Students' beliefs surrounding compassionate thinking and compassionate behaviour (e.g. what constitutes self-compassion vs self-critical behaviour and thinking) will be explored, and a critical appraisal of helpful and unhelpful behaviours in the workplace examined. Students will discuss stress-coping strategies and role-play

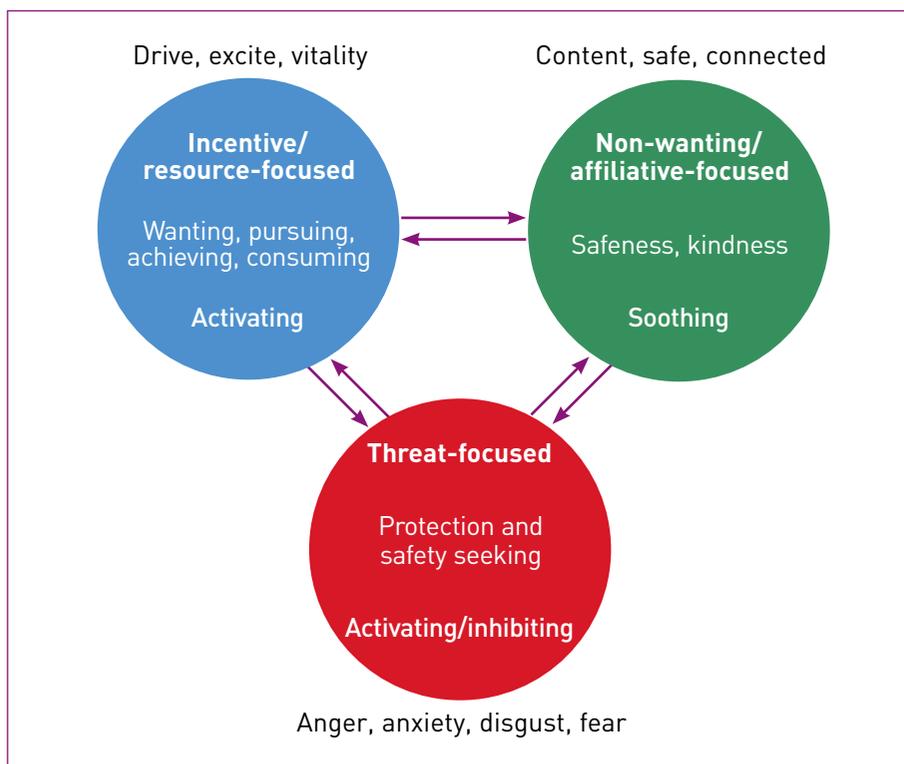


Figure 2. Three types of affect regulation system. Adapted from Gilbert (2009) with kind permission from Constable Robinson

exercises will be used to help equip students with the necessary tools to face workplace stressors. Students will recall memories of giving and receiving compassion.

### Step 3: Formulation

The reflections in step 2 will be reinforced through learning about early life experiences and how to create coping strategies to self-soothe, drive forward, and defend against threat. Self-awareness will be bolstered through exploring interactions students have with their own 'self'; for example, what tone of voice is used when a mistake is made, what fears are learnt in childhood, and what helpful and unhelpful strategies are used to regulate emotions and interactions with others. Fears, blocks and barriers to compassion will be examined.

### Step 4: Cultivating and building compassionate capacities

Participants will be introduced to a variety of interventions, such as breathing and imagery techniques that create safeness and calm. Exercises designed to help student midwives experience 'compassion as a flow' will be introduced. In addition, mindfulness and focused attention will be taught, to direct attention towards being in the present moment without judgement or criticism. Breathing exercises—including soothing

**Table 2. The key attributes and skills of compassion**

First psychology of compassion (compassionate attributes)	Second psychology of compassion (compassionate skills)
<b>Care for wellbeing:</b> Developing a caring motivation to notice and turn toward suffering with a wish to alleviate distress	<b>Attention:</b> Learning how to notice that our attention can be directed by us (what we focus on expands). This is linked to mindfulness, being in the present moment without judging or criticising
<b>Sensitivity to distress:</b> Learning to recognise and be attentive to one’s own and other people’s distress	<b>Reasoning:</b> Learning to reason in ways that are helpful (exploration of cognitive processes with a focus on ‘what will be genuinely helpful right now’)
<b>Sympathy:</b> The ability to be emotionally moved by feelings of distress rather than feeling dissociated from it	<b>Behaviour:</b> Behaving in ways that are helpful (facing fears, reducing safety behaviours, acts of gratitude, compassionate letter writing, doing helpful things for self or others)
<b>Distress tolerance:</b> Using the compassionate mind to tolerate difficult emotions by moving toward suffering rather than avoiding suffering	<b>Sensory:</b> Using breathing practices, vocal tones, facial and body postures to generate physical states, which are conducive to affect regulation and compassion
<b>Empathy:</b> Seeing the world through the eyes of another and understanding our own emotions, which can involve taking the perspective of our different parts (angry self, sad self, compassionate self, critical self)	<b>Feeling:</b> Learning to pay attention to, and compassionately respond to, the different emotions we feel
<b>Non-judgement:</b> The process involves acceptance and non-judgement. Individuals are taught techniques that aim to help them become more aware of and let go of self-attacking and self-criticism	<b>Imagery:</b> Using imagery and meditation exercises to stimulate the soothing systems

From: Gilbert, 2009

rhythm breathing (SRB), which moderates heart rate variability and is linked to positive health outcomes—will be incorporated into training. SRB engages the soothing-affiliative system and produces feelings of calm. Creating a safe place using guided imagery interventions will help student midwives create a sense of safety and calm. In addition, compassion-focused imagery exercises will be taught, which stimulate the soothing system. Participants will create in their mind, or through art, an image of their ideal compassionate other. The image created requires that the person uses a compassionate, non-judgmental approach (Gilbert, 2009; 2014).

**Step 5: Building compassionate capacity using behavioural practices**

The compassionate qualities cultivated in step 4 will be used to challenge unhelpful behaviours and self-critical thoughts; for example, a student midwife criticising his/her ability to cope when a childbearing woman experiences an adversity, such as an infant abnormality.

The skills acquired in these steps will be used to explore helpful alternative assertive behaviours. Student midwives will also be introduced to creative ways of developing self-compassion, through use of acting and art to depict the ‘bully within’ and the ‘compassionate self’.

**Step 6: Using the compassionate mind to engage with difficulties**

Participants will use their compassionate mind to engage with self-criticism, organisational pressures, and trauma memories. Discussions about sad, angry or anxious parts, which respond simultaneously in a situation, will take place—for example, a student midwife may simultaneously experience sadness about leaving university, anxiety about commencing a new role, and joy at successfully completing the course. In contrast, participants will also explore how to engage with compassion to help self-criticism, which involves employing the compassionate part of self and directing compassionate attributes (such as empathy, distress tolerance and non-judgement) to self-critical parts.

**Conclusion**

While many students face similar challenges, student midwives face a set of distinctive emotional challenges that can test their confidence, knowledge and capacity. Student midwives work with women and families who, at times, experience high levels of distress. Being part of these traumatic experiences, if not well managed, can propagate emotional fallout. In this instance, we are talking about experiencing symptomology of secondary traumatic stress and

As compassionate mind training has proven effective in treating symptoms of trauma in clinical populations, it has shown potential to benefit midwives who bear witness to trauma

burnout. Given the evidence that health-care educators' levels of self-compassion improved, and self-critical judgement reduced, post-CMT training (Beaumont et al, 2016b), and because CMT has proven effective in treating symptoms of trauma in clinical populations (Beaumont et al, 2012; Beaumont and Hollins Martin, 2013; 2015), it has shown potential to benefit midwives who bear witness to trauma. As such, the authors recommend that CMT be incorporated into a midwifery undergraduate degree programme, and its effectiveness measured. In the current climate, it is timely and appropriate for midwifery educators to explore concepts of compassion in greater depth. **BJM**

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## Key points

- Compassion-focused interventions focus on helping individuals to employ self-soothing techniques and create affiliative feelings towards themselves and others
- Midwives bear witness to the traumas of others. This makes considering an intervention to help student midwives who may experience symptoms of stress, burnout, compassion fatigue, self-criticism, or low levels of self-compassion while in training important
- 'Being kinder to oneself' in times of distress may help student midwives cope with academic, placement, organisational and emotional demands
- Introducing student midwives to interventions that aim to promote self-care is vital, because it may furnish them with the coping strategies needed to manage emotional distress
- Compassionate mind training (CMT) has the potential to have an impact on levels of compassion for oneself and others. The authors recommend that CMT be incorporated into a midwifery undergraduate degree programme, and its effectiveness measured

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## **The effects of Compassionate Mind Training on student psychotherapists**

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## Abstract

**Purpose:** This study examines pre and post outcome measures following a course of Compassionate Mind Training (CMT). Participants were students enrolled on a Post Graduate Diploma in Cognitive Behavioural Psychotherapy (CBP). The aim of the research was to explore whether the training would increase self-compassion, compassion for others and dispositional empathy. **Method:** Twenty-one participants who had enrolled on the CBP programme took part in the study. Data were collected using the Self-Compassion Scale, Interpersonal Reactivity Index and the Compassion for Others Scale. **Findings:** Results reveal an overall statistically significant increase in self-compassion scores and statistically significant reduction in self-critical judgement scores post training. There was no statistically significant difference post training on the Interpersonal Reactivity Index or the Compassion for Others Scale. **Research limitations/implications:** CMT training may help students develop healthy coping strategies, which they can use to balance their affect regulation systems when faced with organisational, placement, client, academic and personal demands. Further research using a larger sample size is needed to examine whether cultivating compassion whilst on training can help students build resilience and provide a barrier against empathic distress fatigue, compassion fatigue, and burnout. **Practical Implications:** Incorporating CMT into psychotherapy training may bring changes in student levels of self-compassion and self-critical judgement. **Originality/value of the paper:** This inaugural study examines whether incorporating CMT into a CBP programme impacts on students levels of compassion, dispositional empathy and self-critical judgement. The findings from this preliminary study suggest the potential benefits of training students in compassion focused practices.

