PROFESSIONAL DOCTORATES

Compassion in the NHS: An exploration of the experiences of mental health staff.

Drobinska, Kamila

Award date:
2020

Awarding institution:
Bangor University

PRIFYSGOL
BANGOR
UNIVERSITY

Compassion in the NHS:

An exploration of the experiences of mental health staff.

Kamila Drobinska

North Wales Clinical Psychology Programme

Bangor University

This thesis is submitted in partial fulfilment of the requirements for the degree of

Doctor in Clinical Psychology

May 2020

Content

Section 1

Compassion in the NHS: An exploration of the experiences of mental health staff.

This thesis explores the experience of compassion satisfaction and compassion-focused groups amongst mental health staff.

The narrative systematic literature review focused on identifying factors associated with higher compassion satisfaction in mental health professionals. A search of five databases identified 35 relevant studies. Findings indicated that a range of compassion satisfaction variables were investigated in mental health staff, such as self-care practices, workplace support and belongingness, cognitive facets of empathy, and competence. The review concluded that a range of organisational factors can help promote compassion satisfaction, thus protecting mental health professionals from burnout and compassion fatigue. The review is limited by the cross-sectional nature of the included studies.

The empirical paper employed a mixed-method design to explore the feasibility and acceptability of compassion focused groups for staff working in inpatient mental health services. Ten participants completed session-by-session feasibility and acceptability measures. Eight participants were interviewed to explore the experience of the group and reasons for attrition. In spite of high acceptability ratings, supported by themes of positive affect, common humanity and changes in relating to self and others, the group had high attrition. Interviews were analysed using thematic analysis, identifying an overarching theme relating to systemic barriers to attending with five main themes: (1) The nature of the ward; (2) Slowing down is not allowed; (3) It's not in our nature; (4) Guilt and threat; (5) We're not important. The results indicated that although compassion-focused groups may be experienced as a helpful intervention, they are not

feasible to offer in the current design unless the identified barriers are addressed.

Implications for future research, theory development and clinical practice are discussed.

Declaration

I hereby declare that this thesis is the result of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Signed: 

Date: 28/05/2020

Acknowledgments

Firstly, I would like to thank Dr Mike Jackson, Dr David Oakley and Dr Carrie Way for their endless compassion towards me and their commitment to this project from the start. Thank you for your support especially during the most difficult time – the two months during the Covid-19 'lockdown', when I found it at times particularly difficult to write.

I would like to offer a heartfelt thanks to all my research participants. Without their contribution, this project would not have been possible to complete. Their kindness to offer their time and their courage to speak so openly with me about their experiences, has enabled me to gain a deeper understanding of the challenges and opportunities of what compassion focused staff support can offer in inpatient mental health services.

I am grateful to my friends and my family for their patience, validation and encouragement.

I would like to especially thank Doreen, Emma, Lindsay, Cassie and Martyn (and their Spaniel Cliff). Being able to share laughter and tears together with you has been very much appreciated. I value the understanding and support each of you provided. I could not have done it without you.

Finally, I would like to express my gratitude for the privilege to undertake my professional training in beautiful North Wales. Feeling so welcomed by the local community, hiking and discovering rock climbing has helped me see this project through. I am deeply grateful I have found home here, among the mountains of Snowdonia.

Section 2: Literature Review

Factors Associated with Higher Compassion Satisfaction in Mental Health Professionals. A Narrative Review.

Kamila Drobinska[a*], David Oakley[b], Carrie Way[b], Mike Jackson[a]

[a]North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK; [b]Betsi Cadwaladr University Health Board, North Wales, UK

***Corresponding Author:** Kamila Drobinska, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK.

kamila.drobinska@gmail.com

This paper is intended to be submitted to the Issues in Mental Health Nursing journal: https://www-tandfonline-com.ezproxy.bangor.ac.uk/action/authorSubmission?show=instructions&journalCode=imhn20

Factors Associated with Higher Compassion Satisfaction in Mental Health Professionals. A Narrative Review.

Mental health professionals can experience compassion satisfaction as a result of helping others and it is suggested that compassion satisfaction may protect from compassion fatigue. There is no consensus as to what factors may be associated with compassion satisfaction, but a number of studies have investigated the possible correlates. The aim of this review was to examine research on variables associated with compassion satisfaction in mental health professionals. The results highlights factors, such as engagement with self-care practices, empathy, competence, workplace support and sense of belonging in the workplace, associated or predictive of compassion satisfaction. Implications and limitations are discussed.

Keywords: compassion satisfaction, mental health professionals, ProQOL

Introduction

Mental health professionals (MHPs) witness distress in their working life. Many of those they help have experienced significant traumas in their life prior to accessing mental health services. Professionals also work in highly emotive and often demanding environments. Unsurprisingly, working in this field can have an impact on the mental health of the helper. The well-being of MHPs has been attracting the interest of researchers over the past thirty years. An extensive body of literature exists evidencing the negative psychological implications for those working with traumatised individuals with mental health problems (Collins & Long, 2003; Linley & Joseph, 2007; Thompson, Amatea, & Thompson, 2014; Voss Horrell, Holohan. Didion & Vance, 2011). Compassion Fatigue (CF) is one of the possible implications (Figley, 2002).

CF is seen (Figley, 1995) as the consequence of being a mental health professional. Figley (1995) conceptualises it as the cost the helper pays for the act of caring, emotional investment and empathy towards the suffering. In his definition CF is a form of caregivers' burnout. In Stamm's (2005) concept of the Professional Quality of Life (ProQoL), CF has two components – Burnout (BO) and Secondary Traumatic Stress (STS). According to Stamm (2010) BO constitutes the feelings of frustration, anger, depression, hopelessness and exhaustion in relation to work. STS is related to the exposure to a traumatic material of the person the MHP is helping, resulting in similar 'symptoms' to those of the client, such as fear/anxiety, intrusive images, sleep problems and avoidance of the reminders of the traumatic event. STS is a similar concept to Vicarious Trauma (Pearlman & Saakvitne, 1995). A number of studies examined the well-being of MHPs through the concept of ProQoL and found a prevalence of CF

(Conrad & Kellar-Guenther, 2006), STS (MacRitchie & Leibowitz 2010) as well as BO (Baldschun, Hämäläinen, Töttö, Rantonen & Salo, 2019).

Poorer staff well-being is suggested to be associated with patients' experiences and outcomes (Maben, 2010) and has been linked to absenteeism and higher turnover in organisations (Robertson & Cooper, 2010), which has obvious financial implications. It is not surprising that there has been a growing interest in investigating what factors precisely may lead to the development of CF, BO and STS in mental health professionals. A recent systematic review (Turgoose & Maddox, 2017) investigating predictors of compassion fatigue in MHPs found a number of factors associated with CF, such as professionals' own trauma history, mindfulness, empathy and caseload. Research findings may inform organisational preventative initiatives, such as staff group programmes and individual interventions to help reduce the risk of CF, STS and BO, and maximize mental health professionals' well-being.

Compassion Satisfaction in Mental Health Professionals

The positive aspects and psychological implications of being a mental health professional have often been overlooked in research, and may offer an important contribution to the literature on staff well-being, retention, service and patient outcomes. In recent years research on the negative implication of being a 'helper' began shifting its approach from a problem-oriented one, to focusing on resilience, strengths and factors that can contribute to the well-being of the professional (Richardson, 2002). Indeed, working in a mental health profession can have many positive aspects that may underpin decisions to pursue a career in mental health. Perhaps the most commonly, anecdotally reported reason for choosing this career is the desire and opportunity to help others in need or in distress. Other positive aspects of working as a helper are seeing

people recover (Collins & Long, 2003) and develop personal growth (Linley & Joseph, 2007). Many MHPs report enjoying their work and experiencing compassion satisfaction (Birck, 2001).

Compassion Satisfaction (CS) is the pleasure and positive feelings one derives from helping others (Stamm, 2005). It is the satisfaction a helper experiences in their role and is to do with being able to assist a person in their recovery. It also involves how MHPs feel about their colleagues and contributions they make to their service, organisation, or larger community. Studies suggest that self-reported levels of CS within the mental health profession vary, and MHPs can simultaneously experience CS and compassion fatigue. However, typically findings suggest that as CS increases, CF decreases (Bride, Radey & Figley, 2007) and it is further suggested that CS may protect against CF, burnout and secondary traumatic stress (Collins & Long, 2003; Ray, Wong, White & Heaslip, 2013; Samios, Abel & Rodzik, 2013; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 2005). A recent study by Baugerud, Vangbæk and Melinder (2018) suggested that a low level of CS was the largest predictor of BO. Given the suggested protective role of CS, more and more studies have been recently investigating associations between potential individual and organisational factors and CS, to shed light on what may promote CS in mental health professionals.

Aim

There is currently a growing body of research examining factors associated with or predicting compassion satisfaction in mental health professionals. A recent meta-analysis of predictors of CS and compassion fatigue has been undertaken but it focused solely on nurses in different specialties (Zhang, Zhang, Han, Li, Wang, 2018). The

analysis found that positive affect was significantly associated with CS, but demographic or professional factors were not. To our knowledge, no systematic review of literature for wider MHPs has been carried out. Given the distinct nature of working within mental health care, a review of the existing studies examining CS of professionals working in this specific setting, is warranted. The aim of the current review is to answer the following question:

What factors are associated with higher compassion satisfaction in mental health professionals?

There is large body of research that examines correlations between CS and compassion fatigue, burnout and secondary traumatic stress. Compassion satisfaction might be related to many factors, other than CF, BO and STS. The primary aim was to investigate individual and organisational correlates, other than CF, BO and STS, in mental health professionals.

Method

Inclusion and exclusion criteria

Compassion Satisfaction is commonly measured by the ProQoL scale. The scale replaced the Compassion Fatigue Self-Test (CFS; Figley, 1995), which has been noted to have psychometric problems. Given that a body of literature exists using the later ProQoL scale, only studies that used this validated measure of CS have been included in this review. The other inclusion requirement was for the studies to investigate factors associated with CS, other than CF, BO and STS; studies using quantitative analyses

(with cross-sectional, longitudinal, correlational, experimental or quasi-experimental design, or mixed methods); studies with participants who worked as mental health professionals; studies published in peer-reviewed journals, between January 1990 and April 2020; and studies published in English or where an English translation was accessible.

Qualitative studies; studies with participants who do not work as mental health professionals or are in training or volunteers; and studies that did not use ProQoL as a measure of CS, were excluded from this review.

Search strategy

Five databases (PsycINFO, PubMed, Medline, CINAHL, PILOTS) were searched in January 2020 and re-run in April 2020 to identify relevant studies. The search strategy encompassed the following search terms: "compassion satisfaction" AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR resilience OR vulnerable OR vulnerability OR risk OR “risk factor*”) AND ("mental health nurse*" OR "psychiatric nurse*" OR therapist* OR psychotherapist* OR psycholog* OR counse?lor OR "mental health physician*" OR “mental health practitioner” OR "mental health professional*" OR "mental health staff" OR psychiatr* OR "social worker*").

In addition to searching the five databases, a search of reference lists of all articles included was carried out, identifying nine additional studied that warranted screening.

Results

The search yielded a total of 475 studies out of which 371 were identified as duplicates or not meeting the inclusion criteria after screening title and abstracts. The remaining 104 research articles were examined in more detail to determine whether they met the inclusion criteria, and a further 69 were excluded with reasons, leaving a total of 35 studies included in the review. A breakdown of the study selection process can be found in the Prisma Flow Diagram in Figure 1.

The selection process for inclusion eligibility was carried out by the first author. To ensure reliability and replicability in the decision-making process, the second and third author screened two papers against the inclusion/exclusion criteria.

Overview of study design and demographic information

The studies included in this review were published in 2007 or after. Any studies published after April 2020 were not included in this review. Seventeen studies were conducted in USA, two in Canada, one in Mexico, two in Australia, three in the UK, one in Norway, one in Sweden, one in Spain, two in Italy, two in Greece and three in Israel. Thirty-three studies were quantitative and employed a cross-sectional design. Two studies (Killian, 2008; Lusk & Terrazas, 2015) were mixed methods employing a cross-sectional design investigating factors associated with CS. All studies used the ProQoL measure of CS, however different versions of the measure were utilised (the third, fourth or fifth edition) and several studies did not report which version they used. All studies performed correlational, linear or multiple regression analyses to examine relationships between CS and the investigated variables. Independent samples *t*-tests

were employed to examine difference between dichotomous groups (i.e. gender, workplace settings).

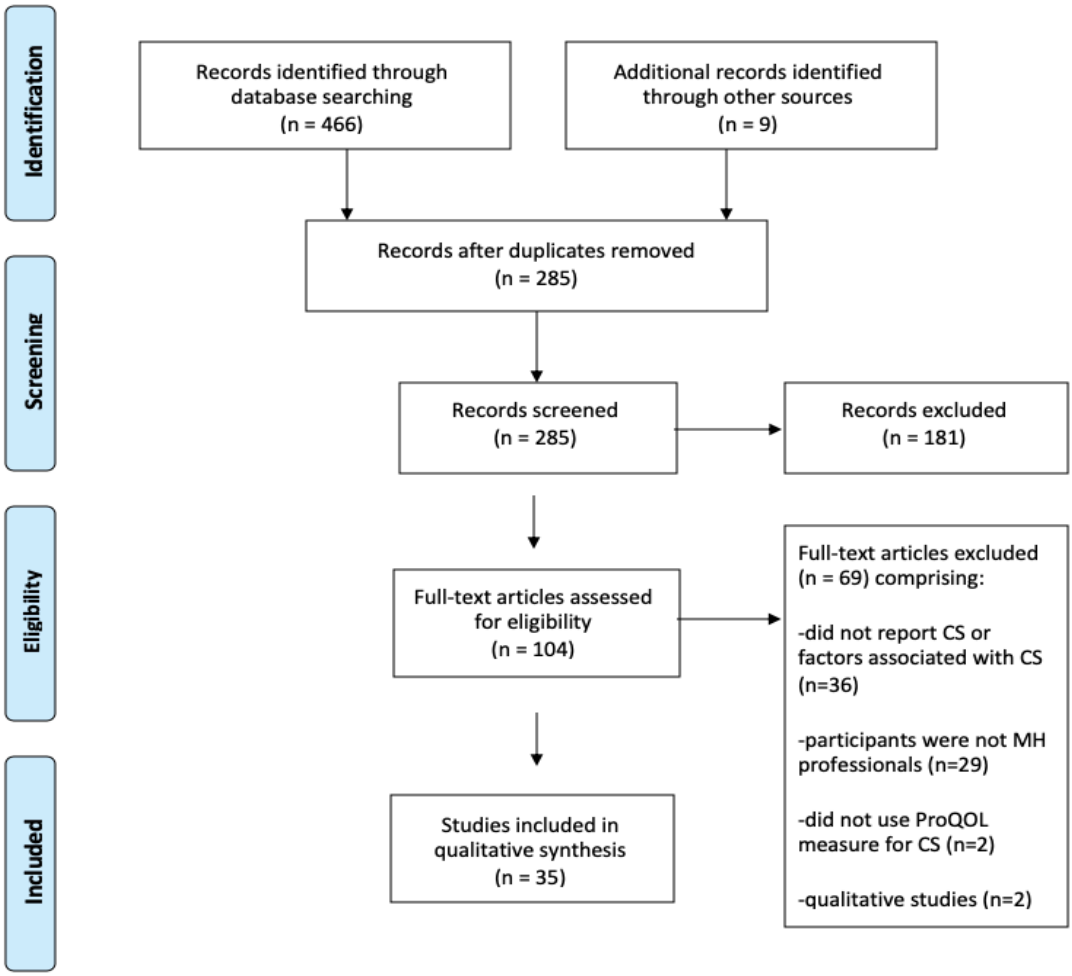


Figure 1. PRISMA Flow Diagram

The sample sizes ranged between 31 and 1,121 participants, with a median of 174. The study samples consisted of mental health professionals – 13 studies focused solely on social workers, 9 examined psychotherapists, 2 consisted of mental health nurses and 11 studies investigated mixed samples of mental health workers from a range of disciplines (i.e. psychologists, psychiatrists, family therapists, social workers and mental health nurses).

Overview of study quality

A critical appraisal tool for cross-sectional studies (AXIS; Downes, Brennan, Williams & Dean, 2016) was used to assess the methodological quality of the included studies and to examine the potential for bias in the design, conduct and analysis of their studies (Downes et al., 2016). The scale consists of 20 items measuring different aspects of study quality, such as: justification of the sample size, representativeness of the sample, response rate, use of validated measures, description of the statistical analyses, declaration of funding and conflicts of interest. Each study can score between 0 to 20, with highest score reflecting highest quality (lowest risk of bias).

The quality assessment was used to inform the synthesis and interpretation of the study results.

Factors associated with Compassion Satisfaction

Studies included in this review investigated a wide range of factors associated with CS, such as: years of experience (e.g. Wagaman, Geiger, Shockley & Segal, 2015), age (e.g. Sodeke-Gregson, Holttum & Billings, 2013), gender (e.g. Bae et al., 2019), experience of trauma (e.g. La Mott & Martin, 2019), self-care practices (e.g. Cuartero & Campos-Vidal, 2018), workplace support and belongingness (e.g. Killian, 2008), competence (e.g. Craig & Sprang, 2010), empathy (e.g. Laverdière, Ogrodniczuk & Kealy, 2019), hours of clinical contact per week (e.g. Beder et al., 2012) and work autonomy (e.g. Cetrano et al., 2017). A summary of main findings is listed in Table 1. (Appendix 2).

Demographic variables: Years of Experience, Age and Gender

The demographic variable most frequently reported in the studies was the amount of professional experience. Seventeen studies investigated the relationship between years of experience and compassion satisfaction (Avieli, Ben-David & Levy, 2016; Bae et al.,2019; Beder, Postiglione & Strolin-Goltzman, 2012; Bloomquist, Wood, Friedmeyer-Trainor & Kim, 2016; Carmel & Friedlander, 2009; Craig & Sprang, 2010; Itzhaki, Peles-Bortz, Kostistky, Barnoy, Filshtinsky & Bluvstein, 2015; Kjellenberg, Nilsson, Daukantaité & Cardeña, 2014; Laverdière, Kealy et al., 2019; Lusk & Terrazas, 2015; Mangoulia, Koukia, Alevizopoulos, Fildissis & Katostaras, 2015; Salloum, Kondrat, Johnco & Olson, 2015; Sodeke-Gregson et al., 2013; Thomas, 2013; Thomas & Otis, 2010; Towey-Swift & Whittington, 2019; Wagaman et al., 2015). Of these seventeen studies, twelve reported significant associations between years worked in the profession and compassion satisfaction. Ten studies found that with increased years of experience as a mental health professional, there was an increase in CS. Avieli et al. (2016) found that higher CS was predicted by five or more years of experience. In one study (Thomas, 2013) however, it was a significant but small positive correlation. Two studies (Salloum et al., 2015; Towey-Swift &Whittington, 2019) found a significant negative effect: lower CS was predicted by more years of experience. In the first study, MHPs who worked more than one year reported lower CS. In the latter study, this relationship became insignificant when other factors were added to the regression analysis. Sodeke-Gregson et al. (2013) also found that although there was a positive association between years of clinical experience and CS, CS was not significantly predicted by experience, but other factors predicted it.

With regard to non-significant findings, five studies found that there were no significant associations between years of experience and CS (Beder et al., 2012; Itzhaki et al., 2018; Kjellenberg et al., 2014; Mangoulia et al., 2015; Thomas & Otis, 2010).

In terms of age, fourteen studies investigated potential associations between age and CS, though their results are inconsistent. Five studies found a positive correlation between age and CS (Carmel & Friedlander, 2009; Sodeke-Gregson et al., 2013; Somoray, Shakespeare, Finch & Armstrong, 2017; Sprang, Clark & Whitt-Woosley, 2007; Thomas, 2013. In three of those studies (Sodeke-Gregson et al., 2013; Somoray, et al., 2017; Sprang et al., 2007) older age predicted higher CS. However, one study found a negative correlation between age and CS (Kjellenberg et al., 2014) suggesting that younger age was correlated with higher CS. Eight studies found no association between age and CS (Bae et al., 2019; Baugerud, Vangbæk & Melinder, 2018; Itzhaki et al., 2018; Rossi el al., 2012; Salloum et al.,2015; Thomas & Otis, 2010; Towey-Swift & Whittington, 2019; Van Hook & Rothenberg, 2009).

With regard to gender, ten studies investigated the relationship between gender and CS (Bae et al., 2019; Beder et al., 2012; Craig & Sprang, 2010; Laverdière, Kealy et al., 2019; Rossi el al., 2012; Salloum et al., 2015; Sprang et al., 2007; Thomas, 2013; Thomas & Otis, 2010; Van Hook & Rothenberg, 2009). Nine of the studies found no association between the two variables. The study of Salloum et al. (2015) is the only study that found gender significantly associated and predicting CS, with women reporting higher CS.

Experience of Trauma

Six studies explored whether and how mental health professionals' own trauma is associated with compassion satisfaction (Itzhaki et al., 2018; La Mott & Martin, 2019; Sodeke-Gregson et al., 2013; Thomas & Otis, 2010; Thomas, 2013; Somoray et al., 2017). Four studies assessed the presence of personal or work-related trauma by asking single question(s) about the presence of childhood/adult trauma history within the demographic and background questionnaires. One study (Itzhaki et al., 2018) used the Violence Exposure Questionnaire (Itzhaki et al., 2015), whereas La Mott and Martin (2019) used the Adverse Childhood Experiences Questionnaire (ACE; Felitti et al., 1998), which consists of 10 questions asking about the frequency and type of adverse childhood experiences the MHP had encountered. The results of the studies are mixed. The study of La Mott and Martin (2019) found that higher CS levels were reported by providers with no history of ACE, in comparison to those with a history of ACE (regardless of the type and quantity of the experiences), whilst Somoray et al. (2017) found that higher personal history of trauma (but not work-related trauma) predicted higher CS. The results of the four studies (Itzhaki et al., 2018; Sodeke-Gregson et al., 2013; Thomas, 2013; Thomas & Otis, 2010) suggest that there are no significant associations between trauma history (in the adulthood or childhood) and CS. However, work-related trauma was associated with increased work stress, which in turn was associated with lower CS in the study of Itzhaki et al. (2018).

Self-care practices

The factor most commonly investigated were self-care practices, with eleven studies examining the associations between self-care practices and CS (Bae et al., 2019; Bloomquist et al., 2016; Cetrano et al., 2017; Cuartero & Campos-Vidal, 2018; Killian, 2008; La Mott & Martin, 2019; Lawson & Myers, 2011; Salloum et al., 2015; Sodeke-Gregson et al., 2013; Wachter, Schrag & Wood; 2019; Xu, Harmon-Darrow & Frey; 2019). Of the eleven studies, nine found that self-care was significantly positively associated with compassion satisfaction.

None of the studies used the same measure of self-care which leads to challenges in making inferences and generalising the findings. Two studies used formal measures of work-life balance (Bae et al., 2019; Cetrano et al., 2017), seven studies used six different self-care or coping strategies scales (Bloomquist et al., 2016; Cuartero & Campos-Vidal, 2018; La Mott & Martin, 2019; Salloum et al., 2015; Sodeke-Gregson et al., 2013; Wachter et al., 2019; Xu et al., 2019). Only two studies used the same measure of self-care (Bloomquist et al., 2016; Xu et al., 2019), although Xu et al. (2019) used an adapted version of the scale used by Bloomquist et al. (2016). One study used a non-validated measure of self-care activities and strategies developed by the researcher based on the qualitative part of their study (Killian, 2008). Seven studies measured a range of activities within the self-care construct, including activities within work (i.e. engaging in supervision, peer support, research and development activities) and several different self-care domains outside work (i.e. engaging with leisure activities, hobbies, exercise, spiritual self-care), whilst two studies measured the perception of balance between work and private life (Bae et al., 2019; Cetrano et al., 2017) and two studies used scales that primarily measured work-related self-care activities (Lawson & Myers,

2011; Salloum et al., 2015). The study of Salloum et al. (2015) investigated a specific, trauma-informed type of self-care, which included using regular supervision, peer support and training.

Higher CS was predicted by higher instances of self-care perception, beliefs and behaviours (La Mott & Martin, 2019; Bloomquist et al., 2016; Salloum et al. (2015) and better work-life balance (Bae et al., 2019) after controlling for other socio-demographic variables (i.e. gender, years of practice, client contact per week) in two of the studies (La Mott & Martin, 2019; Bloomquist et al., 2016). In the study of La Mott and Martin (2019), each domain of self-care (physical, psychological, emotional, professional, spiritual, work-life balance) was positively associated with CS, and other studies suggested that the more frequently professionals engaged with self-care or coping behaviours, the higher they reported their CS to be (Cuartero & Campos-Vidal, 2018; Lawson & Myers, 2011; Sodeke-Gregson et al., 2013; Wachter et al., 2019). On the other hand, perceived higher interference of work with personal life (Bae et al., 2019; Cetrano et al., 2017) or personal life interference with work (Bae et al., 2019), was associated with lower CS.

Two of the eleven studies found self-care to not significantly predict CS (Killian, 2008; Xu et al., 2019). The study of Killian (2008) however used a non-validated list of self-care behaviour and strategies that emerged from their qualitative study and the study of Xu et al. (2019) although relatively high in quality, had a small sample and low response rate.

Workplace Support and Belongingness

Eight studies explored the potential relationship between CS and perceived supportiveness of the work environment, and found significant positive associations between workplace support and belongingness and CS. Somoray et al., (2017) found that higher CS was strongly predicted by workplace belongingness. A similar finding was reported in another study (Baugerud et al., 2018), where CS was positively associated with a sense of belonging to an inspiring organisation and perceived superior and co-worker support, as measured by the QPS Nordic, mentioned earlier, and The Relationship Questionnaire (Bartholomew & Horowitz, 1991). In the study of Killian (2008), higher CS was predicted most significantly by higher perceived social support, followed by sense of autonomy (accounting for 41 per cent of variance). Cetrano et al. (2017) found that higher CS was predicted by higher perceived quality of meetings and perceived security about future, after controlling for other variables (as measured by the Quality of Working Life Questionnaire, mentioned previously). One study found that psychiatric nurses who perceived their working environment and teamwork as very good, reported more CS (Mangoulia et al., 2015), although this study used a non-validated questionnaire to measure work environment therefore these results need to be interpreted with caution. Towey-Swift and Whittington (2019) and Wachter et al., (2019) both using the validated Areas of Worklife Scale (AWS; Leiter & Maslach, 2011) found that a sense of community in work was correlated with higher reported CS. However, only workload remained significant at multivariate analysis in the study of Towey-Swift and Whittington (2019), and the relationship between community and CS was fully mediated by coping behaviours in the study of Wachter et al. (2019).

With regard to supervision, the study of Sodeke-Gregson et al. (2013) suggests that positive beliefs about supervision and more time spent time in supervision, as measured by the Coping Strategies Inventory (CSI; Bober, Regehr & Zhou, 2006) were both positively associated with CS. Furthermore, higher CS was also predicted by higher perceived management support and supervision support. One study (Laverdière, Kealy et al., 2019) found no association between CS and the experience of supervision, however this study rated as lower quality than the study of Sodeke-Gregson et al. (2013) with a high response rate.

Competence

Eight studies (Baugerud et al., 2018; Carmel & Friedlander, 2009; Cetrano et al., 2017; Craig & Sprang, 2010; Finzi-Dottan & Kormosh, 2016; Lakioti, et al., 2020; Sodeke-Gregson et al., 2013; Sprang et al., 2007) examined associations between CS and training, perceived competence/mastery, self-efficacy and professional self-esteem. All of these variables were measured differently but share similar features, for example training is likely to lead to an increased competence, self-efficacy and professional self-esteem. These constructs share a sense of being able to do your work well. All have been found associated with CS. Three studies found that CS was positively associated with: experience or competence in working with a specific client group (Carmel & Friedlander (2009), sense of mastery at work (Baugerud et al., 2018) as measured by the valid and reliable Nordic Questionnaire for Psychological and Social Factors at Work (QPS Nordic; STAMI, 2001), higher professional self-esteem (Finzi-Dottan & Kormosh, 2016) as measured by The Professional Self-esteem Scale (Carmel, 1997) showing a high reliability score. Higher CS was also predicted by higher counselling

self-efficacy (Lakioti et al., 2020) assessed by the Counsellor Activity Self-Efficacy Scale (CASES; Lent, Hill & Hoffman, 2003). Findings of two studies suggest that specialist trauma training was positively associated with higher CS in professionals (Craig & Sprang, 2010; Sprang et al., 2007), and one study found that more days of trauma training since qualification was associated with higher reported CS (Sodeke-Gregson et al., 2013). However, Cetrano et al. (2017) found that higher CS was predicted by higher perceived need for training (as measured by the Quality of Working Life Questionnaire mentioned earlier). This may seem contradictory. It is possible that the professionals felt they have not had enough training. It is also plausible that previously received training increased their awareness of the importance of continuous professional development.

Empathy

Six studies assessed the links between empathy and CS (Lakioti, Stalikas & Pezirkianidis, 2020; Laverdière, Kealy et al., 2019; Laverdière, Ogrodniczuk et al., 2019; Thomas, 2013; Thomas & Otis, 2010; Wagaman et al., 2015) and one study examined the relationship between self-differentiation and CS (Finzi-Dottan & Kormosh, 2016), and one studied emotional separation (Thomas & Otis, 2010), which are similar concepts to 'self-other awareness', one of the component of the empathy construct measured in the study of Wagaman et al. (2015).

Empathy was measured using different instruments. Three studies (Laverdière, Ogrodniczuk & Kealy, 2019; Thomas, 2013; Thomas & Otis, 2010) used The Interpersonal Reactivity Index (IRI; Davis, 1983) consisting of four scales measuring

different components of dispositional empathy (Empathic Concern, Perspective Taking, Fantasy and Personal Distress). One study (Lakioti et al., 2020) used the abbreviated version of the IRI - the Brief Interpersonal Reactivity Index (B-IRI; Ingoglia, Lo Coco, & Albiero, 2016). One study (Laverdière, Kealy et al., 2019) used the Toronto Empathy Questionnaire (TEQ; Spreng, McKinnon, Mar & Levine, 2009) a self-report measure that assesses the respondent's perception of their own ability to empathise. One study (Wagaman et al., 2015) used The Empathy Assessment Index (EAI; Gerdes, Lietz & Segal, 2011), a self-report instrument that has four subscales measuring the components of interpersonal empathy (Affective Response, Self–Other Awareness, Perspective Taking and Emotion Regulation). In terms of investigating the relationship between the mental health professional's ability to separate themselves from the client, Thomas and Otis (2010) used the Maintenance of Emotional Separation Scale (Corcoran, 1982, 1983) measuring the ability to disengage from the client's emotional experience, whereas Finzi-Dottan & Kormosh (2016) investigated self-differentiation using Haber's Self-differentiation Scale examining self-differentiation on two factors: Emotional Maturity and Emotional Dependency.

All seven studies found significant associations between empathy, the empathy components and CS. In the study of Laverdière, Kealy et al. (2019) dispositional empathy was a strong predictor of CS. With regard to the components of the empathy construct as measured by the Interpersonal Reactivity Index, Thomas (2013) found that CS had a strong positive correlation with perspective taking. Laverdière, Kealy et al. (2019) also found lower CS levels associated with lower and moderate levels of the perspective taking, if the MHP provided only individual therapy. Higher CS was associated with the higher end of perspective taking, regardless of whether the MHP worked with individuals exclusively versus in the context of multi-person treatment

settings. In this study, CS was also modestly positively associated with empathic concern. In other words, psychotherapists who strongly wished to alleviate others' suffering experienced greater CS in their work. Thomas and Otis (2010) found a similar positive correlation between CS and empathic concern, however in their study the association was weak. In terms of the self-other awareness/ emotional separation, three studies found that higher CS was predicted by higher emotional separation (Thomas & Otis, 2010) as measured by the Maintenance of Emotional Separation Scale, higher self-others awareness (Wagaman et al., 2015), the cognitive component of empathy as measured by the Empathy Assessment Index and, higher level of self-differentiation as measured by the Self-differentiation Scale, in the study of the highest quality (Finzi-Dottan & Kormosh, 2016). Higher CS has also found to be significantly predicted by higher affective response, the physiological component of empathy (Wagaman et al., 2015), which may be inconsistent with two other studies (Laverdière, Ogrodniczuk et al., 2019; Thomas, 2013) of a slightly higher quality. The two studies found that CS was negatively associated with personal distress, the physiological component of empathy. Thomas and Otis (2010) also found negative associations between personal distress and CS, although the association was weak. In the later study of Thomas (2013), higher personal distress predicted lower levels of CS. Wagaman et al. (2015) suggested that the aforementioned affective response is different to personal distress, and may only lead to personal distress if left unregulated.

Clinical hours per week

Six studies investigated the relationship between the hours per week professionals spent working clinically, and levels of CS. Their findings are mixed. Two studies

(Kjellenberg et al., 2014; La Mott & Martin, 2019) found that CS did not appear to be correlated with clinical contact hours per week. However, three studies suggested significant correlations. Two found that lower CS was predicted by higher number of clinical contacts per week (Killian, 2008) and was negatively associated with working clinically more that 50 per cent of their week (Beder et al., 2012). One study which investigated time spent engaging in research and development activities (Sodeke-Gregson et al., 2013) found that the more time was spent engaging in these activities, the more CS the professional reported. On the other hand, Lusk and Terrazas (2015) found that CS had moderate positive associations with hours per week, suggesting that as hours of working with clients per week increased, so did CS. However, this study was of the lowest quality rating which should be taken into consideration when interpreting the results.

Work Autonomy

Five studies that investigated association between a sense of autonomy in work and compassion satisfaction, found positive correlations (Bae et al., 2019; Cetrano et al., 2017; Killian, 2008; Towey-Swift & Whittington, 2019; Wachter et al., 2019) suggesting that the higher the professional perceived their workplace autonomy to be, the higher their self-reported CS levels were. Wachter et al. (2019) found that the relationship between control and CS was fully mediated by the amount of time spent engaging with coping strategies, from: time spent with family, engaging with hobbies and exercise, to regular supervision and discussing cases in team meetings.

Three studies used three different questionnaires measuring autonomy and only two studies used the same scale. This affects how generalisable the findings can be

since they may measure different constructs. The study of Bae et al. (2019) used the Work Autonomy Scale (Breaugh,1999) with good reliability, and the study of Cetrano et al. (2017) used the Quality of Working Life Questionnaire developed by Gosetti (2014; as cited in Cetrano et al., 2017). Killian (2008) utilised five questions measuring a sense of autonomy or locus of control developed by other researchers' in their study (Trudeau, Russell, de la Mora & Schmitz, 2001). The remaining two studies (Towey-Swift & Whittington, 2019; Wachter et al., 2019) used The Areas of Worklife Scale (AWS; Leiter & Maslach, 2011) measuring six areas of work life/ person-job congruence (Workload, Control, Reward, Community, Fairness, Values) which yielded good reliability.

Discussion

The aim of this review was to explore factors that are associated and predict compassion satisfaction amongst mental health professionals. Thirty-five studies were included in this review and investigated a variety of factors. In spite of this variety, the review identified a number of main common factors that were examined. Several studies reported mixed results with regard to certain variables, including age, experience of trauma, clinical contacts per week, therefore it is not clear whether these variables are associated with CS and if so, what the nature of this relationship is. A high proportion of studies investigated other variables and found positive associations with CS suggesting they may act as 'enhancers' for CS. These variables were years of experience, self-care, workplace support, competence, autonomy and empathy.

With regard to years of experience, it is possible that some professionals had high levels of CS at the start of their career and have stayed in their role for longer as a

result. It may also be that with increasing years in the field, MHPs accumulate experience which contributes to a greater sense of gratification. However, it is reasonable to assume that the relationship between years of experience and CS is mediated by other factors. For example, with years in the field comes knowledge and competence which helps with self-efficacy and feeling more able to do a better job in the caring role. It is also possible that with years individuals acquire more coping strategies, which increases psychological resilience, in turn helping to derive more satisfaction from their job even in face of challenges. It is also plausible that the more experienced professionals become, the more of a supervisory role they take on, thus spending less time in a clinical role (though, still helping their, more junior colleagues). Other factors (e.g. organisational or individual variables) may also be contributing to higher CS.

The findings regarding the relationship between self-care and CS are consistent with Figley's (2002) and other research concerning the role of engaging with self-care behaviours and keeping a work-life balance in the maintenance of caring for others, job satisfaction or quality of life in health care professionals (Sanchez-Reilly et al., 2013). This review shed light on the variety of ways self-care can be defined, domains it consists of (i.e. work-life balance versus work-life interference, trauma-informed self-care, professional, emotional, psychological, physical and spiritual self-care, leisure activities) and settings within which it can be utilised (within work versus outside work). Better work-life balance was found to be associated with higher CS, after controlling for variables such as: gender, age and years of experience. Furthermore, professionals who perceived self-care more positively and engaged more frequently with self-care behaviours, reported higher CS. These findings are consistent with the results of other studies (Goncher, Sherman, Barnett & Haskins, 2013). They are also

consistent with the review of Turgoose and Maddox (2017) identifying coping behaviours as risk or protective factors associated with compassion fatigue, depending whether it was a maladaptive or adaptive coping behaviour. This review found that each self-care activity measured was positively associated with CS amongst MHPs. Furthermore, the more self-care behaviours professionals engaged with, the higher their professional quality of life was, regardless of the type of self-care activity. Further research might look into the relationship between different self-care behaviours and CS and examine the relationships between self-care, CS and compassion fatigue.

The review of Turgoose and Maddox (2017) found that empathy was positively correlated with CF, however it was difficult to establish whether more empathic individuals are indeed more at risk of developing CF, because the latter can potentially also lead to a decrease in empathy. The review suggested that empathy was a risk factor only if a clinician had a history of trauma. Not enough studies in this review examined the relationship between personal trauma and CS, and results of the studies that have are inconclusive. However, this review revealed that dispositional empathy can also be strong predictor of CS, not just a risk factor for CF. It illuminates the relationships between different facets of empathy and CS. Studies in this review found that higher empathic concern, higher end of perspective taking and increased affective response all related to higher CS. It is suggested that it is the personal distress dimension of empathy that may predict both lower CS and higher CF. On the other hand, self-other awareness, emotional separation or self-other differentiation predicted higher CS. It could be speculated whether the ability to differentiate between oneself and the other might regulate the affective response, thus preventing distress. Further research is warranted to clarify this.

Research relating to workplace factors highlighted a range of important variables. The factors that were most commonly studied and that found significant positive relationships with CS were autonomy, support and workplace belongingness. Having an increased sense of control and autonomy in their day-to-day work was associated with an increased CS, which has been found in other studies (Iliopoulou & While, 2010). Higher CS was positively associated or predicted by higher perceived sense of belongingness to the organisation, support from colleagues and management. This is consistent with other literature investigating the relationships between social support and job satisfaction (Acker, 2004; Ducharme & Martin, 2000; Harris et al., 2007), connectedness and the quality of working life (Hannif, Nadiyah & Fernando, 2008). The work of Gilbert (2015a; 2015b) and Lucre (2018) suggests that experiencing compassion from others affects how people process and respond to threat and stress within the organisation and increase professional quality of life. Working in a service with limited resources and high demands may lead to MHPs spending less time with patients and more time performing administrative tasks, which may lead to fatigue and burnout. It would be interesting to explore whether receiving support within a workplace, in the form of sessions facilitating the opportunity to experience compassion leads to an increase in CS because it changes the perception of how professionals feel about their work and/ or because of a change in their practice, or whether and how other variables (e.g. regulation of affective response and affiliative emotions) play a part in it.

