Doctoral Thesis

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The Relationships Between the Flows of Compassion and Job-Related Affective Wellbeing in Helpline Volunteers

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Word Count

Thesis Sections	Main Text	Appendices (including tables, figures and references)	Total
Thesis Abstract	275	-	275
Systematic Literature Review	7993	11983	19976
Empirical Research Paper	8000	7966	15966
Critical Appraisal	3980	849	4829
Ethics Documentation	5650	1318	6968
Total	25898	22116	48014

Thesis Abstract

This thesis contains four sections including a systematic literature review, an empirical research paper, a critical appraisal, and the ethics application section. Section one reports a qualitative systematic literature review exploring the experience of Compassion Focused Therapy (CFT) for individuals with mental health difficulties. Six papers were included in the review and were synthesised using a meta-ethnographic approach to produce six themes and two subthemes. The findings highlighted processes of CFT which individuals reported as fundamental in their therapeutic experience. The review identified a need for further qualitative research that focused on the experience of CFT within clinical populations.

Section two reports an empirical research examining the extent to which the three flows of compassion (compassion to others, compassion received from others and self-compassion) predicted job-related affective wellbeing (affective wellbeing hereafter), when controlling for other demographic variables. Active helpline volunteers providing emotional and wellbeing support were invited to take part in a survey online. Data were then analysed using correlational analyses and multiple hierarchical regression. The findings indicated that self-compassion and compassion for others were significantly and positively correlated with affective wellbeing. In the regression model, the flows of compassion accounted for a significant amount of variance (21.6%) in affective wellbeing when age, gender and length of time volunteering had been taken into account. The findings indicted self-compassion and compassion for others as important factors in determining affective wellbeing in helpline volunteers.

Section three provides a critical appraisal. This includes an overview of both papers, highlighting some of the key challenges and decisions, and personal reflections. The last section

includes the ethical proposal along with supporting documents utilised in the ethical application process.

Declaration

This thesis presents research undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University. The research and work presented is the authors' own except where due reference is made. The research has not been submitted for the award of another degree or academic award elsewhere.

Name: Julieanne Briones

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Firstly, I would like to thank the participants of this study. Thank you for giving your time, especially during a time that has been difficult for so many. A huge thank you to the voluntary organisations that helped to advertise and circulate the study to their volunteers.

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Section 1: Systematic Literature Review

Exploring the Experience of Compassion Focused Therapy for Individuals with Mental Health Difficulties: A Meta-Synthesis

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Prepared in accordance with guidelines for authors for: Clinical Psychology Review (see Appendix A)

Abstract

Quantitative literature reviews exploring the effectiveness of Compassion Focused Therapy (CFT) reported promising results for individuals with clinical diagnoses of mental health disorders. However, there has been no review of the qualitative research exploring the experience of CFT for individuals with mental health disorders. The current review aimed to address this gap in research using a meta-ethnographic approach. The review identified six themes and two subthemes. It highlighted important features of the process of CFT such as safeness, experiencing, and staying with overwhelming emotions, and having a felt experience rather than just a cognitive shift. Individuals reported a better understanding of themselves and past experiences, reducing the experience of self-blame as well as recasting the role self-criticism. Individuals also reported a shift in viewing self-compassion as a weakness to something that was empowering, which enabled participants to feel a sense of agency. The results proposed implications for practice and highlighted a need for further qualitative research within different clinical populations that explore the experience and therapeutic process of CFT.

Highlights:

- Individuals described a recasting of the self-critic rather than replacing or getting rid of it
- Safeness within CFT was an integral aspect for individuals
- Psychoeducation and experiencing emotions are important aspects of treatment
- The findings support suitability of CFT delivered as a group intervention
- CFT requires active participation and pushing through difficult experiences

Introduction

Over the last 20-30 years, there has been an increase in the development of compassion-based interventions aiming to improve and address mental health issues and psychological wellbeing (Gilbert, 2020; Kirby, 2017). For example, Compassion Focused Therapy (CFT; Gilbert, 2009a), Mindful Self-Compassion (Neff & Germer, 2013), Compassion Cultivation Training (Jazaieri et al., 2013), Cognitively Based Compassion Training (Pace et al., 2009), Cultivating Emotional Balance (Kemeny et al., 2012) and Loving-Kindness Meditations (Hofmann et al., 2011). The theoretical underpinnings of CFT, developed by Paul Gilbert, distinguishes it from other compassion-based interventions as it includes a combination of evolutionary psychology, attachment theory, and social mentality theory (Kirby et al., 2017). It focuses on helping individuals to understand their challenges in the context of evolution, how the dynamics of emotions present in the brain, and the social factors that shape the self, particularly early experiences (Kolts, 2016). Quantitative literature reviews exploring the effectiveness of CFT reported promising results for individuals with clinical diagnosis of mental health disorders (Beaumont & Hollins Martin, 2015; Craig et al., 2020; Leaviss & Uttley, 2015; Kirby et al., 2017). However, there has been no review of the qualitative research exploring the experience of CFT with individuals who have a diagnosis of a mental health disorder or who are accessing support from mental health services. A review of this nature will add an understanding of how CFT is experienced and what contributes to its effectiveness.

CFT was designed for and with people with complex mental health difficulties, who experience high levels of shame and self-criticism (Gilbert, 2009b; 2022b). It was developed in response to the recognition that for a number of people who engaged in Cognitive Behaviour Therapy (CBT) they became skilled at generating alternatives for their negative thoughts and beliefs but may not necessarily 'feel' this at an emotional level for example, "I know I'm not to blame for the abuse but I still feel that I am." Therefore, a key element of CFT is related to the observation that individuals with high levels of shame and self-criticism, can find it difficult to develop an internal sense of safeness, security, and contentment in their relationship with others and themselves, and self-soothing can be difficult (Gilbert, 2009a; 2009b).

Gilbert (2014) theorises the human brain is a product of evolution, and human thought, emotion, motivation and behaviour can be understood in terms of Darwinian "selection for

function" (Buss, 2009; Panksepp & Watt, 2011). CFT aims to help individuals become aware that the evolved brain comprises of multiple, interacting and competing systems (Gilbert, 2022a), by providing psychoeducation on the "tricky brain" and how the sense of self is partly a social construction, and the way their brain works is "not their fault" (Gilbert, 2014).

CFT proposed that motives generate and guide emotions, and identified three main evolved functions of emotions, which are: to identify threat and activate the body's defensive strategies (threat system), resource seeking and acquiring (drive system), and provide information on safeness allowing for rest, soothing, contentment and openness (soothing system) (Gilbert 2014, 2015). The three emotional regulation systems, and the way they interact and regulate each other are central in CFT (Gilbert 2014). According to Gilbert (2005, 2015), a developed soothing system plays an essential role in determining mental health as the soothing system can regulate the threat and drive systems. Gilbert (2014) highlighted that some people would have had little opportunity, during their early life, to develop a soothing system and abilities to regulate the threat and drive systems. Therefore, a fundamental goal for CFT is to help individuals develop and *experience* an internal sense of safeness, secure base and safe haven, and the mental shifts that come with this (Gilbert, 2020; Kolts, 2016). Part of the CFT therapist's role is to help individuals to experience safeness in their interactions with them, to tolerate and feel safe with what they explore in therapy and to replace self-criticism with self-kindness (Gilbert, 2009a).

An integral part of CFT is compassionate mind training (CMT) (2009c). These are a set of techniques and practices aiming to build an individual's inner compassion motives and competencies. It aims to stimulate physiological systems that are linked to caring, affiliation and affect regulation, and desensitise the threat system. CMT (Gilbert 2010, 2014) seeks to develop mental competencies and physiological states that facilitate the process of compassion: 1) to identify suffering, and tolerate and engage with this, and 2) learning to do what is helpful to alleviate and prevent suffering. CMT practices include exercises such as ways of breathing, mindfulness, use of imagery, promotion of people's awareness, letter writing and Chairwork (Gilbert 2009c, 2010, 2020).

Kolts (2016) proposed that research in CFT should explore the process of change and their link to specific intervention methods, why it is important in specific areas, and how best to

target those areas (Kolts, 2016). Furthermore, a recent scoping review recommended that since CFT is a process-focused therapy, research in CFT needs to be targeted to specific processes the therapy proposes it can address (Basran et al., 2022).

These suggestions highlight the importance of qualitative research investigating the experiential process of CFT as a therapy, and there have been several qualitative research studies that have explored this. Therefore, a qualitative systematic literature review investigating the experience of CFT is timely as it collates and summarises current findings, as well as make suggestions for the direction of future research. CFT is offered as an intervention across a variety of mental health diagnoses (Gilbert 2022b). A synthesis of current findings will allow for an understanding of the impact of CFT as an intervention, and comparing and contrasting the experience of CFT from a transdiagnostic perspective would offer a theory that specifically applies to people with a mental health diagnosis. In particular, using a meta-ethnographic approach will allow for an in-depth exploration and understanding of individual's experience, build on existing theory and uncover new understandings (Seers, 2015).Therefore, the review aim is to examine and synthesise qualitative research exploring the experience of CFT within a transdiagnostic mental health populations. The review questions are: What is the experience of adults with a diagnosis of mental health disorder or who are accessing support from mental health services who undertook CFT? Secondly, what aspects of CFT did they feel were important?

Method

Design

A comprehensive systematic review was conducted following Noblit and Hare's (1988) interpretative meta-ethnographic framework and Britten et al.'s (2002) worked example that adapted Noblit and Hare's framework for health research. A meta-ethnography reporting guideline, eMERGe (France et al., 2019), was used to guide the reporting of the review process, findings, and discussion.

Search Strategy

The protocol for the meta-synthesis was pre-registered on PROSPERO (ID: CRD42021289431). The primary review question to be addressed was, "What is the experience

of adults with a diagnosis of mental health disorder or who are accessing support from mental health services who undertook CFT?" This identified two search strings: CFT and qualitative methodology. A highly sensitive search strategy was co-designed with a library advisor. Search terms for CFT were based on previous reviews of CFT (Craig et al., 2020; Leaviss & Uttley, 2015) and a scoping search completed with the library advisor. A comprehensive list of search terms for qualitative methodology was generated using the APA thesaurus (Gallagher-Tuleya, 2007). Search terms were combined using Boolean operators and can be found in Appendix B. The only restriction applied during the search stage was to only include peer reviewed papers. Although language was not restricted during the search stage, only papers in English language were reviewed due to a lack of resources for translation of papers. The following bibliographic databases were used: PsychINFO, CINAHL, MEDLINE and AMED. The systematic search was completed by the author on 13 December 2021.

The search retrieved 1760 papers and were collated into EndNote, a referencing software program. A diagrammatic representation of the search process is presented in Figure 1. Duplicates were removed using the method proposed in Bramer et al. (2016). Following the de-duplication process, titles were screened for relevance. Abstracts of the remaining papers were reviewed and papers not meeting inclusion criteria were discarded. Finally, the full text of remaining papers were obtained and reviewed for eligibility according to inclusion and exclusion criteria (a comprehensive list can be found in Appendix C).

The inclusion and exclusion criteria were operationalised in line with the aim of the review. For example, studies which focused on non-clinical samples were excluded, as the aim was to explore the experience of CFT as a therapy to treat mental health populations. Additionally, the exclusion criteria of neurodevelopmental disorders resulted in exclusion of studies that explore the experience of people with an intellectual disability (ID) (e.g. Clapton et al., 2018; Goad & Parker, 2021; Hardiman et al., 2018). This was justified by NICE guidelines (2016) that recommended completing research into specific experiences of people with ID and common mental health problems in accessing psychological interventions. The guidelines proposed research exploring psychological interventions, specifically CBT, for adults with ID have various and inconsistent adaptations. The guidelines stated that modifications of psychological therapies for ID need to be tested and any modifications are clearly explained and documented. Furthermore, a recent review by Evans and Randle-Phillips (2020), highlighted

several challenges and therapeutic dilemmas that are specific to people with ID accessing psychological therapy, when compared to the general mental health population. This review included a paper on CFT. The review found current adaptations to therapy are not of an acceptable level to support the needs of those with ID to fully understand content and maintain long-term changes. The differences in these experiences will have an impact on the applicability and utilisation of the synthesis within the general mental health population and ID population. Therefore, the decision was made to maintain this exclusion criteria.

Study Characteristics

Nine studies (description can be found in Table 1) were identified for the meta-synthesis. All studies were completed in the UK with a mixture of diagnosis and settings. In particular, Heriot-Maitland et al., (2014), was completed within a mental health inpatient service. Three studies (Bell et al., 2019; 2020a; 2020b) specifically investigated participants' experience of Chairwork within a course of CFT. Bell et al. (2019) and Bell et al. (2020a) also utilised the same dataset. Mullen et al. (2020), specifically used CFT-E, a programme designed for eating disorder with techniques from CBT.

Quality Appraisal

Quality appraisals of the papers included were completed using the Critical Appraisal Skills Programme (CASP; 2018). The CASP is a 10-item checklist which allows for systematic quality appraisal of health-related research. Duggleby et al.'s (2010) three-point rating system (Appendix D) was applied to determine scores for items 3-10. CASP scores are presented in Table 2. Noblit and Hare (1988) originally described quality in terms of the quality of the metaphor provided therefore, the decision was taken not to exclude studies based on their perceived quality. Instead, the CASP results were used to enable consideration of the strengths and weaknesses of the studies included in the review.

Data Synthesis

Data synthesis followed the principles of Noblit and Hare's (1988) meta-ethnography which outlined a seven-step process (Table 3). All data relating to the review question was extracted from the studies and were added to Microsoft Excel spreadsheets. One column included all the quotations from participants labelled first order constructs (FOC), alongside

another column which included key themes and authors' interpretations labelled second order constructs (SOC). Data were extracted verbatim to preserve original terminology used by the authors and participants, and to reduce the risk of losing important data (Atkins et al., 2008; Sattar et al., 2021). A third column was added for notes regarding initial interpretations about the data, labelled third order of constructs (TOC).

A line of argument synthesis was completed following Sattar et al.'s (2021) procedure. In this particular review, half of the papers explored the full experience of CFT and the other half explored the experience of Chairwork within CFT. Therefore, data was synthesised by 1) reciprocal translations of the full CFT experience, 2) reciprocal translations of the experience of Chairwork and 3) a line of argument synthesis which contributed to the identification of the key experiences of individuals completing CFT.

A list of initial emerging themes was developed by noting shared concepts from the TOC spreadsheet. At this stage, 10 emerging themes were identified (Appendix E). The initial themes were grouped and re-grouped in ways that best represented TOC interpretations from across the studies using a spreadsheet. Following supervision from research supervisors, six overarching themes and two subthemes were developed. The themes and how the papers contributed to the themes can be found in Table 4. Appendixes F to H provide examples of data synthesis. The use of third-order interpretations and themes captures the interpretative nature of a meta-ethnography review which aims to extend the meaning of the reviewed papers, whilst also maintaining the original authors' and participants' interpretations of experiences.

Results

Theme 1: The importance of safeness within therapy

Safeness is at the centre of the CFT therapeutic process (Gilbert, 2020). Safeness in therapy was described by individuals as necessary for their therapeutic experience (Ashfield et al., 2020; Heriot-Maitland et al., 2014; Lawrence & Lee, 2013; Mernagh et al., 2020; Mullen et al., 2020). Safeness was generated by the therapists and the therapeutic relationship was described as helpful and important (Ashfield et al., 2020; Lawrence & Lee, 2013). The participants perceived the therapists as human beings who genuinely cared for them, which they felt was important in providing a sense of containment. Participants perceived the therapists as caring, knowledgeable, credible, non-judgemental, and validating; who also challenged them.

Additionally, Lawrence and Lee reported that the therapeutic relationship helped in enabling participants to shift their beliefs about themselves which led to the difference between *thinking* and *feeling* that they were not to blame.

> One of the strongest things was the actual therapists themselves. They were so kind. The kindness was amazing. Not only as doctors but as human beings. Their generosity was, I'd never come across that level of kindness before and, and their empathy at the same time they were very challenging and they made us work hard. (Lawrence & Lee, 2013, p499)

For those who attended group therapy having clear group rules and boundaries reduced the threat and distress initially felt by participants. Safeness within a group led to a sense of belonging, shared compassion for one another, and connectedness. For some participants, being in a group played an important role as it provided strength, hope and inspiration for making changes. This is consistent with the idea that social safeness within a community can provide a sense of social connection and mutual support (Gilbert 2022b).

> The actual session was very soothing in itself, very safe. You felt as if you're being listened to unconditionally, and that really helped. (Mernagh et al., 2020, p2021)

> It did feel like we were a little bunch of warriors … it amped me up, it gave me the strength that I needed to push through that kind of big brick wall of denial. (Ashfield et al., 2021, p294)

Specific characteristics of CFT, such as Safe Place imagery, generated feelings of being comforted and soothed (Heriot-Maitland et al., 2014). Additionally, clear group structures and goal setting were perceived as important which provided a sense of containment:

> I thought it was very helpful… it was so structured and that you knew what to expect on a weekly basis and especially for the treatment sessions and the ten, that ten weeks that you know, goals were set and then every goal was followed up and if it didn't work then there was ways around it, discussed you know rather than random goal setting which does happen in other groups. (Mullen et al., 2020, p257)

Theme 2: Staying with the overwhelming emotions

The experience of overwhelming emotions and staying with this was referred to in the majority of the studies (excluding Lucre & Corten, 2013; Heriot-Maitland et al., 2014) and appeared to be important for the therapeutic experience. All studies indicated that prior to therapy emotions were avoided and were experienced as distressing or overwhelming. Mernagh et al (2020), who specifically investigated mind-body attunement, reported participants

experienced physiological symptoms and discomfort with their emotional distress. The physiological discomfort was described as unwelcomed, debilitating, and difficult to engage with.

> I've always prided myself on not showing emotion and keeping it buttoned down and now I realise that's something really quite negative to do to yourself, and I remember...I just burst out crying and couldn't stop and she [other group member] gave me a really big hug and it made me cry more but that was what was important and going back in to tackle the rest of that week... meant that I was emotionally raw and receptive and I think that's why I got such a strong epiphany, 'cause I was already kind of open and I wouldn't have necessarily had that if I'd dissociated and shut everything down. (Ashfield et al., 2021, p295)

A common theme that was found was the experience of therapy evoking a strong, powerful emotional response. This was described as intense, overwhelming and distressing in nature. Additionally, sharing emotions with others in a group was described as exhausting (Mullen et al., 2020). However, participants reported that ultimately this was an important experience for their change process and this was cathartic. This is consistent with Gilbert's (2009a) suggestion that CFT requires individuals to have courage and direct exposure to threatening and feared feelings. This allowed individuals to increase their resources for managing difficult emotions, which aligns with CFT's goal of regulating threat-based emotions (Gilbert 2009c). For example, after expressing and processing emotions that were previously avoided participants said:

> This is the calmest I've been all week. I've been so anxious and felt horrible all week and I'm just like now I feel calm, so it has like an immediate impact and effect on me which is good. (Bell et al., 2019, p149)

For participants diagnosed with PTSD (Ashfield et al., 2021) it led to a sense of readiness to engage in exposure therapy as they reported having increased resources for managing difficult emotions. Participants in Mernagh et al (2020), reported a reduction in their emotional and physical distress, and an improvement in their relationships as a result of not reacting impulsively to their emotions.

Specific techniques utilised such as Chairwork (Bell et al., 2019; 2021a; 2021b) enabled individuals to be more open and willing to feel each emotion, allowing for greater capacity to focus and express emotions. They described accessing emotions as a form of discovery and were

surprised at the depth of the experience and variety of emotions present. Again, this was described as intense and distressing. However, participants felt that the emotional nature of Chairwork was essential to their therapeutic experience as it created a deeper understanding of emotions that might have previously been avoided. This led to an increased emotional connection with the self, and emotions were treated with acceptance, care and support, rather than criticising, avoiding or supressing them.

> It develops your understanding, you have got a lot of different emotions and inclinations and, you know, there's lots pulling you in different directions and the self is very messy… I feel like I'm doing well to organise such complex thoughts now, there is a sense of pride in that I guess. (Bell et al., 2021a, p229)

Similarly, the use of multiple-self exercises (Mullen et al., 2020) helped in the understanding and tolerating of emotions.

> …like the multiple-self exercise I thought that was quite good cause a lot of the time if I came in I was just muddled with emotions and it kind of helped to separate it. (Mullen et al., 2020; p260)

Theme 2.1: Genuinely feeling emotions rather than just considering them hypothetically

Three studies reported a common theme of participants describing their experience as feeling the emotions and compassion in the body not just in the mind (Bell et al., 2019; 2021b; Lawrence & Lee, 2013).

> In the beginning I didn't believe it. I'm trying to be compassionate to myself but I don't actually see that… But as it went on now I can feel it in my body than, rather than just in my mind. (Lawrence & Lee, 2013, p500)

Participants described Chairwork as a helpful exercise to connect and stay with their emotions (Bell et al., 2019; 2021b). Chairwork made the experience of emotions 'real,' more memorable and easier to recall.

> You start to feel, really genuinely. In the exercise it wasn't just hypothetically, It was something that was real. (Bell et al., 2021b, p9)

Participants compared this experience with previous experience of cognitive exercises and interventions. They described having a genuine and deeper connection with the felt emotion, rather than the emotion being something abstract which led to a feeling of disconnect in previous cognitive experiences. This is in line with the aim of CFT as it was developed in response to the

recognition that a number of people may generate alternatives for their negative thoughts but may not necessarily 'feel' this at an emotional level (Gilbert, 2009a).

> And that was a definite feel-it moment. Whereas I could talk to you about it all day long, that was a definite feel-it. I get it in here what is happening and having had CBT I get it up here but I do need to feel it and I definitely felt it today. (Bell et al., 2019, p149)

Theme 3: Understanding of self and experiences

All studies provided psychoeducation on the evolution of the "tricky brain" in line with Gilbert (2014). All studies reported a sense of better understanding of the self from the participants following CFT. It seemed that having a better understanding of the self led to a decrease in participants' self-blame. Ashfield et al. (2021) and Bell et al. (2021b) specifically reported that psychoeducation and being able to relate emotions to their evolutionary origin helped participants to make sense, comprehend and predict their patterns of thinking, feeling and behaving.

> I really liked the sort of clinical psychology aspect of it. . .explaining to us how our brain works because then you don't feel like it's such a personal problem, it's like, well all humans have the same brains and this is why my brain's done that and you don't feel alone you think oh I'm part of the human race then and this is how we all work. (Ashfield et al., 2021, p294)

However, two individuals from Heriot-Maitland et al., (2014) paper described valuing group discussions more than the didactic aspect of group CFT. They also described valuing space and time for reflection to consolidate learning. Therefore, it is important for clinicians delivering CFT to explore individuals' preference and learning consolidation.

Participants also reported experiencing a sense of common humanity and shared experiences, as normalising and validating, and less isolating (Ashfield et al., 2021; Bell et al., 2021b; Heriot-Maitland et al., 2014; Lawrence & Lee 2013; Lucre & Corten 2013; Mullen et al., 2020). Heriot-Maitland et al., found that part of the 'de-shaming process' was individuals seeing their own stories reflected in the stories of others.

> Yeah it felt good that people were all in the same boat and then you were kind of listening to people going "oh yeah, well I do that and oh she does that too" —so yeah you didn't feel alone which was nice. (Mullen et al., 2020; p257)

Furthermore, the realisation that participants were not to blame for their experiences was reported as an integral part to the change process as it allowed participants to create a different and more compassionate relationship with themselves (Ashfield et al., 2021; Lawrence & Lee 2013; Mullen et al., 2020). The understanding and acceptance of oneself and their past was described as an effortful and intentional change (Mullen et al., 2020). This understanding allowed individuals to develop the belief that they were worthy of compassion and of addressing their difficulties.

> I had to realise that it's not my fault. . . it was the other, the person who was in an adult mind and I was a child and so the blame is with them, it was nothing to do with me, I think that was one of the biggest moments, I mean, so much helped but that was one of the biggest ones to see I didn't have to blame myself anymore. (Ashfield et al., 2021, p295)

For participants in Mernagh et al. (2020), CFT led to a better understanding of their body and discomfort, which led to an increase in connection between mind and body.

> I think it's a question of interpretation chest constriction - heart attack? No. This is not the end, this is just a symptom of something that's happening for you right now, because there's something triggering that. (Mernagh et al., 2020, p2020)

Participants reported Chairwork led to new insights to the function and motivation of each self and their internal relationships (Bell et al., 2019). They reported a better understanding of their emotions which led to 'negative' emotions being utilised and redirected for alternative purpose. Similar findings were reported in Bell et al. (2021a), where participants were able to make links to the origin of the self-critic which led to an understanding of the self-critic's protective function, increasing empathy.