**Keywords:** self-compassion, compassionate mind training, compassion focused therapy, cognitive behavioural psychotherapy, education

## **Introduction**

Counselling and psychotherapy students face a number of client, organisational, academic, placement, supervision and personal demands whilst on training (Beaumont, 2016; Beaumont & Hollins Martin, 2016). Without adequate self-care students may experience emotional distress that can be both physically and psychologically challenging. According to Porter (1995), self-care serves three main functions, to protect the therapist by reducing occupational hazards such as burnout, to enhance therapy by modelling healthy behaviour, and to protect clients by reducing risks of ethical violations. Self-care and self-reflection is an ethical imperative for psychological practitioners (Barnett, Baker, Elman & Schoener, 2007) and helps the individual remain emotionally fit for purpose (Harris, 2007).

Incorporating interventions into psychotherapy training that assist the flow of compassion may help students care for their own well-being. The practice of self-care has been found to promote psychological and physical health and improve well-being (Williams-Nickelson, 2001), increase capacity for empathic understanding and lower levels of anxiety and depression (Schure, Christopher & Christopher, 2008).

This study intends to examine whether incorporating Compassionate Mind Training (CMT) into a psychotherapy training programme increases self-compassion, compassion for others, dispositional empathy and reduces self-critical judgement in a sample of student Cognitive Behavioural Psychotherapists (CBP's).

## **Psychotherapy Training Demands**

Students undergoing psychotherapy training may be more vulnerable to symptoms of stress and burnout (Beaumont, 2016; Beaumont & Hollins Martin, 2016; Boellinghaus, Jones & Hutton, 2013; Rønnestad & Skovholt, 2003) because they may work in settings that are emotionally and physically draining, with clients that experience high

levels of distress (De Stefano, Atkins, Noble & Heath, 2012). Students enrolled on counselling and psychotherapy courses face idiosyncratic demands whilst training. For example, they may work with clients presenting with suicidal thoughts or work with clients who self-harm, which can present professional challenges (Reeves, Bowl, Wheeler & Guthrie, 2004; Reeves & Dryden, 2008). Students may also experience anxiety especially because they may need to react quickly to ethical and legal issues relating to confidentiality and client disclosure (De Stefano et al., 2012; Moore & Cooper, 1996). This in turn may lead to self-critical judgement and students may feel overwhelmed, fearful or incompetent (Reeves & Mintz, 2001; Wheeler, Bowl & Reeves, 2004). It is therefore essential that therapists strive to provide quality care for clients, whilst at the same time, take care of themselves (Beaumont & Hollins Martin, 2016; Bell, Dixon & Kolts, 2016).

Rønnestad and Skovholt (2003) carried out a longitudinal study looking at the development of 100 counsellors and therapists and propose that counsellors and therapists move through six phases; the lay helper, the beginning student, the advanced student, the novice professional, the experienced professional, and the senior professional. Rønnestad and Skovholt (2003) suggest that students initially question their personal characteristics and abilities, whilst gaining an awareness that in reality the practice and the theory of psychotherapy pose different obstacles. During the early stages in student development, direct or subtle criticism (actual or perceived), or negative feedback from clients, could impact negatively on morale, prompting self-criticism. During training, students were only expected to function at a basic professional level of competence, however, many had higher aspirations for themselves, reporting that they felt pressure to perform perfectly. Trying to become the 'perfect practitioner' can result in a more anxious psychotherapeutic approach and

an excessive and misunderstood sense of responsibility toward clients (Jacobsson, Lindgren & Hau, 2012). Jacobsson et al. (2012) echo this view and found in a sample of student psychotherapists, that experiencing anxiety was a phenomenon of the education process and part of each student's journey toward development of their individual psychotherapeutic identity.

Rønnestad and Skovholt (2003) suggest that for some students, psychotherapy supervision experiences also had particular significance. During the advanced student phase, students felt that they were supposed to master professional tasks with a greater level of competence. Supervision conflicts peaked during this stage of training with students reporting increased tension and constant self-evaluation, which suggests that although supervision may be rewarding for many students, for others it may exacerbate anxiety and self-criticism. Liddle (1986) reinforces this idea suggesting that whilst supervision intends to be supportive, it can incite self-criticism due to a fear of negative evaluation by supervisors, feelings of shame or embarrassment and/or impression management. Fears relating to incompetence can lead to non-disclosure during supervision with trainees endeavoring to conceal their perceived flaws. Practising interventions, which encourage self-acceptance, self-compassion, and self-reflection, could help students gain more value and support from clinical supervision and psychotherapy training. Bennett-Levy, Thwaites, Haarhoff and Perry (2015) suggest that self-practice enhances the therapeutic relationship because it provides students with an understanding regarding the process of therapy.

Beaumont, Durkin, Hollins Martin and Carson (2016) found in a sample (n=54) of student cognitive behavioural therapists and student counsellors that higher levels of self-compassion was correlated with lower levels of compassion fatigue and burnout. Higher self-judgement scores however, correlated positively with symptoms

of burnout, compassion fatigue and reduced psychological well-being. Beaumont, Durkin, Hollins Martin and Carson (2016) suggest that students may benefit from using psychological interventions that increase levels of self-compassion.

Compassion fatigue is a form of burnout affecting individuals working in the caregiving professions (Joinson, 1992; Figley, 1995), who as a result of their role bear witness to the suffering of others. Klimecki and Singer (2012) hold a similar view, they use the term empathic distress fatigue, which is a consequence of listening to the trauma stories of clients. Empathic distress fatigue occurs as a result of emotional, psychological, spiritual, physical and occupational exhaustion and according to Klimecki and Singer (2012), is the cause of compassion fatigue and burnout.

Klimecki and Singer (2012) propose that the neural pathways linked with compassion can be activated to enhance well-being by using techniques that aim to increase compassion, empathy, and altruistic behaviour. This idea is reinforced by Beaumont (2016), who suggests that cultivating compassion may help students build resilience, develop compassion for their own suffering, and may help protect them from the symptoms associated with empathic distress fatigue, secondary trauma, compassion fatigue and burnout.

Gilbert (2005) suggests that self-compassion helps individuals feel calm, cared for and connected. Developing self-compassion and responding to the *“bully within, by being kinder to oneself”* (Beaumont, Galpin & Jenkins, 2012, p.42), in times of suffering may help students on their journey to become CBP’s. Cultivating self-compassion may act as a remedy to self-criticism (Beaumont, 2016) and is necessary for self-care. Therefore examining educational interventions, which aim to cultivate compassion and promote self-care is worthy of exploration.

## **Cultivating compassion**

The growing body of literature in relation to self-compassion appears to indicate that it may serve as a barrier against psychological distress (Beaumont, 2016; Beaumont & Hollins Martin, 2016; Dorian & Killebrew, 2014, Gilbert, 2005, Neff & McGehee, 2010). Furthermore, cultivating self-compassion may help CBP's develop the skills and psychological resources needed in order to develop empathy and compassion for others, a crucial foundation in psychotherapy training (Dorian & Killebrew, 2014, Hick & Bien, 2008).

Neff (2003a) suggests that self-compassion can be viewed as having the ability and the desire to treat ourselves with kindness, to be open to our own suffering, and be non-judgmental in relation to our own inadequacies. Neff (2003a) proposes that there is a link between self-compassion and psychological well-being, with high levels of self-compassion being associated with happiness, conscientiousness, life satisfaction, social connectedness and optimism. In addition, high levels of self-compassion is correlated with reduced levels of anxiety (Neff, 2003a; Neff et al., 2007), self-criticism (Gilbert & Proctor, 2006), trauma symptoms (Beaumont et al., 2012: Beaumont & Hollins Martin, 2013; Beaumont, Durkin, McAndrew & Martin, 2016) and rumination (Neff & Vonk, 2007). This is supported by Neff and McGehee, (2010) who suggest that self-compassion is linked to psychological resilience. In a sample of adolescents (n=235) and young adults (n= 287), Neff and McGehee, (2010) found that self-compassion was strongly associated with well-being.

Appropriate self-care is viewed by Barnett et al. (2007) as a critical component in the prevention of harm to clients caused by the psychotherapist or psychotherapy. They suggest that training models focusing on both the personal and professional aspects of self-care across the life span, should be incorporated into graduate training

programmes and discuss the importance of practicing self-acceptance and self-compassion. Although the practice of self-compassion has been recommended to promote therapist wellness (Beaumont & Hollins Martin, 2016; Beaumont, Durkin, Hollins Martin & Carson, 2016) and reduce work-related stress (Barnett et al., 2007; Mahoney, 2005), there are very few research studies that have investigated how psychotherapists employ self-compassion (Patsiopoulos & Buchanan, 2011). Boellinghaus et al. (2013) reviewed the effectiveness of mindfulness-based interventions and loving-kindness meditation and report that trainee therapists who undertook a programme of loving kindness meditation found that the practice increased their self-awareness and compassion for self and others. Participants reported that they were able to bring this increased compassion with them to the therapy room and integrate it into their clinical work.

Addressing a potential gap in student psychotherapists training, Beaumont and Hollins Martin (2016) proposed that Compassionate Mind Training, an intervention which was specifically designed to help individuals in clinical populations with high levels of shame and self-criticism (Gilbert, 2009; 2010), be adapted and introduced into student psychotherapy training. Beaumont and Hollins Martin (2016) present a six-step programme that has potential to enhance well-being through incorporating creative interventions, which aim to increase levels of self-compassion.