The present literature found an inconclusive relationship between supervision and CS. This seems in contrast with wider literature that found that supervision was associated positively with job satisfaction (Schroffel, 1999; Hyrkäs, 2005). Some facets of self-care constructs in the included studies did involve seeking and engaging with supervision and found positive associations. Future studies could investigate which

aspects of self-care, and which aspects of supervision and social support (e.g. instrumental or emotional) are related to CS and how. Supervision might enhance professionals' competence and mastery since it may involve aspects of teaching, as well as promote professionals' CS through reflecting on 'cases that went well' thus boosting professionals' self-efficacy and self-esteem. Supervision might also be playing a role in enhancing or preserving clinicians' perspective taking and empathic concern, whilst regulating professionals' affect. Future research could explore a potentially mitigating role of supervision in the relationship between CS and empathy.

Implications

To our knowledge this is the first literature review focusing on the positive aspect of helping others, i.e. compassion satisfaction, and associated factors that may promote it. One of the strengths of this review is a high number of studies that were included providing an overview of investigated factors and allowing to extract factors most commonly investigated. This review emphasises that as well as compassion fatigue, mental health professionals also experience compassion satisfaction. It is possible that CS is what motivated an individual to seek this type of career in the first place. It is suggested that this factor might buffer against the experience of CF, secondary traumatic stress or burnout. Many factors are associated and predict higher CF as well as lower CS, thus contributing to an increase in vulnerability of the professional. This review provides information that highlights most commonly researched factors that can promote CS. The review provides a better understanding of how different facets of empathy may be related to CS; which may be risk factors and which may be protective of CS. The review also highlights that some factors related to CS are individual and place responsibility on the professional to pay attention to, such as frequent engagement in self-care behaviours, use of support, engagement in continuous professional

development and training. However, the majority of factors are workplace related and all factors, even the individual ones, require mental health care organisations and services, to fully support and help professionals to engage with, in order to maintain and enhance their CS and mitigate their CF, BO and STS.

In the context of decreased NHS resources, it is unlikely that MHPs will have a reduced workload. Because of the nature of the profession, it is also expected it will be emotionally demanding. Engaging in self-care behaviours is crucial but not enough to maintain professional quality of life. It is also not enough to only engage with self-care behaviours outside of work. This review highlighted that more attention needs to be given to organisational and service level initiatives and interventions promoting workplace belongingness and managerial and social support. Encouraging service managers to build in worktime and protect the time and space for mental health staff to engage with professional and other self-care behaviours regularly during work, is required. Facilitation of staff group sessions and practices that could improve a sense of connectedness, community and sense of belongingness, is needed. Sessions like these may also help staff regulate their affect, enhance perspective taking, empathic concern and self-other differentiation. Research on Schwartz Rounds (Goodrich, 2011; Maben et al., 2018) suggest that the rounds taking place in the workplace is a promising avenue for healthcare staff, with outcomes indicating increased empathy, compassion for others and changes in practice. Further research is needed examine the various interactions between the different facets of empathy and self-care and CS, as well as research examining the role engaging in more compassionate behaviours and self-other differentiation may play in deriving satisfaction from helping others.

Limitations and Future Directions

All of the studies included in this review were cross-sectional in nature, therefore caution needs to be exercised when interpreting results of the research as one cannot infer causality from correlational analyses. More experimental and longitudinal research is needed to determine which factors affect CS.

Studies included in the research suffered from a varied degree of selection bias due to selection processes and levels of response rate. It is possible that professionals who did not participate in the research had lower CS levels, and those that did participate responded to questions in a biased way due to a 'social desirability bias', or a belief that MHPs should be highly functioning and coping individuals and be highly satisfied in their job.

Including qualitative studies in this review would have shed more light or provided more information about other potential variables leading to higher CS. Furthermore, no intervention studies identified in the search met inclusion criteria for this review. The study of Lucre (2018) investigating compassion-focused staff support for perinatal staff had promising outcomes. More research is needed investigating the effectiveness of interventions and organisational initiatives in improving the professional quality of life, including CS in MHPs

Another limitation relates to how constructs, for example how self-care, empathy or CS are defined, operationalised and measured. For example, studies within this review used different measures of self-care, which included a variety of self-care behaviours overlapping with other factors. There is a need to develop a more precise definition and more consistency with regard to using the same validated measure. This review only included studies that measured CS using one measure (ProQOL). This

could have limited the scope of the review as there may have been studies investigating variables associated with job satisfaction in mental health professionals using different measures.

The majority of studies included in this review were conducted in the USA, whilst only three studies took place in the UK, thereby limiting the generalisability of the findings to the UK context. More research is needed investigating CS and its correlates in the context of the NHS to produce more generalisable findings.

Conclusion

This review explored the literature concerning possible factors associated with higher compassion satisfaction in mental health professionals. CS may help MHPs to remain well in their caring role and remain in their job for longer. Knowing what factors are associated with CS can help organisations as well as the professionals themselves to take steps to improve their professional quality of life. Whilst there are potential risk factors that may diminish CS, such as personal distress and increased clinical contact hours, there are also factors may help maintain or enhance CS, in particular self-care, sense of belongingness and support in the workplace, including providing space to promote perspective taking, empathic concern. The review provided more understanding of the variety of variables that may play a role in the maintenance of CS. It highlighted a need for further research of the complex relationships between the different aspects of empathy, self-care and organisational factors. It also highlighted the need for more experimental research exploring the potential effect of organisational initiatives and interventions on the professional quality of life of MHPs. Longitudinal research is required to establish how CS changes over time and determine causal

relationships. It would also provide information whether interventions addressing CS lead to higher retention MHPs in the long-term and improved patient care.

References

Acker, G. M. (2004). The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development, and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community mental health journal*, *40*(1), 65-73.

*Allsbrook, K., Atzinger, C., He, H., Engelhard, C., Yager, G., & Wusik, K. (2016). The relationship between the supervision role and compassion fatigue and burnout in genetic counseling. *Journal of Genetic Counseling*, *25*(6), 1286–1297. https://doi.org/http://dx.doi.org/10.1007/s10897-016-9970-9

*Avieli, H., Ben-David, S., & Levy, I. (2016). Predicting professional quality of life among professional and volunteer caregivers. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(1), 80–87. https://doi.org/http://dx.doi.org/10.1037/tra0000066

*Bae, J., Jennings, P. F., Hardeman, C. P., Kim, E., Lee, M., Littleton, T., & Saasa, S. (2019). Compassion Satisfaction Among Social Work Practitioners: The Role of Work–Life Balance. *Journal of Social Service Research*, *0*(0), 1–11. https://doi.org/10.1080/01488376.2019.1566195

Baldschun, A., Hämäläinen, J., Töttö, P., Rantonen, O., & Salo, P. (2019). Job-strain and well-being among Finnish social workers: exploring the differences in occupational well-being between child protection social workers and social workers without duties in child protection. *European Journal of Social Work*, *22*(1), 43–58. https://doi.org/10.1080/13691457.2017.1357025

Bartholomew, K. and Horowitz, L. (1991). Attachment styles among young adults: A test of a four-category model, *Journal of Personality and Social Psychology*, *61*(2), 226–44.

*Baugerud, G. A., Vangbæk, S., & Melinder, A. (2018). Secondary traumatic stress, burnout and compassion satisfaction among Norwegian child protection workers: Protective and risk factors. *British Journal of Social Work*, *48*(1), 215–235. Retrieved from https://search.proquest.com/docview/2099718545?accountid=14874

*Beder, J., Postiglione, P., & Strolin-Goltzman, J. (2012). Social Work in the Veterans Administration Hospital System: Impact of the Work. *Social Work in Health Care*, *51*(8), 661–679. https://doi.org/10.1080/00981389.2012.699023

Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology*, *7*(2), 85–90. https://doi.org/http://dx.doi.org/10.1177/153476560100700203

*Bloomquist, K. R., Wood, L., Friedmeyer-Trainor, K., & Kim, H.-W. (2016). Self-care and Professional Quality of Life: Predictive Factors among MSW Practitioners. *Advances in Social Work*, *16*(2), 292–311. https://doi.org/10.18060/18760

Bober, T., Regehr, C., & Zhou, Y. R. (2006). Development of the coping strategies inventory for trauma counsellors. Journal of Loss and Trauma, *11*(1), 71-83.

Breaugh, J. (1999). Further investigation of the work autonomy scales: Two studies. *Journal of Business and Psychology, 13*(3), 357–373. doi:10.1023/A:1022926416628

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, *35*(3), 155–163.

Carmel, S. (1997). The professional self-esteem of physicians scale, structure, properties and the relationship to work outcomes and life satisfaction. *Psychological Reports*, *80*(2), 591–602.

*Carmel, M. J. S., & Friedlander, M. L. (2009). The relation of secondary traumatization to therapists' perceptions of the working alliance with clients who commit sexual abuse. *Journal of Counseling Psychology*, *56*(3), 461–467. https://doi.org/http://dx.doi.org/10.1037/a0015422

*Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., Manthorpe, J., Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research, 17*(1), 755. https://doi.org/10.1186/s12913-017-2726-x

Collins, S. & Long, A. (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing*, *10*(1), 17–27. https://doi.org/http://dx.doi.org/10.1046/j.1365-2850.2003.00526.x

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, *30*(10), 1071–1080. https://doi.org/http://dx.doi.org/10.1016/j.chiabu.2006.03.009

Corcoran, K. J. (1982). An exploratory investigation into self-other differentiation: Empirical evidence for a monistic perspective on empathy. *Psychotherapy: Theory, Research, and Practice, 19*(1), 63-68. https://doi:10.1037/h0088418

Corcoran, K. J. (1983). Emotional separation and empathy. J*ournal of Clinical Psychology, 39*(5), 667- 671. https://doi:10.1002/1097-4679(198309)39:5<667::AID- JCLP2270390505>3.0.CO;2-C

*Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping: An International Journal*, *23*(3), 319–339. https://doi.org/http://dx.doi.org/10.1080/10615800903085818

Craig, C., & Sprang, G. (2009). Exploratory and confirmatory factor analysis of the trauma practices questionnaire. *Research on Social Work Practice*, *19*(2), 221-233.

*Cuartero, M. E., & Campos-Vidal, J. F. (2018). Self-care behaviours and their relationship with satisfaction and compassion fatigue levels among social workers. *Social Work in Health Care*, *58*(3), 274–290. https://doi.org/http://dx.doi.org/10.1080/00981389.2018.1558164

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44*(1), 113–126. http://dx.doi.org/10.1037/0022-3514 .44.1.113

Downes, M.J., Brennan, M.L., Williams, H.C. & Dean, R.S. (2016). Development of a critical appraisal tool to assess the quality of cross- sectional studies (AXIS). *BMJ Open, 6*, 1-7. http://doi:10.1136/bmjopen-2016- 011458

Ducharme, L.J. & Marting, J.K. (2000). Unrewarding Work, Coworker Support, and Job Satisfaction: A Test of the Buffering Hypothesis. *Work and Occupations*, *27*(2), 223–243. https://doi.org/10.1177/0730888400027002005

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P. & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258

Figley, C.R. (2002), Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, *58*(11), 1433-1441. http://doi:10.1002/jclp.10090

*Finzi-Dottan, R., & Kormosh, M. B. (2016). Social workers in Israel: Compassion, fatigue, and spillover into married life. *Journal of Social Service Research*, *42*(5), 703–717. https://doi.org/http://dx.doi.org/10.1080/01488376.2016.1147515

Gerdes, K. E., Lietz, C. A., & Segal, E. A. (2011). Measuring empathy in the 21st century: Development of an empathy index rooted in social cognitive neuroscience and social justice. *Social Work Research*, *35*(2), 83–93.

*Gibbons, S., Murphy, D., & Joseph, S. (2011). Countertransference and positive growth in social workers. *Journal of Social Work Practice*, *25*(1), 17–30. https://doi.org/http://dx.doi.org/10.1080/02650530903579246

Gilbert, P. (2015a). Affiliative and prosocial motives and emotions in mental health. *Dialogues in clinical neuroscience*, *17*(4), 381–389.

Gilbert, P. (2015b). An Evolutionary Approach to Emotion in Mental Health With a Focus on Affiliative Emotions. *Emotion Review*, *7*(3), 230-237. https://doi.org/10.1177/1754073915576552

Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. *Training and Education in Professional Psychology, 7*(1), 53-60. doi: http://dx.doi.org/10.1037/a0031501

Goodrich, J. (2011). *Schwartz Centre Rounds. Evaluation of the UK pilots.* London: The King's Fund.

Hannif, Z. Nadiyah. & Fernando, M. (2008). Connectedness in work relationships and quality of working life: evidence from Australian call centres. In M. Wilson (Eds.), *Australian and New Zealand Academy of Management Conference* (pp. 1-15). Auckland, New Zealand: University of Auckland Business School.

Harris, J. I., Winskowski, A. M., & Engdahl, B. E. (2007). Types of workplace social support in the prediction of job satisfaction. *The career development quarterly*, *56*(2), 150-156.

Hyrkäs, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in mental health nursing*, *26*(5), 531-556.

Iliopoulou, K. K. & While, A. E. (2010). Professional autonomy and job satisfaction: survey of critical care nurses in mainland Greece. *Journal of advanced nursing*, *66*(11), 2520-2531.

Ingoglia, S., Lo Coco, A., & Albiero, P. (2016). Development of a brief form of the Interpersonal Reactivity Index (B–IRI). *Journal of Personality Assessment*, *98*(5), 461–471. http://dx.doi.org/10.1080/00223891 .2016.1149858

*Itzhaki, M., Bluvstein, I., Peles Bortz, A., Kostistky, H., Bar Noy, D., Filshtinsky, V., & Theilla, M. (2018). Mental health nurse's exposure to workplace violence leads to job stress, which leads to reduced professional quality of life. *Frontiers in Psychiatry, 27*(9). https://doi.org/http://dx.doi.org/10.3389/fpsyt.2018.00059

Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V., Bluvstein, I. (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. *International Journal of Mental Health Nursing*, *24*(5), 403–12. https://doi:10.1111/inm.12151

*Killian, K. D. (2008). Study of Compassion Fatigue, Burnout, *Traumatology*, *14*(2), 32–44.

*Kjellenberg, E., Nilsson, F., Daukantaité, D., & Cardeña, E. (2014). Transformative narratives: The impact of working with war and torture survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(2), 120–128. https://doi.org/http://dx.doi.org/10.1037/a0031966

*La Mott, J., & Martin, L. A. (2019). Adverse childhood experiences, self-care, and compassion outcomes in mental health providers working with trauma. *Journal of*

Clinical Psychology, *75*(6), 1066–1083. https://doi.org/http://dx.doi.org/10.1002/jclp.22752

*Lakioti, A., Stalikas, A., & Pezirkianidis, C. (2020). The role of personal, professional, and psychological factors in therapists' resilience. *Professional Psychology: Research and Practice*. https://doi.org/10.1037/pro0000306

*Laverdière, O., Kealy, D., Ogrodniczuk, J. S., Chamberland, S., & Descôteaux, J. (2019). Psychotherapists' professional quality of life. *Traumatology*, *25*(3), 208–215. https://doi.org/http://dx.doi.org/10.1037/trm0000177

*Laverdière, O., Ogrodniczuk, J. S., Kealy, D. (2019). Clinicians' empathy and professional quality of life. *Journal of Nervous and Mental Disease*, *207*(2), 49–52. https://doi.org/http://dx.doi.org/10.1097/NMD.0000000000000927

*Lawson, G., & Myers, J. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps Us well? *Journal of Counseling and Development*, *89*(2), 163–171. https://doi.org/10.1002/j.1556-6678.2011.tb00074.x

Leiter, M. P., & Maslach, C. (2004). Areas of worklife: A structured approach to organizational predictors of job burnout. In P. Perrewe and D. C. Ganster (Eds.), *Research in occupational stress and well-being* (Vol. 3, pp. 91–134). Oxford: Elsevier.

Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the Counselor Activity Self-Efficacy Scales. *Journal of Counseling Psychology*, *50*(1), 97–108. http://dx.doi.org/10.1037/0022- 0167.50.1.97

Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, *26*(3), 385–403. https://doi.org/10.1521/jscp.2007.26.3.385

Lucre, K. (2018). Compassion Focused Staff Support - Cultivating Compassion in Perinatal Services. Conference Paper.

*Lusk, M., & Terrazas, S. (2015). Secondary trauma among caregivers who work with Mexican and Central American refugees. *Hispanic Journal of Behavioral Sciences*, *37*(2), 257–273. https://doi.org/http://dx.doi.org/10.1177/0739986315578842

Maben, J. (2010). The feelgood factor: Evidence for a link between staff well-being and the quality of patient care. *Nursing Standard, 24*(30), 70-71.

MacRitchie, V. & Leibowitz, S. (2010). Secondary traumatic stress, level of exposure, empathy and social support in trauma workers. *South African Journal of Psychology*, *40*(2), 149–158. Retrieved from: https://search.proquest.com/docview/906555719?accountid=14874

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., Ross, S., Shuldham, C., Bennett, L., & Foot, C. (2018). *A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England*. NIHR Journals Library.

*Mangoulia, P., Koukia, E., Alevizopoulos, G., Fildissis, G., & Katostaras, T. (2015). Prevalence of Secondary Traumatic Stress Among Psychiatric Nurses in Greece. *Archives of Psychiatric Nursing*, *29*(5), 333–338. https://doi.org/10.1016/j.apnu.2015.06.001

National Institute of Occupational Health (STAMI) (2001) Users Guide for the QPS Nordic, available online at https://www.qps-nordic.org/no/doc/Brukerveiledning_ qpsnordic.pdf

*Newmeyer, M., Keyes, B., Palmer, K., Kent, V., Spong, S., Stephen, F., & Troy, M. (2016). Spirituality and religion as mitigating factors in compassion fatigue among trauma therapists in Romania. *Journal of Psychology and Theology*, *44*(2), 142–151. Retrieved from https://search.proquest.com/docview/1812939517?accountid=14874

Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. W W Norton & Co.

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology*, *19*(4), 255–267. https://doi.org/http://dx.doi.org/10.1177/1534765612471144

Richardson, Glenn. (2002). The Metatheory of Resilience and Resiliency. *Journal of clinical psychology,* 58(3), 307-21. 10.1002/jclp.10020.

Robertson, I.T., Copper, C. (2010). Full engagement: the integration of employee engagement and psychological well-being. *Leadership and Organization Development Journal,* 31(4), 324-336.

*Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G. & Amaddeo, F. (2012). Burnout, compassion

fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, *200*(2–3), 933–938. https://doi.org/http://dx.doi.org/10.1016/j.psychres.2012.07.029

*Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54–61. https://doi.org/10.1016/j.childyouth.2014.12.023

*Samios, C., Abel, L. M., & Rodzik, A. K. (2013). The protective role of compassion satisfaction for therapists who work with sexual violence survivors: An application of the broaden-and-build theory of positive emotions. *Anxiety, Stress & Coping: An International Journal*, *26*(6), 610–623. https://doi.org/http://dx.doi.org/10.1080/10615806.2013.784278

Sanchez-Reilly, S., Morrison, L. J., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., Periyakoil, V. S., & Thomas, J. (2013). Caring for oneself to care for others: physicians and their self-care. *The journal of supportive oncology*, *11*(2), 75–81. https://doi.org/10.12788/j.suponc.0003

Schroffel, A. (1999). How does clinical supervision affect job satisfaction? *The Clinical Supervisor*, *18*, 2, 91-105.

*Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, *30(*4), 1-10. https://doi.org/10.3402/ejpt.v4i0.21869

*Somoray, K., Shakespeare-Finch, J., & Armstrong, D. (2017). The impact of personality and workplace belongingness on mental health workers' professional quality of life. *Australian Psychologist*, *52*(1), 52–60. https://doi.org/http://dx.doi.org/10.1111/ap.12182

*Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, *12*(3), 259–280. https://doi.org/http://dx.doi.org/10.1080/15325020701238093

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of Personality Assessment*, *91*(1), 62–71. https://dx.doi.org/10.1080/ 00223890802484381

Stamm, B. (2005). The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales. Retrieved from: http://www.isu.edu/bhstamm

Stamm, B. (2010) The Concise ProQOL Manual. 2nd Edition, Pocatello, ID: ProQOL.org.

*Thomas, J. T., & Otis, M. D. (2010). Intrapsychic correlates of professional quality of life: Mindfulness, empathy, and emotional separation. *Journal of the Society for Social Work and Research*, *1*(2), 83–98. https://doi.org/http://dx.doi.org/10.5243/jsswr.2010.7

*Thomas, J. (2013). Association of personal distress with burnout, compassion fatigue, and compassion satisfaction among clinical social workers. *Journal of Social Service Research*, *39*(3), 365–379. https://doi.org/http://dx.doi.org/10.1080/01488376.2013.771596

Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and Contextual Predictors of Mental Health Counselors' Compassion Fatigue and Burnout. *Journal of Mental Health Counseling*, *36*(1), 58–77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

*Towey-Swift, K., & Whittington, R. (2019). Person-job congruence, compassion and recovery attitude in Community Mental Health Teams. *Journal of Mental Health*, *28*(1–9). https://doi.org/10.1080/09638237.2019.1608931

Trudeau, L., Russell, D. W., de la Mora, A., & Schmitz, M. F. (2001). Comparisons of marriage and family therapists, psychologists, psychiatrists and social workers on job- related measures and reactions to managed care in Iowa. *Journal of Marital and Family Therapy, 27*(4), 501-507.

Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology, 23*(2), 172–185.

*Van Hook, M. P. & Rothenberg, M., (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers: A study of the child welfare workers in community-based care organizations in Central Florida. *Social Work*, *36*(1), 36–54. Retrieved from https://search.proquest.com/docview/622112591?accountid=14874

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice*, *42*(1), 79–86. https://doi.org/http://dx.doi.org/10.1037/a0022297

*Wachter, K., Schrag, R. V., & Wood, L. (2020). Coping Behaviors Mediate Associations between Occupational Factors and Compassion Satisfaction among the Intimate Partner Violence and Sexual Assault Workforce. *Journal of Family Violence*, *35*(2), 143–154. https://doi.org/10.1007/s10896-019-00072-0

*Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work*, *60*(3), 201–209. https://doi.org/http://dx.doi.org/10.1093/sw/swv014

*Xu, Y., Harmon-Darrow, C., & Frey, J. J. (2019). Rethinking professional quality of life for social workers: Inclusion of ecological self-care barriers. *Journal of Human Behavior in the Social Environment*, *29*(1), 11–25. https://doi.org/10.1080/10911359.2018.1452814

Zhang, Y., Zhang, C., Han, X., Li, W., Wang, Y. (2018). Determinants of compassion satisfaction, compassion fatigue and burn out in nursing, Medicine, 97(26). DOI: 10.1097/MD.000000000001

Literature Review Appendices Index

Appendix 1

PsychINFO systematic search

PubMed systematic search

Search Details

Query Translation:

("compassion satisfaction"[All Fields] AND ((predict[All Fields] OR predict''[All Fields] OR predict''[All Fields] OR predict's[All Fields] OR predict2[All Fields] OR predict29[All Fields] OR predict7[All Fields] OR predicta[All Fields] OR predictab[All Fields] OR predictabe[All Fields] OR predictabel[All Fields] OR predictabilities[All Fields] OR predictability[All Fields] OR predictability'[All Fields] OR predictability's[All Fields] OR predictable[All Fields] OR

Search URL

Result:

182

Quoted phrase not found:

"mental health physician*"

Translations:

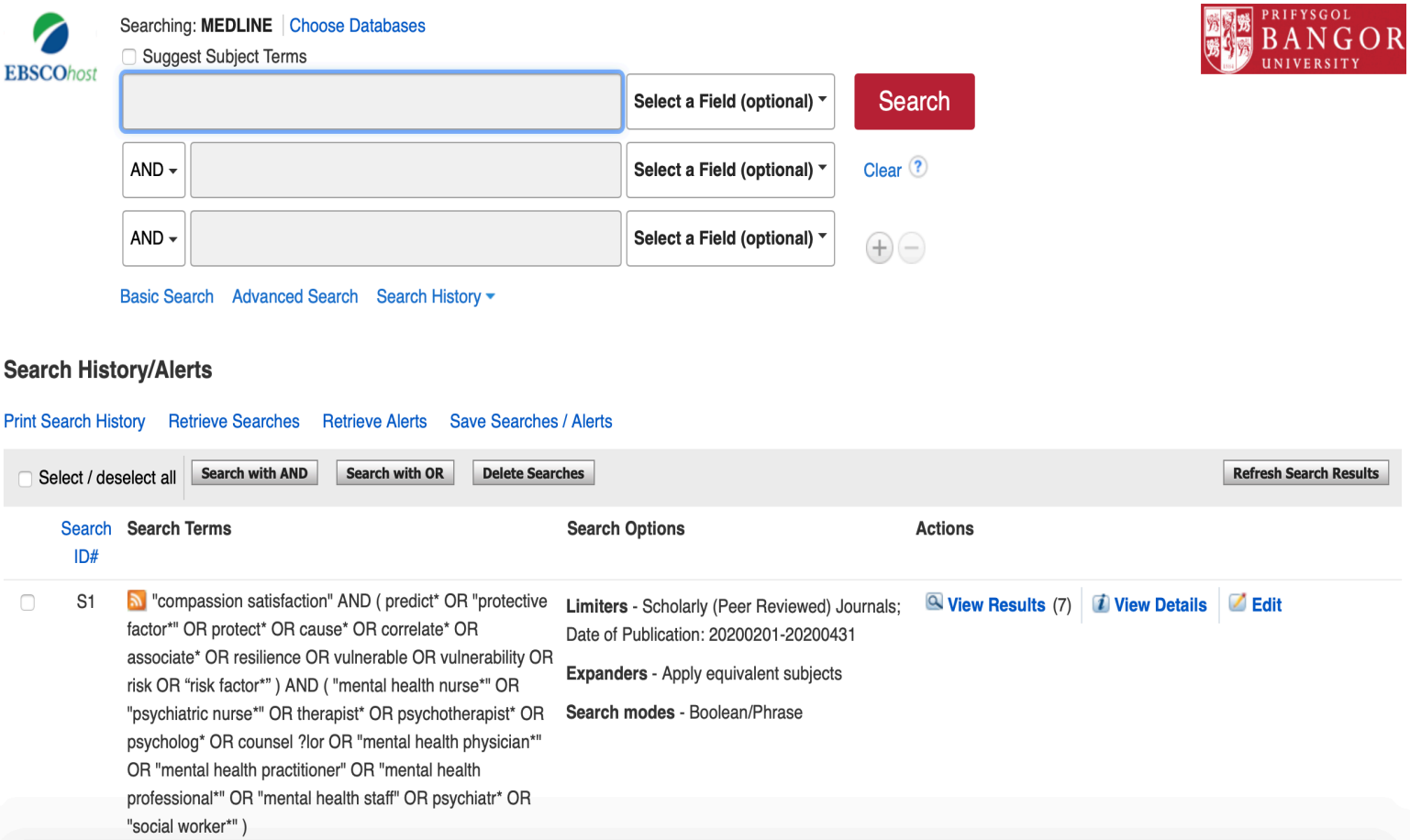
risk	"risk"[MeSH Terms] OR "risk"[All Fields]
mental health	"mental health"[MeSH Terms] OR ("mental"[All Fields] AND "health"[All Fields]) OR "mental health"[All Fields]
physician*	"physicians"[MeSH Terms] OR "physicians"[All Fields] OR "physician"[All Fields]

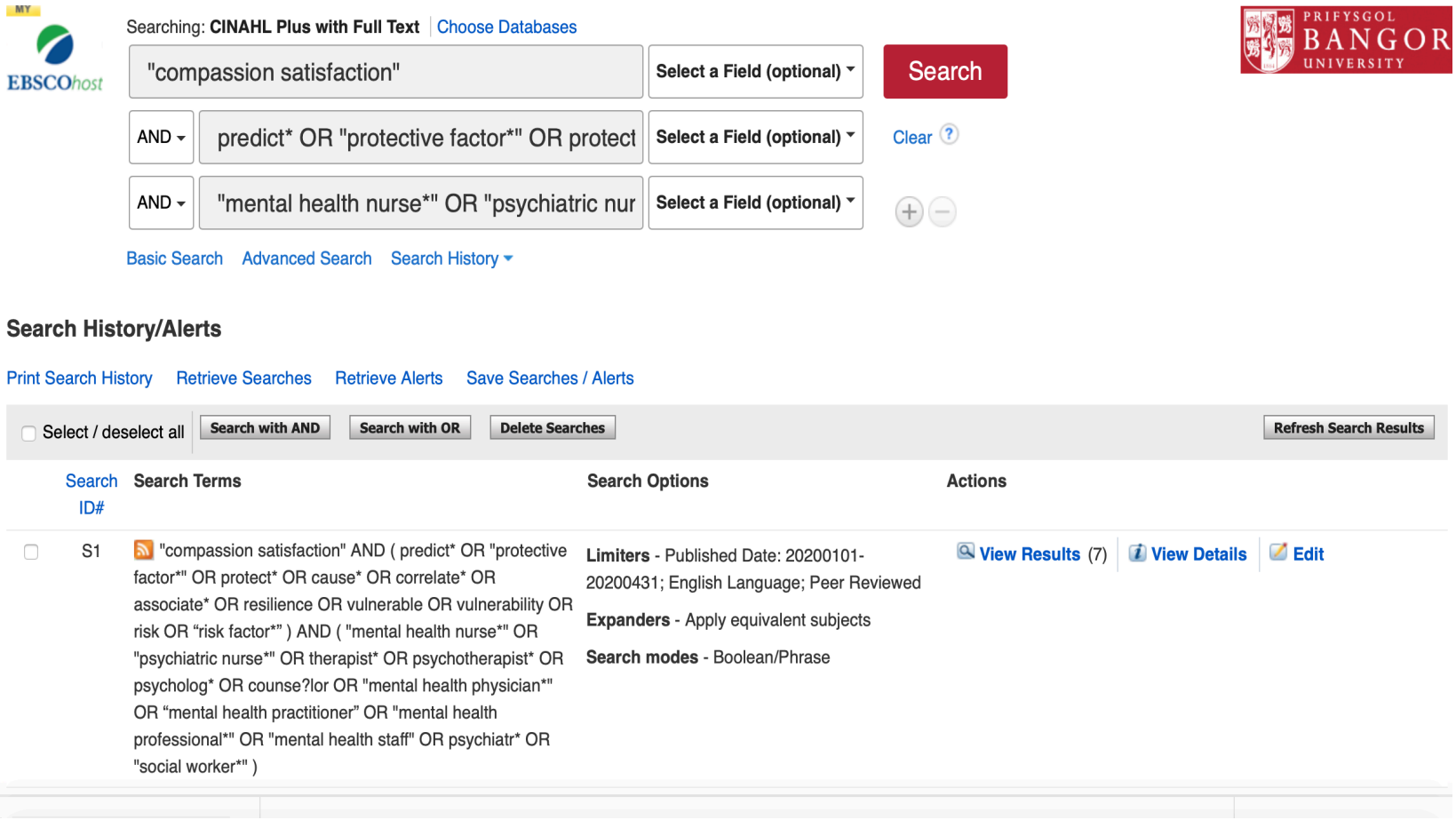
Database:

PubMed

User query:

(("compassion satisfaction") AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR resilience OR vulnerable OR vulnerability OR risk OR "risk factor*")) AND ("mental health nurse*" OR "psychiatric nurse*" OR therapist* OR psychotherapist* OR psycholog* OR counsel ?lor OR "mental health physician*" OR "mental health practitioner" OR "mental health professional*" OR "mental health staff" OR psychiatr* OR


EBSCOhost
Searching: MEDLINE | Choose Databases
Suggest Subject Terms
Select a Field (optional)
Search
AND
Select a Field (optional)
Clear
AND
Select a Field (optional)
Basic Search
Advanced Search
Search History
PRIFYSGOL BANGOR UNIVERSITY
Search History/Alerts
Print Search History
Retrieve Searches
Retrieve Alerts
Save Searches / Alerts
Select / deselect all
Search with AND
Search with OR
Delete Searches
Refresh Search Results
Search ID#
Search Terms
Search Options
Actions
S1
"compassion satisfaction" AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR resilience OR vulnerable OR vulnerability OR risk OR "risk factor*") AND ("mental health nurse*" OR "psychiatric nurse*" OR therapist* OR psychotherapist* OR psycholog* OR counsel ?lor OR "mental health physician*" OR "mental health practitioner" OR "mental health professional*" OR "mental health staff" OR psychiatr* OR "social worker*")
Limiters - Scholarly (Peer Reviewed) Journals; Date of Publication: 20200201-20200431
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (7)
View Details
Edit



Searching: **CINAHL Plus with Full Text** | Choose Databases

"compassion satisfaction" — Select a Field (optional) — Search

AND — predict* OR "protective factor*" OR protect — Select a Field (optional) — Clear

AND — "mental health nurse*" OR "psychiatric nur — Select a Field (optional)

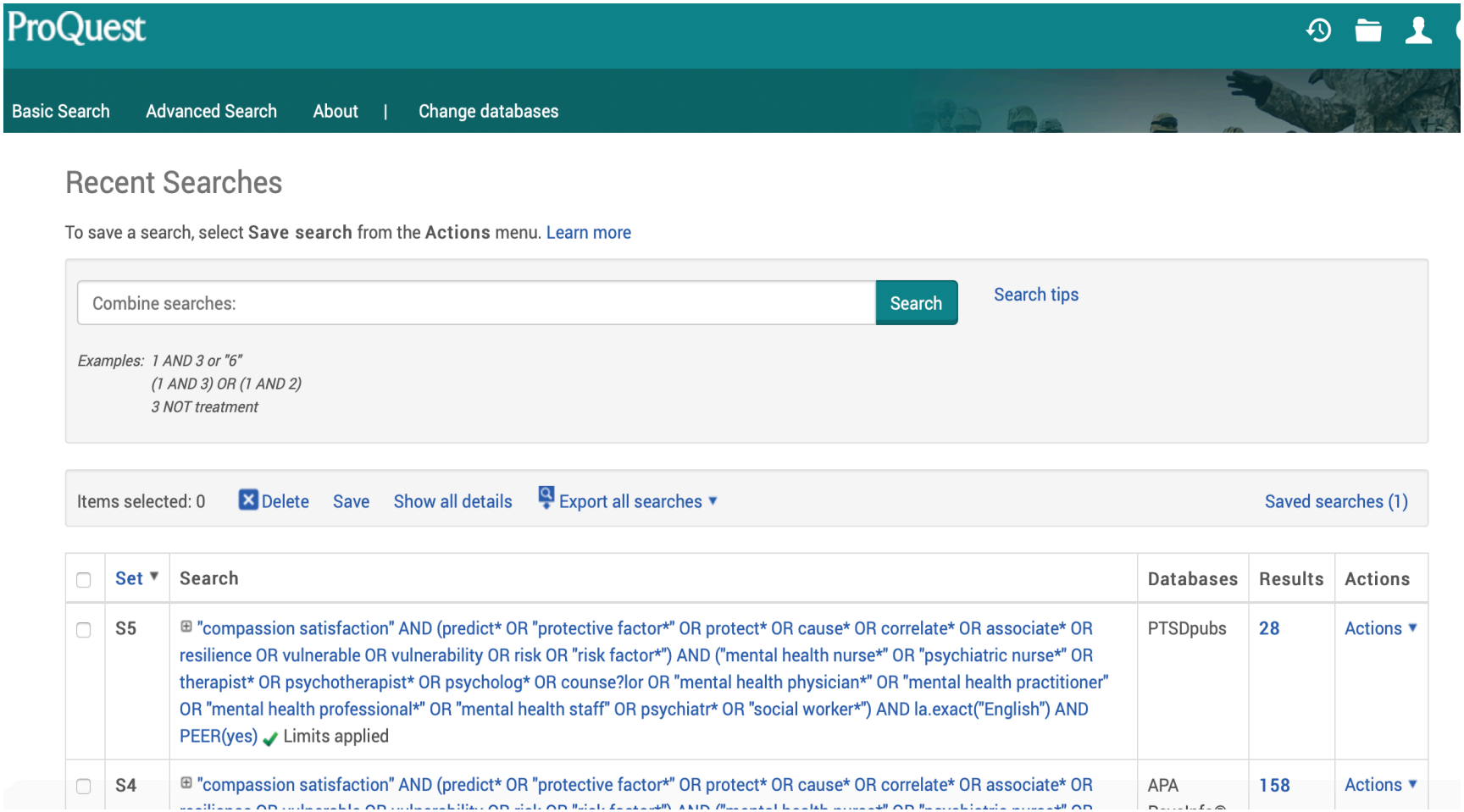
Basic Search | Advanced Search | Search History

Search History/Alerts

Print Search History | Retrieve Searches | Retrieve Alerts | Save Searches / Alerts

Select / deselect all | Search with AND | Search with OR | Delete Searches | Refresh Search Results

Search ID#	Search Terms	Search Options	Actions
S1	"compassion satisfaction" AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR resilience OR vulnerable OR vulnerability OR risk OR “risk factor*”) AND ("mental health nurse*" OR "psychiatric nurse*" OR therapist* OR psychotherapist* OR psycholog* OR counse?lor OR "mental health physician*" OR “mental health practitioner” OR "mental health professional*" OR "mental health staff" OR psychiatr* OR "social worker*")	**Limiters** - Published Date: 20200101-20200431; English Language; Peer Reviewed **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (7) | View Details | Edit



ProQuest

Basic Search Advanced Search About | Change databases

Recent Searches

To save a search, select **Save search** from the **Actions** menu. Learn more

Combine searches: Search Search tips

Examples: 1 AND 3 or "6"
(1 AND 3) OR (1 AND 2)
3 NOT treatment

Items selected: 0 Delete Save Show all details Export all searches Saved searches (1)

Set	Search	Databases	Results	Actions
S5	"compassion satisfaction" AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR resilience OR vulnerable OR vulnerability OR risk OR "risk factor*") AND ("mental health nurse*" OR "psychiatric nurse*" OR therapist* OR psychotherapist* OR psycholog* OR counse?lor OR "mental health physician*" OR "mental health practitioner" OR "mental health professional*" OR "mental health staff" OR psychiatr* OR "social worker*") AND la.exact("English") AND PEER(yes) Limits applied	PTSDpubs	28	Actions
S4	"compassion satisfaction" AND (predict* OR "protective factor*" OR protect* OR cause* OR correlate* OR associate* OR	APA	158	Actions

Appendix 2.

Table 1: Overview of Study Characteristics, Main Findings and Quality ratings

No	Study	Sample size and characteristics	Country	Measures	Quality	Main findings
1.	Avieli, Ben-David & Levy (2016)	183 Professional and Volunteer Mental Health Workers	Israel	Professional Quality of Life (ProQOL), Ethical Behaviour Questionnaire.	15	Professional practitioners reported higher CS than volunteers. Increased CS was positively associated and predicted by more years of experience and ethical behaviour CS was negatively associated with STS and BO.
2.	Bae, Jennings, Hardeman et al. (2019)	120 Social Workers	USA	ProQOL, Brief Emotional Intelligence Scale (BEIS-10), Breaugh's Work Autonomy Scale, Hayman's Work-life Balance Scale, Socio-demographic Questionnaire.	16	CS was positively associated with emotional intelligence, work autonomy and work-life balance after controlling for sociodemographic factors -gender, race, marital status, license status, practice role, and years of practice. Higher CS was associated with higher work/personal life enhancement. Lower CS was correlated with increased work interference with personal life and increased personal life interference with work. CS was associated positively with years of experience & active social work licensure status. CS was not associated with age, gender & race.
3.	Baugerud, Vangbæk, Melinder (2018)	506 Child Protection Workers	Norway	ProQOL V, The Nordic Questionnaire for Psychological and Social Factors at Work (QPS Nordic), The Relationship Questionnaire.	16	Higher CS was positively correlated and predicted by positive challenges at work, then mastery of work, followed by internal motivation to work and organisational commitment to fostering engagement in work. CS was not associated with age and attachment style of the professional. CS was negatively associated with BO. Low levels of CS were the largest predictor of BO, followed by workload.