> Actually a reasonable response based on situations that I've been in before. I've been in a similar situation where something bad has happened so naturally I'm going to be, my defence system is going to be kicking in, so in that sense, it was helpful in legitimizing the voice (Bell et al., 2021a, p232)

Theme 4: Recasting the self-critic

A core aim of CFT is to help individuals replace self-criticism with self-kindness by developing an internal compassionate relationship (Gilbert 2009a). During CFT, the different forms and functions of self-criticism is analysed, and individuals learn to turn to "compassionate self-correction" (Gilbert, 2020). This theme identifies the process of individuals analysing the

forms and functions of self-criticism. However, individuals did not refer to replacing self-criticism. Instead, they described recasting the self-critic and this theme identifies how this process was experienced by individuals. As previously mentioned, the participants reported an increase in their understanding of the role of the self-critic, which led to a better relationship with the self-critic. Prior to this the self-critic was viewed as a way to cope with negative emotional experiences (Lawrence & Lee, 2013), threat (Bell et al., 2021a; Lucre & Corten, 2013) particularly when the threat is related to being vulnerable to external criticism, rejection or harm, and experience of shame and eating-disordered behaviours (Mullen et al., 2020). The self-critic was understood as something that motivated and enabled people to achieve, maintain personal performance and standards (Bell et al., 2021a; Lawrence & Lee, 2013). Therefore, it was understandable that participants expressed a reluctance to give up their previous way of coping and questioned their self-identity if they were not self-critical (Lawrence & Lee, 2013).

> Am I going to like the person that I've become? because I've been like this, with these memories and these thoughts and this for so long. (Lawrence & Lee, 2013, p499)

However, there was a clear acknowledgement that the critic's focus was on preventing performance failure rather than promoting positive attributes (Bell et al., 2021a). Alongside the self-critic was the self-blame (Ashfield et al., 2021; Lawrence & Lee, 2013) and "deep set self-hatred" (Ashfield et al., 2021). It was identified as a barrier to self-compassion and was difficult for individuals to tolerate. For example, Ashfield et al., found as participants became more self-compassionate, their self-critical thinking also increased.

> I didn't expect that the kind of negative voice would get a lot stronger as the positive compassionate voice was growing… there's like two warring sides as one is kind of beginning to challenge it, the other side has fought even stronger to kind of cling on to those things. (Ashfield et al., 2021, p297)

Bell et al. (2019) also reported the process of experiencing the self-critic during Chairwork was distressing and temporarily beyond individuals' capacity to tolerate. However, emotionally feeling the distress caused by the self-critic was an integral part in understanding the nature of the self-critic and its full impact.

> I thought she was a bitch, the critical woman … it was that chair, that she was a bitch and she [other chair] needed to pull herself together, why let someone treat you like that, and then I started

> crying because I realized, literally I would never do that to anyone else. I would never do that to anybody. (Bell et al., 2019, p148)

Lucre and Corten (2013) and Mullen et al., (2020) found that individuals were able to identify when they were engaging with the self-critic. Individuals reported a shift in their perspective and found different strategies for dealing with the self-critic rather than blaming themselves for its existence. The understanding and reappraisal of the role of the self-critic was important in the therapeutic process. For example, participants reported that understanding the self-critic's origins and motivation such as, threat protection, led to an increase in empathy (Bell et al., 2021a). The self-critic being viewed as a protector, or like the "kid" who had negative experiences, led to wanting to soothe the self-critic and working with it rather than rejecting it. The role of the self-critic was reappraised as a prompt to the compassionate self to address the need for safety and support. It was as if the self-critic was recast as a defensive response.

> When you are looking at it from your compassionate side you see where it comes from and what it is trying to do, you see it is part of you, you see it is kind of just like a kid almost, like a kid who grew up with a bunch of negative experiences to deal with stuff and you are there like, it is fine, I'll help you out. (Bell et al., 2021a, p232)

Theme 5: The mediating and empowering role of the compassionate self

The development of self-compassion was reported as gradual and challenging (Ashfield et al., 2021) and was described as unexpected as it was different to their expectations of what self-compassion might feel like (Lawrence & Lee, 2013). Participants reported a sense of fear of self-compassion. It was described as a new concept with not many participants having experienced it before.

> It's as if I was frightened of it [self-compassion]. I was frightened of how I was going to feel. How I was going to react. Because I was never used to doing things to help myself" (Lawrence & Lee, 2013, p499)

Participants also expressed scepticism about self-compassion and felt they are undeserving of self-compassion, that it did not feel right, it was self-indulgent and it was a sign of weakness. This is in line with Gilbert's (2010) hypothesis that self-compassion can trigger metacognitive beliefs in individuals that they are not deserving of compassion or perceiving this as weakness.

> I'm a compassionate person towards others but compassion towards me is a sign of weakness so I was very much, it's not for me, so it's for others and I can give it, but I don't want it, I don't want it for myself and I don't want it from others. (Ashfield et al., 2021, p293)

However, despite the fears and scepticism, all studies (excluding Heriot-Maitland et al., 2014) reported that participants were able to develop self-compassion and overall, participants reflected on this as having a positive emotional impact. The development of self-compassion led to a sense of empowerment, increased self-worth, feeling stronger, being more assertive with needs, and the belief they are deserving of self-care rather than viewing this as something that needs to be "earned" (Ashfield et al., 2021; Lucre & Corten, 2013; Mernagh et al., 2020; Mullen et al., 2020). It also led to improved abilities to access feelings of soothing and a sense of looking after themselves.

> I'm compassionate to myself, and its related, because if I'm kind to myself, I listen when my body tells me 'You've had enough, you need to rest'. (Mernagh et al., 2020, p2021)

> It made me feel like I've put on a compassionate armour where y'know I'm able to handle each day better and I feel like I've got a security armour on and I'm able to just be compassionate with all aspects of my life… it makes me feel stronger and feel more empowered. (Ashfield et al., 2021, p296)

Three studies specifically explored participants experience of Chairwork where participants are prompted to embody and enact each emotional self; therefore, self-compassion was experienced from the compassionate self (Bell et al., 2019; 2021a; 2021b). The compassionate self was experienced as someone who has a caring motivation with caring intention, capable of empathy for one's own reactions and experiences and as having a 'parenting role' (Bell et al., 2021a; 2021b).

> …Being the compassionate one, it just felt like, you know, wise and knowing and love, pure love. While those two were fighting out of fear [self-critic and self], the compassionate self was just pure love and so wise. A wise part of me. (Bell et al., 2021a, p231)

Chairwork studies (Bell et al., 2019; 2021a; 2021b) pointed towards the suggestion that the compassionate self had a role to unify internal, conflicting motivations. For example, participants reported positioning the compassionate self in the middle of the self-critic and the criticised self, which was linked to the mediating and integrating role of the compassionate self (Bell et al., 2019). The compassionate self was viewed as having the capacity for reason and

balance and led individuals to accept and work with difficult emotions in a constructive and healthy manner, rather than attempting to criticise or avoid or suppress the emotions (Bell et al., 2021a; 2021b). This sense of balance between affective states was also reported in Mernagh et al. (2020). Participants in Bell et al. (2021b) reflected that the role of the compassionate self was to understand, reorganise and coordinate emotions into a coherent whole.

> For me it is about the last compassionate self acknowledging that all of that together makes up one individual... combine it all and make it so you are a fully functioning adult human that is capable of making decisions and living life the way you want to. (Bell et al., 2021b, p11)

Theme 5.1: Compassion for others facilitated compassion for self

Previous studies suggests that an increase in any of the flows of compassion, can lead to an increase in the other two flows and vice versa (Gilbert et al., 2017; Henshall et al., 2018). This process was observed in five studies when developing self-compassion (Ashfield et al., 2021; Bell et al., 2019; 2021a; 2021b; Mullen et al., 2020). Ashfield et al. highlighted the importance of participants hearing other's experience as this facilitated their understanding of their own experience. It seemed this led to experiencing compassion for others and questioning how they treat themselves. Ashfield et al. and Mullen et al. also highlighted that experiencing and accepting compassion from others within group therapy was an important step for participants becoming receptive to developing self-compassion.

> I think it was just listening to everybody else and seeing how upset (they are) and their little prisons that they were in and it was like a reflection of me, is this what I'm like? Because I wouldn't want that for that person, and yet I'm doing it for me. (Ashfield et al., 2021, p294)

In the Chairwork studies (Bell et al., 2019; 2021a; 2021b) participants treating themselves compassionately as if they were another person (externalised as a chair) made it easier to accept self-compassion. By utilising their capacity to care for others (self as chair) they were able to relate this to themselves, helping to overcome blocks to self-compassion.

> It is nice with a separate chair if you like, separate people, and you can almost imagine what it would be like said to another person and yeah, suddenly it becomes a lot nicer, easier. (Bell et al., 2019, p148)

In contrast, individuals within the inpatient setting (Heriot-Maitland et al., 2014) described becoming more sensitive to others' wellbeing and learned ways to show compassion for others. However, individuals did not discuss how compassion could be applied to themselves.

The study did not explore reasons for this. However, this difference could be due to the group therapy structure being shorter and included less content, as compared to the other groups.

Theme 6: Feeling more in charge

One of the goals of CFT is developing competencies, which are described as a sensitivity to the suffering of self and others, and a motivation to try to alleviate and prevent suffering (Gilbert, 2009c; 2019). The review found that participants have a more self-compassionate mindset which included actively engaging with their distress, then actively doing something about this (Ashfield et al., 2020; Lawrence & Lee, 2013; Mernagh et al., 2020; Mullen et al., 2020). For example, engaging in self-care or allowing themselves to engage in activities they enjoy. To do this, participants reported developing a sense of agency which was found in the majority of the studies (excluding Heriot-Maitland et al., 2014). As reported in the previous theme, the development of self-compassion was reported as challenging. Participants spoke about having to actively push through the self-critic to experience and feel self-compassion, with this being in their control (Lawrence & Lee, 2013; Lucre & Corten, 2013; Mullen et al., 2020). Participants also reported that self-compassion required practice, and work must continue after therapy (Ashfield et al., 2021).

> I felt a bit stupid to start with. You feel a little bit stupid talking to yourself but you kind of, that's the crucial point when you have to push yourself through that phase and then force yourself to do it. (Lawrence & Lee, 2013, p499)

Participants in Mernagh et al. (2020) described feeling like they have more choice in how they respond to their body, and being more present in the moment.

> You feel more in charge if you like... the horse is still galloping, but you have the reigns on it. (Mernagh et al., 2020, p2022)

Furthermore, doing Chairwork resulted in the identification of a sense of agency over emotions and multiple selves (Bell et al., 2019; 2021a; 2021b). This included being able to choose which aspect of the self or emotion is given a voice, space or attention while quietening the others.

> It is a lot easier to jump into it, like jumping into another outfit or something and then you can quickly and more effectively deliver some compassion and then you can obviously when you isolate when you criticize yourself, I can recognize that, oh it is just that part and set it aside. (Bell et al., 2021a, p229)

Discussion

As CFT is a process-focused therapy, it was recommended that research should explore the process of change in CFT (Kolts, 2016) and focus on specific processes the therapy proposes it can address (Basran et al., 2022). CFT was designed for and with people with complex mental health difficulties (Gilbert, 2009b). A strength of this review is that it provided a synthesis of the published literature around the therapeutic experience of individuals with varying mental health difficulties who undertook CFT. The research questions and application of a meta-synthesis methodology, across several papers, enabled for new insights to be gathered with key concepts and themes. It highlighted aspects and processes that individuals found important for their therapeutic experience and change process. This included safeness within therapy, experiencing and staying with difficult emotions, understanding of self and experiences, feeling compassion for others which facilitated compassion for themselves, and their active role in therapy such as pushing through difficult experiences.

The findings of the synthesis presented how CFT as an intervention was experienced by individuals with mental health difficulties. For example, it was proposed that CFT therapists' role is to help individuals experience safeness in their interactions with them (Gilbert, 2009a). It was highlighted in the review how this was experienced by individuals and contributed an understanding that therapists also had to be someone who was credible and who challenged individuals in therapy. Furthermore, a core aim of CFT is to help individuals develop an internal compassionate relationship with themselves and replace self-criticism with self-kindness (Gilbert, 2009a). The result of this review presented the process of recasting the self-critic rather than replacing this; it was something to connect with, rather than to oppose or destroy It also presented how individuals developed self-compassion and how they were able to shift from viewing self-compassion as a weakness to something that was empowering, a process that enabled participants to feel more in control. Other experiences highlighted in this review were experiencing overwhelming emotions which contributed to the 'felt' sense of therapy rather than only having an abstract and disconnected cognitive experience, the experience of self-criticism becoming heightened during the development of self-compassion, and a developed sense of agency when engaging with their distress.

Clinical Implication

The results highlighted the importance of safeness within therapy for individuals. This sense of safeness was generated from the therapists and other group members for those who engaged in group therapy. It was unclear if this was specific to CFT or the therapist themselves. For example, Gilbert (2010) proposed that CFT aims to help individuals to accept and direct warmth and compassion to the self, with the therapist helping to validate, normalise, contain, and work with feelings of shame and fear of compassion (Gilbert, 2009a). Nevertheless, it is important that CFT therapists are aware of the value that individuals placed on perceiving therapists as human beings who genuinely cared for them.

Furthermore, the findings contribute to theoretical ideas that group therapy for people with mental health difficulties can help to reduce shame, stigma and feelings of isolation, and can provide inspiration and hope to individuals (Yalom & Leszcz, 2005). It supports the suitability of CFT delivered as a group intervention. This sense of connectedness within groups was possible through participants feeling safe within the group. The feeling of safeness was facilitated through having clear group rules and boundaries, as well as having clear group structures and goal settings, which are important for CFT group facilitators to note.

Themes two and three, emphasise the importance of psychoeducation and allowing space for individuals to work through difficult emotions and processes, for CFT to be effective. This is particularly important to note when delivering CFT within services that places pressure on therapy being time limited. Cost-effectiveness has become a key point within the delivery of psychological interventions due to the increasing constraints within NHS mental health services (Economic and Social Research Council, 2013) consequently, time limited psychological therapy has become the principal framework implemented across mental health services (Clark, 2011).

The results also highlighted the challenges of CFT and individuals having to “push through” difficult emotions and experiences. The individuals spoke about their active role in therapy and after therapy in practicing self-compassion. It is important for individuals wanting to or currently undertaking CFT to have an awareness of these challenges and note that this is part of the process.

Limitations and Future Studies

A limitation concerns the influence of the author in the synthesis of the studies. For example, the researcher had some knowledge and pre-conceptions of CFT which may influence the synthesis. However, a meta-ethnographic approach is interpretative in nature with the aim of developing a third-order, interpretative account. Additionally, Yardley (2008) proposed that researchers completing qualitative research must accept the inevitable influence they have on the research process, with reflexivity being considered throughout.

The small number of studies within this review highlights a clear need for further research into the experiences of individuals with mental health difficulties engaging in CFT. In particular, research exploring the change process using a constructivist grounded theory (Charmaz, 2014) to develop explanatory theoretical models would be valuable to further understand the therapeutic change experienced by individuals, similar to the method used in Ashfield et al., (2021).

A fundamental process that was mentioned in the CFT literature was working through emotions of grief (Gilbert 2022b). However, this did not appear in any of the papers included in the review. Reasons for this could be that this was not expressed by the participants or the focus of the research questions did not allow for exploration of this process. It would be valuable for future research to explore the experience of this process.

The role of the therapist was discussed in the CFT literature and within this review. It would be valuable to also investigate the therapists' perception of the therapeutic change. For example, individuals reported intense emotions during therapy. Additionally, the findings highlighted those individuals who experienced self-criticism appeared to have a barrier to accessing self-compassion. It would be beneficial to investigate therapists' experience of the exploration of intense emotions and how they work with individuals to overcome barriers, particularly if it is a fear of compassion that is blocking the flow of compassion. It may also be valuable to explore the experience of individuals' completing therapy , alongside the therapists, to identify how their experiences matched or differed.

All the participants in the research papers included in this review completed a full course of CFT; therefore, exploration of the experience of those who dropout of CFT would be valuable. Although there are many factors contributing to a person not continuing with therapy, exploring their experiences could potentially lead to an understanding of what processes may be

unhelpful for them. For example, a meta-analysis on the dropout from CBT proposed possible clinical applications such as using preparatory strategies (Fernandez et al., 2015).

Furthermore, future research should consider the engagement of individuals who may have had lived experience of using CFT in co-designing research. For example, Fylan et al., (2021) proposed using experience-based co-design research with patients, carers and healthcare professionals to develop theory-based interventions. Although, this is targeted at medicine, they proposed ideas of how to collaboratively involve patients in the process of research. Collaborating with experts by experience could potentially lead to novel and useful research outcomes.

Conclusion

The present review explored the experience of CFT within adults with mental health difficulties. The syntheses identified themes that explored individuals' experience of self-criticism, development of self-compassion, understanding of themselves, and development of a sense of agency. It also explored individuals' experience within CFT such as, experiencing intense emotions, having a 'felt' experience, and the importance of having a sense of safeness within therapy. The findings highlighted a need for further qualitative research within different populations that explore the experience and mechanisms of therapeutic change in CFT.

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Tables and Figures

Figure 1: *Flow diagram of the systematic search process following PRISMA guidelines* (Page et al., 2020).

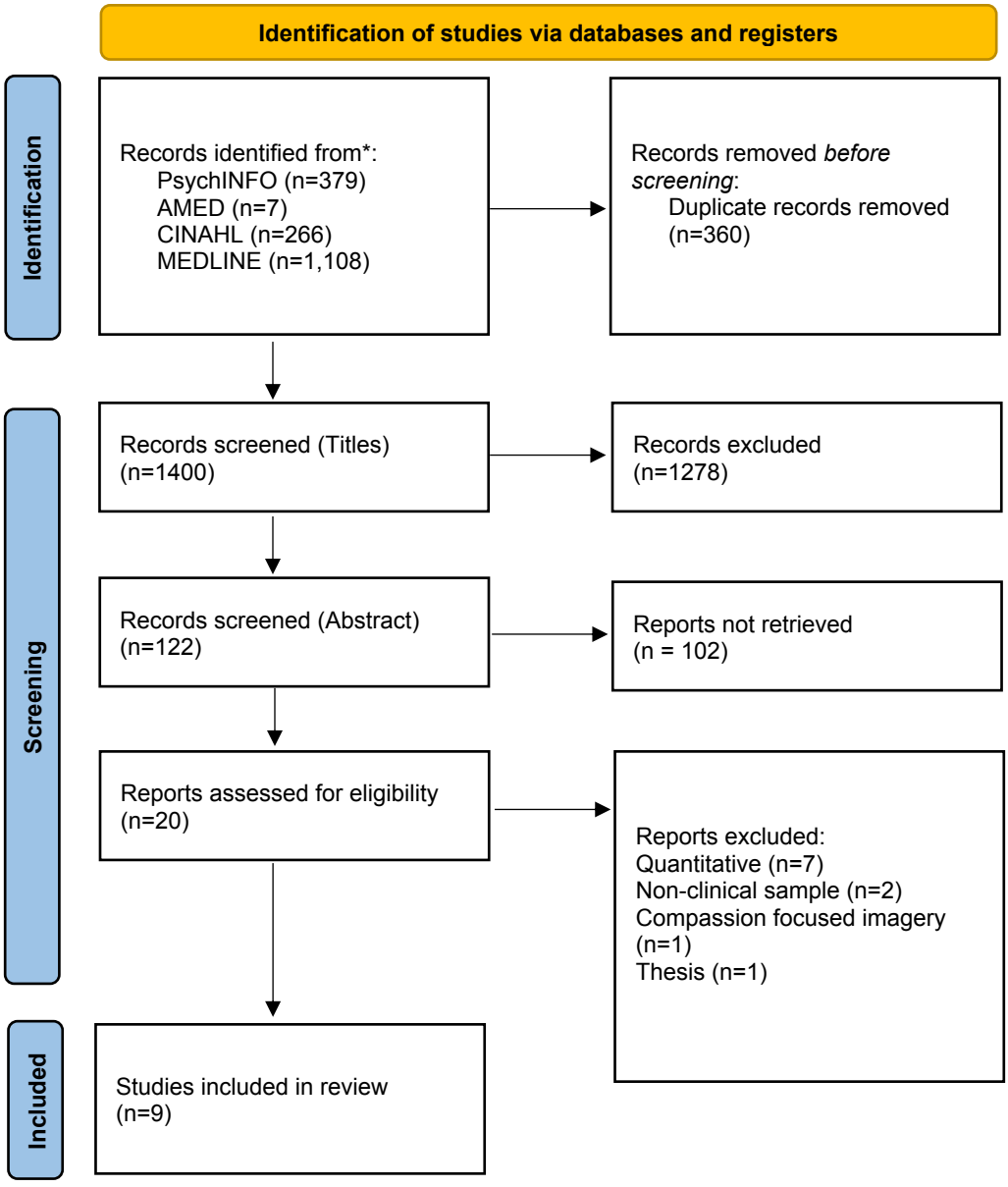

Table 1

Included Papers Characteristics

Paper and Country of Origin	Research Aims	Data Collection and Methodology	Participant Characteristics	Mode of CFT	Themes and Main Findings
Lawrence, V. & Lee, D. (2013) UK	To produce an in-depth understanding of the experience of completing a course of compassion-focused therapy and of the process of developing self-compassion.	Semi-structured interview Interpretative Phenomenological Analysis	n = 7 (female = 5, male =2) All participants met criteria for DSM-IV criteria for a diagnosis of PTSD Aged between 30 to 54 years	4 Participants completed CFT in a group format 3 Participants completed CFT individually	5 superordinate themes and 10 subordinate themes 1. The battle to give up the inner critic: who am I if I am not self-critical? 1.1 Fear of loss of self-identity 1.2 The relationship between self-compassion and self-criticism 2. An aversive and alien experience: how it feels to develop self-compassion 2.1 Self-compassion is alien and a frightening experience 2.2 I don't deserve self-compassion 2.3 The desire to reject self-compassion and CFT: it feels hopeless 3. The emotional experience of therapy 3.1 The importance of the therapeutic relationship 3.2 Feeling versus thinking compassion - realizing it's not my fault 3.3 I am not alone in my struggles 4. Self-compassion as a positive emotional experience 5. A more positive outlook in the present and for the future 5.1 Enjoying life rather than just living it 5.2 A new sense of hopefulness for the future"

Table 1 *(Continued)*

Paper and Country of Origin	Research Aims	Data Collection and Methodology	Participant Characteristics	Mode of CFT	Themes and Main Findings
Ashfield, E., Chan, C., & Lee, D. (2021) UK	To understand the process of change for individuals with complex PTSD who had attended a group treatment based on CFT.	Semi-structured interview Constructivist Grounded Theory	n = 11 (all female) All participants were assessed as having complex PTSD Aged between 22 to 62 years Identified as white (n=10) Identified as mixed-race (n=1)	CFT based group treatment	*Pre-group* - Experiences prior to attending the group - Overcoming barriers and readiness for change *Change process* - The group - Mechanism I - Understanding - Mechanism II - Experiencing - It's not my fault - Self-compassion cycle *Personal changes* ***Outcomes described:*** - Improvements in self-worth and assertiveness - Changes in relationships, both positive and challenging - Increased self-compassion and self-care - Reduction in PTSD symptoms - Feeling more prepared for processing trauma memory in exposure therapy
Mernagh, M., Baird, K. & Guerin, S. (2020) UK	To investigate subjective bodily changes with attending transdiagnostic CFT group.	Phenomenological interview Thematic Analysis	n = 23 (female = 16, male = 7) Average age: 49 Self reported mental health difficulty: Comorbid depression and anxiety (n =10)	CFT group - eleven weekly and three monthly, three-hour sessions that run over approximately 6 months	1. The body knows what's wrong (but is not always heard) 2. Aligning wavelengths: tuning into the body 2.1 Increased awareness of emotional distress in the body 2.2 Increased listening to one's body 2.3 Increased acceptance of bodily discomfort

Table 1 *(Continued)*

Paper and Country of Origin	Research Aims	Data Collection and Methodology	Participant Characteristics	Mode of CFT	Themes and Main Findings
			Depression/dysthymia (n = 4) Bipolar disorder (n = 5) Other (anxiety, personality disorder diagnosis, schizo-affective disorder diagnosis, chronic fatigue) (n = 3) Unknown (n= 1)		2.4 Increased identification of situational reasons for bodily discomfort 2.5 Decrease in worrying about bodily sensations 3. Building body-informed behaviour 4. A body heard is a balanced body 5. Compassion - a bedrock for body-related change
Lucre, K., & Corten, N. (2013) UK	To evaluate a newly developed CFT groupwork programme for people with a diagnosis of Personality Disorder	Written therapy reflections and documented feedback Content Analysis	n = 8 (female = 6 and male = 2) Aged between 18 and 54 years All participants have a diagnosis of a Personality Disorder	CFT based group treatment	Themes: 1. Taking responsibility for one's thoughts and reassurance 2. The comfort of shared group experiences 3. Fear of compassion 4. Awareness of self-criticism and addressing it with assertive action
Heriot-Maitland, C., Vidal, J., Ball, S., & Irons, C. (2014) UK	This study aimed to explore the development and administration of a CFT group in inpatient mental health settings, characterized by unpredictable admission lengths, various or uncertain diagnoses, and high levels of distress.	Semi-structured Interview Thematic Analysis	n = 4 Transdiagnostic group within an inpatient Mental Health service	CFT based group treatment	Themes: 1. Common humanity and affiliative relating 2. Understanding compassion 3. Activating positive affect 4. Experiences of the group