### **Compassionate Mind Training**

Compassionate Mind Training (CMT) and Compassion Focused Therapy (CFT) were developed for clinical populations to help individuals create self-supportive voices, in response to shame, low mood, and self-criticism (Gilbert, 2005; 2009; 2010; 2014). Individuals with high levels of shame and self-criticism often experience high levels of

external threat, for example, fear rejection and criticism, and also experience high levels of internal threat, for example, feel a failure, inferior or flawed (Gale, et al., 2012). Cultivating a compassionate mind includes having a caring motivation to face suffering, tolerate distress and take action to help alleviate suffering (Gilbert, 2009). Using compassion and wisdom, the skills and attributes of compassion are developed. This process involves integrating self-care strategies into daily life, which aim to help the individual learn to think, behave and react to feelings and physiological responses with compassion. CMT refers to the interventions used to cultivate compassion, whereas CFT comprises the process of therapy. Interventions used within clinical settings include; compassionate letter writing, mindfulness, imagery exercises, working creatively to build a compassionate self and using safe place exercises that aim to trigger affiliative emotions (Gilbert, 2009; 2014).

CFT explores how the evolution of affiliative emotions helps people to regulate threat. Gilbert (2009) postulates that we have three emotion regulation systems; *the threat protection system*, *the drive resource seeking and excitement system* and *the affiliative/soothing and safeness system*. *The threat protection system* responds with feelings such as anger, anxiety and disgust which warn the body to take action. *The drive resource seeking and excitement system* developed to motivate animals to find useful resources (e.g., shelter) and seek out sexual opportunities. *The affiliative/soothing and safeness system* is linked to social connection. When this system is activated it creates feelings of security (Gilbert, 2009). Self-care activities that stimulate the *soothing/affiliative system* increase compassion and help regulate threat responses such as self-criticism. In essence, self-criticism ignites *the threat protection system*, whereas *the affiliative/soothing system* creates affiliative feelings,

enabling the individual to self-soothe (see Gilbert, 2014 for a comprehensive exploration of the model).

## **Rationale**

Student CBP's work collaboratively with people experiencing distress, with the goal of helping ease suffering. However, students may experience higher levels of stress if they have high levels of compassion for others but lack self-compassion (Gilbert & Choden, 2013). This is further justification for teaching student CBP's interventions that aim to cultivate compassion.

Symptoms of stress, high levels of self-criticism and a lack of self-care and compassion for oneself, if not managed, could lead to secondary trauma, empathic distress fatigue, compassion fatigue, or burnout. Student CBP's will bear witness to the trauma stories of others and may face difficulties whilst training as a result of organisational, academic, placement and personal demands, which can all prompt a threat response (*see Figure 1*). This makes considering interventions that aim to help individuals cultivate self-compassion potentially important (Beaumont, 2016; Beaumont & Hollins Martin, 2016).

This current study reports on the first phase of a longitudinal project and explores the impact that CMT has on student CBP's. The second phase of the project examines the effect CMT has on students and their CBP practice by collecting qualitative data via a focus group. The long-term aim of this project is to examine whether CMT improves psychotherapists' well-being, compassion levels, and professional quality of life and reduces self-critical judgement.

**INSERT FIGURE 1**

Although Cognitive Behavioural Psychotherapy may be combined with CMT or CFT (Gilbert, 2009; 2010) with clients, this is the first study that integrates CMT into a CBT training programme.

## **Method**

### *Design*

This study used a multiple method design (Bryman, 2008), whereby both quantitative and qualitative data were collected. Multiple method approaches enable researchers to collect data in a way that best works to address the research questions. A strength of choosing a multiple method approach is that the data can be collected at different stages of research (Bryman, 2008; Creswell, 2003). A staged design involving two separate phases was used in this project. Quantitative data was collected pre and post training, potentially aiming to generalise the results to a wider population and then qualitative data was collected via a focus group a month after the training. Each phase was designed to answer sub questions, seek convergence across qualitative and quantitative methods (Creswell, 2003; Jick, 1979) and will be triangulated to form a comprehensive whole (Morse, 2003). Phase two of the project will be reported in a separate paper.

This paper examines the results from phase one of the project. A pre and post repeated measures design was used to establish the impact CMT had on student CBP's. Quantitative data were collected at the start of a Post Graduate Diploma in CBP programme and at the end of training. Post training, participants were informed that they would be invited to attend a focus group to discuss the training.

### *Participants*

A non-random convenience sample consisting of thirty-five participants undertaking a Post Graduate Diploma in CBP from a University in England (UK), agreed to take part in the research project. Twenty-one students, which consisted of nineteen female participants and two male completed the training. Nine of the thirty five participants agreed to be part of the control group, however, only three sets of pre and post questionnaires were completed. Two of the nine participants from the control group interrupted their studies to take a break before starting their second module, and four participants did not attend the final session where data were collected post training. Therefore participant numbers in the control group were too small to compare with the experimental condition as this would increase the risk of a type 1 error. A type 1 error occurs when the null hypothesis is rejected when it may be true.

### *Procedure*

In order to train staff to facilitate the additions to the CBP programme, a three-day workshop was commissioned, evaluated and published (Beaumont, Irons, Rayner & Dagnall, 2016). In a sample (n=28) of healthcare providers and educators, Beaumont Irons, Rayner and Dagnall (2016) found an overall statistically significant increase in self-compassion scores and a reduction in self-judgement scores post CFT training. The researchers concluded that compassion training has potential to help healthcare practitioners develop greater self-care and emotional resilience.

All students commencing the first module on the Post Graduate Diploma in CBP were approached and asked if they would like to take part in this study. Students were advised that they could attend the additional sessions even if they decided not to take part in the research. Information sheets and consent forms were given to each student,

followed by a brief presentation and question and answer session. Participants were introduced to the CMT model and to the qualities and skills of compassion (Gilbert, 2009). Various compassion focused practical strategies were practised throughout the training (*see Table 1 for an outline of these*).

Ethical approval was given by the College Research Governance and Ethics Committee.

## **INSERT TABLE 1**

### *Questionnaires*

The Self-Compassion Scale (Neff, 2003b), Compassion-for-Others Scale (Pommier, 2011) and the Interpersonal Reactivity Index (Davis, 1980) were used to collect data.

### *Compassion-for-Others-Scale (Pommier, 2011)*

The *Compassion-for-Others-Scale* contains 24-items and is subdivided into 6 subscales; kindness, indifference, common humanity, separation, mindfulness, and disengagement. To compute a total mean compassion score, the mean of each subscale is calculated after reverse scoring the negative items. Participants respond to items on a 1-5 scale (1 = almost never to 5 = almost always).

### *Self-Compassion-Scale-Long-Version (Neff, 2003b)*

The *Self-Compassion-Scale-Long-Version* comprises of 26-items that measure how individuals respond toward themselves during difficult times. The scale consists of 6 subscales, self-kindness, self-judgement, mindfulness, common humanity, isolation, and over identification, with items scored on a scale (1 = almost never to 5 = almost always). López, et al. (2015) suggests that the scale measures two separate factors,

self-critical judgement and self-compassion. Self-compassion scores were therefore calculated by combining the data from the subscales self-kindness, common humanity and mindfulness and self-critical judgement scores were calculated by collating data from the subscales isolation, self-judgement and over-identification (López, et al., 2015).

#### *The Interpersonal Reactivity Index (Davis, 1980)*

The Interpersonal Reactivity Index is a 28 item questionnaire measuring dispositional empathy which provides separate scores for four distinct scales, fantasy (the tendency to strongly identify with a fictional character), perspective taking (the tendency to adopt the perspective of another), empathic concern (the responses of warmth, compassion and concern for others), and personal distress (experiencing feelings of discomfort and anxiety whilst witnessing the negative experiences of other people). Scoring for each subscale is achieved by adding together responses to the seven items making up the subscale (after first reverse-coding the negatively worded items). Scores range from 0 to 4 and each subscale produces a potential score of between 0 – 28. Internal reliability of the four subscales is found to be at satisfactory levels.

## **Results**

Statistical analyses used SPSS 20 for Windows. Following participation in CMT, changes between pre and post scores were assessed using repeated measures paired sample t-tests. It was predicted that post training scores on the Self-Compassion Scale, Compassion For Others Scale and Interpersonal Reactivity Index would improve when compared to pre training scores. Mean and standard deviation scores are presented in *Table 2*.

## **INSERT TABLE 2**

### **Self-Compassion Scale**

Scores were calculated by analysing two separate factors, self-compassion and self-critical judgement. The self-compassion scores were calculated by collating data from the common humanity, self-compassion and mindfulness subscales. Self-critical judgement scores were calculated by collating data from the isolation, self-judgement and over-identification subscales.

#### *Self-compassion*

A significant difference was observed pre to post training ( $M= 3.26$ ,  $SD = 0.7$  versus  $M = 3.61$ ,  $SD = 0.8$ ). Results revealed a statistically significant increase in self-compassion ( $t(20) = -2.473$ ,  $p = 0.022$ ) post training.

#### *Self-critical judgement*

A significant difference was observed pre to post training ( $M= 3.34$ ,  $SD = 0.9$  versus  $M = 2.96$ ,  $SD = 1$ ). Results revealed a statistical significant reduction in self-critical judgement ( $t(20) = -2.782$ ,  $p = 0.012$ ) post training.

### **Compassion for Others**

Post training, compassion for others scores were higher ( $M = 4.10$ ,  $SD = 0.4$  versus  $M = 4.24$ ,  $SD = 0.4$ ) than pre training scores. However, scores did not reach statistical significance ( $t(17) = -1.559$ ,  $p = 0.139$ )

### **Interpersonal Reactivity Index Scales**

Pre and post training scores for empathic concern did not differ significantly although scores increased post training ( $M = 17.4, SD = 3.8$  versus  $M = 17.8, SD = 3.7$ ), ( $t(19) = -4.67, p = 6.46$ ). Pre and post training scores for the fantasy scale ( $M = 14.1, SD = 4.2$  versus  $M = 14.3, SD = 4.1$ ), ( $t(20) = -3.23, p = 7.50$ ) and pre to post training scores for perspective taking ( $M = 18.3, SD = 3.6$  versus  $M = 17, SD = 4.4$ ), ( $t(20) = 1.630, p = 1.19$ ) did not differ significantly. Pre and post training scores for personal distress did not differ significantly although scores did reduce post training ( $M = 14.4, SD = 3.1$  versus  $M = 12.9, SD = 2.6$ ), ( $t(20) = 1.552, p = 1.37$ ).