No	Study	Sample size and characteristics	Country	Measures	Quality	Main findings
4.	Beder, Postiglione, Strolin-Goltzman (2012)	535 Social Workers	USA	ProQOL, Socio-demographic Questionnaire.	14	Case managers, those that were personally in the military or having a family member in the military reported higher CS, when controlling for other variables. Lower CS was predicted by working 50% or more of their time per week with veterans. CS was not associated with years of experience and gender.
5.	Bloomquist, Wood, Friedmeyer-Trainor et al. (2016)	786 Social Workers	USA	ProQOL V, Self-care Practice Scale, Self-care Perception Scale	13	Higher CS was correlated and predicted by more positive perceptions of self-care, more practice of professional and emotional self-care, and by more years of experience.
6.	Carmel & Friedlander (2009)	106 Psychotherapists of sex offenders	USA	ProQOL IV, Working Alliance Inventory – Short Form (WAIS), Impact of Events Scale-R (IES-R)	15	CS was positively associated with years of experience, specific experience and age. Higher CS was associated with and predicted higher therapeutic alliance ratings.
7.	Cetrano, Tedeschi, Rabbi et al. (2017)	400 Mental Health Practitioners (Psychiatrists, Psychologists, Social Workers, Psychiatric Nurses)	Italy	ProQOL III, Quality of Working Life Questionnaire	17	Higher CS was positively associated and predicted by higher perceived quality of meetings, need of training, and perceived security about future, after controlling for other variables. Higher CS was associated with higher organizational commitment, autonomy and trust. Lower CS was associated with increased ergonomic problems & impact of work on life.
8.	Craig & Sprang (2010)	532 Trauma Specialists (Clinical Psychologists and Social Workers)	USA	ProQOL III, Trauma Practices Questionnaire, Socio-demographic Questionnaire.	16	Higher CS was associated with and predicted by more years of experience and the use of evidence-based practice. Higher CS was associated with specialist training in trauma treatment. Professionals working in community mental health centres reported higher CS than those from private non-profit agencies. CS was not associated with gender.

No	Study	Sample size and characteristics	Country	Measures	Quality	Main findings
9.	Cuartero & Campos-Vidal (2018)	270 Social Workers	Spain	ProQOL IV, Self-care Behaviours Scale adapted for Social Workers	15	Higher CS was associated with increased engagement with self-care practices. CS was negatively correlated with CF.
10.	Finzi-Dottan & Kormosh (2016)	202 Social Workers	Israel	ProQOL III, Burnout Measure Short (BMS), Haber's Level of Self-differentiation Scale, The Professional Self-esteem Scale, Work-Family Linkage Questionnaire, Marriage Quality Short Version Questionnaire.	19	Higher CS was associated with higher professional self-esteem and higher level of self-differentiation. CS was negatively correlated to BO.
11.	Gibbons, Murphy & Joseph (2011)	62 Social Workers	UK	ProQOL, Posttraumatic Growth Inventory, Changes in Outlook Questionnaire, Perceived Value of Social Work Scale.	14	Higher CS was associated with feeling more valued within professional role, positive growth and positive change. CS was negatively associated with negative change.
12.	Itzhaki, Bluvstein, Peles Bortz et al. (2018)	114 Mental Health Nurses	Israel	ProQOL, Violence Exposure Questionnaire, Job Stress Questionnaire.	14	Higher CS was associated with lower perceived work stress. CS was not associated with exposure to workplace violence at work, but exposure to violence was positively associated with perceived work stress. CS was not associated with years of experience or age.
13.	Killian (2008)	104 Therapists of trauma survivors	USA	ProQOL III, Social Support Index, List of Traumatic Events, Brief COPE, List of Self-care Strategies, Maslach Burnout Inventory, Emotional Self-Awareness Questionnaire, Work Environment Perception, Sense of	15	Higher CS was predicted by higher perceived social support, then by higher autonomy at work. Lower CS was predicted by higher number of clinical contact hours per week. CS was not significantly predicted by self-care strategies and affective coping style.

				Autonomy Questionnaire, Work Drain Questionnaire.		
No	**Study**	**Sample size and characteristics**	**Country**	**Measures**	**Quality**	**Main findings**
14.	Kjellenberg, Nilsson, Daukantaité, Cardeña (2014)	69 Mental Health Professionals working with War and Torture Survivors	Sweden	ProQOL, The Posttraumatic Growth Inventory (PTGI), The Stanford Acute Stress Reaction Questionnaire (SASRQ), Traumatic Experience Checklist (TEC), The Death Attitude Profile – Revised (DAP-R), The Fear and Resignation towards Human Evil (EVIL).	16	Higher CS was predicted by younger age and decreased fear of death. CS was not correlated with gender, clinical contact hours per week or years of experience. CS was negatively correlated with CF, STS, BO.
15.	La Mott & Martin (2019)	371 Mental Health Providers working with Childhood Trauma	USA	ProQOL V, Brief Resilience Scale (BRS), Self-Care Assessment Worksheet (SCAW), Adverse Childhood Experiences (ACE) Questionnaire.	16	Providers with no history of ACE reported higher CS, in comparison to those with a history of ACE (regardless of type and quantity). Higher CS levels were correlated with and predicted by higher frequency of self-care behaviours (after controlling for resiliency, gender, years of experience, client contact per week). Self-care was an independent predictor of CS. Each domain of self-care was positively associated with CS, incl. work-life balance.
16.	Lakioti, Stalikas & Pezirkianidis (2020)	163 Mental Health Professionals	Greece	ProQOL V, Counsellor Activity Self-Efficacy Scales (CASES); Brief Interpersonal Reactivity Index (B-IRI); PERMA Profiler.	15	Higher CS was positively associated and predicted by counselling self-efficacy, meaning in life and positive emotion (components of wellbeing). CS was positively correlated with engagement, accomplishment and positive interpersonal relationships component of wellbeing. CS was not correlated with work setting and Empathic Concern (EC) and Perspective Taking (PT) dimensions of Empathy. CS had a negative relationship with BO.
17.	Laverdière, Kealy, Ogrodniczuk, et al. (2019)	240 Psychotherapists	Canada	ProQOL, Toronto Empathy Questionnaire (TEQ), Demographic and Work	15	Professionals working in private practice reported higher CS in comparison to those in institutional settings. CS was positively correlated and strongly predicted by dispositional empathy.

				Conditions Questionnaire.		CS was negatively associated with psychodynamic orientation and with clinical work only with individual adults. CS was positively associated with years of experience. CS was not associated with gender, suicidal risk, experience of supervision or personal therapy.
No	**Study**	**Sample size and characteristics**	**Country**	**Measures**	**Quality**	**Main findings**
18.	Laverdière, Ogrodniczuk & Kealy (2019)	240 Psychotherapists	Canada	ProQOL, The Interpersonal Reactivity Index (IRI)	16	Higher CS was associated with the higher Empathic Concern (EC) and Perspective Taking (PT) dimension of empathy and was not significantly influenced by working with individuals exclusively vs. working in the context of multi-person treatment settings. CS was negatively associated with Personal Distress (PD) dimension of empathy.
19.	Lawson & Myers (2011)	506 Counsellors	USA	ProQOL III, 5F-Wel, Career-Sustaining Behaviours Questionnaire (CSBQ).	15	Counsellors in private practice, with lower percentage of high-risk clients on caseloads reported higher CS. Higher CS was positively correlated with Wellness and Career-Sustaining Behaviours.
20.	Lusk & Terrazas (2015)	31 Professional Caregivers working with refugees	Mexico	ProQOL V, Secondary Traumatic Scale (STSS)	10	Higher CS was moderately associated with more years of experience and more hours per week working with refugees.
21.	Mangoulia, Koukia, Alevizopoulos, et al. (2015)	174 Psychiatric nurses	Greece	ProQOL IV, Demographic Questionnaire with personal and work-related questions	14	Higher CS associated with nurses' choice to work in psychiatric unit. Higher CS was associated with excellent physical and mental health, very good working environment and teamwork. CS was not associated with years of experience. CS was negatively correlated with CF and BO.
22.	Newmeyer, Keyes, Palmer et al. (2016)	46 Trauma therapists	USA / Romania	ProQOL III, Ego Resiliency Scale, Daily Spiritual Experience Scale (DSES), Religious Commitment Inventory (RCI-10), Stress Vulnerability Scale	12	CS was positively associated with Religious Commitment. CS was negatively associated with Daily Spiritual Experience Scale (lower scores=more daily experiences).

				(SVS), Secondary Stress Trauma Scale		
No	**Study**	**Sample size and characteristics**	**Country**	**Measures**	**Quality**	**Main findings**
23.	Rossi, Cetrano, Petrile el al. (2012)	260 Community Mental Health Workers	Italy	ProQOL III, General Health Questionnaire (GHQ-12), Socio-demographic Questionnaire.	16	Professionals with a fixed-term contract reported higher CS compared with those with an open-ended contract. CS was negatively associated with psychological distress. CS was not associated with age and gender.
24.	Salloum, Kondrat, Johnco et al. (2015)	104 Child Welfare Workers	USA	ProQOL V, Trauma-Informed Self-Care (TISC) measure, Socio-demographic Questionnaire.	16	Higher CS was associated with and predicted by less than a year of experience, being of female gender and higher frequency of trauma-informed self-care (TISC). CS was not associated with age. CS was negatively associated with BO and STS.
25.	Samios et al. (2013)	61 Therapists who work with sexual violence survivors	Australia	ProQOL, Depression and Anxiety sub-scales from the Depression, Anxiety & Stress Scale, Bradburn Affect Balance Scale, Positive Reframing subscale from Brief Cope.	14	CS was positively related to positive emotionality and positive reframing. Higher CS was predicted by greater levels of positive emotionality and this was partially mediated by positive reframing. CS was not related to STS, depression, anxiety.
26.	Sodeke-Gregson, Holttum, Billings (2013)	253 Psychotherapists working with adult trauma clients	UK	ProQOL V, Coping Strategies Inventory (CSI), Demographic Qs	17	Higher CS was predicted by older age, time spent engaging in research and development activities, a higher perceived management support and supervision support. CS was positively associated with age, number of years post-qualification (but was not significantly predicted by it) and highest qualification, days of trauma specific training since qualification, beliefs about leisure, time spent engaging in self-care, time in supervision. CS was not associated with gender, service settings, trauma history. CS was negatively correlated with both BO and STS
27.	Somoray, Shakespeare-Finch, Armstrong	156 Mental Health Workers	Australia	ProQOL V, NEO Five-Factor Inventory, Psychological	14	CS was strongly and positively associated and predicted by workplace belongingness. Higher CS was predicted by older age and presence of personal

	(2017)	(psychologists, counsellors, social workers)		Sense of Organisational Membership (PSOM)		history of trauma. CS was positively associated and predicted by extraversion and conscientiousness. CS was positively associated with openness & agreeableness and negatively associated with neuroticism. CS was not predicted by gender.
No	**Study**	**Sample size and characteristics**	**Country**	**Measures**	**Quality**	**Main findings**
28.	Sprang, Clark, Whitt-Woosley (2007)	1,121 Behavioural Health Providers (psychologists, psychiatrists, social workers, psychotherapists and counsellors)	USA	ProQOL, 102-item survey design to solicit information about other variables	15	Higher CS was predicted by older age. CS was enhanced by specialised trauma training in evidence-based practice.
29	Thomas & Otis (2010)	171 Social Workers	USA	ProQOL IV, The Interpersonal Reactivity Index (IRI) measure of empathy, Maintenance of Emotional Separation, Trauma Questions, Socio-demographic Questionnaire.	14	Higher CS was correlated and predicted by higher scores on mindfulness and emotional separation. Strong associations: CS was positively correlated with Perspective Taking and negatively correlated with personal distress Weak associations: CS was positively correlated with empathic concern components of empathy CS levels were not significantly affected by age, gender, years of practice experience, adult trauma history, or childhood trauma.
30	Thomas (2013)	171 Social Workers	USA	ProQOL IV; The Interpersonal Reactivity Index (IRI), Trauma Questions, Socio-demographic Questionnaire.	14	Lower CS was correlated with and predicted by higher Personal Distress (PD dimension of empathy). Higher PD also predicted higher CF. CS had a strong positive correlation with Perspective Taking. CS had a small significant positive correlation with age and years of work. CS was not associated with gender and adult trauma history but adult trauma was associated with Personal Distress
31.	Towey-Swift & Whittington (2019)	132 Community Mental Health Workers	UK	ProQOL, Areas of Worklife Scale (AWS), Recovery	18	CS was correlated with all six worklife areas (workload, control, reward, community, fairness, values). CS was negatively associated and significantly predicted by

				Knowledge Inventory (RKI), Socio-demographic Questionnaire.		workload. CS was negatively correlated with the years worked in current setting (although became insignificant when six AWS subscales were added to analysis). CS was not significantly associated with age and recovery attitude.
No	**Study**	**Sample size and characteristics**	**Country**	**Measures**	**Quality**	**Main findings**
32.	Van Hook & Rothenberg (2009)	175 Child Welfare Workers	USA	ProQOL	13	CS levels were not significantly correlated with age and gender. Higher CS was correlated with lower levels of CF/STS and BO.
33.	Wachter, Schrag & Wood (2019)	623 Intimate Partner Violence & Sexual Assault Workforce	USA	ProQOL V, adapted version of The Time Spent in Coping Strategies Scale, Areas of Worklife Scale (AWS), Perceived Job Security Question, Workforce Assets (Adapted Connor-Davidson Resilience Scale CD-RISC-10)	14	Higher CS associated with higher frequency of engaging in a range of coping behaviours (CB). CS was predicted by workload, values and resilience independently, and through partial mediation of CB. CS was positively correlated with control, rewards, community, fairness and perceived job security. This relationship was fully mediated by Coping Behaviours.
34.	Wagaman, Geiger, Shockley et al. (2015)	173 Social Workers	USA	ProQOL; The Empathy Assessment Index (EAI)	13	Higher CS was correlated and significantly predicted by increased self-others awareness (cognitive component of empathy) and increased affective response (physiological component of empathy). Higher CS was associated with more years in profession.
35.	Xu, Harmon-Darrow & Frey (2019)	61 Social Workers	USA	ProQOL, Adapted Bloomquist's et al. (2016) Self-care Perception Scale, The Appraisal of Self-Care Agency Scale–Revised (ASAS-R)	17	Bachelor-degree social workers had lower levels of compassion satisfaction than Master or Doctoral-degree holders. CS was not significantly predicted by self-care behaviours and self-care barriers.

Note: ProQOL= Professional Quality of Life, CS= Compassion Satisfaction, CF= Compassion Fatigue, BO= Burnout, STS= Secondary Traumatic Stress

Table 2: The critical appraisal tool for cross-sectional studies template (AXIS; Downes, Brennan, Williams & Dean, 2016)

	Yes	No	Do not know / Comment
Introduction 1. Were the aims/objectives of the study clear?			
Methods 2. Was the study design appropriate for the stated aim(s)? 3. Was the sample size justified? 4. Was the target / reference population clearly defined? (Is it clear who the research was about?) 5. Was the sample frame taken from an appropriate population base so that it closely represented the target/ reference population under investigation? 6. Was the selection process likely to select subjects/ participants that were representative of the target/ reference population under investigation? 7. Were measures undertaken to address and categorise non-responders? 8. Were the risk factor and outcome variables measured appropriate to the aims of the study? 9. Were the risk factor and outcome variables measured correctly using instruments/ measurements that had been trialled, piloted or published previously? 10. Is it clear what was used to determine statistical significance and/or precision estimates? (e.g. p values, CIs) 11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results 12. Were the basic data adequately described? 13. Does the response rate raise concerns about non-response bias? 14. If appropriate, was information about non-responders described? 15. Were the results internally consistent? 16. Were the results for the analyses described in the methods, presented?			
Discussion 17. Were the authors' discussions and conclusions justified by the results? 18. Were the limitations of the study discussed?			
Other 19. Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results? 20. Was ethical approval or consent of participants attained?			

Table 3: The critical appraisal tool with study quality rating

Study	Quality Rating
1. Avieli, Ben-David & Levy (2016)	15
2. Bae, Jennings, Hardeman et al. (2019)	16
3. Baugerud, Vangbæk, Melinder (2018)	16
4. Beder, Postiglione, Strolin-Goltzman (2012)	14
5. Bloomquist, Wood, Friedmeyer-Trainor et al. (2016)	13
6. Carmel & Friedlander (2009)	15
7. Cetrano, Tedeschi, Rabbi et al. (2017)	17
8. Craig & Sprang (2010)	16
9. Cuartero & Campos-Vidal (2018)	15
10. Finzi-Dottan & Kormosh (2016)	18
11. Gibbons, Murphy & Joseph (2011)	14
12. Itzhaki, Bluvstein, Peles Bortz et al. (2018)	14
13. Killian (2008)	15
14. Kjellenberg, Nilsson, Daukantaité, Cardeña (2014)	16
15. La Mott & Martin (2019)	16
16. Lakioti, Stalikas & Pezirkianidis (2020)	15
17. Laverdière, Kealy, Ogrodniczuk, et al. (2019)	15
18. Laverdière, Ogrodniczuk, Kealy (2019)	16
19. Lawson & Myers (2011)	15
20. Lusk & Terrazas (2015)	10
21. Mangoulia, Koukia, Alevizopoulos, et al. (2015)	14
22. Newmeyer, Keyes, Palmer et al. (2016)	12
23. Rossi, Cetrano, Petrile el al. (2012)	16
24. Salloum, Kondrat, Johnco et al. (2015)	16
25. Samios et al. (2013)	14
26. Sodeke-Gregson, Holttum, Billings (2013)	17
27. Somoray, Shakespeare-Finch, Armstrong (2017)	14
28. Sprang, Clark, Whitt-Woosley (2007)	15
29. Thomas (2013)	14
30. Thomas & Otis (2010)	14
31. Towey-Swift &Whittington (2019)	18
32. Van Hook, Rothenberg, Hook et al. (2009)	13
33. Wachter, Schrag & Wood (2019)	14
34. Wagaman, Geiger, Shockley et al. (2015)	13
35. Xu, Harmon-Darrow & Frey (2019)	17

Section 3: Empirical Paper

"You apply it to the patients, but you forget to apply it to staff":

A Mixed Method Feasibility and Acceptability Study of a Compassion-Focused Group for Inpatient Mental Health Staff.

Kamila Drobinska[a*], David Oakley[b], Carrie Way[b], Mike Jackson[a]

[a]North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK; [b]Betsi Cadwaladr University Health Board, North Wales, UK

***Corresponding Author:** Kamila Drobinska, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK.

kamila.drobinska@gmail.com

This paper is intended to be submitted to the Issues in Mental Health Nursing journal: https://www-tandfonline-com.ezproxy.bangor.ac.uk/action/authorSubmission?show=instructions&journalCode=imhn20

“You apply it to the patients, but you forget to apply it to staff”:

A Mixed Method Feasibility and Acceptability Study of a Compassion-Focused Group for Inpatient Mental Health Staff.

This study explored the feasibility and acceptability of a compassion-focused group for staff. Two groups were run on two hospital sites. Session-by-session feasibility measures were collected, and semi-structured interviews conducted to explore the experience of the group and reasons for attrition. The results show that participants found the sessions beneficial and enjoyable, suggesting that compassion focused support may be an acceptable approach for this staff group. High attrition rate and themes relating to organisational barriers suggest that for a staff intervention to be feasible in inpatient mental health services, organisational changes are required. Implications and limitations are discussed.

Keywords: compassion, compassion focused staff support, inpatient mental health, staff support

Introduction

Mental health services across the UK are currently under enormous pressure. In Wales, there has been an increase in reported mental health problems (Mental Health Foundation, 2016) and there is a UK-wide increase in demand for psychological services (Lubian et al., 2016). Despite receiving more funding than any other services in the NHS (Welsh Government [WG], 2016), mental health services report this to be not enough (Gilburt, 2015). Recent shifts towards offering care in the community rather than institutional settings and acute services, has led to a fall in the number of beds available in hospitals in the UK (Ewbank, Thompson, McKenna & Anandaciva, 2020). In Wales, there has been a decrease in the number of admissions to mental health facilities since 2013 (WG, 2018a). Inpatient mental health services support a population at the higher end of need, with complex, enduring mental health problems, often admitted against their will, in the midst of a mental health crisis (Heriot-Maitland, Vidal, Ball & Irons, 2014).

Appropriate staffing numbers are required to deliver high quality and safe care. However, the number of mental health nurses has dropped by 25 per cent between 2009 and 2017 (Gilburt, 2018). The implications of staff shortage and reliance on bank staff may be a less settled and less stable ward environment, increased agitation in patients (Todd Jones & Lamers, 2017), and possibly a higher rate of incidents. It is not uncommon for staff to experience or witness verbal aggression or violent behaviour towards patients and staff on the ward, which may lead to interventions, like de-escalation, restrain and seclusion (Royal College of Psychiatrists, 2005). Staff are legally required to develop and follow detailed care and treatment plans, risk management procedures and report incidents on the ward in a timely manner (WG, 2010; WG, 2018b). It has been suggested that the demands to meet legal requirements

of completing necessary paperwork, accountability for failing to do so, in the context of staff shortages, has led to the development of a task-focused workforce with reduced time allocated to spend with the patient and reduced time for staff support, for example in the form of supervision (Crawford & Brown, 2010).

Seddon (2008) suggests that systems under stress and driven by targets create "threat stress" and may have a negative impact on the well-being of staff. Studies suggest that mental health staff appear to have poor mental health with high levels of stress, burnout and impaired psychological wellbeing, including depression and anxiety (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler 2012; Rossi et al., 2012; Salyers, Rollins, Kelly, Lysaker & Williams, 2013; Wren & Michie, 2003). Research suggests that as a result of prolonged exposure to suffering and trauma in patients or feeling unable to provide the care that is seen as appropriate, staff may experience compassion fatigue (Austin, Goble, Leier & Byrne, 2009; Figley, 1995; Wright, 2004). Figley (1995) defines compassion fatigue as physical, emotional exhaustion and impaired empathy that may further lead to clinical errors and poor treatment planning (Adams, Figley & Boscarino, 2008; Bride, Radey & Figley, 2007; Figley, 2002). Stress and burnout also have been found to have negative impact on attention and decision-making and staff members' ability to establish relationships with service users (Shapiro, Brown, Biegel, 2007).

Work-related stress may lead to sickness absence. Mental health services had the second highest rates of sickness in NHS organizations in 2019 (NHS Digital, 2019; WG, 2020). Poorer psychological well-being, stress and burnout have been associated with low rates of staff retention and high staff turnover (Robertson & Cooper, 2010). Furthermore, staff well-being has been linked to patients' satisfaction (Maben, 2010) and the quality and safety of care (Hall, Johnson, Watt, Tsipa & O'Connor, 2016;

Holmes, 2002; Johnson et al., 2017). Reports on the failings in patient's care in Winterbourne View (Department of Health, 2012) and Mid Staffordshire Hospitals (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), and more recent events locally leading to the closure of the local Tawel Fan ward (BBC, 2018) raised concerns from the public about the lack of compassionate care within the NHS and called for a transformation of care.

Different approaches, alternative to the traditional model of care have been proposed and developed in recognition that both patients and staff need support in working together towards better outcomes (Health Service Ombudsman, 2011; The King's Fund, 2009). More locally, the Welsh Government (2013) also stated that in order to ensure the provision of compassionate care to patients, the workforce must be supported to facilitate such care. To provide such support to staff Schwartz Rounds (Rounds) were introduced in the UK in 2009. A recent mixed-methods evaluation of the rounds (Maben et al., 2018) suggested that the rounds positively affected the well-being of staff, increased empathy and compassion for patients and colleagues. Researchers investigating compassion and compassion-focused approaches also suggest that the NHS workforce could benefit from being supported to cultivate compassion towards themselves and each other, as they find themselves working in very challenging environments and times (Cole-King & Gilbert, 2011; Crawford, Gilbert, Gilbert, Gale, & Harvey, 2013).

Compassion-focused therapy (CFT) was developed by Paul Gilbert (2000) for individuals with high levels of shame and self-criticism. However, compassion-based approaches have also been developed and researched by others (Neff, 2013a). CFT is rooted in evolutionary and attachment psychology, neuroscience and Buddhism. Gilbert (2009) suggests that there are three key emotion regulation systems: threat, drive and

the affiliative soothing system. These systems are associated with a range of corresponding emotions, motivations and behaviours, which include competing, cooperation, caring and nurturing, seeking and responding to care. Research suggests psychological and neurophysiological processes and benefits of affiliative relating, for example the role of oxytocin in processing threat, soothing, calmness, trust and feelings of affiliation (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Gilbert, 2009; Porges, 2007). It has been suggested that affiliative relationships play a role in regulating threat (Cacioppo & Patrick, 2008; Cozolino, 2007; Siegel, 2012).

Compassion is related to the affiliative emotion regulation system. Gilbert (2000) defines compassion as sensitivity to suffering coupled with motivation to alleviate it. Compassion involves compassion to the self, to others, and allowing the flow of compassion from others to oneself, with certain attributes and skills key in cultivating this flow. His model proposes the flow of compassion may be blocked in threat-focused organisations. This was suggested by the study of Henshall, Alexander, Molyneux, Gardiner & McLellan (2018) where staff operating in conditions of threat within their organisation had reduced capacity for compassion to self and others. In Gilbert's model, stress and burnout are the result of an over-activation of the threat and the drive systems, and under-activation of the affiliative soothing system.

CFT is suggested to be a promising approach for both non-clinical and clinical populations with a range of difficulties, in particular for those with high self-criticism (Leaviss & Uttley, 2015). With regard to compassion-based interventions for health care staff, some evidence suggests that practicing compassion may have many benefits. The study of Henshall et al. (2018) suggested that increased self-compassion and increased level of compassion staff felt they received at work regulated their threat response and maintained or improved their compassion to service users and work colleagues.

Furthermore, self-compassion and perceived organisational compassion were significantly better predictors of level of compassion for others than was perceived organisational threat. Allen and Leary (2010) suggested that increased self-compassion was positively associated with positive cognitive restructuring and negatively associated with avoidance when coping with negative stressful experiences. Self-compassion was found to be associated with better sleep and resilience, which are factors related to burnout and quality of care (Cramer, Kemper, Mo & Khayat, 2016; Raab, 2014); to increased motivation to self-improve (Breines & Chen, 2012); to reduced self-criticism (Bazarko, Cate, Azocar & Kreitzer, 2013; Shapiro et al., 2007); to reduced burnout, reduced compassion fatigue, increased well-being (Beaumont, Durkin, Hollins Martin & Carson, 2016) and increased empathy (Bazarko et al., 2013).

There is a paucity of research on interventions for NHS mental health staff (McNally, 2019). Efforts are being made to develop and implement compassion-focused staff support groups in different NHS settings, however, to date no peer-reviewed literature concerning compassion-focused groups for NHS staff exists.

This study builds on the existing research on compassion-focused group interventions for mental health staff. The study of Heriot-Maitland et al. (2014) which explored the feasibility of group CFT for acute inpatients had high attrition, however showed promising outcomes and was well received by participants. Exploring the impact of attending such groups on inpatient staff was recommended. Examining the feasibility and acceptability of compassion-focused groups for inpatient mental health staff is potentially a useful area for research that can inform clinical practice in terms of developing, implementing and evaluating future compassion-focused approaches for this staff group.

Aim

The aim of this study was to examine the feasibility and acceptability of a compassion-focused group for staff working in inpatient mental health services. Because of the novel character of the intervention and mental health staff belonging to a potentially hard-to-reach staff group, the study aimed to explore participants' experience of the group, and reasons for potential attrition. Mixed method approach was deemed to be the most suitable, enabling analysing data at both macro and micro level (Powell, Mihalas, Onwuegbuzie, Suldo, & Daley 2008; Onwuegbuzie & Leech 2005).

Method

Ethics

The study received a favourable opinion from Bangor University Ethics Committee, the Health Research Authority and Health and Care Research Wales and the local health board's Research and Development Department (Section 5, Appendices 1-6).

Recruitment procedure

Participants were recruited from staff working across local NHS acute adult and older adult inpatient mental health and dementia services. The nature of the groups and the study were discussed with the senior management of the relevant health board. The compassion-focused staff groups were advertised by the psychologist based in one of the inpatients sites. Convenience purposive sampling was employed to recruit participants. Potential participants were identified by ward managers. The aim of the group and the study was explained to participants, and sufficient time given to make an

informed decision whether to participate in this study or not. Each group was planned to consist of 7 members.

Participants

A total of 13 participants were identified as suitable for the groups. Ten participants gave written consent to take part in the research and to be contacted to arrange a further interview. One participant who was unable to complete the first group, was invited to the second one. Eight were interviewed. Written consent was given to audio record the interviews, for later verbatim transcription, and for the use of anonymised quotes in the paper. Those who volunteered to participate in the interview were given a £15 Amazon gift voucher in acknowledgment of their contribution to the study.

Intervention

Two closed groups ran consecutively in two different NHS inpatient sites in North Wales. Each group consisted of six weekly sessions of two hours duration. Sessions took place in the morning at a time identified as most convenient. Group sessions were agreed to be incorporated into participants' rota prior to the groups starting. The groups were facilitated by two clinical psychologists trained in Compassion-Focused Therapy. The sessions began with an introduction to compassion and psychoeducation on the evolutionary aspect of the human brain and the three emotion-regulation systems. The sessions facilitated a 'slowing down' of the mind and body compassionate approach, in order to create a safe space enabling affiliative relating to one another. The sessions consisted of experiential compassion cultivation practices, such as soothing rhythm breathing and compassionate imagery, and a space for reflections. An outline of key components can be found in Appendix 1.

Method of evaluation

A mixed quantitative and qualitative methods design was employed. Participants were asked to anonymously complete feasibility and acceptability measures developed by the research team prior to groups starting (Section 5, Appendix 7). The measures examined within-session changes in wellbeing and consisted of several questions for the participants to answer on a visual analogue scale including: (1) how much of the session was understood; (2) whether the group and practices were helpful; (3) how much they enjoyed the sessions. Participants were also asked to rate how they felt before and after each session, to ascertain whether the sessions are helpful or causing any distress to participants. Recruitment and attrition rates were examined and evaluated against criteria and critical feasibility outcomes (Appendix 2, Table 1) developed by the research team. Additionally, participants were asked to complete outcome measures of compassion (Gilbert et al., 2017; Neff, 2003b) and professional quality of life (Stamm, 2009) pre- and post- group to preliminarily explore the potential effect of the intervention.

Semi-structured interviews with eight participants were conducted after the group to explore their immediate experience of the group. Those who attended less than 4 sessions (i.e. non-completers), were also interviewed to explore reasons for attrition. Interview transcripts were analysed using thematic analysis (Brown & Clarke, 2013). This method was deemed the most suitable as part of a mixed method design and due to the primary aim of the study, i.e. exploring feasibility and acceptability of an intervention within a new area. The researcher was aware of their prior knowledge and experience of working in inpatient mental health services, as well as their personal investment in the project. Every effort was made to approach the data without pre-existing assumptions, ideas and concepts. The codes and themes were determined by the data in line with an inductive approach, however the data

were analysed through the researcher's lens, and as such has elements of both inductive and deductive approach to thematic analysis.

Results

The group was attended by nurses, assistant psychologists, health care assistants and activity coordinators. Eight identified as female and two as male. The majority of the sample were white (90%), whilst the remaining identified as black; 30% identified as Welsh, 30% as Other, 20% as English and 20% as British. The modal age group was 35-44. The mean duration of NHS employment was 3 years and 9 months (*SD*=2years). A detailed breakdown of demographic characteristics of the study participants can be found in Table 2 (Appendix 2).

Quantitative data

Data were exported into an Excel database and descriptive statistics used to summarise the data.

Group attendance and attrition

Attendance data for the two groups showed that out of the 12 initial attendees, 4 (two per group) completed the group attending 4 to 6 sessions (33%). Eight per cent attended 3 sessions, 25 per cent attended 2 sessions and 33 per cent attended only 1 session. Attrition rates were high and are shown in Figure 1. For session-by-session attendance and non-attendance with reasons, see Table 3 (Appendix 2) and Figure 2 (Appendix 3).

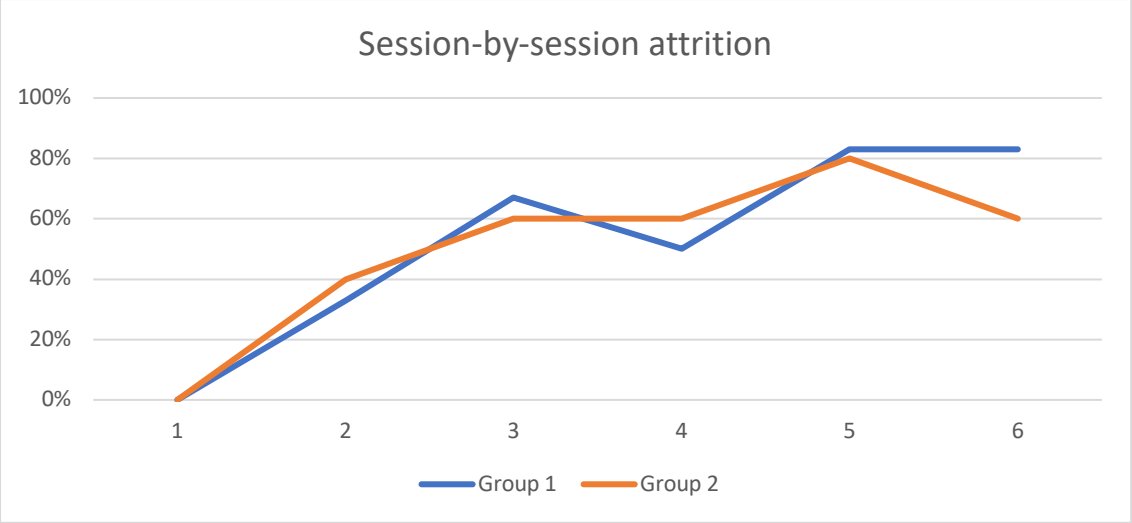


Figure 1. Session-by-session attrition rate

Session-by session feasibility and acceptability measures

A sample of 10 research participants filled in feedback forms each session. The number of returned forms each session and overall, as well as attrition rate is shown in Table 2.

Table 2. Overall number and attrition for returned data (*n*=26)

Sessions (both groups)	**Participants returning data**		
	Starting pre-	**Completing pre- & post-**	**Attrition rate (%)**
Session 1	10	8	20%
Session 2	7	7	0%
Session 3	4	4	0%
Session 4	5	5	0%
Session 5	2	1	50%
Session 6	3	1	67%
Total: 12 session	31	26	16%

Overall, participants found the sessions easy to understand and useful, with mean ratings of 87 (*SD*=12) and 89 (*SD*=11), respectively out of a 100, for all sessions. The majority found within-session practices helpful, with a mean rating of 84 (*SD*=20) and felt calmer with a mean rating of 86 (*SD*=15). Means ratings of acceptability are shown in Figure 2. For a detailed session-by-session break down of for participants' and facilitators' feedback see Figures 2.-6. (Appendix 3).

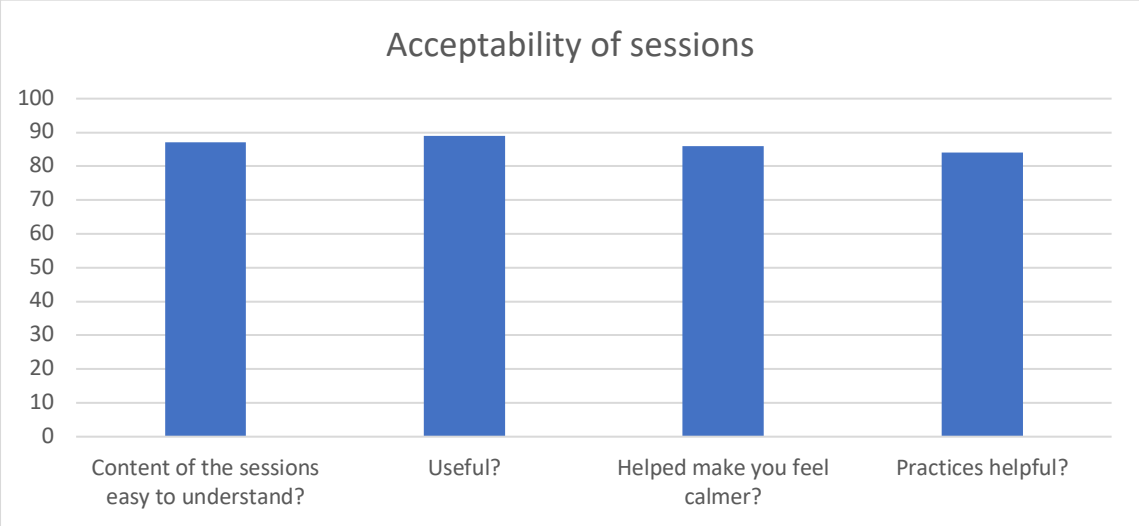


Figure 2. Mean ratings of sessions' acceptability (*n=26*)

Mean ratings from completed pre- and post- of well-being *(n*=26) can be found in Figure 3. Data suggests an increase in ratings post- session, especially in session 3. Wilcoxon Signed Ranks test was used to compare the difference in pre- and post- ratings for all sessions. This revealed a significant increase in well-being for all sessions ($Z = -3.634$, $p < .001$), from a mean rating of 71 (*SD*=16) pre-sessions to a mean rating of 85 (*SD*=13) post-sessions.

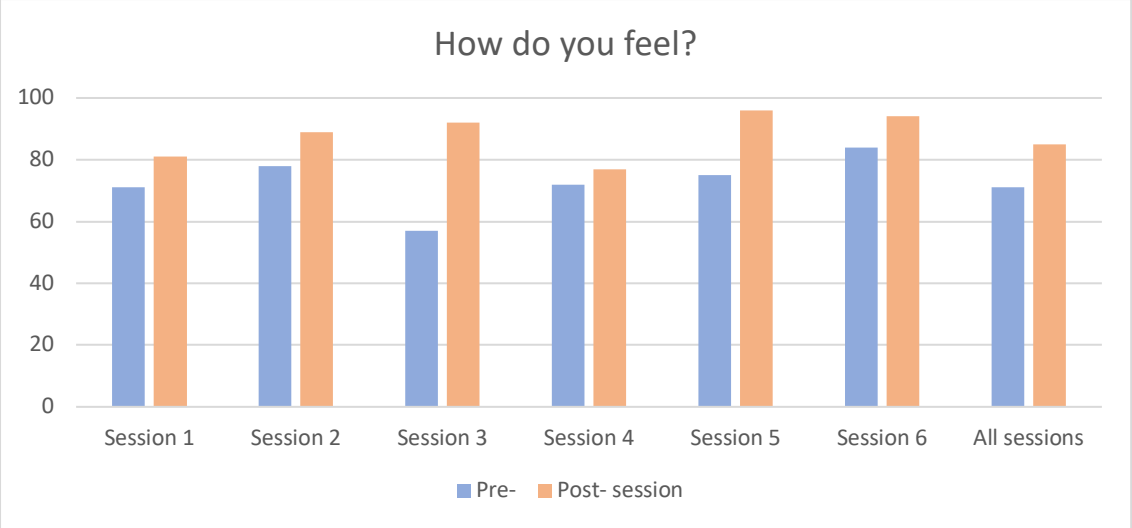


Figure 3. Mean pre- and post- session ratings of well-being (*n=26*)

In summary, results suggest that the sessions were overall acceptable and did not cause people to feel any distress that would cause a drop out.