Table 1 *(Continued)*

Paper and Country of Origin	Research Aims	Data Collection and Methodology	Participant Characteristics	Mode of CFT	Themes and Main Findings
Mullen, G., Dowling, C., Doyle, J., & O'Reilly, G. (2020) UK	To use a Social Mentality Theory framework to explore the experiences of individuals attending a CFT-E2 group intervention.	Semi-structured Interview Thematic Analysis and Relational Analysis	n = 9 (all female) Aged between 21-58 All with a diagnosis of Eating Disorder	All participants completed CFT-E2 (CFT programme designed for eating disorders with established techniques from cognitive behavioural therapy for eating disorders)	Participants' experiences during CFT-E2 group intervention themes: 1. Flow of compassion and knowledge 2. Sharing, connecting and belonging 3. Hope and trust 4. Structure and accountability 5. Strength, struggle and practice 6. Managing dilemmas
Bell, T., Montague, J., Elander, J. & Gilbert, P. (2019) UK	To explore how clients with depression experience, receive and understand a specific compassion-focused chair-work intervention that targets self-criticism.	Semi-structured Interview Interpretative Phenomenological Analysis	n = 12 (female = 9 and male = 3) Aged between 19 and 49 years All accessing Improving Access to Psychological Therapies (IAPT) Services White-British (n = 8) White-Bulgarian (n = 1) White-Irish (n = 1) Asian-British (n = 1) Chinese (n = 1)	All participants were completing individual CFT: Chairwork intervention conducted during a single, one hour session	3 superordinate themes and 2 sub-ordinate themes 1. Embodiment and enactment 2. Externalising the self in physical form 3. Emotional intensity - Accessing and experiencing emotion - Overwhelming emotion and avoidance
Bell, T., Montague, J., Elander, J. & Gilbert, P. (2021a) UK	To answer the following questions: How do clients experience and	Semi-structured Interview	n = 12 (female = 9 and male = 3)	All participants were completing individual CFT: Chairwork	3 superordinate themes and 6 subthemes 1. Differentiating selves - Singular to multiple

Table 1 *(Continued)*

Paper and Country of Origin	Research Aims	Data Collection and Methodology	Participant Characteristics	Mode of CFT	Themes and Main Findings
	understand notions of "self-multiplicity" during Chairwork intervention? What is the lived experience of shifting social mentalities when working with self-multiplicity? And what occurs to various internal selves or parts when related with compassion?	Interpretative Phenomenological Analysis	Aged between 19 and 49 years All accessing Improving Access to Psychological Therapies (IAPT) Services White-British (n = 8) White-Bulgarian (n = 1) White-Irish (n = 1) Asian-British (n = 1) Chinese (n = 1)	intervention conducted during a single, one hour session	- New selves, new potential 2. Mental imagery of selves - Seeing selves - Past selves (memory and imagery) 3. Integrating and transforming selves with compassion - From conflict to integration - Transforming the critic: fears and function
Bell, T., Montague, J., Elander, J. & Gilbert, P. (2021b) UK	To understand clients' experience of the approach with the aim of improving its clinical application.	Semi-structured Interview Interpretative Phenomenological Analysis	n = 9 (female = 6, male = 3) Aged between 26 and 54 years All accessing Improving Access to Psychological Therapies White-British (n = 7) Black-British (n = 1) Mixed-Other (n = 1)	All participants were completing individual CFT: Chairwork intervention conducted during a single, one hour session	3 superordinate themes and 5 sub-themes 1. Appreciating emotional complexity - Multiplicity and differentiation - Dominance, absence and interaction 2. The role of Chairwork process - Embodiment to identify and access selves - Standing up, looking back: the benefits of moving chairs 3. Compassionate integration - Empathy, acceptance and integration

Table 2
CASP scores

CASP questions	Study Scores								
	Lawrence and Lee (2013)	Ashfield et al. (2021)	Mernagh et al. (2020)	Lucre and Corten (2013)	Heriot-Maitland et al. (2014)	Mullen et al. (2020)	Bell et al. (2019)	Bell et al. (2020a)	Bell et al. (2020b)
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	3	2	3	2	3	2	1	1	3
4. Was the recruitment strategy appropriate to the aims of the research?	3	3	3	3	2	3	2	2	3
5. Was the data collected in a way that addressed the research issue?	3	3	2	2	3	3	3	2	3
6. Has the relationship between researcher and participants been adequately considered?	3	3	1	1	1	3	3	3	3
7. Have ethical issues been taken into consideration?	3	3	3	1	2	2	2	2	2
8. Was the data analysis sufficiently rigorous?	3	3	1	1	1	3	3	3	3
9. Is there a clear statement of findings?	3	3	2	2	2	3	3	3	3
10. How valuable is the research?	3	3	3	2	3	3	3	3	3
TOTAL	24	23	18	14	17	22	20	19	23

Table 3
Meta-ethnography steps

1.	Getting stared
2.	Deciding what is relevant to the initial interest
3.	Reading the studies
4.	Determining how the studies are related
5.	Translating the studies into one another
6.	Synthesising translations
7.	Expressing the synthesis

Table 4

Themes and how the papers contributed to each theme

Themes	Lawrence and Lee (2013)	Ashfield et al. (2021)	Mernagh et al. (2020)	Lucre and Corten (2013)	Heriot-Maitland et al. (2014)	Mullen et al. (2020)	Bell et al. (2019)	Bell et al. (2020a)	Bell et al. (2020b)
1. The importance of safeness within therapy	✓	✓	✓		✓	✓			
2. Staying with the overwhelming emotions	✓	✓	✓			✓	✓	✓	✓
2.1: Genuinely feeling emotions rather than just considering them hypothetically	✓						✓		✓
3. Understanding of self and experiences	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Recasting the self-critic	✓	✓		✓		✓	✓	✓	✓
5. The mediating and empowering role of the compassionate self	✓	✓	✓	✓		✓	✓	✓	✓
5.1 Compassion for others facilitated compassion for self	✓	✓	✓		✓	✓	✓	✓	✓
6. Feeling more in charge	✓	✓	✓	✓		✓			

Appendix A

Clinical Psychology Review Author's Guidelines

Submission checklist
You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.
Ensure that the following items are present:
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• Full postal address
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• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)
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- Ensure manuscript is a comprehensive review article (empirical papers fall outside the scope of the journal)
- Ensure that literature searches and reviews are as up to date as possible and at least to 3 months within date of submission
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  • Journal policies detailed in this guide have been reviewed
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- Ensure Highlights do not exceed 3 to 5 bullet points with a maximum of 85 characters, including spaces, per bullet point

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References

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Appendix B

Search Terms

(DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" OR DE "Qualitative Measures") OR (Qualitative OR questionnaire* OR survey* OR interview* OR focus group* OR case stud* OR observ* OR thematic OR "content analy*" OR ethnog* OR phenomenol* OR (purpos* N1 sampl) OR EMIC OR ETIC OR hermeneutic* OR heuristic* OR semiotics OR (data N1 satur*) OR (participant N1 observ*) OR "field study*" OR "lived experience*" OR narrative OR (discourse N3 analysis) OR "grounded theor*" OR multi-method* or mixed-method* OR triangula* OR "formative evalua*" OR "process evalua*") OR AB (Qualitative OR questionnaire* OR survey* OR interview* OR focus group* OR case stud* OR observ* OR thematic OR "content analy*" OR ethnog* OR phenomenol* OR (purpos* N1 sampl) OR EMIC OR ETIC OR hermeneutic* OR heuristic* OR semiotics OR (data N1 satur*) OR (participant N1 observ*) OR "field study*" OR "lived experience*" OR narrative OR (discourse N3 analysis) OR "grounded theor*" OR multi-method* or mixed-method* OR triangula* OR "formative evalua*" OR "process evalua*")

AND

(("compassion-focused" OR "compassion focused" OR "compassion based" OR "compassion-based") N5 (therap* Or intervention*)) OR CFT OR "compassionate mind train*"

Appendix C

Inclusion and Exclusion Criteria

Inclusion	Exclusion
Adults with a diagnosis of Mental Health Disorder – research that identifies participants with a mental health disorder diagnosis through any version of Diagnostic and Statistical Manual of Mental Disorders (DSM), International Classification of Diseases (ICD), by referrer, medical records, clinical report, and case notes	Individuals under 18
Adults accessing Mental Health services	Neurological disorders
Compassionate focused therapy (individual or group) OR Compassionate mind training	Neurodevelopmental disorders
Qualitative methodology	Compassion intervention that is not Compassion Focused Therapy
Empirical data collection using qualitative methods (e.g. interviews)	Quantitative methodology and data analysis
Qualitative analysis of the data	
Mixed method studies that utilised qualitative methods and qualitative analysis	
Must include one or more participants	
Peer Reviewed	

Appendix D

Duggleby et al.'s (2010) three-point rating system

1	Offered little to no justification or explanation for a particular issue (e.g. where, when, or how the data were collected was not mentioned)
2	Addressed the issue but did not fully elaborate on it (e.g. the justification for using constant comparisons was presented but the procedure itself was not explained)
3	Extensively justified and explained the issue at hand (e.g. authors explained that semi-structured interviews were used, transcribed verbatim, and modified part way through the study, and then offered some example interview questions)

Appendix E

Emerging Themes

List of Emerging Themes

1. Self-Criticism
2. What was needed in therapy
    - 2.1 Therapist Characteristics
    - 2.2 Safeness in Group therapy
3. Active Role / Sense of Agency
4. Understanding of Self and Experiences
    - 4.1 Acceptance of Self
5. Felt Experience Instead of Cognitive
6. Shared Experience
7. Changed Direction of Compassion
8. Intense Emotions
9. Outcomes
10. Self-Compassion

Appendix F

Extraction of First and Second Order Constructs, and Development of Third Order Constructs Example

Study 1

Second Order Construct	First Order Construct	Third Order Construct
The battle to give up the inner critic: Who am I if I am not self-critical *Fear of loss of identity* This highlights that participants understood self-criticism to be important in enabling them to achieve and protecting them from a very negative self-identity. It also suggests that their experience of being asked to give up this previous way of coping evoked a void in which they began to question their self-identity	'am I going to like the person that I've become? because I've been like this, with these memories and these thoughts and this for so long' 'You have to push yourself, you have to. And then if you don't push yourself well you're just a bad person. You must be a high achiever because if you are not you are nothing. To start off with there was a vacuum and it was well that vacuum shows that I am nothing. I am worthless'	Self-criticism is part of identity - enabled individuals to achieve and cope (coping strategy) Sense of fear of losing this identity and way of coping Having to push through the self-critic to feel/experience self-compassion
The battle to give up the inner critic: Who am I if I am not self-critical *The relationship between self-compassion and self-criticism* When describing being introduced to the concept of self-compassion and what this felt like, participants talked about their experience of increased self-critical thoughts. Participants' experiences of increased self-criticism prevented them from becoming self-compassionate. It seemed that self-criticism was an important way in which participants coped with negative emotional experiences and that they were therefore reluctant to relinquish this familiar coping strategy.	'I felt a bit stupid to start with. You feel a little bit stupid talking to yourself but you kind of, that's the crucial point when you have to push yourself through that phase and then force yourself to do it' 'it isn't easy just to feel it [self-compassion] and get it and sometimes I get tired of it. I just think I'm bloody useless and I don't want to feel better. I don't want to think nice things. I don't want to feel good. And sometimes it is hard to do that but most times I can make myself feel that way'	
An aversive and alien experience: how it feels to develop self-compassion *Self-compassion is alien and a frightening experience* A number of participants described this process as alien in nature and something that they had never experienced before. Self-compassion was therefore a very difficult concept to understand and evoked a powerful emotional response.	Dread. Erm, it's as if, I don't know, it's as if I was frightened of it [self-compassion]. I was frightened of how I was going to feel. How I was going to react. Because I was never used to doing things to help myself' 'but it's [developing self-compassion] hard because you erm, it's like being an atheist and someone trying to convert you'	Self-compassion is a new, difficult and frightening experience - It's not usually people's way of relating to themselves Rejecting/avoiding self-compassion and feeling undeserving of self-compassion

An aversive and alien experience: how it feels to develop self-compassion *I don't deserve self-compassion* They therefore resisted becoming self-compassionate at the start of therapy and a number of participants commented on the experience of self-compassion as not feeling 'right', suggesting that this was not their usual way of relating to themselves.	'It's really difficult to start off with. Erm. It doesn't feel right to be kind to yourself. That was the hardest thing. I really sort of railed and struggled against that, because basically I felt that my illness was all my fault' 'I didn't want to be kind to myself. Because I still felt I didn't deserve to be happy or to have nice thoughts or to be kind to myself. I thought that by [being compassionate], there were things that would make me smile and I felt, well, I know it sounds silly, as if I wasn't allowed to smile'	Hopeless and sceptical about the therapy and being able to be self-compassion
An aversive and alien experience: how it feels to develop self-compassion *The desire to reject self-compassion and CFT: it feels hopeless* From their accounts of this experience, it seems that becoming self-compassionate felt like an impossible task, and one that they wanted to avoid.	There's no way that I'm going to think what you're telling me I am gonna think (laugh). There is no way at the end of 6 months that I am gonna think like this at all. I thought I might as well go home now' I think I just felt sceptical and the reason for that was it had been going on for so long without feeling any great improvement. You kind of begin to doubt whether you are ever going to feel any kind of improvement. Erm which is where the resistance comes from'	
The emotional experience of therapy *The importance of the therapeutic relationship* Acceptance, non-judgement, feeling valued and under- stood and feeling believed in were characteristics of the therapeutic relationship that participants described as helpful and important. Of particular importance to participants was their perception of the therapists as human beings, rather than just professionals, who genuinely cared for them rather than providing them with the tools to feel better. the therapists' belief in them enabled them to shift their beliefs about them selves. The experience of feeling safe in the mind of another was therefore of fundamental importance.	'One of the strongest things was the actual therapists themselves. Erm they were so kind. Erm the kindness was amazing. Erm not only as doctors but as human beings. Their generosity was, I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard' 'You need that kind of person steering you and guiding you through the process and actually just, just keep saying to you that it is okay to feel like this. It is okay to want to cry. It is okay to be nice to yourself. It is a good thing to be good to yourself'	Importance of therapist characteristics i.e. being human, non-judgemental, kind, empathy, validating, normalising experience, showing genuine care > but also challenging and making them work hard Therapists' belief in them enabled them to shift their beliefs about themselves
The emotional experience of therapy *Feeling versus thinking compassion - realizing it's not my fault* An interesting characteristic of the participants' experiences of this process was that they spoke of the difference between thinking that they were not to blame and feeling that they were not to blame.	I'm trying to be compassionate to myself but I didn't actually see that...I'd think to myself oh, you know, well, that's fine and I'm happy and on the surface everything's okay. But I never felt it. But as it went on, now, I can feel it. You know, I can feel it in my body than, rather than just in my mind' 'we just did a lot of work on blame and how it made us feel and how it wasn't our fault and things and I just had a "switch on" moment I suppose. To think well hang on a minute none of what happened to me was actually my fault'	Realising they are not to blame for past experiences was important particularly feeling they are not to blame and **feeling** this in the body than just in the mind (emphasise on difference between thinking and feeling they were not to blame)

The emotional experience of therapy *I am not alone in my struggles* Experiencing a sense of common humanity and shared understanding was important to them.	You think you are the only one and then you realize that you are not alone. There are other people who feel the same and you are not alone. It's just unfortunate that you have been through these experiences' 'It can make you feel less desperate. That there are other people that feel like you and you are not the only person who went through that experience. If you are really struggling it could be quite hard to see. Or it could be good to know of other people that have been through it and are doing better in life than you are. So it's quite, I think when you get to know people better, you get to know that actually you all have the same issues, the same anxieties'	Realising they are not alone in their experiences, and experiencing common humanity and shared understanding was important in the therapeutic experience
Self-compassion as a positive emotional experience participants also reflected on the positive experience of self-compassion. This appeared to be surpris- ing to them and different to their expectations of what self- compassion might feel like. The sense of surprise that participants expressed suggests that this was an unexpected and novel outcome and a feeling that they had not previously experienced.	'it was like getting a drink of water in the desert. Erm. Once I had kind of given up the addictions of blaming myself it was like this whole guilt trip had gone' 'I had a reaction that I could feel. No question about it there was a definite wow, that sort of feeling that you get shivers all the way down your back. It's like wow! Erm really quite something. You know a real sort of wow'	Impactful, positive emotional experience of self-compassion (surprising and unexpected - not previously experienced) Sense of feeling this in the body i.e. "shivers all the way down your back"
A more positive outlook in the present and for the future *Enjoying life rather than just living it* They described a new form of achievement in doing things that they enjoyed or from simple things in life, which reflects a more compassionate relationship with themselves. They had begun to allow themselves enjoyment from life, which they had neglected to do previously.	'I'm very generous with myself now and you know I wouldn't have gone anywhere as well. I had this thing about not, not, not being compassionate. Not taking myself off to the theatre and I love the theatre' 'I look forward to every day. I get a real sense of happiness and a real sense of achievement. It's a different kind of achievement to what I used to have. Just actually looking back at the end of the day and thinking actually I've done all those things and I've enjoyed them gives me a far greater sense of achievement and purpose than there used to be'	Allowing self to enjoy simple things and enjoying life - leads to a sense of achievement. Which they neglected to do previously
A more positive outlook in the present and for the future *A new sense of hopefulness for the future* They had developed a new belief that they deserved to be happy, which they had not held previously. This also reflects a more compassionate relationship with themselves.	'My whole outlook is different. I feel like I've got a future now, which I didn't feel, well I've never felt like that really. No, so I feel like I've got a future now, which I didn't feel like 6 months ago' 'It is still very, very difficult but I can see actually now I've got a future. I need to look towards my future and I deserve to have my future'	More compassionate relationship with self led to the development of a positive outlook of the future and a new belief that they deserve to be happy

Appendix G

Third Order Construct Excel Sheet with Emerging Themes

Each study was allocated a colour

	A	B	C	D	E	F	G	H	I	J
1	**Self Criticism**	**What was needed in therapy (Therapist/Group)**	**Active role / Sense of Agency**	**Understanding of self/experiences Acceptance**	**Felt experience instead of cognitive**	**Shared experience**	**Changed direction of compassion**	**Intense Emotions**	**Outcomes**	**Self-compassion**
2	Self-criticism is part of identity	*Therapist characteristics are important:* human being, kind, non-judgemental, empathic, validating, normalising, genuine care	Actively pushing through self-criticism to experience self-compassion	Realisation they are not to blame	**FELT** experience of they are not to blame rather than just thinking it	Realisation they are not alone in their experiences, common humanity, shared understanding	Compassion towards others turned towards self	Increased resources for managing difficult emotions	Allowing self to enjoy life and simple things	Self-compassion is new
3	Self-criticism as a way of coping	Therapist have to challenge patients	Self-compassion requires active practice	Better understanding of difficulties	Tangible experience of creating a sense of realness - rather than talking from a disconnected position	Isolating and feeling of being stigmatised	Experiencing and accepting compassion from others was an **important step to developing self-compassion**	Impactful and positive emotional experiecne of self-compassion	Sense of achievement	Self-compassion is difficult
4	Self-criticism prevents self-compassion	Therapists belief in participants enabled them to shift beliefs about themselves	Increase ability to self-soothe	Realisation that it is not their fault (integral change process)	Physical act - created a speaker and hearer - each self was both literally and metaphorically heard	Reduction of feeling isolated (from group)	Shocked at their treatment of another and realisation the distress caused by their self-criticism	"strong epiphany" - emotionally raw, strong emotional reactions, overwhelming emotions	More compassionate relationship with self	Self-compassion is frightening
5	Actively pushing through self-criticism to experience self-compassion	Psychological safeness in group - feeling understood, validated and valued	Allowing rather than fighting bodily discomfort **(Actively)** taking to self	Reduction of feelings of shame about experiences	Moving around chairs - understand and interact with inner experiences	Shared experience, felt listened to, non-judgemental, feel cared for (group)	Allowed for flow of compassion outward, as if to another, to be focused back toward self	Feeling emotions that was avoided before	New belief of being deserving of happiness	Feeling undeserving of self-compassion
6	Self-blame and self-critic	*Therapist characteristics:* knowledgeable and credible	Compassionate self - motivated participants to take more steps to care for their mody and be more balanced	Better understanding of difficulties	Contrasted experience with previous cognitive or lexical exercises that focused on rationale challenge or change i.e. "I get it up here but I do need to feel it"	Process was extraordinaroy/unusual for some participants - but understood that this was a shared/normal experience	Interacted with self as if they were interecting with another human being > applying social relational skills to internal world (increased slef-comp)	Able to connext with emotions	Positive outlook of the future	Reject or avoiding self-compassion
7	Felt they deserve their past difficult experiences	Understanding and normalising experiences	Development of more self-compassionate mindset **(Actively** doing something about this)	Able to connext with emotions	Genuinely feeling the emotion and expreience rather than hypothetical or abstract discussion - there was no emotional disconnect as previously experienced in cognitive interventions	Validating experiences as part of 'normal' human experiences		Physiological symptoms with emotional distress	Sense of empowerment and more assertivness with their needs	Impactful and positive emotional experiecne of self-compassion
8	Self-critic increased as self-compassion increased (at beginning)	Tangible experience of creating a sense of realness - rather than talking from a disconnected position	Acceptance but also feeling more in control i.e. more choice in how to respond to their body	Shame and threat somewhat reduced - balanced view of this	Bodily experience (impacted whole body and shaped its expression)			Reduced emotional and physical distress	Feeling deserving of self-care	Self-compassion was surprising and unexpected (not previously experienced)
9	Difference between the critical and the being criticised self - physical movements, expressions, posture	Contrasted experience with previous cognitive or lexical exercises that focused on rationale challenge or change i.e. "I get it up here but I do need to feel it"	identification of a degree of agency over emotions	Listening to body rather than "ploughing through"	Being in criticised chaire described as too much and temporarily beyond their capacity to tolerate			Emotions were felt as overwhelming - cathartic and helpful	Increase ability to self-soothe	Scepticism about self-compassion
10	Feeling the distress caused by critic's attack was integral in understanding nature of self-criticism and its full impact	Sense of playfulness, curiosity and discovery - found surprising	Sense of agency over which aspect of self is given space/attention	Able to acknowledge bodily discomfort - conversation with self about what is causing/happening	Feeling the distress caused by critic's attack was integral in understanding nature of self-criticism and its full impact			Blocks to emotions during the exercise were idiosyncratic	Better relationships	Compassion towards others turned towards self
11	Being in criticised chaire described as too much and temporarily beyond their capacity to tolerate	Genuinely feeling the emotion and expreience rather than hypothetical or abstract discussion - there was no emotional disconnect as previously experienced in cognitive interventions	**Intentional and active** use of imagery to connect with self and to access compassion when language prove to be inadequate	Understanding of reasons for bodily discomfort	feeling-based experience of self-compassion and a cognitive experience			Intensity and surprising emotions	Acknowledgement/Re-evaluation of difficult/problematic relationships	Increased self-worth (key in maintaining self-compassion)