To conclude, CMT had favourable effects on SCS ratings. Self-compassion increased and self-critical judgement reduced post training. Compassion for others increased post training although scores did not reach statistical significance and the training had no statistical significant effect on the IRI subscales.

## **Discussion**

This study looked at whether introducing CMT to student CBP's would increase participant's levels of self-compassion, compassion for others, improve empathic qualities and reduce levels of self-critical judgement.

This was only a short addition to the CBP programme where the students' main objective was to develop their skills as a student psychotherapist and pass the course. The results are interesting and feedback post training suggest that students found utilising compassionate mind interventions helpful. Students reported that the model was easy to understand and that they valued using creative methods to cultivate self-compassion. The data from this study suggests that students reported higher levels of self-compassion post training and reported a reduction in self-critical judgement post

training. Students were more aware of the commonality of suffering (that we are all in the same boat) and reported that they felt less isolated post training.

This study supports other research studies in demonstrating that compassion-focused interventions can instigate changes in levels of self-critical judgement and compassion (Barnard & Curry, 2011; Beaumont, Irons, Rayner & Dagnall, 2016; Boellinghaus et al., 2013). If curriculum designers can incorporate interventions into programmes that aim to increase compassion and reduce self-critical judgement, this may help students as they start their psychotherapy journey. Long-term this may improve student well-being, may protect students from the symptoms associated with empathic distress fatigue, secondary trauma, compassion fatigue, and burnout and may improve quality of care.

Students enrolled on counselling and psychotherapy training programmes can experience increased anxiety, self-evaluation and the pressure to succeed without making mistakes (Rønnestad & Skovholt, 2003). The findings from this study add to the growing literature that highlights the importance of cultivating strategies that promote well-being (Beaumont & Hollins Martin, 2016; Harris, 2007). Through the cultivation of self-compassion, students may start to view themselves with increased kindness. Such kindness may encourage openness and honesty during psychotherapy supervision (Liddle, 1986) and reduce the fear of supervisor negative appraisal. Additionally, incorporating CMT interventions into practitioner training could help students remember that failure and imperfection are part of the human experience (Neff & Vonk, 2009). This could help students manage their reaction to negative feedback from clients (Rønnestad & Skovholt, 2003). Neff and Vonk (2009) suggest that increased levels of self-compassion may reduce the need to defend one's ego making it easier for students to admit to mistakes and limitations.

An interesting finding was that dispositional empathy scores did not reach statistical significance. This could suggest that CMT may act as a regulatory factor for the emotional connection usually displayed during empathic engagement. According to Figley (1995) compassion fatigue occurs by virtue of an emotional contagion when expressing empathy towards clients. An alternative explanation could be that the absence of statistical significant results may be due the high scores reported at the pre intervention stage. Comparable results from the IRI questionnaire were reported in studies using mindfulness based interventions (Beddoe & Murphy, 2004; Birnie et al., 2010; Galantino et al., 2005), leaving the researchers to conclude that this may have been due to a ceiling effect of baseline empathy levels. Similarly, pre to post compassion for others scores did not reach statistical significance. However, scores were already high at the start of training, which would be expected for students wanting a career within the helping professions.

### **Limitations**

This is the first study to examine whether CMT could impact on students' level of self-compassion, compassion for others and self-critical judgement. However, there are limitations to consider.

Although nine students volunteered to be part of a control group only three completed pre and post questionnaires were collected, which meant that we could not objectively compare groups. This is a limitation of the study because it makes it difficult to ascertain whether the CBT programme alone would help students develop compassion and reduce self-critical judgement. Participation was voluntary and therefore only students who engage in self-practice and self-reflection may have enrolled on the training.

## **Further research**

The results in this study report on phase one of a multiple method research project. A second paper examining the data collected from a focus group post training is currently underway and suggests that students found immense benefit from CMT. Assessing the long-term benefits of CMT could also provide more fruitful data. For example, examining whether cultivating compassion whilst on clinical training thwarts symptoms of stress, empathic distress fatigue, compassion fatigue, and burnout may be illuminating. A second cohort of students are currently receiving CMT, and in this next stage of the project we hope to have further data to report.

Further research could examine the impact CMT has on student experiences of supervision. Given that non-disclosure for fear of judgement can have an impact on student well-being (Farber, 2006; Wallace & Alonso, 1994), the influence CMT has on disclosure within supervision could also be examined.

## **Implications**

The findings suggest that CBP's students found benefit from CMT. The training appeared to help the students in this sample who were starting on a journey to become a psychotherapist, increase their levels of self-compassion and reduce self-critical judgement.

## **Summary and Conclusion**

Given that CMT has been found useful for helping people experiencing high levels of self-criticism in clinical settings (Beaumont & Hollins Martin, 2015), and has been found useful in helping healthcare educators develop self-compassion (Beaumont, Irons, Rayner & Dagnall, 2016), a CMT teaching programme was designed to explore

whether CMT could help student CBP's develop compassion and empathy, and reduce self-critical judgement. This study provides some preliminary data regarding the impact of CMT on students' level of self-compassion and self-critical judgement. This is important given the difficulties that CBP's face within organisational and clinical settings. Teaching students wanting a career within counselling and psychotherapy techniques that help cultivate self-compassion may help students respond to their own distress with compassion, understanding, and kindness.

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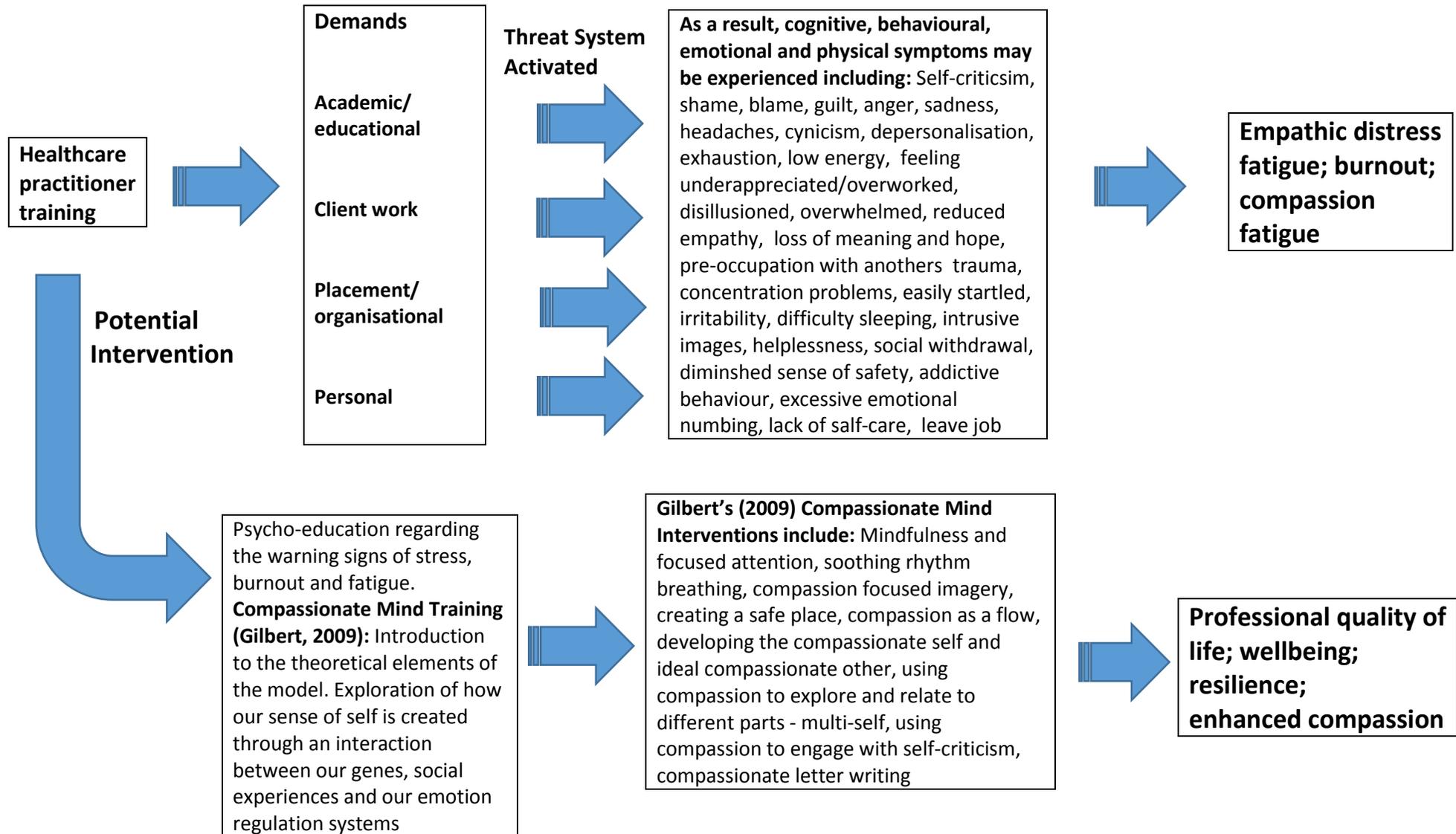
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**Figure 1: Compassionate Mind Training Model for Healthcare Practitioners and Educators**