With regard to preliminarily exploring the effect of the group on participants' professional quality of life, self-compassion, compassion engagement and action, there was an overall slight increase in mean scores as shown in Figure 8-10 (Appendix 3), however due to the underpowered sample, significance testing was not warranted.

Qualitative analysis

Qualitative data were analysed in six stages (Appendix 4). in line with thematic analysis as described by Braun and Clark (2006; 2013).

In relation to participants' experience of the group, the analysis yielded five themes: Positive Affect; Changes in Relating to Self and Others; Common Humanity; Guilt and Anger; Desire to Alleviate Suffering. In relation to reasons for non-attendance one overarching theme emerged: "The System is the Problem", with five themes consistently identified across data (1) The nature of the ward; (2) Slowing down is not

allowed; (3) It is not in our nature (4) Guilt & Threat (5) We are not important. A visual representation of the themes and subthemes, and relationships between them can be found in Figure 1 and 2 (Appendix 8).

All participants reported positive experiences arising from attending the compassion-focused group intervention. The theme of *Positive Affect* captured the positive emotions participants experienced during the group sessions. A few participants shared that they felt valued and positive when hearing about the planned group for staff and when attending the sessions. All participants enjoyed all the sessions they attended. Two aspects that were commented upon most frequently were: the *pace and atmosphere* of the sessions, and the *practices* during the sessions prompting feelings of calmness and joy.

Another theme of *Common Humanity* captured participants experiencing the value of being able to get together with colleagues, offering space to notice they are not alone with their struggles, that others feel similar. The sessions provided them with the opportunity to share experiences at work and to give and receive compassion from each other.

The majority reported benefiting from the sessions, which were captured under the theme of *Changes in Relation to Self and Others*, with two subthemes identified - *Understanding of your 'tricky brain'* and *Increased self-compassion and compassion to others*. The participants that attended at least half of the sessions explained that they had become more aware and understanding of their tricky brain and their response to stressful situations at work. These participants reported increased self-compassion in the form of self-care behaviours or how they talk to themselves both at work and outside of work.

All participants expressed an enthusiasm and a need for compassion-focused sessions, or similar supportive sessions for staff to continue in the future. This was captured under the theme of *Desire to Alleviate the Suffering of Self and Others*. The majority reflected on the importance of having time and space for reflection on the impact of work and for compassion. Many shared the challenges of working on the ward, how it affected their mental or physical health, and the importance of their leaders and colleagues to notice. This subtheme of *Suffering of the team* was identified within the theme *Common Humanity* and was closely related to a theme of wanting and needing things to change, captured under the aforementioned *Desire to Alleviate Suffering.*

Overall, the experiences of the group were positive. However, all participants reported some difficult feelings, such as guilt and frustration during the time of the group programme taking place, captured under the theme of *Guilt and Anger*. These emotional experiences were prompted by the group taking place within the context of the ward, not by the content of the sessions, highlighting possibly a general organisational threat the participants experience day-to-day at work. This theme is closely linked to the themes relating to reasons for attrition. The majority of participants reported feelings of guilt about being in the sessions whilst their colleagues were having to stay on the ward, even though the group was planned in advance to allow for the rotas to be accommodated and time to be protected. The sessions taking place in the same building and/or during work hours, meant it was harder to engage with the group content and feel safe. All participants reported feeling frustrated about the challenges to attending, i.e. incidents, staffing issues, lack of time protection. The frustration was generally directed at those in leadership and/or higher managerial roles.

Overarching theme: "The system is the problem"

In relation to the reasons for non-attendance, all participants discussed the nature of the ward environment. Many talked about the specificity of working in an inpatient service, drawing a picture of a very challenging and exceptionally busy environment, with risk management and safety frequently brought up. This theme captures the culture of the workplace the participants are part of, how they related to one another and themselves during shift; how they perceive themselves and those in leadership roles; how they perceive their value to be in their workplace.

Theme 1: "Sometimes things happen overnight" - The Nature of the Ward

Many participants discussed the nature of the ward, with unpredictability and lack of time consistently identified across data.

Unpredictability and threat. This sub-theme related to changing rota, incidents, low staffing numbers and patients' safety, painting a picture of unpredictability where *everyone else is running around, there is chaos restraints going on […] you have to react in a busy setting when everything is kicking off*. Decisions are made in response to 'the needs' of the ward. The environment is seen as unpredictable, chaotic and threatening where *there are days when it's quiet and you have really lovely days and there are other days where you could pull your hair out* making it impossible to release staff and where *you can have good intentions to attend but sometimes it just doesn't work out that way*. In an environment where unpredictability is ever so present, where *even when it's calm and quiet, you're suspicious why it is calm and quiet*, the sense of threat and maintaining safety or 'safe staffing numbers' became the main focus and takes precedence over the needs of staff:

> It's the acuity, if you got a patient who is on the ward, who is at risk of self-harm, suicide […] they're more likely to hurt themselves in the immediate time frame than I am to suffer from staff burnout.

There is no time. All participants talked about how busy the ward was because of staffing and workload. This meant many found it difficult to see how they could balance the pressure of getting their work done with coming to sessions. In the majority of accounts, the 'time pressure' and 'no time' for anything other than what needs to be done, meant that many participants may have perceived the session as a burden. Many reported that there was no time to stop and reflect on their practice; or for staff to get together and support each other informally, let alone attend sessions like these:

> It's hard to be compassionate towards yourself and your colleagues when you just don't have the time simply it is really important to have that bit of time […] you just like a machine 'go on go on and go on'.

Theme 2: "Just letting staff know that actually it is ok to do" - It's not allowed to slow down

All participants discussed not having their time protected and a felt sense of pressure from managers or colleagues to stay on the ward.

Time is not protected. A common sub-theme reoccurring across the data was the fact that the sessions were not on a rota or were not made mandatory:

> […] with things being on a rota, it's like mandatory - you have to go […] if I had known that I had the choice to go and it was on my rota, I still would have turned up, it's just it wasn't even down.

A minority reported frustration about their rota changing which meant they were no longer 'allowed' to attend further sessions. The importance of time protection but also – choice was highlighted in majority of accounts.

Lack of leadership support. Three participants who completed the group reported that they were able to do that thanks to the support and encouragement from their ward manager or a colleague, or because of having more autonomy in their job. Many participants reported a lack of support to attend sessions from the middle or higher management. The lack of support or encouragement from managers, was often a key factor. Half of the participants felt that the narratives in the workplace is that of prioritising the needs of the ward rather than their own, and the required permission to attend:

> I think that's the main barrier, the staffing levels and managers actually allowing it […] well, it's not been said straight but that's the message that comes from the conversations so that would have to change but that would have to come from the managers' attitude, changing the attitude.

Many participants talked about managers not releasing staff to sessions due to their anxiety about incidents and the consequences of these decisions. The threat in the system was perceived to be due to 'unsafe staff numbers', which meant there was pressure to maintain 'safe' numbers on the ward:

> You know you've still got those numbers if it's absolute emergency but I think people panic when we drop below our minimum numbers if something happens which it shouldn't be like that because the senior management could all come down, they could come and help.

Some participants commented on the discrepancy between how they are expected to treat patients and how they felt to be treated by their leaders and by one another. If they struggled, they felt they were *expected [to] 'just get on with it* and that it was *very bizarre because it's not what we say to our patients but yet we say it to staff*. They felt the services should be a role model for the whole NHS and the reality felt far from it.

Pressure from the ward. Some participants talked about the felt pressure to stay on the ward from their colleagues:

> […] sometimes there's a lot of pressure to… I think certain staff like to come in and see big round tables doing things […] I think there's a lot of pressure to seem busy and be busy.

Many felt that although the ward was indeed busy, in theory it is was possible to make time for these sessions. A culture of 'threat', being 'busy' and 'doing' was depicted as an implicit barrier to attending as it meant losing numbers on the ward. Taking your time to reflect, taking care of oneself and a slower pace felt also incongruent with the pace of the ward.

Theme 3: "We tend to look after everyone else"- It's not in our nature

This theme relates to an identified block to the flow of compassion more generally. However, it was reasonable to interpret it as a barrier to attending sessions. The majority of participants reported not having the habit of thinking about their own needs and prioritising them over the needs of others' because they are *so used to putting other people first and thinking about other people, it's alien to think about what's best for yourself*.

We Put Patients First. Many participants reported prioritising the patients' needs and their safety over anything else. This sub-theme captures one of the values of the organisation the participants work in, which have become an internalised narrative they shared where *you always put the patients first, no matter what. Even if it is at the end of the day and you're exhausted*. The work perceived by the helper, was one where they felt there was no other way than to sacrifice their own well-being for the benefit of others:

> […] we give up a lot of our own wellness and our own well-being and put ourselves second so that we can look after other people. It's just represents exactly what goes on every day.

The last two quotes are depictions of extreme self-sacrifice, where the carer helps until they can no longer do their work.

We don't practice what we preach. Many participants identified a discrepancy between what they 'preach' to patients about self-care and self-kindness, or applying compassion to patients, but not practicing self-compassion themselves:

> I guess I'm in a position a lot of the time where I might be working with people and talking about, you know, being more kind or being more compassionate towards yourself and I guess I don't often practice that personally.

This discrepancy was initially a motivation to attend, and at the same time may have been a block to attending. Attending sessions which focus on staff well-being may be incongruent with the beliefs and behaviours of the helpers perhaps leading to cognitive dissonance, because *we're here to look after patients*.

Theme 4: "You feel bad if you stop" – Guilt and Threat.

All participants said that leaving the ward to attend sessions as well as attempting to apply self-compassion during work prompted experiencing difficult emotions, such as guilt because *especially here on this ward you feel bad if you stop*. The sessions encourage slowing one's pace down and cultivating 'being with', engaging with own or others' feelings. This seemed to be in contrast with the pace of the ward. This urge to be 'busy' was described previously due to an external pressure experienced from the ward, however the internal pressure stemming from own guilt may have also inhibited attending. One participant talked about how attending sessions meant:

> […] no activities happening on the ward now and there's pressure from the patients. I went to see them this morning I said I won't be there until twelve and they were like 'oooh'.

In spite of it, this participant recognised the supportive role of these sessions and had enough autonomy to allow him to attend. Another participant who was able to attend most sessions thanks to their supervisor's support, also experienced guilt seeing other colleagues pulled out of the group:

> You kind of feel like other people are having to go and they don't have lots of time to be able to stay and take part in the group, I'm thinking 'maybe I should you know join in and help'.

One participant who attended only one session, described difficulty 'justifying' attending to her manager, or perhaps to themselves because *it's different, you are taking your time to do something that's for you rather than for the service if that makes sense*. Many participants felt they had to prioritise work over attending the group. The group was seen as something separate to work and attending may have been experienced as aversive because of perceptions that it would only benefit them and not the service.

Many participants talked about feared consequences, such as accountability because *if they* [colleagues*] don't cope it will be sort of my fault for not being there*, or:

> If I was to contest 'oh no sorry I need to do this because obviously my well-being comes first' I'd get into trouble for that because you're doing your job and when it all comes down to doing your job properly then it's hard.

This participant described earlier that their decision not to attend was collaborative with their manager due to workload. Here they implied they felt unable to disagree, that they felt it would cause 'trouble'. A minority talked about perceived 'expectations' to make

the ‘right choices’, in other words to stay on the ward because *people are observing what choices you make so it makes it difficult to attend when the ward is really busy cause you feel guilty and you want your feedback to be good*. These narratives seem to capture a threatening and possibly punitive environment; where it is difficult to make autonomous decisions, especially if they’re not in the best, short-term interest of the ward.

Theme 5: “Nobody cares about staff well-being here” – We are not important.

The majority of participants shared that the difficulties experienced with attendance represented little value and little recognition for their work and their efforts. They may not be explicitly told they are *replaceable,* but the minority felt they *were*, and many felt they were not looked after:

> If we’re not looked after and don’t feel valued, it’s difficult to do your role. I find it very difficult without any support […] if I’m going through tough time, I’d like someone to actually speak to me maybe see if I was doing alright. I appreciate people are being busy and are having a lot to do but there needs to be time for this.

Many participants felt that seeing the obstacles to attendance was difficult because *you find time for mandatory training, you find time for meetings, endless meetings all week*, therefore *there is no real reason why we couldn’t find time* [for this]. This reinforced in some a sense of how unimportant they felt. A sense of powerlessness and resignation whereby *there’s nothing to be done about that* was captured:

> It's amazing how many nurses and carers I see miss non-mandatory training or groups like this, because they have to stay in the ward and that's the way it is. I suppose that's the life, what can you do.

Some participants wondered whether *people get pulled out because the managers think 'what's that worth when you've got these tasks to do*. It may be that participants thought themselves that these sessions were not important enough. The majority felt these sessions should be mandatory or time protected to help increase the perceived importance:

> […] you wouldn't need to justify it yourself for attending it ((silence)) it forces the system to change; it forces them to see the staff as important and encourage the staff to see themselves as important.

A minority of participants felt that if the sessions were to be made mandatory, it would run the risk of taking choice away and further disempowering them, whilst placing the responsibility for 'fixing it' within the individual, and blame for not coping, rather than seeing staff well-being, including self-compassion as an organisational issue. This may represent how well-being initiatives may be perceived by staff, as illustrated by the below quote:

> Then, worst case scenario you burn out or make a terrible error and the organisation can say to you: 'well, we did tell ya - self-care', like in moving

and handling, ‘you’ve signed it now, so if you do your back in, it’s your fault, we’ve trained ya’. Terrible.

The participants felt they could not or would not attend sessions without the support and encouragement of others due to the many systemic barriers. Their narratives portray an environment where maintaining compassion for themselves and their colleagues may be perceived as an impossible endeavour due to the same barriers identified that stopped them attending the sessions.

Discussion

This study aimed to explore the feasibility and acceptability of compassion-focused groups for inpatient mental health staff. The high recruitment rate (86%) demonstrated potential feasibility and acceptability of the study and this was supported by participants’ reports regarding the need and relevance of this kind of intervention for this staff group. However, the high attrition rate (60% and 83%) supported by qualitative data revealed numerous barriers to subsequent attendance. Most of the barriers were organisational and were consistent with other studies of group-based interventions in acute inpatient mental health settings or overall NHS (Clarke & Wilson, 2009; Heneghan, Wright & Watson, 2014; Herriot-Maitland et al., 2014). They also highlighted the perceived lack of leadership support, lack of protected time and the unpredictable nature of the ward environment. This study suggests additional difficulties that threatened group attendance, such as difficulties leaving the ward due to the ward culture, where focus on ‘safe numbers’, on ‘doing’ and ‘keeping busy’ is

desired, whilst ‘getting together’, taking the time to reflect on struggles and ‘supporting one another’ is not part of the ward culture. Leaving the ward may also seem too difficult to do when one does not feel to have the autonomy or power. It may prompt guilt and anxiety; and these may be difficult to tolerate. This study suggests that once barriers were overcome, the sessions had a potential to be acceptable and beneficial for staff. Session-by-session acceptability measures consistently reported the group as acceptable by staff who attended. Data from pre- and post- session measure of well-being, suggest positive impact of the group, or that at the very least, the session did not cause any distress to participants. Participants gave consistently elevated ratings in areas such as: level of understanding of the content, helpfulness and calming effect. All participants were able to engage with the compassion practices in the sessions and reported that these were helpful and beneficial.

The results from the measures were supported by what the participants reported in the interviews. Themes of positive affect, changes in relating to self and others, common humanity, desire to alleviate suffering, as well as perceived potential longer-term individual and organisational benefits emerged from data. These themes were consistent with the literature on the impact of compassion-based interventions reported in an early systematic review (Leaviss & Uttley, 2015). However, qualitative data also highlighted participants’ doubt in the ability to maintain engagement with practices learned in the group or to maintain the reported benefits due to the short duration of the groups and the identified barriers relating to the nature of the system. Furthermore, the difficulties with getting to sessions, either own or witnessed in others, led to anger and guilt experienced by participants. Our measures suggest that this was not a direct result of the sessions, and therefore this might be an indicator of the many challenges of setting up a group in this context. In the interviews the participants reported negative

affect, indeed due to facing or witnessing many obstacles to attending, that potentially may be feeding into a sense of 'unimportance', 'not being cared about' and 'powerlessness' identified across the data.

Implications

To our knowledge this was the first attempt to explore the feasibility and acceptability of a compassion-focused group for inpatient mental health staff.

It is suggested that the pressure on mental health services will continue to grow (Johnson et al., 2018; The King's Fund, 2020), especially in the coming months following the Covid-19 outbreak (Durcan, O'Shea & Allwood, 2020). It is currently unknown how this will affect government funding plans for mental health services and staff support, however compassionate support embedded in the workplace seems to be even more crucial now than ever.

Previous research and literature have highlighted nurses' self-sacrifice schemas (Sahoo, Pradhan & Kumar, 2012; Wabnitz, 2018). This study identified mental health staff's self-sacrificing beliefs and guilt prompted by attempts at self-compassion and self-care through attending group sessions. Self-sacrifice may be associated with stress and burnout when it is at the expense of own health (Wabnitz, 2018). This may have significant implications for the well-being, absenteeism and retention level of the local health board and calls for action. Employers are expected to safeguard the mental health of their workforce by creating a supportive environment and encouraging the provision of health education and activities promoting health in the workplace (Department of Health, 1998). Compassion-focused staff support sessions could potentially be a promising approach for staff in inpatient services, for example to help staff develop an

awareness and healthy balance between self-sacrifice, self-compassion and self-care; help recognise and regulate increased levels of guilt; cultivate empathic concern and motivation to engage with and alleviate distress in self and others. However, the study identified numerous organisational barriers, for example: lack of protected time, which may be applicable to setting up and uptake of any future staff support sessions. This study suggested that participants viewed their organisation as pressurised and uncompassionate towards their staff, and viewed themselves as powerless in being able to change anything. A short-term compassion-focused intervention was difficult to attend and perceived as unlikely to be helpful in the longer-term, indeed because of the nature of their work environment. Previous research has also suggested that offering short-term staff support, as a "one off" intervention may not be sustainable, and that it may be more beneficial to incorporate and integrate them into the organizational systems (Kelly & Tyson, 2017). In this study participants advocated for either a group of a shorter duration but repeated to allow everyone to attend and /or open-ended sessions. There are arguments for both. Interventions of a shorter duration might be more feasible to 'complete' given the shift-pattern of work that participants attended an average of three sessions. However, to create a sense of safety within a group, and to maintain benefits and create a culture change, ongoing compassion-cultivating sessions embedded in the workplace are required. The model of Compassion-Focused Staff Support proposed by Lucre (2018), seems more feasible, whereby an all-staff well-being day and three days of CFT training for clinical staff are followed by ongoing compassion-focused staff support sessions. Another approach could be offering open-ended sessions for both staff and patients. This could potentially help address the challenge of releasing staff to attend when the ward is short-staffed. Providing an intervention to both staff and patients, simultaneously may also have a potential benefit

in reducing the 'othering' or split between 'them' (patients) and 'us' and potentially increase a sense of 'common humanity' and affiliative relating on the ward. Clinical practice and future research could consider shortening or, expanding the number of sessions and comparing the short- and long-term individual and service outcomes for both. Considering sessions for staff and patients together might be an endeavour worth exploring in terms of feasibility, acceptability and therapeutic impact.

This study suggests that compassionate approaches are unlikely to be successful if they are only to take place with a fraction of the organization and not the whole. Numerous meetings with senior management took place prior to the groups starting, and their approval had been granted. However, this appears to not have filtered down or been communicated to staff effectively. Sessions were not put on rota to protect the time or rotas changed on short notice. This meant staff perceived their leaders not to be in support for these sessions. Only a minority of the study participants considered the pressure their leaders themselves are under, especially in the context of special measures that had been introduced five years ago and the recent report of slow progress made by the health board (BBC, 2019). To nurture a culture of compassion and enable a flow of compassion within the workplace, organizations need their leaders at all levels to embody compassion (West, Eckert, Collins & Chowla, 2017). Consideration need to be given to the threats and demands all NHS employees face at all levels, from their leaders to domestic staff. An important implication from this study is that staff who experience their organisation as not caring about them, may find it difficult to relate to themselves, their colleagues and patients in a compassionate way. The organisation needs to care for its staff and treat its' staff compassionately, in order for staff to experience self-compassion and provide compassionate care for patients.

Limitations and Future directions

Several limitations to this study have been identified. One of the facilitators of the compassion-focused groups was external and one was working for the service and was known to the participants which may have affected attendance and engagement with the group.

Mixed method approaches attract criticism because of their nature. There are arguments that quantitative and qualitative methods are not compatible due to their inherently different paradigms (Tashakkori & Teddlie, 1998). However, the usefulness of mixed methods in providing an understanding of potentially contradicting quantitative and qualitative results is also highlighted (Wisdom & Creswell, 2013). Furthermore, this approach gave a voice to study participants and enabled a deeper understanding of the reasons for attrition which seemed imperative when exploring feasibility.

Given the limited time frame of the research project and the nature of the setting known for its challenges with recruitment, only a small number of attendees could be invited to the two planned groups. Following the initial attrition, only a small sample was recruited to take part in the study. The sample represented a variety of salary bands and roles however the majority of participants were White British females.
A larger and more heterogeneous sample would potentially generate other themes, perhaps pertaining to gender differences. Qualitative data from participants provided a rich insight into their experience of the group and barriers they have come across to attendance. Although, it is not the aim of qualitative studies to produce generalisable findings, one of the limitations is that it is not possible to assume that findings from this study would apply to other inpatient mental health services. Replicating this study in

other services and with a larger sample is warranted. When thinking about conducting a future feasibility study or setting up a compassion-focused staff support group, a recommendation would be to increase organisational buy-in and transparent communication of support for it.

The findings from the qualitative analysis could inform further qualitative research. Participants reported benefits from attending the sessions. Future research with a larger sample, a control group, short- and longer-term outcome measures, would enable more robust statistical analyses to ascertain whether the reported positive changes are significant and which aspects of the group are most helpful, and whether the benefits are long lasting. The above were beyond the scope this feasibility and acceptability study.

Conclusion

The findings suggest that compassion-focused groups for inpatient mental health staff have the potential to be an acceptable and promising approach warranting further exploration and research in inpatient mental health settings. Numerous barriers to attendance were identified, for example: perceived lack of leadership support and communication of such support in the form of protected time and encouragement to attend. Future adaptions of the group could potentially involve increasing the organisational buy-in into the benefits of such sessions, encouraging communication of support for such sessions by leaders and offering such support to those in leadership roles at all levels. Within the current design, i.e. six weekly sessions it is may not be a feasible intervention to offer, and it is suggested that a regular and open-ended design

would be more feasible and acceptable. Future research could potentially demonstrate feasibility with more participants being able to attend sessions and could explore short-term and longer-term individual and organisational benefits of compassion-focused staff support.

References

Adams, R.E., Figley, R.C., & Boscarino, J.A., (2008). The compassion fatigue scale: its use with social workers following urban disaster. Research on Social Work Practice, 18(3), 238-250.

Allen, A. B., & Leary, M. R. (2010). Self-Compassion, Stress and Coping. *Social and Personality Psychology Compass, 4*(2), 107–118.

Atkins, P.W.B., & Parker, S.K. (2012). Understanding individual compassion in organisations: the role of appraisals and psychological flexibility. *Academy of Management Review, 37*(4), 524–46.

Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion fatigue: The experience of nurses. *Ethics and Social Welfare, 3*(2), 195–214. https://doi.org/10.1080/17496530902951988

Bazarko, D., Cate, R. A., Azocar, F., & Kreitzer, M. J. (2013). The Impact of an Innovative Mindfulness-Based Stress Reduction Program on the Health and Well-Being of Nurses Employed in a Corporate Setting. *Journal of Workplace Behavioral Health*, *28*(2), 107–133.

BBC (2019). Wales mental health patients 'needlessly' placed miles away. Retrieved from: https://www.bbc.co.uk/news/uk-wales-48599970

BBC (2019). *Betsi Cadwaladr health board progress 'unacceptably slow'*. Retrieved from: https://www.bbc.co.uk/news/uk-wales-48384038

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

Berry, K., Barrowclough, C., Innes, C., Fitzgerald, M., Hartley, S., & Haddock, G. (2012). A description and evaluation of a challenging behaviour workshop. *Journal of Mental Health*, *21*(5), 478-484.

Bowers, L., Allan, T., Simpson, A., Jones, J., van der Merwe, M., & Jeffery, D. (2009). Identifying key factors associated with aggression on acute inpatient psychiatric wards. *Issues in Mental Health Nursing, 30*(4), 260–271.

Boorman, S. (2009). *NHS Health and Well- Being: Final Report*. Department of Health. Retrieved from : http://www.healthyregions.eu/uk/Boorman%20NHS%20HWB%20Final%20Report%20Nov%2009.pdf

Brown, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brown, V., & Clarke, V. (2013). *Successful qualitative research. A practical guide for beginners.* London: Sage.

Breines, J. G. & Chen, S. (2012). Self-Compassion Increases Self-Improvement Motivation. *Personality and Social Psychology Bulletin*, *38*(9), 1133–1143.

Bride, B.E., Radey, M., & Figley, C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-163.

Cacioppo, J. T., & Patrick, W. (2008). *Loneliness: Human nature and the need for social connection*. WW Norton & Company.

Carson, J., Cavagin, J., Bunclark, J., Maal, S., Gournay, K., Kuipers, E., ... & West, M. (1999). Effective communication in mental health nurses: did social support save the psychiatric nurse? *NT research*, *4*(1), 31-42.

Carter, C.S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology, 23*(8), 779-818.

Cohen-Katz, J., Wiley, S.D., Capuano, T., Baker, D.M., Deitrick, L. & Shapiro S. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout – A quantitative and qualitative study part III. *Holistic Nurse Practitioner, 19*(2), 78-86.

Cole-King, A. & Gilbert, P. (2011). Compassionate care: the theory and the reality. *Journal of holistic healthcare*, 8, 3, 29-36.

Cozolino, L. (2007). The neuroscience of human relationships: Attachment and the developing brain . New York: Norton.

Cramer, H., Kemper, K., Mo, X., & Khayat, R. (2016). Are mindfulness and self-compassion associated with sleep and resilience in health professionals? *Journal of Alternative & Complementary Medicine, 21*, 496-504.

Crawford, P. & Brown, B. (2011). Fast healthcare: Brief communication, traps & opportunities. *Patient Education & Counselling, 82*(1), 3-10.

Crawford, P., Gilbert, P., Gilbert, J., Gale, C. & Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research, 20*(10), 1-9.

Dawson, J. (2014). *Staff experience and patient outcomes – what do we know?* A report commissioned by NHS Employers on behalf of NHS England. London: NHS Confederation.

Department of Health (1998) *Modernising Mental Health Services: Safe, Sound and Supportive.* London: Department of Health.

Department of Health (2002). *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision.* Department of Health.

Department of Health (2012). *Transforming care: A National Response to Winterbourne view Hospital.* Department of Health.

Depue, R.A., Morrone-Strupinsky, J.V. (2005). A neurobehavioral model of affiliative bonding. *Behavioural Brain Science*, *28*(3), 313-395.

Durcan, G., O'Shea, N. & Allwood, L. (2020). *Covid-19 and the nation's mental health. Forecasting needs and risks in the UK: May 2020*. Centre for Mental Health. Retrieved from: https://www.centreformentalhealth.org.uk/sites/default/files/2020-05/CentreforMentalHealth_COVID_MH_Forecasting_May20.pdf

Dutton, J.E., Workman, K.M. & Hardin, A.E. (2014). Compassion at work. *The Annual Review of Organisational Psychology and Organisational Behaviour*, *1*(1), 277-304 doi: 10.1146/annurev-orgpsych-031413-091221

Ewbank, L., Thompson, J, McKenna, H., & Anandaciva, S. (2020). NHS Hospital bed numbers: past, present, future. London: The King's Fund.

Figley, C.R. (Ed.). (1995) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.

Figley, C. R., & Stamm, B. H. (1996). Psychometric review of Compassion Fatigue Self Test. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 127–130). Baltimore, MD: Sidran Press.

Figley, C.R. (2002). Compassion fatigue: psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*, 1433-1441.

Gilbert P (2000). Social mentalities: internal 'social' conflict and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert & K.G. Bailey (Eds.), *Genes on the Couch: Explorations in Evolutionary Psychotherapy* (pp. 118–150), Brunner-Routledge: East Sussex, UK.

Gilbert, P. (2009). *The compassionate mind: A new approach to the challenge of life.* London: Constable & Robinson.

Gilbert, P. (2010). *Compassion-Focused Therapy: Distinctive Features*. Routledge/ Taylor & Francis Group.

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 4.

Gilburt, H. (2015). Mental Health Under Pressure. London: The King's Fund.

Gilburt, H. (2018). Funding and staffing of NHS mental health providers: still waiting for parity. London: The King's Fund.

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. *PLoS One, 11*(7), DOI: 10.1371/journal.pone.0159015

Healthcare Commission: *National Audit of Violence 2003-2005.* London: Royal College of Psychiatrists. Retrieved from: https://www.wales.nhs.uk/documents/FinalReport-violence.pdf. Accessed on 11/01/2019.

Health Service Ombudsman (2011). Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people. Retrieved from: https://www.ombudsman.org.uk/sites/default/files/2016-10/Care%20and%20Compassion.pdf

Heneghan, C., Wright, J. & Watson, G. (2014). Clinical Psychologists' Experiences of Reflective Staff Groups in Inpatient Psychiatric Settings: A Mixed Method Study. *Clinical Psychology and Psychotherapy, 21*(4), 324-340. DOI: 10.1002/cpp.1834

Henshall, L. E., Alexander, T., Molyneux, P., Gardiner, E. & McLellan, A. (2018). The relationship between perceived organisational threat and compassion for others: Implications for the NHS. *Clinical Psychology and Psychotherapy*, *25*(2), 231–249. https://doi.org/10.1002/cpp.2157

Heriot-Maitland, C., Vidal, J.B., Ball, S., & Irons, C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *British Journal of Clinical Psychology*, *53*(1), 78-94.

Holmes, J. (2002). Acute wards: Problems and solutions: Creating a psychotherapeutic culture in acute psychiatric wards. *Psychiatric Bulletin*, *26*(10), 383–385. DOI: 10.1192/pb.26.10.383.

Jalil, R., Huber, J. W., Sixsmith, J. & Dickens, G. L. (2017). Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: Cross sectional questionnaire survey. *International Journal of Nursing Studies, 75*, 130–138. DOI: 10.1016/j.ijnurstu.2017.07.018

Johnson, J., Louch, G., Dunning, A., Johnson, O., Grange, A., Reynolds, C., Hall, A., & O'Hara, J. (2017). Burnout mediates the association between symptoms of depression and patient safety perceptions: A cross-sectional study in hospital nurses. *Journal of Advanced Nursing*, *73*(7), 1667– 1680.

Johnson, P., Kelly, E., Lee, T., Stoye, G., Zaranko, B., Charlesworth, A., Firth, Z., Gerlshlick, B. & Watt, T. (2018). Securing the future: funding health and social care to the 2030s. *Institute for Fiscal Studies.* Retrieved from: *https://www.ifs.org.uk/publications/12994* [Accessed on 04/04/2020]

Kelly, M., & Tyson, M. (2017). Can mindfulness be an effective tool in reducing stress and burnout, while enhancing self-compassion and empathy in nursing? *Mindfulness, 1,* 12–18.

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, *92*(5), 887–904. https://doi.org/10.1037/0022- 3514.92.5.887

Leaviss, J. & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychological Medicine, 45*(5), 927-945. doi:10.1017/S0033291714002141

Lubian, K. Weich, S., Stanfeld, S., Bebbington, P., Brugha, T., Spiers, N., Cooper, C. (2016). Mental health treatment and services. In S. McManus., P. Bebbington, R. Jenkins & T. Brugha, (Eds.), *Mental health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Lucre, Katherine. (2018). Compassion Focused Staff Support - Cultivating Compassion in Perinatal Services. Conference paper. Retrieved from: https://www.researchgate.net/publication/328191946_Compassion_Focused_Staff_Support_-_Cultivating_Compassion_in_Perinatal_Services

López, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderen, E., Ranchor, A., & Schroevers, M. J. (2015). A reconsideration of the Self-Compassion Scale's total score: self-compassion versus self-criticism. *PloS One*, 10(7), e0132940.

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., Ross, S., Shuldham, C., Bennett, L., & Foot, C. (2018). *A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England*. NIHR Journals Library.

Maben, J. (2010). The feelgood factor: Evidence for a link between staff well-being and the quality of patient care. *Nursing Standard, 24*(30), 70-71.

Mental Health Foundation. (2016). Fundamental Facts About Mental Health 2016. Mental Health Foundation: London. Retrieved from: https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016

McNally, D. (2019). *Special measures, burnout and occupational stress in National Health Service staff: Experiences, interpretations and evidence-based interventions* (Doctoral thesis). Bangor University, School of Psychology, Bangor, North Wales.

Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary.* Retrieved from http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M. & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

Needham, I., Abderhalden, C., Halfens, R. J., Fischer, J. E. & Dassen, T. (2005). Non-somatic effects of patient aggression on nurses: A systematic review. *Journal of Advanced Nursing, 49*(3), 283–296.

Neff, K. D. (2003a). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85–101. https://doi.org/10.1080/15298860309032

Neff, K. D. (2003b). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.

NHS Digital (2018). *NHS Sickness Absence Rates - November 2019, Provisional Statistic.* Retrieved from: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/november-2019 [Accessed on 04/04/2020]

Onwuegbuzie, A.J., & Leech, N.L. (2005). On becoming a pragmatist researcher: The importance of combining quantitative and qualitative research methodologies. *International Journal of Social Research Methodology: Theory & Practice*, *8*(5), 375–387.

Pines, A.M., Aronson, E. (1988). Career Burnout: Causes and Cures. Free Press, New York.

Porges, S.W. (2007). The polyvagal perspective. *Biological Psychology, 74*(2), *116-143*

Powell, H., Mihalas, S., Onwuegbuzie, A.J., Suldo, S., & Daley, C. (2008). Mixed methods research in school psychology: A mixed methods investigation of trends in the literature. *Psychology in the Schools, 45*(4), 291–309, DOI: 10.1002/pits.20296.

Raab, K., Sogge, K., Parker, N. & Flament, M. F. (2015). Mindfulness-based stress reduction and self-compassion among mental healthcare professionals: a pilot study. *Mental Health, Religion and Culture*, *18*(6), 503–512.

Raab, K. (2014). Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature. *Journal of Health Care Chaplaincy*, *20*(3), 95–108.

Robertson, I.T., Copper, C. (2010). Full engagement: the integration of employee engagement and psychological well-being. *Leadership and Organization Development Journal,* 31(4), 324-336.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G., & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research, 200*(2-3), 933-938.

Sahoo, S., Kumar, A. & Pradhan, N. (2012). Cognitive schemas among mental health professionals: Adaptive or maladaptive? *Journal of research in medical sciences: the official journal of Isfahan University of Medical Sciences*, *17*(6), 523-526.

Salyers, M. P., Rollins, A. L., Kelly, Y. F., Lysaker, P. H., & Williams, J. R. (2013). Job satisfaction and burnout among VA and community mental health workers. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(2), 69–75. https://doi.org/10.1007/s10488-011-0375-7

Seddon, J. (2008). *Systems thinking in the public sector: the failure of the reform regime… and a manifesto for a better way*. London: Triarchy Press.

Shapiro, S., Brown, K.W., Biegel, G.M. (2007). Teaching self-care to caregivers: effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology 1*(2), 105-115.

Shipton, H., Armstrong. C., West, M., Dawson, J. (2008). The impact of leadership and quality climate on hospital performance. *International Journal for Quality in Health Care, 20*(6), 439–445.

Siegel, D. (2012). The developing mind, second edition: How relationships and the brain interact to shape who we are. New York, NY: New York Guilford Press.

Stamm, B. H. (2009). Professional quality of life: Compassion satisfaction and fatigue version 5 (ProQOL 5) [Measurement instrument] Retrieved from: http://proqol.org/ProQol_Test.html

Tashakkori, A., & Teddlie, C. (1998). Mixed methodology: Combining quantitative and qualitative approaches. California: Sage Publications, Inc.

The Guardian (2018). *NHS mental health crisis worsens as 2,000 staff quit per month.* Retrieved from: https://www.theguardian.com/society/2018/sep/15/nhs-mental-health-crisis-staff-quit [Accessed on 11/01/2019]

The Guardian (2018). *Delays in NHS mental health treatment 'ruining lives'.* Retrieved from: https://www.theguardian.com/society/2018/oct/09/mental-health-patients-waiting-nhs-treatment-delays [Accessed on 11/01/2020]

The King's Fund (2020). *The NHS budget and how it has changed.* Retrieved from: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget [Accessed on 04/04/2020]

The King's Fund (2016). *Improving Quality in the English NHS.* Retrieved from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf [Accessed on 04/04/2020]

The King's Fund (2009). *The Point of care: Enabling compassionate care in acute hospital settings.* Retrieved from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/poc-enabling-compassionate-care-hospital-settings-apr09.pdf [Accessed on 04/04/2020]

Thompson, D. & Ciechanowski, P.S. (2003). Attaching a new understanding to the patient-physician relationship in family practice. *The Journal of the American Board of Family Practice, 16*(3), 219-226.

Todd Jones, J. & Lamers, C. (2017). *Are staffing levels and agitation behaviours in dementia patients linked? An evaluation of staffing levels and the Cohen-Mansfield Agitation Inventory measure on a dementia assessment ward* (Service Related Research Project), Bangor University, School of Psychology, Bangor, North Wales.

Totman, J., Hundt, G.L., Wearn, E., Moli, P. & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. *BMC Psychiatry*, 11, 68. DOI: https://doi.org/10.1186/1471-244X-11-68

Turgoose, D. & Maddox, L. (2017). *Predictors of Compassion Fatigue in Mental Health Professionals: A Narrative Review.* Traumatology, *23*(2), 172-185. http://dx.doi.org/10.1037/trm0000116

Wabnitz, P. (2018). Early maladaptive schemas in psychiatric nurses and other mental health professionals in Germany. DOI: 10.13140/RG.2.2.34799.53925.

Wall, T. D., Bolden, R. I., Borrill, C. S., West, M., Wall, T. D., Bolden, R. I., Borrill, C. S., Carter, A. J., Golya, D. A., Hardy, G. E., Haynes, C. E., Rick, J. E., & Shapiro, D. (1997). Minor psychiatric disorders in NHS trust staff: occupational and gender differences. *British Journal of Psychiatry, 171,* 519–523.

Welsh Government (2010). Mental Health (Wales) Measure. Retrieved from: http://www.legislation.gov.uk/mwa/2010/7/contents

Welsh Government (2013). Delivering Safe Care, Compassionate Care. Learning for Wales from The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Retrieved from: www.cymru.gov.uk [Accessed on: 07/05/2020]

Welsh Government (2016). *New three-year plan to improve mental health services in Wales*. Retrieved from https://gov.wales/newsroom/ healthandsocialcare/2016/mental-health/?lang=en/ [Accessed on: 05/05/2020]

Welsh Government. (2018a). *Health statistics Wales*. Retrieved from https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Admissions-to-Mental-Health-Facilities/admissionstomentalhealthfacilitiesbylhb [Accessed on: 05/05/2016].

Welsh Government (2018b). NHS Delivery Framework and Reporting Guidance. Retrieved from https://gov.wales/sites/default/files/publications/2019-03/nhs-wales-delivery-framework-and-reporting-guidance-2018-2019.pdf [Accessed on 07/05/2020]

Welsh Government (2020). Sickness absence in the NHS in Wales, quarter ended 30 June 2019. Retrieved from: https://gov.wales/sites/default/files/statistics-and-research/2019-11/sickness-absence-nhs-april-june-2019-439.pdf

Wisdom, J. & Creswell, J.W. (2013). Mixed Methods: Integrating Quantitative and Qualitative Data Collection and Analysis While Studying Patient-Centred Medical Home Models. Rockville, MD: Agency for Healthcare Research and Quality. February 2013. AHRQ Publication No. 13-0028-EF.