	Self Criticism	What was needed in therapy (Therapist/Group)	Active role / Sense of Agency	Understanding of self/experiences Acceptance	Felt experience instead of cognitive	Shared experience	Changed direction of compassion	Intense Emotions	Outcomes	Self-compassion
12	Shocked at their treatment of another and realisation the distress caused by their self-criticism	Emotional self was treated with acceptance, care and support	**Deliberate** analysis of reactions - appreciating nuance and detail of emotional complexity	Acceptance of situation and bodily discomfort				Deeper knowing of emotions rather than avoiding emotions	Reduction in PTSD symptoms	Self-compassion requires active practice
13	Relief at 'shedding' part of the critic	Shared experience, felt listened to, non-judgemental, feel cared for (group)	Excersise provided sense of agency and flow over emotions i.e. being able to move between chair (symbolic sense of stepping out of emotional selves)	Balance beween affective stats				Better understanding of emotions	Felt able to engage in further therapy	Compassionate self - motivated participants to take more steps to care for their mody and be more balanced
14	Understanding of the role of self-critic and recasting this as a signal of fear or distress	Need to be ready for change	Emotional self was treated with acceptance, care and support	Acceptance but also feeling more in control i.e. more choice in how to respond to their body				Idiosyncratic emotional profiles	Increased resources for managing difficult emotions	Compassionate-self can be soothing and comforting
15	See critic as protection reaction to threat i.e threat to being vulnerable to external criticism, rejection or harm		Rather than avoiding, criticising or supresing emotions, particpants were able to motivate themselves (**active role**) to access self-compassion	Understanding of the function and motvation of each self and internal relationships they continue to create				Emotions were acknowledged as completely absent from their lives or awareness	Shame and threat somewhat reduced - balanced view of this	Direct comparison between internaly and external relating - helpful when attempting to generate self-compassion
16	Understanding origin of self-critic led to increased empathy		Increase taking control back from bodily discomfort	Shocked at their treatment of another and realisation the distress caused by their self-criticism				Emotions could be internally and externally directed, blocked or absemt at an interpersonal or intrapersonal level	Hopeful for future	Compassionate self was initially experienced as form of external position
17	Critic's presence was ultimately reappraised as a prompt to **"switch"** to the compassionate self to address the need for safeness and support		Motivation and willingess to attend and engage with material	Clarify and label emotions and ability to differentiate between each self				Witnessed emotional conflicts in real time- Emotions were experienced as interactive and dynamic with one emotion overriding and overwhelming or reacting to another	Wanting to enjoy life	Compassionate self - parental/caring intention, denonstrate capacity for reason and balance, willingness to open dialogue
18	Understanding of self led to reduction in self-criticism and self-blame			Understanding of reasons for emotions and 'negative' emotions				Enabled active balancing of emotion, down-regulating some emotions whilst holding space for others	Compassionate self - motivated participants to take more steps to care for their mody and be more balanced	Critic's presence was ultimately reappraised as a prompt to **"switch"** to the compassionate self to address the need for safeness and support
19				Ability to utilise and redirect emotions for an alternative purpose				Sensations were experienced as intense and amplified in manner	Improved ability to access feelings of soothing	Increased self-compassion to themselves and their emotions
20				Deeper knowing of emotions rather than avoiding emotions				Tangible expressions offered additional insights into the nature of each emotion	Balance beween affective stats	Compassionate self experienced as more reflective, rational, capable of empathy for ones reaction and expriences - Genuine affection to self

	Self Criticism	What was needed in therapy (Therapist/Group)	Active role / Sense of Agency	Understanding of self/experiences Acceptance	Felt experience instead of cognitive	Shared experience	Changed direction of compassion	Intense Emotions	Outcomes	Self-compassion
12	Shocked at their treatment of another and realisation the distress caused by their self-criticism	Emotional self was treated with acceptance, care and support	**Deliberate** analysis of reactions - appreciating nuance and detail of emotional complexity	Acceptance of situation and bodily discomfort				Deeper knowing of emotions rather than avoiding emotions	Reduction in PTSD symptoms	Self-compassion requires active practice
13	Relief at 'shedding' part of the critic	Shared experience, felt listened to, non-judgemental, feel cared for (group)	Excersise provided sense of agency and flow over emotions i.e. being able to move between chair (symbolic sense of stepping out of emotional selves)	Balance beween affective stats				Better understanding of emotions	Felt able to engage in further therapy	Compassionate self - motivated participants to take more steps to care for their mody and be more balanced
14	Understanding of the role of self-critic and recasting this as a signal of fear or distress	Need to be ready for change	Emotional self was treated with acceptance, care and support	Acceptance but also feeling more in control i.e. more choice in how to respond to their body				Idiosyncratic emotional profiles	Increased resources for managing difficult emotions	Compassionate-self can be soothing and comforting
15	See critic as protection reaction to threat i.e threat to being vulnerable to external criticism, rejection or harm		Rather than avoiding, criticising or supresing emotions, particpants were able to motivate themselves (**active role**) to access self-compassion	Understanding of the function and motvation of each self and internal relationships they continue to create				Emotions were acknowledged as completely absent from their lives or awareness	Shame and threat somewhat reduced - balanced view of this	Direct comparison between internaly and external relating - helpful when attempting to generate self-compassion
16	Understanding origin of self-critic led to increased empathy		Increase taking control back from bodily discomfort	Shocked at their treatment of another and realisation the distress caused by their self-criticism				Emotions could be internally and externally directed, blocked or absemt at an interpersonal or intrapersonal level	Hopeful for future	Compassionate self was initially experienced as form of external position
17	Critic's presence was ultimately reappraised as a prompt to **"switch"** to the compassionate self to address the need for safeness and support		Motivation and willingess to attend and engage with material	Clarify and label emotions and ability to differentiate between each self				Witnessed emotional conflicts in real time- Emotions were experienced as interactive and dynamic with one emotion overriding and overwhelming or reacting to another	Wanting to enjoy life	Compassionate self - parental/caring intention, denonstrate capacity for reason and balance, willingness to open dialogue
18	Understanding of self led to reduction in self-criticism and self-blame			Understanding of reasons for emotions and 'negative' emotions				Enabled active balancing of emotion, down-regulating some emotions whilst holding space for others	Compassionate self - motivated participants to take more steps to care for their mody and be more balanced	Critic's presence was ultimately reappraised as a prompt to **"switch"** to the compassionate self to address the need for safeness and support
19				Ability to utilise and redirect emotions for an alternative purpose				Sensations were experienced as intense and amplified in manner	Improved ability to access feelings of soothing	Increased self-compassion to themselves and their emotions
20				Deeper knowing of emotions rather than avoiding emotions				Tangible expressions offered additional insights into the nature of each emotion	Balance beween affective stats	Compassionate self experienced as more reflective, rational, capable of empathy for ones reaction and expriences - Genuine affection to self

1	Self Criticism	What was needed in therapy (Therapist/Group)	Active role / Sense of Agency	Understanding of self/experiences Acceptance	Felt experience instead of cognitive	Shared experience	Changed direction of compassion	Intense Emotions	Outcomes	Self-compassion
20				Deeper knowing of emotions rather than avoiding emotions				Tangible expressions offered additional insights into the nature of each emotion	Balance beween affective stats	Compassionate self experienced as more reflective, rational, capable of empathy for ones reaction and expriences - Genuine affection to self
21				Feeling the distress caused by critic's attack was integral in understanding nature of self-criticism and its full impact				Greater awareness of emotions' motivation and function via changes in physical tensions and urges	Balance in bodily functions	Rather than avoiding, criticising or supresing emotions, particpants were able to motivate themselves **(active role)** to access self-compassion
22				Increased ability to clarify and organise internal experiences				Excersise provided sense of agency and flow over emotions i.e. being able to move between chair (symbolic sense of stepping out of emotional selves)	Reduced emotional and physical distress	
23				Clarification of relational context in which specific self-parts developed				Allowed for different perspective i.e. like CCTV to emotional selves	Less likely to react impulsively to emotions = better relationships	
24				Acceptact of all selves - working together rather than reject or exclude				Rather than avoiding, criticising or supresing emotions, particpants were able to motivate themselves **(active role)** to access self-compassion	Increased physical activities and/or back to employment	
25				Understanding origin of self-critic led to increased empathy				Able to view the function and aims of the threat of emotions	Understanding origin of self-critic led to increased empathy	
26				Better understanding of emotions					Critic's presence was ultimately reappraised as a prompt to **"switch"** to the compassionate self to address the need for safeness and support	
27				Provided new insights to broader personal patterns and tendencies i.e. daily functioning						
28				Offered a means to access the emotional 'root' of the problem						
29				Greater awareness of emotions' motivation and function via changes in physical tensions and urges						
				Understanding of experiences and acknowledgement of impact of childhood relationships i.e. cause of presence and intensity of emotions						
				Psychoeducation - helped to comprehend and predict patterns of thinking and feeling						
				Understanding of self led to reduction in self-criticism and self-blame						
				Emotional self was treated with acceptance, care and support						
				final sense of unity was not achieved by removing complexity or difference between the emotions, but rather by finding a balance and equilibrium to create a 'richer' and more intentional life.						
				Reduction of feelings of shame about experiences						
				Enactments of different selves led to new insights						

Appendix H

Development of Line of Argument Example

Third Order Constructs (S2) – full experience of CFT	Third Order Constructs (S4-6) – Chair Work	Third Order Construct – Key Experience	Theme
Experiencing and accepting compassion from others was an important step to developing compassion	Allowed for flow of compassion outward, as if to another, to be focused back toward self	An increase of flow of compassion to others increased self-compassion	**Flow of compassion towards self-compassion**
Compassion towards others (engaging with their distress) turned towards self	Interacted with self as if they were interacting with another human being > applying social relational skills to internal world (increased self-compassion)	Engaging with the distress of another led to questioning of how one treats themselves – leading to the development of self-compassion	
	Individuals were shocked at their treatment of another (when in the self-critic chair) and this came with a realisation of the distress caused by their self-criticism		

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Section 2: Empirical Research Paper

The Relationships Between the Flows of Compassion and Job-Related Affective Wellbeing in Helpline Volunteers

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Abstract

Objectives: The aim of the present study was to investigate whether the three flows of compassion (compassion to others, compassion received from others and self-compassion) predicted job-related affective wellbeing.

Design and Methods: The study utilised quantitative methodology. Active helpline volunteers providing emotional and wellbeing support were invited to take part in a survey online via Qualtrics. Job-related affective wellbeing and the flows of compassion were assessed using the Job-related Affective Wellbeing Scale (van Katwyk et al., 2000) and the Compassionate Engagement and Action Scales (Gilbert et al., 2017). Data was analysed using correlational analysis and a multiple hierarchical regression model.

Results: Correlational analyses demonstrated that self-compassion and compassion for others were significantly and positively correlated with job-related affective wellbeing. When entered in a multiple hierarchical regression, the flows of compassion accounted for a significant amount of variance in job-related affective wellbeing when age, gender and length of time volunteering had been taken into account. Self-compassion and compassion to others were significant variables in the final model of the multiple hierarchical regression.

Conclusions: The findings indicated that the flows of compassion predicted job-related affective wellbeing in helpline volunteers. Exploratory analyses also suggested that self-compassion and compassion to others are significant predictors of job-related affective wellbeing. Further research suggestions are recommended to explore how engagement and action, from the different flows of compassion, interact with job-related affective wellbeing.

Keywords:

Helpline volunteers, flows of compassion, job-related affective wellbeing

Practitioner points:

- The current research sought to identify factors that could potentially improve wellbeing, in helpline volunteers.
- Self-compassion and compassion for others was found to predict wellbeing in helpline volunteers.

- Helpline volunteers may benefit from evidence-based interventions or training in self-compassion; in particular, learning to recognise and engage with their distress, and skills to alleviate distress.

Introduction

When young people were asked a hypothetical question, "If someone you knew was suicidal, what would you do first?" they were more likely to call a suicide helpline, than call emergency services or go to the emergency room (Larkin et al., 2011). Helplines provide an important service to individuals in crisis and experiencing mental health difficulties by offering free, anonymous, non-judgemental, non-directive and accessible support (Morgan et al, 2012; Samaritans 2015). The majority of such helplines are staffed by volunteers. Recent literature reviews investigating the wellbeing of helpline volunteers found poor wellbeing outcomes as a result of volunteering (Kitchingman et al., 2018b; Willem et al., 2020). Volunteering in mental health helplines is a complex task, involving caring for others and caring for oneself, given the pressures of the role. Compassion is a multifaceted process involving compassion to the self, towards others and from others (Gilbert et al., 2011). This may provide a useful exploratory framework for understanding the impact of volunteering with implications for intervention.

Voluntary helpline organisations ('helplines' hereafter), like the Samaritans, provide a relief on statutory services struggling to meet service demands (Hvidt et al., 2016). The Trades Union Congress (TUC, 2018) found staffing numbers failed to meet the growing demands on mental health services across England, placing a huge pressure on the workforce. It is forecasted that the demand on mental health services across England will increase further due to the COVID-19 pandemic (O'Shea, 2020). During the coronavirus pandemic, charities that provided helpline support reported an increase in people contacting their helplines (Beat, 2020; Centre for Mental Health, 2020; Cruse Bereavement Care, 2020; Refuge, 2021; Samaritans, 2021; Switchboard, 2020; The Mix, 2020).

In 2015, the Care Quality Commission (CQC) found only half of community teams were able to offer 24/7 crisis care. The NHS long term plan (2019) identified the need for mental health crisis line services so people will be able to access crisis care 24/7. Helplines are viewed as complementary to secondary mental health services, with Community Mental Health Teams recommending these services to their clients, as well as adding them to clients' contingency plans (Morgan et al., 2012). Morgan et al. proposed that helplines used in primary and specialist care settings could reduce the use of more expensive services for example, by preventing a crisis, and were viewed by GPs as a cost-effective means to support callers outside of office hours.

Helpline services have been found to decrease callers' crisis states, hopelessness, suicidality, psychological pain, sadness, anger, guilt, shame, isolation and depressive mental state (Dalgin et al., 2011; Hvidt et al., 2016; Kalafat et al., 2007; Gould et al., 2007). Callers reported feeling supported, more in control, and enabled to cope better (Morgan et al., 2012) and a decrease in the perceived severity of their problem (Fukkink & Hermanns, 2009). Moreover, research suggests that helplines can also effectively facilitate engagement with relevant mental health interventions or services. For example, Gould et al., (2012) found approximately 50% of callers who were recommended by helpline staff to access statutory services reported following this advice.

Furthermore, the nature of helplines can help to overcome some of the barriers to accessing services such as transportation difficulties, concerns about being seen while emotional, concerns about stigma, control of when the contact ends and time constraints/availability (Mohr et al., 2006; Reese et al., 2006). Some people felt the anonymity and confidentiality of helplines reduced psychological barriers that prevented them from seeking help and made them feel less burdensome, guilty or embarrassed by their need to call and the nature of their disclosure, and provided a sense of security (Christogiorgos et al., 2010; Lazter & Gilat, 2005; Pollock et al., 2010). Callers also expressed feeling valued and felt they could rely on these services when they have no one else to turn to or when other services were not available (Sheehy et al., 2006; Pollock et al., 2010; Rethink 2003).

Impact of volunteering on volunteers' wellbeing

A systematic literature review by Kitchingman et al., (2018b) found telephone crisis support workers (a mixture of paid staff and volunteers) reported experiencing stress, symptoms of vicarious trauma, burnout, and psychological disorders. Willem et al. (2020) also found similar results from their systematic literature review, with crisis line volunteers reporting burnout, compassion fatigue, disruptions in beliefs (safety, trust, esteem, intimacy and control), subjective distress, perceived stress, symptoms of psychological distress, and for a small number of participants, suicidal ideation. Both reviews reported varying prevalence rates in terms of the symptoms reported and conclusions were difficult to reach due to methodological limitations and the use of invalidated instruments.

There are several reasons reported why helpline volunteers may be at risk of poor mental health. Helpline volunteers are frequently exposed to callers' distress (Gould et al., 2007; Kalafat et al., 2007; Mishara et al., 2007). Their role requires them to have detailed conversations about complex topics such as emotional distress, thoughts of harm to self, suicide, abuse experiences, low mood, bereavement and isolation (Coveney et al., 2012). Volunteers reported that a central aspect of their role is bearing the pain of the caller and tolerating their distress (Vattøe et al., 2020). Helpline volunteers also receive sexually inappropriate, abusive, disingenuous, and manipulative calls which can lead to frustrations from volunteers (Pollock et al., 2013). These types of calls were reported as "massively damaging" to volunteer morale and it was important to the volunteers how these were dealt with by the organisation (Pollock et al., 2010).

Another emotional stressor for helpline volunteers is the inability to actively intervene (Willems et al.,2020). Volunteers expressed feeling helpless and discouraged partly because the issues they encountered were complex, and partly due to anonymity that prohibits them from actively intervening (Vattøe et al., 2020). Additionally, not knowing the outcome and consequences of a contact with a caller can contribute to helpline volunteers' burnout (Willems et al., 2020).

Some volunteers may face additional risks to their wellbeing if they work in a helpline where they have relevant lived experience or previous trauma and respond to callers with similar personal experiences (Helplines Partnership, 2015). This is not uncommon given that a number of helpline volunteers' motivation for volunteering is sometimes due to having received support from the specific helpline they volunteer at or have someone close to them be affected to the cause of the organisation (Morgan et al., 2010; Pollock et al., 2010).

Coping strategies

Cyr and Dowrick (1991) found volunteers employed various productive coping strategies such as having realistic expectations, focusing on the benefits of voluntary work, setting personal boundaries, asking for feedback, taking time off, attending to health and undertaking relaxing activities. Volunteers also found actively being a part of a community, inclusion and solidarity within their volunteer community, and seeking peer support from colleagues contributed positively to their wellbeing (Lewig et al., 2007; Smith et al., 2020; Willems et al., 2020). However, volunteers also reported non-productive strategies. For example, not being able to

identify and self-report their negative emotions, not seeking help when experiencing distress, self-blame, worrying, expecting appreciation from callers, and ignoring the problem (Cyr & Dorwick, 1991; Dunkley & Whelan, 2006; Kitchingman et al., 2017; Kitchingman et al., 2018a).

Several Samaritan helpline volunteers reported avoidant coping styles, which consistently predicted higher levels of burnout and worse health status, along with higher volunteering hours and less social support (Roche & Ogden, 2017). Furthermore, Pollock et al. (2010) and Smith et al. (2020) found the narrative around being a "Good Samaritan" can have a negative impact on Samaritan helpline volunteers. For example, the narrative places pressure on volunteers to sacrifice more time for the organisation and perhaps over-commit, with volunteers being less focused on aspects of self-care. Additionally, staff may feel that in disclosing their difficulties, they may not feel they live up to the "Good Samaritan" ideal, therefore, not seeking support. Similarly, Kitchingman et al. (2018a) found an absence in help-seeking among Australian crisis-line volunteers and hypothesised that they may not self-report the negative impact of the work on their wellbeing to be perceived as competent and to continue supporting callers.

Organisational factors

Organisational factors were reported to be important for the mental wellbeing of crisis line volunteers. For example, volunteers felt unhappy when they felt organisations treated them as employees rather than volunteers, did not recognise or appreciate their work, and felt underappreciated if the organisation did not acknowledge their pre-existing skills (Sundram et al., 2018).

Nencini et al., (2016) found volunteers' perceptions of organisational climate can have an impact on volunteers' experience and their motivation and intention to leave the organisation. Lewig et al. (2007) proposed that in order to retain volunteers, organisations must provide a work environment where volunteers feel valued by the organisation, ensure the volunteers understand and support the organisation's values, supported to perform their role (including having access to peer support), and ensure volunteer's wellbeing are monitored. Additionally, adequate supervision, consistent support from supervisors and sufficient training were identified as protective factors for burnout and increased job satisfaction for helpline volunteers (Willems et al., 2020).

Job-Related Affective Wellbeing (affective wellbeing hereafter)

Research focusing on the wellbeing of helpline volunteers is scarce (Coveney et al., 2012; Willems et al., 2020). The literature indicated the emotional and psychological impact that volunteering can have on helpline volunteers. One of the aims of the study was to investigate this impact further by directly investigating wellbeing in relation to the voluntary role rather than general wellbeing. However, to the researchers' knowledge, there has been no tool or scale developed to measure the direct impact of volunteering on wellbeing. Therefore, job-related affective wellbeing was investigated as this measures an individual's general level of positive or negative feelings towards their jobs (Van Katwyk et al., 2000). Job-related affective wellbeing has been positively correlated with psychological and physical health, and is associated with decreased rate of burnout and lower staff turnover (Harter et al., 2002; Sivanathan et al., 2004). Investigating the impact of volunteering on the wellbeing of helpline volunteers is important because a decline in mental wellbeing has been linked with high staff turnover, lower patient satisfaction, staff shortage, and staff sickness among mental health professionals (Department of Health, 2002; Salyers et al., 2015). Additionally, research exploring factors that can increase job-related affective wellbeing could potentially lead to the identification of interventions that may help protect volunteers from the negative impacts of volunteering.

Compassion

Aside from research that reported positive coping strategies of helpline volunteers, there appears to be a gap in the literature regarding factors that could potentially improve the wellbeing of volunteers. Kitchingman et al. (2018) proposed, in their literature review, that future research should examine helpline volunteers' processes to maintain wellbeing such as self-care, and staff support strategies. Similarly, Willems et al. (2020) recommended the development of interventions for volunteers that focus on the cultivation of effective coping mechanisms to positively influence the mental wellbeing of helpline volunteers. Compassion has been defined as a sensitivity to suffering in self and others, and a motivation to try to alleviate and prevent suffering (Gilbert, 2009; Goetz et al., 2010). Gilbert et al. (2011) proposed that compassion has three directional flows. There is the compassion that people have for others, the experience of compassion from other people, and self-compassion. There is growing evidence that each direction of the flow of compassion can have distinct psychological and physiological effects. Additionally, it was found the three flows of compassion are related, such that an increase in any of the flows related to an increase in the other two and vice versa (Gilbert et al., 2017; Henshall

et al., 2018). Furthermore, compassion can also be cultivated and enhanced. There are a number of compassion-based interventions that aim to improve and address mental health difficulties and psychological wellbeing (Kirby, 2017), which organisations can implement in their staff training or volunteers themselves can access.

Compassion has not been investigated in helpline volunteers apart from Willem et al., (2021) who investigated self-compassion in crisis line volunteers. For the purpose of this paper, research on mental health and healthcare staff and the impact of compassion on wellbeing are presented below.

Self-compassion

Neff (2003a, 2003b) proposed that self-compassion has three components: 1) self-kindness, 2) common humanity, and 3) mindfulness. Among healthcare and mental health staff, self-compassion has been associated with reduction in burnout, depression perceived stress, stress symptoms, emotional regulation difficulties, self-criticism, empathetic distress, compassion fatigue symptoms, while maintaining wellbeing, better sleep functions and resilience (Atkinson et al., 2017; Babenko et al., 2018; Bazarko et al., 2013; Beaumont et al., 2016; Cramer et al., 2016; Dev et a;., 2018; Duarte et al., 2016; Finlay-Jones et al., 2015; Rabb, 2014 Raab; et al., 2015; Richardson et al., 2020).

Helpline volunteers reported experiencing symptoms of psychological distress, burnout and compassion fatigue (Kitchingman et al., 2018b; Willem et al., 2020). Willems et al. (2021) found that self-compassion buffers the effects of work-related demands and emotional strains on distress among crisis line volunteers. Self-compassion was also found to predict happiness in volunteers, and the higher their self-compassion levels the better physical, psychological and spiritual wellbeing they experienced (Thammarongpreechachai et al., 2021).

Compassion for others

Compassion for others was reported to have a significant negative correlation with self-judgement and compassion fatigue (Beaumont et a., 2016), and a significant positive correlation with compassion satisfaction (Durkin et al., 2016) among healthcare workers. Furthermore, Cosley et al. (2010) found compassion for others could buffer against the physiological effects of stress. However, this was only found when they were able to draw social support from others. They found those who did not receive social support did not report the same buffer against stress

regardless of the level of compassion they report. They hypothesised that compassion for others may increase someone's ability or desire to draw on social support which can lead to a reduction in stress. This is in line with Crocker and Canevello's (2008) findings who suggested that an increase in compassion predicted increases in feelings of closeness, connectedness, trust, and social support. Additionally, Henshall et al., (2018) found that as perceived organisational threat by an individual increases, their ability to show compassion decreases. They also found perceived organisational compassion predicted compassion for others.

The role of helpline volunteers is unique given their inability to actively intervene while having to bear the pain and tolerate the distress of their callers, possibly hindering the action of compassion for others (Vattøe et al., 2020; Willems et al., 2020). Therefore, it would be interesting to see how this predicts wellbeing.

Compassion from others

Gilbert (2015) proposed experiencing validation, care and support from others can have an impact on how people process and respond to threats and emotions associated with threats. This is particularly relevant to helpline volunteers as they reported 'seeking peer support from colleagues' as an important coping strategy and have a positive impact on their wellbeing (Willems et al., 2020)

Healthcare professionals (Crawford et al., 2013) and healthcare educators (Rayner et al., 2021) expressed the significance of receiving compassion from their organisations and the leaders within their organisation to their capacity to provide compassion to others and themselves. Similarly, Lilius et al. (2008) found when hospital employees experienced compassion on the job from their supervisor and colleagues it had a significant positive relationship to their affective commitment and positive emotions. Furthermore, Hermanto et al. (2016) found that the ability to receive compassion from others has been observed to buffer the relationship between self-criticism and depression. Literature on helpline volunteers found organisational factors such as, feeling valued by the organisation and being supported to perform their role, have an impact on the retention of volunteers (Lewig et al., 2007; Sundram et al., 2018). Therefore, it may be valuable to investigate compassion from others within helpline volunteers to see how it predicts wellbeing.