**Table 1.** Compassionate Mind Training additions to the Post Graduate Diploma in Cognitive Behavioural Psychotherapy

Session number	Curriculum based on Gilbert's (2009, 2014) model
(1) Psycho-education	<ul style="list-style-type: none"> <li>• Definition of compassion</li> <li>• Student therapists were introduced to the core theoretical elements of Gilbert's (2009; 2014) model</li> <li>• Introduction to the 3 circles model (threat, drive and soothing)</li> <li>• Discussion regarding 'our tricky brain'. E.g., we are all prone to rumination and self-criticism</li> <li>• Introduction to Mindfulness</li> <li>• Soothing Rhythm Breathing</li> </ul>
(2) Psycho-education. Developing the compassionate self	<ul style="list-style-type: none"> <li>• Discussion regarding self-care and the symptoms associated with stress/burnout/empathic distress fatigue/compassion fatigue</li> <li>• Safe Place – creating a place in the mind that produces affiliative feelings</li> <li>• Developing the compassionate self - using memory and imagery to cultivate compassion</li> <li>• Exploration regarding the qualities of compassion and introduction to the fears and blocks to compassion</li> </ul>
(3) Formulation. Developing the skills of compassion	<ul style="list-style-type: none"> <li>• Exploration of significant life events. How early experiences impact upon how we view ourselves</li> <li>• Timeline exercise – offering compassion to the younger learner</li> <li>• Introduction to the skills of compassion</li> <li>• Compassionate letter to the self, focusing on psychotherapy practice and learning on the programme</li> </ul>
(4) Using compassion to engage with self-criticism	<ul style="list-style-type: none"> <li>• Exploration of the functions of self-criticism. Self-correction vs self-persecution and the impact of shame</li> <li>• Creating an internal compassionate CBT coach</li> <li>• Enhancement of compassionate thoughts from the CBT coach in relation to psychotherapy practice and learning on the programme</li> </ul>
(5) CFT within the therapeutic arena	<ul style="list-style-type: none"> <li>• Using Compassion Focused Therapy as an adjunct to Cognitive Behavioural Therapy</li> <li>• Research evidence surrounding Compassion Focused Therapy</li> <li>• Self-compassionate language vs self-critical - 'the bully within'</li> <li>• Introduction to the concept of method acting</li> <li>• Self-compassion diary and acts of kindness</li> </ul>
(6) Compassion as a flow & engaging with difficulties using a compassionate mind-set	<ul style="list-style-type: none"> <li>• Compassion flows in three ways, from others to us, from us to others and from and to ourselves</li> <li>• Challenges to compassion. Examination of thoughts including "I'm not good enough to do CBT"</li> <li>• Using the compassionate mind to engage with angry-self, sad-self and anxious-self</li> <li>• Meditation of compassionate CBT guide to enhance compassionate thoughts</li> </ul>

- Creation of cue cards with compassionate statements on and reading statements using partner, mirror or phone camera
  - Reflecting compassionately on practice. E.g., using a compassionate guide to set homework tasks that aim to increase self-compassion.
-

**Table 2.** Pre and post Mean and Standard Deviation Scores on the Compassion for Others Scale, Self-compassion Scale and the Interpersonal Reactivity Index.

<b>Scale</b>	<b>N</b>	<b>Pre CMT</b>	<b>Post CMT</b>
Compassion for Others	17	M=4.10 (0.4)	M=4.24 (0.4)
Self-Compassion	21	M=3.26 (0.7)	M=3.61 (0.8)
Self-Critical Judgement	21	M=3.34 (0.9)	M=2.96 (1.0)
Perspective taking	20	M=18.3 (3.6)	M=17.0 (4.4)
Fantasy scale	20	M=14.1 (4.2)	M=14.3 (4.1)
Empathic concern	20	M=17.4 (3.8)	M=17.8 (3.7)
Personal distress	20	M=14.4 (3.1)	M=12.9 (2.6)

## **Appendix 2**

### **Statement of candidate's independent work and individual contribution**

## Appendix 2

### Statement regarding candidate's independent work

The candidate has made a unique and independent contribution in each of the papers under scrutiny. The contributions are specified below and confirmed by co-authors (Appendix 3). As well as the papers described above, there are papers related to this topic that are under review or in late stages of writing.

Study	Independent/unique contribution	Joint Contribution
<b>Paper 1:</b> Beaumont, E., & Hollins-Martin, C. J. (2015). A narrative review. How effective is Compassion Focused Therapy?	Conceived the project and led the writing of the paper (90%).	Professor Hollins-Martin (10%) commented on drafts and final manuscript.
<b>Paper 2:</b> Beaumont, E., Durkin, M., McAndrew, S., & Martin, C. (2016). Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service Personnel suffering with trauma-related symptoms.	Conceived and designed the study, collected the data, conducted the data analysis and interpretation and led the writing of the paper (75%).	Mark Durkin (10%) contributed to the data analysis, Dr. Sue McAndrew (10%) commented on drafts of the paper and Professor Colin Martin contributed to the data analysis (5%).
<b>Paper 3:</b> Beaumont, E., Hickey, A., McAndrew, S., Goldman, S., & Warne, T. (2016). Minding the gaps: Using narrative accounts to explore people's experience of using North Staffs MIND's Adult Counselling Service.	Contributed to the design and write up of the paper and data analysis (40%).	Dr. Anthony Hickey (20%) and Dr. Sue McAndrew (20%) contributed to the design, write up and data analysis. Dr. Stacey Goldman (10%) and Professor Tony Warne (10%) commented on drafts of the paper.
<b>Paper 4:</b> Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J. (2015). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey.	Contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%).	Mark Durkin (35%), and Professor Hollins-Martin (15%) contributed to the design of the study, write-up and collected the data Professor Carson (15%) contributed to the design of the study and write-up.

<p><b>Paper 5:</b> Beaumont, E., Durkin, M., Hollins-Martin, C. J., &amp; Carson, J. (2015). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists.</p>	<p>Contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%).</p>	<p>Mark Durkin (35%) contributed to the design of the study, write-up and collected the data. Professor Hollins-Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and statistical analysis.</p>
<p><b>Paper 6:</b> Durkin, M., Beaumont, E., Hollins-Martin, Carson, J. (2016) A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among UK community nurses.</p>	<p>Contributed to the design, write-up and statistical analysis (35%).</p>	<p>Mark Durkin (35%), Professor Hollins-Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and data collection and statistical analysis.</p>
<p><b>Paper 7:</b> Beaumont, E., Irons, C., Rayner, G., &amp; Dagnall, N. (2016). Compassion Focused Therapy Training for Healthcare Educators and Providers: Does this increase self-compassion, and reduce self-persecution and self-criticism?</p>	<p>Conceived and designed the study, collected the data, conducted the data analysis and data interpretation and led the writing of the research paper (75%).</p>	<p>Dr. Chris Irons (10%) commented on drafts and final manuscript. Dr. Gillian Rayner (10%) contributed to the organisation of the project and commented on drafts of the paper. Dr. Neil Dagnall (5%) provided support regarding the data interpretation.</p>
<p><b>Paper 8:</b> Beaumont, E &amp; Hollins Martin, C.J. (2016a) A proposal to support student therapists to develop compassion for self and others through use of Compassionate Mind Training.</p>	<p>Conceived the idea and led the writing of the paper (90%).</p>	<p>Professor Hollins Martin (10%) commented on drafts of the paper.</p>

<p><b>Paper 9:</b> Beaumont, E &amp; Hollins Martin, C.J. (2016b) Heightening levels of compassion towards self and others in midwives through use of Compassionate Mind Training.</p>	<p>Conceived the idea and led the writing of the paper (90%).</p>	<p>Professor Hollins Martin (10%) commented on drafts of the paper.</p>
<p><b>Paper 10:</b> Beaumont, E., Rayner, G., Durkin, M., &amp; Bowling, G. (2017) The effects of Compassionate Mind Training on student Psychotherapists.</p>	<p>Co-designed the project. Collected the data and conducted the data analysis and interpretation. Led the writing of the research paper and designed CMT workshops for students (70-75%).</p>	<p>Dr. Gillian Rayner (15-20%) led the staff team, collected data and also organised and delivered workshops. Mark Durkin (5%-10%) contributed to the statistical analysis. Gosia Bowling (5%) contributed to the writing of the paper.</p>
<p><b>Paper under review</b> Rayner, G., Beaumont, E., &amp; Irons, C. Developing more compassionate healthcare professionals: A focus group exploring the impact of a three day compassion focused therapy training programme.</p>	<p>Conceived and designed the study, led the ethical approval process, contributed to the writing of the research paper, methodology and data analysis.</p>	<p>Dr. Gillian Rayner collected data from the focus group and led the writing of the paper. Dr. Chris Irons commented on drafts and final manuscript.</p>
<p><b>Paper</b> Rayner, G., Beaumont, E., Bluff, L., &amp; Walker, E. A focus group study exploring the effects of Compassionate Mind Training on CBT students.</p>	<p>Contributed to the design of the study and data analysis. Organised and delivered CMT workshops for students.</p>	<p>Dr. Gillian Rayner contributed to the design of the study, led the writing of the paper and research team. Lisa Bluff and Emma Walker contributed to the write up of the paper and data analysis.</p>

## **Appendix 3**

# **Letters from collaborating authors confirming contribution**

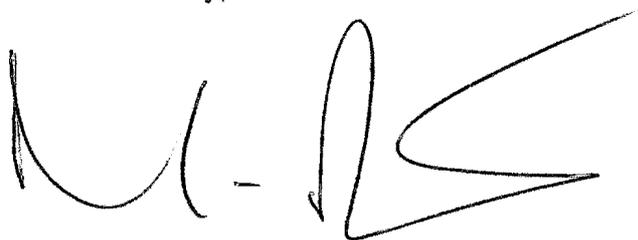
Mark Durkin (MSc, BSc)  
Group therapy co-ordinator  
MhIST (Mental health Independent support Team)  
Hanover House  
Hanover Street  
Bolton  
BL1 4TG

12<sup>th</sup> April 2016

**RESEARCH PROJECT: Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service Personnel suffering with PTSD**

I am writing to confirm that Elaine Beaumont conceived and designed the project. Elaine provided the psychotherapeutic intervention for Greater Manchester Fire and Rescue Service and led the writing of the manuscript and submission process. I Mark Durkin commented on drafts of the paper, estimating my own contribution to the paper as approximately 10%.