Wren, B., Michie, S. (2003). Staff experience of the Health Care System. In Llewellyn, S., Kennedy, P. (Eds.) (2003). *Handbook of Clinical Health Psychology.* Oxford: Wiley.

Wright, B. (2004). Compassion fatigue: how to avoid it. *Palliative Medicine, 18*(1), 3-4.

Empirical Paper Appendices Index

Appendix 1.

Table 1. Key elements of Compassion-Focused Group sessions content

Sessions	Key elements
1. Introduction	• Introduction to the concept of compassion • Discussion of the group's understanding and current relating to compassion
2. Psychoeducation	• Three affect-regulation system (threat-drive-affiliative) • Old brain and new brain • 'It's not our fault' we do our best to cope with our experiences and tricky brain • Awareness of how we talk to ourselves
3. Compassion and Imagery	• Learning to be compassionate towards feelings rather than avoid them • Differentiation between compassion to giving compassion to yourself, to others and receiving compassion • Practice of compassionate ideal
4. Imagery	• Practice of relating to compassionate object to generate feelings of warmth and kindness
5. Reflecting on learning & practice	• Reflection on practices and learnings
6. Drawing it together& ending	• Compassionate letter writing. • *

*Low numbers in last sessions did not warrant a full group session

Appendix 2.

Table 1. Proposed criteria and critical feasibility outcomes

Criterion	Critical feasibility outcome	Other feasibility and acceptability data relevant to the criterion	Proposed thresholds on critical outcome	Outcome
1) Recruitment rate	Number of participants consented to take part in the intervention.	- Number of participants contacted and invited to take part (including number placed on work rota), - Number of participants eligible to take part, - Reason for non-eligibility or withdrawal of interest.	🟢 Feasibility will be demonstrated where at least 80% of the participants invited to the intervention consented to take part (i.e. attended 1st session). 🟡 If at least 50% of the participants consented, then a future intervention will be feasible but additional strategies to support recruitment (e.g. informed by other relevant feasibility data). 🔴 Feasibility will not be demonstrated if less than 50% of the invited participants consent.	🟢 Out of the 14 originally approved to attend the programme, 12 consented to attend (86%) and attended the first two sessions. 2 individuals attended no sessions (14% attrition).
2) Intervention retention	% who dropped out	- Session record form for each session of the group, - Number of sessions attended, - Qualitative interviews with participants / reason for drop out.	🟢 Feasibility will be demonstrated when at least 70% of the participants completed the intervention (i.e. attended 4 sessions or more). 🟡 If 50-70% of the participants completed the group, then a future intervention will be feasible if strategies to overcome barriers are identified (e.g. informed by data relevant to this criterion, including qualitative interviews with participants who dropped out). 🔴 If less than 50% of participants will complete the intervention, feasibility within the current design will not be demonstrated.	🔴 Out of 12 attendees that attended the first two sessions, 33% attended 4 or more sessions. Sixty seven percent attended 3 or less due a mixture of reasons incl: staff shortage, lack of protected time, annual leave, changes in rota, sickness, etc.
3) Intervention acceptability	Ratings from session-by-session rating scales filled in by the participants.	- Qualitative interviews with participants who completed and dropped out.	🟢 Feasibility will be demonstrated when at least 80% of the participants rated over 80% of the sessions as acceptable. 🟡 If 50-80% of the participants rated 50-80% of the sessions as acceptable, then a future	🟡 All participant rated sessions they attended as easy to understand, helpful and evoking positive affect. They

			intervention will be feasible if strategies to overcome barriers are identified. 🔴 If less than 50% of participants rated 50-80% (or above) of the sessions acceptable and/or, 50-80% of participants or above, rated at least 80% of the sessions as not acceptable, feasibility within the current design will not be demonstrated.	also thought of it as needed. Qualitative analysis revealed barriers in attendance & engagement with sessions content (burden due to effort required to attend if no support is in place, negative affect as a result of attending without support, time required to attend) & barriers to ability to perform behaviours taught in the intervention during work without support of the wider system (leadership and colleagues).
4) Intervention fidelity	Adherence ratings from session-by-session rating scales filled in by the group facilitators.		🟢 Feasibility will be demonstrated when over 80% of the sessions are rated as acceptable. 🟡 If 50-80% of the sessions are rated as acceptable, then a future intervention will be feasible if strategies to overcome barriers are identified. 🔴 If less than 50% of the sessions are rated as acceptable, feasibility within the current design will not be demonstrated.	🟢 Faciitators rated all of the sessions they facilitated as acceptable, in terms of participants understanding and engagement with session content. Deviation from session plan and flexibility were necessary to meet the needs of the changing number of participants.

Table 2. Demographic characteristics of group participants (*n=10*)

Characteristics	*n*	%
Gender		
Female	8	80%
Male	2	20%
Age (years)		
18-24	2	20%
25-34	3	30%
35-44	4	40%
45-54	1	10%
Ethnicity & Nationality		
White British	1	10%
White Welsh	3	30%
White English	2	20%
White Other	3	30%
Black British	1	10%
Length of time in current post		
<1	4	40%
1 - 3 years	3	30%
4 - 6 years	3	30%
Length of employment in NHS		
1 - 3 years	4	40%
4 - 6 years	5	50%
7 - 10 years	1	10%
Banding		
n/a	1	10%
3	4	40%
4	2	20%
5	1	10%
6	2	20%

Table 3. Session-by- session attendance and non-attendance with reasons (*n=12*)

			Attendance session-by-session					
Attendance rate			**Session 1**	**Session 2**	**Session 3**	**Session 4**	**Session 5**	**Session 6**
Group 1	17%	**Attendee 1**	✓	Agreement with manager to not attend the rest of sessions due to workload				
	17%	Attendee 2*	✓	Pulled out from session 1 due to staff shortage. Reasons for non-attendance afterwards not known, not heard back				
	33%	**Attendee 3**	✓	Annual leave		✓	Rota changed, not on rota to attend.	
	67%	Attendee 4	✓	✓	✓	✓	Reasons for non-attendance afterwards not known, not heard back.	
	67%	**Attendee 5**	✓	✓	Annual leave		✓	✓
	33%	**Attendee 6**	✓	✓	Annual leave and no support to attend, shortage of staff			
	50%	**Attendee 7**	Miscommunication regarding location	✓	✓	✓	No support to attend, shortage of staff	
Group 2	83%	**Attendee 8**	✓	✓	✓	✓	Off sick	✓
	100%	**Attendee 9**	✓	✓	✓	✓	✓	✓
	33%	**Attendee 10**	✓	✓	Incident on ward	Completed placement.		
	17%	Attendee 11*	✓	Unsure of reasons to non-attendance, not heard back.				
	17%	Attendee 12	✓	Did not attend rest, not consent to participate in research (no demographic/questionnaire data used).				

Note: Attendee 2* & 11* is the same person who was invited to both groups and attended session 1 of both groups. Attendees in **bold** were interviewed participants.

Appendix 3.

Figure 1. Session-by-session attendance rate

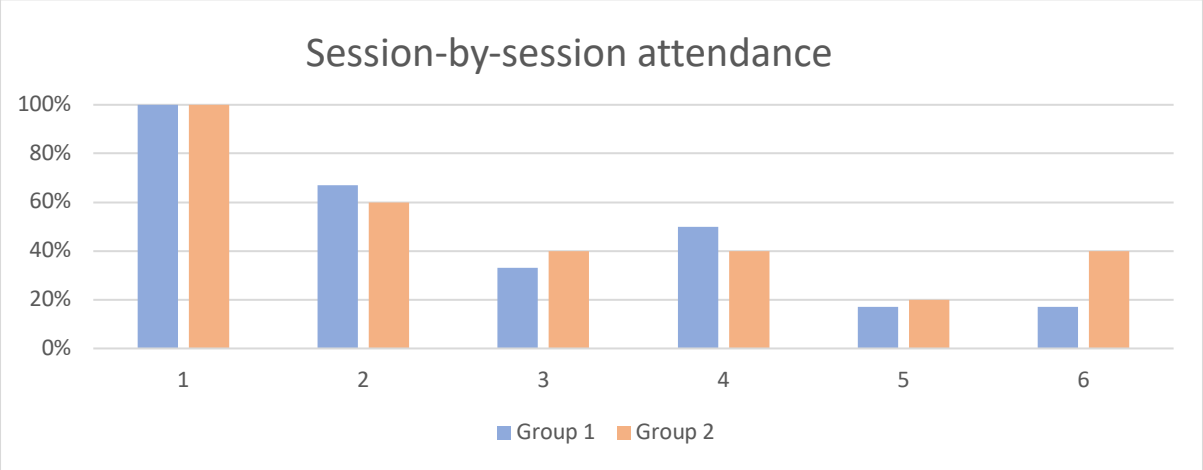


Figure 2. Groups attendance and attrition flow chart

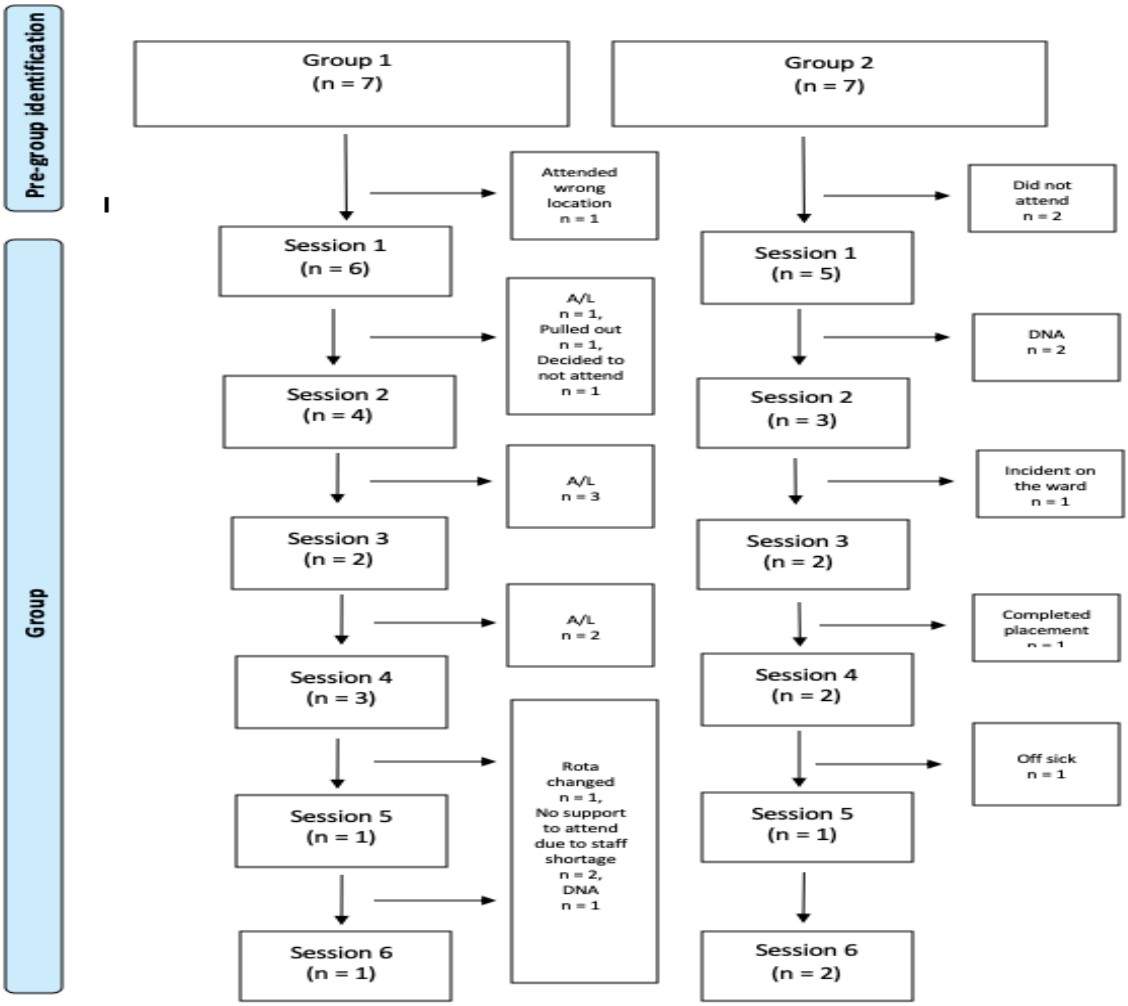
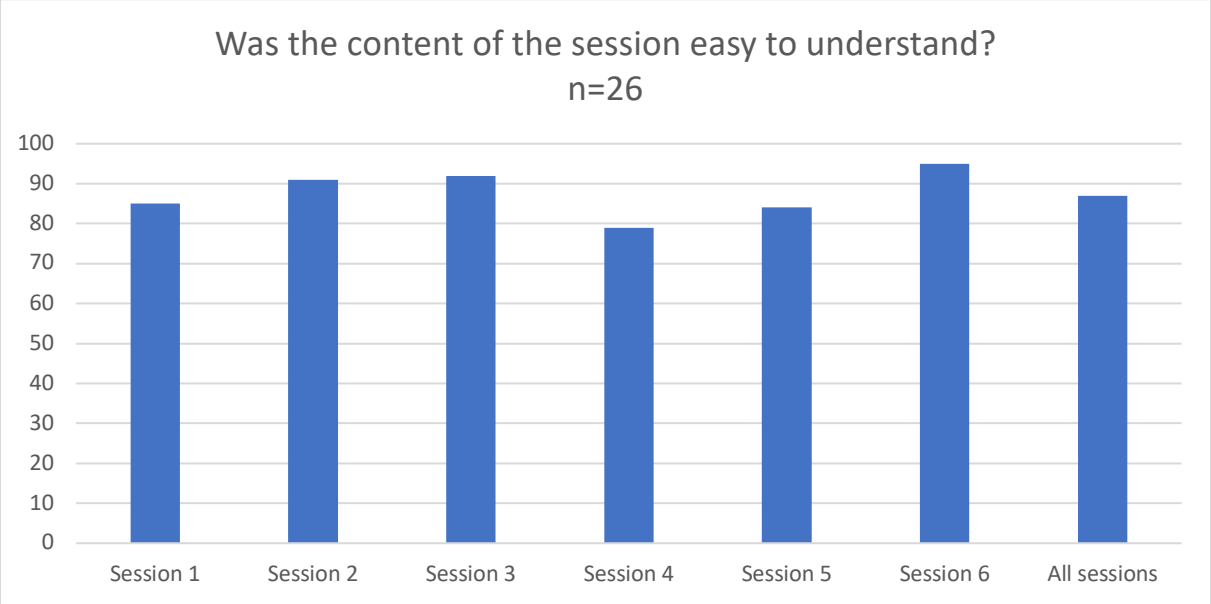
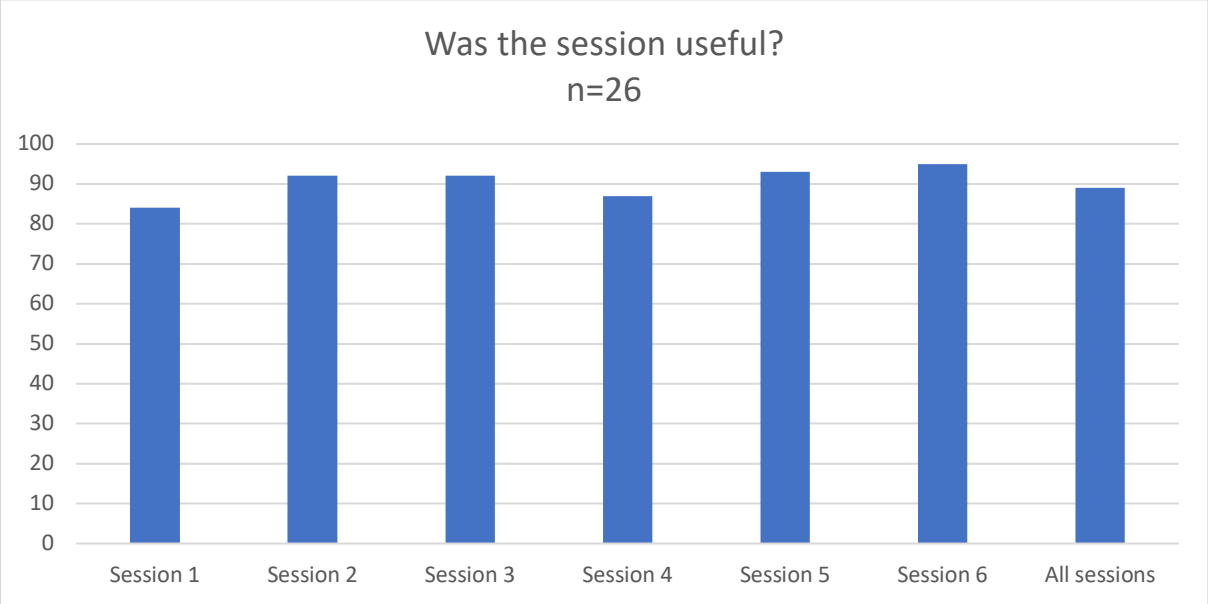


Figure 3. Session-by-session ratings of understanding



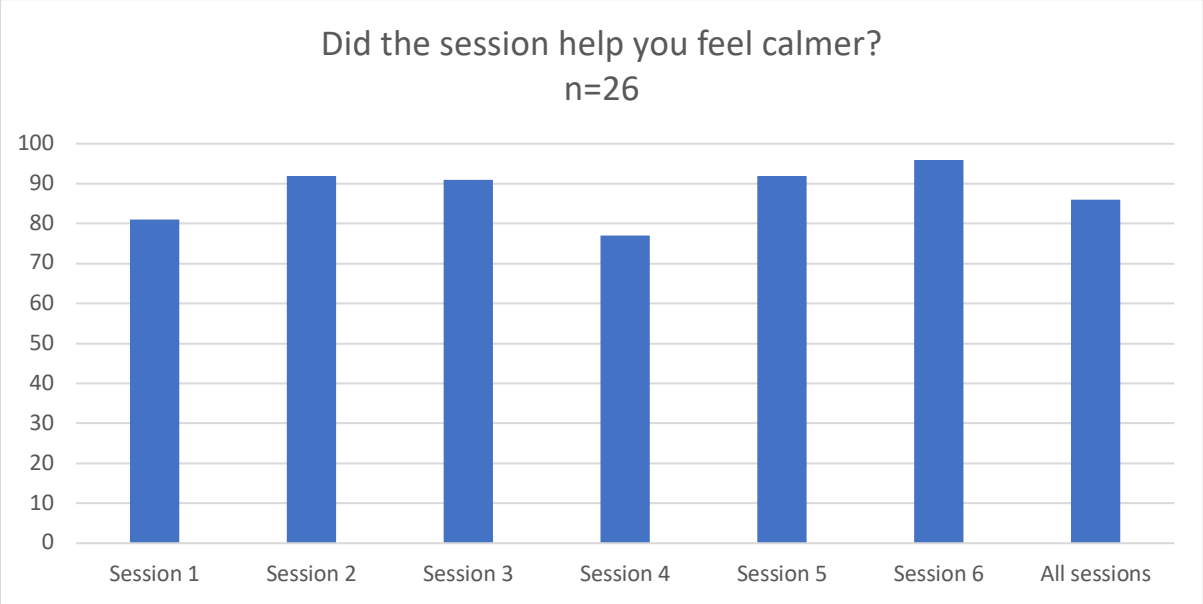
*Session one 85 (*SD*=14), two 91 (*SD*=5), three 92 (*SD*=9), four 79 (*SD*=17), sessions five and six have data only from 1 participant. Mean rating of all sessions 87 (*SD*=12)

Figure 4. Session-by-session acceptability ratings of usefulness



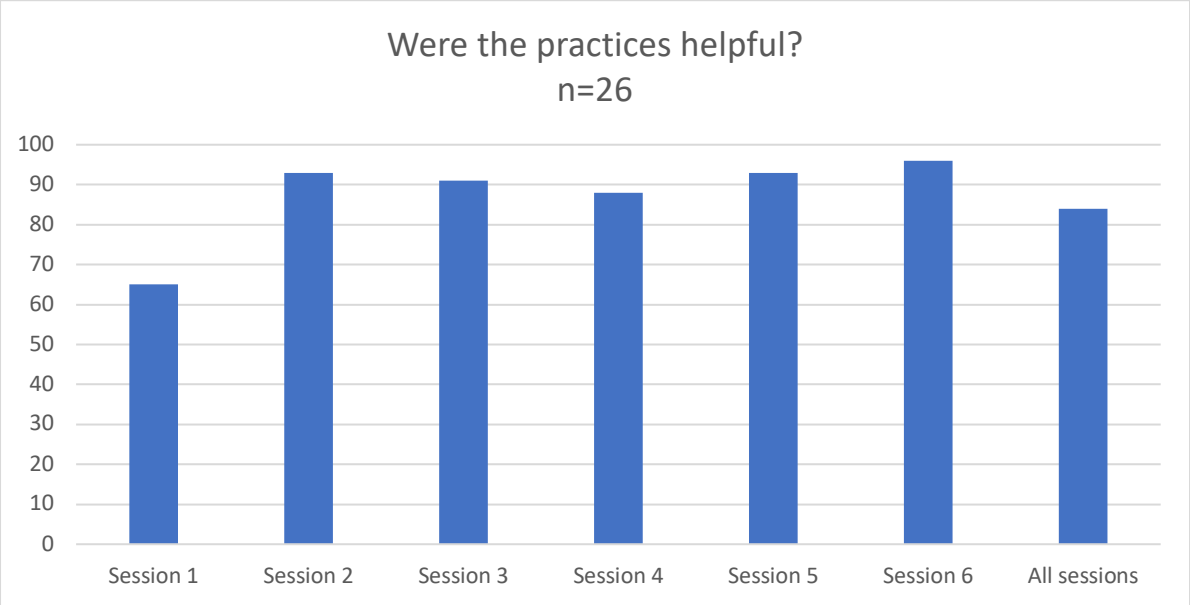
*Session one 84(*SD* =16), two 92 (*SD*=5), three 92 (*SD*=9), four 87 (*SD*=11), sessions five and six have data only from 1 participant. Mean rating of all sessions 89 (*SD*=11)

Figure 5. Session-by-session acceptability ratings of feeling calmer



*Session one 81(*SD* =20), two 92 (*SD*=8), three 91 (*SD*=8), four 77 (*SD*=18), sessions five and six have data only from 1 participant. Mean rating of all sessions 86 (*SD*=15)

Figure 6. Session-by-session ratings of helpfulness of practices



*Session one 65(*SD* =29), two 93 (*SD*=5), three 91 (*SD*=8), four 88 (*SD*=8), sessions five and six have data only from 1 participant. Mean rating of all sessions 84 (*SD*=20)

Figure 7. Facilitators session-by-session feasibility and acceptability ratings

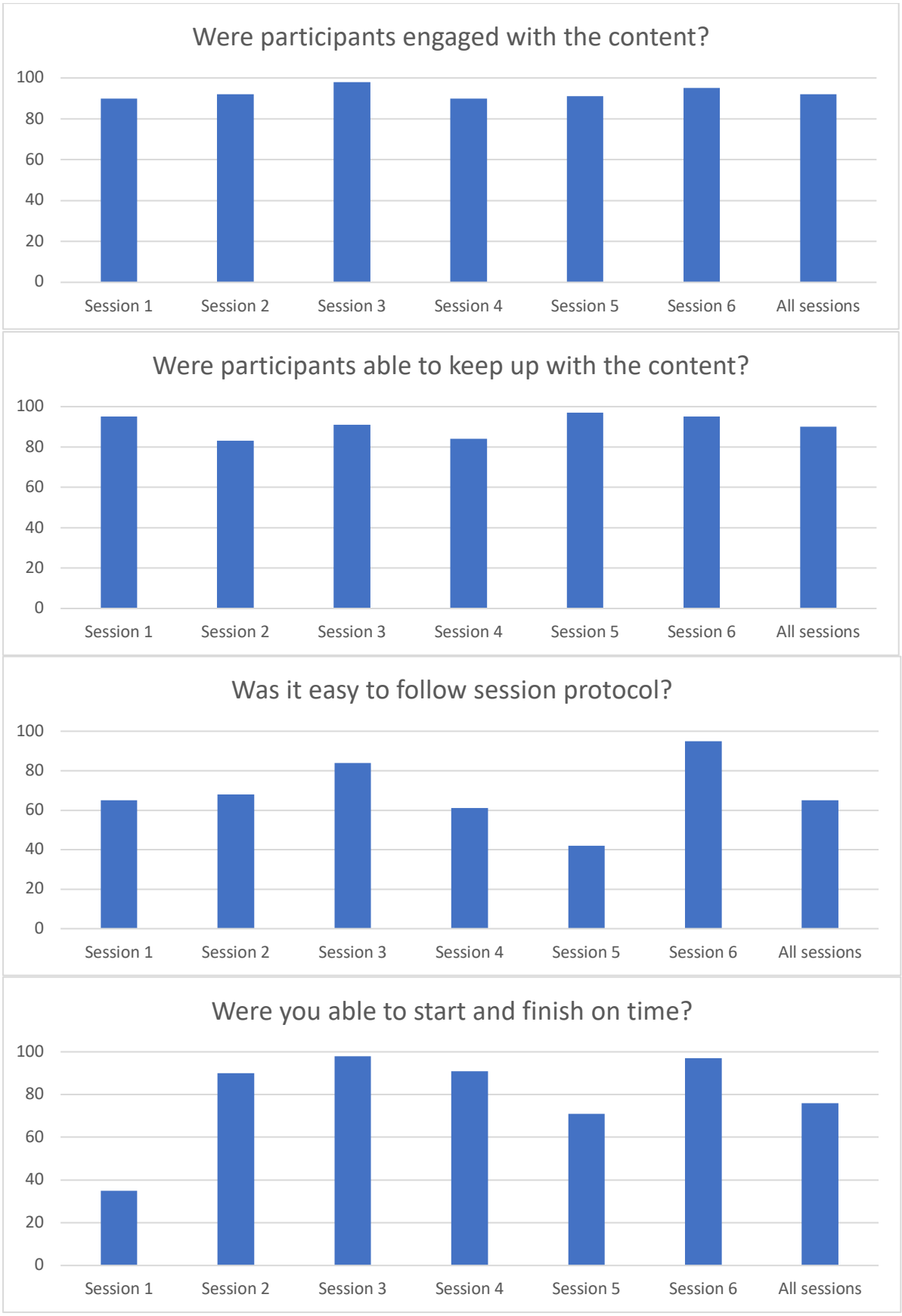
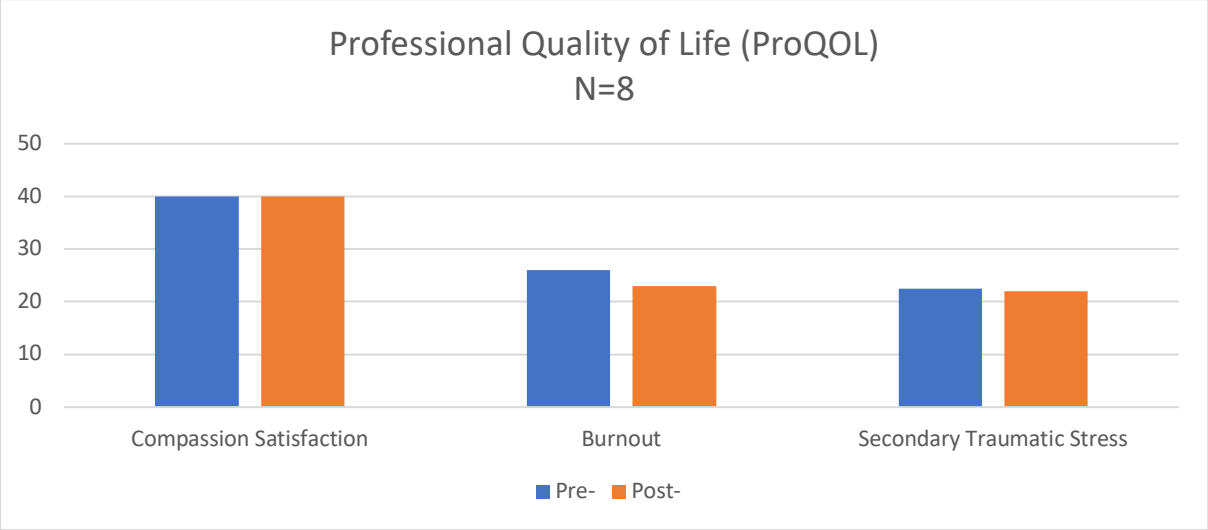
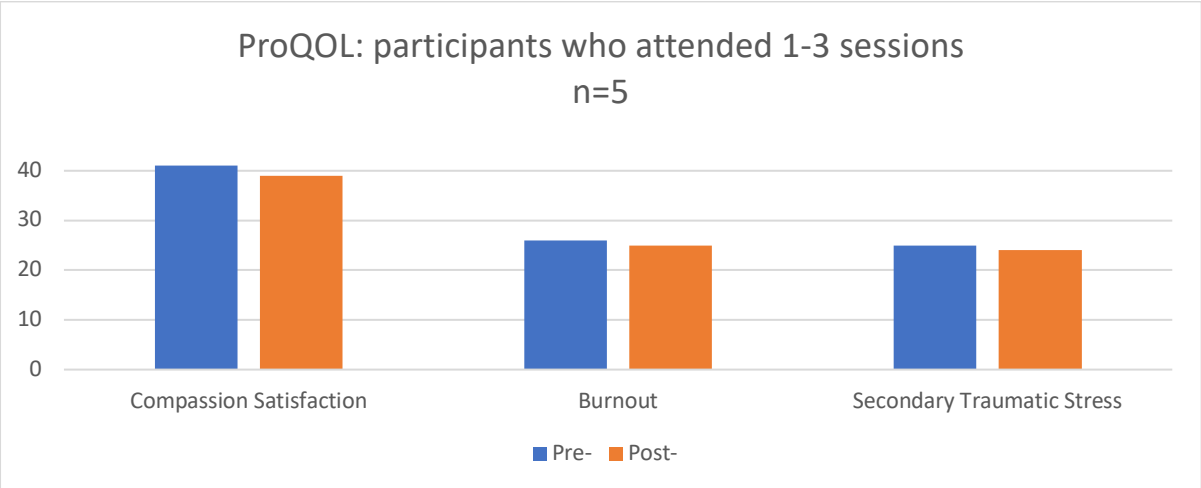


Figure 8. Pre- and post- intervention ProQOL outcome measures



***Pre:** CS=40 (*SD*=2.31), BO= 26 (*SD*=5.46), STS=22.5 (*SD*=7.31); **Post:** CS 40 (*SD*=2.77), BO= 23 (*SD*=5.58), STS=22 (*SD*=5.82)



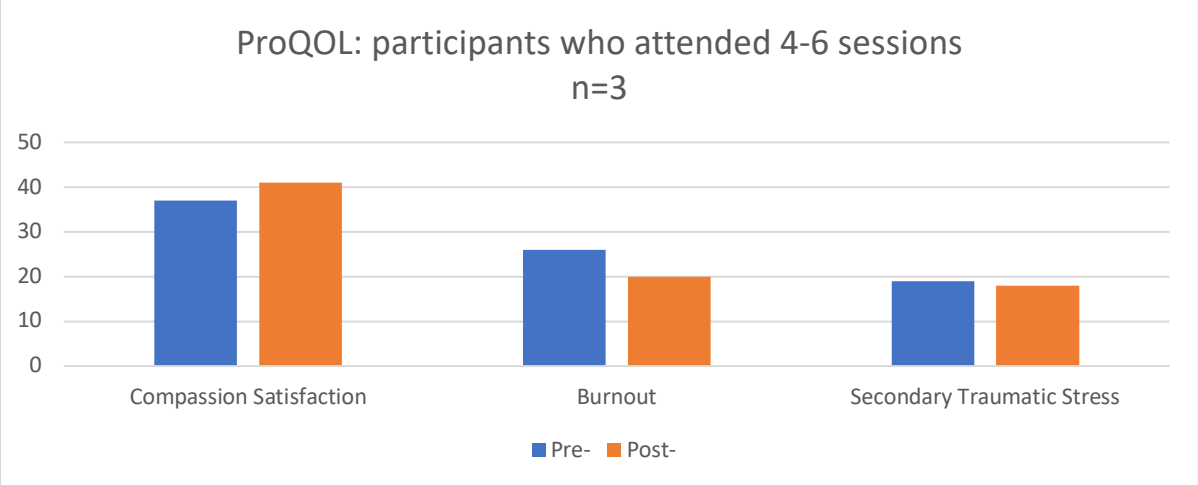
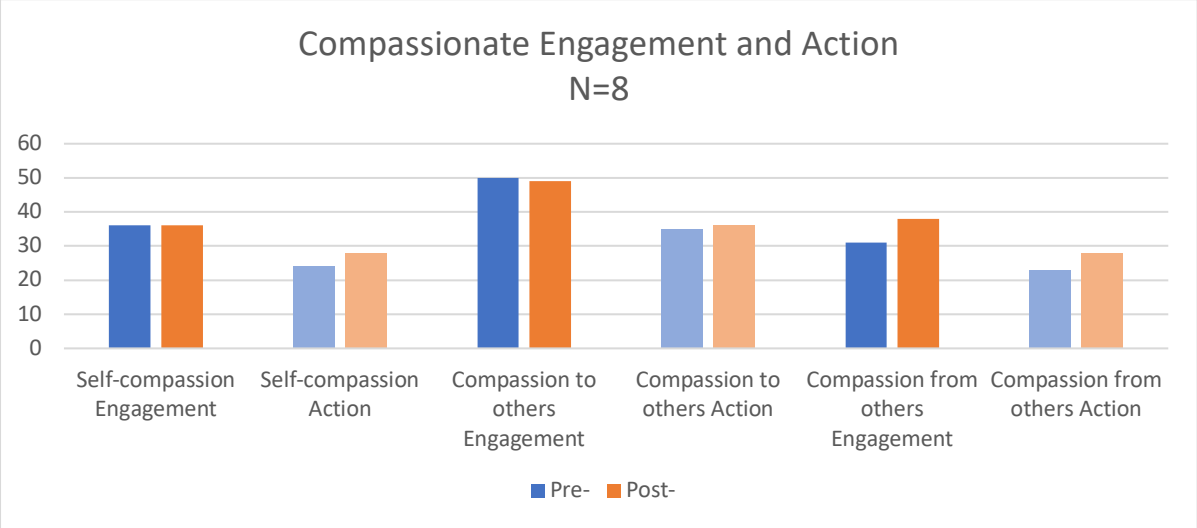
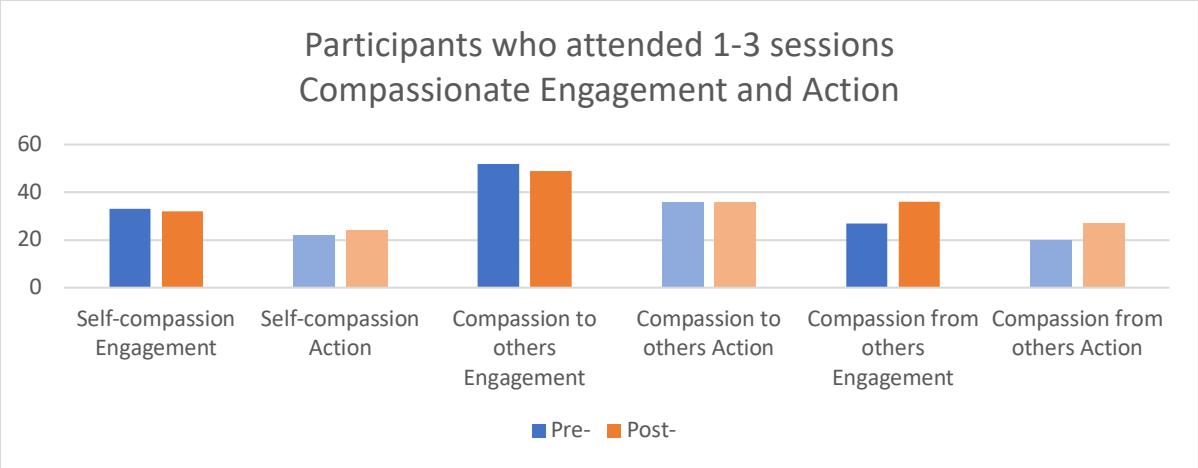


Figure 9. Pre- and post- intervention Compassionate Engagement and Action Scale



***Pre:** Self-compassion Engagement= 36 (*SD*=8.59), Self-compassion Action= 24 (*SD*=8.03), Compassion to Others Engagement= 50 (*SD*=6.05), Compassion to Others Action= 35 (*SD*=3.62), Compassion from Others Engagement= 31 (*SD*=6.92), Compassion from Others Action= 23 (*SD*=8.48); **Post:** Self-compassion Engagement= 36 (*SD*=8.48), Self-compassion Action= 28 (*SD*=9.5), Compassion to Others Engagement= 49 (*SD*=5.90), Compassion to Others Action= 36 (*SD*=3.02), Compassion from Others Engagement= 38 (*SD*=8.30), Compassion from Others Action= 28 (*SD*=7.75)