Research aims and hypotheses

The current study aims to explore the relationships between the three flows of compassion and job-related affective wellbeing in helpline volunteers. The literature on the three flows of compassion suggests positive wellbeing outcomes and research in this area can provide implications for helpline volunteer training and recruitment. Consequently, the following hypotheses were identified:

1. The three flows of compassion will have a significant positive relationship with job-related affective wellbeing.

2. The three flows of compassion would predict a significant amount of variance in job-related affective wellbeing in a regression model.

Method

Design

To explore the relationship between wellbeing and the three flows of compassion, the study used a non-experimental, non-randomised, single-group, cross-sectional correlational design.

Participants

Participants were recruited using a convenience sampling, by contacting (via email) UK based and charitable organisations that offered emotional and wellbeing support via helplines operated by volunteers. Organisations were asked to circulate a recruitment email to their volunteers which included a PDF version of the information sheet and the link embedded in both the email and information sheet. Organisations were identified through Google searches and by going through the Helplines Partnership list. Examples of organisations contacted included: Samaritans, Switchboard, Beat and Self-Injury support (organisations contacted can be found in Appendix B). Additionally, the survey was advertised on Twitter and a specific Volunteering forum using a recruitment poster (Appendix C). There were no monetary incentives offered however, organisations who responded to the Email were offered to be added to the dissemination list of the research once completed.

A predictive power calculation using G*Power 3.1 (Faul et al., 2009), for a linear multiple regression, with 6 control variables (predictor variables: self-compassion, compassion to

others, compassion from others; Demographics: age, gender, and number of years volunteering) indicated that a minimum sample size of 98 was needed to detect a medium effect ($f^2 = 0.15$).

Initially, the inclusion criteria indicated specifically mental health helpline volunteers. However, due to recruitment difficulties the criteria extended to helpline volunteers providing emotional and wellbeing support. This change was approved by the ethics committee. People were eligible to participate in the study if they were an active helpline volunteer providing emotional and wellbeing support, and were aged 18 and above. A total of 176 participants consented to take part in the study. Of these, 99 provided responses that could be utilised in the final study.

Ethical considerations

The study received ethical approval from the University Faculty of Health and Medicine Research Ethics committee (Appendix D). It was not anticipated that completing the study would result in significant risk or raise significant ethical issues however, participants were aware that they were free to withdraw from the study at any time by exiting the survey. The start of the survey is an information sheet (Appendix E) detailing how data will be stored, who the researcher was, and the purpose of the study. Once participants click 'next' they are presented with a consent form (Appendix F) which they need to confirm before they can continue with the survey. All responses collected were anonymous and no sensitive or identifiable information was collected.

Data collection and measures

Data were collected via an online survey using Qualtrics, a web-based survey data collection software licensed for use by Lancaster University students. Qualtrics uses Transport Layer Security encryption and only the researchers have access to the responses. This was a voluntary, open survey which is defined as a survey open for each visitor of a site and is not a password-protected survey. A 'force response' condition was added to the survey which prompts participants to answer a question they might have missed before they are able to continue. Participants were able to review and change their answers through a 'back' button.

The survey was developed using Qualtrics and was checked for usability and technical functionality prior to distribution, by the researcher and a small number (N=5) of trainee clinical

psychologists. The average completion time was approximately 10 minutes, including reading the information sheet. Data was collected from 22 September 2020 to 04 November 2021. Only completed data-sets were analysed however, partial responses were retained to identify any differences between those who completed and those who did not complete the survey.

Demographics

Demographical factors such as age (Kitchingman et al., 2018a; Roche & Ogden, 2017), gender (Kitchingman et al., 2018a) and length of time volunteering (Helplines Partnership, 2015; Kitchingman et al., 2018a; Pollock et al., 2010; Smith et al., 2020) have been found to have an impact on helpline volunteers' experience, wellbeing and ability to cope. Additionally, literature on compassion suggests that gender is a predictor for an individual's level of compassion for others (Davalos-Batallas et al., 2020; Gilbert et al., 2017; Henshall et al., 2018; Pommier et al., 2020), and there may be gender differences in how compassion and self-compassion are experienced (Campion & Glover, 2016; Mercadillo et al., 2011; Stellar et al., 2012). Therefore, participants were asked to disclose age, gender, and number of years volunteering.

Compassionate Engagement and Action Scales (CEAS)

The aim of the study was to explore the three flows of compassion in relation to job-related affective wellbeing in helpline volunteers. The Compassionate Engagement and Action scales (Gilbert et al., 2017) is the only scale that measures the three flows of compassion: self-compassion, compassion for others, and the perceived amount of compassion received from others (Appendix G). Each scale has 13 items and participants are asked to rate each item according to how frequently the statement occurs on a scale of 1 (Never) to 10 (Always). The three scales were separated across three survey pages. For each scale two subscales can be explored further: engagement and action. Engagement assesses motivation and the ability to notice and be moved by suffering, and to approach it with empathy and distress tolerance. Action assesses the motivation and ability to be able to take actions to prevent and alleviate distress/suffering. In the original study, Gilbert et al. (2017), found the three scales have good validity and are reliable measures, with Cronbach alpha scores ranging from .74 to .94.

Job-Related Affective Wellbeing Scale (JAWS)

The Job-Related Affective Wellbeing Scale (van Katwyk et al., 2000) is designed to assess people's positive and negative emotional reactions to their job. The scale has 30 items with each item relating to an emotion. The 30 items were distributed across three survey pages. Respondents are asked how often they have experienced each item at work on a five-point scale (Never, Rarely, Sometimes, Quite often, Extremely often or Always) over the last 30 days (Appendix H). Overall, the participants can have a score between 30 and 150. The scores represent a continuum, with higher scores indicating higher levels of job-related affective wellbeing, with no cut-offs for high or low wellbeing. The scale includes both negative and positive emotional experiences. The scale presented with a Cronbach's alpha of .95 in the original study (van Katwyk et al., 2000).

The scale indicates a "job" which participants may interpret as paid employment rather than their voluntary role. To address this, the questionnaire instructions specified for participants to think about their "voluntary job" when answering the questions.

Procedure

When participants clicked on the survey link, they were asked to read the participant information sheet before continuing to the study and were then asked to confirm consent. They were also informed that once they submitted the questionnaire, it would not be possible to withdraw their data. Inclusion criteria were enforced by asking participants if they were active volunteers and their age. If they answered no or were under 18 they were automatically exited from the questionnaire. Following the questionnaire, participants were provided with debrief information (Appendix I).

Data Analysis

The data was analysed using Statistical Package for Social Science (IBM SPSS) version 22. Due to the data not being normally distributed, Spearman Rho's correlations were completed between the key variables. The variables were then entered into a multiple hierarchical regression model with JAWS scores as the outcome variable. The predictor variables were entered into the model in three steps: 1) Demographic variables (age and gender), 2) Length of time volunteering, and 3) the flows of compassion (compassion from others, self-compassion, and compassion to others).

An exploratory analysis was also completed with the flows of compassion subscales, engagement and action, as predictor variables and JAWS scores as the main outcome variable. The flows of compassion subscales were entered simultaneously in a forced entry multiple regression model.

Results

Participant characteristics

A total of 99 participants responses were recorded. The mean age of the participants was 39.85 years (SD = 19.54) with a range of 19 to 82 years and 11 months. The mean number of years that participants have volunteered was 3.67 years (SD = 6.52), with a range from 2 months to 43 years. The majority of the participants were female (N=80) followed by males (N=17) and non-binary (N=2). There were some partial responses, with 40 participants completing demographic information. Only completed questionnaires were analysed however, partial responses were retained to identify any significant differences between the completers and non-completers' demographics which can be found in Table 1.

A Kolmogorov-Smirnov test indicated that the participants' age ($D(139) = .195$, $p < .000$) and number of years volunteering ($D(139) = .289$, $p < .000$) do not follow a normal distribution. Therefore, a Mann-Whitney was considered the most appropriate statistical test to compare differences. The Mann-Whitney test indicated that the ages of the completers (*Mdn* = 30 years) was not significantly different to the age of the non-completers *(Mdn* = 30 years 6 months), U = 1915, $p = .762$. Similarly, the number of years volunteering also did not have a significant difference between the completers (*Mdn* = 12) and non-completers (*Mdn* = 13.5), U = 1966, $p = .948$. Furthermore, the participant demographics figures closely mirror the demographic information on volunteers reported by the NCVO (2021) who also reported a large range in volunteers' age, and that the voluntary sector is disproportionately staffed by women. This suggests that the sample for this research is somewhat representative of the voluntary population.

Internal Consistency of Measures

The Cronbach's alpha coefficients for the responses in the present study indicated high internal consistency. The alpha values ranged from 0.86 to 0.92, which were similar to other

published studies using the same measures. The Cronbach's alpha value, means and standard deviations for the measures are presented in Table 2.

Correlational analyses

Normality of distributions were checked with Kolmogorov-Smirnov test of normality. Scatterplots, histograms, boxplots and Q-Q plots were also checked for linearity and normality. The JAWS, and the self-compassion and compassion from others subscales of the CEAS were not normally distributed. Therefore, non-parametric tests of correlation were used. Spearman's rho correlations are provided in Table 3.

The number of years volunteering and gender did not correlate with any of the main outcome and predictor variables. However, age was found to be significantly and positively correlated with self-compassion (r_s =.286 p = .004).

All the flows of compassion also had a significant positive relationship between one another; self-compassion and compassion from others (r_s =.370 p < .001); self-compassion and compassion to others (r_s =.508 p < .001); and compassion from others and compassion to others (r_s =.329 p < .001). This supports previous research that proposed the three flows of compassion are positively correlated with one another (Gilbert et al., 2017; Henshall et al., 2018).

One of the hypotheses predicted that there would be a significant relationship between JAWS and the three flows of compassion. JAWS had a significant positive relationship with self-compassion (r_s =.367 p < .001) and compassion to others (r_s =.354 p < .001), but not compassion from others (r_s =.157 p = .120). Therefore, only partially supporting the proposed hypothesis.

Multiple Hierarchical Regression

The data were checked on SPSS to ensure that the assumptions of a hierarchical multiple regression model were met as recommended in Field (2017). The outcome variable was linearly related to all predictors (as indicated by scatterplots of predictor and outcome variables), residual terms were uncorrelated (as assessed by a Durbin-Watson statistic of 2.036), residuals at each level of the predictor had similar variance (homoscedasticity; indicated by scatterplots of residuals and predictor variable), errors were normally distributed (indicated by histogram and P-P Plots of residuals), and no multicollinearity was present (indicated by variance inflation factors (VIF) that ranged between 1.062 and 1.692, and tolerance statistics that ranged between .591 and

.941). Data were checked for outliers and influential cases. One outlier was identified, and this data was replaced using the Winsorizing method (Field, 2017). No influential cases were identified as indicated by scatterplots and Cook's distance, with all value falling below 1.

Data from non-binary gender participants (N=2) were combined into one category. Given that there were only two participants in this category, a decision was made to exclude their data from the model. The alternative option was to include all participants and remove gender from the model. Alternative analyses were ran excluding gender from the model (Table J1) and another alternative analysis with all participants included (Table J2), results can be found in Appendix J. The results indicated that despite changes in the model, there were no meaningful differences between the results displayed in the main analysis.

The results of the multiple hierarchical regressions analyses are provided in Table 4. The regression analyses indicated that Steps 1 and 2 of the model accounted for 1.6% of the variance in JAWS scores which was non-significant ($F(1, 93) = .004$, $p = .948$). The flows of compassion model were found to increase the exploratory power of the final model to 23.2%. The flows of compassion therefore explained 21.6% of the variance in the JAWS scores, and the overall model was significant ($F(3, 90) = 8.43$, $p < .001$). This supports the hypothesis that the three flows of compassion would predict a significant amount of variance in affective wellbeing.

In the final model, Bivariate and adjusted associations were estimated. The variables that were found to be significant were self-compassion (Standardised $\beta = .288$, $p = .014$) and compassion to others (Standardised $\beta = .306$, $p = .005$) but not compassion from others (Standardised $\beta = -.085$, $p = .421$). Similar results were found from the Bivariate analyses indicating that there has been no suppression in the regression model. Self-compassion and compassion to others were found to have significant association with JAWS but not compassion from others. The results of these analyses are presented in Table 5.

Exploratory Results

The multiple hierarchical regression found the flows of compassion model explained a significant variance in JAWS scores, with self-compassion and compassion to others being the only significant variables in the model. The demographic variables (age, gender and length of volunteering) did not yield significant relationships with JAWS scores, and can therefore be removed from the model. Because of these reasons, an exploratory analysis was deemed

appropriate to explore how the flows of compassion interacted with JAWS. It was highlighted by Gilbert et al., (2017) that there are two independent and interacting psychology competencies to compassion. Engaging with the distress of others or self, and action to alleviate the distress. The CEAS can be separated to two subscales (engagement and action) to measure these competencies for all flows of compassion, making six variables. The study recruited a sufficient number of participants for six variables in a multiple linear regression. Therefore, the six subscales of the CEAS were entered simultaneously in a multiple linear regression using a forced entry method with JAWS as the outcome variable. Results are presented on Table 6. Bivariate linear regression analyses with the flows of compassion subscales and JAWS scores were also completed and presented in Table 6 to account for any suppression that may be present in the multiple linear regression model. It is important to note that the following results are exploratory and are not testing for hypotheses. Therefore, the reader should treat the following results with greater caution.

The simultaneous multiple regression indicated that the flows of compassion subscales accounted for 24.4% of the variance in JAWS scores ($r = .494$ $p < .001$). However, only self-compassion action ($\beta = .609$, $p = .018$) and compassion to others engagement ($\beta = .528$, $p = .043$) remained significant within the model.

Discussion

The present study examined the relationship between affective wellbeing and the three flows of compassion, using a cross-sectional survey design. The findings supported the hypothesis that the flows of compassion would predict a significant amount of the variance in the affective wellbeing of helpline volunteers. Regression analyses of the data revealed higher self-compassion and compassion to others predicted better JAWS scores. This partially supports the first study hypothesis as compassion received from others did not have a significant positive relationship with affective wellbeing.

The flows of compassion

After accounting for gender, age and length of volunteering, the flows of compassion accounted for a significant amount of variance in affective wellbeing. This suggests that the flows of compassion predicted affective wellbeing in helpline volunteers. Henshall et al. (2018) proposed that all direction of flows are related and that an increase in any of the flow related to

an increase in the other two and vice versa, which was also found in this study. This suggests that an increase in any of the flows of compassion could lead to an increase in the other flows of compassion as well as affective wellbeing. The current study utilises correlational analysis therefore, causality cannot be ascertained, however the findings suggest that this is a plausible hypothesis.

The study found higher self-compassion predicted higher levels of wellbeing at work. This suggests that self-compassion led to increased affective wellbeing in helpline volunteers. This finding supports that of the current evidence indicating that self-compassion may be associated with better wellbeing outcomes among crisis line volunteers (Willems et al., 2021) and volunteers in general (Thammarongpreechachai et al., 2021). A clinical implication of this is that self-compassion has a positive impact on affective wellbeing. It would be beneficial for services to consider evidence-based interventions in self-compassion to increase this within their volunteers, for example, by adding this to their current training package. In particular, having training on self-compassion, learning to recognise and engage with their distress, and having the motivation and skills to alleviate distress would be beneficial. This is due to previous reports that volunteers can have non-productive strategies such as not being able to identify and self-report their negative emotions, not seeking help, and ignoring the problem (Cyr & Dorwick, 1991; Dunkley & Whelan, 2006; Kitchingman et al., 2017; Kitchingman et al., 2018a).

Additionally, exploratory analysis indicated that self-compassion action was a significant variable when entered in multiple regression model indicating that self-compassion action was a necessary component in predicting helpline volunteers' affective wellbeing. This further supports the need for volunteers to have productive coping strategies and engage in activities that alleviate or prevent their own distress or suffering to protect them from poor wellbeing. This finding is similar to previous conclusions of the importance of action in self-compassion. For example, Gilbert (2017) proposed that self-compassion positively correlated with pathology variables and self-criticism depends on how a person responds to their own suffering and distress. Neff (2003a) also proposed that when a person has high self-compassion, they are able to engage in proactive behaviours aimed at promoting or maintaining wellbeing and more effective emotional regulation. Given that this was highlighted in the exploratory analysis, this can only be suggested tentatively, further investigations of this mechanism would be beneficial to the volunteer and self-compassion literature.

Compassion for others was also shown to predict affective wellbeing. This suggests that compassion for others led to better affective wellbeing for helpline volunteers. This finding further adds to the evidence indicating the positive outcomes relating to compassion for others such as, better wellbeing, lower compassion fatigue and lower levels of burnout (Beaumont et al., 2016; Durkin et al., 2016). Gilbert et al., (2017) proposed that the first competencies in compassion are the ability to be emotionally moved and tolerate the distress experienced by others, which is the engagement part of compassion. In terms of helpline volunteers, they are required for their job to bear the pain of their caller and tolerate their distress (Vattøe et al., 2020) suggesting high levels of compassion for others engagement. This was further supported by the exploratory results which indicated that compassion to others (engagement) was a significant variable when predicting affective wellbeing.

However, this is in contrast to previous literature suggestions that exposure to callers' distress could lead to poor mental health (Gould et al., 2007; Kalafat et al., 2007; Mishara et al., 2007). A reason for this could be that although a large part of the helpline volunteers' job is to engage with the callers' distress and tolerate this, some volunteers considered having such an intimate contact with callers a privilege, and reported a sense of satisfaction, fulfilment and doing something 'worthwhile' (Pollock et al., 2010). It seems that being emotionally moved by the distress experienced by others may moderate the potential negative outcomes of being exposed to callers' distress. Moreover, Gilbert et al., (2017) suggested that being emotionally connected to the suffering of others, which is a large part of the helpline volunteer role, will have a different impact to people's wellbeing from just being helpful to someone. A clinical implication of this could be that identifying qualities of compassion for others through recruitment could have implications for helpline volunteers' wellbeing and retention. Therefore, further research investigating helpline volunteers' compassion for others (engagement) may be beneficial in understanding motivation for volunteering and possibly the retention of helpline volunteers.

Literature on helpline volunteers and volunteers in general indicated the importance of organisational factors and receiving support from their colleagues as a factor that predicted wellbeing (Lewig et al., 2007; Smith et al., 2020; Willems et al., 2020). However, compassion from others was not found to predict affective wellbeing. One reason for this could be that the questions from the CEAS do not directly indicate the participants as actively requesting support

for their distress. Additionally, the current research did not measure for compassion received from the organisation but rather, from others generally. Cosley et al. (2010) proposed that being able to draw support from others buffer against stress regardless of the levels of compassion reported. This indicated an active role in seeking support for distress from others. Furthermore, in the volunteer literature volunteers described actively being a part of their volunteer community and seeking support from their colleagues (Lewig et al., 2007; Smith et al., 2020; Willems et al., 2020). There seems to be an additional process for receiving compassion from others particularly when receiving this in a professional capacity such as, from organisation and colleagues. Gilbert et al., (2017) also proposed there is another dimension to compassion from others such as the ability to elicit compassion and the ability to be responsive to the compassion received, rather than being defensive or pushing away compassion when it is offered. The measure used in the current research only measured the perceived amount of compassion received from others. Further research specifically investigating receiving compassion from organisation and colleagues, and the mechanisms that underpin this within the voluntary population would be beneficial.

Limitations

Cross-sectional design presents a number of known limitations, including time-specific effects (Bowen & Wiersema, 1999). For example, if the participant had a recent bad experience at their voluntary role, this could have had an impact on their response. In particular, this research was completed during the Coronavirus pandemic where helplines experienced an increase in callers while volunteers were also dealing with the impact of Coronavirus themselves. Therefore, the results may not be representative of how volunteers would have responded prior to and following the pandemic.

Furthermore, Matos et al., (2022) found that receiving compassion from others significantly buffered against the negative impact of fear of contracting COVID-19 on social safeness and connectedness to others. The period of time in which the data was collected included the second national lockdown and the implementation of two-meter social distancing rules within workplaces. As the scale measured perceived compassion received from others, the data collection period likely impacted on how participants responded to the questions as they may not have had access to their usual peer support and general support from others. This poses

the question of the suitability of the measure. Gilbert et al. (2017) proposed that the scales measured compassion competencies, however it would seem that it could be influenced by the context of the participants.

The nature of correlational analysis meant that relationships can be detected, but causal inferences cannot be made. Therefore, it is difficult to distinguish if having more compassion to others and self-compassion influence wellbeing or if having better wellbeing meant people are more able to be compassionate to others and practice in self-compassion. Furthermore, the use of self-report measures is open to bias (Robins et al., 2007). This is possibly relevant to this population given the narratives around volunteering. For example being the "Good Samaritan" (Pollock et al., 2010) may mean that volunteers respond to questions in a self-critical manner if they do not view themselves as a "Good Samaritan" or in a way that upholds the "Good Samaritan" image, leading to skewed responses. In particular, upholding the "Good Samaritan" image could have had an impact on how participants responded to how compassionate they are to others.

In terms of the measures used, the benefit of using the CEAS was that it measured all three flows of compassion, and the two components of compassion: engagement and action. However, it does not identify in more detail specfic skills or factors of compassion. For example, Neff's (2003b) self-compassion scale measures six components relating to self-compassion. Furthermore, given that the JAWS was validated and created with paid employees rather than volunteers, and research highlighted volunteers felt unhappy when they are treated as employees rather than volunteers (Sundram et al., 2018), the appropriateness of the use of this scale needs to be considered. As previously stated, there has been no tool or scale developed to measure the direct impact of volunteering on wellbeing therefore, the JAWS was considered the most appropriate measure to investigate this. It might have been helpful to add a caveat at the beginning of the survey to inform volunteers of this dilemma. Nevertheless, the results indicated good internal relability for this scale when completed with this population. Measures to account for mood and depression as confounding variables may have strenghtened the research method and analysis, however this must be weighed against the risk of burdening participants with multiple items and losing valuable data. Future studies investigating helpline volunteers and wellbeing should take this into consideration given that a number of volunteers have relevant lived experience of mental health difficulties or previous trauma (Helplines Partnership, 2015).

Additionally, future studies should consider volunteering hours and social support as confounding variables. Roche and Ogden (2017) found these variables predicted higher levels of burnout and poorer health status.

The online recruitment allowed for a national sample to be recruited which eliminated a geographical bias. Online methodology in psychological research has been recognised as being beneficial as it offers an effective means of expanding the scale and scope of research (Kraut et al., 2004) However, a self-selecting sample could have introduced selection bias. For example, the participants reported a relatively high score average for affective wellbeing which poses the question, that those who did not continue with the survey may possibly have felt they did not have capacity to complete the survey at the present time.

Further Research

The present study provides evidence of the predictive capacity of self-compassion and compassion to others in regard to affective wellbeing. This suggests that increasing self-compassion and compassion to others in this population could have beneficial effects on wellbeing, therefore, it would be useful to examine the impact of self-compassion training or Compassionate Mind Training in this population. In terms of self-compassion, it may be beneficial to examine self-compassion using Neff's (2003b) self-compassion scale and analyse the 6 subscales separately in order to identify certain aspects of self-compassion that could be targeted at training or which elements of self-compassion are more strongly related to particular wellbeing outcomes in helpline volunteers, as suggested by Neff (2016).

It would be beneficial to better understand how compassion from others is experienced by helpline volunteers and the mechanisms that underpin this. This may be explored with further quantitative studies which solely focus on compassion received from both the organisation and from colleagues. This could also be explored through qualitative methodology by interviewing helpline volunteers about their experience of compassion received from their organisation and colleagues and the impact this has on their wellbeing and motivation.

The exploratory results indicated that the CEAS subscales (engagement and action) predicted affective wellbeing. Although caution should be taken from these findings, they indicate that there is a difference in the relationships between the flows of compassions' engagement and action components, and affective wellbeing in helpline volunteers. Further

research, investigating how engagement and action interact with affective wellbeing may identify specific skills that could be targeted during training and recruitment.

Furthermore, the CEAS do not indicate in which context the participants should identify themselves but rather a general social environment and context. There may have been a difference in how the participants viewed themselves and others depending on their context, such as, as a volunteer or within their personal life. Therefore, future research should consider investigating if there is a difference in the relationship between the flows of compassion and wellbeing if the participants were asked to think specifically about their voluntary role.

Conclusion

This research highlighted that the flows of compassion predicted affective wellbeing in helpline volunteers, after accounting for age, gender, and length of volunteering. More specifically, it identified that self-compassion and compassion to others are significant predictors of affective wellbeing. This suggests that higher self-compassion and compassion to others may be associated with improved affective wellbeing. Therefore, suggestions were made in relation to fostering and developing self-compassion through training, and identifying those with qualities of compassion for others through recruitment as these may be beneficial to both helpline volunteers and volunteer retention. Exploratory investigations of the CEAS subscales indicated a difference in relationship between the flows of compassion engagement and action, and affective wellbeing . Therefore, further research which investigates how engagement and action interact with affective wellbeing was suggested, as this may be beneficial for the helpline volunteer and compassion literature.