Yours Sincerely,

A handwritten signature in black ink, appearing to be 'M. Durkin', written in a cursive style.

Mark Durkin Group therapy co-ordinator MhIST

**Dr Sue McAndrew**

School of Nursing, Midwifery, Social Work & Social Sciences  
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12<sup>th</sup> April 2016

**RESEARCH PROJECT: Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service Personnel suffering with PTSD**

I am writing to confirm that Elaine Beaumont conceived and designed the project. Elaine provided the psychotherapeutic intervention for Greater Manchester Fire and Rescue Service and led the writing of the manuscript and submission process. I Dr Sue McAndrew commented on drafts of the paper, estimating my own contribution to the paper as being no more than 10%.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Sue McAndrew', is written on a light yellow rectangular background.

Sue McAndrew

To whom it may concern

**RE: RESEARCH PROJECT: Using Compassion Focused Therapy as an adjunct to Trauma-Focused CBT for Fire Service Personnel suffering with PTSD**

I am writing to confirm that Elaine Beaumont conceived and designed the project and sought ethical approval for the project. Elaine provided the psychotherapeutic intervention for Greater Manchester Fire and Rescue Service and led the writing of the manuscript and submission process. I Professor Colin Martin commented on drafts of the paper, estimating my own contribution to the paper as being no more than 5%.

Yours Sincerely,

*Colin Martin*

**Professor Colin R Martin RN BSc MSc MBA PhD YCAP FHEA CPsychol CSci AFBPsS  
Room 2.11  
Faculty of Society and Health  
Buckinghamshire New University  
Uxbridge Campus  
106 Oxford Road, Uxbridge, Middlesex, UB8 1NA, UK.  
Tel: 01494 522141 Extension 2349  
Mobile: 07747 473217  
Fax: 01494 603179  
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web: [www.bucks.ac.uk](http://www.bucks.ac.uk)  
Follow me on Twitter: [www.twitter.com/colin\\_r\\_martin](https://www.twitter.com/colin_r_martin)**

**Latest book: Martin, C.R., Preedy, V.R. and Patel, V. (2016). *Comprehensive Guide to Post-Traumatic Stress Disorder*. Springer, New York, USA.**

**Latest book: Martin, C.R., Fleming, M.P. and Smith, H. (2016). *Mental Health and Wellbeing in the Learning and Teaching Environment*. Swan and Horn, Fife, UK.**

**Dr Sue McAndrew**

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12<sup>th</sup> April 2016

**RE: Minding the gaps: Exploring the effectiveness of a voluntary sector mental health counselling service**

I am writing to confirm that Elaine Beaumont led the writing of the manuscript and submission process. Elaine contributed to the design, data analysis and write up of the paper. The contribution agreed by the project team was as follows: Elaine Beaumont 40 percent, Dr Anthony Hickey and Dr Sue McAndrew 20 percent and Professor Tony Warne and Dr Stacey Goldman 10 percent.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Sue McAndrew', is written on a light yellow rectangular background.

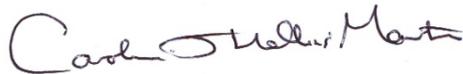
Sue McAndrew

Prof Caroline J Hollins Martin  
Professor in Maternal Health  
Theme Lead (Women And Children's Health And Wellbeing (WACHAW))  
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Email: [C.HollinsMartin@napier.ac.uk](mailto:C.HollinsMartin@napier.ac.uk)  
Telephone 0131 455 2782  
5th April 2015

To whom it may concern,

I, Caroline J Hollins Martin have contributed to Elaine Beaumont's papers in the following ways and percentages.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Caroline J Hollins Martin', written in a cursive style.

Prof/Dr Caroline J Hollins Martin

<p>Beaumont, E., &amp; Hollins-Martin, C. J. (2015).</p> <p>A narrative review. How effective is Compassion Focused Therapy?</p>	<p>Elaine conceived the project and led the writing of the paper (90%)</p>	<p>Professor Hollins-Martin (10%) commented on drafts and final manuscript and supervised the project.</p>
<p>Beaumont, E., Durkin, M., Hollins-Martin, C. J., &amp; Carson, J. (2016).</p> <p>Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in students midwives: A quantitative survey.</p>	<p>Elaine contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%)</p>	<p>Mark Durkin (35%), Professor Hollins-Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and data collection</p>
<p>Beaumont, E., Durkin, M., Hollins-Martin, C. J., &amp; Carson, J. (2016).</p> <p>Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists.</p>	<p>Elaine contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%)</p>	<p>Mark Durkin (35%), Professor Hollins-Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and data collection</p>
<p>Beaumont, E &amp; Hollins Martin, C.J. (2016)</p> <p>Heightening levels of compassion towards self and others in midwives through use of Compassionate Mind Training</p>	<p>Elaine conceived the idea and wrote the paper (90%)</p>	<p>Professor Hollins Martin (10%) commented on drafts of the paper and the final manuscript.</p>

<p>Beaumont, E &amp; Hollins Martin, C.J. (2016)</p> <p>Enhancing therapists levels of self-compassion through use of Compassionate Mind Training</p>	<p>Elaine conceived the idea and wrote paper (90%)</p>	<p>Professor Hollins Martin (10%) commented on drafts of the paper and the final manuscript</p>
<p>Durkin, M., Beaumont, E., Hollins-Martin, Carson, J. (2016)</p> <p>A quantitative study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among nurses.</p>	<p>Elaine contributed to the design, write-up and statistical analysis (35%)</p>	<p>Mark Durkin (35%), Professor Hollins Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and data collection</p>
<p>Durkin, M., Beaumont, E., Hollins Martin, C.J. &amp; Carson, J. (Under Review)</p> <p>Self-compassion, self-judgement and well-being among healthcare students.</p>	<p>Elaine contributed to the design, write-up and statistical analysis (35%)</p>	<p>Mark Durkin led the writing of the project (35%), Professor Hollins Martin (15%) &amp; Professor Carson (15%) contributed to the design of the study, write-up and data collection</p>

To: Beaumont Elaine  
04 April 2016 16:12

Elaine,

I am happy with this. I am recovering and back at work today. Good luck with the Prima Facie.

Jerome

Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J.

> Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in students midwives: A quantitative survey.

>

> Elaine contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%)

>

> Mark Durkin (35%), Professor Hollins-Martin (15%) & Professor Carson (15%) contributed to the design of the study, write-up and data collection

>

> Beaumont, E., Durkin, M., Hollins-Martin, C. J., & Carson, J.

> Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists.

>

> Elaine contributed to the design, write-up and statistical analysis. Led the writing of the manuscript (35%)

>

> Mark Durkin (35%), Professor Hollins-Martin (15%) & Professor Carson (15%) contributed to the design of the study, write-up and data collection

>

> Durkin, M., Beaumont, E., Hollins-Martin, Carson, J.

> A quantitative study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among nurses.

>

> Elaine contributed to the design, write-up and statistical analysis (35%)

>

> Mark Durkin (35%), Professor Hollins-Martin (15%) & Professor Carson (15%) contributed to the design of the study, write-up and data collection

29<sup>th</sup> March 2016



To whom it may concern,

**Re: Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in students midwives: A quantitative survey. *Midwifery*.  
<http://dx.doi.org/10.1016/j.midw.2015.11.002>**

In relation to the research described in the above paper. I am writing to confirm that Elaine Beaumont lead the writing of the manuscript, contributed to the design of the project, completed the review of literature and contributed to the data analysis.

Yours Sincerely,

A handwritten signature in blue ink, appearing to read "J. Carson".

Dr. Jerome Carson,

Professor of Psychology.

**University of Bolton**  
Deane Road  
Bolton  
BL3 5AB

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**+44 (0)1204 900600**  
Fax:  
**+44 (0)1204 399074**  
Website:  
**www.bolton.ac.uk**

Vice Chancellor: Dr G.E. Holmes



INVESTOR IN PEOPLE

29<sup>th</sup> March 2016



To whom it may concern,

**Re: Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists. *Journal of Counselling and Psychotherapy Research*, 16 (1) 15-23. <http://dx.doi.org.10.1002/capr.12054>**

In relation to the research described in the above paper. I am writing to confirm that Elaine Beaumont lead the writing of the manuscript, contributed to the design of the project, completed the review of literature and contributed to the data analysis.

Yours Sincerely,

A handwritten signature in blue ink, appearing to read "J. Carson".

Dr Jerome Carson,

Professor of Psychology.

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Vice Chancellor: Dr G.E. Holmes



Mark Durkin (MSc, BSc)  
Group therapy co-ordinator  
MhIST (Mental health Independent Support Team)  
Hanover House,  
Hanover Street,  
Bolton,  
BL1 4TG

29<sup>th</sup> March 2016

To whom it may concern,

**Re: Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in students midwives: A quantitative survey. *Midwifery*.  
<http://dx.doi.org/10.1016/j.midw.2015.11.002>**

**In relation to the research described in the above paper. I am writing to confirm that Elaine Beaumont led the writing of the manuscript and submission process, contributed to the design of the project, completed the review of literature and contributed to the data interpretation and statistical analysis.**

**I can confirm Elaine's contribution of at least thirty-five percent.**

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'M. Durkin', with a stylized flourish at the end.