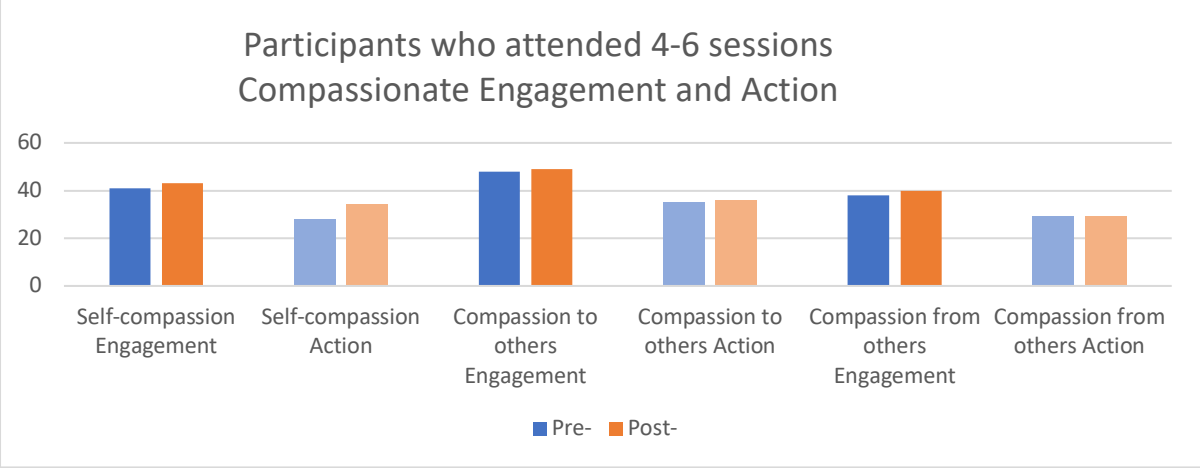
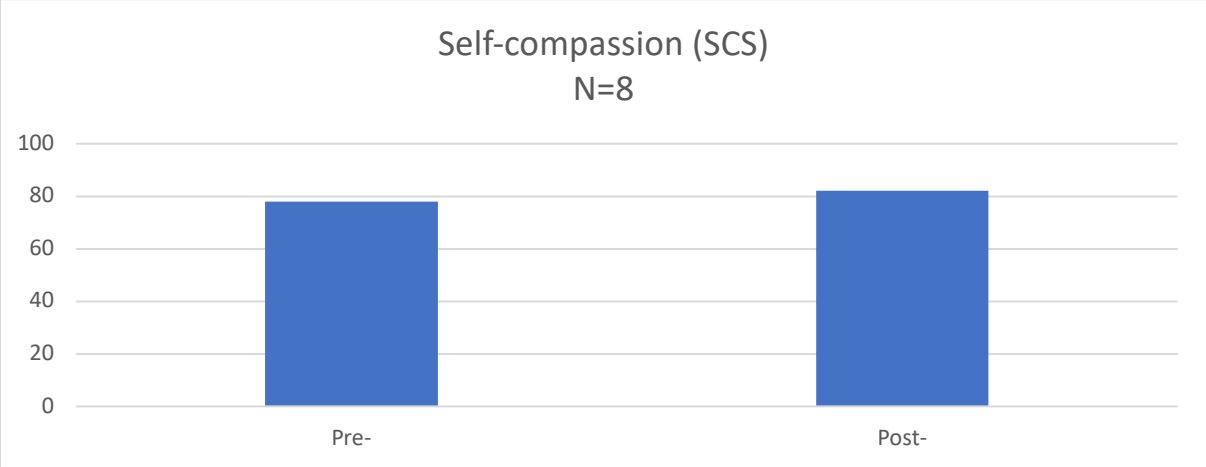
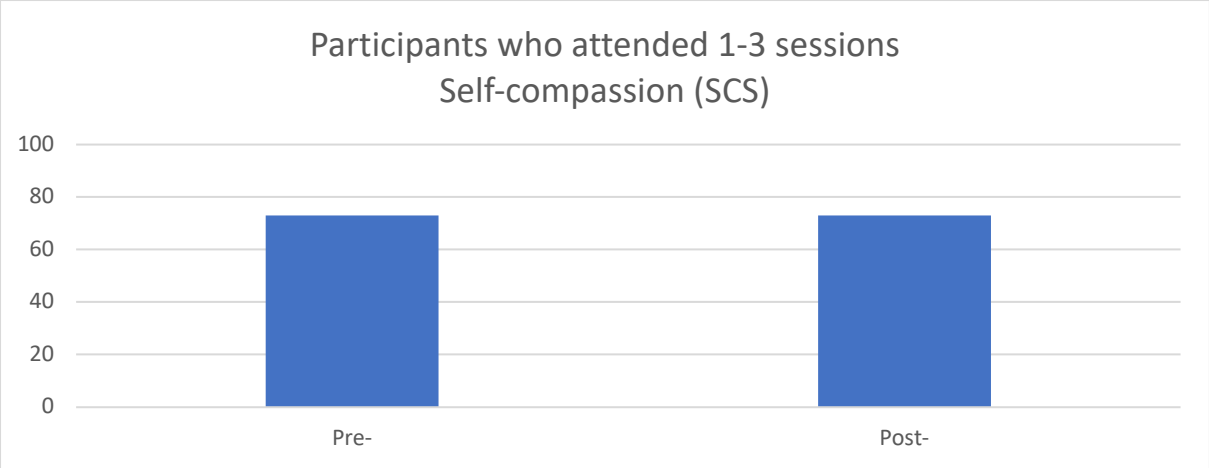


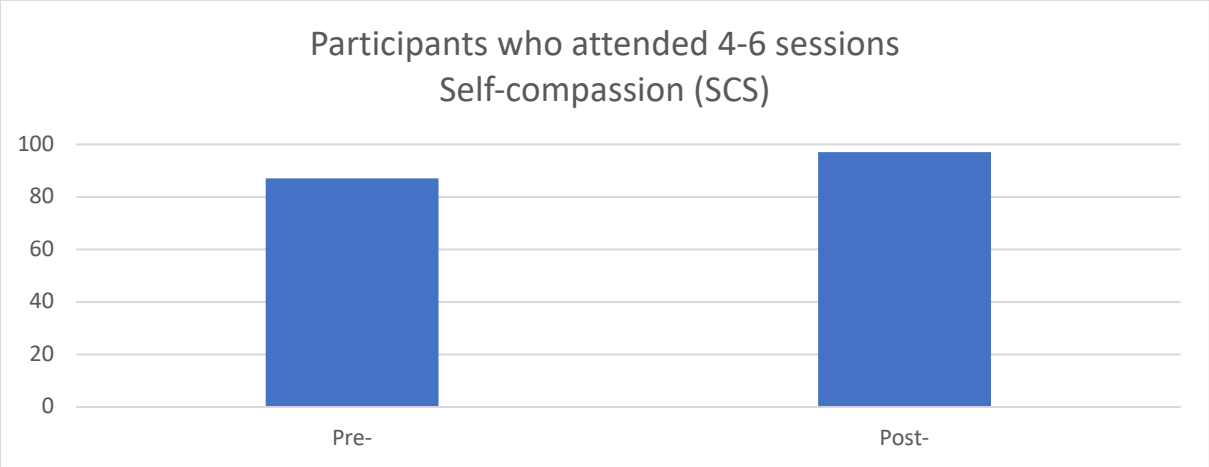
Figure 10. Pre- and post- intervention Self-compassion (SCS) measure



***Pre:** SCS= 78 (*SD*=20.79); **Post:** SCS= 82 (*SD*=20.24)



***Pre:** SCS= 73 (*SD*=25.17); **Post**: SCS= 73 (*SD*=20.94)

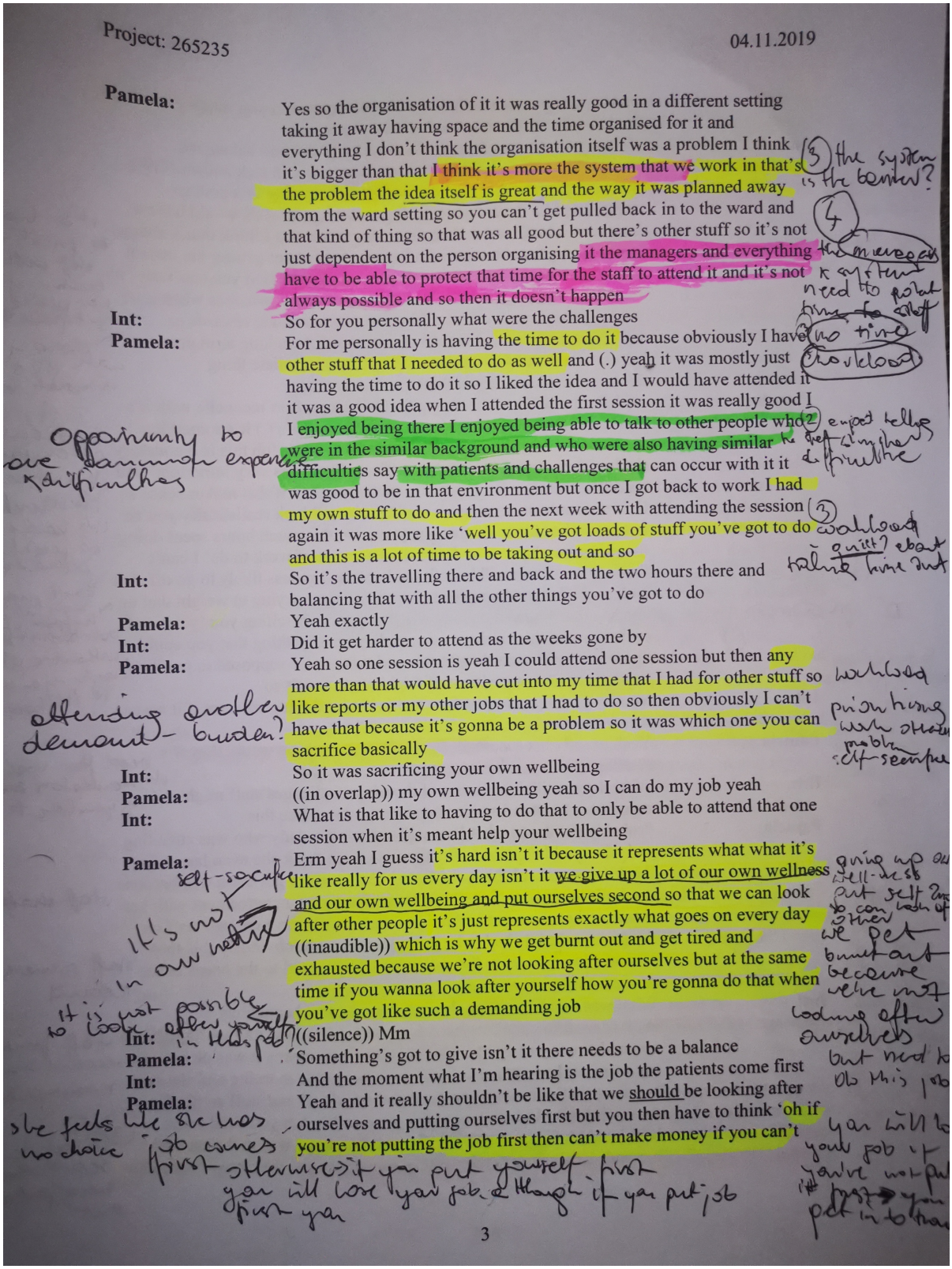


***Pre:** SCS= 87 (*SD*=8.96); **Post:** SCS= 97 (*SD*=6.24)

Appendix 4. Six steps of Thematic Analysis (adapted from Brown & Clarke, 2013)

Stage 1	Transcription of eights interviews. Familiarisation with data – each interview transcript read several times. Taking notes of items of potential interest relating to study aims.
Stage 2	Complete coding across entire data set i.e. across eight interview transcripts. Preliminary identifying codes that are repeated across data set. Collating codes with data extracts into master coding table.
Stage 3	Searching for themes. Collating and grouping codes together searching for similarities and patterns. Identifying provisional themes and subthemes.
Stage 4	Reviewing candidate themes. Producing visual thematic maps to explore themes and relationships between them. Identifying a potential overarching theme. Returning to the codes to ensure codes fit the central organising concept of each theme and that themes capture well and reflect the entire data set.
Stage 5	Defining and naming themes. Ensure themes have a clear central organising concept, definition, short name. Participants' quotes were used to name themes. Data analysed in a detailed manner, ensuring it reflected the narrative of the data set.
Stage 6	Finalising the analysis. Produced written report with data extracts clearly representing the themes and subthemes and capturing the overarching narrative of the entire data set.

Appendix 5. Interview transcript extract with comments and initial codes



Project: 265235 04.11.2019

Pamela: Yes so the organisation of it it was really good in a different setting taking it away having space and the time organised for it and everything I don't think the organisation itself was a problem I think it's bigger than that I think it's more the system that we work in that's the problem the idea itself is great and the way it was planned away from the ward setting so you can't get pulled back in to the ward and that kind of thing so that was all good but there's other stuff so it's not just dependent on the person organising it the managers and everything have to be able to protect that time for the staff to attend it and it's not always possible and so then it doesn't happen

Int: So for you personally what were the challenges

Pamela: For me personally is having the time to do it because obviously I have other stuff that I needed to do as well and (.) yeah it was mostly just having the time to do it so I liked the idea and I would have attended it it was a good idea when I attended the first session it was really good I I enjoyed being there I enjoyed being able to talk to other people who were in the similar background and who were also having similar difficulties say with patients and challenges that can occur with it it was good to be in that environment but once I got back to work I had my own stuff to do and then the next week with attending the session again it was more like 'well you've got loads of stuff you've got to do and this is a lot of time to be taking out and so

Int: So it's the travelling there and back and the two hours there and balancing that with all the other things you've got to do

Pamela: Yeah exactly

Int: Did it get harder to attend as the weeks gone by

Pamela: Yeah so one session is yeah I could attend one session but then any more than that would have cut into my time that I had for other stuff so like reports or my other jobs that I had to do so then obviously I can't have that because it's gonna be a problem so it was which one you can sacrifice basically

Int: So it was sacrificing your own wellbeing

Pamela: ((in overlap)) my own wellbeing yeah so I can do my job yeah

Int: What is that like to having to do that to only be able to attend that one session when it's meant help your wellbeing

Pamela: Erm yeah I guess it's hard isn't it because it represents what what it's like really for us every day isn't it we give up a lot of our own wellness and our own wellbeing and put ourselves second so that we can look after other people it's just represents exactly what goes on every day ((inaudible)) which is why we get burnt out and get tired and exhausted because we're not looking after ourselves but at the same time if you wanna look after yourself how you're gonna do that when you've got like such a demanding job

Int: ((silence)) Mm

Pamela: Something's got to give isn't it there needs to be a balance

Int: And the moment what I'm hearing is the job the patients come first

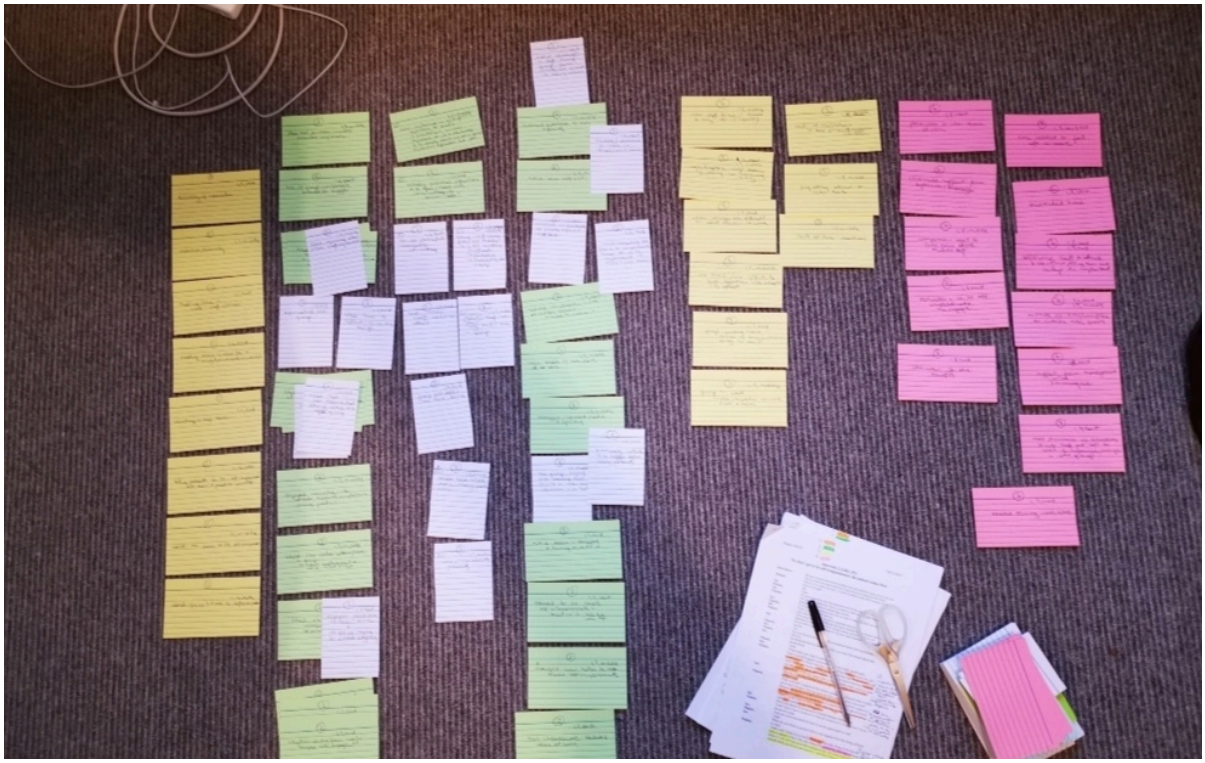
Pamela: Yeah and it really shouldn't be like that we should be looking after ourselves and putting ourselves first but you then have to think 'oh if you're not putting the job first then can't make money if you can't

Appendix 6. Collated data extracts with three example codes

Self-sacrifice	It's hard to abandon colleagues	There is no time for compassion
Anne: I think it's because it's not a common thing for staff to try look after themselves (3,6,49-55) **Beth:** You're so focused on helping everyone else cause that's in your nature working in healthcare (6,5,13) **Nona:** You're so used to putting other people first and thinking about other people it's alien to think about what's best for yourself (4,2,24-25) **Kerry:** We tend to look after everybody else before ourselves (5,3,3-4) **Poppy:** I wouldn't have the thought not as often as I probably would be talking to other people about doing it if that makes sense (1,1,31-35) **Pam:** We give up a lot of our own wellness and our own wellbeing and put ourselves second so that we can look after other people it's just represents exactly what goes on every day (2,3,32-34)	**Beth:** When you're working with unexperienced staff it's hard to leave them on the ward on their own because you've got obligations (6,5,37-42) **Kerry:** When I was on the ward it took a while to get off the ward because obviously your face is here and staff thinks you're staying and you get dragged into things and then there was twice when I couldn't attend because I was on the ward (5,2,14-17) **John:** On Tuesday mornings I've someone coming volunteering, so it was quite difficult (7,1,30) **Owain:** Just worrying on behalf of others how they're gonna cope (8,3,23) **Nona:** I feel like it would have been better if it was somewhere else because in here you are constantly wondering about how they're doing on the ward (4,5,7-9)	**Pam:** The staff never actually really get any time to look after themselves, other things take precedence over that (2,2,1-3) **Beth:** It's hard to be compassionate towards yourself and your colleagues when you just don't have the time simply […] you just like a machine 'go on go on and go on' (6,1,52-53) **Owain:** […] we don't have time as nurses to be spending time with the patients which is ridiculous (8,6,18-19) **Anne:** There's no time to be self-compassionate, there's no time to even think about it, we've go patients to look after, constantly in this drive mode (3,6,42-43) **Nona:** You don't really get time to stop and think about how you feel yourself. (4,2,8-9) **John:** I think we're all so busy that you don't really take the time to think about it from that angle (.) […] I don't really take a lot of time to think about myself in that way (7,1,25) **Kerry:** […] when I'm sat in front of the computer and I've got constant ((inaudible)) and it is constant I just learned to kind of stop for a little bit I don't do it every day but when I think about it I do (5,3,51-53)

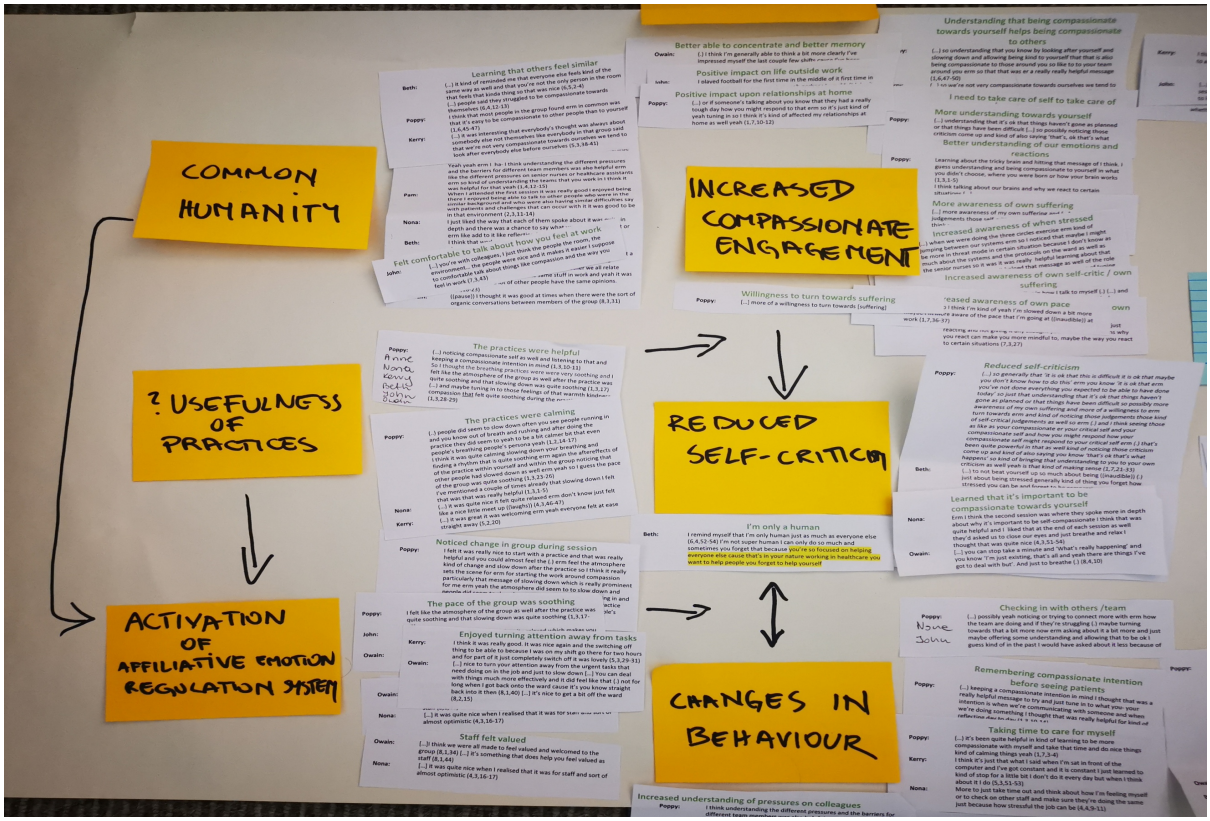
Appendix 7.

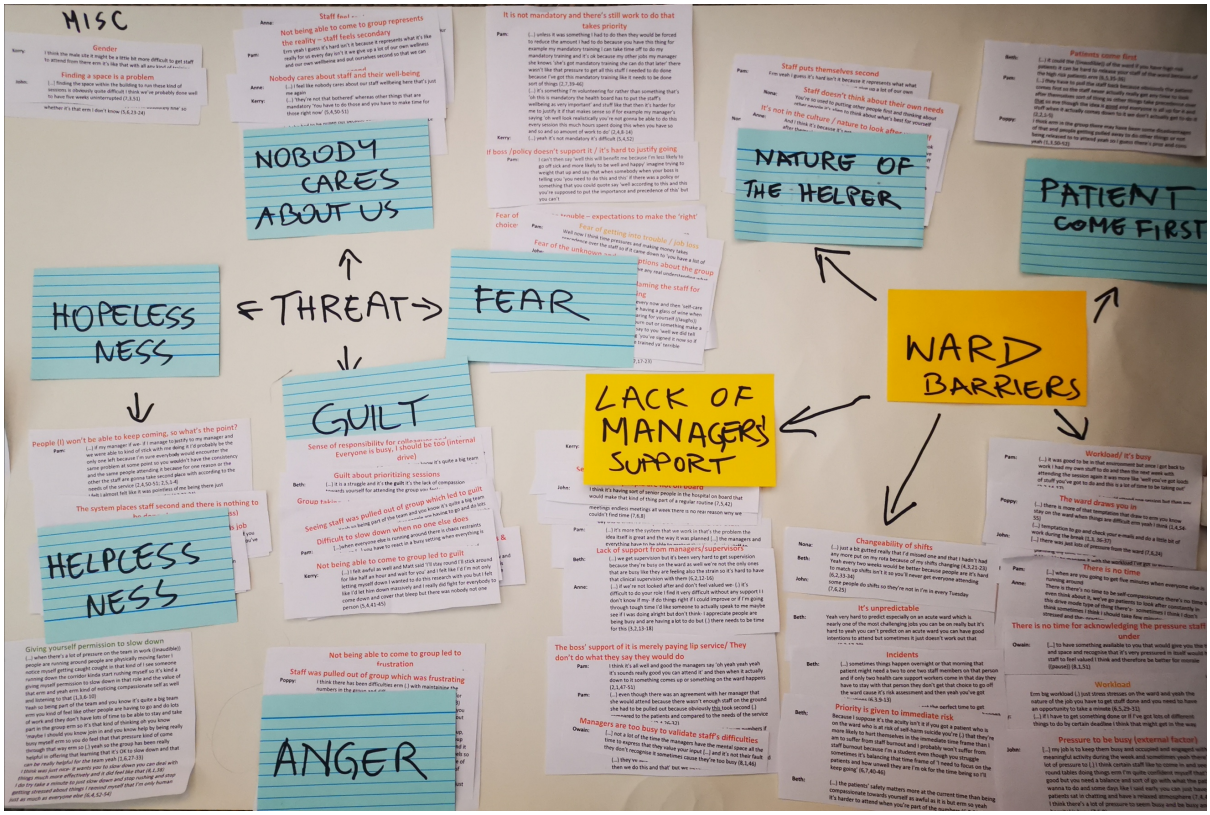
Initial codes



Generation of themes

Initial Thematic Maps with candidate themes





Appendix 8. Final Visual Thematic Map

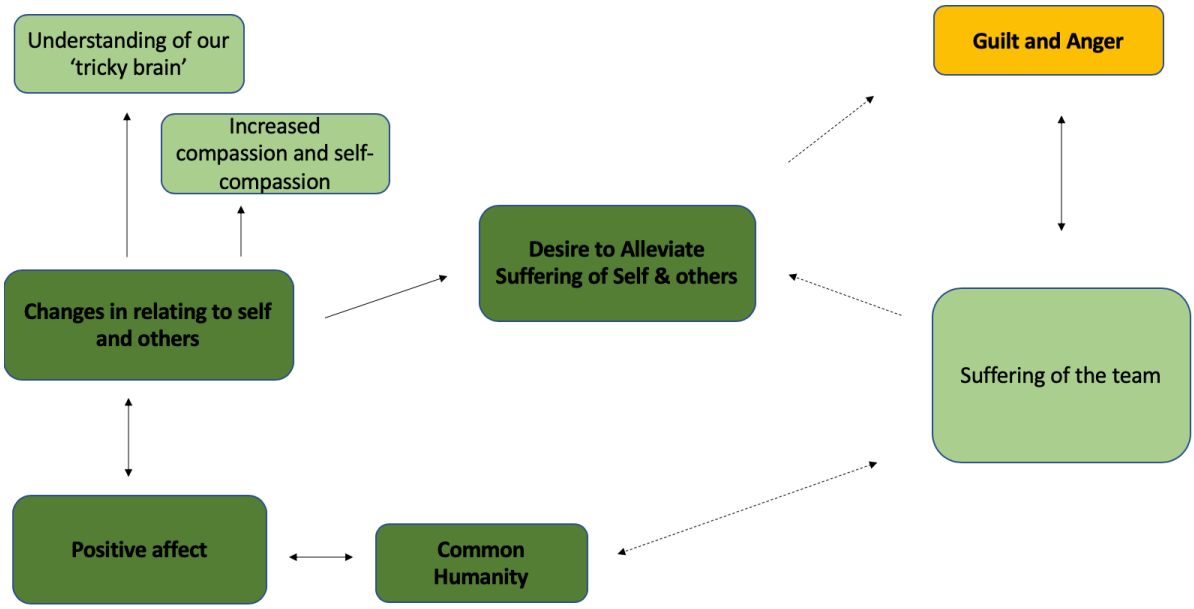


Figure 1. Thematic Map relating to participants' experience of the group

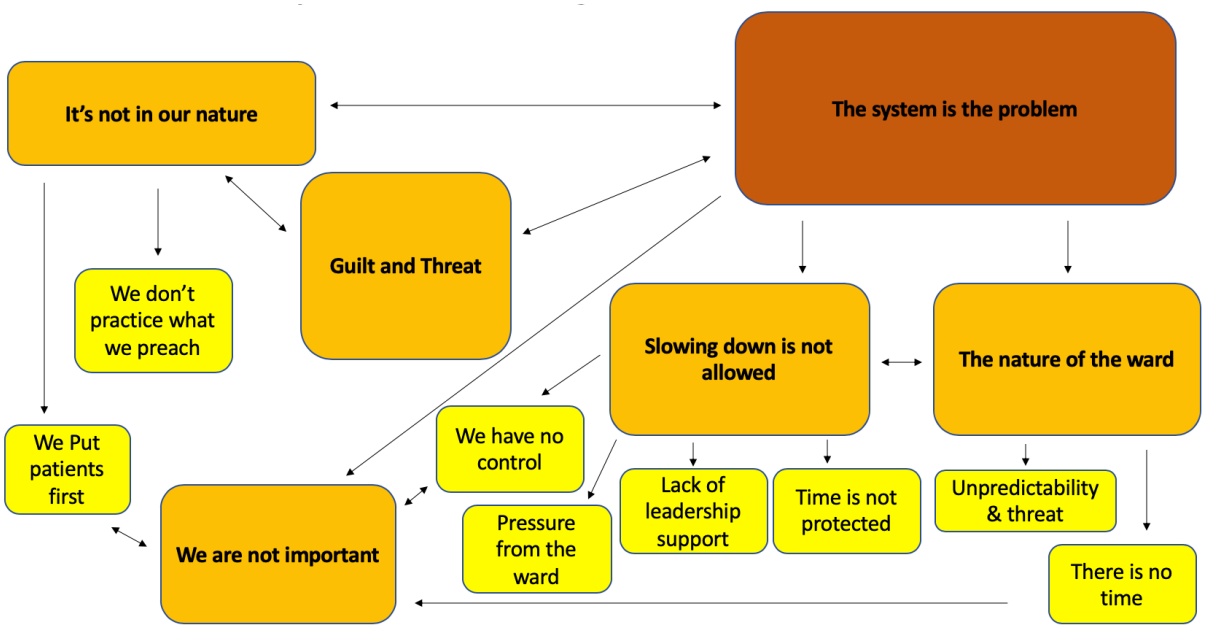


Figure 2. Thematic Map relating to reasons for attrition

Appendix 9. Excerpt from reflective diary

Reflections on Interview No 5 15th November 2019

Before:

- Finally managed to schedule this interview! It took a lot of back and forth e-mailing to try and find an appropriate time and location. I notice feeling guilty for taking up her time, she clearly is so busy…
- I wonder how she feels about the interview? Is she feeling pressurised into it? Is she being compliant? Better double check consent at the start…
- We agreed to do it on the ward. She said there might be interruptions, she might be called out of the room, I say that this is fine, I can be flexible and we can do this in chunks.
- I'm expecting to be on the ward for a few hours. I'm going to bring my lunch just in case…

After:

- I didn't wait long in the reception. She seemed rushed but very friendly and warm. I warmed up to her straight away.
- She said she was about to send me a message saying that it was not a good time as they had an emergency on the ward and are short staffed. She is very apologetic about this. I felt sympathy. My heart sank but I was expecting this might happen.
- I sensed she felt guilty by her tone of voice. Was my disappointment visible? I say that this is not a problem, that I understand, that it's not her fault.
- She said she might be free later but she can't say when. I explained that I was prepared for it, that I have my laptop and lunch and I don't mind just doing my work and wait until she's free. We can do it in chunks. She looked relieved and more relaxed.
- She took me to a small room, is this the nursing station? It was tiny, long desk along the wall with a few desktop computers. Tiny window. Cluttered and untidy
- There was a nurse sitting here. Very friendly. She said she prefers to be on the ward than in this room, she doesn't like it in here. I can't blame her. I'm noticing my own judgements about this room. Is it not possible to have a room for staff a bit more welcoming and pleasant? Or at least tidier?
- One note on the wall draws my attention – it's a 'Thank you' from a patient complimenting the care they received on the ward, with an e-mail attached to it, guessing from a manager saying "Well done all staff. You all work so hard" I thought this was a lovely recognition but felt sad. One note about the quality of care someone barely noticeable in this cluttered tiny room no one wants to be in…
- I only managed to sit down and log into my computer when she arrives with two cups of tea saying she's free now. I notice my surprise as it was completely unexpected by me? Is this what it is like normally? Or were her worries about time overestimated? Was she just preparing for the worst? Assuming she won't be able to make it based on past experience? Or was she feeling so guilty about me she made arrangements? Or the busy times peak and trough and I was lucky…

- Her responses were thoughtful. I sense frustration about losing protected time she had and staff had on the ward, she is frustrated with senior management in the hospital for not supporting her so that she could go to the session
- I notice myself feeling sad and thinking 'I've heard this before' this might be a theme…
- She talked about guilt, feeling she'd let herself down and others down for not being able to get to the group. But there is also sense of guilt for leaving ward to go to group

  Is she feeling like this about being in the interview? I noticed myself feeling anxious about this interview being interrupted any time. And guilt for interviewing her here at work. I felt like asking more questions but I was keeping her out of the ward. Is she thinking this or is it just me?
- How this and other interviews would have been different if they took place elsewhere, not on the ward? Is this a good thing because all the emotions and thoughts present are more accessible whilst on the ward? Or would their responses be different if they weren't on the ward and had more physical distance and separation from what's going on the ward?
- How is the fact that I'm taking on so much of this anxiety and guilt affect the research and my analysis? Am I going to pick up on something I wouldn't have and it's mine not theirs and the analysis is through that lens? Am I picking up this threat (guilt, anger, anxiety) because they're in it, this is what they are saying and experiencing?

Section 4: Contribution to Theory and Clinical Practice

Summary of Findings

The literature review suggested that there are a number of factors that can maintain or promote higher compassion satisfaction in mental health professionals, which are: engagement with self-care practices in and outside of the workplace, workplace support and sense of belonging, sense of competence, cognitive components of empathy and sense of autonomy within work. The review highlighted a lack of consistency in the definition of the construct of self-care and subsequently how self-care was measured. The review also highlighted a lack of interventions for mental health professionals explicitly measuring the effect of such interventions on their compassion satisfaction.

Some of the reasons for paucity in research investigating interventions for mental health staff may be found in the empirical study. The study highlighted many barriers participants had encountered to attending a compassion-focused group for inpatient mental health staff. The barriers related to organisational issues, workplace culture and individual factors which may have prompted feelings of guilt, threat and unimportance for the participants, subsequently contributing to difficulties with attending. In spite of this, the empirical paper proposes that a compassion-focused group may be an acceptable intervention for inpatient mental health staff once the barriers are addressed. Participants who did attend reported positive experiences and benefits from practices which cultivated compassion for self and others and facilitated affiliative relating.

The findings from the literature review and empirical paper raise several implications for future research, theory development and clinical practice.

Implications for Future Research and Theory Development

Definitions of self-care, self-care measures and self-care barriers

Self-care is widely encouraged due to playing a vital role in in maintaining or enhancing well-being and preventing ill health in the general population (Greaves & Campbell, 2007) and in individuals with physical and mental health problems (Lucock et al., 2011). Considering the particularly difficult nature of their role, mental health professionals are susceptible to experiencing negative consequences of their work as a helper. Self-care and coping behaviours have been identified as factors that may be helpful in reducing or preventing these negative consequences (Richards, Campenni & Muse-Burke, 2010; Turgoose & Maddox, 2017; Wise, Hersh & Gibson, 2012). The literature review highlighted that there has been an interest in investigating the role of self-care in maintaining and enhancing compassion satisfaction in mental health professionals. The findings suggest that self-care can help maintain or promote compassion satisfaction, a factor that may buffer or protect from burnout and compassion fatigue. However, it also highlighted an issue with what constitutes self-care and how it is measured, which has been identified in literature on self-care before (Lucock et al., 2011). The studies included in the literature review used different measurements of self-care, from checklists to scales and questionnaires, with varied degree of reliability and mixing different aspects of self-care (e.g. engaging with trauma-informed self-care practices within work, such as mindfulness or reflective practice, maintaining work-life balance, engaging with leisure and physical activities, spending time with family and friends). Future research may wish to consider using most reliable and consistent measurement of self-care and clarify which aspects of self-

care are most helpful in maintaining or enhancing compassion satisfaction. The literature highlighted the potential pivotal role self-care practices built into work time may play in enhancing compassion satisfaction and it would it be important to disentangle further exactly which aspects are most helpful (e.g. informal mindfulness sessions for staff versus group reflective practices or team formulation sessions)

Mental health professionals are required to attend to their well-being in order to maintain fitness for practice. The literature review highlighted the associations between positive perceptions of self-care and engagement with self-care. However, research may have overlooked how much autonomy within the workplace and organisational factors, such as support from the wider team and number of clinical hours, may affect the ability and the motivation to engage with self-care as well as perceiving self-care as not important enough to engage with. The empirical paper highlighted that perceptions of workplace supportiveness, perceptions of own role as a helper and expectations that stem from it (i.e. to self-sacrifice, to be 'coping well'), were all identified as barriers to engagement with self-care in the form of attending compassion-focused sessions for staff, or using self-care strategies outside of the sessions within the workplace. There is currently still insufficient evidence on what the facilitators and what the barriers are to effective self-care. More research is warranted. Future prospective studies might wish to explore whether and how workplace support, as well as which aspects of workplace support, help increase engagement with self-care behaviours and affect compassion satisfaction in mental health staff.

Social rank theory and the NHS

Working in threat-drive organisations can further exacerbate difficulties that may be possible consequences of working in mental health services, such as burnout, compassion fatigue or secondary traumatic stress. Furthermore, NHS inpatient services are hierarchical with banding and coloured scrubs helping to identify where one 'belongs' in the hierarchy. Social rank theory developed by Gilbert (as cited in Wetherall, Robb.& O'Connor, 2019), suggests that there is a relationship between the perception of social rank and mental health. A recent systematic review by Wetherall et al. (2019) indicated that perceiving oneself as having a lower rank comparing to others is associated with higher depressive symptoms. Gilbert (2001) suggested that perceiving oneself as inferior may be associated with behaving submissively. From an evolutionary point of view engaging with defensive strategies such as withdrawing, reducing efforts towards activities perceived as unsuccessful, goals perceived as unachievable, have adaptive functions. They may be a result of finding oneself in an adverse situation (Gilbert, 2001). However, this adaptive behaviour may become problematic as it may get in the way of engaging with innovative ideas and practices. The social rank theory dimensions describe ideas of inferiority and group fit (Gilbert and Alan, 1998), so how an individual perceives themselves and how they fit with others (e.g. strong-weak, insider-outsider). It may offer a further understanding of the development of mental health difficulties amongst some mental health staff and barriers to attending group staff support sessions. The empirical paper suggests that perceiving themselves as unimportant, guilt about leavings colleagues on the ward and fear about accountability may have influenced the perception of the importance of the sessions and influenced the decision not to attend. Further investigation into understanding the relationship between

how mental health staff perceive their position in their organisation and their well-being, and how these are associated with organisational outcomes, is warranted.

Social distancing, team belongingness and their relationships with compassion satisfaction and self-compassion

The literature review and empirical paper highlighted the importance of social support and sense of belongingness for self-compassion and compassion satisfaction in mental health staff. Currently NHS mental health services are required to observe social distancing and work remotely, where possible. Concerns are raised by the public and professionals bodies that social distancing may contribute to an increased sense of disconnect and loneliness. Loneliness has been linked to mental health difficulties in the general population (Mushtaq, Shoib, Shah, Mushtaq, 2014), but it is reasonable to assume that it may also affect mental health professionals working remotely. It is also unclear how the new circumstances will affect compassion satisfaction and other outcomes such as compassion fatigue and burnout in mental health professionals. Some evidence suggest that virtual meetings can lead to reduced stress due to, for instance decreased time spent travelling however may increase stress for those unfamiliar with technology (Voytenko, Arnfalk, Mont, Klintman & Voytenko, 2012). The literature review highlighted that work interference with personal life, as well as interference of personal life with work, may be associated with lower compassion satisfaction. Working remotely may appear to have the potential to affect social connectedness and to disrupt a sense of belongingness to the work team. The loss of 'informal' chats with colleagues by the kitchen kettle in between meetings and sessions with clients may affect this sense of connectedness and belongingness. This may have implications for

how professionals perceive their contributions to their community of 'helpers' and their compassion satisfaction. There has been however anecdotal reports of a paradoxical increased sense of closeness and intimacy with colleagues and those offered therapy (Gottlieb, 2020). Future research could help understand if a sense of belonging to the team can still be maintained or enhanced whilst working remotely. The current situation may provide fruitful ground for further research into the relationship between social distancing or working remotely and compassion satisfaction, as well as how work support and belongingness may be mitigating or moderating these relationships.