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Tables

Table 1
Participant Demographics

		Completers (N=99)	Non-Completers (N = 40)
Age			
	Mean	39.85 (*SD* = 19.54)	37.78 (*SD* = 6.11)
	Median	30 (Range = 63.92)	30 and 6 months (Range = 56)
	Min	19	18
	Max	82 and 11 months	74
Number of years volunteering			
	Mean	3.67 (*SD* = 6.52)	3 and 6 months (*SD* = 6.11)
	Median	1 (Range = 42.83)	1.13 (Range = 29.92)
	Min	2 months	1 month
	Max	43	30
Gender			
	Male	17 (17.2%)	9 (22.5%)
	Female	80 (80.8%)	30 (75.0%)
	Non-Binary	2 (2.0%)	1 (2.5%)

Table 2

Reliability values, Means and Standard Deviations of Measures

Measure	α	M (SD)
Job-Related Affective Wellbeing Scale	.92	114.01 (13.34)
Compassionate Engagement and Action Scales		
Compassion from others	.92	67.57 (16.84)
Self-compassion	.87	71.54 (15.04)
Compassion to others	.86	82.67 (10.88)

Table 3

Spearman's Rho correlation matrix between variables

	1	2	3	4	5	6	7
1. Gender	-						
2. Age	-.272*	-					
3. Years volunteering	-.340**	.445**	-				
4. JAWS	.090	.051	-.113	-			
5. CFO	.184	-.071	.084	.157	-		
6. SC	-.036	.286*	.113	.367**	.370**	-	
7. CTO	0.16	.179	.093	.354**	.329**	.508**	-

**p≤.05, two-tailed. **p<.001, two-tailed.*

JAWS = Job Affective Wellbeing Scale. CFO = Compassion from others. SC = Self-compassion. CTO = Compassion to others.

Table 4
Results of Multiple Hierarchical Regression for JAWS

	Unstandardised B	SE	*Standardised B*	*t*	*p*	R^2	Adj. R^2	R^2 Change	*F*
Step 1						**.016**	**-.005**	**.016**	**.766**
Demographic variables									
Age	.005	.006	.084	.798	.427				
Gender	4.125	3.714	.117	1.111	.270				
Step 2						**.016**	**-.016**	**.000**	**.004**
Length of time volunteering									
Age	.005	.007	.088	.722	.472				
Gender	4.053	3.894	.115	1.041	.301				
Length of time volunteering	-.001	.022	-.008	-.065	.948				
Step 3						**.232**	**.181**	**.216**	**8.430****
Flows of compassion									
Age	-.005	.007	-.094	-.785	.434				
Gender	3.058	3.589	.087	.852	.396				
Length of time volunteering	.010	.020	.058	.488	.627				
Compassion from others	-.067	.083	-.085	-.808	.421				
Self-Compassion	.256	.102	.288	2.509	.014*				
Compassion to others	.375	.132	.306	2.848	.005*				

**p≤.05, two-tailed. **p<.001, two-tailed.*

Table 5

Results of linear regression analyses with JAWS as outcome

Predictor	Bivariate		Adjusted[a]	
	Unstandardised *B* (95% CI)	***p***	**Unstandardised *B* (95% CI)**	***p***
Compassion from others	.099 (-.059, .258)	.216	-.067 (-.233, .098)	.421
Self-Compassion	.341 (.176, .506)	<.001	.256 (.053, .458)	.014
Compassion to others	.506 (.281, .731)	<.001	.375 (.113, .637)	.005

[a] *Adjusted analyses control for age, gender, length of time volunteering*

Table 6

Results of Exploratory Analyses with JAWS as Outcome

			Bivariate		Adjusted[a]					
Predictor	***R***	***R²***	**Unstandardised *B* (95% CI)**	***p***	**Unstandardised *B* (95% CI)**	***p***	***R²***	***Adj. R²***	***R² Change***	***F***
Forced Entry							**.244**	**.195**	**.244**	**4.960**
CFO Engagement	.144	.021	.186 (-.071, .443)	.154	.105 (-.328, 537)	.633				
CFO Action	.085	.007	.156 (-.212, .524)	.402	-.131 (-.713, 450)	.655				
SC Engagement	.300	.090	.464 (.167, 761)	.003	-.104 (-.540, 332)	.637				
SC Action	.424	.179	.750 (.427, 1.073)	<.001	.609 (.108, 1.110)	.018				
CTO Engagement	.408	.166	.840 (.461, 1.219)	<.001	.528 (.017, 1.039)	.043				
CTO Action	.341	.116	.836 (.371, 1.301)	.001	.062 (-.557, .682)	.843				

[a]*Results from Forced Entry method*

CFO = Compassion from others. SC = Self-compassion. CTO = Compassion to others.

Appendix A

Psychology and Psychotherapy Theory, Research and Practice Journal

Author's Guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/paptrap

Click here for more details on how to use **Editorial Manager**.

All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

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Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

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To submit, login at **https://www.editorialmanager.com/paptrap/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

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Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

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The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

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Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

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As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

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All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

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The Preregistered Badge recognizes researchers who preregister their research plans (research design and data analysis plan) prior to engaging in research and who closely follow the preregistered design and data analysis plan in reporting their research findings. The criteria for earning this badge thus include a date-stamped registration of a study plan in such venues as the Open Science Framework (**https://osf.io**) or Clinical Trials (**https://clinicaltrials.gov**) and a close correspondence between the preregistered and the implemented data collection and analysis plans.

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requirement for publishing with *Psychology and Psychotherapy: Theory, Research and Practice*, but these badges are further incentive for authors to participate in the Open Research movement and thus to increase the visibility and transparency of their research. If you are interested in applying, please note that you will be asked to complete the Disclosure Form when submitting a revised manuscript.

More information about the Open Research Badges is available from the Open Science Framework **wiki**.

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For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 28th August 2019

Appendix B

List of Charities Contacted

Charities Contacted	Response / support provided	Charities contacted with no response
Switchboard LGBT+ helpline	Internal newsletter circulation	SANE line
Self Injury support	Email circulation	SupportLine
Lifeline	Email circulation	The silver line
Beat Eating Disorders	Email circulation	Mood swings
Child death helpline	Email circulation	Rethink
Cruse bereavement support	Email circulation	VictimSupport
Leeds Survivor-Led Crisis Service	Email circulation	NoPanic
Nightline Association	Email circulation	OCD Action
Lancaster Nightline	Email circulation	Young Minds
Nottingham Nightline	Email circulation	Refuge
Newcastle Nightline	Email circulation	Muslim Youth Helpline
Birmingham Nightline	Email circulation	Leeds Nightline
Anxiety UK	Unable to support	Sheffield Nightline
PAPYRUS HopelineUK	Staffed by employed staff	Surrey Nightline
Samaritans	Unable to support	Edinburgh Nightline
Breathing space	Staffed by employed staff	York Nightline
CALM	Unable to support	SOS (Silence of Suicide)
Survivors UK	Unable to support	Men’s advice line
Mankind	Staffed by employed staff	Galop
CALM	Staffed by employed staff	Aanchal's women's aid
Family lives	Unable to support	Stop Hate UK
		The Mix
		RASASC (Rape and Sexual Abuse Centre)
		SARAC (Sexual Abuse Rape Advice Centre)

Appendix C

Recruitment Poster

Appendix D

Ethical Approval

Applicant: Julieanne Briones
Supervisor: Dr James Kelly & Dr Laura Twist
Department: DHR
FHMREC Reference: FHMREC20191

13 August 2021

Re: FHMREC20191
The Relationships Between the Flows of Compassion and Mental Wellbeing in Mental Health Helpline Volunteers

Dear Julieanne,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]
Research Ethics Officer, Secretary to FHMREC.

Appendix E

Participant information sheet

Lancaster University

Participant Information Sheet

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Relationships between the flows of compassion and mental wellbeing in volunteers within mental health helpline services

My name is Julieanne Briones and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The study is about the mental wellbeing of volunteers providing emotional support via mental health helplines. Specifically, the study aims to explore the relationship between the three flows of compassion (self-compassion, compassion from others, and compassion for others) and the mental wellbeing of volunteers.

Why have I been approached?

You have been approached because the study requires information from people who are actively volunteering for for helpline services providing emotional and wellbeing support.

Do I have to take part?

No. It is completely up to you to decide whether or not you take part. Even if you agree to take part, you can still change your mind; you can stop the study at any point by exiting the webpage. However, after you submit the questionnaire, it will not be possible to withdraw your consent and data.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be asked to read and complete a consent form. Following this, you will be asked to complete a questionnaire. This should not take any longer than 10-15 minutes to complete. The questionnaire along with the consent form must be completed in one sitting; if you were to close the webpage the answers completed up to that point would be lost. Once you have finished the questionnaire, you have completed the study and will not be asked to participate in any follow-up studies.

Will my data be identifiable?

No. Your responses are anonymous, meaning that your data cannot be traced back to you. All data collected for this study will be stored securely on a password protected, secure platform.

What will happen to the results?

The results will be summarised and reported in a doctoral thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress during the study you are free to leave the study at any point.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. However, your answers will help us to improve our understanding of the wellbeing of volunteers working for mental health helplines. We will share our findings with organisations providing mental health helplines and seek to publish our findings in a scientific journal.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

If you have any questions about the study, please contact the main researcher:
Julieanne Briones; j.briones@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the research, you can contact:
Professor Bill Sellwood, Research Director
Email: b.sellwood@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

If you would like to take part, please click **'NEXT'** to provide consent and take the survey.

Appendix F

Consent Form

Before proceeding to the survey, please read the following statements carefully before choosing to consent.

I confirm that I have read the information sheet and fully understand what is expected of me within this study.

I confirm that I have had the opportunity to ask any questions and to have them answered.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that once I have completed the survey, it will not be possible to withdraw my data.

I understand that my responses will remain anonymous, and I consent for this data to be used for the purpose of research outlined in the participant information sheet.

I consent to take part in the above study

I do not consent to take part in the above study

← →

Appendix G

Compassionate Engagement and Action Scales Instructions

Lancaster University

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 i**mportant 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. You will be asked a series of questions 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 each of the items.

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...

	Never 1	2	3	4	5	6	7	8	9	Always 10
Other people are actively *motivated* to engage and work with my distress when it arises.	○	○	○	○	○	○	○	○	○	○

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...

	Never 1	2	3	4	5	6	7	8	9	Always 10
Others direct their *attention* to what is likely to be helpful to me.	○	○	○	○	○	○	○	○	○	○

Lancaster University

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. You will be asked a series of questions 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 each of the items.

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...

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

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...

	Never 1	2	3	4	5	6	7	8	9	Always 10
I direct my *attention* to what is likely to be helpful to me.	○	○	○	○	○	○	○	○	○	○

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 compassion. The *first* is the ability 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. 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. You will be asked a series of questions 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 each of the items.

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...

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

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

When others are distressed or upset by things...

	Never 1	2	3	4	5	6	7	8	9	**Always** 10
I direct *attention* to what is likely to be helpful to others.	○	○	○	○	○	○	○	○	○	○

Appendix H

Job-Related Affective Wellbeing Scale Instructions

You will be shown 30 statements that describe different emotions that a job can make a person feel. Please indicate the amount to which any part of your voluntary job (e.g. the work, coworkers, supervisor, clients) has made you feel that emotion in the past 30 days.

←

→

Please check **one** response for each item that best indicates how often you've experienced each emotion at work over the past 30 days.

	Never	Rarely	Sometimes	Quite often	Extremely often
My job made me feel disgusted	○	○	○	○	○

Appendix I

Participant debrief information

Lancaster University

End of study.

Thank you very much for taking part in this study.

Research shows that mental health helpline volunteers can experience low levels of wellbeing, and little is known as to why. This study aims to explore the impact of compassion on wellbeing in volunteers. Compassions is described as the ability to recognise someone's suffering and doing something to stop the suffering. It is said that compassion has three flows: compassion for ourselves, compassion that we receive from others, and our compassion for others. Research suggests that each flow of compassion can have a positive impact on wellbeing. Results from this study will be analysed to see if there are relationships between volunteers' wellbeing and the three flows of compassion. Recommendations will then be made based on the findings.

If you have any questions or concerns about the study, please don't hesitate to contact the researcher. The contact details are as follows:
Main researcher: Julieanne Briones – j.briones@lancaster.ac.uk
Research supervisor: Dr James Kelly – j.kelly@lancaster.ac.uk

If you feel you would benefit from any support, please find below details of relevant organisations that offer support:

To speak with someone, the Samaritans helpline offer support 24 hours a day, 7 days a week

- Telephone: 116 123
- Email: jo@samaritans.org (Response time: 24 hours)

For mental health information and signposting service, Mind's Infoline is available 9am to 6pm, Monday to Friday (except for bank holidays)

- Telephone: 0300 123 3393
- Email: info@mind.org.uk
- Text: 86463

For practical advice and general help on living with mental illness, Rethink Mental Illness offers an advice and information service 9:30am to 4pm, Monday to Friday.

- Telephone: 0300 5000 927
- Email: advice@rethink.org

We acknowledge that you might be familiar with these services and may be volunteering in one of them. If you feel you need further support please contact your GP and ask for an emergency appointment or contact your local crisis team. If, at any time, you experience suicidal thoughts or thoughts of wanting to harm yourself, please call 999 or attend to A&E.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the research, you can contact:

Professor Bill Sellwood, Research Director

Email: b.sellwood@lancaster.ac.uk

To complete the study please click 'SUBMIT' below. Once you click 'SUBMIT', you will no longer be able to withdraw your data.

Appendix J

Multiple hierarchical regression with gender variations

Table J1

Results of Multiple Hierarchical Regression for JAWS without gender variable

	Unstandardised B	SE	*Standardised B*	*t*	*p*	R^2	Adj. R^2	R^2 Change	*F*
Step 1						**.002**	**-.008**	**.002**	**.240**
Demographic variables									
Age	.003	.006	.050	.490	.625				
Step 2						**.004**	**-.017**	**.001**	**.127**
Length of time volunteering									
Age	.004	.007	.073	.603	.548				
Length of time volunteering	-.007	.021	-.043	-.357	.722				
Step 3						**.223**	**.181**	**.219**	**8.734****
Flows of compassion									
Age	-.006	.007	-.104	-.876	.383				
Length of time volunteering	.005	.019	.030	.266	.791				
Compassion from others	-.049	.081	-.062	-.606	.546				
Self-Compassion	.250	.101	.282	2.477	.015*				
Compassion to others	.378	.130	.309	2.899	.005*				

**p<.05, two-tailed. **p≤.001, two-tailed*

Table J2

Results of Multiple Hierarchical Regression for JAWS with non-binary participants included

	Unstandardised B	SE	*Standardised B*	*t*	*p*	R^2	Adj. R^2	R^2 Change	*F*
Step 1						**.017**	**-.003**	**0.17**	**.853**
Demographic variables									
Age	.005	.006	.082	.782	.436				
Gender	4.088	3.378	.127	1.210	.229				
Step 2						**.018**	**-.013**	**.000**	**.009**
Length of time volunteering									
Age	.005	.007	.087	.723	.471				
Gender	4.016	3.482	.124	1.153	.252				

Length of time volunteering	-.002	.021	-.011	-.093	.926				
Step 3						**.232**	**.182**	**.214**	**8.565****
Flows of compassion									
Age	-.006	.007	-.097	-.814	.418				
Gender	3.376	3.196	.104	1.054	.295				
Length of time volunteering	.010	.020	.059	.518	.606				
Compassion from others	-.065	.082	-.082	-.795	.428				
Self-Compassion	.255	.101	.287	2.522	.013*				
Compassion to others	.374	.130	.305	2.867	.005*				

**p<.05, two-tailed. **p≤.001, two-tailed*

Doctorate in Clinical Psychology | Lancaster University

Section 3: Critical Appraisal

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The aim of this critical appraisal is to highlight some of the key challenges and decisions that shaped the thesis as well as considering the rationale for some of the decisions made. It also makes suggestions for future research directions. It starts by providing an epistemological statement for the thesis. Following this, the empirical paper and systematic literature review were discussed. Lastly, personal reflections are presented regarding the thesis.

Epistemological position

A critical realist position was adopted for this thesis as it allows for the research methodology to be dictated by the nature of the research question/problem (McEvoy & Richards, 2006). Within a critical realist framework, it is proposed that both qualitative and quantitative methodologies can be used to research underlying mechanisms that cause actions and events (Healy & Perry, 2000). Olsen (2002, as cited in McEvoy & Richards, 2006) argued that the most effective approach would be to use a combination of quantitative and qualitative methodologies. Critical realism proposes the idea that there is an external 'truth' independent form our perceptions and constructions however, the construction of truth is influenced by the social context in which it exists (Maxwell, 2012). Consequently, a critical realist does not assume that data directly reflect reality/truth but it acknowledges that data needs to be interpreted, recognising subjectivity as essential to the production of knowledge (Madill et al., 2000). A critical realist must draw on knowledge, theories and evidence from outside the research being conducted to interpret the data. Additionally, critical realism suggests that interpretations represent possibilities rather than certainties allowing for the researcher to present findings tentatively (Willig, 2012). The findings in both the papers are therefore considered to be a tentative account of me making sense of the participants making sense of their truth/reality.

Empirical Paper

The empirical paper was underpinned by the theory that compassion has three directional flows: compassion that people direct to others, the experience of compassion from other people and self-compassion, and the growing evidence that each flow can have distinct psychological and physiological effects (Gilbert et al., 2011; Gilbert et al., 2017). The aim of the study was to take this established phenomenon and apply it to mental health staff populations, to identify if specific flows of compassion can predict positive psychological outcomes. In doing so, we hoped that research outcomes could suggest targeted interventions to improve staff wellbeing. Helpline

volunteers providing emotional and psychological support are the focus of the research and reasons for this are highlighted in this report. Systematic literature reviews investigating the wellbeing of telephone crisis line volunteers found that volunteers experienced poor wellbeing outcomes such as symptoms of vicarious trauma, burnout, psychological disorders, compassion fatigue, and psychological distress (Kitchingman et al., 2018; Willem, 2020). The findings of the study indicated that the flows of compassion had a significant role in predicting job-related affective wellbeing (JRAW) in helpline volunteers, specifically self-compassion and compassion for others. These findings provided preliminary evidence that self-compassion interventions may be beneficial for the JRAW of helpline volunteers and identifying qualities of compassion for others could have implications for volunteers' retention and JRAW.

Research topic

When the COVID-19 outbreak occurred, I was in the process of completing my research ethics application, which impacted on the research topic. The British Psychological Society (BPS, 2020) provided guidance that trainees who would have required NHS ethical approvals to consider changing the scope of their projects to allow university ethics to be used instead due to NHS guidelines that only research directly related to COVID-19 would be considered through NHS ethics. Prior to this, the research topic was focused on how the specific flows of compassion predicted the wellbeing of NHS mental healthcare staff. My supervisors and I considered re-designing the project to not require NHS ethics. At the time, the news often reported an increase in callers to mental health helplines which prompted my interest of this population. This made me reflect on my placement in a community mental health team (CMHT) service that often recommended calling the Samaritans or similar services, to patients if they feel they are in a crisis, with this being added to patient care plans; this was similar to findings in Morgan et al., (2012). Morgan et al., found that CMHT members viewed helplines as complimentary to secondary mental health services with a large majority of the members recommending helpline to their patients. CMHT members also reported using helpline themselves to access information for their patients. Prior to the Doctorate training, I only had experience of working within inpatient and residential settings, where crisis and risk are managed by the staff team. I reflected on the impact of crisis management in person and became interested in the impact this could have on someone who is on the phone and are unable to 'physically' do something but listen.

A scoping search highlighted that helpline volunteers experience similar poor wellbeing symptoms to healthcare and mental health care staff such as, experiencing stress, symptoms of vicarious trauma, burnout, psychological disorders, compassion fatigue and subjective distress (Kitchingman et al., 2018; Willem et al., 2020). The scoping search also highlighted a gap in the research that focused on factors that could potentially improve wellbeing outcomes in helpline volunteers. I felt that this research was particularly important given the positive outcomes reported by callers, and the reliance of statutory services on these charitable organisations, which in turn, relied on volunteers. Therefore, research that could potentially lead to the identification of interventions that may help to protect volunteers from the negative impact of volunteering would be valuable.

The British Psychological Society (BPS, 2021b) code of human research ethics highlights that research generating psychological knowledge should support beneficial outcomes. It was important to me that the research outcome would be relevant to helpline voluntary services and be beneficial for helpline volunteers. My supervisors and I recognised that we had limited knowledge of voluntary helpline organisations and agreed to seek stakeholder involvement. Including stakeholders in research can bring knowledge and expertise to the research that can build a shared understanding and make information from research relevant to services (Deverka et al., 2012; Klein et al., 2012). Additionally, they can help to shape research questions and design, communicate findings, support recruitment, and implement results (Hoffman et al., 2010; Lomas, 2000). When this research was being designed, a well-known helpline organisation with an established research team was approached for their input on the design of the project to ensure it is collaborative and relevant. Understandably, they were unable to support the research due to the additional demands placed on the organisation due to the COVID-19 pandemic. I would have ideally approached other stakeholders such as volunteers themselves however, due to the time constraints, this was not feasible.

Recruitment

Although several organisations agreed to circulate the online survey multiple times, there was still difficulties in recruiting to meet the number of required participants for a medium effect size. A factor that could have had an influence on this could be that helplines experienced an increase in their callers during COVID-19 (Beat, 2020; Centre for Mental Health, 2020; Cruse

Bereavement Care, 2020; Refuge, 2021; Samaritans, 2021; Switchboard, 2020; The Mix, 2020) which might have added pressure on the volunteers.

The decision was then made to expand the inclusion criteria from specifically mental health helpline volunteers to helpline volunteers that provide emotional and wellbeing support. It was identified that a number of helpline organisations provided emotional and wellbeing support to those who may be experiencing crisis or mental health difficulties but may not necessarily label themselves as mental health organisations. For example, helplines providing wellbeing support to victim of domestic abuse. Ethical approval was received to add these organisations to the included population. It would have been interesting to see if there was a difference between the results of the different types of helplines however, it was not possible separate these as this data was not collected.

Future Research Suggestions

The research proposed that interventions focussed on improving self-compassion and identifying qualities of compassion for others could have implications for volunteers' JRAW. Considerations could be made for the development of a training programme particularly focusing on self-compassion. Research using qualitative models could explore further the specific needs of the helpline volunteers to better understand individual barriers and needs when developing the training programme. An evaluation of the training programme and its impact on staff wellbeing should also be considered to identify feasibility, outcomes and efficacy as it would be beneficial in potentially implementing the training widely. It would also be valuable to explore the volunteers' experience of this through qualitative research as this could provide a better understanding of potential outcomes as well as improve the training package.

The definition of compassion used to underpin the research, was that compassion is a sensitivity to the suffering of self and others, and a motivation to try to alleviate and prevent this suffering (Gilbert, 2009). For helpline volunteers, the ability to alleviate the suffering of others may have been hindered due to the nature of helplines as they are anonymous and are unable to physically intervene. Additionally, volunteers emphasised that their primary role is to listen and offer an emotional "presence" rather than offering advice or solutions (Vattøe et al., 2020). Research found that the inability to actively intervene can be an emotional stressor for helpline volunteers (Willems et al., 2020), and can lead to staff feeling helpless and discouraged (Vattøe

et al., 2020). It would be interesting to further investigate the experience of helpline volunteers having to supress the motivation to alleviate and prevent the suffering of others as this may contribute to the compassion literature and potentially identify ways in which organisations can support helpline volunteers with this experience.

The research utilised the Job-related Affective Wellbeing Scale (JAWS, van Katwyk et., 2000) which included both negative and positive affects. One limitation of the research was the potential of the regression analyses obscuring the fact that the flows of compassion could be predicting either or both positive and negative affects. However, these were not analysed as separate variables as the research did not have adequate participants to power further analysis. Future research could investigate whether each flow of compassion predicted positive and/or negative affective wellbeing, or if any of the flows of compassion acted as protective factors from negative affective wellbeing. Given that the research suggested that helpline volunteers' compassion for others action is hindered, it would be interesting to explore how suppressing the motivation to alleviate the distress of others impacts on volunteers' positive and negative affective wellbeing. Furthermore, research that split the positive and negative affective wellbeing could potentially add to the understanding of the flows of compassion literature.

Systematic Literature Review

The systematic literature review explored the experience of Compassion Focused Therapy (CFT) within a clinical population. Results were synthesised from six qualitative research papers using a meta-ethnographic approach. The findings suggest that CFT was able to facilitate individuals' understanding of themselves and past experiences. In doing so, individuals experienced a shift in their relationship with the self-critic viewing this as an indicator and protector for threat, and a signal to the self-compassion to 'act.' There was also a shift in how individuals viewed self-compassion. Self-compassion was initially viewed as a weakness which shifted to the self-compassion being regarded as something that was empowering which also enabled individuals to feel a sense of agency. It also highlighted important CFT processes which were individuals feeling safe, experiencing and tolerating overwhelming emotions, and having a felt experience rather than just a cognitive shift. The review identified that overall there was a limited amount of research that focused on the experience of CFT within clinical populations and it was clear these needed consideration in future research and highlighted the need to do so.