Mark Durkin

Group Therapy Co-ordinator MhIST

Mark Durkin (MSc, BSc)  
Group therapy co-ordinator  
MhIST (Mental health Independent Support Team)  
Hanover House,  
Hanover Street,  
Bolton,  
BL1 4TG

29<sup>th</sup> March 2016

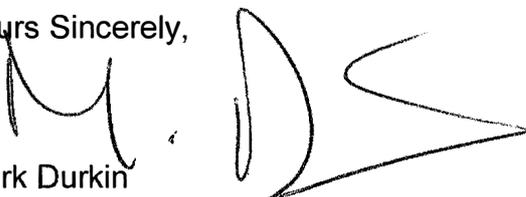
To whom it may concern,

**Re: Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists. *Journal of Counselling and Psychotherapy Research*, 16 (1) 15-23. <http://dx.doi.org.10.1002/capr.12054>**

I am writing to confirm that Elaine Beaumont led the writing of the manuscript and the submission process, contributed to the design of the project, completed the review of literature and jointly contributed to the data interpretation and statistical analysis.

I can confirm Elaine's contribution of at least thirty-five percent.

Yours Sincerely,

  
Mark Durkin

Group therapy co-ordinator MhIST

**School of Nursing, Midwifery , Social Work  
& Social Sciences**

University of Salford

Mary Seacole Building  
Frederick Road Campus

SALFORD, Greater Manchester

M6 6PU United Kingdom

Tel: +44(0)845 234 0184

Fax: +44(0)161 295 7293

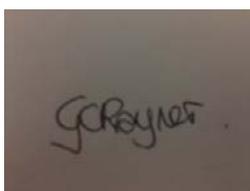
[www.salford.ac.uk/nmsw](http://www.salford.ac.uk/nmsw)

5/4/16

Compassion Focused Therapy Training for Healthcare educators and providers: Does this increase self-compassion, and reduce self-persecution and self-criticism?

This letter stands as evidence that I worked with Elaine on this paper as a co-author and I contributed approximately 10% of the work. She has been an absolute pleasure to work with.

Yours Sincerely

A square image showing a handwritten signature in black ink on a light-colored background. The signature appears to read "G. Rayner".

Dr Gillian Rayner

MS3.12 Mary Seacole Building

Fredrick Rd campus

University of Salford

Manchester

M66 PU

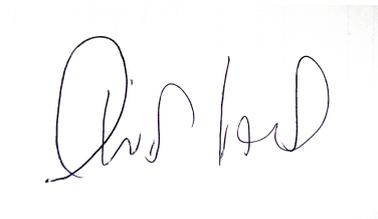
3<sup>rd</sup> April 2016

To whom it may concern,

**RE: Compassion Focused Therapy Training for Healthcare Educators and Providers: Does this increase self-compassion, and reduce self-persecution and self-criticism?**

I am writing to confirm that Elaine Beaumont led the writing of the manuscript, managed the project and submission process. Elaine managed the ethical approval process and conceived the project. Elaine was responsible for the data collection and statistical analysis. I, commented on drafts of the paper contributing ten-fifteen percent.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Chris Irons', is centered on the page. The signature is written in a cursive, flowing style.

Dr Chris Irons

Clinical Psychologist

[chris@balancedminds.com](mailto:chris@balancedminds.com)



Manchester  
Metropolitan  
University

Manchester Metropolitan University  
Department of Psychology  
Birley Building  
53 Bonsall Street  
Manchester  
M15 6GX

3<sup>rd</sup> April 2016

To whom it may concern,

**RE: Compassion Focused Therapy Training for Healthcare Educators and Providers:  
Does this increase self-compassion, and reduce self-persecution and self-criticism?**

I am writing to confirm that Elaine Beaumont led the writing of the manuscript, ethical approval and submission process. Elaine conceived and designed project and completed the review of literature. Elaine was responsible for the data collection and statistical analysis. I, Neil Dagnall commented on drafts of the results section, contributing five percent to the research project.

Yours Sincerely,

A handwritten signature in black ink that reads "N. Dagnall".

Neil Dagnall  
Joint Acting Head of Psychology

15<sup>th</sup> April 2016

**RESEARCH PROJECT: The effects of Compassionate Mind Training on students enrolled on a Cognitive Behavioural Psychotherapy training programme.**

I am writing to confirm that Elaine Beaumont co-conceived the project and contributed to the design of the project and data collection. Elaine was part of a team that provided the training workshops for students enrolled on the Cognitive Behavioural Psychotherapy Programme. Elaine completed the search, conducted the statistical analysis and led the writing of the manuscript and submission process. I, Gosia Bowling contributed to the writing of the paper and data collection, estimating my own contribution to the paper as being approximately 5%.

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Gosia', with a large, stylized initial 'G' and a long, sweeping tail.

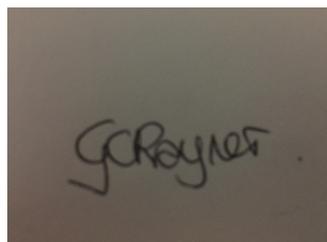
Gosia Bowling

28<sup>th</sup> February 2017

**RE: The effects of Compassionate Mind Training on students undertaking a Cognitive Behavioural Psychotherapy training programme.**

I am writing to confirm that Elaine Beaumont provided a large contribution to the design, organisation and data collection for this study. Elaine completed the methodology, literature review, conducted the data analysis and statistical interpretation in this paper. Elaine led the writing of this manuscript and the submission process. She provided CMT workshops for the students using exercises from the Compassionate Mind Workbook. I, Dr Gillian Rayner led the research and programme team to co-design the project, then led the co-design of the student training sessions and data collection. I provided and designed some of the student sessions. I then contributed to the writing of the paper (15-20%).

Yours Sincerely,

A rectangular box containing a handwritten signature in black ink. The signature appears to be 'G. Rayner'.

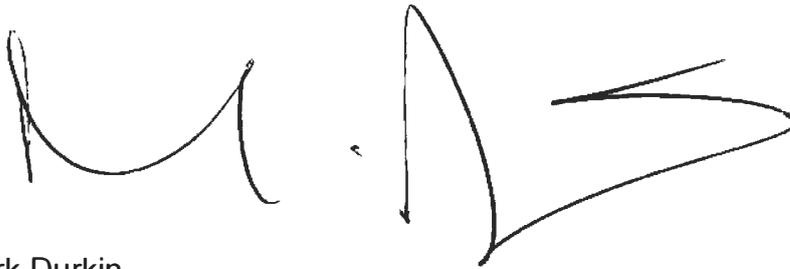
Dr Gillian Rayner

25/1/2017

**RE: The effects of Compassionate Mind Training on student psychotherapists.**

I am writing to confirm that Elaine Beaumont contributed to the design of the study and data collection. Elaine provided CMT workshops for the students and completed the methodology, data analysis and statistical interpretation. Elaine led the writing of the manuscript and led the submission process. I, Mark Durkin commented on drafts of the paper and contributed to the statistical analysis. My contribution to the project was five-ten percent. I confirm Elaine's seventy percent contribution to the project.

Yours Sincerely,

A handwritten signature in black ink, appearing to be 'M. Durkin', written in a cursive style.

Mark Durkin  
University of Bolton

**Appendix 4**  
**Ethical approval**  
**letters**

**From:** Jenkins Peter  
**Sent:** 19 April 2010 09:48  
**To:** Beaumont Elaine A  
**Subject:** FW: Application for Ethical Approval

Dear Elaine,

Very good news! It is rare to get approval on your first attempt, so this is to your credit.

Yours,

Peter

---

**From:** Wolstenholme Clare L  
**Sent:** 16 April 2010 14:44  
**To:** Beaumont Elaine (E.Beaumont) PGT  
**Cc:** Jenkins Peter  
**Subject:** Application for Ethical Approval

Dear Elaine

*Research project: A comparative study exploring therapy outcome measures of 2 groups: 1 group receiving cognitive behaviour therapy following a traumatic incident and 1 group receiving cognitive behaviour therapy and compassionate mind training following a traumatic incident.*

Thank you for submitting an application for ethical approval. The decision from the Ethics Committee was to **approve** your application.

You may now continue with your project.

Kind regards

**Clare Wolstenholme**  
Faculty Administrative Assistant  
Faculty of Health & Social Care

T: 0161 295 2129  
E: [c.l.wolstenholme@salford.ac.uk](mailto:c.l.wolstenholme@salford.ac.uk)

Research, Innovation and  
Academic Engagement Ethical  
Approval Panel  
College of Health & Social Care  
AD 101 Allerton Building  
University of Salford  
M6 6PU  
T +44(0)161 295 2280  
HSresearch@salford.ac.uk  
www.salford.ac.uk/

14 May 2015

Dear Sue,

**RE: ETHICS APPLICATION HSCR15/38 – The impact of N. Staffs Mind’s Adult Counselling service on the mental health of their clients**

Based on the information you provided, I am pleased to inform you that application HSCR15/38 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

*Sarah Starkey*

Sarah Starkey  
Engagement & Innovation Assistant

17 February 2014

Dear Elaine,

**RE: ETHICS APPLICATION HSCR14/01 – A study examining the outcome measures of a 3 day staff workshop on Compassionate Mind Training for health and social care professionals. Does the training increase self-compassion, self-reassurance and reduce self-criticism?**

Based on the information you provided, I am pleased to inform you that application HSCR14/01 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

*Rachel Shuttleworth*

Rachel Shuttleworth  
College Support Officer (R&I)

University of Salford,  
Manchester.



. 29th March 2016.

Dear Colleagues,

RE: Research Project, ***“Practice what you preach: investigating factors that lead to more compassionate care among health care staff.”***

I am pleased to confirm that this project received ethical approval from the Psychology Department at the University of Bolton in February 2014. All proposals are vetted by two qualified psychologists and are then scrutinized by the Departmental lead for Ethics, in this case Dr Sharon Xuereb. The project was conducted by Mark Durkin and Elaine Beaumont supervised by myself and Professor CJ Hollins-Martin. It was our hope that this project would lead to active collaboration between the Universities of Bolton and Salford and I am delighted to confirm that this is what has transpired. I look forward to further joint work between our organisations.

Yours sincerely,

A handwritten signature in blue ink, appearing to read "Jerome Carson", with a long horizontal flourish extending to the right.