Implication for Clinical Practice

Social desirability and compassionate support

Compassion fatigue and burnout are prevalent in mental health staff. Compassion satisfaction and cultivating compassion may help maintain and enhance staff's well-being. However, the empirical paper suggested that some mental health staff may believe that they should prioritise others' needs, and they should be in a better position to cope with stress. This has been suggested in other literature as well (Nelson-Gardell & Harris, 2003). Recent public initiatives such as 'NHS heroes and Thursday clapping for NHS staff' may be further encouraging self-sacrifice in staff at the expense of self-care and own well-being. The identified organisational barriers to engagement with strategies and practices than can help facilitate compassion, may make it even more difficult to seek support when experiencing difficulties. These points paint a complex

picture that requires initiatives and interventions at all organisational levels, including policy and organisational approaches to: normalise experiences of staff as part of the 'human condition' and of working in threat-driven environments; facilitate time and space for staff to be able to voice their difficulties, in the context of psychological safety where they are met with compassion; facilitate practices that can help staff feel respected, connected and supported in their workplace. Literature on compassion at work highlighted that in a fast-paced culture of 'doing', where there is no time to step back, no space for reflection, distress in staff goes unnoticed and there are many missed opportunities to alleviate it (Dutton, Workman & Hardin, 2014). The group sessions in the empirical study provided staff with time and safe space where they had the opportunity to give and receive compassion, towards their own experiences. Participants reported these sessions to be helpful and beneficial. Literature and research highlights other approaches where this can be achieved, such as Schwartz Rounds (Cornwell & Goodrich2010; Lown & Manning, 2010), Balint Groups (as cited in Omer & McCarthy 2010) and Reflective Practice Groups (Graham, 2000). Clinical psychology has a key role in sharing the evidence-base and encouraging mental health services leaders and managers to protect the time for staff to facilitate group sessions so compassion to each can be experienced. This may also increase a sense of belongingness and increase perceived supportiveness of their workplace. This seems to be particularly important in a time of threat caused by a pandemic, which may impact the mental health and well-being of frontline staff (Gerada & Walker, 2020), including inpatient mental health staff (The Guardian, 2020). Opportunities to 'get together' may be a challenge, discouraged or abandoned altogether due to social distancing and fear of social judgement. Clinical psychologists have an important role to play in normalising these feelings and working

flexibly to facilitate sessions in smaller groups, with social distancing adhered to, or via virtual means.

Synthesis of workplace factors that may facilitate opportunities for mental health staff to engage with compassion and experience compassion satisfaction

The literature review highlighted a number of factors that can contribute to higher compassion satisfaction in mental health staff, for example:

- Engagement with self-care behaviours within and outside workplace,
- Sense of belonging and support within the workplace,
- Cognitive facets of empathy,
- Sense of competence,
- Sense of autonomy at work.

Facilitating group sessions for mental health staff can provide opportunities and space for reflecting on practice, thus increase a sense of competence and mastery. Sessions facilitated in a spirit of compassion and non-judgement can facilitate psychological safety enabling staff to learn from experience, share concerns about practices, as well as give and receive compassion to each other. When engaging with case discussions time should be allocated to learning from 'cases that went well' to increase a sense of accomplishment and satisfaction. Where clinicians work with complex difficulties their clients or patients may present with, every effort should be taken to reflect on and validate difficulties and point out the significance and meaning of the work they are doing, celebrating even small compassionate actions that matter to staff and clients. Time should be allocated for discussions of clients who may pose challenges for the

team which can contribute to ‘splitting’ of the team. Compassionate staff support can encourage engagement with activities that involve perspective taking and compassion towards the client and members of the team. Separate time should be allocated for offering staff the opportunity to engage with self-care, such as compassion-focused staff support sessions or mindfulness sessions that can help with affect regulation through formal practice and affiliative relating to other colleagues.

There are numerous potential benefits of such sessions for staff, including increased compassion satisfaction and compassion to self and others within the workplace. However, the empirical paper also highlighted numerous barriers that should be considered in clinical practice as they may affect staff’s engagement with staff support sessions that are ‘non-mandatory’. These barriers might be applicable to all staff support sessions, not limited to those that cultivate compassion to self and others and provide a space to ‘slow down’ and reflection on experience. The barriers are of particular relevance to inpatient staff but can also apply to other NHS settings and should be taken into consideration when planning groups for staff:

- Lack of protected time due to staff shortages and workload,
- Unpredictability on the ward due incidents leading to reactiveness of the system and making it difficult to plan ahead,
- Pressure from managers and colleagues to stay on the ward due to staff numbers,
- Guilt and fear about leaving the ward due to perceived role and accountability,
- Tendency to self-sacrifice,
- Lack of control and autonomy within the workplace.

Due to these factors there is a risk of high attrition when sessions are offered and short-term staff interventions having limited impact due to the aforementioned barriers.

Nonetheless, these sessions appear to have the potential to benefit to the well-being of staff and help with staff retention. The empirical paper points to a certain paradox: some of the barriers discussed by the study participants were the exact reasons why they felt these sessions are needed. Some implications and recommendations that stem from the empirical paper are as follows:

- Raising awareness amongst policy makers, heads of services, managers on all levers and frontline staff about the organisational barriers informed by the research and other literature,
- Raising awareness amongst staff about the evidence-base for benefits of staff support sessions and offering compassion-focused staff support sessions to service leads to acknowledge pressures they are under and to help develop and enhance compassionate leadership as outlined by Atkins & Parker (2012),
- Encouraging heads of services and managers to time protect sessions for staff and encourage transparent communication about this to frontline staff,
- Offering sessions that are regular, time protected, open-ended near the ward at a time most convenient to staff, built into work time,
- Encouraging leaders to attend sessions for frontline staff to provide opportunity for perspective taking on both sides, and for leaders to model compassion, i.e. attend to staff's struggles, provide an understanding, empathise and help,
- Creative problem solving to allow opportunities for connection and compassion in the workplace whilst observing social distancing,
- Identifying opportunities for conversations cultivating compassion and incorporating them in day-to-day work,
- Supporting staff with engagement with practice of self-compassionate in daily work.

The last point is of particular relevance in current times where opportunities to connect may be discouraged and precedence given to minimising risks of virus transmission. Research on compassion (Gilbert, 2009) highlights how threat system processing can inhibit compassion. Compassion for NHS staff and compassionate leadership (Bailey & West, 2020) have been suggested to be particularly essential to make time for in the current crisis, and critical for the well-being of staff and the population that will access NHS mental services in the months and years to come.

Personal Reflections

Having worked in health care for a decade now, first as support worker in the third sector, then in NHS mental health services as a mental health practitioner, I have always been curious as to why we chose to do such a demanding job and about the impact this kind of work may have on our own well-being. I remain genuinely hopeful that it is compassion - the motivation to help and alleviate suffering, that is the underlying reasons for the chosen career path, amongst others. Therefore, on reflection his project did not start in 2019. It started many years ago… I also always wondered how many of the mental health practitioners are in fact 'wounded healers' like myself, with personal experiences of insecure attachments and, perhaps traumas in their 'informal' CVs. Working as a 'helper' perhaps makes us more vulnerable to developing mental health difficulties if the 'right' circumstances align, but I also truly believe that it creates many opportunities for developing resilience and personal and professional growth. Early on in my career in the NHS I have learned about the importance of self-care and 'practicing what you preach' to maintain my own well-being, as well as to increase my confidence and credibility as a clinician. However, I was astounded to witness how little self-care

was built-in within the workplace itself: how often there was little space in the actual building to encourage self-care; how staff mindfulness sessions were offered and soon got forgotten amongst the daily tasks and targets. I wondered why, in spite of 'forgetting' about them myself at times. I also became aware of the presence of stigma surrounding the disclosure of own struggles with mental health within the profession, an expectation that as a someone working within mental health service, you somehow should know how to cope and be a well-functioning and emotionally regulated individual. However, unless you invested private time and money into pursuing own therapy or guided self-help practices outside of work, why would you be 'more equipped' than the average person, who does not work in mental health care. Overtime, working in the reality of a busy NHS the initial satisfaction one gets from this type of work, from being able to make a difference in someone's life, fluctuates and may diminish under the heavy workload and targets within the workplace. The fact that a person found it helpful to connect in a meaningful way with you and tell their story, did not seem to matter as much as your 'numbers of contact per week, discharge and recovery rates' as a clinician. I wondered how these numbers may affect my compassion to my clients as a clinician, as time went on. Becoming a trainee clinical psychologist, with a smaller caseload, more time for personal and professional development and supervision has put me in a very privileged position to be able to reconnect with the values and reasons for entering the profession. However, the experience on placements has never allowed me to forget about the pressures my fellow mental health colleagues experience day-to-day. During the placements and training I had the privilege to work with and be supported by incredibly compassionate clinical psychologists. They inspired me to pursue my interest in applying compassionate-focused approaches to

mental health staff and give mental health staff a voice with regards to their experience of receiving compassion in their workplace.

The whole research process from meetings with my supervisors, developing the research proposal, through to applying for ethical approval, collecting data and the analysis, I found incredibly challenging and inspiring at the same time. Going through the process of applying for ethical approval was a frustrating but a necessary step that has helped me think through some of the aspects of the research I was not sure about and be in a better and more prepared position to start the research. Throughout the whole time I was acutely aware of my self-doubts in my competence to complete this project: my self-doubts about doing qualitative research and whether I am doing it 'right', doubts in my ability to write it up in a coherent manner. The support and guidance I received from my supervisors as well as self-study, have enabled me to grow in some confidence.

The context of possibly a collective trauma unfolding in front of my eyes due to the pandemic and the lockdown, added an extra 'jug' of water to my metaphorical 'stress bucket'. It made it very difficult to engage with the process of writing up my research findings. Writing does not come naturally to me at best of times. The sudden changes in my lifestyle and remote working required a lot to adjust to, as it was for many. I was acutely aware of the major reduction in people contact which took away one of my biggest coping strategies. All the support I got from my very compassionate and patient supervisors, and my interest in compassion-focused approaches and the theories underpinning it, helped me make sense of what was, and is still going on for me and others. It helped experience more acutely how being in 'threat mode' leads to all these understandable feelings and reactions, and how they may inhibit my self-compassion.

This project felt like a curse a times and a blessing at other. The very nature of this project, reminded me every day of the importance of self-care, listening to my needs and seeking support from others. Allowing myself to show my vulnerable side, the one who is struggling, to my supervisors led to receiving acceptance and compassion from them. Perhaps this experience and their understanding allowed me to find meaning in this research again which in turn helped me re-engage with writing (whilst maintaining kindness towards myself at times when it was too difficult to do). What came to light for me so strongly during this time, is our very mammalian nature, i.e. the importance of being with others to regulate our threat system, the importance and the comfort of touch and a hug in a time of distress. The very thing that is being discouraged in these strange circumstances.

Speaking to my participants, as well as the process of going through the stressful third year of training, with the 'lockdown' finale, meant that the below words never sounded more true to me: that one needs to experience compassion from others to be able to give true and genuine compassion to themselves. And in order to give compassionate care to others, you need to give it to yourself first.

Having heard the participants accounts on the relevance and helpfulness of compassion-focused groups and having paid attention to the experience of receiving compassion from my supervisors and close friends during this difficult time, helped me turn towards my own suffering and show compassion to my own self. It helped me be even more passionate about offering this same opportunity to mental health staff. I am hopeful that the silver lining in the current crisis is staff support being seen as pivotal to providing compassionate care and that it continues receiving appropriate attention, and funding, so

that in can be incorporated into planning of day-to-day service delivery. And that eventually, it will become embedded in the NHS mental health culture as time goes on.

References

Atkins, P.W.B., & Parker, S.K. (2012). Understanding individual compassion in organisations: the role of appraisals and psychological flexibility. *Academy of Management Review,* 37(4), 524–46.

Bailey, S. & West, M. (2020). Covid-19: why compassionate leadership matters in crisis. The King's Fund. Retrieved from: https://www.kingsfund.org.uk/blog/2020/03/covid-19-crisis-compassionate-leadership?fbclid=IwAR158VUhtiWuh4ThkeNazM3PYzm0t6X72b0CXGH8wDsVnG2NYrRVOYEGAbs [Accessed on 18/05/2020]

Cornwell, J., & Goodrich, J. (2010). Supporting staff to deliver compassionate care using Schwartz Center rounds--a UK pilot. *Nursing times*, *106*(5), 10-12.

Dutton, J.E., Workman, K.M. & Hardin, A.E. (2014). Compassion at work. *The Annual Review of Organisational Psychology and Organisational Behaviour*, *1*(1), 277-304 DOI: 10.1146/annurev-orgpsych-031413-091221

Gerada, C. & Walker, C. (2020). Covid fatigue is taking an enormous toll on healthcare workers. The British Medical Journal Opinion. Retrieved from: https://blogs.bmj.com/bmj/2020/05/04/covid-fatigue-is-taking-an-enormous-toll-on-healthcare-workers/?utm_campaign=shareaholic&fbclid=IwAR0wPs-UoI6rGr-0wj5Go-rFH0ecTwWZrumh5fdaQTuJQP7I3N7JKxePni0 [Accessed on 16/05/2020]

Gilbert, P. & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: an exploration of an evolutionary view. *Psychological Medicine*, *28*(3), 585–598.

Gilbert, P. (2001). Depression and stress: a biopsychosocial exploration of evolved functions and mechanisms. *Stress, 4*(2), 121–135.

Gilbert, P. (2009). *The Compassionate Mind*. Constable Robinson, London.

Gottlieb, L. (2020). The surprising intimacy of online therapy sessions during the pandemic. The Washington Post. Retrieved from: https://www.washingtonpost.com/opinions/2020/05/18/surprising-intimacy-online-therapy-sessions-during-pandemic/?arc404=true&fbclid=IwAR0YnR1QLsKkf-0n9B2afpLTn8KCSgdzgg9USJIULi0GYK7Fta0LiCZVMl0 [Accessed on 24/05/2020]

Graham, I. W. (2000). Reflective practice and its role in mental health nurses' practice development: a year-long study. *Journal of Psychiatric and Mental Health Nursing*, *7*(2), 109-117.

Greaves, C. J., & Campbell, J. L. (2007). Supporting self-care in general practice. *The British journal of general practice: the journal of the Royal College of General Practitioners*, *57*(543), 814–821.

Lown, B.A., & Manning, C.F. (2010). The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centred Communication, Teamwork and Provider Support. *Academic Medicine,* 85(6), 1073-1081.

Lucock, M., Gillard, S., Adams, K., Simons, L., White, R. and Edwards, C. (2011), Self-care in mental health services: a narrative review. *Health & Social Care in the Community*, *19*(6), 602-616. DOI:10.1111/j.1365-2524.2011.01014.x

Mushtaq, R., Shoib, S., Shah, T., & Mushtaq, S. (2014). Relationship between loneliness, psychiatric disorders and physical health? A review on the psychological aspects of loneliness. *Journal of clinical and diagnostic research: JCDR*, *8*(9), https://doi.org/10.7860/JCDR/2014/10077.4828

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare, 82*(1), 5–26.

Omer, S., & McCarthy, G. (2010). Reflective practice in psychiatric training: Balint groups. *Irish journal of psychological medicine*, *27*(3), 115-116.

Richards, K., Campenni, C. & Muse-Burke, J. (2010). Self-care and Well-being in Mental Health Professionals: The Mediating Effects of Self-awareness and Mindfulness. *Journal of Mental Health Counseling, 32*, 247-264. 10.17744/mehc.32.3.0n31v88304423806.

The Guardian (2020). My mental health ward is not equipped for coronavirus. Retrieved from: https://www.theguardian.com/society/2020/apr/14/mental-health-ward-not-equipped-coronavirus-feel-sitting-ducks-ppe?utm_source=dlvr.it&utm_medium=facebook&fbclid=IwAR18gWd8Qz7wGKzzuyywiV7_zZS4mVxmoYOZa49zlRhEA4AQ7UmlgqmiArg [Accessed on 13/05/2020]

Turgoose, D. & Maddox, L. (2017). Predictors of Compassion Fatigue in Mental Health Professionals: A Narrative Review. *Traumatology, 23*(2), 172-185. http://dx.doi.org/10.1037/trm0000116

Voytenko, Y., Arnfalk, P., Mont, O., Klintman, M., & Voytenko, Y. (2012). Potential Effects of Virtual Meetings on Employees in Swedish Public Authorities. *Management*, *33*, 276-284.

Wetherall, K., Robb, K.A.& O'Connor, R.C (2019). Social rank theory of depression: A systematic review of self-perceptions of social rank and their relationship with depressive symptoms and suicide risk, *Journal of Affective Disorders*, *246*(3), 300-319.

West, M., Eckert, R., Collins, B. & Chowla, R. (2017). *Caring to change: How compassionate leadership can stimulate innovation in health care*. Kings Fund https://doi.org/http://dx.doi.org/10.1037/a0041064

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Re-envisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, *43*(5), 487.

Section 5: Ethics Appendices Index

Appendix 1. Ethics Application to School of Psychology, Bangor University

Application for Ethical Approval

Project Title: Developing self-compassion within teams: a feasiblity study of a compassion-based intervention for mental health staff.

Principal investigator: Drobinska, Kamila

Other researchers: Oakley,David , Jackson,Mike

Pre-screen Questions

Type of Project
D.Clin.Psy

What is the broad area of research
Clinical/Health

Funding body
Internally Funded

Type of application (check all that apply)
Study in the area of health and social care requiring sponsorship from BU

Proposed methodology (check all that apply)
Other type of research, please specify. Questionnaires and Interviews
Further details: A mixed methods approach will be employed to examine the feasibility of the compassion-based intervention for staff. The participants will be asked to: 1. Complete feasibility and acceptability measures administered after each session of the intervention, 2. Attend a Focus Group that will take place after the final session of the intervention and/or a follow up individual interview, (3). Those participants who did not attend the intervention or dropped out, will also be invited to a brief individual interview to explore barriers to attending. Additionally, participants will be asked to fill in twice pre- and post- measures of self-compassion and professional quality of life to preliminary explore potential effect of the intervention, on their levels of self-compassion, and on their well-being.

Do you plan to include any of the following groups in your study?
Further details: N/A Participants will be staff working in NHS mental health services.

Does your project require use of any of the following facilities and, if so, has the protocol been reviewed by the appropriate expert/safety panel? If yes please complete Part 2:B
Further details: N/A

If your research requires any of the following facilities MRI, TMS/ tCS, Neurology Panel, has the protocol been reviewed by the appropriate expert/safety panel?
Not applicable (the research does not require special safety panel approval)

Connection to Psychology, (i.e. why Psychology should sponsor the question)
Investigator is a student in Psychology (including the North Wales Clinical Psychology Programme)

Does the research involve NHS patients? (NB: If you are conducting research that requires NHS ethics approval make sure to consult the Psychology Guidelines as you may not need to complete all sections of the Psychology online application)
No
Further details: The research involves NHS staff.

Has this proposal been reviewed by another Bangor University Ethics committee?
No

NHS checklist. Does your study involve any of the following?
Use of NHS Staff or resources e.g. recruitment through the NHS, access to Medical records, use of premises etc.
Further details: Research participants will be NHS mental health staff. Recruitment will take place through the NHS. The study will involve participating in a focus group and individual interviews

during which staff's experience of taking part in the intervention will be explored as well as barriers to attending the intervention. This will also take place on their workplace premises.

Part 1: Ethical Considerations

Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?
Yes

Will you tell participants that their participation is voluntary?
Yes

Will you obtain written consent for participation?
Yes

If the research is observational, will you ask participants for their consent to being observed?
N/A

Will you tell participants that they may withdraw from the research at any time and for any reason?
Yes

With questionnaires, will you give participants the option of omitting questions they do not want to answer?
Yes

Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?
Yes

Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?
Yes

Will your project involve deliberately misleading participants in any way?
No

Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If *Yes*, give details and state what you will tell them to do should they experience any problems (e.g., who they can contact for help)
No
Further details: It is not the aim of the focus group and interviews to discuss sensitive personal topics and it is not a reflective practice group. The focus group will focus on understanding and building coping skills, and will not involve prolonged discussions of difficult experiences, and so it is unlikely that focus group discussions about the intervention will cause distress. In the unlikely event of any of the participants becoming upset, debrief will be offered by the researcher and the participants signposted to services that offer support, if appropriate.

Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?
No

Does your project involve work with animals? If *Yes* please complete Part 2: B
No

Does your project involve payment to participants that differs from the normal rates? Is there significant concern that the level of payment you offer for this study will unduly influence participants to agree to procedures they may otherwise find unacceptable? If *Yes* please complete Part 2: B and explain in point 5 of the full protocol
No

If your study involves children under 18 years of age have you made adequate provision for child protection issues in your protocol?
N/A

If your study involves people with learning difficulties have you made adequate provision to manage distress?
N/A

If your study involves participants covered by the Mental Capacity Act (i.e. adults over 16 years of age who lack the mental capacity to make specific decisions for themselves) do you have appropriate consent procedures in place? NB Some research involving participants who lack capacity will require review by an NHS REC. If you are unsure about whether this applies to your study, please contact the Ethics Administrator in the first instance
N/A

If your study involves patients have you made adequate provision to manage distress?
N/A

Does your study involve people in custody?
No

If your study involves participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel then has the protocol been reviewed by the appropriate expert/safety panel?
N/A

If your study includes physically vulnerable adults have you ensured that there will be a person trained in CPR and seizure management at hand at all times during testing?
N/A

Is there significant potential risk to investigator(s) of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research)?
No

Is there significant potential risk to the institution in any way? (e.g., controversiality or potential for misuse of research findings.)
No

Part 3: Risk Assessment

Is there significant potential risk to participants of adverse effects?
No

Is there significant potential risk to participants of distress?
No
Further details: It is not anticipated that taking part in this research will cause participants any disadvantages or discomfort. The potential psychological harm or distress will be the same as any experienced in everyday life. For example, some discussions may bring to mind difficulties at work. Should this happen, ways of managing this will be discussed. However, the aim of the focus group is to explore the feasibility of an intervention building self-compassion and coping strategies. The interview questions are formed to enquiry about this and not to explore difficult and sensitive issues.

Is there significant potential risk to participants for persisting or subsequent illness or injury that might require medical or psychological treatment?
No

Is there significant potential risk to investigator(s) of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research)?
No

Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)
No

Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?
No

Does the experimental procedure involve touching participants?
No

Does the research involve disabled participants or children visiting the School?
No

Declaration

Declaration of ethical compliance: This research project will be carried out in accordance with the guidelines laid down by the British Psychological Society and the procedures determined by the School of Psychology at Bangor. I understand that I am responsible for the ethical conduct of the research. I confirm that I am aware of the requirements of the Data Protection Act and the University's Data Protection Policy, and that this research will comply with them.
Yes

Declaration of risk assessment The potential risks to the investigator(s) for this research project have been fully reviewed and discussed. As an investigator, I understand that I am responsible for managing my safety and that of participants throughout this research. I will immediately report any adverse events that occur as a consequence of this research.
Yes

Declaration of conflict of interest: To my knowledge, there is no conflict of interest on my part in carrying out this research.
Yes

Part 2: A

The potential value of addressing this issue

Further details: Mental health staff supports an increasingly unwell population. The nature of the work as well as the current economical and political context of the NHS creates a potentially difficult and stressful environment to be working in. Mental health staff appears to have poorer mental health with high levels of stress, burnout, compassion fatigue and impaired psychological wellbeing, including depression and anxiety. Staff's well-being is key to patients' experience, outcomes, job satisfaction, staff sickness and retention. The proposed research aims to build on the existing literature and research on the subject of compassion and interventions to increase staff's wellbeing. To date, there is little research on interventions targeting the wellbeing of staff working in mental health. Compassion-based interventions (Compassion-Focused Staff Support) are being developed by the Compassionate Mind Foundation, however there appears to be little to no published research on compassion-based interventions for staff working in mental health services to date. Given that compassionate care is currently on the agenda of NHS strategy (Health Service Ombudsman, 2011; The King's Fund's, 2009), exploring feasibility and potential benefits of compassion-based intervention for staff could be a useful area for research that can inform clinical practice in terms of developing future interventions for staff and developing compassionate care within mental health services.

Hypotheses

Further details: The main aim of the study is to explore participants experience of the development and administration of a compassion-based intervention for staff working in NHS mental health services. The aim is to investigate how feasible and acceptable such intervention is, for this staff group. There are many challenges in providing such service to staff which might affect recruitment, for example in inpatient services, unpredictability of the ward environment, limited availability of staff due to staff shortage may be a barrier to attending and therefore sustaining an intervention targeting the well-being of staff.

Participants recruitment. Please attach consent and debrief forms with supporitng documents

Further details: Participants will ideally consist of 6-12 members of staff (nurses, health care assistants, OTs, psychiatrists) working in mental health services within Betsi Cadwaladr University Health Board. It is hoped that participants will consist also of staff in leadership roles (i.e. managers and/or modern matrons). Meetings with head of services will take place to advertise the research and receive an initial approval to approach potential participants. The nature and aims of the research will be discussed in those meetings initially and then with potential participants at time convenient to them and the service. Potential participants will be supplied with an information sheet and consent form. They will be given as long as they require within the confines of the study to consider whether to take part or not. They will be informed that they may withdraw from the study without any consequences at any point.

Research methodology

Further details: A mixed methods approach will be employed to examine the feasibility of a compassion-based intervention for staff: 1. Qualitative semi-structured interview employed during a focus group and individual interviews with a small number of participants to explore their experience of the intervention, 2. Quantitative feasibility and acceptability measures administered after each session of the intervention. Additionally, pre- and post- measures of self-compassion and professional quality of life to preliminary explore potential effect of the intervention, will be administered. The trainee clinical psychologist who is the principal investigator will not be involved in the facilitation of the intervention but will faciliate the focus group/ interviews. A semi-structured interview schedule will be employed to explore participants motivation to attend, what has been learned from the sessions, what the most/least helpful part was, would participants attend such intervention again if it was offered in their service, what could be improved, etc. The interviews will aim to be around 60 minutes long, will be audio recorded, transcribed and anonymised before analysis. The collection and analysis of data during this phase will be informed by the principles of

deductive thematic analysis following Braun's and Clarke's (2006) suggestions to capture emerging themes when exploring feasibility and acceptability. The data will be analysed utilising computer software (when available) to produce sub-themes and themes.

Estimated start date and duration of the study.
Further details: It is estimated that the focus groups will take place immediately after the intervention in the Autumn of 2019, followed by individual interviews.

For studies recruiting via SONA or advertising for participants in any way please provide a summary of how participants will be informed about the study in the advertisement. N.B. This should be a brief factual description of the study and what participants will be required to do.
Further details: The study will be informally 'advertised' by the psychologist working in the service where the intervention will be rolled out. The inclusion criteria will specify that participants need to be NHS employees; working in mental health services. Participants will be presented with an information sheet about the study and a consent form.

Part 2: B

Brief background to the study

The hypotheses

Participants: recruitment methods, age, gender, exclusion/inclusion criteria

Research design

Procedures employed

Measures employed

Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)

Venue for investigation

Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).

Data analysis

Potential offence/distress to participants

Procedures to ensure confidentiality and data protection

****How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)***

Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.

Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)

Payment to: participants, investigators, departments/institutions

Equipment required and its availability

If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.

Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

Part 4: Research Insurance

Is the research to be conducted in the UK?
Yes

Is the research based solely upon the following methodologies? Psychological activity, Questionnaires, Measurements of physiological processes, Venepuncture, Collections of body secretions by non-invasive methods, The administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements
Yes
Further details: Psychological activity and questionnaires

Research that is based solely upon certain typical methods or paradigms is less problematic from an insurance and risk perspective. Is your research based solely upon one or more of these methodologies? Standard behavioural methods such as questionnaires or interviews, computer-based reaction time measures, standardised tests, eye-tracking, picture-pointing, etc; Measurements of physiological processes such as EEG, MEG, MRI, EMG, heart-rate, GSR (not TMS or tCS as they involve more than simple 'measurement'); Collections of body secretions by non-invasive methods, venepuncture (taking of a blood sample), or asking participants to consume foods and/or nutrients (not including the use of drugs or other food supplements or caffine).
Yes
Further details: Questionnaires and interview

Appendix 2. Ethical Approval from School of Psychology

Ethical approval granted for 2019-16551 Developing self-compassion within teams: a feasiblity study of a compassion-based intervention for mental health staff.

Flag for following up.

E

ethics@bangor.ac.uk
Tue 25/06/2019 14:13
Kamila Drobinska

Dear Kamila,

2019-16551 Developing self-compassion within teams: a feasiblity study of a compassion-based intervention for mental health staff.

Your research proposal number 2019-16551
has been reviewed by the School of Psychology Ethics and Research Committee
and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix 3. Bangor University Liability Insurance

TO WHOM IT MAY CONCERN

1st August 2019

Dear Sir/Madam

BANGOR UNIVERSITY AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following cover is currently in place:

PROFESSIONAL INDEMNITY

Certificate of Entry No.	UM026/95
Period of Indemnity	1st August 2019 to 31st July 2020
Limit of Indemnity	£5,000,000 any one claim and in the aggregate except for Pollution where cover is limited to £1,000,000 in the aggregate
Cover provided by	U.M. Association Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

Paul Cusition
For U.M. Association Limited

5 St Helen's Place, London EC3A 6AB | T: 020 7847 8670 | www.umal.co.uk

Appendix 4. Research Protocol included in NHS Ethics IRAS Application Form

1. **Project title**

Developing self-compassion within teams: a feasibility study of a compassion-focused group programme for staff working in NHS mental health services.

2. **Supervision:**

- Lead supervisor: Dr David Oakley, Clinical Psychologist, Ablett Unit, BCUHB
- Supervisor: Dr Carrie Way, Clinical Psychologist, Older Adult Community Mental Health Team, BCUHB.
- Academic supervisor: Dr Mike Jackson, Consultant Clinical psychologist, Head of Research, Bangor University.

3. **Background**

3.1. Introduction: Working in NHS inpatient mental health services

Working in NHS mental health can be extremely rewarding and at the same time has many challenges. The role of mental health staff, in particular those working on psychiatric wards, is to support an increasingly unwell population, often patients in acute distress, detained under section, in midst of a mental health crisis, presenting with self-harming and/or suicidal behaviour. It is not uncommon for staff to experience or witness verbal aggression or violent behaviour towards patients and staff, which may lead to interventions, such as de-escalation, restrain and seclusion (Royal College of Psychiatrists, 2005). Some reports highlight the impact of physical violence on staff mental health (Needham et al. 2005), whilst other research suggest that it is verbal aggression that may be more critical (Bowers et al. 2009; Jalil et al. 2017).

Mental healthcare staff currently working in the NHS is under a lot of pressure for other reasons as well. Two thousand staff leave NHS mental health services every month in England according to the Department of Health and Social Care (Guardian 2018). There is a nationwide difficulty with recruitment of new staff. Service are underfunded, understaffed and overstretched which leads to waiting lists for treatments (Guardian 2018). Services have financial and performance targets to meet, for example to assess and discharge service users or patients over an agreed period of time. Psychiatric inpatient services have raised thresholds for admission, with more acutely unwell and distressed patients detained under section and with a shorter length of stay. This can potentially create a less settled and stable ward environment.

NHS mental health services and how they operate, attract media interest and are under more scrutiny over the past few years, following reports on the failings of patient's care in Mid Staffordshire NHS Trust, Winterbourne, and, more locally, on the Tawel Fan ward. Concerns are being raised by service users and carers about mental health care on psychiatric wards.

In summary the nature of the work as well as the current economical context of the NHS creates a potentially difficult and stressful environment to be working in for mental health care staff.

3.2. Impact on staff wellbeing, patient experience & outcomes and the wider organisation

On the whole mental health staff appears to have poorer mental health with high levels of stress, burnout, compassion fatigue and impaired psychological wellbeing, including depression and anxiety (Salyers et al., 2013; Rossi et al., 2012; Morse et al., 2012; Wren & Michie, 2003).

Research shows that prolonged exposure to suffering and trauma in patients may lead to compassion fatigue (Figley, 1995; Wright, 2004). A qualitative study (Austin, 2009) suggested that nurses experienced compassion fatigue when they felt unable to provide the care that is seen as appropriate.

Compassion fatigue may lead to "misjudgements, clinical errors and poor treatment planning" (Figley, 2002a; Bride et al., 2007, Adams et al., 2008). Shapiro et al. (2007) found that stress and burnout has a negative impact on "attention, concentration, decision-making skills and staff's ability to establish relationships with service users". Henshall et al. (2017) found that staff operating in conditions of threat ("Perceived Organisational Threat" involving stressors and challenges faced by staff) have reduced capacity for compassion to self and others.

Poorer psychological well-being, stress and burnout are associated with low rates of staff retention, high rates of absenteeism and high staff turnover (Robertson & Cooper, 2010). Mental health services in England had the 2nd highest rates of sickness in NHS organizations in 2018. The staff group with the highest sickness rate was Health Care Assistants, followed by Ambulance staff and Nurses (NHS Digital, 2018).

Staff's wellbeing is found to be associated with patients' experience and outcomes. The Boorman review of NHS staff care (Maben, 2010) showed higher levels of patient's satisfaction recorded in Trusts where injury rates, stress levels and turnover rates were lower and job satisfaction was higher.

In summary, staff's psychological wellbeing should be a concern and it seems imperative for head of services, managers and those in leadership roles to attend to staff's wellbeing. Poorer staff well-being, sickness, retention and high turner over, may affect how patients are cared for, poorer patients' experience and outcomes.

3.3. Compassion to self and others - theoretical background

Dalai Lama (1995) defines compassion as a "non-judgemental sensitivity to the suffering of self and others, with a commitment to prevent and alleviate that suffering".

Gilbert (2009) suggests that there are three key emotion regulation systems: threat, drive and soothing system. In this model, distress and burnout are results of an over-activation of the threat and the drive system, and under-activation of the soothing system. In terms of staff, if this is coupled with relating to their experiences in a self-critical or harsh way may increase the distress experienced by staff.

According to Gilbert (2009) compassion involves compassion to the self, to others, and also involves allowing the flow of compassion from others to oneself. Six attributes and skills are key in cultivating this flow of compassion ("motivation to care for well-being, empathy and sympathy, distress tolerance instead of avoiding or controlling emotions, sensitivity to distress, and a non-judgemental stance"). Gilbert (2009) also outlines the compassionate skills needed to develop these six attributes (imagery to help evoke feelings and sensations of warmth and kindness; directing attention in a compassionate and mindful way; "thinking and reasoning in a helpful and honest way, without rumination; and behaving compassionately to the self and to others"). According to Neff (2003) who developed the concept of self- compassion, there are three necessary components: "self- kindness (being warm and understanding towards ourselves); common humanity (recognising that suffering and personal inadequacy is part of the human experience); and mindfulness (taking a balanced, non-judgemental approach to our emotions so that they are neither suppressed nor exaggerated)".

3.4. Impact of increasing compassion in staff – research evidence

It is recognized that human suffering within an organization is unavoidable, whether it is "organizationally induced" or due to personal life events. It is argued that, rather than offering interventions, such mindfulness, as "one off" experience, it may be more beneficial for staff's wellbeing to incorporate and integrate them into the organizational systems (Kelly and Tyson, 2017). More and more attention is being drawn to the concept of compassion within organisations and compassionate leadership (West et al., 2017; Dutton, Workman & Hardin, 2016). To nurture a culture of compassion, organizations need their leaders at all levels to embody compassion. Compassionate leadership (where leaders model commitment to high quality care and the four elements of compassion, as outlined by Atkins and Parker (2012) i.e. attending, understanding, empathizing and helping) has been found to have a significant impact on: clinical effectiveness; patient safety; patient experience; the efficiency with which resources are used; the health, wellbeing and engagement of staff; the extent of innovation within the healthcare system (Dawson, 2014; Shipton et al., 2008).

A culture of compassion creates psychological safety needed for "staff to feel confident in speaking out about errors, problems and uncertainties and feel empowered and supported to develop and implement ideas for new and improved ways of delivering services" (West et al., 2017).

Practicing compassion can help in how staff responds to threat. The study of Henshall et al. (2017) suggested that by encouraging self-compassion and increasing the level of compassion that staff feel they receive at work, they may be better able to maintain or improve their compassion to service users and their work colleagues. Furthermore, self-compassion and perceived organisational compassion were significantly better predictors of level of compassion for others than was perceived organisational threat.

A study of Allen & Leary (2010) suggests that increased self-compassion is positively associated with positive cognitive restructuring and negatively associated with avoidance when coping with negative stressful experiences. Furthermore, self-compassion is associated with: better sleep and resilience – factors related to burnout and quality of care (Cramer et al., 2016; Raab, 2014); increased motivation to self-improve (Breines & Chen 2012); reduced self-criticism (Bazarko et al., 2013; Shapiro et al., 2007); reduced burnout, reduced compassion fatigue and increased well-being (Beaumont et al., 2016) and increased empathy (Bazarko et al., 2013).

The proposed research aims to build on the existing literature and research on the subject of compassion and interventions to increase staff's wellbeing. To date, there is little research on interventions targeting the wellbeing of staff working in mental health, in particular staff working on psychiatric wards. Compassion-based interventions (Compassion-Focused Staff Support) are being developed by the Compassionate Mind Foundation, however there is no published research on compassion-based interventions for staff working in inpatient mental health services to date.
Given that compassionate care is currently on the agenda of NHS strategy (Health Service Ombudsman, 2011; The King's Fund's, 2009), exploring feasibility and potential benefits of compassion-based intervention for staff could be a useful area for research that can inform clinical practice in terms of developing future well-being programmes for staff and developing compassionate care within services.

4. Research question(s)

The main aim of the study is to evaluate the feasibility and acceptability of compassion-focused group programme for staff working in inpatient mental health services, i.e. to explore what staff experience of this programme was, what supported their attendance of the compassion-based programme and helps maintain their self-compassion in their workplace; and to explore reasons for attrition amongst non-attendees.

There are many challenges in providing such service to mental health staff, in particular those working in inpatient services. Staff's limited availability and the unpredictability of the ward environment have been anecdotally known as barriers to attending services offered by psychologists for this staff group.

5. Participant recruitment

Participants: 6-20 members of staff (nurses, health care assistants, OTs, psychiatrists) working in mental health services within Betsi Cadwaladr University Health Board. It is hoped that participants will consist also of staff in leadership roles (i.e. managers and modern matrons).

Procedure for recruitment: A compassion-focused group programme for staff is planned to be rolled out in Autumn/Winter of 2019 within one of BCUHB's inpatient mental health service. Staff attending the intervention will be informed that the intervention will be evaluated and that this evaluation is a research project undertaken as a part of doctoral qualification. The staff will be given an information sheet (Appendix 2) and also verbally explained what the research is about (attending a focus group and /or interview and filling in questionnaires and feedback forms). The potential research participants will have as long as they need to think about participating in the study and to ask questions about it. The participants will be given consent forms (Appendix 3) and asked if they could be contacted by the researcher to at a later date to gain informed consent. Written consent with a signature on a consent sheet will be then obtained.

Have I got initial approval to access participants from relevant people: Provisional general discussions have been held by professionals involved with this project (Lead Supervisor and trainee; Lead Supervisor and the Head of Nursing in the Mental Health service of interest) with favourable response from both ~~professionals.~~ There a ~~planned discussions~~ to be held with other senior members of staff.

6. Design and Procedures

What will participants be asked to do: Participants will be asked to fill in pre- and post-measures at the start and end of the intervention and at follow up. They will also be asked to fill in a session-by-session feasibility measure. They will be invited to take part in a Focus Group immediately after the intervention has finished to capture their immediate experience of the programme, and to an individual interview approximately one to three months after the Focus Group. Participants who have not attended part of the programme, i.e. have dropped out, will also be invited to individual interviews to explore the barriers to attending.