Research question

Attempting to formulate a research question for the systematic review was initially challenging. I had already decided the focus of the empirical paper, therefore in the literature review I was initially interested in both volunteer wellbeing literature and the compassion literature. As my empirical paper was quantitative, I was initially focused on identifying a quantitative literature review question. However, through initial scoping searches I quickly realised that the research on volunteer wellbeing was scarce and was too heterogenous to create a meaningful and focused narrative. Additionally, for the compassion literature, there were a number of rigorous quantitative reviews that were completed recently (Craig et al., 2020; Kirby et al., 2017). I considered other topics such as online based compassion-based interventions; however, the sample for this was again too heterogenous. The idea of completing a review on the experience of CFT within a clinical population was then explored. This prompted a scoping search of the literature. There were initial concerns regarding the small number of research papers however, this highlighted a gap in the literature and that this area required further attention.

Reflexivity

The systematic literature review explored qualitative research where the importance of reflexivity is highlighted. Reflexivity refers to the researcher bringing their awareness and actively acknowledging their own unconscious bias, actions and decisions that will inevitably have an impact on the people being studied, questions being asked, data being collected and data interpretation (Berger, 2015; Buetow, 2019; Horsburgh, 2003). As I was completing a review, I did not have direct access to the participants of the primary research or had influence on the data being collected. However, it was still important that I reflected on how my contextual positioning influenced the understanding I constructed from the findings of previous research. Suri (2014) proposed that reflexivity and collaborative sense-making are ways to enhance the quality of systematic review which I felt I was able to do through supervision and from draft read feedback. It was important for me to remain reflexive about how my own context and subjective positioning is having an influence, and being influenced, by the review findings through keeping a note of my reflections and supervision. For example, as a therapist I have an interest in how therapy can influence change therefore, I was drawn to identifying mechanisms of change which

moved away from the primary experience of CFT which may or may not involve change. This was something I kept in mind as I analysed the data and proposed implications from the research. Additionally, having had a limited amount of training and experience in Compassion Focused Therapy (CFT) I was particularly interested in learning about the theory that underpins CFT which became apparent when I was analysing the data. Consequently, the initial themes identified and results structure reflected a top-down expert position informed by CFT theory and language. For example, initially the first two themes reported in the results section were "experiences of self-criticism" and "experiences of self-compassion." My research supervisors offered feedback and reflection on this which helped me to shift my focus more onto the experience of the participants leading to a re-evaluation and restructuring of the results section. This led to the results section being more focused on the experience of participants and structured in a way that provide a narrative of how CFT was experienced.

Major et al., (2010) also highlighted the importance of critically reflecting on the contextual position of the authors of the included studies in the review, and how they might have influenced the findings of the original studies. Again, this was something that I kept in mind when analysing the data, which made me reflect on the themes identified in the primary studies and the quotes that accompany these. Completing a meta-ethnographic approach meant that I was able to make sense of both and develop my own interpretation of the data presented. I felt that a majority of the studies had a focus on the theory underpinning CFT which consequently influenced my initial themes and interpretation of the data which was something I discussed in supervision. In doing so, we were able to discuss the importance of focusing on the reported experience of the participants and being guided by the quotes used. For example, reading all the quotes related to self-criticism led to a felt sense of how important the self-critic was and led to my understanding of how its role was understood and recast by the participants.

Reflections on results

As a therapist with an interest in delivering CFT in my future work, I reflected on the results that specifically mentioned the role of the therapist within the CFT process. The participants highlighted the value of a therapist who they perceived as a human being who genuinely cared for them and were knowledgeable, credible, non-judgemental and validating. I wondered whether there was anything specific about CFT that made it so individuals were able

to experience this from their therapists. I considered that it could be a mixture of both the therapists' attributes and a sense that in CFT individuals are helped to develop a sense of common humanity (Gilbert 2020) this potentially helped in viewing the therapists as 'human' with shared human experiences and difficulties.

The SLR highlighted individuals' experience of overwhelming emotions during therapy and the importance of staying with these emotions. I recommended that future studies should consider exploring both the therapists and the patients' experience simultaneously, in order to identify how their experiences matched or differed. Upon reflection, I realised that my rationale for proposing this research was due to my interests as a therapist. One of my concerns as a therapist is individuals finding the intense emotions too overwhelming which could potentially lead to their disengagement. Therefore, when I noticed this as a theme from the SLR I wondered how the therapists experienced and explored this. In terms of the definition of compassion, it highlights the ability to being sensitive to the distress of others. Future research exploring therapists experience of identifying distress and the most intense moments of individuals' subjective experience, and how this is explored would contribute in the understanding of the process of individuals' experience of exposure to threatening and feared emotions

General Reflection

Compassion

Both the literature review and empirical paper highlighted the importance of self-compassion. Throughout the process of this thesis, I have reflected on my self-to-self relationship and my motivation to alleviate my own distress. The thesis process, although has been enjoyable in parts, has also caused stress which resulted in me not engaging in self-care as I normally would. I noticed my own fears, blocks and resistances to compassion such as feeling "too busy" for it and at times feeling that it was self-indulgent. For example, I felt that there was a level of guilt associated with engaging with self-care, such as going for a long walk or spending time with family, particularly as I felt that time could be better spent on reading another paper or writing another paragraph. There were times when it was easier to engage in self-care. However, I later realised that sometimes what I needed to do in order to alleviate my distress was to complete work. There were conflicting emotions that came with this, as I felt guilt when my usual 'self-care' took a step back. I recognise now that the self-to-self relationship is quite

dynamic with its own conflicts and challenges. This made me reflect on how I present the idea of self-compassion and self-to-self relationship to the people that I work with. For example, self-care will look very different for each individual and this could differ from day-to-day.

Additionally, part of the definition that underpinned compassion throughout this thesis was the sensitivity to distress. I feel that immersing myself in the compassion literature has made me aware of how I have engaged with my own distress throughout the doctorate training. I realised that I paid little attention to my own distress or how I might ignore this and not engage with it until I have to, for example when experiencing a migraine. I feel that moving forward, it is important for me to engage with my signs of distress and actively do something about this. This prompted a reflection on how I might also suggest this to future clients or colleagues. For example, how might we know when we are in distress and how often might we ignore these signals, and how easy or difficult might it be to actively do something about the distress. While also considering that there will be things that are not in our control.

Research

The BPS (2021a) Code of Ethics and Conduct, and Health and Care Professions Council (HCPC, 2018) Standards of Proficiency highlights the importance of evidence-based practice to continue the development and maintenance of high standards of competence in professional work. I recognise the importance of working within my own competence and being aware of new research developments within my area of work. Through the process of completing a thesis, I have learned to be more critical of the evidence base and reflected on how the evidence base develops, what is put forward as 'gold standard,' and the impact of this on my own practice and the people that I work with.

Prior to the doctoral training, I had an unconscious preference towards quantitative research. A reason for this was due to my Undergraduate training placing an importance on randomised controlled trials (RCTs) as the 'gold standard.' This belief was strengthened by the National Institute for Health and Care Excellence (NICE) guidelines, which suggests that RCTs are often the most appropriate type of research to assess efficacy, including cost effectiveness, (NICE, 2022) leading to the proposal of specific therapies as treatment for specific mental health difficulties. Completing a qualitative systematic literature review meant that I had to immerse myself in qualitative research. In doing so, it highlighted to me the importance of qualitative

research and its implications for theories and therapies. In particular, hearing the voice of the participants through their quotes were really impactful for me and helped me engage with the review at an emotional level. As a clinician I always emphasised the importance of giving service users a voice. Now, as a researcher, I recognise the importance of exploring people's experience through research in order to guide practice and guidelines. Moving forward to the next stage of my career, I will continue to have a critical stance about the research that I read and will always seek out qualitative research to help my understanding of how therapy is experienced by those who completed it. However, I would remain mindful of the influence that research question and researcher have had on what is published as well as those who might not have participated in research, and the generalisability of the research.

Conclusion

The impact of COVID-19 on the research project led me to identify an area of service provision that is not only important for service users, but also for the support they offer statutory services, a population that I otherwise wouldn't have considered. Although the empirical paper had limitations, overall I feel that the empirical paper was successful in gaining valuable insights into the wellbeing of helpline volunteers and the role of compassion. It has provided implications that are hopefully relevant to the voluntary services, with suggestions for adding self-compassion training within their training packages. More research is needed, with varying methodological designs, to further understand the role of compassion and compassion experienced from others on the wellbeing of helpline volunteers.

Furthermore, the literature review highlighted important processes in CFT and provided an insight to how CFT is experienced by those within a clinical population. The review also highlighted a clear need for further research that focuses on the experience of CFT within clinical populations.

It is hoped that this critical appraisal illustrated the rationale for the decisions made throughout the thesis process, as well as suggesting directions for future research. I have also highlighted my reflections regarding my experience of completing this thesis and how this has shaped my clinical identity and practice.

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Doctorate in Clinical Psychology | Lancaster University

Section 4: Ethics Documentation

Ethics proposal for the empirical study: The Relationships Between the Flows of Compassion and Job-Related Affective Wellbeing in Helpline Volunteers

Julieanne Briones *[1]

*[1] Department of Clinical Psychology, Lancaster University, Lancaster, UK

*[1] Corresponding author. Department of Clinical Psychology. Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster, United Kingdom, LA1 4AT.

Email: j.briones@lancaster.ac.uk

Health & Medicine | Lancaster University

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: The Relationship Between the Flows of Compassion and Mental Wellbeing in Mental Health Helpline Volunteers

Name of applicant/researcher: Julieanne Briones

ACP ID number (if applicable)*: **Funding source (if applicable)**

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

Clinical Psychology, Div. Of Health Research,
Lancaster University, Lancaster, LA1 4YG

SECTION ONE

1. Appointment/position held by applicant and Division within FHM

2. Contact information for applicant:
E-mail: j.briones@lancaster.ac.uk **Telephone:** [redacted] please give a number on which you can be contacted at short notice)

Address: Clinical Psychology, Div. Of Health Research, Lancaster University, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr James Kelly, Lecturer in research methods & Principal Clinical Psychologist
Dr Laura Twist, Clinical Tutor & Clinical Psychologist

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr James Kelly & Dr Laura Twist

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:
Dr James Kelly, Lecturer in research methods (Clinical Psychology, Div. Of Health Research, Lancaster University, LA1 4YG)
Dr Laura Twist, Clinical Tutor (Clinical Psychology, Div. Of Health Research, Lancaster University, LA1 4YG)

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk
3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o
4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? n o
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder
7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes
b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Research shows that mental health helpline volunteers (MHHVs) can experience low levels of wellbeing, but the reasons for this are poorly understood. This study aims to explore the impact of compassion on wellbeing in MHHVs. Compassion has been described as the ability to recognise suffering in oneself and in others, and the motivation to stop this suffering. Compassion is thought to have three flows: compassion for ourselves, compassion that we receive from others, and our compassion for others. Research suggests that each flow of compassion can have a positive impact on wellbeing.

MHHVs from different organisations, such as the Samaritans and Papyrus, will be recruited. Participants will be asked to complete questionnaires that measure their levels of wellbeing, and experienced compassion from the three different flows. These will then be analysed to see if there are relationships between them. Recommendations will then be made based on the findings.

2. **Anticipated project dates (month and year only**)

Start date: January 2021 End date: March 2022

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

A minimum sample size of 98 is needed to detect a medium effect ($f^2 = 0.15$) with 6 control variables (predictor variables: self-compassion, compassion to others, compassion from others; Demographics: age, gender, and number of years volunteering). The maximum number of participants sought will be 110.

Inclusion criteria
• Participants must be an active mental health helpline volunteer OR an active volunteer providing emotional and wellbeing support via helplines
• Participants must be aged 18 or over
• Participants must be able to understand English to complete the measures and provide informed consent
Exclusion criteria
• Participants will not be able to take part in the study if they are not active volunteers
• Participants will not be able to take part in the study if they do not provide support via helplines

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

A list of charitable organisations that offer mental health helpline or provide emotional and wellbeing support via helpline will be compiled including the Samaritans, Papyrus, Mind, and Rethink mental illness. The organisations will then be approached via email to gain their support in circulating the questionnaires to their volunteers. Organisations will be provided with an information sheet **(Appendix A on supporting document)** when contacted and will be asked to circulate this to volunteers – the email and the information sheet will include a link to the study. The research protocol will also be available if they request this.

Additionally, social media platform promotion will also be requested from the organisations. An online poster **(Appendix B on supporting document)** will be used to promote the research on social media for example, advertising on their Facebook and retweeting on Twitter. The poster will include an outline of the research, inclusion criteria, researcher contact details, and a link to the study.

Twitter will also be used to promote the research using a professional Twitter account. The online poster **(Appendix B on supporting document)** will be used to promote the research on twitter. The research will be promoted widely using hashtags and requesting for organisations to share the tweet therefore, the content will be widely and publicly available. To obtain consent, the Qualtrics link will direct potential participants to an information sheet and will then be asked on the next page to consent to participating in the study. If the participant click 'NO' they will automatically be exited from the questionnaire.

Online Forums will also be utilised to promote the study. Forum admins will be asked to post the online poster to promote the research. Similarly to above, the content will be widely and publicly available. However, consent will be obtained via Qualtrics.

A request to advertise the research on the Lancaster University website will also be completed.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data will be collected via an online survey using Qualtrics and participants will be provided with a dedicated link to the Qualtrics survey. Demographic information including age, gender, and number of years volunteering will be collected alongside The Job-related Affective Wellbeing Scale (JAWS; Katwyk et al.,2000) and The compassionate engagement and action scale (Gilbert et al., 2017). More information on these scales including their validity is included in the Research Protocol.

First, a Pearson's R correlation will be used to examine associations between key variables. If the data is not normally distributed then a Spearman correlation will be used. Following this, a block design multiple regression (enter method) will be used to analyse the variance in job-related affective wellbeing predicted by demographics and the three flows of compassion. Blocks will be entered as follows; block 1: demographics; block 2: demographics and years of service; block 3: demographics, years of service and flows of compassion. In the case of non-normally distributed date, we will use bootstrapping (1000 reps).

The primary aim is to enter all three flows of compassion into the regression however, if there are not enough participants and insufficient power, a regression analysis will be completed using only compassion from others for the main analysis. In addition, we will run exploratory analyses for Compassion to Self and Compassion to others.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Data collection will be in compliance with GDPR guidelines regarding the collection, storage and processing of personal information. Data collected for this study will be stored securely and only the researcher and research supervisors will have access to the data.

The survey will be completed and stored on Qualtrics which uses Transport Layer Security encryption, only the researcher and research supervisors will have access to the responses directly and during supervision. As there are no information which could identify individuals taking part in the research, all data collected is anonymous. The data will then be exported to SPSS for statistical analysis.

Following the completion of the research project (inclusive of passing the viva) the data will move to long-term storage by the researcher and programme Research Coordinator. In terms of long-term storage this will be in compliance with the procedure developed by the Doctorate in Clinical Psychology programme (which can be found here https://wp.lancs.ac.uk/dclinpsy/data-storage-information-governance-and-ethics/) :
(1) All data will be encrypted and saved electronically by the researcher, including consent forms on OneDrive which only the researcher will have access to.

(2) Data will then be transferred by the researcher securely to the programme Research Coordinator who will save the files in a password-protected file space on the university server.
(3) The data will be stored for 10 years and will be destroyed by the Research Coordinator following 10 years.

7. Will audio or video recording take place? ☒ no ☐ audio ☐ video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder
8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will not be stored on PURE or a depository. As above, the data will be stored for 10 years in a password-protected file space on the university server.

8b. Are there any restrictions on sharing your data ?

Data can be made available upon request to the researcher. The researcher/organisation requesting the data must provide information regarding their proposed use or the purpose of their request.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

The participants will first be provided with an information sheet and will be asked to read all the information on Qualtrics (**Appendix C on supporting document)**. At the end of the information sheet the researcher's contact details will be available should participants need to ask further questions. If a potential participant requests an information sheet via email, they will be provided with a link to the Qualtrics survey as the information sheet will be available on this prior to the start of the study. Participants can then access the study by clicking on the Qualtrics link or on Qualtrics by clicking 'NEXT'.

Once participants continue on Qualtrics they will be shown the consent form **(Appendix D on supporting document)** which consists of statements confirming that they have read the information sheet. Participants are given the option to consent or not consent to the study. Participants need to consent to continue with the study. If they click the option for not consenting, they will be exited from the study.

The consent form will be provided online via Qualtrics and participants will have to provide their consent prior to continuing with the study. The participants will be provided with a participant information sheet (via Qualtrics) with the researcher's contact details, which will allow them to ask questions prior to giving consent.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Although it is not anticipated that completing the study will result in significant risks to participants or raise significant ethical issues there is a risk that completing the questionnaires may be distressing for others therefore, participants will be free to withdraw from the study at any time. Participants will be provided with this information on the participant information sheet.

They will also be provided with resources as well as the researcher's details. Additionally, they will be able to contact a member of the programme not within the research's team if they are unhappy with any aspect of the study.

Participants may withdraw consent at any point during the completion of the questionnaires by clicking off the study. Following the completion/submission of the questionnaires participants will no longer be able to withdraw their consent as data cannot be traced back to the participant.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There are no anticipated risks to the researcher given the online format of the study.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits for taking part however, once the study is completed there may be implications for training/intervention which will be shared with the relevant charitable organisations.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
There will be no incentives/payments made to participants

14. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.
Participants' responses are anonymous, and data cannot be traced back to individuals for example, information about their organisation is not collected.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The Samaritans research department was contacted to gain their support in the designing of the study. However, due to the additional pressure of the initial COVID-19 lockdown they were unable to provide their support.

A pilot study with a small number of MHHVs was considered due to the concern that the questionnaire's completion time might be lengthy leading to non-completion. However, doing a pilot study would mean that their data will not be used for the main analysis. Therefore, instead of a pilot study Qualtrics participation will be monitored on a weekly basis for non-completion. If non-completion is observed, reducing the questions will be considered.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The research will be submitted as a thesis and findings will be presented to staff and students from the Clinical Psychology Doctorate in 2022. It is anticipated that the research will be submitted for publication in a relevant, high impact peer reviewed academic journal. The research findings will also be disseminated to mental health helpline services.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

The primary ethical concern will be potential distress in filling in the questionnaires. However, the questionnaires have been used in previous research with no reports of concerns noted.

SECTION FOUR: signature

Applicant electronic signature: [redacted] Date 15.10.2020

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr James Kelly Date application discussed 20.10.2020

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the following materials for your study, if relevant, into a single word document:
        a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
        a. existing documents/data only;
        b. the evaluation of an existing project with no direct contact with human participants;

c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>**

Ethical Approval Letter

Applicant: Julieanne Briones
Supervisor: Dr James Kelly & Dr Laura Twist
Department: DHR
FHMREC Reference: FHMREC20191

13 August 2021

Re: FHMREC20191
The Relationships Between the Flows of Compassion and Mental Wellbeing in Mental Health Helpline Volunteers

Dear Julieanne,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]
Research Ethics Officer, Secretary to FHMREC.

Doctorate in Clinical Psychology | Lancaster University

Research Protocol
Version 2
Date: 09 August 2021

Title: The Relationships Between the Flows of Compassion and Mental Wellbeing in Mental Health Helpline Volunteers

Principal investigator: Julieanne Briones, Trainee Clinical Psychologist
Research supervisor: Dr James Kelly
Field supervisor: Laura Twist

Introduction

Background

The Five Year Forward View (National Health Service (NHS), 2014) identified voluntary and charitable sectors as having an impact well beyond what statutory services alone can achieve and explicitly referred to building stronger partnerships with such organisations. Additionally, Mental Health services rely on helplines to provide support when they cannot such as, out of hours support. For example, Morgan et al., (2012) found that Community Mental Health teams viewed helplines as complementary to secondary mental health services and recommend these to their clients often, as well as adding them to clients' contingency plans. They proposed that helplines used in primary or specialist care settings could reduce the use of more expensive services for example, by preventing a crisis.

Voluntary helpline services provide an important service to individuals in crisis and experiencing mental health difficulties by offering free, anonymous, non-judgemental, non-directive and accessible support to individuals accessing the service (Morgan et al., 2012; Samaritans, 2015). Helpline services have been found to decrease callers' crisis states, hopelessness, suicidality, psychological pain and depressive mental state (Hvidt, Ploug, & Holm 2016; Kalafat et al., 2007; Gould et al., 2007).

A systematic review found that Mental Health Helpline Volunteers (MHHVS) reported symptoms of compassion fatigue, burnout, moderate level of perceived stress, and moderate to very high symptoms of psychological distress (Willems et al., 2020). This is not surprising given the role of MHHVs, which requires them to have detailed conversations about complex topics such as, emotional distress, thoughts of harm to self, abuse experiences, low mood, bereavement and isolation (Coveney et al., 2012). In addition to this, they have to manage inappropriate calls including those that are abusive, manipulative and sexually inappropriate (Pollock et al., 2012). Furthermore, Coveney et al., found that helpline volunteers reported non-productive coping strategies such as, not being able to identify and describe their own negative emotions, not seeking help when experiencing distress, self-blame, and ignoring the problem.

Research on the impact of volunteering on the mental wellbeing of helpline volunteers is important as burnout and poor staff wellbeing has been linked with high staff turnover, lower patient satisfaction, staff shortage, and staff sickness among mental health professionals (Department of Health, 2002; Salyers et al., 2015). However, research focussing on the wellbeing of MHHVs, is scarce (Coveney et al., 2012).

There is evidence to suggest that compassion has been linked to positive wellbeing outcomes. Compassion has been defined as a state of concern for a person who is suffering, coupled with the motivation to alleviate their suffering (Goetz et al., 2010). Gilbert et al. (2011) proposed that compassion flows in three directions which can have an impact on wellbeing; self-compassion, compassion to others, and compassion from others. Self-compassion has been shown to reduce perceived stress among healthcare staff and reduces emotional regulation difficulties, reducing stress symptoms (Finlay-Jones, Rees, & Kane, 2015; Rabb, 2014) and potentially prevent the development of compassion fatigue symptoms (Duarte et al., 2016). The ability to receive compassion from others has been observed to buffer the relationship between self-criticism and depression (Hermano et al., 2016). Furthermore, self-compassion and perceived organisational compassion were found to be strong predictors of compassion for others (Henshall et al., 2018). Research in this area can provide insight to how MHHVS experience compassion and its impact on their wellbeing.

The role of Clinical Psychologists within the current NHS includes service improvement work and to provide support and training to staff teams (Longwill, 2015). Therefore, Clinical Psychologists should consider evidence-based practice in promoting volunteers' wellbeing as well as supporting voluntary organisations to improve service quality to better support individuals.

Research aims

The project aims to explore the relationship between wellbeing in MHHVS and the three flows of compassion. Specifically, the research will explore the following questions:

- Does compassion from others predict job-related wellbeing?
- Is self-compassion a predictor of job-related wellbeing?
- Does compassion for others predict job-related wellbeing?

Method

Design

The study will use a non-experimental, non-randomised, single-group, cross-sectional, correlational design to explore the relationship between wellbeing and the three flows of compassion.

Participants

Participants will be volunteers from charitable organisations providing emotional and wellbeing support via helplines. A power calculation using G*Power 3.1 (Faul et al., 2009), with 6 control variables (predictor variables: self-compassion, compassion to others, compassion from others; Demographics: age, gender, and number of years volunteering) indicated that a minimum sample size of 98 is needed to detect a medium effect ($f^2 = 0.15$). If there are not enough participants recruited to have sufficient power, a regression analysis using only compassion from others as a predictor in addition to the control variables will be completed. As above, a power calculation using G*Power with 4 control variables (i.e. predictor variable: compassion from others; Demographics: age, gender, and number of years volunteering) indicated a minimum sample size of 85 is needed to detect a medium effect.

The inclusion and exclusion criteria are as follows:

Inclusion criteria

- Participants must be an active mental health helpline volunteer OR a helpline volunteer providing emotional and wellbeing support – Experience of volunteer (i.e. hours or years worked) were not included as an inclusive criterion as there seems to be a trend in volunteer literature that the inclusion criteria is mainly that volunteers are actively volunteering. To address this, the research will add years volunteers as a demographic to be measured
- Participants must be aged 18 or over
- Participants must be able to understand English to complete the measures and provide informed consent

Exclusion criteria

- Participants will not be able to take part in the study if they are not active volunteers
- Participants will not be able to take part in the study if they do not provide support via helplines

Materials

Demographic information will be collected including age, gender, and number of years volunteering. The questionnaires that will be used within the study are: The compassionate engagement and action scale (Gilbert et al., 2017), and the Job-related affective wellbeing scale (Katwyk et al., 2000). Electronic versions of these questionnaires will be delivered using Qualtrics, a web-based survey data collection software licensed for use by Lancaster University students.