Jerome Carson, BA (Hons), MSc., PhD, C.Psychol  
Professor of Psychology.

**University of Bolton**  
Deane Road  
Bolton  
BL3 5AB

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+44 (0)1204 900600  
Fax:  
+44 (0)1204 399074  
Website:  
[www.bolton.ac.uk](http://www.bolton.ac.uk)

Vice Chancellor: Dr G.E. Holmes



22 January 2014

Dear Gillian,

**RE: ETHICS APPLICATION HSCR13/62 – The effects of compassionate mind training on a cognitive behavioural psychotherapy training programme**

Based on the information you provided, I am pleased to inform you that application HSCR13/62 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

*Rachel Shuttleworth*

Rachel Shuttleworth  
College Support Officer (R&I)

24 November 2014

Dear Gillian,

**RE: REQUEST TO AMEND ETHICS APPLICATION HSCR13/62 – The effects of compassionate mind training on a cognitive behavioural psychotherapy training programme**

Following your request submitted to the Panel to amend this previously approved ethics application, based on the information you provided I am pleased to inform you that this has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

*Rachel Shuttleworth*

Rachel Shuttleworth  
College Support Officer (R&I)

2 September 2016

Dear Elaine,

**RE: ETHICS APPLICATION HSCR 16-79 – Does Compassionate Mind Training (CMT) increase levels of self-compassion, compassion for others, professional quality of life, well-being and reduce levels of self-criticism in a sample of healthcare students?**

Based on the information you provided, I am pleased to inform you that application HSCR16-79 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting [Health-ResearchEthics@salford.ac.uk](mailto:Health-ResearchEthics@salford.ac.uk)

Yours sincerely,



Sue McAndrew  
Chair of the Research Ethics Panel

## **Appendix 5**

### **Greater Manchester Fire and Rescue**

#### **Service approval**

Your Reference

Our Reference TJA/OHWA/POD

Contact Mrs Tracey Akturan  
0161 608 4247  
Akturant@manchesterfire.gov.uk



**GREATER MANCHESTER  
FIRE AND RESCUE SERVICE**

Elaine Beaumont  
Beaumont Psychotherapy  
The Worsley Centre for Psychotherapy & Counselling  
50 Bridgewater Road  
Worsley  
M28 3AE

County Fire Officer & Chief Executive  
Steve McGulirk, CBE, QFSM, DL,  
MA BA(Hons), BSc, FRSA, FIFireE

Greater Manchester Fire and Rescue  
Service  
146 Bolton Road  
Swinton  
Manchester M27 8US  
Telephone 0161 736 5866  
Fax 0161 743 1777  
[www.manchesterfire.gov.uk](http://www.manchesterfire.gov.uk)

Date 06 April 2010

Dear Elaine,

I refer to your recent communication regarding your research relating to Cognitive Behaviour Therapy, Eye Movement, Desensitisation and Reprocessing and Compassionate Mind Training and can confirm that we are happy for you to proceed. I can confirm that Greater Manchester Fire and Rescue Service are happy for you to continue providing each individual referred for therapy gives consent to take part in the research.

Yours Sincerely

A handwritten signature in black ink that reads 'TJA' followed by a wavy line.

Tracey Akturan  
Occupational Health & Wellbeing Advisor  
People and Organisation Development

## **Appendix 6**

### **THE COMPASSIONATE MIND WORKBOOK:**

**A Step-by-Step Guide to Developing your**

**Compassionate Self**

**Dr Chris Irons and Elaine Beaumont**

## **CONTENTS**

### **SECTION I: – WHY WE NEED COMPASSION**

Chapter 1: We have tricky brains

Chapter 2: We are shaped by our circumstances

Chapter 3: Our emotion systems

Chapter 4: Understanding ourselves

### **SECTION II: UNDERSTANDING COMPASSION**

Chapter 5: What is compassion

Chapter 6: The different flows of compassion

Chapter 7: Why compassion can be difficult for us

### **SECTION III: DEVELOPING THE FOUNDATIONS OF OUR COMPASSIONATE MIND**

Chapter 8: Attention and Mindfulness

Chapter 9: Building the Soothing System I – Body and Breathing

Chapter 10: Building the soothing System II – Imagery

Chapter 11: Building the Drive System

### **SECTION IV: DEVELOPING OUR COMPASSIONATE MIND**

Chapter 12: Developing our Compassionate Mind – Creating your Ideal Compassionate Self

Chapter 13: Developing our Compassionate Mind – Creating your Ideal Compassionate Other

Chapter 14: Developing our Compassionate Team

### **SECTION V: DIRECTING OUR COMPASSIONATE MIND - COMPASSION AS FLOW**

Chapter 15: Directing your Compassionate Mind - Compassion from Self to Others

Chapter 16: Directing your Compassionate Mind - Experiencing compassion from others

Chapter 17 Directing your Compassionate Mind - Self-Compassion

## **SECTION VI: DEVELOPING THE SKILLS OF OUR COMPASSIONATE MIND**

Chapter 18: Putting our Compassionate Mind to Work – Attention

Chapter 19: Putting our Compassionate Mind to Work – Thinking

Chapter 20: Putting our Compassionate Mind to Work – Emotion

Chapter 21: Putting our Compassionate Mind to Work – Behaviour

Chapter 22: Compassionate Letter Writing – Bringing together the skills of our compassionate mind

## **SECTION VII: PUTTING OUR COMPASSIONATE MIND TO WORK WITH COMMON DIFFICULTIES**

Chapter 23: Bringing our compassionate mind to shame and self-criticism

Chapter 24: Compassion for our different parts

Chapter 25: Working with fears, blocks and resistances to compassion

## **SECTION VIII: SUSTAINING OUR COMPASSIONATE MIND**

Chapter 26: Looking forward - Sustaining our Compassionate Mind

## **RESOURCES**

**Appendix 7**

**Example**

**questionnaires**

## Experience of Compassionate Mind Interventions

We are interested in how helpful students have found compassionate mind exercises. Below are a series of exercises that you may have explored whilst doing your CBT training. We would be very interested in your view of how helpful the exercises were and how much you use them in your everyday life. Please read each statement carefully and circle the number that best describes how you feel in the contexts below.

### How helpful were the exercises

Please use the following scale for your ratings:

Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful	Extremely helpful
0	1	2	3	4

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. I found training my mind to be compassionate helpful  | 0 | 1 | 2 | 3 | 4 |
| 2. Learning about the three circles model was helpful  | 0 | 1 | 2 | 3 | 4 |
| 3. Learning about the skills (compassionate attention, thinking, behaviour, feeling) of compassion helped me | 0 | 1 | 2 | 3 | 4 |
| 4. I found using the practise diaries helped me  | 0 | 1 | 2 | 3 | 4 |
| 5. Learning that our thoughts and images affect our mind and brain was helpful                               | 0 | 1 | 2 | 3 | 4 |
| 6. Learning about my 'internal bully' was helpful  | 0 | 1 | 2 | 3 | 4 |
| 7. Showing compassion to my 'inner critic' was helpful   | 0 | 1 | 2 | 3 | 4 |

8. I found working with my anxious self helped me	0	1	2	3	4
9. Using Mindfulness was helpful	0	1	2	3	4
10. Imagining kindness and compassion flowing from me to others was helpful	0	1	2	3	4
11. I found the imagery exercises helpful	0	1	2	3	4
12. I found using the safe place exercise helpful	0	1	2	3	4
13. Engaging in soothing rhythm breathing was helpful	0	1	2	3	4
14. The body scan and relaxation exercises were helpful	0	1	2	3	4
15. I found compassionate letter writing helpful	0	1	2	3	4
16. I found keeping a compassionate reflective log helpful	0	1	2	3	4
17. I found remembering experiences where I felt gratitude and joy helpful	0	1	2	3	4
18. Building a compassionate (ideal) image helped me	0	1	2	3	4
19. Learning about compassion focused thought balancing helped me	0	1	2	3	4
20. I found creating a sense of being a compassionate person helpful (may you be well, may you be happy, may you be free from suffering exercises)	0	1	2	3	4
21. I found doing acts of kindness for other people helped me	0	1	2	3	4
22. I found doing acts of kindness for myself helped me	0	1	2	3	4
23. Compassionate flashcards helped me	0	1	2	3	4
24. Compassion in the mirror exercises helped me	0	1	2	3	4
25. My internal compassionate CBT coach helped me	0	1	2	3	4
26. The Compassionate ladder exercise helped me	0	1	2	3	4

27. The compassionate planning log (PDA log) helped me 0 1 2 3 4

**How much do you use the CMT exercises in your everyday life?**

Please use the following scale for your ratings:

Not at all	Occasionally	Often	A few times a week	Every day
0	1	2	3	4

- 1. Soothing rhythm breathing 0 1 2 3 4
- 2. Mindfulness exercises (e.g., mindful labelling) 0 1 2 3 4
- 3. The body scan and/or safe place exercises 0 1 2 3 4
- 4. Your ideal compassionate other 0 1 2 3 4
- 5. Compassion as a flow exercises/directing your compassionate mind 0 1 2 3 4
- 6. Compassionate actions (e.g. acts of kindness for myself/other people) 0 1 2 3 4
- 7. Compassionate colour/object/picture 0 1 2 3 4
- 8. Compassion focused imagery 0 1 2 3 4
- 9. Compassionate thought balancing/diaries 0 1 2 3 4
- 10. Compassionate flash cards 0 1 2 3 4
- 11. Compassion in the mirror 0 1 2 3 4

12. Acting skills to develop your compassionate self	0	1	2	3	4
13. An internal compassionate CBT coach	0	1	2	3	4
14. Showing compassion to your inner critic	0	1	2	3	4
15. Compassionate ladder exercise	0	1	2	3	4
16. Compassionate planning log (PDA log)	0	1	2	3	4
17. Compassionate letter writing	0	1	2	3	4