Where will the research take place: In a separate room in their workplace.

How many people will be in the sample: a minimum of 6-12 and a maximum of 20.

Method of recruitment: The sample will be recruited via purposive sampling. Only participants who were invited to take part in the group programme will be invited to participate in the study. They will be identified through discussion with the supervisor and ward management.

Inclusion criteria: The sample will include staff currently working in mental health services in a range of roles/bands, including those in leadership roles.

Where will they be recruited from: The participants will be recruited on NHS grounds in the mental health service where the compassion-focused group programme is planned to be rolled out.

Recruitment and consent: Participants, once identified, will be approached about taking part in the study and supplied with a Participant Information sheet (PIS) about the study. A number of key ethical factors that must be adhered to when carrying out research on participants, will be covered in PIS and the consent form attached to it. If the participants wish to take part in the study after being fully informed and having had time to think about the research, they will be given a consent form which must be signed by them to provide written consent. Once written and verbal consent has been obtained and recorded on paper and digital recorder, data collection can begin.

Design: A mixed methods approach will be employed to examine the feasibility and acceptability of a compassion-focused group programme for staff:

1. Quantitative feasibility and acceptability measures administered after each session; recruitment, attendance/drop out will be monitored and evaluated against feasibility criteria;
2. Qualitative semi-structured interview employed during focus groups and individual interviews with participants to explore their immediate experience of the programme

and one to three months after. Participants who did not attend the focus group and/or have dropped out from the programme will be invited to take part in individual semi-structured interviews to explore barriers to attending.

Additionally, pre- and post- measures of self-compassion, compassion and professional quality of life to preliminary explore potential effect of the intervention, will be administered.

A simple interview schedule will explore participants experience of the intervention – their motivation to attend, what the most/least helpful part was, whether participants would attend such intervention again if it was offered in the future, what could be improved, etc., as well as barriers to attending and maintaining gains from the group.

The focus groups will take about 60-90 minute. The one-to-one interviews – 30 to 60 minutes. An interview schedule is included in Appendix 4.

Once the focus groups / interviews are finished, participants will be debriefed and given opportunity to ask questions about what has been discussed and any other aspects of the study. It will be reiterated that their data will be stored securely and confidentially in line with the Data Protection Act. Participants will also be thanked for participating in the study. They will also be reminded of how the information will be disseminated through publications, posters, conference talks. Information specific to identifiers will be discussed so they understand how their information will be anonymised.

7. Measures

Feasibility and acceptability measures will be administered after each session of the intervention. The session-by-session self-reports of participants' experience and perceived helpfulness of the intervention and qualitative data regarding staff's experiences of and within the intervention will be gathered and examined.

The criteria and critical feasibility outcomes analysed in the study, are as follows:

1) Recruitment rate – number of participants consented to take part in the intervention.
2) Intervention retention - % who dropped out and % who did not attend any of the sessions.
3) Acceptability - ratings from session-by-session rating scales filled in by the participants and qualitative data from interviews.
4) Intervention fidelity – adherence ratings from session-by-session rating scales filled in by the group facilitators.

The potential effects of the intervention on the levels of compassion to self, to/ from others, burnout, compassion fatigue and compassion satisfaction, will be measured using:

- *Self-Compassion Scale* (SCS; Neff, 2003) is a 26-item scale designed to assess an individual's self-compassion across three components: self- kindness, common humanity, and mindfulness. This provides an overall self-compassion score (Neff, 2015), or a two-factor structure where the original six subscales are separated into 'self-compassion' (positive subscales: self-kindness, common humanity, mindfulness) and 'self-criticism' (negative subscales: self- judgement, isolation, over-identification) factors (Costa et al., 2015; López et al., 2015). The Self-Compassion

Scale (SCS) has demonstrated good psychometric properties.
https://self-compassion.org/wp-content/uploads/2015/06/Self_Compassion_Scale_for_researchers.pdf

- *The Compassionate Engagement and Action Scales* (Gilbert et al., 2017) are three scales measuring Self-Compassion, Compassion we feel To Others and the perceived availability of Compassion ~~From~~ Others. Each scale assesses 1. engagement with distress/suffering with exploration of different aspects of compassion (e.g., motivation and becoming sensitive to suffering, distress tolerance with empathic insight and 2. being able to take (wise) actions to prevent and alleviate distress/suffering. The three scales have robust psychometrick properties.
https://compassionatemind.co.uk/resourcesresources/scales
- *The Professional Quality of Life* (~~ProQol~~; ~~Stamm~~, 2009; 2016) is a 30-item self-report measure of the negative and positive effects of helping others who experience suffering and trauma comprising of three subscales (measuring Burnout, Compassion Fatigue and Compassion Satisfaction). The ~~ProQol~~ has been reported to be reliable measure (Figley & ~~Stamm~~, 1996; ~~Stamm~~, 2010).
https://progol.org/ProQol_Test.html

Additional demographic/data will be collected for the following:

- Age, gender, ethnicity, job role (including banding) length of work in mental health services (months, years), length of work in current post (months, years)

Not all demographic information will be utilised for the project or included in write up to avoid additional identifiers.

8. Data management and analysis

The researcher will adhere to the standards and codes of conduct in professional research (e.g. the BPS code of human research ethics) when handling the research data.
Data will be stored securely in line with data protection act and within NHS ethical guidelines (in a locked cupboard in a locked room on NHS grounds). This will apply to both digital data which will be kept on an NHS encrypted memory stick and kept on location and stored securely, and to paper-based documents including transcripts, information sheets and consent forms.

The data obtained from the focus groups and interviews will be transcribed and analysed using deductive thematic analysis following Braun's and Clarke's (2006) suggestions, to capture emerging themes when exploring feasibility and acceptability of the compassion-focused group intervention.

The quantitative data will be analysed using SPSS 22.0. Descriptive statistics will be employed to analyse the feasibility outcome measures.

With regard to evaluating the potential efficacy of the intervention, within-group comparisons for pre- and post-group mean scores across outcome measures will be performed to assess this. A significance level of 95% (p<.05) will be applied in all data analysis procedures.

9. Diversity

I will aim to approach as diverse a sample as is available to me and ensure that there are no barriers to any participants taking part regardless of age, gender, ethnicity, culture, disability, religion or sexual preference.

The study is primarily addressing diversity issues by evaluating the feasibility of delivering an intervention to staff working in inpatient mental health services. The nature of working in inpatient services means it might be difficult for staff to participate in a focus group, unless it is a part of the working rota. This will be proposed in the initial meetings with head of services and ward managers when promoting the study.

The timing of the focus group and potential travel (e.g. summer school holidays, outside working hours) may contribute poor recruitment / higher attrition amongst parents and/or carers. A number of solutions have been considered to address this, for example: scheduling the focus groups during working hours after last session of the programme and obtaining management's consent to do so; scheduling interviews at times convenient to the participants; conducting the study in the workplace, offering a £15 Amazon gift voucher to those participants for giving their time to research outside of their working hours.

It is likely that a significant number of staff in North Wales is Welsh speaking. This means that those that are less confident speaking in English may not engage with the intervention or focus group and/or it may affect their experience / helpfulness of it. Where possible, every effort will be made to provide written translations of any materials used when facilitating the focus groups.

10. Ethical/Registration issues

As this is research on NHS staff, ethical approval will be required from the School of Psychology Research Ethics Committee at Bangor University, and Betsi Cadwaladr University Health Board's Research Department

Several key ethical factors must also be adhered to when carrying out research on participants which will be covered in the PIS (Appendix 2) and the consent form (Appendix 3). These include: the study they are being asked to take part in and its purpose; why the participant has been approached for the study; what will be required of the participant and the potential benefits of them taking part; information that states participation is entirely voluntary and that they will need to sign a consent form and give verbal consent on the tape to take part; how any data they provide will be anonymised including all information identifying participants and individuals they mention; how all the data collected along with accompanying identification information will be destroyed at the end of the study; the participant's right to withdraw at any point and to have their data removed from the project; how all data will be kept in a locked cupboard in a locked room, with electronic data kept on NHS encrypted memory sticks; how the participant can have access to their transcript; how the participants will have the opportunity to discuss participation at any point before, during or after any part of the study; contact details for the researcher, the research team, the university department and the Health Board complaints department; what will happen if the participant discloses information about threatening to harm themselves or someone else; what will happen if the participant is harmed during the course of the research due to someone's negligence; what will happen to the results of the study and where ethical approval came from. If participants

wish to take part in the study after being fully informed and having had time to think about the research, then the participant will be supplied with a consent form which must be signed by them in order to provide written consent.

11. Feedback

Participants will be given choice if they would like to be informed about the findings of the study once it is completed.

12. Risk Assessment

Risk to participants: The intervention itself is focused on building self-compassion and coping strategies and interview questions will be focused around the experience of it. Although, participants may bring to mind experiences around perceived demands at work during discussions, it is not anticipated that participation will cause distress greater than the experiences of everyday life. Should participants become distressed at any point during the study, debrief/support will be offered. Staff will be encouraged to seek support from their GP, BCUHB Occupational Health Department or other agencies, if required and appropriate. Information will be provided regarding managing stress and services available in the area in the form of a help sheet with useful contact details on it if the participant requires them. Time to attend the Focus Groups and interviews may be an issue. Initial general discussion with the Head of Nursing and Lead Supervisor indicated that time to attend the focus group will be incorporated into the time of the final session of the compassion-focused group intervention to help with recruitment to the study / minimise barriers to attending. Participants will be asked about times suitable for them to attend the interviews.

Risk to researcher: The focus groups / interviews will be conducted on NHS grounds with the researcher's location always known. The researcher will be in contact with their supervisor(s) after the completion of interviews to inform them of their whereabouts.

13. Data storage:

Data will be stored securely (in a locked cupboard in a locked room). The relevant legislation e.g. the Data Protection Act (1998) and NHS ethical guidelines will be adhered to. This will apply to both digital data which will be kept on an NHS encrypted memory stick and kept on location and stored securely, and to paper-based documents including transcripts, information sheets and consent forms. Raw and identifiable data will be destroyed when the study has finished in June 2020. Anonymised data will be stored securely for further 5 years. Guidance from the study supervisors and the NWCPP research staff will also be sought when required.

14. Financial information

Finance will be required for paper and photocopying as well as for financial renumeration for participants. A detailed breakdown of costs is available in the expenses form in Appendix 5.

15. Timetable:

This research is expected to be completed and submitted within 7 months from July-October 2019. Once ethical clearance is gained from both Bangor University and NHS Research department, the researcher will aim to complete the data collection within two months. This is deemed possible as the compassion-focused group intervention is planned to be rolled out in the Autumn and Winter of 2019 and the researcher will have access to potential participants through their supervisor's job role within the service.

16. References

Appendix 5. Ethical Approval from HRA and HCRW

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr David Oakley
Ablett Unit
Glan Clwyd Hospital
Bodelwyddan
LL18 5UT

Email: Wales.REC1@wales.nhs.uk

30 August 2019

Dear Dr Oakley

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Developing self-compassion within teams: a feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.**
IRAS project ID:	**265235**
Protocol number:	**N/A**
REC reference:	**19/HCRW/0022**
Sponsor	**School of Psychology, Bangor University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study
-

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **265235**. Please quote this on all correspondence.

Yours sincerely,

Carl Phillips
Approvals Specialist

Email: Wales.REC1@wales.nhs.uk

Copy to: Dr Mike Jackson

Ms K Drobinska

Appendix 6. Local Research and Development Ethical Approval

Re: IRAS 265235 - No objection to the research BCUHB (Kamila Drobinska's Project)

From: Laura Longshaw (BCUHB - Research & Development) <Laura.Longshaw@wales.nhs.uk>
Sent: Monday, October 28, 2019 9:47:57 AM
To: Kamila Drobinska (BCUHB - Clinical Psychology) <Kamila.Drobinska@wales.nhs.uk>; Kamila Drobinska <sepa8a@bangor.ac.uk>
Cc: Mike Jackson <mike.jackson@bangor.ac.uk>; David Oakley (BCUHB - Clinical Psychology) <David.Oakley2@wales.nhs.uk>; Carrie Way (BCUHB - Clinical Psychology) <Carrie.Way@wales.nhs.uk>; Huw Ellis <huw.ellis@bangor.ac.uk>; Kelly Andrews (BCUHB - Research & Development) <Kelly.Andrews@wales.nhs.uk>
Subject: IRAS 265235 - No objection to the research BCUHB (Kamila Drobinska's Project)

Dear Kamila,

Developing self-compassion within teams: a feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

IRAS 265235

In line with the HRA approval letter we have noted that this project does not require a formal confirmation of capacity and capability. However, we do confirm that BCUHB R&D has no objections and the study may proceed. Please find the attached signed OID document.

We wish you every success with your research.

If you have any queries, please let me know.

Many thanks

Cofion, Regards

Laura Longshaw
Deputy Research and Development Manager / Dirprwy Rheolwr Ymchwil a Datblygiad
Bwrdd Iechyd Prifysgol Betsi Cadwaladr/Betsi Cadwaladr University Health Board

Appendix 7. Forms, measures and materials

Participant Information Sheet

Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

Participant Information Sheet

INTRODUCTION

We would like to invite you to participate in a research study. This study is a research project that is a part of an educational (doctoral) qualification. The aim of this information sheet is to help you to understand why the research is being done and what would be involved in it, before you decide whether to take part or not. Please read the following information carefully.

WHAT IS THE PURPOSE OF THIS STUDY?

Working in NHS mental health service can be both rewarding and difficult. Staff are exposed to trauma and suffering of the patients they care for while simultaneously experiencing great stress in the context of top-down pressures and overstretched resources. Caring for a population with complex physical and mental health needs in this context can be very difficult. This is intensified when staff relates to their experience in a harsh and self-critical way, and may lead to an increased distress.

Research suggests there is a negative impact on staff wellbeing, and that staff wellbeing is associated with the quality of care. There is limited research evaluating interventions aimed at improving the wellbeing of staff working in NHS mental health services, in particular research evaluating compassion-based interventions for staff, aimed at increasing staff's self-compassion.

The aim of this study is to evaluate the feasibility and acceptability of a compassion-focused group programme that you have been invited to attend. The programme is based on Compassion Focused Therapy and the theory underpinning it. The aim of the group is to support staff in their workplace to enhance their own wellbeing.

This research is not evaluating your ability to understand or implement the group intervention. We are interested in your experience of participating in the intervention. We would like to know what factors can be helpful in setting up a programme like this, what can be the barriers and how helpful the programme is for staff. We would also like to preliminary evaluate the potential impact of this group on self-compassion and psychological well-being of staff. This will hopefully help develop compassion-focused programmes for staff in the future.

WHAT WILL TAKING PART INVOLVE?

We will ask you to provide us with feedback about the group programme.

The group will take place over six weekly sessions and you will be asked to fill in a brief feedback form after each of the session that you attend. You will also be asked to fill in brief questionnaires at the start of the group programme, at the end of it and at follow-up. This will take approximately 15 minutes.

Immediately after the last session of the programme, you will be invited to attend a focus group with other members of staff that attended the programme. This will be facilitated by the researcher and will last about 60-90 minutes. You will be asked about your experience of the programme – for example what was helpful and what was less so. You will also be invited to a one-to-one follow up interview with the researcher approximately a month to three months later to discuss some of the above topics again.

If you did not attend some of the sessions or did not complete the group programme (i.e. did not attend the focus group) you will be invited to attend a one-to-one interview to reflect on the barriers to attending the session(s) and what could have been improved to enable your attendance. The one-to one interview will last about 30-60 minutes.

The focus group and interviews will be audio recorded and transcribed by the researcher, for the purpose of analysing your feedback in more detail.

WHERE WILL THE RESEARCH TAKE PLACE?

The focus group and interviews will be carried out within your workplace away from clinical setting in a room suitable for conducting an interview.

WHEN WILL THE RESEARCH TAKE PLACE?

The focus group will take place immediately after the last session of the group intervention. The timing of the one-to-one interviews will be a collaborative decision between the interviewer and yourself, mainly based around when you are free to take part.

WHY HAVE YOU BEEN INVITED TO TAKE PART?

You have been selected to take part because you are a member of staff who works in an inpatient mental health service and were invited to take part in the compassion-focused group programme this study aims to evaluate. Therefore, you will have the knowledge and experience of working in this setting, and of attending the intervention.

DO YOU HAVE TO TAKE PART?

Your participation is completely voluntary. If you decide to take part, you will be able to keep a copy of this information sheet and you should sign the agreement on the attached

consent form. Please bring these along to the first session of the group programme, where the researcher will be present at the start to answer any questions you might have.

You have the right to refuse participation in this study, refuse to answer any questions during the focus group, and withdraw your participation at any time without any consequence whatsoever. You do not have to give a reason. Whether you take part or not, it will have no effect on your employment.

WHAT ARE THE POSSIBLE BENEFITS AND RISKS OF TAKING PART?

It is hoped that your involvement will help develop future initiatives and programmes aimed at increasing staff's self-compassion and psychological well-being. Self-compassion is defined as the "ability to notice own suffering and the desire and action towards alleviating it". Psychological well-being, in short, can be described as how you feel about yourself and your life.

You may notice some benefits of participating in this study, for example: learning strategies to help you increase your self-compassion may help you cope better with stress.

You will also be eligible for a £15 Amazon gift voucher if taking part in the individual interviews falls outside of your working hours.

It is not anticipated that taking part will cause you any disadvantages or discomfort. However, some discussions during the interview may bring to mind difficult work-related situations. This may make you feel mildly distressed. Should this happen, ways of managing this will be discussed in the context of the sessions thus far. Although, taking part in the research is not intended as a therapy session, you will be signposted towards the right direction to access support, should that need arise.

WILL TAKING PART BE CONFIDENTIAL?

All information you share during the study will be kept strictly confidential. The researcher will manage the study data by adhering to professional research standards and codes of conduct (e.g. the BPS code of human research ethics). When the interview transcript is written up you will be identified only with a 'code' number which is known only to the research team. Non-anonymous data in the form of signed consent forms, the information that we collect about you and original audio recordings will be collected and stored securely in a locked file cabinet and on a password protected computer account in a locked office of a locked NHS psychology department. Only the researcher and her supervisors will have access to this data. This data will be destroyed as soon as the study is finished (June 2020). The transcript of the interviews in which all identifying information has been removed and all other anonymised data will be retained for a further five years. In order to convey your experiences accurately we would like to use anonymous quotes at random from the focus group and/ or your interview responses. You will be given the opportunity to review your interview transcript for errors. Please note that efforts will be made to ensure your

anonymity is protected when using direct quotes that may feature in the write up and possible publications that may come from this research.

WHAT HAPPENS IF YOU DISCLOSE SOMETHING THAT MAY NEED REPORTING?

If disclosures are made during the focus group or one-to-one interview that reveal the potential of threat or harm to yourself or someone else, for example: misconduct towards a patient or member of staff, this information will be shared with your line manager.

HOW DO YOU WITHDRAW?

You may withdraw from this study at any time by contacting the researcher during or after the interview using the details listed below with your name and contact details. Please note following the submission of a manuscript for publication the withdrawal of data will not be possible.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The results of the study will be published in the form of a doctoral thesis and a journal article. The results will also be disseminated through oral presentations at conferences and seminars. The results may also be used to for teaching purposes or inform future research. If you would like to be informed about the results, please indicate this on attached consent form to participate in the research.

WHO HAS ETHICALLY REVIEWED THE STUDY?

This study has been ethically reviewed to protect your interest and given a favourable opinion by the School of Psychology Research Ethics Committee at Bangor University and by Betsi Cadwaladr University Health Board's Research Department.

WHAT IF THERE IS A PROBLEM OR SOMETHING GOES WRONG?

If you have concerns about anything related to the study you can speak to the research team in the first instance. You can also contact the School of Psychology at Bangor University (see below for contact details). If you remain unhappy and wish to formally complain you can do this by contacting the Health Board and asking for the complaints department on 01248 384194.

In the event that something does go wrong or you are harmed during this research, due to someone's negligence, you may have grounds to take legal action for compensation against Bangor University or Betsi Cadwaladr University Health Board, but you may have to pay your legal costs. You may also be signposted towards the relevant services for your problem.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

Should you have any further questions or queries, please contact:

Researcher Contact Details

Kamila Drobinska
NWCPP
School of Psychology
Brigantia Building
Bangor University
Bangor
North Wales
LL57 2DG

(*m*) 07799907558
kamila.drobinska@wales.nhs.uk
sepa8a@bangor.ac.uk

Supervisor Contact Details

Dr David Oakley
Uned Ablett Unit
Ysbyty Glan Clwyd Hospital
Bodelwyddan
North Wales
LL18 5UT

(*t*) 01745 585484
david.oakley2@wales.nhs.uk

Supervisor Contact Details

Dr Carrie Way
Older Adult Community Mental Health
Uwch Dderw
Llandudno
North Wales
LL30 1LA

(*t*) 01492863360
carrie.way@wales.nhs.uk

Academic supervisor Contact Details

Dr Mike Jackson
NWCPP
School of Psychology
Brigantia Building
Bangor University
Bangor
North Wales
LL57 2DG

(*t*) 01248 388746
mike.jackson@bangor.ac.uk

Bangor University North Wales Clinical Psychology Programme: 01248 388 365
Betsi Cadwaladr University Health Board: 01678 520 542

Thank you for taking time to read this. We hope that the above information provides answers to any questions you might have.

Participant Information Sheet transparency wording for Non-Commercial Studies

Bangor University is the sponsor for this study based in Wales. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bangor University will keep identifiable information about you until the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at URL:

https://www.bangor.ac.uk/governance-and-compliance/dataprotection/documents/Data%20Protection%20Policy%20final%20July%2018%20v6.pdf

or by contacting:

Governance and Compliance, Bangor University, Bangor, Gwynedd, LL57 2DG.
Phone: (01248) 382043

Betsi Cadwaladr University Health Board will keep your name and contact details confidential and will not pass this information to Bangor University. Betsi Cadwaladr University Health Board will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Bangor University and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Bangor University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Betsi Cadwaladr University Health Board will keep identifiable information about you from this study until the study is finished in June 2020.

Bangor University will collect information about you for this research study from Betsi Cadwaladr University Health Board. Betsi Cadwaladr University Health Board will not provide any identifying information about you to Bangor University. We will use this information to match your data with your 'unique' code assigned to you at the start of the study.

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

Participant Consent Form

Title of the study: Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

Researcher: Kamila Drobinska

Please initial each box:

☐	I have read and understood the Participant Information Sheet for the above study.
☐	I have had the opportunity to consider the information, ask questions and have them answered to a satisfying level.
☐	I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason and without repercussion.
☐	I understand that my participation in this study will involve: filling in questionnaires, attending a focus group and a one-to-one interview.
☐	I understand that the focus group and interview will be audio recorded.
☐	I understand that my data will be anonymised (e.g. I will be assigned a code and pseudonym).
☐	I understand that direct quotes will be used and may feature in the write up and possible publications that may come from this research.
☐	I understand that data collected during the study may be looked at by individuals from the Betsi Cadwaladr Health Board and Bangor University, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
☐	I understand that I am free to ask any questions at any time, or to discuss my concerns with the researcher.
☐	I understand that the data I provide may be used for research, teaching and research dissemination.
☐	I agree to take part in the above study.
☐	I agree to the use of audio recording.

Name (PRINT):	Signed:	Date:
Researcher (PRINT):	Signed:	Date:

One copy of page 1 for the participant and one copy for the researcher 1 of 2

V.2.0 Project: 265235 05.08.2019

Thank you for taking part in the research. The researcher will contact you after the focus group to arrange a suitable date and time to meet with you for an individual interview. Please state how you would like to be contacted and provide your contact details below:

.....
.....
.....
.....
.....

☐ Please tick this box if you would like to be informed about the results of the study you agreed to participate in.

If you would like to be informed about the results of the study, please indicate how you would like to be informed (e.g. by e-mail or letter) and provide contact details below:

.....
.....
.....
.....
.....

Please refer to the questionnaire pack in the attached envelope and carefully answer each question. Thank you!

Participant ID:

Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

'About You' Questionnaire

Instructions: Please answer each question as accurately as possible by filling in the space provided or ticking the appropriate box (please tick only one box).

1. How old are you?

☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 and over

2. What is your gender? _____

3. How would you describe your ethnic origin?

☐ Asian or Asian British ☐ Black or Black British ☐ Mixed ☐ White

☐ Other ethnic group (including Chinese)

4. How would you describe your national identity?

☐ English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐ British ☐ Other (Please write in below)

_____

5. How long have you worked in the NHS (please include years and months)?

_____

6. How long have you been in your current post (please include years and months)?

_____

7. What is your band and job role? _____

Self-Compassion Scale (SCS; Neff, 2003b)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

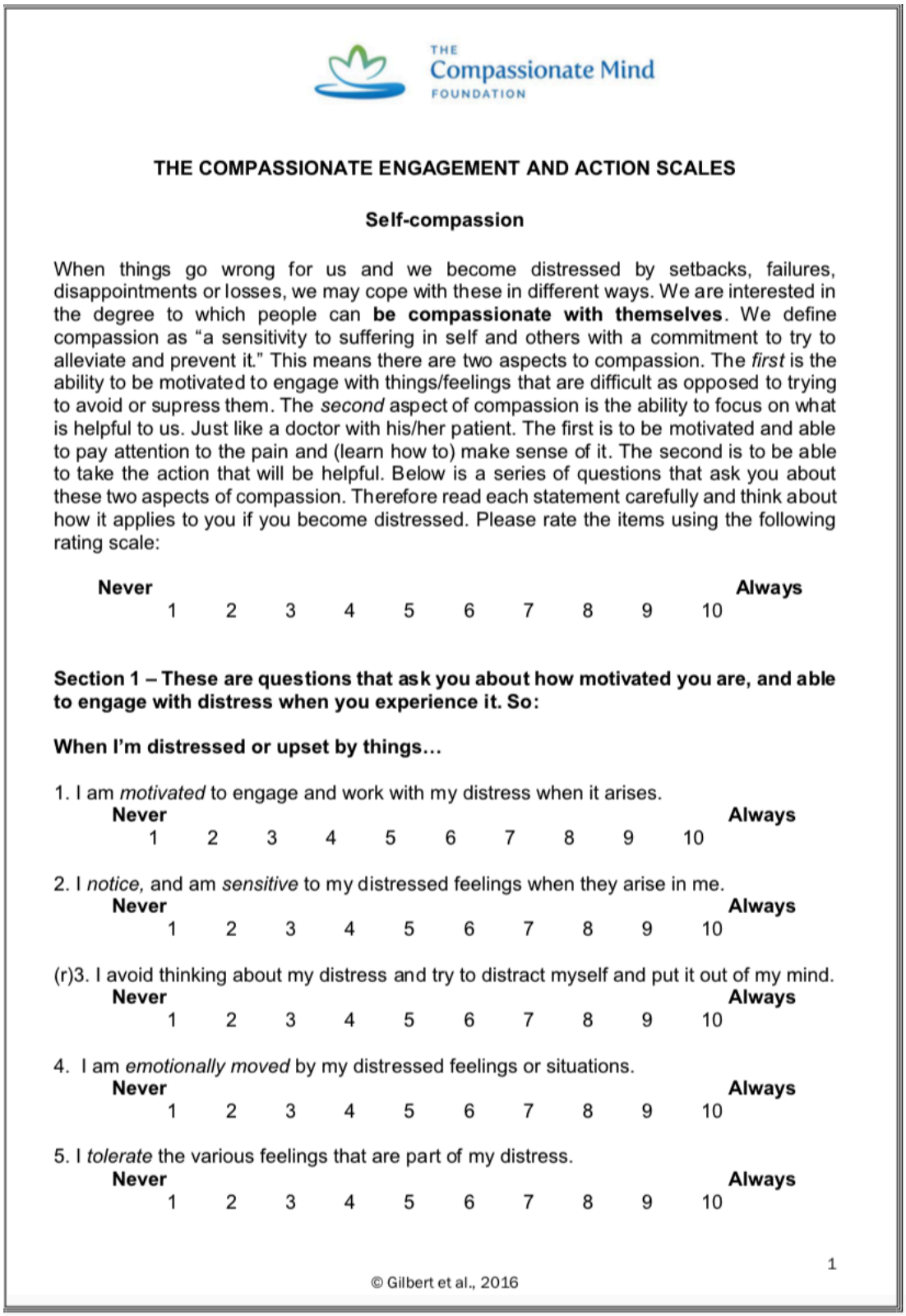
Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
_____ 5. I try to be loving towards myself when I'm feeling emotional pain.
_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
_____ 8. When times are really difficult, I tend to be tough on myself.
_____ 9. When something upsets me I try to keep my emotions in balance.
_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
_____ 14. When something painful happens I try to take a balanced view of the situation.
_____ 15. I try to see my failings as part of the human condition.
_____ 16. When I see aspects of myself that I don't like, I get down on myself.
_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
_____ 19. I'm kind to myself when I'm experiencing suffering.
_____ 20. When something upsets me I get carried away with my feelings.
_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
_____ 23. I'm tolerant of my own flaws and inadequacies.
_____ 24. When something painful happens I tend to blow the incident out of proportion.
_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

The Compassionate Engagement and Action Scales (Gilbert et al., 2017)



THE Compassionate Mind FOUNDATION

THE COMPASSIONATE ENGAGEMENT AND ACTION SCALES

Self-compassion

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, we may cope with these in different ways. We are interested in the degree to which people can **be compassionate with themselves**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you if you become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with distress when you experience it. So:

When I'm distressed or upset by things…

1. I am *motivated* to engage and work with my distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice,* and am *sensitive* to my distressed feelings when they arise in me.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about my distress and try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by my distressed feelings or situations.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of my distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

1

THE Compassionate Mind FOUNDATION

6. I *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate being distressed.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively cope in compassionate ways with emotions, thoughts and situations that distress you. So:

When I'm distressed or upset by things…

1. I direct my *attention* to what is likely to be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think* about and come up with helpful ways to cope with my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help myself.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and do the things that will be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I create inner feelings of *support, helpfulness and encouragement*.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

THE Compassionate Mind FOUNDATION

Compassion to others

When things go wrong for other people and they become distressed by setbacks, failures, disappointments or losses, we may cope with their distress in different ways. We are interested in the degree to which people can be **compassionate to others**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you when **people in your life** become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with other people's distress when they are experiencing it. So:

When others are distressed or upset by things…

1. I am *motivated* to engage and work with other peoples' distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice* and *am sensitive* to distress in others when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about other peoples' distress, try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by expressions of distress in others.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of other people's distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

THE Compassionate Mind FOUNDATION

6. I *reflect on* and *make sense* of other people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate other peoples' distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of others people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively respond in compassionate ways when other people are distressed. So:

When others are distressed or upset by things…

1. I direct *attention* to what is likely to be helpful to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think about and come up* with helpful ways for them to cope with their distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help other people when they are distressed.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and *do the things* that will be helpful to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I express feelings of *support, helpfulness and encouragement* to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

THE Compassionate Mind FOUNDATION

Compassion from others

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, others may cope with our distress in different ways. We are interested in the degree to which you feel that **important people in your life can be compassionate to your distress**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us or others. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to the **important people in your life** when you become distressed. Please rate the items using the following rating scale:

Never									**Always**
1	2	3	4	5	6	7	8	9	10

Section 1 – These are questions that ask you about how motivated you think others are, and how much they engage with your distress when you experience it. So:

When I'm distressed or upset by things…

1. Other people are actively *motivated* to engage and work with my distress when it arises.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

2. Others *notice* and *are sensitive* to my distressed feelings when they arise in me.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

(r)3 Others avoid thinking about my distress, try to distract themselves and put it out of their mind.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

4. Others are *emotionally moved* by my distressed feelings.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

5. Others *tolerate* my various feelings that are part of my distress.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

THE Compassionate Mind FOUNDATION

6. Others *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7. Others do not tolerate my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. Others are *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how others actively cope in compassionate ways with emotions and situations that distress you. So:

When I'm distressed or upset by things…

1. Others direct their *attention* to what is likely to be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. Others *think about* and come up with helpful ways for me to cope with my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. Others don't know how to help me when I am distressed

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. Others take the *actions* and do the things that will be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. Others treat me with feelings of *support, helpfulness and encouragement.*

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

Professional Quality of Life (ProQOL; Stamm, 2009)

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

PRIFYSGOL BANGOR UNIVERSITY

ID:

Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

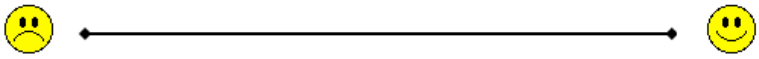
Session-by-session feedback form for group participants
Session number:

Pre-session

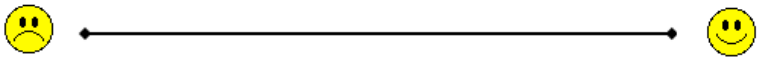
What thoughts and feelings are you bringing to the group today?

Please answer the following questions about today's session by making a mark on the lines below.

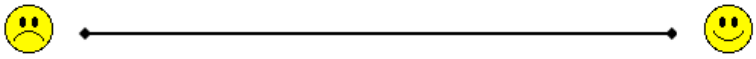
1. How do you feel today?



2. Do you feel you will be able to engage with group today?



3. Do you feel you can ask questions if you want to?



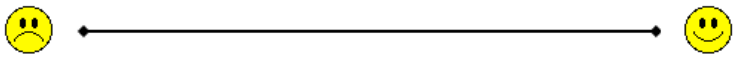
ID:

Post-session

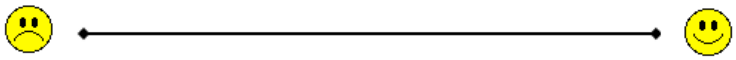
What thoughts and feelings are you taking away from the group today?

Please answer the following questions about today's session by making a mark on the lines below.

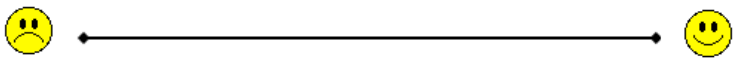
1. How do you feel now?



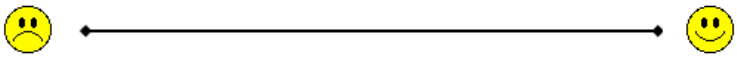
2. Did you feel engaged with the activity?



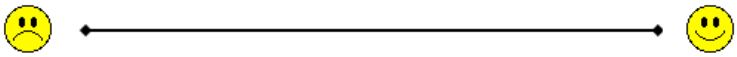
3. Did you feel listened to and respected?



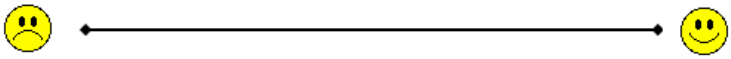
4. Did you find the session interesting?



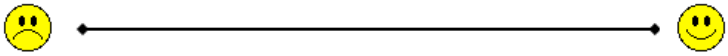
5. Was the session easy to understand?



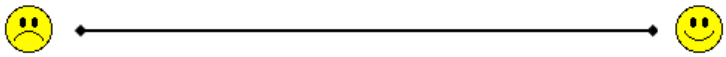
6. Were you able to keep up with the content?



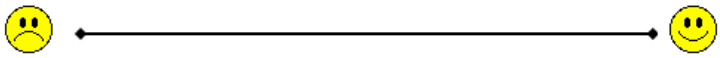
7. Was the session useful?



8. Did the session make you feel calmer?



9. Did you find the practices (e.g. breathing) helpful?



Any other feedback about today's session:

Thank you for attending the group.

Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

Session-by-session feedback form for group facilitators:
Session number:

Please answer the following questions about today's session by making a mark on the lines below.

1. **Were you able to start and finish on time?**

Not at all ——————————— Absolutely

Comments:

2. **Was it easy to follow the session protocol?**

Not at all ——————————— Absolutely

Comments:

3. **Were participants able to keep up with the content?**

Not at all ——————————— Absolutely

Comments:

4. **Were participants engaged with the content?**

Not at all ——————————— Absolutely

Comments:

Any other feedback about today's session:

Thank you.

Developing self-compassion: A feasibility study of a compassion-focused group programme for staff working in NHS inpatient mental health services.

1) Interview Schedule for Focus Group

1. **What made you want to participate in this programme?**
2. **What do you think of the organisation of the programme – time, location, staff on rota, etc?**
3. **What do you think of how it was delivered?**
4. **What was your experience of being in the group?**

PROMPT:

- What, if any were the most helpful aspects of the group?
- What were the most soothing aspects of the group?
- What, if any were the least helpful aspects of the programme?
- What were the threatening aspects of the group?

PROMPTS: What could have helped to improve the experience? Does anyone else have a different point of view or experience than those already voiced?

5. **What, if anything, has changed in your everyday life because of participating in the programme?**

PROMPTS:

- How, if at all did the group change the way you feel about, talk to, and treat yourself and others?
- Does anyone else have a different point of view or experience than those already voiced?

6. **What do you think it would be like to put the ideas of self-compassion from the group programme into practice in your workplace?**

PROMPTS: What support do you think might be helpful?

7. **How interested are you in signing up to programme like this again?**

8. **Is there anything else anyone would like to share or comment on?**

2) Interview Schedule for follow up one-to-one interviews

1. **How do you feel now about the experience of being in the group programme?**
2. **What, if anything, has changed in your work / life because of participating in the programme?**

PROMPTS: How, if at all, did the group change the way you feel about, talk to, and treat yourself (and others)?

3. **What has it been like to put the practices and ideas of self-compassion into practice in your workplace?**

PROMPTS: What helped and what were the barriers? What could help?

4. **Is there anything else you would like to share or comment on?**

3) Interview Schedule for participants who did not attend or dropped out from the programme

1. **How many sessions did you attend?**
2. **What made you want to /not want to participate in this programme?**
3. **What was your experience of the sessions you attended?**
4. **What would have to be different to have enabled you to attend (more of) the sessions?**
5. **What, if anything, did you learn from the sessions you attended?**
6. **What do you think of an intervention like this being offered to staff?**

PROMPTS: Is it important / needed? Helpful? Unhelpful? Why?

7. **How interested are you in signing up to programme like this again?**
8. **What do you think / feel other barriers might be, if there are any, for staff to attend a group programme like this?**
9. **Is there anything else you would like to share or comment on?**

Word count statement

(prior to amendments)

Thesis Components	**Word Count**
Section/Title pages	241
Thesis Abstract	284
Literature Review	7,114
Empirical Paper	7,176
Contributions to Theory and Clinical Practice	3931
Word count excluding tables, figures, reference lists and appendices	**18,746**

Tables, figures, reference lists and appendices

Content list	411
Acknowledgements and Declarations	309
Literature review Figure	72
Literature Review References	2497
Literature Review Appendix 1 (Pictures)	20
Literature Review Appendix 2. (Table)	2454
Empirical Paper Table and Figures	124
Empirical Paper References	2452
Empirical Paper Appendix 1 (Table 1)	148
Empirical Paper Appendix 2 (Table 1,2 & 3)	948
Empirical Paper Appendix 3 (Figures 1-9)	773

Empirical Paper Appendix 4	203
Empirical Paper Appendix 5 (Picture)	687
Empirical Paper Appendix 6 (Table)	479
Empirical Paper Appendix 7 (Pictures)	17
Empirical Paper Appendix 8 (Pictures)	122
Empirical Paper Appendix 9	807
Contributions to Theory and Clinical Practice References	575
Word count for tables, figures, reference lists and appendices, excluding ethic appendices	**13,098**

Ethics appendices

Appendix 1	2813
Appendix 2	209
Appendix 3	117
Appendix 4	5716
Appendix 5	408
Appendix 6	208
Appendix 7	506
Word count for ethics appendices	**6,548**

Word count for tables, figures, reference lists and all appendices	**19,646**

Total Word Count	**38,392**