The compassionate engagement and action scales are three scales which measure self-compassion, the ability to be compassionate to others, and the ability to receive compassion

from others. Each scale has 13 items and participants are asked to rate each item according to how frequently the statement occurs on a scale of 1 (Never) to 10 (Always). For each scale two subscales can be explored further: engagement and action. In the original study, Gilbert et al. (2017), it was found that the three scales are valid and reliable measures, with Cronbach alpha scores ranging from .74 to .94.

The Job-related affective well-being scale is designed to assess people's emotional reactions to their job. The scale has 30 items with each item relating to an emotion. Respondents are asked how often they have experienced each item at work on a five-point scale (Never, Rarely, Sometimes, Quite often, Extremely often or Always). The scale includes both negative and positive emotional experiences. The scale presented with a Cronbach's alpha of .95 (Katwyk et al., 2000).

Procedure

Recruitment

A list of charitable organisations that offer mental health helpline or provide emotional and wellbeing support via helpline will be compiled including the Samaritans, Papyrus, Mind, and Rethink mental illness. The organisations will then be approached via email to gain their support in circulating the questionnaires to their volunteers. Organisations will be provided with an information sheet **(Appendix A)** when contacted and will be asked to circulate this to volunteers – the email and the information sheet will include a link to the study. The research protocol will also be available if they request this.

Additionally, social media platform promotion will also be requested from the organisations. An online poster **(Appendix B)** will be used to promote the research on social media for example, advertising on their Facebook and retweeting on Twitter. The poster will include an outline of the research, inclusion criteria, researcher contact details, and a link to the study.

Twitter will also be used to promote the research using a professional Twitter account. The online poster (Appendix B on supporting document) will be used to promote the research on twitter. The research will be promoted widely using hashtags and requesting for organisations to share the tweet therefore, the content will be widely and publicly available. To obtain consent, the Qualtrics link will direct potential participants to an information sheet and will then be asked on the next page to consent to participating in the study. If the participant click 'NO' they will automatically be exited from the questionnaire.

Online Forums will also be utilised to promote the study. Forum admins will be asked to post the online poster to promote the research. Similarly to above, the content will be widely and publicly available. However, consent will be obtained via Qualtrics.

A request to advertise the research on the Lancaster University website will also be completed.

Data collection

Data will be collected via an online survey using Qualtrics and the participants will be provided a dedicated link to the Qualtrics survey. Demographic information including age, gender, and number of years volunteering will be collected alongside the measures mentioned above.

Data collection will be in compliance with GDPR guidelines regarding the collection, storage and processing of personal information. Data collected for this study will be stored securely and only the researcher and research supervisors will have access to the data.

The survey will be completed and stored on Qualtrics which uses Transport Layer Security encryption, only the researcher and research supervisors will have access to the responses. As there are no information which could identify individuals taking part in the research, all data collected is anonymous.

Analysis

First, a Pearson's R correlation will be used to examine associations between key variables. If the data is not normally distributed then a Spearman correlation will be used. Following this, a block design multiple regression (enter method) will be used to analyse the variance in job-related affective wellbeing predicted by demographics and the three flows of compassion. Blocks will be entered as follows; block 1: demographics; block 2: demographics and years of service; block 3: demographics, years of service and flows of compassion. In the case of non-normally distributed date, we will use bootstrapping (1000 reps).

The primary aim is to enter all three flows of compassion into the regression however, if there are not enough participants and insufficient power, a regression analysis will be completed using only compassion from others for the main analysis. In addition, we will run exploratory analyses for Compassion to Self and Compassion to others.

Practical/potential issues

A potential issue that may arise would be a lack of participants recruited. The Samaritans research team was contacted to determine the feasibility of gaining their support in recruitment and the development of the design of the study. They responded that given the current climate (COVID-19) they are unable to support research. Following this, other charitable organisations, including the Samaritans, will be contacted and a clear outline of what their support would entail will be outlined for example, for them to circulate the questionnaires to volunteers via global mailing lists and/or to promote via their social media platforms.

Ethical considerations

Ethical approval will be sought from the University Faculty of Health and Medicine Research Ethics Committee. Although it is not anticipated that completing the study will result in significant risks to participants or raise significant ethical issues there is a risk that completing the questionnaires may be distressing for others therefore, participants will be free to withdraw from the study at any time. Participants will be provided with this information along with a brief outline of the study in the participant information sheet. Following the completion of the questionnaires participants will be presented with a debrief sheet and a list of available organisations to contact should they require additional support. It will be acknowledged that the resources available will be from helpline services some of which they might already volunteer for. Additionally, the researcher's contact details will be available.

Dissemination

It is anticipated that the research will be submitted for publication in a relevant, high impact peer reviewed academic journal. The research findings will also be disseminated to mental health helpline services.

Estimated time scale

October/November 2020 – Submit ethics application for either November or December meeting

November/December 2020 – Compile list of charitable organisations with helpline service to approach following ethical approval

January 2021 – Start data collection

April/June 2021 – Submit first draft of introduction and method to research supervisor

July/August 2021 – Finish data collection

October/December 2021 – Complete data analysis and submit draft of results and discussion to research supervisor

January/March 2022 – Final drafts, Final formatting of thesis, Thesis submission

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Appendix A

Participant Information Sheet (for email attachment)

Please carefully read all of the information below.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

The Relationships Between the Flows of Compassion and Mental Wellbeing in Mental Health Helpline Volunteers

My name is Julieanne Briones and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The study is about the mental wellbeing of volunteers providing emotional support via mental health helplines. Specifically, the study aims to explore the relationship between the three flows of compassion (self-compassion, compassion from others, and compassion for others) and the mental wellbeing of volunteers.

Why have I been approached?

You have been approached because the study requires information from people who are actively volunteering for helpline services providing emotional and wellbeing support.

Do I have to take part?

No. It is completely up to you to decide whether or not you take part. Even if you agree to take part, you can still change your mind; you can stop the study at any point by exiting the webpage. However, after you submit the questionnaire, it will not be possible to withdraw your consent and data.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be asked to read and complete a consent form. Following this, you will be asked to complete a questionnaire. This should not take any longer than 10-15 minutes to complete. The questionnaire along with the consent form must be completed in one sitting; if you were to close the webpage the answers completed up to that point would be lost. Once you have finished the questionnaire, you have completed the study and will not be asked to participate in any follow-up studies.

Will my data be identifiable?

No. Your responses are anonymous, meaning that your data cannot be traced back to you. All data collected for this study will be stored securely on a password protected, secure platform.

What will happen to the results?

The results will be summarised and reported in a doctoral thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress during the study you are free to leave the study at any point.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. However, your answers will help us to improve our understanding of the wellbeing of volunteers working for mental health helplines. We will share our findings with organisations providing mental health helplines and seek to publish our findings in a scientific journal.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

If you have any questions about the study, please contact the main researcher:
Julieanne Briones; j.briones@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Professor Bill Sellwood, Research Director
Email: b.sellwood@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:
Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk

Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

If you would like to take part, please click on the link below to provide consent and take the survey.

(LINK TO QUALTRICS)

Appendix B
Recruitment poster (for social media use)

Appendix C

Participant Information Sheet (on Qualtrics)

Lancaster University

Participant Information Sheet

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Relationships between the flows of compassion and mental wellbeing in volunteers within mental health helpline services

My name is Julieanne Briones and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The study is about the mental wellbeing of volunteers providing emotional support via mental health helplines. Specifically, the study aims to explore the relationship between the three flows of compassion (self-compassion, compassion from others, and compassion for others) and the mental wellbeing of volunteers.

Why have I been approached?

You have been approached because the study requires information from people who are actively volunteering for for helpline services providing emotional and wellbeing support.

Do I have to take part?

No. It is completely up to you to decide whether or not you take part. Even if you agree to take part, you can still change your mind; you can stop the study at any point by exiting the webpage. However, after you submit the questionnaire, it will not be possible to withdraw your consent and data.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be asked to read and complete a consent form. Following this, you will be asked to complete a questionnaire. This should not take any longer than 10-15 minutes to complete. The questionnaire along with the consent form must be completed in one sitting; if you were to close the webpage the answers completed up to that point would be lost. Once you have finished the questionnaire, you have completed the study and will not be asked to participate in any follow-up studies.

Will my data be identifiable?

No. Your responses are anonymous, meaning that your data cannot be traced back to you. All data collected for this study will be stored securely on a password protected, secure platform.

What will happen to the results?

The results will be summarised and reported in a doctoral thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress during the study you are free to leave the study at any point.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. However, your answers will help us to improve our understanding of the wellbeing of volunteers working for mental health helplines. We will share our findings with organisations providing mental health helplines and seek to publish our findings in a scientific journal.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

If you have any questions about the study, please contact the main researcher:

Julieanne Briones; j.briones@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the research, you can contact:

Professor Bill Sellwood, Research Director

Email: b.sellwood@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973

Chair of FHM REC Email: l.machin@lancaster.ac.uk

Faculty of Health and Medicine

(Lancaster Medical School)

Lancaster University

Lancaster

LA1 4YG

Thank you for taking the time to read this information sheet.

If you would like to take part, please click **'NEXT'** to provide consent and take the survey.

NEXT

Appendix D

Consent form (on Qualtrics)

Before proceeding to the survey, please read the following statements carefully before choosing to consent.

I confirm that I have read the information sheet and fully understand what is expected of me within this study.

I confirm that I have had the opportunity to ask any questions and to have them answered.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that once I have completed the survey, it will not be possible to withdraw my data.

I understand that my responses will remain anonymous, and I consent for this data to be used for the purpose of research outlined in the participant information sheet.

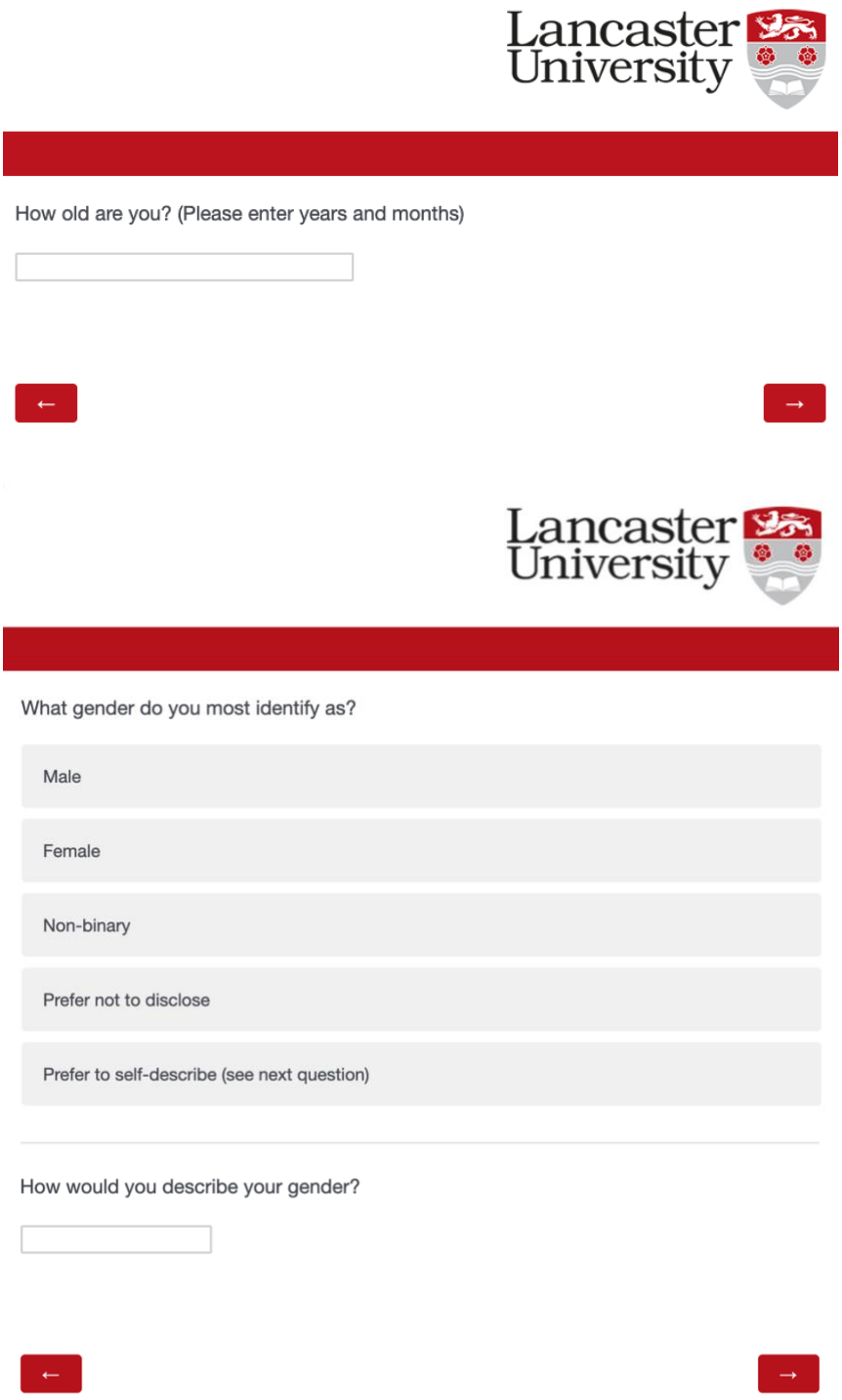
I consent to take part in the above study

I do not consent to take part in the above study

← →

Appendix E

Online Questionnaire


Lancaster University
How old are you? (Please enter years and months)
←
→
Lancaster University
What gender do you most identify as?
Male
Female
Non-binary
Prefer not to disclose
Prefer to self-describe (see next question)
How would you describe your gender?
←
→

You will be shown 30 statements that describe different emotions that a job can make a person feel. Please indicate the amount to which any part of your voluntary job (e.g. the work, coworkers, supervisor, clients) has made you feel that emotion in the past 30 days.

← →

Please check **one** response for each item that best indicates how often you've experienced each emotion at work over the past 30 days.

	Never	Rarely	Sometimes	Quite Often	Extremely often
My job made me feel at ease	○	○	○	○	○
My job made me feel angry	○	○	○	○	○
My job made me feel annoyed	○	○	○	○	○
My job made me feel anxious	○	○	○	○	○
My job made me feel bored	○	○	○	○	○
May job made me feel cheerful	○	○	○	○	○
My job made me feel calm	○	○	○	○	○
My job made me feel confused	○	○	○	○	○
My job made me feel content	○	○	○	○	○
My job made me feel depressed	○	○	○	○	○

← →

Please check **one** response for each item that best indicates how often you've experienced each emotion at work over the past 30 days.

	Never	Rarely	Sometimes	Quite often	Extremely often
My job made me feel disgusted	○	○	○	○	○
My job made me feel discouraged	○	○	○	○	○
My job made me feel elated	○	○	○	○	○
My job made me feel energetic	○	○	○	○	○
My job made me feel excited	○	○	○	○	○
My job made me feel ecstatic	○	○	○	○	○
My job made me feel enthusiastic	○	○	○	○	○
My job made me feel frightened	○	○	○	○	○
My job made me feel frustrated	○	○	○	○	○
My job made me feel furious	○	○	○	○	○

← →

Please check **one** response for each item that best indicates how often you've experienced each emotion at work over the past 30 days.

	Never	Rarely	Sometimes	Quite often	Extremely often
My job made me feel gloomy	○	○	○	○	○
My job made me feel fatigued	○	○	○	○	○
My job made me feel happy	○	○	○	○	○
My job made me feel intimidated	○	○	○	○	○
My job made me feel inspired	○	○	○	○	○
My job made me feel miserable	○	○	○	○	○
My job made me feel pleased	○	○	○	○	○
My job made me feel proud	○	○	○	○	○
My job made me feel satisfied	○	○	○	○	○
My job made me feel relaxed	○	○	○	○	○

← →

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 i**mportant 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. You will be asked a series of questions 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 each of the items.

← →

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...

	Never 1	2	3	4	5	6	7	8	9	Always 10
Other people are actively *motivated* to engage and work with my distress when it arises.	○	○	○	○	○	○	○	○	○	○
Others *notice* and *are sensitive* to my distressed feelings when they arise in me.	○	○	○	○	○	○	○	○	○	○
Others avoid thinking about my distress, try to distract themselves and put it out of their mind.	○	○	○	○	○	○	○	○	○	○
Others are *emotionally moved* by my distressed feelings.	○	○	○	○	○	○	○	○	○	○
Others *tolerate* my various feelings that are part of my distress.	○	○	○	○	○	○	○	○	○	○

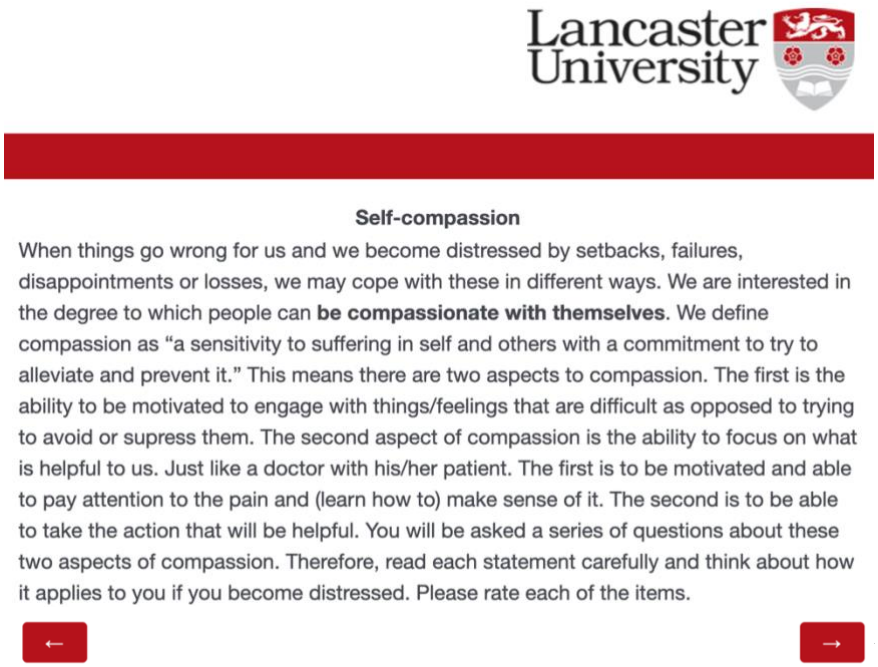
Others *reflect on* and *make sense* of my feelings of distress.	○	○	○	○	○	○	○	○	○	○
Others do not tolerate my distress.	○	○	○	○	○	○	○	○	○	○
Others are *accepting, non-critical and non-judgemental* of my feelings of distress.	○	○	○	○	○	○	○	○	○	○

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...

	Never 1	2	3	4	5	6	7	8	9	**Always** 10
Others direct their *attention* to what is likely to be helpful to me.	○	○	○	○	○	○	○	○	○	○
Others *think about* and come up with helpful ways for me to cope with my distress.	○	○	○	○	○	○	○	○	○	○
Others don't know how to help me when I am distressed.	○	○	○	○	○	○	○	○	○	○
Others take the *actions* and do the things that will be helpful to me.	○	○	○	○	○	○	○	○	○	○
Others treat me with feelings of *support, helpfulness and encouragement.*	○	○	○	○	○	○	○	○	○	○

← →



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. You will be asked a series of questions 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 each of the items.

← →

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...

	Never 1	2	3	4	5	6	7	8	9	**Always** 10
I am *motivated* to engage and work with my distress when it arises.	○	○	○	○	○	○	○	○	○	○
I *notice,* and am *sensitive* to my distressed feelings when they arise in me.	○	○	○	○	○	○	○	○	○	○
I avoid thinking about my distress and try to distract myself and put it out of my mind.	○	○	○	○	○	○	○	○	○	○
I am *emotionally moved* by my distressed feelings or situations.	○	○	○	○	○	○	○	○	○	○
I *tolerate* the various feelings that are part of my distress.	○	○	○	○	○	○	○	○	○	○
I *reflect on* and *make sense* of my feelings of distress.	○	○	○	○	○	○	○	○	○	○

I do not tolerate being distressed.	○	○	○	○	○	○	○	○	○	○
I am *accepting, non-critical, and non-judgemental* of my feelings of distress.	○	○	○	○	○	○	○	○	○	○

← →

Lancaster University

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...

	Never 1	2	3	4	5	6	7	8	9	**Always** 10
I direct my *attention* to what is likely to be helpful to me.	○	○	○	○	○	○	○	○	○	○
I *think* about and come up with helpful ways to cope with my distress.	○	○	○	○	○	○	○	○	○	○
I don't know how to help myself.	○	○	○	○	○	○	○	○	○	○
I take the *actions* and do things that will be helpful to me.	○	○	○	○	○	○	○	○	○	○
I create inner feelings of *support, helpfulness and encouragement.*	○	○	○	○	○	○	○	○	○	○

← →

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 compassion. The *first* is the ability 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. 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. You will be asked a series of questions 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 each of the items.

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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...

	Never 1	2	3	4	5	6	7	8	9	Never 10
I am *motivated* to engage and work with other people's distress when it arises.	○	○	○	○	○	○	○	○	○	○
I *notice* and *am sensitive* to distress in others when it arises.	○	○	○	○	○	○	○	○	○	○
I avoid thinking about other people's distress, try to distract myself and put it out of my mind.	○	○	○	○	○	○	○	○	○	○
I am *emotionally moved* by expressions of distress in others.	○	○	○	○	○	○	○	○	○	○
I *tolerate* the various feelings that are part of other people's distress.	○	○	○	○	○	○	○	○	○	○
I *reflect on* and *make sense* of other people's distress.	○	○	○	○	○	○	○	○	○	○

I do not tolerate other people's distress.	○	○	○	○	○	○	○	○	○	○
I am *accepting, non-critical, and non-judgemental* of other people's distress.	○	○	○	○	○	○	○	○	○	○

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

When others are distressed or upset by things...

	Never 1	2	3	4	5	6	7	8	9	**Always** 10
I direct *attention* to what is likely to be helpful to others.	○	○	○	○	○	○	○	○	○	○
I *think about and come up* with helpful ways for them to cope with their distress.	○	○	○	○	○	○	○	○	○	○
I don't know how to help other people when they are distressed.	○	○	○	○	○	○	○	○	○	○
I take the *actions* and *do the things* that will be helpful to others.	○	○	○	○	○	○	○	○	○	○
I express feelings of *support, helpfulness and encouragement* to others.	○	○	○	○	○	○	○	○	○	○

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Appendix F

Debrief sheet (on Qualtrics)

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End of study.

Thank you very much for taking part in this study.

Research shows that mental health helpline volunteers can experience low levels of wellbeing, and little is known as to why. This study aims to explore the impact of compassion on wellbeing in volunteers. Compassions is described as the ability to recognise someone's suffering and doing something to stop the suffering. It is said that compassion has three flows: compassion for ourselves, compassion that we receive from others, and our compassion for others. Research suggests that each flow of compassion can have a positive impact on wellbeing. Results from this study will be analysed to see if there are relationships between volunteers' wellbeing and the three flows of compassion. Recommendations will then be made based on the findings.

If you have any questions or concerns about the study, please don't hesitate to contact the researcher. The contact details are as follows:
Main researcher: Julieanne Briones – j.briones@lancaster.ac.uk
Research supervisor: Dr James Kelly – j.kelly@lancaster.ac.uk

If you feel you would benefit from any support, please find below details of relevant organisations that offer support:

To speak with someone, the Samaritans helpline offer support 24 hours a day, 7 days a week

- Telephone: 116 123
- Email: jo@samaritans.org (Response time: 24 hours)

For mental health information and signposting service, Mind's Infoline is available 9am to 6pm, Monday to Friday (except for bank holidays)

- Telephone: 0300 123 3393
- Email: info@mind.org.uk
- Text: 86463

For practical advice and general help on living with mental illness, Rethink Mental Illness offers an advice and information service 9:30am to 4pm, Monday to Friday.

- Telephone: 0300 5000 927
- Email: advice@rethink.org

We acknowledge that you might be familiar with these services and may be volunteering in one of them. If you feel you need further support please contact your GP and ask for an emergency appointment or contact your local crisis team. If, at any time, you experience suicidal thoughts or thoughts of wanting to harm yourself, please call 999 or attend to A&E.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the research, you can contact:

Professor Bill Sellwood, Research Director

Email: b.sellwood@lancaster.ac.uk

To complete the study please click 'SUBMIT' below. Once you click 'SUBMIT', you will no longer be able to withdraw your data.

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← SUBMIT